NOTICE OF PROPOSED RULEMAKING

On July 1, 2024, the New Mexico Human Services Department (the Department) will become the New Mexico Health Care Authority ("HCA"), pursuant to the passage of S16 during the 2023 NM Legislative Session and signed into law by NM Governor Michelle Lujan Grisham. To bring the New Mexico Administrative Code (NMAC) into full alignment with this change, the Department is proposing to repeal and replace the following rules, pursuant to 1.24.11.9 NMAC, to change the department's name, update wording in two rules to change "aliens" to "non-citizens," and follow current NMAC formatting rules. These are the only substantive proposed changes to these rules, there are no programmatic changes proposed.

The process of repeal and replacement is necessary because 1.24.11.9 NMAC requires that when an agency amends a rule that was not filed in the current style and format, it must reformat the entire part and officially adopt the current style and formatting requirements in conjunction with the amendment. There are no programmatic changes proposed.

Section 9-8-6 NMSA 1978, authorizes the HSD Secretary to promulgate rules and regulations that may be necessary to carry out the duties of the Department and its divisions. Rules to be repealed and replaced are listed at the end of this Notice.

These proposed repeals are available on the HSD website at: https://www.hsd.state.nm.us/lookingforinformation/registers/ and https://www.hsd.state.nm.us/2024-comment-period-open/. If you do not have internet access, a copy of the proposed register and rule may be requested by contacting HSD at (505) 709-8865.

Notice Date: May 7, 2024
Hearing Date: June 7, 2024
Proposed Effective Date: July 1, 2024

A public hearing to receive testimony on these repeals will be held on **June 7, 2024, at 9:00 am** Mountain Time (MT). There are three options for attending the hearing:

1. Attend in person by coming to the large conference room at the Administrative Services Division (ASD), 1474 Rodeo Rd., Santa Fe, NM 87505.

2. Join the Zoom webinar on your computer, mobile app or room device:
   https://us02web.zoom.us/j/88954952376?pwd=cERwNU1JY0xMd21SelZjbHNjcjhaUT09

   Webinar ID 889 5495 2376
   Passcode 757646

3. Or call in (audio only):

   +1-253-205-0468,,88954952376# or +1-253-215-8782,,88954952376#

   Webinar ID 889 5495 2376
   Passcode 757646

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact HSD at (505) 709-8865. The Department requests at least 10 working days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available upon request by providing copies directly to a requestor or by making them available on the Department's website or at a location within the county of the requestor.

Interested persons may address written comments to:

Human Services Department
Office of the Secretary
ATTN: HSD/HCA Rule Change Public Comments
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Recorded comments may be left at (505) 709-8865. Interested persons may also address comments via electronic mail to: Diane.Bilodeau@hsd.nm.gov. Written mail, electronic mail and recorded comments must be received **no later than 5 p.m. MT on June 7, 2024.** Written and recorded comments will be given the same consideration as oral testimony made at the public hearing. All written comments received will be posted as they are received on the HSD website at https://www.hsd.state.nm.us/2024-comment-period-open/. along with the applicable register and rule. The public posting will include the name and any contact information provided by the commenter.

HSD Rules to be Repealed and Replaced

Rule number	Rule name
8.2.2 NMAC	REQUIREMENTS FOR PARTICIPATION IN THE CHILD AND ADULT CARE FOOD PROGRAM
8.2.3 NMAC	REQUIREMENTS FOR PARTICIPATION IN THE SUMMER FOOD SERVICE PROGRAM
8.21.540 NMAC	EMERGENCY ASSISTANCE PROGRAMS, AID TO FAMILIES WITH DEPENDENT CHILDREN – CHILD SAFETY RESTRAINT SEAT PROGRAM
8.50.105 NMAC	INTAKE
8.50.106 NMAC	LOCATION
8.50.107 NMAC	DETERMINATION OF PARENTAGE
8.50.116 NMAC	NATIVE AMERICAN INITIATIVE
8.100.100 NMAC	GENERAL OPERATING PROCEDURES
8.100.110 NMAC	GENERAL OPERATING POLICIES – APPLICATIONS
8.100.120 NMAC	GENERAL OPERATING POLICIES – CASE MANAGEMENT
8.100.130 NMAC	GENERAL OPERATING POLICIES – ELIGIBILITY AND VERIFICATION STANDARDS
8.100.150 NMAC	GENERAL OPERATING POLICIES – RECORD RETENTION/MANAGEMENT
8.100.180 NMAC	GENERAL OPERATING POLICIES – EXTERNAL COMMUNICATIONS
8.100.390 NMAC	GENERAL SUPPORT – INFORMATION SYSTEMS
8.102.110 NMAC	GENERAL OPERATING POLICIES – APPLICATIONS
8.102.120 NMAC	ELIGIBILITY POLICY – CASE ADMINISTRATION
8.102.230 NMAC	GENERAL FINANCIAL – PAYABLES AND DISPERSEMENT
8.102.400 NMAC	RECIPIENT POLICIES – DEFINING THE ASSISTANCE GROUP
8.102.410 NMAC	RECIPIENT POLICIES – GENERAL RECIPIENT REQUIREMENTS
8.102.420 NMAC	RECIPIENT POLICIES – SPECIAL RECIPIENT REQUIREMENTS
8.102.500 NMAC	ELIGIBILITY POLICY – GENERAL INFORMATION
8.102.501 NMAC	TRANSITION BONUS PROGRAM
8.102.510 NMAC	ELIGIBILITY POLICY- RESOURCES/PROPERTY
8.102.520 NMAC	ELIGIBILITY POLICY – INCOME
8.102.610 NMAC	DESCRIPTION OF PROGRAM/BENEFITS – BENEFIT DELIVERY
8.102.611 NMAC	EDUCATION WORKS PROGRAM
8.102.620 NMAC	DESCRIPTION OF PROGRAM BENEFITS – BENEFIT DETERMINATION/GENERAL

8.106.110 NMAC	GENERAL OPERATING POLICIES – APPLICATIONS
8.106.120 NMAC	ELIGIBILITY POLICY – CASE ADMINISTRATION
8.106.230 NMAC	GENERAL FINANCIAL – PAYABLES AND DISBURSEMENT
8.119.110 NMAC	GENERAL OPERATING POLICIES APPLICATIONS
8.119.410 NMAC	RECIPIENT POLICIES – GENERAL RECIPIENT REQUIREMENTS
8.119.500 NMAC	ELIGIBILITY POLICY – GENERAL INFORMATION
8.119.510 NMAC	ELIGIBILITY POLICY – RESOURCES/PROPERTY
8.119.520 NMAC	ELIGIBILITY POLICY – INCOME
8.139.100 NMAC	GENERAL PROVISIONS FOR THE FOOD STAMP PROGRAM
8.139.110 NMAC	GENERAL ADMINISTRATION – APPLICATION PROCESSING
8.139.120 NMAC	CASE ADMINISTRATION – CASE MANAGEMENT
8.139.400 NMAC	RECIPIENT POLICY – WHO CAN BE A RECIPIENT
8.139.420 NMAC	RECIPIENT REQUIREMENTS – SPECIAL HOUSEHOLDS
8.139.500 NMAC	FINANCIAL ELIGIBILITY – NEED DETERMINATION
8.139.510 NMAC	ELIGIBILITY POLICY – RESOURCES AND PROPERTY
8.139.610 NMAC	PROGRAM BENEFITS – ISSUANCE AND RECEIPT
8.139.647 NMAC	FOOD STAMP PROGRAM – ADMINISTRATIVE DISQUALIFICATION PROCEDURES
8.150.100 NMAC	GENERAL PROVISIONS FOR THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
8.150.110 NMAC	APPLICATIONS
8.150.410 NMAC	GENERAL RECIPIENT REQUIREMENTS
8.150.500 NMAC	ELIGIBILITY
8.150.510 NMAC	RESOURCES/PROPERTY
8.150.520 NMAC	INCOME
8.150.600 NMAC	DESCRIPTION OF PROGRAM/BENEFITS
8.150.620 NMAC	BENEFIT DETERMINATION/GENERAL
8.150.624 NMAC	RETROACTIVE BENEFIT COVERAGE
8.200.450 NMAC	REPORTING REQUIREMENTS
8.201.500 NMAC	INCOME AND RESOURCE STANDARDS
8.206.500 NMAC	INCOME AND RESOURCE STANDARDS
8.206.600 NMAC	BENEFIT DESCRIPTION
8.240.400 NMAC	RECIPIENT POLICIES
8.240.500 NMAC	INCOME AND RESOURCE STANDARDS
8.240.600 NMAC	BENEFIT DESCRIPTION
8.245.400 NMAC	RECIPIENT POLICIES
8.245.500 NMAC	INCOME AND RESOURCE STANDARDS
8.248.400 NMAC	RECIPIENT POLICIES
8.248.500 NMAC	INCOME AND RESOURCE STANDARDS
8.248.600 NMAC	BENEFIT DESCRIPTION
8.252.400 NMAC	RECIPIENT POLICIES
8.280.500 NMAC	INCOME AND RESOURCE STANDARDS
8.285.500 NMAC	INCOME AND RESOURCE STANDARDS
8.285.600 NMAC	BENEFIT DESCRIPTION
8.290.500 NMAC	INCOME AND RESOURCE STANDARDS
8.300.1 NMAC	GENERAL PROGRAM DESCRIPTION

8.300.2 NMAC	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) POLICIES
8.300.6 NMAC	RESPONSIBILITY AND DELEGATION OF AUTHORITY
8.300.11 NMAC	CONFIDENTIALITY
8.300.17 NMAC	CONFLICT OF INTEREST
8.300.21 NMAC	MEDICAL ASSISTANCE DIVISION POLICY MANUAL
8.301.5 NMAC	MEDICAL MANAGEMENT
8.301.6 NMAC	CLIENT MEDICAL TRANSPORTATION SERVICES
8.302.1 NMAC	GENERAL PROVIDER POLICIES
8.302.4 NMAC	OUT-OF-STATE AND BORDER AREA PROVIDERS
8.310.4 NMAC	FEDERALLY QUALIFIED HEALTH CENTER SERVICES
8.311.2 NMAC	HOSPITAL SERVICES
8.313.2 NMAC	INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED
8.313.3 NMAC	COST RELATED REIMBURSEMENT OF ICF-MR FACILITIES
8.315.2 NMAC	PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
8.324.10 NMAC	AMBULATORY SURGICAL CENTER SERVICES
8.325.2 NMAC	DIALYSIS SERVICES
8.325.4 NMAC	HOSPICE CARE SERVICES
8.325.9 NMAC	HOME HEALTH SERVICES
8.325.10 NMAC	EMERGENCY MEDICAL SERVICES FOR ALIENS
8.326.2 NMAC	CASE MANAGEMENT SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES
8.349.2 NMAC	APPEALS AND GRIEVANCE PROCESS
7.21.1 NMAC (Renumbered as 8.372.1 NMAC)	GENERAL PROVISIONS
7.21.2 NMAC (Renumbered as 8.372.2 NMAC)	STANDARDS OF DELIVERY FOR BEHAVIORAL HEALTH SERVICES
7.21.3 NMAC (Renumbered as 8.372.3 NMAC)	BEHAVIORAL HEALTH ENTITY CONTRACTING

The Human Services Department will become the Health Care Authority (HCA) effective July 1, 2024. By virtue of the statutory authority and jurisdiction given to the HCA, the Department is repealing an older version of each of the following rules and replacing it with an updated version that changes the department's name, updates its statutory authority, and follows current NMAC formatting rules:

The Human Services Department, which will become the Health Care Authority approved the repeal of 7.21.1 NMAC - Behavioral Health - General Provisions (filed 7/29/2011) and replaced it with 8.372.1 NMAC - Behavioral Health - General Provisions (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority approved the repeal of 7.21.2 NMAC - Standards Of Delivery For Behavioral Health Services (filed 7/29/2011) and replaced it with 8.372.2 NMAC - Standards Of Delivery For Behavioral Health Services (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority approved the repeal of 7.21.3 NMAC - Behavioral Health Entity Contracting (filed 7/29/2011) and replaced it with 8.372.3 NMAC - Behavioral Health Entity Contracting (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority approved the repeal of 8.2.2 NMAC - Requirements For Participation In The Child And Adult Care Food Program (filed 5/28/2009) and replaced it with 8.2.2 NMAC - Requirements For Participation In The Child And Adult Care Food Program (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.2.3 NMAC - Requirements For Participation In The Summer Food Service Program (filed 11/16/2001) and replaced it with 8.2.3 NMAC - Requirements For Participation In The Summer Food Service Program (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.21.540 NMAC - Emergency Assistance Programs, Aid To Families With Dependent Children - Child Safety Restraint Seat Program (filed 9/15/1995) and replaced it with 8.21.540 NMAC - Emergency Assistance Programs, Aid To Families With Dependent Children - Child Safety Restraint Seat Program (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.50.105 NMAC - Intake (filed 12/13/2010) and replaced it with 8.50.105 NMAC - Intake (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.50.106 NMAC - Location (filed 12/13/2010) and replaced it with 8.50.106 NMAC - Location (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.50.107 NMAC - Determination Of Parentage (filed 12/30/2009) and replaced it with 8.50.107 NMAC - Determination Of Parentage (adopted on 6/xx/2024) effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.50.116 NMAC - Native American Initiative (filed 5/14/2001) and replaced it with 8.50.116 NMAC - Native American Initiative (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.100 NMAC - General Operating Procedures (filed 3/26/2001) and replaced it with 8.100.100 NMAC - General Operating Procedures (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.110 NMAC - General Operating Policies - Applications(filed 3/26/2001) and replaced it with 8.100.110 NMAC - General Operating Policies - Applications (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.120 NMAC - General Operating Policies - Case Management - Applications(filed 3/26/2001) and replaced it with 8.100.120 NMAC - General Operating Policies - Case Management - Applications (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.130 NMAC - General Operating Policies - Eligibility And Verification Standards (filed 7/17/2008) and replaced it with 8.100.130 NMAC - General Operating Policies - Eligibility And Verification Standards (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.150 NMAC - General Operating Policies - Record Retention/Management (filed 3/26/2001) and replaced it with 8.100.150 NMAC - General Operating Policies - Record Retention/Management (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.180 NMAC - General Operating Policies - External Communications (filed 3/26/2001) and replaced it with 8.100.180 NMAC - General Operating Policies - External Communications (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.100.390 NMAC - General Support - Information Systems (filed 3/26/2001) and replaced it with 8.100.390 NMAC - General Support - Information Systems (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.110 NMAC - General Operating Policies - Applications (filed 6/18/2001) and replaced it with 8.102.110 NMAC - General Operating Policies - Applications (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.120 NMAC - Eligibility Policy - Case Administration (filed 6/18/2001) and replaced it with 8.102.120 NMAC - Eligibility Policy - Case Administration (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.230 NMAC - General Financial - Payables And Dispersement (filed 6/18/2001) and replaced it with 8.102.230 NMAC - General Financial - Payables And Dispersement (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.400 NMAC - Recipient Policies - Defining The Assistance Group (filed 6/18/2001) and replaced it with 8.102.400 NMAC - Recipient Policies - Defining The Assistance Group (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.410 NMAC - Recipient Policies - General Recipient Requirements (filed 6/18/2001) and replaced it with 8.102.410 NMAC - Recipient Policies - General Recipient Requirements (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.420 NMAC - Recipient Policies - Special Recipient Requirements (filed 6/18/2001) and replaced it with 8.102.420 NMAC - Recipient Policies - Special Recipient Requirements (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.500 NMAC - Eligibility Policy - General Information (filed 6/18/2001) and replaced it with 8.102.500 NMAC - Eligibility Policy - General Information (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.501 NMAC - Transition Bonus Program (filed 6/2/2008) and replaced it with 8.102.501 NMAC - Transition Bonus Program (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.510 NMAC - Eligibility Policy - Resources/Property (filed 6/18/2001) and replaced it with 8.102.510 NMAC - Eligibility Policy - Resources/Property (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.520 NMAC - Eligibility Policy - Income (filed 6/18/2001) and replaced it with 8.102.520 NMAC - Eligibility Policy - Income (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.610 NMAC - Description Of Program/Benefits - Benefit Delivery (filed 6/18/2001) and replaced it with 8.102.610 NMAC - Description Of Program/Benefits - Benefit Delivery (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.611 NMAC - Education Works Program (filed 11/30/2005) and replaced it with 8.102.611 NMAC - Education Works Program (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.102.620 NMAC - Description Of Program Benefits - Benefit Determination/General (filed 6/18/2001) and replaced it with 8.102.620 NMAC - Description Of Program Benefits - Benefit Determination/General (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.106.110 NMAC - General Operating Policies - Applications (filed 6/17/2004) and replaced it with 8.106.110 NMAC - General Operating Policies - Applications (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.106.120 NMAC - Eligibility Policy - Case Administration (filed 11/17/2009) and replaced it with 8.106.120 NMAC - Eligibility Policy - Case Administration (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.106.230 NMAC - General Financial - Payables And Disbursement (filed 11/17/2009) and replaced it with 8.106.230 NMAC - General Financial - Payables And Disbursement (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.119.110 NMAC - General Operating Policies Applications (filed 3/6/2001) and replaced it with 8.119.110 NMAC - General Operating Policies Applications (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.119.410 NMAC - Recipient Policies -General Recipient Requirements (filed 3/2/2001) and replaced it with 8.119.410 NMAC - Recipient Policies -General Recipient Requirements (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.119.500 NMAC - Eligibility Policy-General Information (filed 3/2/2001) and replaced it with 8.119.500 NMAC - Eligibility Policy-General Information (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.119.510 NMAC - Eligibility Policy-Resources/Property (filed 3/2/2001) and replaced it with 8.119.510 NMAC - Eligibility Policy-Resources/Property (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.119.520 NMAC - Eligibility Policy-Income (filed 3/2/2001) and replaced it with 8.119.520 NMAC - Eligibility Policy-Income (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.139.100 NMAC - General Provisions For The Food Stamp Program (filed 10/12/2023) and replaced it with 8.139.100 NMAC - General Provisions For The Food Stamp Program (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.139.110 NMAC - General Administration - Application Processing (filed 4/26/2001) and replaced it with 8.139.110 NMAC - General Administration - Application Processing (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.139.120 NMAC - Case Administration - Case Management (filed 4/26/2001) and replaced it with 8.139.120 NMAC - Case Administration - Case Management (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.139.400 NMAC - Recipient Policy - Who Can Be A Recipient (filed 4/26/2001) and replaced it with 8.139.400 NMAC - Recipient Policy - Who Can Be A Recipient (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.139.420 NMAC - Recipient Requirements - Special Households (filed 4/26/2001) and replaced it with 8.139.420 NMAC - Recipient Requirements - Special Households (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.139.500 NMAC - Financial Eligibility - Need Determination (filed 4/26/2001) and replaced it with 8.139.500 NMAC - Financial Eligibility - Need Determination (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.139.510 NMAC - Eligibility Policy - Resources And Property (filed 4/26/2001) and replaced it with 8.139.510 NMAC - Eligibility Policy - Resources And Property (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.139.610 NMAC - Program Benefits - Issuance And Receipt (filed 4/26/2001) and replaced it with 8.139.610 NMAC - Program Benefits - Issuance And Receipt (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.139.647 NMAC - Food Stamp Program - Administrative Disqualification Procedures (filed 4/26/2001) and replaced it with 8.139.647 NMAC - Food Stamp Program - Administrative Disqualification Procedures (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.100 NMAC - General Provisions For The Low Income Home Energy Assistance Program (filed 9/17/2000) and replaced it with 8.150.100 NMAC - General Provisions For The Low Income Home Energy Assistance Program (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.110 NMAC - Applications (filed 9/17/2001) and replaced it with 8.150.110 NMAC - Applications (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.410 NMAC - General Recipient Requirements (filed 9/17/2001) and replaced it with 8.150.410 NMAC - General Recipient Requirements (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.500 NMAC - Eligibility (filed 9/17/2001) and replaced it with 8.150.500 NMAC - Eligibility (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.510 NMAC - Resources/Property (filed 9/17/2001) and replaced it with 8.150.510 NMAC - Resources/Property (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.520 NMAC - Income (filed 9/17/2001) and replaced it with 8.150.520 NMAC - Income (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.600 NMAC - Description Of Program/Benefits (filed 9/17/2001) and replaced it with 8.150.600 NMAC - Description Of Program/Benefits (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, which will become the Health Care Authority, approved the repeal of 8.150.620 NMAC - Benefit Determination General (filed 9/17/2001) and replaced it with 8.150.620 NMAC - Benefit Determination General (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.150.624 NMAC - Retroactive Benefit Coverage (filed 9/17/2001) and replaced it with 8.150.624 NMAC - Retroactive Benefit Coverage (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.200.450 NMAC - Reporting Requirements (filed 12/18/2000) and replaced it with 8.200.450 NMAC - Reporting Requirements (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.201.500 NMAC - Income And Resource Standards (filed 9/2/2009) and replaced it with 8.201.500 NMAC - Income And Resource Standards (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.206.500 NMAC - Income And Resource Standards (filed 12/15/2001) and replaced it with 8.206.500 NMAC - Income And Resource Standards (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.206.600 NMAC - Benefit Description (filed 9/13/2013) and replaced it with 8.206.600 NMAC - Benefit Description (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.240.400 NMAC - Recipient Policies (filed 6/13/2003) and replaced it with 8.240.400 NMAC - Recipient Policies adopted on 6/xx/2024, effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.240.500 NMAC - Income And Resource Standards (filed 6/25/2010) and replaced it with 8.240.500 NMAC - Income And Resource Standards adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.240.600 NMAC - Benefit Description (filed 9/3/2013) and replaced it with 8.240.600 NMAC - Benefit Description adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.245.400 NMAC - Recipient Policies (filed 11/16/2009) and replaced it with 8.245.400 NMAC - Recipient Policies adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.245.500 NMAC - Income And Resource Standards (filed 11/16/2009) and replaced it with .245.500 NMAC - Income And Resource Standards adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.248.400 NMAC - Recipient Policies (filed 1/13/2006) and replaced it with 8.248.400 NMAC - Recipient Policies (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.248.500 NMAC - Income And Resource Standards (filed 1/13/2006) and replaced it with 8.248.500 NMAC - Income And Resource Standards (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.248.600 NMAC - Benefit Description (filed 1/13/2006) and replaced it with 8.248.600 NMAC - Benefit Description adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.252.400 NMAC - Recipient Policies (filed 6/14/2002) and replaced it with 8.252.400 NMAC - Recipient Policies NMAC adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.280.500 NMAC - Income And Resource Standards (filed 11/15/2006) and replaced it with 8.280.500 NMAC - Income And Resource Standards adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.285.500 NMAC - Income And Resource Standards (filed 11/17/2008) and replaced it with 8.285.500 NMAC - Income And Resource Standards adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.285.600 NMAC - Benefit Description (filed 11/17/2008) and replaced it with 8.285.600 NMAC - Benefit Description adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.290.500 NMAC - Income And Resource Standards (filed 4/16/2002) and replaced it with 8.290.500 NMAC - Income And Resource Standards adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.300.1 NMAC - General Program Description (filed 4/16/2004) and replaced it with 8.300.1 NMAC - General Program Description adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.300.2 NMAC - Health Insurance Portability And Accountability Act Of 1996 (Hipaa) Policies (filed 6/16/2003) and replaced it with 8.300.2 NMAC - Health Insurance Portability And Accountability Act Of 1996 (Hipaa) Policies adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.300.6 NMAC - Responsibility And Delegation Of Authority (filed 3/25/2009) and replaced it with 8.300.6 NMAC - Responsibility And Delegation Of Authority adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.300.11 NMAC - Conflict of Interest (filed 6/16/2003) and replaced it with 8.300.11 NMAC - Conflict of Interest (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.300.17 NMAC - Conflict Of Interest (filed 6/16/2003) and replaced it with 8.300.17 NMAC - Conflict Of Interest adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.300.21 NMAC - Medical Assistance Division Policy Manual (filed 3/25/2009) and replaced it with 8.300.21 NMAC - Medical Assistance Division Policy Manual adopted on 6/xx/2024 and effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.301.5 NMAC - Medical Management (filed 6/14/2001) and replaced it with 8.301.5 NMAC - Medical Management (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.301.6 NMAC - Client Medical Transportation Services (filed 2/14/2011) and replaced it with 8.301.6 NMAC - Client Medical Transportation Services (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.302.1 NMAC - General Provider Policies (filed 12/9/2022) and replaced it with 8.302.1 NMAC - General Provider Policies (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.302.4 NMAC - Out-Of-State And Border Area Providers (filed 7/24/2008) and replaced it with 8.302.4 NMAC - Out-Of-State And Border Area Providers (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.310.4 NMAC - Federally Qualified Health Center Services (filed 10/12/2004) and replaced it with 8.310.4 NMAC - Federally Qualified Health Center Services (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.311.2 NMAC - Hospital Services (filed 12/24/2008) and replaced it with 8.311.2 NMAC - Hospital Services (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.313.2 NMAC - Intermediate Care Facilities For The Mentally Retarded (filed 10/17/2000) and replaced it with 8.313.2 NMAC - Intermediate Care Facilities For The Mentally Retarded (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.313.3 NMAC - Cost Related Reimbursement Of Icf-Mr Facilities (filed 10/18/2000) and replaced it with 8.313.3 NMAC - Cost Related Reimbursement Of Icf-Mr Facilities (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.315.2 NMAC - Program Of All-Inclusive Care For The Elderly (Pace) (filed 11/15/2006) and replaced it with 8.315.2 NMAC - Program Of All-Inclusive Care For The Elderly (Pace) (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.324.10 NMAC - Ambulatory Surgical Center Services (filed 10/12/2004) and replaced it with 8.324.10 NMAC - Ambulatory Surgical Center Services (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.325.2 NMAC - Dialysis Services (filed 10/15/2004) and replaced it with 8.325.2 NMAC - Dialysis Services (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.325.4 NMAC - Hospice Care Services (filed 2/13/2006) and replaced it with 8.325.4 NMAC - Hospice Care Services (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.325.9 NMAC - Home Health Services (filed 1/18/1995) and replaced it with 8.325.9 NMAC - Home Health Services (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.325.10 NMAC - Emergency Medical Services For Non-Citizens (filed (11/14/2003) and replaced it with 8.325.10 NMAC - Emergency Medical Services For Non-Citizens (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.326.2 NMAC - Case Management Services For Adults With Developmental Disabilities (filed 1/18/1995) and replaced it

with 8.326.2 NMAC - Case Management Services For Adults With Developmental Disabilities (adopted on 6/xx/2024), effective 7/1/2024.

The Human Services Department, which will become the Health Care Authority, approved the repeal of 8.349.2 NMAC - Appeals And Grievance Process (filed 2/13/2006) and replaced it with 8.349.2 NMAC - Appeals And Grievance Process (adopted on 6/xx/2024), effective 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 21 TRANSPORTATION ASSISTANCE AND SUPPORT
PART 540 EMERGENCY ASSISTANCE PROGRAMS, AID TO FAMILIES WITH DEPENDENT CHILDREN - CHILD SAFETY RESTRAINT SEAT PROGRAM

8.21.540.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA), Income Support Division, Financial Assistance Bureau (505) 827-6257.
[8.21.540.1 NMAC - Rp 8.21.540.1, 7/1/24]

8.21.540.2 SCOPE: The rule applies to the general public.
[8.21.540.2 NMAC - Rp 8.21.540.2, 7/1/24]

8.21.540.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Article 1 and 2 authorize the state to administer the Aid to Families with Dependent Children Program. Title IV of the Social Security Act and the rules and regulations of the federal department of health, education and welfare, carried under Title 45, Code of Federal Regulations, established the requirements for state plans for assistance to families with dependent children.

A. Section 9-8-1 et seq. NMSA 1978 establishes the Health Care Authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.21.540.3 NMAC - Rp 8.21.540.3 NMAC, 7/1/24]

8.21.540.4 DURATION: Permanent.
[8.21.540.4 NMAC - Rp 8.21.540.4 NMAC, 7/1/24]

8.21.540.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.21.540.5 NMAC - Rp 8.21.540.5 NMAC, 7/1/24]

8.21.540.6 OBJECTIVE: The objective of the AFDC - Emergency Assistance Child Safety Restraint Seat Program is to assist needy children and their families by providing newborn children with child safety restraint seats. The seats as well as training on their use will be provided to families with a newborn child upon their release from a hospital. The program is a joint effort between HCA and the department of health (DOH) as DOH is responsible for assuring the health and safety of New Mexico residents. In such capacity, DOH has agreed to obtain and distribute child safety restraint seats for the purpose of the EACSRS program.
[8.21.540.6 NMAC - Rp 8.21.540.6, 7/1/24]

8.21.540.7 DEFINITIONS: RESERVED]
[8.21.540.7 NMAC - Rp 8.21.540.7 NMAC, 7/1/24]

8.21.540.8 ELIGIBILITY REQUIREMENTS: Eligibility is based upon four requirements: destitution, emergency situation, compliance with project forward components and birth.

A. Destitution: To be eligible to receive AFDC - Emergency Assistance Child Safety Restraint Seat Program benefits, an applicant's respective family is required to receive AFDC and provide documentation of such. Consequently, in order to receive a child safety restraint seat and the associated training, applicant families will be required to present proof of AFDC benefits, preferably by presenting their medicaid card.

B. Emergency situation: To be eligible to receive AFDC - Emergency Assistance Child Safety Restraint Seat Program benefits, applicants are required to be in an emergency situation. Consequently, an emergency situation needs to be designated by respective hospital personnel.

C. Compliance with project forward components: To be eligible to receive AFDC - Emergency Assistance Child Safety Restraint Seat Program benefits, applicant's respective families must have complied with project forward components. The emergency condition must not have arisen because an adult family member refused to accept employment or training for employment.

D. Birth requirements: To be eligible to receive AFDC - Emergency Assistance Child Safety Restraint Seat Program benefits, applicant's respective families must have recently given birth. Applicants must receive benefits upon their first release from the hospital.
[8.21.540.8 NMAC - Rp 8.21.540.8 NMAC, 7/1/24]

HISTORY OF 8.21.540 NMAC: [**RESERVED**]

History of Repealed Material:
8.21.540 NMAC, filed 10/1/1995 - Repealed effective 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 105 INTAKE

8.50.105.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Enforcement Division.
[8.50.105.1 NMAC – Rp 8.50.105.1 7/1/24]

8.50.105.2 SCOPE: To the general public. For use by the IV-D agency and recipients of IV-D services.
[8.50.105.2 NMAC – Rp 8.50.105.2 7/1/24]

8.50.105.3 STATUTORY AUTHORITY: Public Assistance Act, NMSA 1978, Section 27-2-27. The health care authority is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the Health Care Authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.105.3 NMAC – Rp 8.50.105.3 7/1/24]

8.50.105.4 DURATION: Permanent.
[8.50.105.4 NMAC – Rp 8.50.105.4 7/1/24]

8.50.105.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.50.105.5 NMAC – Rp 8.50.105.5 7/1/24]

8.50.105.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.105.6 NMAC – Rp 8.50.105.6 7/1/24]

8.50.105.7 DEFINITIONS: [RESERVED]
[8.50.105.7 NMAC – Rp 8.50.105.7 7/1/24]

8.50.105.8 PROVISION OF SERVICES: The IV-D agency shall provide services to anyone who has filed a proper application for services.

A. Services to residents and non-residents: Services will be made available to residents of other states on the same terms as to residents of the state of New Mexico. The IV-D agency shall not be required to provide services when neither party resides in the state of New Mexico and the state is not actively seeking reimbursement of public assistance paid. There is no citizenship requirement as a pre-condition for Title IV-D services.

B. Provision of services for recipients of other benefit programs: Federal regulations also require the IV-D agency to provide services equally to intrastate and interstate cases, including IV-D, IV-E, medicaid only, and non-IV-A cases. Information detailing the services offered by the IV-D agency, the responsibilities of the custodial party, the IV-D agency's fee schedule, and requirements to cooperate must be provided to all recipients of IV-A and medicaid benefits within five (5) days of referral to the IV-D agency. The IV-A agency provides this information to all applicants/recipients of IV-A and medicaid benefits when the IV-A case is opened.

C. Provision of services when all dependants are emancipated:

(1) Intrastate cases: The IV-D agency will not accept an application or re-open a closed case for the establishment or enforcement of a support order when all dependants are emancipated. The existence of a public assistance benefit history does not obligate the IV-D agency to pursue or re-open a case when the dependants are emancipated.

(2) Interstate cases: The IV-D agency will not establish paternity or an order of support after all dependants are emancipated. The IV-D agency will, however, enforce an existing order of support when all dependants are emancipated in accordance with NMSA 1978, Section 40-6A-101 et seq.
[8.50.105.8 NMAC - Rp, 8.50.105.8 7/1/24]

8.50.105.9 NON-PUBLIC ASSISTANCE APPLICATIONS: The IV-D agency shall make applications for child support services readily accessible to the public. When an individual requests an application for IV-D services, the application shall be provided on the day the individual makes the request in person. The application shall be sent within no more than five (5) working days of a written or telephone request. An application is

considered to be filed on the day it is received by the IV-D agency. The IV-D agency shall not accept applications from individuals seeking to pursue claims of parentage or support against their biological or adoptive parents.
[8.50.105.9 NMAC – Rp 8.50.105.9 7/1/24]

8.50.105.10 PROCESSING REFERRALS AND APPLICATIONS: For all cases appropriately referred and for all applications, federal regulations mandate that within twenty (20) calendar days of receipt of an appropriate referral or application submitted to the IV-D agency, the IV-D staff opens a case by establishing a case record. Based on an assessment of the case to determine necessary action, within the same twenty (20) calendar days the IV-D agency must:

A. solicit necessary and relevant information from the custodial party and other relevant sources;

B. initiate verification of information, which may include interviewing the custodial party to determine the next action on the case; and

C. if there is inadequate information to proceed, a request for additional information must be made or the case referred for parent location services.
[8.50.105.10 NMAC – Rp 8.50.105.10 7/1/24]

8.50.105.11 GENERAL REQUIREMENTS FOR APPLICANTS AND RECIPIENTS OF IV-D BENEFITS:

A. Title IV-D applicants and recipients: The state IV-D agency will provide services relating to the establishment of paternity or the establishment, modification, or enforcement of support obligations for a child, as appropriate, under the plan with respect to each child for whom:

(1) assistance is provided under the state program funded under Title IV-A of the Social Security Act;

(2) benefits or services for foster care maintenance are provided under the state program funded under Title IV-E of the Social Security Act;

(3) medical assistance is provided under the state plan approved under Title XIX of the Social Security Act and an assignment of support rights is indicated;

(4) any other child, if an individual, who is either a biological parent, adoptive parent, or a legal custodian of the child, applies for such services with respect to the child.

B. Title IV-A, IV-E foster care, and medicaid only recipients: Appropriate recipients of Title IV-A, IV-E foster care, and medicaid only (where an assignment of rights is indicated and cooperation is required) are referred to the IV-D program and are eligible for all IV-D services. When a family needs support from a non-custodial parent and is approved for IV-A, IV-E foster care, non-IV-E medicaid, or medicaid benefits, a referral is made to the IV-D regional office. The medicaid only recipient, who has assigned support rights and whose cooperation is required, must receive medical support services but can decline receipt of all other IV-D services. In addition, post-IV-A recipients will continue to receive IV-D services until they inform the division that they no longer desire these services.

C. Non-IV-A applicants: Non-IV-A families can apply for program services through the completion of a non-IV-A application for services.

D. Non-resident applicant: A non-resident applicant who applies for services through the IV-D agency in his/her state of residence is eligible for assistance from the New Mexico IV-D program under applicable laws, so long as the other party resides in the state of New Mexico.

E. Non-custodial parent applicant: The non-custodial parent can apply for program services for the purpose of establishing paternity, child support, medical support, making support payments, or to request a review of an existing child support court order. Any other person or entity who has standing to request an adjustment to the child support order may apply for services.
[8.50.105.11 NMAC – Rp 8.50.105.11 7/1/24]

8.50.105.12 SUPPORT ASSIGNMENT AND COOPERATION REQUIREMENTS:

A. Cooperation with the IV-D agency is required of all recipients of IV-D services regardless of public assistance benefit status. The IV-D agency pursues sanction and disqualification of recipients of services, as appropriate, and may close any IV-D case for a failure to cooperate. Cooperation includes, but is not limited to:

(1) providing all information regarding the identity and location of the absent parent (including the names of other persons who may have information regarding the identity or location of the absent parent);

(2) appearing for scheduled appointments;

(3) reviewing and signing forms and court documents;

(4) providing documentation relevant to the claim for an award of support;

(5) appearing at court or administrative hearings, as required;

(6) immediately notifying the IV-D agency if the dependant(s) is no longer in the care or custody of the custodial party;

(7) reporting all direct payments made to the custodial party prior to and during the provision of services by the IV-D agency;

(8) immediately notifying the IV-D agency if the dependant(s) is involved in adoption proceedings;

(9) keeping the IV-D agency informed of changes in contact information; and

(10) providing all requested information to the IV-D agency in a timely manner.

B. If there is an assignment of support rights pursuant to NMSA 1978, Section 27-2-28, the IV-D agency will request a sanction or disqualification of a member of a public assistance benefit group for noncompliance with IV-D agency cooperation requirements. The IV-D agency will notify the appropriate agency of compliance if the custodial party resolves the issue of noncompliance with the IV-D agency.

(1) IV-A public assistance benefits - referrals for sanctions or disqualifications are sent to and handled by the IV-A agency.

(2) Title XIX medicaid - if there is an assignment of support rights and cooperation is mandated, the IV-D agency will request disqualification of the member that is not cooperating with the IV-D agency. The disqualification status continues until the member cooperates with the IV-D agency.

[8.50.105.12 NMAC – Rp 8.50.105.12 7/1/24]

8.50.105.13 BENEFITS OF COOPERATION: The establishment of a child's paternity may give the child rights to future social security, veteran's or other government benefits as well as inheritance rights should the non-custodial parent become disabled or deceased. The amount established for child support (with medical support) under child support award guidelines can help provide financially for the child. Medical support in the form of private health insurance can help provide for the medical needs of the child. Pursuant to federal law, the State IV-D agency is required to make determinations related to custodial party cooperation in locating absent and alleged parents, establishing parentage, and establishing and enforcing support obligations in Title IV-A cases.

[8.50.105.13 NMAC – Rp 8.50.105.13 7/1/24]

8.50.105.14 GOOD CAUSE FOR REFUSAL TO COOPERATE: In some cases it may be determined by the IV-D agency that the IV-A or medicaid applicant recipient's refusal to cooperate is with good cause.

A. Good cause may be claimed when the applicant's/recipient's cooperation in establishing paternity, securing child or medical support or pursuing liability for medical services is reasonably anticipated to result in the following:

(1) physical or emotional harm to the child for whom support is to be sought;

(2) physical or emotional harm to the caretaker/parent with whom the child is living that reduces the capacity to care for the child adequately.

B. Good cause may also be claimed when at least one of the following circumstances exist and the IV-D worker believes that proceeding to establish paternity, secure child or medical support or pursuing liability for medical services would be detrimental to the child for whom assistance is sought:

(1) the child was conceived as a result of incest or rape; or

(2) legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or

(3) the applicant/recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three (3) months.

C. Any person requesting a good cause exemption to a public assistance benefit requirement to cooperate, must fill out a request for a good cause exemption on a form provided by the IV-D agency and provide any documentation requested by the IV-D agency. The request for a good cause exemption will be reviewed by the IV-D agency and the requestor will be informed of the decision in writing. The requestor's failure to complete the form or provide the requested documentation will result in an automatic denial of the request.

[8.50.105.14 NMAC – Rp 8.50.105.14 7/1/24]

8.50.105.15 DOMESTIC VIOLENCE AND CHILD ABUSE: The IV-D agency ensures that no information is released that may result in harm to any person related to a case. Reasonable evidence of domestic violence or child abuse is defined as the existence of a protective order or an affidavit completed by the requesting person that indicates there is reasonable evidence that physical or emotional harm will occur if personal and locate information is released in the administration of the case. If there is an order for unsupervised visitation, the requestor must also demonstrate through documentation that to limit the release of information by presenting a copy of a protective order to the Title IV-D agency. The IV-D agency, however, cannot protect the name of a person(s). A custodial party or a non-custodial party using a substitute address pursuant to NMSA 1978, Section 40-13-11 must inform the Title IV-D agency of his or her current address when he or she is no longer participating in or has been denied the use of the substitute address through the New Mexico secretary of state's office.
[8.50.105.15 NMAC – Rp 8.50.105.15 7/1/24]

History of 8.50.105 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.
ISD CSEB 518.0000, Establishing The CSEB Case Record, 6/23/1980.
ISD CSEB 522.0000, Non-AFDC Forms, 6/23/1980.
ISD CSEB 522.0000, Non-AFDC Forms, 1/20/1981.
ISD CSEB 519.0000, Cooperation In Obtaining Support, 6/23/1980.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.
8.50.105 NMAC, Intake, filed 5/14/2001 - Repealed effective 12/30/2010.
8.50.105.1 NMAC, Intake, filed 12/30/2010 – Repealed effective 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 106 LOCATION

8.50.106.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Enforcement Division.
[8.50.106.1 NMAC – Rp 8.50.106.1, 7/1/2024]

8.50.106.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.
[8.50.106.2 NMAC – Rp 8.50.106.2, 7/1/2024]

8.50.106.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the Health Care Authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.106.3 NMAC – Rp 8.50.106.3, 7/1/2024]

8.50.106.4 DURATION: Permanent.
[8.50.106.4 NMAC – Rp 8.50.106.4, 7/1/2024]

8.50.106.5 EFFECTIVE DATE: December 30, 2010, unless a later date is cited at the end of a section.
[8.50.106.5 NMAC – Rp 8.50.106.5, 7/1/2024]

8.50.106.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.106.6 NMAC – Rp 8.50.106.6, 7/1/2024]

8.50.106.7 DEFINITIONS: [RESERVED]
[8.50.106.7 NMAC – Rp 8.50.106.7, 7/1/2024]

8.50.106.8 LOCATION OF NON-CUSTODIAL PARENTS: The state is required to use appropriate federal, interstate, and local location sources and to use appropriate state agencies and departments as authorized by state law in locating the non-custodial parent, his or her employer, and all sources of income and assets.
[8.50.106.8 NMAC – Rp 8.50.106.8, 7/1/2024]

8.50.106.9 TIME FRAMES FOR PARENT LOCATE: Federal regulations require that within 75 calendar days of determining that location is necessary, the Title IV-D agency will access all appropriate location sources.
[8.50.106.9 NMAC – Rp 8.50.106.9, 7/1/2024]

8.50.106.10 VERIFICATION OF LOCATION: Location information must be verified prior to service of process. Federal regulations require that the Title IV-D case record contain documentation of the date, time, and name of each location source, even when the source failed to provide helpful information.

A. Location sources will be verified by a second source verification when necessary.

B. The following location sources are acceptable forms of location verification for single source verification:

(1) employer letter;

(2) driver's license or vehicle registration with a date of issuance which is 90 days or less;

(3) federal, state and local agencies and departments sources; and

(4) personal knowledge as to the non-custodial parent's whereabout where the person is willing to testify to that fact.

[8.50.106.10 NMAC – Rp 8.50.106.10, 7/1/2024]

8.50.106.11 THE STATE PARENT LOCATOR SERVICE: The New Mexico Title IV-D agency established a state parent locator service (SPLS) that operates out of the agency's central office. The state parent locator service is authorized to submit location information requests to the federal parent locator service. If all

attempts to locate a non-custodial parent fail at the local office level, these cases may be referred to the state parent locator service provided that at least the non-custodial parent's full name and either an approximate date of birth or social security number are known.
[8.50.106.11 NMAC – Rp 8.50.106.11, 7/1/2024]

8.50.106.12 FEDERAL PARENT LOCATOR SERVICE (FPLS): The Title IV-D agency may utilize the FPLS in accordance with 42 USC 653 and 45 CFR § 303.70. All information obtained is subject to federal and state laws regarding confidentiality of information. Neither parties nor their respective private legal representative may apply directly to the SPLS for FPLS information in parental kidnapping and child custody cases. Parties or their respective legal representative may, however, petition a state district court to request location information from the FPLS concerning the absconding parent and missing child. A party can request appropriate state officials who are authorized persons to make a locate request. A state district court may request FPLS information in connection with a child custody determination in adoption and parental rights determination cases.
[8.50.106.12 NMAC – Rp 8.50.106.12, 7/1/2024]

8.50.106.13 DECEASED PARTIES: If a party or dependent is reported as deceased, the death must be verified. Verification may consist of written verification from the vital statistics bureau, office of the medical investigator or from any other accepted official source.
[8.50.106.13 NMAC – Rp 8.50.106.13, 7/1/2024]

8.50.106.14 STATE CASE REGISTRY: The Title IV-D agency established a state case registry that contains records with respect to:

A. each case in which services are being provided on or after October 1, 1998 by the state Title IV-D agency; and

B. each support order established or modified in the state on or after October 1, 1998, whether or not the order was obtained by the Title IV-D agency. (Section 27-1-8 et seq., NMSA 1978).

[8.50.106.14 NMAC – Rp 8.50.106.14, 7/1/2024]

8.50.106.15 LOCATOR INFORMATION FROM INTERSTATE NETWORKS: The state Title IV-D agency is authorized to have access to any system used by the state to locate an individual for purposes relating to motor vehicle or law enforcement.
[8.50.106.15 NMAC – Rp 8.50.106.15, 7/1/2024]

8.50.106.16 STATE DIRECTORY OF NEW HIRES: The authority established a state directory of new hires pursuant to the State Directory of New Hires Act ("Act"), Section 50-13-1 et seq., NMSA 1978. The authority may, at its discretion, contract this service, as appropriate. All information required by the act may be provided to a contractor designated by the authority.
[8.50.106.16 NMAC – Rp 8.50.106.16, 7/1/2024]

History of 8.50.106 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, 6/23/1980.
ISD CSEB 531.0000, Location Efforts at the Local Level, 6/23/1980.
ISD CSEB 539.0000, Use of the Federal Parent Locator Service (FPLS) in Parental Kidnapping and Child Custody Cases, 2/15/1983.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12/30/1994.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.
8.50.106 NMAC, Location, filed 5/14/2001 - Repealed effective 12/30/2010.
8.50.106 NMAC, Location, filed 12/30/2010 - Repealed effective 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 107 DETERMINATION OF PARENTAGE

8.50.107.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Enforcement Division
[8.50.107.1 NMAC – Rp 8.50.107.1, 7/1/2024]

8.50.107.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of Title IV-D services.
[8.50.107.2 NMAC – Rp 8.50.107.2, 7/1/2024]

8.50.107.3 STATUTORY AUTHORITY: Public Assistance Act, Section 27-2-27 et seq., NMSA 1978. The health care authority is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the Health Care Authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.107.3 NMAC – Rp 8.50.107.3, 7/1/2024]

8.50.107.4 DURATION: Permanent.
[8.50.107.4 NMAC – Rp 8.50.107.4, 7/1/2024]

8.50.107.5 EFFECTIVE DATE: January 1, 2010, unless a later date is cited at the end of a section.
[8.50.107.5 NMAC – Rp 8.50.107.5, 7/1/2024]

8.50.107.6 OBJECTIVE: To provide regulations in accordance with federal and state law and regulations.
[8.50.107.6 NMAC – Rp 8.50.107.6, 7/1/2024]

8.50.107.7 DEFINITIONS: [RESERVED]
[8.50.107.7 NMAC – Rp 8.50.107.7, 7/1/2024]

8.50.107.8 DETERMINATION OF PARENTAGE: A determination of parentage is necessary for the establishment of child support. The Title IV-D agency extends full faith and credit to a determination of parentage made by another jurisdiction, whether established through voluntary acknowledgment or through administrative or judicial process. Alleged fathers may initiate parentage actions through the Title IV-D agency. The Title IV-D agency may petition a court of competent jurisdiction to establish parentage so long as the dependent child is still under the age of majority.

A. Federal time-frames and requirements for establishment of parentage. The IV-D agency shall establish an order for support or complete service of process necessary to commence proceedings to establish a support order and, if necessary, parentage (or document unsuccessful attempts to serve process) within 90 calendar days of locating the alleged father or non-custodial parent. (45 CFR Section 303.4(d)).

B. The Title IV-D agency is not required to establish parentage or pursue genetic testing in any case involving incest or rape, or in any case in which legal proceedings for adoption are pending, or if, in the opinion of the IV-D agency, it would not be in the best interests of the child.

C. The Title IV-D agency may identify and use laboratories that perform, at reasonable cost, legally and medically acceptable genetic tests that tend to identify the biological parent or exclude the alleged biological parent. The IV-D agency may make available a list of such laboratories to appropriate courts and law enforcement officials, and to the public upon request.

D. The Title IV-D agency may seek entry of a default order by the court or administrative authority in a parentage case according to state law and rules of procedure regarding default orders.

E. The Title IV-D agency may seek to establish maternity in compliance with the New Mexico Uniform Parentage Act, as appropriate.

F. The IV-D agency will not initiate an action to rescind or disestablish parentage.

G. If a child in a Title IV-D case has an acknowledged, presumed, or an adjudicated father as defined within the New Mexico Uniform Parentage Act, then parentage has been determined and the Title IV-D agency will pursue the establishment of support on behalf of or against the parent, as appropriate.
[8.50.107.8 NMAC – Rp 8.50.107.8, 7/1/2024]

8.50.107.9 PARENTAGE INVOLVING MINOR FATHERS AND MOTHERS: If the biological parent is under the age of emancipation, and is not otherwise emancipated by law, the Title IV-D agency will take measures to establish parentage and support, as appropriate. If a biological parent is a minor, his or her parent, legal guardian, or attorney who has entered an appearance on behalf of the minor biological parent may be present at all meetings or discussions between the minor biological parent and the representatives of the Title IV-D agency. The Title IV-D agency will seek to establish parentage. If the alleged minor non-custodial parent is employed, the Title IV-D agency will pursue guideline support. Any order or stipulation will include a requirement that the minor non-custodial parent will notify the Title IV-D agency of his or her employment and educational status on a regular basis. In uncontested cases, the Title IV-D agency may seek the concurrence of the minor biological parent's parent(s), legal guardian, or attorney. In contested cases, the minor biological parent(s) may request the court to appoint a guardian ad litem. Any legal notices or pleading prepared following the appointment of the guardian ad litem will be sent in accordance with the rules of civil procedure.
[8.50.107.9 NMAC – Rp 8.50.107.9, 7/1/2024]

8.50.107.10 DETERMINATION OF PARENTAGE THROUGH VOLUNTARY ACKNOWLEDGMENT OF PATERNITY: State and federal laws provide for voluntary acknowledgment of paternity after the birth of a child. A man is determined to be the natural father of a child if he and the mother acknowledge parentage by filing a written acknowledgment with the vital statistics bureau of the public health division of the department of health, in accordance with the requirements of Article 3 of the New Mexico Uniform Parentage Act.
[8.50.107.10 NMAC – Rp 8.50.107.10, 7/1/2024]

8.50.107.11 LONG ARM STATUTE CASES:

A. The Title IV-D agency will use the long arm statute as appropriate to exercise jurisdiction over a non-custodial parent residing in another state pursuant to Section 40-6A-201 et seq., NMSA 1978.

B. Genetic testing may be used in long arm statute cases in the establishment of parentage. New Mexico shall advance the costs associated with the testing in cases wherein the state initiated long arm statute actions. The Title IV-D agency shall seek reimbursement for the advancement of the costs pursuant to the genetic testing section below.
[8.50.107.11 NMAC – Rp 8.50.107.11, 7/1/2024]

8.50.107.12 GENETIC TESTING:

A. The Title IV-D agency provides genetic testing services, as appropriate. The Title IV-D agency will not provide genetic testing services when parentage is presumed by law or has already been adjudicated unless ordered by a court of competent jurisdiction to do so. The Title IV-D agency will seek the admission into evidence, for purposes of establishing parentage, the results of a genetic test that are performed by a laboratory contracted with the Title IV-D agency to provide this specific service, unless the results are otherwise stipulated to by the parties. Any party to a Title IV-D case may seek genetic testing outside of the Title IV-D agency, at his or her own expense and obtain a genetic test and report in compliance with Sections 40-11A-503 to 504 et seq., NMSA 1978. The Title IV-D agency will not present or introduce into evidence the results of a genetic test report obtained through a laboratory not contracted with the Title IV-D agency.

B. The Title IV-D agency may charge any individual who is not a recipient of state aid for the cost of genetic testing in accordance with the fee schedule in 8.50.125 NMAC. The Title IV-D agency may advance the cost of the fee if the IV-D agency is a party in a pending court case and is providing full services. If the Title IV-D agency is not a party in a pending court case and is not providing full services, the Title IV-D agency may require payment of the fee from any or all parties prior to scheduling the genetic testing. If a party paying any or all of the genetic testing fee wants reimbursement from the other party, he or she must seek a court order against that party.

C. The Title IV-D agency will charge a father for genetic testing when parentage is already presumed by law or has already been adjudicated, regardless of the results of the paternity test. The Title IV-D agency will charge an alleged father for genetic testing when parentage is not presumed by law or adjudicated and the results of the test show the alleged father to be the biological father. The Title IV-D agency will charge the mother for genetic testing when parentage is not presumed by law or adjudicated and the results of the test show the alleged father not to be the biological father.
[8.50.107.12 NMAC – Rp 8.50.107.12, 7/1/2024]

8.50.107.13 JUDGMENTS AND ORDERS IN PARENTAGE CASES: The judgment or order of the court determining the existence or nonexistence of the parent and child relationship is determinative for all purposes. The IV-D agency will seek the following orders, as appropriate:

A. an order adjudicating parentage in accordance with the New Mexico Uniform Parentage Act, and

B. after parentage has been adjudicated, the establishment of child and medical support for the minor child(ren).

[8.50.107.13 NMAC – Rp 8.50.107.13, 7/1/2024]

History of 8.50.107 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD CSEB 501.1100, State and Local Requirements, filed 6/23/80.

ISD CSEB 551.0000, Procedures for the Establishment of Paternity, filed 6/23/80.

ISD CSEB 555.0000, Blood Tests, filed 6/23/80.

NMAC History:

8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, filed 12/30/94.

History of Repealed Material:

8 NMAC 5.CSE, Child Support Enforcement, filed 12/30/94 - Repealed effective 5/31/2001.

8.50.107 NMAC, Establishment of Paternity, filed 5/14/2001 - Repealed effective 1/1/2010.

8.50.107 NMAC, Establishment of Paternity, filed 1/1/2010 – Repealed effective 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 50 CHILD SUPPORT ENFORCEMENT PROGRAM
PART 116 NATIVE AMERICAN INITIATIVE

8.50.116.1 ISSUING AGENCY: New Mexico Health Care Authority - Child Support Enforcement Division.
[8.50.116.1 NMAC - Rp 8.50.116.1, 7/1/2024]

8.50.116.2 SCOPE: To the general public. For use by the Title IV-D agency and recipients of IV-D services.
[8.50.116.2 NMAC - Rp 8.50.116.2, 7/1/2024]

8.50.116.3 STATUTORY AUTHORITY: Public Assistance Act, NMSA 1978, Section 27-2-27. The health care authority is designated as the single state agency for the enforcement of child and spousal support obligations pursuant to Title IV-D of the Social Security Act (42 USC 651 et. seq.). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.50.116.3 NMAC - Rp 8.50.116.3, 7/1/2024]

8.50.116.4 DURATION: Permanent.
[8.50.116.4 NMAC - Rp 8.50.116.4, 7/1/2024]

8.50.116.5 EFFECTIVE DATE: May 31, 2001, unless a later date is cited at the end of a section.
[8.50.116.5 NMAC - Rp 8.50.116.5, 7/1/2024]

8.50.116.6 OBJECTIVE: To provide regulations in accordance with federal and state laws and regulations.
[8.50.116.6 NMAC - Rp 8.50.116.6, 7/1/2024]

8.50.116.7 DEFINITIONS: [RESERVED]
[8.50.116.7 NMAC - Rp 8.50.116.7, 7/1/2024]

8.50.116.8 CHILD SUPPORT ENFORCEMENT FOR INDIAN TRIBES: The IV-D agency may enter into cooperative agreements with any or all of the nineteen pueblos and three tribes that comprise the twenty-two separate Indian nations having lands located within the borders of New Mexico and with tribal IV-D agencies within the state of New Mexico. (42 USC 654 and 45 CFR Section 309). There is a specialized Native American initiative within the Title IV-D agency to deal with these matters.
[8.50.116.8 NMAC - Rp 8.50.116.8, 7/1/2024]

History of 8.50.116 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD CSEB 501.1100, State and Local Requirements, 6-23-80.

NMAC History:
8 NMAC 5.CSE.000 through 8 NMAC 5.CSE.970, 12-30-94.

History of Repealed Material:
8 NMAC 5.CSE, Child Support Enforcement - Repealed effective 5/31/2001.
8.50.116.1 NMAC, Child Support Enforcement, filed 5/31/2001 – Repealed effective 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 100 GENERAL OPERATING PROCEDURES

8.100.100.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.100.1 NMAC – Rp 8.100.100.1, 7/1/2024]

8.100.100.2 SCOPE: The rule applies to the general public.
[8.100.100.2 NMAC – Rp 8.100.100.2, 7/1/2024]

8.100.100.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the health care authority to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority (HCA) was created by the secretary under authority granted by Paragraph (3) of Subsection B of Section 9-8-6 NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.100.100.3 NMAC – Rp 8.100.100.3, 7/1/2024]

8.100.100.4 DURATION: Permanent.
[8.100.100.4 NMAC – Rp 8.100.100.4, 7/1/2024]

8.100.100.5 EFFECTIVE DATE: July 1, 1997.
[8.100.100.5 NMAC – Rp 8.100.100.5, 7/1/2024]

8.100.100.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.100.6 NMAC – Rp 8.100.100.6, 7/1/2024]

8.100.100.7 DEFINITIONS: [**RESERVED**]
[8.100.100.7 NMAC – Rp 8.100.100.7, 7/1/2024]

8.100.100.8 RULES AND REGULATIONS: The HCA secretary has authority to adopt rules and regulations governing the activities of HCA. These rules and regulations are subject to differing requirements regarding prior notice or hearing. This section details the differing types of rules and requirements relative to promulgation of those rules.

A. Regulations

(1) Internal rules: The HCA secretary has the authority to adopt rules governing the internal operations of the authority without giving prior notice or opportunity for a hearing

(2) Permanent rules: The secretary approves final rules implementing proposals to adopt, amend or repeal authority rules and regulations in accordance with the provisions and procedures set forth in Subsections B-F of 8.100.100.8 NMAC.

(3) Interim rulemaking: Under Section 9-8-6-F NMSA 1978, the secretary may adopt interim rules where necessary due to reductions in federal funding which do not allow the time necessary to proceed through the regular rule promulgation process. In this process, the secretary must give at least 20 days individual notice of the change, but may then implement on an interim basis until the normal proposed rule publication and hearing process can be carried out. Following that process, the interim rule is superseded by the final rule developed in accordance with the provisions set forth below.

B. Notice of public hearing: A notice of public hearing on the proposed action shall include:

(1) description of the proposed action stated in a manner designed to be easily understood by individuals not knowledgeable in the field of administrative law;

(2) time, place and date of the public hearing on the proposed action, and name of contact person;

(3) manner in which interested individuals may present their views on the proposed action and the cost, if any, to an individual of a copy of the proposed regulations.

C. Publication of notice of public hearing: A public hearing notice is published once, at least 30 days before the hearing date, in at least one newspaper of general circulation in the state.

D. Request for advance notice: Anyone interested in routinely receiving notices of public hearings on HCA proposed rule-making actions may file a written request to be placed on a public notice mailing list. HCA mails copies of hearing notices to all such individuals at least 30 days before the hearing date.

E. Hearing procedures: A hearing is held in accordance with the hearing notice. HCA provides a reasonable opportunity for interested individuals to comment on and state their views regarding the proposed action. The hearing is conducted informally and the rules of evidence do not apply. HCA may, but is not required to, make a verbatim record of the hearing through stenographic notes, tape recording or similar methods.

F. Final decision by the secretary: After a public hearing, the secretary may adopt, change or reject the proposed action. The secretary's decision is delivered in writing, including the reasons for making it and a copy of any rule or regulation adopted or amended. The secretary takes reasonable steps to publicize the final decision but is not required to publish it in a manner other than that required under the State Rules Act unless otherwise required by law.

G. The adoption, amendment or repeal of a rule or regulation under this section is filed and becomes effective in accordance with the provisions of the State Rules Act.

[8.100.100.8 NMAC – Rp 8.100.100.8, 7/1/2024]

8.100.100.9 MISSION STATEMENT:

A. ISD's primary mission is to relieve, minimize or eliminate poverty and to make available certain services for eligible low-income individuals and families through statewide programs of financial assistance, food assistance, and employment assistance and training services.

B. Human dignity and client rights: HCA has a commitment to respect for human dignity. Therefore, all programs are administered in a manner respectful of the dignity and personal privacy and rights of program beneficiaries. Discrimination based on personal judgments of a client's behavior, social status, religion, race, cultural patterns, personality, political beliefs, color, handicap or sex, is a violation of the law and a violation of ISD policy.

[8.100.100.9 NMAC – Rp 8.100.100.9, 7/1/2024]

8.100.100.10 CATEGORIES OF ASSISTANCE: Each assistance program in which eligibility is determined under ISD2 (HCA's automated eligibility system), the authority's eligibility and payment determination and issuance system is referred to as a category of assistance. A two-digit number is assigned to each category indicating the program of assistance. Following is a list of categories, program titles to which they refer, and the type of assistance provided under each. This listing is for informational purposes only.

Category	Title	Explanation
01 03 04	aid to the aged, blind, and disabled	medical - former SSI cases eligible because of the disregard of social security increases received after July, 1977 (medicaid extension applies only to former SSI recipients).
02	NMW	financial and medical
05	general assistance	financial - temporary disability
06	non IV-E foster care	medical
08	general assistance	financial - unrelated children
09	general assistance	financial - permanent disability
10	state supplement for residential shelter care	financial - medical assistance for these cases is available based on SSI availability
14	refugee foster care	medical
17	IV-E adoption subsidy - established in another state	medical
19	refugee assistance	financial - medical
27	post-NMW medical	medical - four months medicaid coverage when NMW closing caused by increased child support
28	transitional medicaid	medical - up to 12 months medicaid coverage when NMW closing caused by increased earnings

30	medical assistance for women & children (MAWC)	medical - full medicaid coverage for pregnant women
31	medical assistance for women & children	medical - twelve months medicaid coverage for newborns
32	medical assistance for women & children	medical - for children born after September 30, 1983
33	medical assistance for women & children	medical - NMW denied because of deemed income from stepparents, alien sponsors, grandparents or siblings (deemed income is any income of another individual which is counted in determining the recipient's eligibility)
34	medical assistance for women & children	medical - SSI denials because of deemed income from stepparents or alien sponsors
35	medical assistance for women & children	medical - medicaid coverage restricted to pregnancy related matters for pregnant women
37	IV-E in-state adoption subsidy	medical
39	food stamps	food
40	qualified medicare beneficiary (QMB)	payment of medicare Part A premium and the coinsurance and deductible amounts on medicare covered services
42	qualified disabled working individuals	medical
45	specified low income medicare beneficiary	payment of medicare Part B premium for applicants who already have Part A. (state will not pay Part A premium).
46	out-of-state foster care	medical - no card issued, services by prior approval only
47	out-of-state adoption subsidy	medical - no card issued, services by prior approval only
49	refugee assistance	medical
	medical assistance for the seriously ill	
51	aged	medical
53	blind	medical
54	disabled	medical
59	refugee medical assistance (spend down required)	medical
66	IV-E foster care	medical
	medical assistance for persons requiring institutional care	
81	aged	medical
83	blind	medical
84	disabled	medical
85	emergency assistance for ineligible aliens	medical
86	IV-E foster care custody out- of-state	medical
	in-home and community based medicaid waiver programs	
90	AIDS	medical
91	aged	medical
93	blind	medical
94	disabled	medical
95	medically fragile	medical
96	developmentally disabled	medical
97 98 99	aged developmentally disabled disabled/blind	categories not eligible for federal matching funds under Title XIX. These categories were closed to new approvals effective November, 1989.

[8.100.100.10 NMAC – Rp 8.100.100.10, 7/1/2024]

8.100.100.11 GENERAL PROGRAM DESCRIPTIONS:

A. NMW:

(1) Purpose: The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, assisting parents to develop the discipline necessary for self-sufficiency and to improve their self-esteem. The further purpose of the program is to increase family income through family employment and child support and by viewing financial assistance as a support service to enable and assist parents to participate in employment.

(2) The program accomplishes this purpose by providing cash assistance, medical assistance, and work program services, including education, job training, and transportation to assist recipients in obtaining and keeping employment that is sufficient to sustain their families thereby ensuring the dignity of those who receive assistance and strengthening families and the families' support for their children.

(3) Legal basis: The New Mexico Works Act assigns responsibility for administration of the New Mexico works program to the health care authority. The governor of the state of New Mexico has designated the authority as the TANF state agency in the state's biennial TANF block grant plan, pursuant to the requirements of Section 401 of Title IV-A of the federal Social Security Act.

B. General assistance

(1) Purpose: General assistance (GA) is a limited program providing financial assistance to needy individuals and families who are not eligible for assistance under the New Mexico works program or under the federal supplemental security income (SSI) program. GA payments are made to:

(a) disabled adults who do not qualify for NMW who are not eligible for SSI because their disability is not severe enough;

(b) disabled adults who do not qualify for NMW;

(c) on behalf of children under 18 years of age who would be eligible for NMW except that they are not living with a person who is eligible to receive NMW; and

(d) SSI recipients who reside in licensed adult residential care homes.

(2) Legal basis: Section 27-1-3 NMSA (Repl. 1984) provides that "the state department shall: administer assistance to the needy, blind and otherwise handicapped and general relief."

C. Food stamps

(1) Purpose: The food stamp program is designed to promote the general welfare and to safeguard the health and well-being of the nation's population by raising the levels of nutrition among low-income households.

(2) Section 2 of the Food Stamp Act of 1977 states, in part: Congress hereby finds that the limited food purchasing power of low-income households contributes to hunger and malnutrition among members of such households. To alleviate such hunger and malnutrition, a food stamp program is herein authorized which will permit low-income households to obtain a more nutritious diet through normal channels of trade by increasing food purchasing power to all eligible households who apply for participation.

(3) Legal basis: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U. S. C. 2011 et seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration by HCA, including its authority to issue regulations, is governed by Chapter 9, Article 8 NMSA (Repl. 1983).

D. Refugee resettlement program

(1) Purpose: The purpose of the refugee resettlement program (RRP) is to help refugees, political asylees and entrants, regardless of national origin, achieve economic self-sufficiency as quickly as possible. The purposes of the program are accomplished through financial and medical assistance while support services are provided to help refugees acclimate to American society, learn English and get a job. Federal legislation gives eligible refugees and their dependents financial and medical assistance through 100% federal reimbursement to states, including administrative costs, for the first 18 months after entry into the United States.

(2) Legal basis: The refugee resettlement program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the U.S. department of health and human services as the federal administering agency. RRP program regulations are issued by DHHS in the Code of Federal Regulations Title 45, Part 400, supplemented by administrative and program instructions issued by the federal department from time to time. By Executive Order No. 80-62, dated 10/1/81, the governor of the state of New Mexico has designated HCA as the single state agency responsible for administering the program in New Mexico.

E. Medical assistance programs

(1) Medicaid

(a) **Purpose:** 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 "Salud!", the authority's medicaid managed care program.

(b) **Eligible individuals include:**

(i) families who meet New Mexico's AFDC requirements as it existed, or is considered to have existed, on July 16, 1996, as amended;

(ii) individuals who have been NMW recipients and are in transition to self-support due to employment, child support, or both;

(iii) pregnant women who meet income and resource requirements for the state's AFDC program as it existed, or is considered to have existed on July 16, 1996 as amended (full-coverage medicaid);

(iv) children under 19 years of age whose income is below 185% of federal poverty levels;

(v) pregnant women with income below 185% of federal income poverty levels (for pregnancy-related services);

(vi) recipients of assistance under the federal SSI program and those who have lost their SSI eligibility because of cost-of-living increases in Title II benefits;

(vii) aged, blind, and disabled individuals in institutions who meet all standards for SSI except income;

(viii) individuals who meet all standards for institutional care but can be cared for at home;

(ix) qualified medicare beneficiaries(QMBs), qualified disabled working individuals (QDs),

(x) and specified low income medicare beneficiaries (SLIMBs), limited coverage for medicare beneficiaries; and

(xi) certain foster children in the custody of the state.

(c) **Legal basis:** HCA 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 State department of health and human services rules establish the requirements for state plans for medical assistance.

(2) **Special medical needs**

(a) **Purpose:** The special medical needs program for seriously ill individuals is an entirely state-funded medical assistance program for individuals who suffer serious illnesses. Individuals applying under this program must be eligible according to New Mexico statutes and HCA policy. No new recipients are being added to this category.

(b) **Legal basis:** State authority for administering the special medical needs program is contained in Sections 27-4-1 to 27-4-5 NMSA 1978 (Repl. 1984).

(3) **Medical assistance to refugees**

(a) **Purpose:** This program operates in accordance with the provisions of the medicaid program but is at present 100% funded by the federal government. Medical assistance is provided to individuals and families qualifying for assistance under the refugee resettlement program.

(b) **Legal basis:** State authority for administering the medical assistance to refugees program is contained in Section 27-2-12 NMSA 1978 (Repl. 1984).

(4) **Waivers for in-home care:** The New Mexico department of health, under waivers from DHHS, provides certain in-home care services as an alternative to institutionalization. These waivers authorize services for: elderly, blind and physically handicapped individuals; developmentally disabled individuals; and medically fragile individuals, AIDS. Services under the waiver program are provided to both medicaid-eligible individuals and those who have income and resources in excess of medicaid standards. Within the authority, the medical assistance division (MAD) is responsible for developing policy and regulations for these waiver programs.

F. **Energy assistance**

(1) **Purpose:** Three energy assistance programs to assist low-income households during periods of high heating costs are administered by HCA:

(a) low income home energy assistance program (LIHEAP);

(b) emergency crisis intervention assistance program (ECIAP); and

(c) low income utility assistance program (LIUAP).

(2) Energy assistance is provided for home heating costs incurred during the months of November, December, January, and February of each year. The authority may extend the program season by one or more months subject to the availability of supplemental state or federal funds.

(3) **Legal basis:** These programs are governed by the federal, state and other pertinent laws and regulations established for a defined program period, including but not limited to the following:
42 USC Section 8601: Chapter 94, Subchapter II, Low Income Home Energy Assistance Act (LIHEAA);
Sections 27-6-11 to 27-6-16 NMSA 1978 (Repl. 1984) Low Income Utility Assistance Act (LIUAA).

(4) Funding for the LIHEAP and ECIAP programs is from the LIHEAA block grant.

G. Child support services

(1) Every specified parent/relative caretaker who applies for or receives NMW from HCA is required, as a condition of eligibility, to make an assignment of support rights to the state and to cooperate with the state, if necessary, in establishing paternity and securing support.

(2) **Exception:** The cooperation requirement is not applied in cases where it would not be in the best interests of the child to cooperate.

(3) The provisions of the child support enforcement program are contained in Title IV-D of the Social Security Act, and the agency responsible for its implementation is frequently referred to as the IV-D agency. In New Mexico, the IV-D agency is the HCA child support enforcement division (CSED).

[8.100.100.11 NMAC – Rp 8.100.100.11, 7/1/2024]

8.100.100.12 RESPONSIBILITY AND DELEGATION:

A. Division responsibilities: The income support division (ISD) is responsible for administering all relevant assistance programs in an accurate and timely fashion while treating clients with respect and dignity. The Division administers those programs described in 8.100.100.10 NMAC, categories of assistance, and 8.100.100.11 NMAC, general program description.

B. Central office responsibilities: The division's central office includes the director, deputy directors and staff. Generally, central office is responsible for developing and managing division programs, program and organizational budgets and division personnel. It provides oversight and supervision of division field offices.

C. Field office responsibilities: ISD county field offices are located in the majority of counties in the state. Counties without ISD field offices may be served by scheduled itinerant visits. The county field office is the ISD unit responsible for the direct administration of ISD's food, medical, energy and financial assistance programs. The offices administer programs according to HCA regulations and policies. Each county office is supervised by a county director, who is responsible for the overall operation of the office, supervising office employees, and administering ISD programs. County directors report to and are supervised by ISD's deputy director for field operations.

D. Privacy

(1) Procedures used to determine eligibility must respect the rights of the client under the United States constitution, the Social Security Act, Title VI of the Civil Rights Act of 1964, or any other relevant provisions of state and federal laws. Intrusions on a client's privacy and personal dignity are limited to what is reasonably necessary to make sure that expenditures made under the programs are accurate and legal.

(2) **Prohibited activities:** Specifically prohibited activities include:

(a) entering a home by force or without permission;

(b) making home visits outside of normal ISD working hours; and

(c) searching a home for clues of possible deception.

[8.100.100.12 NMAC – Rp 8.100.100.12, 7/1/2024]

8.100.100.13 CONFIDENTIALITY:

A. Both the Social Security Act and the Food Stamp Act require the state agencies responsible for the administration of these programs to provide for the confidentiality of information about applicants for and recipients of program benefits.

B. **"Confidential information"** includes all information about an applicant for or recipient of program assistance contained in division records, as well as information obtained by division employees in their official capacity, whether such information is recorded or not. The term also includes records of division evaluations of recorded information. The term does not include general information of a statistical nature that cannot be identified with a particular individual or family group.

C. Access to Information: All information and documentation contained in a case record, with the exception of medical information and narrative dated before February 1, 1977, may be released to an adult family member and/or his/her representative on request. In financial assistance cases, confidential information is not released to the dependent children or the spouse (if not the other parent) of the specified relative, unless permission to do so is given by the specified relative.

D. Specific legal basis

(1) Federal law: The Social Security Act, as amended, requires that state agencies administering the temporary assistance for needy families (TANF) program limit the release or use of information about applicants or recipients, including medical reports, to:

(a) purposes directly connected with the administration of TANF (Title IV-A), child support enforcement (Title IV-D), medicaid (Title XIX), social services (Title XX), and SSA program (Title V) SSI program (Title XVI);

(b) investigations, prosecutions or civil or criminal proceedings conducted in connection with the administration of these programs;

(c) agencies administering any other federal or federally-aided program which provides assistance in cash, in kind, or in services directly to individuals based on need, provided that the client's permission to release the information has been obtained in writing; the Food Stamp Act of 1977 and succeeding amendments require safeguards restricting the use or disclosure of information obtained from applicant or recipient households to persons directly connected with the administration or enforcement of the provisions of the act or regulations issued pursuant to the act.

(2) State law: Section 17 of the New Mexico Works Act of 1998 requires the authority to establish and enforce rules governing the custody and use of records, papers, files and communications and restricting the use or disclosure of information in these documents concerning applicants and recipients of assistance in accordance with federal legislation.

[8.100.100.13 NMAC – Rp 8.100.100.13, 7/1/2024]

8.100.100.14 CLIENT INFORMATION:

A. ISD case record:

(1) ISD case records, consisting of forms, records, narrative material, correspondence and documents, are scanned into electronic format and maintained in the authority's secure electronic data management system. Documents submitted in person will be electronically scanned and returned to the individual. Original documents mailed to or left with the office will be photocopied and the originals mailed back to the client at his/her last known address known to the authority. The copied documents will be electronically scanned and destroyed once successful completion of a scan into electronic format is confirmed. The case record documents the current and historical eligibility of a recipient group and thereby to establish the validity of decisions to approve or deny assistance.

(2) Case records are the property of the authority and are established and maintained solely for use in the public assistance programs administered by the authority. Information contained in the case record(s) is confidential and is released only under the limited circumstances and conditions as provided in federal and state laws and regulations, including 8.100.100 NMAC, Sections 13 through 15. Case records and their contents must remain in the possession of the authority, its contractors, or approved federal employees. Copies of case records may be released in accordance with federal and state laws and regulations or pursuant to a court order.

(3) Electronic eligibility system information: Client information stored on the authority's electronic eligibility system is subject to the same guidelines for release of information as the authority's case record.

B. Persons with access to confidential information:

(1) Client: The name of an individual(s) providing confidential information to the authority regarding a client is not released to a client or his or her authorized representative. The release of all other case information is subject to the following conditions:

(a) A client or his or her authorized representative must complete a request for access to a case record each time he or she wishes to have access to the case record. If the client wishes to have his or her authorized representative review the record in his or her absence, the client must provide formal documentation authorizing the named individual(s) to access the identified case information for a specified purpose and time frame. This includes an individual(s) acting as the client's authorized representative in a fair hearing. Only the client or the client's authorized representative may authorize another individual(s) to review the record.

(b) The record must be reviewed in the presence of the county director or designee.

(c) If a client disagrees with information contained in the case record, he or she may make a written rebuttal which is made part of the case record. Contested material may not be removed from the case record.

(2) Inquiries on client's behalf: Inquiries made on behalf of a client regarding eligibility for or amount of assistance received are treated as coming from private individuals, regardless of whether they come from a private citizen, elected official, or public or private agency. The authority must receive formal documentation from the client or his or her authorized representative permitting the release of information.

(3) Authority employees: Confidential information is available to employees or agents of the authority who need it in connection with the various services and public assistance programs administered by the authority. This includes field and central office staff, representatives of the child support enforcement division (CSED) and medical assistance division (MAD), and private firms or other agencies under contract with the authority that perform work or provide services related to public assistance programs. Confidential information is also available to employees of the federal government concerned with the public assistance programs administered by the authority.

(4) Non-authority employees: Confidential information about applicants for and recipients of public assistance may be released to other agencies or individuals including law enforcement officers that meet all of the following standards:

(a) agency or individual is involved in the administration of a federal or a federally-assisted program that provides assistance in cash, in kind or in services, directly to individuals on the basis of need;

(b) information is to be used for the purpose of establishing eligibility, determining amount of assistance or for providing services for applicants or recipients;

(c) agency or individual is subject to standards of confidentiality comparable to those of the authority; and

(d) agency or individual has actual or implied consent of the applicant or recipient to release the information; in an emergency, information may be released without permission, but the client must be informed of its release immediately thereafter; consent may be considered as implied if a recipient or member of the assistance group has made application to the inquiring agency for a benefit or service.

(5) Funding agencies/auditors: The authority's public assistance programs' funding agencies and auditors may have access to and use of client information and is subject to the confidentiality requirements specified above and in accordance with federal and state laws and regulations.

(6) Employers: To claim a tax credit on wages paid to cash assistance recipients, as provided under the Revenue Act of 1978, an employer may request and receive information from the authority as to whether an employee is a recipient who meets the criteria for either (a) the welfare tax credit (NMW recipient during the three (3) month period consisting of the month hired and the two (2) months immediately preceding the date of hire); or (b) the targeted jobs tax credit (recipient of GA who received GA for at least thirty (30) days, ending within the sixty (60) day period which ends on the hiring date). Such releases are to be made on a case by case basis and must be accompanied by a consent to release information signed by the client.

C. Medical records: Medical reports and medical information in the authority's possession, regardless of how they were obtained, may not be shown to a client, unless they are released as part of a fair hearing. Because of the potentially upsetting nature of the facts contained in some reports and because a physician's knowledge is frequently necessary to interpret those facts, a client shall be referred to his/her physician regarding any questions.

D. Court proceedings:

(1) Program-related court cases:

(a) Criminal or civil court proceedings involving the establishment of paternity and enforcement of child and medical support for recipients, prosecution for fraud, suits for recovery of fraudulently obtained public assistance benefits, third-party recovery, and custody hearings regarding custody of children for whom public assistance is being provided are considered part of the public assistance programs administered by the authority. The authority or its interests may be represented in such cases by an attorney from the office of general counsel (OGC), CSED, CYFD, by a local district attorney, by a representative of the attorney general's office or by a federal prosecutor.

(b) If information contained in a case record or known to a authority employee is needed in preparation for or as part of a court proceeding, the authority employee(s) will cooperate in making sure that needed information is supplied. Although employees may receive a subpoena to testify in such a court proceeding, a subpoena is not needed if the court proceeding relates to the public assistance programs administered by the authority. To the extent possible, attorneys responsible for a case, or other persons helping in preparing the

case for court action, will notify the authority, or other custodian of a case record, in advance and in writing, of the need for court testimony, whether the record should be brought, and of the time, date and place of hearing. If there is not enough time before the hearing to provide written notice, a phone call that the authority logs in the narrative section of the case record, is sufficient. If it is not clear whether a court proceeding relates to the public assistance programs administered by the authority, the local county office may contact the OGC or the appropriate division director's office for help.

(2) Non-program related court cases: Any person or attorney seeking confidential information from a case record for a non-program related court case should direct a properly issued subpoena to the appropriate local county office with a copy also sent to the authority's OGC. The authority will seek to preserve the confidentiality of the case record unless the release of the information is expressly authorized by federal and state laws and regulations or is otherwise ordered by a court of competent jurisdiction.

[8.100.100.14 NMAC – Rp 8.100.100.14, 7/1/2024]

8.100.100.15 PUBLIC INFORMATION ACT:

A. Policy and procedures manual: The regulations for the public assistance programs administered by the authority are located on the official website of the New Mexico administrative code located at http://www.nmcpr.state.nm.us/nmac/. Procedures and policy guidance is located at the official authority website under the specified division at http://www.HCA.state.nm.us/. Copies of appropriate regulations and procedures and policy guidance will be provided to the claimant as part of the summary of evidence in a fair hearing pursuant to Subsection F of 8.100.970.10 NMAC.

B. State program and plan materials: The authority state plans are available at the official authority website under the specified division at http://www.HCA.state.nm.us/.

C. Other printed materials: Additional printed materials, such as brochures and pamphlets describing basic financial and nonfinancial eligibility criteria, the application process, and participant rights and responsibilities, are available at the local county offices, social security administration offices, state employment services offices, other agencies providing public assistance services, and the official authority website at http://www.HCA.state.nm.us/.

D. Federal laws, regulations and other materials: Federal materials should be obtained by contacting the responsible federal agency directly. The university of New Mexico is a federal repository. Many federal agencies post regulations, planning documents and requirements as well as program instructions on the internet.

[8.100.100.15 NMAC – Rp 8.100.100.15, 7/1/2024]

8.100.100.16 NONDISCRIMINATION/PROGRAM ACCESS AND DELIVERY OF SERVICE:

A. Statement of nondiscrimination: HCA programs must be administered in a manner which makes sure that no person is denied any aid, care, services or other benefits on the grounds of race, color, age, sex, handicap, religious creed, national origin or political beliefs, or is otherwise subjected to unlawful discrimination.

B. Right to file complaint: Any individual who thinks he/she is discriminated against because of race, color, sex, handicap, religious creed, national origin or political beliefs has the right to file a complaint with the central or any local HCA office, or with the U.S. department of health and human services, the U.S. department of justice, the U.S. department of agriculture, or the civil rights commission in Washington D.C.

(1) Complaint form: Individuals wishing to file complaints with HCA may use forms provided by ISD on request. A letter or statement, written or oral, expressing a belief of being unlawfully discriminated against is also accepted as a complaint.

(2) Unwritten complaints: If an individual alleges that a discriminatory act has been committed, but refuses or is reluctant to put the complaint in writing, the person receiving the complaint does so.

(3) Written complaints: Written complaints are accepted even if the information listed below (in Paragraph 6 of Subsection B of 8.100.100.16) is incomplete.

(4) Investigation: HCA investigates any complaints received. Individuals making complaints are told whether unlawful discrimination is found to exist and what other action may be taken by complainants who are not satisfied with the decision.

(5) Food stamp complaint deadline: A complaint claiming unlawful discrimination in the food stamp program must be filed no later than 180 days after the date of the alleged discrimination. However, this deadline may be extended by the U.S. secretary of agriculture.

(6) Information needed:

(a) name, address and telephone number or other means of contacting complainant;

(b) location and name of individual/agency responsible for delivering service and accused of discriminatory practices;

(c) nature of incident or action causing the complainant to allege unlawful discrimination; or an example of the aspect of the program administration which is alleged to harm potential participants or the individual making the complaint;

(d) basis on which complainant feels unlawful discrimination exists (age, race, handicap, sex, religious creed, color, national origin or political beliefs);

(e) names, titles and addresses of persons who may have knowledge of the discriminatory acts;

(f) date or dates on which the alleged discriminatory actions occurred.

C. Complaint system: Complaints regarding individual case deficiencies, such as processing standards or service to participants and applicants, are referred to the relevant county office.

(1) Exclusions: This procedure does not include:

(a) complaints that can be pursued through a fair hearing; and

(b) some mail issuance complaints: for example, if a recipient complains of nonreceipt of coupons through the mail, the procedures for replacement of coupons lost in the mail are followed; however, if the complaint concerns the mailing system, (staggered issue, use of certified mail, etc.) the complaint is handled through the complaint procedure.

(2) Filing: No special format is necessary for an individual to file a complaint. Instead, the complainant is encouraged to lodge a complaint by telephone (using HCA's toll-free number), through the mail, or in person. If a complainant needs help lodging the complaint, an ISS provides this help.

(3) Response: A complainant receives a response to his/her complaint within 10 days after receipt of the complaint.

(4) Public information: ISD personnel give information regarding the complaint system and civil rights complaints to all program recipients, applicants, and other interested persons. Such information is provided to clients during interviews, included in brochures, and publicized by posters displayed in all ISD offices.

D. Bilingual services: The state provides bilingual outreach materials and staff. This service is provided to households without an English-speaking adult. If a recipient has limited literacy or comprehension of English, the HCA employee provides, in a language understood by the recipient, an explanation containing the following elements:

(1) that the information requested is needed to determine eligibility for assistance;

(2) the consequences of providing incorrect or incomplete information;

(3) that changes in circumstances must be reported to HCA according to specific program changes;

(4) the consequences of failure to report changes;

(5) that HCA takes appropriate legal and/or administrative steps to recover overpayments which result from incorrect, incomplete or late reporting of information;

(6) a list of all information or changes which must be reported;

(7) monthly or other periodic reporting requirements.

[8.100.100.16 NMAC – Rp 8.100.100.16, 7/1/2024]

8.100.100.17 BENEFIT ISSUANCE SYSTEM:

A. Electronic benefit transfer (EBT): SNAP and cash benefits are issued through a direct deposit into an EBT account. The benefits are maintained in a central database and accessed by the household through an individual debit card issued to the household.

B. Initial issuance of EBT card: The EBT card is issued to the designated payee of the eligible household or to the designated authorized representative.

(1) The EBT card is mailed to the head of household or the designated authorized representative on the first working day after the application is registered. The applicant or recipient shall receive training on the use of the EBT card prior to activation of the EBT card.

(2) The EBT card shall be issued to the payee for an eligible household through the most effective means identified by HCA which may include issuance at the county office or by mail.

(3) The applicant or recipient must verify his or her identity.

(4) The payee for the eligible household may select the four-digit personal identification number that will allow access to the household’s benefits.

C. Replacement of the EBT card: The recipient or designated authorized representative shall be instructed on the procedure for replacement of an EBT card that has been lost, stolen or destroyed.

(1) The recipient or designated authorized representative may report a lost, stolen or destroyed EBT card through the HCA EBT contractor customer service help desk, HCA EBT customer service help desk or any ISD field office.

(2) The lost, stolen, or destroyed EBT card shall be deactivated prior to a replacement card being issued to the household.

(3) ISD shall make replacement EBT cards available for client to pick up or place the card in the mail within two business days following notice by the household to ISD that the card has been lost, stolen or damaged.

(4) ISD may impose a replacement fee by reducing the monthly allotment of the household receiving the replacement card, however, the fee may not exceed the cost to replace the card.

D. Excessive replacement cards: The HCA office of inspector general (HCA OIG) will generate a warning letter to SNAP recipients that have replaced their EBT card five or more times in a 12 month period. The letter is a notice of warning and will explain that as a result of the recipient's high number of replacement EBT cards, their EBT SNAP transactions will be closely monitored. The letter will become part of the recipient's case record. The letter will:

(1) be written in clear and simple language;

(2) meet the language requirements described at 7 CFR 272.4(b);

(3) specify the number of cards requested and over what period of time;

(4) explain that the next request, or the current request if the threshold has been exceeded, requires contact with ISD before another card is issued;

(5) provide all applicable information on how contact is to be made in order for the client to comply, such as whom to contact, a telephone number and address; and

(6) include a statement that explains what is considered a misuse or fraudulent use of benefits and the possibility of referral to the fraud investigation unit for suspicious activity.

E. Inactive EBT accounts: EBT accounts which have not been accessed by the recipient in the last 90 days are considered a stale account. HCA may store stale benefits offline after notification to the household of this action.

(1) The notification to the household shall include the reason for the proposed action and the necessary steps required by the recipient to reactive the account.

(2) The recipient may request reinstatement of their EBT account anytime within 364 days after the date of the last benefit account activity.

F. EBT benefit expungement: When benefits have had no activity:

(1) SNAP: HCA may expunge benefits that have not been accessed by the household after a period of 274 days. HCA must attempt to notify the household prior to expungement. Expunged benefits are no longer available to the household. Requests for reactivation must be received prior to expungement and a determination shall be made by the director or designee of the income support division.

(2) Cash: Cash assistance benefits which have had no activity for an excess of 180 days will be expunged. All benefits older than 180 days in the account will no longer be accessible to the household. The household loses all rights to all expunged benefits. The department shall attempt to notify the household no less than 45 days prior to the expungement of the cash assistance benefits.

[8.100.100.17 NMAC – Rp 8.100.100.17, 7/1/2024]

8.100.100.18 TRAINING:

A. General statement: Effective staff development and training is an integral part of successful ISD program operations. ISD supports employee attendance at job-relevant training opportunities. Attendance at training sessions needs supervisory approval. Priorities for such approval are:

(1) training to improve skills needed in an employee's current position;

(2) training to add new skills useful in an employee's current position;

(3) training for an employee's career development.

B. Budget: ISD managers are encouraged to develop training plans and budgets for their administrative units. Such plans must be coordinated with the ISD training staff. ISD training staff members are available for consultation in developing these plans and budgets.

[8.100.100.18 NMAC – Rp 8.100.100.18, 7/1/2024]

8.100.100.19 ADMINISTRATIVE TRAINING:

A. Personnel: New employees: ISD encourages prompt attendance at new-employee orientation sessions and requires completion of these sessions as specified in the division's training plan(s).

B. Professional development: ISD supports attendance at training sessions for an employee's professional development needs and goals. Such attendance requires supervisory review and approval and must not interfere with timely performance of an employee's ongoing duties.

[8.100.100.19 NMAC – Rp 8.100.100.19, 7/1/2024]

8.100.100.20 PROGRAM TRAINING:

A. New employee training: The division maintains a new-employee training curriculum for all major programs administered by ISD. This program is accessible to all division and HCA employees who need training in food stamps, financial assistance or medical assistance programs.

B. Training standards: ISD training programs conform to the following standards:

(1) Needs assessments: Training programs are developed based upon generally accepted methods of training needs assessment, for example; formal analysis, training needs survey, performance statistics.

(2) Objectives and skills: Training developed and presented by ISD staff must be objective or competency based.

(3) Agenda and prior notification: Training provided to ISD staff members by other HCA employees must, at a minimum:

(a) be planned in advance with enough notice to adjust work schedules;

(b) have a written agenda;

(c) be coordinated with the ISD training staff.

(4) Training event report: All individuals who provide individual training sessions to ISD staff must complete an ISD training event report and submit the form to the ISD training staff.

[8.100.100.20 NMAC – Rp 8.100.100.20, 7/1/2024]

8.100.100.21 PROVIDER TRAINING: Provision of training sessions - The ISD training staff provides program training to providers on request as scheduling permits.

[8.100.100.21 NMAC – Rp 8.100.100.21, 7/1/2024]

8.100.100.22 SECURITY:

A. Physical property: It is the responsibility of each ISD county director or bureau chief to develop and maintain plans for insuring the security office equipment, furniture and facilities according to department and other state and federal government guidelines.

B. Personnel security: ISD staff are provided training in tools and techniques to reduce the incidence or likelihood of violence or threats directed towards the ISD employee.

[8.100.100.22 NMAC – Rp 8.100.100.22, 7/1/2024]

8.100.100. 23 ITINERANT SERVICES:

A. ISD provides itinerant service to clients residing at a distance from local ISD offices. Income support specialists visit specified locations on a regularly scheduled basis and conduct required interviews.

B. Itinerant schedules are available through local ISD offices. An itinerant location may not be eliminated by ISD without public notice and adequate justification.

[8.100.100.23 NMAC – Rp 8.100.100.23, 7/1/2024]

History of 8.100.100 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD Rule 100, Program Descriptions, 2/9/1988.
ISD Rule 131, Administrative Policy, 2/10/1988.
ISD Rule 141, Treatment of Clients, 2/9/1988.
ISD Rule 141, Treatment of Clients, 6/18/1990.
ISD Rule 150, Confidential Information, 2/9/1988.

History of Repealed Material:

8 NMAC 3.ISD.000, 8 NMAC 3.ISD.010, 8 NMAC 3.ISD.020, 8 NMAC 3.ISD.030, 8 NMAC 3.ISD.050, 8 NMAC 3.ISD.060, General Administration and 8 NMAC 3.ISD.100, General Operating Procedures - Repealed, 7/1/1997.
8.100.100 NMAC, General Operating Procedures, filed 4/13/2001 – Repealed effective 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 110 GENERAL OPERATING POLICIES - APPLICATIONS

8.100.110.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.110.1 NMAC – Rp 8.100.110.1, 7/1/2024]

8.100.110.2 SCOPE: The rule applies to the general public.
[8.100.110.2 NMAC – Rp 8.100.110.2, 7/1/2024]

8.100.110.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the authority to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Section 9-8-6-B-(3) NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.100.110.3 NMAC – Rp 8.100.110.3, 7/1/2024]

8.100.110.4 DURATION: Permanent.
[8.100.110.4 NMAC – Rp 8.100.110.4, 7/1/2024]

8.100.110.5 EFFECTIVE DATE: July 1, 1997, unless a later date is cited at the end of a section.
[8.100.110.5 NMAC – Rp 8.100.110.5, 7/1/2024]

8.100.110.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.110.6 NMAC – Rp 8.100.110.6, 7/1/2024]

8.100.110.7 DEFINITIONS: [**RESERVED**]
[8.100.110.7 NMAC – Rp 8.100.110.7, 7/1/2024]

8.100.110.8 RIGHT TO APPLY: Each individual shall have the opportunity to apply for public assistance programs administered by the authority or to have an authorized representative do so on his or her behalf. Paper application forms must be readily accessible in the ISD local office lobby and provided to any person who requests the form. Applications are made in a format prescribed by the authority to include paper forms or electronic submissions. All forms and notices will be accessible to individuals with limited-English proficiency or disabilities. ISD will post signs in local field offices which explain the application processing standards and the right to file an application on the day of initial contact.

A. Screening: Every applicant shall have the opportunity to meet, face to face or telephonically, with ISD when an application is submitted during regular business hours. ISD will review the application, assist the applicant in completing the application, if it is incomplete or assistance is otherwise necessary, and will assist in identifying the public assistance program(s) for which the applicant wishes to apply.

(1) Screening for supplemental nutrition assistance program (SNAP) expedited service: ISD will screen SNAP applicants for entitlement to expedited processing, using the standard formula and documenting the application, at the time the household requests assistance.

(a) If the applicant is eligible for expedited service, the SNAP application will be processed in accordance with 8.139.110.16 NMAC.

(b) If expedited SNAP processing is denied, the applicant will be informed of the right to request an agency review conference to be held within two (2) days of the request unless the household requests a later date pursuant to Paragraph (4) of Subsection E of 8.100.970.10 NMAC.

(2) Proof checklist: ISD shall provide each household at the time of application for certification and recertification with a notice that informs the household of the verification requirements the household must meet as part of the application process. The notice shall also inform the household of ISD's responsibility to assist the household in obtaining required verification provided the household is cooperating with

ISD as specified in 7 C.F.R. 273.2(d)(1) and Section F of 8.139.110.11 NMAC. The notice shall be written in clear and simple language and shall meet the bilingual requirements designated in 7 C.F.R. 272.4(b). At a minimum, the notice shall contain examples of the types of documents the household should provide and explain the period of time the documents should cover.

(3) Scheduling the appointment: ISD must schedule an interview for all applicant households who are not interviewed on the day their application is received by ISD. An interview should be held within 10 working days from the date the application is received by ISD and, to the extent possible, convenient for both the applicant and ISD. To the extent practicable, ISD must schedule the interview to accommodate the needs of groups with special circumstances, including working households. ISD must schedule all interviews as promptly as possible to ensure eligible households receive an opportunity to participate within 30 days after the application is filed. ISD will send an appointment letter for an interview that includes contact information for ISD, date, time and place of the appointment. ISD must notify each household that misses its interview appointment that it missed the scheduled interview and that the household is responsible for rescheduling a missed interview. If the household contacts ISD within the 30-day application processing period, ISD must schedule a second interview. ISD may not deny a household's application prior to the 30th day after application if the household fails to appear for the first scheduled interview. If the household requests a second interview during the 30-day application processing period and is determined eligible, ISD must issue prorated benefits from the date of application.

B. Alternative interviews: Specific requirements for telephone and out of office interviews are outlined in each program's chapter on this topic.

C. Screening applications received by alternative means: ISD will screen applications for all public assistance programs and for expedited SNAP eligibility which includes applications received by alternative means. Alternative means include mail, fax, online, electronic transmission, or through an authorized representative.

[8.100.110.8 NMAC – Rp 8.100.110.8, 7/1/2024]

8.100.110.9 SUBMISSION OF FORMS: Applicants may submit forms to a local county office in person or through an authorized representative, through the approved authority web portal, by fax or by mail. The date the application and forms are received by ISD will be documented on the form. Applications submitted after regular business hours shall be considered received after business hours.

A. Incomplete application: An applicant has the right to file an incomplete form as long as the form contains the applicant's name, address and the signature of a responsible household or benefit group member or the household or benefit group's authorized representative, if one is designated.

B. Requesting application forms: When ISD receives a request for an application for assistance, ISD will mail, fax or hand deliver a paper application and provide the approved web portal address (for online applications), as indicated by the requestor, on the same day the request is received.

C. ISD shall provide households that complete an on-line electronic application in person at the ISD office the opportunity to review the information that has been recorded electronically and provide them with a copy of that information for their records, upon request.

[8.100.110.9 NMAC – Rp 8.100.110.9, 7/1/2024]

8.100.110.10 INTERVIEWS: Specific requirements for the interview are outlined in each program's chapter on this topic. Related verification issues for the interview are located in the verification section.

[8.100.110.10 NMAC – Rp 8.100.110.10, 7/1/2024]

8.100.110.11 PROCESSING APPLICATIONS:

A. Cash Assistance (CA)/SNAP combined cases: To facilitate participation in SNAP, the Food Stamp Act requires that individuals applying for CA be able to apply for SNAP benefits at the same time.

(1) Application: A household applying jointly for CA and SNAP is required to file only one application on a form prescribed by ISD. The application contains the information necessary to complete the application process whether it was submitted by paper format or electronically online. If it is unclear to ISD whether the applicant intends to apply for SNAP, ISD will ask the applicant during the CA interview or other contact may be made with the applicant. An application for SNAP will be processed in accordance with time standards and procedures set forth in federal and state laws and regulations governing SNAP, including expedited processing provisions.

(2) Single interview: Whenever possible, a single interview will be held with an applicant who applies jointly for CA and SNAP benefits.

(3) Categorical eligibility: A SNAP household that meets criteria set forth in 8.139.420.8 NMAC is categorically eligible. If a household does not meet SNAP eligibility criteria, but is potentially categorically eligible, ISD must postpone denying the SNAP application until the thirtieth (30th) day.

(4) Application processing: Shall be processed in accordance with 7 C.F.R 273.2 j(1)(iv). As a result of differences in CA and SNAP application processing procedures and timeliness standards, eligibility for SNAP benefits may be determined prior to CA eligibility determination. Action on a SNAP application may be postponed until categorical eligibility is established to afford the household any benefits of this provision. However, SNAP approval may not exceed the applicable SNAP expedited or regular application processing timeliness standards.

(5) Application is denied: If a CA application is denied, an applicant is not required to file a new SNAP application. SNAP eligibility will be determined on the basis of the original application filed jointly for CA and SNAP, as well as any other documentation and information obtained in the course of the CA determination that is relevant to SNAP eligibility and benefit amount. A SNAP application may not be denied based on a CA denial reason, but must be based on the SNAP eligibility criteria.

(6) Denial retrieval: A SNAP application that is denied on the thirtieth (30th) day must be readily retrievable for another 30 days, in case the household is later determined eligible for CA or supplemental security income (SSI) benefits. When this occurs, ISD will use the original SNAP application, update any information and approve the SNAP case with prorated benefits as of the date of CA or SSI approval or payment effective date, whichever is later. A second interview is not necessary, however, the applicant or authorized representative should initial all changes and sign and date the verification of the changes.

B. Reporting changes: All participants in public assistance programs administered by the authority are required to report any changed circumstances that relate to their eligibility for assistance or level of benefits. Each participant is provided with a list of the specific information he or she is required to report and the reporting time limits. When a change is reported, ISD must ensure that adjustments are made in the client's eligibility status or allotment for those months that the reported change is in effect, in accordance with each program's chapter on this topic.

(1) Notice: Whenever a client's benefits are altered as a result of changes, or whenever a certification period is shortened to reflect changes in the household's circumstances, the client is notified of the action by ISD in accordance with the notice requirements found in 8.100.180.10 NMAC and 8.100.180.11 NMAC. If the certification period is shortened, the household's certification period may not end any earlier than the second month following the month ISD determines the certification period should end. This allows adequate time to send a notice of expiration and for the household to timely reapply. If CA benefits are terminated, but the household is still eligible for SNAP benefits, members of the household must be informed about SNAP employment & training and ABAWD requirements, if applicable.

(2) CA reduction or termination within SNAP certification period: Whenever a reported change results in the reduction or termination of a client's CA benefits within the SNAP certification period, action will be taken to determine how the change affects the client's SNAP eligibility and benefit levels.

(a) Sufficient information: When there is sufficient information to determine how the change affects SNAP eligibility and benefit levels, the following actions will be taken:

(i) Reduction/termination of SNAP benefits: A change that reduces or terminates SNAP, CA or both benefits will generate a notice of adverse action for each category of assistance that is sent to the household and authorized representative. The notice(s) of adverse action will inform the household of its fair hearing rights and method for requesting continuation of benefits.

(ii) Increase in SNAP benefits: If the reduction/termination of CA benefits results in the increase of SNAP benefits, the increase in SNAP benefits occurs after the CA notice period expires and the CA grant is actually reduced or terminated.

(b) Insufficient information: Whenever there is insufficient information to determine how the CA change affects the client's SNAP eligibility and benefit level, the following actions shall be taken:

(i) CA notice of adverse action required: Where a CA notice of adverse action has been sent and the client requests a fair hearing and CA benefits are continued pending the appeal, the household's SNAP benefits will be continued on the same basis. However, the household must recertify for SNAP benefits if the SNAP certification period expires before the fair hearing process is completed.

(ii) CA notice of adverse action not required: If a CA notice of adverse action is not required, or the client decides not to request a fair hearing and continuation of CA benefits, the household must be notified that its certification period will expire at the end of the month following the month the

notice of expiration is sent, and that it must reapply if it wishes to continue to participate in the SNAP. The notice of expiration will also explain to the household that the certification period is expiring because of changes in its circumstances that may affect its SNAP eligibility and benefit level.

(3) Certification periods: ISD will assign CA and SNAP certification periods that expire at the same time. In no event are CA and SNAP benefits to be continued beyond the end of a certification period.

(4) Recertification: Households in which all members are contained in a single CA grant or in a single general assistance (GA) grant will have their SNAP interviews for recertification, to the extent possible, at the same time they are redetermined for CA.

(5) Reopened cases: If the CA and SNAP cases are closed or the SNAP certification expires, and the former recipient reapplies for one or both programs for the month following closure or expiration, benefits are prorated from the date of application for SNAP. If reapplication is made for CA or SNAP or both, following a break of one full month or more, SNAP and CA benefits for the month of application will be determined prospectively under beginning month provisions.

C. Other processing standards

(1) SSI Households: Households in which all members are applying for SSI benefits are handled in the same manner as CA households with respect to the postponement of SNAP approval or denial and the retrieval of denied SNAP applications.

(a) Since ISD cannot monitor the progress of the SSI application, and if the SNAP application is denied on the 30th day, the household must be advised to reapply for SNAP when it has been notified of SSI approval.

(b) SSI households are also entitled to apply for SNAP and be recertified at the social security administration (SSA) offices. SSA will accept the application and forward the completed application, transmittal form, and any available verification to the designated local ISD field office. When SSA accepts and refers the application, the household is not required to appear at a second office interview, although ISD may request additional verification or information needed to make an eligibility determination. Processing time limits begin when the SNAP application is registered at the SSA office.

(2) GA households: Households in which all members are applying for state administered GA are to be processed jointly for GA and SNAP benefits. However, since these households are not, nor will they become categorically eligible, the provisions to postpone approval or denial and to retrieve denied SNAP applications do not apply.

(3) Mixed households: Households in which some but not all of the household members are applying for NMW benefits will file separate applications for CA and SNAP benefits. Applications will be handled under the same processing provisions required for nonfinancial assistance households. However, if those not applying for CA benefits are recipients of SSI, the SNAP application would be jointly processed, because SSI recipients are already considered CA recipients.

(4) Application processing standards joint applications other than CA/SNAP: Each type of benefit applied for will be processed according to its specific procedures and timeliness standards. No benefit's processing will be delayed waiting for other benefit's requirements.

[8.100.110.11 NMAC – Rp 8.100.110.11, 7/1/2024]

8.100.110.12 TIME LIMITATIONS: A decision shall be made promptly on applications in accordance with the timeliness standards set forth in 8.100.130.11 NMAC. These deadlines ensure that eligibility decisions are made promptly without restricting the applicant's right to supply verification of eligibility factors throughout the application processing period.

[8.100.110.12 NMAC – Rp 8.100.110.12, 7/1/2024]

History of 8.100.110 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD Rule 170, FA/FS Combined Cases, 2/9/1988.

History of Repealed Material:

8 NMAC 3.ISD.110, General Operating Policies, Applications - Repealed, 7/1/1997.

8 NMAC 3.ISD.110, General Operating Policies, Applications, filed 7/1/1997 – Repealed effective 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 120 GENERAL OPERATING POLICIES - CASE MANAGEMENT

8.100.120.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.120.1 NMAC – Rp 8.100.120.1, 7/1/2024]

8.100.120.2 SCOPE: The rule applies to the general public.
[8.100.120.2 NMAC – Rp 8.100.120.2, 7/1/2024]

8.100.120.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the authority to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Section 9-8-6-B-(3) NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.100.120.3 NMAC – Rp 8.100.120.3, 7/1/2024]

8.100.120.4 DURATION: Permanent.
[8.100.120.4 NMAC – Rp 8.100.120.4, 7/1/2024]

8.100.120.5 EFFECTIVE DATE: July 1, 1997, unless a later date is cited at the end of a section.
[8.100.120.5 NMAC – Rp 8.100.120.5, 7/1/2024]

8.100.120.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.120.6 NMAC – Rp 8.100.120.6, 7/1/2024]

8.100.120.7 DEFINITIONS: [**RESERVED**]
[8.100.120.7 NMAC – Rp 8.100.120.7, 7/1/2024]

8.100.120.8 CASE ASSIGNMENT: County directors are responsible for equitable and efficient assignment of assistance cases.
[8.100.120.8 NMAC – Rp 8.100.120.8, 7/1/2024]

8.100.120.9 REVIEWS: County directors and ISS supervisors conduct case reviews as directed by their district operations managers.
[8.100.120.9 NMAC – Rp 8.100.120.9, 7/1/2024]

History of 8.100.120 NMAC:
Pre-NMAC History: [**RESERVED**]

History of Repealed Material:
8 NMAC 3.ISD.120, General Operating Policies, Case Management - Repealed, 7/1/1997.
8 NMAC 3.ISD.120, General Operating Policies, Case Management, filed 7/1/1997 - Repealed, 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 130 GENERAL OPERATING POLICIES - ELIGIBILITY AND VERIFICATION STANDARDS

8.100.130.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.130.1 NMAC - Rp 8.100.130.1 NMAC, 7/1/2024]

8.100.130.2 SCOPE: The rule applies to the general public.
[8.100.130.2 NMAC - Rp 8.100.130.2 NMAC, 7/1/2024]

8.100.130.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the department to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority (HCA) was created by the HCA Secretary under authority granted by Chapter 9, Article 8 NMSA 1978 (Repl. 1983).

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.100.130.3 NMAC - Rp 8.100.130.3 NMAC, 7/1/2024]

8.100.130.4 DURATION: Permanent.
[8.100.130.4 NMAC - Rp 8.100.130.4 NMAC, 7/1/2024]

8.100.130.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.100.130.5 NMAC - Rp 8.100.130.5 NMAC, 7/1/2024]

8.100.130.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.130.6 NMAC – Rp 8.100.130.6 NMAC, 7/1/2024]

8.100.130.7 DEFINITIONS: [Reserved]
[8.100.130.7 NMAC - Rp 8.100.130.7 NMAC, 7/1/2024]

8.100.130.8 PRINCIPLES OF ELIGIBILITY: The income support division (ISD) is responsible for administering food, cash, energy, and medical assistance programs. These programs are funded through federal or state sources and provide assistance to individuals who meet certain eligibility factors. State and federal regulations determine eligibility factors for each program. ISD determines if an individual qualifies for a program, and ensures that eligible individuals receive the assistance as quickly as possible and, in any event, within the application time frames for the applicable program.

A. Proof of eligibility: Determining eligibility for assistance requires that certain verification regarding an applicant/recipient's circumstances be made available to ISD. This verification is retained in the case record or noted in the case narrative.

(1) Applicant/recipient responsibility: The applicant/recipient is responsible to provide and obtain the verification necessary to determine eligibility.

(2) ISD responsibility: ISD is responsible for the following:

(a) to explain program participation requirements and the program specific eligibility factors to applicants/recipients;

(b) to explain the information and documents that must be provided to establish eligibility under each eligibility factor for a specific program;

(c) to offer and provide assistance in obtaining verification of an eligibility factor when the applicant/recipient indicates that verification may be difficult or costly to obtain; difficulty in obtaining verification may arise as a result of such circumstances as an applicant/recipient's limited ability to read, speak or understand the English language, mental impairments, physical illness, disability, lack of funds, lack of transportation or lack of knowledge about how to obtain the information; assistance by ISD includes explaining written information orally in the applicant/recipient's language, providing an interpreter, providing an address or

telephone number of a person or agency, making telephone or written inquiries, allowing an applicant/recipient to use the telephone, locating a document, instructing an applicant in obtaining a document, requesting a document on behalf of an applicant/recipient or contacting a collateral contact; the assistance offered and provided is based on the particular needs of the applicant and ISD's ability to address those needs;

(d) to inform applicants/recipients in writing of their responsibility to provide necessary verification.

(3) Incomplete information: When available information is inconclusive, incomplete or indefinite, ISD shall be responsible for explaining, in writing, what questions remain and how they can be resolved. The explanation must make it clear that eligibility cannot be established without the information or documents and that failure to provide them shall result in denial, reduction or termination of assistance.

(a) The applicant/recipient shall also be informed they may reapply at any time but that the information, documentation or actions may affect the reapplication. If the applicant/recipient does not provide all of the verification needed, a decision shall be made to the extent possible, based on the existing verified information.

(b) For MAGI medicaid purposes, reasonable compatibility will be effectuated in accordance with 42 CFR 435.952.

(c) When assistance is denied, reduced, delayed or terminated due to failure to provide information or documents as requested, the case record must contain the explanation that such failure is the basis for the action. The client shall be informed in writing of the action.

B. Failure to provide verification: An applicant/recipient cannot be considered eligible for assistance until necessary verification is obtained. To the extent possible, ISD shall make eligibility determinations based on verified eligibility issues rather than failure to provide information.

C. Applicants/recipients may submit documentary evidence in person, by mail, facsimile, or other electronic device or through an authorized representative.

[8.100.130.8 NMAC - Rp 8.100.130.8 NMAC, 7/1/2024]

8.100.130.9 METHODS OF VERIFICATION:

A. Verification to determine eligibility and benefit level is obtained through six methods. Not all methods will necessarily be used in each case. The six methods are outlined in Subsections B - G of this section as well as the circumstance in which they may be used.

B. Prior case data not subject to change: Verification of an eligibility factor not subject to change which previously has been verified is accepted. At the application interview, ISD shall advise the applicant/recipient of any eligibility factors which have previously been established through documents in ISD's possession and that are not subject to change. ISD shall not require further verification of any eligibility factors already established. Such factors include, U.S. citizenship, permanent residency, birth date, relationship, social security enumeration and deprivation due to the death of a parent.

C. Electronic data: Every applicant/recipient shall be informed that the information provided is subject to verification through federal, state, local and contracted data systems. ISD shall review the information received from the data source with the applicant/recipient and not require additional verification of such information unless it is disputed by the applicant/recipient, the information is otherwise questionable, or the information does not comply with specific benefit requirements. Questionable information is defined in 8.100.130.12 NMAC. Electronic data checks are automatically made and are not considered to be collateral contacts. The electronic data checked includes, but is not limited to:

(1) SSA and SSI information through the beneficiary data exchange (BENDEX) and the state data exchange (SDX) systems:

(a) the household shall be given an opportunity to verify the information from another source if the SDX or BENDEX information is contrary to the information provided by the household or is unavailable;

(b) eligibility and benefit level determination shall not be delayed past the application processing standards of 8.100.130.11 NMAC of this part if SDX or BENDEX data is unavailable;

(2) wage data and unemployment compensation benefits (UCB) through the interface with the New Mexico department of workforce solutions (NMDWS) - unemployment insurance database;

(3) interest, dividends, unearned income and self-employment wages through interfaces with the BENDEX wage data and internal revenue service (IRS) available through income and eligibility verification systems (IEVS):

(a) if the IEVS-obtained information is questionable, this information shall be

considered unverified upon receipt and ISD shall take action to request verification of the information;

(b) except as noted in this paragraph, prior to taking action to terminate, deny or reduce benefits based on IEVS-obtained information, ISD shall request verification of the information;

(4) vehicle registration and driver's license information available from the New Mexico motor vehicle division; and

(5) child support payment information and absent parent information available from the child support enforcement division.

(6) Restrictions: Information on earnings, benefits, resources and absent parents disclosed through government data systems shall be used only for the purpose of:

(a) verifying an applicant/recipient's eligibility;

(b) verifying the proper amount of benefits;

(c) investigating to determine whether recipients received benefits to which they were not entitled; and

(d) substantiating information which will be used in conducting criminal or civil prosecution based on receipt of benefits to which recipients were not entitled.

D. Documentary evidence: ISD shall use documentary evidence as the primary source of verification for all items except residency and household size. These items may be verified either through readily available documentary evidence, collateral contact or data from federal, state, local or contracted data sources, without a requirement being imposed that documentary evidence must be the primary source of verification. Documentary evidence consists of a written confirmation of a household's circumstances. Although documentary evidence shall be the primary source of verification, acceptable verification shall not be limited to any single type of document and may be obtained through the household or other source. Whenever documentary evidence cannot be obtained or is insufficient to make a determination of eligibility or benefit level, the eligibility worker may require collateral contacts or home visits. ISD is responsible for obtaining verification from acceptable collateral contacts. If a collateral contact is not available, a sworn statement shall be accepted from the household. ISD shall provide applicants/recipients with receipts for verification documents provided.

E. Collateral contacts: A collateral contact is an oral or written confirmation of a household's circumstances by a person outside the household. ISD shall document the reason for utilizing a collateral contact in the case file.

(1) A collateral contact can be used only when the applicant/recipient selects a collateral contact as the source of verification and:

(a) ISD cannot verify using a trusted electronic source;

(b) the applicant/recipient indicates difficulty in obtaining acceptable documentary evidence; or

(c) the documentary evidence provided by the applicant/recipient is inadequate or questionable.

(2) Selection of a collateral contact: The applicant/recipient and ISD shall select a mutually agreed upon collateral contact. A collateral contact must have knowledge of the applicant/recipient's circumstances and must be able to give accurate third party information.

(a) ISD may select a collateral contact only if the household fails to designate one or designates one who lacks knowledge of the applicant/ recipient's circumstances or cannot give accurate information. If the applicant/recipient does not agree to the collateral contact and does not designate an acceptable collateral contact, the application may, in appropriate circumstances, be denied for failure to verify.

(b) A collateral contact shall not be rejected solely based on the following criteria:

(i) they are related to the applicant/recipient;

(ii) they are a recipient of public assistance; or

(iii) they do not have a telephone.

(3) Failure on the part of a collateral contact: ISD shall not deny or delay an eligibility decision solely because of failure of a collateral contact to provide information. ISD shall decide the applicant/recipient’s eligibility and benefit amounts based on all readily available information.

F. Home visits: Home visits may be used as verification only when electronic data or documentary evidence is insufficient to make a firm determination of eligibility or benefit level, or cannot be obtained. Home visits shall be selected as a method of verification with the applicant/recipient’s consent. ISD shall schedule the home visit with the applicant/recipient in advance during normal business hours. ISD shall document the reason for the home visit in the case record.

G. Sworn statements:

(1) If the applicant/recipient has an immediate need for assistance, ISD shall accept and, if necessary, assist the applicant/recipient to identify necessary factors to be included in the statement, an applicant/recipient's sworn statement to verify one or more eligibility factors when there is:

(a) a reasonable explanation as to why electronic data documentary verification or a collateral contact is not readily available to establish the factors; and

(b) the applicant/recipient's statement does not contradict other credible information received by ISD; in such instances where the statement contradicts the other information, ISD may require additional verification within a reasonable time after approval and authorization of assistance: an applicant/recipient who objects to such an additional request for information shall have the right to request and receive a fair hearing.

(2) A sworn statement is defined as the applicant/recipient's statement signed under penalty of perjury.

[8.100.130.9 NMAC - Rp 8.100.130.9 NMAC, 7/1/2024]

8.100.130.10 SELECTION OF VERIFICATION: Verification shall be requested only when necessary to establish a specific eligibility factor or benefit amount for a program and is not available or acceptable from an electronic source, in accordance with other benefit requirements. The method of verification which is selected to establish eligibility on a factor is determined through discussion between ISD and the applicant/recipient.

A. Only necessary verification: ISD shall only request verification which is necessary to establish eligibility or benefit amounts for the assistance program(s) for which the applicant/recipient has applied.

B. Ready availability: The determination that verification is readily available will be made through discussion with the applicant/recipient. A readily available document is one which can be obtained by the applicant/recipient within five working days and at no cost to the applicant/recipient.

C. Verification of a negative statement: Verification, other than by sworn statement, of a negative statement shall not be required unless the statement is or becomes questionable as defined in 8.100.130.12 NMAC and at least one specific method of verifying the statement is readily available. A negative statement is a statement by an applicant/recipient that something does not exist or did not occur. Negative statements may be discussed with the applicant/recipient depending on the applicant/recipient's circumstances.

D. Verifying more than one factor: To the extent possible, ISD shall use a document to establish more than one eligibility factor.

[8.100.130.10 NMAC - Rp 8.100.130.10 NMAC, 7/1/2024]

8.100.130.11 TIMEFRAME FOR PROVISION OF VERIFICATION: An applicant/recipient is always allowed the complete time processing deadline for the program to provide necessary verification. The minimum amount of time allowed is specific to the program. This requirement pertains to requests for verification for initial applications as well as for verification for ongoing eligibility. Below are the time frames for provision of verification by type of assistance. ISD shall make an eligibility decision within three work days of the receipt of all necessary verification.

A. Food assistance and NMW/EWP cash assistance programs: The application disposition deadline for SNAP and cash assistance programs is 30 calendar days.

(1) Expedited (emergency) SNAP: If applicant is eligible for expedited SNAP processing, issue benefits no later than the sixth day following the date of application to be available to the applicant/recipient on the seventh day or the preceding work day if the sixth day falls on a weekend or holiday.

(2) Day 1: Calendar day following date of application.

(3) Approvals: If verification provided establishes eligibility and the 30th calendar day after the application is:

(a) Monday by the preceding Friday, the 27th day;

(b) Tuesday by the preceding Monday, the 29th day;

(c) Wednesday by the preceding Tuesday, the 29th day;

(d) Thursday by the preceding Wednesday, the 29th day;

(e) Friday by the preceding Thursday, the 29th day;

(f) Saturday by the preceding Friday, the 29th day;

(g) Sunday by the preceding Friday, the 28th day;

(h) Monday holiday by the preceding Friday, the 27th day;

(i) if necessary verification is not received by these deadlines but is received on or before the end of the processing period, approve on the day that full verification is provided.

(4) Need-based determination: ISD must make a need-based eligibility determination for

SNAP within 30 days of the date of the application or by the preceding work day if the 30th day falls on a weekend or holiday, if all mandatory verification has been received, with the following specific provisions. If one or more household members have failed to turn in mandatory individual verification that is not required for all the mandatory members of a household, ISD will deny those members missing verification, and will determine eligibility for the remaining members.

(5) Procedural denials:

(a) Lack of verification: In cases where ISD was able to conduct an interview and request all necessary verification on the same day or any day before the 30th day after the application was filed, and no subsequent requests for verification have been made, ISD may deny the application on the 30th day. Following the day of application, if ISD provided assistance to the household in obtaining the verification in accordance with 7 CFR 273.2(f)(5), but the household failed to provide the requested verification, ISD may deny the application on the 30th day after the application was filed.

(b) Missed interview: If the household failed to appear for a scheduled interview and made no subsequent contact with ISD to express interest in pursuing the application, the application shall be denied on the 30th day following the day of application. The household must file a new application if it wishes to participate in the program.

(6) Extension of time beyond the 30th day: If ISD does not determine a household's eligibility and provide an opportunity to participate within 30 days following the date the application was filed, ISD shall take action in accordance with 7 CFR 273.2(h).

(a) Household caused: If by the 30th day ISD cannot take any further action due to the fault of the household, the household shall lose its entitlement to benefits for the month of application and a notice of denial shall be issued. The household will be given an additional 30 days to take the required action.

(i) If the household takes the required action within 60 days following the date of application, the case shall be reopened without requiring a new application. If the household is found eligible during the second 30 day period, benefits shall be provided only from the month following the month of application. The household is not entitled to benefits for the month of application when the delay was the fault of the household.

(ii) If the household is at fault for not completing the application process within 60 days following the date of initial application, ISD shall deny the application and require the household to file a new application if it wishes to participate.

(b) ISD caused:

(i) Whenever a delay in the initial 30 day period is the fault of ISD, immediate corrective action shall be taken. If the household is found to be eligible during the second 30 day period, the household shall be entitled to benefits retroactive to the date of application. If, however, the household is found to be ineligible, ISD shall deny the application.

(ii) If ISD is at fault for not completing the application process by the end of the second 30-day period, and the case is otherwise complete, ISD shall continue to process the original application until an eligibility determination is reached.

(iii) If ISD is at fault for not completing the application process by the end of the second 30-day period, but the case is not complete enough to reach an eligibility determination, ISD may continue to process the original application, If ISD was also at fault for the delay in the initial 30 days, the amount of benefits lost would be calculated from the month following the month of application.

B. Medical assistance: As per 42 CFR 435.912 (c)(3), the determination of eligibility for any medicaid applicant may not exceed:

(1) 90 days for applicants who apply for medicaid on the basis of disability; and

(2) 45 days for all other medicaid applicants.

C. The 45-day processing timeframe is the following:

(1) Day 1: The date of application is the first day.

(2) No later than day 44 by the preceding work day if day 44 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if the day following day 44 is not a work day, then decision must be made earlier than day 44 to allow for mailing on or before the deadline.

(3) No later than day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is not provided until day 42 - 44.

(4) Day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is provided on day 45, or is not provided.

(5) After day 45:

(a) When an applicant/recipient requests one or more 10-day extensions of time to provide needed verification. An applicant/recipient is entitled to receive up to three 10-day extensions of time upon request.

(b) The eligibility decision must be made as soon as possible and within three work days of receipt of all necessary verification.

(c) HCA provides a reasonable opportunity period to individuals who have made a declaration of citizenship or satisfactory immigration status in accordance with 8.200.410.13 NMAC.

D. The 90-day processing timeframe is the following: An application for medicaid shall be processed no later than 90 days from the date the application is filed.

(1) No later than day 89: by the previous work day if day 89 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if day following day 89 is not a work day, then decision must be made earlier than day 89 to allow for mailing on or before deadline.

(2) No later than day 90 by the next work day if day 90 falls on a weekend or holiday, if needed verification is not provided until day 87 - 89.

(3) Day 90 by the next work day if day 90 falls on a weekend or holiday, if needed verification is provided on day 90, or is not provided. The eligibility decision must be made as soon as possible and within three-work days of receipt of all necessary verification.

E. General assistance: An application for general assistance shall be processed no later than 90 days from the date the application is filed.

(1) No later than day 89: by the previous work day if day 89 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if day following day 89 is not a work day, then decision must be made earlier than day 89 to allow for mailing on or before deadline.

(2) No later than day 90 by the next work day if day 90 falls on a weekend or holiday, if needed verification is not provided until day 87 - 89. The only exceptions are days with system maintenance activities and network outage or down time.

(3) Day 90 by the next work day if day 90 falls on a weekend or holiday, if needed verification is provided on day 90. The eligibility decision must be made as soon as possible and within three-work days of receipt of all necessary verification.

(4) If needed verification is not provided, case must be processed on day 90.

(5) Reconsideration: A reconsideration of a disability determination may be requested, verbally or in writing, by a client within 15 days of the date of the denial for not meeting conditions of disability. The reconsideration period shall not exceed 30 days from the date of denial. Disability will be evaluated based on additional medical evidence provided by the client during the reconsideration period. Should no request be made or the client does not provide additional medical evidence during the reconsideration period the denial shall remain and the client may reapply.

(6) Tracking the application processing time limit: The application processing time limit begins on the day after the signed application is received in the ISD county office.

(7) Delayed determination: If an eligibility determination is not made within the required application processing time limit, the applicant/recipient shall be notified in writing of the reason for the delay and that the applicant/recipient has the right to request a fair hearing regarding ISD's failure to act within the time limits. Where applicable, NMAC subsections for specific programs detail how delays will be notified.

[8.100.130.11 NMAC - Rp 8.100.130.11 NMAC, 7/1/2024]

8.100.130.12 QUESTIONABLE INFORMATION/VERIFICATION:

A. To be considered questionable, incomplete or inadequate, the information or verification must be documented as one of the following:

(1) inconsistent with statements made by the applicant/recipient;

(2) inconsistent with other information on the application or previous applications;

(3) inconsistent with credible information received by ISD;

(4) questionable on its face.

B. Resolving questionable information: Upon receiving questionable, incomplete or inadequate verification needed to determine an applicant/recipient's eligibility or benefit amount, ISD shall promptly provide the applicant/recipient a notice which shall include the following:

(1) advise the applicant/recipient of the receipt of the information;

(2) why it is questionable, incomplete or inadequate;

(3) the additional information that must be provided;

(4) the alternative methods of providing the information,

(5) the deadline for supplying the information (10 working days or the end of the applicable application processing time period, whichever is later);

(6) that the applicant/recipient may discuss with ISD whether any other readily available verification is acceptable;

(7) that ISD is available to assist the applicant/recipient if the information is not readily available; and

(8) that a failure to supply the needed information or contact ISD by the deadline may result in a delay, a denial of eligibility, a reduction in the amount of benefits or termination of benefits.

[8.100.130.12 NMAC - Rp 8.100.130.12 NMAC, 7/1/2024]

8.100.130.13 NON-FINANCIAL VERIFICATION STANDARDS - IDENTITY:

A. SNAP and cash assistance programs: Verification of identity for the applicant is mandatory at application for the SNAP and cash assistance programs. Documents that can be used to verify identity for the SNAP and cash assistance programs include, but are not limited to:

(1) photo ID; including driver's license;

(2) birth certificate;

(3) school record;

(4) church record;

(5) hospital or insurance card;

(6) letter from community resources;

(7) voter registration card;

(8) work ID;

(9) ID for another assistance or social service program;

(10) wage stubs;

(11) additional items as listed in ISD 135, “proof checklist”; or

(12) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

B. Medical assistance programs: Verification of citizenship and identity for the applicant/recipient is mandatory at initial application. Acceptable documentary evidence of citizenship and identity is found at 8.200.410.12 NMAC in accordance with 42 CFR 435.407.

[8.100.130.13 NMAC - Rp 8.100.130.13, 7/1/2024]

8.100.130.14 NON-FINANCIAL VERIFICATION STANDARDS: NONCONCURRENT RECEIPT OF ASSISTANCE:

A. Verification of nonconcurrent receipt of assistance is mandatory. ISD has responsibility for verifying nonconcurrent receipt of benefits usually through government data systems or other state agencies.

(1) For SNAP purposes, non-receipt of SNAP benefits from this state or another state or receipt of tribal commodities must be verified.

(2) For medicaid, ineligibility to receive medicaid benefits from this state or another state in the current month must be verified.

(3) For cash assistance, ineligibility for and non-receipt of assistance from the supplemental security income (SSI) program and bureau of Indian affairs general assistance (BIA GA) program, TANF assistance from New Mexico tribal programs, cash assistance from a HCA administered program and adoption subsidies funded through Title IV-E of the Social Security Act must be verified.

B. Non-receipt of benefits from another state must be verified for applicants who indicate a recent move to New Mexico from another state and prior receipt of assistance from that state.

C. Methods which can be used to verify nonconcurrent receipt of assistance include:

(1) ISD eligibility system for non-receipt of assistance from ISD programs;

(2) state data exchange (SDX) for non-receipt of SSI;

(3) contact with the New Mexico children, youth and families department for non-receipt of assistance;

(4) document from another state showing termination of benefits;

(5) collateral contact - oral statement from other state for termination of SNAP, TANF, or medicaid;

(6) collateral contact - oral statement from bureau of Indian affairs for non-receipt of BIA-GA; or

(7) collateral contact - oral statement from tribal TANF programs for non-receipt of tribal TANF

[8.100.130.14 - Rp 8.100.130.14, 7/1/2024]

8.100.130.15 NON FINANCIAL VERIFICATION STANDARD - ENUMERATION:

A. Verification that the enumeration requirement for an applicant/recipient has been met is mandatory for applicants who are seeking benefits for themselves unless the benefit program does not require enumeration, or the applicant seeking benefits is in an immigration status not requiring enumeration. The applicant/recipient must provide the social security number (SSN) which has been issued to the individual no later than 60 days following approval. ISD shall verify the SSN through the following methods:

(1) **When an SSN is provided:** The SSN will be verified through a data match with the SSA. If the SSN is not validated through the data match, the following sources of verification listed below may be utilized to validate the SSN:

(a) ISD eligibility system;

(b) social security card (OA-702);

(c) ISD social security number validation report form (ISD 260);

(d) an original SSA document containing the SSN; or

(e) the individual who has provided their SSN will not be required to produce proof of SSN unless the SSN is found to be questionable.

(2) **When an SSN is not provided:** The applicant/recipient must provide verification of application for an SSN. The verification must indicate an application was made prior to approval of the individual for assistance. The verification shall be retained in the case record. Documents that can be used to verify an application for SSN include:

(a) SSA 2853 enumeration at birth form;

(b) signed and dated statement from the hospital showing enumeration at birth has been done;

(c) original SSA document showing an application for SSN has been made and accepted; or

(d) completed SS-5; the completed SS-5 must be dated and submitted prior to the date of approved; a copy of the completed and submitted SS-5 must be retained in the case record.

B. There is no requirement of enumeration for medicaid-newborn (Category 31).

[8.100.130.15 - Rp 8.100.130.15, 7/1/2024]

8.100.130.16 NON-FINANCIAL VERIFICATION STANDARD-CITIZENSHIP AND ELIGIBLE NON-CITIZEN STATUS: This section details the specific types of information and documents to be used in establishing the citizenship and non-citizen status for individuals who are applying for food assistance, cash assistance and medical assistance programs for themselves.

A. **Citizenship for SNAP and cash assistance:** Citizenship for SNAP and cash assistance programs will be verified only when questionable (as defined by section 8.100.130.12 NMAC). Information and documents that can be used to verify citizenship include:

(1) social security number;

(2) birth certificate;

(3) naturalization papers from the department of homeland security United States citizenship and immigration services (DHS) such as DHS Forms I-179 or I-197;

(4) U.S. passport;

(5) military service papers;

(6) hospital record of birth;

(7) baptismal record, when place of birth is shown;

(8) Indian census records;

(9) DHS 400 for alien children who can derive citizenship through citizen father or mother;

(10) additional items as listed on ISD 135, “proof checklist”;

(11) any document listed in Subsection B of this section; or

(12) if electronic verification is not available, and documentary evidence is not readily available, use other acceptable methods of verification as described in 8.100.130.9 NMAC.

B. Medical assistance programs: After July 1, 2006, an individual seeking medical assistance benefits for themselves must provide the income support division with a declaration signed under penalty of perjury that the applicant is a citizen, or a national of the United States, or is in an eligible immigration status. Applicants must present information allowing for verification of attested status. An alien applicant who declares to be in an eligible immigration status is required to present immigration status information that can be used to verify attested status (such as an "A-number" or an "I-94 number"). Verification of citizenship for the applicant/recipient is mandatory at initial application. Acceptable documentary evidence of citizenship and identity is found at 8.200.410.12 NMAC in accordance with 42 CFR 435.407.

C. Non-citizen status: A non-citizen must have information allowing attested status to be verified.

D. Systematic alien verification for entitlement (SAVE):

(1) All applicants who attest to eligible immigration status will be subject to verification through the United States department of homeland security's (USDHS) database (SAVE) system.

(2) Conflicting information regarding the alien status provided by the applicant/recipient will require additional verification by the USDHS.

[8.100.130.16 - Rp 8.100.130.16, 7/1/2024]

8.100.130.17 NON FINANCIAL VERIFICATION STANDARDS - RESIDENCE:

A. Verification of New Mexico residence is mandatory. Residence may be verified by the use of documentary evidence provided for other eligibility criteria.

B. Documents that can be used to verify residency include:

(1) rent or mortgage receipt;

(2) statement from landlord;

(3) utility bills;

(4) statement from an employer;

(5) employment records;

(6) tax office records;

(7) post office records;

(8) church or synagogue records;

(9) utility company records;

(10) school records;

(11) proof of ownership of property;

(12) current driver's license;

(13) canceled letters;

(14) additional items as listed on ISD 135, "proof checklist"; or

(15) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC

[8.100.130.17 - Rp 8.100.130.17, 7/1/2024]

8.100.130.18 NON FINANCIAL VERIFICATION STANDARDS - HOUSEHOLD COMPOSITION:

A. The applicant/recipient's statement regarding household composition will be accepted.

B. Household composition will only be verified when determined questionable as defined by 8.100.130.12 NMAC. Documents that may be used to verify household composition include:

(1) lease agreement listing household members;

(2) landlord's written statement of household composition;

(3) additional items as listed on ISD 135, "proof checklist"; or

(4) if documentary evidence is not readily available, use other methods of verification as in 8.100.130.9 NMAC.

[8.100.130.18 - Rp 8.100.130.18, 7/1/2024]

8.100.130.19 NON FINANCIAL VERIFICATION STANDARDS - AGE:

A. Age of child: Verification of age of children is mandatory for cash and medical assistance for children programs.

(1) For cash assistance: Age of the child is verified prior to approval.

(2) For medical assistance for children: Age of the child is verified to determine if the child is under the specified age limit**.**

B. Age of adults: Age of adult members is verified in the following circumstances if age is questionable:

(1) SNAP:

(a) if the individual is claiming a medical deduction on the basis of age (60 and over); or

(b) if the individual is working and income is being disregarded due to age (under age 18).

(2) Cash assistance:

(a) if the parent/caretaker relative is being considered for work program participation on the basis of being a minor parent and the parent claims to be age 20 or over;

(b) if the parent is living in his/her parent's home and is claiming emancipation on the basis of age (18 or over);

(c) if the parent/caretaker relative is not living in his/her parents' home and cooperation with child support enforcement is an issue due to age of the specified relative (under 18); or

(d) if the caretaker relative, parent or other adult member claims exemption from work program participation requirements based on age (60 and over).

(3) General assistance for the disabled:

(a) if the individual is claiming to be 18 or over and evidence is to the contrary; or

(b) if the individual is claiming to be under age 65 and evidence is to the contrary.

(4) Medical assistance for pregnant women:

(a) if the pregnant woman is living in her parent's home and is claiming emancipation on the basis of age (18 or over); or

(b) if the pregnant woman is under the age of 18 and is not living in her parent’s home and cooperation with child support enforcement is an issue.

(5) Documents that can be used to verify age include:

(a) birth certificate;
(b) adoption papers or records;
(c) hospital or clinic records;
(d) church records;
(e) baptismal certificate;
(f) bureau of vital statistics records;
(g) U.S. passport;
(h) Indian census records;
(i) local government records;
(j) immigration and naturalization records;
(k) social security records;
(l) school records;
(m) census records;
(n) court support order;
(o) physician's statement;
(p) juvenile court records;
(q) voluntary social service agency records;
(r) insurance policy;
(s) minister's signed statement;
(t) military records;
(u) driver's license;
(v) additional items as listed on ISD-135, “proof checklist”; or
(w) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

[8.100.130.19 - Rp 8.100.130.19, 7/1/2024]

8.100.130.20 NON FINANCIAL VERIFICATION STANDARD - SCHOOL ATTENDANCE:

A. The statement of the parent, specified relative, or caretaker of school attendance for children under 18 years of age is acceptable to verify school attendance for the cash assistance program, unless questionable.

B. Verification of school attendance for all minor unmarried parents and dependent children over 18 years of age is mandatory for the cash assistance program. Documents that can be used to verify school attendance include:

(1) written statement from school official;

(2) current report card;

(3) additional items as listed on ISD 135, "proof checklist"; or

(4) if the preceding documentary evidence is not readily available, other acceptable methods of verification are set forth in 8.100.130.9 NMAC.

[8.100.130.20 – Rp 8.100.130.20, 7/1/2024]

8.100.130.21 NON FINANCIAL VERIFICATION STANDARD - RELATIONSHIP:

A. Verification of relationship is mandatory in the cash assistance program. The relationship between the parent or other caretaker relative and each child included in the benefit group must be verified.

B. Documents that can be used to verify relationship include:

(1) birth certificate;

(2) adoption papers or records;

(3) Indian census records;

(4) bureau of vital statistics or local government records;

(5) DHS records;

(6) hospital or public health records of birth and parentage;

(7) baptismal records;

(8) marriage certificate showing legal marriage between parents;

(9) court records of parentage such as support orders, divorce decrees, etc.;

(10) juvenile court records;

(11) paternity records from CSED;

(12) ISD acknowledgment of paternity form;

(13) CSED acknowledgment of paternity packet for alleged or non-court ordered determined parents living with children;

(14) church records including a statement from a priest, minister, etc.;

(15) additional items as listed on ISD 135, "proof checklist"; or

(16) if documentary evidence is not readily available, use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

C. The documentary evidence must contain the names of both the child and the specified relative. When the last name of the child differs from the specified relative, the difference must be resolved and documented in the case record. Divorce papers or marriage licenses can be used to help establish the relationship when the child's last name differs from the last name of the specified relative.

(1) If the relative is other than a parent, the relationship must be traced.

(2) In situations involving both parents in the home and the father is not the legal father, where paternity has not been established by operation of law or determined through court order, it will be necessary to establish the relationship of the child to the father by completion of the CSED acknowledgment of paternity packet.

(3) If the child is living with a relative of the alleged father, it will also be necessary to establish the father-child relationship. The preferred method of proving the relationship will be through acknowledgment of paternity, although other documents will be acceptable means of establishing relationship.

[8.100.130.21 - Rp 8.100.130.21, 7/1/2024]

8.100.130.22 NON-FINANCIAL VERIFICATION STANDARDS - OTHER:

A. Fraud conviction for dual state receipt of benefits: The existence of a fraud conviction for simultaneous receipt of benefits from two states is determined based upon client statement on the application form. If ISD receives other information indicating the existence of a dual state benefit fraud conviction, ISD shall verify it by contacting the appropriate authorities.

B. Fleeing felon, probation or parole violator:

(1) Fleeing Felon: An individual determined to be a fleeing felon shall be an ineligible household member. To establish an individual as a fleeing felon ISD must verify that an individual is a fleeing felon. A federal, state, or local law enforcement officer acting in his or her official capacity must present an outstanding felony arrest warrant that conforms to one of the following national crime information center uniform

offense classification codes, to the department to obtain information on the location of and other information about the individual named in the warrant:

(a) escape (4901); or

(b) flight to avoid prosecution, confinement, etc (4902); or

(c) flight-escape (4999).

(2) Probation or parole violator: An individual determined a parole or probation violator shall not be considered to be an eligible household member. To be considered a probation or parole violator, an impartial party, as designated by ISD, must determine that the individual violated a condition of his or her probation or parole imposed under federal or state law and that federal, state, or local law enforcement authorities are actively seeking the individual to enforce the conditions of the probation or parole. Actively seeking is defined as:

(a) a federal, state, or local law enforcement agency informs ISD that it intends to enforce an outstanding felony warrant or to arrest an individual for a probation or parole violation within 20 days of submitting a request for information about the individual to ISD; or

(b) a federal, state, or local law enforcement agency presents a felony arrest warrant as provided in Paragraph (1) of Subsection B of this section; or

(c) a federal, state, or local law enforcement agency states that it intends to enforce an outstanding felony warrant or to arrest an individual for a probation or parole violation within 30 days of the date of a request from ISD about a specific outstanding felony warrant or probation or parole violation.

(3) Certain convicted felons: An individual who is or has been determined to be convicted on or before February 7, 2014, as an adult of the following crimes shall not be eligible for inclusion in the cash assistance benefit group:

(a) aggravated sexual abuse under section 2241 of title 18, United States Code;

(b) murder under section 1111 of title 18, United States Code;

(c) an offense under chapter 110 of title 18, United States Code;

(d) a federal or state offense involving sexual assault, as defined in section 40002(a) of the Violence Against Women Act of 1994 (42 U.S.C. 13925(a)); or

(e) an offense under state law determined by the attorney general to be substantially similar to an offense described in clause (i), (ii), or (iii); and

(f) the individual is not in compliance with the terms of the sentence of the individual or the restrictions under 8.139.400.12 C NMAC.

(4) Response time: ISD shall give the law enforcement agency 20 days to respond to a request for information about the conditions of a felony warrant or a probation or parole violation, and whether the law enforcement agency intends to actively pursue the individual. If the law enforcement agency does not indicate that it intends to enforce the felony warrant or arrest the individual for the probation or parole violation within 30 days of the date of ISD's request for information about the warrant, ISD shall determine that the individual is not a fleeing felon or a probation or parole violator and document the household's case file accordingly. If the law enforcement agency indicates that it does intend to enforce the felony warrant or arrest the individual for the probation or parole violation within 30 days of the date of ISD's request for information, ISD will postpone taking any action on the case until the 30-day period has expired. Once the 30-day period has expired, ISD shall verify with the law enforcement agency whether it has attempted to execute the felony warrant or arrest the probation or parole violator. If it has, ISD shall take appropriate action to deny an applicant or terminate a participant who has been determined to be a fleeing felon or a probation or parole violator. If the law enforcement agency has not taken any action within 30 days, ISD shall not consider the individual a fleeing felon or probation or parole violator, shall document the case file accordingly, and take no further action.

(5) Application processing: ISD shall continue to process the application while awaiting verification of fleeing felon or probation or parole violator status. If ISD is required to act on the case without being able to determine fleeing felon or probation or parole violator status in order to meet the time standards in 7 CFR 273.2(g) or 273.2(i)(3), ISD shall process the application without consideration of the individual's fleeing felon or probation or parole violator status.

[8.100.130.22 - Rp 8.100.130.22, 7/1/2024]

8.100.130.23 FINANCIAL VERIFICATION STANDARDS - RESOURCES: The applicant/recipient's statement is acceptable for verification of resources unless the household is near the resource maximum limit and the information given is not questionable. If information is questionable, inconsistent or the household is near the maximum; ISD must clearly document why the household's statement was questionable in the case record and request additional verification. When further information or verification is requested the following items shall be

acceptable:

A. Bank accounts (checking, savings, certificates of deposit, savings bond, or Keogh's). Documents which may be used to verify bank or financial institution accounts include:

(1) current bank statement;

(2) statement from the bank or institution showing the value of the resource or the penalties for early withdrawal of deposit showing the total value and the penalty for early withdrawal;

(3) savings bond(s) showing total value and statement from bank/institution of penalty for early withdrawal;

(4) additional items as listed in ISD 135, "proof checklist"; or

(5) if documentary evidence is not readily available, use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

(6) Joint bank accounts: see appropriate program chapter for proper verification requirements.

B. **Stocks and bonds:** Documents which may be used to verify the value of stocks or bonds include:

(1) newspaper publications of the stock exchange;

(2) statement from the stock broker;

(3) additional items as listed in ISD 135, "proof checklist"; or

(4) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

C. **Life insurance:** Documents which may be used to verify the cash surrender value of life insurance include:

(1) insurance policy;

(2) statement from the insurance company, insurance agent, lodges or fraternal organizations;

(3) statement from the union or employer who provide the insurance;

(4) statement from the veteran's administration;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC;

(7) if the cash surrender value of the life insurance policy makes the applicant/recipient ineligible, liens against the insurance shall be explored; this will be done through use of acceptable methods of verification set forth in 8.100.130.9 NMAC; the cash surrender value of life insurance is necessary in programs only where it is countable.

D. **Real estate contracts, purchase contracts:** Documents which may be used to verify the value of real estate or purchase contracts include:

(1) statement from a bank or financial institution, commodity broker, real estate agent, or expert in the field of real estate contracts or purchase contracts;

(2) additional items as listed in ISD 135, "proof checklist"; or

(3) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

E. **Non-recurring lump sum payment:** Documents which may be used to verify a nonrecurring lump-sum payment include:

(1) statement from a company, agency or organization that provided payment;

(2) copy of a check or check stub;

(3) award letters;

(4) statement from an attorney;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

F. **Tools and equipment:** Documents which may be used to verify the value of tools and equipment include:

(1) recent sales slips;

(2) insurance or tax appraisals;

(3) catalogs or newspaper ads;

(4) statement from a bank, broker, local merchant or expert on tools and equipment;

(5) additional items as listed in ISD 135, "proof checklist"; or

(6) if documentary evidence is not readily available, use other acceptable methods of

verification as in 8.100.130.9 NMAC.

G. Real property: Documents which may be used to verify the value of real property the applicant/recipient does not use include:

(1) a written statement from a real estate agent or broker stating the fair market value of property;

(2) statement from a bank or financial institution stating value and equity;

(3) additional items as listed in ISD 135, “proof checklist”; or

(4) if documentary evidence is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

[8.100.130.23 - Rp 8.100.130.23, 7/1/2024]

8.100.130.24 FINANCIAL VERIFICATION STANDARDS - UNEARNED INCOME: Verification of income is mandatory for all programs.

A. Social security benefits (OASDI, SSI): Documents which may be used to verify OASDI/SSI benefits include:

(1) award letter (Form SSA 1610);

(2) copy of a check(s) - amount of medicare premium must be added in;

(3) letter from SSA;

(4) direct deposit receipt - amount of medicare premium must be added in;

(5) additional items as listed in ISD 135, “proof checklist”; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the social security administration (TPQY) may be selected as verification of OASDI/SSI or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

B. Veteran's benefits: Documents which may be used to verify veteran's benefits include:

(1) award letter;

(2) copy of a check(s);

(3) written verification from a regional VA office;

(4) direct deposit receipt(s);

(5) additional items as listed in ISD 135, “proof checklist”; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the veteran's administration may be selected as verification of veteran's benefits use other acceptable methods of verification as in 8.100.130.9 NMAC.

C. Railroad retirement benefits: Documents which may be used to verify railroad retirement benefits include:

(1) award letter;

(2) copy of a check;

(3) letter from SSA;

(4) direct deposit receipt;

(5) additional items as listed in ISD 135, “proof checklist”; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the regional director of retirement claims may be selected as verification of railroad retirement benefits or use acceptable methods of verification as in 8.100.130.9 NMAC.

D. Military allotments: Documents which may be used to verify military allotment include:

(1) written statement from the appropriate military service center;

(2) copy of the allotment authorization;

(3) copy of a check;

(4) direct deposit receipt;

(5) additional items as listed in ISD 135, “proof checklist”; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the appropriate military service center may be selected as verification of a military allotment or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

E. Workers' compensation benefits: Documens which may be used to verify worker's compensation include:

(1) employer's statement;

(2) written statement from workers’ compensation administration;

(3) written statement from insurance company;

(4) additional items as listed in ISD 135, “proof checklist”; or

(5) if documentary evidence is not readily available or is questionable, a collateral contact with the New Mexico department of workforce solutions (NMDWS) or with the insurance company may be selected as verification of workers' compensation benefits or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

F. Unemployment compensation benefits (UCB): Verification of unemployment compensation benefits should first be explored through the NMDWS web link. If it is not available through the NMDWS web link, the following documents may be used to verify UCB include:

(1) award letter;

(2) copy of a check;

(3) statement from the New Mexico DWS;

(4) additional items as listed in ISD 135, “proof checklist”; or

(5) if documentary evidence is not readily available, a collateral contact with the NMDWS may be selected as verification of unemployment compensation benefits or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

G. Child/spousal support: Verification of child or spousal support should first be explored through the CSED automated system If it is not available through the CSED system, documents which may be used include:

(1) written statement from the contributor;

(2) written statement from the court;

(3) copy of a check or a canceled check;

(4) divorce or separation decree;

(5) court order;

(6) support agreement;

(7) correspondence from the contributor regarding support payments;

(8) court records;

(9) attorney's records;

(10) income tax return from the prior year;

(11) employer's record of attached wages;

(12) additional items as listed in ISD 135, “proof checklist”; or

(13) if documentary evidence is not readily available or is questionable, a collateral contact may be selected to verify child/spousal support or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC;

(14) no contact with the absent parent shall be made without the consent of the applicant/recipient. If good cause for failure to cooperate with CSED has been filed, contact with the absent parent must not be made.

H. Educational scholarships, grants or loans: Documents which may be used to verify amounts of an educational scholarship, grant, or loan include:

(1) financial aid award letter or a budget sheet from the institution;

(2) written statement from the institution;

(3) written statement from veteran's administration;

(4) additional items as listed in ISD 135, “proof checklist”;

(5) as educational expenses are deducted from the educational scholarship, grant or loan, it will be necessary to obtain verification of the expenses; verification may be obtained from the institution; or

(6) if documentary evidence is not readily available or is questionable, a collateral contact with the institution may be selected as verification of an education scholarship, grant or loan or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

I. Non-recurring lump sum: See Subsection E of 8.100.130.23 NMAC.

J. Contributions: Documents which may be used to verify contributions include:

(1) written statement from the contributor;

(2) additional items as listed in ISD 135, “proof checklist”; or

(3) if documentary evidence is not readily available or is questionable, a collateral contact with the contributor may be selected as verification of a contribution or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

K. Loans: Verification of a loan must contain the name of the person making the loan, the amount of the loan, date the loan was made and the repayment arrangement for the loan. Documents which may be used to verify loans include:

(1) written statement from the person or organization making the loan;
(2) promissory note;
(3) loan agreement;
(4) additional items as listed in ISD 135, "proof checklist"; or
(5) if documentary evidence is not readily available or is questionable, a collateral contact with the person or organization making the loan may be selected as verification of a loan or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

L. Individual development accounts (IDA)

(1) The IDA is verified by reviewing the trust documents creating the IDA and documents verifying deposits and withdrawals from the account during the period since the previous certification. The trust documents must show the terms and conditions governing the IDA, including withdrawal provisions.

(2) ISD shall review deposits and withdrawals to ensure that no funds are being withdrawn except for those allowed under IDA policy and to ensure that the individual was employed during the time that any deposits were made.

[8.100.130.24 NMAC - Rp 8.100.130.24, 7/1/2024]

8.100.130.25 FINANCIAL VERIFICATION STANDARDS - EARNED INCOME:

A. Wages and salaries: Documents which may be used to verify current wages and salaries include:
(1) wage stubs;
(2) written statement from the employer;
(3) additional items as listed in ISD 135, "proof checklist"; or
(4) if documentary evidence is not readily available or is questionable, a collateral contact with the employer may be selected as verification of wages and salaries or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

B. Self-employment: Verification of required tax and employer identification numbers, and tax-related and employer-related forms that the applicant/recipient was required to file is mandatory. It may not be possible to verify self-employment income through any single document. Documents which are used to verify self-employment income include:
(1) required state and federal tax and employer identification numbers;
(2) required federal and state tax forms for the current and prior tax year, including state and federal income and employer wage reporting and withholding reporting forms, gross receipts and occupation tax reporting forms;
(3) bills which indicate self-employment costs;
(4) other papers showing income and business expenses;
(5) all required business and occupation licenses;
(6) completed personal wage record;
(7) additional items as listed in ISD 135, "proof checklist"; or
(8) if documentary evidence of non-mandatory documents is not readily available, use other acceptable methods of verification as in 8.100.130.9 NMAC.

