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TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT RULES
PART 400 GENERAL MEDICAID ELIGIBILITY

8.200.400.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA).
[8.200.400.1 NMAC - Rp, 8.200.400.1 NMAC, 1/1/2019; A/E, 10/1/2024; A, 2/1/2025]

8.200.400.2 SCOPE: The rule applies to the general public.
[8.200.400.2 NMAC - Rp, 8.200.400.2 NMAC, 1/1/2019]

8.200.400.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.
[8.200.400.3 NMAC - Rp, 8.200.400.3 NMAC, 1/1/2019]

8.200.400.4 DURATION: Permanent.
[8.200.400.4 NMAC - Rp, 8.200.400.4 NMAC, 1/1/2019]

8.200.400.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.200.400.5 NMAC - Rp, 8.200.400.5 NMAC, 1/1/2019]

8.200.400.6 OBJECTIVE: The objective of this rule is to provide specific instructions when determining eligibility for the medicaid program and other health care programs. Generally, applicable eligibility rules are detailed in the medical assistance division (MAD) eligibility policy manual, specifically 8.200.400 NMAC, *General Medicaid Eligibility*. Processes for establishing and maintaining MAD eligibility are detailed in the income support division (ISD) general provisions 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.200.400.6 NMAC - Rp, 8.200.400.6 NMAC, 1/1/2019]

8.200.400.7 DEFINITIONS: [**RESERVED**]

8.200.400.8 MISSION: We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.
[8.200.400.8 NMAC - Rp, 8.200.400.8 NMAC, 1/1/2019; A, 1/1/2022; A/E, 10/1/2024; A, 2/1/2025]

8.200.400.9 GENERAL MEDICAID ELIGIBILITY: Medicaid services are jointly financed by the federal government and the state of New Mexico and are administered by medical assistance division (MAD).

A. Within broad federal regulations, New Mexico determines categories of eligible recipients, eligibility requirements, types and range of services, levels of provider reimbursement and managed care capitation, and administrative and operating procedures.

B. New Mexico administers medical assistance programs using waivers of the Social Security Act for comparability of services, rules for income and resources and freedom of choice of provider.

C. Payments for medical and behavioral health services, durable equipment and supplies are made directly to service providers, not to the medicaid eligible recipient.

D. This chapter describes the New Mexico categories of medicaid and medical assistance programs eligibility. Each medicaid and medical assistance program includes detailed eligibility requirements which are organized into the following three chapter types:

(1) recipient requirements (.400);
(2) income and resources standards (.500); and
(3) benefit description (.600).

[8.200.400.9 NMAC - Rp, 8.200.400.9 NMAC, 1/1/2019]

8.200.400.10 BASIS FOR DEFINING GROUP - MEDICAID CATEGORIES:

A. Except where noted, the HCA income support division (ISD) determines eligibility in the categories listed below:

(1) other adult (Category 100);
(2) parent caretaker (Category 200);
(3) pregnant women (Category 300);
(4) pregnancy-related services (Category 301);
(5) loss of parent caretaker due to earnings from employment or due to spousal support (Categories 027 and 028);
(6) newborn (Category 031);
(7) children under age 19 (Categories 400, 401, 402, 403, 420, and 421);
(8) children, youth, and families department medicaid (Categories 017, 037, 046, 04, 066, and 086); and
(9) family planning (Category 029).

B. Medicare savings program (MSP): MSP assists an eligible recipient with the cost of medicare.

(1) Medicare is the federal government program that provides health care coverage for individuals 65 or older; or under 65 who have a disability. Individuals under 65 who have a disability are subject to a waiting period of 24 months from the approval date of social security disability insurance (SSDI) benefits before they receive medicare coverage. Coverage under medicare is provided in four parts.

(a) Part A hospital coverage is usually free to beneficiaries when medicare taxes are paid while working.

(b) Part B medical coverage requires monthly premiums, co-insurance and deductibles to be paid by the beneficiary.

(c) Part C advantage plan allows a beneficiary to choose to receive all medicare health care services through a managed care organization.

(d) Part D provides prescription drug coverage.

(2) The following MSP programs can assist an eligible recipient with the cost of medicare.

(a) Qualified medicare beneficiaries (QMB) - Categories 041 and 044: QMB covers low income medicare beneficiaries who have or are conditionally eligible for medicare Part A. QMB benefits are limited to the following:

(i) cost for the monthly medicare Part B premium;
(ii) cost of medicare deductibles and coinsurance; and
(iii) cost for the monthly medicare Part A premium (for those enrolling conditionally).

(b) Specified low-income medicare beneficiaries (SLIMB) - Category 045: SLIMB medicaid covers low-income medicare beneficiaries who have medicare Part A. SLIMB is limited to the payment of the medicare Part B premium.