[8.100.130.25 NMAC - Rp 8.100.130.25, 7/1/2024]

8.100.130.26 DEDUCTIONS/ALLOWANCES VERIFICATION STANDARDS - SHELTER:

A. The applicant/recipient's statement is acceptable for verification of shelter expenses, if the information given is not questionable. If information is questionable or inconsistent; ISD must clearly document why the household's statement was unacceptable and what information requires additional verification. When further information or verification is requested the following items shall be acceptable:

(1) An obligation to pay for shelter is considered a deduction for SNAP. If the expense is questionable and verification of a shelter expense is requested and not provided, SNAP benefits will be determined without allowing a deduction for shelter expenses. When further verification is requested, documents which may be used to verify an obligation to pay for shelter include:
(a) mortgage payment book;
(b) written statement from the bank or other financial institution;
(c) rent receipt;
(d) written statement from the landlord;
(e) lease agreement;
(f) copies of bills for property taxes or house insurance;

(g) correspondence with the taxing authority or insurance agency; or

(h) additional items as listed on ISD 135 "proof checklist".

(2) If documentary evidence is not readily available or is questionable, a collateral contact may be selected to verify the obligation to pay shelter or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

B. Utilities: The applicant/recipient's statement is acceptable for verification of utility expenses, if the information given is not questionable. If information is questionable or inconsistent; ISD must clearly document why the household's statement was unacceptable and what information requires additional verification. Documents which may be used to verify an obligation to pay for utilities include:

(1) utility bills;

(2) rent receipt, lease agreement, or written statement from the landlord showing the household is responsible for payment of utilities;

(3) written statement from a utility provider;

(4) additional items as listed on ISD 135 "proof checklist"; or

(5) if documentary evidence is questionable, a collateral contact with the landlord or the utility provider may be selected to verify the obligation to pay for utilities or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

[8.100.130.26 NMAC - Rp 8.100.130.26, 7/1/2024]

8.100.130.27 DEDUCTIONS/ALLOWANCES VERIFICATION STANDARDS - MEDICAL EXPENSES:

A. Verification of medical expenses is mandatory for SNAP if the applicant/recipient meets one of the criteria listed below. The applicant/recipient's statement that no reimbursement will be received will be accepted unless questionable. If the household claims a reimbursement, a deduction cannot be allowed until the un-reimbursed portion of the expense is verified.

(1) the individual claiming the medical expense is age 60 or older or disabled; and

(2) the amount of the medical expenses exceeds $35; or

(3) allowance of the medical expenses would potentially result in a deduction;

(4) failure to provide verification of medical expenses will result in a determination of eligibility and amount of benefits without considering medical expenses.

B. Documents which may be used to verify a medical expense include:

(1) current bill;

(2) monthly statement from the provider;

(3) medical insurance policy;

(4) appointment cards, travel receipts (lodging and transportation) to verify travel costs associated with obtaining medical care;

(5) additional items as listed in ISD 135 "proof checklist"; or

(6) if documentary evidence is questionable, a collateral contact with the landlord or the utility provider may be selected to verify the obligation to pay for utilities or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

[8.100.130.27 NMAC - Rp 8.100.130.27, 7/1/2024]

8.100.130.28 DEDUCTIONS/ALLOWANCES VERIFICATION STANDARDS - DEPENDENT CARE:

A. The applicant/recipient's statement is acceptable for verification of dependent care expenses, if the information given is not questionable. If information is questionable or inconsistent; ISD must clearly document why the household's statement was unacceptable and why information requires additional verification.

B. Documents which may be used to verify dependent care costs:

(1) current bill;

(2) written statement from the provider;

(3) additional items as listed in ISD 135 "proof checklist"; or

(4) if documentary evidence is not readily available, or is questionable a collateral contact with the care provider may be used as verification of dependent care costs or use other acceptable methods of verification as set forth in 8.100.130.9 NMAC.

[8.100.130.28 NMAC – Rp 8.100.130.28, 7/1/2024]

HISTORY OF 8.100.130 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD Rule 160, Eligibility and Verification Standards, 2/9/1988.
ISD Rule 160, Eligibility and Verification Standards, 9/15/1993.

History of Repealed Material:
8 NMAC 3.ISD.130, General Operating Policies, Eligibility/Verification Standards, filed 6/16/1997 - Repealed, 7/1/1997.
8.100.130 NMAC, General Operating Policies - Eligibility and Verification Standards, filed 3/26/2001 - Repealed, 8/1/2008.
8.100.130 NMAC, General Operating Policies - Eligibility and Verification Standards, filed 8/1/2008 - Repealed, 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 150 GENERAL OPERATING POLICIES - RECORD RETENTION/MANAGEMENT

8.100.150.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.150.1 NMAC – Rp 8.100.150.1, 7/1/2024]

8.100.150.2 SCOPE: The rule applies to the general public.
[8.100.150.2 NMAC – Rp 8.100.150.2, 7/1/2024]

8.100.150.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the authority to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Section 9-8-6-B-(3) NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.100.150.3 NMAC – Rp 8.100.150.3, 7/1/2024]

8.100.150.4 DURATION: Permanent.
[8.100.150.4 NMAC – Rp 8.100.150.4, 7/1/2024]

8.100.150.5 EFFECTIVE DATE: July 1, 1997, unless a later date is cited at the end of a section.
[8.100.150.5 NMAC – Rp 8.100.150.5, 7/1/2024]

8.100.150.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.150.6 NMAC – Rp 8.100.150.6, 7/1/2024]

8.100.150.7 DEFINITIONS: [Reserved]
[8.100.150.7 NMAC – Rp 8.100.150.7, 7/1/2024]

8.100.150.8 RECORD RETENTION: Various records, forms and documents have differing periods of relevance and usefulness. Certain material in the record should be deleted on a scheduled basis when the material is no longer needed. To facilitate record management, as well as to establish the minimum period of time for which material must be retained, specific retention periods for case record materials have been established. Record retention schedules for each form are listed in the HCA forms manual table of contents.
[8.100.150.8 NMAC – Rp 8.100.150.8, 7/1/2024]

8.100.150.9 RETENTION CODES:

A. P-retain permanently: Forms and documents must be retained in the case record permanently.

B. 4-retain four years: Federal regulations provide that fiscal documents must be retained for three years after the end of the period to which they apply. By retaining these records for four years, adjustment is made for post-closure reporting and audit periods within the federal requirements. If a record is part of a federal exception in an audit, the record is kept until the audit exception is resolved.

C. 1-retain one year: Many financial and medical assistance administrative forms, appointment letters, change notices, review schedules, etc., not needed for eligibility and/or benefit determination do not need to be kept for long periods of time, and can be destroyed when superseded or obsolete. Disposal of general correspondence not related to the eligibility conditions of clients is authorized when the purpose of the correspondence has been served.

D. SI-special instructions: There are some forms that can be destroyed when obsolete or no longer needed, or that are not filed in the case record. These forms have been identified under "SI" for reference purposes, and the user decides suitable disposition.
[8.100.150.9 NMAC – Rp 8.100.150.9, 7/1/2024]

8.100.150.10 RETENTION OF NARRATIVE AND DOCUMENTS:

A. Narrative: All narratives are kept permanently.

B. Documents: Copies of documents such as court orders, medical information, birth certificates, social security cards, death certificates, contracts, etc., are filed in the record permanently.

[8.100.150.10 NMAC – Rp 8.100.150.10, 7/1/2024]

8.100.150.11 RETENTION OF CORRESPONDENCE: Correspondence used to establish eligibility should be retained for four years. Correspondence not used to establish eligibility may be deleted after one year.

[8.100.150.11 NMAC – Rp 8.100.150.11, 7/1/2024]

History of 8.100.150 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD Rule 131, Administrative Policy, 2/10/1988.

History of Repealed Material:

8 NMAC 3.ISD.150, General Operating Policies, Records Retention/Management - Repealed, 7/1/1997.

8 NMAC 3.ISD.150, General Operating Policies, Records Retention/Management, filed 7/1/1997 – Repealed effective 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 180 GENERAL OPERATING POLICIES - EXTERNAL COMMUNICATIONS

8.100.180.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.180.1 NMAC – Rp 8.100.180.1, 7/1/2024]

8.100.180.2 SCOPE: The rule applies to the general public.
[8.100.180.2 NMAC – Rp 8.100.180.2, 7/1/2024]

8.100.180.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the authority to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs

B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Section 9-8-6-B-(3) NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.100.180.3 NMAC – Rp 8.100.180.3, 7/1/2024]

8.100.180.4 DURATION: Permanent.
[8.100.180.4 NMAC – Rp 8.100.180.4, 7/1/2024]

8.100.180.5 EFFECTIVE DATE: July 1, 1997, unless a later date is cited at the end of a section.
[8.100.180.5 NMAC – Rp 8.100.180.5, 7/1/2024]

8.100.180.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.180.6 NMAC – Rp 8.100.180.6, 7/1/2024]

8.100.180.7 DEFINITIONS: [Reserved]
[8.100.180.7 NMAC – Rp 8.100.180.7, 7/1/2024]

8.100.180.8 COMMUNICATION WITH RECIPIENT - General communication: Both oral and written communications with applicants/recipients must be courteous. ISD shall inform the client promptly and in accord with state and federal regulations of actions relating to an application or ongoing case.
[8.100.180.8 NMAC – Rp 8.100.180.8, 7/1/2024]

8.100.180.9 DENIAL/APPROVAL OF APPLICATION: Prompt notification of action on a specific application is required. See specific program sections in this manual.
[8.100.180.9 NMAC – Rp 8.100.180.9, 7/1/2024]

8.100.180.10 NOTICE OF AN ADVERSE ACTION: Before any action to withhold a cash assistance payment or to reduce or terminate medical, food stamp or cash assistance benefits, the authority must issue timely and adequate advance notice of an adverse action.

A. Adverse action defined: Adverse action means an action taken by HCA that adversely affects eligibility or the amount of benefits a household or benefit group receives, including withholding, suspending, reducing or terminating benefits.

B. Timing: A notice shall be issued to the household or benefit group before taking and adverse action. Benefits will not be reduced until 13 days from the date on the adverse action notice. If the 13th day falls on a weekend or holiday, the next working day is counted as the last day of the 13-day adverse action notice period.

C. Contents

(1) General: An adverse action notice shall contain, in easily understood language:

(a) reason for the proposed action, including the specific regulations supporting the action and the information on which the proposed action is based;

(b) date the action will take place;

(c) statement of the right to request a fair hearing and how to request a fair hearing;

(d) phone number of the caseworker in the event the client wants more information or wants to request a fair hearing;

(e) date by which the client must request a fair hearing to continue receiving assistance at the current rate;

(f) liability of the recipient for any overissuance or overpayment;

(g) right to be represented by legal counsel, friend or other spokesperson;

(h) notice that free legal help may be available to the household;

(i) the current benefit amount and proposed benefit amount after reduction for any reason.

(2) Specific:

(a) For a disqualification from participation in the food stamp program, the notice must also include the disqualification period, as appropriate, and the action the disqualified individual must take to end ineligibility.

(b) For sanctions from cash assistance, the notice must also include the conciliation period, if applicable, and the sanction period, as appropriate, as well as the action the sanctioned individual must take to end ineligibility.

(c) For termination of cash assistance benefits due to reaching the TANF 60-month term limit, the notice must also include the actions the participant must take to apply for a hardship extension, found at 8.102.410.17 NMAC, and the availability of support services in the event the benefit group is not eligible for a hardship extension.

[8.100.180.10 NMAC – Rp 8.100.180.10, 7/1/2024]

8.100.180.11 CONCURRENT NOTICE: A concurrent notice is one which is mailed no later than the date the benefit is or would have been received. It is also referred to as an adequate notice.

A. Food stamps: HCA notifies a household that its FS benefits are reduced or terminated no later than the date the household receives, or would have received, its allotment, in the following circumstances:

(1) the household reports the information which results in the reduction or termination;

(2) the reported information is in writing and signed by an adult household member;

(3) HCA can determine the household's allotment or ineligibility based solely upon the household's written information;

(4) the household retains its right to a fair hearing;

(5) the household retains its right to continued benefits by requesting a fair hearing within the time period provided by the adverse action notice;

(6) HCA continues (or supplements) the household's previous benefit level, if necessary, within five working days of the household's request for a fair hearing.

B. FA and medical: HCA notifies a benefit group that its benefits are reduced or terminated by no later than the date the group receives, or would have received, its benefit in the following circumstances.

(1) Death: Termination or reduction of assistance is necessary because of the death of an FA benefit group member or a MA recipient whose death is documented.

(2) Admission to institution: Reduction of assistance is necessary because the client enters a skilled nursing home or intermediate care facility, or termination is necessary because of the client's admission to an institution which makes him/her ineligible for payment.

(3) Client request: The client requests in writing that the FA or MA assistance be reduced or terminated; the client gives information in a signed statement that causes a termination or reduction of services and the client indicates in writing that he/she understands this is the consequence of supplying such information.

(4) Whereabouts unknown: Withholding FA or MA assistance is necessary because of the unknown whereabouts of the client, as evidenced by agency mail to the client's last known address having been returned to the ISD as undeliverable.

(5) Other assistance: The client is accepted for FA or MA assistance in another county or state, or under another jurisdiction (including SSI) and the effective date of coverage has been established.

(6) Removal of child: Termination or reduction of FA is necessary because of the removal of a recipient child from the home through judicial determination or the voluntary placement of the child in foster care by the legal guardian or specified relative.

(7) Change in medical care: A change in a client's level of medical care is prescribed by his/her physician.

(8) Special allowance: A special allowance granted to a client for a specific period of time is terminated and the client has been informed at the time the allowance was granted that it would terminate at a specific time.

(9) Fair Hearings: An adverse action has been suspended pending a fair hearing and the fair hearing determination is not in the client's favor.

(10) Recertification: A recertification is not completed by the time the certification expires and a notice of suspension is issued, or the non-certified case has been in payment suspension for a month, and the case is being closed.

(11) Sanction: An FA payment is being reduced or terminated because an individual is not cooperating with the child support enforcement program or is failing to meet work program requirements.

(12) A client is also informed of his/her right to request a hearing on the action, the way to make such a request, and the conditions under which assistance will be continued if a hearing is requested. In any contact with the county office or in a hearing, the client may speak for him/herself, or be represented by legal counsel or a friend or other spokesperson.

[8.100.180.11 NMAC – Rp 8.100.180.11, 7/1/2024]

8.100.180.12 FOOD STAMP EXCEPTIONS: Adverse action notices are not required under the following conditions.

A. Mass changes: The state initiates a mass change.

B. Death: The ISS determines, based on reliable information, that all members of a household have died.

C. Move from project area: The ISS determines, based on reliable information, that the household has moved from the project area, or will move before the next FS issue.

D. Completion of restoration of lost benefits: The client has been receiving an increased allotment to restore benefits, the restoration is complete, and the client has been previously notified in writing when the increased allotment would end.

E. Anticipated changes in monthly benefit amount: A household's allotment varies from month to month within the certification period to take into account changes which are anticipated at the time of certification, and the household was notified at the time of certification of the allotment variations.

F. Benefit reduction upon approval of household's FA application: The household jointly applied for FA and FS benefits, and has been receiving food stamps pending the approval of the FA grant, and was notified at the time of certification that FS benefits would be reduced upon approval of the FA grant.

G. Household member disqualified for intentional program violation: The benefits of the remaining household members are reduced or terminated to reflect the disqualification of a household member.

H. Benefits contingent upon providing postponed verification: The ISS has assigned a normal certification period to a household certified on an expedited basis, for whom verification was postponed, and the household was given a written notice that the receipt of benefits beyond the month of application was contingent upon its providing the required verification.

I. Conversion: Converting a household from cash and/or FS benefit recovery to recoupment (benefit reduction) because of failure to make agreed-upon repayment.

J. Loss of certification by drug or alcoholic treatment center or group living arrangement.: The ISS terminates the eligibility of a resident of a drug or alcoholic treatment center or a group living arrangement because the facility loses either its certification from the New Mexico health department or other appropriate state agency, or has its status as an authorized representative suspended because FCS has disqualified it as a retailer.

K. Transfer between FSP and food distribution programs. If a local office is notified by the appropriate Indian tribal organization (ITO) that a participating household wishes to switch programs, the ISS:

(1) advises the ITO of the earliest date that program transfer may occur without risk of dual participation;

(2) closes the FS case without advance notice; and

(3) follows up with the appropriate ITO-provided form.

L. Household requests termination.

[8.100.180.12 NMAC – Rp 8.100.180.12, 7/1/2024]

8.100.180.13 FRAUD: If the agency obtains facts indicating that FA or MA should be suspended, terminated or reduced because of probable fraud by the recipient which has been verified, if possible, by collateral sources, notice of the action being taken is mailed at least five days before the action is to become effective.

[8.100.180.13 NMAC – Rp 8.100.180.13, 7/1/2024]

8.100.180.14 CONTINUATION OF BENEFITS: If a fair hearing request is filed, benefits are continued, under the circumstances described below, until the fair hearing determination is completed.

A. Timely requests

(1) Advance notice: If a household requests a fair hearing within the advance notice period provided by the advance adverse action notice, and its certification period has not expired, the household's participation in the program is continued on the same basis authorized immediately before the adverse action notice, unless the household specifically waives a continuation of benefits.

(2) All fair hearing request forms contain a space for a household to indicate whether or not continuation of benefits is requested. If the form does not positively indicate that the household has waived continuation of benefits, the ISS assumes that continuation of benefits is desired and the benefits are issued accordingly. Such benefits are continued until the end of the certification period or the resolution of the fair hearing, whichever is first.

B. Concurrent notice: If a benefit group requests a fair hearing within 13 days of issuance of a concurrent adverse action notice, and its certification period has not expired, cash assistance, food stamps and medicaid benefits are reinstated. Unless other intervening changes occur, assistance is not reduced or terminated, nor may the manner or form of payment be changed to a protective payment, during the period until the hearing decision is rendered, except as provided in regulations at 8.100.180.10 and 8.100.180.15.

(1) Additionally, receipt of continued benefits ends if a determination is made at the hearing that the sole issue is one of federal policy or law, or change in such policy or law, and not one of incorrect grant computation.

(2) If a later change affecting the client's grant occurs while the hearing decision is pending and the client does not request a hearing regarding the change, the payment which the client continues to receive during the hearing period is adjusted only by the amount required by the change.

(3) If assistance is to be continued, it is continued through the end of the month in which a decision on the hearing is reached.

(4) If hearing decisions are delayed, assistance is continued only if the delay is caused by HCA or if a delay of five days or less is requested by the client because of unusual circumstances beyond his/her control.

C. Late requests

(1) If a hearing request is not made within the period provided by the adverse action notice, benefits are reduced or terminated as provided in the notice.

(2) If a client demonstrates that failure to make the request within the advance notice period was for good cause, benefits are reinstated to the previous level. The hearing unit supervisor decides if the failure was for good cause.

[8.100.180.14 NMAC – Rp 8.100.180.14, 7/1/2024]

8.100.180.15 MASS CHANGES

A. General: Certain changes initiated by the state or federal government may affect the entire caseload or significant portions of it. These changes include, but are not limited to, increases or decreases in eligibility or payment standards changes in excluded or deducted items or amounts. Mass changes affecting income include annual adjustments of Social Security, SSI, and other federal benefit programs, and any other changes in eligibility criteria based on legislative or regulatory actions.

B. Notice of mass changes: Adverse action notices are required for mass changes resulting from statutory or regulatory changes in eligibility or payment standards, benefit, changes in excluded or deducted items or amounts for purposes of eligibility or calculation of benefit levels. The authority will either provide concurrent notice to affected households of the mass change no later than the date the household receives, or would have received, its benefit issuance, or the affected cases will be notified through the media, and/or posters in county offices.

C. Appeal rights: Notice of the change will include the recipient’s right to appeal. A hearing is not available, and benefits are not continued, when automatic benefit adjustments are required by federal or state law unless the specific, express basis for the hearing request is incorrect benefit computation. If the recipient requests a fair hearing within the advance notice period, benefits will be continued at the former amount. If the appeal results in a decision that the reduction or closure was incorrect, the difference between what the recipient received pending the appeal decision and the amount that should have been received will be restored to the recipient.

[8.100.180.15 NMAC – Rp 8.100.180.15, 7/1/2024]

8.100.180.16 DISPUTED CONTINUATION OF BENEFITS: If a client and the ISS disagree about the continuation of benefits, the client may request a fair hearing. Adverse action defined. "Adverse action" is action taken by HCA which adversely affects the amount of benefits a client receives. Such actions include holding mailing of assistance warrants, and suspension, reduction or termination of benefits.
[8.100.180.16 NMAC – Rp 8.100.180.16, 7/1/2024]

8.100.180.17 HOME VISIT NOTICE: The worker shall give advance notice to an applicant or recipient of any visit to the applicant's or recipient's home.

A. Verbal notice: The advance notice may be in the form of a verbal communication between the worker and the applicant or recipient. The time and date of the visit must be mutually agreeable and should, in most cases, be made at least one day in advance of the visit. The worker shall provide an explanation of the need for the visit to the applicant or recipient. The worker shall document the discussion in the case narrative and provide a justification if the period of advance notice is any less than one day.

B. Written notice: The home visit notice may be written. The written notice shall be mailed at least 10 days in advance of the intended visit. The notice shall indicate the time, date, and purpose of the visit. The notice shall request the applicant or recipient to confirm the appointment date with the worker. In the absence of a response from the applicant or recipient, the visit shall take place and the applicant or recipient is expected to be at home for the visit.
[8.100.180.17 NMAC – Rp 8.100.180.17, 7/1/2024]

History of 8.100.180 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD Rule 180, Notice Requirements, 2/9/1988.

History of Repealed Material:
8 NMAC 3.ISD.180, General Operating Policies, External Communications - Repealed, 7/1/1997.
8 NMAC 3.ISD.180, General Operating Policies, External Communications, filed 7/1/1997 – Repealed effective 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 100 GENERAL PROVISIONS FOR PUBLIC ASSISTANCE PROGRAMS
PART 390 GENERAL SUPPORT - INFORMATION SYSTEMS

8.100.390.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.100.390.1 NMAC – Rp 8.100.390.1, 7/1/2024]

8.100.390.2 SCOPE: The rule applies to the general public.
[8.100.390.2 NMAC – Rp 8.100.390.2, 7/1/2024]

8.100.390.3 STATUTORY AUTHORITY:

A. Section 27 NMSA 1978 (1992 Repl.) provides for the authority to "...adopt, amend and repeal bylaws, rules and regulations..." It also provides for administration of public assistance programs.

B. The income support division (ISD) of the health care authority (HCA) was created by the HCA secretary under authority granted by Section 9-8-6-B-(3) NMSA 1978.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.100.390.3 NMAC – Rp 8.100.390.3, 7/1/2024]

8.100.390.4 DURATION: Permanent.
[8.100.390.4 NMAC – Rp 8.100.390.4, 7/1/2024]

8.100.390.5 EFFECTIVE DATE: July 1, 1997, unless a later date is cited at the end of a section.
[8.100.390.5 NMAC – Rp 8.100.390.5, 7/1/2024]

8.100.390.6 OBJECTIVE: The objective of these regulations is to provide general policy and procedures for income support division (ISD) administered programs.
[8.100.390.6 NMAC – Rp 8.100.390.6, 7/1/2024]

8.100.390.7 DEFINITIONS: [Reserved]
[8.100.390.7 NMAC – Rp 8.100.390.7, 7/1/2024]

8.100.390.8 FORMS ANALYSIS, DESIGN, MANAGEMENT

A. Official form defined: An official form is any form with the authority logo and a number assigned in central office. An official form must include a statement as to the purpose of the form and instructions for completion, distribution, and retention of the form.

(1) All statements regarding participant rights and responsibilities which appear on forms must be exactly as they are in the policy manual.

(2) Forms used in ISD field offices will be indexed in the forms manual.

B. Forms covered by these procedures and forms not covered by these procedures: All forms used in ISD county offices and intended for public use are to be developed in accordance with these procedures. Forms intended for internal office use only may be developed by an office without using these procedures. Internal use forms are forms not sent out of the office and not used, received, or reviewed by program participants.

C. Sources for new and revised forms and pamphlets: New forms and pamphlets, and revisions to existing forms and pamphlets, may be proposed and developed by each division, as well as other HCA staff. In addition, the public information officer may also initiate new pamphlets and revisions to existing pamphlets in coordination with the appropriate program staff.

D. Assigning form numbers: Each division is responsible for developing its own forms numbering system. Numbering systems should appear in some reasonable order. It is recommended that this be done in the order in which forms are used in case processing. Sufficient space should be left between form numbers to allow for expansion of the system.

E. Responsibilities

(1) Forms - program specific: The division, or program area responsible for the policy which is addressed by a form will have primary responsibility for the development and revision of the form. Each division will assign its own form numbers and maintain a log of its form numbers. A central log of all form

numbers will also be kept by the graphics unit.

(2) ISD forms - program shared: Forms which are shared by more than one program and forms which do not involve any specific program will be assigned the suffix "ISD." The ISD form numbers log will be maintained by the ISD forms manager. The division or program area which proposes a new form or revision to an existing form will have primary responsibility for developing the new form or revising the existing form. The cost of producing the new or revised form will be prorated among the program areas which rely on the form. This proration will be based on caseload size.

(3) Forms - other sources: If the proposal for a new form or a revision comes from a field staff person or unit, the appropriate program, or division will review and approve the form prior to submission to the forms advisory team

(4) Pamphlets: Pamphlets should provide information and improve access to HCA programs. The most common purposes for the development of pamphlets are:

(a) HCA implements new programs;

(b) HCA makes significant policy changes; or

(c) auxiliary services are available.

(5) Responsibility for each pamphlet will reside with the which has primary responsibility for the policy issues addressed in the pamphlet. The unit which originates and develops the pamphlet will have responsibility for the distribution of the pamphlet within the authority and elsewhere as required by the governing federal oversight agency. The public information officer will handle any other distribution of the pamphlet.

(6) All other situations: In the absence of clear responsibility, the forms advisory team will assign responsibility for the design and development of the new or revised form. The division forms manager is available for consultation on forms manual issues.

F. Forms review procedures: All proposed new forms will be typed or printed in draft for review. Drafts of revisions to existing forms will be submitted on copies of the existing forms with changes marked clearly in red. Once the draft of the form and its instructions are complete, it may be necessary for the draft and instructions to be submitted to various agencies for review. Not all forms will be reviewed. Some will be reviewed in all four areas below and some will receive no review in these areas.

(1) Literacy review: All applications and forms pertaining to the eligibility process must be reviewed for appropriate literacy level. This will be accomplished by the office which develops the new form or revises an existing form.

(2) Review by general counsel: Any form to be sent to or completed by HCA clients or applicants must be reviewed by the HCA Office of general counsel in order to assure compliance with current legal standards. All drafts of pamphlets and informational items for general distribution to the public must also be reviewed by the office of general counsel before being sent to the public information officer for final approval.

(3) Approval by the public information officer: Following review by the office of general counsel, all drafts of pamphlets and informational items for general distribution to the public will be sent to the public information officer for final approval (see PIO-033.1).

(4) Review by inspector general: Forms authorizing certain payment, e.g. client medical travel expense, may also require review by the office of the inspector general. This requirement may change periodically. Those developing or revising forms of this nature should first consult with the OIG. Forms requiring review in any of these areas must be returned for re-review if **any** changes are made.

G. Forms advisory team review: After the new or revised form has been given all necessary review, the form and its instructions will be forwarded to the ISD forms manager. The forms manager will acknowledge receipt of the form and notify the primary program of the date of the review by the forms advisory team. A member of the program staff should be present when the forms advisory team meets to review the new or revised form.

(1) For new and revised forms, the forms advisory team will consider:

(a) Does the form address a new policy or program change?

(b) Does the form address a significant policy change?

(c) Is a form necessary or would clear procedural instructions meet the needs of implementation?

(d) If the form is necessary, is it user friendly and time efficient, and will it enhance the accuracy rate of the authority?

(2) For revised forms, the forms advisory team will also require that one of the following three conditions be met:

(a) the current form no longer addresses all policy issues;

(b) the revision will streamline the user's completion of the form; or

(c) the revision is necessary to comply with audit/accountability/program policy requirements.

(3) Once the form has been reviewed and approved by the forms advisory team, it will be returned to the originating staff for submission to the graphics unit for printing.

[8.100.390.8 NMAC – Rp 8.100.390.8, 7/1/2024]

8.100.390.9 GRAPHICS UNIT PROCESS:

A. The originating staff will complete a request/format approval form HCA 053 (green copy), attach the approved draft, and submit to the graphics unit. All drafts of proposed new forms submitted to the graphics unit must be typed or printed. The request/format approval form must include:

(1) quantity;

(2) dimensions;

(3) weight and type of paper;

(4) color of paper and inks;

(5) multiple copies;

(6) padding;

(7) stapling;

(8) drilling;

(9) stitching;

(10) wrapping;

(11) and any other special instructions.

B. The graphics unit will prepare a camera ready copy and contact the GSD state printing facility to obtain a price quote for the preparation of the procurement document. The graphics unit will return the price quote with the specifications to the originating staff who will prepare the procurement document. A copy of the camera ready will be reviewed, approved, and signed for by the originating staff. After approval and signature by the originating staff, the graphics unit will submit the camera ready to the GSD's state printing facility for printing. In some instances, camera readies may be copied at the HCA copy center. This decision will be made by the originating staff.

[8.100.390.9 NMAC – Rp 8.100.390.9, 7/1/2024]

8.100.390.10 AUTOMATED FORMS: Forms that are generated by automated systems are controlled by the information systems bureau general supporting policy section 8.100.390 NMAC.

[8.100.390.10 NMAC – Rp 8.100.390.10, 7/1/2024]

8.100.390.11 HCA SUPPLY: For forms stored at the HCA central warehouse, originating staff should consult the warehouse manager to determine: inventory status of the form; status of outstanding orders; and estimated date the form supply will be exhausted. This information will be used to determine the quantity of revised forms to be ordered and the revision date to be indicated on the revised form. The warehouse will notify the originating staff within 24 hours of receipt of the revised form/pamphlet. The originating staff will not release the form or pamphlet to the field offices until the warehouse has stock from which the field can order.

[8.100.390.11 NMAC – Rp 8.100.390.11, 7/1/2024]

8.100.390.12 RELEASE OF MANUAL REVISION: Once notified by the warehouse that a supply of the new or revised form is available, the originating staff will prepare the manual revision cover memo. A copy of the completed manual revision, form, and instructions will be submitted to the ISD forms manager. The forms manager will update the forms manual indexes and submit the manual revision to the director's office for signature and numbering. The signed and numbered manual revision will be returned by the director's office to the originating staff for distribution to the field.

[8.100.390.12 NMAC – Rp 8.100.390.12, 7/1/2024]

8.100.390.13 REORDERING FORMS: To re-order forms, the originating staff member fills out a form order/re-order memo and submits it to the warehouse manager for processing. The warehouse manager will complete the purchase document and return it to the program staff for signature.

[8.100.390.13 NMAC – Rp 8.100.390.13, 7/1/2024]

8.100.390.14 DISCONTINUATION OF FORMS: If an originating staff member determines a form is to be discontinued and destroyed, the originating staff will first consult with the forms advisory team. When the discontinuation or destruction of a form is agreed on, the originating staff will fill out a form discontinuation memo and submit it to the forms manager for processing along with a copy of the manual revision deleting the form from the forms manual. This will ensure the updating of the index. The forms manager will then submit the documents to the warehouse manager.
[8.100.390.14 NMAC – Rp 8.100.390.14, 7/1/2024]

History of 8.100.390 NMAC:
Pre-NMAC History: [**RESERVED**]

History of Repealed Material:
8 NMAC 3.ISD.390, General Support, Information Systems - Repealed, 7/1/1997.
8 NMAC 3.ISD.390, General Support, Information Systems, filed 7/1/1997 – Repealed effective 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 110 GENERAL OPERATING POLICIES - APPLICATIONS

8.102.110.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.110.1 NMAC - Rp 8.102.110.1, 7/1/2024]

8.102.110.2 SCOPE: The rule applies to the general public.
[8.102.110.2 NMAC - Rp 8.102.110.2, 7/1/2024]

8.102.110.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the authority is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified authority to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.110.3 NMAC - Rp 8.102.110.3, 7/1/2024]

8.102.110.4 DURATION: Permanent.
[8.102.110.4 NMAC - Rp 8.102.110.4 NMAC, 07/01/2024]

8.102.110.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.102.110.5 NMAC - Rp 8.102.110.5, 7/1/2024]

8.102.110.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.110.6 NMAC - Rp 8.102.110.6, 7/1/2024]

8.102.110.7 DEFINITIONS: [RESERVED]
[8.102.110.7 NMAC - Rp 8.102.110.7, 7/1/2024]

8.102.110.8 GENERAL

A. Application form: The application shall be submitted on a form designated by the authority either electronically or in writing and is made under oath by an applicant with whom a dependent child resides. The authority shall assist an applicant in completing the application for cash assistance or services. The application must contain a statement of the age of the child; residence; a statement of property in which the applicant has an interest;

a statement of the income that the applicant or other benefit group members have at the time the application is filed; a signature under penalty of perjury from the applicant; and other information required by the authority.

B. Interview:

(1) A face-to-face interview with the applicant shall be required in order to obtain information needed to the determine eligibility, verify, and record the facts supporting the application; and to give the applicant information about authority programs and program requirements. When circumstances warrant, the household shall be interviewed by telephone or another place reasonably accessible and agreeable to by the applicant and the caseworker in accordance with 8.102.110.11 NMAC.

(2) The applicant must identify all individuals living in the residence whether or not the individuals are requesting assistance. The applicant and the authority shall identify all individuals who must be included in the benefit group.

(3) Other information, documents, and collateral contacts may be required to determine eligibility. Requests for verification are made in accordance with provisions set forth in 8.100.130 NMAC.

C. Resource planning session: The applicant shall be provided a resource planning session no later than 30 days after an application is filed. The authority shall attempt to provide a resource planning session prior to approving the application, but it is not mandatory. Failure to provide a resource planning session shall not impede registration or processing of the application. The focus of the resource planning session is to ascertain the applicant's immediate needs, assess the applicant's financial and non-financial options, and to provide general information about authorityal assistance programs. The caseworker shall assist the applicant in exploring and accessing any other financial or non-financial options that may meet the benefit group's needs. If there is any indication that the applicant might be eligible for SSI, the relative advantages of the SSI program shall be explained and the applicant shall be referred to the local social security office.

D. EBT orientation: NMW cash assistance benefits shall be authorized and available through an electronic benefit transfer (EBT) account. The authority shall provide EBT training to an applicant in order to be able to access cash assistance benefits.

E. Application processing time limit: An application for NMW cash assistance shall be processed no later than 30 days after an application is filed. No later than five days after the application is approved, a reimbursement for childcare shall be provided, subject to the appropriation and availability of state or federal funds. [8.102.110.8 NMAC - Rp 8.102.110.8, 7/1/2024]

8.102.110.9 RIGHT TO APPLY

A. An individual has the right to make a formal application for any cash, food or medical assistance program administered by the authority, regardless of whether the individual appears to meet the conditions of eligibility. Any individual requesting information or assistance, who wishes to apply for assistance, shall be encouraged to complete the application that same day. The individual shall be informed:

(1) of the right to apply, whether or not it appears the individual may be found eligible; and

(2) that the date of application affects the benefits.

B. Availability of applications: The authority shall provide the YES- New Mexico web portal address to submit an application online or paper applications for cash assistance to anyone requesting an application, and to local agencies and organizations that have regular contact with the public. When the authority receives a request for an application for assistance, the authority will either mail or hand deliver a paper application, provide the web portal address for YES-New Mexico (for online applications), or provide both as indicated by the requestor. [8.102.110.9 NMAC - Rp 8.102.110.9, 7/1/2024]

8.102.110.10 SUBMISSION OF THE APPLICATION FORM

A. Items completed: To be accepted and registered, the cash assistance application, at a minimum, must be submitted on a form designated by the authority either electronically or in writing, identify the benefit group member applying, the program applied for, and have a signature of a responsible benefit group member or authorized representative.

B. Who completes the application: The application form must be completed by the applicant, an authorized representative, guardian, or another appropriate individual.

(1) Authorized representatives must be:

(a) designated in writing by the applicant/ head of household; and

(b) be an adult who has sufficient knowledge about the applicant’s circumstances to complete the application form correctly.

(2) If an authorized representative or another appropriate individual completes an application form, the applicant must review and approve the completed form. The applicant is liable for improper payments resulting from erroneous information given by the authorized representative or another appropriate individual.

(3) The caseworker may assist in completing the form if there is no one else to help the applicant.

(4) **Application for minor children:** Application for cash assistance for minor children, including unemancipated minor parents, must be made by the adult with whom the child resides and who is assuming responsibility for the support and care of the child.

(a) If a minor parent is living in a second-chance home, maternity home, or other adult-supervised supportive living arrangement, the application must be made by the supervising adult as the authorized representative for the minor parent.

(b) An emancipated minor may file an application in the emancipated minor's own right.

C. Signature:

(1) The application form must be signed by the applicant and authorized representative if one is designated. A signature means that the applicant is verifying the information provided by the household and has read and agrees with all of the statements on the application or other form requiring a signature. A signature is the depiction of the individual's name either, handwritten, electronic or recorded telephonically. Electronic and telephonically recorded signatures are valid only if provided in a format or on a system approved by the authority, which includes verification of the identity of the person providing the signature.

(2) If an applicant receives help from someone other than a caseworker in completing the form, that individual must also sign at the bottom of the form.

(3) An individual who cannot sign the individual's own name must sign the application with a mark and have it witnessed. A mark, which is not witnessed, shall not be accepted as a valid signature. A caseworker may not witness signatures on an application the caseworker will be processing.

(4) If the application is made on behalf of a child, the form shall be signed by the relative or caretaker with whom the child is living, or by the authorized representative.

(5) If the individual, relative, or caretaker has a legally appointed guardian, the guardian must complete and sign the form.

D. Where filed: An application may be submitted to the authority in person, by mail, via facsimile or by other electronic means which may include the YES-New Mexico web portal.

E. Incomplete applications: If an application is incomplete, prompt action shall be taken by the authority to notify the applicant. The individual who completed the application form must add the missing or incorrect information and initial and date the entries. All reasonable action shall be taken by the authority to avoid any unnecessary delay of the applicant's eligibility determination.

F. Out-of-state applicants: An application mailed in from out of state shall be accepted, but shall not be registered until the applicant contacts ISD to confirm presence in the state. If the applicant does not contact the ISD within 30 days, the application shall be returned to the applicant.

G. Application registration: Completed and signed in-state applications shall be registered effective the date on which the application is received during regular business hours; this includes applications that are dropped off, submitted in person and electronically. Applications that are dropped off or submitted electronically after regular scheduled business hours, holidays and weekends will be considered received as of the next business day.

H. Tribal TANF programs: An application for NMW benefits received from an applicant residing in a tribal TANF service delivery area shall be accepted by ISD and registered as of the date the application was received during regular business hours. Applications that are dropped off or submitted electronically after regular scheduled business hours, holidays and weekends will be considered received as of the next business day.

(1) Effective upon implementation of a tribal TANF program, the applicant shall be required to apply for the tribal TANF program in the service delivery area in which the applicant resides.

(2) Prior to finalizing an application for NMW benefits received from an applicant residing in a tribal TANF service delivery area, the applicant shall be informed he or she must apply for tribal TANF.

(a) The applicant shall be informed in writing that the applicant must provide verification of the disposition of the applicant's tribal TANF application.

(b) The applicant shall be referred to the appropriate tribal TANF service delivery area serving the community or county in which the benefit group lives.

[8.102.110.10 NMAC - Rp 8.102.110.10, 7/1/2024]

8.102.110.11 INTERVIEWS

A. Application interview: All applicants shall be interviewed in person at the local office or, when circumstances warrant, at another place reasonably accessible and agreeable to both the applicant and the caseworker. The applicant may bring any individual to the interview.

B. Alternative interviews:

(1) A cash assistance applicant shall not be required to have a face-to-face interview if the applicant is unable to appoint an authorized representative and the household has no member(s) able to come to the authority due to one of the hardship conditions listed in Paragraph (2) of Subsection B this section.

(2) Hardship conditions: The face-to-face interview for cash assistance households shall be waived when the applicant meets one of the following conditions:

(a) over the age of 60;

(b) disabled;

(c) employed 20 or more hours per week;

(d) has transportation difficulties;

(e) prolonged severe weather;

(f) other hardship identified as situations warrant; as authorized by the county director.

(3) A face-to-face interview must be granted to any recipient who requests one. If the recipient is unable to come to the office due to the issues listed in Paragraph 1 or 2 of this subsection, then an interview may be scheduled at a location agreed upon by the caseworker and the applicant.

C. Home visits: A home visit may be made to conduct the interview and obtain the information needed, as long as the authority gives adequate prior notice of the visit.

D. Scheduling interviews: An interview shall be scheduled upon receipt of the application. The interview shall take place within 10 working days of the date an application is filed and, to the extent possible, at a time that is convenient for the applicant.

E. Missed interviews: The applicant shall be responsible for scheduling a second appointment. If the applicant does not contact the office or does not appear for the rescheduled interview, the application shall not be denied until the 30th calendar day (or the next workday if the 30th is not a workday) after the application was filed.

F. Purpose and scope of interview

(1) Prior to approval there shall be an interview with the applicant. The purpose and scope of the interview shall be explained to the applicant. The interview is an official and confidential discussion of benefit group circumstances between the applicant and the caseworker. The interview allows the caseworker to explore and clarify unclear or incomplete information reported on the application and is intended to provide the applicant with information regarding the work program, child support benefits and requirements, the temporary nature of the program, eligibility requirements, and to provide the caseworker with the necessary facts to make an accurate eligibility determination.

(2) For cash assistance cases, at initial application, a brief history shall be required in the case narrative explaining the circumstances, which led to the application. The narrative shall include information clearly describing the child's situation with respect to child support from a non-custodial parent or parents.

G. Applicant information: During the course of the interview all reasonable steps shall be taken to make the applicant feel at ease and protect the applicant's right to privacy. The interviewer shall tell the applicant about the following:

(1) services available and requirements which must be met under the cash assistance program and the child support enforcement programs;

(2) school attendance and reporting requirements;

(3) complaint and hearing procedures;

(4) work program procedures;

(5) work requirements;

(6) application processing standards;

(7) procedures in cases of overpayment or underpayment;

(8) responsibility to report changes;

(9) non-discrimination policy and procedures;

(10) timeliness standards; and

(11) semiannual reporting requirements.

[8.102.110.11 NMAC - Rp 8.102.110.11, 7/1/2024]

8.102.110.12 APPLICATION PROCESSING TIME LIMITS

A. Timeliness: The caseworker shall explain time limits and the applicant's right to request an administrative hearing if the application is not processed within the applicable time limits.

B. Processing time limit: Cash assistance applications shall be completed within 30 calendar days from the date of application.

C. "Clocking" of time limits: "Clocking" of time limits begins on the day after the date of application.

D. Delayed assistance: If an eligibility determination is not made within the required time limits, the applicant shall be notified in writing of the reason for the delay. The notice shall also inform the applicant of the applicant's right to request an administrative hearing regarding the issue of ISD's failure to act within the time limits.
[8.102.110.12 NMAC - Rp 8.102.110.12, 7/1/2024]

8.102.110.13 DISPOSITION OF APPLICATION/NOTICE

A. Denials: If an application is denied, ISD shall issue a written notice to the applicant of a denial. The denial notice shall include the date of denial, reason for denial, the regulation section under which the denial was made, the applicant's right to a fair hearing concerning the denial, and the time limits for filing a fair hearing request. The notice shall also explain that the applicant may discuss the decision with the caseworker, supervisor, or county director.

B. Approvals: If the application is approved, the applicant shall be notified by mail or by electronic means which may include the YES-New Mexico web portal. The notice shall report the initial month of eligibility, amount of payment, how the payment is calculated, and the members who have been determined eligible.

C. Application withdrawal: An applicant may voluntarily withdraw the application at any time before eligibility determination. An effort shall be made to confirm the applicant's desire to withdraw the application. Applicants shall be advised that withdrawal of the application has no effect upon the right to apply for assistance in the future.

D. Tribal TANF requirements:

(1) If an applicant fails to provide documentation of denial for tribal TANF within thirty days, the NMW application shall be:

(a) held for thirty days beginning with the day after the date of application;

(b) denied on the thirtieth day or on the next business day if the thirtieth is not a business day.

(2) If the applicant provides documentation of denial for tribal TANF within thirty days, ISD shall determine the cause for denial prior to processing the NMW application. Applicants who verify denial of tribal TANF within thirty days shall be processed according to current NMW policy.

(a) An applicant denied tribal TANF benefits for the following reasons shall be immediately denied NMW cash assistance:

(i) failure to provide information;

(ii) failure to cooperate with the application process;

(iii) failure to comply with any tribal TANF non-financial eligibility criteria; or if

(iv) the benefit group is currently within a sanction period involving total benefit group ineligibility.

(b) Individuals qualifying for or receiving tribal TANF benefits shall be denied NMW cash assistance.
[8.102.110.13 NMAC - Rp 8.102.110.13, 7/1/2024]

8.102.110.14 APPROVAL EFFECTIVE DATE: NMW cash assistance shall be approved effective the date of authorization or no later than 30 days following the date of application, whichever is earlier. Payment in the initial month shall be prorated from the date of authorization.
[8.102.110.14 NMAC - Rp, 8.102.110.14, 7/1/2024]

8.102.110.15 ELECTRONIC CASE FILE

A. Documents in paper format will be imaged into an electronic case file (ECF). The ECF is located within the automatic system program and eligibility network (ASPEN). ASPEN will digitize the volume of paper documents received from individuals and manage them electronically in a centralized repository.

B. Implementation of the electronic document management solution provides ISD the capability to administer and manage eligibility related processes and tasks.

C. Once the existing paper case files are imaged the electronic record will be considered the official record.

[8.102.110.15 NMAC – Rp 8.102.110.15, 7/1/2024]

History of 8.102.110 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 210.0000, The Application Process for Financial and Medical Assistance, 2/22/1980.

ISD FA 210, Application Process, 2/9/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.

8.102.110 NMAC General Operating Policies - Applications - Repealed, 07/01/2001.

8.102.110 NMAC General Operating Policies – Applications, filed 7/1/2001 – Repealed effective 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 120 ELIGIBILITY POLICY - CASE ADMINISTRATION

8.102.120.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.120.1 NMAC - Rp 8.102.120.1, 7/1/2024]

8.102.120.2 SCOPE: The rule applies to the general public.
[8.102.120.2 NMAC - Rp 8.102.120.2, 7/1/2024]

8.102.120.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the authority is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the authority administers the supplemental nutrition assistance program (SNAP) employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.120.3 NMAC - Rp 8.102.120.3, 7/1/2024]

8.102.120.4 DURATION: Permanent.
[8.102.120.4 NMAC - Rp 8.102.120.4, 7/1/2024]

8.102.120.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.102.120.5 NMAC - Rp 8.102.120.5, 7/1/2024]

8.102.120.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.120.6 NMAC - Rp 8.102.120.6, 7/1/2024]

8.102.120.7 DEFINITIONS: [RESERVED]
[8.102.120.7 NMAC - Rp 8.102.120.7, 7/1/2024]

8.102.120.8 [RESERVED]

8.102.120.9 ELIGIBILITY REVIEWS:

A. Follow-up reviews:

(1) A follow-up review shall be scheduled during a certification period whenever information becomes known to the county office indicating a possible change in a benefit group's circumstances that may affect eligibility or payment amount.

(2) Review of a specific condition may be made by home visit, office visit, third party contacts or correspondence as needed.

(3) Circumstances which may require follow-up review include, but are not limited to:

(a) change in NMW participation work requirements;

(b) school attendance of children age six or older;

B. Recertification:

(1) Cash assistance shall be approved for a fixed certification period at the end of which the assistance shall be terminated.

(2) The recertification shall consist of a complete review of all conditions of eligibility; determination of eligibility for an additional period of time and redetermination of the amount of assistance payment. The recertification requires a redetermination of eligibility on those conditions that are subject to change. There shall be a prospective determination beginning the month following the month the certification expires.

(3) The caseworker shall ensure that CSED has been notified of all pertinent information regarding any non-custodial parent who has a child in the benefit group, including but not limited to the current address and work place of the non-custodial parent.

(4) **Conditions not subject to change:** Unchanged information shall not be re-verified unless it is incomplete, inaccurate, inconsistent, or outdated. Outdated is defined as unchanged verification that is more than 60 days old relative to the current month of participation.

(5) **Work program:** The caseworker shall give information to the NMW participants about earned income incentives, assistance through the transitional child care program, medicaid transitional benefits, and work program requirements, opportunities and services. Work program participation shall be reviewed.

(6) **Need and payment determination:** The caseworker shall obtain current information about family and benefit group:

(a) **Income:** if the source has changed or the amount has changed by more than $50;

(b) **Resources:** if the total of all countable resources for the benefit group exceed the $1500 liquid or $2000 non-liquid resource limit; and

(c) any other information which has changed or is questionable.

(7) **Change reporting:** The caseworker shall review with the client the possible changes in circumstances which must be reported if they occur.

(8) **Providing verification:**

(a) If electronic verification is not available, the household has primary responsibility for providing documentary evidence to support statements on the application and to resolve any questionable information.

(b) ISD shall assist a household in obtaining verification, provided the household is cooperating in the application process.

(c) A household or their authorized representative may supply documentary evidence in person, by mail, fax, electronic device or through the YES NM web portal.

(d) A household shall not be required to supply verification in person at the ISD office or to schedule an appointment to provide such verification.

(e) ISD shall accept any reasonable documentary evidence provided by the household and must be primarily concerned with how adequately the verification proves the statements on the application.

(9) **Recertification time standards:**

(a) **Timely reapplication:** Applications filed before the 15th of the expiration month will be considered timely. A household member or authorized representative that attends an interview and provides all necessary verification by the end of the household's current certification period, will have the opportunity to participate by the household's normal issuance cycle in the month following the end of the current certification period, if all eligibility factors have been met.

(b) **Reapplication after the 15th:** If an application for recertification is submitted after the 15th but before the end of a household's certification period and the household is determined eligible for the first month following the end of the certification period, that month is not considered an initial month and benefits are not prorated.

(c) Late applications: An application that is submitted to ISD after the certification period has expired can be accepted within 30 days after the certification period expires or the case has been closed for any reason. Initial month verification standards will be used for all applications received during this time frame and the benefits for a late recertification will be prorated from the date of approval.

C. Certification scheduling:

(1) Each case must have eligibility and payment reviewed at least once during the period specified for that category. Cash assistance cases, which also receive SNAP, shall be recertified at the same time the SNAP certification is completed.

(2) The certification period shall not exceed the following standards:

(a) Regular reporting benefit groups: A benefit group not subject to simplified reporting requirements shall be certified for:

(i) five months or less: education works program;

(ii) 12 months: state supplement for SSI recipients in residential care;

(iii) eight months from date of arrival: refugee resettlement program.

(b) Simplified reporting benefit groups: Certification provisions that apply to a NMW benefit group subject to simplified reporting are set forth at Subsection A of 8.102.120.11 NMAC.

D. Interview:

(1) All recertification interviews shall be in person at the local office or, when circumstances warrant, over the phone or at another place reasonably accessible and agreeable to both the recipient/relative or caretaker and the caseworker. The recipient may bring any individual to the interview.

(2) The interview must be with the recipient, unless the recipient's physical or mental condition makes the interview impossible or inadvisable. See 8.100.130 NMAC for instructions on obtaining information.

(3) To help a recipient report changes that may affect the recipient's eligibility or amount of payment, the caseworker shall make available a change report form upon request, which the client may use to notify the county office of changes in circumstance.

E. Scheduling recertification reviews: The certification period end date shall be scheduled for the appropriate interval indicated in Subsection C of 8.102.120.9 NMAC, starting with the initial month of eligibility, or the month following the month in which previous certification expired.

F. Exchange of information with SSA:

(1) If information received during any eligibility review indicates that a participant in NMW or GA may be eligible for supplemental security income (SSI) benefits, (this includes children and adults who appear disabled, and needy adults over 65), the caseworker shall promptly refer the participant to the social security administration district office for application. An individual found eligible for SSI must participate in that program.

(2) During the review process, ISD will sometimes learn information relevant to the eligibility of a family member who is a SSI recipient. If there is a clear indication that a SSI recipient's countable income exceeds the maximum allowable under the SSI program, the discrepancy shall be reported to the social security administration (SSA) district office. SSA shall also be notified when it appears that the resources of an SSI recipient exceed SSI program standards.

[8.102.120.9 NMAC - Rp 8.102.120.9, 7/1/2024]

8.102.120.10 HANDLING BENEFIT GROUP AND RESIDENCE STATUS CHANGES:

A. Change of name or payee: Whenever there is a change in a participant's name or the payee for cash assistance, the caseworker shall immediately make the appropriate changes.

(1) New caretaker:

(a) If a new caretaker assumes responsibility for a dependent child in a case, the case shall be closed and a new application processed.

(b) If the new caretaker is already payee for other dependent children, the cash assistance case of the children being transferred to the new payee shall be closed, an add-on application shall be processed, and the children added to the existing benefit group.

(2) Payee change after benefits are issued: The EBT account shall be made accessible to another family member by authorization of a new PIN under the old account.

(3) Changes in name or payee are indicated when:

(a) a payee legally changes his name and the change has been processed through the social security administration;

(b) a legal guardian is appointed or dismissed;

(c) the parent of an incompetent adult client begins to serve as natural guardian; or

(d) there is a change of payee for an NMW grant.

B. Change in benefit group composition: A request for assistance for a new benefit group member shall be treated as add-on an application. An add-on application shall be processed using the timeliness and verification standards applicable to regular applications.

C. Move to another state: If a participant advises the county office in advance of the participant's departure from the state, the participant shall be contacted to determine whether the participant intends to:

(1) be out of the state for a temporary period with a plan to return once the purpose of the visit has been accomplished; or

(2) abandon residence in New Mexico;

(3) the caseworker shall cover the following points:

(a) whether the client wishes to continue receiving assistance out-of-state during a temporary absence;

(b) whether the client intends to apply for assistance in another state;

(c) how long the participant intends to be out-of-state;

(d) the purpose of the visit;

(e) whether a place of residence in New Mexico is being maintained in the participant 's absence.

(4) If it appears on the basis of this information that New Mexico residence is being abandoned, assistance shall be terminated. If absence is temporary, cash assistance shall be continued and the client must keep the authority informed of the client's address and circumstances.

D. Illness: If a participant who is temporarily visiting outside New Mexico is unable to return to New Mexico because of illness, cash assistance may continue until such time as the participant is able to return. In this situation, the participant's inability to return to New Mexico because of illness must be verified by medical report.

E. DVR training: If plans are made in conjunction with DVR for a participant's participation in a training course in another state, cash assistance may be continued for the duration of the training course for the participant and the participant's dependents, if they accompany the participant, provided that the benefit group intends to return to New Mexico when training is completed.

[8.102.120.10 NMAC - Rp 8.102.120.10, , 7/1/2024]

8.102.120.11 SIMPLIFIED REPORTING: Simplified reporting (SR) is a periodic reporting requirement for benefit groups that receive NMW cash assistance. A benefit group assigned to SR must file an interim report form in the sixth month of a 12-month certification period.

A. Certification period:

(1) Initial application: A benefit group that is applying for both SNAP and NMW, shall be assigned a NMW certification period that ends in the same month as the SNAP certification period with the exception of those SNAP benefit groups assigned to a 24-month certification.

(2) An initial applicant for NMW that is already participating and assigned to simplified reporting in the SNAP program:

(a) if approved for NMW, shall be assigned a NMW certification period that will end the same month as the SNAP certification period; and

(b) must file an interim report form in the same month that one is due in the SNAP program;

(c) if NMW is approved in the same month an interim report form is due in the SNAP program, the requirement in Subparagraph (b), above, is waived for NMW.

(3) A benefit group that is approved for NMW, but does not receive SNAP shall be assigned a twelve-month certification period:

(a) beginning the first month of eligibility; and

(b) shall have an interim report form due in the sixth month of the NMW certification period.

(4) A benefit group that is receiving NMW and applies for SNAP shall have NMW eligibility re-determined at the same time that the SNAP eligibility is determined.

(a) If NMW benefits increase, the increase shall be effective the month following the first month of approval for SNAP and NMW shall be assigned a certification period that ends in the month the simplified reporting SNAP certification ends.

(b) If approved for SNAP and the NMW benefit decreases, the decrease shall be effective the month following the month the NOAA expires, and the NMW benefit group shall be assigned a certification period that ends in the same month the SNAP certification ends.

(c) If approved for SNAP and the NMW benefit is terminated, the termination shall be effective the month following the month the NOAA expires, and the SNAP case shall be transitioned to TFS.

(5) Recertification: A benefit group that is recertifying and is approved and assigned to simplified reporting shall be assigned a certification period that:

(a) is 12 months long;

(b) begins the month after the current certification ends; or

(c) is set to end in the same month as a SNAP case with a common member.

B. Excluded from simplified reporting: The simplified reporting requirement shall be assigned to all NMW benefit groups except programs listed in Paragraph (2) of Subsection C of 8.102.120.9 NMAC.

C. Simplified reporting requirements: A benefit group assigned to simplified reporting shall be required to file an interim report form no later than the tenth day of the sixth month of the 12-month certification period, or in compliance with the SNAP simplified report, whichever is appropriate. The benefit group must include the following information along with necessary verification, as required at 8.100.130 NMAC:

(1) any change in benefit group composition, whether a member has moved in or out of the home along with the date, the change took place;

(2) a change in the source of income, including starting or stopping a job or changing jobs, if the change in employment is accompanied by a change in income;

(3) changes in either:

(a) the wage rate or salary or a change in full-time or part-time employment status as defined in Subsection C of 8.102.461.11 NMAC, provided the household is certified for no more than six months;

(b) a change if earned income of more than one hundred dollars ($100) a month from the amount last used to calculate the household's allotment, provided the household is certified for no more than six months.

(4) a change of more than one hundred dollars ($100) in the amount of unearned income;

(5) changes in countable resources if the total of all countable resources for the benefit group exceed the $1500 liquid or $2000 non-liquid resource limit;

(6) dependent care expenses;

(7) changes in residence, only if, there has been a change in residence since the last certification;

(8) changes in child support receipt; and

(9) changes in immigration status for a benefit group member.

D. Budgeting methodology for simplified reporting at initial application and recertification:

(1) Prospective budgeting shall be used for an applicant benefit group at initial application and at recertification as set forth at 8.102.500.9 NMAC.

(2) At initial application, eligibility and amount of payment for the applicant benefit group shall be determined prospectively for the each of the first six months of the certification.

(3) At recertification, eligibility and amount of payment shall be determined prospectively for six months following last month benefit group's certification period.

E. Budgeting methodology for simplified reporting:

(1) At processing the interim report form, eligibility and amount of payment shall be determined prospectively for the six months following the month the interim report form is due.

(2) In determining a benefit group's eligibility and payment amount, the income already received shall be used to prospectively anticipate income the benefit group expects to receive during the certification period according to the following schedule:

(a) **Weekly:** For income received weekly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(b) **Bi-weekly:** For income received bi-weekly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(c) **Semi-monthly:** For income received semi-monthly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(d) **Monthly:** For income received monthly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(e) **Income received more frequently than weekly:** For benefit groups with income received more frequently than weekly, exact income, rather than averaged and converted income shall be used to determine benefits. For income received more frequently than weekly the participant benefit group must submit and ISD shall accept as verification income received from any consecutive past 30-day period that includes 60 days prior to the month the interim report form is due.

(f) If a determination is made that the use of the pay data for the methods described in (a) through (e), above, does not give the most accurate estimate of monthly earnings due to unique circumstances; the caseworker shall use whatever method gives the most accurate estimate of earnings.

(g) **Income received less frequently than monthly:** The amount of monthly gross income that is received less frequently than monthly shall be determined by dividing the total income by the number of months the income is intended to cover. This includes, but is not limited to, income from sharecropping, farming, and self-employment. It also includes contract income and income for a tenured teacher who may not have a contract.

(3) **Self-employment:**

(a) Requirements for determination of self- employment income are set forth at Subsection E of 8.139.520.10 NMAC, and the verification standards for business and self-employment income are set forth at 8.100.130.25 NMAC.

(b) A benefit group assigned simplified reporting that has had self-employment income annualized by ISD shall be required to report changes in self-employment income only if the benefit group has filed a tax return subsequent to its last approval or recertification for NMW.

(c) A benefit group assigned simplified reporting that does not have the self-employment income annualized must report self-employment income on the interim report form. The income reported on the simplified report form will be calculated in the following manner.

(i) If a self-employment enterprise has been in existence for less than one year, the income from self-employment shall be averaged over the period of time the business has been in operation. The resulting monthly amount shall be projected for the duration of the certification period.

(ii) **Seasonal income:** Self-employment income that is intended to meet a benefit group's needs for only part of the year shall be averaged over the time the income is intended to cover.

(d) A benefit group required to report simplified self-employment income that fails to provide verification of an allowable deduction at the interim or during the month the interim report form is due shall not be allowed the deduction. ISD shall process the report if all other mandatory verification has been provided.

(4) **Use of conversion factors:** Whenever a full month's income is anticipated and is received on a weekly or biweekly basis, the income shall be converted to monthly amount as follows:

(a) income received on a weekly basis is averaged and multiplied by four;

(b) income received on a biweekly basis is averaged and multiplied by two;

(c) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $.50 or more are rounded up; amounts resulting in $.49 or lower are rounded down.

F. **Time limits for submission and processing an interim report form:**

(1) An interim report form shall be mailed to a benefit group in the month prior to the month the report is due.

(2) A benefit group assigned to simplified reporting shall be required to submit an interim report form by the tenth calendar day of the month the interim report form is due in order to receive uninterrupted benefits.

(3) The interim report form shall be reviewed for completeness within ten days of receipt.

(a) If the form is complete and all verifications are provided, ISD shall complete the processing of the form within 10 days of receipt.

(b) If the form is complete and all verifications are provided except for verification of an allowable deduction, the report shall be processed without the deduction. The household shall be:

(i) notified that verification is lacking; and

(ii) shall be given 10 days to provide verification of an allowable deduction;

(iii) a deduction that is verified within the month the interim report form is due shall be processed as part of the interim report;

(iv) a deduction that is verified in the month after the interim report form is due shall be processed as a change reported by the household;

(v) a deduction that does not have the required verification shall not be allowed until verification of the expense is provided.

(4) Incomplete interim report form is received**:**

(a) An interim report form that is not signed shall be returned to the household for a signature. The household:

(i) shall be notified that the form is incomplete;

(ii) what needs to be completed for the interim report form; and

(iii) shall be given 10 calendar days to provide the signed interim report form to be reviewed for completeness.

(b) An interim report form that is incomplete because required verification is not provided shall not be returned to the household. The household:

(i) shall be notified that the form is incomplete;

(ii) what information must be provided to complete the interim report form; and

(iii) shall be given 10 calendar days to provide the verification to process the interim report form.

(5) The benefit group must return the completed interim report form and all required verification within 10 calendar days to avoid a break in benefits. A benefit group that fails to submit an interim report form by the end of the month in which it is due, shall be issued a notice of case action.

G. Information requirements for the interim report form:
The interim report form shall specify:

(1) the date by which a benefit group must submit the form for uninterrupted benefits;

(2) the consequences of submitting a late or incomplete form;

(3) that verification must be submitted with the interim report form;

(4) where to call for help in completing the form;

(5) the consequences of providing incorrect information; and

(6) notice of rights.

H. Requirement to report certain changes between reporting periods: A benefit group must report changes within 10 days of the date a change becomes known to the benefit group:

(1) a benefit group reports income in excess of eighty-five percent of federal poverty guidelines for size of the benefit group;

(2) a parent must report when a dependent child, age six years or older, drops out of school or has three unexcused absences from school within 14 days of occurrence;

(3) a mandatory adult who is participating in NMW Program has moved in or out of the home;

(4) a mandatory child who has moved in or out of the home;

(5) a household member has passed away;

(6) a mandatory member has moved from New Mexico;

(7) unearned income in excess of the maximum monthly benefit for the size of the benefit group;

(8) changes in countable resources if the total of all countable resources for the benefit group exceed the $1500 liquid or $2000 non-liquid resource limit;

(9) in the absence of a written report, a 13-day notice of adverse action is required if the change will result in a reduction or termination of benefits.

I. Action on changes reported between reporting periods for benefit groups assigned to simplified reporting: In addition to changes that must be reported in accordance with Subsection H of 8.102.120.11 NMAC, ISD must act on changes in between interim report forms, if it would increase the household's benefits. ISD shall not act on changes that would result in a decrease in the household's benefits unless:

(1) The household has voluntarily requested that its case be closed;

(2) ISD has information about the household's circumstances considered verified upon receipt. Verified upon receipt is defined as:

(a) information is not questionable; and

(b) the provider of the information is the primary source of information;

(c) the trusted data sources must be pulling their own data not from third party information; or

(d) the recipient's attestation exactly matches the information received from a third party.

(3) A newborn shall be added to the benefit group effective the month following the month the report is received.

(4) The loss of earned income shall be considered for eligibility in the second month after the loss and ongoing until the next scheduled interim report or end of certification whichever is first, provided that:

(a) the loss of income was reported to the agency, and verified by the benefit group; and

(b) the loss of income was not due to voluntary quit.

(5) The loss of unearned income shall be considered for eligibility in the month after the loss and ongoing until the next scheduled interim report or end of certification whichever is first, provided that the loss of income was reported to the agency, and verified by the benefit group.

(6) A household member has been identified as a fleeing felon or probation violator in accordance with 8.102.410.15 NMAC.

J. Responsibilities on reported changes outside of the interim report: When a household reports a change, ISD shall take action to determine the household's eligibility or TANF benefit amount within 10 working days of the date the change is reported.

(1) Decreased or termination of benefits: For changes that result in a decrease or termination of household benefits, ISD shall act on the change as follows:

(a) if the household's benefit level decreases or the household becomes ineligible as a result of the change, ISD shall issue a notice of adverse action within 10 calendar days of the date the change was reported unless one of the exemptions to the notice of adverse action in 7 CFR 273.13 (a)(3) or (b) applies.

(b) when a notice of adverse action is used, the decrease in the benefit level shall be made effective no later than the allotment for the month following the month in which the notice of adverse action period has expired, provided a fair hearing and continuation of benefits have not been requested.

(c) when a notice of adverse action is not used due to one of the exemptions in 7 CFR 273.13 (a)(3) or (b), the decrease shall be made effective no later than the month following the change. Verification which is required by 7 CFR 273.2(f) must be obtained prior to recertification.

(2) Increased benefits: For changes that result in an increase of household benefits, ISD shall act on the change as follows:

(a) for changes which result in an increase in a household's benefits, other than changes described in Subparagraph (b) of this section, ISD shall make the change effective no later than the first allotment issued 10 calendar days after the date the change was reported to ISD.

(b) for changes which result in an increase in a household's benefits due to the addition of a new household member who is not a member of another certified household, or due to a decrease of $50 or more in the household's gross monthly income, ISD shall make the change effective not later than the first allotment issued 10 calendar days after the date the change was reported.

(i) in no event shall these changes take effect any later than the month following the month in which the change is reported.

(ii) if the change is reported after the last day to make changes and it is too late for ISD to adjust the following month's allotment, ISD shall issue a supplement or otherwise provide an opportunity for the household to obtain the increase in benefits by the 10th calendar day of the following month, or the household's normal issuance cycle in that month, whichever is later.

(3) No change in TANF benefit amount: When a reported change has no effect on the TANF benefit amount, ISD shall document the change in the case file and notify the household of the receipt of the report.

(4) Providing verification: The household shall be allowed 10 calendar days from the date a change is reported to provide verification, if necessary. If verification is provided at the time a change is reported or by the deadline date, the increase in benefits shall be effective in accordance with Subparagraph (a) and (b) of Paragraph (2) above. If the household fails to provide the verification by the deadline date, but does provide it at a later date, the increase shall be effective in the month following the month the verification is provided. If the household fails to provide necessary verification, its SNAP benefit amount shall revert to the original benefit amount.

K. Resolving unclear information:

(1) During the certification period, ISD may obtain information about changes in a household's circumstances from which ISD cannot readily determine the effect of the change on the household's benefit amount. The information may be received from a third party or from the household itself. ISD must pursue clarification and verification of household circumstances using the following procedure if unclear information received outside the periodic report is:

(a) information fewer than 60 days old relative to the current month of participation; and,

(b) if accurate, would have been required to be reported under simplified reporting rules, in accordance with 8.102.120.11 NMAC.

(c) ISD must pursue clarification and verification of household circumstances in accordance with the process outlined in Subsection B of 8.100.130.12 NMAC, for any unclear information that appears to present significantly conflicting information from that used by ISD, at the time of certification.

(2) Unclear information resulting from certain data matches:

(a) if the authority receives match information from a trusted data source as described in 7 CFR 272.13 or 7 CFR 272.14, ISD shall send a notice in accordance with Subsection B of 8.100.130.12 NMAC in accordance with 7 CFR 272.13(b)(4) and 7 CFR 272.14 (c)(4). The notices must clearly explain what information is needed from the household and the consequences of failing to respond to the notice.

(b) if the household fails to respond to the notice or does respond but refuses to provide sufficient information to clarify its circumstances, ISD shall remove the individual and the individual's income from the household and adjust benefits accordingly. As appropriate, ISD shall issue a notice of adverse action.

L. Failure to report changes: If ISD discovers that the household failed to report a change as required, ISD shall evaluate the change to determine whether the household received benefits to which it was not entitled or if the household is entitled to an increased benefit amount.

(1) Decreased benefit amount: After verifying the change, ISD shall initiate a claim against the household for any month in which the household was over issued TANF benefits. The first month of the over issuance is the month following the month the adverse action notice time limit would have expired had the household timely reported the change. If the discovery is made within the certification period, the household is entitled to a notice of adverse action if its benefits will be reduced.

(2) Increased benefit amount: When a household fails to timely report a change which will result in an increased TANF benefit amount, the household is not entitled to a supplement for any month prior to and including the month in which the change was reported. The household is entitled to an increased benefit amount effective no later than the first benefit amount issued 10 calendar days after the date the change was reported.

M. Non-reporting sanctions: A benefit group assigned to simplified reporting shall be subject to a non-reporting sanction in accordance with regulations at 8.102.620.11 NMAC for failure to provide accurate change information on the interim report form or for failure to report by the tenth calendar day of the month following the month that household income exceeds eighty-five percent of federal poverty guidelines for the size of the benefit group.

[8.102.120.11 NMAC – Rp 8.102.120.11, 7/1/2024]

History of 8.102.120 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 272.000, Procedures and Conditions Applicable to Continuing Eligibility for Financial and Medical Assistance, 5/22/80.

ISD FA 520, Eligibility Reviews, 2/11/1988.

ISD FA 510, Monthly Reporting and Changes, 2/10/1988.

ISD FA 510, Changes in Budget Group Circumstances, 4/30/1992.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 7/1/1997.

8.102.120 NMAC Eligibility Policy - Administration - Repealed, 7/1/2001.

8.102.120 NMAC Eligibility Policy – Administration, filed 7/1/2001 – Repealed effective 7/1/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 230 GENERAL FINANCIAL - PAYABLES AND DISBURSEMENT

8.102.230.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.230.1 NMAC - Rp 8.102.230.1 NMAC, 07/01/2024]

8.102.230.2 SCOPE: The rule applies to the general public.
[8.102.230.2 NMAC - Rp 8.102.230.2 NMAC, 07/01/2024]

8.102.230.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the authority is creating the New Mexico works program as one of its financial assistance programs.

E. In close coordination with the NMW program, the authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.230.3 NMAC - Rp 8.102.230.3 NMAC, 07/01/2024]

8.102.230.4 DURATION: Permanent.
[8.102.230.4 NMAC - Rp 8.102.230.4 NMAC, 07/01/2024]

8.102.230.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.102.230.5 NMAC - Rp 8.102.230.5 NMAC, 07/01/2024]

8.102.230.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, assisting parents to develop the discipline necessary for self-sufficiency and to improve their self-esteem. The further purpose of the program is to increase family income through family employment and child support and by viewing financial assistance as a support service to enable and assist parents to participate in employment.

B. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program like NMW or the federal program of supplemental security income (SSI).

C. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

D. The objective of the burial assistance program is to assist in payment of burial expenses for deceased, low-income individuals.
[8.102.230.6 NMAC - Rp 8.102.230.6 NMAC, 07/01/2024]

8.102.230.7 DEFINITIONS: [**RESERVED**]
[8.102.230.7 NMAC - Rp 8.102.230.7 NMAC, 07/01/2024]

8.102.230.8 [**RESERVED**]

[8.102.230.8 NMAC - Rp 8.102.230.8 NMAC, 07/01/2024]

8.102.230.9 DEATH OF CLIENT

A. Payment: Payment may be made on behalf of a client who died before an EBT withdrawal was made, if the client was alive on the first day of the month for which cash assistance benefits were issued, and all eligibility conditions were met at the time of death. The person authorized to use the deceased recipient's benefits is the surviving spouse, next of kin, or a person with responsibility for the deceased recipient's affairs.

B. Withdrawing EBT benefits: When payment is made in accordance with these procedures, the county office shall not restrict or dictate the use of the money paid.

[8.102.230.9 NMAC - Rp 8.102.120.10 NMAC, 07/01/2024]

History of 8.102.230 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 271.0000, Procedures Applicable to Payment and Related Changes, 5/16/1980.

ISD FA 450, Payment, 2/10/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.

8.102.230 NMAC General Financial - Payables and Disbursement - Repealed, 07/01/2001.

8.102.230 NMAC General Financial - Payables and Disbursement, filed 7/1/2001 – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 400 RECIPIENT POLICIES - DEFINING THE ASSISTANCE GROUP

8.102.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.400.1 NMAC - Rp 8.102.400.1 NMAC, 07/01/2024]

8.102.400.2 SCOPE: The rule applies to the general public.
[8.102.400.2 NMAC - Rp 8.102.400.2 NMAC, 07/01/2024]

8.102.400.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the authority is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified authority to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.400.3 NMAC - Rp 8.102.400.3 NMAC, 07/01/2024]

8.102.400.4 DURATION: Permanent.
[8.102.400.4 NMAC - Rp 8.102.400.4 NMAC, 07/01/2024]

8.102.400.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.102.400.5 NMAC - Rp 8.102.400.5 NMAC, 07/01/2024]

8.102.400.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term carrier development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.400.6 NMAC - Rp 8.102.400.6 NMAC, 07/01/2024]

8.102.400.7 DEFINITIONS: [RESERVED]
[8.102.400.7 NMAC - Rp 8.102.400.7 NMAC, 07/01/2024]

8.102.400.8 WHO CAN BE A RECIPIENT: To be a recipient of cash assistance, a person must be individually eligible according to requirements set forth in 8.102.410 NMAC and 8.102.420 NMAC. The person or persons meeting individual eligibility requirements and for whom application has been or must be made constitute the benefit group.
[8.102.400.8 NMAC - Rp 8.102.400.8 NMAC, 07/01/2024]

8.102.400.9 BASIS FOR DEFINING THE BENEFIT GROUP:

A. At time of application for cash assistance and services, an applicant and the authority shall identify everyone who is to be considered for inclusion in the benefit group. A decision to request assistance for a specific individual may require the inclusion of other individuals as well. There may be more than one benefit group in a residence.

B. ISD shall add or delete a person from the benefit group upon request of the household, except when the participant is a mandatory benefit group member. Changes in benefit group composition must be evaluated as it may affect who must be included in the benefit group.

C. Benefit groups containing dependent children: The benefit group for the NMW cash assistance program or EWP cash assistance program consists of a pregnant woman or a group of people that includes a dependent child, all of that dependent child's full, half, step- or adopted siblings living with dependent child's parent or relative within the fifth degree of relationship and the parent with whom the children live and the spouse of a parent.

D. NMW Adult only benefit groups: An adult only benefit group may consist of:

(1) a parent or relative, and the spouse of the parent or relative, when all of the dependent children are receiving SSI;

(2) a pregnant woman in her third trimester of pregnancy who has no dependent children living with her and the father of the unborn child, if he is living in the home.

[8.102.400.9 NMAC - Rp 8.102.400.9 NMAC, 07/01/2024]

8.102.400.10 MANDATORY MEMBERS: Certain participants must be included in the dependent child assistance group, provided they meet the eligibility requirements.

A. Include the dependent child who is the natural child, adopted child, or stepchild who is 17 years of age or younger or who are 18 years of age and enrolled in high school.

B. Include all of that dependent child’s full, half, step-siblings or adopted siblings living with the dependent child.

C. Include the natural parent, adoptive parent, or stepparent of the dependent child for whom assistance is being requested.

D. Include in the benefit group the parent of any child included in the budget group and the spouse of the parent, if living in the home.

[8.102.400.10 NMAC - Rp 8.102.400.10 NMAC, 07/01/2024]

8.102.400.11 OPTIONAL MEMBERS: NMW dependent child benefit groups may include in the benefit group:

A. any unrelated dependent child living in the home;

B. the specified relative who is a caretaker and who is within the fifth degree of relationship and the specified relative's spouse, if the parent is not living in the home;

C. any dependent child who is within the fifth degree of relationship and not full, half, step or adopted sibling of the dependent child whom the assistance is requested;

D. the legal guardian(s) of the dependent child.

[8.102.400.11 NMAC - Rp 8.102.400.11 NMAC, 07/01/2024]

8.102.400.12 SPECIAL MEMBERS

A. Minor unmarried parents:

(1) A minor unmarried parent and child who live with the minor unmarried parent's parent or other adults shall be included as dependent children in the larger NMW benefit group if there is one. A minor unmarried parent and child living with parent(s) may constitute a benefit group in their own right if the minor parent is the primary caretaker for the child and the parent(s) are not receiving NMW. The minor parent's parent shall be the applicant and payee for the benefit.

(2) Limitations regarding minor unmarried parents:

(a) Living arrangements: An unmarried minor parent and the dependent child in her care must reside in the household of a parent, legal guardian, or other adult relative unless:

(i) the child is living in a second-chance home, maternity home, or other appropriate adult-supervised supportive living arrangement which takes into account the needs and concerns of the minor unmarried parent;

(ii) the minor parent has no living parent or legal guardian whose whereabouts is known, and there are no other appropriate adult-supervised supportive living arrangements available;

(iii) no living parent or legal guardian of the minor parent allows the minor parent to live in the minor parent's home and there are no other appropriate adult-supervised supportive living arrangements available;

(iv) the minor unmarried parent is or has been subjected to serious physical or emotional harm, sexual abuse, or exploitation in the home of the parent, legal guardian or other adult relative and there are no other appropriate adult-supervised supportive living arrangements available;

(v) there is substantial evidence of an act or failure to act that presents an imminent or serious harm to the minor unmarried parent and/or the child of the minor unmarried parent if they live in the same residence with the parent legal guardian or other appropriate adult and there are no other appropriate adult-supervised supportive living arrangements available; if a minor parent makes allegations supporting the conclusion that the physical or emotional health or safety of the minor unmarried parent or the dependent child(ren) will be jeopardized, the caseworker shall file any documentation regarding this allegation in the case record and grant the exemption; acceptable documentation will include written reports and statements from the children, youth, and families department, other social service agencies, and police reports; if no written documentation exists, the caseworker should summarize the client's statement in a memo to the ISD director or designee and a determination shall be made.

(vi) the authority determines there is otherwise good cause for the minor parent and dependent child to receive assistance while living apart from the minor parent's parent, legal guardian, or other adult relative, or an adult-supervised supportive living arrangement; an adult-supervised supportive living arrangement is defined as a private family setting or other living arrangement (not including a public institution), which is maintained as a family setting, as evidenced by the assumption of responsibility for the care and control of the minor parent and dependent child or the provision of supportive services, such as counseling, guidance, or supervision; for example, foster homes and maternity home are adult-supervised supportive living arrangements.

(b) Notification: Minor applicants shall be informed about the eligibility requirements and their rights and obligations under this manual section. Minor applicants shall be advised of the possible exemptions and specifically asked whether one or more of these exemptions applies in their situation.

(c) Payment: If the minor parent lives with an adult receiving NMW, the minor parent and child shall be included in that NMW benefit group. If the minor parent and the minor parent's dependent child do not live with an adult who is receiving NMW, payment is made to the supervising adult in the form of a protective payment.

B. Pregnant woman:

(1) A pregnant woman who has no minor dependent children living with her can constitute a NMW benefit group during her last trimester of pregnancy. The woman is eligible only if the child, were it born, would be living with her and would be eligible for NMW. The pregnancy must be verified by a medical report.

(2) The needs, income and resources of an unborn child shall be considered in the determination of eligibility for NMW. The needs of the unborn child are not considered in the amount of payment.

(3) Father living with the pregnant woman: The needs, income and resources of the father of the unborn child shall be considered in determining eligibility and payment if the father lives in the home. The mother and the alleged father of the unborn child must provide the authority with a written sworn statement attesting to paternity.

(4) A pregnant woman who has one or more dependent children living with her must meet the conditions of Subsection H of 8.102.400.9 NMAC; benefit groups containing dependent children.

C. Specified relative of SSI child: A specified relative whose only minor dependent child is an SSI recipient meets the requirement of living with a related minor child and constitutes a NMW benefit group. Other household members may also be included, subject to limitations set forth at 8.102.400.10 NMAC and 8.102.400.11 NMAC.

[8.102.400.12 NMAC - Rp 8.102.400.12 NMAC, 07/01/2024]

8.102.400.13 [RESERVED]

[8.102.400.13 NMAC - Rp 8.102.400.13 NMAC, 07/01/2024]

8.102.400.14 NMW LIVING ARRANGEMENTS - REQUIREMENTS:

A. For a NMW benefit group to exist, a dependent child must be living in the home of a parent or specified relative as specified in 8.102.400.15 NMAC. The relative must be the primary caretaker for the child and

must be within the fifth degree of relationship, as determined by New Mexico's Uniform Probate Practice Code (see Subsection A of 8.102.400.16 NMAC). To be considered as the caretaker, the specified relative in a NMW benefit group, the participant must be living, or considered to be living, in the home with the child.

B. A child or the caretaker relative may in certain situations be temporarily domiciled away from home, but nonetheless be considered as living at home. Such situations result when the parent or caretaker relative has decided to domicile the child elsewhere because of a specific need identified by the parent or caretaker relative and provided that the parent or caretaker relative remains responsible for providing care and support to the child and retains parental control over the child.

[8.102.400.14 NMAC - Rp 8.102.400.14 NMAC, 07/01/2024]

8.102.400.15 NMW LIVING IN THE HOME

A. Basic requirements:

(1) To be eligible for inclusion in the NMW cash assistance benefit group, the dependent child must live with a parent or a specified relative acting as the head of household. A child lives with a participant when:

(a) the participant's home is the primary place of residence for the child, as evidenced by the child's customary physical presence in the home;

(b) the participant may or may not be the child's parent or caretaker;

(c) the caretaker is the person taking primary responsibility for the care of the child, the caretaker will be a parent, relative or it may be an unrelated adult; the caretaker may or may not be the head of household.

(2) The determination of whether a given participant functions as the parent or caretaker relative for NMW purposes shall be made by the client unless other information known to the caseworker clearly indicates otherwise.

B. Extended living in the home:

(1) Under the circumstances described in this section, a child may be physically absent from the home for periods of time, but, because of the nature of the absence and because the parent or caretaker relative continues to exercise parental control over and to provide care for the child during the time the child is physically away from the family's home, the child nonetheless remains a regular on-going member of the benefit group. Similarly, under certain circumstances, the caretaker could be physically absent from the home and still retain membership status as caretaker for purposes of eligibility.

(2) The circumstances where this occurs are:

(a) attending boarding schools or college and

(b) inpatient treatment in medicaid facilities; in order for either the child or the caretaker to retain living-in-the-home status, the person acting as the caretaker must retain responsibilities for providing care, support and supervision for the child which are appropriate to the child's specific living arrangements.

(3) In considering whether the caretaker retains care and support responsibilities for a child who is hospitalized or at school, issues which shall be reviewed include the degree to which the parent:

(a) provides financial support to the child from the cash assistance payment;

(b) continues to maintain living quarters for the child until the child reestablishes full-time physical presence in the home; and

(c) continues to make decisions regarding the care and control of the child(ren), including decisions about medical care and treatment, class scheduling, and other similar parental decisions;

(d) maintains contact with the child through regular visits or telephone calls.

(4) The determination whether living-in-the-home status is retained is fully discussed with the caretaker and carefully documented in the case record.

(a) Boarding school: A child or caretaker relative who is attending school away from home lives in the home if the caretaker relative retains primary responsibility for the child relative.

(b) Medicaid:

(i) Caretaker: A caretaker receiving treatment in a Title XIX facility remains a member of the benefit group of which the caretaker was a member at the time of hospitalization until the caretaker leaves the facility and returns to that home or some other. If the caretaker does not return to the home following hospitalization, the living-in-the-home requirement shall be reassessed.

(ii) Dependent children: For the purposes of the cash assistance program, a child hospitalized for care or treatment in a Title XIX (medicaid) facility retains living-in-the-home status, without

regard to the length of hospitalization, provided that the caretaker continues to be the person with primary responsibility for control of the child and for meeting the child's physical and emotional needs. This includes children receiving treatment in acute care hospitals, freestanding psychiatric hospitals and rehabilitation hospitals as well as residential treatment centers and group homes reimbursed by medicaid for psychosocial rehabilitation services. Medical assistance division institutional care staff may be contacted to verify New Mexico medicaid provider status of RTCs and group homes.

(5) For a child to retain living-in-the-home status while receiving rehabilitation services, including psychosocial treatment services, certain conditions must be met. Treatment of the child is the primary objective, but the program should be family-based with one objective being strengthening of family ties. Treatment plans must provide for a significant level of continuing authority, responsibility, and participation by the caretaker. In order for children receiving treatment in a Title XIX facility to be "living in the home", the caretaker must retain the authority to decide when the child should leave the facility, grant authority for provision of necessary treatment, and retain responsibility for provision of pocket money, clothing, etc.

(6) A significant issue in determining whether a child retains living-in-the-home status is the authority of the caretaker to control the child's treatment and duration of stay. Under the state's mental health code, a court order placing the child in a psychiatric facility must be issued. The court findings serve to make sure that the child needs such treatment. Such orders do not prevent the specified relative from removing the child from the facility. These orders must be differentiated from correctional commitments or sentences. A child receiving treatment in a Title XIX facility, or placed in other substitute care living arrangements by juvenile authorities as the result of a sentence or commitment by a judicial authority does not meet the definition of actually living in the home, as the caretaker no longer has significant control over the child.

(7) A child may qualify for extended living-in-the-home provisions under these conditions:

(a) the child must have been living in the home before hospitalization;

(b) the child must have been living in the home before attending boarding school or college.

C. Joint custody: A child who is in the joint custody of divorced parents who are living apart and who is actually spending equal amounts of time with both parents shall not be considered to be living with the caretaker. If the divorce decree specifies equal joint custody, but the child is actually spending more time with one parent than the other, the child would be determined to be living with the parent with whom the child spends the most time.

D. Absence from the home:

(1) A minor child may remain in the benefit group and remain eligible for benefits for up to 45 days following the date of departure or expected absence from the home. Such a child may not simultaneously be in another NMW or GA benefit group.

(2) A child shall be considered to have left the home, when the child is physically absent from the home and is under the care, control, custody, of himself, another relative or another adult, social services or correctional agency, or other agency of state, local, or tribal government.

E. Reporting departure of child from the home: Pursuant to Section 408 (a)(10)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the parent, relative, or caretaker of a minor child included in the NMW benefit group is ineligible to be included in the benefit group if the parent or relative or caretaker fails to report the absence from the home of a minor child who is a member of the benefit group. To be eligible, the adult must report the departure of the minor child by no later than 5 days after the adult becomes aware that the child is absent or will be absent in excess of the 45 days allowed under Subsection D of 8.102.400.15 NMAC. The adult shall remain ineligible for the number of months that the benefit group is sanctioned for non-reporting as provided for at 8.102.620.11 NMAC.

[8.102.400.15 NMAC - Rp 8.102.400.15 NMAC, 07/01/2024]

8.102.400.16 RELATIONSHIP

A. NMW requirement:

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

(a) father (biological or adoptive);

(b) mother (biological or adoptive);

(c) grandfather, great grandfather, great-great grandfather, great-great-great grandfather;

(d) grandmother, great-grandmother, great-great-grandmother, great-great-great grandmother;

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

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

(g) brother, half-brother, brother-in-law, stepbrother;

(h) sister, half-sister, sister-in-law, stepsister;

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

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

(k) first cousin and spouse of first cousin;

(l) son or daughter of first cousin (first cousin once removed);

(m) son or daughter of great aunt or great uncle (first cousin once removed) and spouse;

(n) nephew/niece and spouses.

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

(3) GA is not provided to dependent children where a NMW application has been made and verification of relationship is pending.

(4) Below is the table of relationship based on the Uniform Probate Practice Code. The relationships shown with an "X" are not within the fifth degree of relationship.

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

C. Table of relationships:

					5 Great-Great-Great Grandparents
				4 Great-Great Grandparents	X
			3 Great Grandparents	5 Great-Grand Uncles and Aunts	
		2 Grandparents	4 Great Aunt Great Uncle	X	
	1 Parents	3 Aunt/Uncle	5 First Cousin Once-Removed		
Dependent Child	2 Siblings	4 First Cousins	X		
	3 Nephew/ Niece	5 First Cousin Once-Removed			
	4 Grand Nephew Grand Niece	X			
	5 Great Grand Nephew or Niece				

	X				

D. Verifying relationship: Standards for verification of relationship are set forth at Subsection H of 8.100.130.13 NMAC.
[8.102.400.16 NMAC - Rp 8.102.400.16 NMAC, 07/01/2024]

History of 8.102.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD FA 220, AFDC/GA Budget Group, 2/9/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.400 NMAC Recipient Policies- Defining the Assistance Group - Repealed 07/01/2001.
8.102.400 NMAC Recipient Policies- Defining the Assistance Group, filed 07/1/2001 – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 410 RECIPIENT POLICIES - GENERAL RECIPIENT REQUIREMENTS

8.102.410.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.410.1 NMAC - Rp 8.102.410.1 NMAC, 07/01/2024]

8.102.410.2 SCOPE: The rule applies to the general public.
[8.102.410.2 NMAC - Rp 8.102.410.2 NMAC, 07/01/2024]

8.102.410.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the authority is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.410.3 NMAC - Rp 8.102.410.3 NMAC, 07/01/2024]

8.102.410.4 DURATION: Permanent.
[8.102.410.4 NMAC - Rp 8.102.410.4 NMAC, 07/01/2024]

8.102.410.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.102.410.5 NMAC - Rp 8.102.410.5 NMAC, 07/01/2024]

8.102.410.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.410.6 NMAC - Rp 8.102.410.6 NMAC, 07/01/2024]

8.102.410.7 DEFINITIONS: [RESERVED]
[8.102.410.7 NMAC - Rp 8.102.410.7 NMAC, 07/01/2024]

8.102.410.8 REQUIREMENTS: This section describes eligibility requirements which each recipient of cash assistance must meet in order to be included in the benefit group.
[8.102.410.8 NMAC - Rp 8.102.410.8 NMAC, 07/01/2024]

8.102.410.9 ENUMERATION: The participant, or the specified relative on behalf of a dependent child, must

report the participant's social security number (SSN) within 60 days of approval for the cash assistance program. Failure to meet this requirement shall result in ineligibility for the benefit group member without a reported or verified SSN.
[8.102.410.9 NMAC - Rp 8.102.410.9 NMAC, 07/01/2024]

8.102.410.10 CITIZENSHIP AND ALIEN STATUS:

A. Eligibility for TANF funded cash assistance:

(1) Participation in the NMW cash assistance program is limited to a U.S. citizen, a naturalized citizen or a non-citizen U.S. national.

(2) A non-citizen, other than a non-citizen U.S. national, must be both a qualified and eligible alien in order to participate in the NMW cash assistance program.

B. Definitions:

(1) Continuously lived in the U.S.: means that a non-citizen has lived in the U.S. without a single absence of more than 30 days or has lived in the U.S. without a total of aggregated absences of more than 90 days.

(2) Federal means-tested public benefit: means benefits from the food stamp program; the food assistance block grant programs in Puerto Rico, American Samoa, and the commonwealth of the Northern Mariana Islands; supplemental security income (SSI); and the TANF block grant program under title IV of the Social Security Act; medicaid, and SCHIP.

(3) Five-year bar: means the federally imposed prohibition on receiving federal means-tested public benefits for certain qualified aliens who entered the United States on or after August 22, 1996, until they have continuously lived in the U.S for five years. If an alien enters the U.S. on or after August 22, 1996, but does not meet the definition of a qualified alien, the five-year bar begins on the date the non-citizen attains qualified alien status.

(4) Immigrant: means a non-citizen or an alien within the meaning found in title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(5) Non-citizen U.S. national: means a person who is not a U.S. citizen but was born in an outlying possession of the United States on or after the date the U.S. acquired the possession, or a person whose parents are non-citizen U.S. nationals. A person who resides on one of the following U.S. island territories is a non-citizen U.S. national: American Samoa, Swains Island or the Northern Mariana Islands.

(6) Permanently residing under color of law (PRUCOL): means a person whose presence in the US is known by the department of homeland security (DHS) and the DHS does not intend to deport the person. Persons classified as PRUCOL may or may not also be qualified aliens.

C. Qualified alien: A qualified alien is any of the following types of non-citizens:

(1) who is lawfully admitted for permanent residence under the Immigration and Nationality Act (an LPR);

(2) who is granted asylum under Section 208 of the INA (an asylee);

(3) who is a refugee admitted to the U.S. under Section 207 of the INA (a refugee);

(4) who is paroled into the U.S. under Section 212(d)(5) of the INA for at least one year (a parolee);

(5) whose deportation is being withheld under Section 241(b)(3) or 243(h) of the INA;

(6) who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980;

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

(8) who is a victim of a severe form of trafficking, regardless of immigration status, under the Trafficking Victims Protection Act of 2000.

D. Qualified alien due to battery or extreme cruelty: means a non-citizen, regardless of alien status, who has been battered or subjected to extreme cruelty, as long as the following elements are met:

(1) there is a substantial connection between such battery or cruelty and the need for the cash benefits; and

(2) the abused non-citizen is not currently living with the abuser; and

(3) the INS or executive office of immigration review (EOIR) has:

(a) approved a self-petition seeking permanent residency, or

(b) approved a petition for a family based immigrant visa; or

(c) approved an application for cancellation of removal or suspension of

deportation; or

(d) found that a pending petition or application establishes "prima facie" (true and valid) case for approval; and

(4) the non-citizen has been battered or subjected to extreme cruelty in the US by a spouse or parent, or by a member of the spouse or parent's family residing in the same household as the abused non-citizen and the spouse or parent of the abused non-citizen consented to, or acquiesced in such battery or cruelty; or

(5) the non-citizen has a child who has been battered or subjected to extreme cruelty in the US by the non-citizen's spouse or parent, as long as the non-citizen does not actively participate in the battery or cruelty; or a non-citizen whose child is battered or subjected to extreme cruelty by a member of the non-citizen's spouse or parent's family residing in the same household and the non-citizen's spouse or parent consented or acquiesced to such battery or cruelty; or

(6) the non-citizen is a child who resides in the same household as a parent who has been battered or subjected to extreme cruelty in the US by the parent's spouse or by a member of the spouse's family residing the same household and the non-citizen's spouse consented or acquiesced to such battery or cruelty.

(7) **U.S. citizen:** means, but may not be limited to:

(a) a person born in the United States;

(b) a person born in Puerto Rico, Guam, U.S. Virgin Islands or Northern Mariana Islands who has not renounced or otherwise lost his or her citizenship;

(c) a person born outside the U.S. to at least one U.S. citizen parent; or

(d) a person who is a naturalized citizen.

E. Aliens who are eligible to participate: An alien who meets the definition of a qualified alien shall be eligible to participate in the NMW cash assistance program if the alien:

(1) physically entered the U.S. prior to August 22, 1996 and obtained qualified alien status before August 22, 1996;

(2) physically entered the U.S. prior to August 22, 1996, obtained qualified alien status on or after August 22, 1996 and has continuously lived in the U.S. from the latest date of entry prior to August 22, 1996 until the date the participant or applicant obtained qualified alien status;

(3) physically entered the U.S. on or after August 22, 1996, meets the definition of a qualified alien and has been in qualified alien status for at least five years (five year bar);

(4) physically entered the U.S. before August 22, 1996 and did not continuously live in the U.S. from the latest date of entry prior to August 22, 1996 until obtaining qualified alien status, but has been in qualified alien status for at least five years;

(5) is a lawfully admitted permanent resident alien under the INA, who has worked or can be credited with 40 qualifying quarters; or

(6) is a veteran of the military with an honorable discharge that is not based on alien status who has fulfilled the minimum active duty requirements; or the non-citizen who is on active duty military service; or the person is the spouse, surviving spouse who has not remarried, or an unmarried dependent child of a veteran or active duty service member;

(7) an alien is eligible for a period of five years from the date an alien:

(a) is granted status as an asylee under Section 208 of the INA;

(b) is admitted as a refugee to the U.S. under Section 207 of the INA;

(c) has had his or her deportation withheld under Section 241(b)(3) or 243(h) of the INA;

(d) is admitted as an Amerasian immigrant under Section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988; or

(e) is admitted as a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980; and

(8) a qualified alien who entered the United States on or after August 22, 1996, to whom the five-year bar applies, may participate in the state-funded TANF program without regard to how long the alien has been residing in the United States.

F. Victim of severe form of trafficking: A victim of a severe form of trafficking, regardless of immigration status, who has been certified by the U.S. department of health and human services (DHHS), office of refugee resettlement (ORR), is eligible to the same extent as a refugee.

(1) The date of entry for a victim of trafficking is the date of certification by ORR (which appears in the body of the eligibility letter from the ORR).

(2) A victim of a severe form of trafficking:

(a) must have and present a certification of eligibility letter from ORR for adults or letter for children (similar to but not necessarily a certification letter) as proof of status; and

(b) is not required to provide any immigration documents, but may have such documents and may present such documents.

(3) Determining eligibility for a victim of trafficking must include a call to the trafficking verification line at 1-866-401-5510.

(4) The caseworker must inform ORR of the benefits for which the victim of trafficking has applied.

G. Quarters of coverage:

(1) SSA reports quarters of coverage through the quarters of coverage history system (QCHS).

(2) The number of qualifying quarters is determined under Title II of the Social Security Act, including qualifying quarters of work not covered by Title II of the Social Security Act, and is based on the sum of: quarters the alien worked; quarters credited from the work of a parent of the alien before the alien became 18 (including quarters worked before the alien was born or adopted); and quarters credited from the work of a spouse of the alien during their marriage if they are still married or the spouse is deceased.

(a) A spouse may not get credit for quarters of a spouse when the couple divorces prior to a determination of eligibility.

(b) If eligibility of an alien is based on the quarters of coverage of the spouse, and then the couple divorces, the alien's eligibility continues until the next recertification. At that time, the caseworker shall determine the alien's eligibility without crediting the alien with the former spouse's quarters of coverage.

(3) Disputing quarters: If a participant or applicant disputes the SSA determination of quarters of coverage, the participant may not participate based on having 40 qualifying quarters until a determination is made that the participant or applicant can be credited with 40 qualifying quarters. The participant or applicant may participate as a state-funded benefit group member, if otherwise eligible.

(4) Federal means-tested benefit: After December 31, 1996, a quarter in which an alien received any federal means-tested public benefit, as defined by the agency providing the benefit shall not be credited toward the 40-quarter total. A parent's or spouse's quarter is not creditable if the parent or spouse actually received any federal means-tested public benefit. If the alien earns the 40th quarter of coverage prior to applying for a federal means- tested public benefit in that same quarter, the caseworker shall allow that quarter toward the 40 qualifying quarters total.

H. Verification of citizenship/eligible alien status: U.S. citizenship is verified only when client statement of citizenship is inconsistent with statements made by the applicant or with other information on the application, previous applications, or other documented information known to HSD.

(1) Questionable U.S. citizenship: Any mandatory benefit group member whose U.S. citizenship is questionable is ineligible to participate until proof of U.S. citizenship is obtained. The member whose citizenship is questionable shall have all of his resources and a pro rata share of income considered available to any remaining benefit group members.

(2) Eligible alien status: Verification of eligible alien status is mandatory at initial certification. Only those benefit group members identified as aliens with qualified and eligible alien status are eligible to participate in the NMW program.

(3) Ineligible or questionable alien status: Any household member identified as an ineligible alien, or whose alien status is questionable cannot participate in the NMW program.

I. Need for documentation:

(1) Benefit group members identified as aliens must present documentation, such as but not limited to, a letter, notice of eligibility, or identification card which clearly establishes that the alien has been granted legal status.

(2) A caseworker shall allow an alien a reasonable time to submit acceptable documentation of eligible alien status. A reasonable time shall be 10 days after the date the caseworker requests an acceptable document, or until the 30th day after application, whichever is longer.

(3) If verification of an participant 's eligible status is not provided by the deadline, the eligibility of the remaining benefit group members shall be determined. Verification of eligible alien status provided at a later date shall be treated as a reported change in benefit group membership.

(4) During the application process, if an individual has been determined to be a qualified alien and either the individual or HSD submits a request to a federal agency for documentation to verify eligible alien status, HSD must certify the individual in the TANF benefit group as a state-funded participant until a

determination is made that the individual is eligible for TANF funded cash assistance.

(5) Inability to obtain INS documentation: If a benefit group indicates an inability to provide documentation of alien status for any mandatory member of the benefit group, that member shall be considered an ineligible alien. The caseworker shall not continue efforts to contact INS when the alien does not provide any documentation from INS.

J. Failure to cooperate: If a benefit group or a benefit group member indicates an unwillingness to provide documentation of alien status for any member, that member shall be considered an ineligible alien. The caseworker shall not continue efforts to get documentation.

K. Reporting undocumented (illegal) non-citizens:

(1) HSD shall inform the local DHS office only when an official determination is made that any mandatory member of a benefit group who is applying for and receiving benefits is present in the U.S. in violation of the INA. A determination that a non-citizen is in the US in violation of the INA is made when:

(a) the non-citizens unlawful presence is a finding of fact or conclusion of law that is made by HSD as part of a formal determination about the individuals eligibility; and

(b) HSD's finding is supported by a determination by DHS or the executive office of immigration review (EOIR) that the non-citizen is unlawfully residing in the U.S. such as a final order of deportation.

(2) An non-citizen who resides in the US in violation of the INA shall be considered an ineligible benefit group member until there is a finding or conclusion of law through a formal determination process by the INS or EOIR.

(3) Illegal non-citizen status is considered reported when the caseworker enters relevant information about the non-citizen on the benefit group's computer file.

(4) A systematic alien verification for entitlements (SAVE) response showing no service record on an individual or an immigration status making the individual ineligible for a benefit is not a finding of fact or conclusion of law that the individual is not lawfully present.

L. Income and resources of ineligible aliens: All the resources and a prorated share of income of an ineligible alien, or of an alien whose alien status is unverified, shall be considered in determining eligibility and the cash assistance benefit amount for the remaining eligible benefit group members.

[8.102.410.10 NMAC - Rp 8.102.410.10 NMAC, 07/01/2024]

8.102.410.11 RESIDENCE:

A. To be eligible for inclusion in a benefit group, the individual must be living in New Mexico (NM) and demonstrate an intention to stay. At application, the residency determination shall be made prior to the date cash assistance is authorized. Once established, NM residency continues until the individual takes action to end it.

B. Residence shall not be considered to exist if the person is just passing through or is present in NM for purposes such as vacation, family visits, medical care, temporary employment, or other similar short-term stays where the person does not intend to remain. Residence shall not exist if an individual claims residence in another state.

C. Establishing residence: Residence in New Mexico shall be established by being present in the state on an ongoing basis and carrying out the types of activities associated with normal day-to-day living, such as occupying a house, enrolling a child in school, renting a post office box, obtaining a state driver's license, joining a church or other local organization, obtaining or seeking a job in the state, registering to vote in the state, etc.

D. Homeless persons: A homeless person must meet the residence requirement; however, their personal situations may prevent them from establishing the types of residence indicators listed above. As much information as possible shall be obtained and entered into the record, but absence of the more common types of verifications shall not be a barrier to eligibility.

E. Assistance from another state: An individual receiving assistance from another state shall be considered a resident of that state, until that state is notified of the individual's intention to abandon residence. An individual who received TANF from another state shall be considered to be in receipt of concurrent assistance for that month, as set forth in 8.102.410.12 NMAC.

F. Temporary absence from the state:

(1) A temporary absence from the state shall not be considered an interruption of residence. Temporary absence occurs when an individual leaves the state for a specific, time-limited purpose. After the temporary absence, the individual must intend to return to the state. An absence related to the following purposes shall be considered temporary:

(a) short-term visits with family or friends for 30 days or less;

(b) out-of-state stays for medical treatment;

(c) attendance at an out-of-state school, with returns to the state during vacations.

(2) A statement by a participant of intent to return to the state will be accepted, provided that the participant does not take action in another state to establish permanent residence.

G. Residency abandonment: Residence shall be considered to have been abandoned when:

(1) an individual leaves the state and indicates that an intent to establish residence in the other state; or

(2) an individual leaves the state for no specific purpose and with no clear intention to return;

(3) an individual leaves the state and applies for food, financial or medical assistance from another state, which makes residence in that state a condition of eligibility; or

(4) an individual has been absent from the state for a period of more than 30 days and has not notified the caseworker of the absence or of any intention to return.

H. Residence of children: A dependent child shall be considered to be a resident of the same state as the specified relative or caretaker adult with whom the child is living.

[8.102.410.11 NMAC - Rp 8.102.410.11 NMAC, 07/01/2024]

8.102.410.12 NONCONCURRENT RECEIPT OF ASSISTANCE:

A. To be eligible for inclusion in a NMW benefit group, the individual cannot already be included in or receiving benefits from:

(1) another authority cash assistance benefit group;

(2) an SSI grant;

(3) a tribal TANF program or BIA-GA program;

(4) a government-funded adoption subsidy program;

(5) a TANF program in another state; or

(6) foster care payments as defined in Title IV of the Social Security Act.

B. An individual may not be the payee for more than one NMW cash assistance payment.

C. Supplemental security income:

(1) Ongoing SSI eligibility: A person eligible for SSI on an ongoing basis is not eligible for NMW or refugee assistance benefits on the basis of concurrent receipt of assistance. The SSI recipient is not included in the benefit group for purposes of financial assistance eligibility and benefit calculation. The income, resources, and needs of the SSI recipient are excluded in determining benefit group eligibility and payment.

(2) SSI applicants: An individual receiving cash assistance benefits from the authority may apply for and receive SSI benefits for the same months for which the authority has already issued benefits. Cash assistance benefits issued by the authority are considered in determining the amount of retroactive SSI benefits. NMW ineligibility or overpayments shall not be established for any month for which SSI issues a retroactive benefit. When verification is received that a benefit group member is approved for SSI on an ongoing basis, that member shall be immediately removed from the benefit group.

D. Subsidized adoptions: Children in receipt of state or federal adoption subsidy payments are included as benefit group members, and their income is counted in determining eligibility and payment.

E. Other authority programs: Non-concurrent receipt of assistance limitations apply to authority programs authorized in 8.102 NMAC, 8.106 NMAC, 8.119 NMAC, tribal TANF programs, SSI, and payments for foster care under Title IV of the Social Security Act. SNAP, medicaid, LIHEAP and other similar programs are not considered concurrent assistance and shall not make an individual ineligible for cash assistance and tribal TANF programs.

[8.102.410.12 NMAC - Rp 8.102.410.12 NMAC, 07/01/2024]

8.102.410.13 WORK PROGRAMS: The NMW work program is designed to improve the participant's capacity to improve income and strengthen family support. If an individual who is required to meet work program requirements fails to do so, the benefit group may be subject to the payment sanctions described in 8.102.620.10 NMAC.

[8.102.410.13 NMAC - Rp 8.102.410.13 NMAC, 07/01/2024]

8.102.410.14 [RESERVED]

[8.102.410.14 NMAC - Rp 8.102.410.14 NMAC, 07/01/2024]

8.102.410.15 PROGRAM DISQUALIFICATIONS:

A. Dual state benefits: An individual who has been convicted of fraud for receiving TANF, SNAP, Medicaid, or SSI in more than one state at the same time shall not be eligible for inclusion in the cash assistance benefit group for a period of 10 years following such conviction. The conviction must have occurred on or after August 22, 1996.

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

C. Certain convicted felons. An individual who is or has been determined to be convicted on or before February 7, 2014, as an adult of the following crimes shall not be eligible for inclusion in the cash assistance benefit group:

(1) aggravated sexual abuse under section 2241 of title 18, United States Code;

(2) murder under section 1111 of title 18, United States Code;

(3) an offense under chapter 110 of title 18, United States Code;

(4) a federal or state offense involving sexual assault, as defined in section 40002(a) of the Violence Against Women Act of 1994 (42 U.S.C. 13925(a); or

(5) an offense under state law determined by the attorney general to be substantially similar to an offense described in clause (i), (ii), or (iii); and

(6) the individual is not in compliance with the terms of the sentence of the individual or the restrictions under 8.139.400.12 C NMAC.

[8.102.410.15 NMAC - Rp 8.102.410.15 NMAC, 07/01/2024]

8.102.410.16 PROGRAM DISQUALIFICATIONS:

A. Dual state benefits: An individual who has been convicted of fraud for receiving TANF, food stamps, medicaid, or SSI in more than one state at the same time shall not be eligible for inclusion in the cash assistance benefit group for a period of 10 years following such conviction. The conviction must have occurred on or after August 22, 1996.

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

[8.102.410.16 NMAC - Rp 8.102.410.16 NMAC, 07/01/2024]

8.102.410.17 [RESERVED]

[8.102.410.17 NMAC - Rp 8.102.410.17 NMAC, 07/01/2024]

8.102.410.18 LIFETIME LIMITS:

A. NMW/TANF:

(1) NMW/TANF cash assistance shall not be provided to or for an adult or a minor head of household for more than 60 months during the individual's lifetime. The benefit group shall be ineligible if the benefit group contains at least one adult, minor head of household or spouse of the minor head of household who has received 60 or more months of NMW/TANF cash assistance, unless the lifetime limit has been waived pursuant to Subsection E of 8.102.410.17 NMAC.

(2) For purposes of determining the 60-month lifetime limit, the count of months of NMW/TANF cash assistance begins on July 1, 1997 and thereafter, and includes assistance received under PROGRESS, or the court-ordered AFDC program in effect until March 31, 1998, or NMW.

(3) Any month in which an adult, a minor head of household, or the spouse of a minor head of household, has received full, partial, prorated, or retroactive NMW/TANF cash assistance shall be considered a month of receipt and shall be counted towards the 60-month lifetime limit for the benefit group in which that individual resides.

(4) The count of months of NMW/TANF assistance shall include cash benefits, supportive services reimbursements, or other forms of benefits designed to meet a family's ongoing basic needs (for food, clothing, shelter, utilities, household goods, personal care items, and general incidental expenses). NMW/TANF cash assistance shall include supportive services such as transportation and childcare provided to a family who is unemployed.

(5) Receipt of TANF assistance from another state after July 1997, or from a tribal entity that does meet the criteria at Subsection C of 8.102.410.17 NMAC is counted as a month of receipt of TANF assistance for purposes of the term limit regulation.

B. Non-countable assistance:

(1) The authority shall not count a month of receipt of NMW/TANF cash assistance or services toward the 60-month lifetime limit if the participant was a minor who was not the head of household or the spouse of the head of household.

(2) Support services, transportation reimbursements, or child care assistance received by a benefit group with earned income shall not be considered as a month of NMW/TANF assistance against the 60-month term limit, as long as the benefit group does not also receive NMW/TANF cash assistance to meet ongoing basic needs.

(3) Assistance shall not be considered a month of NMW/TANF cash assistance if the assistance is a:

(a) non-recurrent short term benefit that will not extend beyond four months, is not intended to meet ongoing basic needs, and is designed to meet a specific crisis situation or episode of need;

(b) work subsidy to an employer to cover the cost of employee wages, benefits, supervision and training and does not use TANF funds;

(c) refundable earned income tax credit;

(d) contribution to or distribution from an individual development account;

(e) service such as counseling, case management, peer support, child care information and referral, transitional services, job retention, job advancement, or other employment related services that do not provide basic income support; and

(f) transportation benefit provided under a job access or reverse commute project to an individual who is not receiving NMW/TANF cash assistance.

(4) Under federal law, TANF funds may be transferred into the social services block grant and the child care development block grant. Benefits provided to individuals from these transferred funds are no longer characterized as TANF funds and do not count against the lifetime limits.

C. Excluded from the term limit count: Any month in which an adult or minor head of household receives NMW or tribal TANF cash assistance or services while residing in Indian country, as the term is defined in 18 U.S.C. subsection 1151, and where at least 50 percent of the adults are not working, shall not be counted toward the lifetime limit.

D. Extension of the term limit due to hardship: Up to twenty percent of the population of TANF participants to whom the term limit applies may be waived from the 60-month term limit based on hardship or being battered or subjected to extreme cruelty.

(1) An extension of NMW/TANF cash assistance shall not be granted to a benefit group prior to exhausting the 60-month lifetime limit.

(2) The term limit extension will end if the condition or situation allowing the extension ceases to exist.

E. Hardship extension types: For purposes of establishing a hardship and eligibility for an extension of NMW/TANF cash assistance, an individual to whom the lifetime limit applies must demonstrate through reliable medical, psychological or mental reports, social security administration (SSA) records, court orders, authority records or police reports that the individual:

(1) is determined eligible for a limited work participation status due to one of the following qualifying conditions:

(a) an impairment, either temporarily or permanently, as determined by IRU in accordance with Paragraph (1) of Subsection C of 8.102.420 NMAC;

(b) is the sole provider of the care for an ill or incapacitated person;

(c) does not have the ability to be gainfully employed because the individual is affected by domestic violence;

(d) has been battered or subjected to extreme cruelty;

(2) has an application for supplemental security income (SSI) pending in the application or appeals process and:

(a) is currently granted a limited participation status because of a temporary or complete disability; or

(b) was granted a limited participation status because of a temporary or complete disability in the previous twenty-four months;

(3) has reached the age of 60 by the end of the last month of his or her term limit;

(4) is otherwise qualified as defined by the authority.

F. Determining hardship and eligibility for an extension:

(1) The incapacity review unit shall make a determination of hardship based on a temporary or complete disability or being the sole provider of home care to an ill or disabled family member based on criteria set forth at 8.102.420.11, 8.102.420.12 and 8.102.420.13 NMAC.

(2) The incapacity review unit may determine contingency requirements or conditions for continued participation of the individual under the applicable hardship type(s).

(3) Hardship based on domestic violence, battery, or extreme cruelty: A certification that an individual cannot be gainfully employed due to domestic violence, or has been battered or subject to extreme cruelty shall be made by a trained domestic violence counselor and shall be part of the case record.

(a) Supporting documentation shall be provided to the authority and made part of the individual's case record. For purposes of determining a hardship, an individual has been battered or subjected to extreme cruelty if the individual can demonstrate by reliable medical, psychological or mental reports, court orders, authority records or police reports that the individual has been subjected to and currently is affected by:

(i) physical acts that result in physical injury;

(ii) sexual abuse;

(iii) being forced to engage in non-consensual sex acts;

(iv) threats or attempts at physical or sexual abuse;

(v) mental abuse; or

(vi) neglect or deprivation of medical care except when the deprivation is based by mutual consent on religious grounds.

(b) The incapacity review unit shall review the documentation provided to demonstrate a hardship type related to domestic violence, battery, or extreme cruelty, shall ensure that the documentation supports a finding of hardship, and shall determine review periods and contingency requirements if applicable.

(4) The authority shall determine the eligibility of the individual for a hardship extension based on age or whether an application for SSI is pending or in the appeals process by reviewing authority records or SSA files.

G. Participating benefit group:

(1) A NMW benefit group in active status at the time the benefit group reaches the 60-month term limit may ask for an extension of NMW/TANF cash assistance under hardship provisions. The benefit group must provide supporting documentation by the 15th day of the 60th month. If otherwise eligible and a hardship type is determined, the benefit group shall be authorized cash assistance from the first day of the 61st month.

(2) A NMW benefit group whose certification period expires in the 60th month of the term limit may be recertified, if otherwise eligible, under hardship provisions, but must provide supporting documentation by the end of the benefit group's certification period.

H. Closed benefit group: A benefit group shall be required to file an application for NMW cash assistance based on hardship under the following conditions:

(1) a NMW benefit group in active status does not submit supporting documentation by the 15th day of the 60th month of receipt of cash assistance; or

(2) a NMW case closes upon reaching the term limit;

(3) a benefit group may file an application on the first day of the 61st month, or at any time after, and if eligible, benefits shall be approved effective the date of authorization or 30 days from the date of application, whichever is earlier.

I. Automatic extension of cash assistance: A NMW benefit group shall be automatically extended NMW/TANF cash assistance based on hardship when the benefit group member who has received 60 months of cash assistance is:

(1) an adult age 60 or over; or

(2) an adult or minor head of household with an application for SSI pending or in the appeals process; or based on verification in the case record that is not older than three months, the benefit group member is:

(3) granted a limited participation status due to a complete disability, either permanently or temporarily;

(4) granted a limited participation status due to being the sole provider of home care to an ill or disabled family member; or

(5) unable to be gainfully employed because the benefit group member has been battered or subjected to extreme cruelty, or affected by domestic violence; or

(6) is otherwise qualified as defined by the authority.

[8.102.410.18 NMAC - Rp 8.102.410.18 NMAC, 07/01/2024]

8.102.410.19 REQUIREMENTS FOR TANF HARDSHIP EXTENSIONS:

A. Benefit group: NMW cash assistance regulations at 8.102 NMAC continue to apply to a NMW/TANF benefit group that receives a cash assistance based on a hardship determination. A benefit group may be sanctioned at the appropriate level in compliance with regulations at 8.102.620.10 NMAC when a benefit group member fails to comply with the requirements at set forth in at 8.102.410.17 NMAC and 8.102.410.18 NMAC.

B. Certification period: In most cases the certification period for the case will be set at six (6) months, beginning with the 61st month of cash assistance. The incapacity review unit may set the certification period for a benefit group that is shorter or longer than six months when the condition for the hardship type warrants such a determination.

C. Limited work participation status individuals:

(1) An individual granted an extension of the 60-month term limit due to a hardship determination shall be required to meet with the work program contractor. The individual shall be referred by the authority to the work program contractor:

(a) no later than the first day of the 61st month for a case in active status in the 60th month; or

(b) by the end of the first month of the benefit group's hardship extension period for a benefit group whose certification period expires in the 60th month; or

(c) upon approval of a hardship extension period for a benefit group whose case is closed.

(2) An individual granted an extension of the 60-month time limit shall be required to comply with the limited work participation hours as determined by the IRU under hardship, including but not limited to, counseling; substance abuse treatment; speech or physical therapy, continuing or follow up medical treatment; keeping doctor's appointments; family counseling; or engaging in programs or activities to address the hardship type.

D. Other benefit group members: Any other individual included in the NMW benefit group must comply with NMW compliance requirements set forth at 8.102.460 NMAC.

E. Case management:

(1) The individual and the work program contractor shall develop a case management plan that includes specific provisions for assessing barriers and determining actions or behaviors that will enhance the ability of the benefit group to become economically independent.

(2) Case management includes, but is not limited to:

(a) making referrals to appropriate agencies and providing any follow up necessary to obtain the assistance needed by the benefit group;

(b) completing an in-depth assessment and identifying individual and family barriers, such as but not limited to, learning disabilities, cognitive disabilities, substance abuse, criminal history, transportation issues, child care, school attendance for dependent children, limited English proficiency; or limited work ability;

(c) making appropriate referrals and seeking the assistance needed to address the barriers;

(d) identifying support services needs; or

(e) placement in appropriate and realistic work activities and follow up on work activity progress.

[8.102.410.19 NMAC - Rp 8.102.410.19 NMAC, 07/01/2024]

History of 8.102.410 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 221.9000, Registration for Manpower Services, Training and Employment Under the Work Incentive Program, 3/24/1980.

ISD FA 310, Non-Financial Eligibility Criteria, 2/9/1988.

ISD FA 350, Work Registration, 2/10/1988.

ISD FA 350, JOBS, 6/25/1990.

ISD 221.7000, Deprivation of Parental Support, 3/6/1980.

ISD FA 320, Deprivation of Parental Support, 2/10/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.410 NMAC Recipient Policies - General Recipient Requirements - Repealed, 07/01/2001.
8.102.410 NMAC Recipient Policies - General Recipient Requirements, filed 07/01/2024 – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 420 RECIPIENT POLICIES - SPECIAL RECIPIENT REQUIREMENTS

8.102.420.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.420.1 NMAC - Rp 8.102.420.1 NMAC, 07/01/2024]

8.102.420.2 SCOPE: The rule applies to the general public.
[8.102.420.2 NMAC - Rp 8.102.420.2 NMAC, 07/01/2024]

8.102.420.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the authority is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified authority to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.420.3 NMAC - Rp 8.102.420.3 NMAC, 07/01/2024]

8.102.420.4 DURATION: Permanent.
[8.102.420.4 NMAC - Rp 8.102.420.4 NMAC, 07/01/2024]

8.102.420.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.102.420.5 NMAC - Rp 8.102.420.5 NMAC, 07/01/2024]

8.102.420.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.420.6 NMAC - Rp 8.102.420.6 NMAC, 07/01/2024]

8.102.420.7 DEFINITIONS: [Reserved]
[8.102.420.7 NMAC - Rp 8.102.420.7 NMAC, 07/01/2024]

8.102.420.8 AGE - NMW: To be eligible for inclusion in the benefit group, a dependent child is a natural child, adopted child or stepchild or ward who is:

A. 17 years of age or younger;

B. 18 years of age and is enrolled in high school; or

C. between 18 and 22 years of age and is receiving special education services regulated by the New

Mexico public education department (PED).
[8.102.420.8 NMAC - Rp 8.102.420.8 NMAC, 07/01/2024]

8.102.420.9 SCHOOL ATTENDANCE:

A. Requirement: A child of school age, as defined by PED, must attend school and have satisfactory attendance to meet the personal responsibility requirements of the parent, specified relative, or caretaker.

B. Student status:

(1) A dependent child of school age must be a full-time student at a certified educational facility or participating and fully complying with a home-schooling program approved by the New Mexico PED. School age means any dependent child who turns six years of age prior to September first and is under 18 years of age.

(2) A participant who is 18 years of age may be included in the NMW benefit group if the individual is enrolled in high school, or the high school equivalent level of vocational or technical training. Such an individual may be eligible to be included in the NMW benefit group until the end of the month in which the individual graduates or until the end of the month in which the individual turns 19 years of age, whichever occurs first.

(3) A student who is between 18 and 21 years of age may be included in the NMW benefit group as long as the student is enrolled in high school and is receiving special education services regulated by the PED. There must be a current valid individual education plan (IEP) for the student to verify the special education services.

(4) A dependent child age 17 years of age or younger who has graduated from high school or has obtained a GED shall be deemed to be a full-time student and to fulfill attendance requirements.

(5) A minor unmarried parent who does not have a child under the age of 12 weeks, must attend school full time to obtain a high school diploma or must participate in a GED program full-time or participate in approved alternate schooling unless the minor unmarried parent has already graduated from high school or obtained a GED.

C. School attendance:

(1) Full time attendance: A child is considered a full-time student based on the below criteria:

(a) School attendance is defined by the standards of the educational facility or program in which the child is enrolled including regularly scheduled vacations and breaks provided the child:

(i) has not been removed for non attendance; and

(ii) resumes attendance when classes start again;

(b) is currently enrolled in a home schooling programming approved by the New Mexico PED.

(2) Verification:

(a) Verification of school attendance must be provided at time application and certification for any:

(i) minor unmarried parent; and

(ii) dependent child 18 years of age and over.

(b) The statement of the parent or caretaker is acceptable verification of school attendance for all other dependent children, unless otherwise questionable.

D. Unsatisfactory attendance:

(1) A child shall be considered not meeting the school attendance requirement when the child:

(a) is not enrolled in school;

(b) has accumulated three unexcused absences in a grading period, but not on the same day;

(c) has dropped out of school during the current grading period; or

(d) has one or more unexcused absences during the time period covered by a current school attendance plan.

(2) Reporting requirement: Within 14 days of the date it becomes known, the parent, specified relative, or caretaker must report to ISD if a child is not enrolled in school, has accumulated three unexcused absences during the current grading period, or has dropped out of school. Failure to report that a child has not met school attendance requirements shall not result in a non-reporting sanction for the parent, or the specified relative or caretaker if included in the benefit group.

(3) Failure to meet: In the absence of good cause for failure to meet the school attendance requirements the conciliation process shall be initiated.

(a) Conciliation process: Prior to removing the child's needs from the benefit group's standard of need, the parent, specified relative or caretaker shall have a 10 working day conciliation period to address school non-attendance. The conciliation period is a 10 working day period affording an opportunity for the parent, child, and the school to develop a plan to ensure regular attendance by the child and comply with NMW requirements.

(i) Within 10 days of receipt of verification that a child has not met school attendance requirements, the caseworker shall take action to initiate a conciliation period by issuing a notice of action.

(ii) The benefit group shall have 10 working days from the date of issuance of the notice to provide a school attendance plan indicating the school's confirmation of satisfactory arrangements.

(iii) If a benefit group fails to provide a school attendance plan, a notice of adverse action shall be sent within five working days.

(iv) If the school confirms that satisfactory arrangements have been made to ensure regular attendance by the child, the child shall remain eligible.

(b) Benefit reduction:

(i) The child shall be removed from the benefit group effective the month following the month the notice of adverse action expires.

(ii) If there is one or more unexcused absence following successful submission of a school attendance plan (the school's confirmation of satisfactory arrangements), the caseworker shall remove the child from the benefit group effective the month following the month the notice of adverse action expires.

(c) Case closure: If the child is the only child included in the benefit group, the cash assistance case shall be subject to closure in the month following the notice of adverse action.

(4) Good cause: A child with unsatisfactory school attendance or enrollment shall be warranted good cause based on the following circumstances:

(a) periods of personal illness or convalescence;

(b) family emergencies, for a period not to exceed 30 days;

(c) participation in or attendance at cultural and religious activities as long as the child has parental consent; or

(d) a minor parent has a child under 12 weeks of age.

E. Regaining eligibility: Once a child has been removed from the benefit group due to failure to comply with school attendance requirements, the child can not be considered a member of any benefit group. Changes in school attendance must be reported by the parent/caretaker. Eligibility may be regained when:

(1) the child has attended school with no unexcused absences for the 30 days;

(2) circumstances of good cause apply as listed in Paragraph (4) of Subsection D; or

(3) during the summer months if the child is promoted, attending summer school or graduating.

[8.102.420.9 NMAC - Rp 8.102.420.9 NMAC, 07/01/2024]

8.102.420.10 [RESERVED]

8.102.420.11 NMW/TANF LIMITED WORK PARTICIPATION STATUS DETERMINATION PROCESS

A. Eligibility: To be eligible for a limited work participation status, a participant must meet at least one of the criteria below as verified by the authority:

(1) Who is age 60 or older.

(2) A single parent, not living with the other parent of a child in the home, or caretaker relative with no spouse, with a child under the age of 12 months. A participant may be eligible for a limited work participation status using this qualification for no more than 12 months during the participant's lifetime.

(3) A single custodial parent caring for a child less than six years of age or who is a medically fragile child if the parent is unable to obtain child care for one or more of the following reasons and the children, youth and families department (CYFD) certifies as to the unavailability or unsuitability of child care:

(a) the unavailability of appropriate child care within a reasonable distance from the parent's home or work site; or

(b) the unavailability or unsuitability of appropriate and affordable formal child care by a relative or under other arrangements; or

(c) the unavailability of appropriate and affordable formal child care by a relative or under other arrangements;

(4) A participant who is a woman in her third trimester of pregnancy, or six weeks post partum.

(5) A participant whose personal circumstances preclude participation for a period not to exceed 30 consecutive days in a calendar year.

(6) A participant who demonstrates by reliable medical, psychological or mental reports, court orders, police reports, or personal affidavits (if no other evidence is available), that family violence or threat of family violence effectively bars the parent from employment.

(7) A participant who is completely impaired, either temporarily or permanently, as determined by IRU.

(8) A participant may be entitled to the family violence option (FVO). This option allows for a parent in a domestic violence environment to be in a limited work participation status for the length of time certified by a trained domestic violence counselor. The certification shall indicate that the parent is in a domestic violence environment which makes them eligible for a limited work participation status.

(a) A participant's FVO limited work participation status shall be reviewed every six months and shall be determined by IRU based on the domestic violence counselor's certification.

(b) A participant who can continue to comply with work requirements as certified by a trained domestic violence counselor may be eligible for a limited work participation status for 24 weeks as described in 8.102.461.15 NMAC.

(9) A participant who is the sole provider of the care for an ill or incapacitated person. In order to meet this exception, the participant must show that the parent is the sole caretaker for a disabled person and must demonstrate that the participant cannot be out of the home for the number of hours necessary to meet standard work participation hours. The following apply to caretaker conditions in determining if the standard work participation rate applies or if a limited work participation rate will be granted:

(a) Only those care activities around which work program activities cannot be scheduled are taken into consideration.

(b) Food purchase and preparation activities, home maintenance chores, etc. are activities which may be scheduled and performed at time other than work program participation hours and are not taken into consideration when determining the standard work participation rate.

(c) A requirement to be on call for the medical emergencies of a medically fragile person is taken into consideration in determining the standard work participation rate for the participant.

(10) A participant may demonstrate good cause for the need for the limited work participation status. A good cause limited work participation status may exist and shall be determined by the authority based on the participant's existing condition(s) to include any barriers identified during the NMW assessment process that impair an individual's ability to comply with the standard work participation rate or capacity to work.

B. Determinations in general: The NMW/TANF determination for a limited work participation status is made independently of and using differing standards from those used for determining OASDI or SSI eligibility, general assistance, workman's compensation, veteran's compensation or in Americans with Disability Act (ADA) determinations. Medical and social information (as appropriate) used by the authority's reviewers may differ between determinations for each type of program, and a participant's condition may improve or worsen over time. As a result, a participant may be classified disabled by one program, but not by another. A disability determination made for another program or purpose is immaterial to the NMW/TANF limited work participation status determination. NMW/TANF determinations shall be made by applying NMW/TANF regulations and medical and non-medical information (as appropriate) known to the authority. An applicant/participant may have more than one condition to qualify for limited work participation status. The limited work participation rate and work activities will reflect accommodations for all identified and approved qualifying conditions.

C. Medical and non-medical based determinations:

(1) Medical conditions: The IRU shall review all documentation and make determinations for participants requesting a limited work participation status or hardship extension due to a medical condition. To be eligible for a limited work participation status from or for a hardship extension, based on a medical condition, the authority must find:

(a) evidence of a physical or mental impairment(s) supported by medical documentation; and

(b) determine that the severity of the impairment(s), as supported by appropriate medical documentation is sufficient to significantly restrict the participant's capacity to fulfill the standard work participation rate or capacity to work; requests for limited work participation status or hardship extension must be supported by medical documentation, but may be supplemented by non-medical documentation provided by the applicant as requested by the IRU.

(2) Caretaker conditions: The IRU shall review all documentation and make determinations for participants requesting a limited work participation status or hardship extension due to caretaker conditions. To be eligible for a limited work participation status or for a hardship extension, as a caretaker, the authority must find the participant is:

(a) the sole provider for an ill or incapacitated family member living in the home who does not attend school on a full time basis; and

(b) providing necessary care to the extent that otherwise precludes the participant's capacity to fulfill standard work participation rates or capacity to work.

(3) Non-medical conditions: The NMW service provider shall review documentation and make determinations regarding requests for limited work participation status for non-medical conditions. If a participant has a medical condition(s) in addition to non-medical conditions, the IRU shall review documentation and make determinations regarding requests for limited work participation status for medical and non-medical conditions. To be eligible for a limited work participation status from the NMW/TANF standard work participation rate based on conditions that are not medical in nature, the authority must find the participant has one of the qualifications for a limited work participation status identified in Subsection A above.

D. Case development process: The caseworker shall be responsible for explaining hardship eligibility, work program requirements, standard work participation rates, and for referring all participants requesting a limited work participation status and hardship extensions to the IRU and NMW service provider, as appropriate. Participants must complete and return the requested information to request a limited work participation status within thirty days of the request.

(1) Limited work participation status requests for medical conditions: Requests for a limited work participation status based on a medical condition shall be sent to the IRU for determination and contain the following:

(a) a completed assessment that has been conducted by the NMW service provider within the six months prior to the date of the request for a change in status;

(b) a completed individual responsibility plan conducted by the NMW service provider;

(c) copies of relevant medical reports made within the last six months;

(d) a work participation agreement with the proposed activity(ies); and

(e) additional documents for evidence of other work related factors.

(2) Limited work participation status requests for non-medical conditions: The NMW service provider shall utilize the following documents to determine eligibility for the limited work participation status:

(a) a completed assessment that has been conducted by the NMW service provider within the six months prior to the date of the request for a change in status; and

(b) a completed individual responsibility plan conducted by the NMW service provider.

E. Provision of documentation: It shall be the responsibility of the participant requesting limited work participation status or hardship extension to provide recent (within the last six months) medical and non-medical information necessary to make a determination. Non-medical evidence will not be considered in the absence of medical documentation for requests based on medical conditions. A participant, who has not provided the necessary information as requested by the authority, contractor or its designee to make a determination within 30 days of the request for the limited work participation status or hardship extension, shall be subject to meeting full participation requirements. Participants who fail to provide the requested documentation within 30 days of the request, but are also eligible for a limited work participation status on the basis of a non-medical condition, shall be referred to the NMW service provider to determine the limited work participation status based on the non-medical condition. The participant is not responsible for providing documentation produced by the authority, its contractors, or its designee.

(1) Medical documents: Written paperwork must be submitted to verify the existence of physical, mental impairment(s) or both; as well as the extent of the caretaking needs. It is the responsibility of the participant to get all information to the IRU for review. Determinations are based on the written evidence provided

in a timely manner to IRU.

(a) Source: Medical documents must be obtained from approved source(s), limited to: medical doctors, physician assistants, doctors of osteopathy or podiatry, ophthalmologists, psychiatrists or psychologists, state-licensed providers, and individuals that meet the minimum mental health professional qualifications set by their community mental health services employer.

(b) Authority assistance: The authority, contractor or its designee shall offer assistance to the participant to include obtaining medical documents or other reasonable accommodations as requested by the participant. If the authority is assisting the participant with obtaining documentation or other accommodation, the participant is still responsible for providing accurate and timely information.

(c) Timeliness of report: The participant shall provide medical records from the past six months. Medical documents over six months old from the date of the request for the limited work participation status or hardship extension may be useful to support a pattern of recurring impairment, but must be accompanied by current medical documents.

(d) Independent medical review: The authority may request additional documentation in order to make a determination regarding a participant's request for limited work participation status. The IRU may request additional documentation in the form of an independent medical review of the participant's condition(s). If the participant is also a recipient of medicaid, the authority may assist with a referral to a medicaid provider, as appropriate.

(2) Non-medical information: Non-medical information may not be used for medical condition determinations without the provision of medical documents. Non-medical information may be submitted to the IRU or the NMW service provider and will be considered if the source is public and private agencies, schools, participants and caregivers, social workers and employers, and other relevant and independent sources to assist in the determination of whether the barriers are of sufficient severity to restrict the participant's capacity to fulfill the standard work participation rate, or that the need to care for an individual are so great as to limit or exclude participation.

F. Case disposition:

(1) Medical based conditions: The IRU shall have sole responsibility for reviewing all medical documents. When making a determination regarding a participant's capacity to fulfill the standard work participation hours, the IRU will within 30 calendar days of receipt complete the following:

(a) conduct a thorough review of the documentary evidence;

(b) make a determination as to whether a medical condition or caretaking need is supported by the evidence provided by the participant;

(c) determine the anticipated duration of the impairment;

(d) adopt or propose participation activities based on the work participation agreement submitted with the participants request packet; and

(e) establish the reduced limited work participation hours if a limited work participation status or hardship extension of the 60 month time limit is granted.

(2) Non-medical based impairments: The NMW service provider shall review all non-medical information and make a determination that a participant is eligible for a limited work participation status. The determination shall identify one of the criteria qualifying for a limited work participation status. The NMW service provider shall identify the non-medical barrier and establish the participation activity(ies) and the limited work participation rate to be included in the approved work participation agreement. All of the non-medical information is considered in assessing the participant's capacity to fulfill the standard work participation rate. Case disposition shall include:

(a) a thorough review of documentary evidence;

(b) a determination as to whether the claim of a non-medical impairment is supported; and

(c) the anticipated duration of the impairment.

(3) Duration of condition(s): The duration of the condition shall be evaluated based on documentation provided and must be expected to last at least thirty days in order to grant a limited work participation status.

(4) Evaluation of medical report(s): Reports shall be reviewed by the IRU for completeness and detail sufficient to identify the caretaking needs, limiting effects of impairment(s), probable duration of the impairment(s), and capacity to perform work program participation standards.

(a) Anatomical and physiological reports shall be reviewed for a description of the medical history, clinical findings, laboratory findings, diagnosis, prescribed treatment and prognosis, and to identify

the participant's ability to sit, stand, move, lift, carry, handle objects, hear, speak and travel.

(b) Psychological assessments shall be reviewed for a description of the participant's behavior, affect, orientation, capacity for appropriate decision-making, response to stress, cognitive function (awareness, memory and intellectual capacity), contact with reality and need for occupational, personal and social adjustment(s).

G. Notification: The authority shall notify the participant regarding the disposition of their request for limited work participation status in compliance with the requirements of adequate notice and notice of adverse action, as applicable.

H. Re-evaluation of status: A participant's limited work participation status shall be re-evaluated on a periodic basis, as determined by the IRU or the NMW service provider, as appropriate. At the time of reevaluation, it shall be necessary to get an update of the medical or non-medical impairment, caretaking need, and any changes in other work-related factors. The IRU shall remain responsible for deciding whether a medical impairment or caretaking need still exists, and the date of the next re-evaluation for continued approval of limited work participation status. The NMW service provider shall remain responsible for deciding whether the non-medical impairment still exists and the date of the next evaluation for continued approval of limited work participation status.

I. Determining the limited work participation rate: after a participant is approved for limited work participation status either at the initial determination or re-evaluation, the IRU or NMW may prescribe conditional work program activities and requirements designed to assist the participant to help accommodate and eliminate barriers. The participant may be assigned to core, non-core and other activities which may include, but not be limited to, one of the contingencies below:

(1) follow treatment plans as prescribed by a physician or mental health provider;

(2) seek and utilize available community based resources;

(3) accept treatment as recommended by a physician or mental health provider;

(4) pursue a referral for DVR, or other available services;

(5) apply for SSI, if applicable; or

(6) any other activity specific to the participant's circumstance and conditions.

J. Transition of currently waived participants to the limited work participation status.

(1) Currently waived: Participants who are waived on or before the effective date of this regulation shall be evaluated for a limited work participation status at their next recertification for TANF benefits or at the next waiver review, whichever is earlier.

(2) Pending waiver determination: Participants who are pending a waiver determination on or before the effective date of this regulation shall be considered for a waiver of the work participation status. They will be determined for a limited work participation status at their next recertification for ongoing TANF benefits or at the next waiver review, whichever is earlier.

[8.102.420.11 NMAC - Rp, 8.102.420.11 NMAC, 07/01/2024]

8.102.420.12 ASSESS CAPACITY FOR WORK

A. General: A medical or mental health condition that precludes a participant's capacity to fulfill the standard work participation rate or capacity to work shall be determined by evaluating the extent of the impairment and other work-related factors. A participant is eligible for a limited work participation status if there is a determination of impairment or condition by the IRU or NMW service provider, as appropriate.

B. Capacity to perform NMW program participation standards: If the participant is determined by IRU or the NMW service provider to have an impairment, the other work-related factors shall be considered. Although a participant may be determined to have some type of impairment, the existence of impairment does not necessarily result in a finding that the participant is incapable of fulfilling the standard work participation hours. A determination that a participant is a caretaker does not necessarily result in a finding that the need to care for an incapacitated or ill household family member is so great as to limit or exclude participation. Many participants with impairments are able to work and thus are not considered to have a medical condition requiring the granting of a limited work participation status according to the standards set forth in the NMW program.

(1) Sedentary work: Sedentary work involves lifting no more than ten pounds at a time and occasionally lifting or carrying articles like docket files, ledgers and small tools. Although a sedentary job is defined as one that involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and sedentary standards are met.

(2) Light work: Light work involves lifting no more than twenty pounds at a time, with frequent lifting or carrying of objects weighing up to ten pounds. Even though the weight lifted may be very little, a

job is placed in this category if it requires a good deal of walking or standing, or if it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities

(3) Medium work: Medium work involves lifting no more than 50 pounds at a time, with frequent lifting or carrying of objects weighing up to 25 pounds.

(4) Heavy work: Heavy work involves lifting no more than 100 pounds at a time, with frequent lifting or carrying of objects weighing up to 50 pounds.

(5) Very heavy work: Very heavy work involves lifting objects weighing more than 100 pounds at a time, with frequent lifting or carrying of objects weighing 50 pounds or more.

C. Psychological impairment: If psychological impairment is being assessed, a participant's mental ability to function at one of the above-mentioned levels shall be evaluated in the following areas:

(1) Judgment: A participant's ability to exercise appropriate decision-making processes in a work situation consistent with the participant's abilities.

(2) Stress reaction: Participant's ability to handle stress consistent with the level of employment.

(3) Cognitive function: Participant's awareness, memory, intellectual capacity and other cognitive functions.

D. Capacity for gainful employment: A participant's verified employment status shall be taken into consideration in determining impairment based on the type, nature, and duration of employment. Impairment may still be determined where the participant is employed minimally or for rehabilitative purposes.

(1) Minimal employment: An individual who is minimally employed may still be considered impaired if the individual cannot reasonably be expected to be self-supporting by at least the standard of need for the size of the benefit group.

(2) Rehabilitative employment: Work made available to an individual through the interest or compassion of others, or to rehabilitate an individual (as in a sheltered workshop), but which would not ordinarily exist on the open labor market, shall not be considered employment in an impairment determination.

E. Other work-related factors: Impairments together with other work-related factors may be considered to establish the participant's capacity to perform basic work program participation standards and engage in gainful employment. While these factors may present an impediment to obtaining employment, they are problems which can be overcome through work program participation. Where such impediments exist, the participant shall be expected to participate in activities which will overcome these barriers. Other work-related factors include but are not limited to the following:

(1) Language barriers: A participant's ability to speak, read, and write English.

(2) Educational level:

(a) Illiteracy: Inability to read or write English. Illiterate individuals are considered suitable for the general labor work force.

(b) Marginal: Eight years of education or less. Marginally-educated individuals are considered suitable for the semi-skilled work force.

(c) Limited: Lack of a high school diploma or GED, but more than eight years of education. Individuals with limited education are considered suitable for the semi-skilled to skilled work force.

(d) High school, GED and above: Indicates an individual's ability to compete in all levels of the job market.

(e) Training program: Completion of training in a particular field of employment may offset limited education in some instances.

(3) Job experience: Experience in a job field can overcome a lack of education, training or both. Jobs held in the last ten years shall be considered. Work experience shall be evaluated based on the type of work previously performed, the length of employment, and the potential for transferring the experience to other types of employment. Inability to continue working in one's prior field of work does not constitute a disability. Job experience is classified in the following categories.

(a) General labor: Does not require the ability to read or write.

(b) Semi-skilled labor: Requires a minimal ability to read, write and do simple calculations.

(c) Skilled labor: Ability to do work in which the ability to read, write and do calculations of a complex nature is needed. Specialized training in the area is also considered.

(4) Appearance: An individual's appearance is generally not the sole reason for an impairment determination. On rare occasions, impairment is disfiguring and may interfere with employment.

(5) Age: Age may affect participants with impairments. The older an individual is, generally, the harder it is for the person to overcome or recover from impairment. A participant's age may be considered when determining the extent of impairment and the support needed to assist a participant.

F. WPA following IRU determination of limited work participation status. After the IRU or NMW service provider, as appropriate, makes a determination to either grant or deny a request for a limited work participation status, the participant must act in accordance with the paragraphs below to ensure they are in compliance .

(1) Limited work participation status granted and adoption of the WPA: Upon approval for the limited work participation status, the participant shall continue to continue to participate in the assigned core or non-core activities or contingencies identified on the WPA submitted to IRU for determination. The WPA shall be considered finalized and the participant shall follow the WPA until the next evaluation date determined by the IRU or NMW service provider.

(2) Limited work participation status granted and modification of the WPA: If the participant is approved for a limited work participation status, but the IRU did not accept the WPA, the participant and the NMW service provider shall meet no later than 15 days following date of the limited work participation status approval to modify the WPA in accordance with the determination of the IRU. The modification will take into consideration the participant's impairment(s) and provide a limited work participation rate and suggested core and non-core work activities.

(3) Limited work participation status denial: If the IRU or NMW service provider, as appropriate, denies the participant's request for limited work participation status, the participant is required to develop a WPA with the NMW service provider no later than 15 days following the date of denial by the IRU or the NMW service provider. Failure to develop a WPA may be considered non-compliance in accordance with 8.102.460 NMAC.

[8.102.420.12 NMAC - Rp, 8.102.420.12 NMAC, 07/01/2024]

8.102.420.13 [RESERVED]

[8.102.420.13 NMAC - Rp, 8.102.420.13 NMAC, 07/01/2024]

8.102.420.14 CHILD SUPPORT:

A. Assignment: By state statute, Section 27-2-28(F), NMSA 1978, any participant who signs an application automatically assigns the participant’s child support rights to the authority. The assignment shall be made with respect to the child for whom NMW is provided and shall be valid as long as the participant receives NMW payments on the child's behalf. The assignment shall also include any spousal support for which the applicant is or may become eligible.

B. Cooperation:

(1) The adult responsible for each child included in the benefit group must cooperate with the child support enforcement division (CSED) in obtaining child support for any dependent child included in the NMW benefit group. Failure to do so will result in payment sanctions. The adult shall be required to cooperate regardless of whether the adult is included in the benefit group.

(2) Failure to cooperate shall result in the personal ineligibility of the participant refusing to cooperate and in a payment sanction against the benefit group, as described in 8.102.620.10 NMAC.

(3) The determination as to whether the participant has cooperated with CSED shall be made by CSED based on CSED requirements. The cooperation requirement may be partially or fully waived by CSED upon demonstration of good cause by the specified relative as indicated in Subsection E of 8.102.420.14 NMAC.

(4) The caretaker relative must transmit to CSED any child support, spousal or medical support payment which the caretaker relative receives directly.

C. Determining that cooperation exists: A caretaker relative who, on the application and certification forms, indicates a willingness to cooperate and who provides basic information determined by CSED as necessary to establish and pursue support shall be considered to have met the cooperation requirement until such time as CSED reports to the caseworker that the participant is failing to cooperate.

D. Action upon receiving notice of noncompliance: On notification by CSED of failure to cooperate, the caseworker shall take immediate action to issue a conciliation notice or to impose a noncompliance sanction.

E. Good cause:

(1) In some situations, it is not in the best interests of the child or parent to pursue support or to require that the caretaker relative cooperate with CSED in pursuing such support. Caretaker relatives therefore

must be:

(a) notified that the requirement to cooperate may be waived;

(b) informed of the requirements involved in the waiver; and

(c) given an opportunity to request a waiver that would exempt them from the cooperation requirement.

(2) If a caretaker relative requests a waiver of the cooperation requirement, assistance shall not be delayed pending determination of good cause, nor may enforcement of support begin or continue while the waiver of the requirement is under consideration. An applicant who makes a waiver request shall not be included in the benefit group until the necessary corroborative information and documents are provided to ISD.

(3) Granting a good cause exemption: The decision whether to grant a good cause exemption shall be made according to the following methods.

(a) Domestic violence exemption: Exemption status shall be reviewed based on the following criteria.

(i) The New Mexico family violence option in the NM TANF state plan allows for exemption from cooperation with CSED requirements due to a domestic violence environment. The ISD caseworker shall exempt an participant from cooperation requirements with CSED where a trained domestic violence counselor has certified that cooperation would make it more difficult to escape the domestic violence or would unfairly penalize the participant in light of current experiences.

(ii) CSED shall exempt a participant from cooperation requirements with CSED when the participant has demonstrated by reliable medical, psychological or mental reports, court orders or police reports that they are subject to or at risk to domestic violence.

(iii) Upon approval of exemption the caseworker shall submit a memo regarding exemption status to CSED and ISD central office.

(b) Other good cause exemptions: All other good cause exemptions, including but not limited to and exemption due to a domestic violence environment that is not certified by a trained domestic violence counselor, from cooperation with CSED requirements shall be made by the director of the CSED or designee.

(4) Notification:

(a) Approval: The caseworker shall send a written notice to the client whether the waiver has been granted and when it will be reviewed. The letter shall also tell the client whether CSED has determined that support can be pursued without danger or risk to the client or child.

(b) Denial: If CSED decides that good cause does not exist, the caseworker shall notify the client that the request has been denied and that the client is expected to cooperate fully in pursuing support, within 10 working days of the day the notice was issued. The notification shall also inform the client that a client has 60 days in which to request an administrative hearing, but that the client is expected to begin cooperating within 10 days after the date of the letter.

[8.102.420.14 NMAC - Rp 8.102.420.14 NMAC, 07/01/2024]

8.102.420.15 [RESERVED]

[8.102.420.15 NMAC - Rp 8.102.420.15 NMAC, 07/01/2024]

8.102.420.16 SSI STATUS: Any individual who is potentially eligible for SSI on the basis of either age or disability must apply for and accept SSI. An individual receiving SSI, or who would be receiving SSI except for recovery of an overpayment, is not eligible to be included in an NMW, or an EWP benefit group.

[8.102.420.16 NMAC - Rp 8.102.420.16 NMAC, 07/01/2024]

8.102.420.17 [RESERVED]

[8.102.420.17 NMAC - Rp 8.102.420.17 NMAC, 07/01/2024]

History of 8.102.420 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 223.3000, Good Cause for not Cooperating in the Pursuit of Child Support, 3/28/1980.

ISD FA 330, Child Support, 2/10/1988.

ISD FA 340, GA Disability, 2/10/1988.

ISD FA 340, GA Disability, 8/30/1994.

ISD FA 310, Non-Financial Eligibility Criteria, 2/9/1988.
ISD 221.7000, Deprivation of Parental Support, 3/6/1980.
ISD FA 320, Deprivation of Parental Support, 2/10/1988.
ISD FA 850, State Supplement for Residential Care, 2/10/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.420 NMAC Recipient Policies - Special Recipient Requirements - Repealed 07/01/2001.
8.102.420 NMAC Recipient Policies - Special Recipient Requirements, filed 07/01/2001 – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 500 ELIGIBILITY POLICY - GENERAL INFORMATION

8.102.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.500.1 NMAC - Rp 8.102.500.1 NMAC, 07/01/2024]

8.102.500.2 SCOPE: The rule applies to the general public.
[8.102.500.2 NMAC - Rp 8.102.500.2 NMAC, 07/01/2024]

8.102.500.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the authority is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.500.3 NMAC - Rp 8.102.500.3 NMAC, 07/01/2024]

8.102.500.4 DURATION: Permanent.
[8.102.500.4 NMAC - Rp 8.102.500.4 NMAC, 07/01/2024]

8.102.500.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.102.500.5 NMAC - Rp 8.102.500.5 NMAC, 07/01/2024]

8.102.500.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participating benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.500.6 NMAC - Rp 8.102.500.6 NMAC, 07/01/2024]

8.102.500.7 DEFINITIONS: [RESERVED]
[8.102.500.7 NMAC - Rp 8.102.500.7 NMAC, 07/01/2024]

8.102.500.8 GENERAL REQUIREMENTS:

A. Need determination process: Eligibility for NMW, state funded qualified aliens and EWP cash assistance based on need requires a finding that:

(1) the benefit group's countable gross monthly income does not exceed the gross income limit for the size of the benefit group;

(2) the benefit group's countable net income after all allowable deductions does not equal or exceed the standard of need for the size of the benefit group;

(3) the countable resources owned by and available to the benefit group do not exceed the $1,500 liquid and $2,000 non-liquid resource limits;

(4) the benefit group is eligible for a cash assistance payment after subtracting from the standard of need the benefit group's countable income, and any payment sanctions or recoupments.

B. Gross income limits: The total countable gross earned and unearned income of the benefit group cannot exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group.

(1) Income eligibility limits are revised and adjusted each year in October.

(2) The gross income limit for the size of the benefit group is as follows:

(a)	one person	$1,033
(b)	two persons	$1,397
(c)	three persons	$1,761
(d)	four persons	$2,125
(e)	five persons	$2,490
(f)	six persons	$2,853
(g)	seven persons	$3,217
(h)	eight persons	$3,582
(i)	add $365 for each additional person.	

C. Eligibility for support services only: Subject to the availability of state and federal funds, a benefit group that is not receiving cash assistance but has countable gross income that is less than one hundred percent of the federal poverty guidelines applicable to the size of the benefit group may be eligible to receive services. The gross income guidelines for the size of the benefit group are as follows:

(1)	one person	$1,215
(2)	two persons	$1,644
(3)	three persons	$2,072
(4)	four persons	$2,500
(5)	five persons	$2,929
(6)	six persons	$3,357
(7)	seven persons	$3,785
(8)	eight persons	$4,214
(9)	add $429 for each additional person.	

D. Standard of need:

(1) The standard of need is based on the number of participants included in the benefit group and allows for a financial standard and basic needs.

(2) Basic needs include food, clothing, shelter, utilities, personal requirements and the participant’s share of benefit group supplies.

(3) The financial standard includes approximately $112 per month for each participant in the benefit group.

(4) The standard of need for the NMW, state funded qualified aliens, and EWP cash assistance benefit group is:

(a)	one person	$327
(b)	two persons	$439
(c)	three persons	$550
(d)	four persons	$663
(e)	five persons	$775
(f)	six persons	$887
(g)	seven persons	$999
(h)	eight persons	$1,134
(i)	add $112 for each additional person.	