(c) Qualified individuals 1 (QI1s) - Category 042: QI1 medicaid covers low-income medicare beneficiaries who have medicare Part A. QI1 is limited to the payment of the medicare part B premium.

(d) Qualified disabled working individuals (QDI) - Category 050: QDI medicaid covers low income individuals who lose entitlement to free medicare Part A hospital coverage due to gainful employment. QDI is limited to the payment of the monthly Part A hospital premium.

(e) Medicare Part D prescription drug coverage - low income subsidy (LIS) - Category 048: LIS provides individuals enrolled in medicare Part D with a subsidy that helps pay for the cost of Part D prescription premiums, deductibles and co-payments. An eligible recipient receiving medicaid through QMB, SLMB or QI1 is automatically deemed eligible for LIS and need not apply. Other low-income medicare beneficiaries must meet an income and resource test and submit an application to determine if they qualify for LIS.

C. Supplemental security income (SSI) related medicaid:

(1) SSI - Categories 001, 003 and 004: Medicaid for individuals who are eligible for SSI. Eligibility for SSI is determined by the social security administration (SSA). This program provides cash assistance and medicaid for an eligible recipient who is:

(a) aged (Category 001);
(b) blind (Category 003); or
(c) disabled (Category 004).

(2) SSI medicaid extension - Categories 001, 003 and 004: MAD provides coverage for certain groups of applicants or eligible recipients who have received supplemental security income (SSI) benefits and who have lost the SSI benefits for specified reasons listed below and pursuant to 8.201.400 NMAC:

(a) the pickle amendment and 503 lead;

(b) early widow(er);
(c) disabled widow(er) and a disabled surviving divorced spouse;
(d) child insurance benefits, including disabled adult children (DAC);
(e) nonpayment SSI status (E01);
(f) revolving SSI payment status "ping-pongs"; and
(g) certain individuals who become ineligible for SSI cash benefits and, therefore, may receive up to two months of extended medicaid benefits while they apply for another MAD category of eligibility.

(3) Working disabled individuals (WDI) and medicare wait period - Category 074: There are two eligibility types:

(a) a disabled individual who is employed; or
(b) a disabled individual who has lost SSI medicaid due to receipt of SSDI and the individual does not yet qualify for medicare.

D. Long term care medicaid:

(1) medicaid for individuals who meet a nursing facility (NF) level of care (LOC), intermediate care facilities for the intellectually disabled (ICF-ID) LOC, or acute care in a hospital. SSI income methodology is used to determine eligibility. An eligible recipient must meet the SSA definition of aged (Category 081); blind (Category 083); or disabled (Category 084).

(2) Institutional care (IC) medicaid - Categories 081, 083 and 084: IC covers certain inpatient, comprehensive and institutional and nursing facility benefits.

(3) Program of all-inclusive care for the elderly (PACE) - Categories 081, 083 and 084: PACE uses an interdisciplinary team of health professionals to provide dual medicaid/medicare enrollees with coordinated care in a community setting. The PACE program is a unique three-way partnership between the federal government, the state, and the PACE organization. The PACE program is limited to specific geographic service area(s). Eligibility may be subject to a wait list for the following:

(a) the aged (Category 081);
(b) the blind (Category 083); or
(c) the disabled (Category 084).

(4) Home and community-based 1915 (c) waiver services (HCBS) - Categories 090, 091, 092, 093, 094, 095 and 096: A 1915(c) waiver allows for the provision of long term care services in home and community based settings. These programs serve a variety of targeted populations, such as people with mental illnesses, intellectual disabilities, or physical disabilities. Eligibility may be subject to a wait list.

(a) There are two HCBS delivery models:

(i) traditional agency delivery where HCBS are delivered and managed by a MAD enrolled agency; or

(ii) mi via self-directed where an eligible recipient, or their representative, has decision-making authority over certain services and takes direct responsibility to manage the eligible mi via recipient's services with the assistance of a system of available supports; self-direction of services allows an eligible mi via recipient to have the responsibility for managing all aspects of service delivery in a person-centered planning process.

(b) HCBS waiver programs include:

(i) elderly (Category 091), blind (Category 093) and disabled (Category 094);
(ii) medically fragile (Category 095);
(iii) developmental disabilities (Category 096); and
(iv) self-directed model for Categories 090, 091, 093, 094, 095, 096 and 092).

E. Emergency medical services for non-citizens (EMSNC): EMSNC medicaid covers certain non-citizens who either are undocumented or who do not meet the qualifying non-citizen criteria specified in 8.200.410 NMAC. Non-citizens must meet all eligibility criteria for one of the medicaid categories noted in 8.285.400 NMAC, except for citizenship or qualified non-citizen status. Medicaid eligibility for and coverage of services under EMSNC are limited to the payment of emergency services from a medicaid provider.

F. Refugee medical assistance (RMA) - Categories 049 and 059: RMA offers health coverage to certain low-income refugees for a period established yearly by the office of refugee resettlement (ORR) based on available appropriated funds for the fiscal year from their date of entry to the United States (U.S.) when they do not qualify for other medicaid categories of eligibility. An RMA eligible refugee recipient has access to a benefit

package that parallels the full coverage medicaid benefit package. RMA is funded through a grant under Title IV of the Immigration and Nationality Act (INA). An RMA applicant who exceeds the RMA income standards may "spend-down" below the RMA income standards for Category 059 by subtracting incurred medical expenses after arrival into the U.S.

G. Breast and cervical cancer (BCC) - Category 052: BCC medicaid provides coverage to an eligible uninsured woman, under the age of 65 who has been screened and diagnosed by the department of health (DOH) as having breast or cervical cancer to include pre-cancerous conditions. The screening criteria are set forth in the centers for disease control and prevention's national breast and cervical cancer early detection program (NBCCEDP). Eligibility is determined using DOH notification and without a separate medicaid application or determination of eligibility.

[8.200.400.10 NMAC - Rp, 8.200.400.10 NMAC, 1/1/2019; A, 1/1/2022; A, 1/1/2023; A/E, 10/1/2024; A, 2/1/2025; A/E, 5/1/2025; A, 8/1/2025]

8.200.400.11 PRESUMPTIVE ELIGIBILITY FOR BREAST AND CERVICAL CANCER: PE provides immediate access to health services when an individual appears to be eligible for Category 052.

A. Breast and cervical cancer (BCC) (Category 052): PE provides temporary medicaid coverage for an uninsured woman, under the age of 65 who has been screened and diagnosed by the DOH as having breast or cervical cancer to include pre-cancerous conditions. Only one PE period is allowed per calendar year.

B. PE is determined by a qualified entity certified by HCA. Qualified entities may include community and rural health centers, hospitals, physician offices, local health departments, family planning agencies and schools.

C. The PE period begins on the date the provider determines presumptive eligibility and terminates at the end of the following month.

D. Providers shall notify the MAD claims processing contractor of the determination within 24-hours of the PE determination.

E. For continued medicaid eligibility beyond the PE period, a completed and signed application for medicaid must be submitted to HCA/ISD. An eligible PE provider must submit the application to ISD within 10 calendar days from the receipt of the application.

[8.200.400.11 NMAC - Rp, 8.200.400.11 NMAC, 1/1/2019; A/E, 10/1/2024; A, 2/1/2025]

8.200.400.12 CONTINUOUS ELIGIBILITY FOR CHILDREN (42 CFR 435.926):

A. HCA provides continuous eligibility for the period specified in Subsection B and C of 8.200.400.12 NMAC for an individual who is:

(1) Under age 19 and

(2) Eligible and enrolled for mandatory or optional coverage under the state plan.

B. The continuous eligibility period is up to six years for children from birth until turning age six. A child enrolled for less than 12 months before turning age six is eligible for 12 months of continuous eligibility. The continuous eligibility period begins on the effective date of the individual's eligibility or most recent redetermination or renewal of eligibility.

C. The continuous eligibility period is 12 months for children age six until turning age 19. The continuous eligibility period begins on the effective date of the individual's eligibility or most recent redetermination or renewal of eligibility.

D. A child's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(1) the child attains the maximum age of 19;

(2) the child or child's representative requests a voluntary termination of eligibility;

(3) the child ceases to be a resident of New Mexico;

(4) the agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or

(5) the child dies.

[8.200.400.12 NMAC - Rp, 8.200.400.12 NMAC, 1/1/2019; A, 9/1/2024; A/E, 10/1/2024; A, 2/1/2025]

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

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

B. Representatives may be authorized to:

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

(2) complete and submit a renewal form;

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

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

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

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

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

[8.200.400.13 NMAC - Rp, 8.200.400.13 NMAC, 1/1/2019; A, 1/1/2023; A/E, 10/1/2024; A, 2/1/2025]

8.200.400.14 RETROACTIVE MEDICAID:

A. HCA must make eligibility for medicaid effective no later than the first or up to the third month before the month of application if the individual:

(1) Requested coverage for months prior to the application month;

(2) received medicaid services, at any time during that period, of a type covered under the plan and;

(3) would have been eligible for medicaid at the time they received the services, if they had applied (or an authorized representative has applied for them) regardless of whether the individual is alive when application for medicaid is made.

B. Eligibility for medicaid is effective on the first day of the month if an individual was eligible at any time during that month.