E. Special needs:

(1) Special clothing allowance: A special clothing allowance may be issued to assist in preparing a child for school, subject to the availability of state or federal funds and a specific allocation of the available funds for this allowance.

(a) For purposes of determining eligibility for the clothing allowance, a child is considered to be of school age if the child is six years of age or older and less than age 19 by the end of August.

(b) The clothing allowance shall be allowed for each school-age child who is included in the NMW, TBP, state funded qualified aliens, or EWP cash assistance benefit group, subject to the availability of state or federal funds.

(c) The clothing allowance is not allowed in determining eligibility for NMW, TBP, state funded qualified aliens, EWP cash assistance, or wage subsidy.

(2) Layette: A one-time layette allowance of $25 is allowed upon the birth of a child who is included in the benefit group. The allowance shall be authorized by no later than the end of the month following the month in which the child is born.

(3) Special circumstance: Dependent upon the availability of funds and in accordance with the federal act, the HCA secretary, may establish a separate, non-recurring, cash assistance program that may waive certain New Mexico Works Act requirements due to a specific situation. This cash assistance program shall not exceed a four month time period, and is not intended to meet recurrent or ongoing needs.

F. Non-inclusion of legal guardian in benefit group: Based on the availability of state and federal funds, the authority may limit the eligibility of a benefit group due to the fact that a legal guardian is not included in the benefit group.

[8.102.500.8 NMAC - Rp 8.102.500.8 NMAC, 07/01/2024]

8.102.500.9 PROSPECTIVE BUDGETING:

A. Eligibility for cash assistance programs shall be determined prospectively. The benefit group must meet all eligibility criteria in the month following the month of disposition. Eligibility and amount of payment shall be determined prospectively for each month in the certification period.

B. Simplified reporting: A benefit group subject to simplified reporting shall be subject to income methodology as specified in Subsection E of 8.102.120.11 NMAC.

C. Changes in benefit group composition: A person added to the benefit group shall have eligibility determined prospectively beginning in the month following the month the report is made.

D. Anticipating income: In determining the benefit group's eligibility and benefit amount, the income already received and any income the benefit group expects to receive during the certification period shall be used.

(1) Income anticipated during the certification period shall be counted only in the month it is expected to be received, unless the income is averaged.

(2) Actual income shall be calculated by using the income already received and any other income that can reasonably be anticipated in the calendar month.

(3) If the amount of income or date of receipt is uncertain, the portion of the income that is uncertain shall not be counted.

(4) In cases where the receipt of income is reasonably certain but the amount may fluctuate, the income shall be averaged.

(5) Averaging is used to determine a monthly calculation when there is fluctuating income within the weekly, biweekly, or monthly pay period and to achieve a uniform amount for projecting.

E. Income received less frequently than monthly: The amount of monthly gross income that is received less frequently than monthly is determined by dividing the total income by the number of months the income is intended to cover. This includes, but is not limited to, income from sharecropping, farming, and self-employment. It includes contract income as well as income for a tenured teacher who may not actually have a contract.

F. Contract income: A benefit group that derives its annual income in a period of less than one year shall have that income averaged over a 12-month period, provided that the income is not received on an hourly or piecework basis.

G. Using exact income: Exact income, rather than averaged income, shall be used if:

(1) the benefit group has chosen not to average income;

(2) income is from a source terminated in the month of application;

(3) employment began in the application month and the income represents only a partial month;

(4) income is received more frequently than weekly.

H. Income projection: Earned income shall be anticipated as described below.

(1) Earned income shall be anticipated based on income received when the following criteria are met:

(a) the applicant and the caseworker are reasonably certain the income amounts

received are indicative of future income and expected to continue during the certification; and

(b) the anticipated income is based on income received from any consecutive 30-day period that includes 30 days prior to the date of application through the date of timely disposition of the application.

(2) When the applicant and the caseworker determine that the income received is not indicative of future income that will be received during the certification period, a longer period of time may be used if it will provide a more accurate indicator of anticipated income.

(3) Provided the applicant and the caseworker are reasonably certain the income amounts are indicative of future income, the anticipated income shall be used for the month of application and the remaining months of the certification period.

I. Unearned income:

(1) Unearned income shall be anticipated based on income received when the following criteria are met:

(a) the applicant and the caseworker are reasonably certain the income amounts received are indicative of future income and expected to continue during the certification; and

(b) the anticipated income is based on income received from any consecutive 30-day period that includes 30 days prior to the date of application through the date of timely disposition of the application.

(2) When the applicant and the caseworker determine that the income received is not indicative of future income that will be received during the certification period, a longer period of time may be used if it will provide a more accurate indicator of anticipated income.

(3) Provided the applicant and the caseworker are reasonably certain the income amounts are indicative of future income, the anticipated income shall be used for the month of application and the remaining months of the certification period.

J. Use of conversion factors: Whenever a full month's income is anticipated and is received on a weekly or biweekly basis, the income shall be converted to monthly amount as follows:

(1) income received on a weekly basis is averaged and multiplied by 4.0;

(2) income received on a biweekly basis is averaged and multiplied by 2.0;

(3) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $0.50 or more are rounded up; amounts resulting in $0.49 or lower are rounded down.

[8.102.500.9 NMAC - Rp 8.102.500.9 NMAC, 07/01/2024]

8.102.500.10 DIVERSION PAYMENTS TO A NMW BENEFIT GROUP:

A. Purpose: The diversion payment is a one-time cash assistance payment, that is intended to assist the benefit group alleviate a specific short-term need: to accept a bona fide offer of employment, retain employment, remedy an emergency situation or an unexpected short-term need.

B. Eligibility criteria:

(1) Applicant: Eligibility for a diversion payment shall be limited to an applicant making an initial application for cash assistance. Initial application shall not include a NMW cash assistance case which is within a six-month mandatory closure because of a third sanction. For the purposes of diversion payments, an initial applicant is one who has never received cash assistance, or one whose cash assistance case has been closed for one or more calendar months.

(a) An applicant for NMW cash assistance who meets all NMW eligibility criteria may volunteer to accept a NMW diversion payment in lieu of monthly cash assistance payments if there is no need for long-term cash assistance to meet basic needs.

(b) The caseworker shall explain the diversion program is not a supplement to other assistance but is in place of it and screen the applicant for eligibility for a diversion payment.

(c) Final approval for all diversion payments shall be made by the county director and documentation submitted to income support division central office.

(2) NMW eligibility is established:

(a) The applicant must be otherwise eligible for NMW cash assistance, except that the applicant demonstrates that monthly cash assistance to meet basic needs is not required by the benefit group because there is a means of on-going financial support, and the applicant chooses to accept a diversion payment in lieu of cash assistance to meet ongoing needs.

(b) An applicant who cannot demonstrate that monthly cash assistance to meet basic

needs is not needed shall not be eligible for a diversion payment.

(3) Specific need: The applicant must make an informed choice whether cash assistance is needed to meet a specific short term need. The applicant may demonstrate a need for a specific item or type of assistance which will allow the applicant to keep a job or accept a bona fide offer of employment, remedy and emergency situation or alleviate a short term need. Such assistance may include, cash, support services, housing, transportation, car repairs, and uniforms.

(4) Eligibility for support services: A recipient of a diversion payment shall remain eligible for support services such as child care and transportation until the end of the 12-month lock-out period, until closure of the case is requested or the participant moves out of state. A referral to the NMW work program service provider and to CYFD shall be made after the applicant signs the agreement to accept a diversion payment and payment is authorized.

(5) Verification and documentation:

(a) The applicant shall be required to provide verification of the specific item or type of assistance which will allow the applicant to meet the basic short-term need.

(b) Documentation shall be required to establish that a diversion payment may be authorized in lieu of cash assistance to meet ongoing needs. An agreement signed by the applicant shall include a description of a diversion payment, terms and conditions, lifetime limitations, availability of work program services, reason for accepting a diversion payment, any prior assistance received in or out of the state.

C. Amounts: Diversion assistance is a one time, lump sum payment. The amount of the diversion payment is as follows:

(1) one to three benefit group members: may be entitled to an amount of up to $1,500 non-recurring payment; or

(2) four or more benefit group members: may be entitled to an amount of up to $2,500 non-recurring payment.

D. Countable assistance: The effects a diversion payment on other categories of assistance is as follows:

(1) the receipt of a diversion payment shall be excluded from income considerations in the medicaid program; and

(2) categorical eligibility is extended to the food stamp benefit group for the lockout period, unless the benefit group requests closure or moves out of New Mexico; and

(3) an applicant who accepts a diversion payment shall be eligible for TANF funded child care assistance for the lockout period, unless the benefit group requests closure or moves out of New Mexico.

E. Limitations and conditions: An applicant may receive a diversion payment a maximum of two times during a participant's 60-month term limit.

(1) Receipt of a diversion payment does not count toward the NMW 60-month term limit for any adult included in the benefit group, unless the benefit group also receives monthly NMW cash assistance during the period covered by the diversion payment.

(2) The acceptance of a diversion payment does not reduce the number of months in a participant's 60-month lifetime limit; however, a diversion payment can only be authorized a maximum of two times during the 60-month lifetime limit. The 60-month lifetime limit began on July 1, 1997 for any adult or minor head of the benefit group, or spouse of the minor, who received TANF since July 1997.

(3) A participant who has reached the 60-month lifetime limit is not eligible for a diversion payment. A participant who has never received a month of TANF is eligible for a diversion payment.

(4) Cash assistance lockout period:

(a) Acceptance of a diversion payment: An applicant who accepts a diversion payment shall be prohibited from participating in the NMW cash assistance program for a period of 12 months beginning in the month the diversion payment is authorized. A written agreement that defines the terms and expectations of the diversion grant; documents the reason why cash assistance to meet basic needs is not required; identifies the need for a specific type of short-term assistance; and describes the support services available to diversion participants must be signed by the participant.

(b) Receipt of a diversion payment from another state: An applicant who has accepted a diversion payment in any other state shall be prohibited from receiving NMW cash assistance or a diversion payment in New Mexico for a period of 12 months, beginning in the month the diversion payment in the other state was authorized, or for the length of the lockout period in the other state, whichever is shorter.

(5) A participant of a diversion payment is not required to comply with work program or child support enforcement requirements.

F. Re-application: A participant may apply for cash assistance during the lockout period based on the following criteria.

(1) Applying during lock-out period: An applicant who determines an inability to adhere to the terms and conditions for receipt of a diversion payment may apply for cash assistance to meet ongoing basic needs.

(a) An applicant is ineligible for cash assistance payment regardless of good cause within the first four months of receiving a diversion payment.

(b) An applicant is eligible for cash assistance payment if good cause is met at least five months after receipt of diversion payment.

(2) Good cause: Good cause must apply in order for an applicant to re-apply for cash assistance during the lockout period. Good cause can only be considered for applicants applying at least five months after initial receipt of a diversion payment. Good cause is not considered to exist for the first four months from initial receipt of a diversion payment. Good cause must be approved by the authority and may include, loss of employment, but not a voluntary quit or dismissal due to poor job performance or failure to meet a condition of employment; or use of an illegal substance or other drug; catastrophic illness or accident of a family member which requires an employed participant to leave employment; a victim of domestic violence; or another situation or emergency that renders an employed family member unable to care for the basic needs of the family.

G. Claims:

(1) A benefit group that receives monthly cash assistance within the 12-month lock out period shall not be subject to an overpayment if the household meets good cause.

(2) A benefit group may be subject to an overpayment if the diversion payment was issued in error and subject to recoupment as specified in 8.102.640 NMAC.

[8.102.500.10 NMAC - Rp 8.102.500.10 NMAC, 07/01/2024]

History of 8.102.500 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD FA 420, Standard of Need, 2/10/1988.
ISD FA 440, Determination of Eligibility and Grant, 2/10/1988.
ISD FA 440, Prospective Eligibility and Budgeting, 4/30/1992.
ISD FA 460, Special Payments, 2/10/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.500 NMAC Eligibility Policy - General Information, - Repealed, 07/01/2001.
8.102.500 NMAC Eligibility Policy - General Information, filed 07/01/2001 - Repealed, effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 501 TRANSITION BONUS PROGRAM

8.102.501.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.501.1 NMAC – Rp 8.102.501.1, 7/1/2024]

8.102.501.2 SCOPE: The rule applies to the general public.
[8.102.501.2 NMAC – Rp 8.102.501.2, 7/1/2024]

8.102.501.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998 (NMW), the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and title IV-A of the federal Social Security Act, the authority is creating the New Mexico works program as one of its financial assistance programs.

E. Effective July 1, 2008, in accordance with the requirements of the New Mexico Works Act, the authority is creating the Transition Bonus Program (TBP) as one of its financial assistance programs.

F. In close coordination with the NMW program, the authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at title 7, code of federal regulations.

G. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.501.3 NMAC – Rp 8.102.501.3, 7/1/2024]

8.102.501.4 DURATION: Permanent.
[8.102.501.4 NMAC – Rp 8.102.501.4, 7/1/2024]

8.102.501.5 EFFECTIVE DATE: July 1, 2008, unless a later date is cited at the end of a section.
[8.102.501.5 NMAC – Rp 8.102.501.5, 7/1/2024]

8.102.501.6 OBJECTIVE:

A. The purpose NMW program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment, child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participant benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

C. The objective of the TBP is to provide for a limited duration and a fixed monthly cash assistance bonus incentive to encourage NMW families to leave NMW cash assistance and participate in the TBP by maintaining a certain number of hours in paid employment and leave the TBP due to increased earnings.
[8.102.501.6 NMAC – Rp 8.102.501.6, 7/1/2024]

8.102.501.7 DEFINITIONS: Limited state or federal funds as discussed in this part means that available funds would warrant a fixed benefit amount of less than $200 per month.

[8.102.501.7 NMAC – Rp 8.102.501.7, 7/1/2024]

8.102.501.8 TRANSITION BONUS PROGRAM:

A. Purpose: The TBP provides a limited duration and fixed month cash assistance bonus incentive to encourage NMW families to leave NMW cash assistance, participate in the TBP by maintaining a certain number of hours in paid employment and leave the TBP due to increased earnings. This program also provides supportive services on an ongoing basis, provided that the participant is eligible to receive the services during the months provided.

B. Method of payment: TBP payments are paid by issuing funds into an electronic benefits transfer (EBT) account accessible to the participant. In some circumstances benefits may be issued by warrant.

C. Fixed benefit amount: A non-prorated, benefit amount of $200.00 will be given to all TBP participants under one-hundred fifty-percent of federal poverty guidelines. The benefit can be reduced to recoup an existing cash assistance overpayment in accordance with 8.100.640 NMAC. The benefit will be countable for the benefit group's eligibility for SNAP and Medicaid benefits unless otherwise excluded.

D. Lifetime limits:

(1) The TBP benefit shall not be provided to an adult, minor head of household or the spouse of a minor head of household for more than 18 months during the individual's lifetime. A benefit group as defined at 8.102.400 NMAC shall be ineligible if the benefit group contains at least one adult, minor head of household or spouse of the minor head of household who has received 18 or more months of the TBP benefit.

(2) Any month in which an adult, a minor head of household, or the spouse of a minor head of household, has received full or partial TBP benefit shall be considered a month of receipt and shall be counted towards the 18 month lifetime limit for any benefit group in which that individual is a member.

(3) Participants who receive state funded TBP shall not have any month received count towards their 60-month lifetime limit for NMW eligibility.

(4) Participants who receive federally funded TBP shall have each month received count toward the 60-month lifetime limit for NMW eligibility.

(5) When state and federal funds are appropriated, the lifetime limit will be applied as follows:

(a) any participant who has received 31 months or more of TANF will receive state funds;

(b) any participant who has received 30 months or less of TANF will receive federal funds.

E. Initial eligibility:

(1) The TBP program shall be subject to all federal and state NMW cash assistance application, eligibility, certification and reporting requirements, except where specified within the TBP regulations. Resources of the budget group are excluded in determining eligibility for the TBP.

(2) **Application requirements:** Active NMW benefit groups that meet the qualifications and eligibility requirements for the TBP shall be eligible without an application. An application will be required if the NMW case is closed.

(3) The TBP shall be available only to a benefit group that meets all of the following criteria:

(a) does not simultaneously participate in the NMW program;

(b) has left the NMW cash assistance program;

(c) meets all TBP requirements and voluntarily chooses to participate in the program;

(d) is currently engaged in paid unsubsidized or subsidized employment, except for subsidized employment funded with TANF, for a minimum of 30 hours per week, and earnings paid at federal minimum wage, or if self-employed, working a minimum of 30 hours per week, and receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours;

(e) has gross income that does not exceed one-hundred fifty percent of federal poverty guidelines;

(f) has received NMW funded cash assistance for at least three months and one of the last three months; and

(g) does not include an adult, minor head of household or spouse of the minor head of household that participated in the TBP for 18 months in their lifetime or 60 months of TANF.

(4) Eligibility for the TBP shall be prospective for a six month period up to a lifetime limit of 18 months.

F. In accordance with Subsection B of 8.102.500.8 NMAC, income eligibility limits for the TBP will be revised and adjusted each year in October.
[8.102.501.8 NMAC – Rp 8.102.501.8, 7/1/2024]

8.102.501.9 CONTINUED ELIGIBILITY:

A. Six month reporting requirement: All benefit groups participating in the TBP shall be assigned to a six month reporting requirement. A benefit group assigned to a six month reporting shall be required to file a six month report no later than the tenth day of the sixth month or in conjunction with the interim report or SNAP recertification, whichever is appropriate. The benefit group must include the following information along with verification:

(1) any change in benefit group composition, whether a member has moved in or out of the home along with the date, the change took place;

(2) the amount of money received from employment by each benefit group member;

(3) the amount of unearned income received by each benefit group member;

(4) verification for residence, only if, there has been a change in residence since the last certification;

(5) changes in child support receipt; and

(6) changes in alien status for a benefit group member.

B. Continued eligibility at the six month reporting: For continued TBP eligibility, the benefit group must meet all of the following criteria:

(1) engaged in paid unsubsidized employment for at least 30 hours per week, averaged over a month;

(2) have earnings from paid unsubsidized employment that do not exceed one-hundred fifty percent of the federal poverty guidelines; and

(3) have not reached the benefit group's 18 month TBP lifetime limit or 60-month lifetime limit as an adult, minor head of household or spouse of a minor head of household.

C. Action on changes reported between reporting periods for benefit groups assigned to six month reporting:

(1) The authority shall not act on reported changes between reporting periods that would result in a decrease in benefits with the following exceptions:

(a) a benefit group reports income in excess of one-hundred fifty percent of federal poverty guidelines for size of the benefit group;

(b) a benefit group report loss of paid unsubsidized employment;

(c) a benefit group reports, or the authority receives documented evidence that the benefit group has moved from the state or intends to move from the state on a specific date;

(d) a benefit group requests closure;

(e) the authority receives documented evidence that the head the of benefit group has died; or

(f) at the time of a mass change.

(2) A newborn shall be added to the benefit group effective the month following the month the report is received, if the addition is reported to the agency by the benefit group or by the hospital for medicaid purposes.

D. Notice: An eligible benefit group that qualifies and is eligible for the bonus shall be issued notice in accordance with policy at 8.102.110.13 NMAC and for the following circumstances:

(1) Approval: An approval notice shall be issued at the time the benefit group is determined eligible. The approval notice shall identify the amount of approval and recertification date.

(2) Benefit change: A benefit group shall be issued a notice at the time the benefit group is increased or decreased. The amount of benefit is subject to change due to the availability of state or federal funds.

(3) Ineligibility: A benefit group shall be issued a notice when the benefit group no longer qualifies or is not eligible for the TBP due to a reportable change or at time of interim reporting.
[8.102.501.9 NMAC – Rp 8.102.501.9, 7/1/2024]

8.102.501.10 BENEFIT ISSUANCE AND DELIVERY:

A. Benefit issuance: The TBP benefits are issued and placed into a benefit group's electronic benefit transfer (EBT) cash assistance account as defined in 8.102.610.8 NMAC.

B. Supportive services: Participants of the TBP shall be eligible to receive NMW case management

and supportive services in accordance with 8.102.620.14, 8.102.620.15, and 8.102.620.16 NMAC.

C. Special allowances: A special clothing allowance for school age children and layette payment shall be issued pursuant to 8.102.500.8 NMAC.

D. Expungement: The TBP benefit shall be subject to expungement in accordance with 8.102.610.9 NMAC.

E. Issuance and replacement of EBT card: To access and use the TBP benefit, the benefit group may use the same EBT card issued for the cash assistance benefits.

F. Approval notification: Upon approval of the transition bonus program benefit, the household shall be notified of the new benefit amount and the notice shall be mailed to the applicant per 8.102.110.13 NMAC.

[8.102.501.10 NMAC – Rp 8.102.501.10, 7/1/2024]

8.102.501.11 NMW PARTICIPATION REQUIREMENTS: A TBP recipient will be encouraged to participate in work program activities and shall be expected to attend and complete all required activities, such as the assessment, individual responsibility plan (IRP), work participation agreement (WPA) and monthly participation requirements in accordance with 8.102.460 NMAC if not otherwise meeting. Participation requirements apply to each benefit group member whether the benefit group is considered to be a two-parent or single-parent benefit group. No TBP participant shall be sanctioned for NMW non-cooperation.

A. Work Participation Agreement activity will include:

(1) 30 hours a week engaged in paid employment at federal minimum wage, or if self-employed, working a minimum of 30 hours per week, and receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours.

(2) Career development that will lead towards meaningful employment.

B. Failure to comply with Subsection A of 8.102.501.11 NMAC will result in closure of TBP and return to regular TANF.

C. Regain eligibility: A participant can regain eligibility by showing they are complying with the TBP NMW participation requirements.

[8.102.501.11 NMAC – Rp 8.102.501.11, 7/1/2024]

8.102.501.12 SUSPENSION OF PROGRAM: The TBP payment for all benefit groups may be denied for a designated time period based on limited state or federal funds. During program suspension disposition of applications shall be made pursuant to 8.106.110.16 NMAC.

A. Application disposition: All applications for TBP shall be denied under this provision without consideration of eligibility.

(1) Interview: TBP applications denied on the basis of suspension shall not require an interview to meet the requirements specific to TBP, other categories of assistance requested by the applicant may require an interview to determine eligibility.

(2) Payment of assistance: There shall be no payment to the TBP recipient during the designated suspension period and any right to the payment is lost. Retroactive payments for pending applicants shall be authorized for months prior to a designated suspension period.

B. Notice to recipient and applicant: No later than 60 days prior to the effective change the authority shall provide transition bonus recipients appropriate notice regarding suspension or restoration of the grant based on the availability of state or federal funds. The notice shall include the citation to the state statute and regulation and fair hearing rights.

C. Public notice: The authority shall issue a public notice 60 days prior to the changes made based on the availability of state or federal funds. Public notice shall include effective date of change and right to fair hearing consistent with mass change requirements at 8.100.180.15 NMAC.

D. **Claims:** Claims for overpayments shall be established in accordance with regulations outlined at 8.100.640.11 NMAC.

E. Expungement: Cash assistance benefits will be expunged in accordance with regulations outlined in Subsection B of 8.102.610.9 NMAC.

[8.102.501.1 NMAC – Rp 8.102.501.1, 7/1/2024]

HISTORY OF 8.102.501 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 510 ELIGIBILITY POLICY - RESOURCES/PROPERTY

8.102.510.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.510.1 NMAC - Rp 8.102.510.1 NMAC, 07/01/2024]

8.102.510.2 SCOPE: The rule applies to the general public.
[8.102.510.2 NMAC - Rp 8.102.510.2 NMAC, 07/01/2024]

8.102.510.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the authority is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.510.3 NMAC - Rp 8.102.510.3 NMAC, 07/01/2024]

8.102.510.4 DURATION: Permanent.
[8.102.510.4 NMAC - Rp 8.102.510.4 NMAC, 07/01/2024]

8.102.510.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.102.510.5 NMAC - Rp 8.102.510.5 NMAC, 07/01/2024]

8.102.510.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.510.6 NMAC - Rp 8.102.510.6 NMAC, 07/01/2024]

8.102.510.7 DEFINITIONS: [RESERVED]
[8.102.510.7 NMAC - Rp 8.102.510.7 NMAC, 07/01/2024]

8.102.510.8 RESOURCE STANDARDS: To be eligible on the condition of need, the value of all countable personal and real property, belonging to, or considered as belonging to or considered available to the benefit group shall not exceed the liquid and non-liquid resource limits. Property in excess of the liquid and non-liquid resource limits makes the benefit group ineligible unless the nature of the property or an express condition of its ownership prohibits its transfer. Resources are evaluated based upon their equity value.

A. Liquid resources: Liquid resources are those properties in the form of cash or other financial instruments which are easily convertible to cash and include but are not limited to: savings accounts, checking accounts, stocks, bonds, mutual fund shares, promissory notes, mortgages, cash value of insurance policies, and similar properties. The value of countable liquid resources may not exceed $1,500.

B. Non-liquid resources: Non-liquid resources are all resources that cannot be easily converted to cash and include, but are not limited to: both real and personal property. The value of countable non-liquid resources may not exceed $2,000.

[8.102.510.8 NMAC - Rp 8.102.510.8 NMAC, 07/01/2024]

8.102.510.9 COUNTABLE RESOURCES:

A. Real property non-liquid:

(1) Real property means land and the structures and improvements affixed to it.

(2) The value of real property owned by or considered available to the benefit group, except as exempted in Subsection A of 8.102.510.10 NMAC, shall be considered in determining whether non-liquid resources exceed $2000.

(3) Grazing permits are classified as real property.

B. Personal property (liquid or non-liquid): The value of personal property other than that exempted in Subsection B of 8.102.510.10 NMAC, belonging to, considered as belonging to, or available to the benefit group, is considered in determining whether the value of property exceeds the resource limits. Personal property is all property other than real property, and includes such possessions as bank accounts, cash (other than the current month's income), motor vehicles, livestock, tools, equipment, and rights to receive money, such as stocks, bonds, contract rights and insurance policies, etc. The types of personal property that must be counted in determining whether the benefit group's resources exceed the resource limits include, but are not limited to the following.

(1) Life insurance:

(a) Life insurance policies owned by a member of the benefit group shall be considered as a resource that may be converted into cash. The cash value of the life insurance policy shall be counted toward the liquid resource limit.

(b) Information about lapsed insurance shall be obtained since many lapsed policies have a cash value.

(2) Cash, bank accounts and other readily negotiable assets: "Other readily negotiable assets" include stocks, bonds, negotiable notes, purchase contracts and other similar assets. For purposes of cash assistance eligibility, the value of such assets is their current market value. These shall be counted toward the liquid resource limit.

(3) Motor vehicles, equipment, and tools:

(a) The equity value of all motor vehicles, equipment and tools is subject to consideration.

(b) The value of motor vehicles, equipment and tools, except as set forth in Paragraph 1 of Subsection B of 8.102.510.10 NMAC below, is subject to the non-liquid resource test.

(4) Asset conversion: Money received from one-time only or sporadic sales of real or personal property such as crops, rugs, jewelry, royalties etc. shall be considered an asset, rather than income, provided that the property is not sold or transferred in connection with a business or self-employment activity. Actual verified expenses associated with the purchase, sale or production of such items shall be deducted from payments received from the sale to arrive at “net asset”. Assets converted into money are subject to the $1,500 liquid assets limitation, regardless of whether they were fully or partially exempt prior to conversion.

(5) Lump sum payments: Payments of a one-time nature, such as retroactive monthly payments, payments in the nature of a windfall, personal injury and worker's compensation awards, gambling winnings, etc, shall be considered to be a resource in the month received. Countable value is considered as a liquid resource. Resource eligibility is determined on the first moment of the first day of the month. Changes during the month do not affect the resource determination for that month; what is left at the first moment of the first day of the month following its receipt will be the countable amount.

[8.102.510.9 NMAC - Rp 8.102.510.9 NMAC, 07/01/2024]

8.102.510.10 RESOURCE EXCLUSIONS:

A. Real property:

(1) The home: The value of the benefit group's home and certain other property, as defined

below, is not considered in determining eligibility. The "home" is the dwelling place occupied by the benefit group. The home is considered to be occupied by the benefit group during a temporary absence from the home when there is a definite plan to return to the home and no one else is occupying it. "Home" includes, in addition to the residence building and the land upon which it is constructed, the following:

(a) a reasonable amount of land within reasonable proximity to the residence building if that land is currently used by and useful to the client;

(b) outbuildings within reasonable proximity to the residence building, such as barn, garage and well, if the well is a principal source of water;

(c) buildings used for rental purposes if located on land contiguous to the land upon which the residence building is constructed and if these buildings cannot be divided from the residence land and sold separately;

(d) grazing permits currently being used to graze livestock owned by the client;

(e) furniture, equipment and household goods necessary for the operation and maintenance of the home.

(2) Other real property - burial plots: One burial plot for each person included in the benefit group; a burial plot shall consist of the space needed to bury members of the immediate family.

B. Exempt personal property: The value of the following items of personal property shall not be considered in determining eligibility for financial assistance.

(1) Vehicles:

(a) Transportation to or from work/daily living: Vehicles used for transportation of benefit group members to or from work or work activities, for daily living activities, or for transportation of goods or services shall not be considered in the determination of resources attributed to the benefit group.

(b) Specially equipped vehicles: A vehicle that is specially equipped for those with physical impairments shall not be considered in the determination of resources attributed to the benefit group.

(2) Exempt income: Any income which is exempt under income provisions is also exempt from consideration as a resource. To maintain its exempt status, exempt income which is accumulated must be kept separately from non-exempt savings.

(3) Funeral agreements: The equity value of funeral agreements owned by a benefit group member. Funeral agreements include any arrangement under which prepaid funeral services are provided or cash benefits which are intended to pay for funeral services are paid upon the death of the person. Included as such agreements are contracts with funeral homes, life or burial insurance, or trust or escrow accounts in financial institutions or banks, provided that the trust or escrow accounts contain provisions making the funds payable only upon the death of a named individual. There is no limit on the amount which can be disregarded.

(4) Contingent and unliquidated claims: A "contingent and unliquidated claim" is an as yet undetermined right of the client to receive, at some future time, a resource such as an interest in an estate not probated or damages or compensation resulting from an accident or injury. Such a claim is not considered a resource to meet requirements if the benefit group member can demonstrate that the client has consulted an attorney, or that under the circumstances, it is reasonable not to have consulted an attorney, and that the benefit group member is making every reasonable effort to prosecute the benefit group member’s claim or to proceed with the probate. If the benefit group member can demonstrate that the client's share in an estate not probated would be less than the expense of the proceedings to probate the estate, the value is not considered a resource.

(5) Work-related equipment exclusion: Work-related equipment, such as the tools of a trades person or the machinery of a farmer, which are essential to the employment or self-employment of a benefit group member, are excluded, in an amount not to exceed $1000 per individual, and remain excludable, if the trades person becomes disabled. Farm machinery retains this exclusion for one year if the farmer ends self-employment.

(6) Livestock: The value of livestock is an excluded non-liquid resource.

C. Individual development account (IDA): As defined in the Individual Development Account Act 58-30 NMSA, 1978, funds in an IDA are exempt from consideration as resources in determining benefit group eligibility are subject to certain requirements. To be disregarded, the IDA must be designated for a qualified use and meet all requirements as follows.

(1) IDA requirements:

(a) the benefit group member must establish the IDA for one of the purposes listed in Paragraph (2) of the this subsection;

(b) in order for such accounts to be excludable, the IDA must be a trust created or organized in the United States, with trust language restricting use of account funds to the qualified uses as designated in this section; and

(c) the IDA must be funded exclusively with income earned by a benefit group member or by contributions made by a non-benefit group member;

(d) funds withdrawn from the account and used for any purpose other than those specified under this section, will cause the account to lose its status as an excluded resource, starting with the month in which the funds are so used; the amounts withdrawn also constitute an overpayment of assistance, and must be reported and shall be recouped.

(2) IDA qualified uses: Allowable uses of the money withdrawn from an IDA are listed in Subparagraph (a) thru (f) of this subsection.

(a) Post-secondary education expenses: In order to be considered used for the qualified purpose, the post-secondary education funds must be paid from an IDA directly to an eligible education institution, as set forth in this section. For purposes of this regulation, post-secondary education expenses include:

(i) tuition and fees required for the enrollment or attendance of a student at an eligible education institution; an eligible institution is an institution described in section 481(a)(1) or 1201(a) of the Higher Education Act of 1965 (20 USC 1088(a)(1) or 1141(a)); an area vocational education school (as defined in section 521(4) of the Carl D. Perkins Vocational and Applied Technology Education Act (20 U.S.C. 2471(4)) which is in any state; or

(ii) books, fees, supplies, and equipment required for courses of instruction at an eligible educational institution.

(b) Business capitalization: In order to be considered used for the qualified purpose, for business capitalization, the funds have to be paid directly from the IDA to a business capitalization account established in a federally insured financial institution that is restricted to use solely for qualified business capitalization expenses. A qualified business means any business that does not contravene any law or public policy. Qualified business capitalization expenses include capital, plant, equipment, working capital, and inventory expenses. To be a qualified business, there must be a business-plan which:

(i) is approved by a financial institution, or by a nonprofit loan fund having demonstrated fiduciary integrity;

(ii) includes a description of services or goods to be sold, a marketing plan, and projected financial statements; and

(iii) may require the eligible individual to obtain the assistance of an experienced entrepreneurial advisor.

(c) First-time home purchase by a qualified buyer: The purpose of the IDA is to assist a qualified first-time home buyer to accumulate part of the cash necessary to initiate purchase of the individual's first home.

(i) Only IDA's established by qualified first-time home buyers shall be disregarded. A qualified first-time home buyer is one who has never had an ownership interest in a principal residence.

(ii) The IDA may be used only for the purchase of a qualified principal residence. A qualified principal residence is one which qualifies as the principal home under Subsection 1034 the federal internal revenue service's code, and the costs for which do not exceed 100 percent of the average area purchase price applicable to such residence, determined in accordance with paragraphs (2) and (3) of Subsection 143(e) of the internal revenue service's code.

(d) Home improvements: Costs of major home improvements or repairs on the home of the account owner.

(e) Death of account owner: The amount deposited by the deceased account owner held in an IDA shall be distributed directly to the account owner's spouse. If the spouse is deceased or there is no spouse the amount shall be distributed to a dependent or other named beneficiary of the deceased. The account and matching funds designated for that account from a reserve account may be transferred and maintained in the name of the surviving spouse, dependent or beneficiary.

(f) Vehicle acquisition: Acquisition of a vehicle necessary to obtain or maintain employment by an account owner or the spouse of an account owner.

D. Federally excluded resources: Certain resources are excluded pursuant to federal law. For a listing of federally excluded resources see 8.139.527 NMAC.

[8.102.510.10 NMAC - Rp 8.102.510.10 NMAC, 07/01/2024]

8.102.510.11 RESOURCE AVAILABILITY:

A. Availability: Resources that are actually available or which are considered to be available are

considered in determining eligibility for assistance. For purposes of cash assistance eligibility, the countable resources of all benefit group members shall be considered to be available to the benefit group. The resource determination shall be made based upon the status of resources on the first moment of the first day of each month. Subsequent changes shall not effect the determination of eligibility or ineligibility until the first moment of the first day of the following month.

B. Potentially available resources: The benefit group is required to take all appropriate steps to make available to itself any property resources to which the group may be entitled but whose value is not currently available, which includes, but is not limited to, an inheritance, where the estate has not yet gone through probate. The fact that specific property is not readily marketable on the client's terms is not a condition prohibiting transfer. The current value of property, which must be partitioned in order to be accessible, is not considered available if the net value (after estimated costs of partition and other closing costs) is less than the resource limit. If the amount likely to be derived from the applicant's or recipient's share of the property exceeds the resource limit, the applicant or recipient will be required to initiate attempts to obtain the recipient's share of the estate.

C. SSI recipients and other non-members: The property of individuals receiving SSI or of other non-members shall not be considered available, regardless of relationship to benefit group members, except as indicated in E. below.

D. Alien sponsor: The gross income and resources belonging to an individual who is the sponsor of an alien included in the cash assistance benefit group, and the income belonging to the sponsor's spouse, shall be counted in its entirety to determine the eligibility and payment amount if the sponsor has executed an affidavit of support pursuant to Subsection 213-A of the Immigration and Nationality Act. The income and resources of the alien sponsor, and spouse, shall be counted until the sponsored alien achieves citizenship or can be credited with 40 qualifying quarters under title II of the federal Social Security Act.

E. Deeming resources: A liquid resource owned by a parent of a minor parent living in the home, shall be deemed on a pro rata basis, unless the parent of the minor parent receives SSI.

F. Joint property:

(1) Joint resources: Resources owned jointly by separate benefit groups shall be considered available in their entirety to each benefit group, unless it can be demonstrated by an applicant or recipient that such resources are inaccessible to it. The benefit group must verify that:

(a) it does not have the use of the resource;

(b) it did not make the purchase or down payment;

(c) it does not make the continuing loan payments; and

(d) the title is transferred to or retained by the other benefit group;

(e) if a benefit group can demonstrate that is has access to only a part of the resource, the value of that part is counted toward the benefit group's resource level; a resource will be considered totally inaccessible, if it cannot be practically subdivided and the benefit group's access to the value of the resource is dependent on the agreement of a joint owner who refuses to comply; for purposes of this provision, ineligible aliens or disqualified individuals residing with a benefit group are considered benefit group members.

(2) Joint bank accounts: If signatories to a joint bank account are separate benefit groups, the funds in the account are considered available to each benefit group to the extent that it has contributed to the account. If the participation benefit group has not contributed to the account, the funds are considered available only if there is clear and convincing evidence that the other benefit group intends that the participation benefit group actually owns the funds.

[8.102.510.11 NMAC - Rp 8.102.510.11 NMAC, 07/01/2024]

8.102.510.12 [RESERVED]

8.102.510.13 ELIGIBILITY DETERMINATION:

A. Determination: After determining what property is available to the benefit group and determining the value of that resource, the net value of the countable real and personal property exceeds resource limits, the benefit group shall be ineligible for assistance on the basis of need. The benefit group shall remain ineligible on the condition of need for as long as the value of the property exceeds the resource standards. The basis of need is determined by:

(1) what property is available to the benefit group;

(2) the value of all available resources;

(3) what the net value of all countable real and personal property.

B. Receipt of resources: Resources acquired by a benefit group member after approval of an

assistance grant shall be evaluated for purposes of financial assistance eligibility at the time of the change. Reporting requirements as indicated in Subsection D of 8.102.630.8 NMAC apply. If ownership or availability of resources makes the benefit group ineligible, assistance is terminated effective the month following the month the notice of adverse action expires.
[8.102.510.13 NMAC - Rp 8.102.510.13 NMAC, 07/01/2024]

8.102.510.14 NON-TRANSFER OF REAL PROPERTY:

A. Requirement:

(1) For the parent or the specified relative to be included in the benefit group, a benefit group member must not have transferred real property for the purpose of becoming eligible for cash assistance within the two-year period preceding the date of application.

(2) A transfer is considered to be for the purpose of becoming eligible if:

(a) the transfer was made without a reasonable return; and

(b) the person had no reasonable plan for support at the time of the transfer other than assistance from the authority.

B. Transfer:

(1) For the purpose of this provision, transfer includes the sale, conveyance by deed, or any other method of transferring the title to the property involved, including transfer by gift. The transfer may be for either the title to the real property or other interests or rights in the property, such as mineral or water rights.

(2) A child under the age of 18 years cannot transfer property, except through a guardian. If facts indicate the existence of a trust, inheritance or prior gifts to the child, it must be determined whether a transfer has taken place.

C. Reasonable return: A reasonable return is considered to have been received when the person who made the transfer received compensation in cash or in kind equal to the value of the property at the time of transfer. The determination as to whether a reasonable return was received is based on the person's equity interest in the property at the time of the transfer.

D. Equity less than $2000: If the value of the person's equity, plus all other countable resources, was less than $2000, the transfer is not considered to be for the purpose of becoming eligible.

E. Reasonable value not received:

(1) When it is determined that the property was transferred for the purpose of becoming eligible, but the client has subsequently made efforts to obtain a reasonable return, or to regain title, and is willing to continue such efforts, if indicated, eligibility on this condition exists. When the client is not willing to pursue a reasonable return, or to attempt to regain title to the property, the case shall not be eligible for six months from the month the authority makes the determination that the transfer was made.

(2) Any proceeds received in return for property transfers shall be evaluated to determine if they affect the client's ongoing eligibility for cash assistance.
[8.102.510.14 NMAC - Rp 8.102.510.14 NMAC, 07/01/2024]

HISTORY OF 8.102.510 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD FA 410, Resources, 2/10/1988.
ISD FA 410, Resources, 6/18/1990.
ISD FA 440, Determination of Eligibility and Grant, 2/10/1988.
ISD FA 440, Prospective Eligibility and Budgeting, 4/30/1992.
ISD FA 310, Non-Financial Eligibility Criteria, 2/9/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.510 Eligibility Policy - Resources/Property - Repealed, 07/01/2001.
8.102.510 Eligibility Policy - Resources/Property, filed 07/01/2002 – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 520 ELIGIBILITY POLICY - INCOME

8.102.520.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.520.1 NMAC - Rp 8.102.520.1 NMAC, 07/01/2024]

8.102.520.2 SCOPE: The rule applies to the general public.
[8.102.520.2 NMAC - Rp 8.102.520.2 NMAC, 07/01/2024]

8.102.520.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the authority is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.520.3 NMAC - Rp 8.102.520.3 NMAC, 07/01/2024]

8.102.520.4 DURATION: Permanent.
[8.102.520.4 NMAC - Rp 8.102.520.4 NMAC, 07/01/2024]

8.102.520.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.102.520.5 NMAC - Rp 8.102.520.5 NMAC, 07/01/2024]

8.102.520.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participating benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.520.6 NMAC - Rp 8.102.520.6 NMAC, 07/01/2024]

8.102.520.7 DEFINITIONS: [RESERVED]
[8.102.520.7 NMAC - Rp 8.102.520.7 NMAC, 07/01/2024]

8.102.520.8 GENERAL:

A. Income eligibility: To be eligible for cash assistance based on income eligibility factors:

(1) the countable gross income available to the benefit group cannot equal or exceed the maximum gross income limit for the size of the benefit group;

(2) the net countable income available to the benefit group cannot equal or exceed the

standard of need applicable to the size of the benefit group;

(3) all income exempted or deducted in the gross income test shall be exempted or deducted in the net income test;

(4) all income considered available in the net income test shall be considered in determining the amount of payment to the benefit group.

B. Gross income test (85 percent test): For the benefit group to be eligible, the countable gross income available to the benefit group cannot exceed eighty-five percent of the federal poverty guidelines for the size of the benefit group.

C. Net income test: For the benefit group to be eligible, the countable net income must be less than the standard of need applicable to the size of the benefit group.

D. Eligibility for support services only: Subject to the availability of state and federal funds, a benefit group that is not receiving cash assistance but has countable gross income that is less than 100 percent of the federal poverty guidelines applicable to the size of the benefit group may be eligible to receive services.

E. Counting income during the certification period:

(1) For the purposes of cash assistance eligibility and payment determination, income is money received by or available to the benefit group in each month of the certification period.

(2) Only income which is actually received, or can reasonably be expected to be received, is counted for financial eligibility and payment calculation.

(3) The benefit group must take appropriate steps to apply for and receive income from any other source to which the group may potentially be eligible. A benefit group may be found ineligible for failing or refusing to apply for or pursue potential benefits from other sources.

(4) A benefit group member who is 62 years of age or older must apply for and take all necessary steps to receive a reduced OASDI benefit in order to comply with this eligibility criterion.

F. Income availability:

(1) The availability of income to the benefit group is determined by who must be included in the benefit group, and whether income must be deemed available to the benefit group.

(2) Income belongs to the person who gains it, either through the person's own efforts, as in the case of earnings, or as a benefit, as in the case of a beneficiary of social security administration income.

(3) Any unearned income, benefits, or payments, such as but not limited to: child support or social security benefits, for a child are considered as belonging to the benefit group in which the child is included.

(4) Alien sponsors: The gross income and resources belonging to an individual who is the sponsor of an alien included in the cash assistance benefit group, and the income belonging to the sponsor's spouse, shall be counted in its entirety to determine the eligibility and payment amount if the sponsor has executed an affidavit of support pursuant to Subsection 213-A of the Immigration and Nationality Act. The income and resources of the alien sponsor, and spouse, shall be counted until the sponsored alien achieves citizenship or can be credited with 40 qualifying quarters under title II of the federal Social Security Act.

G. Unavailable income: In some situations, individuals who are included in the benefit group, either an applicant or participant status, have a legal right to income but do not have access to it. Such income is not counted as available income for purposes of cash assistance eligibility and benefit calculation. A benefit group may be found ineligible for failing or refusing to immediately take all steps necessary to obtain access to the income.

H. Ineligible alien: The countable income belonging to an ineligible alien is deemed available to the benefit group and is prorated according to the size of the benefit group to determine the eligibility and payment amount for the benefit group.

[8.102.520.8 NMAC - Rp 8.102.520.8 NMAC, 07/01/2024]

8.102.520.9 EXEMPT INCOME: The following income sources are not considered available for the gross income test, the net income test, and the cash payment calculation:

A. medicaid;

B. food stamp benefits;

C. government-subsidized foster care, if the child for whom the payment is received is not included in the benefit group;

D. SSI;

E. government-subsidized housing or a housing payment; government includes any federal, state, local or tribal government or a private non-profit or for profit entity operating housing programs or using governmental funds to provide subsidized housing or to make housing payments;

F. income excluded by federal law (described in 8.139.527 NMAC);

G. educational payments made directly to an educational institution;

H. government-subsidized child care;

I. earned income that belongs to a child 17 years of age or younger who is not the head of household; only earned income paid directly to the child is considered as belonging to the child;

J. up to $50.00 child support disregard and $100.00 for one child and $200 for two or more children per month, child support pass-through distributed to the benefit group by the CSED;

K. an emergency one-time only payment made by other agencies or programs;

L. reimbursements for past or future identified expenses, to the extent they do not exceed actual expenses, and do not represent a gain or benefit to the benefit group, such as expenses for job or job training related activities, travel, per diem, uniforms, transportation costs to and from the job or training site, and medical or dependent care reimbursements and any reimbursement for expenses incurred while participating in NMW work program activities; reimbursements for normal living expenses, such as rent, mortgage, clothing or food eaten at home are not excluded;

M. utility assistance payments such as from low-income home energy assistance program (LIHEAP), low-income assistance program (LITAP), or similar assistance programs.

N. subsidized private sector employment: as outlined at Subsection B of 8.102.461.12 NMAC.

O. guaranteed basic income**:** any payments that is funded solely with private funds or mixture of private and public funds will be excluded income.

P. universal basic income: any payments that is funded solely with private funds or mixture of private and public funds will be excluded income.

[8.102.520.9 NMAC - Rp 8.102.520.9 NMAC, 07/01/2024]

8.102.520.10 EARNED INCOME DEFINITION:

A. Earned income means cash or payment in kind that is received as wages from employment, payment in lieu of wages, earnings from self-employment or earnings acquired from the direct provision of services, goods or property, production of goods, management of property or supervision of services.

B. Earnings include gross profit from self-employment, which requires substantial effort on a continuous basis by the participant who is receiving the income.

(1) Income from rental property is considered earnings if the participant regularly does painting, plumbing, carpentry, maintenance, cleaning, or repair work on the property; or if substantial time is spent each month in bookkeeping, collecting rent, or paying bills on the property.

(2) Income from livestock is considered earnings if the participant raises livestock for the purpose of making cash sales. Net income received from the sale of livestock shall be considered in determining amount of the cash assistance grant.

(a) The income received from this operation may be prorated on a semiannual period if it is reasonable to expect that the client will realize the same amount during the next budgetary period.

(b) Domestic pets (cats, dogs, etc.) are not considered livestock, and their value is not considered in determining resource eligibility except where they are bred and raised for sale.

C. The use of property, such as inhabiting a home or apartment, is considered as earnings if it is received in exchange for services provided to the person owning or controlling the property.

[8.102.520.10 NMAC - Rp 8.102.520.10 NMAC, 07/01/2024]

8.102.520.11 DETERMINING INCOME FOR SELF-EMPLOYED INDIVIDUALS:

A. Reporting of earnings as business or self-employment income to state or federal tax authorities is the usual indicator of business or self-employment income. Criteria for verification of business and self-employment income are set forth in Paragraph 2 of Subsection B of 8.100.130.14 NMAC.

(1) Tax returns from the previous year may be used, unless the amount of business and self-employment income reported on tax returns is no longer a good indicator of expected income.

(2) When tax forms are used to annualize and project income, the expenses reported on the tax forms shall be used, allowing for adjustments for those expenses or costs that are treated differently or not allowed under cash assistance policy.

(3) Capital gains are counted in full as income to determine self-employment income. A capital gain is defined as proceeds from the sale of capital goods or equipment.

B. Averaging business or self-employment income: Business or self-employment income is averaged over the period the income is intended to cover, even if the benefit group receives income from other

sources.

(1) Benefit groups which by contract or self-employment derive their annual income in a period of time shorter than one year must have income averaged over a twelve-month period.

(2) If significant changes have occurred because of a substantial increase or decrease in business and averaged income will not accurately reflect the self-employed individuals' income, the self-employment income shall be calculated on the basis of anticipated, not prior, earnings.

(3) If a self-employment enterprise has been in existence for less than one year, the income from self-employment shall be averaged over the period of time the business has been in operation. The resulting monthly amount shall be projected for the coming year.

(4) If the self-employment enterprise has been in operation for such a short time that there is insufficient information to make a reasonable projection, the benefit group shall be required to report income at shorter intervals until there is enough information to make a longer projection of anticipated income.

(5) Seasonal income: Self-employment income that is intended to meet the benefit group's needs for only part of the year shall be averaged over the period of time the income is intended to cover.

C. Determining monthly business or self-employment income: For the period of time over which self-employment income is averaged, the individual's monthly self-employment income is determined by adding all self-employment income, including capital gains, and excluding allowable costs of producing the self-employment income, and dividing the resulting self-employment income by the number of months over which the income will be averaged.

[8.102.520.11 NMAC - Rp 8.102.520.11 NMAC, 07/01/2024]

8.102.520.12 EARNED INCOME DEDUCTIONS:

A. Earnings deductions: Deductions from gross earned income shall be made in determining the net countable earned income of benefit group members.

(1) Earned income deductions may not exceed the amount of a participant's gross earned income.

(2) The earned income deductions may not be used to reduce unearned income, nor may deductions that are not used by one benefit group member be allocated against the earnings of another benefit group member.

(3) An allowable deduction that is not verified at the time of certification or processing of the semiannual report shall not be allowed as a deduction. A deduction verified after certification shall be processed as a change.

(4) An allowable deduction that is verified after a semiannual report is processed shall be handled as set forth at Subsection I of 8.102.120.11 NMAC.

B. Business expenses and self-employment costs: Business expenses and self-employment costs shall be deducted from the gross earnings of a self- employed benefit group member. The income after all allowable business expenses and self-employment costs shall be counted as the gross income of the benefit group member. To be eligible for this expense a tax ID shall be required.

(1) Allowable expenses and costs: Allowable costs of producing self-employment income include, but are not limited to:

(a) costs of materials and supplies;

(b) business travel, but not personal commuting expenses, calculated at $.25 per mile, unless the self-employed individual can prove that the actual expense is greater;

(c) business taxes, including occupational taxes, gross receipts taxes, property taxes on a place of business other than the home, and business licenses.

(d) rental of equipment, tools, and machinery;

(e) rent expense for the place of business, except for the place of business when the individual operates the business out of the individual's residence, unless the individual can demonstrate that the expense has been allowed under federal income tax guidelines;

(f) payments on the principal of the purchase price of income producing real estate and capital assets, machinery, equipment and other durable goods;

(g) interest paid to purchase income producing property.

(2) Expenses and costs not allowed:

(a) Costs for depreciation, personal business, entertainment expenses, personal transportation to and from work.

(b) Expenses or costs of self-employment that are reimbursed by other agencies

cannot also be claimed as costs of self-employment, such as but not limited to, reimbursements made through USDA to individuals who provide home child care.

(3) Expenses or costs that exceed self-employment income shall not be deducted from other income.

C. Work incentive deduction:

(1) To qualify for the work incentive deduction the benefit group member must be a parent of a dependent child included in the benefit group or the caretaker relative of a dependent child included in the benefit group whose parent does not live in the home, or the legal spouse of such parent or caretaker relative.

(2) Allowing the deduction: The work incentive deduction is allowed with no time limit as follows:

(a) $125 and one-half of the remainder for the parent in a single-parent benefit group;

(b) $225 and one-half of the remainder for each parent in a two-parent group;

(c) $125 and one-half of the remainder for a benefit group member in a single-parent or two-parent benefit group who is not a parent; and

(d) $125 for a non-benefit group members whose income is deemed available.

D. Child care costs: Out of pocket expenses for child care that is necessary due to employment of a benefit group member shall be allowed.

(1) From earnings remaining after allowing the excess hours and work incentive deductions, deduct an amount not to exceed $200 per month for a child under age two and $175 per month for a child age two or older.

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

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

E. Contributions made into approved individual development accounts: The actual amount contributed into an approved IDA from an employed benefit group member's earnings shall be an allowable deduction from earned income.

[8.102.520.12 NMAC - Rp 8.102.520.12 NMAC, 07/01/2024]

8.102.520.13 DEEMED INCOME DETERMINATION:

A. The earned and unearned income of certain non-benefit group members shall be deemed available to the eligible benefit group members. The income shall be deemed from the following:

(1) the parent of a minor parent;

(2) a participant or applicant who has been disqualified from participation because of a failure or refusal to provide a social security number;

(3) an ineligible alien.

B. Earned income deductions: An employed ineligible group member's earned income shall be allowed an earned income deduction of $125. The remainder is the net countable earned income of the non-benefit group member.

C. Unearned income: No deductions are allowed from the unearned income of a ineligible group member whose income is deemed available to the benefit group.

D. Deeming of income:

(1) The net countable earned income and all of the unearned income of a non-benefit group member shall be divided by the total number of benefit group and ineligible group members. The result is the prorated income amount.

(2) The deemed income to the eligible benefit group members shall be determined by multiplying the prorated income amount by the number of eligible benefit group members. The non-benefit group member's share of the prorated income shall be excluded from consideration.

[8.102.520.13 NMAC - Rp 8.102.520.13 NMAC, 07/01/2024]

8.102.520.14 NET EARNED INCOME: The income remaining after all allowable exemptions and deductions shall be made from the earned income of benefit group members, plus the deemed income to the benefit group, shall be the net countable earned income of the benefit group. The net countable income shall be used to determine the cash assistance payment to the benefit group.

[8.102.520.14 NMAC - Rp 8.102.520.14 NMAC, 07/01/2024]

8.102.520.15 UNEARNED INCOME:

A. Definition of unearned income: Unearned income means old age, survivors, and disability insurance payments (social security), railroad retirement benefits, veterans administration compensation or pension payments, military retirement and allotments, pensions, annuities and retirement benefits; lodge or fraternal benefits, any other public or private disability or retirement benefit or pension, shared shelter payments, individual Indian money (IIM); royalty or lease payments for land or property owned by a benefit group member; settlement payments resulting from insurance or litigation; worker's compensation benefits; child support; unemployment compensation benefits; union benefits paid in cash; gifts and contributions; and real property income. Unearned income is not subject to deductions.

B. Special conditions:

(1) Direct receipt of child support: Child support payments directly received and retained by the benefit group are considered available to the benefit group in their entirety.

(2) Real property income: Income from real property is considered as unearned income when the benefit group engages in the management of the property less than 20 hours a week. The benefit group shall take all appropriate steps to utilize real property in a manner that will produce maximum benefits for the benefit group's maintenance. Costs associated for maintenance of the property or the production of income for which the benefit group is responsible are deducted from the income received for the use of the property.

(3) Alien sponsor income: All of the income of the alien sponsor and sponsor's spouse is counted as unearned income to the benefit group.

[8.102.520.15 NMAC - N, 07/01/2001; A, 11/15/2007]

HISTORY OF 8.102.520 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD FA 430, Income, 2/11/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.520 Eligibility Policy - Income, - Repealed, 07/01/2001.
8.102.520 Eligibility Policy - Income, filed 07/01/2001 – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 610 DESCRIPTION OF PROGRAM/BENEFITS - BENEFIT DELIVERY

8.102.610.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.610.1 NMAC - Rp 8.102.610.1 NMAC, 07/01/2024]

8.102.610.2 SCOPE: The rule applies to the general public.
[8.102.610.2 NMAC - Rp 8.102.610.2 NMAC, 07/01/2024]

8.102.610.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the authority is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.610.3 NMAC - Rp 8.102.610.3 NMAC, 07/01/2024]

8.102.610.4 DURATION: Permanent.
[8.102.610.4 NMAC - Rn 8.102.610.4 NMAC, 07/01/2001]

8.102.610.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.102.610.5 NMAC - Rp 8.102.610.5 NMAC, 07/01/2024]

8.102.610.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participating benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.610.6 NMAC - Rp 8.102.610.6 NMAC, 07/01/2024]

8.102.610.7 DEFINITIONS: [RESERVED]
[8.102.610.7 NMAC - Rp 8.102.610.7 NMAC, 07/01/2024]

8.102.610.8 CASH ASSISTANCE:

A. Method of payment: Cash assistance benefits are paid by issuing funds into an EBT transfer account.

B. Initial issuance: The EBT card is issued to the payee or designated authorized representative during the application process prior to the application being approved. The applicant or participant shall receive

training on the use of the EBT card prior to activation of the EBT card.

C. Replacement card: The caseworker, the HCA EBT help desk or the contractor customer service help desk shall have the card deactivated once reported by participant that the card is lost, stolen, or destroyed. The card will be deactivated immediately and a replacement card provided to the participant. Once the card is deactivated, it cannot be reactivated for any reason.

D. Authorizing payments:

(1) Cash assistance benefits are authorized, changed, and terminated through the automated benefit delivery system.

(2) Initial payments are issued on the first mailing day following authorization. In the case of EBT, the transfer of funds takes place on the first working day after the day of authorization.

E. Initiation of payment:

(1) Payment is initiated and prorated from the date of authorization or from the 30th day after the day of application, whichever is earlier.

(2) If the case was eligible in a month prior to the month of approval, but is not eligible for payment in the month following the month of disposition, the benefit group is not eligible for payment in any of these months.

(3) Payments effective in the current month: A payment that is issued during the month is deposited into the EBT account no later than the business day after payment is approved.

(4) Payments effective in the ongoing month:

(a) When authorized, the payment amount remains the same from month to month until changed.

(b) EBT issuances are transmitted to the fiscal agent so that the funds are available on the first working day of the month. Payments authorized after the monthly transmission to the fiscal agent are issued as part of the next nightly benefit batch.

F. Change in amount of payment:

(1) Following approval, there is a continuing responsibility on the part of both the participant and the caseworker to make sure that eligibility and benefit amount are correctly determined. Failure on either side to recognize and carry out this responsibility can result in overpayment to the participant. Overpayments are charged to the participant regardless of fault.

(2) A participant's assistance grant shall be increased or decreased after receipt of information indicating that changes in a participant's circumstances may affect the amount of assistance to which the participant is entitled.

(3) Changes in the payment amount shall be made in accordance with changes in program policy.

G. Regular changes: A change in the benefit group circumstance may change the amount for which the group is eligible.

H. Other changes: If a change occurs which cannot be processed before the benefits issuance run, an overpayment or underpayment may occur. If an underpayment occurs, it shall be corrected by issuing a supplemental payment. In case of an overpayment, an overpayment claim shall be filed and appropriate efforts shall be made to recover the overpayment.

I. Whereabouts unknown: Benefits shall be terminated if the whereabouts of the benefit group are unknown to the authority. A benefit group's whereabouts shall be considered to be unknown if:

(1) mail sent to the last known address is returned to the authority indicating that the benefit group no longer lives at that address and at least 30 days have passed since the caseworker sent the mail; or

(2) the participant does not make any withdrawals from the participant 's EBT account for 60 days or more.

J. Death of client:

(1) Payment: Payment may be made on behalf of a client who has been approved for cash benefits but has died before an EBT withdrawal was made. If the client was alive on the first day of the month for which cash assistance benefits were issued and all eligibility conditions were met at the time of death, then another person may be authorized to use the deceased recipient's benefits. A person authorized to use the deceased recipient's benefits must be the surviving spouse, next of kin, or a person with responsibility for the deceased recipient's affairs.

(2) Withdrawing EBT benefits: When payment is made in accordance with these circumstances, the county office shall not restrict or dictate the use of the money paid.

(3) ISD may authorize the issuance of a replacement EBT card to the person authorized to

use the deceased recipient's benefits.

(4) EBT transactions shall not be in any liquor store; any casino, gambling establishment; or any retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

[8.102.610.8 NMAC - Rp 8.102.610.8 NMAC, 07/01/2024]

8.102.610.9 [RESERVED]

[8.102.610.9 NMAC - Rp 8.102.610.9 NMAC, 07/01/2024]

8.102.610.10 SUPPORTIVE SERVICES:

A. The NMW work program provides supportive services on an ongoing basis, provided that the participant is eligible to receive the services during the month provided.

B. Participants must meet minimum participation requirements in order to receive supportive services reimbursements. Reimbursement for supportive services is issued by EBT payment to the benefit group in accordance with 8.102.620.14 NMAC thru 8.102.620.17 NMAC.

[8.102.610.10 NMAC - Rp 8.102.610.10 NMAC, 07/01/2024]

8.102.610.11 [RESERVED]

[8.102.610.11 NMAC - Rp 8.102.610.11 NMAC, 07/01/2024]

8.102.610.12 DIVERSION PAYMENTS TO A NMW BENEFIT GROUP: The diversion payment is a non-recurring lump sum payment, issued to the recipient's EBT account in accordance to eligibility and amount specified at 8.102.500.10 NMAC.

[8.102.610.12 NMAC - Rp 8.102.610.12 NMAC, 07/01/2024]

8.102.610.13 [RESERVED]

[Education Works Program now filed at 8.102.611 NMAC]

HISTORY OF 8.102.610 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 271.0000, Procedures Applicable to Payment and Related Changes, 5/16/1980.

ISD FA 450, Payment, 2/10/1988.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.

8.102.610 NMAC Description of Program/Benefits - Benefit Delivery - Repealed, 07/01/2001.

8.102.610 NMAC Description of Program/Benefits - Benefit Delivery, filed 07/01/2001 – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 611 EDUCATION WORKS PROGRAM

8.102.611.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.611.1 NMAC – Rp 8.102.611.1 NMAC, 07/01/2024]

8.102.611.2 SCOPE: The rule applies to the general public.
[8.102.611.2 NMAC – Rp 8.102.611.2 NMAC, 07/01/2024]

8.102.611.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works (NMW) program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and title IV-A of the federal Social Security Act, the authority is creating the New Mexico works program as one of its financial assistance programs, and in accordance with the Education Works Act of 2003 the education works program (EWP) was created.

E. In close coordination with the NMW program, the authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at title 7, code of federal regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.611.3 NMAC – Rp 8.102.611.3 NMAC, 07/01/2024]

8.102.611.4 DURATION: Permanent.
[8.102.611.4 NMAC – Rp 8.102.611.4 NMAC, 07/01/2024]

8.102.611.5 EFFECTIVE DATE: December 15, 2005, unless a later date is cited at the end of a section.
[8.102.611.5 NMAC – Rp 8.102.611.5 NMAC, 07/01/2024]

8.102.611.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, assisting parents to develop the discipline necessary for self-sufficiency and to improve their self-esteem. The further purpose of the program is to increase family income through family employment and child support and by viewing financial assistance as a support service to enable and assist parents to participate in employment.

B. The objective of the education works program (EWP) is to provide financial assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long -term career development. The applicant or recipient benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

C. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program like NMW or the federal program of supplemental security income (SSI).

D. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

E. The objective of the burial assistance program is to assist in payment of burial expenses for deceased, low-income individuals.
[8.102.611.6 NMAC – Rp 8.102.611.6 NMAC, 07/01/2024]

8.102.611.7 DEFINITIONS: [Reserved]

8.102.611.8 EDUCATION WORKS ASSISTANCE PAYMENTS:

A. Method of payment: Cash assistance benefits are paid by deposit of funds into an EBT account. In some circumstances benefits may be issued by warrant.

B. Authorizing payments:

(1) FA benefits are authorized, changed, and terminated through the automated benefit delivery system.

(2) Initial payments are issued on the first mailing day following authorization. In the case of EBT, the transfer of funds takes place on the first working day after the day of authorization.

C. Initiation of payment:

(1) Payment is initiated and prorated from the date of authorization or from the 30th day after the day of application, whichever is earlier.

(2) If the case was eligible in a month prior to the month of approval, but is not eligible for payment in the month following the month of disposition, the benefit group is not eligible for payment in any of these months.

(3) Payments effective in the current month: Payments authorized during the month are written the night the information is entered into the computerized system and mailed the first business day following authorization. Cash assistance benefits are deposited into the EBT account the business day after payment is authorized.

(4) Payments effective in the coming month:

(a) When authorized, the payment amount remains the same from month to month until changed. Ongoing payments are written or authorized in the regular "monthly check write" process. During the monthly check write, hard copy checks are written the night before the third to the last working day of the month. They are mailed so as to arrive on the first mail delivery day of the month.

(b) EBT deposits are transmitted to the fiscal agent so that the funds are available on the first working day of the month. Payments authorized after the monthly check write are issued on the next nightly benefit write.

D. Change in amount of payment:

(1) Following approval, there is a continuing responsibility on the part of both the recipient and the caseworker to make sure that eligibility and benefit amount are correctly determined. Failure on either side to recognize and carry out this responsibility can result in overpayment to the recipient. Overpayments for any reason are charged to the recipient.

(2) A recipient's assistance grant shall be increased or decreased after receipt of information indicating that changes in a recipient's circumstances may affect the amount of assistance to which the recipient is entitled.

(3) Changes in the payment amount shall be made in accordance with changes in program policy, assistance standards, or adequacy with which need may be met.

E. Regular changes: A change in the benefit group circumstance may change the amount for which the group is eligible.

F. Other changes: If a change occurs which cannot be processed before the benefits issuance run, an overpayment or underpayment may occur. If an underpayment occurs, it shall be corrected by issuing a supplemental payment. In case of an overpayment, an overpayment claim shall be filed and appropriate efforts shall be made to recover the overpayment.

G. Whereabouts unknown: Benefits shall be terminated if the whereabouts of the recipient are unknown to the authority for 30 days or more. A recipient's whereabouts shall be considered to be unknown if:

(1) mail sent to the recipient's last known address is returned to the authority indicating that the recipient no longer lives at that address; or

(2) the recipient does not make any withdrawals from the recipient's EBT account for 90 days or more.

H. Recovery of unused education works program (EWP) funds: Beginning January 1, 2005, New Mexico will recover EWP funds that remain unused in EBT accounts for over 180 days.

(1) Clients will be notified of the agency's intention to close EWP cases that are not in use at 90 days.

(2) After case closure, the casehead will be notified at 135 days of the authority's intention to recover unused EWP funds that remain in inactive accounts for a period of 180 days.

(3) Each complete month of recovered funds will be removed from the 24 months limit for EWP.

[8.102.611.8 NMAC – Rp 8.102.611.8 NMAC, 07/01/2024]

8.102.611.9 SUPPORT SERVICES:

A. Subject to the availability of state and federal funds, a benefit group that has countable gross income that is less than 100% of the federal poverty guidelines applicable to the size of the benefit group may be eligible to receive services.

B. Any month that an EWP participant receives support services will count towards the 60 month temporary assistance to needy families (TANF) lifetime limit if the EWP benefit group has no earned income in accordance with Paragraph (4) of Subsection A of 8.102.410.17 NMAC.

C. Support services for child care will be issued in accordance with Subsection A of 8.102.620.15 NMAC.

[8.102.611.9 NMAC – Rp 8.102.611.9 NMAC, 07/01/2024]

8.102.611.10 EDUCATION WORKS CASH ASSISTANCE:

A. Subject to the availability of allocated state funds, the education works program (EWP) provides state-funded cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. The applicant or recipient benefit group must be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.

(1) The state-funded benefit amount is determined based on the same determination used to calculate the benefit amount in the NMW cash assistance program.

(2) During the initial application or recertification process, the caseworker shall screen an applicant for eligibility for the EWP. The caseworker shall explain the EWP to applicants who have applied for NMW cash assistance or NMW recipients who are applying for continued assistance. The authority's work program contractor may screen recipients of NMW cash assistance for eligibility for participation in the EWP and make a referral to the caseworker for transition to the EWP.

(3) An individual shall not have a month of participation in the EWP applied to the 60-month term limit for receipt of benefits in the state's TANF program.

(4) A benefit group participating in the EWP is considered to meet the categorical eligibility factors for the food stamp program.

(5) A benefit group participating in the EWP shall have its eligibility for medicaid determined. Eligibility shall be based on the rules in place for each medicaid program.

B. Limitations of the education works cash assistance program:

(1) The number of participants in the EWP shall be limited to the number for which state funding is allocated.

(2) Recipients who are actively participating in the NMW cash assistance program, and who meet the requirements for the EWP, shall be given first opportunity to switch programs.

(3) A benefit group shall not participate in the NMW and EWP simultaneously.

(4) A benefit group with income from employment may receive support services funded by the federal TANF block grant. A benefit group that does not have income from employment shall not be eligible to receive support services funded by the TANF block grant.

(5) A recipient may participate in the EWP for no more than twenty-four (24) months, whether or not consecutive, except:

(a) that a recipient may participate in the EWP for one additional academic term following the twenty-four (24) month participation limit if doing so will result in the recipient earning a degree, or

(b) that a recipient may participate in the EWP for two additional academic terms following the twenty-four (24) month participation limit at the discretion of the director if doing so will result in the recipient earning a degree.

(6) A participant must be a full-time student as defined by the educational institution.

C. Eligibility criteria:

(1) Conditions: Eligibility for participation in the EWP shall be based on all eligibility criteria for the NMW cash assistance program. As a condition of approval, an applicant or recipient must:

(a) be otherwise eligible for NMW cash assistance;

(b) be in good standing with the authority; good standing means that sanctions are not currently applied to the benefit group due to noncompliance with work programs, child support enforcement or reporting requirements;

(c) provide proof that the applicant or recipient has been accepted or is enrolled in a two-or four-year post-secondary, graduate or post-graduate degree education program;

(d) apply for all financial aid available, including grants and scholarships.

(2) Level of effort:

(a) A participant must engage in a combination of education, training, study or work-site experience, for an average of 20 hours a week in each month of participation in the EWP.

(b) One and one-half hours of study time shall be credited for each hour of class time.

(c) Work-site experience includes, but may not be limited to, paid employment, work study, training-related practicums, an internship, a clinical placement, or laboratory or field work, or any other work activity pursuant to the NMW cash assistance program.

D. Satisfactory participation in the education works program:

(1) To maintain satisfactory participation in the EWP, a participant shall meet all the requirements and standards of the educational institution that the participant attends, including class attendance.

(2) A participant shall maintain a 2.0 grade point average in each school term.

E. Reporting requirements for recipients:

(1) A recipient must provide ISD with proof of the recipient's final grades for each school term. Final grades must be provided by the end of the month in which the school term ends.

(2) A recipient must provide ISD with a copy of all letters relating to the receipt or denial of financial aid.

(3) A recipient must report to ISD when the recipient intends to drop out of school.

(4) A recipient must report any circumstance that might affect the recipient's ability to participate in the EWP.

(5) School attendance and reporting requirements for dependent children apply to the EWP.

(6) All reporting requirements in the NMW cash assistance program apply to the EWP.

[8.102.611.10 NMAC – Rp 8.102.611.10 NMAC, 07/01/2024]

8.102.611.11 WORK PROGRAM REQUIREMENTS:

A. New applicant responsibilities:

(1) The individual shall have an assessment completed and shall provide verification within 15 days following approval to the EWP.

(2) The individual shall complete a WPA to enter the EWP for the level of effort required of participants. The WPA shall be submitted to ISD no later than 60 days from the date of approval of assistance

(3) ISD and participant shall develop an individual education plan (IEP) in compliance with the EWP cash assistance program's requirements for an IEP. The IEP shall be submitted to ISD no later than 60 days from the date of approval of assistance. The IEP:

(a) shall contain documentation, including, but not limited to, acceptance into a particular area of study that supports the recipient's ability to succeed in the educational program that was chosen;

(b) shall describe how the degree will increase the individual's ability to engage in full-time paid employment.

(4) Currently participating in the NMW cash assistance program: Individuals currently participating in the NMW cash assistance program shall have until the end of the first full month of participation in the EWP to submit a revised WPA and IEP to ISD.

(5) Two-parent family: In a two-parent family where only one of the parents is a participant in the EWP, the other parent, if considered as a mandatory participant in the NMW work program, shall be required to participate in qualified work activities for a minimum of 30 hours per week. At least 20 hours a week must be spent in qualified primary work activities.

B. Changes affecting participation in the EWP:

(1) Twenty-four-month time limit: Participation in the EWP shall be limited to twenty four (24) months, whether or not consecutive, except

(a) that a recipient may participate in the EWP for one additional academic term following the twenty-four (24) month participation limit if doing so will result in the recipient earning a degree, or

(b) that a recipient may participate in the EWP for two additional academic terms following the twenty-four (24) month participation limit at the discretion of the director if doing so will result in the recipient earning a degree; all requests submitted to the director for approval shall include:

(i) verification of satisfactory participation in the education works program and

(ii) verification that the additional academic terms will lead to a degree.

(2) Leaving the program:

(a) A participant who leaves the program for a good cause reason may resume participation when the individual is able and ready to return to the EWP.

(b) An individual who leaves the program on a voluntary basis, and good cause is not established, is not eligible to resume participation in the EWP.

(3) Unsatisfactory participation:

(a) A participant who falls below the standards set by the educational institution at the end of the school term shall be placed on probationary status for the following semester. The participant shall be required to become compliant with the standards set by the educational institution, including improving grades, during the probationary period.

(b) Where the participant's overall GPA for the school term falls below 2.0, the individual shall be placed on probationary status for the following school term in order to bring the overall GPA to 2.0 or better.

(4) State funding limitation: Participation in the EWP may be limited should state funding for the program be reduced or terminated.

(5) Failure to comply with other requirements: The benefit group shall be transitioned back to the NMW cash assistance program and appropriate sanctions applied if a participant fails or refuses to comply with child support enforcement, school attendance, and reporting requirements in the NMW cash assistance program. The transition is effective in the month following the month the failure or refusal to comply is established.

C. Establishing good cause for failure to meet requirements:

(1) Good cause for not meeting the requirements for participation in the EWP is determined on an individual basis. Good cause may be applied to the 20-hour-a-week requirement to engage in education activities, or to a situation that causes a participant to leave the program.

(2) Good cause means that there are circumstances in which the required participation would cause the participant to seriously compromise academic performance. Good cause for leaving the EWP includes academic deficiency as long as the student has consulted with the contractor, all options have been discussed, and the contractor and ISD approve of the action.

(3) Good cause includes, but may not be limited to, a verified situation requiring the participant to care for a family member with special needs; a physical or mental health problem; a chronic illness; accident; death; or a serious personal or family problem that necessitates reducing or ending participation in the EWP.

(4) Good cause for failure to meet requirements may be determined by the contractor or ISD. Final approval of good cause is determined by the ISD.

[8.102.611.11 NMAC – Rp 8.102.611.11 NMAC, 07/01/2024]

8.102.611.12 TERMINATING PARTICIPATION IN THE EDUCATION WORKS PROGRAM:

A. The authority shall take action to terminate an individual's participation in the EWP, or to require an individual to apply for NMW cash assistance, by issuing an advance written notice under the following conditions:

(1) copies of financial aid award or denial letters are not provided;

(2) copies of final grades are not provided;

(3) there is a failure or refusal to comply with reporting requirements of the EWP;

(4) at the end of the probationary period, a participant's grade point average is not 2.0 or better;

(5) at the end of the probationary period, a participant has failed or refused to comply with the standards set by the educational institution, including class attendance;

(6) the participant fails or refuses, without good cause, to participate in education activities for at least 20 hours a week averaged over the month;

(7) funding for the EWP has been exhausted;

(8) an individual participating in the EWP has received a bachelor's degree.

B. Appeal rights: A participant shall have an opportunity to appeal an adverse action taken by the authority in the EWP. Appeals are handled pursuant to the appeal process currently in place for programs administered by the health care authority's ISD.
[8.102.611.12 NMAC – Rp 8.102.611.12 NMAC, 07/01/2024]

HISTORY OF 8.102.611 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 271.0000, Procedures Applicable to Payment and Related Changes, 5/16/1980.
ISD FA 450, Payment, 2/10/88.

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.
8.102.610 NMAC Description of Program/Benefits - Benefit Delivery - Repealed, 07/01/2001.
8.102.610 NMAC Description of Program/Benefits - Benefit Delivery, filed 07/01/2001 – Repealed effective 07/01/2024.

Other History:
8.102.610 NMAC, Section 12, Education Works Cash Assistance replaced by 8.102.611 NMAC, Education Works Program, effective December 15, 2005.

TITLE 8 SOCIAL SERVICES
CHAPTER 102 CASH ASSISTANCE PROGRAMS
PART 620 DESCRIPTION OF PROGRAM BENEFITS - BENEFIT DETERMINATION/GENERAL

8.102.620.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.102.620.1 NMAC - Rp 8.102.620.1 NMAC, 07/01/2024]

8.102.620.2 SCOPE: The rule applies to the general public.
[8.102.620.2 NMAC - Rp 8.102.620.2 NMAC, 07/01/2024]

8.102.620.3 STATUTORY AUTHORITY:

A. New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state.

B. Federal legislation contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 abolished the AFDC program. The federal act created the temporary assistance for needy families (TANF) block grant under Title IV of the Social Security Act. Through the New Mexico Works Act of 1998, the New Mexico works program was created to replace the aid to families with dependent children program.

C. Under authority granted to the governor by the federal Social Security Act, the health care authority is designated as the state agency responsible for the TANF program in New Mexico.

D. Effective April 1, 1998, in accordance with the requirements of the New Mexico Works Act and Title IV-A of the federal Social Security Act, the authority is creating the New Mexico works program as one of its cash assistance programs.

E. In close coordination with the NMW program, the authority administers the food stamp employment and training program (E&T) pursuant to the Food Security Act of 1985 and federal regulations at Title 7, Code of Federal Regulations.

F. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.102.620.3 NMAC - Rp 8.102.620.3 NMAC, 07/01/2024]

8.102.620.4 DURATION: Permanent.
[8.102.620.4 NMAC - Rp 8.102.620.4 NMAC, 07/01/2024]

8.102.620.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.102.620.5 NMAC - Rp 8.102.620.5 NMAC, 07/01/2024]

8.102.620.6 OBJECTIVE:

A. The purpose of the New Mexico works (NMW) program is to improve the quality of life for parents and children by increasing family income, resources and support. The further purpose of the program is to increase family income through family employment and child support and by utilizing cash assistance as a support service to enable and assist parents to participate in employment.

B. The objective of education works program (EWP) is to provide cash assistance to a benefit group where at least one individual is enrolled in a post-secondary, graduate or post-graduate institution. Education and training are essential to long-term career development. The applicant or participating benefit group would be otherwise eligible for NMW cash assistance, but chooses to participate in EWP.
[8.102.620.6 NMAC - Rp 8.102.620.6 NMAC, 07/01/2024]

8.102.620.7 DEFINITIONS: [RESERVED]
[8.102.620.7 NMAC - Rp 8.102.620.7 NMAC, 07/01/2024]

8.102.620.8 CASH ASSISTANCE BENEFITS:

A. The cash assistance grant shall be determined by subtracting the benefit group's countable income from the standard of need applicable to the benefit group as indicated in 8.102.520 NMAC.

B. The payment made to the benefit group shall be determined by subtracting certain amounts from the grant if the group is subject to payment sanctioning or recoupment of an overpayment. The amount left over

after these amounts are deducted from the amount of payment shall be issued to the benefit group.
[8.102.620.8 NMAC - Rp 8.102.620.8 NMAC, 07/01/2024]

8.102.620.9 GRANT DETERMINATION:

A. Determining the payment standard: The payment standard shall be determined based on the eligibility standards and requirements forth in 8.102.500.8 NMAC. The payment standard also includes the special clothing allowance.

B. Determining benefit group income: The benefit group's net countable income considered in the payment determination shall be the sum of:

(1) gross alien sponsor income;

(2) countable earnings after allowable deductions and disregards of benefit group members; and

(3) gross unearned income of benefit group members;

(4) the net income calculation is rounded down removing the cents.

C. Determining the grant: A benefit group whose countable income after allowed deductions and disregards equals or exceeds the standard of need applicable to the benefit group shall not be eligible for payment. The grant shall be a monthly benefit amount determined by subtracting the benefit group's net countable income from the payment standard applicable to the benefit group.
[8.102.620.9 NMAC - Rp 8.102.620.9 NMAC, 07/01/2024]

8.102.620.10 CHILD SUPPORT AND NMW NON-COOPERATION PAYMENT SANCTIONS:

A. General:

(1) The benefit group shall be subject to a non-cooperation payment sanction under either or both of the following circumstances:

(a) failure by a benefit group member to meet NMW requirements; or

(b) failure by the adult responsible for children included in a benefit group to meet child support enforcement division (CSED) cooperation requirements or both;

(c) good cause will be evaluated based on the circumstances of each instance of non-cooperation.

(2) Occurrence of non-cooperation:

(a) Child support:

(i) A benefit group shall be subject to a payment sanction for failure to comply with CSED cooperation requirements, even if the adult required to cooperate with child support requirements is not included in the benefit group.

(ii) Each benefit group member that fails to cooperate with the NMW requirement is subject to a sanction and shall affect the benefit group.

(iii) An occurrence of non-cooperation shall be applied when a sanction progresses to the next sanction level as a result of the noncompliance continuing for three consecutive months without the sanctioned participant reestablishing compliance. Progression to the next sanction level shall be effective in the fourth month.

(iv) A first or second level sanction is considered to be cured upon full cooperation by the sanctioned participant or a sanction shall be reversed based on a hearing decision when the sanction imposed is determined to be invalid.

(b) NMW:

(i) A benefit group is subject to a payment sanction when a participant in the benefit group fails to cooperate with the NMW requirements absent a finding of good cause.

(ii) In a two-parent benefit group, each mandatory benefit group member that fails to cooperate with the NMW requirements is subject to a sanction that affects the benefit group’s sanction level and payment.

(iii) A participant shall not be sanctioned for more than one NMW requirement element at one time. A participant may be sanctioned for the same or a different NMW requirement element only after the original sanction element is cured or reversed. A first or second level sanction may be cured upon full cooperation by the sanction participant and a sanction shall be reversed based on a hearing decision when the sanction imposed is determined to be invalid.

(iv) A participant with limited participation status may not be sanctioned for failure to meet hours or failure to provide a time sheet as identified on the approved work participation

agreement.

(v) An occurrence of non-cooperation shall be applied when a sanction progresses to the next sanction level as a result of the noncompliance continuing for three consecutive months without the sanctioned participant reestablishing compliance. Progression to the next sanction level shall be effective in the fourth month.

(3) Cumulative sanctions:

(a) Non-cooperation sanctions are cumulative within the benefit group and shall occur when:

(i) the participant fails to comply with the NMW and child support enforcement requirements;

(ii) more than one participant in the benefit group have failed to comply with either the NMW and child support enforcement requirement.

(b) Cumulative sanctions, whether or not cured, shall remain the property of that benefit group participant who caused the sanction.

(i) A participant with a sanction who leaves a benefit group relieves the benefit group of that participant's sanction status.

(ii) A participant with a sanction who joins another benefit group subjects the new benefit group to any sanction or sanction level that has not been cured prior to joining the benefit group.

(c) The benefit group's cumulative sanctions and benefit level shall be reevaluated when a sanction is cured or reversed.

(4) Progressive sanctions:

(a) Non-cooperation sanctions are progressive to both the participant and to the benefit group and shall progress to the next level for the benefit group in which the sanctioned participant resides when:

(i) a participant fails to establish compliance in three-month increments; or

(ii) a participant fails to comply with NMW or CSED requirements as a separate occurrence.

(b) A sanction that is not cured for three consecutive months shall progress until compliance is established by the participant.

(c) A participant's compliance cannot reverse the sanction level attributed to the benefit group. Any subsequent sanction is imposed at the next higher level, unless reversed by a hearing decision.

B. The conciliation process:

(1) When conciliation is available: Conciliation shall be available to a participant or applicant once during an occurrence of assistance. There must be a period of at least 12 months between occurrences of cash assistance in order for a conciliation to be available again to the benefit group. NMW conciliation and child support conciliation are independent and are counted separately from each other.

(2) Determining that noncompliance has occurred:

(a) The determination of noncompliance with child support shall be made by CSED. The conciliation and sanctioning process for child support noncompliance is initiated upon receipt of notice from CSED that the participant or applicant has failed to cooperate. Under 8.102.420 NMAC, the non-cooperative participant or applicant shall be individually disqualified from participation in the benefit group.

(b) The determination of noncompliance with NMW requirements shall be made by the caseworker. A finding of noncompliance shall be made if:

(i) the participant has not completed an assessment;

(ii) the participant fails or refuses to complete an IRP;

(iii) the participant fails or refuses to submit an approvable WPA;

(iv) the participant fails to submit timely documentation showing completion of required work hours;

(v) the participant's monthly attendance report shows fewer than the minimum required hours of participation and no other allowable hours of activity can be reasonably attributed by the caseworker towards the monthly participation requirement.

(3) Initiating conciliation: Within 10 days of determining that noncompliance exists, the caseworker shall take action to initiate a conciliation, if the participant's conciliation has not been used. A conciliation is initiated by the authority or its designee issuing a conciliation notice. CSED shall determine noncompliance and notify the caseworker who shall initiate the conciliation process.

(4) Conciliation period: Conciliation gives a participant a 30-calendar day period to correct

the current non-compliance for either a NMW participation or CSED requirement.

(a) The conciliation process is established by the authority, to address the noncompliance, identify good cause for noncompliance or barriers to compliance and shall occur only once prior to the imposition of the sanction.

(i) The participant shall have ten working days from the date a conciliation notice is mailed to contact the authority to initiate the conciliation process. A participant who fails to initiate the conciliation process shall have a notice of adverse action mailed to him after the 10th working day following the date on which the conciliation notice is mailed.

(ii) Participants who begin but do not complete the conciliation process shall be mailed a notice of adverse action 30 days from the date the original conciliation was initiated. The benefit group shall be subject to sanction in the month following the month the notice of adverse action expires.

(b) **Non-cooperation with CSED requirements:** When the participant has initiated the conciliation process, it is the participant's responsibility to contact CSED and to comply with requirements or to request a waiver from CSED due to good cause. If the caseworker does not receive confirmation from CSED within 30 days of issuing the conciliation notice that the participant is cooperating or has requested a waiver for good cause in accordance with 8.50.105.14 NMAC; the conciliation process shall be considered to have failed the benefit group shall be subject to payment sanctioning.

(c) The caseworker shall make the determination whether arrangements have been made to meet NMW requirements or whether there is good cause for waiving the cooperation requirements. If arrangements to meet the requirement or to waive it have not been made by the 30th day following issuance of the conciliation notice, the conciliation shall be considered to have failed and the participant is subject to sanctioning.

C. Sanctioning:

(1) Within 10 days of determining that a participant has failed to meet a NMW requirement, authority or its designee shall issue notice of adverse action that the payment shall be reduced. The payment reduction shall take place with the first payment following expiration of the notice of adverse action.

(2) Notice of adverse action shall apply to all NMW and child support noncompliance sanctions, including those relating to the conciliation process.

(3) A participant who corrects the failure of compliance with NMW or child support enforcement requirements during the notice of adverse action 13-day time period shall not have the sanction imposed against the benefit group or payment amount. The sanction shall not count as a cumulative or progressive sanction, since the reason for the sanction was corrected during the time period of the notice of adverse action and prior to a benefit reduction being imposed. A participant who has failed to meet work participation hours cannot correct the sanction during the notice of adverse action time period.

(4) Failure to comply during the notice of adverse action 13-day time period shall cause the sanction to become effective for a minimum of one month. If the participant later complies with the NMW compliance requirements, as determined by the authority, the sanction may be removed, so long as the participant has received at least one month of reduced benefit due to sanction.

(a) A child support enforcement sanction shall be removed after CSED notifies the caseworker that the participant is in compliance with child support enforcement requirements.

(b) A NMW sanction shall be removed after the caseworker receives verification that the participant has completed an assessment; or has completed an IRP; or has completed a WPA that indicates the appropriate number of monthly hours in work activities; or has met NMW participation hours for at least 30 days; or has good cause to waive work participation requirements.

D. Sanction levels:

(1) First-level sanction:

(a) The first level sanction for failure to comply shall result in a sanction of twenty-five percent of the standard of need. The benefit group shall be given notice of the imposition of the sanction.

(b) A first level sanction that is not cured for three consecutive months shall progress to a second level sanction.

(2) Second-level sanction:

(a) The second level of sanction for failure to comply shall result in a decrease of fifty percent of the standard of need. The second level shall be initiated by:

(i) failure to comply with NMW participation or child support enforcement requirements for more than three months; or

(ii) a second occurrence of noncompliance with a NMW or CSED requirement by a participant; or

(iii) failure of a participant to comply with both CSED and NMW participation requirements simultaneously. The group shall be given concurrent notice of imposition of the second-level sanction.

(b) A second level sanction that is not cured for three consecutive months shall progress to the third level as described below.

(3) Third-level sanction:

(a) The third sanction level is case closure for a period of not less than six months. The group shall be given notice of adverse action prior to imposition of the sanction.

(i) Once a participant is sanctioned at the third level, any subsequent occurrence of failure to comply with NMW or CSED requirements shall immediately result in a third level sanction, and case ineligibility for six months.

(ii) The TANF grant will be counted as unearned income for SNAP benefits for the six month period of ineligibility in accordance with 8.139.520 NMAC.

(b) TANF applications received after a six month closure period will be reviewed for eligibility.

(i) Based on eligibility the TANF will be approved and all mandatory members will be required to meet the NMW compliance requirements set forth in 8.102.460 NMAC;

(ii) If ISD determines the applicant is still non-compliant with CSED, the sanction will remain and the application will be denied.

E. Sanctions by other states or other programs: Participants in sanction status for failure to participate in other programs, such as the food stamp E&T program, or another state's or tribal TANF program, shall not carry that sanction status into NMW.

F. Sanctions with respect to voluntary participants: A voluntary participant is not subject to sanction for failure to participate, but shall be removed from the NMW and lose eligibility for support services

G. Good cause:

(1) Good cause applies to timely completion of assessment, IRP, WPA, work participation rates, and cooperation with the child support enforcement division.

(2) Good cause for failure to meet the NMW requirements.

(a) Good cause may be considered to exist for no more than 30 days in the event of:

(i) family death;

(ii) hospitalization;

(iii) major injury to the participant or a benefit group member for whom the participant has been the primary caretaker;

(iv) reported domestic violence;

(v) catastrophic event; or

(vi) it is shown the authority did not provide the participant reasonable assistance to complete the assessment, IRP, or WPA.

(b) The participant must meet with the NMW service provider prior to the end of the 30-day period to establish a WPA for the full participation standard beginning on day 31 or must request a limited work participation status prior to the end of the 30-day period. The participant may be subject to sanction for failure to complete a WPA if a new WPA has not been established by day 31.

(i) A participant with good cause for failure to meet the NMW requirements, who expects the cause of failure to continue for more than 30 days, must contact the authority to review the participant's circumstances.

(ii) Under no conditions shall good cause be granted for more than 30 days during any given reporting period.

(3) Good cause shall be considered when the authority has failed to submit a notice in accordance with the requirements of adverse action notices, to the participant or provide available support services that would adversely affect the participant's ability to timely meet work participation requirements.

(4) Good cause for refusal to cooperate with the child support enforcement requirements: In some cases it may be determined by the CSED that the TANF/NMW applicant's/recipient' refusal to cooperate is with good cause in accordance with 8.50.105.14 NMAC. Any person requesting a good cause exemption to a TANF/NMW requirement to cooperate must complete a request for a good cause exemption on a form provided by the CSED and provide any documentation requested by CSED. The request for a good cause exemption will be reviewed by the CSED and the requestor will be informed of the decision in writing. The requestor's failure or refusal to complete the form or provide the requested documentation will result in an automatic

denial of the request. The authority may offer assistance to complete the form or obtain the necessary documentation, as appropriate.

(5) It is the applicant's/recipient's responsibility to inform the authority if they are unable to meet the NMW compliance requirements or CSED cooperation requirements.

[8.102.620.10 NMAC - Rp 8.102.620.10 NMAC, 07/01/2024]

8.102.620.11 NON-REPORTING SANCTIONS:

A. General: The eligibility determination and payment calculation process relies upon applicants and participants to provide accurate and timely reports of information affecting their eligibility and payment. Payment sanctions for non-reporting shall be established to encourage timely and accurate reporting and to offset benefits resulting from the reporting of inaccurate or misleading information, the untimely reporting of changes, or the failure to report any required information.

B. Non-reporting sanctions:

(1) Length of sanction: Each non-reporting sanction shall run for a period of four months beginning with the first month in which failure to report occurred. An additional month shall be added for each additional month of non-reporting until the payment is corrected.

(2) Definition of an occurrence of non-reporting: An occurrence of non-reporting exists when an applicant or participant who fails to report information or reports incorrect information which results in an overpayment of cash assistance benefits for which the participant is at fault.

(3) Amount of sanction:

(a) Reporting sanctions shall be calculated at twenty-five percent of standard of need for the size of the benefit group being sanctioned.

(b) Reporting sanctions are not progressive. If there is another occurrence of non-reporting prior to the end of a non-reporting sanction period, the next and any subsequent non-reporting sanctions shall be consecutive and at the twenty-five percent level.

(c) Reporting sanctions, child support sanctions and work program sanctions shall be integrated into a single calculation to determine the final sanction amount.

(d) If a case closes during a reporting sanction period for reasons other than sanctions, the non-reporting sanction shall be suspended and resumed at the same duration the next time the case is opened.

(4) Procedures: The following steps shall be taken in implementing a payment sanction.

(a) The caseworker shall document and establish an overpayment claim using the authority overpayment claims procedures. The caseworker shall also determine whether the participant was at fault for the overpayment.

(b) The county director or a designated supervisor shall review the overpayment and determine the accuracy of the overpayment determination and appropriateness of the determination the participant was at fault for the overpayment. Upon determining that a non-reporting sanction is appropriate, the county director, or designated supervisor shall issue a notice of intent to sanction to be issued to the participant. Failure by the participant to contact the person issuing the notice within 10 working days allowed shall constitute waiver of conciliation rights.

(c) If the participant requests conciliation within the 10 working days of issuance of the notice, the county director or designated supervisor shall schedule a conciliation conference.

(d) The conciliation conference is conducted by the county director or designated supervisor.

(i) The caseworker shall describe the reporting error, how the amount of the overpayment is determined and the reasons for finding the participant at fault for the overpayment.

(ii) The participant shall have the opportunity to discuss the overpayment determination, the finding of fault and to show good cause why the sanction should not be imposed.

(iii) Based upon this determination, the county director or designated supervisor shall determine whether a sanction should be imposed.

(iv) The participant may represent himself or be represented by someone else. If the participant wishes to be represented by another individual, the participant must designate that individual in writing.

(e) Following the conference, the county director shall issue written notice stating whether or not the sanction is to be imposed, and the worker shall affect the sanction causing issuance of a notice of adverse action. The payment reduction takes effect in the month following expiration of the notice of adverse

action.

(f) Participants who disagree with the sanction determination shall have fair hearing rights and access to legal adjudication through the fair hearing process.

[8.102.620.11 NMAC - Rp 8.102.620.11 NMAC, 07/01/2024]

8.102.620.12 RECOUPMENT: Participants and applicants with an outstanding claim for overpayment of cash assistance benefits shall be required to repay the claim. Claim and recoupment situations and procedures are detailed in 8.100.640 NMAC.

[8.102.620.12 NMAC - Rp 8.102.620.12 NMAC, 07/01/2024]

8.102.620.13 PAYMENT:

A. The grant amount remaining after deduction of sanction and recoupment amounts, if any, shall be the amount issued as payment. Any month for which a payment is issued shall be a month counted against the 60-month lifetime limit of each adult or minor head of household included in the benefit group.

B. Payment issuance: The payment for the benefit group shall be issued to the head of household, unless a protective payee has been designated by the head of household. In the event the head of household is unable or unwilling to select a protective payee, ISD shall designate the protective payee on the benefits group's behalf.

[8.102.620.13 NMAC - Rp 8.102.620.13 NMAC, 07/01/2024]

8.102.620.14 SUPPORTIVE SERVICES:

A. An explanation of the supportive services available through the NMW work program, provided funding is available, shall be given to NMW participants during orientation. Participants who need supportive services to participate in the program are eligible for such services.

B. NMW work program participants are eligible to receive an initial supportive services payment in accordance with 8.102.620.15 NMAC. The support services payment may be used by the participant to cover travel, child care costs incurred or both.

C. Ongoing supportive services:

(1) Necessary ongoing supportive services are identified on the WPA, which identifies the services needed and the start and end dates for the services.

(2) If additional supportive services are needed after the initial assessment, the WPA shall be modified to reflect the changes.

[8.102.620.14 NMAC - Rp 8.102.620.14 NMAC, 07/01/2024]

8.102.620.15 CALCULATING THE SUPPORTIVE SERVICES BENEFIT: If state or federal funds are specifically appropriated, the authority may issue supportive services benefits.

A. Child care: The caseworker may authorize child care reimbursement for persons for a period not to exceed 30 days. All other child care shall be authorized by CYFD. The caseworker shall authorize child care in compliance with CYFD program requirements and standards. Child care payments shall not be paid for with federal TANF funds and shall not count towards the TANF term limits.

B. Transportation: NMW participants may receive a standard transportation reimbursement.

(1) Reimbursement:

(a) The NMW allows travel reimbursement for mandatory and voluntary participants traveling to offices for orientation, assessment, reassessment, or employment planning activities. In addition, travel costs are reimbursed for approved NMW activities identified and developed in the WPA.

(b) Mileage costs for paid employment are met through the cash assistance earned income deduction. Except for the one-time only advance, travel reimbursement shall not be made for any NMW activity for which the individual is paid.

(2) Reimbursement standards:

(a) NMW reimbursement for NMW participants using private automobiles shall be at a standard rate based on monthly mileage, as set forth below.

(i) The caseworker shall decide whether the claimed mileage is reasonable and, if the amount claimed is excessive, may adjust the amount downward.

Monthly Mileage	Monthly Reimbursement
1 - 499	$25

500 - 1499	$50
1500 - 2499	$100
2500 or More	$150

(ii) Mileage shall be allowed only if the activity takes place in the individual's home community. Travel may be allowed outside the individual's home community only if the NMW activity is not available in the community or if the NMW activity involves participation in an educational or vocational training program which is not available in the individual's home community.

(b) Bus tokens/passes are issued in lieu of the travel allowance and may not exceed $25 for the month. A participant shall be eligible to receive bus tokens or a one-month bus pass on an interim basis, provided that:

(i) the participant has no access to private transportation; and

(ii) public transportation is a reasonable alternative.

C. Vocational training and education: If state or federal funds are specifically appropriated, the authority may issue supportive services benefits.

(1) Reimbursement for vocational training and educational expenses, but not tuition, shall be available to NMW participants.

(2) NMW participants requesting reimbursement for various vocational training and educational expenses must provide receipts or request letters stating the amount of educational expenses. In addition, NMW participants must provide verification that financial assistance from other sources is unavailable or insufficient to cover the expenses for which the reimbursement is being requested.

(3) To be eligible for reimbursement of vocational training and educational expenses, the NMW participant must:

(a) meet NMW participation requirements;

(b) have an approved WPA which identifies and approves supportive services for further training; a NMW participant is not eligible for reimbursement of vocational training or educational expenses incurred prior to development of the WPA;

(c) apply and be denied for any educational assistance from such other sources as scholarships, PELL grants, WIA, student loans, etc. for which the participant might be eligible;

(d) provide "letters of denial" for the financial assistance listed previously; and

(e) repeat steps (a) through (c) at the beginning of each educational period (semester, quarter, trimester etc. as applicable).

(4) Reimbursable vocational training and education costs shall include only those for which a student is normally responsible, such as book and laboratory fees, special laboratory or shop clothing, work book fees, testing, registration, or graduation fees. In addition, personal classroom supplies, not to exceed $15 per semester, may be reimbursed.

(5) Participants enrolled in a post-graduate studies shall not be not eligible for supportive service reimbursement with respect to their post-graduate studies.

(6) Education and vocational training supportive services cannot be guaranteed beyond the end of the WPA expiration date.

(7) **Test fees:** Fees for completing either the scholastic aptitude test (SAT) or the American college test (ACT) may be reimbursed, provided one of the tests is required for admission into a given educational training institution.

D. Employment-related expense: If state or federal funds are specifically appropriated, the authority may issue supportive services benefits.

(1) A NMW participant may receive assistance to help pay the cost for certain personal items necessary to accept a bona fide job offer, or to retain employment. The assistance shall be limited to no more than $300, and shall be available only once during the individual's lifetime.

(2) **Payment method:**

(a) Payment shall be made as a reimbursement for verified costs already incurred. Reimbursement must be requested within 60 days of employment.

(b) Payment may be issued prospectively, based on a billing statement or a detailed estimate of costs.

(3) **Allowable costs:** Allowable costs include, but are not limited to:

(a) special clothing, licensing and drug testing fees which an employer requires an employee to pay and which are a condition of employment;

(b) vehicle repairs, but not a vehicle purchase or insurance payment;

(c) tools which the employer requires an employee to pay for; or

(d) costs of bringing a home into compliance with certification requirements of the child care food program administered by CYFD, if the full cost is not available from the child care food program or CYFD.

(4) Costs not allowed: Costs associated with the start-up of a business or self-employment venture are not allowed. Such costs must be met through an IDA.

[8.102.620.15 NMAC - Rp 8.102.620.15 NMAC, 07/01/2024]

8.102.620.16 SUPPORTIVE SERVICES BENEFITS:

A. Issuance schedule: If state or federal funds are specifically appropriated, the authority may issue supportive services benefits.

(1) Participants assigned to a NMW activity may receive reimbursement on a monthly basis. Participants must submit participation reports to receive the standard month's reimbursement, timely submission is required to receive the reimbursement. Reimbursement shall be authorized within five working days after receipt of all required verification. Support services shall be issued within 10 working days after authorization.

(2) Participants must submit the monthly participation report to be received no later than the fifth calendar day after a participation month's end. Reports received on the first workday after the fifth shall be considered timely if the fifth occurred on a weekend or holiday. Participants shall not be eligible to receive reimbursement if the report verifying participation is received 30 days or more following the end of the month for which participation is being reported.

B. Retroactive benefit coverage:

(1) Benefit coverage which provides supportive services may be issued retroactively to a participant if, upon individual case review, it is determined that:

(a) the participant was eligible to receive supportive services;

(b) the participant requested supportive services timely; and

(c) NMW staff inadvertently failed to process the reimbursements in a timely manner.

(2) NMW participants must have signed a WPA, which has been approved by the NMW service provider, which identifies the supportive services. Under no circumstances shall NMW participants be eligible to receive supportive service reimbursement for costs incurred prior to enrollment in the NMW.

[8.102.620.16 NMAC - Rp 8.102.620.16 NMAC, 07/01/2024]

8.102.620.17 SUPPORT SERVICES PAYEE: Supportive services reimbursements shall be made payable to the head of household for all travel and educational reimbursement.

[8.102.620.17 NMAC - Rp 8.102.620.17 NMAC, 07/01/2024]

HISTORY OF 8.102.620 NMAC:

History of Repealed Material: 8 NMAC 3.FAP, Financial Assistance Program - Repealed, 07/01/1997.

8.102.620 NMAC Description of Program Benefits - Benefit Determination/General - Repealed, 07/01/2001.

8.102.620 NMAC Description of Program Benefits - Benefit Determination/General, filed 07/01/2001 – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 110 GENERAL OPERATING POLICIES - APPLICATIONS

8.106.110.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.110.1 NMAC – Rp 8.106.110.1 NMAC, 07/01/2024]

8.106.110.2 SCOPE: The rule applies to the general public.
[8.106.110.2 NMAC - Rp 8.106.110.2 NMAC, 07/01/2024]

8.106.110.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.110.3 NMAC - Rp 8.106.110.3 NMAC, 07/01/2024]

8.106.110.4 DURATION: Permanent.
[8.106.110.4 NMAC - Rp 8.106.110.4 NMAC, 07/01/2024]

8.106.110.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.106.110.5 NMAC - Rp 8.106.110.5 NMAC, 07/01/2024]

8.106.110.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program, such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low-income individual at the time of death.
[8.106.110.6 NMAC - Rp 8.106.110.6 NMAC, 07/01/2024]

8.106.110.7 DEFINITIONS: [**RESERVED**]
[8.106.110.7 NMAC - Rp 8.106.110.7 NMAC, 07/01/2024]

8.106.110.8 GENERAL: The application shall be submitted on a form designated by the authority either electronically or in writing and shall be made under oath by an applicant or an applicant on behalf of a dependent child who resides in the home. The application must contain a statement of the age of the applicant or, dependent child, residence in New Mexico, all property in which the applicant has an interest, the income of the applicant or other benefit group members at the time the application is filed; the signature of the applicant, and other information required by the authority.
[8.106.110.8 NMAC - Rp 8.106.110.8 NMAC, 07/01/2024]

8.106.110.9 RIGHT TO APPLY

A. An individual has the right to make a formal application for any cash, food or medical assistance program administered by the authority, regardless of whether or not the individual appears to meet the conditions of eligibility. Any individual requesting information or assistance, or who wishes to apply for assistance, shall be encouraged to complete an application that same day.

B. An individual shall be informed of the right to apply, whether or not it appears the individual will be found eligible.

C. An individual shall be informed that the date of application affects the benefit amount for the first month of issuance.

D. Availability of applications: The authority shall provide the YES-New Mexico web portal to submit the application online or paper applications for general assistance to anyone requesting an application and to

local agencies and organizations that have regular contact with the public. Requests, written, electronic or by phone, for an application for assistance shall be provided with a mailed paper application or the YES-New Mexico web portal address to submit an online application.
[8.106.110.9 NMAC - Rp 8.106.110.9 NMAC, 07/01/2024]

8.106.110.10 THE APPLICATION:

A. Submission of an application: An application may be submitted to the authority in person, by mail, via facsimile or by other electronic means which may include the YES-New Mexico web portal.

(1) Out-of-state applicants: An application received from out-of-state shall be accepted, but shall not be registered until the applicant contacts ISD to confirm his or her presence in the state. If the applicant does not contact the ISD within 30 days from receipt of the application, the application shall be returned to the applicant.

(2) Application for minor children: An application for assistance for minor children, including an un-emancipated pregnant minor, must be made by the adult with whom the child or children reside and who is assuming responsibility for the support and care of the child or children.

(a) If a pregnant minor is living in a second-chance home, maternity home or other adult-supervised supportive living arrangement, the application must be made by the supervising adult as the authorized representative for the minor pregnant woman.

(b) An emancipated minor may submit an application in the emancipated minor's own right.

B. Completeness of an application: To be accepted and registered, the cash assistance application, at a minimum, must identify the individual or individuals applying, the program(s) applied for, and must contain the signature of a responsible benefit group member, caretaker, authorized representative, or other legally responsible individual.

(1) The application form must be completed and signed by the applicant, the authorized representative or other responsible individual.

(2) If an authorized representative or another appropriate individual completes an application form on behalf of an applicant, the actual applicant must review and approve the completed form. The applicant is liable for improper payments resulting from erroneous information given by the authorized representative or other appropriate individual.

(3) The caseworker shall assist in completing the form if there is no other individual who can help the applicant. If an application is incomplete, ISD shall take action to notify the applicant. The individual who completed the application form must add the missing or incorrect information and initial and date the entries.

C. Application registration: A signed application shall be registered effective the date in which the application is received by the authority during regular business hours; this includes applications that are dropped off, submitted in person and electronically. Applications that are dropped off or submitted electronically after regular business hours or on weekends or holidays will be considered received as of the next business day.
[8.106.110.10 NMAC - Rp 8.106.110.10 NMAC, 07/01/2024]

8.106.110.11 INTERVIEWS:

A. Application interview:

(1) All applicants shall have a face to face interview.

(2) The interview may take place at a location reasonably accessible and agreeable to both the applicant and the caseworker.

(3) The applicant may bring any individual to the interview.

(4) The interview shall take place within ten days of the date an application is filed and, to the extent possible, at a time that is convenient for the applicant.

B. Alternatives to an office interview: Waiver of the requirement that the interview be conducted in the ISD office shall be determined on a case-by-case basis for any individual who is unable to appoint an authorized representative, has no one able to accompany the applicant to the office because of transportation difficulties, or similar hardships that the county director determines warrants a waiver of the office interview. These hardship conditions include, but are not limited to: illness, care of benefit group member, prolonged severe weather, or work hours which prevent an in-office interview during work hours. If an office interview is waived, the caseworker shall conduct a telephone interview or a home visit. Home visits shall be scheduled in advance with the benefit group as provided for at 8.100.180.17 NMAC. Waiver of the office interview, in and of itself, shall not be justification for extending the eligibility determination deadlines.

C. Scheduling an interview: An interview shall be scheduled upon receipt of the application. The interview shall take place within ten working days of the date an application is filed and, to the extent possible, at a time that is convenient for the applicant. Applications that are dropped off or submitted electronically after the close of business or on weekends or holidays will be considered received as of the next business day.

D. Missed interview: An applicant who fails to appear for the first interview shall be responsible for scheduling a second appointment for an interview. If the applicant does not contact the office or does not appear for a rescheduled interview, the application shall be denied on the 30th day (or the next workday if the 30th day is not a workday) after the application was filed.

E. Purpose and scope of interview: The interview is an official and confidential discussion of benefit group circumstances between the applicant and the caseworker.

(1) Prior to processing an application, there shall be a face-to-face interview with the applicant. The purpose and scope of the interview shall be explained to the applicant.

(2) The interview is intended to provide the applicant with information regarding eligibility requirements for the program and to provide the caseworker with the necessary information and documentation to make an accurate eligibility determination. In addition, the interview allows the caseworker to clarify unclear or incomplete information reported on the application.

F. Applicant information: During the course of the interview steps shall be taken to make the applicant feel at ease and protect the applicant's right to privacy. The interviewer shall inform the applicant about the following:

(1) the requirements that must be met by the applicant under the requested cash assistance program;

(2) responsibility to report changes;

(3) complaint and fair hearing procedures;

(4) application processing standards;

(5) procedures in cases of overpayment or underpayment of benefits;

(6) non-discrimination policies and procedures;

(7) timeliness standards.

[8.106.110.11 NMAC - Rp 8.106.110.11 NMAC, 07/01/2024]

8.106.110.12 APPLICATION PROCESSING TIME LIMITS:

A. Application processing time limit: The time limit begins on the day after the signed application is received by the ISD office.

(1) ARSCH program supplemental payments shall be processed no later than 30 calendar days after receipt.

(2) Set and variable term general assistance applications shall be processed no later than 90 calendar days, after receipt. Reconsideration determinations shall occur no later than 120 calendar days after receipt of the initial application.

B. Reconsideration: A reconsideration of a disability determination may be requested, verbally or in writing, by a client within 15 days of the date of the denial for not meeting conditions of disability. The reconsideration period shall not exceed 30 days from the date of denial. Disability will be evaluated based on additional medical evidence provided by the client during the reconsideration period. Should no request be made or the client does not provide additional medical evidence during the reconsideration period the denial shall remain and the client may reapply.

C. Delayed determination: If an eligibility determination is not made within the required application processing time limit due to authority failure to assist the applicant or pursue eligibility timely, the applicant shall be notified in writing. The notice shall include the reason for the delay, and that the applicant has the right to request a fair hearing regarding the authority's failure to act within the time limits.

[8.106.110.12 NMAC - Rp 8.106.110.12 NMAC, 07/01/2024]

8.106.110.13 DISPOSITION OF APPLICATION/NOTICE: Applicants shall receive written notice of application disposition, as indicated below:

A. Denials: Provide the reason for denial including regulation citation; the applicant's rights and time limits for requesting a fair hearing; and the applicant's right to discuss the denial with the caseworker, supervisor or county director.

B. Approvals: Inform the applicant who is eligible to receive benefits of the amount of payment and the certification period.

C. Withdrawal: An applicant may voluntarily withdraw the application orally or in writing any time before eligibility determination. Notice shall confirm the applicant's expressed desire to withdraw the application and be informed that the withdrawal does not affect the right to apply for assistance in the future.
[8.106.110.13 NMAC - Rp 8.106.110.13 NMAC, 07/01/2024]

8.106.110.14 APPROVAL EFFECTIVE DATE: General assistance benefits for an approved application shall be effective the date of approval or from the 30th day after the date of application; whichever is earlier. Payment in the first month shall be prorated from the date of authorization.
[8.106.110.14 NMAC - Rp 8.106.110.14 NMAC, 07/01/2024]

8.106.110.15 CASE RECORD TRANSFERS: If a recipient moves to an area administered by another project area, the recipient's case record shall be transferred as follows:

A. Responsibilities of sending project area:

(1) The project area to which the recipient is moving or has moved to shall be notified within 10 days. The record shall not be transferred to the new project area until a new address for the recipient is provided to the sending project area.

(2) Before transferring the case record, the sending project area shall review the case record to ensure the information is complete and updated. The sending project area shall enter the recipient's new address and the geographic and administrative number in the computer system.

B. Responsibilities of receiving project area:

(1) The case is reviewed for changes and continued eligibility at the time of the transfer.

(2) The receiving project area shall transfer in the case by contacting the recipient to update the circumstances of the case and, at a minimum, document the benefit group's current circumstances. The receiving project area shall act on any change that becomes known by the sending project area, the recipient or any other means.

C. Transfer pending approval of an application: If transfer of a benefit group's case record is necessary before eligibility has been determined on an application, the sending project area shall transfer the pending application and associated documents to the receiving project area. The receiving project area shall continue the determination of eligibility based on the new circumstances. The application shall be completed based on the original application date.
[8.106.110.15 NMAC - Rp 8.106.110.15 NMAC, 07/01/2024]

8.106.110.16 APPLICATION MORATORIUM:

A. Based on limited state funds the authority may limit the number of benefit groups by imposing a moratorium, subject to quarterly review, upon all GA applications. All applications for GA shall be denied under this provision without consideration of eligibility.

B. Program suspension: When state funds are unavailable the GA program may be suspended for a designated time period. GA payments will not be made to any benefit group and all rights to payment during the suspension period are lost. All applications for GA shall be denied without consideration of eligibility.

C. Notice: Notice shall be issued within 60 days, to all applicants denied due to moratorium or suspension in accordance and shall explain the applicant's right to discuss the denial with the caseworker, supervisor or county director.

(1) Notice to applicant: Applications denied based on a moratorium shall include the state statute and regulation, the date of denial, reason for denial, the regulation citation under which the denial was made, the applicant's right to a fair hearing, and the time limits for filing a fair hearing request.

(2) Public notice: The authority shall issue a public notice 60 days prior to the imposition of a moratorium or suspension.

D. Interviews: GA applications denied on the basis of a moratorium or suspension shall not require an interview to meet the requirements specific to GA, other categories of assistance requested by the applicant may require an interview to determine eligibility.
[8.106.110.136 NMAC - Rp 8.106.110.16 NMAC, 07/01/2024]

History of 8.106.110 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 120 ELIGIBILITY POLICY - CASE ADMINISTRATION

8.106.120.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.120.1 NMAC – Rp, 8.106.120.1 NMAC, 07/01/2024]

8.106.120.2 SCOPE: The rule applies to the general public.
[8.106.120.2 NMAC - Rp, 8.106.120.2 NMAC, 07/01/2024]

8.106.120.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.120.3 NMAC - Rp, 8.106.120.3 NMAC, 07/01/2024]

8.106.120.4 DURATION: Permanent.
[8.106.120.4 NMAC - Rp, 8.106.120.4 NMAC, 07/01/2024]

8.106.120.5 EFFECTIVE DATE: December 1, 2009, unless a later date is cited at the end of a section.
[8.106.120.5 NMAC - Rp, 8.106.120.5 NMAC, 07/01/2024]

8.106.120.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally-matched financial assistance program, such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.
[8.106.120.6 NMAC - Rp, 8.106.120.6 NMAC, 07/01/2024]

8.106.120.7 DEFINITIONS: [**RESERVED**]

8.106.120.8 REPORTING REQUIREMENTS:

A. Authority responsibilities: The authority shall inform the benefit group of its responsibility to report changes. Appropriate action shall be taken to determine if the change affects eligibility or benefit amount. The date the change is reported and the action taken shall be documented. In some circumstances the authority shall request clarification during a certification period whenever information becomes known to the authority indicating a possible change in a benefit group's circumstances that may affect eligibility or benefit amount. Circumstances that may require follow-up review include, but are not limited to:

(1) compliance with a contingency requirement by an adult with a determined disability;

(2) school attendance of children age six or older who are benefit group members;

(3) any other anticipated or reported change in circumstances that may affect eligibility or benefit amount during a certification period;

(4) the need for a disability review to determine if disability still exists.

B. Benefit group responsibilities at application: A benefit group must report all changes affecting eligibility and benefit amount that may have occurred since the date the application was filed and before the date of the interview. Changes occurring after the interview, but before the date of the approval notice, must be reported by the benefit group within ten days of the date the change becomes known to the benefit group.

C. Set and variable term GA: Within 10 days of the date the change becomes known to the benefit group, a recipient of GA, shall be required to report the following changes:

(1) a benefit group’s income in excess of eighty-five percent of federal poverty guidelines for size of the benefit group;

(2) a benefit group, or the authority receives evidence that the eligible recipient has started receipt of SSI, OASDI or both;

(3) that the benefit group has moved from the state or intends to move from the state on a specific date;

(4) a benefit group requests closure; or

(5) the authority receives documented evidence that the head of benefit group has died.

D. Responsibility to report: A benefit group must report changes within ten days of the date a change becomes known to the benefit group.

(1) A financial change becomes known to the benefit group when the benefit group receives the first payment attributed to an income or resource change, or when the first payment is made for an allowable expense.

(2) A nonfinancial change, including but not limited to a change in benefit group composition or a change in address, becomes known to the benefit group on the date the change takes place.

(3) A change reported by the benefit group on the date the report of change is received by the local county office or, if mailed, the date of the postmark on the benefit group's report, plus three mailing days.

(4) In the absence of a written report, a 13-day notice of adverse action is required if the change will result in a reduction or termination of benefits.

E. Effective date of change: Changes to eligibility based on reported changes shall be effective pursuant to regulation at 8.106.630.9 NMAC.

[8.106.120.8 NMAC - Rp, 8.106.120.8 NMAC, 07/01/2024]

8.106.120.9 CERTIFICATION PERIODS:

A. Set term GA: The certification period shall be for a set length of time dependent upon conditions, beginning from the month of approval and is not subject to review. The certification period shall be set for the length of the disability established by medical documentation, not to exceed eight months.

B. Variable term GA: The certification period shall be set for a length of time, not to exceed 12 months, beginning from the month of approval and is subject to review.

(1) Dependent child in the benefit group: The certification period will be set for up to six months.

(2) ARSCH: The certification period will be set for 12 months.

(3) Disability: The certification period will be set for a length of time not to exceed 12 months, subject to expected duration of disability based on medical documentation.

[8.106.120.9 NMAC - Rp, 8.106.120.9 NMAC, 07/01/2024]

8.106.120.10 ELIGIBLITY RECERTIFICATION:

A. Recertification of eligibility: The authority shall provide notice of recertification 45 days prior to the end of the certification and make a prospective determination of eligibility beginning the month following the month the certification period expires. The recertification shall consist of a determination of eligibility for an additional period of time, redetermination of the amount of cash assistance payment and a complete review of all conditions of eligibility as indicated below.

(1) Financial eligibility: Current financial eligibility must be reviewed at the end of the certification period for the specific program to determine continued eligibility for a new period of time.

(2) Disability: A disability review may or may not be required at the end of the certification period.

(3) Child support enforcement: The authority shall ensure that all pertinent information regarding the noncustodial parent(s) of any dependent child in the benefit group, including but not limited to the current address, social security number and work place of the noncustodial parent is updated.

(4) Other programs: The authority shall provide information about other assistance programs.

(5) Review of record: The authority shall review the documentation contained in the record for completeness. If the record does not contain satisfactory evidence, additional verification shall be obtained.

B. Interview: A face-to-face interview shall take place at the end of the certification period, unless the recipient's physical or mental condition makes the interview impossible or inadvisable. The county director may waive the face-to-face interview on a case-by-case basis for hardship reasons found at 8.106.110.11 NMAC. During the interview the authority shall review with the recipient the possible changes in circumstances that must be reported and may affect the client's eligibility or benefit amount.

C. Exchange of information with the social security administration: During the review process, the caseworker may obtain information relevant to the eligibility of a family member who is an SSI recipient. If there is a clear indication that a SSI recipient's countable income exceeds the maximum allowable under the SSI program, that information shall be reported to the SSA district office. SSA shall also be notified when it appears that the resources of an SSI recipient exceed SSI program standards.
[8.106.120.10 NMAC - Rp, 8.106.120.10 NMAC, 07/01/2024]

8.106.120.11 DISABILITY RECERTIFICATION:

A. The disability review process requires a recertification of an individual's impairment and whether an individual's impairment prevents gainful employment within an individual's capacity. A review of disability may occur simultaneously with recertification for eligibility or occur within the certification period.

B. The review shall include, but may not be limited to:

(1) whether a recipient's disability must be reevaluated;

(2) the next review date for reevaluation;

(3) whether there is a need for current, updated medical reports to update the medical condition;

(4) whether there are any changes in work-related factors;

(5) whether a disability still exists;

(6) whether the client has satisfactorily complied with contingency requirements and if not if good cause applies as outlined at 8.106.410.13 NMAC.

[8.106.120.11 NMAC - Rp, 8.106.120.11 NMAC, 07/01/2024]

8.106.120.12 RECERTIFICATION TIME STANDARDS:

A. GA benefits shall not continue beyond the certification period if eligibility requirements in Section 10 above have not been met; regardless of disability review.

B. Reapplication:

(1) Timely reapplication: Applications submitted before the 15th of the expiration month will be considered timely.

(2) Untimely reapplication: An application received after the 15th but before the end of a benefit group's certification period expires has lost its right to interrupted benefits.

(a) If the benefit group is determined eligible, without regard to disability, the benefit group is entitled to ongoing benefits that are not prorated.

(b) Initial month verification standards will be used for all applications received more than one calendar month after the certification period expires or the case has been closed for any reason.

(3) Late applications: An application that is submitted to ISD within 30 days after the certification period has expired or the case has been closed for any reason can be accepted and recertification standards outlined in 8.102.120.9 NMAC will be followed. If approved, the benefits will be prorated from the date of approval. Any applications received more than 30 days after the certification period expires or closes for any reason will follow the initial month verification standards.

C. Verification: A benefit group that has reapplied timely, completed an interview and provided required verification, specific to eligibility, will be given 10 days to provide the verification or until the certification period expires, whichever is longer. If the certification period expires before the 10-day deadline for submitting the required verification, the benefit group will be entitled to a full month's benefits, if eligible, within five days after verification is submitted.

D. Agency failure to act: A benefit group that has made a timely application for recertification, but due to agency error, is not determined eligible in sufficient time to provide for issuance by the benefit group's normal issuance date in the following month, will be entitled to restoration of lost benefits.
[8.106.120.12 NMAC - Rp, 8.106.120.12 NMAC, 07/01/2024]

HISTORY OF 8.106.120 NMAC:

History of Repealed Material:
8.106.120 NMAC, Eligibility Policy - Case Administration, filed 06/17/2004 - Repealed 12/01/2009.
8.106.120 NMAC, Eligibility Policy - Case Administration, filed 06/17/2004 - Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 106 STATE FUNDED ASSISTANCE PROGRAMS
PART 230 GENERAL FINANCIAL - PAYABLES AND DISBURSEMENT

8.106.230.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.106.230.1 NMAC - Rp, 8.106.230.1 NMAC, 07/01/2024]

8.106.230.2 SCOPE: The rule applies to the general public.
[8.106.230.2 NMAC - Rp, 8.106.230.2 NMAC, 07/01/2024]

8.106.230.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the aid to families with dependent children (AFDC), general assistance (GA), shelter care supplement, the burial assistance programs and such other public welfare functions as may be assumed by the state. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.106.230.3 NMAC - Rp, 8.106.230.3 NMAC, 07/01/2024]

8.106.230.4 DURATION: Permanent.
[8.106.230.4 NMAC - Rp, 8.106.230.4 NMAC, 07/01/2024]

8.106.230.5 EFFECTIVE DATE: December 1, 2009, unless a later date is cited at the end of a section.
[8.106.230.5 NMAC - Rp, 8.106.230.5 NMAC, 07/01/2024]

8.106.230.6 OBJECTIVE:

A. The objective of general assistance is to provide financial assistance to dependent needy children and disabled adults who are not eligible for assistance under a federally matched financial assistance program such as New Mexico works (NMW) or the federal program of supplemental security income (SSI).

B. The objective of the supplement for residential care program is to provide a cash assistance supplement to SSI recipients who reside in licensed adult residential care homes.

C. The objective of the burial assistance program is to assist in payment of burial expenses for an individual who was a low income individual at the time of death.
[8.106.230.6 NMAC - Rp, 8.106.230.6 NMAC, 07/01/2024]

8.106.230.7 DEFINITIONS: [**RESERVED**]

8.106.230.8 PAYMENT ISSUANCE:

A. EBT: The department issues cash assistance benefits through an electronic benefit transfer (EBT) system.

B. Warrants: In some circumstances a payment can be issued by warrant.

C. Death of a recipient: An authorized beneficiary may access and use payments issued on behalf of a recipient who died before an EBT withdrawal was made if the recipient:

(1) was alive on the first day of the month for which cash assistance benefits were issued; and

(2) met all eligibility conditions at the time of death.
[8.106.230.8 NMAC - Rp, 8.106.120.8 & 9 NMAC, 07/01/2024]

HISTORY OF 8.106.230 NMAC:

History of Repealed Material:
8.106.230 NMAC, General Financial -Payables and Disbursement, filed 06/17/2004 - Repealed 12/01/2009.
8.106.230 NMAC, General Financial -Payables and Disbursement, filed 06/17/2004 - Repealed 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 119 REFUGEE RESETTLEMENT PROGRAM
PART 110 GENERAL OPERATING POLICIES APPLICATIONS

8.119.110.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.119.110.1 NMAC - Rp, 8.119.110.1 NMAC, 07/01/2024]

8.119.110.2 SCOPE: The rule applies to the general public.
[8.119.110.2 NMAC - Rp, 8.119.110.2 NMAC, 07/01/2024]

8.119.110.3 STATUTORY AUTHORITY:

A. The refugee resettlement program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the Code of Federal Regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal authority from time to time.

B. In accordance with authority granted to the authority by NMSA 1978, section 27-1-3(J), and pursuant to Executive Order No. 80-62, dated 10/01/81, the governor of the state of New Mexico has designated the health care authority as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.119.110.3 NMAC - Rp, 8.119.110.3 NMAC, 07/01/2024]

8.119.110.4 DURATION: Permanent.
[8.119.110.4 NMAC - Rp, 8.119.110.4 NMAC, 07/01/2024]

8.119.110.5 EFFECTIVE DATE: July 1, 1997, unless a later date is cited at the end of a section.
[8.119.110.5 NMAC - Rp, 8.119.110.5 NMAC, 07/01/2024]

8.119.110.6 OBJECTIVE: The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while, supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).
[8.119.110.6 NMAC - Rp, 8.119.110.6 NMAC, 07/01/2024]

8.119.110.7 DEFINITIONS: [Reserved]
[8.119.110.7 NMAC - Rp, 8.119.110.7 NMAC, 07/01/2024]

8.119.110.8 APPLICATIONS:

A. Processing applications: Application processing requirements, timeliness and verification standards, procedures, forms, and notification requirements established for the NMW program are applicable to the RRP, unless otherwise noted.

B. If there are children nineteen and under included in the household, the applicant's eligibility will first be determined in accordance with all NMW program requirements, procedures and policies. If the applicant is not found eligible for NMW, eligibility shall then be determined under the RRP.

C. Refugees are not required to apply for cash assistance in order to apply for medical assistance.

D. For cash assistance applicants, only those sections of the form dealing with the following information must be completed:

(1) identification and origin of the refugee applicants;

(2) income and resources of the benefit group;

(3) living arrangements; and

(4) statement of agreement and understanding of the circumstances under which cash assistance is granted, signed by the applicant.

E. If an otherwise eligible refugee demonstrates an urgent and immediate need for cash assistance, the application will be processed with due diligence to expedite the initial RCA payment on an emergency basis.
[8.119.110.8 NMAC - Rp, 8.119.110.8 NMAC, 07/01/2024]

8.119.110.9 REFERRAL TO OTHER AGENCIES:

A. Referral to sponsoring agency: The county office is required to notify the refugee's sponsor or local affiliate which provided for the resettlement of the refugee whenever a refugee applies for RCA. This requirement applies to new arrival refugees and to second migration refugee cases. In the event the VOLAG does not have a local affiliate for the latter cases, the VOLAG will be notified. A response from the sponsor is not required and workers should not delay an application for this reason. A current list of VOLAGs is available on the ORR website.

B. Referral to SSI:

(1) All refugee applicants and recipients who are 65 years of age or older, or who are blind or disabled, will immediately be referred by the county office to the social security administration to apply for SSI benefits.

(2) Such refugees will be included in the assistance grant, using the NMW standard of need until SSI benefits take effect. Refugees are advised to report SSI payments when received, to ISD.
[8.119.110.9 NMAC - Rp, 8.119.110.9 NMAC, 07/01/2024]

History of 8.119.110 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD-IPP 81-8, Limiting Assistance to 36 Months After Arrival into U.S. to Refugees (ISD Catagories 19 and 49), 4/10/1981.
ISD-IPP 82-7, Limiting Refugee Assistance to 18 Months After Refugee's Arrival into U.S., 3/15/1982.
ISD 281.0000, Refugee Eligibility Conditions, 6/29/1982.
ISD FA 610, Refugee Resettlement Program, 2/11/1988.
ISD FA 610, Refugee Resettlement Program, 7/2/1990.

History of Repealed Material:

8 NMAC 3.RRP, Refugee Resettlement Program - Repealed, 07/01/1997.
8.119.110 NMAC, Refugee Resettlement Program, filed 07/01/1997 – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 119 REFUGEE RESETTLEMENT PROGRAM
PART 410 RECIPIENT POLICIES -GENERAL RECIPIENT REQUIREMENTS

8.119.410.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.119.410.1 NMAC – Rp 8.119.410.1 NMAC, 07/01/2024]

8.119.410.2 SCOPE: The rule applies to the general public.
[8.119.410.2 NMAC – Rp 8.119.410.2 NMAC, 07/01/2024]

8.119.410.3 STATUTORY AUTHORITY:

A. The refugee resettlement program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the Code of Federal Regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal department from time to time.

B. In accordance with authority granted to the authority by NMSA 1978, section 27-1-3(J), and pursuant to executive order No. 80-62, dated 10/01/81, the governor of the state of New Mexico has designated the health care authority as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.119.410.3 NMAC – Rp 8.119.410.3 NMAC, 07/01/2024]

8.119.410.4 DURATION: Permanent.
[8.119.410.4 NMAC – Rp 8.119.410.4 NMAC, 07/01/2024]

8.119.410.5 EFFECTIVE DATE: July 1, 1997, unless a later date is cited at the end of a section.
[8.119.410.5 NMAC – Rp 8.119.410.5 NMAC, 07/01/2024]

8.119.410.6 OBJECTIVE: The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while, supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).
[8.119.410.6 NMAC – Rp 8.119.410.6 NMAC, 07/01/2024]

8.119.410.7 DEFINITIONS: [**RESERVED**]
[8.119.410.7 NMAC – Rp 8.119.410.7 NMAC, 07/01/2024]

8.119.410.8 GENERAL RECIPIENT REQUIREMENTS:

A. Citizenship

(1) To be eligible for inclusion in the RCA benefit group, the applicant must be classified as a "refugee."

(2) To be eligible for inclusion in the RRP benefit group the individual must provide proof, in the form of documentation issued by USCIS, of one of the following statuses under the INA as a condition of eligibility:

- **(a)** paroled as a refugee or asylee under section 212(d)(5) of INA; or
- **(b)** admitted as a refugee under section 207 of the INA; or
- **(c)** granted asylum under section 208 of the INA; or
- **(d)** Cuban and Haitian entrants including:
  - **(i)** any individual granted parole status as a Cuban/Haitian entrant (status

pending) or granted any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided; and

(ii) any other national of Cuba or Haiti who was paroled into the U.S. and has not acquired any other status under the INA; is the subject of exclusion or deportation proceedings under the INA; or has an application for asylum pending with the INS; and with respect to whom a final, non-appealable, and legally enforceable order of deportation or exclusion has not been entered; or

(e) certain Amerasians from Vietnam who are admitted to the U.S. as immigrants pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of the 9th proviso under Migration and Refugee Assistance in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Acts 1989 (Public Law 100-461 as amended)); or

(f) admitted for permanent residence, provided the individual previously held one of the statuses identified above.

(3) An applicant for asylum is not eligible for assistance under title IV of the INA unless otherwise provided by federal law.

B. Time limits

(1) Eligibility for RCA is limited to 12 months from the date of entry, date of asylum, or date deportation was withheld.

(2) For refugee assistance cases involving U.S. born children, the eligibility for RCA for the child expires when the refugee parent who last arrived in the U.S. has been in the country for eight months.

C. General eligibility requirements

(1) RCA eligibility is limited to those who are ineligible for TANF. The benefit groups' eligibility for TANF must be determined before determining eligibility for RCA.

(2) An individual who is enrolled full-time in an institution of higher education will be ineligible to participate in the RCA program except where such enrollment has been approved as part of the individual's individual employability plan (IEP) and in which the enrollment will last for a period of less than one year.

(a) An individual is considered to be enrolled in an institution of higher education, if the individual is enrolled in a business, technical, trade or vocational school, that normally requires a high school diploma or equivalency certificate for enrollment in the curriculum or if the individual is enrolled in a regular curriculum at a college or university that offers degree programs regardless of whether a high school diploma is required.

(b) The enrollment status of a student shall begin on the first day of the school term. Such enrollment shall be deemed to continue through normal periods of class attendance, vacation and semester breaks. Enrollment status shall terminate when the student graduates, is expelled, does not re-enroll or is suspended for a period in excess of 30 calendar days.

(3) A refugee must provide the name of the resettlement agency which was responsible for his or her resettlement.

(4) Possession of a social security number is not a requirement of eligibility for RCA.

[8.119.410.8 NMAC – Rp 8.119.410.8 NMAC, 07/01/2024]

8.119.410.9 RESIDENCY: To be eligible of assistance under this program, the refugee(s) must be physically present in New Mexico on the date of application or final determination of the eligibility and demonstrate intent to remain in the state.

[8.119.410.9 NMAC – Rp 8.119.410.9 NMAC, 07/01/2024]

8.119.410.10 NON-CONCURRENT RECEIPT OF ASSISTANCE: To be eligible for inclusion in the RCA benefit group, the refugee(s) may not be receiving cash assistance under any other HCA program of cash assistance or SSI.

[8.119.410.10 NMAC – Rp 8.119.410.10 NMAC, 07/01/2024]

8.119.410.11 EMPLOYMENT TRAINING AND WORK REGISTRATION:

A. Requirement

(1) All employable refugees who receive RCA, and all employable members of the assistance group of which they are part, must register for employment with an appropriate agency providing employment services or the department of workforce solutions (NMDWS), and must accept an employment or

training opportunity from any source which is determined appropriate for that refugee by HCA.

(2) Refugees may register for employment services with the contracted provider of the RSS program. As a condition of eligibility each employable member of the benefit group must complete, and comply with, an IEP with the contracted RSS provider. Failure to comply with the IEP may result in disqualification from RCA.

(3) As a condition for receipt of RCA a refugee who is not otherwise exempt, or does not demonstrate good cause, must:

(a) go to job interviews that are arranged by HCA, the contracted RSS provider, or the resettlement agency which was responsible for the initial resettlement of the refugee;

(b) accept at any time an offer of employment, determined to be appropriate by HCA, the contracted RSS provider, or the resettlement agency which was responsible for the initial resettlement of the refugee; and

(c) participate in any employability services program which provides job or language training in the area in which the refugee resides, as deemed to be appropriate by HCA, the contracted RSS provider, or the resettlement agency which was responsible for the initial resettlement of the refugee.

(4) The ISD office shall contact the local sponsor or resettlement agency to determine if the refugee has refused, within 30 days of application, an offer of employment or has voluntarily quit a job without good cause.

B. Appropriateness of placement:

(1) Employment placements must be within the scope of the individuals IEP; the plan may be modified to reflect changes in services or employment conditions.

(2) Services and employment must be related to the capability of the individual to perform the task on a regular basis. Claims, by the individual, of adverse effect on physical or mental health must be based on medical verification from a physician or licensed or certified psychologist;

(3) The total daily commuting time to and from home to the service or employment site must not normally exceed 2 hours, not including the transporting of a child to and from a child care facility, unless a longer commuting distance or time is generally accepted in the community, in which case the round trip commuting time must not exceed the generally accepted community standards.

(4) When childcare is required, the care must meet the standards normally required by the state for NMW recipients.

(5) The service or employment site to which the individual is assigned must not be in violation of applicable federal, state, or local health and safety standards.

(6) Assignments may not be made that are discriminatory in terms of age, sex, race, creed, color, or national origin.

(7) Appropriate employment placements may be temporary, permanent, full-time, part-time, or seasonal employment if such employment meets the other standards of this section.

(8) The service or work site must comply with all applicable federal, state, and local labor laws and regulations.

(9) The wage shall meet or exceed the federal or state minimum wage, whichever is applicable, or if such laws are not applicable, the wage shall not be substantially less favorable than the wage normally paid for similar work in that labor market.

(10) The daily hours of work and the weekly hours of work shall not exceed those customary to the occupation.

(11) No individual may be required to accept employment if:

(a) the position offered is vacant due to a strike, lockout, or other bona fide labor dispute; or

(b) the individual would be required to work for an employer contrary to the conditions of his existing membership in the union governing that occupation; however, employment not governed by the rules of a union in which he or she has membership may be deemed appropriate.

(12) In addition to meeting the other criteria of this paragraph, the quality of training must meet local employers' requirements so that the individual will be in a competitive position within the labor market; the training must be likely to lead to employment which will meet the appropriate work criteria.

(13) If an individual is a professional in need of professional refresher training and other recertification services in order to qualify to practice his or her profession in the U.S., the training may consist of full-time attendance in a college or professional training program, provided that such training:

(a) is approved as a part of the individual's employability plan by the state agency;

(b) does not exceed one year's duration (including any time enrolled in such program in the U.S. prior to the refugee's application for assistance);

(c) is specifically intended to assist the professional in becoming relicensed in his or her profession; and if completed,

(d) can realistically be expected to result in such relicensing; and

(e) may only be made available to individuals who are employed.

C. Job offers: A job offer, if determined appropriate under the requirements of this section, must be accepted by the refugee without regard to whether such job would interrupt a program of services planned or in progress.

D. Failure or refusal to carry out job search or to accept employability services of employment.

(1) Voluntary registrants: Voluntary registrants are recipients of refugee cash assistance who are exempt from registration for training and employment services. When a voluntary registrant fails or refuses to participate in appropriate employability services, to carry out job search, or to accept an appropriate offer of employment, the state agency, may remove the individual from the registry for up to 90 days from the date of determination that such failure or refusal has occurred, but the individual's cash assistance may not be affected.

(2) Mandatory registrants: A mandatory registrant - i.e., an employable recipient of refugee cash assistance who is not exempt from registration, who has failed or refused without good cause to meet the requirements or has voluntarily quit a job, will be disqualified as outlined in paragraph G below.

E. Work requirements - exemptions

(1) An individual is considered employable unless he or she is a minor dependent child. A minor unmarried parent, acting as a head of household, is not considered to be a "dependent child," and is subject to participation as an adult.

(2) Inability to communicate in English does not exempt a refugee from registration for employment services, participation in employability service programs, carrying out job search, and acceptance of appropriate offers of employment.

F. Refusal to accept or termination of employment

(1) Applicants: An applicant is not eligible if 30 consecutive calendar days immediately prior to the receipt of aid, he or she has voluntarily quit a job without good cause, refused to apply for, or accept an appropriate offer of employment, as determined by HCA. The dependent family of such an ineligible applicant may, however, remain eligible for RCA.

(2) Recipients: An employable recipient must not have refused, without good cause, to go to a job interview which is arranged by the RSS provider or have, without good cause, voluntarily quit a job, or have refused to apply for or accept an appropriate offer of employment.

(3) Job search: An employable recipient shall attend job interviews, register for employment and comply with the terms of his or her IEP. Termination of employment, by a recipient, shall only be with good cause. Refusal by a recipient to fulfill the job search requirement, or termination of employment without good cause is noncompliance.

(4) Good cause: Determination of good cause for noncompliance is made by the HCA case worker and is based on the following documented circumstances:

(a) court required appearance or incarceration;

(b) an individual is already engaged in employment consistent with the work plan;

(c) a pregnant woman, starting with the 4th month of pregnancy, provided that the pregnancy and the expected date of birth have been medically verified;

(d) medically verified illness of the participant or his/her infant child. An infant child is defined as a child under 12 months of age.

(5) The refugee must participate in the employment program once good cause for noncompliance has been remedied.

G. Disqualification: Disqualification will follow the procedures set forth below.

(1) Cause for disqualification: A refugee recipient, who refuses an offer of employment, voluntarily quits employment without good cause, as determined by HCA, or fails to comply with his or her IEP is eligible for disqualification.

(2) The refugee shall be provided with a notice of adverse action not less than 13 days prior to the termination date. Additionally, the refugee's sponsor or resettlement agency will be notified of the action taken. The notice of adverse action will follow the policy outlined in 8.100.180.10 NMAC. The notice may include more than one instance of noncompliance or there may be separate notices for each instance of noncompliance. Each instance of noncompliance must be either resolved in a timely manner or a disqualification may occur.

(3) If the refugee regains compliance within the 30 day period after the initial date for noncompliance, assistance shall be continued without interruption so long as the refugee continues to meet the requirements of continued assistance.

(4) A disqualification consists of termination of assistance beginning 30 days after the date of the noncompliance. An employable RRP recipient is ineligible for benefits for the following periods when assistance is terminated due to noncompliance;

(a) for three payment months for the first occurrence.

(b) for six payment months for the second and subsequent occurrences.

[8.119.410.11 NMAC – Rp 8.119.410.11 NMAC, 07/01/2024]

History of 8.119.410 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD-IPP 81-8, Limiting Assistance to 36 Months After Arrival into U.S. to Refugees (ISD Catagories 19 and 49), 4/10/1981.

ISD-IPP 82-7, Limiting Refugee Assistance to 18 Months After Refugee's Arrival into U.S., 3/15/1982.

ISD 281.0000, Refugee Eligibility Conditions, 6/29/1982.

ISD FA 610, Refugee Resettlement Program, 2/11/1988.

ISD FA 610, Refugee Resettlement Program, 7/2/1990.

History of Repealed Material:

8 NMAC 3.RRP, Refugee Resettlement Program - repealed, 7/1/1997.

8.119.410 NMAC, Refugee Resettlement Program – repealed effective 7/1/24.

TITLE 8 SOCIAL SERVICES
CHAPTER 119 REFUGEE RESETTLEMENT PROGRAM
PART 500 ELIGIBILITY POLICY-GENERAL INFORMATION

8.119.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.119.500.1 NMAC – Rp 8.119.500.1 NMAC, 07/01/2024]

8.119.500.2 SCOPE: The rule applies to the general public.
[8.119.500.2 NMAC – Rp 8.119.500.2 NMAC, 07/01/2024]

8.119.500.3 STATUTORY AUTHORITY:

A. The Refugee Resettlement Program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the Code of Federal Regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal department from time to time.

B. In accordance with authority granted to the authority by NMSA 1978, section 27-1-3(J), and pursuant to executive order 80-62, dated 10/01/81, the governor of the state of New Mexico has designated the health care authority as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.119.500.3 NMAC – Rp 8.119.500.3 NMAC, 07/01/2024]

8.119.500.4 DURATION: Permanent.
[8.119.500.4 NMAC – Rp 8.119.500.4 NMAC, 07/01/2024]

8.119.500.5 EFFECTIVE DATE: July 1, 1997, unless a later date is cited at the end of a section.
[8.119.500.5 NMAC – Rp 8.119.500.5 NMAC, 07/01/2024]

8.119.500.6 OBJECTIVE: The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while, supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).
[8.119.500.6 NMAC – Rp 8.119.500.6 NMAC, 07/01/2024]

8.119.500.7 DEFINITIONS: [**RESERVED**]
[8.119.500.7 NMAC – Rp 8.119.500.7 NMAC, 07/01/2024]

8.119.500.8 NEED DETERMINATION:

A. Income and resource eligibility, as well as amount of payment, are determined in accordance with 45 CFR Section 400.66 which requires that RCA adhere to the need determination standards and provisions of the TANF program except as otherwise noted below:

(1) Resources remaining in the refugee's country of origin may not be counted in determining income eligibility.

(2) The income of a refugee's sponsor may not be counted in determining income eligibility.

(3) Any cash grant received by the refugee applicant under the U.S. department of state or department of justice reception and placement programs may not be counted in determining income eligibility.

B. Standard of need: Benefit group requirements are determined in accordance with 45 CFR Section 400.66 which requires that RCA adhere to the need determination standards and provisions of the TANF program.

C. Prospective budgeting: Need and income are determined prospectively in accordance with 45 CFR Section 400.66 which requires that RCA adhere to the need determination standards and provisions of the TANF program.
[8.119.500.8 NMAC – Rp 8.119.500.8 NMAC, 07/01/2024]

History of 8.119.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD-IPP 81-8, Limiting Assistance to 36 Months After Arrival into U.S. to Refugees (ISD Catagories 19 and 49), 4/10/1981.
ISD-IPP 82-7, Limiting Refugee Assistance to 18 Months After Refugee's Arrival into U.S., 3/15/1982.
ISD 281.0000, Refugee Eligibility Conditions, 6/29/1982.
ISD FA 610, Refugee Resettlement Program, 2/11/1988.
ISD FA 610, Refugee Resettlement Program, 7/2/1990.

History of Repealed Material:
8 NMAC 3.RRP, Refugee Resettlement Program - Repealed, 07/01/1997.
8.119.500 NMAC, Refugee Resettlement Program – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 119 REFUGEE RESETTLEMENT PROGRAM
PART 510 ELIGIBILITY POLICY-RESOURCES/PROPERTY

8.119.510.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.119.510.1 NMAC - Rp 8.119.510.1, 07/01/2024]

8.119.510.2 SCOPE: The rule applies to the general public.
[8.119.510.2 NMAC - Rp 8.119.510.2, 07/01/2024]

8.119.510.3 STATUTORY AUTHORITY:

A. The Refugee Resettlement Program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The Act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the code of federal regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by the federal department from time to time.

B. In accordance with authority granted to the authority by NMSA 1978, section 27-1-3(J), and pursuant to Executive Order No. 80-62, dated 10/01/81, the governor of the state of New Mexico has designated the health care authority as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.119.510.3 NMAC - Rp 8.119.510.3, 07/01/2024]

8.119.510.4 DURATION: Permanent.
[8.119.510.4 NMAC - Rp 8.119.510.4, 07/01/2024]

8.119.510.5 EFFECTIVE DATE: July 1, 1997, unless a later date is cited at the end of a section.
[8.119.510.5 NMAC - Rp 8.119.510.5, 07/01/2024]

8.119.510.6 OBJECTIVE: The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while, supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).
[8.119.510.6 NMAC - Rp 8.119.510.6, 07/01/2024]

8.119.510.7 DEFINITIONS: [**RESERVED**]
[8.119.510.7 NMAC - Rp 8.119.510.7, 07/01/2024]

8.119.510.8 GENERAL: RCA need, with respect to resources, is determined in accordance with 45 CFR Section 400.66.
[8.119.510.8 NMAC - Rp 8.119.510.8, 07/01/2024]

8.119.510.9 RESOURCE AVAILABILITY: Resource availability is determined in accordance with 45 CFR Section 400.66.
[8.119.510.9 NMAC - Rp 8.119.510.9, 07/01/2024]

History of 8.119.510 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD-IPP 81-8, Limiting Assistance to 36 Months After Arrival into U.S. to Refugees (ISD Catagories 19 and 49),

4/10/81.
ISD-IPP 82-7, Limiting Refugee Assistance to 18 Months After Refugee's Arrival into U.S., 3/15/1982.
ISD 281.0000, Refugee Eligibility Conditions, 6/29/1982.
ISD FA 610, Refugee Resettlement Program, 2/11/1988.
ISD FA 610, Refugee Resettlement Program, 7/2/1990.

History of Repealed Material:
8 NMAC 3.RRP, Refugee Resettlement Program - Repealed, 07/01/1997.
8.119.519 NMAC, Refugee Resettlement Program – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 119 REFUGEE RESETTLEMENT PROGRAM
PART 520 ELIGIBILITY POLICY-INCOME

8.119.520.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.119.520.1 NMAC - Rp 8.119.520.1, 07/01/2024]

8.119.520.2 SCOPE: The rule applies to the general public.
[8.119.520.2 NMAC - Rp 8.119.520.2, 07/01/2024]

8.119.520.3 STATUTORY AUTHORITY:

A. The refugee resettlement program (RRP) is authorized under Title IV of the Immigration and Nationality Act of 1980. The act designates the federal department of health and human services (DHHS) as the federal administering agency. RRP regulations are issued by DHHS in the code of federal regulations, Title 45, Part 400, which is supplemented by administrative and program instructions issued by DHHS from time to time.

B. In accordance with authority granted to the authority by NMSA 1978, section 27-1-3(J), and pursuant to Executive Order No. 80-62, dated 10/01/81, the governor of the state of New Mexico has designated the health care authority as the single state agency responsible for administering the program in New Mexico.

C. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.119.520.3 NMAC - Rp 8.119.520.3, 07/01/2024]

8.119.520.4 DURATION: Permanent.
[8.119.520.4 NMAC - Rp 8.119.520.4, 07/01/2024]

8.119.520.5 EFFECTIVE DATE: July 1, 1997, unless a later date is cited at the end of a section.
[8.119.520.5 NMAC - Rp 8.119.520.5, 07/01/2024]

8.119.520.6 OBJECTIVE: The objective of the RRP is to assist refugees to become self-sufficient by providing a program of financial and medical assistance while, supportive services are provided, to ensure the effective resettlement of refugees in the state of New Mexico through programs designed to assist with integration, promotion of economic self-sufficiency, and protecting refugees and communities from infectious diseases and other health related issues. HCA has agreed to administer this program subject to the receipt of federal funds. Under the RRP, sponsors(s) and VOLAGs work closely with the federal government to coordinate support services authorized under the program. The RRP includes the provision of refugee cash assistance (RCA), refugee medical assistance (RMA), refugee social services (RSS) and additional support services funded by the office of refugee resettlement (ORR).
[8.119.520.6 NMAC - Rp 8.119.520.6, 07/01/2024]

8.119.520.7 DEFINITIONS: [**RESERVED**]
[8.119.520.7 NMAC - Rp 8.119.520.7, 07/01/2024]

8.119.520.8 EARNED INCOME:

A. Standards: For RCA earned income is determined in accordance with 45 CFR Section 400.66 which requires that RCA adhere to the need determination standards and provisions of the TANF program except as noted below.

B. **Earned Income Deductions:** The work related expenses described in 8.102.520.9 NMAC through 8.102.520.13 NMAC are applicable to RCA eligibility and benefit calculation determinations.
[8.119.520.8 NMAC - Rp 8.119.520.8, 07/01/2024]

8.119.520.9 UNEARNED INCOME: Unearned income for RCA is determined in accordance with 45 CFR Section 400.66 which requires that RCA adhere to the unearned income determination standards and provisions of the TANF program, except as noted below:

A. Reception and placement grant: Any cash grant received by the refugee applicant under the DOS or DOJ reception and placement programs may not be counted as unearned income in determining income

eligibility.

B. Refugee matching grants: Refugees who have been in the U.S. fewer than 180 days may be included under the matching grant program through a local resettlement agency.

(1) Cash payments, received by refugees, as part of the matching grant program are countable as unearned income in determining RCA eligibility.

(2) If a refugee who might be covered by a matching grant program applies to an ISD office for cash assistance, the ISD county office must verify with the refugee's resettlement agency whether the refugee is receiving such assistance and, if so, the amount.

(3) If cash assistance is being provided under a matching grant, the amount must be counted as unearned income.

(4) In-kind services or shelter payments provided to a refugee as part of the matching grant program are not counted in determining eligibility.

(5) Refugees are not eligible to receive both RCA and matching grant at the same time. A refugee client applying for RCA should be advised that approval for RCA will result in ineligibility for the matching grant program. If RCA is approved, the ISD office shall notify the resettlement agency of the approval.

[8.119.520.9 NMAC - Rp 8.119.520.9, 07/01/2024]

History of 8.119.520 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD-IPP 81-8, Limiting Assistance to 36 Months After Arrival into U.S. to Refugees (ISD Catagories 19 and 49), 4/10/1981.

ISD-IPP 82-7, Limiting Refugee Assistance to 18 Months After Refugee's Arrival into U.S., 3/15/1982.

ISD 281.0000, Refugee Eligibility Conditions, 6/29/1982.