C. Eligibility for each retroactive month is determined separately. Retroactive medicaid must be requested within 180 days of the date of the medicaid application.

D. Retroactive medicaid is allowed for up to three months prior to the application month for the following medicaid categories:

(1) other adults (COE 100);

(2) parent caretaker (COE 200);

(3) pregnant women (COE 300);

(4) pregnancy-related services (COE 301);

(5) children under age 19 (COEs 400, 401, 402, 403, 420, and 421);

(6) family planning (COE 029);

(7) children, youth and families department (CYFD COEs 017, 037, 046, 047, 066, and 086);

(8) supplemental security income (SSI COEs 001, 003, and 004);

(9) SSI (COEs 001, 003, and 004, e.g. 503s, disabled adult children, ping pongs, and early widowers);

(10) working disabled individuals (COE 074);

(11) breast and cervical cancer (BCC COE 052);

(12) specified low income beneficiaries (SLIMB COE 045);

(13) qualified individuals (QI1 COE 042);

(14) qualified disabled working individuals (COE 050);

(15) refugees (COE 049); and

(16) institutional care medicaid (COEs 081, 083, and 084) excluding the program for all-inclusive care for the elderly (PACE).

E. The following categories do not have retroactive medicaid:

(1) emergency medical services for non-citizens EMSNC (COE 085). EMSNC provides coverage for emergency services, which may be provided prior to the application month, but is not considered retroactive medicaid. Eligibility is determined in accordance with 8.285.400, 8.285.500, and 8.285.600 NMAC;

(2) home and community based-services waivers (COEs 091, 093, 094, 095, and 096);

(3) PACE (COEs 081, 083, and 084);

(4) qualified medicare beneficiaries (COEs 041 and 044); and

(5) transitional medicaid (COEs 027 and 028).

F. Newborns (COE 031) are deemed to have applied and been found eligible for the newborn category of eligibility from birth through the month of the child's first birthday. This applies in instances where the labor and delivery services were furnished prior to the date of the application and covered by medicaid based on the mother applying for up to three months of retroactive eligibility.

[8.200.400.14 NMAC - Rp, 8.200.400.14 NMAC, 1/1/2019; A, 2/1/2020; A, 1/1/2022; A/E, 10/1/2024; A, 2/1/2025]

8.200.400.15 NMAC AUTOMATIC ENROLLMENT OF SSI RECIPIENTS IN THE QMB GROUP:

A. SSI recipients entitled to premium-free part A: Effective October 1, 2024, the HCA shall automatically deem SSI recipients into QMB the first month they are eligible for SSI Medicaid and entitled to premium-free part A. The start of the part B buy-in coverage is the first month of entitlement to premium-free part A and the QMB eligibility group coverage is the first day of the following month.

B. SSI recipients enrolled in part B only: Effective upon the centers for medicare and medicaid services (CMS) and HCA systems' capacity, the HCA shall automatically deem individuals enrolled in SSI medicaid eligible for the QMB eligibility group the first month they are both enrolled in part B and eligible for a medicare enrollment period, bypassing the need for actual or conditional part A enrolment at the social security administration.

C. Effective January 1, 2024, the HCA's liability for retroactive part B premiums for full-benefit medicaid beneficiaries, including individuals receiving SSI medicaid, is limited to a period of no greater than 36 months prior to the date of the medicare enrollment determination.

D. For SSI medicaid recipients deemed eligible for the QMB group, renewal for QMB is required only to the extent to verify that an individual continues to receive SSI medicaid and has continued medicare part A coverage. The regular renewal process for QMB applies when an individual loses their SSI medicaid.

[8.200.400.15 NMAC - N/E, 10/1/2024; A, 2/1/2025]

8.200.400.16 NMAC [RESERVED]

HISTORY OF 8.200.400 NMAC: The material in this part was derived from that previously filed with the State Records Center:
8 NMAC 4.MAD.400, Recipient Policies, Recipient Rights and Responsibilities, filed 12/30/1994.

History of Repealed Material:
8.200.400 NMAC, General Medicaid Eligibility, filed 6/15/2001 - Repealed effective 1/1/2014.
8.200.400 NMAC, General Medicaid Eligibility, filed 12/2/2013 - Repealed effective 10/1/2017.
8.200.400 NMAC, General Medicaid Eligibility, filed 9/14/2017 - Repealed effective 1/1/2019.

NMAC History:
8.200.400 NMAC, General Medicaid Eligibility, filed 12/2/2013 was replaced by 8.200.400 NMAC, General Medicaid Eligibility effective 10/1/2017.
8.200.400 NMAC, General Medicaid Eligibility, filed 9/14/2017 was replaced by 8.200.400 NMAC, General Medicaid Eligibility effective 1/1/2019.