ISD FA 610, Refugee Resettlement Program, 2/11/1988.

ISD FA 610, Refugee Resettlement Program, 7/2/1990.

History of Repealed Material:

8 NMAC 3.RRP, Refugee Resettlement Program - Repealed, 07/01/1997.

8.119.520 NMAC, Refugee Resettlement Program – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 100 GENERAL PROVISIONS FOR THE FOOD STAMP PROGRAM

8.139.100.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.100.1 NMAC - Rp, 8.130.100.1 NMAC 07/01/2024]

8.139.100.2 SCOPE: General public.
[8.139.100.2 NMAC - Rp, 8.130.100.2 NMAC 07/01/2024]

8.139.100.3 STATUTORY AUTHORITY:

A. The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA 1978.

B. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.100.3 NMAC - Rp, 8.130.100.3 NMAC 07/01/2024]

8.139.100.4 DURATION: Permanent.
[8.139.100.4 NMAC - Rp, 8.130.100.4 NMAC 07/01/2024]

8.139.100.5 EFFECTIVE DATE: November 1, 2023, unless a later date is cited at the end of a section.
[8.139.100.5 NMAC - Rp, 8.130.100.5 NMAC 07/01/2024]

8.139.100.6 OBJECTIVE: Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the health care authority.
[8.139.100.6 NMAC - Rp, 8.130.100.6 NMAC 07/01/2024]

8.139.100.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) Adequate notice: means a written notice sent by mail or electronically that includes a statement of the action HCA has taken or intends to take, reason for the action, household right to a fair hearing, name of the individual to contact for additional information, the availability of continued benefits liability of the household for any over-issuances received if hearing decision is adverse to the household. An adequate notice may be received prior to an action to reduce benefits, or at the time reduced benefits will be received, or if benefits are terminated, at the time benefits would have been received if they had not been terminated. In all cases, participants have 13 days from the mailing or electronic distribution date of the notice to request that benefits be restored to their previous level pending the outcome of an administrative hearing.

(2) Adjusted net income: means the household's gross monthly income less the standard deduction, earned income deduction, dependent care deduction and the shelter deduction. (Medical expenses are allowed for certain eligible members as a deduction from their gross income).

(3) Application: means a request, on the appropriate ISD form, submitted in a written or electronic format with the signature of the applicant or on the applicant's behalf by an authorized representative, for assistance.

(4) Attendant: means an individual needed in the home for medical, housekeeping, or child care reasons.

(5) Authorized representative: means an individual designated by a household or responsible member to act on its behalf in applying for SNAP benefits, obtaining SNAP benefits, or using SNAP benefits to purchase food for the household. This can include a public or private, nonprofit organization or institution providing assistance, such as a treatment or rehabilitation center or shelter which acts on behalf of the

resident applicant.

B. Definitions beginning with "B":

(1) Benefit month: means the month for which SNAP benefits have been issued. This term is synonymous with issuance month defined below.

(2) Beginning month: means the first month for which a household is certified after a lapse in certification of at least one calendar month. Beginning month and initial month are used interchangeably. A household is budgeted prospectively in a beginning month.

(3) Boarder: means an individual to whom a household furnishes lodging and meals for reasonable compensation. Such a person is not considered a member of the household for determining the SNAP benefit amount.

(4) Boarding house: means a commercial establishment, which offers meals and lodging for compensation with the intention of making a profit. The number of boarders residing in a boarding house is not used to establish if a boarding house is a commercial enterprise.

(5) Budget month: means the calendar month for which income and other circumstances of the household are determined in order to calculate the SNAP benefit amount. During the beginning month of application, prospective budgeting shall be used and therefore, the budget month and the issuance month are the same.

C. Definitions beginning with "C":

(1) Capital gains: means proceeds from the sale of capital goods or equipment.

(2) Categorical eligibility (CE): means a SNAP household that meets one of the following conditions:

(a) Financial CE: Any SNAP household in which all members receive Title IV-A assistance (TANF), general assistance (GA), or supplemental security income (SSI) benefits is considered to be categorically eligible for SNAP benefits.

(b) Broad-based CE: Any SNAP household, in good standing, in which at least one member is receiving a non-cash TANF/MOE funded benefit or service and household income is below one hundred sixty-five percent FPG.

(3) Cash assistance (CA) households: (also referred to as financial assistance) means households composed entirely of persons who receive CA payments. Cash assistance (CA) means any of the following programs authorized by the Social Security Act of 1935, as amended: old age assistance; temporary assistance to needy families (TANF); aid to the blind; aid to the permanently and totally disabled; and aid to the aged, blind or disabled. It also means general assistance (GA), cash payments financed by state or local funds made to adults with no children who have been determined disabled, or to children who live with an adult who is not related. CA households composed entirely of TANF, GA or SSI recipients are categorically eligible for SNAP.

(4) Certification: means the authorization of eligibility of a household and issuance of SNAP benefits.

(5) Certification period: means the period assigned for which a household is eligible to receive SNAP benefits. The certification period shall conform to calendar months and includes the requirement for the completion of an interim report form in accordance with Subsection B of 8.139.120.9 NMAC.

(6) Collateral contact: means an individual or agency designated by the household to provide information concerning eligibility.

(7) Communal diner: means an individual 60 years of age or older who is not a resident of an institution or a boarding house, who is living alone or with a spouse, and elects to use SNAP benefits to purchase meals prepared for the elderly at a communal dining facility which has been authorized by USDA/FNS to accept SNAP benefits.

(8) Communal dining facility: means a public or nonprofit private establishment, approved by FNS, which prepares and serves meals for elderly persons, or for SSI recipients, and their spouses; a public or private nonprofit establishment (eating or otherwise) that feeds elderly persons or SSI recipients and their spouses, and federally subsidized housing for the elderly at which meals are prepared for and served to the residents. It also includes private establishments that contract with an appropriate state or local agency to offer meals at concession prices to elderly persons or SSI recipients and their spouses. Such establishments include a facility such as a senior citizen's center, an apartment building occupied primarily by elderly persons, or any public or private nonprofit school (tax exempt) which prepares and serves meals for elderly persons.

(9) Conversion factor: means the calculation used to convert income that is received on a weekly or biweekly basis to an anticipated monthly amount.

D. Definitions beginning with "D":

(1) Date of application: means the date an application is received by the income support division offices during regular business hours. Applications that are dropped off or submitted electronically after regular business hours will be considered received as of the next business day.

(2) Date of admission: means the date established by the United States citizenship and immigration services as the date an alien (or sponsored alien) was admitted for permanent residence.

(3) Date of entry: means the date established by the United States citizenship and immigration services as the date an alien (or sponsored alien) was admitted for permanent residence.

(4) Disability: means the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment.

(5) Disabled member: see elderly or disabled member.

(6) Documentation: means a written statement entered in the paper or electronic case record regarding the type of verification used and a summary of the information obtained to determine eligibility.

(7) Drug addiction or alcoholic treatment and rehabilitation program: means any drug addiction treatment or alcoholic treatment and rehabilitation program conducted by a private, nonprofit organization or institution, or a publicly operated community mental health center under part B of title XIX of the Public Health Service Act (42 U.S.C. 3004 et seq.)

E. Definitions beginning with "E":

(1) Elderly or disabled member:

(a) Elderly: means an individual 60 years or older.

(b) Disabled: means a person who meets any of the following standards:

(i) receives supplemental security income (SSI) under title XVI of the Social Security Act or disability or blindness payments under titles I, II, X, XIV, or XVI of the Social Security Act;

(ii) receives federally or state administered supplemental benefits under section 1616a of the Social Security Act, provided that the eligibility to receive the benefits is based upon the disability or blindness criteria used under title XVI of the Social Security Act;

(iii) receives federally or state administered supplemental benefits under section 211(a) of Pub. L. 93-66, supplemental security income benefits for essential persons;

(iv) receives disability retirement benefits from a government agency (e.g. civil service, ERA, and PERA) because of a disability considered permanent under section 221(i) of the Social Security Act;

(v) is a veteran with a service-connected or non-service connected disability rated by the veterans administration (VA) as total or paid as total by the VA under title 38 of the United States Code;

(vi) is a veteran considered by the VA to be in need of regular aid and attendance or permanently homebound under title 38 of the United States code;

(vii) is a surviving spouse of a veteran and considered by the VA to be in need of regular aid and attendance or permanently homebound or a surviving child of a veteran and considered by the VA to be permanently incapable of self-support under title 38 of the United States code;

(viii) is a surviving spouse or surviving child of a veteran and considered by the VA to be entitled to compensation for service-connected death or pension benefits for a non-service-connected death under title 38 of the United States code and has a disability considered permanent under section 221(i) of the Social Security Act ("entitled" as used in this definition refers to those veterans' surviving spouses and surviving children who are receiving the compensation or pension benefits stated, or have been approved for such payments, but are not yet receiving them); or

(ix) receives an annuity payment under section 2(a)(1)(iv) of the Railroad Retirement Act of 1974 and is determined to be eligible to receive medicare by the railroad retirement board, or section 2(a)(i)(v) of the Railroad Retirement Act of 1974 and is determined to be disabled based upon the criteria used under title XVI of the Social Security Act;

(x) is a recipient of interim assistance benefits pending the receipt of supplemental security income, a recipient of disability related medical assistance under title XIX of the Social Security Act, or a recipient of disability-based state general assistance benefits provided that the eligibility to receive any of these benefits is based upon disability or blindness criteria established by the state agency which are at least as stringent as those used under title XVI of the Social Security Act (as set forth at 20 CFR part 416, subpart I, Determining Disability and Blindness as defined in Title XVI).

(2) Eligible foods: means:

(a) any food or food product intended for human consumption except alcoholic

beverages, tobacco, and hot foods and hot-food products prepared for immediate consumption;

(b) seeds and plants to grow foods for the personal consumption of eligible households;

(c) meals prepared and delivered by an authorized meal delivery service to households eligible to use SNAP benefits to purchase delivered meals, or meals served by an authorized communal dining facility for the elderly, for SSI households, or both, to households eligible to use SNAP benefits for communal dining;

(d) meals prepared and served by a drug addict or alcoholic treatment and rehabilitation center to eligible households;

(e) meals prepared and served by a group living arrangement facility to residents who are blind or disabled as found in the definition of "elderly or disabled member" contained in this section;

(f) meals prepared and served by a shelter for battered women and children to its eligible residents; and

(g) in the case of homeless SNAP households, meals prepared and served by an authorized public or private nonprofit establishment (e.g. soup kitchen, temporary shelter) approved by HCA that feeds homeless persons.

(3) Encumbrance: means debt owed on property.

(4) Equity value: means the fair market value of property, less any encumbrances owed on the property.

(5) Excluded household members: means individuals residing within a household who are excluded when determining household size, the SNAP benefit amount or the appropriate maximum food stamp allotment (MFSA). These include ineligible aliens, individuals disqualified for failure to provide an SSN or to comply with the work requirements, and those disqualified for intentional program violation. The resources and income (counted in whole or in part) of these individuals shall be considered available to the remaining household members.

(6) Expedited services: means the process by which households reporting little or no income or resources shall be provided an opportunity to participate in the FSP, no later than the seventh calendar day following the date the application was filed.

(7) Expungement: means the permanent deletion of SNAP benefits from an EBT account that is stale.

F. Definitions beginning with "F":

(1) Fair hearing: an administrative procedure during which a claimant or the claimant's representative may present a grievance to show why he/she believes an action or proposed action by HCA is incorrect or inaccurate.

(2) Fair market value (FMV): means the amount an item can be expected to sell for on the open market.

(3) FNS: means the food and nutrition service of the United States department of agriculture (USDA).

(4) Food Stamp Act: the Food and Nutrition Act of 2008, and subsequent amendments.

(5) Fraud: intentionally making a misrepresentation of, or failing to disclose, a material fact: with the knowledge that such a fact is material (necessary to determine initial/ongoing eligibility or benefit entitlement); and with the knowledge that the information is false; and with the intent that the information be acted upon (deceive/cheat); with reasonable reliance on the person who hears the information to accept it as the truth.

(6) Full time employment: means working 30 hours or more per week, or earning income equivalent to the federal minimum wage multiplied by 30 hours.

G. Definitions beginning with "G":

(1) General assistance (GA) households: means a household in which all members receive cash assistance financed by state or local funds.

(2) Gross income: means the total amount of income that a household is entitled to receive before any voluntary or involuntary deductions are made, such as, but not limited to, federal and state taxes, FICA, garnishments, insurance premiums (including medicare), and monies due and owing the household, but diverted by the provider. Gross income does not include specific income exclusions, such as, but not limited to, the cost of producing self-employment income, and income excluded by federal law.

(3) Group living arrangements: means a residential setting that serves no more than sixteen residents that is certified by DOH under regulations issued under section 1616(e) of the Social Security Act, or under standards determined by the secretary to be comparable to standards implemented by appropriate state

agencies under section 1616(e) of the Social Security Act. To be eligible for SNAP benefits, a resident shall be living in a public or private non-profit group living arrangement and must be blind or disabled as defined in the definition of "elderly or disabled member" set forth at Items (i) through (x) of Subparagraph (b) of Paragraph (25) of Subsection A of 8.139.100.7 NMAC.

(4) Guaranteed Basic Income: Guaranteed basic income provides an individual or household a one time or recuring cash payment or transfer funded from a public or private source intended to support the basic needs of individuals or households by reducing poverty, promoting economic mobility, or increasing the financial stability.

H. Definitions beginning with "H":

(1) Head of household: the household is the basic assistance unit for the SNAP program. The household has the right to select the head of household in accordance with CFR 273.1 (d).

(2) Homeless individual: means an individual who lacks a fixed and regular nighttime residence, or an individual whose primary nighttime residence is:

(a) a supervised shelter providing temporary accommodations (such as a welfare hotel or congregate shelter);

(b) a halfway house or similar institution providing temporary residence for individuals intended to be institutionalized;

(c) a temporary accommodation for no more than 90 days in the residence of another individual, beginning on the date the individual moves into the temporary residence; or

(d) a place not designed for, or ordinarily used, as a regular sleeping accommodation for human beings (e.g. a hallway, a bus station, a lobby or similar places).

(3) Homeless meal provider: means a public or private nonprofit establishment, (e.g., soup kitchen, temporary shelter), approved by an appropriate state agency, that feeds homeless persons.

I. Definitions beginning with "I":

(1) Immigrant: means a lawfully admitted alien who entered the U.S. with the expressed intention of establishing permanent residence as defined in the federal act.

(2) Ineligible alien: means an individual who does not meet the eligible alien requirements or who is not admitted for permanent residence.

(3) Income: means all monies received by the household from any source, excluding only the items specified by law or regulation. Income is also defined as any monetary gain or benefit to the household.

(4) Income and eligibility verification system: means a system of information acquisition and exchange for purposes of income and eligibility verification which meets the requirements of section 1137 of the Social Security Act, referred to as IEVS.

(5) Initial month: means the first month for which a first-time household is certified for participation in SNAP. An initial month is also a month in which a household is certified following a break in participation of one calendar month or longer. For migrant or seasonal farm worker households, an initial month shall only be considered if there has been an interruption in certification of at least one calendar month.

(6) Inquiry: means a request for information about eligibility requirements for a cash, medical, or food assistance program that is not an application (although the inquiry may be followed by an application).

(7) Institution of higher education: means certain college-level institutions, such as vocational schools, trade schools, and career colleges that award academic degrees or professional certifications.

(8) Institution of post-secondary education: means any public or private educational institution that normally requires a high school diploma or equivalency certificate for enrollment, or that admits persons who are beyond the age of compulsory school attendance in the state in which the institution is located regardless of the high school prerequisite, provided that the institution is legally authorized or recognized by the state to provide an educational program beyond secondary education in the state or provides a program of training to prepare students for gainful employment.

(9) Irrevocable trust: means an arrangement to have monies held by one person for the benefit of another that cannot be revoked.

(10) Issuance month: means the calendar month for which SNAP is issued. In prospective budgeting, the budget and issuance months are the same. In retrospective budgeting, the issuance month follows the budget month.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L": Low-income household means a household whose annual

income does not exceed one hundred and twenty-five percent of the office of management and budget poverty guideline.

M. Definitions beginning with "M":

(1) Maintenance of effort (MOE): means the amount of general funds the state agency must expend annually on the four purposes of temporary assistance for needy families (TANF) to meet a minimum expenditure requirement based on a state's historical assistance to families with dependent children (AFDC) expenditures.

(2) Maximum food stamp allotment (MFSA): means the cost of the diet required to feed a family of four persons consisting of a man and a woman 20 through 50, a child six through eight, and a child nine through 11 years of age. The cost of such a diet shall be the basis for uniform SNAP benefit amounts for all households, regardless of their actual composition. In order to develop maximum SNAP benefit amounts, the USDA makes adjustments for household size taking into account the economies of scale and other adjustments as required by law. The MFSA is used to determine if a boarder is paying reasonable compensation for services. The maximum SNAP allotment (MFSA) was previously named the thrifty food plan (TFP).

(3) Meal delivery service: means a political subdivision, a private nonprofit organization, or a private establishment with which a state or local agency has contracted for the preparation and delivery of meals at concession prices to elderly persons, and their spouses, and to the physically or mentally handicapped, and to persons otherwise disabled, and their spouses, such that they are unable to adequately prepare all of their meals.

(4) Medicaid: medical assistance under title XIX of the Social Security Act, as amended.

(5) Migrant/migrant household: means an individual who travels away from home on a regular basis with a group of laborers to seek employment in an agriculturally related activity. A migrant household is a group that travels for this purpose.

(6) Mixed households: means those households in which some but not all of the members receive cash assistance benefits.

N. Definitions beginning with "N":

(1) Net monthly income: means gross nonexempt income minus the allowable deductions. It is the income figure used to determine eligibility and SNAP benefit amount.

(2) Non-cash assistance (NCA) households: means any household, which does not meet the definition of a cash assistance household, including households composed of both cash assistance and NCA members (mixed household). Same applies to non-financial households (NFA).

(3) Non-cash TANF/MOE benefit or service: means non-cash TANF/MOE benefit or services include programs or services that do not provide cash to recipients, but are funded by the TANF program, either by the federal TANF block grant or the state MOE share. These services may include transportation, childcare, counseling programs, parenting programs, pamphlets or referrals to other TANF/MOE-funded services.

(4) Non-financial assistance (NFA) households: means any household, which does not meet the definition of a financial assistance household, including households composed of both cash assistance and NFA members (mixed household). NFA has the same meaning as non-cash households (NCA).

(5) Non household members: means persons residing with a household who are specifically excluded by regulation from being included in the household certification, and whose income and resources are excluded. No household members include roomers, boarders, attendants, and ineligible students. Included in this classification are institutionalized household members such as children attending school away from home and members who are hospitalized or in a nursing home.

(6) Notice: means written correspondence that is generated by any method including handwritten, typed or electronic, delivered to the client or an authorized representative by hand, U.S. mail, professional delivery or by any electronic means. The term "written notice" and "notice" are used interchangeably.

(7) Notice of adverse action (NOAA): means a notice informing the household that an action is being taken by the authority that adversely affects eligibility or the amount of benefits a household receives, including withholding, suspending, reducing or terminating benefits. The NOAA shall be issued to the household before taking the adverse action. Benefits will not be reduced until 13 days from the date on the adverse action. If the 13th day falls on a weekend or holiday, the next working day is counted as the last day of the 13-day adverse action period.

O. Definitions beginning with "O": Over-issuance means the amount by which SNAP benefits issued to a household exceed the amount the household was eligible to receive.

P. Definitions beginning with "P":

(1) Period of intended use: means the month in which the benefits are issued if issued before the 20th of the month. For benefits issued after the 20th of the month, the period of intended use is the rest of

the month and the following month.

(2) Principal wage earner: means the household member with the greatest amount of earned income in the two months preceding a determination that a program rule has been violated. This applies only if the employment involves 20 hours or more a week or pays wages equivalent to the federal minimum wage multiplied by 20 hours. In making this evaluation, the entire household membership shall be considered, even those who are excluded or disqualified but whose income must be counted for eligibility and benefit amount determination. For purposes of determining noncompliance with the SNAP work requirements, including employment and training components, voluntary quit, and work-fare, the head of household is the principal wage earner unless the household has selected an adult parent of children (of any age) or an adult with parental control over children (under age 18) as the designated head of household as agreed upon by all adult members of the household. A person of any age shall not be considered the principal wage earner if the person is living with a parent or person fulfilling the role of parent or the parent or parent-substitute is:

(a) registered for employment;

(b) exempt because of Title IV compliance;

(c) in receipt of UCB or is registered as part of the UCB process; or

(d) employed or self-employed a minimum of 30 hours a week or receiving income at the federal minimum hourly rate multiplied by 30 hours.

(3) Prospective budgeting: means the computation of a household's eligibility and benefit amount based on a reasonable estimate of income and circumstances that will exist in the current month and future months.

Q. Definitions beginning with "Q": Quality control (QC) means the federal mandate, as part of the performance reporting system whereby each state agency is required to review a sample of active cases for eligibility and benefit issuance, and to review a sample of negative cases for correct application of policy. The objectives are to determine a state's compliance with the Food Stamp Act and CFR regulations, and to establish the basis for a state's error rate, corrective action to avoid future errors, and liability for errors in excess of national standards, or eligibility for enhanced federal funding if the error rate is below national standards.

R. Definitions beginning with "R":

(1) Real property: means land, buildings, and whatever is built on or affixed to the land.

(2) Recipient: means a person receiving SNAP benefits. Recipient is the same as participant.

(3) Refugee: means a lawfully admitted individual granted conditional entry into the U.S.

(4) Reasonable compensation: means a boarder payment amount that equals or exceeds the MFSA for the number of boarders.

(5) Retail food store: means:

(a) an establishment or recognized authority of an establishment, or a house-to-house trade route, whose eligible food sales volume, as determined by visual inspection, sales records, purchase records, or other inventory or accounting record keeping methods that are customary or reasonable in the retail food industry, is more than fifty percent staple food items for home preparation and consumption;

(b) public or private communal dining facilities and meal delivery services; private nonprofit drug addict or alcoholic treatment and rehabilitation programs; publicly operated community mental health centers which conduct residential programs for drug addicts or alcoholics;

(c) public or private nonprofit group living arrangements, or public or private nonprofit shelters for battered women and children, or public or private nonprofit establishments, approved by HCA, or a local agency, that feed homeless persons;

(d) any private nonprofit cooperative food purchasing venture, including those whose members pay for food prior to receipt of the food; a farmer's market.

(6) Retrospective budgeting: means the computation of a household's benefits for an issuance month based on actual income and circumstances that existed in the previous month, the 'budget" month.

S. Definitions beginning with "S":

(1) Self-employed: means an individual who engages in a self-managed enterprise for the purpose of providing support and income and who does not have the usual withholding deducted from this income. Self-employed individuals are not eligible to draw UCB by virtue of their job efforts.

(2) Shelter for battered persons: means a public or private nonprofit residential facility that serves battered persons. If such a facility serves other individuals, a portion of the facility must be set aside on a long-term basis to serve only battered persons.

(3) Simplified reporting: is the reporting requirement for households that receive SNAP

benefits.

(4) Sponsor: means a person who executed an affidavit(s) of support or similar agreement on behalf of an alien as a condition of the alien's entry or admission to the United States as a permanent resident.

(5) Sponsored alien: means an alien lawfully admitted for permanent residence in the United States as an immigrant, as defined in Subsection 101(a)(15) and Subsection 101(a)(2) of the Immigration and Nationality Act.

(6) Spouse: means either of two individuals who:

(a) would be defined as married to each other under applicable state law; or

(b) are living together and are holding themselves out to the community as husband and wife by representing themselves as such to relatives, friends, neighbors, or trades people.

(7) Stale: means EBT accounts which have not been accessed or had any withdrawal activity by the household for 90 days from the most recent date of withdrawal.

(8) Standard utility allowance (SUA): means an average utility amount used year round that includes the actual expense of heating and cooling fuel, electricity (apart from heating or cooling), the basic service fee for one telephone, water, sewerage, and garbage and trash collection. This amount is adjusted annually to reflect changes in expenses. A cooling expense is a verifiable utility expense relating to the operation of air conditioning.

(9) State wage information collection agency: means for New Mexico the department of workforce solutions, employment security division (ESD) which administers the state employment compensation law and provides a quarterly report of employment related income and eligibility data.

(10) Striker: means anyone involved in a strike or concerted work stoppage by employees (including stoppage due to the expiration of a collective bargaining agreement) and any concerted slow down or other concerted interruption of operations by employees.

(11) Student: means an individual attending at least half time, as defined by the institution any kindergarten, preschool, grade school, high school, vocational school, technical school, training program, college, or university.

(12) Supplemental nutrition assistance program (SNAP): The Food and Nutrition Act of 2008 changed the federal name of the food stamp program to the supplemental nutrition assistance program. SNAP is synonymous with the food stamp program.

(13) Supplemental nutrition assistance program trafficking: means:

(a) The buying, selling, stealing, or otherwise effecting an exchange of SNAP benefits issued and accessed via electronic benefit transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signature, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone;

(b) The exchange of firearms, ammunition, explosives, or controlled substances, as defined in section 802 of title 21, United States Code, for SNAP benefits;

(c) Purchasing a product with SNAP benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount;

(d) Purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with SNAP benefits in exchange for cash or consideration other than eligible food; or

(e) Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.

(14) Supplemental security income (SSI): means monthly cash payments made under the authority of:

(a) Title XVI of the Social Security Act, as amended, to the aged, blind and disabled; or

(b) section 1616(a) of the Social Security Act; or

(c) section 212(a) of P.L. 93-66.

(15) SSI household: means a household in which all members are applicants or recipients of SSI. An SSI household may also apply for SNAP through a social security office. The application must be forwarded to the appropriate SNAP (ISD) office for processing. SSI households are categorically eligible.

(16) Supplementary unemployment benefits (SUB): part of the guaranteed annual wage provisions in the auto industry whereby the company supplements state UCB to insure that laid off workers receive a guaranteed amount of income during the layoff period.

T. Definitions beginning with "T":

(1) Thrifty food plan (TFP): see maximum SNAP allotment.

(2) Transitional food stamps: an extension of SNAP benefits up to five months to certain households whose cash assistance benefits have been terminated.

(3) Transitional housing: means housing for which the purpose is to facilitate the movement of homeless individuals and families to permanent housing within 24 months, or such longer period as is determined necessary. All types of housing meant to be transitional should be considered as such for the purpose of determining exclusion. The definition does not exclude specific types of housing and does not require the presence of cooking facilities in a dwelling.

U. Definitions beginning with "U":

(1) Unclear information: Unclear information is information that is not verified, or information that is verified but ISD needs additional information to act on the change.

(2) Universal basic income: Universal basic income is a government-guaranteed program that provides a modest cash income at regular intervals (e.g., each month or year) to every individual or household to meet the basic needs.

V. Definitions beginning with "V":

(1) Vehicles: means a mode of transportation for the conveyance of passengers to or from employment, daily living, or for the transportation of goods. Boats, trailers and mobile homes shall not be considered vehicles, for purposes of SNAP.

(2) Verification: means the use of third-party information or documentation to establish the accuracy of statements on the application.

W. Definitions beginning with "W": [RESERVED]

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]

[8.139.100.7 NMAC - Rp, 8.130.100.7 NMAC 07/01/2024]

8.139.100.8 ABBREVIATIONS & ACRONYMS:

A. Abbreviations and acronyms:

(1) ABAWD: able bodied adults without dependents

(2) AFDC: aid to families with dependent children (replaced by TANF effective July 1, 1997)

(3) BIA-GA: bureau of Indian affairs-general assistance

(4) CA: cash assistance (same as financial assistance)

(5) CE: categorical eligibility or categorically eligible

(6) CFR: code of federal regulations

(7) CPI-U: consumer price index for urban consumers

(8) CS: child support

(9) CSED: (HCA) child support enforcement division

(10) CYFD: (New Mexico) children youth & families department

(11) DOH: (New Mexico) department of health

(12) DOJ: (United States) department of justice

(13) DOL: (New Mexico) department of labor

(14) DOT: dictionary of occupational titles

(15) DRIPS: disqualified recipient information processing system

(16) E&T: employment and training

(17) EBT: electronic benefit transfer

(18) EC: employment counselor

(19) EI: earned income

(20) EW: eligibility worker (now FAA or caseworker)

(21) FA: financial assistance (same as cash assistance)

(22) FAA: family assistance analyst (caseworker)

(23) FCS: food and consumer services of the USDA, now FNS

(24) FFY: federal fiscal year

(25) FMV: fair market value

(26) FNS: food and nutrition service

(27) **FSP:** food stamp program
(28) **GA:** general assistance
(29) **GBI:** guaranteed basic income;
(30) **GED:** general equivalency degree;
(31) **HHS:** (U.S.) health and human services;
(32) **HCA:** (New Mexico) health care authority;
(33) **HUD:** (U.S.) housing and urban development;
(34) **IEVS:** income and eligibility verification system;
(35) **IPV:** intentional program violation;
(36) **ISD:** (HCA) income support division;
(37) **ISD2:** integrated services delivery for ISD;
(38) **ISS:** income support specialist (now FAA or caseworker);
(39) **JOBS:** jobs opportunities and basic skills (a work program under AFDC);
(40) **JTPA:** Job Training Partnership Act (now WIA);
(41) **LIHEAP:** low income home energy assistance program;
(42) **LITAP:** low income telephone assistance program;
(43) **MFSA:** maximum food stamp allotment (benefit amount);
(44) **MRRB:** monthly reporting and retrospective budgeting;
(45) **MVD:** (New Mexico) motor vehicle division;
(46) **NADA:** national automobile dealers association;
(47) **NFA:** nonfinancial assistance (same as non-cash assistance (NCA);
(48) **NMW:** New Mexico works;
(49) **QC:** quality control;
(50) **RR:** regular reporting or regular reporters;
(51) **RSVP:** retired seniors volunteer program;
(52) **SAVE:** systematic alien verification for entitlements;
(53) **SNAP:** supplemental nutrition assistance program;
(54) **SR:** simplified reporting;
(55) **SSA:** social security administration;
(56) **SSI:** supplemental security income;
(57) **SSN:** social security number;
(58) **SUA:** standard utility allowance;
(59) **SWICA:** state wage information collection agency;
(60) **TANF:** temporary assistance to needy families (block grant program under Title IV-A of the Social Security Act);
(61) **TAPP:** tribal assistance project program (Navajo);
(62) **TFP:** thrifty food plan (now the maximum SNAP allotment);
(63) **TFS:** transitional food stamp (benefit amount);
(64) **UBI:** universal basic income;
(65) **UCB:** unemployment compensation benefits;
(66) **USCIS:** United States citizenship and immigration services;
(67) **USDA:** U. S. department of agriculture;
(68) **VA:** veterans administration;
(69) **WIA:** Workforce Investment Act (formally JTPA);

[8.139.100.8 NMAC - Rp, 8.130.100.8 NMAC 07/01/2024]

8.139.100.9 MISSION STATEMENT:

A. The purpose of the program is to provide for improved levels of nutrition among low-income households through a cooperative federal-state program of food assistance to be operated through normal channels of trade.

B. Section 2 of the Food Stamp Act of 1977 states, in part: Congress hereby finds that the limited food purchasing power of low-income households contributes to hunger and malnutrition among members of such households. To alleviate such hunger and malnutrition, a food stamp program is herein authorized which will permit low-income households to obtain a more nutritious diet through normal channels of trade by increasing food purchasing power to all eligible households who apply for participation.

[8.139.100.9 NMAC - Rp, 8.130.100.9 NMAC 07/01/2024]

8.139.100.10 PROGRAM OVERVIEW:

A. Establishment of the food stamp program: Sec. 4 [2013] (a) of the act provides that subject to availability of funds appropriated under section 18, the secretary is authorized to formulate and administer a food stamp program under which eligible households within a state be provided an opportunity to obtain a more nutritious diet through the issuance to the household of an allotment.

B. State participation: A state is prohibited from participating in the food stamp program if it is determined that state or local sales taxes are collected on purchases of food made with coupons issued under the act.

C. Retail stores: Food stamp benefits used by households shall be used only to purchase food from retail food stores which have been approved for participation in the food stamp program. Benefits issued and used as provided in the act shall be redeemable at face value by the secretary through the facilities of the treasury of the United States.

[8.139.100.10 NMAC - Rp, 8.130.100.10 NMAC 07/01/2024]

8.139.100.11 GENERAL PROGRAM DESCRIPTION:

A. Purpose: The supplemental nutrition assistance program (SNAP) is designed to promote the general welfare and to safeguard the health and well-being of the nation's population by raising the levels of nutrition among low-income households.

B. Household participation: Participation in SNAP shall be limited to those households whose income and other financial resources, held singly or in joint ownership, are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet. Eligibility for the program is determined by comparing the applicant group's income, resources, and non-financial eligibility information to the program's policies.

C. National standards: Uniform national standards for determining eligibility and participation are established each year, and are effective every October. A household shall meet income and resource limits and other specific eligibility criteria before approval for participation in SNAP. The income test is based on one hundred and thirty percent of the federal poverty level. Resource eligibility limits are $2,250 for households whose members are under 60 years of age, and $3,250 for households containing one or more individuals 60 years of age or over. The federal government funds program benefits at one hundred percent and administrative costs at fifty percent.

[8.139.100.11 NMAC - Rp, 8.130.100.11 NMAC 07/01/2024]

8.139.100.12 ADMINISTRATION: The state agency of each participating state shall assume responsibility for the certification of applicant households and for the issuance of coupons (benefits). In New Mexico the agency responsible for administration of the food stamp program is the health care authority, income support division. HCA is responsible for control and accountability in the food stamp program. Records shall be kept to ascertain whether the program is being conducted in compliance with provisions of the Food Stamp Act of 1977. Such records shall be available for inspection and audit at any reasonable time and shall be preserved for not less than three years.

[8.139.100.12 NMAC - Rp, 8.130.100.12 NMAC 07/01/2024]

8.139.100.13 DIVISION RESPONSIBILITIES: The income support division of the health care authority shall be responsible for general administration of the food stamp program.

A. Issuance of food stamp coupons to eligible low-income households is accomplished in Santa Fe via direct mail delivery.

B. Since September 1990, benefit delivery was accomplished via electronic benefit transfer in selected counties. The electronic benefit transfer delivery system has been approved statewide.

C. Policy changes and interpretation is forwarded to field staff and other interested parties as it is received from the food and nutrition service of the United States department of agriculture. Individual requests for policy clarifications are also disseminated.

D. The division is responsible for record keeping to satisfy provisions of the Food Stamp Act of 1977, including keeping numbers of participating households, amount of food stamp benefits issued monthly, benefits returned monthly, affidavits filed, and coupons destroyed.

[8.139.100.13 NMAC - Rp, 8.130.100.13 NMAC 07/01/2024]

HISTORY OF 8.139.100 NMAC: [RESERVED]

History of Repealed Material:

8.139.100 NMAC, Food Stamp Program - General Provisions For The Food Stamp Program filed 4/26/2001,

Repealed effective 11/1/2023.
8.139.100 NMAC, Food Stamp Program - General Provisions For The Food Stamp Program filed 4/26/2001, Repealed effective 07/01/2024.

Other: 8.139.100 NMAC, Food Stamp Program - General Provisions For The Food Stamp Program filed 4/26/2001, Replaced by 8.139.100 NMAC, Food Stamp Program - General Provisions For The Food Stamp Program effective 11/1/2023.

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 110 GENERAL ADMINISTRATION - APPLICATION PROCESSING

8.139.110.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.110.1 NMAC - Rp 8.139.110.1 NMAC 07/01/2024]

8.139.110.2 SCOPE: General public
[8.139.110.2 NMAC - Rp 8.139.110.2 NMAC 07/01/2024]

8.139.110.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.110.3 NMAC - Rp 8.139.110.3 NMAC 07/01/2024]

8.139.110.4 DURATION: Permanent.
[8.139.110.4 NMAC - Rp 8.139.110.4 NMAC 07/01/2024]

8.139.110.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.139.110.5 NMAC - Rp 8.139.110.5 NMAC 07/01/2024]

8.139.110.6 OBJECTIVE: Issuance of the revised SNAP policy manual is intended to be used in administration of SNAP in New Mexico. This revision incorporated the latest federal policy changes in SNAP not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the health care authority.
[8.139.110.6 NMAC - Rp 8.139.110.6 NMAC 07/01/2024]

8.139.110.7 DEFINITIONS: [RESERVED]

8.139.110.8 APPLICATION PROCESS: The application process includes completing an application form on paper or electronically, filing the completed application form, being interviewed, and having certain information verified. ISD will make paper application forms readily accessible in the ISD local office lobby to potentially eligible households and to anyone who requests the form. If HCA maintains a web page, the application will be available on the web page in each language for which the printed application is available. Information on how to submit an electronic application will be readily available to potentially eligible individuals as well as to local agencies and organizations that regularly have contact with potential applicants and recipients. The web page will provide the addresses and phone numbers of all ISD field offices and a statement that the household should return the application form to its nearest local office. Households may submit the application in person, or via mail, fax, electronic device, or through an authorized representative. Applications will be accessible to persons with disabilities in accordance with Section 504 of the Rehabilitation Act of 1973, as amended by the Rehabilitation Act Amendments of 1974.
[8.139.110.8 NMAC - Rp 8.139.110.8 NMAC 07/01/2024]

8.139.110.9 RIGHT TO APPLY:

A. Each individual shall have the opportunity to apply for public assistance programs administered by the authority or to have an authorized representative do so on his or her behalf. Paper application forms must be readily accessible in the ISD local office lobby and provided to any person who requests the form. Applications are made in a format prescribed by the authority to include paper forms or electronic submissions. ISD will post signs in local field offices which explain the application processing standards and the right to file an application on the day of initial contact.

B. An individual who requests information or assistance and who wishes to apply, shall be encouraged to complete an application the same day that contact is made with the office.

(1) An individual shall be informed that the date of application affects the benefit amount.

(2) An individual shall be informed that an incomplete application may be filed as long as the form has the applicant's name and address and is signed by a responsible household member or authorized representative.

(3) An interview shall not be required before filing an application.

(4) A household shall be informed, except for a SNAP requirement, that any disadvantages or requirements for applying for or receiving cash assistance do not apply to SNAP and that receiving SNAP shall have no bearing on any other program's time limits that may apply to the household.

(5) If an individual contacts the office by phone or mail and does not wish to come to the office to pick up an application the individual will be mailed an application the same day the office is contacted and offered the option of submitting an electronic application through the YES-New Mexico web portal.

C. SSI applicants:

(1) Whenever a household consists only of SSI applicants or recipients, the household has the right to apply for SNAP benefits and to transact all SNAP business at a social security administration (SSA) office, provided it has not applied for SNAP benefits in the preceding 30 days or does not have a SNAP application pending at a local ISD office.

(a) Such applications are considered filed for normal processing purposes when the signed application is received by SSA.

(b) SSA is required to forward every application to the appropriate ISD office within one working day of receipt.

(c) SSI clients are not required to see ISD or be otherwise subjected to a second interview, although additional information or verification may be requested.

(2) SSI/SNAP prerelease applications: A resident of a public institution who applies for SSI prior to release from the institution under the social security administration (SSA) prerelease program for the institutionalized shall be permitted to apply for SNAP benefits at the same time the individual applies for SSI. The SNAP application shall be processed at a local ISD office in accordance with Paragraph 1 of Subsection C of 8.139.110.9 NMAC above and with the following processing and timeliness standards for joint SSI/SNAP prerelease applications.

(a) Application date:

(i) When a resident of an institution files a joint application for SSI and SNAP benefits with SSA prior to release from the institution, the date of application for filing purposes at the local ISD office shall be the date of release.

(ii) An application shall be denied upon receipt if the applicant is not otherwise eligible, except for the resident of an institution provision as found at Subparagraph (a) of Paragraph (2) of Subsection C of 8.139.110.9 NMAC and Subsection A and B of 8.139.400.13 NMAC.

(b) Normal processing standard:

(i) An application shall be processed as soon as possible and the applicant afforded an opportunity to participate no later than 30 days from the date of release from the institution.

(ii) Benefits for the initial month of certification shall be prorated from the date of the month the applicant is released from the institution.

(c) Expedited service: An applicant who qualifies for expedited service shall receive benefits no later than the seventh calendar day following the applicant's release from the institution.

(d) Categorical eligibility: A potential categorically eligible applicant shall not be considered as such until the individual has been released from the institution and SSA has made a final SSI eligibility determination.

(e) Restored benefits: SSA must notify the local ISD office of the date of the applicant's release from the institution. If for any reason notification is not provided on a timely basis, ISD shall only restore SNAP benefits retroactively to the date of release.

D. Authorized representatives:

(1) Designation: The head of the household or the spouse or any other responsible member of the household may designate an individual who is a non-household member to act on its behalf in:

(a) applying for SNAP benefits; or

(b) obtaining SNAP benefits; or

(c) using the SNAP benefits.

(i) ISD shall obtain a copy of the household's written authorization for the authorized representative and maintain it in the household's case record. No limit shall be placed on the number of households an authorized representative may represent; however, each household may only have one authorized representative at a time.

(ii) Even if the household member is able to make application and obtain benefits, the household should be encouraged to name an authorized representative to use the SNAP benefits in case illness or other circumstances prevent household members from using the benefits themselves.

(iii) The authorized representative's identity shall be verified and a copy of the document maintained in the household's case file.

(2) Liability of households: The head of the household or spouse should prepare or review the household's application whenever possible, even though another household member or the authorized representative will actually be interviewed. The household is liable for any over-issuances resulting from incorrect or untrue information given by the authorized representative.

(3) Application: When the head of the household or spouse cannot apply, another adult member may do so, or an adult who is not a member of the household may be designated as the authorized representative. Nonmember adults shall be designated as authorized representatives for certification purposes only if they are:

(a) designated in writing by the head of the household, or spouse, or another responsible member of the household; and

(b) sufficiently aware of relevant household circumstances to represent it.

(4) Changing authorized representative: An authorized representative may be designated at the time an application is completed; the authorized representative shall be named on the identification (ID) card. This does not preclude the right of the household to make a designation after it has made application to the program. If a household develops a need for a representative, or needs to change the authorized representative before, during, or after the certification process, a new authorized representative may be appointed and a new ID card shall be issued to the household. The authorized representative designated to apply for the household may be the same individual who obtains or uses the benefits for the household, or may be a different individual.

(5) Using SNAP benefits: The authorized representative may use the SNAP benefits to purchase food for the household's consumption with the household's full knowledge and consent, provided that the authorized representative has the household's ID card.

(6) Kinds of authorized representatives:

(a) Emergency authorized representatives:

(i) An emergency authorized representative is someone who obtains benefits for a particular month when the household is unable to obtain the benefits because of unforeseen circumstances.

(ii) A household may designate in writing, on a one-time basis, an emergency authorized representative.

(iii) The household member whose signature is on the household's ID card must sign a designation authorizing the emergency authorized representative to obtain the benefits.

(b) Non-household members: If the only adult living with a household is classified as an excluded household member or nonmember, that individual may be the authorized representative for the minor members who are eligible.

(c) Addiction treatment centers:

(i) Residents of public or private, nonprofit drug or alcohol treatment centers must apply and be certified for program participation through the use of an authorized representative who is an employee of, and designated by, the organization or institution administering the treatment and rehabilitation program.

(ii) The drug or alcohol treatment center, which acts as authorized representative for residents of the facility, must use SNAP benefits for food prepared by and served to the center residents, and is responsible for complying with requirements governing treatment centers.

(d) Group homes:

(i) A resident of a group living arrangement may apply for SNAP benefits and be certified through use of an authorized representative employed and designated by the group home; or on the resident’s own behalf; or through an authorized representative of the applicant’s choice.

(ii) A resident of a group home does not have to be certified through an authorized representative or individually in order for one or the other method to be used.

(iii) The facility is responsible for determining if any resident may apply for benefits on the resident's own behalf. The decision should be based on the resident's physical and mental ability to handle his/her own affairs. The facility is also encouraged to consult with any other agencies of the state providing other services to such a resident prior to this determination.

(iv) Applications shall be accepted for any individual applying as a one-person household, or for any grouping of residents applying as a household.

(v) If a resident applies through a facility's authorized representative, the resident's eligibility shall be determined as a one- person household.

(vi) If a resident is certified on the resident's own behalf, the benefits may either be returned to the facility to be used to purchase food for meals served either communally or individually to eligible residents; used by eligible residents to purchase and prepare food for their own consumption; and/or used to purchase meals prepared and served by the facility.

(7) Disqualification as authorized representative:

(a) Any authorized representative who misrepresents a household's circumstances and knowingly provides false information pertaining to a household, or has made improper use of SNAP benefits, shall be disqualified from participating as an authorized representative for up to one year.

(b) ISD shall be required to send written notification to the affected household(s) and the authorized representative 30 days prior to the date of disqualification. The notification must specify the final action; the reason for the final action; the right to request a fair hearing; the telephone number of the office; and, if possible, the name of the person to contact for additional information.

(c) This provision is not applicable to drug or alcoholic treatment centers and to those group homes that act as authorized representatives for their residents.

(8) Restrictions: HCA employees involved in the certification or issuance process, and retailers who are authorized to accept benefits, cannot act as authorized representatives without the specific written approval of the ISD county director, and then only if the county director determines that no one else is available to serve as an authorized representative. Individuals disqualified for fraud cannot act as authorized representatives during the period of disqualification, unless the disqualified individual is the only adult member of the household able to act on its behalf and only if the county director has determined that no one else is available to serve as an authorized representative. The county director shall decide separately whether such individuals are needed to apply on behalf of the household and use the benefits to purchase food.

[8.139.110.9 NMAC - Rp 8.139.110.9 NMAC 07/01/2024]

8.139.110.10 SUBMISSION OF FORMS

A. Joint cash assistance (CA)/SNAP applications:

(1) To facilitate participation in SNAP, households in which all members are applying for cash assistance (Title IV-A or GA) shall be allowed to apply for SNAP benefits at the same time they apply for other assistance. However, SNAP eligibility and benefit amounts shall be based solely on SNAP eligibility factors pending determination of cash assistance eligibility. All households shall be certified in accordance with the notice and procedural and timeliness requirements of SNAP regulations. (See Subsection B of 8.139.110.11 NMAC, combined CA/SNAP interviews, for further information.)

(2) A household shall be notified of the Privacy Act regarding application information and shall be provided the following information:

(a) The collection of information, including the social security number of each household member, is authorized under the Food Stamp Act of 1977, as amended 7 U.S.C. 2011-2036.

(b) The information shall be used to determine whether a household is eligible or continues to be eligible to participate in the SNAP program.

(c) The information shall be verified through computer matching programs.

(d) The information shall be used to monitor compliance with program regulations and for program management.

(e) The information provided may be disclosed to other federal and state agencies for official examination, and to law enforcement officials for the purpose of apprehending persons fleeing from the law.

(f) If a SNAP claim is filed against a household, the information on the application, including all SSNs, may be referred to federal and state agencies, as well as private claims collection agencies, for claims collection action.

(g) That providing the requested information, including the SSN of each household member, is voluntary, but that failure to provide required information shall result in the denial of SNAP benefits to a household.

B. Items completed: SNAP regulations require only that an application contain the name, address and signature, or witnessed mark, of the applicant in order to be filed and registered.

C. Who completes the application: The application must be completed by a household member or designated authorized representative. If an authorized representative or adult member of the SNAP household completes the application form, the applicant should still review the completed form, since the applicant is liable for improper payments resulting from erroneous information given by an authorized representative. If an applicant needs help completing the form, ISD shall help the applicant complete the form.

D. Signature:

(1) The application must be signed by the applicant and the authorized representative, if one is designated. A signature means that the applicant is verifying the information provided by the household and has read and agrees with all of the statements on the application or other form requiring a signature.

(2) A signature is the depiction of the individual's name(s) that is, handwritten, electronic or recorded telephonically. Electronic and telephonically recorded signatures are valid only if provided in a format or on a system approved by the authority, which includes verification of the identity of the person providing the signature.

(3) If the applicant receives help completing the form, that person must also sign at the bottom of the form.

(4) A person who is unable to sign his own name may sign the application with a mark and have it witnessed. A mark that is not witnessed cannot be accepted as a valid signature. The witness shall be someone other than the interviewer.

E. Filing the application:

(1) An application can be filed in person, through an authorized representative, by mail or by fax or other electronic transmission, including on-line electronic transmission. An application submitted electronically or by fax and containing a handwritten or electronic signature shall be considered an acceptable application.

(2) An application shall be filed at the ISD field office serving the community or county where the applicant lives or through the YES-NM web portal. ISD shall provide households that complete an on-line electronic application in person at the ISD office the opportunity to review the information that has been recorded electronically and provide them with a copy of that information for their records, upon request.

F. Registration of the application: Applications submitted to ISD with at least the applicant's name, address and signature of the applicant, spouse, other adult household member or authorized representative shall be registered effective the date on which an application is received by ISD at the field office or electronically during regular business hours. Applications that are dropped off or submitted electronically after regular business hours will be considered received as of the next business day. Regular business hours are Monday through Friday from 8 a.m. to 4:30 p.m., excluding state holidays or other days/times when the field office is officially closed. Processing deadlines shall be calculated based on the application date.

G. Incomplete applications: Applications that do not contain, at a minimum, the applicant's name, address, and signature, or witnessed mark, are incomplete and cannot be registered. Prompt action shall be taken to return the application form for completion of the minimum required entries. Other missing information does not constitute an incomplete application for purposes of registering the application.

H. Computer inquiries: Computer inquiries shall be completed prior to certification and, where feasible, prior to the interview in order to prevent dual participation and to reveal undetected income and resources. These inquiries include scans for wage and unemployment benefits, SSI benefits, and licensed vehicle ownership, as well as for other available information and appropriate IEVS data.

I. Action on discrepancies:

(1) If computer interfaces show a household member is currently participating in another household or receiving benefits from the food distribution on Indian reservations program (FDPIR), ISD shall discuss the situation with the applicant. The household can be certified only after the other project area has been informed of the situation and the case has been adjusted or transferred whichever is appropriate. If an inquiry shows that the case is on file in another project area, residence shall be established. The application shall be forwarded to the project area in which the applicant household has established residency.

(2) Available information: The household shall be given an opportunity to verify information from another source if information is contradictory to that already provided or is questionable. A

decision on eligibility and benefit amount shall not be delayed beyond normal application processing standards if other sources of data are unavailable. The final decision to approve or deny shall be based on the available information.
[8.139.110.10 NMAC - Rp 8.139.110.10 NMAC 07/01/2024]

8.139.110.11 INTERVIEWS

A. Purpose and scope of interview: The interview is an official and confidential discussion of household circumstances with the applicant. It is intended to provide the applicant with program information, and the worker with the facts needed to make a reasonable eligibility determination. The interview is not simply to review the information on the application, but also to explore and clarify any unclear and incomplete information. The scope of the interview shall not extend beyond examination of the applicant's circumstances that directly relate to determining eligibility and benefit amounts. The interview shall be held prior to disposition of the application.

B. Joint cash assistance/SNAP interview: At initial application for cash assistance (CA), a single interview shall be conducted concurrently for both cash assistance and SNAP benefits if the client wishes to apply for both programs. Federal SNAP regulations specifically provide that applicants for both programs shall not be required to see a different ISD worker or be otherwise subjected to two interviews in order to obtain the benefits of both programs. Following the single interview, the application may be processed by separate workers to determine eligibility for SNAP benefits and cash assistance. In an expedited SNAP certification situation, a second interview is permitted if an immediate interview for cash assistance cannot be arranged.

C. Individuals interviewed: Applicants, including those who submit applications by mail, shall be interviewed in person at the local ISD office. When circumstances warrant, the household shall be interviewed by telephone, or at another place reasonably accessible and agreeable to both the applicant and ISD. The applicant may bring any person he chooses to the interview.

D. Out of office interviews:

(1) A SNAP applicant shall not be required to have an initial office interview if the applicant is unable to appoint an authorized representative and the household has no member(s) able to come to ISD because the member(s) is elderly or disabled, as defined.

(2) The initial office interview can also be waived if requested by any household that is unable to appoint an authorized representative who is willing and able to perform this function, and who lives in a location not served by a certification office.

(3) Hardship conditions: The office interview for SNAP households shall be waived when the applicant meets one of the following conditions:

(a) older than the age of 60;
(b) disabled;
(c) employed 20 or more hours per week;
(d) has a dependent child younger than the age of six;
(e) has transportation difficulties;
(f) illness;
(g) care of a household member;
(h) resides in a rural area;
(i) prolonged severe weather;
(j) other hardship identified as situations warrant; as authorized by the county director.

(4) A face-to-face interview must be granted to any recipient who requests one.

E. Face-to-face/telephone interviews: A household must have a face-to-face interview at initial certification and at least once every 12 months thereafter.

(1) A household certified for longer than 12 months is excluded.

(2) At recertification, a household is considered to have met the face-to-face requirement when alternative recertification interviews are conducted by telephone.

(3) No household shall have the face-to-face interview waived for two consecutive recertifications.

(4) The requirement for a face-to-face interview may be waived on a case-by-case basis because of household hardship conditions.

F. Applicant information: During the application interview all reasonable steps shall be taken to make the applicant feel at ease and protect the applicant’s right to privacy.

(1) All applicants shall be provided with the following information at initial certification and recertification:

(a) ISD's nondiscrimination policy and procedures;

(b) complaint and fair hearing procedures and clients' rights;

(c) program procedures, including the use of IEVS, SDX, BENDEX information, and CSED and MVD interfaces;

(d) application processing standards, including time limits;

(e) procedures in cases of over-issuance or under-issuance;

(f) requirement for cooperation with quality control reviewers (QC), including penalties for non-cooperation;

(g) work requirements and penalties for non-cooperation, including voluntary quit and associated penalties;

(h) responsibility to contact the local ISD office to reschedule missed appointments; and

(i) exemption from gross receipts tax collection by the retailer on eligible food purchased with SNAP benefits.

(j) For households applying for cash assistance programs and SNAP, ISD must explain that limits and other requirements that apply to the receipt of cash benefits do not apply to the receipt of SNAP benefits.

(k) ISD has a responsibility to help applicants obtain verification if the applicant indicates that the verification may be difficult for the applicant to obtain and offer to assist with obtaining verification if it appears the household will not be able to obtain it.

(l) ISD will provide an explanation of information that still needs to be verified and how to verify in accordance with 8.100.130.9 NMAC and 8.100.130.10 NMAC.

(m) Review all information that ISD has on file and will not require further verification of eligibility factors already established that are not subject to change.

(n) ISD will review all household information received from data scans with the household during the interview and will not require further verification unless it is questionable or outdated.

(o) Simplified reporting requirements for those households assigned to simplified reporting including the following:

(i) a written and oral explanation of how simplified reporting works as defined at 8.139.120.9 NMAC; and

(ii) a written and oral explanation of the reporting requirements which includes: what needs to be reported and verified; when the report is due; how to obtain assistance; and the consequences of failing to file a report. Simplified reporting requirements are found at 8.139.120.9 NMAC.

(2) Fair hearing information:

(a) Notification of right to request hearing: At the time of application each household shall be informed in writing of its right to a hearing, of the method by which a hearing may be requested, and that its case may be presented by a household member or representative, such as a legal counsel, relative, friend or other individual.

(b) Periodic notification: At any time a household informs the local office that it disagrees with an HCA action, the household shall be reminded of the right to request a fair hearing.

(c) Forwarding hearing request: A request for a hearing made either orally or in writing by a household or representative shall be forwarded to the fair hearings bureau. If it is unclear from a request what action a household or representative wishes to appeal, a clarification may be requested by HCA. The freedom to make a request for a hearing shall not be limited or interfered with in any way.

(d) Providing a hearing: The fair hearing process shall be available to any household which feels an action taken by HCA is incorrect, and which affects participation of the household in the SNAP.

(e) Other representation: If there is an individual or organization available that provides free legal representation, the household shall be informed of the availability of that source.

(3) Agency conference information: A household shall be informed of the availability of an agency conference to resolve a dispute. HCA shall schedule an agency conference for a household when a dispute arises.

(a) Denial of expedited service: An agency conference shall be offered to a household which wishes to contest a denial of expedited service. An agency conference for such a household shall

be scheduled within two working days, unless the household requests that it be scheduled later or states that it does not wish to have an agency conference.

(b) Adverse actions: ISD may also offer an agency conference to a household adversely affected by an ISD action.

(c) Use of agency conference: ISD shall inform a household that use of an agency conference is optional and that it shall in no way delay or replace the fair hearing process.

G. Scheduling interviews: ISD will schedule an interview to be held within 10 working days of the date the application was received that is, to the extent possible, convenient for both the applicant and ISD. The application received date is the first day the application is received within regular business hours. ISD will provide the applicant with a written appointment letter that will include: the date, time and place of the appointment, the name and telephone number of the local county office, the consequences of missing an appointment, how to reschedule an appointment, the possibility of a telephone interview, and that the spouse, any other responsible person in the household, or an authorized representative may attend the interview with the applicant or in the applicant's place.

H. Missed interviews: ISD shall notify a household that it missed its first interview appointment and that the household is responsible for rescheduling a missed interview. ISD shall send the household a notice of missed interview that may be combined with the notice of denial. If a household misses its scheduled interview and requests another interview, the ISD shall schedule a second interview. The household is responsible for rescheduling a missed interview. If the household requests a second interview ISD within the 30-day application-processing period, ISD shall schedule a second interview. When the applicant contacts the local ISD office, either orally or in writing, ISD shall reschedule the interview as soon as possible within the 30-day processing period, without requiring the applicant to provide good cause for failing to appear. If the household is determined eligible, benefits will be pro-rated from the date of application. If the applicant does not contact the office or does not appear for the rescheduled interview, the application shall be denied on the 30th day (or the next work day) after the application was filed (see Section 8.139.110.12 NMAC).

[8.139.110.11 NMAC - Rp 8.139.110.11 NMAC 07/01/2024]

8.139.110.12 PROCESSING APPLICATIONS:

A. HCA is responsible for timely and accurate issuance of benefits to eligible households. All applications for assistance will be processed as soon as possible. Applicants who complete the application process will have their eligibility determined and be given an opportunity to participate within the time limits mandated for expedited or normal application processing. ISD will explain the time limits to the applicant and inform them of the date by which the application will be processed. With the exception of those manual provisions that specify "working days," time limits begin on the first calendar day following the action that triggered the time limit.

B. Household cooperation: To determine eligibility an application form must be completed and signed, a household or its authorized representative interviewed, and certain information on the application verified.

(1) At application: If a household refuses to cooperate in completing the process, the application will be denied at the time of refusal. For a determination of refusal to be made, a household must be able to cooperate, but clearly demonstrates that it will not take action that it can take and that is required to complete the application process. If there is any question that a household has failed to cooperate as opposed to refused to cooperate, it will not be denied. Once denied for refusal to cooperate, a household may reapply but will not be determined eligible until it cooperates with ISD.

(2) Subsequent reviews: A household will be determined ineligible if it refuses to cooperate in a subsequent review of eligibility. Such reviews include those because of reported changes and at application for recertification. Once terminated for refusal to cooperate, a household may reapply, but will not be determined eligible until it cooperates with ISD.

(3) Outside sources: A household will not be determined ineligible when an individual outside the household fails to cooperate with a request for verification. Individuals identified as ineligible household members in 8.139.400.12 NMAC will not be considered as individuals outside the household.

(4) Cooperation with quality control (QC): A household will be determined ineligible if it fails or refuses to cooperate in a QC review of eligibility and benefit amount.

(a) Period of ineligibility:

(i) A household that refuses to cooperate with a state QC review will be determined ineligible effective the month following the month the adverse action notice time limit expires. Ineligibility will continue until 125 days from the end of the annual QC review period (February 4) during which non-cooperation is found. The annual QC review period begins October 1 and ends September 30.

(ii) A household that refuses to cooperate with a federal QC review will be ineligible effective the month following the month the adverse action notice time limit expires. Ineligibility will continue until nine months from the end of the annual review period (May 1) during which non-cooperation is found. The annual QC review period begins October 1 and ends September 30.

(b) Re-establishing eligibility:

(i) A household may reapply during the period of ineligibility, but will not be determined eligible until it cooperates with the QC review, and is otherwise eligible.

(ii) A household which reapplies at the end of the period of ineligibility will not be determined ineligible because of its failure or refusal to cooperate with a state or federal QC review. The household must provide verification necessary to determine eligibility at reapplication in accordance with Subsection H of 8.139.110.11 NMAC.

C. Verification standards: Verification is use of third-party information or documentation to establish the accuracy of statements on the application, or information provided by the applicant or recipient.

(1) Initial certification: Verification is mandatory for the following information prior to initial certification for both new and reopened cases.

(a) Financial information:

(i) gross nonexempt income, and

(ii) resources.

(b) Any of the following if the expense would result in a deduction:

(i) utility expenses;

(ii) continuing shelter expenses;

(iii) dependent care expenses;

(iv) deductible medical expenses including the amount of reimbursements;

(v) legally obligated child support expenses, and amount actually paid;

(vi) if any of the above expenses will not result in a deduction, verification shall not be required (for example, less than $35 in medical expenses, or shelter expenses that do not exceed fifty percent of income after all other deductions).

(c) Nonfinancial information:

(i) residence;

(ii) citizenship, if questionable, and alien status of household members who are individually applying for benefits only;

(iii) identity of the applicant and authorized representative, if designated;

(iv) household size and composition;

(v) disability, if necessary;

(vi) social security numbers, except that eligibility or issuance of benefits shall not be delayed solely to verify the social security number of a household member, and

(vii) any questionable information that must be verified to determine eligibility.

(2) Verification subsequent to initial certification: Verification of the following is mandatory in accordance with the individual's reporting requirements found at 8.139.120.9 through 12 NMAC:

(a) a change in income if the source has changed or the amount has changed by more than $50;

(b) a change in utility expenses if the source has changed;

(c) previously unreported medical expenses, and total recurring medical expenses which have changed by more than $25;

(d) new social security numbers, for individuals who are applying for benefits, that shall be verified as detailed in 8.139.410.8 NMAC;

(e) any other information which has changed or is questionable;

(f) unchanged information shall not be re-verified unless it is incomplete, inaccurate, inconsistent, or outdated.

(g) satisfactory compliance with time limits for individuals subject to the time limit in accordance with 8.139.410.14 NMAC.

(3) Providing verification:

(a) If electronic verification is not available, the household has primary responsibility for providing documentary evidence to support statements on the application and to resolve any questionable information.

(b) ISD shall assist a household in obtaining verification, provided the household is cooperating in the application process.

(c) A household or their authorized representative may supply documentary evidence in person, by mail, fax, electronic device or through the YES NM web portal.

(d) A household shall not be required to supply verification in person at the ISD office or to schedule an appointment to provide such verification.

(e) ISD shall accept any reasonable documentary evidence provided by the household and must be primarily concerned with how adequately the verification proves the statements on the application.

(4) Documentation: A case file shall be documented to support eligibility, ineligibility, and benefit amount determination. Documentation shall be in sufficient detail to permit a reviewer to determine the reasonableness and accuracy of the determination.

[8.139.110.12 NMAC - Rp 8.139.110.12 NMAC 07/01/2024]

8.139.110.13 TIME LIMITS:

A. Opportunity to participate: ISD shall provide eligible households that complete the initial application process an opportunity to participate as soon as possible, but no later than 30 calendar days following the date the application was filed, except for residents of public institutions who apply jointly for SSI and SNAP benefits prior to release from the institution in accordance with Paragraph (2) of Subsection C of 8.139.110.9 NMAC. Residents of institutions who apply for SNAP benefits prior to their release from the institution will be provided the opportunity to participate as soon as possible but no later than 30 calendar days from the date of the applicant's release from the institution.

B. Move during eligibility determination: When an office that is processing an application for assistance learns that the applicant has moved to another county, that office will immediately transfer the case in pending status. The application will be processed by the new office using the original registration date from the first office.

C. Withdrawing the application: An applicant may voluntarily withdraw their application at any time prior to the determination of eligibility. A notice will be sent advising the household of the action taken. An applicant will be advised that withdrawal of his/her application has no effect on his/her right to apply for assistance in the future. The agency will document the reason for withdrawal, if any was given.

D. Delayed eligibility determinations:

(1) Establishing cause for delay: When an application for SNAP is not processed by the end of the 30 day time limit, a determination as to whether the delay is the fault of the applicant or ISD will be made.

(2) Applicant delays: A delay is the fault of the applicant if they have failed to complete the application process. ISD will send the household a delay notice on the 30th day in accordance with 7 CFR 273.2(h), after the application is filed when the interview has not been held by the 30th day and the appointment has been rescheduled beyond the 30th day. The notice will inform the applicant that all changes in circumstances since the application was filed must be reported. ISD must have taken the following actions, as appropriate, before the delay can be considered the fault of the household:

(a) For applicants who have failed to complete the application form, ISD must have offered, or attempted to offer, assistance in its completion.

(b) For applicants who have failed to provide complete verification, ISD must have provided the household with a statement of required verification, offered assistance as required, and allowed the household sufficient time to provide the missing verification. Sufficient time is at least 10 days from the date of ISD’s initial request for the particular verification that is missing.

(c) For applicants who have failed to appear for an interview ISD must notify the applicant that it missed the scheduled interview and that the applicant is responsible for rescheduling a missed interview. If the applicant contacts ISD by the 30th day following the date of application, ISD must schedule a second interview. If the applicant fails to schedule a second interview or the subsequent interview is postponed at the applicant’s request or cannot otherwise be rescheduled until after the 20th day but before the 30th day following the date the application was filed, the applicant must appear for the interview, bring verification, and register

household members for work by the 30th day following date of application. Otherwise, the delay is the fault of the applicant.

(d) If the applicant has failed to appear for the first interview, fails to schedule a second interview, or the subsequent interview is postponed at the applicant's request until after the 30th day following the date the application is filed, the delay shall be the fault of the applicant. If the applicant has missed both scheduled interviews and requests another interview, any delay shall be the fault of the applicant.

(e) If one or more members of the household have failed to register for work in accordance with 7 CFR 273.7, ISD must have informed the household of the need to register for work, determined if the household members are exempt from work registration, and given the household at least 10 days from the date of notification to register these members.

(3) Denial of the household application: Applicants that are found to be ineligible shall be sent a denial notice as soon as possible but not later than 30 days following the date the application was filed. If the applicant has failed to appear for a scheduled interview and has made no subsequent contact with ISD, ISD shall send a denial notice on the 30th day following the date of application. The applicant must file a new application if they wish to participate in the program. In cases where ISD was able to conduct an interview and request all the necessary verification on the same day the application was filed, and no subsequent requests for verification were made, ISD may also deny the application on the 30th day, if ISD provided assistance to the applicant in obtaining verification, but the applicant failed to provide the requested verification.

(4) ISD delays: Delays that are the fault of ISD include, but are not limited to, cases where ISD fails to provide the required assistance, fails to observe time limits, fails to schedule timely interviews, or fails to provide other proper procedural help to the applicant. ISD is at fault when the applicant has met his obligations in a timely manner, but ISD fails to complete the application process in a timely manner.

(a) Action on ISD delays: If the delay in the initial 30-day period is caused by ISD, ISD will take immediate corrective action and the application will not be denied. The applicant will be notified that the application is pending and informed of any action to take to complete the application process, including reporting any changed circumstances since the application was filed. ISD will send the applicant a notice of delay in accordance with 7 CFR 273.2(h).

(b) Retroactive benefit rights: If the applicant is found to be eligible during the second 30-day period, the household is entitled to benefits retroactive to the date of application.

(c) Denial of an application: If the household is determined ineligible, the application will be denied and a notice sent no later than the 60th day after the application was filed, or the following work day if the 60th day falls on a weekend or holiday.

(5) ISD action on applicant delays:

(a) If by the 30th day ISD cannot take any further action on the application due to the fault of the applicant, the applicant shall lose its entitlement to benefits for the month of application and a denial notice will be sent.

(b) ISD shall give the applicant an additional 30 days to take the required action. If the applicant takes the required action within 60 days following the date the application was filed, ISD shall reopen the case without requiring a new application.

(c) If the applicant fails to provide requested verification by the 60th day, no further action is required by ISD.

(d) If the applicant was at fault for the delay in the first 30 day period, but is found to be eligible during the second 30 day period, benefits shall be provided only from the month following the month of application.

(6) Delays beyond 60 days:

(a) ISD delays:

(i) If ISD is at fault for not completing the application process by the end of the second 30-day period, and the record is otherwise complete, the application process will be continued until an eligibility determination is accomplished.

(ii) If the household is determined eligible, and ISD was at fault for the delay in the initial 30 days, the household shall receive SNAP benefits retroactive to the date of original application, but only for those months that it is determined eligible.

(iii) If ISD is at fault for not completing the application process by the end of the second 30-day period, but the case record is not complete enough to reach an eligibility determination, the application will be denied and the household advised to file a new application. The household shall be advised of possible entitlement to lost benefits caused by an ISD delay.

(iv) If ISD was at fault for the delay in the initial 30-day period, the amount of lost benefits will be calculated from the date of application.

(b) Household delays:

(i) If the household is at fault for not completing the application process by the end of the second 30-day period, the application will be denied and the household will be required to file a new application, if it still wishes to participate in the program. The household shall not be entitled to any lost benefits even if the delay in the initial 30 days was the fault of ISD.

(ii) If the initial delay was the household's fault, the household will receive SNAP benefits retroactive only to the month following the month of application.

[8.139.110.13 NMAC - Rp 8.139.110.13 NMAC 07/01/2024]

8.139.110.14 DISPOSITION OF APPLICATION/NOTICES:

A. Approval of SNAP: Notification of the final eligibility determination will be mailed via US postal service and or through approved electronic methods to the applicant in time to be received not later than the last day of the time limit that is, mailed by the 28th day after the date of application to be received by the 30th day.

B. Contents of the notice: The notice of approval provides the household with written notice, sent by mail or electronically, of the amount of the benefits and the beginning and ending dates of the certification period. If the initial benefit amount is prorated or contains benefit amounts for both the month of application and the current month, the notice will explain that the initial month's SNAP benefit amount differs from the benefit amount for the remainder of the certification period. The notice also states that if households that have applied jointly for financial assistance and SNAP begin to receive a financial assistance check, their SNAP benefit amount will be reduced or terminated without advance notice. The notice will contain a telephone number for the customer service call center which will accept calls throughout working hours.

C. Denial of SNAP: If the application is denied, a written or electronic notice will be sent to the applicant explaining the basis for the denial, the right to request a fair hearing, and the telephone number of the ISD office where the household can get information concerning an individual or organization that provides legal representation. Households determined to be ineligible will be sent a denial notice as soon as possible, but not later than 30 days following the date the application was filed. The household must file a new application if it wishes to have eligibility re-determined, subsequent to the initial denial.

[8.139.110.14 NMAC - Rp 8.139.110.14 NMAC 07/01/2024]

8.139.110.15 DESIGNATING THE HEAD OF HOUSEHOLD: A household has the right to select its head of household at each certification action or whenever there is a change in household composition reported in accordance with change reporting requirements.

A. No special requirements: The head of household designation will not be used to impose special requirements on the household, such as requiring the head of household, rather than another responsible member, to appear at the certification office to apply for benefits.

B. Households with children:

(1) When designating the head of household, the household is allowed to select:

(a) an adult parent of children (of any age) living in the household; or

(b) an adult with parental control over children (under age 18) living in the household.

(2) All the adult household members must agree to the selection.

(3) A household with children which fails to select an adult parent of children (of any age) or an adult with parental control over children (under age 18) as the head of household loses the right to this designation option. In such a case, the household member with the most income will be the principal wage earner and will be treated as the head of household.

(4) If all adult household members cannot agree to the selection of, or decline to select, an adult parent of children (of any age) or an adult with parental control over children (under age 18) as the head of household, ISD will permit the household to make another selection, or ISD will designate the head of household.

(5) No person of any age living with a parent or person fulfilling the role of a parent who is:

(a) registered for work; or

(b) exempt from work registration requirements because such parent or person fulfilling the role of a parent is subject to and participating in any work requirement under Title IV of the Social Security Act; or

(c) in receipt of unemployment compensation (or has registered for work as part of

the application for or receipt of unemployment compensation); or

(d) is employed or self-employed and working a minimum of 30 hours weekly or receiving weekly earnings equal to the federal minimum wage multiplied by 30 hours; will be considered the head of household unless the person is an adult parent of children (of any age) and the household elects to designate the adult parent as its head of household.

C. Denial of benefits, delay of certification prohibited: In no event will a denial of benefits or delay of certification action result if an otherwise eligible household fails to select an adult parent of children (of any age) or an adult with parental control over children (under age 18) as its head of household.

D. Households with no adult parent or adult with parental control: If a household does not have an adult parent of children (of any age) or an adult with parental control over children (under age 18) living in the household, the household may designate another member as the head of household or ISD will do so.

E. Designation of head of household by ISD: ISD can designate the head of household only if:

(1) all the adult household members have not agreed to a selection; or

(2) the household declines to select an adult parent or adult with parental control as the head of household and declines to make another selection.

[8.139.110.15 NMAC - Rp 8.139.110.15 NMAC 07/01/2024]

8.139.110.16 EXPEDITED SNAP SERVICE:

A. Identifying eligible households: Households meeting the federal requirements of income and resources may be entitled to receive SNAP benefits within seven days after an application is received by ISD, in accordance with 7 C.F.R 273.2(i). Applications will be screened to identify eligible households at the time the household requests assistance.

(1) Entitlement to expedited service: The following households will be expedited, provided that they are otherwise SNAP eligible:

(a) households with less than $150 in gross monthly income, and with liquid resources (i.e., cash on hand, checking or savings accounts, savings certificates, lump sum payments, and the like) not exceeding $100;

(b) households with combined gross monthly income and liquid resources less than the household's monthly rent, or mortgage, and utilities. The mandatory SUA may be used in making this determination, provided that the household qualifies for the SUA; or

(c) migrant or seasonal farm worker households with $100 or less in liquid resources and determined to be destitute as defined by the special income calculations in 8.139.400.14 NMAC, migrant and seasonal farm workers.

(2) Verification requirements: All households entitled to expedited service must verify identity through readily available documentation or through a collateral contact. All other eligibility factors may be postponed. Reasonable efforts must be made by ISD to verify residence, income, liquid resources, and all other eligibility factors. Benefits will not be delayed because of an inability to verify such factors or any questionable information but for identity.

(3) SSNs and work registration: Applicant households are specifically permitted to receive their first expedited SNAP benefit amount before providing social security numbers (SSN) or applying for them. Such households are required to do so before their next benefit issuance, but will remain eligible for participation as long as good cause exists. Unless exempt, the household's work registration status will be established at the time of certification for expedited service. If an individual's work registration exemption status is in question, benefits will not be delayed solely to verify the exemption.

B. Time limits:

(1) Expedited time limits: All households entitled to expedited service will receive their benefits no later than the seventh calendar day after the date the application is received by ISD.

(2) Out-of-office interview: If a household is entitled to expedited service and waiver of the office interview, the interview will be conducted and the eligibility determination completed within the expedited service time limits, unless the household cannot be reached. The first day of this count is the first calendar day after the application is filed. If a telephone interview is conducted and the application must be mailed to the household for signature, the mailing time involved will not be calculated in the expedited service time limits.

(3) Late identification: If screening fails to identify a household as being entitled to expedited service and it is subsequently determined that the household was so entitled, the household's application will be processed immediately; the time limits in such instances are calculated from the date that it is discovered that the household was entitled to expedited service.

(4) Certification periods: Households entitled to expedited service which provide all necessary verification prior to certification may be assigned a certification period in accordance with 8.139.120.9 NMAC. Households whose verification requirements are outstanding due to an inability to verify via electronic means and the household not providing necessary documentation, will be certified for the month of application, and the following month, or for households whose circumstances warrant, an assigned certification period in accordance with 8.139.120.9 NMAC. When a certification period of more than one month is assigned, the written notification to the household will state that no further benefits will be issued until the verification requirement is completed. The notice also advises that if verification results in changes in eligibility or SNAP benefit amount, ISD will act on these changes without advance notice of adverse action.

(5) Continuation of benefits: Households providing verification by the 30th day after the application date will have their benefits continued. The second month's benefits will be issued within five working days from the date verification is received, or the first day of the second month, whichever is later.

(6) Termination of benefits: Except for migrant farm workers needing out-of-state verification, when the verification requirement is not completed within 30 days of the date of application, the household's participation in the program will be terminated and no further benefits issued.

(7) Denial of expedited service: Households determined ineligible for expedited service will have their applications processed according to normal standards. A household wishing to contest a denial of expedited service will be offered an agency conference to discuss the denial. The conference will be scheduled within two working days of the request for a conference, unless the household requests a later date or states that it no longer wishes to have an agency conference.

C. Number of expedited issuances:

(1) Limits: There is no limit to the number of times a household can be certified under expedited procedures, as long as prior to each expedited certification the household either has completed the verification requirements outstanding from the last expedited certification or has been certified under normal processing standards since the last expedited certification.

(2) At every application: Expedited services will be available at initial application based on the circumstances existing in the month of application. If a participating household applies for recertification before the end of its current certification period, the expedited service provision will not be applied.

[8.139.110.16 NMAC - Rp 8.139.110.16 NMAC 07/01/2024]

HISTORY OF 8.139.110 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 411.0000, General Terms and Conditions, 7/21/1980.
ISD-Rule 411.0000, Food Assistance - Time Limits for Processing Applications, 11/4/1982.
ISD 421.0000, Application Processing, 7/31/1980.
ISD-Rule 410.0000, Food Assistance - Application Processing, 11/4/1982.
ISD-Rule 412.0000, Food Assistance - Filing an Application, 11/4/1982.
ISD-Rule 412.0000, Food Assistance - Filing an Application, 9/8/1983.
ISD 413.0000, Operating Guidelines, 7/21/1980.
ISD-Rule 413.0000, Food Assistance - Handling Applications, 11/4/1982.
ISD-Rule 413.0000, Food Assistance - Handling Applications, 9/8/1983.
ISD-Rule 413.0000, Food Assistance - Handling Applications, 1/12/1984.
ISD-Rule 414.0000, Food Assistance - Interviews, 11/4/1982.
ISD-Rule 414.0000, Food Assistance - Interviews, 9/8/1983.
ISD-Rule 414.0000, Food Assistance - Interviews, 4/24/1984.
ISD-Rule 416.0000, Food Assistance - Handling Applications for FA, GA, and SSI Households, 11/4/1982.
ISD Rule 416.0000, Food Assistance - Handling Applications for AFDC, SSI, and GA Households, 3/2/1987.
ISD-Rule 438.0000, Food Assistance - Actions Due to Delayed Eligibility Determinations, 11/4/1982.
ISD-Rule 452.0000, Food Assistance - SSI Households/Joint Processing, 11/5/1982.
ISD-Rule 452.0000, SSI Households/Joint Processing, 10/13/1983.
ISD-Rule 452.0000, SSI Households/Joint Processing, 4/24/1984.
ISD FS 210, Food Stamp Application Process, 6/2/1989.
ISD-Rule 417.0000, Food Assistance - Expedited Service Provisions, 11/4/1982.
ISD-Rule 417.0000, Food Assistance - Expedited Service Provisions, 2/9/1983.
ISD-Rule 417.0000, Food Assistance - Expedited Service Provisions5/18/1983.

ISD FS 220, Expedited Food Stamp Service, 2/29/1988.

History of Repealed Material: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 120 CASE ADMINISTRATION - CASE MANAGEMENT

8.139.120.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.120.1 NMAC – Rp 8.139.120.1 NMAC, 07/01/2024]

8.139.120.2 SCOPE: General public.
[8.139.120.2 NMAC – Rp 8.139.120.2 NMAC, 07/01/2024]

8.139.120.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.120.3 NMAC – Rp 8.139.120.3 NMAC, 07/01/2024]

8.139.120.4 DURATION: Permanent.
[8.139.120.4 NMAC – Rp 8.139.120.4 NMAC, 07/01/2024]

8.139.120.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.139.120.5 NMAC – Rp 8.139.120.5 NMAC, 07/01/2024]

8.139.120.6 OBJECTIVE: Issuance of the revised supplemental nutrition assistance program (SNAP) policy manual is intended to be used in administration of SNAP in New Mexico. This revision incorporated the latest federal policy changes in SNAP not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the health care authority.
[8.139.120.6 NMAC – Rp 8.139.120.6 NMAC, 07/01/2024]

8.139.120.7 DEFINITIONS: **[RESERVED]**

8.139.120.8 RECERTIFICATION: When a household's certification period expires, its eligibility to participate in SNAP ends. SNAP benefits will not be continued beyond the certification period. Timely applications for recertification will be approved or denied before the end of the current certification period. ISD must establish procedures for notifying households of expiration dates, providing application forms, scheduling interviews, and recertifying eligible households prior to the expiration of certification periods.

A. Notice and time standards: ISD shall provide households certified for one month or certified in the second month of a two-month certification period a notice of expiration (NOE) at the time of certification. ISD shall provide other households the NOE before the first day of the last month of the certification period, but not before the first day of the next-to-the-last month. Jointly processed Public Assistance ("PA") (as defined at 7 C.F.R. 271.2), and General Assistance ("GA") (as defined at 7 C.F.R. 271.2) households need not receive a separate SNAP notice if they are recertified for SNAP at the same time as their PA or GA redetermination. Every household will be provided with a notice of expiration, as follows:

(1) For a household certified for one or two months, the notice of expiration will be provided at the time of certification. The household will have 15 days from the date the notice is received to submit a timely application for recertification. The household will be approved and provided an opportunity to participate, if eligible, or be denied, within 30 days after obtaining its last SNAP benefit amount.

(2) For all other households, a notice of expiration will be sent by HCA prior to the start of the last month of the household's certification period. A household has reapplied timely if the application for recertification is filed by the 15th day of the last month of the household's certification period.

(3) ISD will complete the application process if the household meets all requirements and finishes the necessary processing steps; ISD will approve or deny timely applications before the end of the household's current certification period.

B. Failure to submit timely application:

(1) A household that does not submit an application for recertification by the 15th day of the expiration month loses its right to uninterrupted benefits.

(2) SNAP benefits will be prorated from the date of application if a household's application is received in the month after its certification period has expired or participation has been terminated for any reason.

(3) ISD will ensure that any eligible household that does not submit a timely application for recertification be provided the opportunity to participate, if eligible, within 30 calendar days after the date the application is filed.

C. ISD caused delayed processing: If an eligible household files an application before the end of the certification period but the recertification process cannot be completed within 30 days after the date of application because of ISD fault, ISD must continue to process the case and provide a full month's allotment for the first month of the new certification period, and will send a delay notice in accordance with Subsection D of 8.139.110.13 NMAC. If the household fails to take required action, ISD may deny the case at the time of application, at the end of the certification period, or at the end of 30 days. ISD shall determine cause for any delay in processing a recertification application in accordance with the provisions of 7 C.F.R. 273.2(h)(1).

D. Scheduling interviews: ISD shall schedule interviews so that the household has at least 10 days after the interview in which to provide verification before the certification period expires. A household will not be required to appear for an interview, or to file an application for recertification, in the month before the last month of its current certification period. An interview may be scheduled in the month before the last month of certification, or prior to the date the application is timely filed, provided the household is not denied for failing or refusing to appear for the interview. If an interview was scheduled, or if household member or authorized representative failed to attend an interview which was scheduled prior to the date a household files a timely application, ISD will schedule an interview on or after the date an application is timely filed.

E. Failure to appear: If a household member or authorized representative fails to appear for a recertification interview scheduled on or after a timely application is filed, the household loses the right to uninterrupted participation. ISD shall send the household a notice of missed interview that may be combined with the notice of denial. If a household misses its scheduled interview and requests another interview, the ISD shall schedule a second interview. The household is responsible for rescheduling a missed interview.

F. Prospective eligibility determination: A household's eligibility and SNAP benefit amount at recertification will be determined prospectively based on circumstances anticipated for the certification period, beginning with the month following the expiration of the current certification period.

G. Eligibility and benefits: Eligibility will be determined at recertification according to the standards described below.

(1) Timely reapplication: Applications filed before the 15th of the expiration month will be considered timely. A household member or authorized representative that attends an interview and provides all necessary verification by the end of the household's current certification period, will have the opportunity to participate by the household's normal issuance cycle in the month following the end of the current certification period, if all eligibility factors have been met.

(2) Reapplication after the 15th: If an application for recertification is submitted after the 15th but before the end of a household's certification period and the household is determined eligible for the first month following the end of the certification period, that month is not considered an initial month and benefits are not prorated.

(3) First month ineligibility: If an application for recertification is submitted before the end of a household's certification period, but the household is determined ineligible for the first month following the end of the certification period, the first month of any subsequent certification period will be considered an initial month and SNAP benefits will be prorated.

(4) Late applications:

(a) Recertification verification standards, in accordance with Paragraph (2) of Subsection C of 8.139.110.12 NMAC, will be used when an application is received within 30 days after the certification period expires. Initial month verification standards, in accordance with Paragraph (1) of Subsection C of 8.139.110.12 NMAC, will be used if the application is received more than one calendar month after the certification period expires or the case has been closed for any reason.

(b) Initial month certification provisions and proration of benefits for migrant and seasonal farmworker households will apply when more than 30 days have passed since the household was certified for participation. (See 8.139.400.14 NMAC for more information on migrant and seasonal farmworker households).

(5) Pending verification: A household member or authorized representative that has reapplied timely, attended an interview, and is required to provide verification, will be given 10 days to provide the verification, or until the certification period expires, whichever is longer. If the certification period expires before the 10-day deadline for submitting the required verification, the household will have the opportunity to participate, if eligible, within five working days after verification is submitted. The household is entitled to a full month's benefits.

[8.139.120.8 NMAC – Rp 8.139.120.8 NMAC, 07/01/2024]

8.139.120.9 SIMPLIFIED REPORTING: All households will be assigned to simplified reporting (SR). Households must submit an interim report once every six or twelve months, depending on their certification period. Households assigned to a 12-month certification period have an interim report form due at six months. Households assigned to a 24-month certification period have an interim report form due at 12 months.

A. Household Certification Periods: A household that is approved for SNAP benefits shall be assigned the longest certification period possible in accordance with the household's circumstances. Households wherein all adult members are elderly or disabled, with no earned income, will be assigned a 24-month certification period. All other households will be assigned a 12-month certification period.

B. Household responsibility to turn in interim report form:

(1) A household assigned to a 12-month certification period shall be required to file an interim report form no later than the tenth day of the sixth month of the certification period in order to receive uninterrupted benefits.

(2) A household assigned to a 24-month certification period shall be required to file an interim report form no later than the tenth day of the twelfth month of the certification period in order to receive uninterrupted benefits.

C. Information that ISD is responsible to provide to households regarding simplified reporting: At the initial certification and at recertification, ISD shall provide the household with the following:

(1) a written and oral explanation of how simplified reporting works;

(2) a written and oral explanation of the reporting requirements including:

(a) what needs to be reported and verified;

(b) when the interim report form is due;

(c) how to obtain assistance; and

(d) the consequences of failing to file an interim report form.

(3) special assistance in completing and filing interim reports to households whose adult members are all either mentally or physically handicapped or are non-English speaking or otherwise lacking in reading and writing skills such that they cannot complete and file the required report; and

(4) a toll-free number which the household may call to ask questions or to obtain help in completing the interim report.

D. Information requirements for the interim report form: The interim report form will be written in clear, simple language, include information on the availability of a bilingual version of the document described in 7 CFR 272.4(b), and shall specify:

(1) the deadline date to submit the form to ISD to ensure uninterrupted benefits if the household is determined eligible;

(2) the consequences of submitting a late or incomplete form including whether ISD shall delay benefits if the form is not received by the due date;

(3) verification the household must submit with the form;

(4) a statement to be signed by a member of the household indicating his or her understanding that the information provided may result in a reduction or termination of benefits;

(5) where to call for help in completing the form;

(6) a statement explaining that ISD will not change certain deductions until the household's next recertification and identify those deductions if ISD has chosen to disregard reported changes that affect certain deductions in accordance with paragraph (c) of section 7 CFR 273.12;

(7) a brief explanation of fraud penalties; and

(8) how the agency may use social security numbers.

E. The following information, along with required verification, must be returned to ISD with the interim report form:

(1) a change of more than one hundred twenty-five dollars ($125) in the amount of unearned income, except changes relating to public assistance (PA) or general assistance (GA) programs when jointly

processed with SNAP cases;

(2) a change in the source of income, including starting or stopping a job or changing jobs, if the change in employment is accompanied by a change in income;

(3) changes in either:

(a) the wage rate or salary or a change in full-time or part-time employment status as defined in Subsection C of 8.102.461.11 NMAC, provided the household is certified for no more than six months; or

(b) a change in the amount earned of more than one hundred twenty-five dollars ($125) a month from the amount last used to calculate the household's allotment, provided the household is certified for no more than six months.

(4) all changes in household composition, such as the addition or loss of a household member;

(5) changes in residence and the resulting shelter costs;

(6) the acquisition of a licensed vehicle, unless the household is categorically eligible as defined at Sections 8 and 9 of 8.139.420 NMAC or the vehicle is not fully excludable under 8.139.527 NMAC;

(7) when cash on hand, stocks, bonds and money in a bank account or savings institution reach or exceed the resource limit set at 8.139.510.8 NMAC, unless the household is categorically eligible as defined at Sections 8 and 9 of 8.139.420 NMAC;

(8) changes in the legal obligation to pay child support;

(9) for able-bodied adults subject to the time limit of 7 CFR 273.24, any changes in work hours that bring an individual below 20 hours per week, averaged monthly, as defined in 7 CFR 273.24(a)(1)(i); and

(10) In accordance with 7 CFR 273.12(a)(2), SNAP households must report substantial lottery and gambling winnings;

(a) if the substantial lottery and gambling winning is won by multiple beneficiaries and is over the elderly and disabled resource standard, each SNAP member's share must be reported;

(b) if the winning is less than the elderly and disabled resource standard it does not need to be reported;

F. ISD's responsibility with interim report forms:

(1) Interim report form is not received: If a household fails to file a report by the specific filing date, defined in Subsection B of 8.139.120.9 NMAC, ISD will send a notice to the household advising of the missing report no later than 10 calendar days from the date the report should have been submitted. If the household does not respond to the notice, the household's participation shall be terminated.

(2) Incomplete interim report form is received:

(a) An interim report form that is not signed shall be returned to the household for a signature. The household:

(i) shall be notified that the form is incomplete;

(ii) what needs to be completed to complete the interim report form; and

(iii) shall be given 10 calendar days to provide the signed interim report form to be reviewed for completeness.

(b) An interim report form that is incomplete because required verification is not provided shall not be returned to the household. The household:

(i) shall be notified that the form is incomplete;

(ii) what information must be provided to complete the interim report form; and

(iii) shall be given 10 calendar days to provide the verification to process the interim report form.

(3) Complete interim report form is received:

(a) A form that is complete and all verifications are provided, shall be processed within 10 calendar days of receipt.

(b) A form that is complete, and all verifications are provided except for verification of an allowable deduction, shall be processed, unless the verification is otherwise questionable, in accordance with 8.100.130.12 NMAC. The household:

(i) shall be notified that verification is questionable; and

(ii) shall be given 10 calendar days to provide the verification to process the allowable deduction.

(c) A deduction that is verified within the month the interim report form is due shall

be processed as part of the interim report form.

(d) A deduction that is verified in the month after the interim report form is due shall be processed as a change reported by the household.

(e) If the household files a timely and complete report resulting in reduction or termination of benefits, ISD shall send a notice of case action. The notice must be issued so that the household will receive it no later than the time that its benefits are normally received. If the household fails to provide sufficient information or verification regarding a deductible expense, ISD will not terminate the household, but will instead determine the household's benefits excluding the deduction from the benefit calculation.

G. Changes that must be reported at any time during certification period: Households must report changes no later than 10 days from the end of the calendar month in which the change occurred, provided that the household has at least 10 calendar days within which to report the change. If there are not 10 days remaining in the month, the household must report within 10 days from the date the work hours fall below 20 hours per week, averaged monthly or when income exceeding the gross federal poverty limit as mentioned below is first received. The interim report form is the sole reporting requirement for any information that is required to be reported on the form, except that a household must report at any time during the certification period:

(1) the household must report when its monthly gross income exceeds one hundred thirty percent of poverty level. A categorically eligible household defined in accordance with 8.139.420.8 NMAC, must report when its monthly gross income exceeds one hundred sixty-five percent of poverty level. The household shall use the monthly gross income limit for the household size that existed at the time of certification or recertification regardless of any subsequent changes to its household size; and

(2) able-bodied adults subject to the time limit in accordance with 7 CFR 273.24 shall report whenever their work hours fall below 20 hours per week, averaged monthly.

(3) in accordance with 7 CFR 273.12(a)(2), SNAP households must report substantial lottery and gambling winnings within 10 days of the end of the month in which the household received the winnings.

(a) if the substantial lottery and gambling winning is won by multiple beneficiaries and is over the elderly and disabled resource standard, each SNAP member’s share must be reported.

(b) if the winning is less than the elderly and disabled resource standard it does not need to be reported.

H. Action on changes reported outside of the interim report form: In addition to changes that must be reported in accordance with Subsection G of 8.139.120.9 NMAC, ISD must act on changes in between interim report forms, if it would increase the household’s benefits. ISD shall not act on changes that would result in a decrease in the household’s benefits unless:

(1) The household has voluntarily requested that its case be closed.

(2) ISD has information about the household’s circumstances considered verified upon receipt. Verified upon receipt is defined:

(a) information is not questionable; and

(b) the provider of the information is the primary source of information; or

(c) the recipient’s attestation exactly matches the information received from a third party.

(3) A household member has been identified as a fleeing felon or probation violator in accordance with 7 CFR 273.11(n);

(4) There has been a change in the household’s cash grant, or where cash and SNAP cases are jointly processed in accordance with 7 CFR 273.2(j)(2).

I. Responsibilities on reported changes outside of the interim report form: When a household reports a change, ISD shall take action to determine the household's eligibility or SNAP benefit amount within 10 working days of the date the change is reported.

(1) During the certification period, action shall not be taken on changes to medical expenses of households eligible for the medical expense deduction which ISD learns of from a source other than the household and which, in order to take action, requires ISD to contact the household for verification. ISD shall act only on those changes in medical expenses that it learns about from a source other than the household, if those changes are verified upon receipt and do not necessitate contact with the household.

(2) Decreased or termination of benefits: For reported and verified changes that result in a decrease or termination of household benefits, ISD shall act on the change as follows:

(a) Issue a notice of adverse action within 10 calendar days of the date the change was reported and verified unless one of the exemptions to the notice of adverse action in 7 CFR 273.13 (a)(3) or (b) applies.

(b) When a notice of adverse action is used, the decrease in the benefit level shall be made effective no later than the allotment for the month following the month in which the notice of adverse action period has expired, provided a fair hearing and continuation of benefits have not been requested.

(c) When a notice of adverse action is not used due to one of the exemptions in 7 CFR 273.13 (a)(3) or (b), the decrease shall be made effective no later than the month following the change. Verification which is required by 7 CFR 273.2(f) must be obtained prior to recertification.

(3) Increased benefits: For reported and verified changes that result in an increase of household benefits, ISD shall act on the change as follows:

(a) For changes which result in an increase in a household's benefits, other than changes described in paragraph (b) of this section, ISD shall make the change effective no later than the first allotment issued 10 calendar days after the date the change was reported to ISD.

(b) For changes which result in an increase in a household's benefits due to the addition of a new household member who is not a member of another certified household, or due to a decrease of fifty dollars ($50) or more in the household's gross monthly income, ISD shall make the change effective not later than the first allotment issued 10 calendar days after the date the change was reported.

(i) In no event shall these changes take effect any later than the month following the month in which the change is reported.

(ii) If the change is reported after the last day to make changes and it is too late for ISD to adjust the following month's allotment, ISD shall issue a supplement or otherwise provide an opportunity for the household to obtain the increase in benefits by the tenth day of the following month, or the household's normal issuance cycle in that month, whichever is later.

(4) No change in SNAP benefit amount: When a reported change has no effect on the SNAP benefit amount, ISD shall document the change in the case file and notify the household of the receipt of the report.

(5) Providing verification: The household shall be allowed 10 calendar days from the date a change is reported to provide verification, if necessary. If verification is provided at the time a change is reported or by the deadline date, the increase in benefits shall be effective in accordance with (a) and (b) above. If the household fails to provide the verification by the deadline date, but does provide it at a later date, the increase shall be effective in the month following the month the verification is provided. If the household fails to provide necessary verification, its' SNAP benefit amount shall revert to the original benefit amount.

J. Resolving unclear information:

(1) During the certification period, ISD may obtain information about changes in a household's circumstances from which ISD cannot readily determine the effect of the change on the household's benefit amount. The information may be received from a third party or from the household itself. ISD must pursue clarification and verification of household circumstances using the following procedure if unclear information received outside the periodic report is:

(a) information fewer than 60 days old relative to the current month of participation; and,

(b) if accurate, would have been required to be reported under simplified reporting rules, in accordance with 8.139.120.9 NMAC.

(c) ISD must pursue clarification and verification of household circumstances in accordance with the process outlined in Subsection B of 8.100.130.12 NMAC, for any unclear information that appears to present significantly conflicting information from that used by ISD, at the time of certification.

(2) Unclear information resulting from certain data matches:

(a) if the authority receives match information from a trusted data source as described in 7 CFR 272.13 or 7 CFR 272.14, ISD shall send a notice in accordance with Subsection B of 8.100.130.12 NMAC in accordance with 7 CFR 272.13(b)(4) and 7 CFR 272.14 (c)(4). The notices must clearly explain what information is needed from the household and the consequences of failing to respond to the notice.

(b) if the household fails to respond to the notice or does respond but refuses to provide sufficient information to clarify its circumstances, ISD shall remove the individual and the individual's income from the household and adjust benefits accordingly. As appropriate, ISD shall issue a notice of adverse action.

K. Failure to report changes: If ISD discovers that the household failed to report a change as required, ISD shall evaluate the change to determine whether the household received benefits to which it was not entitled or if the household is entitled to an increased benefit amount.

(1) Decreased benefit amount: After verifying the change, ISD shall initiate a claim

against the household for any month in which the household was over issued SNAP benefits. The first month of the over issuance is the month following the month the adverse action notice time limit would have expired had the household timely reported the change. If the discovery is made within the certification period, the household is entitled to a notice of adverse action if its benefits will be reduced. No claim shall be established because of a change in circumstances that a household is not required to report in accordance with Subsection G of 8.139.120.9 NMAC above.

(2) Increased benefit amount: When a household fails to make a timely report of a change which will result in an increased SNAP benefit amount, the household is not entitled to a supplement for any month prior to and including the month in which the change was reported. The household is entitled to an increased benefit amount effective no later than the first benefit amount issued 10 calendar days after the date the change was reported.

[8.139.120.9 NMAC – Rp 8.139.120.9 NMAC, 07/01/2024]

8.139.120.10 [RESERVED]

[8.139.120.10 NMAC – Rp 8.139.120.10 NMAC, 07/01/2024]

8.139.120.11 [RESERVED]

[8.139.120.11 NMAC – Rp 8.139.120.11 NMAC, 07/01/2024]

8.139.120.12 [RESERVED]

[8.139.120.12 NMAC – Rp 8.139.120.12 NMAC, 07/01/2024]

8.139.120.13 REQUIREMENTS FOR MASS CHANGES:

A. Mass changes: Certain changes initiated by the state or federal government may affect the entire caseload or significant portions of it.

(1) Mass changes include, but are not limited to, increases in excluded or deducted items or amounts.

(2) Mass changes affecting income include annual adjustments to social security, SSI, and other federal benefit programs, and any other changes in eligibility criteria based on legislative or regulatory actions.

(3) Information concerning mass change notice and hearing requirements are set forth in 8.100.180.15 NMAC.

(4) Notice of mass changes: Adverse action notices are not required for mass changes resulting from federal adjustments to eligibility standards, the maximum SNAP allotment, standard deduction, shelter deduction, and state adjustments to the mandatory utility standard. Announcement of anticipated mass changes may be made through the media, posters in ISD offices, and other likely places frequented by households, or through a general notice mailed to a participating household. When HCA makes a mass change in food stamp eligibility or benefit amount affecting the entire caseload or a part of it, affected households shall be mailed a notice of any change, reduction or termination of benefits. HCA shall issue a notice to affected households as far in advance of the household's next scheduled issuance date as is reasonably possible, but by no later than the date the affected benefit is issued.

B. Federal changes: Authorized adjustments which may affect SNAP benefit amount for participating households include the maximum SNAP allotment, standard deduction, excess shelter and dependent care deductions, and income eligibility standards. These changes go into effect for all households annually on October 1. Adjustments to federal standards are made prospectively.

C. Cost of living adjustments: Cost of living increases and any other mass changes in federal benefits, such as social security and SSI benefits, shall be treated as mass changes for SNAP purposes. ISD is responsible for automatically adjusting a household's SNAP benefit amount to reflect such a change. Households shall not be responsible for reporting these changes.

D. Mass changes in public assistance: When overall adjustments to cash assistance payments are made, corresponding adjustments in SNAP benefits shall be handled as a mass change. Households shall be given advance notice of any adjustment in the SNAP benefit amount. If a household requests a fair hearing, benefits shall continue at the former amount only if the issue being appealed is that eligibility or SNAP benefit amount was determined incorrectly.

E. Utility standard: Authorized adjustments shall be effective for all October SNAP issuances. Households whose certification periods overlap annual adjustments in the state’s mandatory utility allowance shall be informed at the time of certification that the adjustment shall be effective in October 1; the household shall be

informed of the adjusted benefit amount, if known at the time of certification. Adjustments in the state's mandatory utility allowance are made prospectively.
[8.139.120.13 NMAC – Rp 8.139.120.13 NMAC, 07/01/2024]

8.139.120.14 OTHER CHANGES AFFECTING SNAP HOUSEHOLDS:

A. Failure to report changes:

(1) If ISD discovers that the household failed to report a change as required, ISD shall evaluate the change to determine whether the household received benefits to which it was not entitled.

(2) After verifying the change, ISD shall initiate a claim against the household for any month in which the household was over issued SNAP benefits. The first month of the over issuance is the month following the month the adverse action notice time limit would have expired had the household timely reported the change.

(3) If the discovery is made within the certification period, the household is entitled to a notice of adverse action if its benefits will be reduced.

(4) No claim shall be established because of a change in circumstances that a household is not required to report.

B. Noncompliance with program requirements or fraud:

(1) Intentional failure to comply or fraud: No household shall receive an increase in SNAP benefits when benefits from another program have been decreased (reduced, suspended or terminated) for intentional failure to comply with the other program eligibility requirements or for an act of fraud. This provision applies in cases where the other program is a means-tested, federal, state or local welfare or public assistance program, which is governed by welfare or public assistance laws or regulations and which distributes public funds.

(2) Failure to comply shall be determined as provided in Paragraph (3) of Subsection I of 8.139.520.9 NMAC.

(3) Verification of recoupment: Agencies administering means-tested, publicly funded assistance programs provide recipients with written advance notice of proposed changes in benefit amounts. Such notices provide information which shall determine if the reduction in cash assistance is because of a properly reported change in circumstances. In most cases, the notice shall document whether the reduction is because of a recoupment of overpaid benefits resulting from intentional failure to report changes. If the notice is not detailed enough to make a determination, the agency which initiated recoupment shall be contacted to obtain the necessary information. SNAP benefits shall not be delayed beyond normal processing standards pending the outcome of this determination.

(4) Calculating benefits: When a recipient's assistance benefits are decreased to recoup an overpayment, that portion of the decrease that is the recoupment shall first be identified. The recoupment is the amount of decrease attributed to the repayment of benefits over issued. If a Title IV-A recipient intentionally underreports income, the Title IV-A grant is first reduced to reflect the corrected income, then reduced further by the recoupment amount. In such a case, the SNAP calculation would reflect the Title IV-A amount reduced because of income, but not the second reduction caused by recoupment.
[8.139.120.14 NMAC – Rp 8.139.120.14 NMAC, 07/01/2024]

8.139.120.15 CHANGE NOTICES:

A. Agency responsibilities:

(1) ISD shall take action on any change reported by a household, and on any change which becomes known through other sources.

(2) The household shall be issued a change notice.

(a) If there is a reduction or termination of benefits, the household shall be issued an adverse action notice, unless the change has been reported by the household in writing.

(b) If the household reports the change in writing, advance notice of the change in benefit amount is required before the household's next issuance.

(c) If there is no change in the benefit amount, the household shall be notified that the change resulted in no change in benefit amount.

(3) If a household receiving cash assistance reports a change, it shall be considered to have also reported the change for SNAP purposes. A notice shall be sent to the household acknowledging the reported change, even if there is no change in benefits. A notice of adverse action shall be sent if there is a reduction or termination in the SNAP benefit amount and the change was not reported in writing.

B. Notice of adverse action:

(1) Prior to any action to reduce or terminate a household's SNAP benefits within the certification period, the household shall be provided with a timely and adequate advance notice before the adverse action is taken, unless the change was reported by the household in writing. A written change report submitted by the household is subject to the adequate notice requirements in subsection C of 8.139.120.15 NMAC.

(2) At a minimum, the adverse action notice shall include the following information:

(a) proposed action and reason for the action;

(b) month in which the change takes effect;

(c) adjusted benefit amount;

(d) household's right to request a fair hearing, circumstances under which the household can continue benefits at the greater amount, and deadline dates for requesting a hearing;

(e) household's liability for any benefits over issued if the decision of the fair hearing is that the authority took the correct action;

(f) general information on whom to contact for additional information, including the right to representation by legal services.

(3) Individual notices of adverse action shall not be provided when:

(a) there is a mass change;

(b) ISD determines on the basis of reliable information that the household has moved from the project area;

(c) ISD determines on the basis of reliable information that all members of a household have died;

(d) the household has received an increased benefit amount to restore lost benefits, the restoration is complete, and the household has been notified in writing of the date the increased benefit amount would terminate;

(e) the household's benefit amount varies from month to month within the certification period to take into account changes anticipated at the time of certification, and the household was notified of such variations at the time of certification;

(f) the household applied for cash assistance and SNAP benefits at the same time, has been receiving SNAP benefits pending approval of cash assistance, and the household was notified at the time of certification that SNAP benefits would be reduced upon approval of the cash assistance grant;

(g) a household member is disqualified for intentional program violation, or the benefits of the remaining household members are reduced or terminated to reflect the disqualification of the household member.

(h) the household was certified on an expedited basis, is assigned a certification period longer than one month, and verification has been postponed; the household must have received written notice that receipt of benefits beyond the month of application is contingent on the household providing the postponed verification;

(i) the eligibility of a resident of a drug or alcoholic treatment center or a group living arrangement is terminated because the treatment center or group living arrangement loses either its certification or its status as authorized representative;

(j) the household voluntarily requests, in writing or in the presence of ISD, that its participation be terminated.

C. Adequate notice: If a change was reported in writing that will result in a reduction or termination in SNAP benefits, the household shall be provided with adequate advance written notice confirming the change. Adequate notice does not preclude the household's right to request a fair hearing. The household shall be notified that its benefits are being reduced or terminated no later than the date the household will receive, or would have received, its SNAP benefits. Adequate notice shall be provided when changes reported in writing meet the following conditions:

(1) the household reports the information which results in the reduction or termination;

(2) the reported information is in writing and signed by a member of the household;

(3) ISD can determine the household's reduced benefit amount or ineligibility based solely on the information provided by the household in the written report;

(4) the household retains its right to a fair hearing;

(5) the household retains its right to continued benefits if the fair hearing is requested within the advance notice time limit;

(6) ISD continues the household's previous benefit amount if required, within five working days of the household's request for a fair hearing.

[8.139.120.15 NMAC – Rp 8.139.120.15 NMAC, 07/01/2024]

8.139.120.16 TRANSFER OF HOUSEHOLDS: When a household transfers from one project area to another, the household's case record and computer file shall be transferred accordingly. Procedures for handling households which transfer between project areas within the state and between offices within a single project area are described below.

A. Transfer of inactive cases: Inactive cases are those that have been certified and are subsequently closed. ISD in the new project area is responsible for requesting that the case record be transferred. The former project area is responsible for transferring case records and making sure they are complete.

B. Transfer of active cases: Active cases are those presently certified.

(1) Timely reporting: Transfers within the state shall be considered like any other reported change in circumstances. The household must timely report a move and verify its new address and shelter expenses, as well as any change in household composition and income, before benefits may continue or be issued (see Subsection A of 8.139.120.12 NMAC). The former project area shall update the household's address on its computer file and transfer the case in active status to the new project area. The new project area shall verify the household's new circumstances, including but not limited to, address, shelter expenses, income, and household composition (see Paragraph 1 of Subsection B of 8.139.120.12 NMAC).

(2) Not reported: If a project area becomes aware that a household has moved but has not been informed of a new in-state address, either by the household or its designee or by another project area, participation shall be terminated immediately based on unverified residence. If the household wishes to continue participation, it must file a new application.

C. Procedures for nonreceipt of benefits: If a household which has moved to a different project area has not received its current month's SNAP benefits, action required by ISD shall depend on circumstances described below:

(1) If the SNAP benefits are returned to the central mail issuance unit, reissuance is authorized by the new project area to the household's address in the new project area.

(2) If the SNAP benefits are not returned to the central mail issuance unit, an affidavit shall be submitted by the new project area, as described in Subsection G of 8.139.610.14 NMAC, replacement of benefits lost in the mail, even though the original issuance was from the former project area. The new project area shall make sure that the household's residence and mailing address are changed prior to submitting the affidavit.

[8.139.120.16 NMAC – Rp 8.139.120.16 NMAC, 07/01/2024]

8.139.120.17 COOPERATION WITH LAW ENFORCEMENT AGENCIES:

A. Notwithstanding any other provision of law, upon written request, HCA shall make available to any federal, state, or local law enforcement officer the address, social security number, and photograph (if available) of any household member, if the officer furnishes HCA with the name of the individual and notifies HCA that:

(1) the individual is fleeing to avoid prosecution, or custody or confinement after conviction for a crime, or attempt to commit a crime, that under the law of the place the member is fleeing is a felony, or in New Jersey is a high misdemeanor; or

(2) the individual is violating a condition of probation or parole imposed under federal or state law.

B. Information shall be provided if it is needed for the officer to conduct an official duty related to Paragraphs (1) or (2) of Subsection A of 8.139.120.17 NMAC above; locating or apprehending the individual as an official duty; and the request is being made in the proper exercise of an official duty.

C. Providing information to law enforcement shall not interfere with the authority's responsibility to immediately report to the immigration and naturalization service (INS) the ineligibility of any individual who is present in the United States in violation of the Immigration and Nationality Act.

[8.139.120.17 NMAC – Rp 8.139.120.17 NMAC, 07/01/2024]

HISTORY OF 8.139.120 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD-Rule 439.0000, Monthly Reporting/Retrospective Budgeting (MRRB), 10/13/1983.
ISD-Rule 439.0000, Monthly Reporting/Retrospective Budgeting (MRRB), 4/24/1984.
ISD-Rule 439.0000, Monthly Reporting/Retrospective Budgeting (MRRB), 8/3/1984.
ISD-Rule 441.0000, Food Assistance - Actions Subsequent to Determine Eligibility, 11/5/1982.

ISD-Rule 440.0000, Actions Subsequent to Determine Eligibility, 2/9/1983.
ISD-Rule 440.0000, Actions Subsequent to Determine Eligibility, 9/8/1983.
ISD-Rule 440.0000, Actions Subsequent to Determine Eligibility, 10/13/1983.
ISD-Rule 440.0000, Actions Subsequent to Determine Eligibility, 4/24/1984.
ISD-Rule 442.0000, Food Assistance - Transfer of Households, 11/14/1982.
ISD-Rule 442.0000, Food Assistance - Transfer of Households, 9/8/1983.
ISD 424.0000, Recertification, 7/28/1980.
ISD-443.0000, Food Assistance - Recertification, 11/4/1982.
ISD-443.0000, Food Assistance - Recertification, 9/8/1983.
ISD-443.0000, Food Assistance - Recertification, 10/13/1983.
ISD-443.0000, Food Assistance - Recertification, 1/12/1984.
ISD FS 510, Food Stamp Reporting and Recertification, 3/2/1988.
ISD FS 510, Food Stamp Reporting and Recertification, 4/30/1992.

History of Repealed Material: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 400 RECIPIENT POLICY - WHO CAN BE A RECIPIENT

8.139.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.400.1 NMAC – Rp 8.139.400.1 NMAC, 07/01/2024]

8.139.400.2 SCOPE: General public
[8.139.400.2 NMAC – Rp 8.139.400.2 NMAC, 07/01/2024]

8.139.400.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.400.3 NMAC – Rp 8.139.400.3 NMAC, 07/01/2024]

8.139.400.4 DURATION: Permanent
[8.139.400.4 NMAC – Rp 8.139.400.4 NMAC, 07/01/2024]

8.139.400.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.139.400.5 NMAC – Rp 8.139.400.5 NMAC, 07/01/2024]

8.139.400.6 OBJECTIVE: Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the health care authority.
[8.139.400.6 NMAC – Rp 8.139.400.6 NMAC, 07/01/2024]

8.139.400.7 DEFINITIONS: [**RESERVED**]

8.139.400.8 BASIS FOR DEFINING GROUP (HOUSEHOLD COMPOSITION):

A. Households: The basic assistance unit of the food stamp program is the household. A household is composed of an individual or a group of individuals who customarily purchase and prepare meals together for home consumption. There can be more than one household living in one place.

B. Verification of information

(1) Identity: It is mandatory that the applicant's identity be verified. Identity may be established through readily available documentary evidence, or, if this is not possible, through a collateral contact or home visit. Acceptable documentary evidence includes, but is not limited to, driver's license; work or school ID; school records; ID for health benefits or for another assistance or social services program; voter registration card; wage stubs or marriage certificate. Any document that reasonably establishes the applicant's identity must be accepted. No requirement for a specific type of document, such as a birth certificate, may be imposed.

(2) Household composition: Information regarding household composition must be verified before certification, recertification, or when a change is reported. If household size and/or composition becomes questionable, the income support specialist (ISS) must request verification. Findings must be documented in the case file.

C. Household composition: A food stamp household may be composed of any of the following:

(1) an individual living alone;

(2) an individual living with others who customarily purchases food and prepares meals for home consumption separate and apart from the others;

(3) a group of individuals who live together and who customarily purchase food and prepare meals together for home consumption;

(4) an individual 60 years of age or older (and the spouse of such individual) who lives with

others and cannot purchase and prepare food because he/she suffers from a disability considered permanent under the Social Security Act or suffers from a nondisease-related, severe, permanent disability; the income of the others with whom such an individual resides (excluding the income of the individual and spouse) cannot exceed one hundred sixty-five percent of the poverty line (Subsection E of 8.139.500.8 NMAC);

(5) separate status may be granted on a case-by-case basis to other individuals or groups of individuals who have customarily purchased and prepared food apart from the individual(s) with whom they are now living.

[8.139.400.8 NMAC – Rp 8.139.400.8 NMAC, 07/01/2024]

8.139.400.9 MANDATORY MEMBERS:

A. Separate household status: For purposes of participation in the food stamp program, there can be more than one household living in a single dwelling. To be considered separate, an individual or group of individuals must purchase food and prepare meals separately from the other individual(s) living in the dwelling. It is not necessary to store food separately or use a different stove or refrigerator. Individuals who wish to be certified separately from those with whom they live are responsible for verifying their separate status.

B. Spouses and able-bodied parents under age 60 who are away from home all or most of the time with traveling jobs, such as truckers or salespersons, will be considered members of the household, provided they have not established residence away from home.

C. Spouses and parents who are employed away from home, such as construction workers, do not lose or relinquish residence with the household even though a majority of their meals are eaten away from home, provided that they will be in the home at least part of every month. Dual participation will not be permitted.

D. Elderly/disabled: Individuals who are elderly and disabled, and unable to prepare their own meals, but who wish to be considered separate from the others with whom they live, are responsible for obtaining the cooperation of the others in providing necessary income information, and for providing the ISS verification that such individuals meet the Social Security Administration's permanent disability standards. Any household member claiming a permanent disability under the definition of elderly/disabled, who has a disability that is questionable or not apparent to the ISS must provide a statement from a physician, or licensed or certified psychologist, to help the ISS make a disability determination.

E. Ineligible for separate status: The following individuals living with others or groups of individuals living together will be considered as customarily purchasing food and preparing meals together even if they do not do so:

(1) Spouse: Spouses who live together, as defined in Section 8.139.650 NMAC, definitions.

(2) Children: Children (excluding foster children) under 18 years of age who live with and are under the parental control of a household member other than their parent. Children are considered to be under parental control if the children are financially or otherwise dependent on a member of the household.

(3) Parents and children living together: Parents living with their natural, adopted, or stepchildren 21 years of age or younger, or such children living with such parents.

[8.139.400.9 NMAC – Rp 8.139.400.9 NMAC, 07/01/2024]

8.139.400.10 NONHOUSEHOLD MEMBERS - INDIVIDUALS RESIDING WITH THE HOUSEHOLD: Individuals, described below, residing with a household will not be considered members for the purpose of determining household size, eligibility, or food stamp benefit amount:

A. Roomers: Individuals to whom a household furnishes lodging, but not meals, for compensation.

B. Boarders: Individuals who are furnished lodging and meals for compensation (see Paragraph 1 of Subsection C of 8.139.400.11 NMAC).

C. Live-in attendants: Individuals who live with a household to provide medical care, housekeeping, child care, or similar personal services.

D. Foster care children: Children in foster care will be included as household members only if the household chooses to include them. Income received for care of foster children is counted only if the household chooses to include the foster child.

E. Extended absence: Household members who do not return home at least part of the month, for example, children who attend school away from home and return only for vacation, and spouses who have established residence elsewhere, such as military personnel assigned overseas, are nonmembers.

F. Others: Unrelated individuals who share living quarters with the household and customarily purchase food or prepare meals separately from the household are not household members.

[8.139.400.10 NMAC – Rp 8.139.400.10 NMAC, 07/01/2024]

8.139.400.11 SPECIAL MEMBERS:

A. Students:

(1) Eligibility: An individual who is enrolled at least half-time in an institution of higher education will be ineligible to participate in SNAP unless the individual qualifies for one of the exemptions contained in Paragraph (3) of Subsection A of 8.139.400.11 NMAC. Half-time enrollment status is determined by the definition of the institution in which the individual is enrolled or attending.

(2) Enrollment:

(a) Students enrolled in an institution of higher education less than half time are not considered students for purposes of SNAP eligibility, and do not have to meet an exemption at Paragraph (3) of Subsection A of 8.139.400.11 NMAC to be eligible for SNAP.

(b) Students who are enrolled at least half-time in an institution of higher education in a program that normally requires a high school diploma or equivalency certificate for enrollment in a "regular curriculum," are students and have to meet an exemption at Paragraph (3) of Subsection A of 8.139.400.11 NMAC to be eligible for SNAP. The following programs are not in the "regular curriculum," and if enrolled in one of these programs, the student would not be considered a student for purposes of SNAP eligibility:

(i) Career or technical certificate programs. Career and technical certificate programs are programs which offer a sequence of courses that provide individuals with coherent and rigorous content aligned with challenging academic standards and relevant technical knowledge and skills needed to prepare for further education and careers in current or emerging professions; provide technical skill proficiency, an industry- recognized credential, a certificate, or an associate degree; and may include prerequisite courses that meet the requirements of this subparagraph; and include competency-based applied learning that contributes to the academic knowledge, higher-order reasoning and problem-solving skills, work attitudes, general employability skills, technical skills, and occupation- specific skills, and knowledge of all aspects of an industry, including entrepreneurship, of an individual.

(ii) English as a second language;

(iii) adult basic education;

(iv) literacy; or

(v) community education courses

(c) Students who are enrolled at least half-time in a "regular curriculum," at a college or university that offers degree programs regardless of whether a high school diploma is required are considered students for purposes of SNAP eligibility, and have to meet an exemption found at Paragraph (3) of Subsection A of 8.139.400.11 NMAC to be eligible for SNAP.

(d) The enrollment status of a student shall begin on the first day of the school term. Such enrollment shall be deemed to continue through normal periods of class attendance, vacation and semester breaks. Enrollment status shall terminate when the student graduates, is expelled, does not re-enroll or is suspended for a period in excess of 30 calendar days

(e) Students who reside on campus as defined at 34 CFR 668.46(a) and who have opted to or are required to purchase a meal plan which provides fifty percent or more of their meals are ineligible for SNAP in accordance with 7 CFR 273.1(b)(7)(vi).

(3) Student exemptions: To be eligible, a student must meet at least one of the following exemptions:

(a) Age: Be age 17 or younger or age 50 or older.

(b) Physical or mental unfitness: For exemption purposes, physical or mental unfitness per Paragraph (3) of Subsection A of 8.139.400.11 NMAC and 7 CFR 273.5(b)(2) is defined as follows: An individual who has a mental or physical illness or disability, temporary or permanent, which reduces their ability to financially support themselves. Unfitness can be obvious to the authority and documented in the case file; or not obvious to the authority, but is documented by a physician, physician's assistant, nurse, nurse practitioner, a licensed or certified psychiatrist or a licensed or certified psychologist, or social worker as being unfit to work; the claim of physical or mental unfitness must be substantiated by written documentation identifying the physical or mental condition and certifying that the person is unfit for employment.

(i) If an individual claims to be physically or mentally unfit for purposes of the student exemption, and the unfitness is not evident to ISD, verification may be required.

(ii) Appropriate verification may consist of receipt of temporary or permanent disability benefits issued by government or private sources, or of a statement from a physician or licensed or certified psychologist.

(c) Education/training program: Assigned to or placed in an institution of higher education through or in compliance with the requirements of:

(i) a program under the Job Training Partnership Act of 1974 (JTPA);

(ii) an employment and training program under 7 CFR 273.7;

(iii) a program under Section 236 of the Trade Act of 1974 [19 U.S.C. 2296]; or

(iv) an employment and training program for low-income households that is operated by a state or local government where one or more of the components of such program is at least the equivalent to an acceptable SNAP employment and training program component.

(d) Employment: Employed a minimum of 20 hours per week and paid for such employment, or, if self-employed, working a minimum of 20 hours per week, and receiving weekly earnings at least equal to the federal minimum wage multiplied by 20 hours. Students whose employment hours fluctuate week to week will be considered to have met the minimum work hour requirement, as long as they maintain an average of 20 hours per week or 80 hours per month.

(e) Work study: Be participating in a state or federally financed work study program during the regular school year.

(i) The student must be approved for work study at the time of application for SNAP benefits, the work study must be approved for the school term, and the student must anticipate actually working during that time.

(ii) The exemption will begin with the month in which the school term begins or the month work study is approved, whichever is later.

(iii) Once begun, the exemption will continue until the end of the month in which the school term ends, or it becomes known that the student has refused an assignment.

(iv) The exemption will not continue between terms when there is a break of a full month or longer, unless the student is participating in work study during the break.

(f) Children: Responsible for a dependent household member who:

(i) is under age 6; or

(ii) has reached the age of 6 but is under age 12 when ISD has determined that adequate child care is not available to enable the student to attend class and comply with the 20-hour work requirement in (d) or the work study requirement in (e) above.

(g) Single parents: Enrolled in an institution of higher education on a full-time basis (as determined by the institution) and be responsible for the care of a dependent child under age 12.

(i) This provision applies when only one natural, adoptive or stepparent (single, widow/ widower, separated, divorced) is in the same SNAP household as the child.

(ii) If there is no natural, adoptive or stepparent in the same SNAP household as the child, another full-time student in the same SNAP household as the child may qualify for eligible student status under this provision if he/she has parental control over the child and is not living with his/her spouse.

(h) Title IV-A: Receiving Title IV-A cash assistance.

(i) Work incentive program: Participation in the job opportunities and basic skills program under Title IV of the Social Security Act or its successor programs.

(j) On-the-job training: Be participating in an on-the-job training program. An individual is considered to be participating in an on-the-job training program only during the period of time the individual is being trained by the employer.

B. Strikers: Households with members on strike are ineligible to participate in the SNAP, unless the household was eligible for benefits the day before the strike began and is otherwise eligible at the time of application. A striker is anyone involved in a strike or concerted stoppage of work by employees, including a stoppage because of the expiration of a collective bargaining agreement, and any concerted slowdown or other concerted interruption of operations by employees. Employees participating in a sympathy strike will be considered strikers. The household will not receive an increased SNAP benefit amount as a result of the decrease in income of the striking member(s) of the household.

(1) Nonstrikers: The following individuals are not considered strikers and are eligible for program participation:

(a) any employee affected by a lockout;

(b) an individual who goes on strike who is exempt from work registration (Subsection B of 8.139.410.12 NMAC) the day before the strike, except those who were exempt because of employment;

(c) employees whose workplace is closed by an employer in order to resist demands of employees (i.e., a lockout);

(d) employees unable to work as a result of other striking employees (e.g., truck drivers who are not working because striking newspaper pressmen prevent newspapers from being printed;

(e) employees who are not part of the bargaining unit on strike but who do not want to cross a picket line for fear of personal injury or death;

(f) employees who are fired or laid off, or who are permanently replaced or officially resign; and

(g) employees who will not be permitted to return to their old jobs but are offered different ones.

(2) Striker eligibility:

(a) Striker eligibility is determined by considering the day before the strike as the day of application and assuming the strike did not occur.

(b) Eligibility at the time of application is determined by comparing the striking member's income before the strike to the striker's current income and adding the higher of the two to the current income of the nonstriking household members during the month of application.

(c) To determine benefits (and eligibility for households subject to the net income eligibility standard), deductions will be calculated for the month of application as for any other household. Whether the striker's prestrike earnings are used or the current income is used, the earnings deduction is allowed if appropriate.

(d) Strikers whose households are eligible to participate in the SNAP will be required to register for work unless otherwise exempt.

C. Boarders: Boarders are defined as individuals or groups of individuals residing with others and paying reasonable compensation to those others for lodging and meals. An individual furnished both lodging and meals by a household, but paying less than reasonable compensation to the household for such services, will be considered a household member. Foster care children placed in the home of relatives or other individuals or families will be considered boarders. Foster care payments made to the household will not be counted as income, unless the household chooses to include the foster child. Payment to a household for lodging and meals will be treated as self-employment income to the household.

(1) Reasonable compensation: To determine if an individual is paying reasonable compensation for meals and lodging in making a determination of boarder status, only the amount paid for meals will be used, provided that the amount paid for meals can be distinguished from the amount paid for lodging. A reasonable monthly payment will be either of the following:

(a) A boarder whose board arrangement is for more than two meals a day must pay an amount which equals or exceeds the maximum SNAP benefit amount for the appropriate size of the boarder household.

(b) A boarder whose board arrangement is for two meals or less per day must pay an amount which equals or exceeds two-thirds of the maximum SNAP benefit amount for the appropriate size of the boarder household.

(2) Included boarders: A household which provides boarding services may request that the boarder be included as a member of the household. Boarders are not eligible to participate in the SNAP separately from the household providing the board. All the income and resources of included boarders will be counted in determining the eligibility and SNAP benefit amount of the household.

(3) Excluded boarders: The income and resources of boarders who are not included as household members will not be considered available to the household.

[8.139.400.11 NMAC – Rp 8.139.400.11 NMAC, 07/01/2024]

8.139.400.12 INELIGIBLE HOUSEHOLD MEMBERS: The following individuals shall be included as household members for the purpose of defining a household, but shall not be included as eligible members when determining the household's size, comparing the household's monthly income with the income eligibility standard, or assigning a benefit amount by household size.

A. Excluded household members:

(1) Ineligible aliens: Individuals who do not meet citizenship or eligible alien status requirements, or eligible sponsored alien requirements. The income and resources of such individuals shall be counted in determining the household's eligibility and benefit amount in accordance with the requirements in Subsection C of 8.139.520.10 NMAC.

(2) Ineligible students: Individuals enrolled in an institution of higher education who are ineligible because they do not meet the student eligibility requirements in Subsection A of 8.139.400.11 NMAC. Ineligible students are considered as non-household members in determining the household's eligibility and benefit amount. Income and resources are considered in accordance with the requirements in Subsection D of 8.139.520.10 NMAC.

B. Disqualified household members:

(1) SSN disqualified: Individuals who are disqualified for refusal or failure to provide a social security number.

(2) Work noncompliance: Individuals who have been disqualified for failure or refusal to comply with work requirements.

(3) IPV: Individuals disqualified for an intentional program violation.

C. Disqualification for fleeing felons and probation/parole violators: No member of an otherwise eligible household shall be eligible to participate in the FSP as a member of the household during any period in which the individual is:

(1) fleeing to avoid prosecution, or custody or confinement after conviction, under the law of the place from which the individual is fleeing, for a crime or attempt to commit a crime, that is a felony, or in New Jersey a high misdemeanor, under the law of the place from which the individual is fleeing; or

(2) violating a condition of probation or parole imposed under a federal or state law.

(3) Treatment of income and resources: The income and resources of an individual described in Paragraphs (1) and (2) of Subsection C of 8.139.400.12 NMAC shall be attributed in their entirety to the household while the individual is in the home.

D. Disqualification for certain convicted felon: The disqualification contained in Subsection D of 8.139.400 NMAC shall not apply to a conviction if the conviction is for conduct occurring on or before February 7, 2014. An individual shall not be eligible for SNAP benefits if the individual is convicted as an adult of:

(1) aggravated sexual abuse under section 2241 of title 18, United States Code;

(2) murder under section 1111 of title 18, United States Code;

(3) an offense under chapter 110 of title 18, United States Code;

(4) a federal or state offense involving sexual assault, as defined in section 40002(a) of the Violence Against Women Act of 1994 (42 U.S.C. 13925(a)); or

(5) an offense under state law determined by the attorney general to be substantially similar to an offense described in Paragraph (1), (2), or (3) of Subsection D of 8.139.400.12 NMAC; and

(6) The individual is not in compliance with the terms of the sentence of the individual or the restrictions under Subsection C of 8.139.400.12 NMAC.

[8.139.400.12 NMAC – Rp 8.139.400.12 NMAC, 07/01/2024]

8.139.400.13 SPECIAL HOUSEHOLDS:

A. Institutions: An individual shall be considered a resident of an institution if the institution provides two or more meals daily, and the institution has not been authorized to accept food stamp benefits.

B. Eligibility: Residents of institutions shall not be eligible to participate in the food stamp program, with the following exceptions:

(1) Federally subsidized housing: Residents of federally subsidized housing for the elderly, built under Section 202 of the Housing Act of 1959 (even if residents are not elderly), provided that they otherwise qualify for participation.

(2) Drug/alcoholic treatment centers: Drug addicts or alcoholics who, for the purpose of regular participation in a drug or alcohol treatment and rehabilitation program, live in a public or private nonprofit facility or treatment center.

(3) Disabled/blind group living arrangement: Disabled or blind individuals as defined in (i) through (x) of Subparagraph b of Paragraph 23 of Subsection A of 8.139.100.7 NMAC who are residents in a group living arrangement.

(4) Battered women/children: Women, or women with their children, temporarily residing in a shelter for battered women and children. Such persons temporarily residing in shelters for battered women and children shall be considered individual households for the purposes of applying for and participating in the food stamp program.

(5) Homeless: Residents of public or private nonprofit shelters for the homeless.

C. Residents of drug/alcohol treatment centers: A drug addict or alcoholic who regularly participates in a drug or alcoholic treatment or rehabilitation program as a resident of the center may voluntarily

apply for food stamp benefits. Children living with their eligible parent(s) in a drug or alcohol treatment center shall be considered household members when determining eligibility and benefit amount. A caseworker shall certify residents of addict/alcoholic treatment centers, and their children, by using the same provisions applied to all other applicant households, except that certification must be accomplished through an authorized representative employed by the institution. (For further information, Subsection D of 8.139.110.9 NMAC)

(1) Processing:

(a) Expedited services: Residents of treatment centers or rehabilitation centers for drug addiction or alcohol treatment, and their children, may qualify for expedited service in the same way as any other household. Food stamp benefits shall be received no later than the seventh calendar day following the date of application, and verification may be postponed. Verification requirements shall be completed before the second month's benefits are issued. (See 8.139.110.16 NMAC for more information on expedited service and continuation of benefits).

(b) Normal processing: If normal processing standards apply, the caseworker shall complete the verification and documentation requirements before making an eligibility determination for the initial application (see 8.139.110.12 NMAC and 8.139.110.13 NMAC).

(c) Changes and recertifications: Changes and recertifications shall be processed for resident households using the same standards outlined at 8.139.120.10 NMAC. Households shall be extended the same rights to notices of adverse actions, to fair hearings, and to entitlement to lost benefits as are all other food stamp households (see 8.139.120.8 NMAC and 8.139.120.10 NMAC).

(2) Treatment centers eligibility status:

(a) Food and nutrition service authorization: Before certifying any resident for food stamp benefits, a caseworker shall verify that the treatment center is authorized by FNS as a retailer if the center wishes to accept food stamp benefits. If the center is not authorized by FNS, the treatment center's status under Part B of Title XIX of the Public Health Service Act (42 USC, 300 et seq.) shall be verified.

(b) List of residents: Each treatment and rehabilitation center must provide the appropriate county office a list of currently participating residents. The list must include a statement signed by a responsible center official attesting to the list's validity. The list is required on a monthly basis.

(c) On-site visits: The county director or designee shall conduct periodic, random, on-site visits to the center to ensure the accuracy of the list and that the appropriate county office records are consistent and up-to-date.

(d) Change notification: The treatment center must notify the caseworker of changes in a household's income or other circumstances and when an addict or alcoholic leaves the treatment center. The treatment center must return the household's food stamp benefits to the county office if the household has left the center without its share.

(3) When household leaves center: When a household leaves the center, the center must give the resident household its ID card and any unused food stamp benefits. The household, not the center, shall be allowed to participate during any months remaining in the certification period.

(a) A household shall receive the full food stamp benefit amount if no benefits were spent on its behalf. This is applicable at any time during the month.

(b) If food stamp benefits have already been issued and any amount has been spent on behalf of a household, and the household leaves the program before the 16th day of the month, the treatment center must return to the household one-half of the monthly food stamp benefit amount. If a household leaves after the 16th of the month, and the food stamp benefits have already been issued and used, no food stamp benefits shall be returned to the household.

(c) The treatment center must, if possible, give the household a change report form to report the household's new address and other circumstances after leaving the center, and must advise the household to return the form to the appropriate county office within ten days.

(d) When the household leaves the treatment center, the center is no longer allowed to act as the household's authorized representative.

(4) Organization/institution responsibilities:

(a) The organization or institution is responsible for:

(i) Program rules: An organization or institution is legally responsible for any misrepresentation or intentional program violation which it knowingly commits in the certification of center residents.

(ii) Awareness of household circumstances: As an authorized representative, the organization or institution must be aware of the household's circumstances and should carefully

review those circumstances with any resident before applying on their own behalf.

(iii) Proper use of food stamp benefits: The organization or institution shall be strictly liable for any loss or misuse of food stamp benefits held on behalf of resident households, and for all overissuances that occur while the households are residents of the treatment center. The organization or institution may be penalized or disqualified if it is determined administratively or judicially that food stamp benefits were misappropriated or used for purchases that did not contribute to a certified household's meals.

(b) The county office shall notify the food assistance bureau when it has reason to believe that an organization or institution is misusing food stamp benefits in its possession. The food assistance bureau shall notify FNS. HCA shall take no action before FNS action against the organization or institution.

(c) HCA shall establish a claim for overissuance of food stamp benefits held on behalf of resident clients if any overissuance is discovered during an investigation or hearing procedure for redemption violations.

(d) If FNS disqualifies an organization or institution for any period of time, HCA shall suspend its authorized representative status for the same period.

D. Residents in group living arrangements: A disabled or blind resident of a public or private non-profit group living arrangement may choose to apply for food stamp benefits on his own, or through an authorized representative of the resident's own choosing, or through the facility's authorized representative. The group living arrangement facility must determine if the resident may apply on the resident's own behalf based on the resident's physical and mental ability to handle his own affairs. If a resident applies through the facility's authorized representative, eligibility shall be determined as a one-person household. If a household applies on its own behalf, the household size shall be determined according to the rules at Subsection C of 8.139.400.8 NMAC. Such residents shall be certified using the same provisions applied to all other households. HCA shall determine that the group living arrangement facility is a non-profit organization as established by its articles of incorporation with the New Mexico public regulation commission, and the group living arrangement facility must provide verification that it is authorized by FNS or certified by the New Mexico department of health as a group living arrangement, before any of the residents are certified for food stamps.

(1) Resident's rights/responsibilities:

(a) The rights and responsibilities listed in Paragraph 1 of Subsection C of 8.139.400.13 NMAC, for residents of treatment centers also apply to blind or disabled residents of group living arrangements when the facility acts as the resident's authorized representative.

(b) If a household has made application on its own behalf, the household is responsible for reporting changes to the county office within 10 days of the date the change becomes known to the household.

(c) If a resident, or a group of residents, receives food stamp benefits on the resident's or group's own behalf and retain use of the resident's or group's food stamp benefits, the resident or group is entitled to keep the food stamp benefits when the resident or group leaves. If a group of residents has received food stamp benefits as one household, a pro rata share of the remaining food stamp benefits shall be provided to any departing member.

(d) Residents of group living arrangements receiving food stamp benefits on their own behalf are responsible for overissuances, as would any other household (see (d) of Paragraph 2 of Subsection C of 8.139.400.13 NMAC).

(2) Group home responsibilities:

(a) The same responsibilities apply to authorized representatives of a group living arrangement as to treatment centers (Paragraph 4 of Subsection C of 8.139.400.13 NMAC). These provisions are not applicable if a resident has applied on the resident's own behalf. (For further information see Subsection B of 8.139.110.9 NMAC, authorized representatives).

(b) A group living facility shall give the appropriate county office a list of currently participating residents. This list shall include a statement by a responsible center official attesting to the validity of the list. The list is required on a monthly basis.

(c) The county director or designee shall conduct periodic, random on-site visits to ensure the accuracy of the list and make sure that the appropriate county office records are consistent and up-to-date.

(d) If a group living facility acts in the capacity of authorized representative, it must notify the caseworker of changes in a household's income or other household circumstances, and when an individual leaves the group living arrangement.

(e) When a household leaves a group living facility, the facility, if it either acted as authorized representative or retained use of food stamp benefits on behalf of residents, gives the departing household

its ID card and any unused benefits. The household, not the group living facility, shall be allowed to sign for and receive any remaining food stamp benefits.

(f) A departing household must receive the full food stamp benefit amount, if issued, and if no food stamp benefits have been spent on behalf of that household. These procedures are applicable at any time during the month.

(g) If the food stamp benefits have been issued and any portion spent on behalf of the household, and the household leaves the group living arrangement before the 16th day of the month, the group living facility must return the ID card and one-half of the monthly food stamp benefit amount to the departing household. If the household leaves on or after the 16th of the month and the food stamp benefits have already been issued and used, the household shall not receive any food stamp benefits.

(h) If a group of residents is certified as one household and gives the food stamp benefits to the group living facility to use, departing residents must be given a pro rata share of one-half of the household's monthly food stamp benefit amount if the group leaves prior to the 16th day of the month. When a household leaves, the group living facility may no longer act as the household's authorized representative.

(i) The group living facility shall, if possible, give the household a change report form to report the household's new address and other circumstances after leaving the facility, and shall instruct the household to return the form to the appropriate county office within ten days.

(3) Use of benefits:

(a) A group living facility may purchase and prepare food for eligible residents on a group basis if residents normally get their meals at a central location as part of the group living arrangement services, or if meals are prepared at a central location for delivery to the individual residents.

(b) If residents purchase and/or prepare food for home consumption, as opposed to communal dining, the group living facility must make sure that each resident's food stamps are used for meals intended for that resident.

(c) If residents retain use of their own food stamp benefits, they may either use the food stamp benefits to purchase meals prepared for them by the facility or to purchase food to prepare meals for their own consumption.

E. Battered women's shelters:

(1) Before certifying residents of a battered women's shelter, a caseworker shall make sure that the shelter is a public or private nonprofit residential facility serving battered women and their children.

(2) If a facility serves other individuals as well as battered women and their children, a caseworker shall make sure that a part of the facility is set aside on a long term basis to serve only battered women and their children.

(3) Shelters with FNS authorization to redeem food stamps at wholesalers shall be considered to be meeting the definition and the caseworker is not required to make any further determination. The caseworker shall document the basis of this determination.

(4) Local ISD offices are required to maintain and update a current list of shelters meeting the battered women's shelter definition to facilitate prompt certification of eligible residents.

(5) Special certification procedures:

(a) Many shelter residents have recently left a household containing the person who abused them. The former household may be certified for participation in the food stamp program, and its certification may be based on a household size that includes the woman and children who have just left. Shelter residents included in such a certified household may nevertheless apply for and (if otherwise eligible) participate in the program as a separate household, and concurrently, if the household that included them is the household containing the person who abused them. Shelter residents included in such a household may receive additional food stamp benefits as a separate household only once in a month.

(b) Shelter residents who apply as separate households shall be certified solely on the basis of their own income and resources and the expenses for which they are responsible. They shall be certified without regard to the income, resources, and expenses of their former household. Jointly held resources shall be considered inaccessible.

(c) Room payments from the residents to the shelter shall be counted as shelter expenses. Any shelter residents eligible for expedited service shall be handled in accordance with the provisions in 8.139.110.16 NMAC.

(6) Handling the former household: The caseworker shall take prompt action to make sure that the former household's eligibility or food stamp benefit amount reflects the change in household size and composition.

[8.139.400.13 NMAC – Rp 8.139.400.13 NMAC, 07/01/2024]

8.139.400.14 MIGRANT AND SEASONAL FARMWORKER HOUSEHOLDS:

A. Migrant or seasonal farmworker households are entitled to special handling of their application as described below. Only migrant or seasonal farmworker households will be classified as destitute and receive the special income considerations outlined in this section. For migrant or seasonal farmworker households only, the initial month is defined as the first month for which the household will be certified for participation in the food stamp program following any period of more than 30 days during which the household was not certified for participation. More than 30 days must pass before the application month is considered an initial month and benefits are prorated from the date of application. If 30 days have not passed, the household is entitled to a full month's benefits.

B. Destitute households: Migrant or seasonal farmworker households may have little or no income at the time of application and may be in need of immediate food assistance, even though a household may have received income at some time during the month of application. The following procedures will be used to determine whether migrant or seasonal farmworker households may be considered destitute and therefore entitled to expedited service and special income calculation procedures, except that migrant or seasonal farmworker households with resources of $100.00 or more will not be entitled to expedited service.

(1) Terminated income source:

(a) Expedited service: Migrant or seasonal farmworkers whose only income for the month of application was received before the date of application, and was from a terminated source, will be considered destitute and entitled to expedited service.

(b) Monthly or more frequent income: If income is received on a monthly or more frequent basis, it will be considered as coming from a terminated source if it will not be received again from the same source during the balance of the month of application or during the following month.

(c) Less often than monthly income: If income is normally received less often than monthly, the nonreceipt of income from the same source in the balance of the month of application or in the following month is inappropriate to determine whether or not the income is terminated. Therefore, for households normally receiving income less often than monthly, the income will be considered as coming from a terminated source if it will not be received in the month in which the next payment would normally be received.

(2) New income source:

(a) Households whose only income for the month of application is from a new source will be considered destitute and entitled to expedited service if income of more than $25 from the new source will not be received by the 10th calendar day after the date of application.

(b) Income normally received on a monthly or more frequent basis will be considered to be from a new source if income of more than $25 has not been received from that source within 30 days before the date the application was filed.

(c) If income is normally received less often than monthly, it will be considered to be from a new source if income of more than $25 was not received within the last normal interval between payments.

(3) Income from terminated and new source:

(a) Households may receive income from both a terminated source before the date of application and from a new source after the date of application, and still be considered destitute if they receive no other income in the month of application and if income of more than $25 from the new source will not be received by the 10th day after the date of application.

(b) A household member who changes jobs but continues to work for the same employer will be considered as still receiving income from the same source. A migrant farmworker's source of income is considered to be the grower/employer for whom the migrant is working at a particular point in time, and not the crew chief. A migrant who travels with the same crew chief but moves from one grower/employer to another will be considered to have moved from a terminated income source to a new source.

(4) Travel advances: Some employers provide travel advances to cover the costs of new employees who must travel to the location of their new employment. To the extent that these payments are excluded as a reimbursement, receipt of travel advances will not affect the determination of when a household is destitute. If a travel advance is, by written contract, an advance of wages to be subtracted from wages later earned by the employee rather than a reimbursement, the wage advance will be counted as income. Receipt of a wage advance for travel costs of a new employee will not affect the determination of whether subsequent payments from the employer are from a new source of income, or whether a household will be considered destitute.

C. Special income calculation: The eligibility and food stamp benefit amount of destitute households will be calculated for the month of application by considering only income which is received between the first of the month and the date of application. Any income from a new source that the household anticipates receiving after the date of application will be disregarded. Destitute household eligibility will be determined using the special income calculations in Subsection B of 8.139.400.14 NMAC, and by comparing as appropriate the household's gross and/or net income to the income eligibility standards in Subsection E of 8.139.500.8 NMAC. The procedures described in Subsection B of 8.139.400.14 NMAC above apply at initial application and at recertification, but only for the first month of each certification period. At recertification, income from a new source will be disregarded in the first month of the new certification period if income of more than $25 will not be received from the new source by the 10th calendar day after the date of the household's normal issuance cycle.

D. Prospective budgeting: Migrant or seasonal households will be entitled to a prospective determination of eligibility and food stamp benefit amount during the time they are in the migrant stream.

(1) Anticipating income:

(a) Income received during the past 30 days will be used as an indicator of the income that is and will be available to the household during the certification period.

(b) An ISS will not use past income as an indicator of income anticipated for the certification period if changes in income have occurred or can be anticipated.

(c) If income fluctuates to the extent that a 30-day period alone cannot provide an accurate indication of anticipated income, the ISS and the household may use a longer period of past time if it will provide a more accurate indication of anticipated fluctuations in future income. Similarly, if income fluctuates seasonally, it may be appropriate to use the most recent season comparable to the certification period, rather than the last 30 days, as one indicator of anticipated income.

(2) Handling anticipated income:

(a) Income anticipated during the certification period will be counted as income only in the month it is expected to be received, unless the household chooses to have its income averaged.

(b) At recertification, income from a new source will be disregarded in the first month of the new certification period, if more than $25 income will not be received from this new source by the 10th calendar day after the date of the household's normal issuance cycle.

(3) Continuous employment:

(a) In cases where the head of a migrant or seasonal household is steadily employed, income from the previous month is usually a good indicator of the amount of income that can be anticipated in the month of application and following months.

(b) If the information supplied by a household or a collateral contact (8.139.650.7 NMAC) indicates that future income will differ from the previous month's income, the ISS will use such information to make a reasonable estimate of anticipated income.

(c) The method used to determine income must be fully documented in the case record.

(4) Hourly and piecework wages:

(a) When income is received on an hourly or piecework basis, it may fluctuate if a wage earner works less than eight hours some days or is required to work overtime on others. The ISS will discuss with the household to determine the "normal" amount of the income to be expected as a result of one week's work and whether the income can be reasonably expected to be available during the certification period. The amount which is reasonably expected will be used to determine monthly income.

(b) The option of averaging income should be discussed with the household.

(5) Withheld wages:

(a) Wages held at the request of an employee will be counted as income to the household in the month the wages would otherwise have been paid by the employer.

(b) Wages held by the employer as a regular practice, even if in violation of law, will not be counted as income, unless the household anticipated asking for and receiving an advance, or receiving income from wages that were previously held by the employer as a regular practice, and that were, therefore, not previously counted as income.

(c) Wage advances will count as income in the month received only if reasonably anticipated.

(6) Varied eligibility: Because of anticipated changes, a household may be eligible for the month of application but ineligible in a later month. The household will be entitled to food stamp benefits for the month of application even if the processing of its application results in the food stamp benefits being issued in a

subsequent month. Similarly, a household may be ineligible for the month of application, but eligible in the subsequent month because of anticipated changes in circumstances. Even though benefits are denied for the month of application, the household does not need to reapply in the following month. The same application will be used for the denial of the month of application and the determination of eligibility for subsequent months.

(7) Varied benefit amount: As a result of anticipating changes, a migrant or seasonal household's food stamp benefit amount for the month of application may differ from its food stamp benefit amount for subsequent months. The ISS must establish a certification period for the longest possible period over which changes in circumstances can be reasonably anticipated. The food stamp benefit amount will vary from month to month within the certification period, unless the household chooses to have its income averaged.

E. Income averaging: Destitute migrant or seasonal farmworker households may choose to have income averaged. Income will not be averaged for destitute households, unless the household so chooses, because averaging would result in assigning to the month of application income from future periods which is not available to the destitute household for its current needs. If the income averaging option is chosen, it cannot be changed during the certification period.

F. Deductible expenses: For migrant or seasonal households in the job stream, deductible expenses are determined prospectively in accordance with the following procedures (see 8.139.500.11 NMAC for more information).

(1) Anticipating expenses: A household's expenses will be calculated based on the expenses for which the household expects to be billed during the certification period. Anticipation of these expenses will be based on the most recent month's bills, unless it is reasonably certain a change will occur. The ISS will not average past expenses, such as utility bills, for the last several months, as a method of anticipating utility costs for the certification period. When the household's actual costs for utilities, including a heating or cooling cost, are anticipated to be less than the state's standard utility allowance (SUA), the SUA is applied. Similarly, when more than one household shares utility expenses, and a household's share of the billing for heating or cooling costs is less than its prorated share of the SUA, the household will be given its prorated share of the SUA.

(2) Averaging expenses: Migrant households may choose to average anticipated expenses as follows.

(a) Households may choose to have fluctuating expenses averaged.

(b) Households may choose to have one-time only expenses averaged over the certification period in which they are billed.

(c) Households may choose to have expenses that are billed less often than monthly averaged forward over the interval between scheduled billings, or, if there is no scheduled interval, averaged forward over the period the expense is intended to cover.

G. Certification periods:

(1) A household will be assigned the longest certification period possible based on the predictability of the household's circumstances. Because of the uncertainty of income and the likelihood of frequent and significant change in income or household circumstances, migrant or seasonal households usually are certified for one month. A two- or three- month certification period may be assigned if income and circumstances are stable and the household chooses to average income and expenses.

(2) Expedited migrant households: A migrant or seasonal household eligible for expedited service and assigned a certification period of longer than one month, will receive the first month’s benefits. If verification is postponed, the household will be notified in writing that postponed verification from sources within and out-of-state must be provided before food stamp benefits for the second month are issued. Migrants will be entitled to postpone out-of-state verification only once each season. If a migrant or seasonal household requesting expedited service has already received this consideration during the current season, the ISS will grant a postponement of out-of-state verification only for the initial month's issuance and not for the second month's issuance. The notice to the household will state that if the verification results in a change in the household's eligibility or food stamp benefit amount, the ISS will act on the change without advance notice of adverse action.
[8.139.400.14 NMAC – Rp 8.139.400.14 NMAC, 07/01/2024]

8.139.400.15 DISASTER VICTIMS:

A. Authority:

(1) Section 409 of the Disaster Relief Act of 1974 authorizes the president to distribute emergency food stamp benefits through USDA to low-income households which are unable to purchase adequate amounts of nutritious food as a result of a major disaster.

(2) The Food Stamp Act of 1977 also provides for development of disaster relief provisions.

During a major disaster declared by the president or by USDA/FNS, disaster relief provisions will be implemented in those areas declared in need of disaster relief.

B. Determination of need:

(1) FNS will establish temporary eligibility standards for the duration of an emergency for households that are disaster victims as defined in this section. In addition, FNS will provide for emergency food stamp benefits to eligible households to replace food destroyed in a disaster. The emergency food stamp benefits will be equal to the value of the food destroyed, but not greater than the applicable maximum food stamp benefit amount for the household size.

(2) HCA is authorized to distribute emergency food stamp benefits to households residing in those areas determined to be adversely affected by a major disaster, but only upon the determination by USDA/FNS that such households have food assistance needs that cannot be met by the existing program in the project area(s), and only to those households that meet the eligibility criteria.

(3) The HCA food assistance bureau, after contact with USDA/FNS, will provide direction for implementation of disaster provisions.

(4) Under no circumstances may an ISD county office implement the emergency disaster provisions without specific direction and approval from the income support division, food assistance bureau.

C. Eligibility criteria-conditions: To be eligible for emergency food stamp benefits during a disaster, a household must meet all the following standards:

(1) At the time the disaster struck, the household must have been residing within the geographical area which is considered a disaster area. Such a household may be certified for disaster food stamp benefits even though the household at present is occupying temporary accommodations outside the disaster area. (A household representative must go to the certification site to be certified for disaster food stamp benefits).

(2) The household will purchase food and prepare meals during the disaster benefit period. A household residing in a temporary shelter that is providing all the household's meals is not eligible.

(3) The household must have experienced at least one of the following adverse effects of the disaster:

(a) The household's income becomes inaccessible or there is a termination of income or a significant delay in receipt of income, for example, if a disaster has caused a place of employment to close or reduce its work days, or if paychecks or other payments are lost or destroyed, or if there is a significant delay issuing paychecks or other payments. The household's income can become inaccessible if the work location is inaccessible because of the disaster.

(b) The household's liquid resources become inaccessible. Inaccessibility of liquid resources includes situations in which the financial institution(s) holding the household's resources is expected to be closed because of the disaster for most of the disaster benefit period, or if the household is otherwise unable, and is not expected to be able, to reach its cash resources for most of the disaster benefit period.

(4) Expenses paid during the disaster period:

(a) A household must have paid, or expect to pay for, expenses during the disaster benefit period to be eligible for a shelter expense deduction. The expense is not deductible if the household will not pay for it until after the disaster benefit period is over.

(b) If a household has received, or is reasonably certain to receive, a reimbursement for all or part of the expense during the disaster benefit period, only the net expense after reimbursement is allowed as a shelter expense deduction. If a reimbursement is expected, but it is not reasonably certain that it will be provided during the disaster benefit period, the full amount of the expense is deductible. The following household expenses are deductible:

(i) repairing damage to home or property essential to the employment or self-employment of a household member;

(ii) temporary shelter if a home is uninhabitable or the household cannot reach its home;

(iii) moving out of an area evacuated because of a disaster;

(iv) protecting property from disaster damage;

(v) medical expenses for disaster-related injury to a person who was a household member at the time of the disaster (including funeral and burial expenses in the event of death).

(vi) any other expenses may not be considered.

(5) Disaster income calculation: Disaster income is calculated by adding the household's take-home pay to the household's available cash resources and then deducting the household's disaster-related expenses. The result must be less than or equal to the food stamp maximum disaster income limit for the household

size.

(6) Maximum disaster income limit: The maximum disaster income limit is calculated by adding the food stamp net income limit for the appropriate household size, the standard deduction, and the maximum shelter deduction. Medical deductions for the elderly and disabled, the earned income deduction, the uncapped shelter deduction for the elderly and disabled and the dependent care deduction will not be used to calculate the maximum disaster income limit.

(7) Countable income: Income counted to determine eligibility includes:

(a) wages a household actually receives after taxes and other payroll deductions are taken out;

(b) assistance payments or other unearned income a household receives; and

(c) net self-employment income earned after personal income and social security taxes as well as expenses of producing the self-employment income are subtracted;

(d) income is only counted if it has already been received in the benefit period or if the household is reasonably certain the income will be received during the disaster benefit period;

(e) all cash resources (cash on hand and all funds in savings and checking accounts) will be counted as income unless the ISS determines that such funds will be inaccessible for most of the disaster benefit period; the resource standards do not apply under disaster certification rules.

(8) Certification periods: Certification periods must coincide with the disaster benefit period.

(a) If the disaster benefit period is for one month, income over this full month period will be counted; disaster-related expenses paid or expected to be paid over the full month period will be deducted to determine the net income.

(b) If the disaster benefit period will be for one- half month, estimated income over the half-month period will be counted, disaster-related expenses paid or expected to be paid over this period will be deducted, and the income limit will be only one-half of the monthly food stamp maximum disaster income limit.

(9) Household estimates: Applicant households must provide estimates of total take-home pay, cash resources, and allowable disaster-related expenses. Verification is not required, nor is an ISS required to request itemization of individual expenses or of different sources of income or resources.

(10) Variable criteria: FNS may, in certain disaster situations where circumstances warrant, establish eligibility standards that differ from those set forth above.

D. FSP operations:

(1) Regular FS program: The regular food stamp program will continue to operate and to process applications and make eligibility determinations in its normal manner during a disaster benefit period. If an applicant household does not meet the eligibility requirements for the disaster program, the household will be informed of the potential availability of food stamp benefits under the regular program, including provisions to consider costs of home repair caused by a natural disaster as an allowable shelter expense.

(2) Personnel: HCA may use volunteers and other agency personnel to help the certification staff make eligibility determinations during a disaster. A disaster relief agency designated by HCA and approved by FNS may also determine the eligibility of applicant households. HCA may set up alternate certification and issuing points that are accessible to the affected population.

(3) General standards: To apply for food stamp benefits under the disaster assistance program, a household must complete and submit a short form application, be interviewed, and provide limited verification, as specified below. HCA may use group sessions to screen applicants, explain rights and responsibilities, and explain how to complete an application.

(4) Verification: Except for identity and residence, all other verification requirements are waived for disaster emergency assistance. Since verification documents may have been lost or destroyed in the disaster, interviewers may use collateral sources to provide verification and to expedite certification. The household will not be denied for lack of verification of residence in unusual situations, such as if a household has recently moved to the area, has no documentary evidence of residence, and is not known to others in the disaster area.

(5) Period for processing: No emergency food stamp benefits will be authorized after the end of the disaster period. If the period is extended by FNS, HCA may be authorized to permit households already certified for emergency food stamp benefits to apply for recertification, if the households continue to meet the disaster eligibility requirements. A household applying for recertification must submit a new application and be interviewed. Identity and residence need not be reverified unless they are questionable. If an extension is granted, HCA will issue a press release notifying those concerned that the disaster authorization period has been extended, and where and when they may reapply for extended food stamp benefits.

(6) Benefit calculation: Households meeting the eligibility requirements will receive the maximum food stamp benefit amount for their household size as listed in Subsection E of 8.139.500.8 NMAC, if the disaster benefit period is a full month. If the disaster benefit period is for a half month, the household will receive half the maximum food stamp benefit amount.

(7) Certification notices: In certifying disaster benefit applicants, written notification requirements will be waived. The notification that interviewers are required to give applicants may be given orally.

(8) ID cards: Participants in a disaster emergency program will be issued an identification card (ID) marked with the word "disaster" or some similar designation for disaster food stamp issuance. The ID card will serve to identify the household at an issuing point or in retail food stores as a legitimate food stamp participant.

(9) Transition to FSP: Households issued emergency food stamp benefits which are later determined eligible to participate in the ongoing food stamp program will have their emergency food stamp benefits deducted from their regular program food stamp benefits if the disaster certification period and the ongoing certification period overlap. The ISS will calculate food stamp benefits to be issued under the regular program as follows:

(a) the number of days overlapping the disaster certification period and the certification period for ongoing food stamp benefits will be determined;

(b) disaster food stamp benefits will be prorated over the number of days in the disaster period to determine the disaster food stamp benefit amount issued on a daily basis; and

(c) the food stamp benefit amount to be issued under the regular program will be offset against the amount of overlapping disaster benefits determined in Subparagraph (b) of Paragraph 9 of Subsection D of 8.139.400.15 NMAC above.

(d) Interviewers must act promptly on all applications. HCA will give eligible households an opportunity to get disaster food stamp benefits the day of application, unless restrictions such as curfews make it impossible to meet this standard; in such a situation, a household must be given an opportunity to get benefits no later than the day following the date the application is filed.

(10) Controls: HCA will establish a system to detect duplicate applications for disaster food stamp benefits. The system will include an exchange of case index cards or lists of certified disaster households between the appropriate certification and issuance sites used in the disaster operation. HCA will also use computer checks, address checks, and telephone calls to keep households from receiving duplicate disaster benefits.

E. Application process:

(1) Forms:

(a) The short application form for temporary emergency assistance (ISD459) will be used to gather the minimum amount of information needed to establish eligibility and the food stamp benefit amount. It also serves as an issuance document.

(b) To determine eligibility, an application must be completed and signed, the household or its authorized representative must be interviewed, and certain information on the application must be verified.

(c) The short disaster application form will provide warnings of the civil and criminal provisions and penalties for violations of the Food Stamp Act, and of the fact that the household may be subject to a post-disaster review.

(2) Filing: To file an application for emergency food stamp assistance, a household must submit a completed form, in person or through an authorized representative, at a certification site. To be processed under disaster procedures, the application must be filed during the disaster period. Households applying outside this period will be processed according to regular food stamp program procedures.

(3) Household cooperation: If a household refuses to cooperate with an interviewer in completing the application process, the application will be denied at the time of refusal.

(4) Interviews: All applicants for emergency disaster assistance must be interviewed. HCA will screen applicants before the interview to identify those who do not meet eligibility requirements.

(a) The interview will be conducted as an official discussion of household circumstances. It is designed to process the application quickly and not hinder disaster operations.

(b) Interviews will be conducted by ISSs as well as by volunteers and other non-HCA personnel, such as representatives of an authorized disaster relief agency designated by HCA.

(c) The interviewer will review the information that appears on an application and resolve unclear or incomplete information.

(d) At the interview, a household will be advised orally of the disposition of its

application, its rights and responsibilities, when its certification period for emergency assistance ends, and of the ongoing food stamp program.

(e) If a household wishes to file an application for the ongoing program, the interviewer will advise the household of the address and telephone number of the appropriate office.

(f) The interviewer will inform each certified household of the proper use of food stamp benefits.

F. Treatment of current FSP household:

(1) Eligibility: Households currently certified for the ongoing food stamp program may also be eligible for temporary emergency food stamp assistance during disasters. Such households will be allowed to apply for disaster food stamp assistance, and their eligibility will be determined in the same manner as for any other disaster victim. The ISS must, however, reduce the disaster food stamp benefit amount by the amount of regular food stamp benefits issued to the household under the ongoing program for any part of the disaster benefit period. If the household's food has been damaged by the disaster, and it must replace the food, the disaster food stamp benefit amount will not be reduced by the amount of food stamp benefits issued under the ongoing program. If it is not practical to determine, verify, or otherwise take into account ongoing program benefits, HCA will issue full disaster food stamp benefits to those households, with FNS approval.

(2) Replacements: A household requesting a replacement of food stamp benefits it had received under the ongoing program that were destroyed in the disaster, or of food destroyed in a disaster that was purchased with food stamp benefits issued under the ongoing program, will be handled by the ongoing program. A household will not be given a replacement if it has received, or will receive, disaster food stamp assistance for the same period.

(3) Reporting changes: Households certified under the ongoing program who report required changes during the application process for emergency assistance, will be referred to the ongoing program. The household is responsible for reporting the required information directly to the office that handles its regular case.

G. Issuance of emergency food stamps: Emergency food stamp benefits will be issued by normal procedures in effect in a project area if the opportunity to participate standards can be met. Such issuance arrangements may not be practical because of the effects of the disaster. HCA, with FNS approval, will make temporary arrangements during an emergency period to facilitate the issuance of benefits to disaster victims.

H. Fair hearings: Households denied disaster food stamp benefits may request a fair hearing. Households requesting a fair hearing must be offered an immediate supervisory review of their circumstances because of the time that is likely to pass before a fair hearing decision can be made. The supervisory review is not a replacement for a fair hearing, but may be held in addition to the fair hearing.

[8.139.400.15 NMAC – Rp 8.139.400.15 NMAC, 07/01/2024]

HISTORY OF 8.139.400 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 430.0000, Certification of Eligible Households, 8/8/1980.
ISD 460.0000, Action on Households with Special Circumstances, 8/15/1980.
ISD-Rule 421.0000, Food Assistance - Eligibility Standards, 11/5/1982.
ISD-Rule 420.0000, Eligibility Standards, 2/21/1983.
ISD-Rule 427.0000, Food Assistance - Students, 11/4/1982.
ISD-Rule 427.0000, Students, 2/9/1983.
ISD-Rule 427.0000, Students, 5/3/1984.
ISD-Rule 451.0000, Food Assistance - Action on Households with Special Circumstances, 11/5/1982.
ISD-Rule 450.0000, Action on Households with Special Circumstances, 10/13/1983.
ISD-Rule 450.0000, Food Assistance - Action on Households with Special Circumstances, 4/24/1984.
ISD-Rule 457.0000, Food Assistance - Residents of Drug/Alcoholic Treatment and Rehabilitation Programs, 11/5/1982.
ISD-Rule 458.0000, Food Assistance - Other Households with Special Circumstances, 11/5/1982.
ISD-Rule 458.0000, Food Assistance - Other Households with Special Circumstances, 2/23/1983.
ISD-Rule 458.0000, Food Assistance - Other Households with Special Circumstances, 10/13/1983.
ISD FS 230, Food Stamp Households, 2/29/1988.
ISD FS 240, Special Food Stamp Households, 2/29/1988.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 420 RECIPIENT REQUIREMENTS - SPECIAL HOUSEHOLDS

8.139.420.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.420.1 NMAC – Rp 8.138.420.1 NMAC, 07/01/2024]

8.139.420.2 SCOPE: General public.
[8.139.420.2 NMAC – Rp 8.138.420.2 NMAC, 07/01/2024]

8.139.420.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.420.3 NMAC – Rp 8.138.420.3 NMAC, 07/01/2024]

8.139.420.4 DURATION: Permanent.
[8.139.420.4 NMAC – Rp 8.138.420.4 NMAC, 07/01/2024]

8.139.420.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited below a section.
[8.139.420.5 NMAC – Rp 8.138.420.5 NMAC, 07/01/2024]

8.139.420.6 OBJECTIVE: Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the health care authority.
[8.139.420.6 NMAC – Rp 8.138.420.6 NMAC, 07/01/2024]

8.139.420.7 DEFINITIONS: [**RESERVED**]

8.139.420.8 CATEGORICAL ELIGIBILITY (CE): All members of a food stamp household must maintain CE status for the household to be considered CE. Categorically eligible one and two person households are entitled to the minimum food stamp benefit amount, except in an initial month if the prorated benefit is less than $10.

A. Determining CE: Households may be CE by receiving financial assistance or by receiving a non-cash TANF/MOE funded benefit or service, known as broad-based CE.

(1) Financial assistance/SSI CE: A food stamp household is considered CE for the entire month when all of its members receive or has been determined eligible to receive any combination of the benefits or services from the following:

(a) financial assistance;

(b) financial, in-kind benefits, or services funded either under Title IV-A of the Social Security Act or by the state as part of the TANF maintenance of effort;

(c) SSI under Section 1619(a) or 1619(b) of the Social Security Act (42 U.S.C. 1382h(a) or (b)).

(2) Broad-based CE due to receiving a non-cash TANF/MOE funded benefit or service: A food stamp household is considered to be a broad-based CE household for the month of application and the entire certification period when the household's gross income is less than 165% FPG and the household has received a non-cash TANF/MOE funded benefit or service.

(3) Households not entitled to CE: A household shall not be considered CE if:

(a) any member is disqualified for an IPV;

(b) any member is disqualified for failure to comply with work registration or E&T requirements, including voluntarily quitting a job or reducing employment hours without good cause;

(c) any member is disqualified because of fleeing felon status or parole/probation

violations;

(d) the household is institutionalized; or

(e) the household refuses to cooperate in providing information that is necessary to determine eligibilit;

(f) households that lose eligibility because an individual member received substantial lottery or gambling winnings will remain ineligible until they meet the income and resource limits detailed in 7 CFR 273.8 and 273.9. The next time such a household reapplies and is certified for SNAP after losing eligibility under this rule, the household would not be considered categorically eligible. This requirement is not permanent; it applies only to the first time a household is certified under regular SNAP rules following the loss of eligibility for substantial lottery and gambling winnings.

(4) Households may be CE if they contain non-household members such as ineligible students, ineligible non-citizens, ABAWDs who are ineligible due to time limits.

B. Eligibility factors for CE households: All CE households are subject to food stamp eligibility requirements, including, but not limited to, verification of household composition, if questionable; benefit determination (income and deductions); disqualification for any reason; claims recovery and restored benefits; notices and fair hearings; and all reporting requirements.

(1) Financial assistance/SSI households: Households entitled to CE because of receipt of financial assistance or SSI do not have to provide verification of the following eligibility factors:

(a) resources;

(b) social security number;

(c) sponsored non-citizen information; and

(d) residency.

(2) Broad-based households: Households entitled to CE because they received a non-cash TANF/MOE funded benefit or service do not have to verify resources.

C. Case management for all CE households:

(1) Applicant households: Caseworkers shall postpone denying a potentially CE household until the 30th day to allow financial assistance or SSI benefit approval. If within 30 days following the denial date, the caseworker becomes aware of, approval which makes the household CE benefits shall be paid using the original application and any other information which has become available since that time.

(2) Responsibility to report changes: CE households subject to simplified or regular reporting must report changes in accordance with 8.139.120 NMAC.

(3) Action on changes to CE status: When a household reports a change or the authority becomes aware of a change, the caseworker shall take action to determine if the household is still entitled to continue CE.

(a) Financial assistance: When the household reports a loss or the authority becomes aware of a loss of SSI or financial assistance, the household should be evaluated for broad-based CE.

(b) Broad-based CE: The caseworker shall take action to determine if the household still meets the criteria for broad-based CE status per Paragraph (2) of Subsection A above. Should the reported change result in a loss of broad-based CE the household will be notified in writing. Any household no longer entitled to broad-based CE status may still participate in the food stamp program and are subject to all eligibility requirements including resource and reduced income limits.

[8.139.420.8 NMAC – Rp 8.138.420.8 NMAC, 07/01/2024]

8.139.420.9 SPONSORED NON-CITIZENS:

A. Definition of a sponsored non-citizen: A non-citizen lawfully admitted for permanent resident status into the United States, for which an individual has executed an affidavit of support pursuant to section 213A of the Immigration and Nationality Act. Not all lawful non-citizens are sponsored. Only in the event that the sponsored non-citizen is eligible in accordance with of 8.139.410.9 NMAC shall HCA consider available to the household the income and resources of the sponsor and spouse.

B. Date of entry or date of admission: The date established by the immigration and naturalization service (INS) as the date the sponsored non-citizen was admitted for permanent residence.

C. Sponsor: An individual who has executed an affidavit of support or similar agreement on behalf of a non-citizen, as a condition of the non-citizen's entry or admission into the United States as a permanent resident.

D. Exempt non-citizens: The provisions of this section do not apply to the following:

(1) a non-citizen participating in the food stamp program as a member of the sponsor's food

stamp household;

(2) a non-citizen sponsored by an organization or group rather than an individual;

(3) a non-citizen who is not required to have a sponsor under the Immigration and Nationality Act; or

(4) a non-citizen that ISD has determined is indigent.

(a) For purposes of this paragraph, the term indigent means that the sum of the eligible sponsored non-citizen's household's own income, the cash contributions of the sponsor and others, and the value of any in-kind assistance the sponsor and others provide, does not exceed 130% of the poverty income guidelines for the household's size.

(b) The caseworker shall determine the amount of income and other assistance provided in the month of application.

(c) If the non-citizen is indigent, the amount that HCA shall count shall be the amount actually provided for a period beginning on the date of such determination and ending 12 months after such date. Each indigence determination is renewed for additional 12-month periods.

(5) A battered non-citizen spouse, non-citizen parent of a battered child, or child of a battered non-citizen, for 12 months after HCA determines that the battering is substantially connected to the need for benefits, and the battered individual does not live with the batterer. After 12 months, HCA shall not deem the batterer's income and resources if the battery is recognized by a court or the INS and has substantial connection to the need for benefits, and the non-citizen does not live with the batterer.

E. Sponsored non-citizen's responsibility: HCA shall attribute the entire amount of income and resources to the applicant eligible sponsored non-citizen until the non-citizen provides the information specified below. The sponsored non-citizen is responsible for:

(1) obtaining the cooperation of the non-citizen's sponsor(s) to provide the caseworker, at the time of application or recertification, with the information or documentation necessary to determine the income and resources of a sponsor and a sponsor's spouse;

(2) providing the names and other identifying factors of other non-citizens for whom the non-citizen's sponsor has signed an affidavit of support;

(3) reporting the require information about the sponsor and sponsor's spouse should the non-citizen obtain a different sponsor during the certification period;

(4) reporting a change in income should the sponsor or the sponsor's spouse change or lose employment or die during the certification period.

F. Information required: The following information shall be obtained from the non-citizen at the time of initial application and at recertification:

(1) the full amount of the income and resources of a non-citizen's sponsor;

(2) the full amount of the income and resources of a sponsor's spouse, if the spouse is living with the sponsor;

(3) provision of the Immigration and Nationality Act under which the non-citizen was admitted;

(4) date of the non-citizen's entry or admission as a lawful permanent resident as established by INS;

(5) the non-citizen's date of birth, place of birth, and non-citizen registration number;

(6) number of dependents claimed or who could be claimed as dependents by the sponsor and the sponsor's spouse for federal income tax purposes;

(7) name, address and phone number of the non-citizen's sponsor;

(8) the above information shall be verified at initial application and at recertification.

G. Deemed income:

(1) The monthly income of the income of a sponsor and the sponsor's spouse (if living with the sponsor) shall be considered the unearned income of the sponsored non-citizen, until the non-citizen achieves US citizenship through naturalization or has worked 40 qualifying quarters of coverage as defined by the social security administration. If the sponsored non-citizen can demonstrate that the non-citizen's sponsor is the sponsor of other non-citizens, HCA shall divide the income by the number of such sponsored non-citizens. The spouse's income shall be counted even if the sponsor and spouse were married after the sponsoring agreement was signed. The monthly income attributed to the sponsored non-citizen is the total gross earned and unearned income (less exclusions) of the sponsor and sponsor's spouse (if living with the sponsor) at the time the household containing the sponsored non-citizen member applies or is recertified for participation in the FSP, reduced by:

(a) a twenty percent earned income amount for the portion of the income

determined as earned income of the sponsor and the sponsor's spouse; and

(b) an amount equal to the FSP's monthly gross income eligibility limit for a household equal in size to the sponsor, the sponsor's spouse, and any other person who is claimed or could be claimed by the sponsor or the sponsor's spouse as a dependent for federal income tax purposes.

(2) TANF-sponsored non-citizen income: If a non-citizen has already reported gross income information about the non-citizen's sponsor according to TANF sponsored non-citizen rules, that income amount shall be used for food stamp deeming purposes.

(3) Sponsor-paid money: Actual money paid to the non-citizen by the sponsor or the sponsor's spouse shall not be counted as income to the non-citizen unless the amount paid exceeds the amount deemed to the non-citizen. The amount paid that actually exceeds the amount deemed shall be counted as income to the non-citizen, in addition to the deemed amount.

H. Deemed resources:

(1) The full amount of the resources reduced by $1500 of a sponsor and the sponsor's spouse (if living with the sponsor) shall be deemed to be the resources of the sponsored non-citizen until the non-citizen achieves US citizenship through naturalization or has worked 40 qualifying quarters of coverage as defined by the social security administration. The spouse's resources shall be counted even if the sponsor and spouse were married after the sponsoring agreement was signed. If the sponsored non-citizen can demonstrate that the non-citizen's sponsor is the sponsor of other non-citizens, HCA shall divide the resources by the number of such sponsored non-citizens. Resources available to the sponsor shall be determined in accordance with the provisions found in 8.139.510 NMAC.

(2) TANF sponsored non-citizen resources: If a non-citizen has already reported all resource information on the non-citizen's sponsor according to TANF sponsored non-citizen rules, that resource amount shall be used for food stamp deeming purposes as the amount to be attributed to the non-citizen.

I. Determining eligibility and benefit amount: The amount of income and resources deemed to be that of the sponsored non-citizen is considered in determining the eligibility and benefit amount of the household of which the non-citizen is a member.

J. Sponsors:

(1) Sponsoring more than one non-citizen: If the sponsored non-citizen can demonstrate that the non-citizen's sponsor is the sponsor of other non-citizens, HCA shall divide the income and resources by the number of such sponsored non-citizens.

(2) Non-citizen switches sponsors: If the non-citizen reports that the non-citizen has changed sponsors during the certification period, deemed income and resources shall be recalculated based on information and verification about the new sponsor and the sponsor's spouse. The change shall be handled in accordance with change- reporting requirements, time frames and procedures, as appropriate.

(3) Loss of sponsorship: If a non-citizen loses their sponsor, and does not get another, the full amount of the income and resources of the previous sponsor continues to be attributed to the non-citizen until the non-citizen achieves US citizenship through naturalization or has worked 40 qualifying quarters of coverage as defined by the social security administration. If the non-citizen sponsor dies, the income and resources shall no longer be attributed to the non-citizen.

K. Awaiting verification: Until the non-citizen provides information or verification necessary to determine eligibility, the sponsored non-citizen is ineligible. The caseworker shall determine the eligibility of any remaining household members. The caseworker shall consider available to the remaining household members the income and resources of the ineligible non-citizen in determining the eligibility and benefit level of the remaining household members. If the sponsored non-citizen refuses to cooperate in providing information or verification, other adult members of the non-citizen's household are responsible for providing the information or verification required. If the caseworker subsequently receives information or verification, the caseworker shall act on the information as a reported change in household membership in accordance to timeliness standards. If the same sponsor is responsible for the entire household, the entire household is ineligible until such time as the household provides the needed sponsor information or verification. The caseworker shall assist the non-citizen in obtaining verification.

L. Over-issuance: A non-citizen's sponsor and the non-citizen shall be jointly liable for repayment of any over-issuance of food stamp benefits resulting from incorrect information provided by the sponsor. The sponsor of an non-citizen or the non-citizen shall also be independently responsible for the obligation to repay any over-issuance of food stamp benefits resulting from incorrect information provided by the sponsor.

(1) Good cause/sponsor: If an non-citizen's sponsor has good cause or is without fault for supplying the incorrect information, the non-citizen's household is solely liable for repayment of the over-issuance.

The caseworker shall determine whether good cause exists in such situations, and shall consider the facts and circumstances, including information submitted by the non-citizen and by the sponsor. Good cause includes, but is not limited to, a misunderstanding by a sponsor of the responsibility to report information about the sponsor's resources and income or a lack of information provided at the time a sponsor executed the affidavit of support or similar agreement on behalf of the non-citizen. Problems caused by the inability of a sponsor or non-citizen to speak, read, or write English may constitute good cause.

(2) Establishing the claim: If a sponsor does not have good cause, the caseworker shall determine whether to establish a claim for the over-issuance against the sponsor or the non-citizen's household, or both. HCA may choose to establish claims against both parties at the same time or to establish a claim against the party considered most likely to repay first. If a claim is established against the non-citizen's sponsor first, the caseworker shall ensure that a claim is established against the non-citizen's household if the sponsor fails to respond to a demand letter within 30 days of receipt. HCA shall return to the non-citizen's sponsor and/or the non-citizen's household any amounts repaid in excess of the total amount of the claim.

(3) Claims collection against sponsor:

(a) The restitution bureau initiates a collection action by sending an non-citizen's sponsor a written demand letter which informs the sponsor of the amount owed, the reason for the claim, and how the sponsor may pay the claim. The sponsor shall be informed that they shall not be held responsible for repayment of the claim if the sponsor can demonstrate good cause or absence of personal fault for the incorrect information having been supplied to HCA. In addition, the restitution bureau shall follow up the written demand letter with personal contact, if possible. HCA may pursue other collection actions as appropriate to obtain payment of a claim against any sponsor who fails to respond to a written demand letter. The restitution bureau shall end a collection action against a sponsor at any time if it has documentation that the sponsor cannot be located, or if the cost of further collection efforts is likely to exceed the amount that can be recovered. If a non-citizen's sponsor responds to a written demand letter and is financially able to pay the claim at one time, the restitution bureau shall collect a lump sum cash payment. The restitution bureau shall negotiate a payment schedule with the sponsor for repayment of the claim, as long as payments are made in regular installments. For more information on handling claims, see 8.139.640.11 NMAC.

(b) Exception: A sponsor who is participating in the food stamp program as a household shall be excluded from any demand for repayment of the value of food stamp benefits issued to a sponsored non-citizen.

(4) Fair hearing: A sponsor is entitled to a fair hearing either to contest a determination that the sponsor was at fault for giving incorrect information, or to contest the amount of the claim.

(5) Claims collection against non-citizen households: Before initiating collection against a sponsored non-citizen's household for repayment of an over issuance caused by incorrect information having been supplied concerning the sponsor or sponsor's spouse, a caseworker shall determine whether the incorrect information supplied was due to an inadvertent household error or an intentional program violation (IPV) on the part of the non-citizen. Claims collection against a household shall be pursued regardless of the current eligibility status of sponsored non-citizen or non-citizen households.

(a) Intentional misrepresentation: If sufficient documentary evidence exists to substantiate that incorrect information was provided by an act of IPV on the part of the non-citizen, the case shall be referred as a request for IPV disqualification, in accordance with the procedures in 8.139.647.8 NMAC. A claim against an non-citizen's household shall be handled as an inadvertent error claim until there is a determination of an IPV by an administrative disqualification hearing official or a court of appropriate jurisdiction.

(b) Misunderstanding/unintended error. If it is determined that incorrect information was supplied because of a misunderstanding or unintended error on the part of the sponsored non-citizen, the claim shall be handled as an inadvertent household error claim.

M. Memorandum of agreement: An agreement has been entered into by the secretary of the United States department of agriculture (USDA), the U.S. secretary of state, and the U.S. attorney general regarding sponsored non-citizen and their sponsors. A sponsor and non-citizen, at the time the sponsor executes an affidavit of support or similar agreement on behalf of the non-citizen, will be informed of the requirements of Sec. 1308 of P.L. 97-98. Under the agreement, the bureau of consular affairs of the state department and local INS offices provide information to HCA that is needed to carry out the provisions of the agreement. The agreement lists the specific information that must be released by all parties to facilitate identification of the non-citizen and sponsor and enable HCA to verify required information supplied by the non-citizen which is essential for eligibility determinations.
[8.139.420.9 NMAC – Rp 8.138.420.9 NMAC, 07/01/2024]

8.139.420.10 HOMELESS HOUSEHOLDS: Homeless households residing in public or private nonprofit shelters for homeless individuals will be exempt from the residents of an institution eligibility requirements (Subsection A of 8.139.400.13 NMAC). Such households may not be denied benefits for lack of a conventional or fixed residence, or be required to have a street address or post office box for mailing purposes. Homeless households may use their food stamp benefits to purchase meals from homeless meal providers that have been authorized by FCS to accept coupons for meal payments.

A. Homeless shelter standard: HCA will use a standard estimate of shelter expenses for households in which all members are homeless and are not receiving free shelter throughout the calendar month. All homeless households that incur, or reasonably expect to incur, shelter expenses during a month will be eligible for the homeless shelter standard unless higher shelter expenses are verified. The homeless shelter standard, which includes both shelter and utility expenses, is adjusted annually, and is effective every October (Paragraph (3) of Subsection F of 8.139.500.8 NMAC).

B. Restrictions:

(1) Households: No special restrictions will be imposed on homeless households living in shelters.

(2) Homeless meal providers: Homeless meal providers may not act as authorized representatives for homeless households. If a homeless shelter is authorized by FNS as a homeless meal provider, the shelter may not require a homeless household to surrender its food stamp benefits to the shelter. The shelter can only request voluntary use of food stamp benefits from homeless food stamp recipients.

(3) Cost of food: A shelter for the homeless may not require households using food stamp benefits to pay more than the average cost of the food purchased by the homeless meal provider. For purposes of this section, "average cost" will be calculated by averaging food costs over a period of up to one calendar month. The value of donated foods from any source will not be used to calculate the average cost, nor to determine the amount requested from food stamp recipients. All indirect costs, such as those incurred in the acquisition, storage, or preparation of the food used in meals, will also be excluded. Homeless meal providers may only use uncancelled, unmarked $1 food stamp benefit amounts in making change for meal purchases by homeless households. Change in the form of cash or credit slips is prohibited. In addition, if other shelter residents have the option of eating free or making a monetary donation, food stamp recipients in the shelter must be given the option of eating free or making a voluntary donation in money or food stamp benefits.

C. Shelter authorization procedures:

(1) To be authorized to accept food stamp benefits from homeless recipients, a homeless meal provider must file an application with FNS and be determined eligible as a homeless meal provider. The conditions that a homeless meal provider must meet are:

(a) the homeless meal provider must be a public organization or a private, nonprofit organization defined by the IRS [I.R.C. 501(c)(3)];

(b) the homeless meal provider must serve meals that include food purchased by the organization (providers serving meals consisting entirely of donated food are not authorized); and

(c) the homeless meal provider must obtain written approval from HCA that the organization does in fact serve meals to homeless persons.

(2) FNS may limit the participation of any homeless meal provider in order to preserve the integrity of the food stamp program.

[8.139.420.10 NMAC – Rp 8.138.420.10 NMAC, 07/01/2024]

HISTORY OF 8.139.420 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 460.0000, Action on Households with Special Circumstances, 8/15/1980.
ISD-Rule 451.0000, Food Assistance - Action on Households with Special Circumstances, 11/5/1982.
ISD-Rule 450.0000, Action on Households with Special Circumstances, 10/13/1983.
ISD-Rule 450.0000, Food Assistance - Action on Households with Special Circumstances, 4/24/1984.
ISD-Rule 457.0000, Food Assistance - Residents of Drug/Alcoholic Treatment and Rehabilitation Programs, 11/5/1982.
ISD-Rule 458.0000, Food Assistance - Other Households with Special Circumstances, 11/5/1982.
ISD-Rule 458.0000, Food Assistance - Other Households with Special Circumstances, 2/23/1983.
ISD-Rule 458.0000, Food Assistance - Other Households with Special Circumstances, 10/13/1983.
ISD FS 240, Special Food Stamp Households, 2/2/1988.

History of Repealed Material: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 500 FINANCIAL ELIGIBILITY - NEED DETERMINATION

8.139.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.500.1 NMAC – Rp 8.139.500.1 NMAC, 07/01/2024]

8.139.500.2 SCOPE: General public.
[8.139.500.2 NMAC – Rp 8.139.500.2 NMAC, 07/01/2024]

8.139.500.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.500.3 NMAC – Rp 8.139.500.3 NMAC, 07/01/2024]

8.139.500.4 DURATION: Permanent
[8.139.500.4 NMAC – Rp 8.139.500.4 NMAC, 07/01/2024]

8.139.500.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.139.500.5 NMAC – Rp 8.139.500.5 NMAC, 07/01/2024]

8.139.500.6 OBJECTIVE: Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the health care authority.
[8.139.500.6 NMAC – Rp 8.139.500.6 NMAC, 07/01/2024]

8.139.500.7 DEFINITIONS: [**RESERVED**]

8.139.500.8 BASIS OF ISSUANCE:

A. Income standards: Determination of need in SNAP is based on federal guidelines. Participation in the program is limited to households whose income is determined to be a substantial limiting factor in permitting them to obtain a nutritious diet. The net and gross income eligibility standards are based on the federal income poverty levels established in the Community Services Block Grant Act [42 USC 9902(2)].

B. Gross income standards: The gross income eligibility standards for the 48 contiguous states, District of Columbia, Guam and the Virgin islands is one hundred thirty percent of the federal income poverty levels for the 48 states and the District of Columbia. One hundred thirty percent of the annual income poverty guidelines is divided by 12 to determine monthly gross income standards, rounding the results upward as necessary. For households larger than eight, the increment in the federal income poverty guidelines is multiplied by one hundred thirty percent, divided by 12, and the results rounded upward if necessary.

C. Net income standards: The net income eligibility standards for the 48 contiguous states, District of Columbia, Guam and the Virgin islands are the federal income poverty levels for the 48 contiguous states and the District of Columbia. The annual income poverty guidelines are divided by 12 to determine monthly net income eligibility standards, (results rounded upward if necessary). For households larger than eight, the increment in the federal income poverty guidelines is divided by 12, and the results rounded upward if necessary.

D. Yearly adjustment: Income eligibility limits are revised each October 1st to reflect the annual adjustment to the federal income poverty guidelines for the 48 contiguous states and the District of Columbia and can be found at https://www.fns.usda.gov/snap/cost-living-adjustment-cola-information.

E. Deductions and standards:

(1) Determination: Expense and standard deduction amounts are determined by federal guidelines and may be adjusted each year. Households eligible based on income and resource guidelines, and other relevant eligibility factors, are allowed certain deductions to determine countable income.

(2) Yearly adjustment: The expense and standard deductions may change each year. If federal guidelines mandate a change, it is effective each October 1st, and can be found at https://www.fns.usda.gov/snap/cost-living-adjustment-cola-information and http://www.HCA.state.nm.us/LookingForInformation/Federal_Poverty_Level_Guidelines.aspx
[8.139.500.8 NMAC – Rp 8.139.500.8 NMAC, 07/01/2024]

8.139.500.9 PROSPECTIVE BUDGETING:

A. Initial month procedures: "Initial month" means the first month for which a household is certified for participation in the food stamp program following any period during which the household was not certified for participation. Eligibility and food stamp benefit amount for households submitting an initial application will be based on circumstances for the entire calendar month in which a household files its application.

(1) Changing eligibility:

(a) Because of anticipated changes, a household may be eligible for the month of application, but ineligible in the next month. The household is entitled to benefits for the month of application, even if the application is processed and benefits issued in the subsequent month.

(b) A household may be ineligible for the month of application but eligible in the next month because of anticipated changes in circumstances.

(c) Even if denied for the month of application, a household does not need to reapply in the next month. The same application is used for the denial of the month of application and the determination of eligibility in subsequent months.

(2) Prorating initial month's food stamp benefit amount: A household's food stamp benefit amount for the initial month is based on the day of the month the household applies.

B. Varied benefit amount: As a result of anticipating changes, a household's food stamp benefit amount for the month of application may differ from the amount in later months.

(1) The income support specialist (ISS) will establish a certification period for the longest period over which changes in the household's circumstances can reasonably be anticipated.

(2) For changes discussed at the application interview, a household's food stamp benefit amount may vary from month to month during the certification period to reflect changes anticipated at the time of certification.

(3) Adverse action notices will not be required for any subsequent month in which the food stamp benefit amount decreases. Adequate notice will be required for each month in which the food stamp benefit amount changes.

C. Retroactive benefits: For households that have completed the application process by the 30th day after application, and have been determined eligible, the food stamp benefit amount will be provided retroactively to the date of application.

D. Recertification procedures: Eligibility and food stamp benefit amount for recertification will be determined prospectively based on circumstances anticipated for the certification period beginning the month following the expiration of the current certification period.

E. Mass change procedures: Adjustments to the maximum food stamp benefit amount, income standards, shelter and dependent care deduction limits, state utility standard adjustments, and overall adjustments to financial assistance payments and mass changes in federal benefits, such as social security and SSI benefits, are made by a mass change. The adjustment is made in the month before the change is effective to allow for adequate notice to affected households.

F. Determining resources: Available resources at the time the household is interviewed will be used to determine the household's eligibility.

(1) Nonrecurring lump sum payments are counted as resources in the month received and are not counted as income.

(2) Resources received or available in the month of application but expended before the day of the interview are not used to determine the household's eligibility, unless the resource was transferred for the purpose of qualifying for food stamp benefits.
[8.139.500.9 NMAC – Rp 8.139.500.9 NMAC, 07/01/2024]

8.139.500.10 DETERMINING INCOME:

A. Anticipating income: In determining a household's eligibility and SNAP benefit amount ISD shall use income already received by the household during the certification period and any income the household and ISD are reasonably certain shall be received during the remainder of the certification period.

(1) If the amount of income or date of receipt is uncertain, that portion of the household's income that is uncertain shall not be counted.

(2) If the exact amount of the income is not known, that portion of the income which can be anticipated with reasonable certainty shall be considered income.

(3) In cases where the receipt of income is reasonably certain but the monthly amount may fluctuate, a household may choose to average its income.

B. Income received during any past 30-day consecutive period that includes 30 days prior to the date of application through the date of timely disposition shall be used as an indicator of the income that is and shall be available to the household during the certification period.

(1) Past income is not used as an indicator of income anticipated for the certification period if changes in income have occurred or can be anticipated during the certification period.

(2) If income fluctuates to the extent that a single four-week period does not provide an accurate indication of anticipated income, a longer period of past time can be used if it gives a more accurate indication of anticipated fluctuations in income.

(3) Income already received is not used and verification is obtained from the income source, if the household and ISD decide that income already received by the household is not indicative of income expected to be received in future months.

C. Simplified reporting: A household filing an interim report form is subject to the income methodology specified at 8.139.500.9 NMAC.

D. Income anticipated during the certification period shall be counted only in the month it is expected to be received, unless the income is averaged.

E. Use of conversion factors: Whenever a full month's income is anticipated and is received on a weekly or biweekly basis, the income shall be converted to monthly amount as follows:

(1) income received on a weekly basis is averaged and multiplied by four;

(2) income received on a biweekly basis is averaged and multiplied by two;

(3) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $.50 or more are rounded up; amounts resulting in $.49 or lower are rounded down.

F. Held wages:

(1) Wages withheld at the request of an employee shall be considered income to a household in the month the wages would otherwise have been paid by the employer.

(2) Wages withheld by the employer as a general practice, even in violation of the law, shall not be counted as income to a household, unless the household anticipates that it will ask for and receive an advance.

(3) If a household anticipates asking for and receiving income from wages that were previously withheld by the employer as a general practice, the income shall be counted to determine eligibility.

G. Earned income:

(1) Earned income shall be anticipated based on income received when the following criteria are met:

(a) the applicant and ISD are reasonably certain the income amounts received are indicative of future income and expected to continue during the certification period; and

(b) the anticipated income is based on income received from any consecutive past 30-day period that includes 30 days prior to the date of application through the date of timely disposition of the application.

(2) When the applicant and ISD determine that the income received is not indicative of future income that will be received during the certification period, a longer period of time may be used if it will provide a more accurate indicator of anticipated income.

(3) Provided the applicant and ISD are reasonably certain the income amounts are indicative of future income, the anticipated income shall be used for the month of application and the remaining months of the certification period.

H. Unearned income:

(1) Unearned income shall be anticipated based on income received when the following criteria are met:

(a) the applicant and ISD are reasonably certain the income amounts received are

indicative of future income and expected to continue during the certification; and

(b) the anticipated income is based on income received from any consecutive past 30-day period that includes 30 days prior to the date of application through the date of timely disposition of the application.

(2) When the applicant and ISD determine that the income received is not indicative of future income that will be received during the certification period, a longer period of time may be used if it will provide a more accurate indicator of anticipated income.

(3) Provided the applicant and ISD are reasonably certain the income amounts are indicative of future income, the anticipated income shall be used for the month of application and the remaining months of the certification period.

(4) Households receiving state or federal assistance payments, such as Title IV-A, GA, SSI or social security payments on a recurring monthly basis are not considered to have varied monthly income from these sources simply because mailing cycles may cause two payments to be received in one month.

I. Income received more frequently than weekly: The amount of monthly gross income paid more frequently than weekly (i.e., daily) is determined by adding all the income received during the past four weeks. The gross income amount is used to anticipate income in the application month and the remainder of the certification period. Conversion factors shall not be applied to this income.

J. Income received less frequently than monthly: The amount of monthly gross income paid less frequently than monthly is determined by dividing the total income by the number of months it is intended to cover. ISD shall carefully explain to the household how the monthly income was computed and what changes might result in a reportable change. Documentation shall be filed in the case record to establish clearly how the anticipated income was computed.

K. Use of conversion factors: Whenever a full month's income is anticipated but is received on a weekly or biweekly basis, the income shall be converted to monthly amount as follows:

(1) income received on a weekly basis is averaged and multiplied by four;

(2) income received on a biweekly basis is averaged and multiplied by two;

(3) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $.50 or more are rounded up; amounts resulting in $.49 or lower are rounded down.

L. Known changes in income for future months at application:

(1) At application or recertification, it shall be determined if any factors affecting income will change in future months. Such factors include a new income source, termination of income, or increases or decreases in income.

(2) Income is considered only when the amount of the income and the date it will be received are reasonably certain.

(3) In the event that a change is known for future months, benefits are computed by taking into account the change in income.

M. Averaging income over the certification period:

(1) All households may choose to have their income averaged. Income is usually not averaged for destitute households because averaging would result in assigning to the month of application income from future periods which is not available for its current food needs.

(2) To average income, ISD uses a household's anticipation of income fluctuations over the certification period. The number of months used to arrive at the average income need not be the same as the number of months in the certification period.

(3) Contract income: Households which, by contract, derive their annual income in a period of less than one year shall have that income averaged over a 12-month period, provided that the income is not received on an hourly or piecework basis.

(a) Contract income includes income for school employees, farmers, self-employed households, and individuals who receive annual payments from the sale of real estate.

(b) These procedures do not include migrant or seasonal farm worker households.

(4) Educational monies: Households receiving scholarships, deferred educational loans, or other educational grants shall have such income, after exclusions, averaged over the period for which it is provided. All months which the income is intended to cover shall be used to average income, even if the income is received during the certification period. If the period has elapsed completely, the educational monies shall not be considered income.

N. Using exact income: Exact income, rather than averaged income, shall be used if:

(1) the household has chosen not to average income;

(2) income is from a source terminated in the application month;

(3) employment has just begun in the application month and the income represents only a partial month;

(4) in the month of application, the household qualifies for expedited service or is considered a destitute, migrant or seasonal farm worker household; or

(5) income is received more frequently than weekly, (i.e., daily).

[8.139.500.10 NMAC – Rp 8.139.500.10 NMAC, 07/01/2024]

8.139.500.11 DETERMINING DEDUCTIBLE EXPENSES: Household expenses which can be deducted from income include only certain costs of dependent care, child support, medical and shelter expenses.

A. Expenses not allowed as deductions:

(1) Vendor payments and reimbursements: An expense covered by an excluded reimbursement or vendor payment is not deductible. Vendor payments are those paid directly to a household's creditors by a non-household member, while reimbursements are paid to a household after it has paid creditors.

(2) Reimbursable medical expenses: That portion of an allowable medical expense which is reimbursable will not be included as a household's medical expense when calculating the medical expense deduction.

(3) Service provided by household member: Expenses will be deductible only for a service provided by someone outside a participating household, and for which the household makes a money payment. Only money received from an outside source is considered income to a household; money paid to a provider outside the household is counted as a deductible expense.

(4) Child care expenses: Child care expenses which are reimbursed or paid for by the Jobs Opportunities and Basic Skills Training Program (JOBS) under Title IV-F of the Social Security Act [42 USC 681] or the transitional child care (TCC) program will not be deductible when calculating the dependent care deduction allowed for a household.

(5) Child support expenses: A child support deduction will not be allowed if the household does not report or verify its monthly child support payment or a change in its legal obligation.

B. Billed expenses:

(1) Allowing a deduction: A deduction is allowed only in the month the expense is billed or otherwise becomes due, regardless of when the household intends to pay it.

(2) Arrears: Amounts carried forward from past billing periods (arrears) are not deductible, even if included in the most recent billing and actually paid by the household, unless these expenses are billed less often than monthly and are averaged. A particular expense may be deducted only once. Rent, mortgage payments or property taxes that are in arrears are not allowed, even if they were not previously allowed in any certification period.

(3) Expense not allowed: If a household receives a bill during the certification period but does not report it until it is past due, the expense may not be allowed as a deduction. Similarly, late charges assessed to a household on a past due bill are not allowed as a deductible expense.

(4) Billed medical expenses: If a household claims a deduction for billed medical expenses, but does not know or cannot verify the portion of billed expenses that will be reimbursed, the expense is allowed after the reimbursement is received or can otherwise be verified, rather than in the month the bill is received. Only the unreimbursed amount of the bill is deductible. A deduction will be allowed when the household verifies that a billed medical expense will not be paid directly to the provider by a third party, or will not be reimbursed to the household by an insurance company or government program.

(5) Child support deduction:

(a) Child support is not an allowable deduction when billed. Verification of payment must be received prior to allowance of the deduction.

(b) The child support deduction will include amounts paid toward arrearages, provided that the household has at least a three month record of payments.

C. Anticipating expenses: A household's expenses will be calculated based on the expenses the household expects to be billed during the certification period.

(1) Anticipation of expenses is based on the most recent month's bills, unless the household is reasonably certain a change will occur.

(2) If actual costs for a household's heating/cooling or other utility expenses are anticipated to be less than the appropriate mandatory utility standard, the appropriate mandatory utility standard shall be

allowed.

(3) Income conversion procedures will apply to anticipated expenses billed on a weekly or biweekly basis.

(4) Child support will be anticipated based on actual payments during past months and reasonably certain changes expected in the future.

D. Averaging expenses: A household may choose to have fluctuating expenses averaged.

E. One-time expenses: A household may choose to have a one-time only expense averaged over the entire certification period, or allowed in the month the expense is billed or becomes due.

(1) If a household chooses the one-time expense deduction, the caseworker will document the expense in the case file. Such expenses include annual property taxes and insurance.

(2) A one-time expense may be averaged over the period the billing is intended to cover.

(3) A household may choose to have a one-time only expense reported at certification deducted in a lump sum or averaged over the certification period.

(4) A household reporting a one-time only medical expense during its certification period may choose to have a one-time expense deduction or to have the expense averaged over the remaining months of the certification period.

(a) If a household incurs a one-time only medical expense and makes arrangements with the provider to pay in monthly installments (beyond the current certification period), the expense may be allowed each month as arranged.

(b) A household reporting a one-time only medical expense during the certification period may choose to have a one-time deduction or to have the expense averaged over the remaining months of the certification period. Averaging would begin the month the change becomes effective.

(c) If a household is billed for and reports an expense during the last month of the certification period, the deduction may not be allowed unless it will be paid in installments during the following certification period. The deduction will be allowed during the appropriate number of months in the following certification period.

F. Expenses billed less often than monthly: Households may choose to have expenses which are billed less often than monthly averaged forward over the interval between scheduled billings or, if there is no scheduled interval, averaged forward over the period the expense is intended to cover. Averaging may be used even if the bill is received before the certification period. Averaging is governed by the scheduling of the bill or the period the expense is intended to cover.

G. Fluctuating medical expenses: Fluctuating medical expenses will be allowed as deductions if regularly recurring, reasonably anticipated, and verified. Medical expenses will not be calculated by averaging past months' medical expenses. Past expenses are used only as an indicator of what can reasonably be anticipated.

H. Dependent care: Dependent care expenses paid on a weekly or biweekly basis will be averaged if a household has chosen to average income. Conversion procedures will be used if a household is billed on a weekly or biweekly basis.

[8.139.500.11 NMAC – Rp 8.139.500.11 NMAC, 07/01/2024]

8.139.500.12 ESTABLISHING CERTIFICATION PERIODS:

A. The caseworker shall establish a definite period of time within which a household is eligible to receive benefits.

B. Entitlement to SNAP benefits ends at the expiration of the household's certification period. Continued eligibility is determined only when an application has been filed, an interview held, and all verification provided.

C. Under no circumstances shall benefits be continued beyond the end of a certification period without a redetermination of eligibility.

D. A household shall be provided with an expiration notice before or at the beginning of the last month of a certification period.

E. If a household is determined eligible for the initial month but ineligible the following month, it shall be certified for one month only. Conversely, a household may be ineligible for the month of application but eligible for the following month(s). If the household is denied for the month of application, it does not need to file a new application for the following month.

F. Conformity with calendar month: Certification periods shall conform to calendar months. At the initial application, the first month in the certification period is the month of application, even if the household's eligibility is not determined until a later month.

G. Length of certification period: All households will be assigned to simplified reporting and shall be assigned a certification period in accordance with Subsection A of 8.139.120.9 NMAC. Households shall be assigned the longest certification period possible based on the stability of the household's circumstances. A certification period cannot exceed 12 months, except for households in which all adult members in the household are elderly or disabled. Households in which all members are elderly or disabled will be assigned a 24-month certification period. At least one contact with each certified household shall be made every 12 months.

H. Shortening the certification period:

(1) The caseworker may not end a household's certification period earlier than its assigned termination date, unless the caseworker receives information that the household has become ineligible, or the household has not taken action to clarify or provide verification of a change in household circumstances for which the caseworker has requested verification.

(2) Loss of cash assistance or a change in employment status is not sufficient to meet the criteria necessary for shortening a certification period.

I. Lengthening the certification period: The caseworker may lengthen a household's current certification period once it is established, as long as the total months of the certification period do not exceed 24 months for households in which all adult members are elderly or disabled, or 12 months for other households. If the caseworker extends the household's certification period, the caseworker shall issue written notice advising the household of the new certification end date.

[8.139.500.12 NMAC – Rp 8.139.500.12 NMAC, 07/01/2024]

HISTORY OF 8.139.500 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 421.0000, Application Processing, 7/31/1980.
ISD-Rule 439.0000, Monthly Reporting/Retrospective Budgeting (MRRB), 10/13/1983.
ISD-Rule 439.0000, Monthly Reporting/Retrospective Budgeting (MRRB), 4/24/1984.
ISD-Rule 439.0000, Monthly Reporting/Retrospective Budgeting (MRRB), 8/3/1984.
ISD-Rule 441.0000, Food Assistance - Actions Subsequent to Determine Eligibility, 11/5/1982.
ISD-Rule 440.0000, Actions Subsequent to Determine Eligibility, 2/9/1983.
ISD-Rule 440.0000, Actions Subsequent to Determine Eligibility, 9/8/1983.
ISD-Rule 440.0000, Actions Subsequent to Determine Eligibility, 10/13/1983.
ISD-Rule 440.0000, Actions Subsequent to Determine Eligibility, 4/24/1984.
ISD-Rule 442.0000, Food Assistance - Transfer of Households, 11/4/1982.
ISD-Rule 442.0000, Food Assistance - Transfer of Households, 9/8/1983.
ISD 424.0000, Recertification, 7/28/1980.
ISD-443.0000, Food Assistance - Recertification, 11/4/1982.
ISD-443.0000, Food Assistance - Recertification, 9/8/1983.
ISD-443.0000, Food Assistance - Recertification, 10/13/1983.
ISD-443.0000, Food Assistance - Recertification, 1/12/1984.
ISD FS 510, Food Stamp Reporting and Recertification, 3/2/1988.

History of Repealed Material: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 510 ELIGIBILITY POLICY - RESOURCES AND PROPERTY

8.139.510.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.510.1 NMAC – Rp 8.139.510.1 NMAC, 07/01/2024]

8.139.510.2 SCOPE: General public
[8.139.510.2 NMAC – Rp 8.139.510.2 NMAC, 07/01/2024]

8.139.510.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8 NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.510.3 NMAC – Rp 8.139.510.3 NMAC, 07/01/2024]

8.139.510.4 DURATION: Permanent.
[8.139.510.4 NMAC – Rp 8.139.510.4 NMAC, 07/01/2024]

8.139.510.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.139.510.5 NMAC – Rp 8.139.510.5 NMAC, 07/01/2024]

8.139.510.6 OBJECTIVE: Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the health care authority.
[8.139.510.6 NMAC – Rp 8.139.510.6 NMAC, 07/01/2024]

8.139.510.7 DEFINITIONS: [RESERVED]

8.139.510.8 RESOURCE ELIGIBILITY STANDARDS:

A. The maximum allowable resources for a household, including both liquid and non-liquid assets are revised and adjusted each year in October and can be found at https://www.fns.usda.gov/snap/cost-living-adjustment-cola-information.

B. The value of a nonexempt resource is its equity value. Equity value is the fair market value less encumbrances. The value of stocks and bonds, such as U.S. savings bonds, is their cash value, not their face value.

C. It is a household's responsibility to report all resources held at the time of application and any anticipated to be received, or that are later received during the certification period, that might place the household's resources above the maximum allowed.

D. Categorically eligible households: Households that are categorically eligible do not need to meet the resource limits or provisions of this section.

E. Sponsored non-citizens: For households containing sponsored non-citizens, a prorated amount of the countable resources of a non-citizen's sponsor and sponsor's spouse (if living with the sponsor) are deemed to be those of the sponsored non-citizen, in accordance with sponsored non-citizen provisions in 8.139.420.9 NMAC.

F. Non-household members: The resources of non-household members, defined in 8.139.400.10 NMAC shall not be considered available to the household.

G. Resources of ineligible or disqualified household members: The resources of ineligible or disqualified household members shall be counted as available to the household in their entirety. If a resource exclusion applies to a household member, the exclusion shall also apply to the resources of an ineligible or disqualified person whose resources are counted as available to the household.

[8.139.510.8 NMAC – Rp 8.139.510.8 NMAC, 07/01/2024]

8.139.510.9 STANDARDS:

A. Liquid resources: Liquid resources are readily negotiable resources such as, but not limited to:

(1) cash on hand;

(2) money in checking and saving accounts;

(3) savings certificates, stocks and bonds (even if they are producing income consistent with their fair market value), credit union shares, promissory notes, U.S. savings bonds (after they become accessible six months from the date of purchase);

(4) loans, including loans from private individuals as well as from commercial institutions, are considered in the month received.

B. Lump-sum payments: Money received in the form of a nonrecurring lump sum payment is counted as a resource in the month received, unless specifically excluded by other federal laws.

(1) Lump sum payments include, but are not limited to:

(a) income tax refunds, rebates, or credits, including earned income tax credit payments after 2 months;

(b) retroactive lump sum social security, SSI, cash assistance, railroad retirement benefits or similar payments;

(c) lump sum insurance settlements;

(d) refunds of security deposits on rental property or utilities;

(e) substantial lottery or gambling winnings.

(2) Lump sum payments are delayed payments owed to a household for past periods.

C. Other liquid resources: Liquid resources also include:

(1) funds held in individual retirement accounts (IRAs), and

(2) funds held in Keogh plans that do not involve a household member in a contractual relationship with individuals who are not household members; in determining the availability of IRAs or Keogh plans, the caseworker shall count the total cash value minus the amount of the penalty (if any) for early withdrawal of the entire amount.

D. Non-liquid resources: Non-liquid resources include personal property, boats, buildings, land, recreational property, and any other property, provided that the resource is not specifically excluded. Non-liquid resources shall be documented in sufficient detail to permit verification if the resource becomes questionable.

E. Vehicles: The entire value of any licensed or unlicensed vehicle shall be excluded in determining eligibility and benefit amount in the food stamp program.

[8.139.510.9 NMAC – Rp 8.139.510.9 NMAC, 07/01/2024]

8.139.510.10 EXCLUSIONS:

A. In determining the resources of a household, the following shall be excluded:

(1) home and surrounding property (Subsection C of 8.139.510.10 NMAC);

(2) household and personal goods (Subsection D of 8.139.510.10 NMAC);

(3) life insurance, deferred compensation and joint pension funds (Subsection D of 8.139.510.10 NMAC);

(4) all retirement accounts with federal tax-preferred status from the food stamp asset test as well as any tax-preferred retirement accounts that congress creates in the future;

(5) all tax-preferred education accounts, such as 529s;

(6) income-producing property (Subsection E of 8.139.510.10 NMAC);

(7) work-related equipment (Subsection F of 8.139.510.10 NMAC);

(8) inaccessible resources (Subsection G of 8.139.510.10 NMAC);

(9) resources excluded by federal law (8.139.527 NMAC);

(10) resources of non-household members (Subsection F of 8.139.510.8 NMAC);

(11) other exempt resources, such as those of an SSI or Title IV-A recipient;

(12) excluded monies kept in a separate account and not commingled with non-excluded funds; when commingled, the excluded monies retain their exclusion for a period of six months from the date they are commingled.

(13) vehicles: the entire value of a vehicle owned by a household member shall be excluded as a countable resource as set forth at Subsection E of 8.139.510.9 NMAC.

B. Exceptions:

(1) Educational loans and grants of students, commingled with non-excluded funds, retain the exemption for the period over which they are intended to be used.

(2) Operating funds of a self-employment enterprise commingled with non-excluded funds retain the exemption for the period over which they have been prorated as income.

C. Home and surrounding property: A household's home, and surrounding property which is not separated from the home by intervening property owned by others, shall be excluded. Public rights of way, such as roads that run through the surrounding property and separate it from the home, do not affect the exemption of the property. The home and surrounding property remain exempt when temporarily unoccupied for reasons of employment, training for future employment, illness, or uninhabitability caused by casualty or natural disaster, if the household intends to return. No specific time limit is imposed in determining that the absence is temporary. A household that currently does not own a home, but owns or is purchasing a lot on which it intends to build, or is building a permanent home, receives an exclusion for the value of the lot, and, if partially completed, for the home. If part of the land surrounding a home is rented, the land retains this exclusion and the income-producing test in Subsection E of 8.139.510.10 NMAC does not apply. Any income received from renting part of the surrounding property shall be counted in determining income eligibility and food stamp benefit amount.

D. Personal effects:

(1) Households goods, livestock, and personal effects, including one burial plot per household member, and the cash value of life insurance policies shall be excluded. Any amount that can be withdrawn from a prepaid burial plan shall be counted as a resource and cannot be excluded under this provision.

(2) The cash value of pension plans or pension funds shall be excluded.

(3) IRAs and Keogh plans involving no contractual relationship with individuals who are not household members are not excluded.

E. Income-producing property:

(1) Exclusions: The following income-producing property shall be excluded:

(a) Property which annually produces income consistent with its fair market value, even if used on a seasonal basis. Such property includes rental and vacation homes. If the property cannot produce income consistent with its fair market value because of circumstances beyond the household's control, the exclusion remains in effect.

(b) Property, such as farm land, which is essential to the employment or self-employment of a household member. Property essential to the self-employment of a household member engaged in farming continues to be excluded for one year from the date that the household member ends self-employment farming.

(c) An installment contract for the sale of land or a building that is producing income consistent with its fair market value. The value of the property sold under an installment contract or held as security in exchange for the purchase price consistent with the fair market value of that property is also excluded. The value of personal property sold on installment contracts such as boats, automobiles, etc. is also treated in this manner as long as the property sold on contract is not part of a self-employment enterprise.

(2) Determining fair market value: The following guidelines shall be used to determine fair market value:

(a) If it is questionable that property is producing income consistent with its fair market value, the caseworker shall contact local realtors, tax assessors, the small business administration, farmer's home administration or other similar sources to determine the prevailing rate of return. If it is determined that property is not producing income consistent with its fair market value, such property is counted as a resource. If property is leased for a return that is comparable to that on other property in the area leased for similar purposes, it is considered income producing consistent with its fair market value and is not counted as a resource.

(b) Property exempt as essential to employment need not be producing income consistent with its fair market value. For example, the land of a farmer is essential to the farmer's employment; therefore, a good or bad crop year does not affect the exemption of such property as a resource.

F. Work-related equipment exclusion: Work-related equipment, such as the tools of a trades-person or the machinery of a farmer, which are essential to the employment or self-employment of a household member are excluded. The tools of a trades-person are excluded, and remain exempt, if the trades-person becomes disabled. Farm machinery retains this exclusion for one year if the farmer ends self-employment.

G. Inaccessible resources: Resources shall be excluded if their cash value is not accessible to the household, such as, but not limited to:

(1) security deposits on rental property or utilities;

(2) property in probate: when a decision is rendered by the court explaining how the

property is to be divided, the property is no longer in probate, whether or not the household signs papers;

(3) real property that the household is making a good faith effort to sell at a reasonable price and which has not been sold; and

(4) irrevocable trust funds: any funds in a trust, or transferred to a trust, and the income produced by that trust to the extent it is not available to the household, is considered inaccessible to the household if:

(a) the trust arrangement is not likely to cease during the certification period and no household member has the power to revoke the trust arrangement or change the name of the beneficiary during the certification period;

(b) the trustee administering the funds is:

(i) a court;

(ii) an institution, corporation, or organization not under the direction or ownership of any household member;

(iii) an individual appointed by the court with court-imposed limitations placed on the use of the funds;

(c) the trust investments made on behalf of the trust do not directly involve or assist any business or corporation under the control, direction, or influence of a household member; and

(d) the funds held in an irrevocable trust are either:

(i) established from the household's own funds, if the trustee uses the funds solely to make investments on behalf of the trust, or to pay the educational or medical expenses of any person named by the household creating the trust; or

(ii) established from non-household funds by a non-household-member.

(5) Insignificant return: Any resource, that as a practical matter, the household is unable to sell for any significant return because the household's interest is relatively slight or because the cost of selling the household's interest would be relatively great.

(a) A resource shall be so identified if its sale or other disposition is unlikely to produce any significant amount of funds for the support of the household.

(b) This provision does not apply to financial instruments such as stocks, bonds, and negotiable financial instruments, nor to vehicles.

(c) The caseworker may require verification of the value of a resource to be considered inaccessible if the information provided by the household is questionable.

(d) The following definitions shall be used in determining whether a resource may be excluded under this provision:

(i) "significant return" is any return, after estimated costs of sale or disposition, and taking into account the ownership interest of the household, that is estimated to be one half or more of the applicable resource limit for the household;

(ii) "any significant amount of funds" are funds amounting to one-half or more of the applicable resource limit for the household.

H. Joint property:

(1) Joint resources: Resources owned jointly by separate households shall be considered available in their entirety to each household, unless it can be demonstrated by an applicant household that such resources are inaccessible to it. The household must verify that:

(a) it does not have the use of the resource;

(b) it did not make the purchase or down payment;

(c) it does not make the continuing loan payments, and

(d) the title is transferred to or retained by the other household;

(e) if a household can demonstrate that it has access to only a part of the resource, the value of that part is counted toward the household's resource level; a resource shall be considered totally inaccessible, if it cannot be practically subdivided and the household's access to the value of the resource is dependent on the agreement of a joint owner who refuses to comply; for purposes of this provision, ineligible non-citizens or disqualified individuals residing with a household are considered household members.

(2) Joint bank accounts: If signatories to a joint bank account are separate households, the funds in the account are considered available to each household to the extent that it has contributed to the account. If the participating household has not contributed to the account, the funds are considered available only if there is clear and convincing evidence that the other household intends that the participating household actually own the funds.

I. Residents of shelters for battered women and children: Resources shall be considered

inaccessible to individuals residing in shelters for battered women and children if:

(1) resources are jointly owned by shelter residents and members of their former household, and

(2) shelter resident's access to the value of the resource(s) is dependent on the agreement of a joint owner residing in the former household.

J. Other exempt resources:

(1) Earmarked resources: Government payments designated for the restoration of a home damaged in a disaster shall be excluded, if the household is subject to a legal sanction if the funds are not used as intended. However government payments designed to bring homes "up to code" are not exempt and are counted as a resource.

(2) Prorated income: Resources, such as those of students or self-employed individuals which have been prorated as income, shall be excluded.

(3) Indian lands: Indian land held jointly by a participating household and the tribe, or land that can be sold only with the approval of the department of interior's bureau of Indian affairs, shall be excluded.

(4) Business loan collateral: Non liquid assets against which a lien has been placed as a result of taking out a business loan, when the household is prohibited by the security or loan agreement with the lien holder (creditor) from selling the assets, shall be excluded.

(5) Property for vehicle maintenance and use: Property, real or personal, is excluded to the extent that it is directly related to the maintenance or use of a vehicle excluded under Paragraph (1) of Subsection E of 8.139.510.9 NMAC. Only that part of real property determined necessary for actual maintenance or use is excludable under this provision.

(6) Title IV-A/SSI recipients: The resource of any household member who receives:

(a) supplemental security income (SSI) benefits under Title XVI of the Social Security Act; or

(b) aid to the aged, blind, or disabled under Titles I, X, XIV, or XVI of the Social Security Act; or

(c) benefits under part A of Title IV of the Social Security Act shall be considered exempt for food stamp purposes provided resources are also considered exempt under the applicable titles or parts of the Social Security Act.

[8.139.510.10 NMAC – Rp 8.139.510.10 NMAC, 07/01/2024]

8.139.510.11 RESOURCE TRANSFERS:

A. Anyone whose resources are considered available, and who knowingly transfers resources, will be disqualified from participating in the program if the transfer meets all of the following criteria:

(1) the transfer was made within the three-month period immediately preceding the date of application or the household knowingly transferred the resource after approval;

(2) the resources transferred will affect eligibility; if the resources will not affect eligibility, such as furniture, the transfer will not disqualify the household;

(3) the resources were transferred for less than fair market value; if the compensation received in cash, property, services, or other reasonable form of payment is at or near fair market value, the transfer does not disqualify the household;

(4) the transfer was not between members of the same household or persons whose resources are considered available (disqualified members); and

(5) the transfer was made for the purpose of qualifying or attempting to qualify for benefits; if the resources were transferred for reasons other than qualifying or attempting to qualify for food stamp benefits, such as a parent placing funds into an educational trust fund, the transfer does not disqualify the household.

B. Disqualification:

(1) If it is determined that an applicant household knowingly transferred resources for the purpose of qualifying or attempting to qualify for food stamp benefits, the household will be disqualified from participating in the food stamp program for up to one year from the date of the discovery of the transfer.

(2) If the household is applying, the period of disqualification begins with and includes the month of application.

(3) If the household is participating at the time the transfer is discovered, an adverse action notice explaining the reason for and the length of the disqualification will be sent. The period of disqualification will begin the month following the month the notice of adverse action time limit expires, unless the household appeals the action and requests continued benefits.

(4) The fact that a household was certified, but did not receive any food stamp benefits, does not preclude the penalty for transferring resources.

C. Time period for disqualification:

(1) The length of the disqualification period is based on the amount by which the nonexempt transferred resource, when added to other countable resources, exceeds the allowable resource limit.

(2) The following chart will be used to determine the period of disqualification:

Amount in Excess the Resource Unit	**Period of Disqualification**
$0 to $249.99	1 month
$250 to $999.99	3 months
$1,000 to $2,999.99	6 months
$3,000 to $4,999.99	9 months
$5,000 or more	12 months

[8.139.510.11 NMAC – Rp 8.139.510.11 NMAC, 07/01/2024]

HISTORY OF 8.139.510 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 440.0000, Eligibility Criteria - Financial, 8/15/1980.
ISD 440.0000, Eligibility Criteria - Financial, 10/24/1980.
ISD-Rule 428.0000, Food Assistance - Resources, 11/4/1982.
ISD-Rule 428.0000, Food Assistance - Resources, 2/14/1983.
ISD-Rule 428.0000, Food Assistance - Resources, 1/12/1984.
ISD-Rule 428.0000, Food Assistance - Resources, 5/1/1986.
ISD FS 410, Food Stamp Resources, 3/1/1988.

History of Repealed Material: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 610 PROGRAM BENEFITS - ISSUANCE AND RECEIPT

8.139.610.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.610.1 NMAC – Rp 8.139.610.1 NMAC, 07/01/2024]

8.139.610.2 SCOPE: General public
[8.139.610.2 NMAC – Rp 8.139.610.2 NMAC, 07/01/2024]

8.139.610.3 STATUTORY AUTHORITY: The supplemental nutrition assistance program (SNAP) is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering SNAP is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.610.3 NMAC – Rp 8.139.610.3 NMAC, 07/01/2024]

8.139.610.4 DURATION: Permanent
[8.139.610.4 NMAC – Rp 8.139.610.4 NMAC, 07/01/2024]

8.139.610.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.139.610.5 NMAC – Rp 8.139.610.5 NMAC, 07/01/2024]

8.139.610.6 OBJECTIVE: Issuance of the revised SNAP policy manual is intended to be used in administration of the SNAP in New Mexico. This revision incorporated the latest federal policy changes in SNAP not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the health care authority.
[8.139.610.6 NMAC – Rp 8.139.610.6 NMAC, 07/01/2024]

8.139.610.7 DEFINITIONS: [RESERVED]
[8.139.610.7 NMAC – Rp 8.139.610.7 NMAC, 07/01/2024]

8.139.610.8 [RESERVED]
[8.139.610.8 NMAC – Rp 8.139.610.8 NMAC, 07/01/2024]

8.139.610.9 [RESERVED]
[8.139.610.9 NMAC – Rp 8.139.610.9 NMAC, 07/01/2024]

8.139.610.10 ISSUANCE DATE:

A. HCA is responsible for timely and accurate benefit issuance to certified eligible households. A participating household has a definite issuance date so that SNAP benefits are received on or about the same time each month. The issuance date is based on the last two digits of the social security number of the individual to whom the SNAP benefits are issued. A household must have the opportunity to participate before the end of each issuance month.

B. Opportunity to participate: Opportunity to participate means a household is provided with SNAP benefits no later than 30 calendar days after the date an application is filed.

(1) Newly certified household: All newly certified households must be given an opportunity to participate no later than 30 calendar days following the date the application was filed. In EBT issuance situations, benefits must be authorized by the 29th day to be available to the household on the 30th day.

(a) Combined issuance: Households with an application date after the 15th of the month and are eligible for expedited assistance are eligible for combined issuance.

(i) SNAP benefits for the initial month and the second month will be issued the day after approval of expedited service.

(ii) SNAP benefits for the third month will be issued the first day of the third month after approval.

(iii) SNAP benefits for the fourth month will be issued during the first ten days of the month based on a ten day compressed staggered issuance schedule. The issuance schedule uses the last two digits of the head of households SSN to determine the day of the month benefits are issued.

(iv) SNAP benefits for the fifth and ongoing months will be issued on the 20 day staggered issuance schedule. The issuance schedule uses the last two digits of the head of household's SSN to determine the day of the month the benefits are issued.

(b) Households not entitled to combined issuance: The following households will not be entitled to combined issuance of the SNAP benefits:

(i) a household certified for one month only;

(ii) a household determined ineligible for the month of application, but eligible for the second month;

(iii) a household entitled to expedited service who must provide postponed verification to obtain the second month's SNAP benefits; or

(iv) a household that has been recertified.

(c) Standard Issuance: Households with an application date before the 15th of the month and approved in the month of application will have their prorated amount for initial month of benefits issued the day after the case is approved.

(i) SNAP benefits for the second month will be issued the first day of the month in the second month of approval.

(ii) SNAP benefits for the third month during the first ten days of month based on a ten day compressed staggered issuance schedule. The issuance schedule uses the last two digits of the head of households SSN to determine the day of the month benefits are issued.

(iii) SNAP benefits for the fourth and ongoing months will be issued on the 20 day staggered issuance schedule. The issuance schedule uses the last two digits of the head of household's SSN to determine the day of the month the benefits are issued.

(d) Expedited households: Households eligible for expedited service will receive SNAP benefits in the initial month within the expedited time limit. Benefits for the following month will be received on the household's designated issuance date if all postponed verification is provided before the end of the initial month.

[8.139.610.10 NMAC – Rp 8.139.610.10 NMAC, 07/01/2024]

8.139.610.11 USE OF SNAP BENEFITS: Pursuant to Section 15(d) of the Food Stamp Act, SNAP benefits are an obligation of the United States within the meaning of 18 United States Code (U.S.C.) 8. The provisions of Title 18 of the United States Code, "crimes and criminal procedures," relative to counterfeiting, misuse, or alteration of obligations of the U.S., are applicable to SNAP benefits. Any unauthorized issuance, redemption, use, transfer, acquisition, alteration, or possession of SNAP benefits may subject an individual, partnership, corporation, or other legal entity to prosecution under Sections 15(b) and (c) of the Food Stamp Act or other applicable federal, state, or local law, regulation, or ordinance.

A. General uses: SNAP benefits are used by participants to purchase eligible foods, including seeds and plants, for home consumption. A household may designate other individuals to use SNAP benefits to purchase food for them. A household is not required to have cooking facilities or access to cooking facilities to participate in the program.

B. Special uses: Although SNAP benefits were originally intended to be used by eligible households to purchase food for home consumption, certain households are authorized to use SNAP benefits to obtain prepared meals or to facilitate their obtaining food. Authorized special uses for SNAP include:

(1) Communal dining: Eligible household members 60 years of age or over or SSI recipients and their spouses may use SNAP benefits to purchase meals prepared at communal dining facilities authorized by FNS. Communal dining facilities include senior citizen centers, apartment buildings occupied primarily by elderly persons or SSI households, public or private nonprofit establishments (eating or otherwise) that feed elderly persons or SSI recipients, and federally subsidized housing for the elderly at which meals are prepared and served to the residents. They also include private establishments under contract with an appropriate state or local agency to offer meals at concessional prices to elderly persons or SSI recipients.

(2) Meals-on-wheels: Eligible household members 60 years of age or over or members who are homebound, physically handicapped, or otherwise disabled to the extent that they are unable to adequately prepare all their meals, and the spouses of such members, may use their SNAP benefits to purchase meals prepared and delivered to them by a nonprofit meal delivery service authorized by FNS. A meal delivery service is a political subdivision, a private nonprofit organization, or a private establishment with which a state or local agency has contracted for the preparation and delivery of meals at concessional prices to elderly individuals and their spouses, and to the physically or mentally handicapped and individuals otherwise disabled, and their spouses, such that they are unable to adequately prepare all of their meals.

(3) Addicts and alcoholics in treatment programs: Members of eligible households who are narcotics addicts or alcoholics who regularly participate in a drug or alcoholic treatment and rehabilitation program may use their SNAP benefits to purchase meals prepared for them during the course of such programs by a nonprofit organization or institution or a publically operated community mental health center which is authorized by FNS to redeem SNAP benefits.

(4) Residents in group living arrangements: Eligible residents of a group living arrangement may use their SNAP benefits to purchase meals prepared especially for them at a group living arrangement authorized by FNS to redeem SNAP benefits.

(5) Residents of shelters for battered persons: Residents of shelters for battered persons may use their SNAP benefits to purchase meals prepared specifically for them at a shelter authorized by FNS to redeem SNAP benefits.

(6) Residents of shelters for the homeless: Homeless households may use their SNAP benefits to purchase prepared meals from homeless meal providers authorized by FNS.

C. SNAP benefits as income: SNAP benefits provided to an eligible household will not to be considered income or resources for any purpose under federal, state, or local laws, including but not limited to, laws on taxation, welfare, and public assistance programs. No participating state or political subdivision may decrease any other assistance provided to an individual or individuals because such individuals receive SNAP benefits. [8.139.610.11 NMAC – Rp 8.139.610.11 NMAC, 07/01/2024]

8.139.610.12 GENERAL (BENEFIT AMOUNT)

A. The SNAP benefit amount to be issued depends on the number of eligible members in the household and the net monthly income used to determine eligibility.

(1) HCA uses a 30-day calendar month to determine a household's SNAP benefit amount. A household applying on the 31st of the month will be treated as if it applied on the 30th.

(2) When a household is determined eligible, the SNAP benefit amount is calculated, issuance authorization is processed that night, and SNAP benefits are issued the following work day.

B. Maximum SNAP allotments:

(1) The maximum SNAP allotment shall be based on the thrifty food plan (TFP). TFP means the diet required to feed a family of four persons consisting of a man and a woman 20 through 50, a child six through eight, and a child nine through 11 years of age, determined in accordance with USDA calculations. The cost of such diet shall be the basis for uniform allotments for all households regardless of their actual composition. In order to develop maximum SNAP allotments, USDA shall make household size and other adjustments in the thrifty food plan taking into account economies of scale and other adjustments as required by law. The TFP amounts and maximum allotments are adjusted annually.

(2) Except when SNAP benefits are prorated and when reductions are made at the national level, a household's monthly SNAP benefit amount is equal to the maximum SNAP allotment for the household's size reduced by thirty percent of its net monthly income.

(3) The maximum SNAP allotment can be calculated by multiplying a household's net income by thirty percent, rounding the result up to the next whole dollar, and subtracting that amount from the TFP for the appropriate household size (https://www.fns.usda.gov/snap/cost-living-adjustment-cola-information).

C. Initial month: A household's SNAP benefit amount for the initial month of certification will be based on the day of the month the household applies for SNAP benefits. The household receives SNAP benefits from the date of application to the end of the month, unless the applicant household consists of residents of a public institution.

(1) Applying from institutions: For households applying for SSI and SNAP benefits before release from an institution, the SNAP benefit amount for the initial month of certification will be based on the date of the month the household is released from the institution. The household will receive SNAP benefits from the date of the household's release from the institution to the end of the month.

(2) Benefits less than ten dollars ($10.00): If the initial month's calculations yield a SNAP benefit amount of less than ten dollars ($10.00), then no issuance will be made for the initial month. For households entitled to no SNAP benefits in the initial month, but eligible in subsequent months, ISD shall certify a household beginning with the month of application.

D. Minimum benefit amount:

(1) Except during an initial month, all eligible one- and two-person households, including categorically eligible households, will receive a minimum monthly SNAP benefit amount.

(2) Determination: Minimum amounts are determined by federal guidelines and may be adjusted each year. All eligible one and two person households, including categorically eligible households, will receive the minimum monthly SNAP benefit amount, which can be found at https://www.fns.usda.gov/snap/cost-living-adjustment-cola-information.

(3) All eligible households with three or more members which are entitled to no benefits (except because of the proration requirements and the provision precluding issuances of less than ten dollars ($10.00) in an initial month as per Paragraph 2 of Subsection C of 8.139.610.12 NMAC), ISD shall deny the household's application on the grounds that its net income exceeds the level at which benefits are issued. [8.139.610.12 NMAC – Rp 8.139.610.12 NMAC, 07/01/2024]

8.139.610.13 CALCULATING THE BENEFIT AMOUNT: A household's net income is used to determine its SNAP benefit amount. The net income is the gross amount less allowable deductions. To determine the household's net income:

A. The gross monthly income earned by all household members is added to the total monthly unearned income of all household members, less income exclusions, to determine the household's total gross income. The household must qualify at the gross income calculation.

B. The total gross monthly earned income is multiplied by twenty percent; the result is subtracted from the total gross earned income; add the result to the total monthly unearned income; or multiply the total gross monthly earned income by eighty percent and add the result to the total monthly unearned income.

C. Subtract the standard deduction.

D. If the household is entitled to an excess medical deduction, determine if total medical expenses exceed 35 dollars ($35.00). If so, subtract the amount which exceeds 35 dollars ($35.00).

E. Subtract the child support deduction as determined by Paragraph 2 of Subsection G of 8.139.520.11 NMAC.

F. Subtract allowable monthly dependent care expenses, if any, up to the maximum amount per dependent; if the household has no shelter expenses, the net income has been determined at this point; go to step J.

G. If the household has shelter expenses, divide the result in Subsection F by two.

H. Determine if the household is entitled to an excess shelter expense deduction as follows:

(1) For households not entitled to uncapped shelter:

(a) total the allowable shelter expenses;

(b) subtract from the total shelter expenses fifty percent of the household’s monthly income after all other deductions have been subtracted, i.e., the result in Subsection G;

(c) the remaining amount is the excess shelter expense; compare this amount to the current excess shelter deduction limit as found at https://www.fns.usda.gov/snap/cost-living-adjustment-cola-information;

(d) subtract the current excess shelter deduction amount or the result in Paragraph (c), whichever is less, from the household's monthly income determined in Subsection F; the household's net income has been determined; go to step I.

(2) For households entitled to uncapped shelter: Households containing an elderly or disabled member are entitled to an uncapped shelter expense deduction. Such households have the full amount of the shelter expense exceeding fifty percent of the households net income subtracted. To determine the net income for a household entitled to an uncapped shelter expense deduction, complete steps A through G as described above, and then:

(a) total the allowable shelter expenses;

(b) subtract from the total shelter expenses fifty percent of the household's monthly income after all other deductions have been have been subtracted (the result in Subsection G); the remaining amount is the excess shelter expense;

(c) subtract the amount in Paragraph (b) from the monthly income amount determined in Subsection F; the household's net income has been determined; go to step I.

I. Round each income calculation to the nearest dollar (one cent ($.01) through 49 cents ($.49) round down; 50 cents ($.50) through 99 cents ($.99) round up).

J. Multiply the household's net income by thirty percent; round the cents up to the nearest dollar, and subtract that amount from the maximum SNAP benefit amount for the household's size. The SNAP benefit amount for the household is determined.

[8.139.610.13 NMAC – Rp 8.139.610.13 NMAC, 07/01/2024]

8.139.610.14 REPLACEMENT OF BENEFITS:

A. Conditions for replacement: Subject to certain restrictions, households may be authorized a replacement issuance when the household reports the food purchased with SNAP benefits was destroyed in a household misfortune or natural disaster. The loss must be reported within ten calendar days of the day the food purchased with SNAP benefits was destroyed. The loss is ineligible for replacement if the loss is not reported timely.

(1) Replacing benefits: Subject to certain restrictions, households may be authorized a replacement issuance of SNAP benefits when the household reports that food purchased with the SNAP benefits was destroyed in a household misfortune or natural disaster.

(2) Reporting the loss: The loss of food purchased with SNAP benefits must be reported in a timely manner by the household. The report will be considered timely if the loss is reported within 10 days of the date the food purchased with SNAP benefits is destroyed in household misfortune or natural disaster.

(3) Ineligible for replacement: Food purchased with SNAP benefits will not be replaced if:

(a) the household reports that the food purchased with SNAP benefits was destroyed after receipt in an event other than a household misfortune or natural disaster; or

(b) the loss was not timely reported by the household.

(4) Household responsibilities: To qualify for a replacement, the household must:

(a) report the loss in a timely manner, either orally or in writing; and

(b) sign an affidavit or statement attesting to the loss of the household's food purchased with SNAP benefits.

(5) HCA responsibilities: HCA shall issue the replacement SNAP benefit amount if warranted, within 10 days after the report of loss, or within two working days of the date that HCA receives the signed affidavit or statement, whichever is later. Replacement of SNAP benefits will be delayed until a determination of the value of the benefits can be made.

(6) Affidavits: If a signed affidavit is not received by ISD within 10 days of the date the loss is reported, there will be no replacement. If the 10th day falls on a weekend or holiday, the deadline is the day after the weekend or holiday. The affidavit is retained in the client electronic case record. It attests to the destruction of food purchased with the original issuance and specifies the reason for the replacement. It shall also state that the household is aware of the penalties for intentional misrepresentation of the facts, including but not limited to, a charge of perjury for a false claim.

(7) Authorization: There will be no limit on the number of replacements a household may be authorized for food purchased with SNAP benefits which was destroyed in a household misfortune or natural disaster.

(8) Verification of conditions for replacement: Before replacing destroyed food purchased with SNAP benefits, ISD shall determine that the destruction occurred in a household misfortune or natural disaster, such as a fire, as well as in natural disasters affecting more than one household. This is verified through one of the following:

(a) collateral contacts; or

(b) documentation from a community agency such as but not limited to, the fire department or the red cross; or

(c) a home visit; or

(d) FNS has issued a disaster declaration and a household is eligible for emergency SNAP benefits; a household cannot receive both the disaster SNAP benefit and a replacement benefit for a household misfortune or natural disaster.

B. Calculation of replacement: A replacement of the actual value of the loss not to exceed one month’s SNAP benefit amount may be issued if food purchased with SNAP benefits is destroyed in a household misfortune or natural disaster affecting a participating household. HCA will provide a replacement issuance within 10 days of a reported loss.

C. Fair hearings: A household must be informed of its right to a fair hearing to contest denial of a

replacement issuance. Replacements will not be authorized during the appeal process. A replacement is authorized if the appeal is decided in favor of the household.
[8.139.610.14 NMAC – Rp 8.139.610.14 NMAC, 07/01/2024]

8.139.610.15 NATIONAL REDUCTION OR SUSPENSION: If funding for SNAP is depleted, Section 18 of the Food Stamp Act of 1977, as amended, provides for reduction, suspension or cancellation of SNAP benefits for one or more months, or a combination of these three actions.

A. Reduction:

(1) If a reduction in SNAP allotments is deemed necessary, the maximum SNAP allotments amounts for all household sizes is reduced by a percentage specified by FNS. The maximum SNAP allotments amounts for each household size are reduced by the same percentage. This results in all households of a given size having their benefits reduced by the same dollar amount. The dollar reduction is smallest for a one-person household and greatest for the largest households. Since the dollar amount is the same for all households of the same size, the rate of reduction is lowest for zero net income households and greatest for the highest net income households.

(2) All one- and two-person households affected by a reduction action are guaranteed a minimum monthly SNAP benefit, unless the action is a cancellation of SNAP benefits, suspension of SNAP benefits, or reduction in SNAP benefits of ninety percent or more of the total amount of benefits projected to be issued in the affected month. The benefit reduction notice issued by USDA specifies whether the minimum SNAP benefit amount will be provided.

(3) SNAP benefits shall also be able to be adjusted to provide for the rounding of benefit levels of one dollar ($1.00), three dollars ($3.00) and five dollars ($5.00) to two dollars ($2.00), four dollars ($4.00) and six dollars ($6.00), respectively.

B. Suspension or cancellation:

(1) If a decision is made to suspend or cancel the distribution of SNAP benefits in a given month, FNS shall notify HCA of the date the suspension or cancellation will take effect. If SNAP benefits are suspended or cancelled, the minimum benefit provision for one- and two-person households is disregarded and all households will have their benefits suspended or cancelled.

(2) Resumption of benefits: Upon notification by FNS that a benefit suspension has ended, HCA shall act immediately to resume benefit issuance to certified households.

C. Notices: SNAP benefit reductions, suspensions, and cancellations are considered a federal adjustment to SNAP benefits. HCA shall notify all households of benefit reductions, suspensions, or cancellations in accordance with adequate notice provisions in Subsection A of 8.139.120.13 NMAC. HCA shall not provide an adverse action notice to a household affected by a benefit reduction, suspension, or cancellation.

D. Effect of reduction on certification:

(1) Normal processing: Eligibility determination for applicant households under normal (non-expedited) processing will not be affected by a benefit reduction, suspension, or cancellation. HCA shall accept and process applications during a month(s) in which a reduction, suspension, or cancellation is in effect in accordance with 8.139.110.12 NMAC, application processing. The determination of eligibility will also be made according to these provisions. If an applicant household is determined eligible for SNAP benefits and a reduction is in effect, the benefit amount is calculated by reducing the maximum SNAP allotments amount by the appropriate percentage for the applicant's household size and then deducting thirty percent of the household's net SNAP income from the reduced maximum SNAP allotments amount. If an applicant household is determined eligible for SNAP benefits while a suspension or cancellation is in effect, no benefits will be issued to the household until issuance is again authorized by FNS.

(2) Expedited service: Expedited processing continues during the months in which reductions, suspensions or cancellations are in effect.

(a) Reductions: Households receiving expedited service in months in which reductions are in effect and that are determined eligible will be issued reduced benefits. The reduced SNAP benefit amount will be made available within the time frame specified for expedited issuance.

(b) Suspension: Households receiving expedited service in months in which a suspension is in effect and that are determined eligible will have a benefit determination made within the time frames for expedited issuance. If a suspension remains in effect at the time issuance is authorized, the issuance will be suspended until FNS lifts the suspension.

(c) Cancellations: Households eligible for expedited processing which apply for SNAP benefits during months in which cancellations are in effect will receive expedited service. The deadline for

completing the processing is five calendar days or the end of the month of application, whichever date is later. All other rules for providing expedited service are applicable.

(3) Certification periods: The reduction, suspension, or cancellation of SNAP benefits in a given month will have no effect on the certification period assigned to a household. Those households with certification period expiring during a month in which SNAP benefits have been reduced, suspended or cancelled will be recertified and have a new certification period assigned.

E. Fair hearings: Any household that has its SNAP benefit amount reduced, suspended or cancelled as a result of an order issued by FNS may request a fair hearing if the household disagrees with the action. The fair hearing process is subject to the following conditions:

(1) Basis for fair hearings: HCA is not required to hold fair hearings unless the request is based on a household's belief that the SNAP benefit amount was computed incorrectly under suspension, reduction, or cancellation rules or that such rules were applied or interpreted incorrectly. HCA shall deny a fair hearing to a household that is merely disputing the fact that a reduction, suspension, or cancellation was ordered.

(2) Continuation of benefits pending fair hearing: Since the reduction, suspension, or cancellation is necessary to avoid an expenditure of funds beyond those appropriated by congress, households do not have a right to continuation of SNAP benefits pending a fair hearing.

(3) Retroactive benefits: A household will receive retroactive SNAP benefits in an appropriate amount if it is found that its SNAP benefits were reduced by more than the amount by which HCA was directed to reduce SNAP benefits.

F. Restoration of benefits:

(1) HCA shall have issuance services available to serve households receiving restored or retroactive SNAP benefits for a previous, unaffected month if benefit reduction, suspension or cancellation has been ordered.

(2) Households whose SNAP benefits are reduced, suspended or cancelled as a result of these procedures will not be entitled to restoration of lost benefits at a future date. However, if there is a surplus of funds as a result of the reduction or cancellation, FNS will direct HCA to restore benefits to affected households, unless the secretary of agriculture determines that the amount of surplus funds is too small for this to be practical.

(3) HCA shall design procedures to implement the restoration of SNAP benefits promptly if FNS directs the restoration of benefits.

[8.139.610.15 NMAC – Rp 8.139.610.15 NMAC, 07/01/2024]

HISTORY OF 8.139.610 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 450.0000, Determining Household Eligibility and Benefit Levels, 8/15/1980.
ISD 470.0000, Issuance and Use of Coupons, 8/15/1980.
ISD 404.0000, State Agency Administration, 7/15/1980.
ISD 404.0000, Food Assistance - Coupons as Obligations of the United States, 2/10/1981.
ISD-Rule 404.0000, Food Assistance - Coupons as Obligations of the United States, 11/4/1982.
ISD-Rule 436.0000, Food Assistance - Establishing Certification Periods, 11/4/1982.
ISD-Rule 436.0000, Food Assistance - Establishing Certification Periods, 1/20/1984.
ISD-Rule 436.0000, Food Assistance - Establishing Certification Periods, 5/111984.
ISD-Rule 446.0000, Food Assistance - Replacement Allotments, 11/5/1982.
ISD-Rule 447.0000, Food Assistance - Replacement of Coupons Lost in the Mail, 11/5/1982.
ISD-Rule 448.0000, Food Assistance - Allotment Reduction Procedures, 11/5/1982.
ISD FS 450, Issuance and Use of Food Stamps, 3/1/1988.
ISD FS 450, Issuance and Use of Food Stamps, 4/30/1992.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 139 FOOD STAMP PROGRAM
PART 647 FOOD STAMP PROGRAM - ADMINISTRATIVE DISQUALIFICATION PROCEDURES

8.139.647.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.139.647.1 NMAC – Rp 8.139.647.1 NMAC, 07/01/2024.]

8.139.647.2 SCOPE: General public
[8.139.647.2 NMAC – Rp 8.139.647.2 NMAC, 07/01/2024.]

8.139.647.3 STATUTORY AUTHORITY: The food stamp program is authorized by the Food Stamp Act of 1977 as amended (7 U.S.C. 2011 et. seq.). Regulations issued pursuant to the act are contained in 7 CFR Parts 270-282. State authority for administering the food stamp program is contained in Chapter 27 NMSA, 1978. Administration of the health care authority (HCA), including its authority to promulgate regulations, is governed by Chapter 9, Article 8, NMSA 1978 (Repl. 1983). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.139.647.3 NMAC – Rp 8.139.647.3 NMAC, 07/01/2024.]

8.139.647.4 DURATION: Permanent
[8.139.647.4 NMAC – Rp 8.139.647.4 NMAC, 07/01/2024.]

8.139.647.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited for a section.
[8.139.647.5 NMAC – Rp 8.139.647.5 NMAC, 07/01/2024.]

8.139.647.6 OBJECTIVE: Issuance of the revised food stamp program policy manual is intended to be used in administration of the food stamp program in New Mexico. This revision incorporated the latest federal policy changes in the food stamp program not yet filed. In addition, current policy citations were rewritten for clarification purposes or were simply reformatted. Issuance of the revised policy manual incorporated a new format which is the same in all income support division policy manuals. A new numbering system was designated so that similar topics in different programs carry the same number. The revised format and numbering standards were designed to create continuity among ISD programs and to facilitate access to policy throughout the health care authority.
[8.139.647.6 NMAC – Rp 8.139.647.6 NMAC, 07/01/2024.]

8.139.647.7 DEFINITIONS: [**RESERVED**]

8.139.647.8 ADMINISTRATIVE DISQUALIFICATION PROCEDURES

A. Administrative responsibility: HCA will be responsible for investigating any case of alleged intentional program violation (IPV), and ensuring that appropriate cases are acted upon either through administrative disqualification hearings (ADH) or referral to a court of appropriate jurisdiction. Administrative disqualification procedures or referrals for prosecution should be initiated by HCA in cases in which HCA has sufficient documentary evidence to substantiate that an individual has committed one or more acts of intentional program violation. A recommendation to pursue administrative disqualification of an individual is made by the office of the inspector general (OIG) upon review of documentary evidence submitted by the county office. If HCA does not initiate administrative disqualification procedures or refer for prosecution a case involving an over-issuance caused by a suspected act of IPV, HCA will take action to collect the over-issuance by establishing an inadvertent household error claim against a household in accordance with the procedures in Subsection B of 8.139.640.9 NMAC and Subsection A of 8.139.640.10 NMAC.

(1) Initiating hearings: HCA should conduct administrative disqualification hearings in the following situations:

(a) in cases in which HCA believes the facts of the individual case do not warrant civil or criminal prosecution through the appropriate court system;

(b) in cases previously referred for prosecution that were declined by the appropriate legal authority, and

(c) in previously referred cases where no action was taken within a reasonable

period of time and the referral was formally withdrawn by HCA.

(2) When a hearing is not initiated: HCA will not initiate an administrative disqualification hearing against an accused individual whose case is currently being referred for prosecution or subsequent to any action taken against the accused individual by the prosecutor or court of appropriate jurisdiction, if the factual issues of the case arise out of the same, or related circumstances.

(3) Household eligibility: HCA may initiate administrative disqualification procedures or refer a case for prosecution regardless of the current eligibility of an individual.

(4) Determination of administrative disqualification:

(a) HCA will base administrative disqualifications for IPV on the determinations of hearing authorities arrived at through administrative disqualification hearings, or on determinations reached by courts of appropriate jurisdiction.

(b) HCA has the option of allowing accused individuals either to waive their rights to administrative disqualification hearings or to sign disqualification consent agreements for cases of deferred adjudication. If HCA chooses either of these options, the administrative disqualification for IPV may be based on the waived right to an administrative disqualification hearing or on the signed disqualification consent agreement in cases of deferred adjudication.

B. Disqualification penalties:

(1) Individuals found to have committed an intentional program violation (IPV) either through an administrative disqualification hearing or by a federal, state, or local court, or who have signed either a waiver of right to an administrative disqualification hearing or a disqualification consent agreement in cases referred for prosecution, will be ineligible to participate in the food stamp program as follows:

(a) for a period of six months for the first IPV; or for a period of one year for the first IPV if the offense occurred after August 22, 1996;

(b) for a period of one year for the second IPV; or for a period of two years for the second IPV if the offense occurred after August 22, 1996;

(c) permanently for the third finding of an IPV.

(d) one or more intentional program violations which occurred prior to the implementation of the disqualification periods specified above will be considered as only one previous disqualification when determining the appropriate penalty to impose in a case under consideration.

(2) Sale of controlled substances: Individuals found by a federal, state or local court to have used or received food stamp benefits in a transaction involving the sale of a controlled substance (as defined in Sec. 102 of the Controlled Substances Act [21 USC 802]) will be ineligible to participate in the food stamp program:

(a) for a period of one year upon the first occasion of such violation; or for two years upon the first occasion of such violation if the offense occurred after August 22, 1996; and

(b) permanently upon the second occasion of such violation.

(3) Permanent disqualification from participation in FSP:

(a) Individuals found by a federal, state or local court to have used or received food stamp benefits in a transaction involving the sale of firearms, ammunition, or explosives will be permanently ineligible to participate in the FSP upon the first occasion of such violation.

(b) Individuals convicted in federal or state court of trafficking food stamp benefits with a value of $500 or more, for an offense which occurred after August 22, 1996.

(c) The penalties in (2) and (3) above will also apply in cases of deferred adjudication described in Subsection D of 8.139.647.11 NMAC, where the court makes a finding that the individual engaged in the conduct described in (2) or (3). Regardless of when an action taken by an individual which caused an IPV occurred, the disqualification periods in (2) and (3)(a) will apply to any case in which the court makes the requisite finding on or after September 1, 1994.

(4) Dual participation in the FSP: An individual will be ineligible to participate in the FSP as a member of any household for a period of ten years upon a finding of IPV, or conviction in federal or state court, for having made a fraudulent statement or representation with respect to the identity or place of residence of the individual in order to receive multiple benefits simultaneously in the FSP. The provision applies only to an offense which occurred after August 22, 1996.

(5) Court failure to impose disqualification: If a court fails to impose a disqualification period for the IPV, HCA will impose the disqualification penalties specified above, unless it is contrary to the court order.

(6) Disqualifying the individual: HCA will disqualify only the individual found to have committed intentional program violation, or who has signed the waiver of right to an administrative disqualification

hearing or disqualification consent agreement in cases referred for prosecution, and not the entire household.

(7) Restitution by remaining household members: The remaining household members must agree to make restitution within thirty days of the date HCA's written demand letter is mailed, or the households monthly food stamp benefit amount will be reduced.

(a) If the remaining household members agree to make restitution but fail to do so, HCA will impose a benefit reduction on the household's monthly benefit amount.

(b) The remaining household members, if any, will begin restitution during the period of disqualification imposed by HCA or a court of law.

(c) All restitutions will be made in accordance with established procedures for cash repayment, benefit reduction, or coupons for repayment. See 8.139.640.11 NMAC for procedures on claims collection.

C. Notification to applicant households: HCA will inform a household in writing of the disqualification penalties for intentional program violation each time a household applies for Program benefits.

D. Definition of IPV: For purposes of determining through administrative disqualification hearings whether or not an individual has committed an intentional program violation, an IPV will consist of having intentionally:

(1) made a false or misleading statement, or misrepresented, concealed or withheld facts; or

(2) committed any act that constitutes a violation of the Food Stamp Act, food stamp program regulations, or any state statute relating to the use, presentation, transfer, acquisition, receipt, or possession of food stamp benefits.

[8.139.647.8 NMAC – Rp 8.139.647.8 NMAC, 07/01/2024.]

8.139.647.9 DISQUALIFICATION HEARINGS: HCA will publish clearly written rules of procedure for disqualification hearings, and will make these procedures available to any interested party.

A. HCA conducted hearings: When HCA has sufficient documentary evidence indicating that an individual may have committed an intentional program violation (IPV), action will be taken to conduct an administrative disqualification hearing.

(1) Consolidation of ADH with fair hearing: An administrative disqualification hearing and a fair hearing may be combined into a single hearing if the factual issues arise out of the same or related, circumstances and the household receives prior notice that the hearing will be combined.

(a) Time frames: If a disqualification hearing and fair hearing are combined, HCA will follow the time frames for conducting disqualification hearings.

(b) Claims and IPV determination: If the hearings are combined for the purpose of settling the amount of the claim at the same time as determining whether or not intentional program violation has occurred, the household will lose its right to a subsequent fair hearing on the amount of the claim.

(c) Waiving the 30-day advance notice: HCA will allow, upon household request, a household to waive the required 30-day advance notice of hearing when the disqualification hearing and fair hearing are combined.

(2) Administrative disqualification hearing procedures:

(a) Hearing officers: HCA may use the same hearing official for disqualification hearings and fair hearings or may designate hearing officials to conduct only disqualification hearings.

(b) Advising household or representative: At the disqualification hearing the hearing official will advise the household member or representative that they may refuse to answer questions during the hearing.

(c) Time limits for decision: Within 90 days of the date the household member is notified in writing that the hearing has been scheduled HCA will conduct the hearing, arrive at a decision, and notify the household member and local agency of the decision.

(d) Postponing the scheduled hearing: The household member or representative is entitled to a postponement of the scheduled hearing provided that the request for postponement is made at least ten (10) days in advance of the date of the scheduled hearing. The hearing will not be postponed for more than a total of 30 days and HCA may limit the number of postponements to one. If the hearing is postponed the time limits above may be extended for as many days as the hearing is postponed.

(3) Advance notice of hearing: HCA will provide written notice to a household member suspected of intentional program violation at least thirty days in advance of the date a disqualification hearing which is initiated by HCA has been scheduled.

(a) If mailed, the notice will be sent either first class mail or certified mail-return

receipt requested. The notice may also be provided by any other reliable method. If no proof of receipt is obtained, a showing of non-receipt by the household member will be considered good cause for not appearing at the hearing.

(b) The notice will contain, at a minimum:

(i) the date, time and place of the hearing;

(ii) the charge(s) against the household member;

(iii) a summary of the evidence, and how and where the evidence can be examined;

(iv) a warning that the decision will be based solely on information provided by the county office if the household member fails to appear at the hearing;

(v) a statement that the household member or representative will have 10 days from the date of the scheduled hearing to present good cause for failure to appear in order to receive a new hearing;

(vi) a warning that a determination of IPV will result in disqualification periods as determined by 8.139.647.8 NMAC; and a statement of which penalty HCA believes is applicable to the case scheduled for a hearing;

(vii) a listing of the household's member's rights;

(viii) a statement that the hearing does not preclude the state or federal government from prosecuting the household member for IPV in civil or criminal court action, or from collecting the over-issuance;

(ix) the name of an individual or organization, if any, that provides free legal representation;

(x) the date that the signed waiver must be received by the hearing official to avoid holding the hearing;

(xi) a statement of the accused individual's right to remain silent concerning the charge(s), and that anything said or signed by the individual concerning the charge(s) can be used against him/her in a court of law;

(xii) the telephone number and, if possible, the name of the person to contact for additional information; and

(xiii) the fact that the remaining household members, if any, will be held responsible for repayment of the resulting claim.

(4) Scheduling the hearing: The time and place of the hearing will be arranged so that the hearing is accessible to the household member suspected of IPV.

(5) Failure to appear: If the household member or representative cannot be located or fails to appear at a hearing initiated by HCA without good cause, the hearing will be conducted without the household member being represented. Even if the household member is not represented, the hearing official is required to carefully consider the evidence and determine if intentional program violation was committed based on clear and convincing evidence. If the household member is found to have committed intentional program violation but a hearing official later determines that the household member or representative had good cause for not appearing, the previous decision shall no longer remain valid and HCA will conduct an new hearing. The household member has ten days from the date of the scheduled hearing to present reasons indicating a good cause for failure to appear. The good cause decision will be documented into the case record.

(6) Participation while awaiting a hearing: A pending disqualification hearing will not affect the individual's or household's right to be certified and participate the food stamp program. Since a household member cannot be disqualified for IPV until a hearing official finds that individual has committed IPV, HCA will determine eligibility and benefit amount of the household in the same manner it would be determined for any other household. Household benefits will be terminated if the certification period has expired and the household, after receiving its notice of expiration, fails to reapply. The household benefits will be reduced or terminated if HCA has documentation which substantiates that the household is ineligible or eligible for fewer benefits, even if these facts led to the suspicion of intentional program violation and resulting disqualification hearing, and the household fails to request a fair hearing and continuation of benefits pending the hearing. For example, HCA may have documentation which substantiates that a household failed to report a change in circumstances even though HCA has not yet demonstrated that the failure to report involved an act of intentional program violation.

(7) Criteria for determining IPV: The hearing officer will base the determination of IPV on clear and convincing evidence which demonstrates that the household member(s) committed, and intended to commit intentional program violation as defined in Subsection D of 8.139.647.8 NMAC.

(8) Imposition of disqualification penalties:

(a) Beginning the disqualification: The period of disqualification will begin with the first month which follows the date the household member receives written notification of the disqualification. If the act of IPV which led to the disqualification occurred prior to the disqualification periods specified in Subsection B of 8.139.647.8 NMAC, the household member will be disqualified in accordance with the disqualification periods in effect at the time of the offense.

(b) No further appeal: No further administrative appeal procedure exists after an ADH conducted by HCA. The determination of IPV made by a hearing officer cannot be reversed by a subsequent fair hearing decision. The household member, however, is entitled to seek relief in a court having appropriate jurisdiction. The period of disqualification may be subject to stay by a court of appropriate jurisdiction or other injunctive remedy.

(c) Ineligibility at disqualification: If the individual is not certified to participate in the food stamp program at the time the disqualification period is to begin, the disqualification penalty will be imposed immediately upon a determination of IPV, as though the individual was a participant in the FSP.

(d) Disqualification period continues: Once a disqualification penalty has been imposed against a currently participating household member, the period of disqualification will continue uninterrupted until completed, regardless of the eligibility of the disqualified member's household. The disqualified member's household will continue to be responsible for repayment of the over-issuance which resulted from the disqualified member's intentional program violation, regardless of the household's eligibility for food stamp benefits.

(9) Notification of disqualification: If the hearing officer finds that the household member committed IPV, HCA will provide written notice to a household member prior to disqualification.

(a) The notice will inform the household member of the decision; the reason for the decision; and the date the disqualification penalty begins and ends.

(b) Written notice will also be provided to any remaining household members of the benefit amount they will receive during the period of disqualification or that they must reapply because the certification period has expired. A written demand letter for restitution will also be provided.

B. Waived hearings: HCA will provide written notification to the household member suspected of intentional program violation that the member can waive his/her right to an administrative disqualification hearing. Prior to providing written notification to the household member, the evidence must be reviewed by the office of inspector general (OIG). OIG must have made a determination the such evidence warrants scheduling a disqualification hearing.

(1) Contents of written notice: The written notification provided to the household member will include, at a minimum:

(a) The date that the signed waiver must be received by HCA to avoid the holding of a hearing and a signature block for the accused individual along with a statement that the head of household must also sign the waiver if the accused individual is not the head of household, with an appropriately designated signature block;

(b) A statement of the accused individual's right to remain silent concerning the charge(s), and that anything said or signed by the individual concerning the charge(s) can be used against him/her in a court of law;

(c) The fact that a waiver of the disqualification hearing will result in disqualification and a reduction in benefits for the period of disqualification, even if the accused individual does not admit to the facts as presented by HCA;

(d) An opportunity for the accused individual to specify whether or not he/she admits to the facts as presented by HCA. This opportunity will consist of the following statements:

(i) "I admit to the facts as presented, and understand that a disqualification penalty will be imposed if I sign this waiver;" and

(ii) "I do not admit that the facts as presented are correct; however, I have chosen to sign this waiver and understand that a disqualification penalty will result."

(e) The telephone number and if possible the name of the individual to contact for additional information;

(f) The fact that the remaining household members if any will be held responsible for repayment of the resulting claim.

(2) Imposition of disqualification penalties: If the household member suspected of IPV signs the waiver of right to an ADH and the signed waiver is received within the time frames specified by HCA, the household member will be disqualified in accordance with the disqualification periods in Subsection B of 8.139.647.8 NMAC above.

(a) Beginning the disqualification: The period of disqualification will begin with the first month following the date the household member receives written notification of the disqualification. If the act of IPV which led to the disqualification occurred prior to the written notification of the disqualifications specified in Subsection B of 8.139.647.8 NMAC, the household member will be disqualified in accordance with the disqualification period in effect at the time of the offense. The same act of IPV repeated over a period of time will not be separated so that separate penalties can be imposed.

(b) No further appeal: No further administrative appeal procedure exists after an individual waives his/her right to an administrative disqualification hearing and a disqualification penalty has been imposed. The disqualification penalty cannot be changed by a subsequent fair hearing decision. The household member is entitled to seek relief in a court having appropriate jurisdiction. The period of disqualification may be subject to stay by a court of appropriate jurisdiction or other injunctive remedy.

(c) Ineligibility at disqualification: If the individual is not certified to participate in the program at the time the disqualification period is to begin, the disqualification penalty will be imposed immediately upon a determination of an IPV, as though the individual was a participant in the FSP.

(d) Disqualification continues: Once a disqualification penalty has been imposed against a currently participating household member, the period of disqualification will continue uninterrupted until completed regardless of the eligibility of the disqualified members household. The disqualified member's household will continue to be responsible for repayment of the over-issuance which resulted from the disqualified member's IPV regardless of the household's eligibility for program benefits.

(3) Written notification: Written notice will be provided to the household member prior to disqualification. Written notice will also be provided to any remaining household members of the allotment they will receive during the period of disqualification or that the household must reapply because the certification period has expired. A written demand letter for restitution, will also be provided.

C. Court referrals: HCA will refer cases of alleged IPV for prosecution in accordance with an agreement with prosecutors or state law. The agreement will include the understanding that prosecution will be pursued in cases where appropriate. The agreement will also include information on how and under what circumstances cases will be accepted for possible prosecution and any other criteria set by the prosecutor for accepting cases for prosecution. HCA is encouraged to refer for prosecution under state or local statutes those individuals suspected of committing IPV, particularly if large amounts of food stamp benefits are suspected of having been obtained by IPV, or the individual is suspected of committing more than one act of IPV.

(1) Imposition of disqualification penalties: HCA will disqualify an individual found guilty of IPV for the length of time specified by the court. If the court fails to impose a disqualification period, HCA will impose a disqualification period in accordance with the provisions in Subsection B of 8.139.647.8 NMAC, unless contrary to the court order. If disqualification is ordered but a date for initiating the disqualification period is not specified, HCA will initiate the disqualification period for currently eligible individuals within 45 days of the date the disqualification was ordered. Any other court imposed disqualification will begin within 45 days of the date the court found a currently eligible individual guilty of civil or criminal misrepresentation or fraud.

(2) Beginning the disqualification: If the individual is not certified to participate in the program at the time the disqualification period is to begin, the disqualification penalty will be imposed immediately upon a determination of IPV, as though the individual was a participant in the FSP.

(3) Disqualification continues: Once a disqualification penalty has been imposed against a currently participating household member, the period of disqualification will continue uninterrupted until completed regardless of the eligibility of the disqualified member's household. The disqualified member's household will continue to be responsible for repayment of the over-issuance which resulted from the disqualified members IPV regardless of the household's eligibility for program benefits.

(4) Notification of disqualification: If the court finds that the household member committed IPV HCA will provide written notice to the household member. The notice will be provided prior to disqualification, whenever possible. The notice will inform the household member of the disqualification and the date the disqualification will take effect. HCA will provide written notice to the remaining household members, if any, of the benefit amount they will receive during the period of disqualification or that they must reapply because the certification period has expired. HCA will provide a written demand letter for restitution.

D. Deferred adjudication: HCA may allow individuals to sign disqualification consent agreements in cases referred for prosecution. HCA may use this option for those cases in which a determination of guilt is not obtained from a court due to the accused individual having met the terms of a court order or which are not prosecuted due to the accused individual having met the terms of an agreement with the prosecutor.

(1) Advance notification:

(a) HCA will enter into an agreement with the state's attorney general's office or where necessary, with county prosecutors which provides for advance written notification to the household member of the consequences of consenting to disqualification in cases of deferred adjudication.

(b) The written notification provided to the household member which informs him/her of the consequences of consenting to disqualification as a part of deferred adjudication will include, at a minimum:

(i) a statement for the accused individual to sign that the accused understands the consequences of consenting to disqualification, along with a statement that the head of household must also sign the consent agreement if the accused individual is not the head of household, with an appropriately designated signature block;

(ii) a statement that consenting to disqualification will result in disqualification and a reduction in benefits for the period of disqualification, even though the accused individual was not found guilty of civil or criminal misrepresentation or fraud;

(iii) a warning that the disqualification periods for IPV under the food stamp program are as specified in Subsection B of 8.139.647.8 NMAC, and a statement of which penalty will be imposed as a result of the accused individual having consented to disqualification;

(iv) a statement of the fact that the remaining household members, if any will be held responsible for repayment of the resulting claim, unless the accused individual has already repaid the claim as a result of meeting the terms of the agreement with the prosecutor or the court order.

(2) Imposition of disqualification penalties: If the household member suspected of IPV signs the disqualification consent agreement, the household member will be disqualified in accordance with the disqualification periods specified in Subsection B of 8.139.647.8 NMAC, unless contrary to the court order. The disqualification period will begin within 45 days of the date the household member signed the disqualification consent agreement. However, if the court imposes a disqualification period or specifies the date for initiating the disqualification period, HCA will disqualify the household member in accordance with the court order.

(3) Beginning the disqualification: If the individual is not certified to participate in the program at the time the disqualification period is to begin, the disqualification penalty will be imposed immediately upon a determination of IPV, as if the individual was a participant in the FSP.

(4) Disqualification continues: Once a disqualification penalty has been imposed against a currently participating household member, the disqualification period will continue uninterrupted until completed regardless of the eligibility of the disqualified member's household. The disqualified member's household will continue to be responsible for repayment of the over-issuance which resulted from the disqualified member IPV regardless of the household's eligibility for program benefits.

(5) Notification of disqualification: If the household member suspected of IPV signs the disqualification consent agreement, HCA will provide written notice to the household member. The notice will be provided prior to disqualification whenever, possible. The notice will inform the household member of the disqualification and the date the disqualification will take effect. HCA will also provide written notice to the remaining household members, if any, of the benefit amount the household will receive during the disqualification period or that the household must reapply because the certification period has expired. HCA will provide a written demand letter for restitution.

E. Reporting requirements:

(1) HCA will report to food and consumer services (FCS) information concerning individuals disqualified for IPV based on the determination of an administrative disqualification hearing official or a court of appropriate jurisdiction, and those individuals disqualified as a result of signing either a waiver of right to a disqualification hearing or a disqualification consent agreement in cases referred for prosecution. The information must be submitted so that it is received by FCS no later than 30 days after the effective date of the disqualification. HCA will submit required information on each individual disqualified for IPV through a reporting system in accordance with procedures specified by FCS. The following information concerning the individual will be reported to FSC:

(a) social security number, date of birth, full name;
(b) the type and number of the disqualification (1st, 2nd, 3rd);
(c) the state and county in which the disqualification took place;
(d) the date on which the disqualification took effect;
(e) the length of the disqualification period imposed.

(2) Availability to all state agencies: All data submitted will be available for use by any state welfare agency. The data will be used, at a minimum, for the following:

(a) to determine eligibility of individual program applicants prior to certification in cases where there is reason to believe a household member is subject to disqualification in another political jurisdiction and

(b) to ascertain the appropriate penalty to impose, based on past disqualifications in a case under consideration.

(c) **Other uses:** HCA may also use the data in other ways, such as the following:

(i) to screen all program applicants prior to certification, and

(ii) to periodically match the entire list of disqualified individuals against their current caseloads.

(3) **Disqualification valid in all political jurisdictions:** The disqualification of an individual for IPV in one political jurisdiction will be valid in another. However, one or more intentional program violations which occurred prior to the implementation of the disqualification periods specified in Paragraph 1 of Subsection B of 8.139.647.8 NMAC will be considered as only one previous disqualification when determining the appropriate penalty to impose in a case under consideration, regardless of where the disqualification(s) took place. HCA is required to identify any individuals disqualified for fraud prior to implementation of this rule and to submit the information required by this section on such individuals.

(4) **Court reversal of the disqualification:** In cases where the disqualification for IPV is reversed by a court of appropriate jurisdiction, HCA will submit a report to purge the file of the information relating to the disqualification which was reversed. In cases where the determination of IPV is reversed by a court of appropriate jurisdiction, HCA will reinstate the individual in the program if the household is eligible. Food stamp benefits that were lost as a result of the disqualification will be restored.

[8.139.647.9 NMAC – Rp 8.139.647.9 NMAC, 07/01/2024.]

HISTORY OF 8.139.647 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 426.0000, Fraud Disqualifications, 8/1/1980.
ISD-Rule 462.0000, Food Assistance - Fraud Disqualifications, 11/5/1982.
ISD-Rule 462.0000, Disqualification for Intentional Program Violation, 5/31/1983.
ISD-Rule 462.0000, Disqualification for Intentional Program Violation, 9/13/1983.
ISD FS 530, Food Stamp Administrative Disqualification, 3/2/1988.
ISD FS 540, Trafficking of Food Assistance Benefits, 8/31/1994.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 100 GENERAL PROVISIONS FOR THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

8.150.100.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.100.1 NMAC – 8.150.100.1 NMAC, 07/01/2024]

8.150.100.2 SCOPE: The rule applies to the general public.
[8.150.100.2 NMAC – 8.150.100.2 NMAC, 07/01/2024]

8.150.100.3 STATUTORY AUTHORITY: 27 NMSA 1978 (1992 Repl.) provides for the authority to "...adopt, amend and repeal bylaws, rules and regulations...". It also provides for administration of public assistance programs. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.150.100.3 NMAC – 8.150.100.3 NMAC, 07/01/2024]

8.150.100.4 DURATION: Permanent.
[8.150.100.4 NMAC – 8.150.100.4 NMAC, 07/01/2024]

8.150.100.5 EFFECTIVE DATE: November 15, 1996, unless a different date is at the end of a section or paragraph.
[8.150.100.5 NMAC – 8.150.100.5 NMAC, 07/01/2024]

8.150.100.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program.
[8.150.100.6 NMAC – 8.150.100.6 NMAC, 07/01/2024]

8.150.100.7 DEFINITIONS: Unless otherwise apparent from the context, the following definition shall apply throughout these regulations. A life-threatening situation is a related emergency that poses a threat to the health or safety of one or more members of the household.
[8.150.100.7 NMAC – 8.150.100.7 NMAC, 07/01/2024]

8.150.100.8 STATUTORY AUTHORITY: The legal basis for the low income home energy assistance program (LIHEAP) is the Augustus F. Hawkins Human Services Reauthorization Act of 1990 (Public Law 101-501) as amended by Title III of the Human Services Amendments of 1994 (Public Law 103-252). Title XXVI of the Act is referred to as the Low Income Home Energy Assistance Act. The following sections cite the main statutory authorities for the state of New Mexico's administration of the LIHEAP grant award.
[8.150.100.8 NMAC – 8.150.100.8 NMAC, 07/01/2024]

8.150.100.9 SPECIFIC AUTHORITIES:

A. Assist eligible households: Section 2602(a) of the Low Income Home Energy Assistance Act states the purpose of LIHEAP is to assist eligible households in meeting the costs of home energy. HCA defines home energy as an energy expense that is incurred primarily for private residential heating or cooling.

B. Outreach: Section 2605(b)(3) of the Administration for Children and Families (ACF) Health and Human Services (HHS) Office of the Community Services (OCS) LIHEAP statute requires the LIHEAP grantee to conduct outreach activities to ensure eligible households, and especially elderly and disabled households, are made aware of the LIHEAP program as well as similar energy-related assistance, utilizing nonprofit agencies as well as the grantee's own field offices in its outreach efforts.

C. Categorical eligibility: No household is categorically eligible to receive LIHEAP. Eligibility is determined during the application process.

D. Financial eligibility: Households must have income at or below 150% of the federal poverty guideline.

E. 110% state poverty level: Section 2605(b)(2)(B) of the ACF HHS OCS LIHEAP statute further states that no household may be excluded because of income if it has an income which is less than 110% of the state poverty level.

F. Timely issuance of benefits: Section 2605(b)(5) of the ACF HHS OCS LIHEAP statute requires the LIHEAP grantee to provide energy assistance benefits in a timely manner as referenced in 8.100.130.11 NMAC.

G. Crisis funding: Section 2604 (C)(1) of the ACF HHS OCS LIHEAP statute requires the LIHEAP grantee to reserve a reasonable amount of funds for a crisis intervention program and to provide assistance to eligible households within 48 hours, excluding weekends and holidays, of the household's application for benefits. Subsection (2) further requires the LIHEAP grantee to provide assistance within 18 hours, excluding weekends and holidays, to eligible households that apply for benefits in a life-threatening situation.

H. Energy need and vulnerable populations: Section 2605 (b)(5) of the ACF HHS OCS LIHEAP statute requires the LIHEAP grantee to take into account the energy needs of low income households, giving priority to those having members of vulnerable populations such as young children, older individuals and individuals with disabilities.

I. Owners and renters: Section 2605(b)(8) of the ACF HHS OCS LIHEAP statute requires owners and renters to be treated equitably under the program.

J. Tribal LIHEAP: Section 2604(d)(1) of the ACF HHS OCS LIHEAP statute requires that a portion of the grant award be set aside for any Indian tribe in the state requesting an allocation of LIHEAP funds for the purpose of administering its own energy assistance program.

K. Administering agency: Section 2605(b)(6) of the ACF HHS OCS LIHEAP statute allows the grantee to designate local administrative agencies to carry out the program and to give special consideration to nonprofit agencies receiving federal funds for other energy-related assistance programs.

[8.150.100.9 NMAC – 8.150.100.9 NMAC, 07/01/2024]

8.150.100.10 MISSION STATEMENT:

A. HOUSEHOLD RELATED POLICIES:

(1) HCA households: Households that receive benefits from programs administered by HCA will be notified of the LIHEAP application period. Those households that wish to apply for LIHEAP benefits may submit an application. It is HCA's policy to issue regular benefits under this program to eligible households that apply for benefits during the specified period of application for regular benefits and that meet the income eligibility requirement and have a responsibility to pay for energy costs as specified in this policy.

(2) Non-HCA households: It is HCA's policy to issue regular benefits under this program to eligible households that receive no other assistance from HCA but that apply for LIHEAP benefits during the specified period of application for regular benefits and that meet the income eligibility requirement and have a responsibility to pay for energy costs as specified in this policy.

(3) Wood-primary heat source: With the exception of households that use wood as their primary heat source and gather their own wood supply, households that do not incur a direct or indirect home energy cost are not eligible.

(4) Renter with energy costs: Renters who meet the eligibility criteria and incur a home energy cost are eligible for benefits under this program.

(5) Homeless applicants who meet the eligibility criteria are eligible for benefits under this program. Applicants who do not incur an energy cost will not be allowed an energy burden as defined in paragraph (1) of subsection A of 8.150.620.9 NMAC.

B. CRISIS INTERVENTION RELATED POLICIES:

(1) Crisis verification: Eligible households that have received a written disconnect notice from their utility vendor or a statement of non-delivery or sale of fuel from their fuel vendor due to lack of payment or inability to pay may be eligible to receive a LIHEAP benefit. When a crisis situation is identified, the authority is required to provide intervention to resolve the energy crisis. The processing of an application for households in a crisis situation includes, a completed application, all necessary verification required to determine eligibility and contacting the vendor to intercede on the household's behalf to resolve the crisis situation. Eligible households with insufficient funds to open an account with a utility vendor or meet the security deposit requirements of a utility vendor may also be eligible to receive a LIHEAP benefit. These households must also be assisted with crisis intervention. Crisis intervention is not available to households that have received a LIHEAP benefit in the current federal fiscal year.

(2) Crisis situations for eligible households include, but are not limited to, the following scenarios:

(a) a written disconnect notice from utility vendor; or a statement of non-delivery; or sale of fuel from their fuel vendor due to lack of payment, or inability to pay;

(b) have 20% or less bulk fuel; or

(c) have less than a three (3) day supply of firewood.

(3) A life threatening crisis situation for eligible crisis households include but are not limited to the following:

(a) households that contain a child age 1 or younger, or

(b) households that contain elderly age 60 or older, or

(c) households that contain a disabled member,

(d) and contain a household member that their health or wellbeing would likely be endangered if energy assistance is not provided.

(4) Crisis timeliness: Households who apply for LIHEAP benefits and provide documentation that a crisis situation exists will have their application processed in a timely manner.

(a) Assistance to resolve a crisis situation will be provided by the authority within 48 hours, excluding weekends and holidays, of the receipt of the completed application for LIHEAP.

(b) Assistance to resolve a life-threatening crisis situation will be provided by the authority within 18 hours, excluding weekends and holidays, of the receipt of the completed application for LIHEAP.

(5) Utility/vendor mediation: The LIHEAP benefit is intended to be a supplement to assist households with their energy bill. The ultimate responsibility for utility payments is the household's. The household will be notified that the LIHEAP benefit alone will not resolve their crisis situation. The household will be informed of other community resources.

[8.150.100.10 NMAC – 8.150.100.10 NMAC, 07/01/2024]

8.150.100.11 RESPONSIBILITIES AND DELEGATION: The income support division (ISD) of the health care authority is responsible for administering the low income home energy assistance program (LIHEAP).

A. State LIHEAP plan: Every year, ISD submits a state plan to the U.S. department of health and human services (DHHS) for New Mexico's administration of LIHEAP. The proposed state plan and the proposed LIHEAP policy manual are made available for public comment and a public hearing is held.

B. LIHEAP administration: ISD is responsible for such matters as:

(1) formulating and interpreting LIHEAP policy;

(2) coordinating with other divisions within HCA for data processing of LIHEAP eligibility and payment;

(3) allocating and distributing LIHEAP monies;

(4) data entry of applicants/recipients information not available on the authority's computer eligibility system; and

(5) oversight responsibility for LIHEAP policy and procedures training and for the review of all LIHEAP training materials.

[8.150.100.11 NMAC – 8.150.100.11 NMAC, 07/01/2024]

8.150.100.12 ISD FIELD OFFICE RESPONSIBILITIES: Each of the field offices of the income support division in the state is responsible for:

A. providing outreach and referrals regarding the LIHEAP program for low income applicants/recipients, particularly disabled and elderly applicants/recipients, crisis applicants/recipients, and households with high home energy burdens;

B. informing low-income households, particularly disabled and elderly applicants/recipients, about the eligibility determination process and application procedures for the LIHEAP program;

C. providing documentation to households requesting verification of cash benefits received from the health care authority or other documentation available to the authority or in the electronic case file;

D. complying with other LIHEAP program directives as may be issued by ISD;

E. assisting all applicant households to complete the LIHEAP application and resolving questionable information;

F. adhere to the deadlines as stated in paragraph (2) of subsection B of 8.150.100.10 NMAC when processing a crisis or life threatening crisis LIHEAP application, making the necessary vendor contact, and documenting the processing times accurately in the case notes;

G. entering the completed LIHEAP application into the designated LIHEAP computer system;

H. responding to inquiries about the status of a LIHEAP application; and

I. processing any payment errors when identified regardless of the amount; the ISD office must issue a supplement in cases of benefit under-issuances or complete the necessary actions to establish the claim for the over-issuance and refer to the restitution services bureau for recoupment.

[8.150.100.12 NMAC – 8.150.100.12 NMAC, 07/01/2024]

HISTORY OF 8.150.100 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11-20-85.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 110 APPLICATIONS

8.150.110.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.110.1 NMAC – Rp 8.150.110.1 NMAC, 07/01/2024]

8.150.110.2 SCOPE: The rule applies to the general public.
[8.150.110.2 NMAC – Rp 8.150.110.2 NMAC, 07/01/2024]

8.150.110.3 STATUTORY AUTHORITY: 27 NMSA 1978 (1992 Repl.) provides for the health care authority (HCA) to "...adopt, amend and repeal bylaws, rules and regulations...". It also provides for administration of public assistance programs. Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.150.110.3 NMAC – Rp 8.150.110.3 NMAC, 07/01/2024]

8.150.110.4 DURATION: Permanent.
[8.150.110.4 NMAC – Rp 8.150.110.4 NMAC, 07/01/2024]

8.150.110.5 EFFECTIVE DATE: November 15, 1996, unless a different date is at the end of a section or paragraph.
[8.150.110.5 NMAC – Rp 8.150.110.5 NMAC, 07/01/2024]

8.150.110.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program.
[8.150.110.6 NMAC – Rp 8.150.110.6 NMAC, 07/01/2024]

8.150.110.7 DEFINITIONS: [RESERVED]

8.150.110.8 RIGHT TO APPLY:

A. Recipients/applicants: Anyone has the right to apply for any benefits provided by ISD whether or not it appears that he/she will be eligible.

B. Outreach:

(1) HCA responsibilities: HCA conducts outreach regarding the LIHEAP program to eligible households, and particularly elderly and disabled households, through the ISD field offices and all of the offices and suboffices of the state's community action agencies. Additional outreach efforts to elderly and disabled households are made through workshops and conferences held by the state's agency on aging.

(2) Community action agency responsibility: HCA coordinates with the community action agencies to provide information and outreach services regarding LIHEAP and other energy-related assistance programs.

C. Barrier free policy: It is HCA's policy to make the application process for these households as barrier-free as possible. This includes:

(1) paperwork reduction and not requiring reverification by the household of information already available to HCA, such as SSI status;

(2) ease of access to physical locations where application may be made;

(3) provide access to the authority's online application; and

(4) provide additional assistance for any recipient/applicant who requires it.

D. Annual benefit: Each eligible household will be issued one benefit each federal fiscal year. The benefit may be issued in one or multiple payments depending on the funding availability and the approval of the HCA secretary. Receipt of a LIHEAP benefit from any other LIHEAP administering entity (tribe, state or territory) funded by HHS during any federal fiscal year would prohibit the receipt of LIHEAP in New Mexico during that FFY.

E. Supplemental benefit: A supplemental benefit may be established under certain conditions at the direction of the HCA secretary. A supplemental benefit may occur when:

(1) funding levels are predicted to exceed allowable carryover of federal funds to the next federal fiscal year;

(2) emergency weather circumstances.

[8.150.110.8 NMAC – Rp 8.150.110.8 NMAC, 07/01/2024]

8.150.110.9 SUBMISSION OF FORMS:

A. Applicants: Any household may apply for benefits during the specified application period:

(1) in person at any local county income support division office;

(2) through the online application; or

(3) submitting an application via mail or fax to any local county income support division office.

B. Application process: In order for a determination of eligibility for regular benefits to be made for these applicant households, the household's signed application must be received by the deadline date of the application period of October 1st through September 30th for each federal fiscal year. Required verification must be received by the 30th day after the received date stamped on the LIHEAP application.

C. Application period: The period of application for benefits will be year round beginning after the application for the LIHEAP grant has been submitted to the U.S. department of health and human services, and ending September 30. The application period is October 1st through September 30th for each federal fiscal year.

[8.150.110.9 NMAC – Rp 8.150.110.9 NMAC, 07/01/2024]

8.150.110.10 DISPOSITION OF APPLICATION/NOTICE:

A. Income support division county office responsibilities: Households who complete the application process for LIHEAP benefits will be provided with a notice indicating whether they have been approved or denied. Upon acknowledgement of payment by the vendor, households will be provided with a notice indicating that they have been approved. Upon determination of ineligibility by HCA, households will be provided with a notice indicating that they have been denied. If the household fails to provide the verification required to determine eligibility, ISD may deny the application after 30 days from the date of the application.

B. LIHEAP central office responsibilities: LIHEAP central office staff will complete random reviews of LIHEAP approvals and denials. The review will verify whether LIHEAP policy was correctly applied. If an eligibility error is found or the application is incomplete, a determination will be made to identify any payment errors.

C. Notices: All households will be mailed a notice indicating whether they have been approved or denied for LIHEAP benefits. The notice indicating that an applicant has been approved will list the point calculation, point total, the benefit amount and the method of issuance. The notice indicating that an applicant has been denied will indicate the denial reason.

[8.150.110.10 NMAC – Rp 8.150.110.10 NMAC, 07/01/2024]

HISTORY OF 8.150.110 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1982.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11/20/1985.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 410 GENERAL RECIPIENT REQUIREMENTS

8.150.410.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.410.1 NMAC – Rp 8.150.410.1 NMAC, 07/01/2024]

8.150.410.2 SCOPE: The rule applies to the general public.
[8.150.410.2 NMAC – Rp 8.150.410.2 NMAC, 07/01/2024]

8.150.410.3 STATUTORY AUTHORITY: 27 NMSA 1978 (1992 Repl.) provides for the health care authority (HCA) to "...adopt, amend and repeal bylaws, rules and regulations...". It also provides for administration of public assistance programs. Section 9-8-1 et seq. NMSA 1978 establishes the HCA as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.150.410.3 NMAC – Rp 8.150.410.3 NMAC, 07/01/2024]

8.150.410.4 DURATION: Permanent.
[8.150.410.4 NMAC – Rp 8.150.410.4 NMAC, 07/01/2024]

8.150.410.5 EFFECTIVE DATE: November 15, 1996, unless a different date is at the end of a section or paragraph.
[8.150.410.5 NMAC – Rp 8.150.410.5 NMAC, 07/01/2024]

8.150.410.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the Low Income Home Energy Assistance Program.
[8.150.410.6 NMAC – Rp 8.150.410.6 NMAC, 07/01/2024]

8.150.410.7 DEFINITIONS: [**RESERVED**]

8.150.410.8 HOUSEHOLD UNIT: For purposes of LIHEAP, a household is an individual, or group of individuals living together, who incurs a heating or cooling cost. The heating or cooling cost must be to meet residential, not business or industrial, heating or cooling needs.
[8.150.410.8 NMAC – Rp 8.150.410.8 NMAC, 07/01/2024]

8.150.410.9 ENERGY RESPONSIBILITY:

A. Energy cost: To be eligible for LIHEAP benefits, the household must incur an energy cost. The energy cost may be for a primary heat source, i.e., the energy source or fuel with which the household is predominantly heated, or for a secondary heat source. A secondary heat source is an energy source that is essential to the process of providing heat to the home. The energy cost may be for a cooling cost. The cooling cost may be for a primary source, i.e., evaporative cooling or refrigerated air, or secondary cooling. Secondary cooling is the use of energy to operate portable fans, ceiling fans, whole house fans, gable vent fans, or power attic vent fans.

B. Secondary heat source: Electricity to ignite a gas or steam furnace is the most common example of an allowable secondary heat source for LIHEAP purposes. Electricity used only for lighting purposes or to operate fans to distribute heat from a wood-burning stove is not considered an allowable secondary heat source for LIHEAP purposes.

C. Wood-gathering households: Households who use wood as a fuel to heat their home and gather the wood themselves are considered to have a heating responsibility. Regardless of whether a direct or indirect cost was incurred to obtain the wood the household meets this requirement.

D. Direct or indirect utility responsibility: The heating/cooling cost may be direct in the form of a utility payment or fuel purchase, or indirect in the form of a non-subsidized rent payment which either designates or does not designate the included utility cost, or costs associated with obtaining wood for heating households.

E. Crisis intervention: To be eligible for LIHEAP regular or life-threatening crisis intervention, the household must meet the eligibility criteria for regular benefits as specified in 8.150.500.8 NMAC, must not have received a LIHEAP benefit in the current federal fiscal year and, in addition, be able to provide verification that

proves the applicant household is facing a current or impending energy crisis, established with any one of the following:

(1) current notice of disconnect for the household from a utility vendor; or

(2) applicant written or verbal statement of insufficient funds for the household to open an account with a utility vendor or meet the security deposit requirements of a utility vendor; or

(3) statement from the household's fuel vendor that fuel will not be provided without payment.

(4) Life-threatening crisis intervention: The applicant must meet the above criteria for a regular crisis intervention and in addition provide a written or verbal statement advising that the household faces an emergency which poses a threat to the health or safety of one or more members of the household.

F. Community referrals: In circumstances where the household is not eligible for crisis intervention, or if a balance remains after the crisis/life threatening intervention has been provided, the household shall be informed of other resources in the community, which may be able to assist the household in meeting its energy expenses.

[8.150.410.9 NMAC – Rp 8.150.410.9 NMAC, 07/01/2024]

8.150.410.10 [Reserved]

[8.150.410.10 NMAC – Rp 8.150.410.10 NMAC, 07/01/2024]

8.150.410.11 HOUSING TYPE:

A. Non-subsidized rent: Non-subsidized rent is defined as an obligation to pay for shelter which is entirely the responsibility of the household incurring the expense.

(1) Separate direct costs: Households paying non-subsidized rent who incur a separate heating/cooling cost are eligible for LIHEAP.

(2) Utilities included in rent: Households paying non-subsidized rent whose utility costs are included in their rent, even if no such cost is designated, are eligible for LIHEAP.

B. Subsidized rent: Subsidized rent assistance is defined as a payment for shelter, or shelter and utilities, the cost of which has been reduced due to a subsidy from a housing or other assistance program. University housing does not meet this definition and is therefore not considered subsidized housing.

(1) Separate direct costs: Households receiving subsidized rent assistance who incur a separate direct cost for heating/cooling are eligible for LIHEAP benefits;

(2) Subsidized rent/utilities with additional separate utility cost: Households receiving subsidized rent assistance who receive a subsidy for utilities but who incur an additional out-of-pocket expense for utilities are eligible for LIHEAP;

(3) Subsidized rent with utilities included: Households receiving subsidized rent assistance whose heating/cooling cost is included in their subsidized rent and do not incur an additional out-of-pocket heating or cooling expense are not eligible for LIHEAP;

(4) Subsidized rent with rental cost: Households receiving subsidized rent assistance who pay rent but do not pay utilities are not eligible for LIHEAP; and,

(5) Subsidized rent with no cost: Households receiving subsidized rent assistance who pay no rent and no utilities are not eligible for LIHEAP;

C. Mortgaged or free and clear home: Households who pay a mortgage or own their own home and incur a separate heating/cooling cost are eligible for LIHEAP.

[8.150.410.11 NMAC – Rp 8.150.410.11 NMAC, 07/01/2024]

8.150.410.12 INDIAN TRIBAL ELIGIBILITY: In New Mexico, an Indian tribe may choose to administer its own LIHEAP program for tribal members and request from DHHS an allocation of the state's share of the LIHEAP grant award for this purpose. An Indian tribe is defined as a legal entity of a group of Native Americans living on tribal lands with a distinct and separate government. Residents of tribal land may be eligible for tribal administered LIHEAP or HCA-administered LIHEAP under the following circumstances.

A. Tribes that administer LIHEAP: Indian tribal members living on their tribe's tribal lands, whose tribe administers their own LIHEAP program, are not eligible for HCA-administered LIHEAP benefits.

B. Tribes not administering LIHEAP: Indian tribal members living on the tribal lands of tribes not administering their own LIHEAP program may be considered for HCA-administered LIHEAP benefits providing they meet income eligibility and heating/cooling responsibility requirements as specified in this policy.

C. Indians on other tribes' land: Households that are members of Indian tribes administering their own LIHEAP program but not living on their tribe's tribal lands, may be considered for HCA-administered LIHEAP benefits providing they meet income eligibility and heating responsibility requirements, as specified in this policy, and they did not receive LIHEAP benefits from their tribal government for the current LIHEAP season.

D. Non-Indians and non-tribal members on tribal land: Non-Indians living on tribal lands and Indians living on tribal lands who are excluded from eligibility for LIHEAP by the Indian tribe administering their own LIHEAP program may be considered for HCA-administered LIHEAP benefits providing they meet income eligibility and heating/cooling responsibility requirements as specified in this policy.

E. At the direction of the HCA secretary, HCA may serve tribal members normally excluded due to Subsection A of 8.150.410.12 NMAC if they have not been or do not expect to be served by the tribal LIHEAP program.

[8.150.410.12 NMAC – Rp 8.150.410.12 NMAC, 07/01/2024]

8.150.410.13 CITIZENSHIP: To be eligible, a LIHEAP household must contain at least one member who is a (1) U.S. citizen, or (2) a qualified non-citizen considered eligible to participate in the TANF program. See 8 USC Sec. 1641, Title 8, Chapter 14, Subchapter IV, and any subsequent changes.

[8.150.410.13 NMAC – Rp 8.150.410.13 NMAC, 07/01/2024]

8.150.410.14 RESIDENCY: To be eligible, a LIHEAP household must have a residence in New Mexico and be occupying that residence at the time of application. The LIHEAP benefit must be applied toward the utility or fuel costs incurred for that residence.

[8.150.410.14 NMAC – Rp 8.150.410.14 NMAC, 07/01/2024]

8.150.410.15 ENUMERATION: To be eligible for inclusion in the LIHEAP benefit group, a social security number (SSN) or proof of application for a number must be provided for each citizen and qualified non-citizen for which assistance is being requested. Any member(s) of a LIHEAP applicant household who do not meet the requirements of this section will not be eligible for a LIHEAP benefit.

[8.150.410.15 NMAC – Rp 8.150.410.15 NMAC, 07/01/2024]

8.150.410.16 RESIDENCE IN FACILITY OR INSTITUTION: Persons residing in New Mexico but living in group homes, halfway houses, institutions, homeless shelters, or in places not normally intended for human occupation are not eligible unless they can document heating/cooling expenses.

[8.150.410.16 NMAC – Rp 8.150.410.16 NMAC, 07/01/2024]

8.150.410.17 RECIPIENT RIGHTS:

A. Treatment and non-discrimination: Members of a household shall have the right, at all times, to be treated with dignity at all times. Household members may not be discriminated against on the basis of age, sex, race, color, handicap, national origin, or religious or political belief.

B. Confidentiality: Household members have the right to confidentiality as defined in 8.100.100.13 NMAC.

C. Fair hearings: The household has the right to disagree with the determinations made by HCA and to appeal such actions through HCA's fair hearing process.

[8.150.410.17 NMAC - Rp 8.150.430.8 NMAC, 07/01/2024]

8.150.410.18 RECIPIENT RESPONSIBILITIES:

A. Benefit purpose: The household is responsible for using the benefit received for the purpose intended.

B. Erroneously issued benefits: If it is determined the household is not entitled to the benefit received, whether agency or recipient caused, the household is responsible for paying back the benefits received. The household is responsible for repayment whether the benefit was received directly by the household or paid to a vendor per Subsection H of 8.150.100.12 NMAC, a claim must be established for any erroneous benefit issuance.

[8.150.410.18 NMAC – Rp 8.150.410.18 NMAC, 07/01/2024]

HISTORY OF 8.150.410 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11/20/1985.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 500 ELIGIBILITY

8.150.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.500.1 NMAC – Rp 8.150.500.1 NMAC, 07/01/2024]

8.150.500.2 SCOPE: The rule applies to the general public.
[8.150.500.2 NMAC – Rp 8.150.500.2 NMAC, 07/01/2024]

8.150.500.3 STATUTORY AUTHORITY: Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.
[8.150.500.3 NMAC – Rp 8.150.500.3 NMAC, 07/01/2024]

8.150.500.4 DURATION: Permanent.
[8.150.500.4 NMAC – Rp 8.150.500.4 NMAC, 07/01/2024]

8.150.500.5 EFFECTIVE DATE: November 15, 1996, unless a different date is at the end of a section or paragraph.
[8.150.500.5 NMAC – Rp 8.150.500.5 NMAC, 07/01/2024]

8.150.500.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the Low Income Home Energy Assistance Program.
[8.150.500.6 NMAC – Rp 8.150.500.6 NMAC, 07/01/2024]

8.150.500.7 DEFINITIONS: [**RESERVED**]

8.150.500.8 NEED DETERMINATION: To be eligible for LIHEAP benefits households must do the following:

A. An applicant/recipient or representative must complete an application for LIHEAP benefits and will be interviewed face to face or telephonically only if information is questionable, to determine crisis or life threatening situations, or if the client has not been interviewed by the authority for any other ISD program thirty (30) days prior to the application date stamped on the application.

B. The household must provide proof that they meet the qualifications of the LIHEAP program; current documents used in other public assistance programs may be used for LIHEAP application processes, unless questionable:

(1) proof of identity for the applicant using any of the following documentation:
- **(a)** birth certificates(s); or
- **(b)** baptism certificate; or
- **(c)** hospital or birth record; or
- **(d)** divorce papers; or
- **(e)** alien registration card; or
- **(f)** immigration & naturalization service (INS) records; or
- **(g)** U. S. passport; or
- **(h)** Indian census records; or
- **(i)** family bible; or
- **(j)** school or day care records; or
- **(k)** government records; or
- **(l)** social security records; or
- **(m)** social service records; or
- **(n)** insurance policy; or
- **(o)** court records; or
- **(p)** church records; or
- **(q)** voter registration card; or

(r) letter from doctor, religious official or school official, or someone else who knows the applicant; or

(s) applicant sworn statement;

(2) proof of citizenship or legal resident status if questionable, such as birth certificate, permanent resident card, naturalization papers, etc.;

(3) social security numbers for all household members requesting assistance; a social security card is required if the authority is not able to validate or if the number is questionable;

(4) proof of gross income for all household members, such as check stubs, award letters, statement from employer, etc.;

(5) proof of a utility responsibility with an expense incurred in the past twelve months for the household's current residence:

(a) bill for metered service for a one-month period, or

(b) two (2) consecutive purchase receipts for propane, or a history of the account from the vendor, or

(c) receipt for wood purchase which includes a statement from the applicant of the duration of use for said wood, or

(d) rental agreement or landlord statement that utilities are included in rent, or

(e) from the utility or fuel vendor, a signed statement or billing history;

(6) account number at current address for the selected heating or cooling expense;

(7) proof of crisis when the situation exists, such as a current disconnect notice, statement of non-delivery of bulk fuel or statement detailing the cost of initiating service;

(8) proof of a life-threatening crisis when the situation exists, such as a current disconnect notice, statement of non-delivery of bulk fuel or statement detailing the cost of initiating service and a written or verbal statement from the applicant advising that the household faces an emergency which poses a threat to the health or safety of one or more members of the household;

(9) proof of disability for at least one household member as determined by another public assistance or federal or state entity;

(10) proof of emergency expenditures that apply to 8.150.520.18 NMAC; and

(11) proof of the household's main fuel expense for the household's current residence, if applicant/recipient is not requesting LIHEAP for assistance with the main heating or cooling fuel source.

C. eligibility criteria: the household must meet the identity, social security number, income, citizenship, utility responsibility, and residency requirements.

[8.150.500.8 NMAC – Rp 8.150.500.8 NMAC, 07/01/2024]

8.150.500.9 [Reserved]

[8.150.500.9 NMAC – Rp 8.150.500.9 NMAC, 07/01/2024]

8.150.500.10 [Reserved]

[8.150.500.10 NMAC – Rp 8.150.500.10 NMAC, 07/01/2024]

HISTORY OF 8.150.500 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11/20/1985.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.

ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 510 RESOURCES/PROPERTY

8.150.510.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.510.1 NMAC – Rp 8.150.510.1 NMAC, 07/01/2024]

8.150.510.2 SCOPE: The rule applies to the general public.
[8.150.510.2 NMAC – Rp 8.150.510.2 NMAC, 07/01/2024]

8.150.510.3 STATUTORY AUTHORITY: Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.
[8.150.510.3 NMAC – Rp 8.150.510.3 NMAC, 07/01/2024]

8.150.510.4 DURATION: Permanent.
[8.150.510.4 NMAC – Rp 8.150.510.4 NMAC, 07/01/2024]

8.150.510.5 EFFECTIVE DATE: November 15, 1996, unless a different date is at the end of a section or paragraph.
[8.150.510.5 NMAC – Rp 8.150.510.5 NMAC, 07/01/2024]

8.150.510.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program.
[8.150.510.6 NMAC – Rp 8.150.510.6 NMAC, 07/01/2024]

8.150.510.7 DEFINITIONS: [RESERVED]

8.150.510.8 RESOURCE STANDARDS/ELIGIBILITY: No assets test is required to be eligible for LIHEAP benefits.
[8.150.510.8 NMAC – Rp 8.150.510.8 NMAC, 07/01/2024]

HISTORY OF 8.150.510 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11/20/1985.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 520 INCOME

8.150.520.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.520.1 NMAC – Rp 8.150.520.1 NMAC, 07/01/2024]

8.150.520.2 SCOPE: The rule applies to the general public.
[8.150.520.2 NMAC – Rp 8.150.520.2 NMAC, 07/01/2024]

8.150.520.3 STATUTORY AUTHORITY: 27 NMSA 1978 (1992 Repl.) provides for the department to "...adopt, amend and repeal bylaws, rules and regulations...". It also provides for administration of public assistance programs.
[8.150.520.3 NMAC – Rp 8.150.520.3 NMAC, 07/01/2024]

8.150.520.4 DURATION: Permanent.
[8.150.520.4 NMAC – Rp 8.150.520.4 NMAC, 07/01/2024]

8.150.520.5 EFFECTIVE DATE: November 15, 1996, unless a different date is at the end of a section or paragraph.
[8.150.520.5 NMAC – Rp 8.150.520.5 NMAC, 07/01/2024]

8.150.520.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program.
[8.150.520.6 NMAC – Rp 8.150.520.6 NMAC, 07/01/2024]

8.150.520.7 DEFINITIONS: [RESERVED]

8.150.520.8 EARNED GROSS INCOME:

A. Definitions: Earned gross income is defined as income received in the form of wages paid on a predetermined regular basis, pay received irregularly for work performed irregularly, or income resulting from self-employment activities. Income from rental property, if 20 hours or more per week are spent working as a landlord, is also countable as earned income.

B. Exclusions: The following are not counted as gross income:

(1) in-kind benefits: (i.e. good or services realized, provided or exchanged for non-monetary compensation);

(2) vendor payments: (i.e. payments made on behalf of a household to a third party);

(3) lump sum payments: see food stamp regulations on lump sum payments in 8.139.520.9 NMAC;

(4) loans;

(5) charitable contributions from nonprofit agencies to meet household expenses;

(6) earned income tax credits;

(7) value of food stamps;

(8) TANF annual clothing allowance;

(9) monies received for the care of a third party beneficiary who is not a household member; and

(10) monies excluded by federal statute, a listing of which can be found in food stamp policy citation 8.139 NMAC.

[8.150.520.8 NMAC – Rp 8.150.520.8 NMAC, 07/01/2024]

8.150.520.9 SELF EMPLOYMENT GROSS INCOME:

A. Definition: Ongoing self-employment income intended to support the household through the year, that is averaged over a 12 month period, even if the household earns the money in a concentrated period. Self-employment income intended to support the household only for a portion of the year must be averaged over the months it is intended to provide support.

B. Verification sources: Monthly business records detailing profits and expenses or the household's federal income tax return are needed to annualize the household's self-employment income.

C. Gross income calculation: For self-employment income, the net income of the business activity is considered the gross income of the household member. The net income of the business is derived by subtracting the allowable costs of doing business from the business's gross income.

D. Business expenses:

(1) Allowable costs are, generally, those required to produce the business's gross income. These include, but are not limited, to: raw materials, stock, labor, insurance premiums, interest paid on income producing property, taxes paid on income-producing property, transportation for business purposes.

(2) Costs specifically not allowed are payments on the principal of the purchase price of income-producing property, assets, equipment, or machinery, net losses from previous periods, personal income taxes, money set aside for personal expenses, transportation to and from work, charitable contributions, entertainment, and depreciation.

E. Annualizing income: From gross self-employment income, subtract allowable expenses to derive the net self-employment income. Divide the net self-employment income by 12 to produce a monthly (average) figure. This figure is the countable monthly gross income. To determine the household's total gross, this figure must be added to any other income the household receives.

[8.150.520.9 NMAC – Rp 8.150.520.9 NMAC, 07/01/2024]

8.150.520.10 GROSS INCOME OF INELIGIBLE NON-CITIZENS: The gross income received by any ineligible non-citizen household member must be prorated and counted to establish the benefit amount.

A. Definition: If any member of the household providing income to the household is an ineligible non-citizen for TANF purposes, that member's income is not counted in its entirety but is prorated. Prorating results in excluding a portion of the ineligible non-citizen household member's income from consideration because the ineligible non-citizen is not a recipient of public assistance benefits.

B. Proration calculation: Calculate the gross income of the ineligible non-citizen and divide the total by the number of members, eligible and ineligible, in the household. The resulting figure is the pro-rata portion of the income for each member, eligible and ineligible. To determine the portion of the income to be counted, multiply the pro rata portion by the remaining number of eligible household members.

[8.150.520.10 NMAC – Rp 8.150.520.10 NMAC, 07/01/2024]

8.150.520.11 GROSS INCOME OF MIGRANT HOUSEHOLDS:

A. Definition: A migrant household is a group that travels away from home on a regular basis with a group of laborers to seek employment in an agriculturally related activity.

B. Verification sources: The household's federal income tax return is needed to annualize the household's income.

C. Calculation: The household's annual income reported on their federal income tax return should be divided by 12 to determine the household's average monthly income.

[8.150.520.11 NMAC – Rp 8.150.520.11 NMAC, 07/01/2024]

8.150.520.12 GROSS INCOME DETERMINATION: Gross income of the household member is defined as all income received prior to deductions, including taxes, garnishments, whether voluntary or involuntary and net business income.

A. **Income sources:** Gross income includes income from both earned and unearned sources.

B. **Countable income:** The gross unearned income of all household members is counted in its entirety, and the gross earned income of all household members over the age of 18 is counted in its entirety, unless:

(1) the income is specifically exempted; or

(2) the income is self-employment, in which case the income is annualized (see LIHEAP 8.150.520.9 NMAC); or

(3) the income is that of an ineligible non-citizen, in which case the income is prorated (see LIHEAP policy 8.150.520.10 NMAC);

(4) the income is a full month's income and is anticipated to be received on a weekly or biweekly basis; in these circumstances, the income shall be converted to a monthly amount as follows:

(a) income received on a weekly basis is averaged and multiplied by 4.0;

(b) income received on a biweekly basis is averaged and multiplied by 2.0;

(c) averaged income shall be rounded to the nearest whole dollar prior to application of the conversion factor; amounts resulting in $.50 or more are rounded up; amounts resulting in $.49 or lower are rounded down.

C. Gross income receipt period: HCA shall establish income by utilizing the gross income of the household for the 30 day period immediately preceding the date on which LIHEAP eligibility is determined by ISD.

D. Current income verified in other public assistance programs: Current income that has been verified by ISD in another active public assistance programs may be used to verify income for the LIHEAP application, unless deemed questionable.

[8.150.520.12 NMAC – Rp 8.150.520.12 NMAC, 07/01/2024]

8.150.520.13 UNEARNED INCOME:

A. Definition: Unearned income is income received in the form of entitlement, disability, retirement, unemployment benefits or payments, including but not limited to the following:

(1) child support;
(2) alimony;
(3) temporary assistance to needy families (TANF) benefits;
(4) general assistance (GA) payments;
(5) royalties;
(6) dividends and interest; or
(7) tribal benefits.

B. Gross unearned income: The gross amount of the benefit or payment must be counted. In the case of OASDI benefits, the gross amount of the benefit includes the amount deducted for the medicare premium, if applicable.

C. Real estate contracts: Monthly payments resulting from the sale of property and contributions from family or friends are also countable unearned income.

D. Exclusions: The following are not counted as income:

(1) in-kind benefits (i.e. goods or services realized, provided or exchanged for non-monetary compensation);
(2) vendor payments (i.e. payments made on behalf of a household to a third party);
(3) lump sum payments: as defined in food stamp regulations at 8.139.520.9 NMAC;
(4) loans;
(5) charitable contributions from nonprofit agencies to meet household expenses;
(6) earned income tax credits;
(7) value of food stamps;
(8) TANF annual clothing allowance;
(9) monies received for the care of a third party beneficiary who is not a household member; and
(10) monies excluded by federal statute, as listed at 8.139.527 NMAC.

[8.150.520.13 NMAC – Rp 8.150.520.13 NMAC, 07/01/2024]

8.150.520.14 TOTAL GROSS INCOME: The household's total gross income is determined by adding countable earned and unearned income. Income received from self-employment and by ineligible non-citizens is not counted in full. The income of migrant households may be annualized and averaged. The household's total gross income must be equal to or less than income standards published annually in the LIHEAP state plan.

[8.150.520.14 NMAC – Rp 8.150.520.14 NMAC, 07/01/2024]

8.150.520.15 INCOME STANDARD: Income guidelines for eligibility will be updated at the beginning of each federal fiscal year as required by federal statute. The guidelines will be effective for the entire federal fiscal year beginning October 1 and ending September 30. The income guidelines will be determined by the secretary of the health care authority before the beginning of the new federal fiscal year and published annually in the LIHEAP state plan.

[8.150.520.15 NMAC – Rp 8.150.520.15 NMAC, 07/01/2024]

8.150.520.16 CRISIS INTERVENTION STANDARDS: Households who are over the income standards but meet the crisis intervention requirements may be eligible for a crisis LIHEAP benefit. If a household is over the income standards, HCA staff should explore the household's financial circumstances and take into account any

financial crisis in the household that may have resulted in the household's inability to meet its utility or fuel expenses in the past 30 days. In these cases, the household's net income, rather than gross income, may be considered to determine income eligibility for LIHEAP benefits.
[8.150.520.16 NMAC – Rp 8.150.520.16 NMAC, 07/01/2024]

8.150.520.17 NET INCOME:

A. Definition: Net income, except for net business income, for the purposes of LIHEAP policy, is not gross income minus deductions. Rather, it is gross income minus household emergency expenses incurred and paid in 30 days prior to the application date or the initial payment, during that period, of a bill resulting from a recent household emergency.

B. Calculation: To determine the net income for a household, subtract any allowable household emergency expenses from the household's gross income.

C. No emergency expenses: If the household did not incur and pay household emergency expenses or an initial payment for a recent household emergency in the 30 days prior to the application date for LIHEAP benefits, gross income is to be used to make the determination of eligibility.
[8.150.520.17 NMAC – Rp 8.150.520.17 NMAC, 07/01/2024]

8.150.520.18 HOUSEHOLD EMERGENCY EXPENSES:

A. Definition: Household emergency expenses are defined as expenses incurred and paid in full or in part by the household in the 30 days prior to the application date.

B. Examples of emergency expenses include:

(1) hospital, ambulance, doctor and dental bills;

(2) laboratory and other testing bills;

(3) prescriptions and non-prescription items ordered by a licensed health care professional; and

(4) services provided or ordered by a licensed health care professional; or

(5) non-elective medical expenses;

(6) emergency medical expenses, such as:

(7) hospital bills; and

(8) ambulance bills;

(9) expenses resulting from the death of a household member or other major household crisis; or

(10) repair or replacement of the household's primary vehicle.

C. Licensure exemption: Native American practitioners (medicine men), though not licensed by the state, are specifically recognized by HCA as health care providers under this policy.
[8.150.520.18 NMAC – Rp 8.150.520.18 NMAC, 07/01/2024]

8.150.520.19 VERIFICATION: To be considered, the household must provide proof of the incurred expense(s) and proof of payment.
[8.150.520.19 NMAC – Rp 8.150.520.19 NMAC, 07/01/2024]

HISTORY OF 8.150.520 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11/20/1985.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.

ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 600 DESCRIPTION OF PROGRAM/BENEFITS

8.150.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.600.1 NMAC – Rp 8.150.600.1 NMAC, 07/01/2024]

8.150.600.2 SCOPE: The rule applies to the general public.
[8.150.600.2 NMAC – Rp 8.150.600.2 NMAC, 07/01/2024]

8.150.600.3 STATUTORY AUTHORITY: Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.
[8.150.600.3 NMAC – Rp 8.150.600.3 NMAC, 07/01/2024]

8.150.600.4 DURATION: Permanent.
[8.150.600.4 NMAC – Rp 8.150.600.4 NMAC, 07/01/2024]

8.150.600.5 EFFECTIVE DATE: November 15, 1996, unless a different date is at the end of a section or paragraph.
[8.150.600.5 NMAC – Rp 8.150.600.5 NMAC, 07/01/2024]

8.150.600.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program.
[8.150.600.6 NMAC – Rp 8.150.600.6 NMAC, 07/01/2024]

8.150.600.7 DEFINITIONS: [**RESERVED**]

8.150.600.8 BENEFITS - ISSUANCE AND USE AND VENDOR RESPONSIBILITIES:

A. Issuance of benefits: Benefits are issued in one of the following methods:

(1) recipient warrants: HCA issues benefits directly to recipients through recipient warrants when appropriate and only as a last resort;

(2) vendor payments: HCA issues benefits directly to the vendor;

(a) HCA will provide the account name and customer account number for the LIHEAP eligible household to the vendor specified by the household; the vendor will notify HCA of mismatches within a specified time frame;

(b) vendors who carry customer accounts will credit eligible households with the amount of the LIHEAP regular benefit no more than 30 days from the time of the payment; vendors who provide fuel on demand will provide fuel to eligible households equal to the amount of the LIHEAP regular benefit no more than 30 days from the date of the eligible household's contact with the vendor to make arrangements for the provision of such fuel;

(c) vendors shall return to the LIHEAP central office excess LIHEAP benefits from the account originally credited if that account is closed.

(d) vendors should transfer a LIHEAP benefit credit on an account that is closed after the credit is posted; the transfer must be to a new or existing account for the new residence of the recipient household; the vendor must document the transfer in a manner that meets generally accepted audit standards;

(e) vendors may refund LIHEAP benefit credit to a household under certain circumstances when the household moves or will not have service with the company at their residence; the vendor must document the transfer in a manner that meets generally accepted audit standards;

(f) vendors must refund LIHEAP benefit credits on closed accounts to HCA when the credit cannot be transferred to a new account or the household cannot be located.

B. Benefit use: The recipient household which receives a direct payment is responsible for using the benefit for the purpose intended:

(1) to purchase fuel, such as propane, wood, coal, kerosene, fuel oil or other unregulated fuels;

(2) to pay the household's utility charges, such as those for electric or natural gas services;
(3) to purchase gasoline or tools needed when a household gathers/cuts its own firewood;
(4) to pay a landlord for the utility costs that are included in the rent payment;
(5) to pay for a deposit obligation needed to initiate or continue service.

[8.150.600.8 NMAC – Rp 8.150.600.8 NMAC, 07/01/2024]

8.150.600.9 STATE LIHEAP FUNDING:

A. Purpose: To reduce the home heating and cooling costs of low-income New Mexicans.

B. Benefits:

(1) payments that assist low-income households to reduce the costs of home heating/cooling; or

(2) weatherization services for the homes of low-income households.

[8.150.600.9 NMAC – Rp 8.150.600.9 NMAC, 07/01/2024]

8.150.600.10 FUND USES: Unless specified by the New Mexico state legislature, the secretary of the health care authority has the authority to specify the uses of the funding. Funding will be used for purposes similar to those allowed under the federal low income home energy assistance program.

[8.150.600.10 NMAC – Rp 8.150.600.10 NMAC, 07/01/2024]

8.150.600.11 WINTER MORATORIUM ON UTILITY DISCONNECTION: No utility vendor regulated by the public regulation commission shall discontinue or disconnect residential utility service for heating from November 15 through March 15 of the subsequent year for certain customers.

A. Administering authority: The health care authority or a tribal entity that administers its own low income home energy assistance program are designated as the authorities to identify customers who meet the certain qualifications for the winter moratorium. The customer must also meet the New Mexico public regulation commission requirements to receive winter moratorium protection.

B. Qualification: Customers who qualify for the winter moratorium must meet the following income standards:

(1) the customer is a member of a household in which the total gross income is at or below 150% of the current federal poverty guidelines; or

(2) one or more of the household members:

(a) receive supplemental security income; or

(b) are eligible for any federally funded assistance program administered by ISD with income guidelines at or below 150% of the current federal poverty guidelines;

(3) the person in whose name a utility account is listed and the name of the public assistance recipient need not match in order for the customer to be entitled to protection under this section.

C. Proof of qualification:

(1) HCA generated approval notice for public assistance programs whose income guidelines are at or below 150% of the current federal poverty guidelines;

(2) **computer generated notice from HCA; or**

(3) form completed by hand from a local ISD office.

[8.150.600.11 NMAC – Rp 8.150.600.11 NMAC, 07/01/2024]

HISTORY OF 8.150.600 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11-20-85.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.

ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 620 BENEFIT DETERMINATION GENERAL

8.150.620.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.620.1 NMAC – Rp 8.150.620.1 NMAC, 07/01/2024]

8.150.620.2 SCOPE: The rule applies to the general public.
[8.150.620.2 NMAC – Rp 8.150.620.2 NMAC, 07/01/2024]

8.150.620.3 STATUTORY AUTHORITY: Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.
[8.150.620.3 NMAC – Rp 8.150.620.3 NMAC, 07/01/2024]

8.150.620.4 DURATION: Permanent.
[8.150.620.4 NMAC – Rp 8.150.620.4 NMAC, 07/01/2024]

8.150.620.5 EFFECTIVE DATE: November 15, 1996, unless a different date is at the end of a section or paragraph.
[8.150.620.5 NMAC – Rp 8.150.620.5 NMAC, 07/01/2024]

8.150.620.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program.
[8.150.620.6 NMAC – Rp 8.150.620.6 NMAC, 07/01/2024]

8.150.620.7 DEFINITIONS: [**RESERVED**]

8.150.620.8 POINT SYSTEM: A point allocation system is used to insure that the highest level of assistance is provided to those households with the highest energy needs, lowest income and largest household member size while giving priority to those households with vulnerable members.
[8.150.620.8 NMAC – Rp 8.150.620.8 NMAC, 07/01/2024]

8.150.620.9 CALCULATING THE BENEFIT/ASSIGNMENT OF POINTS: To determine the amount of the benefit for households with an energy cost, HCA assigns points for each following factors.

A. Energy costs points: Points are assigned based on the energy burden at the household's current residence for households that have a direct cost for heating or cooling expenses.

(1) Energy burden: Energy burden is "the expenditures of the household for home energy divided by the income of the household." Points are assigned to the household by determining the households' percentage of energy burden. The point allocation for energy burden is:

(a) 0 points for 0 - 5% energy burden;
(b) 1 point for 6 - 10% energy burden;
(c) 2 points for 11 - 15% energy burden; or
(d) 3 points for 16% or more energy burden.

(2) Additional Energy Burden: If the household's energy burden is for the use of propane, an additional two (2) points will be allocated.

(3) Receipt of energy burden points: Certain households do not receive energy burden points:

(a) households whose utilities are included in the rent; or
(b) households that use wood to heat their home and do not purchase wood.

(4) Energy standard allowance (ESA): Each year an ESA will be determined. The standard amount will be based on the fuel and electricity standards calculated for the standard utility allowance (SUA) used in the New Mexico supplemental nutrition assistance program (SNAP). The ESA may be used when the monthly utility costs provided by the applicant are: a) less than the standard; or b) the applicant has new service and costs are not available.

B. Income points: HCA assigns income points using the household's monthly total countable gross income and the household size. The number of points is determined by identifying what percentage the household's income is of the federal poverty guidelines (FPG) for the LIHEAP FFY. For example, if the total monthly income is 60% of the FPG, the household will receive three income points. (See below.)

(1) 3 points - income is 0 - 100% of the FPG

(2) 2 points - income is 100 - 150% of the FPG

C. Vulnerable population points: HCA assigns additional points for any household members in the following vulnerable groups.

(1) Age 60 and over: Two (2) points are assigned to eligible households based on the inclusion of one or more household members age 60 or over as determined by birthdate data.

(2) Age 5 and under: Two (2) points are assigned to eligible households based on the inclusion of one or more household members age 5 and under as determined by birthdate data.

(3) Disability: Two (2) points are assigned to eligible households having one or more members with a disability. Disability is defined as physical or mental impairment resulting in substantial reduction in the ability of an individual to care for him/herself or carry out normal activities. When one or more members receive disability based income, the household is entitled to the points. A doctor's statement of current disability will be required for assignment of the point for this factor if the disabled member does not receive disability-based income.

[8.150.620.9 NMAC – Rp 8.150.620.9 NMAC, 07/01/2024]

8.150.620.10 CALCULATION OF BENEFIT AMOUNT:

A. Prior to the start of the application period projections will be made to determine point value. Anticipated grant of award, potential applicants and the current economy of the state of New Mexico will be used to determine the point value. Households eligible for a LIHEAP benefit will have their point total multiplied times the point value. The product is the amount of payment that is issued to the utility vendor for credit on the household's account or is sent to the household.

B. Based on the availability of funds, benefits are issued for eligible applications received through September 30.

C. At the direction of the HCA secretary, the point value for energy cost points, income points, vulnerable population points, additional energy burden points, or any of their parts, may be adjusted as necessary taking into consideration the factors described in Subsection A of 8.150.620.10 NMAC.

[8.150.620.10 NMAC – Rp 8.150.620.10 NMAC, 07/01/2024]

8.150.620.11 [Reserved]

[8.150.620.11 NMAC – Rp 8.150.620.11 NMAC, 07/01/2024]

8.150.620.12 RETROACTIVE BENEFIT COVERAGE: Households that were denied LIHEAP benefits or received a lesser benefit than they were entitled to but, prevail in an appeal through an agency conference or fair hearing, are entitled a retroactive benefit.

[8.150.620.12 NMAC – Rp 8.150.620.12 NMAC, 07/01/2024]

HISTORY OF 8.150.620 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:

ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11/20/1985.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.

ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 150 LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
PART 624 RETROACTIVE BENEFIT COVERAGE

8.150.624.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.150.624.1 NMAC – Rp 8.150.624.1 NMAC, 07/01/2024]

8.150.624.2 SCOPE: The rule applies to the general public.
[8.150.624.2 NMAC – Rp 8.150.624.2 NMAC, 07/01/2024]

8.150.624.3 STATUTORY AUTHORITY: Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation. It also provides for administration of public assistance programs.
[8.150.624.3 NMAC – Rp 8.150.624.3 NMAC, 07/01/2024]

8.150.624.4 DURATION: Permanent.
[8.150.624.4 NMAC – Rp 8.150.624.4 NMAC, 07/01/2024]

8.150.624.5 EFFECTIVE DATE: November 15, 1996, unless a different date is at the end of a section or paragraph.
[8.150.624.5 NMAC – Rp 8.150.624.5 NMAC, 07/01/2024]

8.150.624.6 OBJECTIVE: The objective of these regulations is to provide policy and procedures for the administration of the low income home energy assistance program.
[8.150.624.6 NMAC – Rp 8.150.624.6 NMAC, 07/01/2024]

8.150.624.7 DEFINITIONS: [RESERVED]

8.150.624.8 RETROACTIVE BENEFIT COVERAGE: Households that were denied LIHEAP benefits or received a lesser benefit than they were entitled to but, as the result of an agency conference or fair hearing, are determined to be entitled to a benefit will be issued a retroactive benefit.
[8.150.624.8 NMAC – Rp 8.150.624.8 NMAC, 07/01/2024]

HISTORY OF 8.150.624 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
ISD 600.0000, Energy Assistance Programs, 11/12/1982.
ISD 600.0000, Low Income Energy Assistance Program, 1/9/1984.
ISD 710.0000, Energy Assistance Programs, 11/15/1985.
ISD 620.0000, Crisis Intervention Assistance, 11/12/1982.
ISD 620.0000, Energy Crisis Intervention Assistance, 12/27/1983.
ISD 714.0000, Energy Crisis Intervention, 11/20/1985.
ISD 630.0000, Program Administration, 11/12/1982.
ISD 630.0000, Program Administration, 12/27/1983.
ISD 715.0000, Administration of Energy Assistance Programs, 11/20/1985.
ISD FA 710, Energy Assistance Programs, 12/5/1989.
ISD CAS 700, Energy Assistance Program, 11/13/1991.
ISD CAS 700, Energy Assistance Program, 11/10/1992.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 5/6/1994.
ISD/CACB/LHP 700, Low Income Home Energy Assistance Program, 7/28/1994.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT RULES
PART 450 REPORTING REQUIREMENTS

8.200.450.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.200.450.1 NMAC – Rp 8.200.450.1 NMAC, 07/01/2024]

8.200.450.2 SCOPE: The rule applies to the general public.
[8.200.450.2 NMAC – Rp 8.200.450.2 NMAC, 07/01/2024]

8.200.450.3 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 health care authority pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.200.450.3 NMAC – Rp 8.200.450.3 NMAC, 07/01/2024]

8.200.450.4 DURATION: Permanent.
[8.200.450.4 NMAC – Rp 8.200.450.4 NMAC, 07/01/2024]

8.200.450.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.200.450.5 NMAC – Rp 8.200.450.5 NMAC, 07/01/2024]

8.200.450.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.200.450.6 NMAC – Rp 8.200.450.6 NMAC, 07/01/2024]

8.200.450.7 DEFINITIONS [**RESERVED**]

8.200.450.8 MISSION: To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[8.200.450.8 NMAC – Rp 8.200.450.8 NMAC, 07/01/2024]

8.200.450.9 REPORTING REQUIREMENTS: A medicaid applicant/recipient must report any change in circumstances which might affect his/her eligibility within 10 days after the change to the local income support division (ISD) office. This provision does not apply to children's medicaid (category of eligibility 032). See 8.232.600.14 NMAC, *changes in eligibility*.
[8.200.450.9 NMAC – Rp 8.200.450.9 NMAC, 07/01/2024]

HISTORY OF 8.200.450 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
8 NMAC 4.MAD.430, Recipient Policies, Recipient Rights and Responsibilities, 12/30/1994.

History of Repealed Material: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 201 MEDICAID ELIGIBILITY - MEDICAID EXTENSION (CATEGORY 01, 03 and 04)
PART 500 INCOME AND RESOURCE STANDARDS

8.201.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.201.500.1 NMAC – Rp 8.201.500.1 NMAC 07/01/2024]

8.201.500.2 SCOPE: The rule applies to the general public.
[8.201.500.2 NMAC – Rp 8.201.500.2 NMAC 07/01/2024]

8.201.500.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.201.500.3 NMAC – Rp 8.201.500.3 NMAC 07/01/2024]

8.201.500.4 DURATION: Permanent
[8.201.500.4 NMAC – Rp 8.201.500.4 NMAC 07/01/2024]

8.201.500.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.201.500.5 NMAC – Rp 8.201.500.5 NMAC 07/01/2024]

8.201.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.201.500.6 NMAC – Rp 8.201.500.6 NMAC 07/01/2024]

8.201.500.7 DEFINITIONS: [**RESERVED**]

8.201.500.8 [**RESERVED**]

8.201.500.9 NEED DETERMINATION: [RESERVED]
[8.201.500.9 NMAC – Rp 8.201.500.9 NMAC 07/01/2024]

8.201.500.10 RESOURCE STANDARDS: To be eligible for medicaid extension, applicants/recipients must meet SSI resource standards. Recipients initially eligible for medicaid extension under E01 status lose eligibility when their resources exceed the SSI resource maximum. See 8.215.500.11 NMAC, *resource standards,* for information on exclusions, disregards, and countable resources.
[8.201.500.10 NMAC – Rp 8.201.500.10 NMAC 07/01/2024]

8.201.500.11 RESOURCE TRANSFERS: The social security administration excluded transfer of resources as a factor of eligibility for non-institutionalized SSI recipients. Transfer of resources is not a factor for consideration in categories that use SSI methodology in the eligibility determination.
[8.201.500.11 NMAC – Rp 8.201.500.11 NMAC 07/01/2024]

8.201.500.12 TRUSTS: See 8.281.510 NMAC and following subsections.
[8.201.500.12 NMAC – Rp 8.201.500.12 NMAC 07/01/2024]

8.201.500.13 INCOME STANDARDS: To be eligible for medicaid extension, an applicant/recipient must have countable income below the SSI FBR. See 8.215.500.18 NMAC, *income,* through 8.215.500.22 NMAC, *disregards*, for information on exclusions, disregards, and countable income.
[8.201.500.13 NMAC – Rp 8.201.500.13 NMAC 07/01/2024]

8.201.500.14 COMPUTATION OF COLA DISREGARDS IN PICKLE AND 503 LEADS CASES:

A. An applicant/recipient's countable income, after exclusion of the Title II COLAs received following SSI termination, must be less than the current SSI federal benefit rate (FBR).

B. To determine the total amount of the applicant/recipient's Title II COLAs received since the applicant/recipient lost SSI, the following calculation must be completed:

(1) divide the current Title II amount by the percentage amount of the previous year's COLA;

(2) repeat this calculation for each Title II COLA benefit received after the applicant lost SSI; computations are based on the previous year's COLA and previous benefit; see 8.200.520.12 NMAC, *COLA disregard computation*, of 503 leads and pickle cases;

(3) when the last computation is completed, the result is the Title II benefit amount the applicant/ recipient was receiving when he/she lost SSI;

(4) subtract this amount from the current Title II benefit amount; the result is the aggregate Title II COLAs the applicant/recipient received after losing SSI; and

(5) subtract the aggregate COLAs from the applicant/recipient's countable income to determine if the income is below the current SSI FBR.

C. If the resulting income is below the current SSI FBR, and the applicant/recipient meets all other requirements for SSI, he/she is eligible for medicaid extension.

[8.201.500.14 NMAC – Rp 8.201.500.14 NMAC 07/01/2024]

8.201.500.15 DEEMED INCOME: If an applicant/recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered. If an applicant/recipient is married and lives with a spouse, deemed income from the spouse must be considered. See 8.215.500.21 NMAC, *deemed income*, for information on deemed income. If an applicant/recipient has a spouse or parent who receives Title II benefits, all COLAs received by the spouse/parent since the applicant/recipient lost SSI are deducted from the spouse/parent's income before it is deemed to the applicant/recipient.

[8.201.500.15 NMAC – Rp 8.201.500.15 NMAC 07/01/2024]

8.201.500.16 [RESERVED]

[8.201.500.16 NMAC – Rp 8.201.500.16 NMAC 07/01/2024]

HISTORY OF 8.201.500 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 370.0000, Procedures for Retroactive Supplemental Security Income (SSI) Medicaid and Medicaid Extension, filed 5/26/1980.
ISD 370.0000, Procedures for Retroactive Supplemental Security Income (SSI) Medicaid and Medicaid Extension, filed 1/26/1982.
MAD Rule 370.0000, Procedures for Retroactive Supplemental Security Income (SSI) Medicaid and Medicaid Extension, filed 12/1/1987.
MAD Rule 870, Retroactive Medicaid Coverage, filed 1/31/1990.
MAD Rule 870, Retroactive Medicaid Coverage, filed 3/11/1992.
MAD Rule 870, Retroactive Medicaid Coverage, filed 11/16/1994.
MAD Rule 372.0000, Medicaid Extension, 12/1/1987.
MAD Rule 872, Medicaid Extension, filed 1/31/1990.
MAD Rule 872, Medicaid Extension, filed 3/11/1992.
MAD Rule 872, Medicaid Extension, filed 8/20/1992.
MAD Rule 872, Medicaid Extension, filed 9/26/1994.

History of Repealed Material:

MAD Rule 872, Medicaid Extension, filed 9/26/1994 - Repealed effective 2/1/1995.
8.201.500.1 NMAC, Medicaid Eligibility - Medicaid Extension (Category 01, 03 and 04), filed 2/01/1995 – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 206 MEDICAID ELIGIBILITY - CYFD CHILDREN (CATEGORIES 006, 017, 037, 046, 047, 060, 061, 066 & 086)
PART 500 INCOME AND RESOURCE STANDARDS

8.206.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.206.500.1 NMAC – Rp 8.206.500.1 NMAC, 07/01/2024]

8.206.500.2 SCOPE: This rule applies to the general public.
[8.206.500.2 NMAC – Rp 8.206.500.2 NMAC, 07/01/2024]

8.206.500.3 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 health care authority pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.206.500.3 NMAC – Rp 8.206.500.3 NMAC, 07/01/2024]

8.206.500.4 DURATION: Permanent.
[8.206.500.4 NMAC – Rp 8.206.500.4 NMAC, 07/01/2024]

8.206.500.5 EFFECTIVE DATE: October 1, 1994, unless a later date is cited at the end of a section.
[8.206.500.5 NMAC – Rp 8.206.500.5 NMAC, 07/01/2024]

8.206.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.206.500.6 NMAC – Rp 8.206.500.6 NMAC, 07/01/2024]

8.206.500.7 DEFINITIONS: [**RESERVED**]

8.206.500.8 [**RESERVED**]

8.206.500.9 NEED DETERMINATION: [RESERVED]
[8.206.500.9 NMAC – Rp 8.206.500.9 NMAC, 07/01/2024]

8.206.500.10 RESOURCE STANDARDS: To be eligible for CYFD medicaid, the value of all countable personal and real property, considered belonging to or available to an applicant/recipient under eighteen (18) years of age or twenty-one (21) years of age in expanded foster care medicaid category 006 or 066 cannot exceed $1,000. If an applicant/recipients owns resource or saving in excess of this amount, he/she is not eligible for CYFD medicaid.
[8.206.500.10 NMAC – Rp 8.206.500.10 NMAC, 07/01/2024]

8.206.500.11 APPLICABLE RESOURCE STANDARDS: The authorized representative from CYFD who completes the application on behalf of the applicant/recipient must initiate all appropriate steps to make available property or resources to which the applicant/recipient may be entitled. Normally, individuals under eighteen (18) do not own/controlled property. Property that is held and/or control on behalf of an applicant/recipient is considered available unless some specific provision in the title to the property precludes it availability.

A. Property not readily marketable: Even property that is not marketable must be assessed in the eligibility determination and is subject to transfer restrictions and penalties.

B. Property share owned: The current value of property which must be partitioned to be accessible is not considered available if the net value after estimated costs of partition and other closing costs is less than the resource limit. If the amount likely to be derived from the sale of the applicant/recipient's share of the property exceeds the resource limit, he/she must initiate attempts to obtain his/her share of the property.

C. Property owned by parent: The value of property owen by the parent who does not live with the applicant/recipient is not considered available to the applicant/recipient.

[8.206.500.11 NMAC – Rp 8.206.500.11 NMAC, 07/01/2024]

8.206.500.12 COUNTABLE RESOURCES: Countable resources include but are not limited to the following:

A. cash value of life insurance policy owned by the applicant/recipient;

B. cash, bank accounts and other readily negotiable assets owned by the applicant/recipient are countable resources;

C. equipment, tools, and motor vehicles (which do not fit the vehicle exemption);

D. livestock; and

E. asset conversion; money received from one-time or sporadic sales of real or personal property such as crops, rugs, or jewelry is considered a resource if the property is not sold or transferred in connection with a business of self-employment activity.

(1) Actual verified expenses associated with the purchase, sale, or production of the property are deducted from money received from the sale to arrive at the net resource value.

(2) Property converted into money is subject to the resource limitation regardless of whether it was fully or partially exempt prior to conversion.

[8.206.500.12 NMAC – Rp 8.206.500.12 NMAC, 07/01/2024]

8.206.500.13 RESOURCE EXCLUSIONS: Certain resources are excluded from the resource computation.

A. Vehicle exclusion: The equity value of one vehicle belonging to the applicant/recipient or in his/her name, is not considered a countable resource if the value of the vehicle is $1,500 or less. Any excess over $1,500 is a countable resource. The value of any apparatus for the handicapped which is installed on the vehicle is also excluded.

B. Income exclusion: Any income which is excluded under income provisions is also excluded from consideration as a resource. Excluded income which is saved must be kept separate from non-excluded savings.

C. Settlement fund payment exclusion: Payments received from the Radiation Exposure Compensation Act is excluded. Payments made under the Agent Orange Settlement Act is also excluded. Payments by the remembrance, responsibility and the future foundation to individual survivors forced into slave labor by the Nazis are excluded.

D. Earned income tax credit payment exclusion: Earned income tax credit payments are not considered resources until the third month after receipt of the payment.

E. Funeral agreement exclusion: The equity value of funeral agreement(s) owned by the applicant/recipients which do not exceed $1,500 are excluded.

F. Contingent and unliquidated claim exclusion: "Contingent and unliquidated claim" is defined as a yet unnamed right of the applicant/recipient to receive, at some future time, a resource such as an interest in an unprobated estate or damages/compensation from an accident or injury. These claims are excluded if the applicant/recipient can demonstrate that he/she has consulted an attorney or that under the circumstances it is reasonable not to have consulted an attorney but that he/she is making effort to prosecute his/her claim or to proceed with the probate. If the applicant/recipient can demonstrate that his/her share in an unprobated estate would be less than the expense of the proceeding to probate the estate, the value is not considered a resource.

G. Chafee medicaid: All resources belonging to recipients of Chafee medicaid who are between eighteen (18) and twenty-one (21) years of age are excluded.

[8.206.500.13 NMAC – Rp 8.206.500.13 NMAC, 07/01/2024]

8.206.500.14 RESOURCE TRANSFERS: To be eligible for CYFD Medicaid, the applicant/recipient must not have transferred resources within two (2) years prior to application for the purpose of qualifying for CYFD medicaid. An applicant/recipient under eighteen (18) years of age cannot transfer property, except through a guardian. Normally, such applicants/recipients do not own property in his/her own right. If facts indicate the existences of a trust, inheritance, or prior gift, the CYFD representative completing the application must determine if a transfer has taken place within the two (2) year period.

A. Transfers made for the purpose of qualifying for medicaid: A transfer is considered to have been made for the purpose of becoming eligible if:

(1) the transfer was made without a reasonable return; and

(2) the applicant/recipient had no reasonable plan for support at the time of the transfer other than receiving CYFD medicaid.

(3) if the value of the applicant/recipient's equity in the transferred property plus all other countable resources is less than $1,000, the transfer is not considered to be for the purpose of becoming eligible.

B. Definitions:

(1) "Transfer" includes the sale, transfer by gift, or conveyance by deed or any other method of transferring the title to the property. The transfer can be for either the title to real property or any other interest or rights in real property, such as mineral rights.

(2) "Reasonable return" is considered to have been received when the applicant/recipient received compensation in cash or in kind equals the value of the property at the time of transfer. This determination is based on the applicant/recipient's equity interest in the property at the time of transfer.

C. Attempts to obtain reasonable return: If the property was transferred for the purpose of becoming eligible but the applicant/recipient subsequently makes and continues to make efforts to obtain a reasonable return or regain the title, the applicant/recipient is not ineligible because of the improper transfer of resources.

D. Period of ineligibility: If a transfer without fair return was made for the purpose of becoming eligible for CYFD Medicaid, the applicant/recipient is ineligible for a period of twenty-four (24) months beginning with the month the resources were transferred.

[8.206.500.14 NMAC – Rp 8.206.500.14 NMAC, 07/01/2024]

8.206.500.15 TRUSTS: If an applicant/recipient is the beneficiary of a trust fund, a copy of the trust document and any other documents pertaining to the creation of the trust must be submitted to the eligibility unit of the medical assistance division for coordination of the trust analysis with the health care authority's office of general counsel.

[8.206.500.15 NMAC – Rp 8.206.500.15 NMAC, 07/01/2024]

8.206.500.16 INCOME STANDARDS:

A. To be eligible for CYFD medicaid, the applicant/recipient's income must be less than the maximum aid to families with dependent children (AFDC) standard for one person. See 8.200.520.10 NMAC, *Income Standards*. Any earned and unearned income that belongs to the applicant/recipient must be totaled and compared to the standard.

B. The authorized representative of CYFD who completes the medicaid application on behalf of the applicant/recipient must take all necessary steps to apply for or obtain any other income which the applicant/recipient may qualify for when the individual becomes aware of the income. If income becomes available to the applicant/recipient, his/her eligibility for CYFD medicaid must be re-evaluated.

C. Sources of potential income includes social security, veterans benefits, supplement security income, trust funds, and contingent claims.

[8.206.500.16 NMAC – Rp 8.206.500.16 NMAC, 07/01/2024]

8.206.500.17 EARNED INCOME:

A. If a applicant/recipient of CYFD medicaid has earned income and is not a full-time student in elementary school, high school, or a course of vocational or technical training, his/her earnings are considered in the earned income calculation.

B. Earned income exclusions:

(1) Exclusion for full-time students: If an applicant/recipient of CYFD medicaid has earned income and is a full-time student in elementary school, high school, or in a course of vocational or technical training, his/her earnings are totally excluded.

(2) Job Training Partnership Act (JTPA) earnings and earned income tax credit exclusion: JTPA earning/reimbursement and earned income tax credit payments are excluded from consideration as income regardless of whether the applicant/recipient is a full-time student.

(3) Work-related expense disregard: An applicant/recipient of CYFD medicaid with earned income from employment is entitled to a deduction of ninety dollars ($90) from gross monthly earnings for work-related expenses.

(4) Census bureau employment: Wages paid by the census bureau for temporary employment related to the census are excluded from consideration as income in the eligibility determination process.

(5) Recipients of Chafee medicaid: All earned income of an applicant/recipient between eighteen (18) and twenty-one (21) years of age is excluded while receiving Chafee independent living assistance from CYFD.

[8.206.500.17 NMAC – Rp 8.206.500.17 NMAC, 07/01/2024]

8.206.500.18 UNEARNED INCOME: Unearned incomes includes but is not limited to social security benefits, child support, gifts, contributions, and all other cash income which does not meet the definition of earned income. Unearned income is counted in the gross amount received.

A. Unearned income exclusions and disregards: Certain amounts of unearned income are excluded from the computation of unearned income.

(1) Educational assistance exclusions: Bona fide loans from private individuals or commercial institutions for education assistance are excluded from unearned income. Income from work study whose purpose is to assist with educational expenses are excluded from unearned income. Educational grants and scholarships whose purpose is to assist with education expenses are excluded regardless of the actual utilization of the funds.

(2) Child nutrition and school lunch benefit exclusion: Child nutritional and school lunch benefits provided in the form of money payments, vouchers, or foodstuffs authorized under the Child Nutritional Act and the National School Lunch Act are excluded.

(3) Income tax return income exclusion: State and federal income tax refunds are excluded from consideration as income. Tax refunds are considered resources.

(4) Native American payment exclusion: Certain payments to Native Americans can be excluded which include:

(a) per capita payment of tribal funds authorized by the tribe or by the secretary of the United States department of the interior; payments received and distributed by the bureau of Indian affairs (BIA) as a trustee for an individual members of a tribe, refer to as individual Indian monies (IAMB) are not considered as per capita payments;

(b) interest derived from retrained per capita payments is disregarded if the retained per capita payments have not been commingled with other savings; and

(c) BIA general assistance payments made to disabled tribal members by the BIA;

(d) any tax exempt payment made under the Alaska Native Claims Act are excluded from consideration as unearned income.

(5) Settlement fund payment exclusions: Payments received from the agent orange settlement fund or from any other fund established pursuant to the agent orange product liability litigation settlement are excluded from unearned income. Payments received from the Radiation Exposure Compensation Act are excluded from unearned income. Payments by the remembrance, responsibility and the future foundation to individual survivors forced into slave labor by the Nazis are excluded from unearned income.

(6) Payments made by division of vocational rehabilitation: Any payment made by the division of vocation rehabilitation to an applicant/recipient in training to help him/her meet additional training costs are disregarded. The entire payment is disregarded unless specific portion is designated for basic maintenance and the applicant/recipient is maintaining only one resident. The portion designated for basic maintenance is considered income.

(7) Child support disregard: The first fifty dollars ($ 50) of child support payments received in a month from an absent parent which represents payment on a support obligation for the month is disregarded in the eligibility determination and redetermination process.

(a) If multiple child support payments are received such as cases where more than one parent is paying or a parent makes weekly or biweekly payments, the disregard is allowed only once during the month.

(b) If a payment included both current support and arrearage, the disregard is allowed only on the current support.

(8) Disregard for payments made by CYFD: Payment made by CYFD to a third party on behalf of an applicant/recipient are not considered income to the applicant/recipient.

(9) Chafee independent living assistance recipients: All unearned income of an applicant/recipient between eighteen (18) and twenty-one (21) years of age is excluded.

[8.206.500.18 NMAC – Rp 8.206.500.18 NMAC, 07/01/2024]

8.206.500.19 DEEMED INCOME: Income is not deemed to an applicant/recipient from his/her parents if the applicant/recipient is the full or partial financial responsibility of CYFD. Any voluntary contributions made by the applicant/recipient's parent(s) is considered as unearned income.

[8.206.500.19 NMAC – Rp 8.206.500.19 NMAC, 07/01/2024]

8.206.500.20 TOTAL INCOME: The combination of the applicant/recipient's earned income and unearned

income minus any applicable exclusions and disregards is compared to the maximum income standard for one person to determine if the applicant/recipient is eligible for CYFD medicaid.
[8.206.500.20 NMAC – Rp 8.206.500.20 NMAC, 07/01/2024]

8.206.500.21 LUMP SUM PAYMENTS: Lump sums are considered as income in the month received and resources (if retained) as of the first moment of the first day of the following month.
[8.206.500.21 NMAC – Rp 8.206.500.21 NMAC, 07/01/2024]

HISTORY OF 8.206.500 NMAC: [**RESERVED**]

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 206 MEDICAID ELIGIBILITY - CYFD CHILDREN (CATEGORIES 006, 017, 037, 046, 047, 060, 061, 066 and 086)
PART 600 BENEFIT DESCRIPTION

8.206.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.206.600.1 NMAC – Rp 8.206.600.1 NMAC, 07/01/2024]

8.206.600.2 SCOPE: The rule applies to the general public.
[8.206.600.2 NMAC – Rp 8.206.600.2 NMAC, 07/01/2024]

8.206.600.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.206.600.3 NMAC – Rp 8.206.600.3 NMAC, 07/01/2024]

8.206.600.4 DURATION: Permanent.
[8.206.600.4 NMAC – Rp 8.206.600.4 NMAC, 07/01/2024]

8.206.600.5 EFFECTIVE DATE: October 1, 1994, unless a later date is cited at the end of a section.
[8.206.600.5 NMAC – Rp 8.206.600.5 NMAC, 07/01/2024]

8.206.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.206.600.6 NMAC – Rp 8.206.600.6 NMAC, 07/01/2024]

8.206.600.7 DEFINITIONS: [**RESERVED**]

8.206.600.8 [**RESERVED**]

8.206.600.9 BENEFIT DESCRIPTION: An applicant/recipient who is eligible for medicaid under this category is eligible to receive the full range of medicaid-covered services.
[8.206.600.9 NMAC – Rp 8.206.600.9 NMAC, 07/01/2024]

8.206.600.10 BENEFIT DETERMINATION:

A. A written signed application must be made for every approved CYFD medicaid case.

(1) For voluntary placements, the parent(s) or guardian(s) must complete and sign the application on behalf of the child.

(2) For involuntary placements, information should be obtained from the parents. The social worker from CYFD may complete and sign the application on behalf of the child.

B. Applications must be acted on within 45 days of the date of application.
[8.206.600.10 NMAC – Rp 8.206.600.10 NMAC, 07/01/2024]

8.206.600.11 INITIAL BENEFITS: Notice of approval or denial of the application for CYFD medicaid is prepared. If the applicant is ineligible, the denial notice contains the reason for denial and explanation of the applicant's right to request an administrative hearing.
[8.206.600.11 NMAC – Rp 8.206.600.11 NMAC, 07/01/2024]

8.206.600.12 ONGOING BENEFITS: A periodic review to re-establish eligibility for medicaid must be done every six (6) months.
[8.206.600.12 NMAC – Rp 8.206.600.12 NMAC, 07/01/2024]

8.206.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three (3) months of retroactive medicaid coverage can be furnished to applicants who have received medicaid-covered services during the retroactive period and would have met applicable eligibility criteria had they applied during the three (3) months prior to the month of application [42 CFR Section 435.914]. Retroactive coverage is not available prior to January 1, 1995 to applicants/recipients of Category 060 and 061.

A. Application for retroactive benefit coverage: Application for retroactive medicaid can be made by checking "yes" in the "application for retroactive medicaid payments" box on the application/redetermination of eligibility for medicaid assistance (MAD 381) form or by checking "yes" to the question on "Does anyone in your household have unpaid medical expenses in the last three (3) months?" on the application for assistance (ISD 100 S) form. Applications for retroactive medicaid benefits must be made by 180 days from the date of application for assistance. Medicaid-covered services which were furnished more than two (2) years prior to application are not covered.

B. Approval requirements: To establish retroactive eligibility, the ISS must verify that all conditions of eligibility were met for each of the three (3) retroactive months and that the applicant received medicaid-covered services. Each month must be approved or denied on its own merits. Retroactive eligibility can be approved on either the ISD2 system (for categories programmed on that system) or on the retroactive medicaid eligibility authorization (ISD 333) form.

C. Notice:

(1) Notice to applicant: The applicant must be informed if any of the retroactive months are denied.

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the ISS must notify the recipient that he/she is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the recipient does not inform all providers and furnish verification of eligibility which can be used for billing and the provider consequently does not submit the billing within 120 days from the date of approval of retroactive coverage, the recipient is responsible for payment of the bill.

[8.206.600.13 NMAC – Rp 8.206.600.13 NMAC, 07/01/2024]

8.206.600.14 CHANGES IN ELIGIBILITY: Case closure must be effective the month following the month the case ceases to meet any of the financial or non-financial eligibility requirements. Case closure information must be transmitted to the medicaid claims processing contractor within thirty (30) days of closure.

[8.206.600.14 NMAC – Rp 8.206.600.14 NMAC, 07/01/2024]

HISTORY OF 8.206.600 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 240 MEDICAID ELIGIBILITY - QUALIFIED MEDICARE BENEFICIARIES (QMB) (CATEGORY 040)
PART 400 RECIPIENT POLICIES

8.240.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.240.400.1 NMAC – Rp 8.240.400.1 NMAC, 07/01/2024]

8.240.400.2 SCOPE: The rule applies to the general public.
[8.240.400.2 NMAC – Rp 8.240.400.2 NMAC, 07/01/2024]

8.240.400.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.240.400.3 NMAC – Rp 8.240.400.3 NMAC, 07/01/2024]

8.240.400.4 DURATION: Permanent.
[8.240.400.4 NMAC – Rp 8.240.400.4 NMAC, 07/01/2024]

8.240.400.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.240.400.5 NMAC – Rp 8.240.400.5 NMAC, 07/01/2024]

8.240.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.240.400.6 NMAC – Rp 8.240.400.6 NMAC, 07/01/2024]

8.240.400.7 DEFINITIONS: [**RESERVED**]

8.240.400.8 [**RESERVED**]

8.240.400.9 QUALIFIED MEDICARE BENEFICIARIES (QMB) - CATEGORY 040: To be eligible for the qualified medicare beneficiaries program (QMB), an applicant/recipient must be covered by medicare part A. Medicare part A is a free entitlement to social security beneficiaries who are sixty-five (65) years of age or older or who have received social security disability payments for twenty-four (24) months. Fully or currently insured workers, or their dependents, who have end-stage renal disease are also covered under medicare. Most applicants/recipients sixty-five (65) years of age or older who do not receive free medicare part A can voluntarily enroll for hospital insurance coverage, with payment of a monthly premium. Voluntary enrollees must also enroll for supplementary medical insurance, medicare part B, and pay that premium, as well.
[8.240.400.9 NMAC – Rp 8.240.400.9 NMAC, 07/01/2024]

8.240.400.10 BASIS FOR DEFINING THE GROUP: Applicants/recipients eligible for medicaid coverage under any other category may be eligible for coverage under QMB. QMB eligibility affords two advantages when an applicant/recipient is already eligible for medicaid:

A. medicare premium part A is payable by medicaid; and

B. medicaid receives federal matching funds for purchase of medicare part B.

[8.240.400.10 NMAC – Rp 8.240.400.10 NMAC, 07/01/2024]

8.240.400.11 GENERAL RECIPIENT REQUIREMENTS:
[8.240.400.11 NMAC – Rp 8.240.400.11 NMAC, 07/01/2024]

8.240.400.12 ENUMERATION: Applicants/recipients must furnish their social security account number(s). QMB eligibility is denied or terminated if applicants/recipients fail to furnish their social security numbers.
[8.240.400.12 NMAC – Rp 8.240.400.12 NMAC, 07/01/2024]

8.240.400.13 CITIZENSHIP:

A. Refer to medical assistance program manual 8.200.410.11 NMAC.

B. Verification of citizenship: Citizenship determinations rendered by the social security administration (SSA) for SSI are final.

(1) Documentation of citizenship: Primary documentation of citizenship is a birth certificate. Secondary documentation includes:

(a) certificate of naturalization;

(b) citizenship certificate;

(c) other resident identification documents issued by the United States immigration and naturalization service, such as:

(i) U.S. passport issued by the U.S. state department;

(ii) consular report of birth;

(iii) certification of birth issued by the U.S. state department, proof of marriage to a U.S. citizen before September 2, 1922, or a card of identity and registration of a U.S. citizen; or

(iv) official communication from an American foreign service post indicating that an applicant/recipient is registered as a United States citizen.

(2) Declaration of citizenship, nationality, or immigration status: As a condition of eligibility, medicaid requires a declaration by the applicant/recipient or by another person on behalf of a child or an applicant/recipient who is mentally incapacitated, which specifies whether the applicant/recipient is a citizen or national of the United States. If not, the declaration must state that the applicant/recipient is in satisfactory immigration status. Eligibility is not denied solely because an applicant/recipient cannot legally sign the declaration and the individual who is legally able to do so refuses to sign on the applicant/recipient's behalf or to cooperate, as required.

[8.240.400.13 NMAC – Rp 8.240.400.13 NMAC, 07/01/2024]

8.240.400.14 RESIDENCE: An applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and have demonstrated intent to remain in the state. If the applicant/recipient does not have the present mental capacity to declare intent, the parent, guardian or adult child can assume responsibility for a declaration of intent. If there is no guardian or relative to assume responsibility for a declaration of intent, the state where the applicant/recipient is living is recognized as the state of residence. A temporary absence from the state does not prevent eligibility. A temporary absence exists if an applicant/recipient leaves the state for a specific purpose with a time-limited goal and intends to return to New Mexico when the purpose is accomplished.

[8.240.400.14 NMAC – Rp 8.240.400.14 NMAC, 07/01/2024]

8.240.400.15 NONCONCURRENT RECEIPT OF ASSISTANCE: A QMB applicant/recipient on buy-in in another state cannot be approved for QMB in New Mexico until the other state's buy-in is terminated.

[8.240.400.15 NMAC – Rp 8.240.400.15 NMAC, 07/01/2024]

8.240.400.16 SPECIAL RECIPIENT REQUIREMENTS: There is no special recipient requirements such as age or disability for QMB.

[8.240.400.16 NMAC – Rp 8.240.400.16 NMAC, 07/01/2024]

8.240.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES: An applicant/recipient is responsible for establishing his/her 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 health care authority (HCA) permission to contact other persons, agencies or sources of information which are necessary to establish eligibility.

[8.240.400.17 NMAC – Rp 8.240.400.17 NMAC, 07/01/2024]

8.240.400.18 ASSIGNMENTS OF MEDICAL SUPPORT: Refer to medical assistance program manual Subsection F of 8.200.420.12 NMAC.

[8.240.400.18 NMAC – Rp 8.240.400.18 NMAC, 07/01/2024]

8.240.400.19 REPORTING REQUIREMENTS: All medicaid recipients must report any change in their circumstances which can affect eligibility to the local income support division (ISD) office within ten (10) days of the change.
[8.240.400.19 NMAC – Rp 8.240.400.19 NMAC, 07/01/2024]

HISTORY OF 8.240.400 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 840, Qualified Medicare Beneficiaries, filed 3/7/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 3/31/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 12/29/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 6/22/1990.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 12/4/1990.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 5/3/1991.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 6/30/1992.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 9/26/1994.

History of Repealed Material:
MAD Rule 840, Qualified Medicare Beneficiaries, filed 9/26/1994 - Repealed effective 2/1/1995.
8.240.400 NMAC, Qualified Medicare Beneficiaries, filed 2/01/1995 – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 240 MEDICAID ELIGIBILITY - QUALIFIED MEDICARE BENEFICIARIES (QMB) (CATEGORY 040)
PART 500 INCOME AND RESOURCE STANDARDS

8.240.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.240.500.1 NMAC – Rp 8.240.500.1 NMAC, 07/01/2024]

8.240.500.2 SCOPE: The rule applies to the general public.
[8.240.500.2 NMAC – Rp 8.240.500.2 NMAC, 07/01/2024]

8.240.500.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.240.500.3 NMAC – Rp 8.240.500.3 NMAC, 07/01/2024]

8.240.500.4 DURATION: Permanent.
[8.240.500.4 NMAC – Rp 8.240.500.4 NMAC, 07/01/2024]

8.240.500.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of the section.
[8.240.500.5 NMAC – Rp 8.240.500.5 NMAC, 07/01/2024]

8.240.500.6 OBJECTIVE: The objective of this rule is to provide eligibility policy and procedures for the medicaid program.
[8.240.500.6 NMAC – Rp 8.240.500.6 NMAC, 07/01/2024]

8.240.500.7 DEFINITIONS: [**RESERVED**]

8.240.500.8 [**RESERVED**]

8.240.500.9 GENERAL NEED DETERMINATION: Applicants for, or recipients of, the qualified medicare beneficiaries (QMB) program must apply for and take all necessary steps to obtain any income or resources to which they may be entitled. Recipients of supplemental security income (SSI) or aid to families with dependent children (AFDC) who apply for QMB are excluded from this requirement. A victim of crime is not required to accept victim compensation payments from a state-administered fund established to aid crime victims as a condition of eligibility.
[8.240.500.9 NMAC – Rp 8.240.500.9 NMAC, 07/01/2024]

8.240.500.10 RESOURCE STANDARDS: The value of an applicant/recipient's individual countable resources must not exceed the amount set forth in Section 8.200.510.14 NMAC, resource amounts for supplemental security income (SSI) related medicare savings programs (QMB and SLIMB/QI). The resource limit for an applicant couple is the amount set forth in Section 8.200.510.14 NMAC. An applicant/recipient with an ineligible spouse is eligible if the couple's countable resources do not exceed the amount set forth in Section 8.200.510.14 NMAC, when resources are deemed. The resource determination is always made as of the first moment of the first day of the month. The applicant/recipient is ineligible for any month in which the countable resources exceed the current resource standard as of the first moment of the first day of the month. Changes in the amount of resources during a month do not affect eligibility for that month. See Section 8.215.500.13 NMAC, countable resources, and Section 8.215.500.14 NMAC, resource exclusions, for specific information on exclusions, disregards, and calculation of countable resources.
[8.240.500.10 NMAC – Rp 8.240.500.10 NMAC, 07/01/2024]

8.240.500.11 RESOURCE TRANSFERS: The social security administration excluded transfer of resources as a factor of eligibility for non-institutionalized SSI recipients. Transfer of resources is not a factor for consideration in categories that use SSI methodology in the eligibility determination.

[8.240.500.11 NMAC – Rp 8.240.500.11 NMAC, 07/01/2024]

8.240.500.12 TRUSTS: See Section 8.281.510 NMAC and following subsections.
[8.240.500.12 NMAC – Rp 8.240.500.12 NMAC, 07/01/2024]

8.240.500.13 INCOME STANDARDS: The income ceiling for QMB eligibility is one hundred percent of the federal income poverty guidelines. These guidelines are updated annually effective April 1st. See Section 8.200.520 NMAC, *Income Standards*. If the applicant is a minor child, income must be deemed from the parent(s). Income must be verified and documented in the case record. See Section 8.215.500.13 NMAC, *countable resources*, and Section 8.215.500.14 NMAC, *resource exclusions*, for specific information on exclusions, disregards, and calculation of countable income.
[8.240.500.13 NMAC – Rp 8.240.500.13 NMAC, 07/01/2024]

8.240.500.14 UNEARNED INCOME:

A. Unearned income exclusions: All social security and railroad retirement beneficiaries receive cost of living adjustments (COLAs) in January of each year. The ISD caseworker must disregard the COLA from January through March when (re)determining QMB eligibility. For redeterminations made in January, February and March and for new QMB applications registered in January, February or March, the ISD caseworker uses the December social security and railroad retirement benefit amounts. For QMB applications registered from April through December, total gross income including the new COLA figures are used to determine income and compared to the new April federal poverty levels. This exclusion does not apply to other types of income.

B. Evaluation of applicant/recipient's income: The ISD caseworker determines the amount of income available to the applicant/recipient using only the applicant/recipient's own income. A standard $20 disregard is allowed in accordance with Section 8.215.500.22 NMAC. The federal poverty level standard disregard is only given if the applicant/recipient lives with an ineligible spouse. See Section 8.240.500.15 NMAC for deemed income.
[8.240.500.14 NMAC – Rp 8.240.500.14 NMAC, 07/01/2024]

8.240.500.15 DEEMED INCOME:

A. Minor applicant/recipient living with parent(s): If the applicant/recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered in accordance with Section 8.215.500.21 NMAC, *deemed income*, and applicable subsections.

B. Applicant/recipient living with an ineligible spouse: If an applicant/recipient is living in the same household with an ineligible spouse, the income of the applicant/recipient and the income of the ineligible spouse must be considered in accordance with the following paragraphs.

(1) Evaluation of applicant/recipient's Income: The ISD caseworker determines the amount of income available to the applicant/recipient using only the applicant/recipient's own income. Allow the standard $20 disregard in accordance with instructions in Subsection B of Section 8.215.500.22 NMAC of the medical assistance division policy manual. If the applicant/recipient has earned income, allow the earned income disregard as specified in Subsection C of Section 8.215.500.22 NMAC. From the combined total of the applicant/recipient's remaining earned and unearned income, subtract up to the difference between one hundred percent of the federal income poverty level for two persons and one hundred percent of the federal income poverty level for one person. This is referred to as the FPL disregard. Compare the remaining countable income of the applicant/recipient to the individual income standard for the QMB program. If the applicant/recipient's remaining countable income is greater than the individual standard, s/he is ineligible for the QMB program. If the applicant/recipient's remaining countable income is less than the individual income standard, proceed to the following section.

(2) Evaluation of the ineligible spouse's gross income: The ISD caseworker determines the total gross earned and unearned income of the ineligible spouse. From this combined amount, subtract a living allowance for any ineligible minor dependent child(ren) of either member of the couple who live(s) in the home. The deductible amount of the ineligible child(ren)'s living allowance cannot exceed the ineligible spouse's total gross income. The amount of the living allowance for an ineligible child is determined by subtracting the child's gross income from the figure which represents the difference between one hundred percent of the federal income poverty level for two persons and one hundred percent of the federal income poverty level for one person. A "child" must be under 18 years of age or under 21 years of age if a full-time student at an institution of learning.

(3) Determination of countable income for eligibility purposes: The ISD caseworker adds the gross unearned income of the applicant/recipient (without applying any disregards) to the gross unearned income

of the ineligible spouse. The ISD caseworker then adds the total gross earned income of the applicant/recipient to the total gross earned income of the ineligible spouse. From the combined total gross earnings of the couple, the ISD caseworker subtracts one earned income disregard (the first $65 of the total earnings plus 1/2 of the remainder). The resulting figure is the total combined countable earnings of the couple. Add the couple's total combined countable earned income to their total gross unearned income. From this figure subtract the standard twenty dollars ($20) disregard determined in accordance with Subsection B of Section 8.215.500.22 NMAC. Next, subtract the amount of the FPL disregard which the applicant/recipient was allowed. Finally, subtract the amount of the ineligible child(ren)'s living allowance which was calculated in Paragraph (2) of Subsection B of Section 8.240.500.14 NMAC. The resulting figure is the countable income of the couple. Compare it to the couple standard for QMB. If the countable income of the couple exceeds the couple standard, the applicant/recipient is ineligible for the QMB program. If the countable income of the couple is less than the couple standard, the applicant/recipient is eligible for the QMB program of the factor of income.
[8.240.500.15 NMAC – Rp 8.240.500.15 NMAC, 07/01/2024]

HISTORY OF 8.240.500 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 840, Qualified Medicare Beneficiaries, filed 3/7/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 3/31/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 12/29/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 6/22/1990.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 12/4/1990.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 5/3/1991.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 6/30/1992.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 9/26/1994.

History of Repealed Material:
MAD Rule 840, Qualified Medicare Beneficiaries, filed 9/26/1994 - Repealed effective 2/1/1995.
8.240.500 NMAC, Qualified Medicare Beneficiaries, filed 2/01/1995 – Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 240 MEDICAID ELIGIBILITY - QUALIFIED MEDICARE BENEFICIARIES (QMB) (CATEGORY 040)
PART 600 BENEFIT DESCRIPTION

8.240.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.240.600.1 NMAC – Rp, 8.240.600.1 NMAC, 07/01/2024]

8.240.600.2 SCOPE: The rule applies to the general public.
[8.240.600.2 NMAC – Rp, 8.240.600.2 NMAC, 07/01/2024]

8.240.600.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 191991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.240.600.3 NMAC – Rp, 8.240.600.3 NMAC, 07/01/2024]

8.240.600.4 DURATION: Permanent.
[8.240.600.4 NMAC – Rp, 8.240.600.4 NMAC, 07/01/2024]

8.240.600.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.240.600.5 NMAC – Rp, 8.240.600.5 NMAC, 07/01/2024]

8.240.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.240.600.6 NMAC – Rp, 8.240.600.6 NMAC, 07/01/2024]

8.240.600.7 DEFINITIONS: [**RESERVED**]

8.240.600.8 [**RESERVED**]

8.240.600.9 BENEFIT DESCRIPTION: For qualified medicare beneficiaries (QMB), medicaid covers payment of medicare premium amounts for Parts A and B and the coinsurance and deductibles on medicare-covered services. Medicaid does not pay for services which are not medicare benefits, services denied by medicare, or services furnished by providers who have not accepted medicare assignment. Reimbursement is made to providers of covered services and not directly to recipients.
[8.240.600.9 NMAC – Rp, 8.240.600.9 NMAC, 07/01/2024]

8.240.600.10 BENEFIT DETERMINATION: Application for QMB is made on the assistance application form. A separate application is not required if the recipient is receiving medicaid under another category. The income support specialist (ISS) must act on applications and send notice of action taken to the applicant within forty-five (45) days after the date of application. After the eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, this notice includes the reason for the denial and an explanation of the recipient's right to a hearing
[8.240.600.10 NMAC – Rp, 8.240.600.10 NMAC, 07/01/2024]

8.240.600.11 INITIAL BENEFITS: Eligibility begins the month after the month the case is approved. No retroactive coverage is available. Enrollment periods for medicare coverage: Individuals who are not entitled to free medicare Part A can purchase it. This is called "premium" or "conditional" Part A coverage. Applicants who are entitled to free medicare Part A may apply for QMB at any time. Enrollment for premium/conditional medicare Part A, is accepted by the social security administration (SSA) once a year, from January through March, with coverage starting in July. If a QMB applicant has an award letter or medicare card showing premium/conditional enrollment for July, the case can be approved in June with coverage beginning in July.
[8.240.600.11 NMAC – Rp, 8.240.600.11 NMAC, 07/01/2024]

8.240.600.12 ONGOING BENEFITS: A redetermination of eligibility conditions must be made at least every twelve (12) months but no more frequently than every six (6) months.
[8.240.600.12 NMAC – Rp, 8.240.600.12 NMAC, 07/01/2024]

8.240.600.13 RETROACTIVE BENEFITS: No retroactive medicaid benefits are available for applicants/recipients in this category.
[8.240.600.13 NMAC – Rp, 8.240.600.13 NMAC, 07/01/2024]

8.240.600.14 CHANGES IN ELIGIBILITY: A case is closed when the recipient becomes ineligible, with provision of advance notice. If a recipient dies, the case is closed the following month.
[8.240.600.14 NMAC – Rp, 8.240.600.14 NMAC, 07/01/2024]

HISTORY OF 8.240.600 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives:
MAD Rule 840, Qualified Medicare Beneficiaries, filed 3/7/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 3/31/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 12/29/1989.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 6/22/1990.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 12/4/1990.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 5/3/1991.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 6/30/1992.
MAD Rule 840, Qualified Medicare Beneficiaries, filed 9/26/1994.

History of Repealed Material:
MAD Rule 840, Qualified Medicare Beneficiaries, filed 9/26/1994 - Repealed effective 2/1/1995.
8.240.600.1 NMAC, Qualified Medicare Beneficiaries, filed 9/26/1994 - Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 245 MEDICAID ELIGIBILITY - SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMB) (CATEGORY 045)
PART 400 RECIPIENT POLICIES

8.245.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.245.400.1 NMAC – Rp 8.245.400.1 NMAC, 07/01/2024]

8.245.400.2 SCOPE: The rule applies to the general public.
[8.245.400.2 NMAC – Rp 8.245.400.2 NMAC, 07/01/2024]

8.245.400.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.245.400.3 NMAC – Rp 8.245.400.3 NMAC, 07/01/2024]

8.245.400.4 DURATION: Permanent.
[8.245.400.4 NMAC – Rp 8.245.400.4 NMAC, 07/01/2024]

8.245.400.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.245.400.5 NMAC – Rp 8.245.400.5 NMAC, 07/01/2024]

8.245.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.245.400.6 NMAC – Rp 8.245.400.6 NMAC, 07/01/2024]

8.245.400.7 DEFINITIONS: [**RESERVED**]

8.245.400.8 MISSION: To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[8.245.400.8 NMAC – Rp 8.245.400.8 NMAC, 07/01/2024]

8.245.400.9 SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMB) - CATEGORY 045: To be eligible for category 045, an applicant/recipient must be covered by medicare part A. The part A insurance is a free entitlement to social security beneficiaries who are 65 years of age or older or who have received social security disability payments for 24 months. Fully or currently insured workers, or their dependents, with end-stage renal disease are also covered under medicare.
[8.245.400.9 NMAC – Rp 8.245.400.9 NMAC, 07/01/2024]

8.245.400.10 BASIS FOR DEFINING THE GROUP: Specified low income medicare beneficiaries (SLIMB) are individuals who would be qualified medicare beneficiaries (QMBs) but for the fact that their income exceeds the income levels established for QMB. Income eligibility for the SLIMB is at least 100 percent of the federal income poverty level, but less than 120 percent.
[8.245.400.10 NMAC – Rp 8.245.400.10 NMAC, 07/01/2024]

8.245.400.11 GENERAL RECIPIENT REQUIREMENTS: [**RESERVED**]

8.245.400.12 ENUMERATION: SLIMB applicants/recipients must furnish their social security account number(s). SLIMB eligibility must be denied or terminated for applicants/recipients who fail to furnish social security numbers.
[8.245.400.12 NMAC – Rp 8.245.400.12 NMAC, 07/01/2024]

8.245.400.13 CITIZENSHIP AND IDENTITY: Individuals entitled to or receiving medicare already meet citizenship and identity requirements.
[8.245.400.13 NMAC – Rp 8.245.400.13 NMAC, 07/01/2024]

8.245.400.14 RESIDENCE: To be eligible for SLIMB, an applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have demonstrated intent to remain in the state. A temporary absence from the state does not prevent eligibility. A temporary absence exists when an applicant/recipient leaves the state for a specific purpose with a time-limited goal, and intends to return to New Mexico when the purpose is accomplished.
[8.245.400.14 NMAC – Rp 8.245.400.14 NMAC, 07/01/2024]

8.245.400.15 NONCONCURRENT RECEIPT OF ASSISTANCE: SLIMB applicants on buy-in in another state cannot be approved for the New Mexico SLIMB program until buy-in from the other state is terminated.
[8.245.400.15 NMAC – Rp 8.245.400.15 NMAC, 07/01/2024]

8.245.400.16 SPECIAL RECIPIENT REQUIREMENTS: Applicants/recipients for SLIMB eligibility must meet the specified age or disability requirements to be eligible for medicare part A. There is no age requirement for SLIMB eligibility.
[8.245.400.16 NMAC – Rp 8.245.400.16 NMAC, 07/01/2024]

8.245.400.17 RECIPIENT RIGHTS AND RESPONSIBILITIES: An applicant/recipient is responsible for establishing his/her 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 health care authority (HCA) permission to contact other persons, agencies or sources of information which are necessary to establish eligibility.
[8.245.400.17 NMAC – Rp 8.245.400.17 NMAC, 07/01/2024]

8.245.400.18 ASSIGNMENT OF SUPPORT: Assignment of medical support: As a condition of eligibility, applicants for or recipients of benefits must do the following, [42 CFR Section 433.146; NMSA 1978 Section 27-2-28 (G)(Repl. Pamp. 1991)]:

A. assign individual rights to medical support and payments to health care authority (HCA); the assignment authorizes HCA to pursue and make recoveries from liable third parties on behalf of a recipient;

B. assign the rights to medical support and payments of other individuals eligible for medicaid, for whom they can legally make an assignment; and

C. assign their individual rights to any medical care support available under an order of a court or an administrative agency.

[8.245.400.18 NMAC – Rp 8.245.400.18 NMAC, 07/01/2024]

8.245.400.19 REPORTING REQUIREMENTS: Medicaid recipients must report any change in their circumstances which may affect eligibility within 10 days after the change to the local income support division (ISD) office.
[8.245.400.19 NMAC – Rp 8.245.400.19 NMAC, 07/01/2024]

HISTORY OF 8.245.400 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center: MAD Rule 843, Specified Low Income Medicare Beneficiaries, filed 9/26/1994.

History of Repealed Material:
MAD Rule 843, Specified Low Income Medicare Beneficiaries, filed 9/26/1994 - Repealed effective 2/1/1995.
8.245.400.1 NMAC, Specified Low Income Medicare Beneficiaries, filed 2/01/1995 - Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 245 MEDICAID ELIGIBILITY - SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMB) (CATEGORY 045)
PART 500 INCOME AND RESOURCE STANDARDS

8.245.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.245.500.1 NMAC – Rp 8.245.500.1 NMAC, 07/01/2024]

8.245.500.2 SCOPE: The rule applies to the general public.
[8.245.500.2 NMAC – Rp 8.245.500.2 NMAC, 07/01/2024]

8.245.500.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.245.500.3 NMAC – Rp 8.245.500.3 NMAC, 07/01/2024]

8.245.500.4 DURATION: Permanent
[8.245.500.4 NMAC – Rp 8.245.500.4 NMAC, 07/01/2024]

8.245.500.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.245.500.5 NMAC – Rp 8.245.500.5 NMAC, 07/01/2024]

8.245.500.6 OBJECTIVE: The objective of this rule is to provide eligibility policy and procedures for the medicaid program.
[8.245.500.6 NMAC – Rp 8.245.500.6 NMAC, 07/01/2024]

8.245.500.7 DEFINITIONS: [**RESERVED**]

8.245.500.8 MISSION: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.245.500.8 NMAC – Rp 8.245.500.8 NMAC, 07/01/2024]

8.245.500.9 NEED DETERMINATION: SLIMB applicants/recipients must apply for and take all necessary steps to obtain any resources to which they may be entitled.
[8.245.500.9 NMAC – Rp 8.245.500.9 NMAC, 07/01/2024]

8.245.500.10 RESOURCE STANDARDS: The value of an applicant/recipient's countable resources must not exceed the amount set forth in 8.200.510.14 NMAC, *resource amounts for supplemental security income (SSI) related medicare savings programs (QMB and SLIMB/QI1).* The resource limit for an applicant couple cannot exceed the amount for a couple set forth in 8.200.510.14 NMAC. An applicant/recipient with an ineligible spouse is eligible if the couple's countable resources do not exceed the amount set forth in 8.200.510.14 NMAC, when resources are deemed. A resource determination is always made as of the first moment of the first day of the month. An applicant/recipient is ineligible for any month in which the countable resources exceed the current resource standard as of the first moment of the first day of the month. Changes in the amount of resources during a month do not affect eligibility for that month. See 8.215.500.13 NMAC, *countable resources,* and 8.215.500.14 NMAC, *resource exclusions*, for information on exclusions, disregards, and countable resources.
[8.245.500.10 NMAC – Rp 8.245.500.10 NMAC, 07/01/2024]

8.245.500.11 RESOURCE TRANSFERS: The social security administration excluded transfer of resources as a factor of eligible for non-institutionalized SSI recipients. Transfer of resources is not a factor for consideration in the medicare savings programs.
[8.245.500.11 NMAC – Rp 8.245.500.11 NMAC, 07/01/2024]

8.245.500.12 TRUSTS: See 8.281.510 NMAC and following subsections.
[8.245.500.12 NMAC – Rp 8.245.500.12 NMAC, 07/01/2024]

8.245.500.13 INCOME STANDARDS: Income standards for this category are at least 100 percent but no more than 120 percent of the federal income poverty guidelines. The federal income poverty guidelines are adjusted annually, effective April 1. See 8.200.520 NMAC, *Income Standards*, and 8.215.500.19 NMAC, *Income Standards*, for information on exclusions, disregards, and countable income. Verification of income must be documented in the case file.
[8.245.500.13 NMAC – Rp 8.245.500.13 NMAC, 07/01/2024]

8.245.500.14 UNEARNED INCOME: Unearned income exclusions: All social security and railroad retirement beneficiaries receive cost of living adjustments (COLAs) in January of each year. The ISD caseworker must disregard the COLA from January through March when (re)determining SLIMB eligibility. For redeterminations made in January, February and March and for new SLIMB applications registered in January, February, or March, the ISD caseworker uses the December social security and railroad retirement benefit amounts. For SLIMB applications registered from April through December, total gross income including the new COLA figures are used to determine income and compared to the new April federal poverty levels. This exclusion does not apply to other types of income.
[8.245.500.14 NMAC – Rp 8.245.500.14 NMAC, 07/01/2024]

8.245.500.15 DEEMED INCOME: If an applicant/recipient is a minor who lives with a parent(s), deemed income from the parent(s) must be considered. If an applicant/recipient is married and lives with a spouse, deemed income from the spouse must be considered. See 8.215.500.21 NMAC, *Deemed Income,* for information on deemed income.
[8.245.500.15 NMAC – Rp 8.245.500.15 NMAC, 07/01/2024]

HISTORY OF 8.245.500 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center: MAD Rule 843, Specified Low Income Medicare Beneficiaries, filed 9/26/94.

History of Repealed Material:
MAD Rule 843, Specified Low Income Medicare Beneficiaries, filed 9/26/1994 - Repealed effective 2/1/1995.
8.245.500 NMAC, Specified Low Income Medicare Beneficiaries, filed 2/01/1995 - Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 248 MEDICAID ELIGIBILITY - MEDICARE DRUG COVERAGE (CATEGORY 048)
PART 400 RECIPIENT POLICIES

8.248.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.248.400.1 NMAC – Rp, 07/01/2024]

8.248.400.2 SCOPE: The rule applies to the general public.
[8.248.400.2 NMAC - Rp, 07/01/2024]

8.248.400.3 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 health care authority pursuant to state statute. See NMSA 1978, 27-2-12 et. seq. (Repl. Pamp. 1991). The legal basis for the low-income subsidy (LIS) program is the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Public Law 108-173. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.248.400.3 NMAC - Rp, 07/01/2024]

8.248.400.4 DURATION: Permanent.
[8.248.400.4 NMAC - Rp, 07/01/2024]

8.248.400.5 EFFECTIVE DATE: February 1, 2006, unless a later date is cited at the end of a section.
[8.248.400.5 NMAC - Rp, 07/01/2024]

8.248.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicare part D - low-income subsidy program.
[8.248.400.6 NMAC - Rp, 07/01/2024]

8.248.400.7 DEFINITIONS: [**RESERVED**]

8.248.400.8 [**RESERVED**]

8.248.400.9 LOW-INCOME SUBSIDY FOR MEDICARE PART D ELIGIBLES: Applicants/recipients who meet certain income and other non-financial requirements can be eligible for the low-income subsidy (LIS) under medicare part D.
[8.248.400.9 NMAC - Rp, 07/01/2024]

8.248.400.10 BASIS FOR DEFINING THE GROUP:

A. Medicare recipients who are eligible for part D medicare coverage under the MMA of 2003 may be eligible for the low-income subsidy program. Eligibility is based on financial criteria, both income and resources, of applicant and spouse (if any) for the appropriate family size.

B. Family size: The following persons are included in the family size:

(1) the applicant;

(2) the applicant's spouse, if living with the applicant; and

(3) any persons who are related by blood, marriage, or adoption, who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support.

[8.248.400.10 NMAC - Rp, 07/01/2024]

8.248.400.11 GENERAL RECIPIENT REQUIREMENTS:

A. Medicare: Applicants must be eligible for and receiving part A or part B medicare benefits.

B. Residence: To be eligible for the low-income subsidy, an applicant/recipient must be physically present in New Mexico on the date of application or final determination of eligibility and must have demonstrated intent to remain in the state. Eligibility for the low-income subsidy (LIS) will transfer to New Mexico if determined by the social security administration (SSA) in another state. If eligibility was determined by another state (not

SSA), eligibility must be re-determined in New Mexico.
[8.248.400.11 NMAC - Rp, 07/01/2024]

8.248.400.12 SPECIAL RECIPIENT REQUIREMENTS: Applicants/recipients must be enrolled in a part D prescription drug plan (PDP) or a medicare advantage prescription drug (MA-PD) plan.
[8.248.400.12 NMAC - Rp, 07/01/2024]

8.248.400.13 RECIPIENT RIGHTS AND RESPONSIBILITIES: An applicant/recipient is responsible for establishing his eligibility for the LIS.

A. 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.

B. An applicant/recipient must also grant the health care authority (HCA) permission to contact other persons, agencies or sources of information that are necessary to establish eligibility.

C. An applicant can voluntarily withdraw an application any time prior to the determination of eligibility. The ISD office advises an applicant that withdrawing an application has no effect upon his right to apply for assistance in the future.
[8.248.400.13 NMAC - Rp, 07/01/2024]

8.248.400.14 REPORTING REQUIREMENTS: A LIS recipient must report to the local ISD office any change in his circumstances that might affect eligibility within ten (10) days of the change.
[8.248.400.14 NMAC - Rp, 07/01/2024]

HISTORY OF 8.248.400 NMAC: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 248 MEDICAID ELIGIBILITY - MEDICARE DRUG COVERAGE (CATEGORY 048)
PART 500 INCOME AND RESOURCE STANDARDS

8.248.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.248.500.1 NMAC – Rp 8.248.500.1, 07/01/2024]

8.248.500.2 SCOPE: The rule applies to the general public.
[8.248.500.2 NMAC - Rp 8.248.500.2, 07/01/2024]

8.248.500.3 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 health care authority pursuant to state statute. See NMSA 1978, 27-2-12 et. seq. (Repl. Pamp. 1991). The legal basis for the low-income subsidy (LIS) program is the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Public Law 108-173. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.248.500.3 NMAC - Rp 07/01/2024]

8.248.500.4 DURATION: Permanent.
[8.248.500.4 NMAC - Rp 8.248.500.4, 07/01/2024]

8.248.500.5 EFFECTIVE DATE: February 1, 2006, unless a later date is cited at the end of a section.
[8.248.500.5 NMAC - Rp 8.248.500.5, 07/01/2024]

8.248.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicare part D (drug benefit) - low income subsidy program.
[8.248.500.6 NMAC - Rp 8.248.500.6, 07/01/2024]

8.248.500.7 DEFINITIONS: [**RESERVED**]

8.248.500.8 [**RESERVED**]

8.248.500.9 NEED DETERMINATION: This section describes the methodology to be used in determining countable resources and income for the low-income subsidy (LIS) program which is based in part on supplemental security income (SSI) methodology. These guidelines are used for initial and on-going eligibility for medicare beneficiaries enrolled in part A or part B medicare. LIS eligibility is determined prospectively. Applicants/recipients must meet, or expect to meet, all financial and non-financial eligibility criteria in the month for which a determination of eligibility is made.
[8.248.500.9 NMAC – Rp 8.248.500.9, 07/01/2024]

8.248.500.10 APPLICATION PROCESS: The income support division (ISD) office is responsible for taking LIS applications from those individuals who do not want to submit their application to the social security administration either directly or through the ISD office.

A. Who does not have to apply: Certain groups of medicare beneficiaries who are also receiving medicaid do not have to apply for the LIS. These individuals are called "deemed eligible" and will automatically be put on the LIS:

(1) full-benefit dual eligibles, who are persons eligible for both medicare and have full medicaid benefits (including drug benefits);

(2) SSI recipients;

(3) medicare beneficiaries, who are participants in the medicare saving programs, which are: QMB, SLIMB, and QI-1;

(4) working disabled individuals (WDI) who are receiving medicare;

(5) HCBW recipients who are receiving medicare; and

(6) individuals screened for QMB, SLIMB, or QI-1 and determined eligible before the application for LIS is processed.

B. Who can apply: Medicare beneficiaries who are not deemed eligible (See Paragraphs (1) through (6) above) and who insist on filing their application with the state rather than with social security administration (SSA).
[8.248.500.10 NMAC – Rp 8.248.500.10, 07/01/2024]

8.248.500.11 RESOURCE STANDARDS: A "resource" is defined as cash and other assets that can be converted to cash within 20 days.

A. Resource determination: The resource determination is made as of the first moment of the first day of the month. An applicant/recipient is ineligible for any month in which his countable resources exceed the allowable resource standard as of the first moment of the first day of the month. Changes in the amount of countable resources during a month do not affect eligibility or ineligibility for that month.

B. Distinguishing between resources and income: Resources must be distinguished from income to avoid counting a single asset twice. As a general rule, ownership of a resource precedes the current month while income is received in the current month. Income held by an applicant/recipient until the following month becomes a resource.
[8.248.500.11 NMAC - Rp 8.248.500.11, 07/01/2024]

8.248.500.12 APPLICABLE RESOURCE STANDARDS: The resource standard for the LIS is $10,000 for an individual and $20,000 for a couple. Resources belonging to other dependent family members are not considered.

A. Cash resources: The face value of cash, savings or checking accounts is considered in determining LIS eligibility.

(1) An applicant/recipient must provide verification of the value of all cash resources. The resource value of a bank account is customarily verified by a statement from the bank showing the account balance as of the first moment of the first day of the month in question. If an applicant/recipient cannot provide this verification, the ISD worker sends a bank or postal savings clearance to the appropriate institution(s).

(2) If the applicant/recipient can demonstrate that a check was written and delivered to a payee but not cashed by the payee prior to the first moment of the first day of the month, the amount of that check is subtracted from the applicant/recipient's checking account balance to arrive at the amount to be considered a countable resource.

B. Other resources: The value of other resources is evaluated according to the applicant/spouse's equity in the resource(s). The equity value of an item is defined as the price for which that item, minus any encumbrances, can reasonably be expected to sell on the open market in the particular geographic area. Other resources which can be converted to cash within 20 days include, but are not limited to: stocks, bonds, mutual fund shares, promissory notes, mortgages, whole life insurance policies, financial institution accounts (savings, checking, CDs, IRAs, 401(K) accounts, and annuities), and real property not contiguous with home property.
[8.248.500.12 NMAC - Rp 8.248.500.12, 07/01/2024]

8.248.500.13 COUNTABLE RESOURCES: Before a resource can be considered countable, the three (3) criteria listed below must be met.

A. Ownership interest: An applicant/recipient must have an ownership interest in a resource for it to be countable. The fact that an applicant/recipient has access to a resource, or has a legal right to use it, does not make it countable unless the applicant/recipient also has an ownership interest in it.

B. Legal right to convert resource to cash: An applicant/recipient must have the legal ability to spend the funds or to convert non-cash resources into cash.

(1) Physical possession of resource: The fact that an applicant/recipient does not have physical possession of a resource does not mean it is not his resource. If he has the legal ability to spend the funds or convert the resource to cash, the resource is considered countable. Physical possession of savings bonds is a legal requirement for cashing them.

(2) Unrestricted use of resource: An applicant/recipient is considered to have free access to the unrestricted use of a resource even if he can take those actions only through an agent, such as a representative payee or guardian.

(3) If there is a legal bar to the sale of a resource, such as a co-owner legally blocking the sale of jointly owned property, the resource is not countable. The applicant/recipient is not required to undertake litigation in order to accomplish the sale.

C. Legal ability to use a resource: If a legal restriction exists which prevents the use of a resource

for the applicant/recipient's own support and maintenance, the resource is not countable.

D. Jointly-held account: If the applicant/spouse is the only subsidy claimant or subsidy recipient who is an account holder on a jointly held account, the state will presume that all of the funds in the account belong to the applicant/spouse. If more than one subsidy claimant or subsidy recipient are account holders, the state will presume that the funds in the account belong to those individuals in equal shares. If the applicant/spouse disagrees with the ownership presumption described in this subsection, he may rebut the presumption. Rebuttal is a procedure that permits an individual to furnish evidence and establish that some or all of the funds in the jointly-held account do not belong to him.

[8.248.500.13 NMAC - Rp 8.248.500.13, 07/01/2024]

8.248.500.14 RESOURCE EXCLUSIONS: The following resources are not to be considered for purposes of determining LIS eligibility:

A. Applicant's home: A home is any property in which the applicant and his spouse have an ownership interest and which serves as his principal place of residence. There is no restriction on acreage of home property. This property includes the shelter in which an individual resides, the land on which the shelter is located, and any outbuildings.

B. Non-liquid resources, other than real property: These include, but are not limited to:

(1) household goods and personal effects;

(2) automobiles, trucks, tractors and other vehicles;

(3) machinery and livestock; and

(4) non-cash business property.

C. Property of a trade or business: Property of a trade or business that is essential to the applicant/spouse's means of self-support.

D. Non-business property: Non-business property that is essential to the applicant/spouse's means of self-support.

E. Stock in regional or village corporations: Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act.

F. Whole life insurance: Whole life insurance owned by an individual (and spouse, if any) if the total face value of all the life insurance policies on any person does not exceed $1,500. When the total face value of all policies exceeds $1,500, the cash surrender value of all policies is countable.

G. Term life insurance: Term life insurance that has no cash surrender value.

H. Restricted, allotted Indian lands: Restricted, allotted Indian lands, if the Indian/owner cannot dispose of the land without the permission of other individuals, his tribe, or an agency of the federal government.

I. Payments or benefits: Payments or benefits provided under a federal statute other than title XVI of the act where exclusion is required by such statute.

J. Federal disaster relief: Federal disaster relief assistance received on account of a presidentially declared major disaster, including accumulated interest, or comparable state or local assistance.

K. Funds of $1,500: Funds of $1,500 for the individual and $1,500 for the spouse who lives with the individual if these funds are intended to be used for funeral or burial expenses of the individual and spouse.

L. Burial spaces: Burial spaces, including burial plots, gravesites, crypts, mausoleums, urns, niches, vaults, headstones, markers, plaques, burial containers, opening and closing of the gravesite, and other customary and tradition repositories for the deceased's bodily remains, for the applicant/spouse.

M. Retained retroactive SSI or social security: Retained retroactive SSI or social security benefits for nine months after the month they are received.

N. Certain housing assistance.

O. Refunds: Refunds of federal income taxes and advances made by an employer relating to an earned income tax credit for the month following the month of receipt, and refunds of child tax credits for nine months after the month they are received.

P. Payments: Payments received as compensation incurred or losses suffered as a result of a crime (victims' compensation payments), for nine months beginning with the month following the month of receipt.

Q. Relocation assistance: Relocation assistance for a state or local government, for nine months, beginning with the month following the month of receipt.

R. Dedicated financial institution accounts: Dedicated financial institution accounts consisting of past-due benefits for an SSI-eligible individual under age 18.

S. Gifts: A gift to, or for the benefit of, an individual who has not attained 18 years of age and who

has a life-threatening condition, from an organization described in section 501(c)(3) of the internal revenue code of 1986 which is exempt from taxation under section 501(a) of such code. The resource exclusion applies to any in-kind gift that is not converted to cash, or to a cash gift that does not exceed $2,000.

T. Funds received: Funds received from a government or nongovernmental agency, program, or health insurance policy whose purpose is to provide medical care or medical services or social services and conserved to pay for medical or social services.

[8.248.500.14 NMAC - Rp 8.248.500.14, 07/01/2024]

8.248.500.15 INCOME STANDARDS: Income is anything the applicant/spouse receives in cash or in-kind that can be used to meet his needs for food or shelter. The gross income of the applicant and his spouse if living with him, but not dependent family members, will be considered. However, dependent family members will be counted in the family size.

[8.248.500.15 NMAC - Rp 8.248.500.15, 07/01/2024]

8.248.500.16 EARNED INCOME:

A. Earned income: Earned income consists of the following types of payments:

(1) wages counted at the earliest of: when received, when credited to the person employed, or when set aside for the employee's use;

(2) net earnings from self-employment counted on a taxable year basis; net losses, if any, are deducted from other earned income, but not from unearned income;

(3) payments for services performed in a sheltered workshop or work activities center counted when received or set aside for the employee's use;

(4) royalties earned by an individual in connection with any publication of his work and any honoraria received for services rendered; and

(5) in-kind earned income is counted based on current market value. If the applicant/spouse receives an item that is not fully paid for and he is responsible for the balance, only the paid up value is income to the applicant.

B. Period under consideration: The period for which earned income is counted is, in 2006, the remainder of the calendar year, starting with the month of application for the subsidy. Adjust prospective earned income based on the number of months remaining in the calendar year. The income standard against which the income is measured should be adjusted to reflect the same number of months. For subsidy applications filed in 2005, eligibility cannot begin prior to January 1, 2006.

C. Earned income exclusions: Earned income exclusions apply in the order listed below:

(1) refund of federal income taxes and payments under the earned income tax credit;

(2) the first $30 of earned income per calendar quarter that is received too irregularly or infrequently to be counted as income;

(3) any portion of the $20 per month exclusion that has not been excluded from combined unearned income;

(4) $65 per month of the applicant/spouse's earned income;

(5) for applicants who are under age 65 and receive a social security disability insurance benefit based on disability, 16.3% of gross earnings for impairment related work expenses (IRWE);

(6) one half of the applicant/spouse's remaining earned income; and

(7) for applicants who are under age 65 and receive a social security disability insurance benefit that is based on blindness, 25% of gross earnings for blind work expenses (BWE).

[8.248.500.16 NMAC – Rp 8.248.500.16, 07/01/2024]

8.248.500.17 UNEARNED INCOME: Unearned income is all income that is not earned income. Unearned income is counted at the earliest of the following points: when received, when credited to the recipient, or when set aside for the recipient's use.

A. Unearned income includes, but is not limited to:

(1) social security;

(2) railroad retirement;

(3) veterans benefits;

(4) temporary assistance for needy families (TANF);

(5) pensions;

(6) annuities;

(7) alimony and support payments;
(8) rents;
(9) workmen's compensation;
(10) in-kind support and maintenance;
(11) death benefits;
(12) royalties not counted as earned income; and
(13) dividends and interest not otherwise excluded under SSI rules.

B. Unearned income disregards:

(1) In-kind support and maintenance is any food and shelter that is given to the applicant/spouse or received because someone else pays for it. This includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewage, and garbage collection services. The maximum amount of income countable for in-kind support and maintenance is limited to one third of the monthly SSI benefit rate for an individual or a couple, if the applicant's spouse is counted, or the current market value of the support, whichever is lower.

(2) When benefits are reduced for overpayments or garnishments, count the gross benefit before deductions.

(3) If part of a payment reflects expenses the applicant/spouse incurred in getting the payment, such as legal fees, damages, or medical expenses, incurred because of an accident, reduce the payment by the amount of the expenses. Do not reduce the payment by the amount of personal income taxes owed on the payment.

(4) Subtract from veterans benefits any amount included in the payment for a dependent. If the applicant/spouse is the dependent, count the portion of the benefit attributable to the dependent if they reside with the veteran or receive their own separate payment from the department of veteran affairs.

(5) Subtract from death benefits the expenses of the deceased person's last illness and death paid by the recipient.

C. Unearned income exclusions: The following types of unearned income are not considered for purposes of determining LIS eligibility:

(1) SSI benefits;
(2) any public agency's refund of taxes on real property or food;
(3) need-based assistance wholly funded by a state or one of its subdivisions, including state supplementation of SSI benefits but not a federal/state grant program such as TANF;
(4) any portion of a grant, scholarship, fellowship, or gift used for paying tuition, fees, or other educational expenses; any portion set aside or used for food, clothing or shelter is countable;
(5) food which the applicant or their spouse raise if it is consumed by them or their household;
(6) assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any federal statute because of a catastrophe which the president of the United States declares to be a major disaster;
(7) Alaska longevity bonus payments made to an individual who is a resident of Alaska and who, prior to October 1, 1985, met the 25-year residency requirement for receipt of such payments in effect prior to January 1, 1983, and was eligible for SSI;
(8) payments for providing foster care to a child who was placed in the applicant's home by a public or private nonprofit child placement or child care agency;
(9) any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become part of the separate burial fund;
(10) home energy assistance (any assistance related to meeting the costs of heating or cooling a home);
(11) one-third of support payments made to or for the applicant by an absent parent if the applicant is a child;
(12) the first $20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another and income based on need;
(13) housing assistance-any assistance paid with respect to a dwelling unit under:
(a) the United States Housing Act of 1937;
(b) the National Housing Act;
(c) Section 101 of the Housing and Urban Development Act of 1965;
(d) Title V of the Housing Act of 1949; or

(e) Section 202(h) of the Housing Act of 1959;

(14) any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement;

(15) gift of a domestic travel ticket received by the applicant or their spouse and not converted to cash;

(16) payments made to the applicant or their spouse from a fund established by the state to aid victims of crime;

(17) relocation assistance provided to the applicant or their spouse by the state or local government that is comparable to relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(18) hostile fire pay received from one of the uniformed services;

(19) the first $60 of unearned income received per calendar quarter that is received too irregularly or infrequently to be counted as income; or

(20) any dividends or interest earned on countable resources, any dividends or interest earned on resources excluded under a federal statute other than the Social Security Act, and any dividends or interest excluded under the Social Security Protection Act of 2004.

[8.248.500.17 NMAC - Rp 8.248.500.17, 07/01/2024]

8.248.500.18 DEEMED INCOME: Deeming income from a spouse to his minor child(ren) or from one spouse to his spouse when living in the same household, does not apply.

[8.248.500.18 NMAC - Rp 8.248.500.18, 07/01/2024]

8.248.500.19 TOTAL COUNTABLE INCOME: Countable income is the sum of unearned income or earned income for the individual or spouse less disregards or0 exclusions. Only one earned income exclusion ($65 plus 1/2 the remainder) is applied and one $20 disregard is applied if using income from both spouses.

[8.248.500.19 NMAC - Rp 8.248.500.19, 07/01/2024]

HISTORY OF 8.248.500 NMAC: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 248 MEDICAID ELIGIBILITY - MEDICARE DRUG COVERAGE (CATEGORY 048)
PART 600 BENEFIT DESCRIPTION

8.248.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.248.600.1 NMAC – Rp 8.248.600.1, 07/01/2024]

8.248.600.2 SCOPE: The rule applies to the general public.
[8.248.600.2 NMAC – Rp 8.248.600.2, 07/01/2024]

8.248.600.3 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 health care authority pursuant to state statute. See NMSA 1978, 27-2-12 et. seq. (Repl. Pamp. 1991). The legal basis for the low-income subsidy (LIS) program is the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Public Law 108-173. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.248.600.3 NMAC – Rp 8.248.600.3, 07/01/2024]

8.248.600.4 DURATION: Permanent.
[8.248.600.4 NMAC – Rp 8.248.600.4, 07/01/2024]

8.248.600.5 EFFECTIVE DATE: February 1, 2006, unless a later date is cited at the end of a section.
[8.248.600.5 NMAC – Rp 8.248.600.5, 07/01/2024]

8.248.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicare part D - low income subsidy program.
[8.248.600.6 NMAC – Rp 8.248.600.6, 07/01/2024]

8.248.600.7 DEFINITIONS: [**RESERVED**]

8.248.600.8 [**RESERVED**]

8.248.600.9 GENERAL BENEFIT DESCRIPTION: An individual or couple who is determined eligible for the low income subsidy (LIS) under part D of medicare, is eligible for financial assistance with the monthly premium, the yearly deductible, the per-prescription co-payment, and continuous coverage with no gap prior to reaching $3,600 in out-of-pocket spending. The financial assistance may be full or partial depending on the income, family size and resources of the beneficiary.
[8.248.600.9 NMAC – Rp 8.248.600.9, 07/01/2024]

8.248.600.10 BENEFIT DETERMINATION: Completed applications must be acted upon and notice of approval, denial, or delay sent out within forty-five (45) days of the date of application. The applicant will have time limits explained, and be informed of the date by which the application should be processed.
[8.248.600.10 NMAC – Rp 8.248.600.10, 07/01/2024]

8.248.600.11 INITIAL BENEFITS: Eligibility is always prospective and begins the month of application, but not earlier than January 1, 2006. When an eligibility determination is made, notice of the approval or denial is sent to the individual. If the application is denied, the notice shall include reason for denial and the applicant's right to request a fair hearing.
[8.248.600.11 NMAC – Rp 8.248.600.11, 07/01/2024]

8.248.600.12 ONGOING BENEFITS: The applicant/recipient is responsible to report changes affecting eligibility within ten (10) days of when the change took place. A re-determination of eligibility is made every twelve (12) months. If a LIS recipient/applicant becomes eligible for certain medicaid categories; SSI, QMB, SLIMB, QI-1, WDI, IC, and HCBW, he will still be eligible for LIS. CMS will notify the beneficiary that he is now deemed eligible, because of categorical relatedness and will take over the re-determination of eligibility on a yearly

basis. A change notice will be sent to the LIS recipient. For the year 2006, all certification periods will end December 31, 2006. Effective January 1, 2007, the certification period will be twelve (12) months from the month of application or re-certification.
[8.248.600.12 NMAC – Rp 8.248.600.12, 07/01/2024]

8.248.600.13 RETROACTIVE BENEFIT COVERAGE: There is no three (3) month retroactive LIS coverage under this program. The subsidy is effective the beginning of the month of application or January 1, 2006, whichever is later.
[8.248.600.13 NMAC – Rp 8.248.600.13, 07/01/2024]

HISTORY OF 8.248.600 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 252 MEDICAID ELIGIBILITY - BREAST AND CERVICAL CANCER PROGRAM (CATEGORY 052)
PART 400 RECIPIENT POLICIES

8.252.400.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.252.400.1 NMAC – Rp 8.252.400.1, 07/01/2024]

8.252.400.2 SCOPE: The rule applies to the general public.
[8.252.400.2 NMAC – Rp 8.252.400.2, 07/01/2024]

8.252.400.3 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 health care authority pursuant to state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991) Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.252.400.3 NMAC – Rp 8.252.400.3, 07/01/2024]

8.252.400.4 DURATION: Permanent
[8.252.400.4 NMAC – Rp 8.252.400.4, 07/01/2024]

8.252.400.5 EFFECTIVE DATE: July 1, 2002, unless a later date is cited at the end of a section.
[8.252.400.5 NMAC – Rp 8.252.400.5, 07/01/2024]

8.252.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.252.400.6 NMAC – Rp 8.252.400.6, 07/01/2024]

8.252.400.7 DEFINITIONS: [**RESERVED**]

8.252.400.8 MISSION: 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.
[8.252.400.8 NMAC – Rp 8.252.400.8, 07/01/2024]

8.252.400.9 BREAST AND CERVICAL CANCER (BCC) - Category 052: The health care authority (HCA) is the single state agency designated to administer the medicaid program in New Mexico. The department of health (DOH) and the HCA are charged with developing and implementing a program for uninsured women under the age of 65 years, who have met screening criteria as set forth in the centers for disease control and prevention's (CDC) national breast and cervical cancer early detection program (NBCCEDP). The DOH is responsible for verifying that women referred for treatment have met screening requirements that include an income test of two hundred and fifty percent of the federal poverty guidelines, and diagnostic testing by a contracted CDC provider resulting in a diagnosis of breast or cervical cancer including pre-cancerous conditions. Women who have met CDC screening criteria and identified as needing treatment for a diagnoses of breast or cervical cancer, including pre-cancerous conditions will be referred for treatment that includes the completion of a medicaid application for the BCC program. The Breast and Cervical Cancer Prevention and Treatment Act allows states to extend presumptive eligibility to applicants in order to ensure that needed treatment begins as early as possible.
[8.252.400.9 NMAC – Rp 8.252.400.9, 07/01/2024]

8.252.400.10 BASIS FOR DEFINING THE GROUP: Women who have been determined as having met CDC program screening requirements will be identified and referred for treatment. Public Law 106-354 does not provide eligibility for men diagnosed with cancer.
[8.252.400.10 NMAC – Rp 8.252.400.10, 07/01/2024]

8.252.400.11 GENERAL RECIPIENT REQUIREMENTS: Eligibility for the breast and cervical cancer program is always prospective. Women must meet, or expect to meet all medicaid and CDC financial and non-financial eligibility criteria in the month for which determination of eligibility is made.
[8.252.400.11 NMAC – Rp 8.252.400.11, 07/01/2024]

8.252.400.12 ENUMERATION: A woman must furnish her social security account number. Medicaid eligibility is denied or terminated for a woman who fails to furnish her social security number. If a woman does not have, a valid social security number, she must apply for one as a condition of medicaid eligibility. Presentation of the application for a social security number, or proof that an application has been made at a social security administration office, meets this requirement. A woman must provide her social security account number upon receipt of the number from SSA but no later than her next recertification.
[8.252.400.12 NMAC – Rp 8.252.400.12, 07/01/2024]

8.252.400.13 CITIZENSHIP: Refer to medical assistance program manual Section MAD 412, 412.1, and 412.2 (Section 11 of 8.200.410 NMAC). Women who do not meet citizenship eligibility criteria may be eligible to receive coverage for emergency services under the emergency medical services for undocumented non-citizens (EMSNC) program.
[8.252.400.13 NMAC – Rp 8.252.400.13, 07/01/2024]

8.252.400.14 RESIDENCE: To be eligible for medicaid, a woman must be physically present in New Mexico on the date of application or final determination of eligibility, and must have intent to remain in the state.

A. Establishing residence: Residence in New Mexico is established by living in the state and carrying out the types of activities normally indicating residency, such as occupying a home, enrolling child (ren) in school, getting a state driver's license, or renting a post office box. A woman who is homeless is considered to have met the residence requirements if she intends to remain in the state.

B. Recipients receiving benefits out-of-state: A women who receives medical assistance in another state is considered a resident of that state until the income support division (ISD) staff receives verification from the other state agency indicating that it has been notified by the woman of the abandonment of residence in that state.

C. Abandonment: Residence is not abandoned by temporary absences. Temporary absences occur when a woman leaves New Mexico for specific purposes with time-limited goals. Residence is considered abandoned when any of the following occurs:

(1) a woman leaves New Mexico and indicates that she intends to establish residence in another state;

(2) a woman leaves New Mexico for no specific purpose with no clear intention of returning;

(3) a woman leaves New Mexico and applies for financial, food or medical assistance in another state.

[8.252.400.14 NMAC – Rp 8.252.400.14, 07/01/2024]

8.252.400.15 NON-CONCURRENT RECEIPT OF ASSISTANCE: A woman may not be receiving assistance in another medicaid category.
[8.252.400.15 NMAC – Rp 8.252.400.15, 07/01/2024]

8.252.400.16 SPECIAL RECIPIENT REQUIREMENTS: A woman must have been screened and diagnosed with breast or cervical cancer or a pre-cancerous condition by a provider of the centers for disease control and prevention's (CDC) national breast and cervical cancer early detection program and be in need of treatment. Women identified as in need of treatment, will be given an application that includes the DOH's CDC contracted provider referral for treatment form. The DOH is responsible for verifying the referring physician is a contracted CDC provider.
[8.252.400.16 NMAC – Rp 8.252.400.16, 07/01/2024]

8.252.400.17 AGE: To be eligible for this category, a woman must be under 65 years of age. Medicaid eligibility ends the last day of the month a woman turns 65 years of age.
[8.252.400.17 NMAC – Rp 8.252.400.17, 07/01/2024]

8.252.400.18 THIRD PARTY LIABILITY: A woman must be uninsured.

A. A woman is considered uninsured when her health insurance policy has lifetime limits and she has exhausted those limits or, she is denied coverage due to a pre-existing condition.

B. Women with high deductibles, or limits on coverage, such as the limit of doctor visits or drug coverage that have not been exhausted are considered insured.

C. There is no penalty for dropping insurance.

[8.252.400.18 NMAC – Rp 8.252.400.18, 07/01/2024]

8.252.400.19 PRESUMPTIVE ELIGIBILITY: A woman may be eligible to receive medicaid services from the date the presumptive eligibility determination is made until the end of the month following the month in which the determination was made, for a period of up to 60 days. The purpose of the presumptive eligibility is to allow medicaid payment for health care services furnished to a woman while her application for medicaid is being processed. Only one presumptive eligibility period is allowed per twelve-month period. The period of presumptive eligibility begins when an approved presumptive eligibility provider establishes eligibility. Presumptive eligibility criteria are a simplified version of Category 052 eligibility requirements.

A. Processing presumptive eligibility information: The medical assistance division (MAD) authorizes certain providers to make presumptive eligibility determinations. The provider must notify MAD through its claims processing contractor of the determination within 24 hours of the determination of presumptive eligibility.

B. Provider responsibility: The presumptive eligibility provider must process both presumptive eligibility as well as an application for medical assistance for the woman.

C. Provider eligibility: Entities who may participate must be a CDC Title XV grantees are those entities receiving funds under a cooperative agreement with CDC to support activities related to the national breast and cervical cancer detection program.

[8.252.400.19 NMAC – Rp 8.252.400.19, 07/01/2024]

8.252.400.20 RECIPIENT RIGHTS AND RESPONSIBILITIES: A woman or her representative is responsible for establishing her eligibility for medicaid. As part of this responsibility, the woman 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. A woman must also grant the health care authority (HCA) permission to contact other persons, agencies or sources of information necessary to establish eligibility. See 8.200.430 NMAC, *Recipient Rights and Responsibilities* for specific information.

[8.252.400.20 NMAC – Rp 8.252.400.20, 07/01/2024]

8.252.400.21 REPORTING REQUIREMENTS: A woman or any other responsible party must:

A. report any changes in circumstances, which may affect the woman's eligibility within 10 days of the date of the change to the county ISD office;

B. 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.

[8.252.400.21 NMAC – Rp 8.252.400.21, 07/01/2024]

HISTORY OF 8.252.400 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 280 MEDICAID ELIGIBILITY - PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)
PART 500 INCOME AND RESOURCE STANDARDS

8.280.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.280.500.1 NMAC - Rp, 8.280.500.1, 7/01/2024]

8.280.500.2 SCOPE: The rule applies to the general public.
[8.280.500.2 NMAC - Rp, 8.280.500.2, 7/01/2024]

8.280.500.3 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 HCA pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.280.500.3 NMAC - Rp, 8.280.500.3, 7/01/2024]

8.280.500.4 DURATION: Permanent
[8.280.500.4 NMAC - Rp, 8.280.500.4, 7/01/2024]

8.280.500.5 EFFECTIVE DATE: December 1, 2006, unless a later date is cited at the end of a section.
[8.280.500.5 NMAC - Rp, 8.280.500.5, 7/01/2024]

8.280.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.280.500.6 NMAC - Rp, 8.280.500.6, 7/01/2024]

8.280.500.7 DEFINITIONS: [**RESERVED**]

8.280.500.8 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.
[8.280.500.8 NMAC - Rp, 8.280.500.9, 7/01/2024]

8.280.500.9 NEED DETERMINATION: Eligibility for PACE is determined prospectively. Applicants/recipients must meet, or expect to meet, all financial eligibility criteria in the month for which a determination of eligibility is made. Applicants for and recipients of medicaid through PACE must apply for, and take all necessary steps to obtain, any income or resources to which they may be entitled. Such steps must be taken within 30 days of the date the HCA (HCA) furnishes notice of the potential entitlement. Failure or refusal to apply for and take all necessary steps to determine eligibility for other benefits after notice is received results in an applicant/recipient becoming ineligible for medicaid.

A. Applicants/recipients who have elected a lower veterans affairs (VA) payment do not need to reapply for veteran's administration improved pension (VAIP) benefits.

B. Crime victims are not required to accept victim's compensation payments from a state-administered fund as a condition of medicaid eligibility.
[8.280.500.9 NMAC - Rp, 8.280.500.9, 7/01/2024]

8.280.500.10 RESOURCE STANDARDS: See 8.281.500.10 NMAC and all following subsections.
[8.280.500.10 NMAC - Rp, 8.280.500.10, 7/01/2024]

8.280.500.11 APPLICABLE RESOURCE STANDARDS: An applicant/recipient is eligible for medicaid on the factor of resources if countable resources do not exceed $2,000. See 8.281.500.11 NMAC.
[8.280.500.11 NMAC - Rp, 8.280.500.11, 7/01/2024]

8.280.500.12 COUNTABLE RESOURCES: See 8.281.500.12 NMAC.
[8.280.500.12 NMAC - Rp, 8.280.500.12, 7/01/2024]

8.280.500.13 RESOURCE EXCLUSIONS: See 8.281.500.13 NMAC.
[8.280.500.13 NMAC - Rp, 8.280.500.13, 7/01/2024]

8.280.500.14 ASSET TRANSFERS: See 8.281.500.14 NMAC for regulations governing transfers of assets. All provisions pertaining to transfers under institutional care medicaid apply to transfers under PACE with the exception of the penalty for transfers without fair return. The penalty for transfers of assets without fair return for PACE applicants/recipients is ineligibility for medicaid under PACE.
[8.280.500.14 NMAC - Rp, 8.280.500.14, 7/01/2024]

8.280.500.15 TRUSTS: See 8.281.500.15 NMAC.
[8.280.500.15 NMAC - Rp, 8.280.500.15, 7/01/2024]

8.280.500.16 RESOURCE STANDARDS FOR MARRIED COUPLES: See 8.281.500.16 NMAC for spousal impoverishment methodology used in the determination of eligibility for married applicants/recipients with a spouse in the home who began receiving PACE services on or after September 30, 1989. A resource assessment is completed as of the first moment of the first day of the month in which the level of care is approved.
[8.280.500.16 NMAC - Rp, 8.280.500.16, 7/01/2024]

8.280.500.17 DEEMING RESOURCES: Not applicable to PACE.
[8.280.500.17 NMAC - Rp, 8.280.500.17, 7/01/2024]

8.280.500.18 INCOME: An applicant/recipients gross countable monthly income must be less than the maximum allowable monthly income standard. See 8.281.500.18 NMAC.
[8.280.500.18 NMAC - Rp, 8.280.500.18, 7/01/2024]

8.280.500.19 INCOME STANDARDS: See 8.281.500.19 NMAC.
[8.280.500.19 NMAC - Rp, 8.280.500.19, 7/01/2024]

8.280.500.20 UNEARNED INCOME: See 8.281.500.20 NMAC.
[8.280.500.20 NMAC - Rp, 8.280.500.20, 7/01/2024]

8.280.500.21 DEEMED INCOME: See 8.281.500.21 NMAC.
[8.280.500.21 NMAC - Rp, 8.280.500.21, 7/01/2024]

8.280.500.22 DISREGARDS: See 8.281.500.22 NMAC.
[8.280.500.22 NMAC - Rp, 8.280.500.22, 7/01/2024]

8.280.500.23 MEDICAL CARE CREDIT: There are medical care credits in PACE only when a PACE recipient enters a nursing facility. See 8.281.500.22 NMAC.
[8.280.500.23 NMAC - Rp, 8.280.500.23, 7/01/2024]

HISTORY OF 8.280.500 NMAC:

History of Repealed Material:
8 NMAC 4.PAC.500, Income and Resource Standards, filed 1/20/1998 - Repealed effective 12/1/2006.
8.280.500 NMAC, Income and Resource Standards, filed 12/01/2006 - Repealed effective 07/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 285 MEDICAID ELIGIBILITY - EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS
PART 500 INCOME AND RESOURCE STANDARDS

8.285.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.285.500.1 NMAC – Rp 8.285.500.1, 7/01/2024]

8.285.500.2 SCOPE: The rule applies to the general public.
[8.285.500.2 NMAC – Rp 8.285.500.2, 7/01/2024]

8.285.500.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.285.500.3 NMAC – Rp 8.285.500.3, 7/01/2024]

8.285.500.4 DURATION: Permanent.
[8.285.500.4 NMAC – Rp 8.285.500.4, 7/01/2024]

8.285.500.5 EFFECTIVE DATE: February 1, 1995, unless a later date was cited at the end of a section.
[8.285.500.5 NMAC – Rp 8.285.500.5, 7/01/2024]

8.285.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.285.500.6 NMAC – Rp 8.285.500.6, 7/01/2024]

8.285.500.7 DEFINITIONS: [**RESERVED**]

8.285.500.8 MISSION: 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.
[8.285.500.8 NMAC – Rp 8.285.500.8, 7/01/2024]

8.285.500.9 NEED DETERMINATION:
[8.285.500.9 NMAC – Rp 8.285.500.9, 7/01/2024]

8.285.500.10 RESOURCE STANDARDS: Non-citizens who receive emergency services must meet the applicable resource standards for an existing medicaid category.
[8.285.500.10 NMAC – Rp 8.285.500.10, 7/01/2024]

8.285.500.11 INCOME STANDARDS: Non-citizens who receive emergency services must meet the income standards for an existing medicaid category.
[8.285.500.11 NMAC – Rp 8.285.500.11, 7/01/2024]

HISTORY OF 8.285.500 NMAC: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 285 MEDICAID ELIGIBILITY - EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS
PART 600 BENEFIT DESCRIPTION

8.285.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.285.600.1 NMAC – Rp 8.285.600.1, 7/01/2024]

8.285.600.2 SCOPE: The rule applies to the general public.
[8.285.600.2 NMAC – Rp 8.285.600.2, 7/01/2024]

8.285.600.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.285.600.3 NMAC – Rp 8.285.600.3, 7/01/2024]

8.285.600.4 DURATION: Permanent.
[8.285.600.4 NMAC – Rp 8.285.600.4, 7/01/2024]

8.285.600.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.285.600.5 NMAC – Rp 8.285.600.5, 7/01/2024]

8.285.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.285.600.6 NMAC – Rp 8.285.600.6, 7/01/2024]

8.285.600.7 DEFINITIONS: [**RESERVED**]

8.285.600.8 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.
[8.285.600.8 NMAC – Rp 8.285.600.8, 7/01/2024]

8.285.600.9 BENEFIT DESCRIPTION: An applicant/recipient who is eligible for medicaid under this category is eligible for emergency services coverage only for the duration of the emergency.
[8.285.600.9 NMAC – Rp 8.285.600.9, 7/01/2024]

8.285.600.10 BENEFIT DETERMINATION:

A. Subsequent to the receipt of emergency services, an applicant must apply through the local county income support division (ISD) office. The application must be filed at the ISD office no later than the last day of the third month following the month the presumed emergency services were received.

B. Documentation requirements: The applicant must bring a completed emergency medical services for non-citizens (EMSNC) referral for eligibility determination form (MAD 308) to the ISD office for the financial eligibility determination. The emergency services provider must complete the referral form.

C. Financial documents: The applicant must provide all necessary documentation to prove that they meet all financial and non-financial eligibility standards. Medical providers cannot submit eligibility applications on behalf of the applicant. The applicant is financially responsible for any services not covered by medicaid. A completed and signed application form must be submitted for each request for EMSNC.
[8.285.600.10 NMAC – Rp 8.285.600.10, 7/01/2024]

8.285.600.11 INITIAL BENEFITS: Applications for medicaid must be acted on within 45 days of the date of application.

A. If an applicant is eligible for medicaid, the individual is sent a notice of case action (NOCA) form.

The approval of financial eligibility is not a guarantee that medicaid will pay for the services. The NOCA form also serves as notice of case closure, since medicaid covers only emergency services received during the specified term of the emergency. The provider is sent the decision for emergency medical services for non-citizens (EMSNC) application (MAD 778) form. The provider must use the MAD 778 form to submit claims to the medicaid utilization review contractor for emergency review.

B. If an applicant is ineligible for medicaid or a decision on the application is delayed beyond the 45 day time limit, the individual is sent a NOCA form regarding the application for EMSNC. The NOCA form explains the reason for denial or delay and informs the applicant of their right to an administrative hearing. If the application is denied, the applicant must notify providers of the denial.

C. The applicant is responsible for payment for the medical services if they fail to apply promptly for coverage, verify eligibility for coverage, or notify the provider of the approval or denial of the application.
[8.285.600.11 NMAC – Rp 8.285.600.11, 7/01/2024]

8.285.600.12 ONGOING BENEFITS: No periodic review is necessary, since this category does not result in continuous eligibility. The eligibility for the specific period will only cover the bona fide emergency services. A medicaid card is not issued. No separate notice of case closure is necessary. Notice of approval serves as notice of closure as it indicates the specific period of eligibility. Medicaid covers emergency services only for the duration of the emergency, as determined by medicaid utilization review contractor.
[8.285.600.12 NMAC – Rp 8.285.600.12, 7/01/2024]

8.285.600.13 RETROACTIVE COVERAGE: There is no retroactive coverage for this category.
[8.285.600.13 NMAC – Rp 8.285.600.13, 7/01/2024]

HISTORY OF 8.285.600 NMAC: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 290 MEDICAID ELIGIBILITY - HOME AND COMMUNITY-BASED SERVICES WAIVER (CATEGORIES 090, 091, 092, 093, 094, 095 AND 096)
PART 500 INCOME AND RESOURCE STANDARDS

8.290.500.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.290.500.1 NMAC – Rp 8.290.500.1, 7/01/2024]

8.290.500.2 SCOPE: The rule applies to the general public.
[8.290.500.2 NMAC – Rp 8.290.500.2, 7/01/2024]

8.290.500.3 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 health care authority pursuant to state statute. See NMSA 1978 Sections 27-2-12 et. seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.290.500.3 NMAC – Rp 8.290.500.3, 7/01/2024]

8.290.500.4 DURATION: Permanent.
[8.290.500.4 NMAC – Rp 8.290.500.4, 7/01/2024]

8.290.500.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.290.500.5 NMAC – Rp 8.290.500.5, 7/01/2024]

8.290.500.6 OBJECTIVE: The objective of these regulations is to provide eligibility criteria for the medicaid program.
[8.290.500.6 NMAC – Rp 8.290.500.6, 7/01/2024]

8.290.500.7 DEFINITIONS: See 8.290.400.7 NMAC.
[8.290.500.7 NMAC – Rp 8.290.500.7, 7/01/2024]

8.290.500.8 MISSION: To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[8.290.500.8 NMAC – Rp 8.290.500.8, 7/01/2024]

8.290.500.9 NEED DETERMINATION: Eligibility for the home and community-based services waiver programs is always prospective. Applicants/recipients must meet, or expect to meet, all financial eligibility criteria in the month for which a determination of eligibility is made. Applicants for and recipients of medicaid through one of the waiver programs must apply for, and take all necessary steps to obtain, any income or resources to which they may be entitled. Such steps must be taken within 30 days of the date the health care authority (HCA) furnishes notice of the potential entitlement.

A. Failure to apply for and take steps to determine eligibility for other benefits: Failure or refusal to apply for and take all necessary steps to determine eligibility for other benefits after notice is received results in an applicant/recipient becoming ineligible for medicaid.

B. Exceptions to general requirement: Applicants/recipients who have elected a lower VA payment do not need to reapply for veterans administration improved pension (VAIP) benefits. Crime victims are not required to accept victims compensation payments from a state-administered fund as a condition of medicaid eligibility.
[8.290.500.9 NMAC – Rp 8.290.500.9, 7/01/2024]

8.290.500.10 RESOURCE STANDARDS: See 8.281.500.10 NMAC and following subsections.
[8.290.500.10 NMAC – Rp 8.290.500.10, 7/01/2024]

8.290.500.11 APPLICABLE RESOURCE STANDARDS: An applicant/recipient is eligible for medicaid on the factor of resources if countable resources do not exceed two thousand dollars ($2,000).

A. Liquid resources: See Subsection A of 8.281.500.11 NMAC.

B. Nonliquid resources: See Subsection B of 8.281.500.11 NMAC and following subsections.

[8.290.500.11 NMAC – Rp 8.290.500.11, 7/01/2024]

8.290.500.12 COUNTABLE RESOURCES: See 8.281.500.12 NMAC and following subsections.

[8.290.500.12 NMAC – Rp 8.290.500.12, 7/01/2024]

8.290.500.13 RESOURCE EXCLUSIONS: See 8.281.500.13 NMAC and following subsections.

[8.290.500.13 NMAC – Rp 8.290.500.13, 7/01/2024]

8.290.500.14 ASSET TRANSFERS: See 8.281.500.14 NMAC, *asset transfers*, and following subsections for rules governing transfers of assets. All provisions pertaining to transfers under institutional care medicaid apply to transfers under the waiver programs with the exception of the penalty for transfers of assets for less than fair market value. The penalty for transfers of assets for less than fair market value for waiver applicants/recipients is ineligibility for long term care medicaid services under the waiver programs. Federal regulations specify that, to be eligible for a waiver program, an individual must be receiving the waiver or long term care services. Because a waiver applicant/recipient is not eligible to receive these services under the medicaid program, they are ineligible for the HCBS waiver program. The period of ineligibility is based on when the assets were transferred during the look back period. After February 8, 2006, the look back period for transfers is 60 months prior to the date of application. As soon as the HCBS waiver applicant has no transfers for less than fair market value during the 60 months look back period, they are eligible to be reconsidered for HCBS provided all financial and non-financial criteria are met. If the transfer for less than fair market value is discovered after the applicant is approved for HCBS, the period of ineligibility begins the first day of the month in which the resources were transferred. If the applicant or recipient enters a nursing facility, a penalty period for the transfer of assets for less than fair market value is calculated based on 8.281.500.14, *asset transfers*. This penalty period runs whether or not the individual remains in the nursing facility.

[8.290.500.14 NMAC – Rp 8.290.500.14, 7/01/2024]

8.290.500.15 TRUSTS: See 8.281.500.15 NMAC and following subsections.

[8.290.500.15 NMAC – Rp 8.290.500.15, 7/01/2024]

8.290.500.16 RESOURCE STANDARDS FOR MARRIED COUPLES:

A. Community property resource determination methodology: See Subsection A of 8.281.500.16 NMAC and Paragraph (2) of Subsection A of 8.281.500.16 NMAC for methodology used in the determination of eligibility for married applicants/recipients who began receiving waiver services for a continuous period prior to September 30, 1989.

B. Spousal impoverishment: See Subsection B of 8.281.500.16 NMAC and following subsections for spousal impoverishment methodology used in the determination of eligibility for married applicants/recipients with a spouse in the home who began receiving waiver services on or after September 30, 1989. The resource assessment is completed as of the first moment of the first day of the month in which the level of care is approved.

[8.290.500.16 NMAC – Rp 8.290.500.16, 7/01/2024]

8.290.500.17 DEEMING RESOURCES: See 8.281.500.17 NMAC. The resources of the custodial parent(s) are deemed available to the applicant/recipient for the entire calendar month in which the allocation letter is issued by the waiver program manager or the representative notifies the ISD worker that a UDR is available for the applicant/recipient. Beginning with the month following the month in which the allocation letter was issued, only the resources directly attributable and available to the applicant/recipient are counted and compared to the resource limit.

[8.290.500.17 NMAC – Rp 8.290.500.17, 7/01/2024]

8.290.500.18 INCOME: To qualify for medicaid under any of the waiver programs, the gross countable income of the applicant/recipient must be less than the maximum allowable monthly income standard. See 8.200.520.16 NMAC, Income Standards. See 8.281.500.18 NMAC and following subsections.

[8.290.500.18 NMAC – Rp 8.290.500.18, 7/01/2024]

8.290.500.19 INCOME STANDARDS. Income exclusions: See 8.281.500.19 NMAC and following subsections.
[8.290.500.19 NMAC – Rp 8.290.500.19, 7/01/2024]

8.290.500.20 UNEARNED INCOME: See 8.281.500.20 NMAC and following subsections.
[8.290.500.20 NMAC – Rp 8.290.500.20, 7/01/2024]

8.290.500.21 DEEMED INCOME: See 8.281.500.21 NMAC and following subsections. The income of the custodial parent(s) is deemed available to the applicant/recipient for the entire calendar month in which the allocation letter is issued by the waiver program manager or the representative notifies the ISD worker that a UDR is available for the applicant/recipient. Beginning with the month following the month in which the allocation letter was issued, only the income directly attributable and available to the applicant/recipient is counted and compared to the income limit.
[8.290.500.21 NMAC – Rp 8.290.500.21, 7/01/2024]

8.290.500.22 DISREGARDS: See 8.281.500.22 NMAC and following subsections.
[8.290.500.22 NMAC – Rp 8.290.500.22, 7/01/2024]

8.290.500.23 POST ELIGIBILITY/MEDICAL CARE CREDIT: There are no medical care credits in the waiver programs. The applicant/recipient is allowed to keep all of his income to maintain his household in the community.
[8.290.500.23 NMAC – Rp 8.290.500.23, 7/01/2024]

HISTORY OF 8.290.500 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, 12/29/94.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID GENERAL INFORMATION
PART 1 GENERAL PROGRAM DESCRIPTION

8.300.1.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.300.1.1 NMAC – Rp 8.300.1.1, 7/1/2024]

8.300.1.2 SCOPE: The rule applies to the general public.
[8.300.1.2 NMAC – Rp 8.300.1.2, 7/1/2024]

8.300.1.3 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 state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.300.1.3 NMAC – Rp 8.300.1.3, 7/1/2024]

8.300.1.4 DURATION: Permanent
[8.300.1.4 NMAC – Rp 8.300.1.4, 7/1/2024]

8.300.1.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.300.1.5 NMAC – Rp 8.300.1.5, 7/1/2024]

8.300.1.6 OBJECTIVE: The objective of these rules is to provide policies for the service portion of the New Mexico medical assistance programs.
[8.300.1.6 NMAC – Rp 8.300.1.6, 7/1/2024]

8.300.1.7 DEFINITIONS: [**RESERVED**]

8.300.1.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[8.300.1.8 NMAC – Rp 8.300.1.8, 7/1/2024]

8.300.1.9 GENERAL PROGRAM DESCRIPTION: Health care authority (HCA), through MAD, is responsible for the administration of the medicaid program and other health care programs. This joint federal and state program provides payment for medically necessary health services furnished to eligible recipients.
[8.300.1.9 NMAC – Rp 8.300.1.9, 7/1/2024]

8.300.1.10 RELATIONSHIP TO MEDICARE: MAD covers medically necessary health services furnished to eligible recipients who meet specific income, resource and eligibility standards. Medicare is a federal program which offers health insurance coverage to eligible recipients 65 years of age or older, to those who have received disability benefits for 24 consecutive months, to those who have end stage renal disease, and to other eligible recipients, as specified by other provisions of the Social Security Act.

A. The state of New Mexico has entered into an agreement with the social security administration to pay medicaid eligible recipient premiums for medicare part B, and under some circumstances, medicare part A premiums.

B. After medicare has made payment for services, the medicaid program pays for the medicare co-insurance and deductible amounts for all eligible medicaid recipients subject to the following medicaid reimbursement limitations.

(1) Medicaid payment for the co-insurance and deductible is limited such that the payment from medicare, plus the amount allowed by medicaid for the co-insurance and deductible, shall not exceed the medicaid allowed amount for the service. When the medicare payment exceeds the amount that medicaid would have allowed for the service, no payment is made for the co-insurance or deductible. The claim is considered paid in full. The provider may not collect any remaining portion of the medicare co-insurance or deductible from the eligible recipient or their personal representative. For services for which medicare part B applies a 50 percent co-

insurance rate, medicare co-insurance and deductible amounts may be paid at an amount that allows the provider to receive more than medicaid allowed amount, not to exceed a percentage determined by HCA.

(2) The medicaid program will pay toward the medicare co-insurance and deductible to the extent that the amount paid by medicare and the allowed medicare co-insurance and deductible together do not exceed the medicaid allowed amount. The medicaid program will pay the medicare co-insurance and deductible when the medicaid program does not have a specific amount allowed for the service.

[8.300.1.10 NMAC – Rp 8.300.1.10, 7/1/2024]

HISTORY OF 8.300.1 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

SP-001.0300, Section 1, Single State Agency Organization Statewide Operations, filed 1/15/1981.
SP-003.0200, Section 3, Services: General Provisions Coordination of Medicaid with Medicare Part B, filed 1/23/1981.
SP-004.0100, Section 4, General Program Administration Methods of Administration, filed 1/23/1981.
SP-004.0600, Section 4, General Program Administration Reports, filed 1/23/1981.
SP-003.0201, Coordination of Title XIX With Part B of Title XVIII, filed 2/25/1981.
SP-004.1000, Section 4, General Program Administration Free Choice of Providers, filed 3/3/1981.
SP-004.1200, Section 4, General Program Administration Consultation to Medical Facilities, filed 3/3/1981.
SP-004.1500, Section 4, General Program Administration Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases, filed 3/5/1981.
SP-004.1800, Section 4, General Program Administration Cost Sharing and Similar Charges, filed 3/5/1981.
SP-004.2500, Section 4, General Program Administration Program for Licensing Administrators of Nursing Homes, filed 3/5/1981.
SP-005.0100, Section 5, Personnel Administration Standards of Personnel Administration, filed 3/5/1981.
SP-005.0300, Section 5, Personnel Administration Training Programs, Subprofessional and Volunteer Programs, filed 3/5/1981.
SP-007.0100, Section 7, General Provisions Plan Amendments, filed 3/5/1981.
SP-001.0201, Section 1, Single State Agency Organization, Organization and Function of State Agency, filed 3/11/1981.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID GENERAL INFORMATION
PART 2 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) POLICIES

8.300.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.300.2.1 NMAC – Rp 8.300.2.1, 7/01/2024]

8.300.2.2 SCOPE: The rule applies to the general public.
[8.300.2.2 NMAC – Rp 8.300.2.2, 7/01/2024]

8.300.2.3 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 state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.300.2.3 NMAC – Rp 8.300.2.3, 7/01/2024]

8.300.2.4 DURATION: Permanent.
[8.300.2.4 NMAC – Rp 8.300.2.4, 7/01/2024]

8.300.2.5 EFFECTIVE DATE: July 1, 2003, unless a later date is cited at the end of a section.
[8.300.2.5 NMAC – Rp 8.300.2.5, 7/01/2024]

8.300.2.6 OBJECTIVE: The objective of this rule is to provide Health Insurance Portability and Accountability Act (HIPAA) instructions and policies for the New Mexico medical assistance programs.
[8.300.2.6 NMAC – Rp 8.300.2.6, 7/01/2024]

8.300.2.7 DEFINITIONS: The following definitions apply to terms used in this chapter.

A. Alternate address: A location other than the primary address on file with HCA for the recipient or the recipient's personal representative.

B. Alternate means of communication: A communication made other than in writing on paper, or made orally to the recipient or their personal representative.

C. Amend or amendment: To make a correction to information that relates to the past, present, or future physical or mental health or condition of a recipient.

D. Authorized HCC employee: A person employed within the health care component (HCC) workforce who is authorized by the immediate supervisor or by HCC policies to perform the task.

E. Business associate: A person or entity that performs certain functions or services on behalf of the HCC involving the use or disclosure of individually identifiable health information. These include claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, and practice management. They also include, other than in the capacity of a member of the HCC workforce, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for the HCC.

F. Covered entity: A health plan, a health care clearinghouse, or a health care provider that transmits any health information in electronic form in connection with a recipient's health care transaction.

G. Disclose or disclosure: To release, transfer, provide access to, or divulge in any other manner (verbally, written, or electronic) protected health information outside the HCC workforce or to an HCC business associate.

H. Health care component (HCC): Those parts of the HCA, which is a "hybrid entity" under HIPAA [45 CFR 164.105], that engage in covered health plan functions and business associate functions involving protected health information. HCA's health care component consists of the medical assistance division, supported by the income support division, the office of inspector general, the office of general counsel, and the office of the secretary.

I. Health care operations: Any of the following activities: quality assessment and improvement activities, credentialing activities, training, outcome evaluations, audits and compliance activities, planning, fraud

and abuse detection and compliance activities, managing, and general administrative activities of the HCC, to the extent that these are related to covered health plan functions.

J. Health oversight agency: An agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.

K. Health Insurance Portability and Accountability Act (HIPAA) privacy rule: The federal regulation Section 45 CFR part 160 and Subparts A and E of Part 164.

L. Health plan: The medicaid program under Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., and the state children's health insurance program (SCHIP) under Title XXI of the Social Security Act, 42 U.S.C. 1397, et seq.

M. HCC workforce: Permanent, term, temporary and part-time employees (classified or exempt), university/federal government placements, volunteers, contractors and others conducting data entry tasks, and contractors and other persons whose conduct and work activities are under the direct control of HCC.

N. Medical record or designated record set: Any HCC item, collection, or grouping of information that includes protected health information (PHI) that is written or electronic and is used in whole or in part, by or for HCC to make decisions about the recipient. This applies to:

(1) the medical records and billing records about the recipient maintained by or for the HCC;

(2) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for HCC; and

(3) this definition ***excludes*** HCC documents such as those related to accreditation compliance activities (e.g., JCAHO), quality assurance, continuous quality improvement, performance improvement, peer reviews, credentialing and incident reports, and investigations.

O. Minimum necessary: The least amount of information needed to accomplish a given task.

P. Notice of privacy practices, notice or NPP: The official HCA notice of privacy practices that documents for a recipient the uses and disclosures of PHI that may be made by HCC and the recipient's rights and HCC's legal duties with respect to PHI.

Q. Payment: All HCC activities undertaken in its role as a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan, and HCC activities undertaken to obtain or provide reimbursement for the provision of health care. Such activities include but are not limited to:

(1) determination of eligibility or coverage;

(2) risk adjusting amounts due based upon health status or demographic characteristics;

(3) billing, claims management, collection activities, and related health care data processing;

(4) review of health care services with respect to medical necessity, coverage, appropriateness of care, or justification of charges;

(5) utilization review activities; and

(6) disclosure to consumer reporting agencies of lawful elements of PHI relating to collection of premiums or reimbursement.

R. Personal representative: A person who has the legal right to make decisions regarding an eligible recipient's PHI, and includes surrogate decision makers, parents of unemancipated minors, guardians and treatment guardians, and agents designated pursuant to a power of attorney for health care.

S. Privacy and security officer (PSO): The individual appointed by HCA pursuant to HIPAA [45 CFR 164.530(a)] who is responsible for development, implementation, and enforcement of the privacy policies and procedures required by HIPAA.

T. Protected health information (PHI): Health information that exists in any form (verbal, written or electronic) that identifies or could be used to identify a recipient (including demographics) and relates to the past, present, or future physical or mental health or condition of that recipient. It also includes health information related to the provision of health care or the past, present, or future payment for the provision of health care to a recipient.

U. Psychotherapy notes: Notes recorded (in any medium) documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the recipient's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms,

prognosis, and progress to date.

V. Public health agency: An agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

W. Requestor: A recipient, personal representative of a recipient, or any other person making a request.

X. Restrict or restriction: To limit the use or disclosure of PHI for purposes of TPO, or for purposes of disclosing information to a spouse, personal representative, close family member or person involved with the eligible recipient's care.

Y. Standard protocols: A process that details what PHI is to be disclosed or requested, to whom, for what purpose, and that limits the PHI to be disclosed or requested to the amount reasonably necessary to achieve the purpose of the disclosure or request.

Z. TPO: Treatment, payment or health care operations.

AA. Treatment: The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a recipient; or the referral of a recipient for health care from one health care provider to another.

BB. Valid authorization: An authorization with all required elements, as specified in HIPAA privacy policy in Section 13 of 8.300.2 NMAC.

[8.300.2.7 NMAC – Rp 8.300.2.7, 7/01/2024]

8.300.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.

[8.300.2.8 NMAC – Rp 8.300.2.8, 7/01/2024]

8.300.2.9 GENERAL HIPAA APPLICATION AND INTERPRETATION: This part describes HIPAA policies including health plan responsibilities, disclosure requirements, minimum necessary, business associates, sanctions, reporting, and documentation requirements. The HCC shall meet all requirements in this chapter.

A. Medicaid is a health plan and a covered entity under HIPAA: The New Mexico medicaid program under title XIX of the Social Security Act qualifies as a health plan under HIPAA regulations at 45 CFR 160.103 and is considered a covered entity.

B. Inconsistency between state and federal law: In the event of any inconsistency between the federal HIPAA privacy rule and New Mexico statutes or regulations, the HIPAA privacy rule shall preempt state law, except where [45 CFR 160.203]:

(1) a determination is made by the secretary of the United States department of health and human services pursuant to 45 CFR 160.204;

(2) the provision of state law relates to the privacy of individually identifiable health information and is more stringent than a standard, requirement, or implementation specification under the HIPAA privacy rule;

(3) the provision of state law and procedures established thereunder provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation or intervention; or

(4) the provision of state law requires the HCC to report, or to provide access to, information for the purpose of management audits, financial audits, program monitoring and evaluation, or the licensure or certification of facilities or individuals.

[8.300.2.9 NMAC – Rp 8.300.2.9, 7/01/2024]

8.300.2.10 NOTICE OF PRIVACY PRACTICES: HCA shall establish policies protecting a recipient's rights regarding HIPAA privacy practices [45 CFR 164.520].

A. Notice of privacy practices requirements:

(1) HCA shall provide notice of privacy practices, update the notice as necessary, and distribute the notice and any revised notices to all recipients or their personal representatives.

(2) All notice of privacy practices required elements listed in the HIPAA privacy rule shall be contained in the HCA notice of privacy practices [45 CFR 164.520].

(3) The name of every recipient and, as applicable, their personal representative to whom the HCA notice of privacy practices is sent shall be recorded.

B. Notice schedule:

(1) For an eligible recipient enrolled in medicaid prior to July 1, 2003, a copy of the notice of privacy practices shall be sent to each eligible recipient's or their personal representative's last known address no later than November 1, 2003.

(2) For revisions made to the notice of privacy practices, a copy of the revised notice of privacy practices shall be mailed to each enrolled MAD eligible recipient or their personal representative within 60 calendar days of the effective date of the revision.

(3) For a new eligible recipient approved after July 1, 2003, a copy of the notice of privacy practices shall be mailed with the eligible recipient's new medicaid card or their eligibility determination notice.

(4) At least once every three years, HCA shall notify eligible recipients or their personal representatives by mail of the availability of the notice of privacy practices and how to obtain the notice of privacy practices.

[8.300.2.10 NMAC – Rp 8.300.2.10, 7/01/2024]

8.300.2.11 RECIPIENT'S RIGHTS: HCA shall establish policies protecting a recipient's rights regarding HIPAA privacy practices.

A. Alternate means of communication: A recipient or their personal representative shall have the right to request an alternate means of communication and an alternative address to receive communications of protected health information (PHI) from the HCC. The HCC shall accommodate such requests when reasonable [45 CFR 164.522(b)].

(1) If the recipient or their personal representative is unable to write the request, the recipient or their personal representative may request assistance from the HCC. If assistance is provided, the HCC shall document that the assistance was given, have the recipient or their personal representative sign and date the document, co-sign and retain the document in the medical record.

(2) The HCC staff may determine the reasonableness of a request. If an HCC staff member is unable to determine if the request is reasonable, the staff member may request a supervisor's assistance.

(3) If the recipient or the recipient's personal representative is present when the request is approved or denied, HCC staff shall notify the recipient or the recipient's personal representative verbally of the decision, and shall document the notification in the recipient's file.

(4) If the recipient or their personal representative is not present when the request is approved or denied, HCC shall notify the recipient or their personal representative of the decision in writing and retain the copy of the decision in the recipient's file.

(5) If the request is approved, an HCC staff member shall record the alternative method or address in the medical record and in the PSO's database.

B. Inspect and copy: A recipient or their personal representative may inspect their own PHI in a medical file (designated record set) as maintained by the HCC. This does not include psychotherapy notes.

(1) For all requests received in writing, the HCC shall respond in writing to the request to inspect or to obtain a copy of HCC PHI no later than 60 calendar days after receipt of the request. The HCC shall then determine, using the criteria in HIPAA privacy rule, if the request will be granted in part, in full, or denied.

(a) If the request will be granted in full, the PSO shall provide a written response arranging with the recipient or their personal representative a convenient time and place to inspect or obtain a copy of the PHI, or may mail the copy of the PHI at the recipient's or their personal representative's request; and shall discuss the scope, format, and other aspects of the recipient's or their personal representative's request with the recipient or personal representative as necessary to facilitate timely provision.

(b) If the PSO is unable to gather the required data within the time period required, the PSO may extend the time for the action by no more than 30 calendar days so long as the recipient or their personal representative is provided with a written statement of the reason(s) for the delay and the date by which the PSO shall complete the action on the request. However, only one such extension of time shall be allowed.

(c) The PSO shall provide a copy of the recipient's PHI to the recipient or their personal representative in the format requested, if possible. If not, the PSO shall provide the PHI in a readable hard copy form or in another format mutually agreed upon by the PSO and the recipient or their personal representative.

(2) If the request is denied, in part or in full, the PSO shall either:

(a) give the recipient or their personal representative access to any permitted PHI requested to the extent possible; or

(b) provide a written denial to the recipient or their personal representative; the denial shall be written in plain language and contain:

(i) the basis for the denial,

(ii) if applicable, a statement of the recipient's review rights, and

(iii) a description of how the recipient or their personal representative may complain to the PSO or to the secretary of HCA; this description shall include the title and telephone number of the PSO and the secretary of HCA.

(3) If the HCC does not maintain the PHI that is the subject of the request for inspection or copying, the PSO shall inform the recipient or their personal representative where to direct the request, if known.

(4) **Exceptions:** A recipient or their personal representative may not inspect the recipient's own protected health information (PHI) in a medical record in connection with:

(a) psychotherapy notes;

(b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding;

(c) PHI maintained by the HCC that is subject to the clinical laboratory improvements amendments (CLIA) to the extent that access to the recipient or their personal representative is prohibited by CLIA;

(d) when the access to the PHI requested is reasonably likely to endanger the life or physical safety of the recipient or another person as determined by a licensed health care professional by using his/her professional judgment;

(e) when the PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that granting the access requested is reasonably likely to cause substantial harm to such other person; or

(f) when the request for access is made by recipient's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the recipient or another person [45 CFR 164.524].

(5) The PSO shall record all actions pertaining to access to inspect and copy

C. **Accounting of disclosures:** Accounting of all disclosures of a recipient's PHI shall be produced via written report by the PSO when the request is made in writing by the recipient or their personal representative and sent to the PSO.

(1) All disclosures shall be reported except for those:

(a) made to carry out TPO [45 CFR 164.506];

(b) for a facility directory;

(c) for notification purposes that include disaster relief, emergencies, or in the case of recipient death;

(d) for national security purposes;

(e) to correctional institutions or law enforcement officials having custody of an inmate;

(f) made prior to July 1, 2003;

(g) made more than six years prior to the date the accounting is requested;

(h) made to the recipient or their personal representative of the recipient's own PHI; or

(i) made to individuals involved in the recipient's care [45 CFR 164.528].

(2) If the HCC does not maintain the PHI that is the subject of the request for accounting, the PSO shall inform the recipient or their personal representative where to direct the request, if known.

(3) When a recipient or their personal representative requests in writing to the PSO an accounting of disclosures of PHI:

(a) within 60 calendar days of receiving a recipient's or their personal representative's request, HCC prepares a report from the PSO's database that includes all required PHI disclosures that occurred during the six years prior to the date of the request for an accounting, unless the recipient or their personal representative requested an accounting for a shorter period of time than six years.

(b) the deadline for producing the disclosure report may be extended for up to 30 calendar days, provided that a written statement is sent to the recipient citing the reasons for the delay and the date by which the accounting shall be received;

(c) the HCC must provide free of charge the first accounting report within any 12-month period; if additional requests for an accounting are made within the same 12-month period, the HCC shall notify the recipient or their personal representative if a fee will be charged for the additional copies;

(d) the accounting disclosure information is entered into the PSO's database.

D. Setting restrictions: A recipient or their personal representative may request restrictions on the uses and disclosures of their own protected health information (PHI) by submitting a request in writing to the HIPAA privacy and security officer (PSO).

(1) The PSO shall approve or deny requests for restriction(s) in writing within 15 calendar days.

(2) If the HCC does not maintain the PHI that is the subject of the request for setting restrictions, the PSO shall inform the recipient or their personal representative where to direct the request, if known.

(3) If a restriction is approved by the PSO, the information shall be entered into the PSO's database and the HCC shall not use or disclose the restricted PHI [45 CFR 164.522(a)].

(4) If the recipient or their personal representative is unable to write the request, the recipient or their personal representative may request assistance from the HCC. If assistance is provided, the HCC shall document that the assistance was given, have the recipient or their personal representative sign and date the document, co-sign and retain the document in the recipient's file.

(5) Limited use and disclosure of PHI is allowable when the recipient or their personal representative is not present for an emergency or because of the incapacity of the recipient or their personal representative.

(6) The HCC shall approve or deny the request as appropriate and ensure that the approval or denial of the restriction is entered into the medical record.

(7) If the restriction would involve more than a single location, the HCC staff worker shall send the request to the HIPAA privacy and security officer.

(8) The PSO shall inform the recipient or their personal representative in writing of the approval or denial of the request to restrict use and disclosure.

(9) The PSO shall document the restriction(s) in the PSO's database.

E. Amendments: It is the policy of the HCC that the HCC shall allow a recipient to request that an amendment be made to the recipient's own protected health information (PHI) contained in a designated record set as long as the PHI was originated by the HCC.

(1) A request for an amendment shall be submitted in writing to the PSO [45 CFR 164.526].

(2) If the HCC does not maintain the PHI that is the subject of the request for amending, the PSO shall inform the recipient or their personal representative where to direct the request, if known.

(3) Within five working days of receiving the recipient's or their personal representative's written request for an amendment, the PSO shall forward the request to the possessor of the PHI requested to be amended for a determination on whether to grant or deny, in whole or in part, the recipient's or their personal representative's request.

(4) The possessor of the PHI shall:

(a) review the recipient's or their personal representative's request for an amendment;

(b) determine whether to grant or deny, in whole or in part, the recipient's or their personal representative's request;

(c) within 45 calendar days of receiving the recipient's or their personal representative written request for an amendment from the PSO, inform the PSO of the decision to grant or deny, in whole or in part, the recipient's or their personal representative's request and the reason(s) for reaching the decision;

(d) within 60 calendar days of the original receipt of the recipient's or their personal representative's request for an amendment, the PSO shall inform the recipient or their personal representative of the decision to grant or deny the requested amendment in whole or in part; and

(e) if the PSO is unable to act on the amendment within the required 60 calendar day period, the time may be extended by no more that 30 calendar days, provided that the PSO provides the recipient or their personal representative with a written statement of the reasons for the delay and the date the action on the request will be completed.

(5) If the recipient's or their personal representative's request is granted in whole or in part:

(a) the possessor shall make the appropriate amendment to the recipient's PHI in the designated record set;

(b) the PSO shall inform the recipient or their personal representative that the amendment is accepted;

(c) the PSO shall obtain the recipient's or their personal representative's agreement and identification of persons that the HCC is to notify of the amendment; and

(d) the PSO shall provide the amendment to those persons identified by the recipient or their personal representative and to persons, including business associates, that the PSO knows have received the PHI that is the subject of the amendment and who may have relied, or could predictably rely, on such information to the detriment of the recipient.

F. Complaints and appeals: It is the policy of the HCC to receive, investigate and resolve complaints made by a recipient or their personal representative of alleged violations of the HIPAA privacy rule. Complaints shall be made in writing, specifying how the recipient's privacy rights have been violated, and submitted to the PSO or to the secretary of HCA [45 CFR 164.530(d)(1), (e), and (f)].

(1) Within five working days of receipt of the complaint, the PSO shall initiate a HIPAA privacy investigation.

(2) The PSO shall enter the complaint into the PSO's database.

(3) Within 30 calendar days of contact by the PSO, the appropriate HCC staff shall conduct the HIPAA privacy investigation and prepares a written report to the PSO documenting the details of the HIPAA privacy investigation and the findings.

(4) Within 30 calendar days after receiving the written report from the appropriate HCC staff, the PSO shall determine the validity of the complaint and notify the recipient or their personal representative, the HCC supervisor and the HCC staff of the action taken. In consultation with the HCC supervisor, the PSO shall take appropriate action to mitigate the adverse effects of any unauthorized disclosure.

(5) For valid complaints, the PSO shall ensure that the appropriate disciplinary action and training are applied as per 8.300.2.24 NMAC.

(6) The PSO shall enter the HIPAA privacy investigation results into the PSO's database.

(7) If the recipient's or their personal representative's request pursuant to this section is denied in whole or in part, the PSO shall:

(a) provide recipient or their personal representative with a timely, written denial, which includes the reason for the denial;

(b) inform the recipient or their personal representative of his/her right to submit, and the procedure for submission of a written statement disagreeing with the denial and also inform the recipient or their personal representative that if no statement of disagreement is submitted, the recipient or their personal representative may request that the HCC provide the recipient's or their personal representative's request for amendment and the denial with any future disclosures of the PHI that is the subject of the amendment request;

(c) if necessary, prepare a written rebuttal to the recipient's or their personal representative's statement of disagreement and provide a copy to the recipient or their personal representative;

(d) identify the record or PHI and append to the designated record set the:

(i) recipient's or their personal representative's request for an amendment;

(ii) the HCC's denial of the request;

(iii) the recipient's or their personal representative's statement of disagreement, if any; and

(iv) the HCC's rebuttal, if any.

[8.300.2.11 NMAC – Rp 8.300.2.11, 7/01/2024]

8.300.2.12 USE AND GENERAL DISCLOSURES OF PROTECTED HEALTH INFORMATION: PHI shall be used or disclosed only by authorized HCC staff or contractors and only in accordance with HCC policies and procedures [45 CFR 164.502(a) and 45 CFR 164.530(i)].

A. Making a disclosure when an authorization is required: When PHI is requested, an authorized HCC employee shall:

(1) determine if a valid authorization is presented. See 8.300.2.13 NMAC;

(2) determine the identity and authority of the requestor as per 8.300.2.21 NMAC;

(3) if a valid authorization is presented and the identity and authority of the requestor is verified, the HCC is authorized to disclose the PHI in accordance with the valid authorization's instructions;

(4) HCC shall retain the valid authorization in the recipient's file;

(5) the valid authorization and the disclosure shall be documented in the PSO's database;

(6) if the request is not accompanied by a valid authorization, the HCC shall determine if an exception to the authorization requirement applies; and

(7) if no exception applies, the HCC shall deny the request for disclosure of PHI, document the denial and instruct the requestor that a valid authorization shall be obtained from the recipient or their personal representative before MAD will disclose PHI.

B. Exceptions: A valid written authorization shall be required from a recipient or their personal representative before any use or disclosure of PHI, with the following exceptions:

(1) disclosures to the recipient or personal representative pursuant to his/her request [45 CFR 164.502(a)(1)(i)];

(2) for purposes of TPO [45 CFR 164.502 and 506];

(3) when a consent, authorization, or other express legal permission in writing was obtained from the eligible recipient prior to July 1, 2003, and is on file in an HCC location that permits the use or disclosure of PHI [45 CFR 164.532]; and

(4) when the use or disclosure of PHI is limited to the minimum necessary to or for the following:

(a) assist disaster relief agencies [45 CFR 164.510(b)(4)];

(b) coroners, medical investigators, funeral directors, and organ procurement organizations as authorized by law [45 CFR 164.512(g) and (h)];

(c) avert a serious and imminent threat to the health or safety of a person or the public [45 CFR 164.512(j)];

(d) health oversight activities [45 CFR 164.512(d)];

(e) disclosures required by law pursuant to a legal duty to disclose or report, such as for law enforcement purposes, child abuse or neglect, judicial or administrative proceedings, or workers compensation proceedings pursuant to a subpoena [45 CFR 164.512(a), (c), (e) and (f)];

(f) public health activities [45 CFR 164.512(b)];

(g) correctional institutions or law enforcement officials who have custody of an inmate [45 CFR 164.512(k)(5)];

(h) government agencies which administer a government program that provides public benefits, where the disclosure is necessary to coordinate, improve, investigate, or manage the program [45 CFR 164.512(d)(1) and (3)]; or

(i) research purposes that have been granted a waiver of authorization by an appropriately constituted institutional review board (IRB), a privacy board or representation that the PHI is necessary for research purposes [45 CFR 164.512(i)].

[8.300.2.12 NMAC – Rp 8.300.2.12 7/01/2024]

8.300.2.13 AUTHORIZATIONS: When a disclosure is made as a result of an exception to an authorization being required, the authorized HCC employee shall follow the specific procedure established for that exception [45 CFR 164.502(b), 45 CFR 164.508, 45 CFR 164.512, 45 CFR 164.532].

A. Treatment, payment, or health care operations (TPO):

(1) When conducting daily business that involves the use or disclosure of PHI, the HCC shall determine whether the use or disclosure is for TPO.

(2) If the person who requested the PHI is unknown, the HCC shall verify the identity and authority in accordance with 8.300.2.21 NMAC.

(3) The HCC shall apply the minimum necessary criteria to disclosures of PHI for payment or health care operations.

(4) The HCC shall ensure that there are no restrictions to the requested disclosure for PHI.

(5) The HCC shall use or disclose the minimum necessary PHI. The minimum necessary criteria do not apply to disclosures or requests by a health care provider for treatment purposes.

(6) Disclosures made for the purpose of providing TPO are not required to be documented.

B. Averting a serious threat:

(1) If in good faith and using professional judgment, the HCC determines that the use or disclosure of PHI is necessary to avert a serious and imminent threat to the health or safety of a person or the public.

(a) If the identity of the requestor is unknown, the HCC shall verify the identity and authority of the requestor in accordance with 8.300.2.21 NMAC.

(b) The HCC shall apply the minimum necessary criteria per 8.300.2.16 NMAC for disclosing PHI to prevent or lessen the threat.

(c) The HCC shall disclose the PHI only to person(s) reasonably able to prevent or lessen the threat, including the target of the threat.

(2) The disclosure of PHI shall be documented in the PSO's database.

C. Workers compensation:

(1) If the identity and authority of the requestor is unknown, the HCC shall verify the information as required per 8.300.2.21 NMAC.

(2) The HCC shall disclose the required PHI to the workers' compensation administration in accordance with the minimum necessary criteria.

(3) The disclosure of PHI shall be documented in the PSO's database.

D. Coroners, medical investigators, funeral directors, and organ procurement organizations: When the PHI request is from coroners, medical investigators, funeral directors, or organ procurement organizations, the HCC shall:

(1) if unknown, verify the identity and authority of the requestor as per 8.300.2.21 NMAC;

(2) apply the minimum necessary criteria per 8.300.2.16 NMAC;

(3) disclose the minimum necessary PHI. Disclosures to the coroner or medical investigator require a valid subpoena; and

(4) record the disclosure in the PSO's database.

E. Disaster relief efforts: When an entity in disaster relief efforts requests PHI to assist in notifying, identifying, or locating a family member, personal representative or other person responsible for the care of the recipient regarding the recipient's location, general condition or death, the HCC shall:

(1) if unknown, verify the identity and authority of the requestor as per 8.300.2.21 NMAC;

(2) apply the minimum necessary criteria per 8.300.2.16 NMAC;

(3) provide recipients or their personal representatives the opportunity to agree to, restrict, or prohibit the use or disclosure of PHI to the disaster relief entity, unless the recipient is not present or is unable to agree to, restrict, or prohibit the disclosure; and

(4) record the disclosure in the PSO's database.

F. Health oversight activities: The health oversight agency may request documents related to a recipient's PHI and record the identity of recipients for whom PHI was accessed. The HCC shall then:

(1) if unknown, verify the identity and authority of the requestor as per 8.300.2.21 NMAC;

(2) apply the minimum necessary criteria per 8.300.2.16 NMAC;

(3) disclose the minimum necessary PHI;

(4) obtain the identity of recipients for whom PHI was accessed; and

(5) record the disclosure in the PSO's database.

G. Public health activities: A public health agency may request documents related to a recipient's PHI. The HCC shall then:

(1) if unknown, verify the identity and authority of the requestor as per 8.300.2.21 NMAC;

(2) apply the minimum necessary criteria per 8.300.2.16 NMAC;

(3) disclose the minimum necessary PHI if the purpose of requesting the information is for:

(a) the prevention or control of disease, injury, or disability including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority;

(b) another public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

(c) a person subject to the jurisdiction of the food and drug administration:

(i) to report adverse events (or similar reports with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations if the disclosure is made to the person required or directed to report such information to the food and drug administration;

(ii) to track products if the disclosure is made to a person required or directed by the food and drug administration to track the product;

(iii) to enable product recalls, repairs, or replacement (including locating and notifying individuals who have received products subject to recalls, withdrawals, or other problems); or

(iv) to conduct postmarketing surveillance to comply with requirements or at the direction of the food and drug administration, or

(d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

(4) record the disclosure in the PSO's database.

H. Required by law:

(1) If the request for the disclosure of PHI appears to be required by law, the HCC shall verify the identity of the requestor and forward the request to the HCA office of general counsel (OGC) for a determination of the validity of the request.

(2) If advised by OGC that the request is valid, the HCC shall disclose the PHI in accordance with the minimum necessary criteria.

(3) The HCC shall record the disclosure in the PSO's database.

I. Law enforcement requests: When the disclosure of PHI is for law enforcement purposes, the HCC shall:

(1) verify identity and authority of the requestor;

(2) forward the request to OGC for a determination of the validity of the request;

(3) if advised by OGC that the request is valid, disclose the PHI in accordance with the minimum necessary criteria; and

(4) record the disclosure in the PSO's database.

J. Legal requests:

(1) If the request for PHI arises from legal proceedings and requests such as judicial or administrative proceedings or subpoenas, the HCC shall verify the identity of the requestor if practicable, and forward the request to OGC, unless documented exceptions from OGC have been received.

(2) If the identity of the requestor has not been previously verified to OGC, the HCC shall verify the identity of the requestor and determine the validity of the legal or law enforcement request.

(3) The HCC shall then disclose the PHI or direct the disclosure to be made.

(4) The HCC shall record the disclosure in the PSO's database.

K. When consent or authorization for the use or disclosure of PHI was made prior to July 1, 2003:

(1) The HCC shall determine if a valid authorization exists for the specific use or disclosure of PHI request.

(2) If a valid authorization does not exist, the HCC shall determine if a consent, an authorization, or other legal permission exists that was obtained before July 1, 2003.

(3) If a consent, an authorization, or other legal permission exists, the HCC shall verify that it is still in effect and that it is for the use or disclosure of the specific PHI requested.

(a) If yes, the HCC shall disclose the PHI and record the disclosure in the PSO's database.

(b) If no, the HCC shall deny the PHI request and instruct the requestor that a valid authorization must be obtained from the recipient. The requestor shall be provided a blank authorization form to be completed by recipient.

[8.300.2.13 NMAC – Rp 8.300.2.13, 7/01/2024]

8.300.2.14 DISCLOSURES FOR RESEARCH PURPOSES:

A. Before a disclosure is made for research purposes, a valid authorization must be signed by the recipient or a waiver of authorization must have been obtained from a properly constituted institutional review board (IRB), a privacy board or representation that the PHI is necessary for research purposes [45 CFR 164.512(i)(l); 45 CFR 164.514(b) and (e)].

B. Disclosure requirements: The HCC shall:

(1) accept requests for PHI for research purposes with an authorization; or without a recipient authorization where the research entity provides documentation reflecting alteration or waiver of the authorization requirement [45 CFR 164.512(i)(1) and (2)];

(2) forward all requests to the PSO;

(3) if the requestor is unknown, verify the identity and authority of the requestor in accordance with 8.300.2.21 NMAC;

(4) grant or deny requests in accordance with the HIPAA privacy rule [45 CFR 164.512(i)]; and

(5) enter the disclosure information into the PSO's database.

[8.300.2.14 NMAC – Rp 8.300.2.14, 7/01/2024]

8.300.2.15 RECORDING AUTHORIZATIONS AND DISCLOSURES: The HCC shall record all valid authorizations and record all disclosures of PHI.

A. Recording of authorizations: All valid authorizations shall be recorded when received in the PSO's database [45 CFR 164.508(b)(6)]. Any disclosures of PHI shall be made and recorded only by authorized members of the HCC workforce in the PSO's database.

B. Exceptions: The only exceptions that shall be allowed to the recording of disclosures of PHI are those:

(1) made to carry out TPO;

(2) for notification purposes that include disaster relief, emergencies, or in the case of recipient death;

(3) for national security purposes;

(4) to correctional institutions or law enforcement officials having custody of an inmate;

(5) made prior to July 1, 2003 [45 CFR 164.528a];

(6) made six years prior to the date the accounting is requested;

(7) made to the recipient of the recipient's own PHI; or

(8) made to individuals involved in the recipient's care.

[8.300.2.15 NMAC – Rp 8.300.2.15, 7/01/2024]

8.300.2.16 MINIMUM NECESSARY: The HCC shall apply minimum necessary criteria to limit PHI for the use, disclosure, or request for PHI to the amount necessary to accomplish the task, except for disclosures to or requests by a health care provider for treatment purposes. The minimum necessary criteria do not apply with respect to disclosures to or requests by a health care provider for treatment. [45 CFR 164.514(d)(2)-(5), 45 CFR 164.502(b)(2)]

A. HCC's use of protected health information:

(1) An HCC supervisor shall determine the minimum necessary PHI needed by each HCC employee to perform his or her job duties and shall:

(a) grant appropriate medical record access;

(b) grant appropriate access to billing and payment information;

(c) grant appropriate access to other files containing PHI; or

(d) grant appropriate electronic access to PHI and set security levels.

(2) Members of the HCC authorized workforce shall use PHI as authorized. Requests for additional access to PHI shall be forwarded to the supervisor if needed to perform job duties.

B. HCC disclosures of protected health information:

(1) Prior to making any disclosures of PHI, an authorized HCC employee shall determine the minimum necessary PHI to disclose by applying the following.

(a) If the disclosure request is made for a medical record maintained within the supervisor's organizational unit, the request must specifically justify in writing why the entire medical record is needed. The HCC employee shall apply professional judgment in determining whether all PHI requested is necessary to be disclosed. Absent such justification, the request shall be denied. The written request and disposition shall be maintained within the medical record.

(b) If a request for PHI to be disclosed is pursuant to a state or federal statute, administrative rule, court order, contract or grant and the disclosure is routine or recurring, the HCC employee shall determine if a MAD protocol for that disclosure exists.

(c) If it does, the HCC employee shall follow the protocol established for that routine and recurring disclosure.

(d) For any other routine or recurring disclosures, the HCC employee shall contact the PSO with a proposed standard protocol that details the minimum necessary PHI to be disclosed, to whom and for what purpose. Once developed and approved, the HCC employee shall follow the protocol established for such routine and recurring disclosures. By following such protocol, the minimum necessary requirement will be met.

(e) If the disclosure is not routine or recurring, the minimum necessary PHI to disclose is the PHI that has been requested by any of the following:

(i) a health care provider or health plan;

(ii) a business associate of the HCC, if the business associate represents that the PHI is the minimum necessary needed; or

(iii) a researcher whose request for PHI is consistent with the documentation of approval of such research by an IRB or privacy board, and which documentation was provided to, and approved by the PSO, in accordance with 8.300.2 NMAC [45 CFR 164.512(h)].

(2) When determining the minimum necessary PHI for all other disclosures, the HCC shall:

(a) review each request and if necessary make appropriate inquiries of the requestor to determine why the PHI is needed;

(b) apply professional judgment in determining whether all of the PHI requested is necessary to be disclosed to accomplish the identified purpose of the requested disclosure;

(c) limit the disclosure to the appropriate PHI to accomplish the identified purpose;

(d) if the disclosure is less than requested, provide an explanation of the limitation.when the disclosure is made;

(e) refer questions concerning the minimum necessary disclosure of PHI to the PSO;

(f) if proposed standard protocols are received, the PSO reviews and approves or disapproves the standard protocol, keeps a copy of all approved standard protocols and notifies the supervisor of the decision; and

(g) authorized HCC employees shall:

(i) follow the standard protocols that have been approved by the PSO;

(ii) forward the request to their immediate supervisor, if disclosure requests are received other than from the recipient;

(iii) provide the minimum necessary PHI that the recipient requested, if the disclosure request is from the recipient; and

(iv) record the disclosure in the PSO's database.

C. HCC requests for protected health information: HCC employees shall determine the minimum necessary PHI to request by applying the following guidelines.

(1) If the request is made for a medical record, the request shall specifically justify why the entire medical record is needed. If the medical record is disclosed to or requested by a health care provider for treatment purposes, minimum necessary does not apply and justification is not required.

(2) If the request for PHI is not routine or recurring, the request shall be limited to the minimum necessary PHI to accomplish the task.

(3) All requests for PHI shall be in writing and a copy given to the PSO for audit purposes.

(4) For any PHI requests that are routine or recurring, employees shall send the proposed standard protocol to the PSO that details the minimum necessary PHI needed to accomplish the task.

(5) The PSO shall maintain written PHI requests and perform audits as necessary.

(6) If proposed standard protocols are received, the PSO shall review and approve or disapprove the standard protocol, keep a copy of all approved standard protocols, and notify the supervisor of the decision.

[8.300.2.16 NMAC – Rp 8.300.2.16, 7/01/2024]

8.300.2.17 DE-IDENTIFICATION OF PROTECTED HEALTH INFORMATION: The HCC may de-identify PHI on recipients by removing all recipient identifiable information [45 CFR 164.514(a)(b)]. Authorized HCC employees shall forward the PHI to be de-identified to a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable; or they shall remove all the following recipient identifiable information.

A. Names.

B. Location: All geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the bureau of the census:

(1) the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(2) the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

C. Dates: All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including

year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

D. Numbers: All elements of numbers, or combination of alpha-numeric and special characters, for identification directly related to an individual, including:

(1) telephone numbers;
(2) fax numbers;
(3) e-mail addresses;
(4) social security numbers;
(5) medical record numbers;
(6) health plan beneficiary numbers;
(7) account numbers;
(8) certificate/license numbers;
(9) vehicle identifiers and serial numbers, including license plate numbers;
(10) device identifiers and serial numbers;
(11) web universal resource locators; (URLs);
(12) internet protocol (IP) address numbers;
(13) any other unique identifying number, characteristic, or code, except as otherwise permitted.

E. Imagery: All elements of physical characteristics captured in any format, or combination of formats, for identification directly related to an individual, including:

(1) biometric identifiers, including finger and voiceprints; and
(2) full face photographic images and any comparable images.

[8.300.2.17 NMAC – Rp 8.300.2.17, 7/01/2024]

8.300.2.18 TERMINATION OF RESTRICTIONS:

A. Termination requirements: Restrictions on the uses and disclosures of PHI shall be terminated if:

(1) the recipient or the recipient's personal representative requests the termination in writing;
(2) the PSO informs the recipient or the recipient's personal representative in writing that the HCC agreement to a restriction has ended and that the termination of the restriction is effective with any PHI created or received after the recipient or the recipient's personal representative is notified of the termination [45 CFR 164.522(a)(2)]; or
(3) if the recipient is unable to write the request, the recipient may request assistance from HCC; if assistance is provided, HCC shall document that the assistance was given, have the recipient sign and date the document, co-sign and retain the document in the medical record.

B. Consideration of request:

(1) The PSO shall approve or deny the request within five working days. If approved, the PSO shall notify the recipient or the recipient's personal representative in writing of the termination request and give the recipient or the recipient's personal representative ten working days to disagree in writing; if denied, the PSO shall notify the requestor in writing.
(2) If the recipient or the recipient's personal representative disagrees, the PSO shall inform the requestor of the disagreement and require a response in three working days to review the communication from the recipient or the recipient's personal representative to ascertain if the disagreement by the recipient has bearing on the PSO final decision to terminate the restriction.
(3) The PSO shall issue a final decision within five working days and notify the recipient or personal representative and the MAD requestor.
(4) The PSO shall record the termination of restriction in the PSO's database.

[8.300.2.18 NMAC – Rp 8.300.2.18, 7/01/2024]

8.300.2.19 BUSINESS ASSOCIATES: The HCC shall have privacy protections in all contracts if the contract anticipates that HCC will make disclosures of PHI to the contractor so that the contractor may use the PHI to perform a business associate function on behalf of MAD relating to TPO. The written protections shall satisfy HIPAA privacy rule 45 CFR 164.504(e).

[8.300.2.19 NMAC – Rp 8.300.2.19, 7/01/2024]

8.300.2.20 MITIGATION:

A. HCC workforce: To the extent practicable, the HCC shall mitigate any harmful effect that is known to the HCC from an improper use or disclosure of a recipient's PHI by an HCC employee by applying the requirements set forth in the HCA HIPAA privacy policies and procedures applicable to an HCC workforce disciplinary action and training [45 CFR 164.530(f)]. See Sections 23 and 24 of 8.300.2 NMAC.

B. Business associates: To the extent practicable, the HCC will mitigate any harmful effect that is known to it from an improper use or disclosure of a recipient's PHI by any of its business associates by including language in its contracts with business associates that may impose fines and/or penalties to the business associate, up to and including immediate termination of a business associate's relationship with the HCC [45 CFR 164.530(f)]. [8.300.2.20 NMAC – Rp 8.300.2.20, 7/01/2024]

8.300.2.21 VERIFYING IDENTITY AND AUTHORITY: If the identity or authority of a requestor of PHI is unknown, the identity and authority of that requestor shall be verified prior to any disclosure [45 CFR 164.514(h)].

A. Identification: Upon receipt of a request for PHI, an authorized HCC employee must determine whether the requestor is a recipient or personal representative of a recipient.

(1) If the requestor is unknown to the authorized HCC employee, the employee shall request proof of identity, such as a photograph ID, credit card issued to the requestor, or medicaid card issued to the requestor.

(2) If the request is made over the phone, the HCC employee shall require proof of identity by asking for a social security number or omnicaid system ID.

(3) If the requestor is the recipient, a valid signed authorization satisfies the authority requirement.

(4) If the requestor is the recipient's personal representative, the HCC employee shall require proof of authority to act on the recipient's behalf.

(5) If the request for PHI disclosure is by a government official, and the government official's identity is unknown, the HCC employee shall verify the identity of the government official by viewing an agency identification badge or other official credentials.

(6) The HCC employee shall forward all requests for PHI for research purposes to the PSO. See 8.300.2.14 NMAC.

B. Authority: Once the identity of the government official is verified (or if already known), the HCC employee shall verify the authority of the request. If the disclosure of PHI is required by law, the employee shall disclose the PHI and record the disclosure in the PSO's database. If there are questions as to whether PHI disclosure is required by law, the employee shall seek assistance from OGC prior to any PHI disclosure.

(1) HCC shall forward all requests for PHI from subpoenas, legal requests, or for law enforcement purposes to OGC within two working days.

(2) For any requests for PHI received, OGC shall determine the identity of the requestor and the authority of the requestor. OGC then shall approve or deny the request and take the appropriate legal action.

C. Restrictions or amendments: If a valid authorization from an ISD location is received because a restriction or amendment is recorded in the PSO's database, the HCC shall take the following action.

(1) If a restriction is already documented, and the valid authorization from the recipient is asking for the restricted PHI to be disclosed, the HCC shall notify the recipient in writing within three working days that a previously set restriction must be revoked in writing by the recipient before the disclosure can be made.

(2) If an amendment is requested, within three working days the HCC shall determine if the PHI to be disclosed has been amended. If yes, the HCC shall disclose the amended PHI.

(3) The HCC shall record the disclosure in the PSO's database.
[8.300.2.21 NMAC – Rp 8.300.2.21, 7/01/2024]

8.300.2.22 SAFEGUARDING PROTECTED HEALTH INFORMATION: PHI shall be confidential and shall be subject to safeguarding procedures. PHI shall be restricted from the public [45 CFR 164.530(c)].

A. Restricting access to PHI: When meeting with recipients or their personal representative, HCC employees shall ensure that any PHI that does not belong to that recipient is not visible. If meeting with the general public, HCC employees shall ensure that no PHI is accessible or visible.

B. Computer monitors: The HCC workforce shall:

(1) ensure that all computer monitors that provide access to PHI that are located in an area accessible to or visible by the general public are not facing the public; and

(2) ensure that each computer monitor that provides access to PHI is locked with a password-protected screen saver or otherwise secure the computer monitor by a method approved by the PSO before leaving the computer monitor for any reason.

C. Facsimile machines: The HCC workforce shall:

(1) when a fax machine is located in an area accessible by the general public, remove incoming and outgoing faxes immediately; and

(2) prior to sending any fax document containing PHI, verify the disclosure is in accordance with 8.300.2.12 NMAC;

(a) apply the minimum necessary criteria in accordance with 8.300.2.16 NMAC;

(b) verify that the number to which the PHI is being sent is the correct number;

(c) determine if the disclosure is required to be recorded, in accordance with 8.300.2.15 NMAC; and

(d) record any required disclosure of PHI in the PSO's database in accordance with 8.300.2.15 NMAC.

D. Electronic mail: Prior to sending an e-mail that contains PHI, the HCC workforce shall:

(1) verify the disclosure is in accordance with 8.300.2.15 NMAC;

(2) apply the minimum necessary criteria in accordance with 8.300.2.16 NMAC;

(3) enter a notation referring to the confidential or sensitive nature of the information in the subject line to further safeguard the confidentiality of electronically submitted data;

(4) verify the recipient's e-mail address; and

(5) determine if the disclosure is required to be recorded in the PSO's database in accordance with 8.300.2.15 NMAC, and if so, record it.

E. Document disposal: When documents that contain PHI that are no longer needed and are not required to be retained under state of New Mexico records and archives requirements, authorized members of the HCC workforce shall request such records be destroyed in accordance with 1.13.30.9 NMAC.

(1) HCC workforce members shall destroy any form of paper that contains PHI by shredding or equivalent means as approved by the PSO. If a shredder is not available at the time the paper containing PHI needs to be destroyed, the papers shall be placed in a secure, locked environment until a shredder is available.

(2) Under no circumstances shall un-shredded paper containing PHI be placed in a trashcan, recycle bin or otherwise disposed of.

F. Physical security: The HCC shall have in place appropriate physical safeguards to protect the privacy of protected health information [45 CFR 164.530(c)].

G. Violations:

(1) The PSO shall perform random audits to assure compliance with this procedure and shall report any confirmed violation to the HCC workforce member's supervisor/coordinator.

(2) The PSO shall implement the appropriate disciplinary action and training (if applicable) described in 8.300.2.24 NMAC and record the confirmed violation and disciplinary action into the employee's file in the HCA office of human resources.

[8.300.2.22 NMAC – Rp 8.300.2.22, 7/01/2024]

8.300.2.23 STAFF TRAINING: All members of the HCC workforce shall be trained within appropriate timeframes on HIPAA privacy policies and procedures regarding the proper use and disclosure of PHI [45 CFR 164.530(b)].

A. Initial training: The HCC shall:

(1) develop a training plan with HCC supervisory staff involvement to determine the timing of and level of training appropriate to members of the HCC workforce;

(2) develop bureau-specific training curricula and materials; the training material shall be maintained for six years;

(3) provide bureau-specific training for the current HCC workforce no later than July 1, 2003; and

(4) ensure documentation of initial training completion and forward documentation to the HCA office of human resources.

B. Continuous training: For HCC workforce members who begin employment or whose job functions change subsequent to July 1, 2003, HCC shall:

(1) within one working day of start date, notify the PSO of the new HCC workforce member, and schedule training for the new workforce member to be completed within ten working days of the start date;

(2) for HCC workforce members whose job functions change, and who thus require a new level of training, notify the PSO and schedule the training prior to having the workforce member assume the new job duties; employees must successfully complete training within ten working days of their start date, and evidence of training must be provided to the HCA office of human resources; and

(3) the HCA office of human resources shall retain the original signed training documentation for six years.

C. Privacy policy changes: When changes are made to HCC policies or procedures or when HCC changes its privacy practices [45 CFR 164.530(b)], HCC shall:

(1) prepare relevant changes to the bureau-specific curricula;

(2) prepare changes to training materials;

(3) retain the training material for six years;

(4) after determining affected staff with supervisor involvement, develop a training plan;

(5) ensure that the HCC workforce successfully completes training and provide individual signed documentation of training to the PSO;

(6) the PSO shall forward the individual documentation of training to the HCA office of human resources; and

(7) the HCA office of human resources shall retain the original signed training documentation for six years.

[8.300.2.23 NMAC – Rp 8.300.2.23, 7/01/2024]

8.300.2.24 [**RESERVED**]
[8.300.2.24 NMAC – Rp 8.300.2.24, 7/01/2024]

8.300.2.25 [**RESERVED**]
[8.300.2.25 NMAC – Rp 8.300.2.25, 7/01/2024]

8.300.2.26 [**RESERVED**]
[8.300.2.26 NMAC – Rp 8.300.2.26, 7/01/2024]

8.300.2.27 [**RESERVED**]
[8.300.2.27 NMAC – Rp 8.300.2.27, 7/01/2024]

8.300.2.28 [**RESERVED**]
[8.300.2.28 NMAC – Rp 8.300.2.28, 7/01/2024]

HISTORY OF 8.300.2 NMAC: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID GENERAL INFORMATION
PART 6 RESPONSIBILITY AND DELEGATION OF AUTHORITY

8.300.6.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA).
[8.300.6.1 NMAC - Rp 8.300.6.1, 7/01/2024]

8.300.6.2 SCOPE: The rule applies to the general public.
[8.300.6.2 NMAC - Rp 8.300.6.2, 7/01/2024]

8.300.6.3 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 Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 2007). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.300.6.3 NMAC - Rp 8.300.6.3, 7/01/2024]

8.300.6.4 DURATION: Permanent
[8.300.6.4 NMAC - Rp 8.300.6.4, 7/01/2024]

8.300.6.5 EFFECTIVE DATE: April 15, 2009, unless a later date is cited at the end of a section.
[8.300.6.5 NMAC - Rp 8.300.6.5, 7/01/2024]

8.300.6.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.300.6.6 NMAC - Rp 8.300.6.6, 7/01/2024]

8.300.6.7 DEFINITIONS: [**RESERVED**]

8.300.6.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[8.300.6.8 NMAC - Rp 8.300.6.8, 7/01/2024]

8.300.6.9 RESPONSIBILITY AND DELEGATION OF AUTHORITY TO DIVISION: MAD administers the state medicaid program and other health care programs. MAD pays for medically necessary services furnished to eligible recipients who qualify for public assistance programs, institutional care programs, and optional programs under federal Social Security Act and other designated programs. See NMSA 1978 27-2-12 et seq. (Repl. Pamp. 2007). Coverage of services by medicaid is based on the federal Social Security Act, as amended, and subject to the appropriations and availability of federal and state funds. Administration may be provided through designated contractors and other state agencies.
[8.300.6.9 NMAC - Rp 8.300.6.9, 7/01/2024]

8.300.6.10 STATUS OF PROVIDER TO HEALTH CARE AUTHORITY: A provider, its agents and employees are independent contractors who perform professional services for eligible recipients served through health care programs administered by HCA or its authorized agents and are not employees of HCA, or the state of New Mexico. A provider shall not purport to bind neither HCA nor the state of New Mexico to any obligation not expressly authorized, unless HCA has given the provider express written permission to do so.
[8.300.6.10 NMAC - Rp 8.300.6.10, 7/01/2024]

HISTORY OF 8.300.6 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
SP-001.0400, Section 1, Single State Agency Organization State Medical Care Advisory Committee, filed 1/15/1981.
SP-004.0700, Section 4, General Program Administration Maintenance of Reports, filed 1/23/1981.

SP-001.0203, Section 1, Single State Agency Organization Professional Medical Personnel and Supporting Staff, filed 3/3/1981.
SP-004.0900, Section 4, General Program Administration Reporting Provider Payments to Internal Revenue Service, filed 3/3/1981.
SP-001.0202, Section 1, Single State Agency Organization and Function of Medical Assistance Unit, filed 3/11/1981.

History of Repealed Material:
8 NMAC 4.MAD.020, Responsibility and Delegation of Authority, filed 1/18/1995 - Repealed effective 4/15/2009.
8.300.6 NMAC, Responsibility and Delegation of Authority, filed 4/15/2009 - Repealed effective 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID GENERAL INFORMATION
PART 11 CONFIDENTIALITY

8.300.11.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.300.11.1 NMAC – Rp 8.300.11.1, 7/01/2024]

8.300.11.2 SCOPE: The rule applies to the general public.
[8.300.11.2 NMAC – Rp 8.300.11.2, 7/01/2024]

8.300.11.3 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 state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.300.11.3 NMAC – Rp 8.300.11.3, 7/01/2024]

8.300.11.4 DURATION: Permanent
[8.300.11.4 NMAC – Rp 8.300.11.4, 7/01/2024]

8.300.11.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.300.11.5 NMAC – Rp 8.300.11.5, 7/01/2024]

8.300.11.6 OBJECTIVE: The objective of these rules is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.300.11.6 NMAC – Rp 8.300.11.6, 7/01/2024]

8.300.11.7 DEFINITIONS: [RESERVED]

8.300.11.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[8.300.11.8 NMAC – Rp 8.300.11.8, 7/01/2024]

8.300.11.9 CONFIDENTIALITY: The following applicant and eligible recipient information is confidential and is safeguarded by the health care authority (HCA), all state agencies, their contractors and other authorized agents and all providers of MAD services. See 42 CFR 431.305(b) and 45 CFR 164.530(c):

A. name, address and social security number;
B. medical services furnished to the applicant and eligible recipient;
C. social and economic conditions or circumstances;
D. agency evaluation of personal information;
E. medical data, including diagnosis and past history of disease or disability;
F. information received to verify income eligibility and the amount of medical payments, including information received from the social security administration and the internal revenue service;
G. information received in connection with the identification of legally liable third parties;
H. telephone numbers;
I. fax numbers;
J. electronic mail addresses;
K. medical record numbers;
L. health plan beneficiary numbers;
M. account numbers; and
N. certificate/license numbers.

[8.300.11.9 NMAC – Rp 8.300.11.9, 7/01/2024]

8.300.11.10 CONFIDENTIALITY OF APPLICANT/RECIPIENT INFORMATION:

A. Safeguarding of confidential applicant and eligible recipient information includes the methods of receiving, maintaining, and communicating individually identifiable health information. See 45 CFR Section 164.530(c).

B. Confidentiality of medical information: Confidential information regarding applicants or eligible recipients will be available to those identified in 8.300.11.9 NMAC for use only in connection with the administration of the New Mexico medical assistance programs and only on a need-to-know basis. See 42 CFR Section 431.300-307. Those using confidential information will only use the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. See 45 CFR Section 164.502(b).

C. Use of confidential medical information: The following individuals have access to medical information: employees of private firms, other divisions within HCA or other state agencies who are performing work or providing services for MAD under contract or business associate agreement or who are providing services, as required by federal law; employees or agents of the federal department of health and human services; and providers of health care services to eligible recipients.

[8.300.11.10 NMAC – Rp 8.300.11.10, 7/01/2024]

8.300.11.11 CONFIDENTIALITY OF ELECTRONIC DATA:

A. Electronic transmission/reception of confidential information: To ensure that the confidential medical information of eligible recipients and applicants is kept confidential, transmission and reception of this information is limited to those individuals allowed to have access to medical information as stated in the use of confidential medical information policy (Paragraph (1) of Subsection B of 8.300.11.10 NMAC) and safeguarding protected health information policy 8.300.2.22 NMAC).

B. Provider participation: Providers who choose to send or receive confidential medical information via fax must have a dedicated fax line or fax machine. Confidential medical information should not be received at a commercial fax center where employees or customers may have access to the information. Providers who choose to send or receive confidential medical information via fax or email must follow the minimum necessary standard. See 45 CFR Section 164.502.

C. Responsibility for failure to follow rule: Providers who fail to adhere to this rule are solely liable for any consequences resulting from the use of this method of transmitting confidential medical information, including any attorney fees, costs or damages. MAD shall mitigate any harmful effect from improper disclosure of individually identifiable health information in accordance with 45 CFR Section 164.530(f).

[8.300.11.11 NMAC – Rp 8.300.11.11, 7/01/2024]

HISTORY OF 8.300.11 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 327.0000, Confidentiality of Information, filed 5/8/80.

SP-004.0300, Section 4, General Program Administration Safeguarding Information on Applicants and Recipients, filed 1/23/81.

History of Repealed Material:

8 NMAC 4.MAD.034.2, Electronic Data Transfer of Medical Records - Repealed 5/31/97.

8 NMAC 4.MAD.034.21, Notice Prior to Transmission - Repealed 5/31/97.

8 NMAC 4.MAD.034.22, Responsibility for Failure to Follow Policy - Repealed 5/31/97.

8.300.11 NMAC, Medicaid General Eligibility, filed 5/31/1997 – Repealed effective 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID GENERAL INFORMATION
PART 17 CONFLICT OF INTEREST

8.300.17.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.300.17.1 NMAC – Rp 8.300.17.1, 7/01/2024]

8.300.17.2 SCOPE: The rule applies to the general public.
[8.300.17.2 NMAC – Rp 8.300.17.2, 7/01/2024]

8.300.17.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.300.17.3 NMAC – Rp 8.300.17.3, 7/01/2024]

8.300.17.4 DURATION: Permanent
[8.300.17.4 NMAC – Rp 8.300.17.4, 7/01/2024]

8.300.17.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.300.17.5 NMAC – Rp 8.300.17.5, 7/01/2024]

8.300.17.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.300.17.6 NMAC – Rp 8.300.17.6, 7/01/2024]

8.300.17.7 DEFINITIONS: [**RESERVED**]

8.300.17.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.300.17.8 NMAC – Rp 8.300.17.8, 7/01/2024]

8.300.17.9 CONFLICT OF INTEREST: To prevent any former employee of the medical assistance division (MAD) from using privileged information or asserting improper influence, statutory provisions have been adopted. See Section 10-16-16 NMSA 1978 (Repl. Pamp. 1991):

A. An employee with "responsibility" must not act as agent or attorney for any other person or business in connection with a judicial or administrative proceeding, application, ruling, contract, claim or other matter relative to the medicaid program for twenty-four (24) months following the date on which he/she ceases to be an employee.

(1) Employee with "responsibility" refers to an employee who is directly involved in or has a significant part in the medicaid decision-making, regulatory, procurement or contracting process.

(2) This provision applies to employees with responsibility for investigating, making rulings or otherwise being substantially or directly involved with activities during their last year of employment with the agency.

(3) This provision also applies to activities which were actually pending and under the employee's responsibility within that period.

B. The secretary of the health care authority (secretary), income support division director, administrative services division or medical assistance director or their deputies must not participate in any judicial or administrative proceeding, application, ruling, contract, claim or other matter relating to medicaid and pending before MAD for twelve (12) months following the date he/she ceases to be an employee.

C. An employee with responsibility must not participate in any judicial or administrative proceeding, application, ruling, contract, claim or other matter relating to medicaid which involved his/her spouse, minor child or any business in which he/she has financial interest, unless prior to each participation:

(1) the employee fully discloses the relationship or financial interest in writing to the secretary; and

(2) a written determination is made by the secretary that the disclosed employee relationship or financial interest is too remote or inconsequential to affect the integrity of the employee's services.

[8.300.17.9 NMAC – Rp 8.300.17.9, 7/01/2024]

8.300.17.10 PENALTIES: Violation of any of the above provisions by an employee is grounds for dismissal, demotion or suspension. A former employee who violates any of the provisions is subject to assessment by the health care authority (authority) of a civil monetary penalty of two hundred and fifty dollars ($250.00) for each violation. MAD shall mitigate any harmful effect from improper disclosure of individually identifiable health information in accordance with 45 CFR Section 164.530(f). Any employee or former employee who violates these provisions may also be subject to criminal prosecution. See Section 10-16-17 NMSA 1978 (Cum. Supp. 1993).

[8.300.17.10 NMAC – Rp 8.300.17.10, 7/01/2024]

8.300.17.11 APPEAL PROCESS: A request for appeal from the imposition of an administrative sanction must be made to the secretary within thirty (30) days of the date on the written notification of a penalty assessment. Unless a proper request is received by the secretary within the thirty (30) day limit, the authority findings are considered a final and binding administrative determination.

[8.300.17.11 NMAC – Rp 8.300.17.11, 7/01/2024]

HISTORY OF 8.300.17 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 301.2000, Provider Agreement, filed 12/21/1979.
ISD 301.2000, Provider Agreement, filed 12/4/1980.
MAD Rule 301, Procedures and Requirements for Provider Participation, filed 11/8/1989.
SP-004.2900, Section 4, General Program Administration Conflict of Interest Provisions, filed 3/5/1981.
ISD 301.3000, Confidentiality, filed 12/21/1979.
ISD 301.4000, Public Disclosure of Information, filed 1/7/1980.
ISD 301.4000, Public Disclosure of Information, filed 11/24/1980.

History of Repealed Material:

MAD Rule 301, Procedures and Requirements for Provider Participation, filed 11/8/1989 - Repealed effective 2/1/1995.
8.300.17.1 NMAC, Medicaid General Information, filed 2/1/1995 – Repealed effective 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID GENERAL INFORMATION
PART 21 MEDICAL ASSISTANCE DIVISION POLICY MANUAL

8.300.21.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA).
[8.300.21.1 NMAC – Rp 8.300.21.1, 7/01/2024]

8.300.21.2 SCOPE: The rule applies to the general public.
[8.300.21.2 NMAC – Rp 8.300.21.2, 7/01/2024]

8.300.21.3 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 Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 2007). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.300.21.3 NMAC – Rp 8.300.21.3, 7/01/2024]

8.300.21.4 DURATION: Permanent
[8.300.21.4 NMAC – Rp 8.300.21.4, 7/01/2024]

8.300.21.5 EFFECTIVE DATE: April 15, 2009, unless a later date is cited at the end of a section.
[8.300.21.5 NMAC – Rp 8.300.21.5, 7/01/2024]

8.300.21.6 OBJECTIVE: The objective of these rules is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.300.21.6 NMAC – Rp 8.300.21.6, 7/01/2024]

8.300.21.7 DEFINITIONS: [**RESERVED**]

8.300.21.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of eligible recipients by furnishing payment for quality health services at levels comparable to private health plans.
[8.300.21.8 NMAC – Rp 8.300.21.8, 7/01/2024]

8.300.21.9 MEDICAL ASSISTANCE DIVISION POLICY MANUAL: The MAD rule manual (the manual) contains detailed information about the New Mexico medical assistance programs. It is intended for use by all participating providers who furnish health services, MAD applicants/recipients, health care authority employees and designees, contractors, and all other interested parties.

A. Purpose of the manual: The purpose of the manual is to provide an overview of general rules on the administration and financing of medicaid and other health care programs administered by MAD, recipient eligibility, coverage of services, and reimbursement by provider group. Once enrolled, MAD providers receive instructions on how to access instructions, and other pertinent materials. The MAD eligibility manual sections are available at the HCA website or other program specific websites.

B. Updating manual: To ensure that MAD rules contained in this manual remains current, providers, local county ISD offices, and other interested parties on the mailing list are notified of updates at the conclusion of the publication process. The finalized rules are available on the HCA website or other program specific websites for viewing and copying.

(1) Rule updates are distributed in the form of New Mexico medical assistance manual revisions (MAD-MR). Each MAD-MR provides the rationale for the rule revision, specific changes, and instructions for updating the affected manual sections.

(2) Updates for claims processing, prior authorization, and utilization review instructions for providers are distributed in the form of MAD supplements.
[8.300.21.9 NMAC – Rp 8.300.21.9, 7/01/2024]

HISTORY OF 8.300.21 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

SP-004.0800, Section 4, General Program Administration Availability of Agency Program Manuals, filed 1/23/81.

History of Repealed Material:
8 NMAC 4.MAD.080, Medical Assistance Division Policy Manual, filed 1/18/1995 - Repealed effective 4/15/2009.
8.300.21 NMAC, Medical Assistance Division Policy Manual, filed 4/15/2009 - Repealed effective 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 301 MEDICAID GENERAL BENEFIT DESCRIPTION
PART 5 MEDICAL MANAGEMENT

8.301.5.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.301.5.1 NMAC – Rp 8.301.5.1, 7/01/2024]

8.301.5.2 SCOPE: The rule applies to the general public.
[8.301.5.2 NMAC – Rp 8.301.5.2, 7/01/2024]

8.301.5.3 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 health care authority pursuant to state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.301.5.3 NMAC – Rp 8.301.5.3, 7/01/2024]

8.301.5.4 DURATION: Permanent.
[8.301.5.4 NMAC – Rp 8.301.5.4, 7/01/2024]

8.301.5.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.301.5.5 NMAC – Rp 8.301.5.5, 7/01/2024]

8.301.5.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.301.5.6 NMAC – Rp 8.301.5.6, 7/01/2024]

8.301.5.7 DEFINITIONS: [**RESERVED**]

8.301.5.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.301.5.8 NMAC – Rp 8.301.5.8, 7/01/2024]

8.301.5.9 MEDICAL MANAGEMENT: The New Mexico medicaid program (medicaid) pays for medically necessary medical services furnished to medicaid recipients. To make sure that recipients receive only necessary services, the New Mexico medical assistance division (MAD) has developed the medical management program. The medical management program is designed to enhance the receipt of health care to a recipient by assigning a designated provider. This may also reduce the use of unnecessary services by medicaid recipients in certain instances. See 42 CFR 431.54(e). Medical management involves the identification of appropriate cases, selection of actual cases, documentation of the health care issue(s) necessitating management, development of assignment recommendations, and evaluation of the effectiveness of the assignments. The medical assistance division (MAD) medical director or another physician specifically appointed by MAD determines whether recipients are assigned to the medical management program.
[8.301.5.9 NMAC – Rp 8.301.5.9, 7/01/2024]

8.301.5.10 SERVICES EXCLUDED FROM MEDICAL MANAGEMENT: Recipients can receive emergency services and inpatient services without referrals from their designated providers. These services are exempt from medical management. Emergency room claims for services provided to any recipient may be reviewed before or after payment. Inappropriate non-emergency use of emergency room services results in denial of payment by medicaid and liability of the recipient for payment.
[8.301.5.10 NMAC – Rp 8.301.5.10, 7/01/2024]

8.301.5.11 IDENTIFICATION OF CANDIDATES: All medicaid recipients are potential candidates for inclusion in medical management, whether enrolled in Salud! or covered under medicaid fee-for-service. Recipients are identified as candidates for review by HCA, the MCO, a provider or other appropriate entities. The following situations may indicate a need for medical management:

A. individuals who overutilize medical services;

B. individuals who are habitually non-compliant and miss appointments, or who frequently seek unauthorized treatment or care; and

C. individuals who frequently change PCPs or simultaneously utilize multiple pharmacy providers;

D. individuals who regularly utilize emergency room services for inappropriate, non-emergency care.

[8.301.5.11 NMAC – Rp 8.301.5.11, 7/01/2024]

8.301.5.12 SELECTION FOR MEDICAL MANAGEMENT: HCA staff analyzes appropriate reports and documentation to decide whether a recipient will be referred to the MAD medical director for medical management determination. After reviewing HCA staff recommendations and supporting documentation, the MAD medical director or another physician designated by MAD determines whether the recipient should be assigned to medical management. Once the determination is made by the physician, the assignment of the recipient to medical management is implemented by MAD. The assignment is subject to the notice requirements and hearing process described in Section 15 of 8.301.5, *Recipient Notice* and Section 16 of 8.301.5, *Recipient Hearings*.

A. Notification of decision: The HCA staff notifies the recipient, the claims processing contractor, the income support division (ISD), and, if enrolled in Salud!, the MCO, of the medical management assignments. Providers are informed that a client is in medical management at the time the provider verifies the client's eligibility for the date the services are provided. Recipients placed in medical management receive medicaid identification cards which indicate "medical management" and the names of their "designated providers".

B. Assignments for recipients covered by third party insurers: Recipients who are eligible for medicare and medicaid services or recipients who have insurance can be assigned to a designated provider for services covered exclusively by medicaid. Recipients in managed care plans are assigned to designated providers who participate in the recipient's plan.

[8.301.5.12 NMAC – Rp 8.301.5.12, 7/01/2024]

8.301.5.13 DESIGNATED PROVIDERS: Recipients who are in medical management are assigned to designated providers based on their specific health care situation. Recipients may be assigned to a designated provider who manages the recipient's overall receipt of health services by making referrals, a designated provider who furnishes only specialty services, or both. Medicaid payment for medical services is restricted to designated providers. Other providers can receive payment for services furnished to a recipient in medical management only with a referral from the designated provider. If a recipient is assigned a designated psychiatrist, only that psychiatrist is reimbursed by medicaid or the MCO for providing outpatient psychiatric services to the recipient, unless the designated psychiatrist determines that it is medically necessary for the recipient to be referred to a second psychiatrist. If a recipient is assigned a designated general provider, only that provider is reimbursed by medicaid or the MCO for providing outpatient services to the recipient, unless the designated general provider determines that it is medically necessary for the recipient to be referred to a secondary provider. If a recipient is assigned a designated pharmacy provider, only that provider is reimbursed by medicaid fee-for-service or the MCO.

A. Selection of designated providers: Providers of outpatient services are selected as "designated providers". The following guidelines are used to select a provider:

(1) the provider must be a medicaid fee-for-service or MCO contracted provider;

(2) the provider agrees to act in the capacity of a designated provider;

(3) the geographic location of the provider must not significantly impair or impede the recipient's access to services; and

(4) when feasible, the provider is one with whom the recipient has previously established a medically-beneficial relationship;

(5) if the designated provider is not the recipient's PCP, then the provider must coordinate with the recipient's PCP.

B. Changing designated providers: When any of the following circumstances occur, the MAD medical director or another physician designated by MAD can approve a request to change the designated providers permanently:

(1) the recipient moves from the geographic area of the designated provider;

(2) the recipient's medical condition changes and the designated provider is unable to furnish care or refer the recipient to an appropriate provider;

(3) the designated provider is no longer available or gives notice that he is no longer willing to serve as a designated provider; or

(4) the designated provider no longer participates in the medicaid program.

[8.301.5.13 NMAC – Rp 8.301.5.13, 7/01/2024]

8.301.5.14 REEVALUATION OF ASSIGNMENT: Initial medical management assignments are reevaluated by the HCA staff within a year of the effective date of the assignment or from the date of reevaluation. The reevaluation focuses on whether assignments met the objectives identified in the HCA staff recommendation or whether the initial assignments need modification. A reevaluation is conducted using information similar to that used in the initial medical management assignment analysis. If continuation or modification of an assignment is necessary, the reasons for the action are documented in the case file. The MAD medical director or another physician designated by MAD makes the final decision as to whether the assignment needs to be continued, modified or removed.

A. Medicaid eligibility changes: Changes in recipient eligibility status do not affect the status of a recipient in medical management or the reevaluation process. If a recipient on medical management becomes ineligible for medicaid benefits but later becomes medicaid eligible within the assignment period, the recipient remains in medical management.

B. Removal from the medical management program: Recipients are removed from medical management by HCA staff when the specific situation necessitating medical management has been resolved.

[8.301.5.14 NMAC – Rp 8.301.5.14, 7/01/2024]

8.301.5.15 RECIPIENT NOTICE: The medical assistance division gives a recipient and the MCO, if the recipient is enrolled in Salud!, 13 working days notice of the decision to place the recipient in medical management. Notice is given for the initial imposition of the assignment, modification of the assignment, or continuation of the assignment.

A. Time constraints: A recipient can submit a request for a hearing of his assignment into medical management, assignment of the designated providers, modification, or continuation of the assignment. If the recipient requests a hearing within the time frame established in Section 16 of 8.301.5, *Recipient Hearing*, the proposed assignment shall remain imposed until a hearing decision states otherwise.

B. Information contained in the notice: The recipient notice contains the following information [42 CFR 431.210]:

(1) statement describing the action MAD intends to take;

(2) reasons for the intended action;

(3) specific state or federal regulations supporting the action or change(s) in the law which require the action;

(4) explanation of the recipient's right to request an administrative hearing and the method and timetable by which the hearing can be requested;

(5) statement explaining the recipient's right to be represented at the administrative hearing by legal counsel, a friend, or other representative;

(6) explanation of the circumstances under which the benefits are continued; and

(7) effective date of the assignment.

[8.301.5.15 NMAC – Rp 8.301.5.15, 7/01/2024]

8.301.5.16 RECIPIENT HEARING: A recipient has a right to request a hearing regarding the MAD decision to assign the recipient into medical management. The request must be submitted to the quality assurance bureau of MAD, the health care authority (HCA) hearing bureau or the local ISD office within 90 days of the date the notice of action was postmarked. See 8.352.2 NMAC, *Recipient Hearings*.

[8.301.5.16 NMAC – Rp 8.301.5.16, 7/01/2024]

HISTORY OF 8.301.5 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:

ISD 325.0000, Medical Care Management, 5/6/1980.

ISD-Rule 325.0000, Medical Care Management, 1/29/1986.

MAD Rule 325.00, Medical Care Management, 3/14/1994.
SP-004.1400, Section 4, General Program Administration Utilization Control, 3/3/1981.

History of Repealed Material:
MAD Rule 325.00, Medical Management Program, Repealed, 1/8/1995.
8.301.5 NMAC, Medical Management Program, filed 1/08/1995 – Repealed effective 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 301 MEDICAID GENERAL BENEFIT DESCRIPTION
PART 6 CLIENT MEDICAL TRANSPORTATION SERVICES

8.301.6.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA).
[8.301.6.1 NMAC – Rp 8.301.6.1, 7/01/2024]

8.301.6.2 SCOPE: The rule applies to the general public.
[8.301.6.2 NMAC – Rp 8.301.6.2, 7/01/2024]

8.301.6.3 STATUTORY AUTHORITY: The New Mexico medicaid and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.301.6.3 NMAC – Rp 8.301.6.3, 7/01/2024]

8.301.6.4 DURATION: Permanent
[8.301.6.4 NMAC – Rp 8.301.6.4, 7/01/2024]

8.301.6.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.301.6.5 NMAC – Rp 8.301.6.5, 7/01/2024]

8.301.6.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.301.6.6 NMAC – Rp 8.301.6.6, 7/01/2024]

8.301.6.7 DEFINITIONS: [**RESERVED**]

8.301.6.8 MISSION STATEMENT: To reduce the impact of poverty on the people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[8.301.6.8 NMAC – Rp 8.301.6.8, 7/01/2024]

8.301.6.9 CLIENT MEDICAL TRANSPORTATION SERVICES: The medical assistance division (MAD) covers expenses for transportation, meals and lodging it determines are necessary to secure MAD covered medical examination and treatment for eligible recipients in or out of their home community [42 CFR 440.170]. Travel expenses include the cost of transportation by long distance common carrier, taxicab, handivan, and ground or air ambulance, all as appropriate to the situation and location of the eligible recipient. When medically necessary, MAD covers similar expenses for an attendant who accompanies the eligible recipient to the medical examination or treatment.
[8.301.6.9 NMAC – Rp 8.301.6.9, 7/01/2024]

8.301.6.10 COVERED SERVICES AND SERVICE LIMITATIONS: MAD reimburses eligible recipients or transportation providers for medically necessary transportation subject to the following:

A. Free alternatives: Alternative transportation services which may be provided free of charge, include volunteers, relatives or transportation services provided by nursing facilities or other residential centers. An eligible recipient must certify in writing that they do not have access to free alternatives.

B. Least costly alternatives: MAD covers the most appropriate and least costly transportation alternatives suitable for the eligible recipient's medical condition. If an eligible recipient can use private vehicles or public transportation, those alternatives must be used before the eligible recipient can use more expensive transportation alternatives.

C. Non-emergency transportation service: MAD covers non-emergency transportation services for an eligible recipient who does not have primary transportation and who is unable to access a less costly form of public transportation.

D. Long distance common carriers: MAD covers long distance services furnished by a common carrier if the eligible recipient must leave their home community to receive medical services. Authorization forms for direct payment to long distance bus common carriers by MAD are available through the eligible recipient's local county income support division (ISD) office.

E. Ground ambulance services: MAD covers services provided by ground ambulances when:

(1) an emergency which requires ambulance service is certified by a physician or is documented in the provider's records as meeting emergency medical necessity as defined as:

(a) an emergency condition that is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part; and

(b) "medical necessity" for ambulance services is established if the eligible recipient's condition is such that the use of any other method of transportation is contraindicated and would endanger the eligible recipient's health;

(2) scheduled, non-emergency ambulance services are ordered by a physician who certifies that the use of any other method of non-emergency transportation is contraindicated by the eligible recipient's medical condition; and

(3) MAD covers non-reusable items and oxygen required during transportation; coverage for these items are included in the base rate reimbursement for ground ambulance.

F. Air ambulance services: MAD covers services provided by air ambulances, including private airplanes, if an emergency exists and the medical necessity for the service is certified by the physician.

(1) An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

(2) MAD covers the following services for air ambulances:

(a) non-reusable items and oxygen required during transportation;

(b) professional attendants required during transportation; and

(c) detention time or standby time up to one hour without physician documentation; if the detention or standby time is more than one hour, a statement from the attending physician or flight nurse justifying the additional time is required.

G. Lodging services: MAD covers lodging services if recipients are required to travel to receive medical services more than four hours one way and an overnight stay is required due to medical necessity or cost considerations. If medically justified and approved, lodging is initially set for up to five continuous days. For a longer stay, the need for lodging must be re-evaluated by the fifth day to authorize up to an additional 15 days. Re-evaluation must be made every 15 days for extended stays, prior to the expiration of the existing authorization. Approval of lodging is based on the medical provider's statement of need. Authorization forms for direct payment to medicaid lodging providers by MAD are available through local county income support division (ISD) offices.

H. Meal services: Medicaid covers meals if a recipient is required to leave their home community for eight hours or more to receive medical services. Authorization forms for direct payment to medicaid meal providers by MAD are available through local county ISD offices.

I. Coverage for attendants: MAD covers transportation, meals and lodging in the same manner as for an eligible recipient, for one attendant if the medical necessity for the attendant is certified in writing by the eligible recipient's medical provider or the eligible recipient who is receiving medical service is under 18 years of age. If the medical appointment is for an adult recipient, MAD does not cover transportation services or related expenses of children under 18 years of age traveling with the adult recipient.

J. Coverage for medicaid waiver recipients: Transportation of a medicaid waiver recipient to a provider of a waiver service is only covered when the service is occupational therapy, physical therapy, speech therapy and behavioral therapy services.

K. Medicaid family planning waiver eligible recipients: MAD does not cover transportation service for recipients eligible for medicaid family planning waiver services.

[8.301.6.10 NMAC – Rp 8.301.6.10, 7/01/2024]

8.301.6.11 NONCOVERED SERVICES: Transportation services are subject to the same limitations and coverage restrictions which exist for other services. A payment for transportation to a MAD non-covered service is subject to retroactive recoupment. MAD does not cover the following services or related costs of travel:

A. attendants where there is not required certification from the eligible recipient's medical provider;

B. minor aged children of the eligible recipient that are simply accompanying the eligible recipient to medical services;

C. transportation to a non-covered MAD service;

D. transportation to a pharmacy provider. See Subsection F of 8.324.14.18 NMAC, *transportation services.* See Section 8.301.3 NMAC, *General Noncovered Services*.

[8.301.6.11 NMAC – Rp 8.301.6.11, 7/01/2024]

8.301.6.12 OUT-OF-STATE TRANSPORTATION AND RELATED EXPENSES: All out-of-state transportation, meals and lodging must be prior approved by MAD. Out-of-state transportation is approved only if the out-of-state medical service is approved. Documentation must be available to the reviewer to justify the out-of-state travel and verify that treatment is not available in the state of New Mexico.

A. Requests for out-of-state transportation must be coordinated through the MAD client services bureau or MAD's designated contractor.

B. Authorization for lodging and meal services by out-of-state providers can be granted for up to 30 calendar days by MAD. Re-evaluation authorizations are completed prior to expiration and every 30 days, thereafter.

C. Transportation to border cities, those cities within 100 miles of the New Mexico border (Mexico excluded), are treated as in-state provider service. An eligible recipient who receives MAD reimbursable services from a border area provider is eligible for transportation services to that provider. See 8.302.4 NMAC, *Out of State and Border Area Providers,* to determine when a provider is considered an out-of-state provider or a border area provider.

[8.301.6.12 NMAC – Rp 8.301.6.12, 7/01/2024]

8.301.6.13 CLIENT MEDICAL TRANSPORTATION FUND: In non-emergency situations, an eligible recipient can request reimbursement from the client medical transportation (CMT) fund through their local county ISD office for money they spend on transportation, meals and lodging. For reimbursement from the CMT fund, an eligible recipient must apply for reimbursement within 30-calendar days after the appointment.

A. Information requirements: The following information must be furnished to the ISD CMT fund custodian within 30-calendar days of the provider visit to receive reimbursement:

(1) submit a letter on the provider's stationary which indicates that the eligible recipient kept the appointment(s) for which the CMT fund reimbursement is requested; for medical services, written receipts confirming the dates of service must be given to the eligible recipient for submission to the local county ISD office;

(2) proper referral with original signatures and documentation stating that the services are not available within the community from the designated MAD medical management provider or MAD primary care provider, when a referral is necessary;

(3) verification of current eligibility for a MAD service for the month the appointment and travel are made;

(4) certification that free alternative transportation services are not available and that the recipient is not enrolled in a managed care organization;

(5) verification of mileage; and

(6) documentation justifying a medical attendant.

B. Fund advances in emergency situations: Money from the CMT fund is advanced for travel only if an emergency exists. "Emergency" is defined in this instance as a non-routine, unforeseen accident, injury or acute illness demanding immediate action and for which transportation arrangements could not be made five calendar days in advance of the visit to the provider. Advance funds must be requested and disbursed prior to the medical appointment.

(1) The ISD CMT fund custodian or a MAD fee-for-service coordinated service contractor or the appropriate utilization contractor verifies that the recipient is eligible for a MAD service and has a medical appointment prior to advancing money from the CMT fund and that the recipient is not enrolled in a managed care organization.

(2) Written referral for out of community service must be received by the CMT fund custodian or a MAD fee-for-service coordinated service contractor or the appropriate utilization contractor no later than 30-calendar days from the date of the medical appointment for which the advance funds were requested. If an eligible recipient fails to provide supporting documentation, recoupment proceedings are initiated. See Section OIG-900, Restitutions.
[8.301.6.13 NMAC – Rp 8.301.6.13, 7/01/2024]

8.301.6.14 CMT REIMBURSEMENT RATES: Reimbursement for lodging and meal expenses is based on the MAD allowable fee schedule. The CMT fund reimbursement rate for transportation services and related expenses are:

A. private automobile use is reimbursed by the mile, based on the established MAD reimbursement schedule;

B. meals are reimbursed at the rate established by MAD; authorization forms used for direct payment to medicaid meal providers by MAD are available through the recipient's local county ISD office;

C. lodging is reimbursed at the rate established by MAD; authorization forms for direct payment to medicaid lodging providers by MAD are available through the recipient's local county ISD office; and

D. the CMT fund reimbursement rate for transportation services is at the established MAD reimbursement schedule per mile when a private automobile is used.
[8.301.6.14 NMAC – Rp 8.301.6.14, 7/01/2024]

HISTORY OF 8.301.6 NMAC: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID GENERAL PROVIDER POLICIES
PART 1 GENERAL PROVIDER POLICIES

8.302.1.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.302.1.1 NMAC - Rp, 8.302.1.1 NMAC, 7/01/2024]

8.302.1.2 SCOPE: The rule applies to the general public.
[8.302.1.2 NMAC - Rp, 8.302.1.2 NMAC, 7/01/2024]

8.302.1.3 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 state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.302.1.3 NMAC - Rp, 8.302.1.3 NMAC, 7/01/2024]

8.302.1.4 DURATION: Permanent.
[8.302.1.4 NMAC - Rp, 8.302.1.4 NMAC, 7/01/2024]

8.302.1.5 EFFECTIVE DATE: January 1, 2023, unless a late date is cited at the end of a section.
[8.302.1.5 NMAC - Rp, 8.302.1.5 NMAC, 7/01/2024]

8.302.1.6 OBJECTIVE: The objective of these rules is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.302.1.6 NMAC - Rp, 8.302.1.6 NMAC, 7/01/2024]

8.302.1.7 DEFINITIONS: Medically necessary services

A. Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

(1) are essential to prevent, diagnose or treat medical conditions or are essential to enable an eligible recipient to attain, maintain or regain functional capacity;

(2) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral health care needs of the eligible recipient;

(3) are provided within professionally accepted standards of practice and national guidelines; and

(4) are required to meet the physical and behavioral health needs of the eligible recipient and are not primarily for the convenience of the eligible recipient, the provider or the payer.

B. Application of the definition:

(1) A determination that a service is medically necessary does not mean that the service is a covered benefit or an amendment, modification or expansion of a covered benefit, such a determination will be made by MAD or its designee.

(2) The authority or its authorized agent making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the specific program's benefit package applicable to an eligible recipient shall do so by:

(a) evaluating the eligible recipient's physical and behavioral health information provided by qualified professionals who have personally evaluated the eligible recipient within their scope of practice, who have taken into consideration the eligible recipient's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate;

(b) considering the views and choices of the eligible recipient or their personal representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

(c) considering the services being provided concurrently by other service delivery systems.

(3) Physical and behavioral health services shall not be denied solely because the eligible

recipient has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition.

(4) Decisions regarding MAD benefit coverage for eligible recipients under 21 years of age shall be governed by the early periodic screening, diagnosis and treatment (EPSDT) coverage rules.

(5) Medically necessary service requirements apply to all medical assistance program rules.

[8.302.1.7 NMAC - Rp, 8.302.1.7 NMAC, 7/01/2024]

8.302.1.8 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.

[8.302.1.8 NMAC - Rp, 8.302.1.8 NMAC, 7/01/2024]

8.302.1.9 GENERAL PROVIDER POLICIES: Medically necessary services are reimbursed by the MAD under Title XIX of the Social Security Act as amended, or by state statute.

[8.302.1.9 NMAC - Rp, 8.302.1.9 NMAC, 7/01/2024]

8.302.1.10 ELIGIBLE PROVIDERS:

A. Upon the approval of a New Mexico MAD provider participation agreement by MAD or its designee, a licensed practitioner or facility that meets applicable requirements is eligible to be reimbursed for furnishing covered services to an eligible program recipient. A provider must be enrolled before submitting a claim for payment to the appropriate MAD claims processing contractor. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billings instructions, utilization review instructions, and other pertinent materials. When enrolled, providers receive instructions on how to access these documents. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to request hard copies of any program rules manuals, billing and utilization review instructions, and other pertinent materials and to obtain answers to questions on or not covered by these materials. To be eligible for reimbursement, a provider is bound by the provisions of the MAD provider participation agreement and all applicable statutes, regulations and executive orders.

B. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[8.302.1.10 NMAC - Rp, 8.302.1.10 NMAC, 7/01/2024]

8.302.1.11 PROVIDER RESPONSIBILITIES AND REQUIREMENTS: A provider who furnishes services to a medicaid eligible recipient agrees to comply with all federal and state laws, regulations, and executive orders relevant to the provision of services. A provider also must conform to MAD program rules, instructions, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. A provider must verify that individuals are eligible for a specific health care program administered by the HCA and its authorized agents and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

A. Eligibility determination: A provider must verify recipient eligibility prior to providing services and verify that the recipient remains eligible throughout periods of continued or extended services.

(1) A provider may verify eligibility through several mechanisms, including using the automated voice response system, contacting MAD or designated contractor eligibility help desks, contracting with an eligibility verification system vendor, or by using the New Mexico medicaid portal.

(2) An eligible recipient becomes financially responsible for a provider claim if the eligible recipient:

(a) fails to identify themselves as a MAD eligible recipient; or

(b) fails to state that an eligibility determination is pending; or

(c) fails to furnish MAD identification before the service is rendered and MAD denies payment because of the resulting inability of the provider to be able to file a claim timely; or

(d) receives services from a provider that lacks MAD enrollment, is not eligible to provide the services or does not participate in MAD programs.

B. Requirements for updating information: A provider must furnish MAD or the appropriate MAD claims processing contractor with complete information on changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability of the provider for any recoverable obligation to MAD which occurred or may have occurred prior to any sale, merger, consolidation, dissolution or other disposition of the provider or person. MAD or the appropriate MAD claims processing contractor must receive this information at least 60 calendar days before the change. Any payment made by MAD based upon erroneous or outdated information is subject to recoupment or provider repayment. The provider must provide MAD with information, in writing, updating their provider participation agreement of any conviction of delineated criminal or civil offenses against the provider or parties with direct or indirect ownership or controlling interest within ten calendar days after the conviction.

C. Additional requirements: A provider must meet all other requirements stated in the program rules, billing instructions, manual revisions, supplements, and signed application forms or re-verification forms, as updated. MAD may require a letter of credit, a surety bond, or a combination thereof, from the provider. The letter of credit, surety bond or combination thereof may be required if any one of the following conditions is met:

(1) the provider is the subject of a state or federal sanction or of a criminal, civil, or departmental proceeding in any state;

(2) a letter of credit, surety bond, or any combination thereof is required for each provider of a designated provider type;

(3) the provider cannot reasonably demonstrate that they have assumed liability and are responsible for paying the amount of any outstanding recoveries to MAD as the result of any sale, merger, consolidation, dissolution, or other disposition of the provider or person; or

(4) the secretary determines that it is in the best interest of MAD to do so, specifying the reasons.

[8.302.1.11 NMAC - Rp, 8.302.1.11 NMAC, 7/01/2024]

8.302.1.12 ELIGIBLE MEDICAID RECIPIENTS: To comply with Title XIX of the Social Security Act, as amended, MAD is required to serve certain groups of eligible recipients and has the option of paying for services provided to other eligible recipient groups [42 CFR 435.1]. MAD is also required to pay for emergency services furnished to non-citizens residing in New Mexico who are not lawfully admitted for permanent residence but who otherwise meet the eligibility requirements. Coverage is restricted to those services necessary to treat an emergency medical condition, which includes labor and delivery services. See 8.325.10.3 NMAC.

A. Recipient eligibility determination: To be eligible to receive MAD benefits, an applicant/recipient must meet general eligibility or resource and income requirements. These requirements vary by category of eligibility and may vary between health care programs. See 8.200 NMAC for information on medicaid eligibility requirements.

(1) An otherwise eligible recipient who is under the jurisdiction or control of the correctional system or resides in a public institution is not eligible for medicaid.

(2) MAD eligibility determinations are made by the following agencies:

(a) the staff of the income support division (ISD) county offices determines eligibility for medicaid categories of eligibility;

(b) the staff of the New Mexico children, youth and families department (CYFD) determines eligibility for child protective services, adoptive services and foster care children;

(c) the staff of the social security administration determines eligibility for social security income (SSI); and

(d) the staff of a federally qualified health center, a maternal and child health services block grant program, the Indian health service, and other designated agents make presumptive eligibility determinations.

B. Recipient freedom of choice: Unless otherwise restricted by specific health care program rules, an eligible recipient has the freedom of choice to obtain services from in-state and border providers who meet the requirements for MAD provider participation. Some restrictions to this freedom of choice apply to an eligible recipient who is assigned to a provider or providers in the medical management program (45 CFR 431.54 (e)). See 301.5 NMAC, *Medical Management.* Some restrictions to this freedom of choice may also apply to purchases of medical devices, and laboratory and radiology tests and other services and items as allowed by federal law (42 CFR 431.54 (d)).

C. Recipient identification: An eligible recipient must present all health program identification cards or other eligibility documentation before receiving services and with each case of continued or extended services.

(1) A provider must verify the eligibility of the recipient to assure the recipient is eligible on the date the services are provided. Verification of eligibility also permits the provider to be informed of any restrictions or limitations on services associated with the recipient's eligibility; of the applicability of co-payments on services; of the need for the eligible recipient's care to be coordinated with or provided through a managed care organization, a hospice provider, a PACE provider, a medical management provider, or similar health care plan or provider. Additionally, information on medicare eligibility and other insurance coverage may be provided.

(2) An eligible recipient whose health care program coverage or benefits may be limited include:

(a) qualified medicare beneficiary (QMB) recipient; and

(b) family planning benefits.

[8.302.1.12 NMAC - Rp, 8.302.1.12 NMAC, 7/01/2024]

8.302.1.13 PATIENT SELF DETERMINATION ACT: A hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, hospice agency and home health agency is required to give an eligible recipient or personal representative information about their right to make their own health decisions, including the right to accept or refuse medical treatment, pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1990. An eligible recipient is not required by this legislation to execute advance directives. Advance directives, such as living wills or durable power of attorney documents, must be established in a manner which is recognized under New Mexico state law. See applicable state law. A health care provider cannot object on the basis of conscience when an eligible recipient or personal representative wishes to implement an advance directive.

A. Information requirements: At the time of admission, a provider is required to provide written information to an adult eligible recipient or personal representative concerning their right to do the following:

(1) make decisions about their medical care;

(2) accept or refuse medical or surgical treatment;

(3) execute advance directives;

(4) execute their rights under HIPAA; and

(5) if an eligible recipient who is already incapacitated is admitted, the provider must provide their personal representatives with this information; if an eligible recipient is no longer incapacitated, the provider must discuss these rights with the eligible recipient.

B. Policies, rules and procedures: A provider must give written information to an eligible adult recipient or their personal representative about provider rules and procedures concerning advance directive rights. A provider must verify that the advance directive complies with state law.

C. Documentation requirements: A provider must document in each eligible recipient's medical record whether their personal representative has established an advance directive. If the eligible recipient or their personal representative presents an advanced directive, a provider must comply with the terms of the document, as directed by state law. If an eligible recipient is incapacitated, unable to communicate, or their personal representative does not present an advance directive, the provider must document that the eligible recipient was unable to receive information or communicate whether advance directives exist. A provider must inform the eligible recipient or their personal representative that it furnishes information and proper forms for completion of advance directives.

D. Provision of care: A provider must not condition the provision of care or discriminate against an eligible recipient based on whether they have established advance directives. If an eligible recipient is entitled to necessary care ordered by a physician, which providers under normal procedures must furnish, care cannot be delayed while waiting for the execution of an advance directive. Once the existence of an advance directive is documented, the directive takes precedence over normal procedures.

E. Changing the advanced directives: A provider must inform an eligible recipient or their personal representative that they have a right to reaffirm an advance directive or change an advance directive at any time and in any manner, including oral statements.

[8.302.1.13 NMAC - Rp, 8.302.1.13 NMAC, 7/01/2024]

8.302.1.14 NONDISCRIMINATION: A provider must furnish covered services to an eligible recipient in the same scope, quality and manner as provided to the general public. Within the limits of medical assistance programs, a provider may not discriminate on the basis of race, color, national origin, sex, gender, age, ethnicity,

religion, sexual orientation, sexual preference, health status, disability, marital status, political belief, or source of payment, (45 CFR 80.3 (a)(b); 45 CFR 84.52 (a); 42 CFR 447.20; and PL 101-366, 104 Stat. 327 (1990)).
[8.302.1.14 NMAC - Rp, 8.302.1.14 NMAC, 7/01/2024]

8.302.1.15 BILLING AND CLAIMS PROCESSING: Reimbursement to a provider for services or procedures is based on the MAD reimbursement fee schedule, reimbursement rate, or reimbursement methodology in place at the time the services were furnished by the provider. A provider who furnishes services to an eligible recipient agrees to accept the amount paid by MAD as payment in full, except as otherwise allowed by rule or regulation (42 CFR 447.15).

A. Requirements for reimbursement: A provider is reimbursed for performing a service or procedure only if any required prior authorization, documentation, certifications, or acknowledgements are submitted with the claim and the claim is received by the appropriate claims processing contractor within the filing limits.

B. Electronic billing requirements: Effective December 1, 2008, electronic billing of claims is mandatory unless an exemption has been allowed by MAD. Electronic billing improves the accuracy of claims submission and payment; provides consistency in billing information; and improves the speed of payment. Exemptions will be given on a case by case basis with consideration given to barriers the provider may face in billing electronically, including when volumes are so small that developing electronic submission capability is impractical. The requirement for electronic submission of claims does not apply to situations for which paper attachments must accompany the claim form.

C. Responsibility for claims: A provider is responsible for all claims submitted under their national provider identifier (NPI) or other provider number including responsibility for accurate coding that represents the services provided without inappropriately upcoding, unbundling, or billing mutually exclusive codes as indicated by published coding manuals, directives, and the CMS correct coding initiative.

D. No billing of recipients or third parties: With the exception of WDI and SCHIP or other specified program co-payments or cost-sharing, a provider may not bill, turn over to collection, or accept payment from an eligible recipient, their personal representative or other third parties determined to be legally responsible for the balance of a claim except as specifically allowed by MAD regulations. Following MAD payment, a provider cannot seek additional payment from an eligible recipient or their personal representative in addition to the amount paid by MAD. Following MAD denial of payment due to provider administrative error in filing a claim, a provider cannot seek payment from an eligible recipient or their personal representative or turn the balance over to collection. See 8.302.3 NMAC, *Third Party Liability Provider Responsibilities*.
[8.302.1.15 NMAC - Rp, 8.302.1.15 NMAC, 7/01/2024]

8.302.1.16 ACCEPTANCE OF RECIPIENT OR THIRD PARTY PAYMENTS: A provider may only bill an eligible recipient or accept payment for services if all of the following requirements are satisfied:

A. The eligible recipient is advised by the provider before services are furnished that a particular service is not covered by MAD or that the particular provider does not accept patients whose medical services are paid for by MAD.

B. The eligible recipient is provided with information by the provider regarding the necessity, options, and charges for the service, and of the option of going to a provider who accepts MAD payment.

C. The eligible recipient still agrees in writing to have specific services provided with the knowledge that he will be financially responsible for payment.
[8.302.1.16 NMAC - Rp, 8.302.1.16 NMAC, 7/01/2024]

8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. (42 CFR 431.107(b)). Services billed to MAD not substantiated in the eligible recipient's records are subject to recoupment. Failure to maintain records for the required time period is a violation of the Medicaid Provider Act NMSA 1978 section 27-11-1, et. seq., and a crime punishable under the Medicaid Fraud Act, NMSA, section 30.44-5. See 8.351.2 NMAC, *Sanctions and Remedies*.

A. Detail required in records: Provider records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services; length of a session of service billed, diagnosis and medical necessity of any service.

(1) When codes, such as the international classification of disease (ICD) or current procedural terminology (CPT), are used as the basis for reimbursement, provider records must be sufficiently detailed to substantiate the codes used on the claim form.

(2) Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

C. Services billed by units of time: Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.

D. Recipient funds accounting systems: If an eligible recipient entrusts their personal funds to a nursing facility, intermediate care facility for the intellectually disabled, or swing bed hospital, or any other facility, the facility provider must establish and maintain an acceptable system of accounting. See 42 CFR 445.22.

E. Record retention: A provider who receives payment for treatment, services, or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:

(1) treatment or care of any eligible recipient;

(2) services or goods provided to any eligible recipient;

(3) amounts paid by MAD on behalf of any eligible recipient; and

(4) any records required by MAD for the administration of medicaid.

[8.302.1.17 NMAC - Rp, 8.302.1.17 NMAC, 7/01/2024]

8.302.1.18 PATIENT CONFIDENTIALITY: A provider is required to comply with the HIPAA privacy regulations. Confidential medical information regarding medicaid information on the applicant or eligible recipient must be released by providers to MAD, and to other state or federal agencies, or their employees at no cost when:

A. the agency is involved in the administration of medicaid;

B. the information is to be used to establish eligibility, determine the amount of assistance or provide services related to medicaid;

C. the agency is subject to the same standards of confidentiality as MAD; and

D. the agency has the actual consent of applicant or eligible recipient or their personal representative for release of the information, or consent is obtained when an eligible recipient or their personal representative or a member of the assistance group makes application for benefits or services with the health care authority.

[8.302.1.18 NMAC - Rp, 8.302.1.18 NMAC, 7/01/2024]

8.302.1.19 PROVIDER DISCLOSURE: A provider must furnish MAD with the following information. See 42 CFR 431.107(b)(2)(3): name and address of each person with an ownership or controlling interest in the entity or in any subcontractor in which the entity has a direct or indirect ownership interest totaling five percent or more, and any relationship (spouse, child or sibling) of these persons to another; name of any other entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest; name of any person with an ownership or controlling interest in the entity who has been convicted of a criminal offense related to that person's involvement in any program established under the medicare or medical assistance programs; and name of any provider who employs or uses the services of an individual who, at any time during the year preceding this employment, was employed in a managerial, accounting, auditing or similar capacity, by an agency or organization which currently serves or at any time during the preceding year served as a medicare or MAD fiscal intermediary or carrier for the provider. A provider must notify MAD of any change in the status of these disclosure provisions.

A. Reports furnished by providers: A provider must give MAD, the appropriate MAD claims processing contractor, MAD audit contractor, MAD utilization review contractor or MAD designated representative financial reports, audits, certified cost statements, medical and other records, or any other data needed to establish a basis for reimbursement at no cost.

(1) All information regarding any claim for services must be provided. See 42 CFR 431.107(b) (2).

(2) Required cost statements must be furnished no later than 150 calendar days of the close of the provider's fiscal accounting period.

(3) MAD records and other documentation needed by MAD or its designee must be available within a defined period, upon request.

B. Penalties: MAD suspends payment for services until the required statements are furnished by the provider.

C. Conflict of interest: MAD does not enter into a provider participation agreement or other contract with a public officer, employee of the state, legislator, or business in which the individual has a substantial interest, unless the individual discloses their substantial interest and provider participation agreement is accepted by MAD and any other contract is awarded pursuant to the state procurement code [NMSA 10-16-7 (Repl. Pamp. 1993)].

[8.302.1.19 NMAC - Rp, 8.302.1.19 NMAC, 7/01/2024]

8.302.1.20 TERMINATION OF PROVIDER STATUS:

A. Provider status may be terminated if the provider or MAD gives the other written notice of termination at least 60 calendar days before the effective termination date.

(1) Facility provider must also give at least 15 calendar days notice to the public by publishing a statement of the date services are no longer available at the facility in one or more newspapers of general circulation within the affected county or region.

(2) Normal termination and notice limits do not apply if the state survey agency or health care financing administration determines that the health and safety of residents in a nursing facility or intermediate care facility for the intellectually disabled or the children, youth and families department determines that the health and safety of children or adolescents in a residential treatment center, group home, or treatment foster care are in jeopardy.

B. Grounds for denial or revocation of enrollment: MAD may, with a 30-calendar days notice, deny or terminate a provider's enrollment in its medical assistance program including, but not limited to, medicaid (Title XIX of the Social Security Act) and other health insurance programs funded by the authority, if any of the following are found to be applicable to the health care provider, their agent, a managing employee, or any person having an ownership interest equal to five percent or greater in the health care provider:

(1) misrepresentation by commission or omission of any information on the MAD provider participation agreement enrollment form;

(2) previous or current exclusion, suspension, termination from, or the involuntary withdrawal from participation in New Mexico medical assistance programs, any other states medicaid program, medicare, or any other public or private health or health insurance program;

(3) conviction under federal or state law of a criminal offense relating to the delivery of any goods, services, or supplies, including the performance of management or administrative services relating to the delivery of the goods, services, or supplies, under New Mexico medical assistance programs any other states medicaid program, medicare, or any other public or private health or health insurance program;

(4) conviction under federal or state law of a criminal offense relating to the neglect, or abuse of a patient in connection with the delivery of any goods, services, or supplies;

(5) conviction under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance;

(6) conviction under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;

(7) conviction under federal or state law of a criminal offense punishable by imprisonment of a year or more which involved moral turpitude, or acts against the elderly, children, or infirmed;

(8) conviction under federal or state law of a criminal offense in connection with the interference or obstruction of any investigation into any criminal offense listed in Paragraphs (3) through (9) of this subsection;

(9) sanction pursuant to a violation of federal or state laws or rules relative to New Mexico medical assistance programs, any other state's medicaid program, medicare, or any other public health care or health insurance program;

(10) violation of licensing or certification conditions or professional standards relating to the licensure or certification of health care providers or the required quality of goods, services, or supplies provided;

(11) failure to pay recovery properly assessed or pursuant to an approved repayment schedule under New Mexico medical assistance programs; and

(12) see 8.351.2 NMAC, *Sanctions and Remedies,* and 8.353.2 NMAC, *Provider Hearings*.

[8.302.1.20 NMAC - Rp, 8.302.1.20 NMAC, 7/01/2024]

8.302.1.21 CHANGE IN OWNERSHIP: As soon as possible, but at least 60 calendar days after a change in ownership, MAD reserves the right to withhold payment on all pending or current claims until any right MAD has to recoup portions or all of those payments is determined. Payment will not be withheld if MAD received written confirmation that the new owner or previous medical assistance program provider agrees to be responsible for any potential overpayment.
[8.302.1.21 NMAC - Rp, 8.302.1.21 NMAC, 7/01/2024]

8.302.1.22 PUBLIC DISCLOSURE OF SURVEY INFORMATION: The findings of a MAD survey used to determine the ability of facility provider to begin or continue as medicaid participating provider is available to the public within 90 calendar days of completion.

A. Documents subject to disclosure: Documents subject to public disclosure include:

(1) current survey reports prepared by the survey agency;

(2) official agency notifications of findings based on these reports, including statements of deficiencies;

(3) pertinent parts of written statements furnished by providers to the survey agency related to these reports and findings, including any corrective action taken or planned; and

(4) information regarding the ownership of nursing facility. See 42 CFR 455.104(a).

B. Release of performance reports: Reports on provider's or contractor's performance reviews and formal performance evaluations are not available to the public until the provider or contractor have a reasonable opportunity (not to exceed 30 calendar days) to review the reports and offer comments. These comments become part of the reports.

C. Availability of cost reports: Provider cost reports used as a basis for reimbursement are available to the public upon receipt of a written request by the MAD audit contractor.

(1) Information disclosure is limited to cost report documents required by social security administration regulations, and in the case of a settled cost report, the notice of medicaid settlement.

(2) The request for information must identify the provider and the specific reports requested.

(3) The cost for supplying copies of the cost reports is billed to the requester.

[8.302.1.22 NMAC - Rp, 8.302.1.22 NMAC, 7/01/2024]

HISTORY OF 8.302.1 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.
ISD 301.2000, Provider Agreement; 12/21/1979.
ISD 301.2000, Provider Agreement, 12/4/1980.
MAD RULE 301, Procedures and Requirements for Provider Participation, 11/8/1989.
ISD 301.3000, Confidentiality, 12/21/1979.
ISD 301.4000, Public Disclosure of Information, 1/17/1980.
ISD 301.4000, Public Disclosure of Information, 11/24/1980.
SP-004.1300, Section 4, General Program Administration Required Provider Agreement, 3/3/1981.
SP-007.0200, Section 7, General Provisions Nondiscrimination, 3/4/1981.
SP-004.2300, Section 4, General Program Administration Use of Contracts, 3/5/1981.
SP--004.2700, Section 4, General Program Administration Disclosure of Survey Information and Provider or Contractor Evaluation, 3/5/1981.
SP-004.3100, Section 4, General Program Administration Disclosure of Information By Providers and Fiscal Agents, 3/5/1981.
SP-007.0201, Section 7, Nondiscrimination, 6/10/1981.
SP-003.0100, Medical and Remedial Care and Services- Amount, Duration and Scope, 6/18/1981.
SP-003.0100, Section 3, Services: General Revisions - Amount, Duration and Scope of Service, 6/24/1981.

History of Repealed Material:
8.302.1 NMAC, Medicaid General Provider Policies - General Provider Policies filed 6/14/2001 - Repealed effective 1/1/2023.
8.302.1 NMAC, Medicaid General Provider Policies - General Provider Policies filed 1/1/2023 - Repealed effective 7/01/2024.

Other: 8.302.1 NMAC, Medicaid General Provider Policies - General Provider Policies filed 6/14/2001 Replaced by 8.302.1 NMAC, Medicaid General Provider Policies - General Provider Policies effective 1/1/2023.

TITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID GENERAL PROVIDER POLICIES
PART 4 OUT-OF-STATE AND BORDER AREA PROVIDERS

8.302.4.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA).
[8.302.4.1 NMAC – Rp 8.302.4.1, 7/01/2024]

8.302.4.2 SCOPE: The rule applies to the general public.
[8.302.4.2 NMAC – Rp 8.302.4.2, 7/01/2024]

8.302.4.3 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 the Social Security Act as amended or by state statute. See NMSA 1978, Sections 27-2-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.302.4.3 NMAC – Rp 8.302.4.3, 7/01/2024]

8.302.4.4 DURATION: Permanent
[8.302.4.4 NMAC – Rp 8.302.4.4, 7/01/2024]

8.302.4.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.302.4.5 NMAC – Rp 8.302.4.5, 7/01/2024]

8.302.4.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.302.4.6 NMAC – Rp 8.302.4.6, 7/01/2024]

8.302.4.7 DEFINITIONS: [**RESERVED**]

8.302.4.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[8.302.4.8 NMAC – Rp 8.302.4.8, 7/01/2024]

8.302.4.9 OUT-OF-STATE AND BORDER AREA PROVIDERS: Border area services are those that are rendered within 100 miles of the New Mexico state border (Mexico excluded). Out-of-state services are those that are rendered in an area more than 100 miles from the New Mexico border (Mexico excluded). To help New Mexico eligible recipients receive medically necessary services, the medical assistance division (MAD) pays for border area services to the same extent and subject to the same rules and requirements that such services are covered when provided within the state. MAD pays for out-of-state services as described under 8.302.4.12 NMAC, *covered out-of-state services.*
[8.302.4.9 NMAC – Rp 8.302.4.9, 7/01/2024]

8.302.4.10 ELIGIBLE PROVIDERS: Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and

executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. The providers listed in Subsections A-C of 8.302.4.10 NMAC, *eligible providers*, are eligible for a provider participation agreement, bill and receive reimbursement for furnishing medical services:

A. Eligible providers include border area and out-of-state providers licensed by or certified by their respective states to practice medicine or osteopathy [42 CFR Section 440.50 (a)(1)(2)]; and other providers licensed or certified by their state to perform services equivalent to those covered by the medical assistance programs in New Mexico; practices or groups formed by these individuals may also receive reimbursement for services.

B. Eligible providers include border area providers within 100 miles of the New Mexico state border (Mexico excluded), subject to the rules governing the provision of services for an in-state provider.

C. Eligible providers include out-of-state providers more than 100 miles from the New Mexico state border (Mexico excluded), subject to the rules governing the provision of services for an in-state provider and any additional rules that may be specified for the specific services and providers within this manual.

[8.302.4.10 NMAC – Rp 8.302.4.10, 7/01/2024]

8.302.4.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care program eligible recipient must comply with all federal and state laws, regulations and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and the centers for medicaid and medicare (CMS) correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must follow that contractor's instructions for billing and for authorization of services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HCA and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HCA, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[8.302.4.11 NMAC – Rp 8.302.4.11, 7/01/2024]

8.302.4.12 COVERED OUT-OF-STATE SERVICES: MAD covers services and procedure furnished by a provider located within 100 geographical miles of the New Mexico border, even though the road miles may be greater than 100 miles, to the same extent and using the same coverage rules as for an in-state provider. See 8.302.4.9 NMAC, *out of state and border area providers*. When it is the general practice for an eligible recipient in a New Mexico locality to access medical services in a location more than 100 geographical miles from the New Mexico border, MAD will treat that out-of-state location as a border area. MAD covers services and procedures furnished by a provider more than 100 geographical miles from the New Mexico border, excluding Mexico, to the extent and using the same coverage rules as for in-state provider when one or more of the following conditions are met.

A. An eligible recipient is out-of-state at the time the services are needed and the delivery of services is of an emergent or urgent nature or if the eligible recipient's health would be endangered by traveling back to New Mexico. Services must be medically necessary to stabilize the eligible recipient's health and prevent significant adverse health effects, including preventable hospitalization. Claims for such services are subject to pre-payment or post-payment reviews to assure the emergent or urgent need or medical necessity of the services.

B. On-going-services provided by a medical assistance program within the state continue to be necessary when the eligible recipient is visiting another state.

C. Care is medically necessary for an eligible recipient that is placed by the state of New Mexico in foster care in an out-of-home placement or in an institution. Care is medically necessary for an eligible recipient that was adopted from New Mexico and resides out-of-state. If the agreement with the other state requires that state's medicaid program pay for covered services, MAD will only consider payment when a service is not covered by the other state and the eligible recipient would be eligible for that service if living in New Mexico.

D. Durable medical equipment, medical supplies, prosthetics or orthotics are purchased from out-of-state vendors.

E. Clinical laboratory tests, radiological interpretations, professional consultations or other services are performed by out-of-state laboratories but do not require the eligible recipient to leave the state.

F. Medical services or procedures considered medically necessary are not available in the state of New Mexico. All services that are not available in New Mexico require prior authorization when provided by an out-of-state provider. An out-of-state service may be limited to the closest provider or an otherwise economically prudent choice of provider capable of rendering the service.

G. Services, such as personal assistance, are needed by an eligible recipient out-of-state if that recipient is eligible to receive services through a medicaid home and community-based services waiver program and is traveling to another state.

[8.302.4.12 NMAC – Rp 8.302.4.12, 7/01/2024]

8.302.4.13 NONCOVERED SERVICES: Services furnished by an out-of-state or border provider are subject to the limitations and coverage restrictions which exist for other services rendered in-state as stated in the relevant administrative, provider, and other services sections of the MAD program policy manual. In addition, MAD programs do not cover the following specific services when furnished by an out-of-state or border provider:

A. services furnished outside the boundaries of the United States; and

B. services furnished in an out-of-state or border area nursing facility or intermediate care facility for the mentally retarded.

[8.302.4.13 NMAC – Rp 8.302.4.13, 7/01/2024]

8.302.4.14 OUT-OF-STATE HOSPITAL SERVICES: All out-of-state hospital, and other residential service claims are subject to prepayment review or periodic re-authorization by MAD or its designee for medical necessity and length of stay, in addition to requiring authorization for the initial placement.

[8.302.4.14 NMAC – Rp 8.302.4.14, 7/01/2024]

8.302.4.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, a provider receives instructions on how to access utilization review documents necessary for prior approval and claims processing.

A. Prior authorization: Certain procedures or services can require prior approval from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. A service provided through an out-of-state or border provider is subject to the same prior authorization and utilization review requirements, which exist for the service when not provided out-of-state.

B. Eligibility determination: Prior authorization of services does not guarantee an individual is eligible for medicaid and other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if the eligible recipient has other health insurance.

C. Reconsideration: A provider who disagrees with prior authorization request denials and other review decisions can request a re-review and a re-consideration. See MAD-953 [8.350.2 NMAC], *Reconsideration of Utilization Review Decisions*.

[8.302.4.15 NMAC – Rp 8.302.4.15, 7/01/2024]

8.302.4.16 OUT-OF-STATE BILLING OFFICES: Services furnished within the state or border areas are subject to the rules for in-state providers even if the billing or administrative office is outside the state.

[8.302.4.16 NMAC – Rp 8.302.4.16, 7/01/2024]

8.302.4.17 REIMBURSEMENT: Reimbursement to an out-of-state or border area provider is made at the same rate as for an in-state provider except as otherwise stated in the relevant specific providers and services sections of the MAD program rules manual.

A. Unless payment for a service is made using a diagnosis related group or outpatient prospective payment system rate, reimbursement to a provider for covered services is made at the lesser of the following:

(1) the billed change which must be the provider's usual and customary charge for service; "usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service; or

(2) the MAD fee schedule for the specific service or procedure.

B. When a provider and an MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obligated to pay, and the provider shall accept, 100 percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations. The "applicable reimbursement rate" is defined as the rate paid by HCA to a provider participating in medicaid or other medical assistance programs administered by HCA and excludes disproportionate share hospital and medical education payments.
[8.302.4.17 NMAC – Rp 8.302.4.17, 7/01/2024]

HISTORY OF 8.302.4 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 303.1000, Covered Services, filed 1/7/1980.
ISD 303.1000, Covered Services, filed 4/2/1982.
MAD Rule 303, Benefits, filed 11/8/1989.
MAD Rule 303, Benefits, filed 4/17/1992.
MAD Rule 303, Benefits, filed 3/10/1994.
SP-004.1700, Section 4, General Program Administration Liens and Recoveries, filed 3/5/1981.

History of Repealed Material:
MAD Rule 303, Benefits, filed 3/10/94 - Repealed effective 2/1/1995.
8.302.4.1 NMAC, Medicaid General Provider Policies – Repealed effective 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 4 FEDERALLY QUALIFIED HEALTH CENTER SERVICES

8.310.4.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.310.4.1 NMAC – Rp 8.310.4.1, 7/01/2024]

8.310.4.2 SCOPE: The rule applies to the general public.
[8.310.4.2 NMAC – Rp 8.310.4.2, 7/01/2024]

8.310.4.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.310.4.3 NMAC – Rp 8.310.4.3, 7/01/2024]

8.310.4.4 DURATION: Permanent
[8.310.4.4 NMAC – Rp 8.310.4.4, 7/01/2024]

8.310.4.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.310.4.5 NMAC – Rp 8.310.4.5, 7/01/2024]

8.310.4.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.310.4.6 NMAC – Rp 8.310.4.6, 7/01/2024]

8.310.4.7 DEFINITIONS: [**RESERVED**]

8.310.4.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.310.4.8 NMAC – Rp 8.310.4.8, 7/01/2024]

8.310.4.9 FEDERALLY QUALIFIED HEALTH CENTER SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible clients. To help New Mexico clients receive necessary services, the New Mexico medical assistance division (MAD) pays for covered outpatient services provided at federally qualified health centers (FQHC's). This part describes eligible providers, covered services, service limitations, and general reimbursement methodology. MAD intends to follow federal regulation applicable to medicare where and if there are any omissions in these regulations with respect to covered services.
[8.310.4.9 NMAC – Rp 8.310.4.9, 7/01/2024]

8.310.4.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by MAD, the following entities are eligible to be reimbursed for furnishing medical services as FQHCs:

(1) entities which receive a grant under Sections 245b, 254c, and 256 of the Social Security Act;

(2) entities which receive funding from such a grant under a contract with the recipient of such a grant indicated above which meet the requirements to receive a grant under Sections 245b, 254c, and 256 of the Social Security Act;

(3) entities which the secretary of the federal department of health and human services determines meet the requirements for receiving such a grant or entities which qualify through waivers authorized by the secretary of the department of health and human services; and

(4) outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organizations receiving funds under the Indian Health Care Improvement Act for the provision of primary health services.

B. Individual providers employed by or under contract with FQHCs must be enrolled with New Mexico medicaid.

C. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[8.310.4.10 NMAC – Rp 8.310.4.10, 7/01/2024]

8.310.4.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid clients must comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid clients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to clients. See 8.302.1 NMAC, *General Provider Policies*.

[8.310.4.11 NMAC – Rp 8.310.4.11, 7/01/2024]

8.310.4.12 COVERED SERVICES: All services provided by the FQHC must be furnished in accordance with applicable federal, state, and local laws and regulations and must be furnished within the limitations applicable to medicaid-covered benefits. If not specified in this section, MAD adopts definitions of coverage delineated in the FQHC sections of medicare statutes. "Other ambulatory services" offered by the FQHC are subject to the same medicaid limitations, utilization review requirements, and coverage restrictions that exist for other providers rendering the delineated service.

A. Physician services:

(1) Physician services are professional services that are performed by a physician, including psychiatrists, employed by or under contract with the FQHC.

(2) Services and supplies incident to a physician's professional service are covered if the service or supply meets delineated requirements. Services and supplies include the professional component of radiology services, laboratory services performed by the FQHC and specimen collection for laboratory services furnished by an off-site laboratory. To meet the definition of "incident to" a professional service, the service and supplies must be:

(a) of a type commonly furnished in a physician's office; [within the meaning of the Code of Federal Regulations (CFR) page 128 Section 405.2413 (a)(1) 10-01-98 edition]

(b) of a type commonly rendered either without charge or included in the FQHC encounter rate;

(c) furnished as an incidental, although integral, part of a physician's professional service;

(d) furnished under direct, personal supervision of a physician; and

(e) in the case of a service, furnished by a member of the FQHC's health care staff who is an employee of the FQHC or under contract with the FQHC.

(3) Inpatient hospital visits are those services furnished to an individual as a "patient" of the FQHC. Therefore, FQHC services furnished off-site (including those furnished to a person who is an inpatient of a hospital or nursing facility) will be considered FQHC services only if the physician's agreement with the FQHC requires that he or she seek compensation from the FQHC. (Section 4704 c of OBRA '90, amended Section 1905 1,2.) (HCFA Letter #91-18 dated March 1991.)

B. Mid-level practitioners: Services furnished by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner are covered as an FQHC core service if the service is:

(1) furnished by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner who is employed by or under contract with the FQHC;

(2) furnished in accordance with FQHC policies and individual treatment plans developed by FQHC personnel for a given client;

(3) a type which the nurse practitioner, physician assistant, nurse midwife or specialized nurse practitioner who furnished the service is permitted by licensure and/or certification;

(4) furnished under the supervision of a physician, if required by New Mexico law.

(a) The physician supervision requirement is met if the conditions specified in Section 491.8 (b) of the Social Security Act and any pertinent requirements specified under New Mexico law are satisfied.

(b) To be covered, the services provided by mid-level practitioners must comply with New Mexico law.

(c) Services and supplies are covered as incident to the provision of services by a mid-level practitioner if the requirements specified in Paragraph (2) of Subsection A of 8.310.4.12 NMAC are met.

(d) The direct personal supervision requirement for mid-level practitioners is met if the mid-level practitioner is permitted to supervise under the written policies governing the FQHC and as defined under New Mexico law.

C. Outpatient mental health services: Diagnosis and treatment of mental illness are covered services when the service is provided by an individual licensed as a physician by the board of medical examiners or board of osteopathy and who is board-eligible or board-certified in psychiatry, a licensed clinical psychologist (Ph.D., Psy. D., or Ed. D.), a licensed independent social worker (LISW), a licensed professional clinical mental health counselor (LPCC), a licensed marriage and family therapist (LMFT), or a clinical nurse specialist certified in psychiatric nursing (CNP) who is employed by or under contract with the FQHC. An FQHC is reimbursed for services furnished by licensed master's level social workers, licensed psychology associates and master's level licensed counselors who are graduates of an accredited program when the services are furnished under the direction and supervision as addressed under Subsection C of 8.310.8.10 NMAC.

D. Visiting nurse services: Visiting nurse services are covered if the FQHC is located in an area identified by the secretary of health and human services as having a shortage of home health agencies. No additional certification is required beyond the FQHC certification. To be covered, visiting nurse services must be:

(1) rendered to clients who meet criteria for home health services;

(2) furnished by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or under contract with the FQHC; and

(3) furnished under a written plan of treatment that is established and signed by a supervising physician; the plan may also be established by a nurse practitioner, physician assistant, nurse midwife, or specialized nurse practitioner employed by or under contract with the FQHC; the plan must be reviewed every 60 days by the supervising physician and revised as the client's condition warrants;

(4) visiting nurse services do not include household and housekeeping services or other services that constitute custodial care.

E. Preventive services:

(1) Preventive primary services that an FQHC may provide are those services as defined in the 42 CFR 405.2448 and include:

(a) medical social services;

(b) nutritional assessment and referral;

(c) individual preventive health education;

(d) well-child care, including periodic screening, to include children's eye and ear examinations;

(e) prenatal and postpartum care;

(f) immunizations for children and adults, including tetanus-diptheria booster and influenza vaccine;

(g) family planning services;

(h) physical examinations targeted to risk, to include blood pressure measurement, weight, and client history;

(i) visual acuity screening;

(j) hearing screening;

(k) cholesterol screening;

(l) stool testing for occult blood;

(m) dipstick urinalyses;

(n) risk assessment and initial counseling regarding risks;

(o) tuberculosis testing for high risk clients;

(p) preventive dental services;

(q) for women only: PAP smears; clinical breast exams; referral for mammography; and thyroid function tests.

(2) Documentation of any service provided by the FQHC must be available in the client's record.

(3) Preventive primary services do not include eyeglasses, hearing aids, group or mass information programs, health education classes, or group education activities, including media productions and publications.

F. Pharmacy services: Pharmacy services and medical supplies are covered services and are included as an allowable cost if dispensed from an FQHC. An FQHC encounter for the provision of medical, behavioral health, and dental services includes related pharmacy services. The FQHC shall not bill a separate encounter for the provision of pharmacy services. To dispense medications, the FQHC must be licensed as a licensed drug clinic under the Pharmacy Practice Act.

G. Dental services: See 8.310.7 NMAC, *Dental Services*, for benefit coverage and service limitation. Dentists and dental hygienists providing services for an FQHC must provide services within the scope of their license as defined in the New Mexico Dental Health Care Act.

H. Case management: Targeted case management services are covered services and are subject to the same requirements that apply to providers who furnish case management services. See 8.326.2 NMAC through 8.326.8 NMAC [MAD-771 - MAD-779].

[8.310.4.12 NMAC – Rp 8.310.4.12, 7/01/2024]

8.310.4.13 UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Approval and Utilization Review*. Once enrolled, providers receive instruction and documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures and services can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that the individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid clients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[8.310.4.13 NMAC – Rp 8.310.4.13, 7/01/2024]

8.310.4.14 NON-COVERED SERVICES AND SERVICE LIMITATION: FQHC services are covered when provided in outpatient settings only, including a client's place of residence, which may be a skilled nursing facility or a nursing facility or other institution used as a client's home. FQHC services are not covered in a hospital as defined in section 1861(e)(1) of the Act.

A. Service limitations: An FQHC may be compensated for provision of other "ambulatory services" covered in the medicaid fee-for-service program (per the Balanced Budget Act of 1997). However, an FQHC must meet licensing and certification requirements for those services as specified in the applicable MAD policy manual section for the specific service.

B. Location of clinic:

(1) Permanent unit: Objects, equipment, and supplies necessary for the provision of services furnished directly by the FQHC must be housed in a permanent structure. Each unit must have individual FQHC certification.

(2) Mobile unit: The objects, equipment, and supplies necessary for the provision of services furnished by the FQHC must be housed in an FQHC mobile structure which has fixed, scheduled locations.

C. Other restrictions: FQHC service providers are subject to the limitations and coverage restrictions which exist for other medicaid services. See 8.301.3 NMAC, *General Non-covered Services* [MAD-602].

[8.310.4.14 NMAC – Rp 8.310.4.14, 7/01/2024]

8.310.4.15 REIMBURSEMENT: FQHCs must submit claims for reimbursement on the UB-92 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services* [MAD-702]. Once enrolled, providers receive

instructions on documentation, billing, and claims processing. Interim reimbursement for services provided by an FQHC is made by MAD based on submitted claims.

A. Initial rates: The initial interim rate for new FQHC providers will be the interim rate set by medicare.

B. Cost settlement:

(1) FQHCs must submit cost reports on an annual basis to MAD or its designee within the time frames specified by medicare. FQHCs will not be granted an extension to the cost report filing time frames.

(2) A final cost settlement based on the audit data will be made in accordance with delineated medicaid requirements and/or applicable medicare cost reimbursement principles when medicaid requirements are not specified. Final cost settlements are based on the allowable cost as audited or desk reviewed costs by MAD or its designee. "Allowable costs" are costs incurred by an FQHC which are reasonable in amount, proper and necessary for the efficient delivery of services by the FQHC (MAD or its designee will follow the HCFA Pub. 15-1 in determining allowable costs). The supporting documentation for "allowable costs" must be available upon request from MAD or its designee.

(3) MAD or its designee may reopen cost reports per HCFA Pub. 15-1 Section 2931 through 2932.1. Providers will be notified on a case-by-case basis thirty (30) days prior to any reopening. MAD uses the productivity standards used in the medicare cost report. However, MAD does not use the costs limits imposed by medicare. If an FQHC disagrees with an audit settlement, the provider can request a reconsideration. See 8.350.4 NMAC, *Reconsideration of Audit Settlement* [MAD-955].

(4) HCA or its designee will complete their initial review of cost settlement materials within 150 days of the receipt of all required information.

C. What constitutes a visit: A visit is a face-to-face encounter between a center client and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, qualified clinical psychologist or qualified clinical social worker. Encounters with more than one health professional and multiple encounters with the same health professional on the same day and at a single location constitute a single visit, except when one of the following conditions exist:

(1) after the first encounter, the client suffers illness or injury requiring additional diagnosis or treatment;

(2) the client has a dental visit, or medical visit and another health visit (e.g., a face-to-face encounter between the client and a clinical psychologist, clinical social worker, or other health professional for mental health services listed in Subsection C of 8.310.4.12 NMAC [MAD 713.33].

D. Supplemental agreements: FQHCs which executed specific agreements with HCA will receive supplemental payments for services rendered to clients enrolled in managed care in the manner and amount specified under the terms of that agreement.

E. Termination or change of ownership: The health care authority (HCA) reserves the right to withhold payment on all current and pending claims until HCA rights to recoup all or portions of such payments is determined from final cost reports when a change of ownership occurs. Payment will not be withheld if HCA is informed in writing the current (new) owner or the previous owner agrees to be responsible for any potential recoupment.

[8.310.4.15 NMAC – Rp 8.310.4.15, 7/01/2024]

HISTORY OF 8.310.4 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

MAD Rule 310.29, Federally Qualified Health Centers (FQHC), filed 5/21/1991.

History Of Repealed Material:

MAD Rule 310.29, Federally Qualified Health Centers (FQHC), filed 5/21/1991 - Repealed effective 2/1/1995.

8.310.4 NMAC, Federally Qualified Health Centers (FQHC), filed 2/1/1995 - Repealed effective 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 311 HOSPITAL SERVICES
PART 2 HOSPITAL SERVICES

8.311.2.1 ISSUING AGENCY: Health Care Authority (HCA).
[8.311.2.1 NMAC – Rp 8.311.2.1, 7/01/2024]

8.311.2.2 SCOPE: This rule applies to the general public.
[8.311.2.2 NMAC – Rp 8.311.2.2, 7/01/2024]

8.311.2.3 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 the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.311.2.3 NMAC – Rp 8.311.2.3, 7/01/2024]

8.311.2.4 DURATION: Permanent
[8.311.2.4 NMAC – Rp 8.311.2.4, 7/01/2024]

8.311.2.5 EFFECTIVE DATE: January 1, 2009, unless a later date is cited at the end of a section.
[8.311.2.5 NMAC – Rp 8.311.2.5, 7/01/2024]

8.311.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.311.2.6 NMAC – Rp 8.311.2.6, 7/01/2024]

8.311.2.7 DEFINITIONS: [**RESERVED**]

8.311.2.8 MISSION STATEMENT: 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.
[8.311.2.7 NMAC – Rp 8.311.2.7, 7/01/2024]

8.311.2.9 HOSPITAL SERVICES: The New Mexico medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico eligible recipients receive necessary services, MAD pays for inpatient, outpatient, and emergency services furnished in general hospital settings.
[8.311.2.8 NMAC – Rp 8.311.2.8, 7/01/2024]

8.311.2.10 ELIGIBLE PROVIDERS: Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Eligible providers include:

A. a general acute care hospital, rehabilitation, extended care or other specialty hospital:
(1) licensed by the New Mexico department of health (DOH), and

(2) participating in the Title XVIII (medicare) program or accredited by the joint commission (previously known as JCAHO accreditation);

B. a rehabilitation inpatient unit or a psychiatric unit in an inpatient hospital (referred to as a prospective payment system exempt unit (PPS-exempt));

C. a free-standing psychiatric hospital may be reimbursed for providing inpatient and outpatient services to an eligible recipient under 21 years of age; see 8.321.2 NMAC*, Inpatient Psychiatric Care in Free-Standing Psychiatric Hospitals;*

D. a border area and out-of-state hospital is eligible to be reimbursed by MAD if its licensure and certification to participate in its state medicaid or medicare program is accepted in lieu of licensing and certification by MAD; and

E. a hospital certified only for emergency services is reimbursed for furnishing inpatient and outpatient emergency services for the period during which the emergency exists.

[8.311.2.10 NMAC – Rp 8.311.2.10, 7/01/2024]

8.311.2.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to an eligible recipient must comply with all federal and state laws, regulations and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, as well as current program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services.

B. A provider must verify that an individual is eligible for a specific health care program administered by the HCA and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient. See 8.302.1 NMAC, *General Provider Policies*.

C. A provider agrees to be paid by the MAD managed care organizations (MCOs) at any amount mutually-agreed between the provider and MCOs when the provider enters into contracts with MCOs contracting with HCA for the provision of managed care services to the MAD population.

(1) If the provider and the MCOs are unable to agree to terms or fail to execute an agreement for any reason, the MCOs shall be obligated to pay, and the provider shall accept, 100 percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations.

(2) The "applicable reimbursement rate" is defined as the rate paid by HCA to the provider participating in medicaid or other medical assistance programs administered by HCA and excludes disproportionate share hospital and medical education payments.

D. When services are billed to and paid by a MAD fee-for-service coordinated services contractor authorized by HCA, under an administrative services contract, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[8.311.2.11 NMAC – Rp 8.311.2.11, 7/01/2024]

8.311.2.12 COVERED SERVICES: MAD covers inpatient and outpatient hospital, and emergency services which are medically necessary for the diagnosis, the treatment of an illness or injury or as required by the condition of the eligible recipient. MAD covers items or services ordinarily furnished by a hospital for the care and treatment of an eligible recipient. These items or services must be furnished under the direction of an enrolled MAD physician, podiatrist, or dentist with staff privileges in a hospital which is an enrolled MAD provider. Services must be furnished within the scope and practice of the profession as defined by state laws and in accordance with applicable federal and state and local laws and regulations.

[8.311.2.12 NMAC – Rp 8.311.2.12, 7/01/2024]

8.311.2.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews may be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain

answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must follow that contractor's instructions for authorization of services.

A. Prior authorization: Certain procedures or services may require prior authorization from MAD or its designee. A procedure that requires prior authorization is primarily one for which the medical necessity may be uncertain, which may be for cosmetic purposes, or which may be of questionable effectiveness or long-term benefit.

(1) All transfers from one acute care DRG reimbursed hospital to another DRG reimbursed hospital.

(2) All inpatient stays for a PPS-exempt psychiatric unit of a general acute care hospital requires admission and continued stay reviews.

(3) All inpatient stays in a rehabilitation hospital, a PPS-exempt rehabilitation unit in a general acute care hospital, and an extended care or other specialty hospital requires admission and continued stay reviews.

(4) Outpatient physical, occupational, and speech therapies services require prior authorization.

(5) Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that an individual is eligible for MAD services. A provider must verify that an individual is eligible for the MAD services at the time services are furnished and determine if an eligible recipient has other health insurance.

C. Consideration: A provider who disagrees with a prior authorization request denial or another review decision may request a re-review and a reconsideration. See *MAD-953, Reconsideration of Utilization Review Decisions.*

[8.311.2.13 NMAC – Rp 8.311.2.13, 7/01/2024]

8.311.2.14 INPATIENT SERVICES: MAD coverage of some inpatient services may be conditional or limited.

A. Medically warranted days: A general hospital is not reimbursed for days of acute level inpatient services furnished to an eligible recipient as a result of difficulty in securing alternative placement. A lack of nursing facility placement is not sufficient grounds for continued acute-level hospital care.

B. Awaiting placement days:

(1) When the MAD utilization review (UR) contractor determines that an eligible recipient no longer meets the care criteria in a rehabilitation, extended care or other specialty hospital or PPS exempt rehabilitation hospital but requires a nursing facility level of care which may not be immediately located, those days during which the eligible recipient is awaiting placement in a lower level of care facility are termed "awaiting placement days". Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for the level of nursing facility services required by the eligible recipient (high NF or low NF).

(2) When the MAD UR contractor determines that a recipient under 21 years of age no longer meets acute care criteria and it is verified that an appropriate reviewing authority has made a determination that the eligible recipient requires a residential level of care which may not be immediately located, those days during which the eligible recipient is awaiting placement to the lower level of care are termed "awaiting placement days". MAD does not cover residential care for individuals over 21 years of age.

(3) Payment to the hospital for awaiting placement days is made at the weighted average rate paid by MAD for residential services that may have different levels of classification based on the medical necessity for the placement of the eligible recipient. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. A separate claim form must be submitted for awaiting placement days.

(4) MAD does not pay for any ancillary services for "awaiting placement days". The rate paid is considered all inclusive. Medically necessary physician visits or**,** in the case of the eligible recipient under 21 years of age requiring residential services, licensed Ph.D. psychologist visits, are not included in this limitations.

C. Private rooms: A hospital is not reimbursed for the additional cost of a private room unless the private room is medically necessary to protect the health of the eligible recipient or others.

D. Services performed in an outpatient setting: MAD covers certain procedures performed in an office, clinic, or as an outpatient institutional service which are alternatives to hospitalization. Generally, these procedures are those for which an overnight stay in a hospital is seldom necessary.

(1) An eligible recipient may be hospitalized if there is an existing medical condition which predisposes the eligible recipient to complications even with minor procedures.

(2) All claims for one- or two-day stays for hospitalization are subject to pre-payment or post-payment review.

E. Observation stay: If a physician orders an eligible recipient to remain in the hospital for less than 24 hours, the stay is not covered as inpatient admission, but is classified as an observation stay. An observation stay is considered an outpatient service.

(1) The following are exemptions to the general observation stay definition:

(a) the eligible recipient dies;

(b) documentation in medical records indicates that the eligible recipient left against medical advice or was removed from the facility by his legal guardian against medical advice;

(c) an eligible recipient is transferred to another facility to obtain necessary medical care unavailable at the transferring facility; or

(d) an inpatient admission results in delivery of a child.

(2) MAD or its designee determines whether an eligible recipient's admission falls into one of the exempt categories or considers it to be a one- or two-day stay.

(a) If an admission is considered an observation stay, the admitting hospital is notified that the services are not covered as an inpatient admission.

(b) A hospital must bill these services as outpatient observation services. However, outpatient observation services must be medically necessary and must not involve premature discharge of an eligible recipient in an unstable medical condition.

(3) The hospital or attending physician can request a re-review and reconsideration of the observation stay decision. See MAD 953*, Reconsideration of Utilization Review Decisions.*

(4) The observation stay review does not replace the review of one- and two-day stays for medical necessity.

(5) MAD does not cover medically unnecessary admissions, regardless of length of stay.

F. Review of hospital admissions: All cases requiring a medical peer review decision on appropriate use of hospital resources, quality of care or appropriateness of admission, transfer into a different hospital, and readmission are reviewed by MAD or its designee. MAD or its designee performs a medical review to verify the following:

(1) admission to acute care hospital is medically necessary;

(2) all hospital services and surgical procedures furnished are appropriate to the eligible recipient's condition and are reasonable and necessary to the care of the eligible recipient;

(3) patterns of inappropriate admissions and transfers from one hospital to another are identified and are corrected; hospitals are not reimbursed for inappropriate admissions or transfers; and

(4) the method of payment and its application by a hospital does not jeopardize the quality of medical care.

G. Non-covered services: MAD does not cover the following specific inpatient benefits:

(1) a hospital service which is not considered medically necessary by MAD or its designee for the condition of the eligible recipient;

(2) a hospital service that requires prior authorization for which the approval was not requested except in cases with extenuating circumstances as granted by MAD or its designee;

(3) a hospital service which is furnished to an individual who was not eligible for MAD services on the date of service;

(4) an experimental or investigational procedure, technology or therapy and the service related to it, including hospitalization, anesthesiology, laboratory tests, and imaging services; see MAD-765*, Experimental or Investigational Procedures or Therapies*;

(5) a drug classified as "ineffective" by the federal food and drug administration;

(6) private duty or incremental nursing services;

(7) laboratory specimen handling or mailing charges; and

(8) formal educational or vocational training services which relate to traditional academic subjects or training for employment.

H. Covered services in hospitals certified for emergency services-only: Certain inpatient and outpatient services may be furnished by a hospital certified to participate in the Title XVIII (medicare) program as an emergency hospital. MAD reimburses a provider only for treatment of conditions considered to be medical or surgical emergencies. "Emergency" is defined as a condition which develops unexpectedly and needs immediate medical attention to prevent the death or serious health impairment of the eligible recipient which necessitates the use of the most accessible hospital equipped to furnish emergency services.

(1) MAD covers the full range of inpatient and outpatient services furnished to an eligible recipient in an emergency situation in a hospital which is certified for emergency services-only.

(2) MAD reimbursement for emergency services furnished in a hospital certified for an emergency services-only is made for the period during which the emergency exists.

(a) Documentation of the eligible recipient's condition, the physician's statement that emergency services were necessary, and the date when, in the physician's judgment, the emergency ceased, must be attached to the claim form.

(b) An emergency no longer exists when it becomes safe from a medical standpoint to move the eligible recipient to a certified inpatient hospital or to discharge the eligible recipient.

(c) Reimbursement for services in an emergency hospital is made at a percentage of reasonable charges as determined by HCA. No retroactive adjustments are made.

I. Patient self determination act: An adult eligible recipient must be informed of his right to make health decisions, including the right to accept or refuse medical treatment, as specified in the Patient Self-Determination Act. See 8.302.1 NMAC*, General Provider Policies*.

J. Psychiatric services furnished to an eligible recipient under 21 years of age in PPS-exempt units of acute care hospitals: Services furnished to an eligible recipient must be under the direction of a physician. In the case of psychiatric services furnished to an eligible recipient under 21 years of age, these services must be furnished under the direction of board eligible/board certified psychiatrist, or a licensed psychologist working in collaboration with a similarly qualified psychiatrist. The psychiatrist must conduct an evaluation of the eligible recipient, in person, within 24 hours of admission. In the case of an eligible recipient under 12 years of age, the psychiatrist must be board eligible/board certified in child or adolescent psychiatry. The requirement for the specified psychiatrist for an eligible recipient under age 12 and under 21 years of age may be waived when all of the following conditions are met:

(1) the need for admission is urgent or emergent, and transfer or referral to another provider poses an unacceptable risk for adverse patient outcomes; and

(2) at the time of admission, a board eligible/board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist is not accessible in the community in which the facility is located; and

(3) another facility which is able to furnish a board eligible/board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist, is not available or accessible in the community; and

(4) the admission is for stabilization only and transfer arrangements to the care of a board eligible/ board certified psychiatrist, or in the case of an eligible recipient under 12 years of age, a child psychiatrist is made as soon as possible with the understanding that if the eligible recipient needs to transfer to another facility, the actual transfer will occur as soon as the eligible recipient is stable for transfer, in accordance with professional standards.

K. Reimbursement for inpatient services: MAD reimburses for inpatient hospital services using different methodologies. See 8.311.3 NMAC, *Methods and Standards for Establishing Payment Rates - Inpatient Hospital Services.*

(1) All services or supplies furnished during the hospital stay are reimbursed by the hospital payment amount and no other provider may bill for services or supplies; an exception to this general rule applies to durable medical equipment delivered for discharge and ambulance transportation.

(2) A physician’s services are not reimbursed to a hospital under Hospital Services regulations, but may be payable as a professional component of a service. See 8.310.2 NMAC, *Medical Services Providers*, for information on the professional component of services.

(3) Transportation services are billed as part of a hospital claim if the hospital is DRG reimbursed and transportation is necessary during the inpatient stay.

(a) Transportation is included in a DRG payment when an eligible recipient is transported to a different facility for procedure(s) not available at the hospital where the eligible recipient is a patient.

(b) Exceptions are considered for air ambulance services operated by a facility when air transportation constitutes an integral part of the medical services furnished by the facility. See 8.324.7 NMAC, *Transportation Services.*

L. Reimbursement limitations for capital costs: Reimbursement for capital costs follows the guidelines set forth in HIM-15. See P.L. 97-248 (TEFRA). In addition, MAD applies the following restrictions for new construction:

(1) The total basis of depreciable assets does not exceed the median cost of constructing a hospital as listed in an index acceptable to MAD, adjusted for New Mexico costs and for inflation in the construction industry from the date of publication to the date the provider is expected to become a MAD provider.

(2) The cost of construction is expected to include only the cost of buildings and fixed equipment.

(3) A reasonable value of land and major movable equipment is added to obtain the value of the entire facility.

[8.311.2.14 NMAC – Rp 8.311.2.14, 7/01/2024]

8.311.2.15 OUTPATIENT SERVICES: MAD covers outpatient services which are medically necessary for prevention, diagnosis or rehabilitation as indicated by the condition of an eligible recipient. Services must be furnished within the scope and practice of a professional provider as defined by state laws and regulations.

A. Outpatient covered services: Covered hospital outpatient care includes the use of minor surgery or cast rooms, intravenous infusions, catheter changes, first aid care of injuries, laboratory and radiology services, and diagnostic and therapeutic radiation, including radioactive isotopes. A partial hospitalization program in a general hospital psychiatric unit is considered under outpatient services. See 8.321.5 NMAC, *Outpatient Psychiatric Services and Partial Hospitalization*.

B. Outpatient noncovered services: MAD does not cover the following specific outpatient benefits:

(1) outpatient hospital services not considered medically necessary for the condition of the eligible recipient;

(2) outpatient hospital services that require prior approval for which the approval was not requested except in cases with extenuating circumstances as granted by MAD or its designee;

(3) outpatient hospital services furnished to an individual who was not eligible for MAD services on the date of service;

(4) experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests, and imaging services; see 8.325.6 NMAC, *Experimental or Investigational Procedures or Therapies*;

(5) drugs classified as "ineffective" by the federal food and drug administration;

(6) laboratory specimen handling or mailing charges; and

(7) formal educational or vocational services which relate to traditional academic subjects or training for employment.

C. MCO payment rates: If a provider and an MCO are unable to agree to terms or fail to execute an agreement for any reason, the MCO shall be obliged to pay, and the provider shall accept, 100 percent of the "applicable reimbursement rate" based on the provider type for services rendered under both emergency and non-emergency situations. The "applicable reimbursement rate" is defined as the rate paid by HCA to the provider participating in medicaid or other medical assistance programs administered by HCA and excludes disproportionate share hospital and medical education payments.

D. Prior authorization: Certain procedures or services performed in outpatient settings can require prior approval from MAD or its designee. Outpatient physical, occupational, and speech therapies services require prior authorization.

E. Reimbursement for outpatient services: Effective November 1, 2010, outpatient hospital services are reimbursed using outpatient prospective payment system (OPPS) rates. The OPPS rules for payment for packaged services, separately reimbursed services are based on the medicare ambulatory payment classification (APC) methodology.

(1) Reimbursement for laboratory services, radiology services, and drug items will not exceed maximum levels established by MAD. Hospitals must identify drugs items purchased at 340B prices.

(2) Services or supplies furnished by a provider under contract or through referral must meet the contract services requirements and be reimbursed based on approved methods. See 8.302.2 NMAC, *Billing For Medicaid Services.*

(3) For critical access hospital providers, the MAD outpatient prospective payment system (OPPS) fee-for-service rate will be set based on the provider's reported cost to charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012.

(4) For services not reimbursed using the outpatient prospective payment system (OPPS) methodology or fee schedule, reimbursement for a MAD fee-for-service provider will be made using the medicare allowable cost method, reducing medicare allowable costs by three percent. An interim rate of payment is

established by MAD. A rate of payment for providers not subject to the cost settlement process is also established by MAD to equal or closely approximate the final payment rates that apply under the cost settlement TEFRA principals. If the provider is not cost settled, the reimbursement rate will be at the provider's cost to charge ratio reported in the provider's most recently filed cost report prior to February 1, 2012. Otherwise, rates are established after considering available cost to charge ratios, payment levels made by other payers, and MAD payment levels for services of similar cost, complexity and duration.
[8.311.2.15 NMAC – Rp 8.311.2.15, 7/01/2024]

8.311.2.16 EMERGENCY ROOM SERVICES: MAD covers emergency room services which are medically necessary for the diagnosis and treatment of medical or surgical emergencies to an eligible recipient and which are within the scope of the MAD program.

A. Covered emergency services: An emergency condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

B. Retrospective review: An emergency room service may be subject to prepayment or post-payment review. A provider, including an enrolled provider, a non-enrolled provider, a managed care organization provider, or an out of network provider cannot bill an eligible recipient for emergency room services including diagnostic and ancillary services which have been denied due to lack of medical necessity or lack of being an emergency except as specifically allowed by 8.302.2 NMAC, *Billing for Medicaid Services*. When an eligible recipient has identified himself or herself to a provider as a medicaid eligible recipient and is enrolled in a managed care organization, the provider of services must accept and adhere to the provisions of 42 CFR 438 Subpart C Enrollee Rights and Protections which state the administrative and payment responsibilities of a managed care organization and limit the financial responsibilities that can be passed on to an eligible recipient. Payment may be limited to medically necessary diagnostic and treatment services to sufficiently assess the recipient's condition and need for emergency services, the duration of a condition, and available alternatives to emergency room services.

C. Prior authorization: Some services or procedures performed in an emergency room setting need prior approval from MAD or its designee. Procedures that require prior approval in non-emergency settings also require prior approval in emergency settings.

D. Noncovered emergency services: MAD does not cover the following specific emergency services:

(1) diagnostic and other ancillary services which are not considered medically necessary as emergency services;

(2) emergency services furnished to individuals who were not eligible for MAD services on the date of service;

(3) experimental or investigational procedures, technologies or therapies and the services related to them, including hospitalization, anesthesiology, laboratory tests and imaging services; see 8.325.6 NMAC, *Experimental or Investigational Procedures or Therapies*;

(4) drugs classified as "ineffective" by the federal food and drug administration; and

(5) laboratory specimen handling or mailing charges.

E. Reimbursement for emergency room service: An emergency service furnished by an eligible provider is reimbursed as outpatient hospital services. See Subsection D of 8.311.2.15 NMAC, *reimbursement for outpatient services*.

(1) An emergency room service furnished in a DRG-reimbursed hospital in conjunction with an inpatient admission is included with the charges for inpatient care. In this case, a payment for an emergency room service is included in the DRG rate.

(2) A physician's service furnished in an emergency room is not reimbursed to a hospital but may be paid as a professional component of a service. See 8.310.2 NMAC, *Medical Services Providers*.

(3) A service furnished in an urgent care center of a hospital which does not meet the definition of an emergency, may not be submitted as an emergency room service.
[8.311.2.16 NMAC – Rp 8.311.2.16, 7/01/2024]

HISTORY OF 8.311.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 310.0200, Hospital Services, filed 1/9/1980.
ISD 310.0200, Hospital Services, filed 12/8/1990.
ISD 310.0200, Hospital Services, filed 12/30/1981.
ISD 310.0200, Hospital Services, filed 4/2/1982.
ISD 310.0200, Hospital Services, filed 7/8/1982.
ISD Rule 310.0200, Hospital Services, filed 4/5/1983.
ISD Rule 310.0200, Hospital Services, filed 2/15/1984.
ISD Rule 310.0200, Hospital Services, filed 4/26/1984.
ISD Rule 310.0200, Hospital Services, filed 2/21/1986.
MAD Rule 310.02, Hospital Services, filed 12/1/1987.
MAD Rule 310.02, Hospital Services, filed 4/27/1988.
MAD Rule 310.02, Hospital Services, filed 5/23/1988.
MAD Rule 310.02, Hospital Services, filed 8/18/1988.
MAD Rule 310.02, Hospital Services, filed 3/20/1989.
MAD Rule 310.02, Hospital Services, filed 7/2/1990.
MAD Rule 310.02, Hospital Services, filed 3/27/1992.
MAD Rule 310.02, Hospital Services, filed 4/21/1992.
MAD Rule 310.02, Hospital Services, filed 5/1/1992.
MAD Rule 310.02, Hospital Services, filed 7/14/1993.
MAD Rule 310.02, Hospital Services, filed 3/10/1994.
MAD Rule 310.02, Hospital Services, filed 6/15/1994.
MAD Rule 310.02, Hospital Services, filed 12/8/1994.

History of Repealed Material:
MAD Rule 310.02, Hospital Services, filed 12/8/1994 - Repealed effective 2/1/1995.
8 NMAC 4.MAD.721, Hospital Services, filed 1/18/1995 - Repealed effective 1/1/2009.
8.311.2 NMAC, Hospital Services, filed 1/1/2009 – Repealed effective 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 313 LONG TERM CARE SERVICES - INTERMEDIATE CARE FACILITIES
PART 2 INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

8.313.2.1 ISSUING AGENCY: Health Care Authority, Medical Assistance Division
[8.313.2.1 NMAC – Rp 8.313.2.1, 7/01/2024]

8.313.2.2 SCOPE: This rule applies to the general public.
[8.313.2.2 NMAC – Rp 8.313.2.2, 7/01/2024]

8.313.2.3 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 health care authority pursuant to state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.313.2.3 NMAC – Rp 8.313.2.3, 7/01/2024]

8.313.2.4 DURATION: Permanent
[8.313.2.4 NMAC – Rp 8.313.2.4, 7/01/2024]

8.313.2.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.313.2.5 NMAC – Rp 8.313.2.5, 7/01/2024]

8.313.2.6 OBJECTIVE: The objective of these regulations is to govern the service portion of the New Mexico medicaid and medical assistance programs. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.313.2.6 NMAC – Rp 8.313.2.6, 7/01/2024]

8.313.2.7 DEFINITIONS: [**RESERVED**]
[8.313.2.7 NMAC – Rp 8.313.2.7, 7/01/2024]

8.313.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of HCA/MAD program eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.313.2.8 NMAC – Rp 8.313.2.8, 7/01/2024]

8.313.2.9 INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to recipients, including services furnished by intermediate care facilities for the mentally retarded [42 CFR 440.150]. This section describes eligible providers, covered services, service restrictions, personal fund accounts, and general reimbursement methodology.
[8.313.2.9 NMAC – Rp 8.313.2.9, 7/01/2024]

8.313.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by New Mexico medical assistance division (MAD), intermediate care facilities for the mentally retarded (ICF-MR) which meet the following conditions for participation are eligible to be reimbursed for providing services to eligible medicaid recipients:

(1) the ICF-MR must be licensed and certified by the division of health improvement, health facility licensing and certification bureau of the New Mexico department of health (DOH) to meet the intermediate care facility requirements. See 42 CFR 483 Subpart I;

(2) the ICF-MR must comply with 8.313.2.17 NMAC, *Recipient Personal Fund Accounts*; and

(3) the ICF-MR must participate in the MAD utilization review process and must agree to operate in accordance with all policies and procedures of that system, including the performance of discharge planning.

B. Once enrolled, providers receive instruction on how to access medicaid and other medical assistance provider program policies, billing instructions, utilization review instructions, and other pertinent material. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements. To be eligible for medical assistance program reimbursement, providers are bound by the provisions of the provider participation agreement.
[8.313.2.10 NMAC – Rp 8.313.2.10, 7/01/2024]

8.313.2.11 APPEALS PROCESS FOR DENIAL, TERMINATION OR NON-RENEWAL OF PARTICIPATION: See Section MAD-967.5, *Appeals for Denial, Termination, or Non-Renewal of Provider Participation*.
[8.313.2.11 NMAC – Rp 8.313.2.11, 7/01/2024]

8.313.2.12 SANCTIONS AND PENALTIES: See Section MAD-967, *Sanctions for Non-Compliance* and Section MAD-968, *Intermediate Remedies*.
[8.313.2.12 NMAC – Rp 8.313.2.12, 7/01/2024]

8.313.2.13 PROVIDER RESPONSIBILITIES:

A. Providers who furnish services to HCA/MAD program eligible recipients must comply with all specified HCA/MAD participation requirements. See Section MAD-701, *General Provider Policies*.

B. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Providers must maintain any and all medical or business records as necessary to fully disclose the type and extent of services provided to recipients. See Section MAD-701, *General Provider Policies*.
[8.313.2.13 NMAC – Rp 8.313.2.13, 7/01/2024]

8.313.2.14 REQUIRED SERVICES: Medicaid does not reimburse ICFs-MR for furnishing services, unless they provide at least the following, see 42 CFR 483.440(a):

A. room and board;

B. continuous active treatment program, including aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed towards the following:

(1) acquisition of the behaviors necessary for the recipient to function with as much self determination and independence as possible; and

(2) prevention or deceleration of regression or loss of current functional status.

C. personal assistance services twenty-four (24) hours a day, seven (7) days a week; personal assistance services are those services, other than professional nursing services, which may be needed by an individual because of age, infirmity, physical or mental limitations, and/or dependence in accomplishing the activities of daily living.
[8.313.2.14 NMAC – Rp 8.313.2.14, 7/01/2024]

8.313.2.15 COVERED SERVICES: Medicaid covers the costs of ICF-MR services identified as allowable. See Section MAD-732-D, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*, Section III.G. Pharmacy services furnished in the ICF-MR are reimbursed separately and are subject to specific requirements. See Section MAD-753, *Pharmacy Services*.
[8.313.2.15 NMAC – Rp 8.313.2.15, 7/01/2024]

8.313.2.16 NONCOVERED SERVICES:

A. Medicaid does not cover the costs of ICF-MR services that are not allowable. See Section MAD-732-D, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*.

B. Medicaid does not pay for residents with a primary diagnosis of mental retardation who are receiving care in a general nursing facility setting. Coverage of these residents is included only when they are residing in an ICF-MR facility or in a nursing facility when they have a medical condition which by and of itself would justify NF care.

[8.313.2.16 NMAC – Rp 8.313.2.16, 7/01/2024]

8.313.2.17 RECIPIENT PERSONAL FUND ACCOUNTS:

A. As a condition for participation in medicaid, each ICF-MR must establish and maintain an acceptable system of accounting for a resident's personal funds when a Title XIX (medicaid) recipient requests that his or her personal funds be cared for by the facility. See 42 CFR 483.10(c).

(1) Requests for ICFs-MR to care or not care for a resident's funds must be made in writing and secured by a request to handle recipient's fund form or a letter signed by the resident or his/her representative. The form or letter is retained in the recipient's file at the facility.

(2) A recipient's personal fund consists of a monthly maintenance allowance established by MAD. If the resident receives any income in excess of this allowance, the excess is applied to the cost of the resident's medical care at the facility. This excess is reported as a medical care credit to the facility by the local county income support division (ISD) office, when applicable.

(3) All facilities must have procedures on the handling of medicaid residents' funds. These procedures must not allow the facility to commingle medicaid residents' funds with facility funds.

(4) Facilities should use these medicaid guidelines to develop procedures for handling resident funds.

(5) Residents have the right to manage their financial affairs and no facility can require residents to deposit their personal funds with the facility.

(6) Facilities must purchase a surety bond or provide self-insurance to ensure the security of all personal funds deposited with the facility.

B. Fund custodians: Facilities must designate a full-time employee and an alternate to serve as fund custodians for handling all medicaid residents' money on a daily basis. Another individual, other than those employees who have daily responsibility for the fund, must do the following:

(1) reconcile balances of the individual medicaid residents' accounts with the collective bank account;

(2) periodically audit and reconcile the petty cash fund;

(3) authorize checks for the withdrawal of funds from the bank account; and

(4) facilities must ensure that there is a full, complete and separate accounting, based on generally accepted accounting principles, of each resident's personal funds entrusted to facilities on the resident's behalf.

C. Bank account: Facilities must establish a bank account for the deposit of all medicaid residents who request the facility to handle their funds. Residents' personal funds are held separately and not commingled with facility funds.

(1) Facilities must deposit any resident's personal funds of more than fifty dollars ($50) in an interest bearing account that is separate from any of the facility operating accounts and which credits all interest earned on the resident's account to that account.

(2) Facilities must maintain residents' personal fund up to fifty dollars ($50) in a non-interest bearing account or a petty cash fund. Residents must have convenient access to these funds.

(3) Individual financial records must be available on the request of residents or their legal representatives.

(4) Within 30 days of the death of residents whose personal funds are deposited with the facility, the ICF-MR must convey the resident's funds and a final accounting of these funds promptly to the individual or probate jurisdiction administering the resident's estate.

D. Establishment of individual accounts: Facilities must establish accounts for each medicaid resident in which all transactions can be recorded. Accounts can be maintained in a general ledger book, card file, or looseleaf binder.

(1) For money received, the source, amount, and date must be recorded. Residents or their authorized representatives must be given receipts for the money. The facility must retain a copy of the deposit in the resident's individual account file.

(2) The purpose, amount and date of all disbursements to or on behalf of residents must be recorded. Any money spent either on behalf of residents or withdrawn by residents or their representatives must be validated by receipts or signatures on individual ledger sheets.

(3) Facilities must notify each medicaid resident when the account balance is two hundred ($200) dollars less than the supplemental security income (SSI) resource limit for one person, specified in section 1611(a)(3)(B) of the Social Security Act. If the amount of the account and the value of the resident's other

nonexempt resources reach the SSI resource limit for one person, the resident can lose eligibility for medicaid or SSI.

E. Personal fund reconciliation: Facilities must balance the individual accounts, the collective bank accounts and the petty cash fund at least once a month. The facility must provide medicaid residents or their authorized representatives with an accounting of the resident's funds at least once a quarter. Copies of individual account records can be used to provide this information.

F. Petty cash fund: Facilities must maintain a cash fund to accommodate the small cash requirements of medicaid residents. Five dollars ($5.00) or less per individual recipient may be adequate. The amount of money maintained in the petty cash fund is determined by the number of residents using the service and the frequency and availability of bank service. A petty cash fund ledger must be established to record all actions regarding money in this fund.

(1) To establish the fund, the ICF-MR must withdraw money from the collective bank account and keep it in a locked cash box.

(2) To use the petty cash fund, the following procedures should be established:

(a) recipients or their authorized representatives request small amounts of spending money;

(b) the amount disbursed is entered on individual ledger record; and

(c) the resident or representative signs an account record and receives a receipt.

(3) To replenish the fund, the following procedures should be used:

(a) money in the cash box is counted and added to the total of all disbursements made since the last replenishment; and

(b) the total of the disbursements plus cash on hand equals the beginning amount;

(c) money equal to the amount of disbursements is withdrawn from the collective bank account.

(4) To reconcile the fund, the following procedures must be established and used at least once each month:

(a) count money on hand; and

(b) total cash disbursed either from receipts or individual account records; the cash on hand plus total disbursements equals the petty cash total.

(5) To close the resident's account, ICFs-MR should do the following:

(a) enter date of and reason for closing the account;

(b) write a check against the collective bank account for the balance shown on the individual account record;

(c) get signature of the recipient or their authorized representative on the individual recipient account record, as receipt of payment;

(d) notify the local ISD office if closure is caused by the death of the recipient so that action can be taken to terminate assistance; and

(e) within 30 days of the death of a resident who had no relatives, the ICF-MR conveys the resident's funds and a final accounting of the funds to the individual or probate jurisdiction administering the resident's estate; see 42 CFR 483.10(c)(6).

G. Retention of records: All account records other than financial and statistical cost reports must be retained until after an audit is complete or six years, whichever is greater. For details on retention of financial and statistical cost reports, see Subsection D of 8.313.3.12 NMAC *Retention of Records*.

H. Non-acceptable uses of recipients' personal funds:

(1) Facilities cannot impose charges against a resident's personal funds for any item or service for which payment is made by medicaid or for any item residents or their representatives did not request. Facilities must not require residents or representative to request any item or services as a condition of admission or continued stay.

(2) Facilities must inform residents or representative requesting non-covered items or services that there is a charge for the item and the amount of the charge.

(3) Non-acceptable uses of residents' personal funds include the following:

(a) payment for services or supplies covered by medicaid or medicare; see 8.313.3 NMAC, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*;

(b) difference between the facility billed charge and the medicaid payment; or

(c) payment for services or supplies routinely furnished by the facility, such as linens and nightgowns.

I. State monitoring of residents' personal funds: Facilities must make all files and records involving residents' personal funds available for inspection by authorized state personnel or federal auditors.

(1) The division of health improvement, health facility licensing & certification bureau of the DOH verifies that facilities have a system of accounting for residents' personal funds, including the components described above. Failure to provide an acceptable accounting system constitutes a deficiency that must be corrected.

(2) The health care authority (HCA) or its designee can complete a thorough audit of residents' personal fund accounts at HCA's discretion.

[8.313.2.17 NMAC – Rp 8.313.2.17, 7/01/2024]

8.313.2.18 LEVEL OF CARE DETERMINATION: Medical necessity, level of care or length of stay determinations, and on-site review activities are carried out in accordance with the MAD utilization review policy and procedures, authorized under Title XIX of the Social Security Act. See MAD-954 [8.350.3 NMAC], *Abstract Submission for Level of Care Determinations*.

[8.313.2.18 NMAC – Rp 8.313.2.18, 7/01/2024]

8.313.2.19 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All HCA/MAD program services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: Certain procedures or services can require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for HCA/MAD programs. Providers must verify that individuals are eligible for HCA/MAD programs at the time services are furnished and determine if HCA/MAD program recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953, *Reconsideration Of Utilization Review Decisions*.

[8.313.2.19 NMAC – Rp 8.313.2.19, 7/01/2024]

8.313.2.20 RESERVE BED DAYS: Medicaid pays to hold or reserve a bed for a resident of an ICF-MR for the following reasons: 1) to allow the resident to make home and community visits, e.g., vacations; 2) to adjust to a new living environment; or 3) for hospitalizations.

A. Coverage of reserve bed days: Without prior authorization, medicaid covers 65 reserve bed days per calendar year for every resident for family visits, vacations, home visits, hospitalizations and adjustment to a new living environment. Reserve bed days used under this section require documentation in the facility or the client records for all absences from the facility. If the absence from the facility is not documented in the facility or the client records, medicaid will recoup the reserve bed day payment. If the resident is away from the facility with facility staff supervision, the absence is not considered a reserve bed day.

B. Prior authorization: After the 65 days have been expended, medicaid covers, with prior authorization, an additional six reserve bed days per calendar year for discharge planning.

(1) A resident’s discharge plan must clearly state the objectives, including how visits to alternative placements relate to discharge plan implementation.

(2) To obtain medicaid prior authorization, the facility must submit the following information in writing to MAD:

- **(a)** the resident’s name;
- **(b)** social security number;
- **(c)** requested approval dates;
- **(d)** copy of the discharge plan;
- **(e)** name and address of the individual who will care for the resident; and
- **(f)** written physician order for trial placement.

(3) Documentation of the resident’s absence from the facility for these six additional reserve bed days must be in the facility or the client records.

C. Documentation of reserve bed days: If residents leave the ICF-MR for any reason, documentation of the absence from the facility must be in the facility or client records. Hospitalizations must be documented in the client records at the ICF-MR.

D. Reimbursement and billing for reserve bed days: Reimbursement for reserve bed days to the ICF-MR is limited to the provider's level III rate. Billing for reserve bed days is based on the facility census, which runs from midnight to midnight. Medicaid pays for the admission day but does not pay for the discharge day. To receive payment for the additional six reserve bed days, which require prior authorization, the provider must attach a copy of the written notification of approval by MAD to the claim.

[8.313.2.20 NMAC – Rp 8.313.2.20, 7/01/2024]

8.313.2.21 Reimbursement: Intermediate care providers must submit claims for reimbursement on the long term care turn around documents (TAD) or its successor. See Section MAD-702, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

A. MAD reimburses ICF-MR the lower of the following:

(1) the provider's billed charges; or

(2) the prospective rate as constrained by the ceilings established by MAD. See Section MAD-732-D, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*.

B. Reimbursement limitations: Medicaid pays only those ICF-MRs which meet the conditions for participation, specified in this section. Payments to ICF-MRs for services are limited to those services which are included as allowable service costs under the approved state plan. All claims for payment submitted to MAD are subject to utilization review and control.

C. Reimbursement methodology: See Section MAD-732-D, *Cost Related Reimbursement of Intermediate Care Facilities for the Mentally Retarded*.

[8.313.2.21 NMAC – Rp 8.313.2.21, 7/01/2024]

HISTORY OF 8.313.2 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
ISD 310.0300, Care In Skilled Nursing Facility And Intermediate Care Facility, 2/27/1980.
SP-004.1401, Utilization Review Plan for Intermediate Care Facilities, 6/10/1981.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility, 12/1/1987.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility, 1/6/1988.
MAD Rule 310.03, Care In Skilled Nursing Facility And Intermediate Care Facility For The Mentally Retarded, 3/27/1992.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 313 LONG TERM CARE SERVICES - INTERMEDIATE CARE FACILITIES
PART 3 COST RELATED REIMBURSEMENT OF ICF-MR FACILITIES

8.313.3.1 ISSUING AGENCY: Health Care Authority, Medical Assistance Division
[8.313.3.1 NMAC – Rp 8.313.3.1, 7/01/2024]

8.313.3.2 SCOPE: This rule applies to the general public.
[8.313.3.2 NMAC – Rp 8.313.3.2, 7/01/2024]

8.313.3.3 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 health care authority pursuant to state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.313.3.3 NMAC – Rp 8.313.3.3, 7/01/2024]

8.313.3.4 DURATION: Permanent
[8.313.3.4 NMAC – Rp 8.313.3.4, 7/01/2024]

8.313.3.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.313.3.5 NMAC – Rp 8.313.3.5, 7/01/2024]

8.313.3.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.313.3.6 NMAC – Rp 8.313.3.6, 7/01/2024]

8.313.3.7 DEFINITIONS:

A. Accrual basis of accounting: Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected. The expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

B. Cash basis of accounting: Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

C. Governmental institution: A provider of services owned and operated by a federal, state or local governmental agency.

D. Allocable costs: An item or group of items of cost chargeable to one or more objects, precesses, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

E. Applicable credits: Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of over-payments or erroneous charges; and other income items which serve to reduce costs. In some instances, the amounts received from the federal government to finance hospital activities or service operations should be treated as applicable credits.

F. Charges: The regular rates established by the provider for services rendered to both medicaid recipients and to other paying patients whether inpatient or outpatient. The rate billed to the authority shall be the usual and customary rate charged to all patients.

G. Cost finding: A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuos or formal basis. It is the determination of the cost of an operation by the allocation of direct costs and the proration of indirect costs.

H. Cost center: A division, department, or subdivision thereof, a group of services or employees or both, or any other unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

I. General service cost centers: Those cost centers which are operated for the benefit of other

general service areas as well as special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant, maintenance of plant, etc. Costs incurred for these cost center are allocated to other cost centers on the basis of services rendered.

J. Special service cost centers: Commonly referred to as ancillary cost center. Such centers usually provide direct identifiable services to individual patients, and include departments such as the physical therapy and supply departments.

K. Inpatient cost centers: Cost centers established to accumulate costs applicable to providing routine and ancillary services to inpatients for the purposes of cost assignment and allocation.

L. Provider: The entity responsible for the provision of services. The provider must have entered into a valid agreement with the medicaid program for the provision of such services.

M. Facility: The actual physical structure in which services are provided.

N. Owner: The entity holding legal title to the facility.

[8.313.3.7 NMAC – Rp 8.313.3.7, 7/01/2024]

8.313.3.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.

[8.313.3.8 NMAC – Rp 8.313.3.8, 7/01/2024]

8.313.3.9 COST RELATED REIMBURSEMENT OF ICF-MR FACILITIES: The New Mexico title XIX program makes reimbursement for appropriately licensed and certified intermediate care facilities for the mentally retarded as outlined in this material.

[8.313.3.9 NMAC – Rp 8.313.3.9, 7/01/2024]

8.313.3.10 GENERAL REIMBURSEMENT POLICY: The health care authority will reimbursement ICF/MR facilities the lower of the following, effective September 1, 1990:

A. billed charges;

B. the prospective rate as constrained by the ceilings (Section V) established by the authority as described in this plan.

[8.313.3.10 NMAC – Rp 8.313.3.10, 7/01/2024]

8.313.3.11 DETERMINATION OF ACTUAL, ALLOWABLE AND REASONABLE COSTS AND SETTING OF PROSPECTIVE RATES

A. Adequate cost data

(1) Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

(2) The cost finding method to be used by ICF-MR providers will be the step-down method. This method recognizes that services rendered by certain non-revenue producing departments or centers are utilized by certain other non-revenue producing centers. All cost of non-revenue producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the non-revenue producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greater amount of expense will be allocated first.

B. Reporting year: For the purpose of determining a prospective per diem rate related to cost for ICF-MR services, the reporting year is the provider's fiscal year. The provider will submit a cost report each fiscal year.

C. Cost reporting

(1) At the end of each fiscal year the provider will provide to the state agency or its audit agent an itemized list of allowable costs (financial and statistical report) on the N.M. title XIX cost reporting form. This cost report must be submitted on an annual basis to MAD or its designee within the time frames specified by medicare. ICFs-MR will not be granted an extension to the cost report filing time frames. Failure to file a cost

report within the specified time frames will result in suspension of title XIX payments.

(2) In the case of a change of ownership, the previous provider must file a final cost report as of the date of the change of ownership in accordance with reporting requirements specified in this plan. The authority will withhold the last two month's payment to the previous provider as security against any outstanding obligations to the authority. The provider must notify the authority 60 days prior to any change of ownership.

D. Retention of records

(1) Each ICF-MR provider shall maintain financial and statistical records of the period covered by a cost report for a period of not less than four years following the date of submittal of the cost report to the state agency. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider shall make such records available upon demand to representatives of the state agency, the state audit agent, or the department of health and human services.

(2) The state agency or its audit agent will retain all cost reports submitted by providers for a period of not less than three years following the date of final settlement of such report.

E. Audits: Audits will be performed in accordance with 42 CFR 447.202.

(1) Desk audit: Each cost report submitted will be subject to a comprehensive desk audit by the state audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the state agency.

(2) Field audit: Field audits will be performed on all providers at least once every three years. The purpose of the field audit of the provider's financial and statistical records is to verify that the data submitted on the cost report are in fact accurate, complete and reasonable. The field audits are conducted in accordance with generally accepted auditing standards and of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost. The field audit will also determine whether the expenses attributable to such proper items of cost were reasonably and accurately determined. After each field audit is performed, the audit agent will submit a complete report of the audit to the state agency. This report will meet generally accepted auditing standards and shall declare the auditor's opinion as to whether, in all material respects, the costs reported by the provider are allowable, accurate and reasonable in accordance with the state plan. These audit reports will be retained by the state agency for a period of not less than three years from the date of final settlement of such reports.

F. Overpayments: All overpayments found in audits will be accounted for on the HCFA 64 report to HHS no later than the second quarter following the quarter in which found.

G. Allowable costs: The following identifies costs that are allowable in the determination of a provider's actual, allowable and reasonable costs. All costs are subject to all other terms stated in the medicare provider reimbursement manual (PRM 15-1) that are not modified by these regulations.

(1) Cost of meeting certification standards: These will include all items of expense that the provider must incur under:

(a) 42 CFR 442;

(b) Sections 1861(j) and 1902(a)(28) of the Social Security Act;

(c) standards included in 42 CFR 431.610;

(d) cost incurred to meet requirements for licensing under state law which are necessary to provide ICF-MR service.

(2) Costs of routine services: Allowable costs shall include all items of expense that providers incur to provide routine services, known as operating costs. Operating costs include such things as:

(a) regular room;

(b) dietary and nursing services;

(c) medical and surgical supplies (including but not limited to syringes, catheters, ileostomy, and colostomy supplies);

(d) use of equipment and facilities;

(e) general services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas;

(f) items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans;

(g) items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol and body rubs, applicators, cotton balls, bandaids, laxatives and fecal softeners, aspirin, antacids, OTC ointments, and tongue depressors;

(h) items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, oxygen

administration equipment, and other durable equipment;

(i) special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician;

(j) laundry services other than for personal clothing;

(k) oxygen for emergency use--the authority will allow two options for the purchase of oxygen for patients for whom the attending physician prescribes oxygen administration on a regular or on-going basis:

(i) the provider may purchase the oxygen and include it as a reimbursable cost in its cost report; this is the same as the method of reimbursement for oxygen administration equipment; or

(ii) the authority will make payment directly to the medical equipment provider in accordance with procedures outlined in medical assistance manual Section 754, medical supplies, and subject to the limitations on rental payments contained in that section.

(l) all services delivered in relation to active treatment, such as physical therapy, occupational therapy, speech therapy, psychology services, recreational therapy, etc.;

(m) managerial, administrative, professional and other services related to the providers operation and rendered in connection with patient care.

(3) Facility cost, for the purpose of specific limitations included in this plan, include only depreciation, lease costs, and long term interest.

(a) Depreciation is the systematic distribution of the cost or other basis of tangible assets, less salvage value, over the estimated life of the assets.

(i) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.

(ii) Historical cost is the actual cost incurred in acquiring and preparing an asset for use.

(iii) Fair market value is the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between an informed buyer and seller, neither being under any compulsion to buy or sell. Fair market value shall be determined by a qualified appraiser who is a registered member of the American institute of real estate appraisers (MAI) and who is acceptable to the authority

(iv) In determining the historical cost of assets where an on-going facility is purchased, the provisions of medicare provider reimbursement manual PRM 15-1 will apply.

(v) Depreciation will be calculated using the straight-line method and estimated useful lives approximating the guidelines published in American hospital association useful live's guide.

(b) Long-term interest is the cost incurred for the use of borrowed funds for capital purposes, such as the acquisition of facility, equipment, improvements, etc., where the original term of the loan is more than one year.

(c) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

H. Non-allowable costs

(1) Bad debts, charity, and courtesy allowances: Bad debts on non-title XIX program patients and charity and courtesy allowances shall not be included in allowable costs.

(2) Purchases from related organizations: Cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere. Providers shall identify such related organizations and costs in the states' cost reports.

(3) return on equity capital.

(4) other cost and expense items identifies as unallowable in PRM 15-1.

(5) interest paid on overpayments as per MAD-702, *Billing for Medicaid Services*.

(6) any civil monetary penalties levied in connection with licensure, certification, or fraud regulations.

[8.313.3.11 NMAC – Rp 8.313.3.11, 7/01/2024]

8.313.3.12 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATES: Prospective per diem rates will be established as follows and will be the lower of the amount calculated using the following formulas, or any applicable ceiling:

A. Base year

(1) For implementation year 1 (effective September 1, 1990), the providers base year will be

for cost reports filed for base year periods ending no later than June 30, 1990. Since these cost reports will not be audited at the time of implementation, an interim rate will be calculated and once the audited cost report is settled, a final prospective rate will be determined. Retrospective settlements of over or under payments resulting from the use of the interim rate will be made.

(2) Re-basing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as year 1, year 2, and year 3. Since re-basing is done every three years, operating year 4 will again become year 1.

(3) Costs incurred, reported, audited and/or desk reviewed for the provider's last fiscal year which falls in the calendar year prior to year 1 will be used to re-base the prospective per diem rate. Re-basing costs in excess of 110% of the previous year's reported cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs.

B. Inflation factor to recognize economic conditions and trends during the time period covered by the facility's prospective per diem rate. Pursuant to budget availability and at the authority's discretion, an inflation factor may be used to recognize economic conditions and trends. A notice will be sent out every September informing each provider that:

(1) MBI will or will not be authorized for determining rates for the year; and

(2) the percentage increase if the MBI is authorized;

(3) if utilized, the index used to determine the inflation factor will be the center for medicare and medicaid services (CMS) market basket index (MBI);

(4) each provider's operating costs will be indexed to a mid-year point of February 28 for operating year 1;

(5) if utilized, the inflation factor will be the actual MBI for the previous calendar year.

C. Incentive to reduce increases in cost

(1) As an incentive to reduce the increases in the administrative and general (A&G) and room and board (R&B) cost center, the authority will share with the provider the savings below the A&G/R&B ceiling in accordance with the formula described below:

$$A = [1/2 (B-C)] < \$1.00$$

(2) Where:

A = allowable Incentive per diem
B = A&G/R&B ceiling per diem
C = allowable A&G/R&B per diem from the base year's cost report

D. Cost centers for rate calculation: For the purpose of rate calculation, costs will be grouped into four major cost centers. These are:

(1) direct patient care (DPC)

(2) administration and general (A&G)

(3) room and board (R&B)

(4) facility costs (FC)

E. Case-mix adjustment

(1) In assuring the prospective reimbursement system addresses the needs of residents of ICF-MR facilities, a case mix adjustment factor will be incorporated into the reimbursement system. The case-mix index (CMI) will be used to adjust the reimbursement levels in the direct patient care cost center. The key objective of the CMI is to link reimbursement to the acuity level of residents in a facility. To accomplish this objective, the authority utilizes level of care criteria which classify ICF-MR residents into one of three levels, with level I representing the highest level of need. Corresponding to each level of care, the relative values are as follows:

level I	1.077
level II	0.953
level III	0.768

(2) Using these level specific relative values, a provider specific base year CMI will be calculated. The CMI represents the weighted average of the residents' level of care divided by the total number of residents in the facility. The CMI is calculated as follows:

$$[(A \times 1.077)+(B \times .953)+(C \times .768)]/N = CMI$$

(3) WHERE: A = number of level I residents
B = number of level II residents
C = number of level III residents
N = total number of provider's residents

F. Calculation of the prospective per diem rate

(1) A prospective per diem rate for each of the three levels of ICF-MR classification will be determined for each provider. Payment will be made based on the rate for the level of classification of the recipient.

(2) The provider's direct patient care (DPC) allowable cost will be divided by the provider's CMI to determine the cost at a value of 1.00 for the base year. The adjusted DPC is then multiplied by the relative value of the level of classification to determine the DPC component of the rate. To this, will be added the allowable A & G and R & B amount and the allowable facility cost. The formula for the rates will be as follows:

(3) The formula for year 1 is: (A1 x RV) + C1 + D + E = PR (year 1)

(4) The formula for year 2 is: [(A1 x RV) + C1) x (1 + MBI)] + D + E = PR (year 2)

(5) The formula for year 3 is: [(A2 x RV) + C2) x (1 + MBI)] + D + E = PR (year 3)

(6) Where:

A = allowable DPC per diem adjusted to a value of 1.00
B = the relative value of the level of classification.
C = allowable A&G and R&B per diem
D = allowable incentive per diem
E = allowable facility cost per diem
MBI = market basket index
PR = prospective rate
RV = the relative value for the level
"1"= the numerical subscript means the date of the data used in the formula; for example, "A1" means the base direct patient care costs established in the base year, while "A2" would refer to the base direct patient care costs adjusted by the MBI.

G. Effective dates of prospective rates: Rates will be effective September 1 of each year for each facility.

H. Calculation of rates for existing providers that do not have actuals as of June 30, 1990, and for new providers entering the program after September 1, 1990. For existing and for new providers entering the program that do not have actuals, the provider's interim prospective per diem rate will become the sum of:

(1) the state wide average patient care cost per diem for each level plus;

(2) the A&G and R&B ceiling per diem plus;

(3) facility cost per diem as determined by using the medicare principles of reimbursement;

(4) after six months of operation or at the provider's fiscal year end, whichever comes later, the provider will submit a completed cost report; this will be audited to determine the actual allowable and reasonable cost for the provider; a final prospective rate will be established at that time, and retroactive settlement will take place.

I. Changes of provider by sale of an existing facility: When a change of ownership occurs, the provider's prospective rate per diem will become the sum of:

(1) the patient care cost per diem for each level, established for the previous owner plus;

(2) the A&G and R&B per diem established for the previous owner; plus

(3) allowable facility costs determined by using the medicare principles of reimbursement.

J. Changes of ownership by lease of an existing facility: When a change of ownership occurs, the provider's prospective per diem rate will become the sum of:

(1) the patient care cost per diem for each level established for the previous owner; plus

(2) the A&G and R&B per diem established for the previous owner; plus

(3) the lower of allowable facility cost or the ceiling on lease cost as described by this plan.

K. Sale/leaseback of and existing facility: When a sale/leaseback of an existing facility occurs, the provider's prospective rate will remain the same as before the transaction.

[8.313.3.12 NMAC – Rp 8.313.3.12, 7/01/2024]

8.313.3.13 ESTABLISHMENT OF CEILINGS: Ceilings on the four major cost centers will be established as follow:

A. Direct patient care: No ceiling will be imposed on this cost center.

B. A&G and R&B: The per diem costs for administration and general and for room and board will be grouped together for the establishment of a ceiling. This ceiling will be calculated at 110% of the median of allowable costs for the base year, indexed to 12/31 of the base year. The ceiling will then be indexed to the mid-point of year 1 and set. For years 2 and 3, the ceiling will not be recalculated, but rather will be indexed forward

using the appropriate inflation factor described earlier in these regulations.

C. Facility cost:

(1) No ceiling will be imposed on this cost center, except in relation to leases.

(2) Effective for leases executed and binding on both parties on or after September 1, 1990, total allowable lease costs for the entire term of the lease for each facility will be limited to an amount determined by a discounted cash flow technique which will provide the lessor and annual rate of return on the fair market value of the facility equal to one times the average of the rates of interest on special issues of public debt obligations issued to the federal hospital insurance trust fund for the twelve months prior to the date the facility became a provider in the New Mexico medicaid program. The rates of interest for this fund are published in both the federal register and the commerce clearing house (CCH).

(3) The rate of return described above will be exclusive of any escalator clauses contained in the lease. The effect of escalator clauses will be considered at the time they become effective and the reasonableness of such clauses will be determined by the inflation factor described in Subsection B of 8.313.3.12 NMAC of these regulations.

(4) Any appraisal necessary to determine the fair market value of the facility will be the sole responsibility of the provider an is not an allowable cost for reimbursement under the program. The appraisals must be conducted by an appraiser certified by a nationally recognized entity, and such appraiser must be familiar with the health care industry, specifically long term care, and must be familiar with geographic area in which the facility is located. Prior to the appraisal taking place, the provider must submit to the authority the name of the appraiser, a copy of his/her certification, and a brief description of the appraiser's relevant experience. The use of a particular appraiser is subject to the approval of the authority.

[8.313.3.13 NMAC – Rp 8.313.3.13, 7/01/2024]

8.313.3.14 ADJUSTMENTS TO BASE YEAR COSTS: Since rebasing of the prospective per diem rate will take place every three years, the authority recognizes that certain circumstances may warrant an adjustment to the base rate. Therefore, the provider may request such an adjustment for the following reasons:

A. Additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation authorities, or applicable law (e.g. minimum staffing requirements, minimum wage change, property tax increases, etc.)

B. Additional costs incurred as a result of uninsurable losses from catastrophic occurrences.

C. Additional costs of approved expansion, remodeling or purchase of equipment.

D. Such additional costs must reach minimum of $5,000 for facilities with 16 or more beds and $1000 for facilities with 15 or less beds, of incurred cost per year for rebasing to be considered. The provider may request consideration of such rebasing no more than twice in its fiscal year. The provider is encouraged to submit such rebasing requests before the cost is actually incurred if possible. The authority will approve or disapprove the rebasing request in a timely manner. If the rebasing is approved, the resulting increase in the prospective per diem rate will go into effect: 1) beginning with the month the cost was actually incurred if prior approval was obtained, or 2) no later than 30 days from the date of receipt of the request if retroactive approval was obtained. At no time will rebasing in excess of any applicable ceilings be allowed.

[8.313.3.14 NMAC – Rp 8.313.3.14, 7/01/2024]

8.313.3.15 RESERVE BED DAYS: Reserve bed days will be paid using the provider's level III rate.

[8.313.3.15 NMAC – Rp 8.313.3.15, 7/01/2024]

8.313.3.16 CAREGIVERS CRIMINAL HISTORY SCREENING: The MAD will reimburse providers for the medicaid portion of the billed amount that providers paid to the New Mexico department of health (DOH). The following is the billing format.

A. Each ICF-MR will pay DOH by check according to DOH regulations.

B. A copy of the check(s) that the ICF-MR sent to DOH will be submitted to medicaid for payment on a quarterly basis on a medicaid reimbursement voucher (available at MAD or at MAD’s designee).

C. Medicaid will only be responsible for the medicaid portion of the billed amount.

D. There will be a one-time charge to medicaid for fingerprinting equipment. Ongoing supplies, such as ink, rubber gloves, and other supplies, will be accounted for on the provider’s cost report.

[8.313.3.16 NMAC – Rp 8.313.3.16, 7/01/2024]

8.313.3.17 RECONSIDERATION PROCEDURES FOR BASE YEAR DETERMINATIONS

A. A provider who is dissatisfied with the base year rate determination or the final settlement (in the case of a change of ownership) may request a reconsideration of the determination by addressing a request for reconsideration to: Director, Medical Assistance Division, P.O. Box 2348, Santa Fe, NM 87504

B. The filing of a request for reconsideration will not effect the imposition of the determination.

C. A request for reconsideration, to be timely, must be filed with or received by the medical assistance division no later than 30 days after the date of the determination notice to the provider.

D. The written request for reconsideration must identify each point on which it takes issue with the audit agent and must include all documentation, citation of authority, and argument on which the request is based. Any point not raised in the original filed request may not be raised later.

E. The medical assistance division will submit copies of the request and supporting material to the audit agent. A copy of the transmittal letter to the audit agent will be sent to the provider. A written response from the audit agent must be filed with or received by the medical assistance division no later than 30 days after the date of the transmittal letter.

F. The medical assistance division will submit copies of the audit agent's response and supporting material to the provider. A copy of the transmittal letter to the provider will be sent to the audit agent. Both parties may then come up with additional submittals on the point(s) at issue. Such follow-up submittals must be filed with or received by the medical assistance division no later than 15 days after the date of the transmittal letter to the provider.

G. The request for reconsideration and supporting materials, the response and supporting materials, and any additional submittal will be delivered by the medical assistance division director to the secretary, or his/her designee, within 5 days after the closing date for final submittals.

H. The secretary, or his/her designee, may secure all information and call on all expertise he/she believes necessary to decide the issues.

I. The secretary, or his/her designee, will make a determination on each point at issue, with written findings and will mail a copy of the determinations to each party within 30 days of the delivery of the material to him. The secretary's determinations on appeals will be made in accordance with the applicable provisions of the plan. The secretary's decision will be final and changes to the original determination will be implemented pursuant to that decision.

[8.313.3.17 NMAC – Rp 8.313.3.17, 7/01/2024]

8.313.3.18 PUBLIC DISCLOSURE OF COST REPORTS

A. Provider's cost reports submitted by participating providers as a basis for reimbursement as required by law are available to the public upon receipt of a written request to the medical assistance division. Information thus disclosed is limited to cost report documents required by social security administration regulations and, in the case of a settled cost report, the notice of program settlement.

B. The request must identify the provider and the specific report(s) requested.

C. The cost for copying will be charged to the requestor.

[8.313.3.18 NMAC – Rp 8.313.3.18, 7/01/2024]

8.313.3.19 SEVERABILITY: If any provision of this regulation is held to be invalid, the remainder of the regulations shall not be affected thereby.

[8.313.3.19 NMAC – Rp 8.313.3.19, 7/01/2024]

HISTORY OF 8.313.3 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:

SP-004.2400 Section 4, General Program Administration Standards for Skilled Nursing And Intermediate Care Facilities, 3/5/1981.

History of Repealed Material: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 315 OTHER LONG TERM CARE SERVICES
PART 2 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

8.315.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.315.2.1 NMAC – Rp 8.315.2.1, 7/01/2024]

8.315.2.2 SCOPE: The rule applies to the general public.
[8.315.2.2 NMAC - Rp 8.315.2.2, 7/01/2024]

8.315.2.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.315.2.3 NMAC - Rp 8.315.2.3, 7/01/2024]

8.315.2.4 DURATION: Permanent
[8.315.2.4 NMAC - Rp 8.315.2.4, 7/01/2024]

8.315.2.5 EFFECTIVE DATE: December 1, 2006, unless a later date is cited at the end of a section.
[8.315.2.5 NMAC - Rp 8.315.2.5, 7/01/2024]

8.315.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.315.2.6 NMAC - Rp 8.315.2.6, 7/01/2024]

8.315.2.7 DEFINITIONS: [**RESERVED**]

8.315.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.315.2.8 NMAC - Rp 8.315.2.8, 7/01/2024]

8.315.2.9 PACE PROGRAM SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including services furnished in nursing facilities. To help New Mexico recipients receive necessary services, the New Mexico medical assistance division (MAD) pays for capitated and community-based services through the PACE program. This project provides a complete package of acute, long term care, personal care and social services to a frail population that meets nursing facility clinical criteria. See Section 9412(b) of the federal Omnibus Budget Reconciliation Act of 1986 and Section 1915(a) of the Social Security Act. This part describes the following: eligible providers, services for recipients who are nursing home eligible, covered services, service limitations, and reimbursement methodology.
[8.315.2.9 NMAC - Rp 8.315.2.9, 7/01/2024]

8.315.2.10 ELIGIBLE PROVIDERS:

A. The eligible provider will have a professional services agreement (PSA) with the health care authority. The provider will also meet the following conditions:

(1) be licensed and certified by the licensing and certification bureau of the department of health (DOH) to meet conditions as a diagnostic and treatment center;

(2) participate in the MAD utilization review process and agree to operate in accordance with all policies and procedures of that system; and

(3) meet and comply with the centers for medicare and medicaid services (CMS) requirements for full provider status for PACE organizations.

B. Once enrolled, the provider will receive a packet of information, including medicaid program policies, utilization review instructions, and other pertinent material from MAD. The provider is responsible for ensuring receipt of these materials and for updating as new materials are received from MAD.
[8.315.2.10 NMAC - Rp 8.315.2.10, 7/01/2024]

8.315.2.11 PROVIDER RESPONSIBILITIES:

A. The provider who furnishes services to medicaid recipients will comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. The provider will verify that individuals are eligible for medicaid, medicare, or other health insurance at the time services are furnished. The provider will verify whether or not an individual is self-pay at the time services are provided. The provider will maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See 8.302.1 NMAC, *General Provider Policies*. The provider will provide the coordination which will enable the client to utilize PACE as the single source for primary care. This will assist the enrollee in the coordination of care by specialists.

B. Outreach and marketing: The provider will have a written plan which accomplishes the following outreach and marketing objectives.

(1) Strategies of how prospective participants are provided adequate program descriptions.

(a) The program descriptions shall be written in a culturally competent format at a language level understandable by the participant (sixth grade). The format should be sensitive to the culture and language common to the service area.

(b) Program descriptions should include the services available through the program. The services include, but are not limited to, the following: enrollment and disenrollment, procedures to access services, after hours call-in system, provisions for emergency treatment, restrictions against using medical providers and/or services not authorized by the interdisciplinary team, and any other information necessary for prospective participants to make informed decisions about enrollment. Prior to enrollment, each participant will be informed of what individualized initial assessment and treatment plan has been developed by the interdisciplinary team.

(2) Development of outreach and enrollment materials (including marketing brochures, enrollment agreements, website and disenrollment forms). These materials should be submitted in draft form to MAD for approval prior to publication. Distribution prior to approval is prohibited.

(3) Submit an active and ongoing marketing plan, with measurable enrollment objectives and a system for tracking its effectiveness. The plan shall also include, but not be limited to, the sequence and timing of promotional and enrollment activities and the resources needed for implementation.

(4) Ensure that prohibited marketing activities are not conducted by its employees or its agents. Prohibited practices are:

(a) discrimination of any kind while maintaining the PACE program requirements;

(b) statements or activities that could mislead or confuse potential participants, or misrepresent the contractor, CMS, or the state medicaid agency;

(c) inducing enrollment through gifts or payments; the Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, imposes civil and misdemeanor criminal penalties for its violation; in addition, the New Mexico criminal statutes impose felony penalties for bribes, gratuities and kickbacks; and

(d) subcontracting outreach efforts to individuals or organizations whose sole responsibility involves direct contact with elderly to solicit enrollment.
[8.315.2.11 NMAC - Rp 8.315.2.11, 7/01/2024]

8.315.2.12 ELIGIBLE RECIPIENTS: Medicaid recipients who meet the eligibility requirements as stated in the medical assistance division eligibility manual may be eligible to participate in the PACE program.
[8.315.2.12 NMAC - Rp 8.315.2.12, 7/01/2024]

8.315.2.13 COVERED SERVICES: The PACE program is a partially capitated, community-based service program. The PACE program will ensure access to a comprehensive benefit package of services to a frail population that meets nursing facility clinical criteria. The provider will provide all medicaid services that are included in a capitated rate. Medicare covered services will be reimbursed through a medicare capitated rate. The provider will provide medicare-eligible PACE participants with all medicare services that are included in the medicare capitated rate. Effective Janaury 1, 2006, upon the implementation of medicare part D prescription drug coverage, pharmacy costs for PACE medicare beneficiaries are covered by the medicare capitated rate. Pharmacy costs for medicaid only recipients would be covered by the medicaid only capitated rate.

A. Adult day health center: The focal point for coordination and provision of the majority of the PACE program services is the adult day health center. The adult day health center will include a primary care clinic and areas for therapeutic recreation, restorative therapies, socialization, personal care and dining. The center shall include the following areas:

(1) examination room(s);
(2) treatment room(s);
(3) therapy room(s);
(4) dining room(s);
(5) activity room(s);
(6) kitchen;
(7) bathroom(s);
(8) personal care room(s);
(9) administrative office(s);
(10) counseling office(s);
(11) pharmacy/medication room; and
(12) laboratory;

B. Interdisciplinary team: The interdisciplinary team is a critical element of the PACE program. The ongoing process of service delivery in this model requires the team to identify participant problems, determine appropriate treatment objectives, select interventions and evaluate efficiencies of care on an individual participant basis. The interdisciplinary team is composed of, but not limited to, the following members: Primary care physician, nurse, dietician, social worker, physical therapist, occupational therapist, speech therapist, recreational therapist or coordinator, day health center supervisor, home care liaison, health workers/aides, and drivers. Some of the interdisciplinary team members may be project staff and some may be contracted positions. All members must meet applicable state licensing and certification requirements and provide direct care and services appropriate to participant need.

C. Benefit package: The benefit package includes the following:

(1) a service delivery system that ensures prompt access to all covered services, including referral protocols, approved by the interdisciplinary team;

(2) access to medical care and other services, as applicable, twenty four (24) hours per day, seven (7) days a week, three hundred sixty five (365) days per year; all care and services shall be available and shall be provided at such times and places, including the participants home or elsewhere, as are necessary and practical;

(3) access to an acute and comprehensive benefit package of services, including, but not limited to:

(a) interdisciplinary assessment and treatment planning;
(b) social work services;
(c) nutritional counseling; see MAD-758, *Nutrition Services* [8.324.9 NMAC];
(d) recreational therapy;
(e) meals;
(f) restorative therapies, including physical therapy, occupational therapy and speech therapy, see MAD-767, *Rehabilitation Service Providers* [8.325.8 NMAC];
(g) home care (personal care, nursing care and disposable medical supplies), see MAD-768, *Home Health Services* [8.325.9 NMAC];
(h) transportation, see MAD-756, *Transportation* [8.324.7 NMAC];
(i) drugs and biologicals; effective January 1, 2006, pharmacy costs are reimbursed by medicare for medicare beneficiaries; pharmacy costs for medicaid-only recipients are reimbursed by medicaid through the medicaid-only capitated rate; see 8.324.4 NMAC, *Pharmacy Services*, and Subsection D of 8.310.2.12 NMAC, *Medical Services Providers*;
(j) prosthetics, medical supplies and durable medical equipment, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures and repairs and maintenance for these items; see 8.324.8 NMAC, *Prosthetics and Orthotics*; 8.310.6 NMAC, *Vision Care Services*; 8.324.6 NMAC, *Hearing Aids and Related Evaluations*; 8.310.7 NMAC, *Dental Services*; 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*; MAD-768, *Home Health Services*;
(k) behavioral health services, 8.310.8 NMAC, *Mental Health Professional Services* and 8.315.3 NMAC, *Psychosocial Rehabilitation Services*;
(l) nursing facility services which include, but are not limited to, the following: semi-private room and board, physician and skilled nursing services, custodial care, personal care and assistance,

biologicals and drugs, physical, speech, occupational and recreational therapies, if necessary, social services, and medical supplies and appliances, see MAD-731, *Nursing Facilities* [8.312.2 NMAC]; MAD-722, *Outpatient Psychiatric Services and Partial Hospitalization* [8.311.4 NMAC]; MAD-767, *Rehabilitation Service Providers* [8.325.8 NMAC]; 8.324.4 NMAC, *Pharmacy Services*; Subsection D of 8.310.2.12 NMAC, *Medical Services Providers*; 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*; and

(m) urgent care services.

(4) coordinating access for the following services:

(a) primary care services including physician and nursing services;

(b) medical specialty services, including but not limited to: anesthesiology, audiology, cardiology, dentistry, dermatology, gastroenterology, gynecology, internal medicine, nephrology, neurosurgery, oncology, ophthalmology, oral surgery, orthopedic surgery, otorhino-laryngology, plastic surgery, pharmacy consulting services, podiatry, psychiatry, pulmonary disease, radiology, rheumatology, surgery, thoracic and vascular surgery, urology; see 8.301.2 NMAC, *General Benefit Description*; 8.310.2 NMAC, *Medical Services Providers*; MAD-721 *Hospital Services* [8.311.2 NMAC]; 8.310.5 NMAC, *Anesthesia Services*; 8.324.6 NMAC, *Hearing Aids and Related Evaluations*; 8.310.7 NMAC, *Dental Services*; and 8.310.6 NMAC, *Vision Care Services*;

(c) laboratory and x-rays and other diagnostic procedures; see MAD-751, *Laboratory Services* [8.324.2 NMAC];

(d) acute inpatient services, including but not limited to, the following: ambulance, emergency room care and treatment room services, semi-private room and board, general medical and nursing services, medical surgical/intensive care/coronary care unit as necessary, laboratory tests, x-rays and other diagnostic procedures, drugs and biologicals, blood and blood derivatives, surgical care, including the use of anesthesia, use of oxygen, physical, speech, occupational, and respiratory therapies, and social services; see 8.301.2 NMAC, *General Benefit Description*; MAD-721, *Hospital Services*; 8.324.8 NMAC, *Prosthetics and Orthotics*; 8.324.10 NMAC, *Ambulatory Surgical Center Services*; and 8.310.5 NMAC, *Anesthesia Services*; MAD-751, *Laboratory Services* [8.324.2 NMAC]; 8.324.4 NMAC, *Pharmacy Services*; Subsection D of 8.310.2.12 NMAC, *Medical Services Providers*; MAD-767, *Rehabilitation Service Providers* [8.325.8 NMAC]; and

(e) hospital emergency room services.

(5) in-area emergency care; all medicaid reimbursable emergency services included in the capitated rate will be reimbursed by the PACE program to a non-affiliated provider when these services are rendered within the PACE program geographic service area; these emergency services will be reimbursed by the PACE program only until such time as the participant's condition permits travel to the nearest PACE program-affiliated facility;

(6) out-of-area emergency care that is provided in, or en route to, a hospital or hospital emergency room, in a clinic, or physicians office, or any other site outside of the PACE program service area; covered services included in the capitation rate will be paid by the PACE program when rendered in and out-of-area medical emergency, but only until such time as the participants condition permits travel to the nearest PACE program-affiliated facility.

[8.315.2.13 NMAC - Rp 8.315.2.13, 7/01/2024]

8.315.2.14 NONCOVERED SERVICES:

A. The following services are not the responsibility of the provider or medicaid:

(1) any medicaid capitated or fee-for-service benefit which has not been authorized by the multidisciplinary team;

(2) in inpatient facilities, private room and private duty nursing, unless medically necessary, and non-medical items for personal convenience, such as telephone charges, radio, or television rental;

(3) cosmetic surgery unless required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy;

(4) experimental medical, surgical or other health procedures or procedures not generally available;

(5) care in a government hospital (veterans administration, federal/state hospital) unless authorized;

(6) service in any hospital for the treatment of chronic, medically uncomplicated drug dependency or alcoholism; and

(7) any services rendered outside of the United States.

B. The participant will be financially responsible for any of the above-mentioned services.

[8.315.2.14 NMAC - Rp 8.315.2.14, 7/01/2024]

8.315.2.15 TREATMENT PLANS:

A. Prior to enrollment, an initial assessment and treatment plan for each participant is developed by the interdisciplinary team.

B. Each participant will be reassessed by the interdisciplinary team on a semi-annual basis and informed about a new treatment plan.

C. The enrollee, enrollees family, or representative shall be included in the initial assessment, treatment plan and semi-annual reassessment of the treatment plan.

[8.315.2.15 NMAC - Rp 8.315.2.15, 7/01/2024]

8.315.2.16 ENROLLMENT OF PARTICIPANTS:

A. The effective date for the recipients enrollment in the program is the first day of the calendar month following the signing of the enrollment agreement, if an approved level of care (LOC) and all financial and non-financial eligibility criteria have been approved by the income support division (ISD).

B. The potential participant signs an enrollment agreement which includes, but is not limited to, the following information:

(1) enrollment and disenrollment data that will be collected and submitted to the authority, including, but not limited to, the following:

(a) social security number;

(b) health insurance claim number (HIC);

(c) last name, first name, middle initial;

(d) date of birth;

(e) address of current residence;

(f) assigned ISD office address;

(g) medicare number (part A and/or part B) for medicare beneficiaries;

(h) medicaid number; and

(i) effective date of enrollment in the PACE program;

(2) benefits available, including all medicare and medicaid covered services, and how services are allocated or can be obtained from the PACE program provider, including, but not limited to:

(a) appropriate use of the referral system;

(b) after hours call-in system;

(c) provisions for emergency treatment;

(d) hospitals to be used; and

(e) the restriction that enrollees may not seek services or items from medicaid and medicare providers without authorization from the interdisciplinary team;

(3) participant premiums and procedures for payment, if any; this includes the medical care credit if the participant enters a nursing home;

(4) participant rights, grievance procedures, conditions for enrollment and disenrollment and medicare and medicaid appeal processes;

(5) participants obligation to notify the PACE program provider of a move or absence from the providers service area;

(6) procedures to assure that applicants understand that all medicaid services must be received through the PACE program provider (the “lock-in” provision);

(7) procedures for obtaining emergency services and urgent care;

(8) statements that the PACE program provider has a program agreement with CMS and the state medicaid agency that may be subject to periodic renewal, and that termination of that agreement may result in termination of enrollment in the PACE program; statement that the PACE program provider and the state medicaid agency enter into a contract, which must be periodically renewed, and that failure to renew the contract may result in termination of enrollment in the PACE program;

(9) participants authorization for the disclosure and exchange of information between CMS, its agent, the state medicaid agency and the PACE program provider; and

(10) participant’s signature and date.

C. Once the participant signs the enrollment agreement, the participant receives the following:

(1) a copy of the enrollment agreement;

(2) participant/provider contract and/or evidence of coverage, if this is different from the enrollment agreement;

(3) a PACE program membership card; and

(4) an emergency sticker to be posted in the participants home in case of emergency.

D. The provider will inform the participant and the ISD office when enrollment is completed.

E. Enrollment and services continue unless eligibility of recipient changes or until the participant either voluntarily disenrolls or involuntary disenrollment occurs as described below.

[8.315.2.16 NMAC - Rp 8.315.2.16, 7/01/2024]

8.315.2.17 DISENROLLMENT OF PARTICIPANTS: All voluntary and involuntary disenrollments will be documented and available for review by the state medicaid agency. The provider will inform the ISD office when a participant is being disenrolled either voluntarily or involuntarily. Disenrollment is effective by the first day of the second calendar month following the date in which enrollment has changed.

A. Voluntary disenrollment: A participant may begin the process of voluntary disenrollment at any time during the month. The provider shall use the most expedient process allowed by medicaid and medicare procedures while ensuring a coordinated disenrollment date. Until enrollment is terminated, the participants are required to continue using the PACE program services and remain liable for any premiums. The provider shall continue to provide all needed services until the date of termination.

B. Involuntary disenrollment: A participant may be involuntarily disenrolled if the participant:

(1) moves out of the PACE program service area;

(2) is a person with decision-making capacity who consistently does not comply with the individual plan of care and poses a significant risk to self or others;

(3) experiences a breakdown in the physician or team participant relationship such that the PACE program provider's ability to furnish services to either the participant or other participant(s) is seriously impaired;

(4) refuses services and/or is unwilling to meet conditions of participation as they appear in the enrollment agreement;

(5) refuses to provide accurate financial information, provides false information or illegally transfers assets;

(6) is out of the PACE program provider service area for more than thirty (30) days (unless arrangements have been made with the PACE program provider);

(7) is enrolled in a PACE program that loses its contracts and/or licenses which enable it to offer health care services;

(8) ceases to meet the financial or non-financial criteria; and

(9) ceases to meet the level of care (LOC) at any time.

[8.315.2.17 NMAC - Rp 8.315.2.17, 7/01/2024]

8.315.2.18 APPROPRIATE REFERRAL FOR OTHER SERVICES:

A. The provider will assist a participant who either voluntarily or involuntarily disenrolls from the PACE program to apply for other possible services, including medicare or private-pay services; and,

B. The provider will work with the state medicaid agency to ascertain the individual's potential eligibility for other medicaid categories.

[8.315.2.18 NMAC - Rp 8.315.2.18, 7/01/2024]

8.315.2.19 PROVISIONS FOR REINSTATEMENT OF PARTICIPANTS TO THE PACE PROGRAM: There are no restrictions placed on a former participant's reinstatement into the PACE program, if the former participant continues to meet financial, non-financial and medical eligibility criteria.

[8.315.2.19 NMAC - Rp 8.315.2.19, 7/01/2024]

8.315.2.20 REDETERMINATION: The ISD office will conduct a redetermination at least annually of all financial and non-financial criteria, per the standards of the medicaid eligibility requirements. See Subsection A of 8.280.600.12 NMAC, *Ongoing Benefits, Regular Reviews*. LOC is determined by the authority's utilization review contractor.

[8.315.2.20 NMAC - Rp 8.315.2.20, 7/01/2024]

8.315.2.21 PARTICIPANT RIGHTS: The provider will have written policies and procedures for ensuring the rights of participants as well as educating the participants to the PACE program. These policies and procedures

should be presented in a culturally competent format at a language level understandable by the participant or their families (sixth grade level) covering, at a minimum, the following:

A. the enrollment/disenrollment process;

B. services available through the program;

C. procedures to access services;

D. after hours call-in system;

E. provisions for emergency treatment; and

F. restrictions against using medical providers and/or services not authorized by the interdisciplinary team.

[8.315.2.21 NMAC - Rp 8.315.2.21, 7/01/2024]

8.315.2.22 GRIEVANCE PROCEDURES: The provider will have participant grievance procedures which provide the participants and their family members with a process for expressing dissatisfaction with the program services, whether medical or nonmedical in nature. The procedures will explain and permit an orderly resolution of informal and formal grievances. These procedures should be presented in a culturally competent format at a language level understandable by the participant or their families (sixth grade level). The procedures will:

A. ensure that all provider grievance procedures and any subsequent changes are prior-approved by MAD in writing and included in the enrollment agreement;

B. ensure that a staff member is designated as having primary responsibility for the maintenance of the grievance procedures, review of their operation, and revision of related policies and procedures whenever necessary;

C. ensure that the grievance procedures clearly explain to participants which staff members are assigned to receive formal and informal complaints, the expected procedure, and the time frames for doing so;

D. ensure that a copy of the participant grievance procedures and complaint forms are available to participants;

E. ensure that procedures are in place for tracking, investigating, recording, resolving and appealing decisions concerning grievances made by participants or others; and

F. ensure there is no discrimination against a participant solely on the grounds the participant filed a grievance.

[8.315.2.22 NMAC - Rp 8.315.2.22, 7/01/2024]

8.315.2.23 QUALITY ASSURANCE SYSTEM:

A. The provider will have a written plan of quality assurance and improvement which provides for a system of ongoing assessment, implementation, evaluation, and revision of activities related to overall program administration and services. The plan will:

(1) ensure that standards are incorporated into the provider policy and procedure manual; the provider standards will be based on the PACE protocol, applicable PACE standards and applicable licensing and certification criteria;

(2) ensure that goals and objectives provide a framework for quality improvement activities, evaluation and corrective action;

(3) ensure that quality indicators are objective and measurable variables related to the entire range of services provided by the PACE program provider; the methodology should assure that all demographic groups, all care settings, e.g., inpatient, the PACE program center and in-home, will be included in the scope of the quality assurance review;

(4) ensure that quality indicators are selected for review on the basis of high volume, high risk diagnosis or procedure, adverse outcomes, or some other problem-focused method consistent with the state of the art;

(5) ensure that the evaluation process and/or procedures review the effectiveness of the interdisciplinary team in its ability to assess participants care needs, identify the participant's treatment goals, assess effectiveness of interventions, evaluate adequacy and appropriateness of service utilization and reorganize treatment plan as necessary;

(6) establish the composition and responsibilities of a quality assurance committee and an ethics committee;

(7) ensure participant involvement in the quality assurance plan and evaluation of satisfaction with services; and

(8) designate an individual to coordinate and oversee implementation of quality assurance activities.

B. The quality assurance committee will hold quarterly meetings with the provider staff, including, but not limited to, the: 1) medical director; 2) interdisciplinary team; and, 3) administrative director. The provider will prepare quarterly written status reports for review at the quality assurance committee meetings. Written status reports will include, at a minimum, a discussion of project progress, problems encountered and recommended solutions, identification of policy or management questions, and requested project plan adjustments.
[8.315.2.23 NMAC - Rp 8.315.2.23, 7/01/2024]

8.315.2.24 DATA GATHERING/REPORTING SYSTEM:

A. Standardized data: The provider will ensure the quality of the data according to MAD medium and frequency of reporting.

B. Software: The provider shall make no use of computer software developed pursuant to the contract, except as provided in the contract or as specifically granted in writing by the authority.
[8.315.2.24 NMAC - Rp 8.315.2.24, 7/01/2024]

8.315.2.25 FINANCIAL REPORTING: The provider is required to submit certain financial reports as follows.

A. A budgeted versus actual financial report for the current and year-to-date periods on a monthly basis forty five (45) days after the end of each month. During the first year of operation, the financial report will be submitted on a monthly basis, 45 days after the end of each month. Thereafter, this report will be submitted on a quarterly basis, 45 days after the end of each quarter. The state medicaid agency reserves the right to extend the submission of this report on a monthly basis should provider performance indicate a need for more frequent monitoring.

B. Fiscal data based on cost center accounting structure provided by the state medicaid agency. At the twelfth month, the year-to-date summary will provide the necessary annual data.

C. Submit a cumulative report to the state medicaid agency in the form and detail described by On Lok senior health services/national PACE association. The interim cost report is due 45 days after the end of each providers fiscal quarter and covers the period from the beginning of the fiscal year through the respective quarter.

D. Submit to the state medicaid agency a cost report in the form and detail prescribed by the state medicaid program no later than 180 days after the end of the providers fiscal year.

E. Submit to the state medicaid agency a quarterly balance sheet for those PACE program providers that are separate corporate entities.
[8.315.2.25 NMAC - Rp 8.315.2.25, 7/01/2024]

8.315.2.26 UTILIZATION REVIEW: All medicaid services, including services covered under the PACE program, are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: To be eligible for the PACE program, a medicaid recipient must require a nursing facility level of care (LOC). Level of care determinations are made by MAD or its designee. The plan of care (POC) developed by the recipients interdisciplinary team must specify the type, amount and duration of service. Some services specified in the POC may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of service does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are financially and medically eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions may request a re-review and a reconsideration. See MAD-953, *Reconsideration of Utilization Review Decisions* [8.350.2 NMAC].
[8.315.2.26 NMAC - Rp 8.315.2.26, 7/01/2024]

8.315.2.27 REIMBURSEMENT: PACE program providers must submit claims for reimbursement on the UB 92 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

[8.315.2.27 NMAC - Rp 8.315.2.27, 7/01/2024]

HISTORY OF 8.315.2 NMAC:

History of Repealed Material:
8 NMAC 4.MAD.777, Pre-PACE Pilot Project Services, filed 1/20/1998 - Repealed effective 12/1/2006.
8.315.2 NMAC, Program of All-Inclusive Care for the Elderly, filed 12/01/2006 - Repealed effective 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 10 AMBULATORY SURGICAL CENTER SERVICES

8.324.10.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.324.10.1 NMAC – Rp 8.324.10.1, 7/01/2024]

8.324.10.2 SCOPE: The rule applies to the general public.
[8.324.10.2 NMAC – Rp 8.324.10.2, 7/01/2024]

8.324.10.3 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 health care authority pursuant to state statute. See NMSA 1978, section 27-2-12 et. seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.324.10.3 NMAC – Rp 8.324.10.3, 7/01/2024]

8.324.10.4 DURATION: Permanent
[8.324.10.4 NMAC – Rp 8.324.10.4, 7/01/2024]

8.324.10.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.324.10.5 NMAC – Rp 8.324.10.5, 7/01/2024]

8.324.10.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.324.10.6 NMAC – Rp 8.324.10.6, 7/01/2024]

8.324.10.7 DEFINITIONS: [**RESERVED**]

8.324.10.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.324.10.8 NMAC – Rp 8.324.10.8, 7/01/2024]

8.324.10.9 AMBULATORY SURGICAL CENTER SERVICES: New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including covered services furnished in ambulatory surgical centers [42 CFR Section 440.20(a)]. This part describes eligible providers, covered services, service limitations and general reimbursement methodology.
[8.324.10.9 NMAC – Rp 8.324.10.9, 7/01/2024]

8.324.10.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation application by the New Mexico medical assistance division (MAD), ambulatory surgical centers certified to participate in medicare under Title XVIII of the Social Security Act as free-standing ambulatory surgical centers are eligible to be reimbursed by medicaid for providing services as ambulatory surgical centers.

(1) The centers for medicare and medicaid (CMS) certify ambulatory surgical centers based on surveys and recommendations submitted by the licensing and certification bureau of the New Mexico department of health (DOH).

(2) Ambulatory surgical centers which are not free-standing but are part of an accredited and certified hospital are subject to 8.311.2 NMAC, *Hospital Services* [MAD-721].

B. Once enrolled, providers receive and are responsible for maintenance of a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. To be eligible for medicaid reimbursement, providers are bound by MAD policies, procedures, billing instructions, reimbursement rates, and all audit, recoupment and withholding provisions unless superceded by

federal law, federal regulation or the specific written approval of the MAD director. Providers must be enrolled as medicaid providers before submitting a claim for payment to MAD claims processing contractor.
[8.324.10.10 NMAC – Rp 8.324.10.10, 7/01/2024]

8.324.10.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the state Medicaid Fraud Act. Providers also agree to conform to MAD policies and instructions as specified in this manual and its appendices, as updated. See 8.302.1 NMAC, *General Provider Policies*.

A. Recipient eligibility determination: Providers must verify that services they furnish are provided to eligible recipients.

(1) Providers may verify eligibility through several mechanisms, including the use of an automated voice response system, contacting the medicaid fiscal agent contractor eligibility help desk, contracting with a medicaid eligibility verification system (MEVS) vendor, or contracting with a medicaid magnetic swipe card vendor.

(2) Providers must verify that recipients are eligible for medicaid through out periods of continued or extended services. By verifying client eligibility, a provider is informed of restrictions that may apply to a recipient's eligibility.

B. Requirements for updating information: Providers must furnish in writing to MAD or MAD claims processing contractor with complete information on changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability for the provider for any dissolution of other disposition of the health care provider or person. MAD or the MAD claims processing contractor must receive this information at least 60 days before the change. Any payment made by MAD based upon erroneous or outdated information is subject to recoupment.

C. Documentation requirements: Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of the services furnished to recipients who are currently receiving or who have received medical services in the past [42 CFR 431.107(b)]. Documentation supporting medical necessity must be legible and available to medicaid upon request. See 8.302.1 NMAC, *General Provider Policies.*
[8.324.10.11 NMAC – Rp 8.324.10.11, 7/01/2024]

8.324.10.12 COVERED SERVICES:

A. Medicaid covers ambulatory surgical center facility services, as required by the condition of the recipient and if the following conditions are met:

(1) the surgical procedure and use of the facility are medically necessary and are covered by medicaid; and

(2) all medicaid requirements for the surgery, such as applicable consent forms or prior authorization requirements, are met by the physician.

B. See 8.310.2 NMAC, *Medical Services Providers*.
[8.324.10.12 NMAC – Rp 8.324.10.12, 7/01/2024]

8.324.10.13 NONCOVERED SERVICES: Ambulatory surgical center services are subject to the limitations and coverage restrictions which exist for other medicaid services. If the surgery is non-covered, the anesthesia is non-covered. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602].

A. Direct payment to physician. Ambulatory surgical centers are not reimbursed by medicaid for physician fees. Reimbursement for physician fees is made directly to the provider of the service.

B. Services furnished to dual eligible recipients. By federal regulation, the medicare program pays ambulatory surgical centers only for an approved list of specific surgical procedures. Medicare is the primary payment source for individuals who are eligible for both medicare and medicaid. For these recipients, medicaid will not pay an ambulatory surgical center for a surgical procedure denied by medicare. Ambulatory surgical centers must refer these recipients to facilities which medicare pays for the surgical procedure, such as an outpatient hospital.
[8.324.10.13 NMAC – Rp 8.324.10.13, 7/01/2024]

8.324.10.14 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See

8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: Certain procedures or services can require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[8.324.10.14 NMAC – Rp 8.324.10.14, 7/01/2024]

8.324.10.15 REIMBURSEMENT: Ambulatory surgical centers must submit claims for reimbursement on the CMS-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

A. Inclusion of all services in the facility fee: All services furnished by the facility are considered reimbursed in the facility fee and cannot be billed separately. The amount paid will be the lesser of the facility's usual and customary charge or the maximum allowed by medicaid.

B. Reimbursement methodology: The facility fee maximum is established at a level which considers the surgical procedure and the area in which the facility is located. Each surgical procedure is assigned to one of nine (9) surgical groups, based on the complexity of the procedure. Each of these surgical groups has a separate reimbursement level. The level of reimbursement is determined by medicaid by utilizing the medicare carrier for procedures payable to ambulatory surgical centers by medicare regulations. The list of surgeries payable under medicare regulations also designates the assigned surgical group for payment purposes. The list is available from the medicare carrier.

(1) For those procedures for which medicare has not established a reimbursement level, MAD assigns the procedure to one of the nine (9) surgical groups. The assignment is based upon the complexity of the procedure or its similarity to procedures within the surgical groups developed by medicare.

(2) Reimbursement is made at the level established by medicaid for that surgical group.

C. Reimbursement for multiple procedures: When more than one covered surgical procedure is performed during the same surgical encounter, reimbursement is made at the rate for the most complex procedure plus fifty percent (50%) of the applicable rate for any additional procedures.

D. Reimbursement for laboratory services:

(1) The following laboratory services are considered included in the facility fee and are not reimbursed separately:

(a) hematocrit;

(b) hemoglobin (colorimetric); and

(c) routine urinalysis, without microscopy.

(2) For an ambulatory surgical center to be reimbursed for laboratory tests which are not included in the facility fee, the following conditions must be met:

(a) ambulatory surgical center laboratories must be separately certified and enrolled as clinical laboratories with valid CLIA numbers;

(b) laboratory tests billed must fall within the approved laboratory specialties/ subspecialties for which the laboratory has been certified;

(c) laboratories must have separate New Mexico medical assistance program provider participation applications approved by MAD to bill for laboratory tests not included in the facility fee; and

(d) laboratory tests must be performed on the premises of ambulatory surgical centers and not sent out to reference laboratories. See 8.324.2 NMAC, *Laboratory Services* [MAD-751].

E. Reimbursement for diagnostic imaging and therapeutic radiology services: Diagnostic radiological, diagnostic ultrasound, peripheral vascular flow measurements and nuclear medicine studies furnished by a facility are considered covered services but payment is considered to be made within the facility fee and are not separately reimbursed services. See 8.324.3 NMAC, *Diagnostic Imaging and Therapeutic Radiology Services* [MAD-752].

[8.324.10.15 NMAC – Rp 8.324.10.15, 7/01/2024]

HISTORY OF 8.324.10 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD-Rule 310.2200, Ambulatory Surgical Center Services, filed 12/17/1985.
MAD Rule 310.22, Ambulatory Surgical Center Services, filed 4/17/1992.

History of Repealed Material:
MAD Rule 310.22, Ambulatory Surgical Center Services, filed 4/17/1992 - Repealed effective 2/1/1995.
8.324.10 NMAC, Ambulatory Surgical Center Services, filed 2/01/1995 - Repealed effective – 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 325 SPECIALTY SERVICES
PART 2 DIALYSIS SERVICES

8.325.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.325.2.1 NMAC – Rp 8.325.2.1, 7/01/2024]

8.325.2.2 SCOPE: The rule applies to the general public.
[8.325.2.2 NMAC – Rp 8.325.2.2, 7/01/2024]

8.325.2.3 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 health care authority pursuant to state statute. See NMSA 1978, section 27-2-12 et. seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.325.2.3 NMAC – Rp 8.325.2.3, 7/01/2024]

8.325.2.4 DURATION: Permanent
[8.325.2.4 NMAC – Rp 8.325.2.4, 7/01/2024]

8.325.2.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.325.2.5 NMAC – Rp 8.325.2.5, 7/01/2024]

8.325.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.325.2.6 NMAC – Rp 8.325.2.6, 7/01/2024]

8.325.2.7 DEFINITIONS: [**RESERVED**]

8.325.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.325.2.8 NMAC – Rp 8.325.2.8, 7/01/2024]

8.325.2.9 DIALYSIS SERVICES: Dialysis services are covered as an optional medical service for New Mexico medicaid program (medicaid) recipients [42 CFR Sections 440.10, 440.20; 440.50]. This part describes eligible dialysis providers, covered services, service limitations, and general reimbursement methodology.
[8.325.2.9 NMAC – Rp 8.325.2.9, 7/01/2024]

8.325.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation applications licensed practitioners or facilities that meet applicable requirements by the New Mexico medical assistance division (MAD), the following providers are eligible to be reimbursed for furnishing dialysis services to medicaid recipients:

(1) individuals licensed to practice medicine or osteopathy;

(2) facilities certified by the licensing and certification bureau of the department of health to furnish renal dialysis services; and

(3) hospitals eligible to participate in the New Mexico medicaid program. See 8.311.2 NMAC, Hospital Services [MAD-721].

B. Once enrolled, providers receive and are responsible for maintenance of a packet of information, which includes medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they understand these materials. To be eligible for medicaid reimbursement, providers are bound by MAD policies, procedures, billing instructions, reimbursement rates, and all audit, recoupment and withholding provisions unless superceded by federal law, or federal regulation.

Providers must be enrolled as medicaid providers before submitting a claim for payment to the MAD claims processing contractor.
[8.325.2.10 NMAC – Rp 8.325.2.10, 7/01/2024]

8.325.2.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients agree to comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the state Medicaid Fraud Act. Providers also agree to conform to the MAD policies and instructions as specified in this manual and its appendices, as updated.

A. Recipient eligibility verification: Providers must verify that services they furnish are provided to eligible recipients. Providers must verify that recipients are eligible and remain eligible for medicaid through periods of continued and extended services. By verifying eligibility, a provider is informed of restrictions that may apply to recipient's eligibility. Providers may verify eligibility through several mechanisms, including using an automated voice response system, contacting the medicaid fiscal agent contractor eligibility help desk, contracting with a medicaid eligibility verification system (MEVS) vendor, or contracting with a medicaid magnetic swipe card vendor.

B. Requirements for updating information: Providers must furnish in writing to MAD or the MAD claims processing contractor with complete information changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability of the provider for any recoverable obligation to MAD which occurred or may have occurred prior to any sale, merger, consolidation, dissolution or other disposition of the health care provider group or individual.

C. Documentation requirements: Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of services furnished to recipients who are currently receiving or who have received medical services in the past [42 CFR 43.107(b)].
[8.325.2.11 NMAC – Rp 8.325.2.11, 7/01/2024]

8.325.2.12 COVERED SERVICES: Medicaid covers renal dialysis services for the first three (3) months of dialysis pending the establishment of medicare eligibility. Medicare becomes the primary reimbursement source for individuals who meet the medicare eligibility criteria. Dialysis providers must assist medicaid recipients in applying for and pursuing final medicare eligibility determinations. Medicaid covers medically necessary dialysis supplies furnished to home-dialyzed recipients. Medicaid covers medically necessary renal dialysis services furnished by providers as required by the condition of the recipient. Medicaid covers the following specific renal dialysis services:

A. Supplies, equipment and services included in the renal dialysis services composite rate: The facility reimbursement fee includes all renal-related facility and home dialysis services, including supplies and equipment. The following are some of the drugs, items and supplies included in the facility fee:

(1) hypertonic saline;
(2) dextrose (glucose);
(3) mannitol or similar product used for volume control;
(4) heparin;
(5) protamine;
(6) antiarrhythmics;
(7) antihistamines;
(8) antihypertensives;
(9) pressor drugs;
(10) antiobiotics (when used at home by a patient to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis);
(11) oxygen;
(12) filters;
(13) bicarbonate dialysate;
(14) cardiac monitoring;
(15) catheters and catheter changes;
(16) suture removal kits and suture removal;
(17) dressing supplies;
(18) crash cart usage for cardiac arrest;
(19) declotting of shunt performed by facility staff in the dialysis unit;

(20) staff time to administer blood;
(21) staff time to administer separately billable parenteral items; and
(22) staff time used to collect all specimens for laboratory tests.

B. Routine laboratory tests: Routine laboratory tests are included in the facility fee. The following list specifies the covered routine tests and allowed frequencies. Routine tests at greater frequencies are reimbursable in addition to the facility fee, but require medical justification by a physician.

(1) For hemodialysis, peritoneal dialysis and continuous cyclic peritoneal dialysis (CCPD):

(a) per dialysis:
(i) hematocrit;
(ii) clotting time;
(iii) hemoglobin.

(b) weekly:
(i) prothrombin time for patients on anticoagulant therapy;
(ii) creatinine; and
(iii) BUN;

(c) monthly:
(i) CBC;
(ii) calcium;
(iii) potassium;
(iv) chloride;
(v) alkaline phosphatase;
(vi) SGOT;
(vii) bicarbonate;
(viii) phosphate;
(ix) total protein;
(x) albumin; or
(xi) LDH.

(2) For continuous abdominal peritoneal dialysis when the facility bills a facility charge (CAPD): **Monthly:** BUN; magnesium; HCT; calcium; HGB; albumin; creatinine; phosphate; LDH; sodium; potassium; SGOT; CO_2; total protein; dialysate protein; alkaline phosphatase.
[8.325.2.12 NMAC – Rp 8.325.2.12, 7/01/2024]

8.325.2.13 SERVICE LIMITATIONS: Tests that are listed as separately billable (not included in the composite rate) and are performed at a frequency greater than specified in the composite rate require medical justification and are covered when furnished at specified frequencies.

A. Tests for hemodialysis, peritoneal dialysis and CCPD: (Not included in the composite rate). These services may be billed separately at the specified frequencies.

(1) Monthly
(a) alkaline phosphatase;
(b) alkaline phosphatase;
(c) blood urea nitrogen (BUN);
(d) serum bicarbonate (CO_2);
(e) dialysis protein;
(f) hematocrit;
(g) hemoglobin;
(h) lactic dehydrogenase (LDH);
(i) magnesium;
(j) serum albumin;
(k) serum creatinine;
(l) serum phosporus;
(m) serum potassium;
(n) SGOT;
(o) sodium;
(p) total protein;
(q) serum calcium;
(r) hepatitis test.

(2) Once every three (3) months

(a) serum aluminum;

(b) serum ferritin;

(c) nerve conductor velocity test;

(d) EKG.

(3) Once every six (6) months: chest x-ray

(4) Once every year: bone survey

B. Tests for CAPD: (Not included in the composite rate). These services may be billed separately at the specified frequencies.

(1) Once every three (3) months

(a) white blood count (WBC);

(b) platelet count;

(c) red blood count.

(2) Once every six (6) months:

(a) 24-hour urine volume;

(b) residual renal function;

(c) chest x-ray;

(d) EKG;

(e) MNCV.

C. Training: Medicaid reimburses for hemodialysis, peritoneal dialysis, continuous cycling peritoneal dialysis and continuous abdominal peritoneal dialysis training sessions if furnished by a renal dialysis facility certified to provide these services. Dialysis training must be performed in the dialysis facility. Fifteen (15) training sessions are allowed without medical justification. To be reimbursed for additional training sessions, a medical justification must be attached to the claim.

[8.325.2.13 NMAC – Rp 8.325.2.13, 7/01/2024]

8.325.2.14 NONCOVERED SERVICES: Dialysis services are subject to the limitations and coverage restrictions of other medicaid services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]

[8.325.2.14 NMAC – Rp 8.325.2.14, 7/01/2024]

8.325.2.15 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: Certain procedures or services can require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[8.325.2.15 NMAC – Rp 8.325.2.15, 7/01/2024]

8.325.2.16 REIMBURSEMENT: Dialysis facilities must submit claims for reimbursement on the UB-92 claim form or its successor. Physicians must submit for reimbursement on the CMS-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. The facility's composite rate reimbursement is a comprehensive payment for all in facility and home dialysis services. Providers cannot bill separately for services inclusive of the composite rate, as defined by medicare, even though payment is made at the medicaid fee schedule. Physicians services are not included in the facilities composite rate. Physicians may bill for their professional services according to the policies and procedures outlined in the 8.310.2 NMAC, *Medical Services Providers*. Laboratory procedures and radiology procedures that are not part of the facilities composite rate, as defined by medicare, may be billed separately.

A. Certified hospital-based dialysis facilities are reimbursed at a rate determined by the medicaid outpatient hospital reimbursement methodology.

B. Hospital providers are reimbursed for inpatient renal dialysis at a rate determined by the medicaid inpatient hospital reimbursement methodology.

C. Renal dialysis facilities acting as suppliers to a home-dialyzed recipient can bill medicaid for the necessary supplies furnished to the recipient only if the facility is not billing a facility fee. Facilities cannot bill for both a facility fee and supplies.

[8.325.2.16 NMAC – Rp 8.325.2.16, 7/01/2024]

HISTORY OF 8.325.2 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD-Rule 310.2100, Dialysis Services, filed 4/8/1985.

History of Repealed Material:

ISD-Rule 310.2100, Dialysis Services, filed 4/8/1985 - Repealed effective 2/1/1995.

8.325.2 NMAC, Dialysis Services, filed 2/01/1995 - Repealed effective 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 325 SPECIALTY SERVICES
PART 4 HOSPICE CARE SERVICES

8.325.4.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.325.4.1 NMAC – Rp 8.325.4.1, 7/01/2024]

8.325.4.2 SCOPE: The rule applies to the general public.
[8.325.4.2 NMAC – Rp 8.325.4.2, 7/01/2024]

8.325.4.3 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 health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.325.4.3 NMAC – Rp 8.325.4.3, 7/01/2024]

8.325.4.4 DURATION: Permanent
[8.325.4.4 NMAC – Rp 8.325.4., 7/01/2024]

8.325.4.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.325.4.5 NMAC – Rp 8.325.4.5, 7/01/2024]

8.325.4.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.325.4.6 NMAC – Rp 8.325.4.6, 7/01/2024]

8.325.4.7 DEFINITIONS: [**RESERVED**]

8.325.4.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.325.4.8 NMAC – Rp 8.325.4.8, 7/01/2024]

8.325.4.9 HOSPICE CARE SERVICES: Hospice services are covered as an optional medical service for New Mexico medicaid program (medicaid) recipients. Hospice services provide palliative and supportive services to meet the physical, psychological, social, and spiritual needs of terminally ill medicaid recipients and their families. This part describes eligible providers covered services, service limitations, and general reimbursement methodology.
[8.325.4.9 NMAC – Rp 8.325.4.9, 7/01/2024]

8.325.4.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation by the New Mexico medical assistance division (MAD), hospice agencies meeting the following conditions are eligible to be reimbursed for providing hospice care services:

(1) meet the conditions for participation: see 42 CFR 418.50 et. seq.;

(2) licensed and certified by the licensing and certification bureau of the New Mexico department of health (DOH); and

(3) are a public or private non-profit or for profit agency or a subdivision of either, primarily engaged in providing care to terminally ill individuals.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[8.325.4.10 NMAC – Rp 8.325.4.10, 7/01/2024]

8.325.4.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the state Medicaid Fraud Act. Providers also agree to conform to MAD policies and instructions as specified in this manual and it appendices, as updated. See, 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of the services furnished to recipients who are currently receiving or who have received medical services in the past [42 CFR 431.107(B)]. Documentation supporting medical necessity must be legible and available to medicaid upon request. See 8.302.1 NMAC, *General Provider Policies*.
[8.325.4.11 NMAC – Rp 8.325.4.11, 7/01/2024]

8.325.4.12 ELIGIBLE RECIPIENTS: To be eligible for hospice care, a physician must provide a written certification that the recipient has a terminal illness. Recipients must elect to receive hospice care for the duration of the election period.

A. Certification of terminal illness: The hospice must obtain a written certification statement signed by the hospice medical director, physician member of the hospice interdisciplinary team or recipient's attending physician that the recipient is terminally ill. The physician must sign the written certification within seven (7) calendar days of the date services are initiated. Certification statements must include information that is based on the recipient's medical prognosis, and the life expectancy is six (6) months or less if the terminal illness runs its typical course.

(1) If a recipient receives hospice benefits beyond 210 days, the hospice must obtain a written recertification statement from the hospice medical director or the physician member of the hospice interdisciplinary group before the 210-day period expires.

(2) Hospice benefits furnished beyond the 210-day period may be subject to medical review.

B. Election of hospice care: Recipients who are eligible for hospice care must elect to receive hospice services. Recipients or their legal representatives elect hospice services by filing an election statement with a particular hospice designee.

(1) For the duration of the election, recipients who elect hospice care, waive their right to medicaid payment for the following services:

(a) services related to treatment of the terminal condition or related condition for which hospice care was elected; and

(b) services equivalent to hospice care, such as home health services, and private duty nursing services under enhanced early and periodic screening, diagnosis and treatment (EPSDT).

(2) Recipients who are receiving home and community based waiver services or other in-home services based on a plan of care must have the plan of care coordinated with the hospice provider and adjusted as necessary to avoid duplicative or unnecessary services.

(3) Hospice coverage continues for 210-day time periods, as long as recipients remain in hospice care and do not cancel the election.

(4) Recipients or their representatives can designate an effective date for the election. The effective date begins with the first or any subsequent day of hospice services.

C. Election statement: The election statement must include the following elements:

(1) designation of the hospice that will provide care;

(2) designation of the recipient's attending physician;

(3) acknowledgement that the recipients or representatives has been given a full understanding of the palliative rather than curative nature of hospice care;

(4) effective date of the election; and

(5) the recipient's or the representative's signature.

D. Revocation of hospice care services:

(1) A recipient or representative can cancel the election of hospice care at any time by filing a statement with MAD or its designee. The statement must include the following information:

(a) recipient is revoking his/her election for medicaid coverage of hospice care;

(b) effective date of the revocation, which is not earlier than the actual date of the revocation; and

(c) the recipient's or the representative's signature.

(2) Upon revocation of the election of hospice services, recipients are no longer covered for medicaid hospice services.

(3) Recipients can elect to receive hospice care services again at any time. The same process for approval of services must be followed when the second election occurs. A new plan of care, certification statement, and election statement must be submitted to MAD or its designee.

E. Change of designated hospice:

(1) Recipients or their representatives can change designated hospice providers by filing statements with MAD or its designee. A statement must contain the following information:

(a) name of the hospice the recipient is leaving;

(b) name of the hospice the recipient is entering; and

(c) effective date of the change.

(2) A change in ownership or name of a hospice is not considered a change in the recipient's designated hospice.

[8.325.4.12 NMAC – Rp 8.325.4.12, 7/01/2024]

8.325.4.13 COVERED SERVICES AND SERVICE LIMITATIONS: For recipients electing hospice care, medicaid covers hospice core services furnished to eligible recipients that are reasonable and necessary for the palliation or symptom management of a recipient's terminal illness and related conditions. Hospice core services include the medications, durable medical equipment and medical supplies needed to deliver palliative care. Hospice providers are reimbursed for the delivery of core services based on daily rate.

A. The hospice services necessary for a specific recipient must be documented in an individualized treatment plan. The plan must be developed by attending physicians, medical directors and interdisciplinary groups and must meet certain requirements: See 42 CFR 418.50 et. seq.

(1) Hospices must designate a registered nurse to coordinate the implementation of each recipient's plan of care.

(2) The interdisciplinary group, including nursing services, medical social services, physician services and counseling services practitioners are responsible for the following:

(a) developing the plan of care;

(b) providing or supervising hospice care and services;

(c) reviewing and updating the plan of care;

(d) establishing policies for daily provision of hospice care and services; and

(e) coordinating with other medicaid support service providers such that the plan of care is not duplicative of hospice services.

(3) All hospice services must be available twenty-four (24) hours per day to the extent necessary to meet the needs of the terminally ill recipients.

B. Core services: Medicaid covers the following nursing, medical social service, physician and counseling services as core hospice services:

(1) nursing services furnished by or under the supervision of registered nurses and based on the treatment plan and recognized standards of practice;

(2) medical social services furnished by a qualified social worker under the direction of a physician;

(3) physician services performed by a doctor of medicine or osteopathy, including palliation and management of terminal illness and related conditions and the recipient's general medical needs not met by the recipient's attending physician;

(4) counseling services available to recipients and family members; counseling can be furnished for training families to provide care and preparing recipients and families to adjust to the recipient's approaching death; counseling includes dietary, spiritual and other counseling for recipients and families and bereavement counseling furnished after a recipient's death; the following counseling services must be furnished by hospices:

(a) organized program of bereavement services under the supervision of qualified professionals; the plan of care for these services must reflect family needs and provide a clear outline of the type, frequency and duration of counseling; bereavement counseling is a required but non-reimbursed service;

(b) dietary counseling, when applicable, furnished by qualified professionals;

(c) spiritual counseling, including notice to recipients of the availability of clergy; and

(d) other counseling, furnished by members of the interdisciplinary group or other qualified professionals.

(5) home health aide and homemaker services at frequencies sufficient to meet the needs of recipients; home health aides must meet training and qualification requirements; see 42 CFR 484.36; registered nurses must visit a recipient's residence every two (2) weeks to assess the performance of the aide or homemaker services;

(6) physical therapy, occupational therapy and speech-language therapy must be available if needed to control symptoms or maintain activities of daily living;

(7) durable medical equipment, medical supplies, and pharmacy services related to the palliation and management of the terminal illness and related conditions:

(a) See 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*.

(b) Medicaid covers only drugs and biologicals defined in Section 1861 (t) of the Social Security Act and used primarily for pain relief and symptom control related to terminal illness. All drugs and biologicals must be administered in accordance with accepted standards of practice.

(c) Every hospice must have a policy for the disposal of controlled drugs kept in the recipient's home when those drugs are no longer needed.

(d) Drugs and biologicals are to be administered only by the following individuals:

(i) a licensed nurse or physician;

(ii) the recipient with the approval of the attending physician; and

(iii) any other individual in accordance with applicable state and local laws;

the individual and each drug and biological they are authorized to administer must be specified in the recipient's plan of care.

(8) short-term inpatient services for pain control and symptom management delivered in a facility which is a medicaid provider; and

(9) short-term inpatient respite services furnished in a facility which is a medicaid provider; medicaid covers five (5) consecutive days of inpatient respite care which can be needed on an infrequent basis to provide respite for the recipient's family or primary caregivers.

(a) The need for and duration of inpatient respite services must be specified in the treatment plan.

(b) Inpatient respite must be furnished by a hospice facility, hospital, or nursing facility that meets the requirements in 42 CFR Section 418.100.

C. Continuous nursing care services: Medicaid covers continuous nursing care required to achieve pain control and symptom management. Continuous care can be covered during a period of crisis if the recipient needs such care to achieve palliation and manage acute medical symptoms at home.

(1) To be considered continuous care, nursing care must be furnished for eight (8) consecutive hours in a twenty-four (24) hour period. Medicaid covers the homemaker and/or aide services furnished during the other sixteen (16) hours as routine home care.

(2) Medicaid covers continuous nursing services for a maximum of seventy-two (72) consecutive hours.

[8.325.4.13 NMAC – Rp 8.325.4.13, 7/01/2024]

8.325.4.14 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: Hospice services are subject to utilization review for medical necessity and program compliance. These reviews can be performed before services are furnished, after services are furnished and before payment is made, after payment is made, or at any point in the service or payment process. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive utilization review instructions and documentation forms which assists in the receipt of prior authorization and claims processing.

A. Prior authorization: Hospice services do not require prior authorization. Services remain subject to review at any point in the payment process for medical necessity.

B. Eligibility determination: Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who are dissatisfied with a utilization review decision or action can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[8.325.4.14 NMAC – Rp 8.325.4.14, 7/01/2024]

8.325.4.15 NONCOVERED SERVICES: Hospice services are subject to the limitations and coverage restrictions that exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]. Medicaid does not cover the following hospice services.

A. Core services furnished by nonemployees. Core services when furnished routinely by non-employees or contracted staff are not covered by medicaid. A hospice can bill only for contracted staff necessary to supplement hospice employees in meeting recipient needs during periods of peak patient loads.

B. Bereavement counseling furnished to families after a recipient's death is a required hospice service, however, hospice agencies are not paid an additional amount for furnishing these services.

C. Inpatient respite care for more than five (5) consecutive days. After five (5) days, additional inpatient respite care is reimbursed as routine home care. Respite care cannot be furnished if the recipient lives in a long-term care facility.

D. Hospice services furnished by nondesignated hospices are not a covered benefit.

[8.325.4.15 NMAC – Rp 8.325.4.15, 7/01/2024]

8.325.4.16 PATIENT SELF DETERMINATION ACT: All adult recipients must be informed of their right to make health decisions, including the right to accept or refuse medical treatment, as specified in the Patient Self-Determination Act. See 8.302.1 NMAC, *General Provider Policies*.

[8.325.4.16 NMAC – Rp 8.325.4.16, 7/01/2024]

8.325.4.17 REIMBURSEMENT: Hospice providers must submit claims for reimbursement on the UB-92 claim form or its successor. Election documentation must be submitted with the initial claim. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing. Medicaid reimbursement for hospice care is made at one of four prospective daily rates, depending on the level of care furnished. The only retroactive adjustment to reimbursement is the year-end application of the limitation on inpatient care payment. Physician services are reimbursed separately from the hospice daily rate.

A. Payment for hospice care:

(1) Payment rates for hospice care services are determined by the centers for medicare and medicaid services (CMS), with local adjustments for wage differences within each category. Reimbursement for hospice services is based on one of four all-inclusive daily rate categories. The daily rate for each category includes all services necessary for palliative care, such as the purchase of needed medications, durable medical equipment, and medical supplies. The following are basic categories of hospice care:

(a) "routine home care day" defined as a day on which the recipient receives hospice care at home that is not defined as continuous care;

(b) "continuous home care day" defined as a day on which the recipient is not in an inpatient facility and receives nursing services for eight (8) consecutive hours in a twenty-four (24) hour period; this care is furnished only during brief periods of crisis to maintain the recipient at home; home health aide and/or homemaker services can also be furnished on a continuous basis, but these services are considered routine care;

(c) "inpatient respite care day" defined as a day on which a recipient receives care in approved facilities on a short-term basis to provider respite for the recipient's family or primary caregiver; and

(d) "general inpatient care day" defined as a day on which a recipient receives care in inpatient facilities for pain control or acute or chronic symptom management that cannot be managed in other settings.

(2) Reimbursement is made to a hospice for each day on which recipients are eligible for hospice care. Reimbursement is based on the appropriate payment amount for each day, regardless of the category of services furnished on any given day.

(3) Reimbursement for a continuous home care day varies, depending on the number of hours of continuous nursing services furnished. The continuous home care rate is divided by twenty-four (24) to yield an hourly rate. The number of hours of care furnished during the continuous home care day is multiplied by the hourly rate to yield the continuous home care payment for that day. Medicaid reimbursement for continuous home care is limited to a maximum of seventy-two (72) consecutive hours of service.

(4) The inpatient reimbursement rate for approved facility for short-term inpatient care depends on the category of care furnished, either inpatient respite or general inpatient.

(a) Reimbursement for inpatient respite care is limited to a maximum of five (5) consecutive days at a time. Medicaid pays for the sixth and any subsequent day of respite care at the routine home care rate.

(b) Medicaid pays the inpatient rate for the admission date and all subsequent inpatient days. For the discharge day, the applicable home care rate is reimbursed. Reimbursement for the discharge day when the recipient is discharged deceased is made at the inpatient rate.

(c) Reimbursement for all inpatient care is subject to a limitation that total inpatient care days for medicaid recipients cannot exceed twenty percent (20%) of the total days for which these recipients elected hospice care. The calculation and any necessary retroactive adjustment of overall payments per provider is completed during the cap period. See 42 CFR 418.302 (f).

B. Reimbursement for physician services:

(1) Medicaid covers the following services performed by hospice physicians as part of the general reimbursement rate for hospice care services:

(a) general supervisory services of the medical director; and

(b) participation in establishing, reviewing and updating plans of care, supervision of care and services, and establishment of governing policies by the physician member of the interdisciplinary group.

(2) For direct patient care services furnished by a hospice employee or a physician working under arrangement with the hospice, not listed above, medicaid reimburses the hospice for each procedure at the lesser of the medicaid fee schedule or the amount billed.

(3) Medicaid does not pay for physician services furnished on a volunteer basis.

(4) Medicaid does not cover physician services furnished by the recipient's attending physician as a hospice service, if he or she is not an employee of the hospice or providing services under arrangements with the hospice. Only the attending physician can bill for these services.

[8.325.4.17 NMAC – Rp 8.325.4.17, 7/01/2024]

8.325.4.18 HOSPICE SERVICES FOR RECIPIENTS IN NURSING FACILITIES: If a recipient does not have family or friends to provide the necessary care to allow the recipient to remain at home (home does not include an adult foster care setting or a home for the aged), a recipient living in a nursing facility (NF) can elect to receive hospice care. The NF is considered the recipient's place of residence. The NF and the designated hospice must sign a cooperative agreement that the hospice is responsible for the professional management of the recipient's hospice care and the NF provides room and board.

A. Room and board services: The agreement must specify that the NF provides the following room and board services:

(1) perform personal care services;

(2) help with activities of daily living;

(3) provide socializing activities;

(4) administer medication;

(5) maintain room cleanliness; and

(6) supervise the use of durable medical equipment and prescribed therapies.

B. Reimbursement for nursing facility room and board: For medicaid recipients living in a NF who elect hospice care, medicaid pays the hospice an additional per diem amount for routine home care and continuous home care days for the NF room and board services.

(1) The room and board reimbursement is ninety-five percent (95%) of the medicaid rate paid to the specific NF for that recipient.

(2) For dual-eligible medicare/medicaid recipients who live in an NF and elect the medicare hospice benefit, medicaid pays the hospice for the NF room and board services if the hospice and NF have a written agreement delineating responsibilities for hospice care and room and board services.

(a) For dual-eligible recipients, medicaid pays any coinsurance amounts for drugs, biological and respite care. See 42 CFR Section 418.400.

(b) For dual-eligible recipients, direct medicaid payment for service to the NF is discontinued.

[8.325.4.18 NMAC – Rp 8.325.4.18, 7/01/2024]

HISTORY OF 325.4 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

MAD Rule 310.26, Hospice Services, filed 3/20/1989.

History of Repealed Material:
MAD Rule 310.26, Hospice Services, filed 3/20/1989 - Repealed effective 2/1/1995.
8.325.4.1 NMAC, Hospice Care Services, filed 2/01/1995 - Repealed effective 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 325 SPECIALTY SERVICES
PART 9 HOME HEALTH SERVICES

8.325.9.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.325.9.1 NMAC – 8.325.9.1, 7/01/2024]

8.325.9.2 SCOPE: The rule applies to the general public.
[8.325.9.2 NMAC – 8.325.9.2, 7/01/2024]

8.325.9.3 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 health care authority pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.325.9.3 NMAC – 8.325.9.3, 7/01/2024]

8.325.9.4 DURATION: Permanent
[8.325.9.4 NMAC – 8.325.9.4, 7/01/2024]

8.325.9.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.325.9.5 NMAC – 8.325.9.5, 7/01/2024]

8.325.9.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.325.9.6 NMAC – 8.325.9.6, 7/01/2024]

8.325.9.7 DEFINITIONS: [RESERVED]

8.325.9.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.325.9.8 NMAC – 8.325.9.8, 7/01/2024]

8.325.9.9 HOME HEALTH SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including home health services [42 CFR, Section 484 and 42 CFR, Section 440.70]. This section [part] describes eligible providers, covered services, service limitations, and the general reimbursement methodology.
[8.325.9.9 NMAC – 8.325.9.9, 7/01/2024]

8.325.9.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), home health agencies that meet the following conditions are eligible to be reimbursed for furnishing services:

(1) meet the conditions of participation. See 42 CFR, Section 484 Subpart B;

(2) are licensed and certified by the licensing and certification bureau of the New Mexico department of health to meet all standards for participation in a federal program established under Title XVIII (medicare) of the Social Security Act. Any provider participating only in medicaid must be licensed and certified to comply with the standards for medicare participation; and

(3) are public agencies, private for-profit agencies, or private non-profit agencies primarily engaged in furnishing skilled nursing services and at least one other therapeutic service.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are

responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.
[8.325.9.10 NMAC – 8.325.9.10, 7/01/2024]

8.325.9.11 PROVIDER RESPONSIBILITIES:

A. Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See Section MAD-701, General Provider Policies [now 8.302.1 NMAC, General Provider Policies].

B. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Providers shall have written policies concerning the acceptance of recipients and the feasibility of meeting the recipient's needs in the home care setting, which include, but are not limited to:

(1) an evaluation visit in the recipient's residence to consider the physical facilities available, capabilities and attitudes of the recipient, family members or significant others, the availability of care givers, if any, to help in the care of the patient, and the appropriateness of home health care for meeting the recipient's needs in a safe environment;

(2) the recipient's need to receive medical care at home;

(3) orders from the recipient's physician;

(4) documentation in the medical record of (1), (2) and (3). Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701, General Provider Policies [now 8.302.1 NMAC, General Provider Policies].
[8.325.9.11 NMAC – 8.325.9.11, 7/01/2024]

8.325.9.12 ELIGIBLE RECIPIENTS:

A. Recipients must have a medical need to receive care at home to be eligible for home health agency services and must be certified as such by their attending physicians. A medical need to receive care at home means that the recipient has a condition caused by illness or injury which renders him/her unable to leave the home to obtain necessary medical care and treatment (i.e., is essentially homebound) or that the medical need for care at home is more appropriate and cost-effective and will prevent or delay institutionalization. Recipients do not need to be bedridden to be considered as having a medical need to receive care at home. Recipients may be considered eligible to receive care at home if they meet one or more of the following criteria:

(1) recipients who cannot leave their residences without the use of wheelchairs, crutches, walkers or assistance from another individual;

(2) recipients who because of severe physical or mental illness or injury must comply with doctor's orders and avoid all stressful physical activity;

(3) recipients who cannot leave their residences because of danger caused by a mental condition;

(4) recipients who have just returned to their residence after hospital stays for severe illness or surgical procedures and whose activities are restricted by their physicians because of pain, suffering, medical limitation or danger of infection.;

(5) recipients who are at high risk during pregnancy, infancy or childhood and for whom home health care is more appropriate to their needs.

(6) recipients are not eligible to receive care at home just because they:

(a) cannot drive,

(b) have multiple medical problems or

(c) live in an isolated area.

B. Infrequent periods away from residence: Recipients can leave their residences occasionally for medical treatment or personal errands and be eligible to receive home health care.

C. Determination of medical need to receive care at home: MAD or its designee reviews information submitted by the provider and determines whether recipients are considered eligible for home health service. Coverage is granted when the home health agency can demonstrate that care at home is appropriate to the medical needs of the recipient, the needed service is not otherwise available, and not receiving care would result in lack of access to health care services, institutionalization of the recipient and greater costs to the medicaid program.

D. Documentation of medical need to receive care at home: The home health agency is responsible for documenting on the written plan of care evidence of the recipient's medical need for home health care.

[8.325.9.12 NMAC – 8.325.9.12, 7/01/2024]

8.325.9.13 COVERED SERVICES:

A. Medicaid covers those home health services which are skilled, intermittent and medically necessary. The focus of home health services shall be on the curative, restorative or preventive aspects of care. The goal of these services shall be to assist the recipient to return to an optimum level of functioning and to facilitate the timely discharge of the recipient to self-care or to care by his/her family, guardian or significant other. Services must be ordered by the recipient's attending physician and included in the plan of care established by the recipient's attending physician in consultation with home health agency staff. The plan of care must be reviewed, signed and dated by the attending physician. The attending physician certifies that the recipient has a medical need to receive care at home at the initial certification, and as part of the plan of care review at recertification. The attending physician certifies that the recipient requires the skilled services of a nurse, physical therapist, occupational therapist or speech therapist. If the recipient requires home health aide services, the physician shall certify the need for these services. The evaluation visit is covered whether or not the recipient is admitted to home health care. Covered services include the following:

(1) skilled nursing services;

(2) home health aide services;

(3) physical and occupational therapy services; and

(4) speech therapy services.

B. Skilled nursing services: Medicaid covers skilled, intermittent and medically necessary skilled nursing services if the following conditions are met:

(1) Services must be ordered by the attending physician and included in the plan of care established by the recipient's attending physician in consultation with the home health agency staff. The plan of care must be reviewed, signed and dated by the attending physician;

(2) Skills of a registered nurse or licensed practical nurse must be required for direct care or supervision of home health aides.

(3) Services must be furnished by or under the supervision of a registered nurse licensed in New Mexico who is responsible for the initial evaluation, care planning and coordination of services.

(4) Services must be reasonable and necessary to the treatment of an illness or injury. To be considered reasonable and necessary, the services furnished shall be:

(a) consistent with the recipient's particular medical needs as determined by the recipient's attending physician.

(b) consistent with accepted standards of medical and nursing practice.

(c) consistent with provision of care in the safest, least restrictive setting for meeting the recipient's needs.

(d) consistent with the New Mexico MAD approved medical necessity criteria for home health.

(5) Skilled nursing care includes, but is not limited to, the following:

(a) observation and evaluation of recipient's health needs

(b) teaching the recipient, family members or significant other caretaker to provide care such as, but not limited to:

(i) giving an injection;

(ii) irrigating a catheter;

(iii) providing wound care, including applying dressings to wounds, positioning, and recognizing signs of infection and other complications;

(iv) using medications properly and safely, and understanding potential side effects;

(v) using special equipment and adaptive devices; and

(vi) home safety.

(c) insertion and sterile irrigation of catheters;

(d) administering injections;

(e) administering intravenous antibiotics and enteral and intravenous total parenteral nutrition;

(f) treating decubitus ulcers and other skin disorders; and

(g) providing other health teaching according to recipient's needs.

C. Therapy services: Medicaid covers the therapy services furnished through the home health agency by licensed physical therapists, occupational therapists or speech language pathologists.

(1) Services must be ordered by the recipient's attending physician and included in the plan of care established by the attending physician in consultation with the home health agency staff.

(2) All therapy services must conform with practice standards and licensing requirements as defined by state law.

(3) Services can be furnished by a public, private for-profit or private non-profit home health agency directly or under arrangement.

D. Home health aide services: Medicaid covers home health aide services if the following conditions are met:

(1) home health aides must complete training and/or a competency evaluation program that meets certain requirements. See 42 CFR, Section 484.36;

(2) services must be ordered by the attending physician and included in the plan of care established by the recipient's attending physician in consultation with the home health agency staff;

(3) written instructions for patient care are prepared by a registered nurse or therapist;

(4) assignment to a particular recipient is made by a registered nurse;

(5) duties of the home health aide include:

(a) performance of simple procedures as an extension of nursing and therapy services;

(b) personal care;

(c) walking and exercises;

(d) household services essential to health care at home;

(e) help with medications that are normally self-administered;

(f) reporting changes in the recipient's condition; and

(g) completing appropriate records.

(6) registered nurses or other appropriate professional staff members must make a supervisory visit to the recipient's residence at least every two (2) weeks to observe and decide whether goals are being met. The recipient's record must contain documentation that, at least every two (2) weeks or more often if necessary, there has been communication between the home health aide and the supervisory nurse or other appropriate professional staff member regarding the recipient's condition; and

(7) services must be furnished directly through the home health agency staff or by contractual arrangement.

E. Durable medical equipment and medical supplies: Medicaid covers medically necessary durable medical equipment and medical supplies which are specified in the plan of care. See Section MAD-754, Durable Medical Equipment and Medical Supplies [now 8.324.5 NMAC, Durable Medical Equipment and Medical Supplies].

(1) Reimbursement is made to the home health agency and is limited to medical supplies necessary during the course of the plan of care. The following durable medical equipment and medical supplies are covered as specified:

(a) Medicaid does not cover stock or routine items, such as band-aids, cotton balls, thermometers, lotion, personal care items, tape and alcohol.

(b) Non-routine supplies, such as catheters, ostomy supplies, feeding tubes, intravenous supplies, dressing supplies, ointments, solutions, chux diapers and home testing kits must be ordered as part of the plan of care.

(2) Utilization review, including retrospective review, can be made by MAD or its designee to assess the medical necessity for durable medical equipment and medical supplies and program compliance. If MAD determines that the equipment and supplies that were billed were not medically necessary or a covered service for the care of that recipient, the MAD payments are recouped.

F. Maternal/child services: Medicaid covers perinatal and pediatric home health services if the following conditions are met:

(1) the service is prescribed by the recipient's attending physician and is included in the plan of care established by the recipient's physician in consultation with home health agency staff;

(2) if the recipient has a medical need to receive care at home, in the sense that care in the home is more appropriate to the needs of the recipient, safe, cost-effective and will prevent or delay institutionalization;

(3) the services are reasonable and medically necessary to treat a high risk pregnancy, at-risk infant, illness, injury and to prevent infection. To be considered reasonable and medically necessary, the services furnished shall be:

(a) consistent with the recipient's particular medical needs as determined by the recipient's attending physician;

(b) consistent with accepted standards of medical and nursing practice;

(c) consistent with the New Mexico MAD approved medical necessity criteria for home health.

[8.325.9.13 NMAC – 8.325.9.13, 7/01/2024]

8.325.9.14 NONCOVERED SERVICES: Home health services are subject to the limitations and coverage restrictions of other medicaid services. See Section MAD-602, General Noncovered Services [now 8.301.3 NMAC, General Noncovered Services]. Medicaid does not cover the following home health agency services:

A. services beyond the initial evaluation which are furnished without prior approval;

B. home health services which are not skilled, intermittent and medically necessary;

C. services furnished to recipients who do not meet the eligibility criteria for home health services;

D. services furnished to recipients in places other than their place of residence;

E. services furnished to recipients who reside in intermediate care facilities for the mentally retarded or nursing facility (NF) residents who require a high NF level of service. Physical, occupational and speech therapy can be furnished to residents of nursing facilities who require a low level of service.

F. skilled nursing services which are not supervised by registered nurses; and

G. services not included in written plans of care established by physicians in consultation with the home health agency staff.

[8.325.9.14 NMAC – 8.325.9.14, 7/01/2024]

8.325.9.15 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See Section MAD-705, Prior Approval and Utilization Review [now 8.302.5 NMAC, Prior Approval and Utilization Review]. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: All home health services beyond initial visits for evaluation purposes, require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process. Prior approval does not guarantee payment, if upon utilization review after payment has occurred, recipients are determined to be ineligible or medical necessity is not found.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval can request a re-review and a reconsideration. See Section MAD-953, Reconsideration of Utilization Review Decisions [now 8.350.2 NMAC, Reconsideration of Utilization Review Decisions].

D. Effect of hospitalization: If a recipient is hospitalized during the certification period and a significant change in condition or course of treatment occurs, the home health agency must treat the recipient as a new patient and submit a new prior approval request and new plan of care. If there is no significant change in the recipient's condition or course of treatment, an agency can resume care under the existing plan of care.

[8.325.9.15 NMAC – 8.325.9.15, 7/01/2024]

8.325.9.16 TREATMENT PLAN [RESERVED]

[8.325.9.16 NMAC – 8.325.9.16, 7/01/2024]

8.325.9.17 REIMBURSEMENT: Home health agencies assume responsibility for any and all claims submitted on behalf of the provider and under the provider's number. Home health agencies must submit claims for reimbursement on the UB-92 claim form or its successor. See Section MAD-702, Billing for Medicaid Services [now 8.302.2 NMAC, Billing for Medicaid Services]. Once enrolled, providers receive instructions on documentation, billing and claims processing. Reimbursement is made based on the Title XVIII (medicare) cost-

finding procedures and reimbursement methodology. Charges are paid at an interim rate basis established under the medicaid guidelines by the medicare audit agent, subject to retroactive settlement when the cost report is final. Cost reports on appropriate forms must be submitted to the audit agent within ninety (90) days of the close of the provider's fiscal accounting period. Failure to provide timely cost reports results in suspension of payments.
[8.325.9.17 NMAC – 8.325.9.17, 7/01/2024]

8.325.9.18 REIMBURSEMENT LIMITATIONS: The following limitations apply to reimbursement made to home health agencies:

A. allowable costs are determined according to medicare and Title XIX (medicaid) reimbursement regulations;

B. the established percentage relationship of the agency's cost to charges per unity of services includes all services;

C. out-of-state providers are reimbursed at seventy percent (70%) of billed charges. Out-of-state home health services are approved only in very unusual circumstances, since home health services are furnished in the recipient's residence and that residence must be in New Mexico; and

D. claims for approved home health services must include the types of visits, dates of visits and number of visits.
[8.325.9.18 NMAC – 8.325.9.18, 7/01/2024]

8.325.9.19 PLAN OF CARE:

A. The plan of care, established by the physician in consultation with the home health agency staff, and the request for prior approval must be received or postmarked within five (5) working days of the proposed start of services or recertification period by MAD or its designee. Plans of care must be signed and dated by the physician, and prior approval must be received from MAD or its designee before claims are submitted to the MAD claims processing contractor. The plan of care must include the following:

(1) all principle diagnoses, surgical procedures, and other pertinent diagnoses;

(2) medications and dosages;

(3) types of services, equipment and non-routine supplies required;

(4) frequency of visits;

(5) safety measures to protect against injury;

(6) nutritional/fluid balance requirements;

(7) allergies;

(8) functional limitations, activities permitted and documentation of homebound status;

(9) mental status;

(10) prognosis;

(11) goals and measurable objectives, including rehabilitation potential, long range projection of likely changes in the recipient's condition and plans for timely discharge to self-care or to care by family, guardian or significant other; and

(12) Clinical findings and updates.

B. The plan of care for home health services is certified by MAD or its designee for specific time periods, not to exceed sixty-two (62) working days.

C. The attending physician and home health agency professional personnel must review the total plan of care prior to a request for recertification and submit the revised plan, including a report on the patient's response to care provided under the previous plan of care and specifying changes in services required.
[8.325.9.19 NMAC – 8.325.9.19, 7/01/2024]

HISTORY OF 8.325.9 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 310.0400, Home Health Agency Services, filed 2/18/1980.
MAD Rule 310.04, Home Health Services, filed 3/27/1992.

History of Repealed Material:
MAD Rule 310.04, Home Health Services, filed 3/27/1992 - Repealed effective 2/1/1995.
8 NMAC 4.MAD.768.7 Home Health Services Treatment Plan - Repealed effective 9/15/1997.
8.325.9 NMAC, Home Health Services Treatment Plan - Repealed effective 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 325 SPECIALTY SERVICES
PART 10 EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS

8.325.10.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA).
[8.325.10.1 NMAC – Rp 8.325.10.1, 7/01/2024]

8.325.10.2 SCOPE: The rule applies to the general public.
[8.325.10.2 NMAC – Rp 8.325.10.2, 7/01/2024]

8.325.10.3 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 the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.325.10.3 NMAC – Rp 8.325.10.3, 7/01/2024]

8.325.10.4 DURATION: Permanent
[8.325.10.4 NMAC – Rp 8.325.10.4, 7/01/2024]

8.325.10.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[8.325.10.5 NMAC – Rp 8.325.10.5, 7/01/2024]

8.325.10.6 OBJECTIVE: The objective of these rules is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.325.10.6 NMAC – Rp 8.325.10.6, 7/01/2024]

8.325.10.7 DEFINITIONS: [**RESERVED**]

8.325.10.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the life of their communities.
[8.325.10.8 NMAC – Rp 8.325.10.8, 7/01/2024]

8.325.10.9 EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS: The New Mexico MAD is required to pay for necessary emergency medical services furnished to individuals who are non-citizens, reside in New Mexico and meet the requirements for MAD eligibility [42 CFR 440.255(c)].
[8.325.10.9 NMAC – Rp 8.325.10.9, 7/01/2024]

8.325.10.10 ELIGIBLE PROVIDERS: Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HCA/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HCA or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HCA or its authorized agents obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.
[8.325.10.10 NMAC – Rp 8.325.10.10, 7/01/2024]

8.325.10.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to a medicaid or other health care program eligible recipient must comply with all federal and state laws, regulations, and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider must follow that contractor's instructions for billing and for authorization of services.

B. A provider may encourage an individual to apply for emergency medical services for non-citizens (EMSA) eligibility at a county office when the provider believes the service may qualify as an EMSA emergency service. A provider must inform the individual if the provider is unwilling to receive medicaid payment for the service when the service meets the EMSA emergency criteria for coverage. A provider must determine if the recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to a non-citizen recipient.

[8.325.10.11 NMAC – Rp 8.325.10.11, 7/01/2024]

8.325.10.12 ELIGIBLE INDIVIDUALS:

A. An applicant must be a noncitizen who is undocumented or who does not meet the qualifying immigration criteria specified in 8.200.410 NMAC, *General Recipient Requirements,* and in 8.285.400 NMAC, *Medicaid Eligibility-Emergency Medical Services for Non-Citizens-Category 085.*

B. Eligibility determinations are made by local county income support division (ISD) offices after the receipt of emergency services. The individual is responsible for completing an application at the local county ISD office and for providing all necessary documentation to prove that he or she meets the applicable eligibility criteria.

(1) An individual must apply for coverage at the ISD office no later than the last day of the third month following the month in which the alleged emergency services were received.

(2) A non-citizen recipient is responsible for notifying providers of the approval or denial of an application.

(3) If an application is denied or an application for coverage is not filed by the last day of the third month following the month in which the alleged emergency services were received, the non-citizen recipient is responsible for payment of the provider bill.

(4) If reimbursement for services is denied by MAD, the individual is responsible for payment and can be billed directly for payment by the provider.

[8.325.10.12 NMAC – Rp 8.325.10.12, 7/01/2024]

8.325.10.13 COVERAGE CRITERIA:

A. "Emergency" as defined for EMSA includes labor and delivery including inductions and cesarean sections, as well as any other medical condition, manifesting itself with acute symptoms of sufficient severity such that the absence of immediate emergency medical attention could reasonably be expected to result in one of the following:

(1) the non-citizen recipient's death;

(2) placement of the non-citizen recipient's health in serious jeopardy;

(3) serious impairment of bodily functions; or

(4) serious dysfunction of any bodily organ or part.

B. Services are covered only when necessary to treat or evaluate a condition meeting the definition of emergency and are covered only for the duration of that emergency.

C. After delivery, a child can have legally documented or citizenship status because of its birth in the United States and, therefore, is not eligible for emergency services for non-citizens. The child may be eligible for another MAD category of eligibility on his or her own.

D. Determination of coverage is made by MAD or its designee.

[8.325.10.13 NMAC – Rp 8.325.10.13, 7/01/2024]

8.325.10.14 SERVICE LIMITATIONS: To meet the categorical eligibility requirements, a recipient who is a non-citizen must be a resident of the state of New Mexico. Proof of residence must be furnished by the non-citizen to the local county ISD office. An individual traveling through New Mexico, entering the United States

through New Mexico en route to another destination, visiting in New Mexico or touring New Mexico with a tourist visa does not meet the residence requirement.
[8.325.10.14 NMAC – Rp 8.325.10.14, 7/01/2024]

8.325.10.15 NONCOVERED SERVICES: MAD does not cover any medical service that is not necessary to treat or evaluate a condition for an individual who is a non-citizen that does not meet the definition of emergency. Additionally, MAD does not cover the following specific services:

- **A.** long term care;
- **B.** organ transplants;
- **C.** rehabilitation services;
- **D.** elective surgical procedures;
- **E.** psychiatric or psychological services;
- **F.** durable medical equipment or supplies;
- **G.** eyeglasses;
- **H.** hearing aids;
- **I.** outpatient prescriptions;
- **J.** podiatry services;
- **K.** prenatal and postpartum care;
- **L.** well child care;
- **M.** routine dental care;
- **N.** routine dialysis services;
- **O.** any medical service furnished by an out-of-state provider;
- **P.** non-emergency transportation; and
- **Q.** preventive care.

[8.325.10.15 NMAC – Rp 8.325.10.15, 7/01/2024]

8.325.10.16 UTILIZATION REVIEW: Claims for services to a recipient who is a non-citizen are reviewed by MAD or its designee before payment to determine if the circumstances warrant coverage.

A. Eligibility determination: A non-citizen recipient who requests MAD coverage for services must meet specific categorical eligibility requirements. Eligibility determinations by local county ISD offices must be made before the review for medical necessity.

B. Reconsideration: A provider and the non-citizen are given notice of the denial when the EMSA emergency criteria are not met. A non-citizen recipient can request a re-review and reconsideration of denied coverage of the service. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953]. A non-citizen recipient can also request a hearing. See 8.52.2 NMAC, *Recipient Hearings*.
[8.325.10.16 NMAC – Rp 8.325.10.16, 7/01/2024]

8.325.10.17 REIMBURSEMENT: Reimbursement is made according to the rules applicable to the provider rendering the service.
[8.325.10.17 NMAC – Rp 8.325.10.17, 7/01/2024]

HISTORY OF 8.325.10 NMAC: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 326 CASE MANAGEMENT SERVICES
PART 2 CASE MANAGEMENT SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES

8.326.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.326.2.1 NMAC – Rp 8.326.2.1, 7/01/2024]

8.326.2.2 SCOPE: The rule applies to the general public.
[8.326.2.2 NMAC – Rp 8.326.2.2, 7/01/2024]

8.326.2.3 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 health care authority pursuant to state statute. See Sections 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.326.2.3 NMAC – Rp 8.326.2.3, 7/01/2024]

8.326.2.4 DURATION: Permanent
[8.326.2.4 NMAC – Rp 8.326.2.4, 7/01/2024]

8.326.2.5 EFFECTIVE DATE: February 1, 1995 [unless a later date is cited at the end of a section]
[8.326.2.5 NMAC – Rp 8.326.2.5, 7/01/2024]

8.326.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.326.2.6 NMAC – Rp 8.326.2.6, 7/01/2024]

8.326.2.7 DEFINITIONS: [**RESERVED**]

8.326.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.326.2.8 NMAC – Rp 8.326.2.8, 7/01/2024]

8.326.2.9 CASE MANAGEMENT SERVICES FOR ADULTS WITH DEVELOPMENTAL DISABILITIES: The New Mexico medical assistance program (medicaid) pays for medically necessary health services furnished to eligible recipients, including covered case management services furnished to adult recipients who have developmental disabilities [42 U.S.C. Section 1396n(g)(1)(2)]. This section [part] describes eligible providers, eligible recipients, covered services, service limitations and general reimbursement methodology.
[8.326.2.9 NMAC – Rp 8.326.2.9, 7/01/2024]

8.326.2.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation agreements by the New Mexico medical assistance division (MAD), the following agencies are eligible to be reimbursed for providing case management services:

(1) state agencies in New Mexico providing case management services to individuals with developmental disabilities;

(2) Indian tribal governments and Indian health service clinics; and

(3) community-based agencies in New Mexico that do not furnish adult day habilitation, work related services, and/or adult residential services to individuals with developmental disabilities.

B. Agency qualification: Agencies must be certified by the developmental disabilities division of the New Mexico department of health and meet the MAD approved standards for agencies providing case management for adults who are developmentally disabled.

(1) Agencies must demonstrate knowledge of the community to be served, its populations and its resources, including methods for accessing those resources.

(2) Agencies must demonstrate direct experience in case management services and success in serving the target population.

(3) Agencies must have personnel management skills, including written policies and procedures that include recruitment, selection, retention and termination of case managers, job descriptions for case managers, grievance procedures, hours of work, holidays, vacations, leaves of absence, wage scales and benefits, conduct and other general rules.

C. Case manager qualifications: Case managers employed by case management agencies must possess the education, skills, abilities and experience to perform case management service for adults with developmental disabilities. At a minimum, case managers must meet one of the following qualifications:

(1) bachelor's degree from an accredited institution in a human services field or any related academic discipline associated with the study of human behavior or human skills development, such as psychology, sociology, speech, gerontology, education, counseling, social work, human development or any other study of services related field and one (1) year of experience working with individuals with developmental disabilities;

(2) licensed as a registered or licensed practical nurse with one year of experience working with individuals with developmental disabilities; or

(3) In the event that there are no suitable candidates with the above qualifications, individuals with the following qualifications and experience can be employed as case managers:

(a) associate's degree and a minimum of three (3) years of experience working with individuals with developmental disabilities; or

(b) high school graduation or general educational development (GED) test and a minimum of four (4) years of experience working with individuals with developmental disabilities.

(4) Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

[8.326.2.10 NMAC – Rp 8.326.2.10, 7/01/2024]

8.326.2.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all specified medicaid participation requirements. See Section MAD-701, General Provider Policies [now 8.302.1 NMAC, General Provider Policies]. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records which are sufficient to fully disclose the extent and nature of the services furnished to recipients. See Section MAD-701, General Provider Policies [now 8.302.1 NMAC, General Provider Policies]. Documentation must substantiate the date of service, type of contact, category of case management service furnished, length/time units of service furnished, nature/content of the service furnished, result of service or intended result and relationship of the service furnished to goals identified in the plan of care.

[8.326.2.11 NMAC – Rp 8.326.2.11, 7/01/2024]

8.326.2.12 ELIGIBLE RECIPIENTS:

A. Case management services are available for eligible medicaid recipients that meet all of the following criteria:

(1) twenty-one (21) years of age or older;

(2) resident of the state of New Mexico;

(3) meet the state definition of an individual with a developmental disability;

(4) placement on the list for developmental disability services by the community services team (CST) of the developmental disabilities division of the department of health;

(5) resides outside a medicaid certified intermediate care facility for the mentally retarded (ICF-MR); and

(6) not a participant in a home and community-based services waiver program.

B. Information on the individual is gathered by the CST and used to complete an assessment and assign an "urgency of need" priority. Recipients assigned a priority one are individuals who are in danger of becoming homeless or victims of abuse, if suitable placement services are not received. Recipients assigned a priority two are individuals whose condition will deteriorate without placement. Recipients assigned a priority three are individuals who could benefit from case management but whose present condition is acceptable.

[8.326.2.12 NMAC – Rp 8.326.2.12, 7/01/2024]

8.326.2.13 COVERED SERVICES: Medicaid coverage for case management services varies by the priority assigned recipients by the CST.

A. Case management services for recipients assigned a priority three: Case management services for recipients assigned a priority three are limited. Medicaid covers assessments of recipients' needs and the coordination and performance of evaluations and assessments. A follow-up is performed during the third month with appropriate recommendations. Medicaid covers case management services for recipients classified as priority three only for an initial ninety (90) day period, unless the recipient's urgency of need priority changes to priority one or priority two.

B. Case management services for recipients assigned priority one or priority two: Medicaid covers case management services for those recipients assigned a priority one or priority two for up to sixty (60) days after suitable placement or services are received. Medicaid covers the following case management service activities for these recipients:

(1) assessment of the recipient's medical and social needs and functional limitations;

(2) coordination and monitoring of evaluations and services;

(3) help in identifying available service providers and programs to enhance the recipient's community access and involvement, including:

(a) arrangement of transportation;

(b) location of housing;

(c) location of providers to teach living skills;

(d) location of vocational or educational services; and

(e) location of civic or recreational services, as needed.

(4) facilitation and participation in the development, review and evaluation of a plan of care and revision of that plan when warranted; and

(5) assessment of the recipient's progress and continued need for services.

C. Administrative activities: Medicaid eligibility determinations or intake processing are covered services for individuals with developmentally disabilities who have not applied for medicaid but who have been referred to the CST for evaluation. These administrative services are billed as administrative activities, not as case management services.

[8.326.2.13 NMAC – Rp 8.326.2.13, 7/01/2024]

8.326.2.14 NONCOVERED SERVICES: Case management services are subject to the limitations and coverage restrictions which exist for other medicaid services. See Section MAD-602, General Noncovered Services [now 8.301.3 NMAC, General Noncovered Services]. Medicaid does not cover the following specific activities:

A. services furnished to individuals who are not medicaid eligible or do not meet the definition of an eligible recipient for these case management services;

B. services furnished by case managers which are not substantiated with appropriate documentation in the recipient's file;

C. formal educational or vocational services which relate to traditional academic subjects or job training;

D. outreach activities to contact potential recipients, except as described under covered services;

E. all administrative activities conducted after the initial ninety (90) day referral by the CST;

F. institutional discharge planning which must be furnished by the institution prior to discharge;

G. services which are furnished under other categories, such as therapies, transportation or counseling;

H. services which are considered by MAD or its designee to be excessive based on the condition of the recipient;

I. monitoring the quality of service provider agencies;

J. resource development; and

K. testifying before governmental bodies, such as city council meetings or legislative committees, even if on behalf of the recipient.

[8.326.2.14 NMAC – Rp 8.326.2.14, 7/01/2024]

8.326.2.15 PLAN OF CARE:

A. Case managers develop and implement plans of care (POC) based on standards developed by the developmental disabilities division of the department of health. For purposes of compliance with medicaid regulations, the following must be contained in the plan of care or documents used to develop the plan of care. The plan of care and supporting documents must be available for review in the recipient's file:

(1) statement of the nature of the specific problem and needs of the recipient;

(2) eescription of the functional level of the recipient, including an assessment and evaluation of the following:

(a) mental status assessment;

(b) intellectual function assessment;

(c) psychological assessment;

(d) educational assessment;

(e) vocational assessment;

(f) social assessment;

(g) medication assessment; and

(h) physical assessment.

(3) description of the intermediate and long-range goals and placement options with the projected timetable for their attainment, including information on the duration and scope of services; and

(4) statement and rationale of the plan of treatment for achieving these intermediate and long-range goals, including review and modification of the plan.

B. The plan of care must be retained by agency providers and available for utilization review purposes. Plans of care must be updated and revised, as indicated, at least every six (6) months or more often, as indicated by the recipient's condition.

[8.326.2.15 NMAC – Rp 8.326.2.15, 7/01/2024]

8.326.2.16 PRIOR APPROVAL AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See Section MAD-705, Prior Approval and Utilization Review [now 8.302.5 NMAC, Prior Approval and Utilization Review]. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

A. Prior approval: Certain procedures or services which are part of the recipients' plan of care can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior approval of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior approval request denials or other review decisions can request a re-review and a reconsideration. See Section MAD-953 [now 8.350.2 NMAC, Reconsideration of Utilization Review Decisions].

[8.326.2.16 NMAC – Rp 8.326.2.16, 7/01/2024]

8.326.2.17 REIMBURSEMENT:

A. Case management providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See Section MAD-702, Billing for Medicaid Services [now 8.302.2 NMAC, Billing for Medicaid Services]. Instructions on documentation, billing and claims processing are sent to approved medicaid providers. Reimbursement for covered case management services is made at the lesser of the following:

(1) the provider's billed charge; or

(2) the MAD fee schedule for the specific service or procedure.

B. The provider's billed charge must be their usual and customary charge for an average month of services to individuals who are part of the target population. Monthly charges are based on a cost analysis conducted periodically by the New Mexico department of health.

C. "Usual and customary charge" refers to the amount which the individual providers charge the general public in the majority of cases for a specific procedure or service.

D. For case management services furnished by an institution, costs associated with case management must be removed from their cost reports prior to cost settlement or rebasing.

[8.326.2.17 NMAC – Rp 8.326.2.17, 7/01/2024]

HISTORY OF 8.326.2 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
MAD Rule 310.33, Case Management Services for Adults with Developmental Disabilities, filed 5/21/1991.
MAD Rule 310.33, Case Management Services for Adults with Developmental Disabilities, filed 3/10/1994.

History of Repealed Material:
MAD Rule 310.33, Case Management Services for Adults with Developmental Disabilities, filed 3/10/1994 - Repealed effective 2/1/1995.
8.326.2.1 NMAC, Case Management Services for Adults with Developmental Disabilities, filed 2/01/1995 - Repealed effective 7/01/2024.

TITLE 8 SOCIAL SERVICES
CHAPTER 349 COORDINATED SERVICE CONTRACTORS
PART 2 APPEALS AND GRIEVANCE PROCESS

8.349.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.349.2.1 NMAC – Rp 8.349.2.1, 7/01/2024]

8.349.2.2 SCOPE: The rule applies to the general public.
[8.349.2.2 NMAC – Rp 8.349.2.2, 7/01/2024]

8.349.2.3 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 health care authority pursuant to state statute. See NMSA 1978, section 27-2-12 et seq. (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.349.2.3 NMAC – Rp 8.349.2.3, 7/01/2024]

8.349.2.4 DURATION: Permanent
[8.349.2.4 NMAC – Rp 8.349.2.4, 7/01/2024]

8.349.2.5 EFFECTIVE DATE: March 1, 2006, unless a later date is cited at the end of a section.
[8.349.2.5 NMAC – Rp 8.349.2.5, 7/01/2024]

8.349.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.349.2.6 NMAC – Rp 8.349.2.6, 7/01/2024]

8.349.2.7 DEFINITIONS: [**RESERVED**]

8.349.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.349.2.8 NMAC – Rp 8.349.2.8, 7/01/2024]

8.349.2.9 COORDINATED SERVICE CONTRACTORS (CSC): CSCs that manage some services of the medicaid program are responsible for any or all aspects of program management, prior authorization, utilization review, claims processing, and issuance of remittance advices and payments.

A. The CSC shall have a grievance system in place for recipients that include a grievance process related to dissatisfaction and an appeals process related to a CSC's action, including the opportunity to request an HCA fair hearing.

B. A grievance is a recipient's expression of dissatisfaction about any matter or aspect of the CSC or its operation, other than a CSC's action, as defined below.

C. An appeal is a request for review by the CSC of a CSC's action. An action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

D. The recipient, legal guardian of the recipient for a minor or an incapacitated adult, or a representative of the recipient as designated in writing to the CSC, has the right to file a grievance or an appeal of the CSC's action on behalf of the recipient. A provider acting on behalf of the recipient, with the recipient's written consent, may file a grievance and/or an appeal of a CSC's action.

E. In addition to the CSC's grievance and appeal process described above, a recipient, legal guardian of the recipient for a minor or an incapacitated adult, or the representative of the recipient has the right to request a fair hearing on behalf of the recipient with HCA directly as described in 8.352.2 NMAC, *Recipient Hearings*, if a CSC's decision results in termination, modification, suspension, reduction, or denial of services to the recipient or if

the recipient believes the CSC has taken an action erroneously. A fair hearing may be requested prior to, concurrent with, subsequent to, or in lieu of a grievance or appeal to the CSC.
[8.349.2.9 NMAC – Rp 8.349.2.9, 7/01/2024]

8.349.2.10 GENERAL REQUIREMENTS FOR GRIEVANCE AND APPEALS:

A. The CSC shall implement written policies and procedures describing how the recipient may submit a request for a grievance or an appeal with the CSC or submit a request for a fair hearing with the health care authority (HCA). The policy shall include a description of how the CSC resolves the grievance or appeal.

B. The CSC shall provide to all service providers and subcontractors in the CSC's network a written description of the CSC's grievance and appeal process and how the provider can submit a grievance and/or appeal.

C. The CSC shall have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

D. The CSC shall name a specific individual(s) designated as the CSC's medicaid recipient grievance coordinator with the authority to administer the policies and procedures for resolution of a grievance and/or an appeal, to review patterns/trends in grievances and/or appeals, and to initiate corrective action.

E. The CSC shall ensure that the individuals that make the decisions on grievances and/or appeals are not involved in any previous level of review or decision-making. The CSC shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

(1) an appeal of a CSC denial that is based on lack of medical necessity;

(2) a CSC denial that is upheld in an expedited resolution;

(3) a grievance or appeal that involves clinical issues.

F. Upon enrollment, the CSC shall provide recipients, at no cost, with an information sheet or handbook that provides information on how they and/or their representative(s) can file a grievance and/or an appeal, and the resolution process. The recipient information shall also advise recipients of their right to file a request for an administrative hearing with the HCA hearings bureau, upon notification of a CSC action, or concurrent with or following an appeal of the CSC action.

G. The CSC shall ensure that punitive or retaliatory action is not taken against a recipient or a provider that files a grievance and/or an appeal, or a provider that supports a recipients's grievance and/or appeal.
[8.349.2.10 NMAC – Rp 8.349.2.10, 7/01/2024]

8.349.2.11 GRIEVANCE: A grievance is a recipient's expression of dissatisfaction about any matter or aspect of the CSC or its operation.

A. A recipient may file a grievance either orally or in writing with the CSC within ninety (90) calendar days of the date the event causing the dissatisfaction occurred. The legal guardian of the recipient for a minor or an incapacitated adult, a representative of the recipient as designated in writing to the CSC, and a provider acting on behalf of the recipient and with the recipient's written consent, have the right to file a grievance on behalf of the recipient.

B. Within five (5) working days of receipt of the grievance, the CSC shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution.

C. The investigation and final CSC resolution process for grievances shall be completed within thirty (30)- calendar days of the date the grievance is received by the CSC and shall include a resolution letter to the grievant or the grievant's representative.

D. The CSC may request an extension from HCA up to fourteen (14) calendar days if the grievant requests the extension, or the CSC demonstrates to HCA that there is need for additional information, and the extension is in the recipient's interest. For any extension not requested by the grievant, the CSC shall give the grievant written notice of the reason for the extension within two (2) working days of the decision to extend the timeframe.

E. Upon resolution of the grievance, the CSC shall mail a resolution letter to the grievant, legal guardian, representative, and/or provider acting on behalf of the recipient. The resolution letter shall include, but not be limited to, the following:

(1) all information considered in investigating the grievance;

(2) findings and conclusions based on the investigation; and

(3) the disposition of the grievance.

[8.349.2.11 NMAC – Rp 8.349.2.11, 7/01/2024]

8.349.2.12 APPEALS: An appeal is a request for review by the CSC of a CSC action.

A. An action is defined as:

(1) the denial or limited authorization of a requested service, including the type of level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial, in whole or in part, of payment for a service;

(4) the failure of the CSC to provide services in a timely manner, as defined by HCA; or

(5) the failure of the CSC to complete the authorization request in a timely manner as defined in 42 CFR 438.408.

B. The CSC shall mail a notice of action to the recipient and/or provider with in 10 days of the date of the action, except for denial of claims that may result in recipient financial liability, which requires immediate notification. The notice shall contain, but not be limited, to the following:

(1) the action CSC has taken or intends to take;

(2) the reasons for the action;

(3) the recipient's or the provider's right to file an appeal of the CSC action through the CSC;

(4) the recipient's right to request an HCA fair hearing and what the process would be;

(5) the procedures for exercising the rights specified;

(6) the circumstances under which expedited resolution of an appeal is available and how to request it; and

(7) the recipient's right to have benefits continue pending resolution of an appeal, how to request the continuation of benefits, and the circumstances under which the recipient may be required to pay the costs of continuing these benefits.

C. A recipient may file an appeal of a CSC action within ninety (90)-calendar days of receiving the CSC's notice of action. The legal guardian of the recipient for a minor or an incapacitated adult, a representative of the recipient as designated in writing to the CSC, or a provider acting on behalf of the recipient with the recipient's written consent, have the right to file an appeal of an action on behalf of the recipient.

D. The CSC has thirty (30)-calendar days from the date the initial oral or written appeal is received by the CSC to resolve the appeal.

E. The CSC shall have a process in place that ensures that an oral or written inquiry from a recipient seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). The CSC shall use its best efforts to assist recipients as needed with the written appeal.

F. Within five (5) working days of receipt of the appeal, the CSC shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The CSC shall confirm in writing receipt of oral appeals, unless the recipient or the provider requests an expedited resolution.

G. The CSC may extend the thirty (30) days time frame by fourteen (14) calendar days if the recipient requests the extension, or the CSC demonstrates to HCA that there is need for additional information, and the extension is in the recipient's interest. For any extension not requested by the recipient, the CSC shall give the recipient written notice of the extension and the reason for the extension within two (2) working days of the decision to extend the time frame.

H. The CSC shall provide the recipient and/or the recipient's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.

I. The CSC shall provide the recipient and/or the representative the opportunity, before and during the appeals process, to examine recipient's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The CSC shall include as parties to the appeal the recipient and his or her representative, or the legal representative of a deceased recipient's estate.

J. For all appeals, the CSC shall provide written notice within the thirty (30)-calendar-day timeframe for resolution to the grievant, legal guardian, representative, and/or provider acting on behalf of the recipient.

(1) The written notice of the appeal resolution shall include, but not be limited to, the following information:

(a) the results of the appeal resolution; and

(b) the date it was completed.

(2) The written notice of the appeal resolution for appeals not resolved wholly in favor of the recipient shall include, but not be limited to, the following information:

(a) the right to request an HCA fair hearing and how to do so:

(b) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(c) that the recipient may be held liable for the cost of continuing benefits if the hearing decision upholds the CSC's action.

K. The CSC may continue benefits while the appeal and/or the HCA fair hearing process is pending.

(1) The CSC shall continue the recipient's benefits if all of the following are met:

(a) the recipient or the provider files a timely appeal of the CSC action within ten (10) days of the date on the notice of action from the CSC);

(b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment:

(c) the services are ordered by an authorized provider;

(d) the recipient requests extension of benefits.

(2) The CSC shall provide benefits until one of the following occurs:

(a) the recipient withdraws the appeal;

(b) ten (10) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the recipient and the recipient has taken no further action;

(c) HCA issues a hearing decision adverse to the recipient;

(d) the time period or service limits of a previously authorized service has expired.

(3) If the final resolution of the appeal is adverse to the recipient, that is, the CSC's action is upheld, the CSC may recover the cost of the services furnished to the member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).

(4) If the CSC or HCA reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending the CSC shall authorize or provide the disputed services promptly and as expeditiously as the recipient's health condition requires.

(5) If the CSC or HCA reverses a decision to deny, limit or delay services and the recipient received the disputed services while the appeal was pending, the CSC shall pay for these services.

[8.349.2.12 NMAC – Rp 8.349.2.12, 7/01/2024]

8.349.2.13 EXPEDITED RESOLUTION OF APPEALS: An expedited resolution of an appeal is an expedited review by the CSC of a CSC action.

A. The CSC shall establish and maintain an expedited review process for appeals when the CSC determines that allowing the time for a standard resolution could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:

(1) a request from the recipient;

(2) a provider's support of the recipient's request;

(3) a provider's request on behalf of the recipient; or

(4) the CSC's independent determination.

B. The CSC shall ensure that the expedited review process is convenient and efficient for the recipient.

C. The CSC shall resolve the appeal within three (3) working days of receipt of the request for an expedited appeal, if the request meets the definition of expedited in 8.349.2.13 NMAC.

D. The CSC may extend the time frame by up to fourteen (14) calendar days if the recipient requests the extension, or the CSC demonstrates to HCA that there is need for additional information and the extension is in the recipient's interest. For an extension not requested by the recipient, the CSC shall give the recipient written notice of the reason for the delay.

E. The CSC shall ensure that punitive action is not taken against a recipient or a provider who requests an expedited resolution or supports a recipient's expedited appeal.

F. The CSC shall provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to an oral or written request from the recipient or provider on behalf of the recipient.

G. The CSC shall inform the recipient of the limited time available to present evidence and allegations in fact or law.

H. If the CSC denies a request for an expedited resolution of an appeal, it shall:

(1) transfer the appeal to the thirty (30)-day timeframe for standard resolution, in which the thirty (30)-day period begins on the date the CSC received the original request for appeal;

(2) make reasonable efforts to give the recipient prompt oral notice of the denial, and follow up with a written notice within two (2) calendar days; and

(3) inform the grievant in the written notice of the right to file an appeal and/or request an HCA fair hearing if the recipient is dissatisfied with the CSC's decision to deny an expedited resolution.

I. The CSC shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

[8.349.2.13 NMAC – Rp 8.349.2.13, 7/01/2024]

8.349.2.14 SPECIAL RULE FOR CERTAIN EXPEDITED SERVICE AUTHORIZATION DECISIONS: In the case of expedited service authorization decisions that deny or limit services, the CSC shall, within seventy-two (72) hours of receipt of the request for service, automatically file an appeal on behalf of the recipient, use its best effort, to give the recipient oral notice of the decision on the automatic appeal and to resolve the appeal.

[8.349.2.14 NMAC – Rp 8.349.2.14, 7/01/2024]

8.349.2.15 OTHER RELATED COORDINATED SERVICE CONTRACTOR (CSC) PROCESSES:

A. Information about grievance system to providers and subcontractors: The CSC shall provide information specified in 42 CFR438.10(g) (1) about the grievance system to all providers and subcontractors at the time that they enter into a contract.

B. Grievance and/or appeal files:

(1) All grievance and/or appeal files shall be maintained in a secure and designated area and accessible to HCA, upon request, for review. Grievance and/or appeal files shall be retained for six (6) years following the final decision by the CSC, HCA, and administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

(2) The CSC shall have procedures for assuring that files contain sufficient information to identify the grievance and/or appeal, the date it was received, the nature of the grievance and/or appeal, notice to the recipient of receipt of the grievance and/or appeal, all correspondence between the CSC and the recipient, the date the grievance and/or appeal is resolved, the resolution, the notices of final decision to the recipient, and all other pertinent information.

(3) Documentation regarding the grievance shall be made available to the grievant, legal guardian representative, and/or provider acting on behalf of the recipient if requested.

[8.349.2.15 NMAC – Rp 8.349.2.15, 7/01/2024]

8.349.2.16 COORDINATED SERVICE CONTRACTOR (CSC) PROVIDER GRIEVANCE PROCESS: The CSC shall establish and maintain written policies and procedures for the filing of provider grievances. A provider shall have the right to file a grievance with the CSC regarding utilization management decisions and/or provider payment issues. Grievances shall be resolved within thirty (30) calendar days. A provider may not file a grievance on behalf of a recipient without written designation by the recipient as the recipient's representative. See 8.349.2.14 NMAC for special rules for certain expedited service authorizations.

[8.349.2.16 NMAC – Rp 8.349.2.16, 7/01/2024]

History of 8.349.2 NMAC: [**RESERVED**]

TITLE 8 SOCIAL SERVICES
CHAPTER 372 INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE
PART 1 GENERAL PROVISIONS

8.372.1.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.372.1.1 NMAC - N, 7/01/2024]

8.372.1.2 SCOPE: This rule applies to the general public.
[8.372.1.2 NMAC - N, 7/01/2024]

8.372.1.3 STATUTORY AUTHORITY: Subsection F of Section 9-7-6.4 NMSA 1978 requires the interagency behavioral health purchasing collaborative (the collaborative) to adopt rules through the health care authority. The collaborative is created by statute and comprised of the secretaries of aging and long-term services; Indian affairs; health care authority; health; corrections; children, youth and families; finance and administration; workforce solutions; public education; and transportation; the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the vocational rehabilitation division of the public education department; the New Mexico health policy commission; and the governor's health policy coordinator, or their designees. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.372.1.3 NMAC - N, 7/01/2024]

8.372.1.4 DURATION: Permanent.
[8.372.1.4 NMAC - N, 7/01/2024]

8.372.1.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.372.1.5 NMAC - N, 7/01/2024]

8.372.1.6 OBJECTIVE: The objective of this rule is to provide policies for the standard of delivery for behavioral health services through contracted behavioral health entities and for approval of contracts by the collaborative.
[8.372.1.6 NMAC - N, 7/01/2024]

8.372.1.7 DEFINITIONS: This section contains the glossary for the New Mexico behavioral health system. The following definitions apply to terms used in this chapter and shall guide any rules promulgated by collaborative members regarding behavioral health.

A. Definitions beginning with letter "A":

(1) Abuse, individual: Any intentional, knowing or reckless act or failure to act that produces or is likely to produce physical or great mental or emotional harm, unreasonable confinement, sexual abuse or sexual assault consistent with 30- 47-1 NMSA 1978.

(2) Abuse, provider: Provider practices that are inconsistent with sound fiscal, business, medical or service related practices and result in an unnecessary cost to the program, or in reimbursement for services that are not medically, clinically, or psychosocially necessary or in services that fail to meet professionally recognized standards for behavioral health care.

(3) Adult behavioral health procedures manual: The procedures manual that includes the psychiatric rehabilitation program requirements and comprehensive community support services requirements.

(4) Advance directive: Written instructions such as a mental healthcare advance directive, psychiatric advance directive, living will, durable health care power of attorney, durable mental health care power of attorney, or advance health directive, relating to the provision of health care when an adult is incapacitated. (See generally, 27-7A-1 - 27-7A-18 NMSA, 1978, and 24-7B-1 – 24-7B-16 NMSA 1978.)

(5) Adverse determination: A determination by the BHE that the behavioral health services furnished, or proposed to be furnished to a consumer, are not medically, clinically or psychosocially necessary or not appropriate.

(6) American society of addiction medicine (ASAM): An organization of professionals in addiction services that developed, in the early 1990s or a set of criteria and tools to identify the level of care best suited to an individual in need of addiction services.

B. Definitions beginning with letter "B":

(1) Behavioral health (BH): The umbrella term for mental health and substance abuse. It includes both mental health (MH), including psychiatric illnesses and emotional disorders, and substance abuse (SA), including addictive and chemical dependency disorders, and includes co-occurring MH and SA disorders and the prevention of those disorders.

(2) Behavioral health entity (BHE): One or more managed care organizations selected by HSD and the collaborative to provide all defined behavioral health service responsibilities, including medicaid behavioral health.

(3) Behavioral health planning council (BHPC): The body created to meet federal and state advisory council requirements and to provide consistent, coordinated input to the behavioral health service delivery system in New Mexico, and with which the BHE will be expected to interact with as an advisory council. (See 24-1-28 NMSA, 1978)

C. Definitions beginning with letter "C":

(1) Chair or co-chairs: The secretary of human services shall serve as the chair of the collaborative. The secretary of health and the secretary of children youth and families shall alternate each state fiscal year as the co-chair of the collaborative.

(2) Clinical necessity: The determination made by a behavioral health professional exercising prudent clinical judgment as to whether a behavioral health service would promote growth and development, prevent, diagnose, detect, treat, ameliorate, or palliate the effects of a behavioral health condition, injury, or disability for the consumer.

(3) Collaborative: The interagency behavioral health purchasing collaborative, responsible for planning, designing and directing a statewide behavioral health system. The collaborative, established under Section 9-7-6.4 NMSA 1978, by its statutory member agencies collectively, operates under by-laws adopted by the collaborative.

(4) Collaborative members or member agencies: The statutory and *ex officio* agency representatives who sit on the collaborative or their agency designees.

(5) Comprehensive community support services (CCSS): CCSS is a recovery and resiliency oriented service which is provided in the community, primarily face-to-face, using natural supports to the maximum extent possible to build on client and family strengths. These services are goal-directed mental health rehabilitation services and supports for children, adolescents, and adults necessary to assist individuals in achieving recovery and resiliency goals. These services assist in the development and coordination of a consumer or member's service plan and include therapeutic interventions which address barriers that impede the development of skills necessary for independent functioning in the community. (See, 8.315.6 NMAC, 8.305.1 NMAC and collaborative adult behavioral health procedural manual.)

(6) Consumer: For purposes of these rules, a person with a mental health or substance use disorder receiving or eligible to receive behavioral health services through collaborative or collaborative member contracts, or a past recipient of such services.

(7) Consumer empowerment: Activities that address the following areas:

(a) consumer choice

(b) consumer voice

(c) self-management

(d) community integration

(8) Continuous quality improvement (CQI): CQI is a process for improving quality that assumes opportunities for improvement are unlimited; is customer-oriented, data driven, and results in implementation of improvements; and requires continual measurement of implemented improvements and modification of improvements, as indicated.

(9) Core service agencies (CSAs): Multi-service agencies that help to bridge treatment gaps in the child and adult treatment systems, promote the appropriate level of service intensity for consumers with complex behavioral health service needs, ensure that community support services are integrated into treatment, and develop the capacity for consumers to have a single point of accountability for identifying and coordinating their behavioral health, health and other social services.

(10) Credentialing: A systematic process whereby the BHE or provider verifies and warrants that an employed, contracted or affiliated behavioral health professional or agency meets specified practice standards including education, experience, licensure and certification.

(11) Cultural competence: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables them to work effectively in cross-cultural

situations, including situations of diverse culture, race, ethnicity, national origin or disability. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and marketing programs that match an individual's culture to increase the quality and appropriateness of behavioral health care and outcomes. *See*, 8.305.1.7 NMAC.

D. Definitions beginning with letter "D":

(1) Delegation: A formal process by which a BHE gives another entity the authority to perform certain functions on its behalf but for which the BHE retains full accountability for the delegated functions.

(2) Designated representative: A person designated under a valid mental health care treatment advance directive as an individual's authorized agent according to the provisions of the Mental Health Care Treatment Decisions Act (Section 24-7B NMSA 1978) and who has personal knowledge of the respondent and the facts as required in Subsection B of the act.

E. Definitions beginning with letter "E":

(1) EPSDT: Early and periodic screening, diagnostic and treatment.

(2) Ex-officio members: Non-voting members of the collaborative, who otherwise serve as full members (e.g. the secretary of higher education department, secretary of veteran's services department, New Mexico public defender, and the children's cabinet coordinator).

(3) Executive committee: A committee of the collaborative comprised of the secretaries of human services, health, and children youth and families. The executive committee is authorized to negotiate, approve and execute contracts and amendments on behalf of the collaborative.

F. Definitions beginning with letter "F":

(1) Family-centered care: When a child is the consumer, the system of care reflects the importance of the family or legal guardian in the way services are planned and delivered. Family-centered care facilitates collaboration between family members and behavioral health professionals, builds on individual and family strengths and respects diversity of families.

(2) Family specialist: An approved provider who is certified as a family specialist through an approved state certification program. *(*See Subsection U of 7.20.11.7 NMAC)

G. Definitions beginning with letter "G":

(1) Grievance (consumer): Oral or written statement by a member expressing dissatisfaction with any aspect of the BHE or its operations that is not a BHE action.

(2) Grievance (provider): Oral or written statement by a provider to the BHE expressing dissatisfaction with any aspect of the BHE or its operations that is not a BHE action.

H. Definitions beginning with letter "H": **HIPAA:** Health Insurance Portability and Accountability Act of 1996.

I. Definitions beginning with letter "I": Indicated prevention: Interventions that identify individuals who are experiencing early signs of substance abuse, mental illness and other related problem behavior and target them with special programs.

J. Definitions beginning with letter "J": [RESERVED]

K. Definitions beginning with letter "K": [RESERVED]

L. Definitions beginning with letter "L":

(1) Letter of direction (LD): Written instructions, detailed action steps, and guidelines to clarify the implementation of programs funded by new funding sources or changes to programs funded by funding sources identified in the BHE contract.

(2) Local collaborative (LC): An advisory body, delineated by either judicial district or tribal grouping and recognized by the collaborative, that provides input on local and regional behavioral health issues to the collaborative, the BHPC and the BHE.

(3) Logic model, prevention services: A logical conceptual framework used to connect the prevention effort with its intended results and the goal of reducing substance abuse. The framework is based upon existing knowledge that is refined or revised with new research. The logic model specifically describes the changes expected within the target population(s), why it is likely that these changes would result from the proposed prevention services and activities, and how this logically relates to the needs assessment.

M. Definitions beginning with letter "M":

(1) Managed care organization (MCO): An organization that contracts with the state of New Mexico to provide a variety of health care services to individuals who are enrolled.

(2) Management letter: A document signed by the co-chairs of the collaborative and a representative of the BHE authorized to bind the BHE that describes a certain task or activity to be pursued or

conducted by the BHE, the specific approach to that task or activity, the expected result and the schedule to be followed to implement the task or activity. Such letters are not intended to be amendments to the BHE contract, but more specific directions for completing contract requirements.

(3) Medicaid: The medical assistance program authorized under Title XIX and Title XXI of the Social Security Act or its successors, furnished to New Mexico residents who meet specific eligibility requirements.

(4) Medically necessary services: Clinical and rehabilitative physical, mental or behavioral health services that:

(a) are essential to prevent, diagnose or treat medical or behavioral health conditions or are essential to enable the consumer to attain, maintain or regain the consumer's optimal functional capacity;

(b) are delivered in the amount, duration, scope and setting that is both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical, mental and behavioral health care needs of the consumer;

(c) are provided within professionally accepted standards of practice and national guidelines; and

(d) are required to meet the physical, mental and behavioral health needs of the consumer and are not primarily for the convenience of the consumer, the provider or the BHE. (Subparagraphs (a) and (b) of Paragraph (7) of Subsection M of 8.305.1.7 NMAC)

N. Definitions beginning with letter "N":

(1) Network provider: An individual provider, clinic, group, association or facility employed by or contracted with a BHE to furnish covered behavioral health services to consumers under the provisions of the BHE contract.

(2) Non-network provider: An individual provider, clinic, group, association or facility that provides covered services and does not have a contract with the BHE.

O. Definitions beginning with letter "O": [RESERVED]

P. Definitions beginning with letter "P":

(1) Peer specialist: An approved provider who is certified as a peer specialist through a state approved certification program. (Paragraph (4) of Subsection A of 8.315.6.10 NMAC)

(2) Performance measures: A system of operational and tracking indicators specified by state or federal requirements or the collaborative, including but not limited to the federal national outcome measures (NOMS).

(3) Prevention services: Services that follow current national standards for prevention including both physical and behavioral health.

(4) Prevention provider: A provider under contract for the exclusive or primary purpose of providing services designed to prevent or reduce the prevalence of substance abuse, mental illness, or other specified behavioral health disorders.

(5) Psychosocial necessity: Services or products provided to a consumer with the goal of helping that individual develop to his/her fullest capacities through learning and environmental supports and reduce the risk of the consumer developing a behavioral health disorder or an increase in the severity of behavioral health symptoms. The consumer need not have a behavioral health diagnosis but rather have a need to improve psychosocial functioning.

Q. Definitions beginning with letter "Q": [RESERVED]

R. Definitions beginning with letter "R":

(1) Recovery: Behavioral health recovery is an individual's personal journey of healing and transformation enabling a person with a behavioral health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

(2) Re-credentialing: A systematic process whereby the BHE verifies and warrants that an employed or affiliated behavioral health professional who is currently credentialed, continues to meet specified practice standards, including education, experience, licensure and certification.

(3) Resiliency: A global term describing a dynamic process, whereby people overcome adversity and go on with their lives in a productive and self-satisfying manner.

(4) Responsible offeror: An offeror who submits a response proposal and who has furnished, when required, information and data to prove that the offeror's financial resources, production or service facilities, personnel, service reputation and experience are adequate to make satisfactory delivery of the services or items of tangible personal property described in the proposal.

S. Definitions beginning with letter "S":

(1) Selective prevention: Prevention interventions targeted at a subgroup of the general population that is determined to be at risk for sexual assault, substance abuse or mental illness.

(2) State: The state of New Mexico, including any entity or agency of the state and including but not limited to the collaborative and member agencies.

(3) Subcontract: A written agreement between the BHE and a third party, or between a subcontractor and another subcontractor, to provide services, and where appropriate approved by the collaborative.

(4) Subcontractor: A third party who contracts with the BHE or a BHE subcontractor for the provision of services.

(5) Supported employment: Integrated work for not less than the federal minimum wage in a setting with ongoing support services for individuals with severe disabilities for whom competitive employment:

(a) has not traditionally occurred;

(b) has been interrupted or intermittent as a result of severe disability, and who,

(c) because of the nature and severity of their disabilities need intensive physical, educational, social or psychological support to perform work.

(6) Supportive housing: Permanent housing that is affordable to individuals with low or no incomes, is chosen by the individual, which a person retains even if their service needs change, and which is an essential ingredient to foster and support a person's journey towards recovery and resiliency.

T. Definitions beginning with letter "T": [RESERVED]

U. Definitions beginning with letter "U": Universal prevention: Prevention interventions intended to reach the entire population or a large share of it, without regard to individual risk factors.

V. Definitions beginning with letter "V": [RESERVED]

W. Definitions beginning with letter "W": [RESERVED]

X. Definitions beginning with letter "X": [RESERVED]

Y. Definitions beginning with letter "Y": [RESERVED]

Z. Definitions beginning with letter "Z": [RESERVED]

[8.372.1.7 NMAC - N, 7/01/2024]

8.372.1.8 MISSION STATEMENT: The mission of the collaborative is to ensure that quality behavioral health services are provided to both medicaid and non-medicaid consumers; that providers are reimbursed timely and accurately; that services promote prevention, recovery, resilience in consumers, and that available resources are used in the most efficient and effective manner. This mission serves the collaborative's vision of establishing a single service delivery system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of substance abuse and mental illness are prevented or reduced.

[8.372.1.8 NMAC - N, 7/01/2024]

HISTORY OF 8.372.1 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 372 INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE
PART 2 STANDARDS OF DELIVERY FOR BEHAVIORAL HEALTH SERVICES

8.372.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.372.2.1 NMAC - N, 7/01/2024]

8.372.2.2 SCOPE: This rule applies to the general public.
[8.372.2.2 NMAC - N, 7/01/2024]

8.372.2.3 STATUTORY AUTHORITY: Subsection F of Section 9-7-6.4 NMSA 1978 requires the interagency behavioral health purchasing collaborative (the collaborative) to adopt rules through the health care authority. The collaborative is created by statute and comprised of the secretaries of aging and long-term services; Indian affairs; health care authority; health; corrections; children, youth and families; finance and administration; workforce solutions; public education; and transportation; the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the vocational rehabilitation division of the public education department; the New Mexico health policy commission; and the governor's health policy coordinator, or their designees. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.372.2.3 NMAC - N, 7/01/2024]

8.372.2.4 DURATION: Permanent.
[8.372.2.4 NMAC - N, 7/01/2024]

8.372.2.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.372.2.5 NMAC - N, 7/01/2024]

8.372.2.6 OBJECTIVE: The objective of this rule is to provide policies for the standard of delivery for behavioral health services through contracted behavioral health entities.
[8.372.2.6 NMAC - N, 7/01/2024]

8.372.2.7 DEFINITIONS: [RESERVED]
[8.372.2.7 NMAC - N, 7/01/2024]

8.372.2.8 MISSION STATEMENT: The mission of the interagency behavioral health collaborative (the collaborative) is to ensure quality behavioral health services are provided to medicaid and non-medicaid consumers; providers are reimbursed timely and accurately; data is collected, and services promote prevention, recovery, resilience, and efficient use of available resources. This mission serves the collaborative vision to establish a behavioral health service delivery system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of substance abuse and mental illness are prevented or reduced.
[8.372.2.8 NMAC - N, 7/01/2024]

8.372.2.9 QUALITY MANAGEMENT: The collaborative recognizes that strong programs of quality improvement and assurance help ensure that better care is delivered in a cost-effective manner with better outcomes for consumers and families. Under the terms of the interagency behavioral health collaborative contracts, quality assurance and management programs are incorporated into behavioral health care delivery and administrative systems.
[8.372.2.9 NMAC - N, 7/01/2024]

8.372.2.10 BROAD STANDARDS:

A. Commitment to persons served: The behavioral health entity (BHE) and provider shall provide or ensure that:

(1) service delivery is individually centered and family-centered, and furthers an individual's capacity for recovery and resiliency;

(2) all services are designed to enhance, promote and expand the recovery, resiliency, independence, self-sufficiency, self-esteem and quality of life of the persons served;

(3) individuals served are involved in the individual planning, decision-making, implementation and evaluation of services provided;

(4) agents under an advance directive, family members, guardians or treatment guardians, caregivers, or other persons critical to the consumer's life and well-being are involved in the individual planning, decision-making, implementation and evaluation of services provided, subject to requirements or principles of confidentiality and individual choice;

(5) the system offers a full range of appropriate behavioral health services for multi-diagnosed clients, including facilitating access to and coordinating care with appropriate medical care providers;

(6) services are based on evidence of effectiveness;

(7) services consider the individual consumer's and family's preferences;

(8) services and providers comply with Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

B. Collaboration and system of care requirements: The BHE shall be responsible for developing a system of care that offers acceptable access and appropriate, effective care to all individuals and families served. The BHE shall coordinate and collaborate with the collaborative in the implementation of the requirements of this or other rules and the requirements of any contracts between the BHE and the collaborative. The BHE shall work with the BHPC and, upon request, with LCs to seek advice and comment during the planning, implementation, and evaluation of services. The BHE shall consult with the BHPC to identify service gaps and needs, including provider training, coaching and supervision needs and opportunities.

C. Reporting requirements: The BHE shall provide to the collaborative such reports as may be required by the BHE contract. The BHE shall verify the accuracy and completeness of data and other information in reports submitted.

D. Behavioral health data: For reporting purposes, behavioral health data shall be collected and reported as required by contract for any consumer or family member receiving any behavioral health service provided by a behavioral health practitioner, regardless of setting or location as required by the collaborative, including behavioral health licensed professionals, practicing within the BHE. The BHE shall monitor and ensure the integrity of data. Findings shall be reported to the collaborative as required by the BHE contract.

E. Emergency response requirements: The BHE shall participate in disaster behavioral health planning and emergency response with the collaborative and in a manner consistent with the protocol of described in the New Mexico department of health emergency operations plan, psychosocial annex. The BHE shall ensure that its network providers are likewise prepared to be responsive and appropriate to the specific needs of an event calling for emergency response and psychosocial support services.

F. Sexual assault: The BHE shall ensure that its providers have the capacity to provide comprehensive, confidential and sensitive services to victims of sexual assault as mandate by the Sexual Crimes and Prosecution and Treatment Act Sections 29-11-1 through 29-11-7, NMSA 1978.

G. Advance directives: The BHE shall have and implement policies and procedures for advance directives. The BHE shall require its providers to honor advance directives within its utilization management protocols.

H. Forensic evaluations: The BHE shall ensure that network and non-network providers providing forensic evaluations shall assure that such evaluations shall be performed pursuant to court authority and either the *Rules of Criminal Procedure for the District Courts,* 5-602.B, NMSA 1978, or other legal authority. Each evaluation file shall have a copy of the court order from the state district court.

I. Special coordination requirements: The BHE shall ensure effective coordination with other service systems and providers. Such coordination shall include at least the following:

(1) physical and behavioral health services;

(2) emergency services;

(3) pharmacy services;

(4) transportation;

(5) supportive housing;

(6) SCI MCOs;

(7) CYFD, including children in CYFD custody;

(8) New Mexico corrections department;

(9) court-ordered or parole board-ordered treatment;

(10) children in tribal custody or under tribal supervision;
(11) adolescents transitioning into the adult system;
(12) children with IEPs;
(13) medicaid eligibility outreach and assistance;
(14) medicaid waiver and non-medicaid disability programs;
(15) aging and long-term services department programs;
(16) HIV/AIDS treatment providers;
(17) individuals with special health care needs;
(18) supported employment.

J. The BHE shall ensure that consumers with both a developmental disability and a mental illness, including consumers with autism spectrum disorders, receive covered services in a manner that meets their unique needs and in accordance with the specific requirements of the BHE contract.

K. The BHE shall comply with all applicable standards, procedure manuals, practice guidance, clinical protocols, orders or regulations issued by the collaborative or by collaborative member agencies or departments.

L. The BHE shall hold subcontractors to all standards, procedure manuals, practice guidance, clinical protocols, orders or regulations issued by the collaborative or by collaborative member agencies or departments and shall monitor and assure compliance. Subcontracts of the BHE shall allow the BHE to observe or review administrative or clinical practices for contract compliance, quality management and outcomes.
[8.372.2.10 NMAC - N, 7/01/2024]

8.372.2.11 STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT:

A. Program structure and operations: Quality management is an integrated approach that links knowledge, structure and processes together throughout a BHE's system to assess and improve quality. The BHE's quality management (QM) and improvement (QI) structures and processes shall be planned, systematic, clearly defined, and in full compliance with the BHE contract. The BHE shall comply with the provisions of 8.305.8.12 NMAC, regardless of the funding source of services. The BHE shall ensure that the QM/QI program is applied to the entire range of covered services and all major demographic population groups in accordance with the BHE contract. The BHE shall have an annual QM/QI work plan, prior approved by the collaborative, and as specified in its BHE contact with the collaborative.

B. Continuous quality improvement/total quality management: The BHE shall base its administrative operations and service delivery on principles of continuous quality improvement/total quality management (QM/QI). Such an approach shall include at least the following:

(1) recognize that opportunities for improvement are unlimited;
(2) ensure that the QM/QI process shall be data driven;
(3) require the continual measurement of clinical and non-clinical effectiveness and programmatic improvements of clinical and non-clinical processes driven by such measurements;
(4) require the re-measurement of effectiveness and continuing development and implementation of improvements as appropriate; and
(5) rely on consumer and stakeholder input.

C. Prevention and coordination of care: The BHE shall institute QM/QI policies and procedures that emphasize and promote prevention and coordination across multiple providers and systems.

D. Consumer/family satisfaction: The BHE shall work with the collaborative in conducting the annual adult and child/family consumer satisfaction survey based on the national mental health statistics improvement project or successor projects. If the BHE conducts any other or separate satisfaction survey, such survey, including the survey instrument and methodology, shall be prior approved by the collaborative. The BHE shall comply with requirements of 8.305.8.11 and such other requirements as the BHE contract may require.

E. Clinical practice guidelines: The BHE shall disseminate recommended practice guidelines, practice parameters, consensus statements and specific criteria for the provision of services for acute and chronic behavioral health care conditions.

(1) The BHE shall select the clinical issues to be addressed with clinical guidelines based on the needs of consumers.
(2) The clinical practice guidelines shall be evidence-based.
(3) The BHE shall comply with the provisions of 8.305.8.12 NMAC regardless of the funding source for services. The BHE shall fully comply with all specifications of the BHE contract regarding clinical practice guidelines and evidence-based practices.

[8.372.2.11 NMAC - N, 7/01/2024]

8.372.2.12 PERFORMANCE MEASURES:

A. BHE shall be accountable as specified in its contract for the achievement of any performance measure targets identified by the collaborative. The BHE shall measure and track performance measures, report on such measures at intervals defined by the collaborative, and incorporate performance measures as part of its QM/QI program. Performance measures include those required by the federal government or specified by the collaborative.

B. Effectiveness of the QI program: The BHE shall evaluate the overall effectiveness of its QI program and demonstrate improvements in the quality of clinical care and non-clinical service to consumers. The BHE shall conduct data-driven evaluations of clinical practices to improve quality of care. The BHE shall demonstrate how it has influenced or changed provider practice patterns.

[8.372.2.12 NMAC - N, 7/01/2024]

8.372.2.13 STANDARDS FOR UTILIZATION MANAGEMENT: The collaborative requires appropriate utilization management (UM) standards to be implemented as well as activities to be performed so that excellent services are provided in a coordinated fashion with neither over nor under-utilization. The BHE shall manage the use of resources, maximize the effectiveness of care by evaluating clinical appropriateness, and authorize the type and volume of services through fair, consistent and culturally competent decision-making processes while ensuring equitable access to care and a successful link between care and outcomes. The consumer's service plan or treatment plan priorities, advance directives, and prolonged service authorizations for individuals with chronic conditions shall be considered in the decision-making process.

A. Necessity requirement: The BHE shall comply with 8.305.8.13 NMAC regarding standards for utilization management. References to "medical necessity" in 8.305.8.13 NMAC shall be read as "clinical and psychosocial necessity" as defined in these rules. References to "member" in 8.305.8.13 NMAC shall be read as "consumer" and shall include the consumer's family, legal guardian, and designated representative as appropriate. All requirements in 8.305.8.13 NMAC regarding providing notice to providers shall include notice to the consumer and consumer's family, legal guardian, and designated representative as appropriate.

B. Use of qualified professionals: The BHE shall ensure the involvement of representative practicing providers, consumers and family members in the development of its UM procedures. The BHE shall evaluate network provider satisfaction with the UM process as part of its annual provider satisfaction survey.

C. Decisions: The BHE shall make available UM decision criteria to providers, consumers, their families, and the public. The BHE shall ensure that consumers have an optimal choice of providers consistent with their treatment needs and available providers.

D. Records: The BHE shall maintain records (both hard and electronic) that verify its utilization management activities and compliance with UM requirements specified in this rule and the specific contractual requirements of the BHE contract.

[8.372.2.13 NMAC - N, 7/01/2024]

8.372.2.14 STANDARDS FOR CREDENTIALING AND RECREDENTIALING: The BHE shall have and implement policies and procedures that comply with 8.305.8.14 NMAC, as well as any other applicable credentialing or recredentialing requirements from collaborative member departments and agencies, including but not limited to any federal block grant or other collaborative practice protocols, rules or other requirements.

A. Practitioner participation: The BHE shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.

B. Credentialing application: The BHE shall use a collaborative-approved application for network participation.

C. Evaluation of practitioner site: The BHE shall perform an initial visit to the offices of potential high volume behavioral health care providers, as determined by the BHE with approval of the collaborative.

D. Assessment of organizational providers: For organizational providers, the BHE shall confirm that the provider is in good standing with state and federal regulatory bodies and has been certified by the appropriate state certification agency, when applicable.

E. Performance evaluation: The BHE shall ensure that all providers maintain the certification and training necessary to provide the services they offer. The BHE shall utilize QM/QI data in conducting provider recredentialing, recontracting or performance evaluations.

F. Practices and programs: The BHE shall ensure that credentialing and recredentialing requirements shall recognize and promote approaches to services such as consumer- and family-run programs,

Native American healing practices and programs, traditional curanderismo, and other legally acceptable programs. [8.372.2.14 NMAC - N, 7/01/2024]

8.372.2.15 RIGHTS AND RESPONSIBILITIES: The BHE and the provider shall have a written policy, approved by the collaborative as required, that states their commitment to treating clients in a manner that respects their rights, respecting and recognizing the consumer's dignity and need for privacy. This policy shall also address the BHE and the provider's expectations with regard to clients' responsibilities. The BHE shall comply with 8.305.12 NMAC and 8.349.2 NMAC regarding grievances and appeals, regardless of funding source. The BHE shall be required to comply with NMAC 8.305.8.15 NMAC, member (consumer) bill of rights, any other collaborative member department or agency's rights' statements, and all consumer rights and responsibilities provisions of the BHE contract with the collaborative.

A. Consumer handbook: The BHE shall maintain a consumer handbook, prior approved by the collaborative, that includes but is not limited to information about consumer rights and responsibilities. The written information provided to consumers or clients of the BHE or provider shall be comprehensible, readable, easily understood and culturally sensitive.

B. Complaints or grievances:

(1) Consumers, their families or legal guardians, and designated representatives have a right and shall have the means to voice complaints or file grievances and appeals about the care provided by the BHE or provider in its network.

(2) The BHE shall establish and maintain written policies and procedures for the filing of provider grievances and appeals.

(3) The BHE and the provider shall have written policies and procedures for the timely resolution of client or provider complaints or grievances.

(4) The BHE shall provide information specified in 42 CFR Section 438.10(g)(1) about its grievance system to all providers and subcontractors at the time they enter a contract.

(5) The BHE shall provide the collaborative regular reporting of all consumer and provider grievances, appeals, and fair hearings, and such other related data and information as specified in the BHE contract. [8.372.2.15 NMAC - N, 7/01/2024]

8.372.2.16 STANDARDS FOR CLINICAL RECORDS:

A. Standards and policies: The BHE shall require clinical records to be maintained in a format and manner that is timely, legible, current, and organized, and that permits effective and confidential consumer care and quality review. The BHE shall fully comply with all medical records, data, and confidentiality requirements of the BHE contract and any relevant state and federal law.

B. Confidentiality: The BHE shall have and implement clinical record confidentiality policies and procedures that implement the requirements of state and federal law and policy, this rule, and the BHE contract. These policies and procedures shall be consistent with confidentiality requirements in 45 CFR parts 160 and 164 for all medical records and any other health and enrollment information that identifies a particular consumer. Medical record contents shall be consistent with the utilization control required in 42 CFR Part 456, 42 CFR 431.305(b) and 45 CFR 164.530(c).

C. Evaluation and treatment or service records:

(1) To promote effective service delivery and quality review, treatment or service records shall be maintained in a manner that is current, comprehensive, detailed, organized, and legible.

(2) The BHE and the provider shall ensure that consumers and family members participate in treatment or service planning, development, and implementation and maximize consumer and family recovery and resiliency. The BHE shall ensure that consumers and family members, where appropriate, are presented with opportunities to proactively engage and participate in the behavioral health service delivery system, with a focus on the family as a potential change agent where consistent with the consumer's preferences and wishes. [8.372.2.16 NMAC - N, 7/01/2024]

8.372.2.17 STANDARDS FOR ACCESS:

A. Ensure access: The BHE shall ensure the accessibility and availability of behavioral health providers for each medically, clinically or psychosocially necessary service. The BHE shall comply with 8.305.8.18 NMAC, regardless of the funding source and shall comply with such geo-access standards as the collaborative may require. The BHE shall maintain and update its service access plan, which shall describe the BHE's system for consumer access to services.

B. Array of services: The BHE shall ensure that in each region of the state there is an array of covered services that allow consumers to be served within the least restrictive setting and in close proximity to their places of residence, with preference given to in-state providers.

C. Appointment standards: The BHE shall ensure that appointment standards detailed in the BHE contract are met by the provider and shall report to the collaborative on the compliance of providers in meeting appointment standards.

D. Access to transportation services: The BHE shall assist consumers in accessing existing transportation benefits and resources to provide transportation to covered services, including transportation to address a behavioral health issue during non-business hours and transportation related to an emergency. The BHE shall coordinate behavioral health transportation services with the consumer's respective MCO, where applicable.

E. Cultural competency: The BHE and provider shall provide effective services to people of all cultures, races, ethnic backgrounds, religions in a manner that respects the worth of the individual and protects the dignity of each individual regardless of the circumstances under which services are sought.

(1) The BHE shall develop, implement, evaluate, and update a cultural competency plan for itself and for all network providers to ensure that consumers and their families, including individuals with disabilities, receive covered services that are culturally and linguistically appropriate to meet their needs.

(2) The BHE shall ensure that providers have access to specific clinical standards, service approaches, techniques and marketing programs that match an individual's culture to increase the quality and appropriateness of behavioral health care and outcomes. The BHE shall ensure compliance with 8.305.1.7 NMAC, regardless of funding source.

[8.372.2.17 NMAC - N, 7/01/2024]

8.372.2.18 DELEGATION: Delegation is a process whereby the BHE gives another entity the authority to perform certain functions on its behalf. The BHE shall be fully accountable for the quality of clinical care and services provided to consumers through its delivery system. The BHE may not delegate the accountability for the quality of services provided. The BHE will be responsible for the QM/QI program and not delegate this responsibility to subcontractors. The BHE shall not assign, transfer or delegate key management functions such as utilization review/utilization management or care coordination without the explicit written approval of the collaborative. The BHE shall ensure its full compliance with all delegation requirements of the BHE contract.

[8.372.2.18 NMAC - N, 7/01/2024]

HISTORY OF 8.372.2 NMAC: [RESERVED]

TITLE 8 SOCIAL SERVICES
CHAPTER 372 INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE
PART 3 BEHAVIORAL HEALTH ENTITY CONTRACTING

8.372.3.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.372.3.1 NMAC - N, 7/01/2024]

8.372.3.2 SCOPE: This rule applies to collaborative member agencies.
[8.372.3.2 NMAC - N, 7/01/2024]

8.372.3.3 STATUTORY AUTHORITY: Subsection F of Section 9-7-6.4 NMSA 1978 requires the interagency behavioral health purchasing collaborative (the collaborative) to adopt rules through the human services department. The collaborative is created by statute and comprised of the secretaries of aging and long-term services; Indian affairs; health care authority; health; corrections; children, youth and families; finance and administration; workforce solutions; public education; and transportation; the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the vocational rehabilitation division of the public education department; the New Mexico health policy commission; and the governor's health policy coordinator, or their designees. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.372.3.3 NMAC - N, 7/01/2024]

8.372.3.4 DURATION: Permanent.
[8.372.3.4 NMAC - N, 7/01/2024]

8.372.3.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.372.3.5 NMAC - N, 7/01/2024]

8.372.3.6 OBJECTIVE: The objective of this rule is to provide policies for the standard of delivery for behavioral health services through contracted behavioral health entities and for approval of contracts by the collaborative.
[8.372.3.6 NMAC - N, 7/01/2024]

8.372.3.7 DEFINITIONS: [RESERVED]
[8.372.3.7 NMAC - N, 7/01/2024; Repealed, 1-15-13]

8.372.3.8 MISSION STATEMENT: The mission of the collaborative is to ensure that quality behavioral health services are provided to medicaid and non-medicaid consumers; that providers are reimbursed timely and accurately; that services promote prevention, recovery, resilience in consumers, and that available resources are used in the most efficient and effective manner. This mission serves the collaborative's vision of establishing a behavioral health service delivery system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of substance abuse and mental illness are prevented or reduced.
[8.372.3.8 NMAC - N, 7/01/2024; A, 1-15-13]

8.372.3.9 ELIGIBLE BEHAVIORAL HEALTH ENTITY (BHE): The collaborative shall award a contract to one or more behavioral health entities which meets applicable requirements and standards delineated under state and federal law including Title IV of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act. The BHE contract shall, at a minimum, manage delivery of all covered behavioral health services (both medicaid and non-medicaid services), including network development and management, tracking funding and expenditures from various funding sources, conducting utilization management, ensuring coordination of services, ensuring quality management and improvement, and conducting various administrative functions.

A. BHE contract procurement: The collaborative may, in conjunction with human services department, jointly procure contractors to provide both BH and other medicaid services.

B. BHE contract issuance: Prior to execution of a contract with a BHE, the collaborative must meet and give approval as to the substance and form of the proposed contract. The executive committee is authorized to negotiate, sign and execute the contract with a BHE without further approval from the other members.

C. BHE contract amendments: The BHE contract shall not be altered, changed or amended other than by an instrument in writing executed by the contractor and the co-chairs of the collaborative. The executive committee is authorized to adopt and execute an amendment to a BHE contract on behalf of the collaborative without obtaining prior approval of the other members.

D. Other contracts: The chair and co-chairs are authorized to negotiate any additional contracts, memoranda of understanding or other agreements, and any amendments or modifications thereto, on behalf of the collaborative without obtaining the prior approval of the members.

[8.372.3.9 NMAC - N, 7/01/2024]

8.372.3.10 [RESERVED]

[8.372.3.10 NMAC - N, 7/01/2024]

8.372.3.11 READINESS REVIEW: Following full execution and prior to the effective date of the BHE contract, the contractor shall demonstrate to the satisfaction of the collaborative that it is able to meet the requirements of the RFP. The readiness review may include, but is not limited to, desk and on-site reviews, system demonstrations, interviews with the contractor's staff and such other review of any and all requirements of the RFP as determined by the collaborative.

[8.372.3.11 NMAC - N, 7/01/2024]

8.372.3.12 CONTRACT MANAGEMENT: The collaborative or its designee shall provide collective and coordinated oversight and administrative functions to ensure BHE compliance with the terms of its contract, assuring each member agency with fiduciary responsibility for funds within the contract is involved and is able to meet its obligations to oversee state and federal funds for which it is responsible. Further, the provisions of 8.305.3.10 apply to all BHE contracts.

[8.372.3.12 NMAC - N, 7/01/2024]

HISTORY OF 8.372.3 NMAC: [RESERVED]