January 2026

NEW MEXICO MEDICAL ASSISTANCE PROGRAMS

Eligibility Categories

Individuals become eligible for New Mexico Medicaid when they meet the specific criteria for one of the eligibility categories. The attached pages give basic information about these eligibility categories. The actual process of determining eligibility is complex because numerous financial and non-financial factors are considered.

Regulations for New Mexico's Medicaid programs are promulgated by the Federal Department of Health and Human Services under Title XIX of the Social Security Act as amended and by the Health Care Authority, Medical Assistance Division. The Department's Income Support Division offices make eligibility determinations for Medicaid, except for those categories administered by the Children, Youth and Families Department, and the Social Security Administration. Updates to this pamphlet are made periodically.

SEE BELOW

MEDICAID ELIGIBILITY CATEGORIES

Category	Description

Affordable Care Categories

100	Other Adults- 19-64 Years of Age with No Medicare Eligibility with FPL 0%-133%
200	Parent/Caretaker Relative Medicaid -Fixed Standard
300	Full Medicaid for Pregnant Women- Fixed Standard
301	Pregnancy Related Medicaid with FPL from Fixed Standard up to 250%
400	Children's Medicaid for children 0 thru 5 with FPL from 0%-200%
401	Children's Medicaid for children 6 thru 18 with FPL from 0%-138%
402	Children's Medicaid for children 0 thru 5 with FPL from 200%-240%
403	Children's Medicaid for children 6 thru 18 with FPL from 138%-190%
420	CHIP Medicaid for children 0 thru 5 with FPL from 240%-300%
421	CHIP Medicaid for children 6 thru 18 with FPL from 190%-240%

General Categories

001	Supplemental Security Income (SSI) or Medicaid Extension (aged)
003	Supplemental Security Income (SSI) or Medicaid Extension (blind)
004	Supplemental Security Income (SSI) or Medicaid Extension (disabled)
007	Children's Medical Services
017	Adoption Subsidy (IV-E), established by other states.
027	Transitional Medicaid-provides benefits for up to 4 months following loss of Parent/Caretaker Category 200 due to increased spousal support.
028	Transitional Medicaid - provides benefits for up to 12 months following loss of Parent/Caretaker Category 200 due to increased gross earnings or loss of earned income disregard.
029	Family Planning Medicaid
031	Newborn Medicaid
037	Adoption Subsidy (IV-E), in-state
041	Qualified Medicare Beneficiaries (QMBs) over 65
042	Qualified Individuals (QIls)
044	Qualified Medicare Beneficiaries (QMBs) under 65
045	Specified Low-Income Medicare Beneficiaries (SLIMBs)
046	Foster Care, placed out of state (no card issued- services by prior approval only)
047	Adoption Subsidy (IV-E), placed out of state (no card issued- services by prior approval only)
049	Medical Assistance for Refugees
050	Qualified Disabled Working Individuals (QD)
052	Breast or Cervical Cancer
059	Refugee Medical Assistance Spend-down

066 Foster Care (IV-E)
074 Working Disabled Individuals (WDI)
081 Institutional Care (aged)
083 Institutional Care (blind)
084 Institutional Care (disabled)
085 Emergency Medical Services for Non-Citizens
086 (IV-E) Foster Care- custody with state other than New Mexico

Home and Community Based Waivers for:

090 AIDS
092 Brain Injury
091 Disabled and Elderly (aged)
093 Disabled and Elderly (blind)
094 Disabled and Elderly (disabled)
095 Medically Fragile
096 Developmentally Disabled

Affordable Care Act Categories

Category 100 – Other Adult-covers individuals age 19 up to 65, with or without dependents with no Medicare entitlement who meet non-financial and financial criteria. Not eligible for category 100 if pregnant; must evaluate for 300 or 301 categories. Income must be less than 133% Federal Poverty Level (FPL) for the household size. There is no resource test for this category.

Category 200 – Parent/Caretaker-covers individuals with one or more dependent children. The individual must be a natural, step or adoptive parent of child, if they live with the child. If the parent(s) do *not* live with the child, specified relative(s) within the fifth degree of relationship by blood or marriage or adoption must be taking care of the child. There is no resource test for this category. The income limit is a fixed dollar amount - the same as category 300.

Category 300 – Full Pregnancy-covers a woman who self attests that she is pregnant. Individual does not need to medically verify *unless* pregnancy is questionable. Un-born child(ren) will be included in budget group. There is no resource test for this category. The income limit for category 200 and 300 is the following fixed dollar amount:

Household Size	Monthly Income Limit
1	$451
2	$608
3	$765
4	$923
5	$1,080
6	$1,238
7	$1,395

8	$1,553

Category 301-Pregnancy Related Medicaid- covers a woman who self attests that she is pregnant. Individual does not need to medically verify unless pregnancy is questionable. Individual must meet all non-financial and financial criteria and have income less than 250% of FPL for the household size. Un-born child(ren) will be included in budget group. There is no resource test for this category.

Category 400 – Children's Medicaid covers children under 6 years of age. Must meet all non-financial and financial criteria and have income less than 200% FPL for the household size. Client may have private health insurance. There is no resource test for this category.

Category 401-Children's Medicaid covers children 6 thru eighteen (18) years of age. Must meet all non-financial and financial criteria and have income less than 138% FPL. Client may have private health insurance. There is no resource test for this category.

Category 402- Children's Medicaid covers children under 6 years of age. Must meet all non-financial and financial criteria and have income within FPL 200%-240%. Client may have private health insurance. There is no resource test for this category.

Category 403-Children's Medicaid covers children 6 thru eighteen (18) years of age. Must meet all non-financial and financial criteria and have income within FPL 138%-190%. Client may have private health insurance. There is no resource test for this category.

Category 420- (CHIP) Children's Medicaid covers children under 6 years of age. Must meet all non-financial and financial criteria and have income between 240%-300% of FPL for the household size. The client cannot have private health insurance. There is no resource test for this category.

Category 421- (CHIP) Children's Medicaid covers children ages 6 thru eighteen (18) years of age. Must meet all non-financial and financial criteria and have income between 190%-240% of FPL for the household size. The client cannot have private health insurance. There is no resource test for this category.

Affordable Care FPL's

Household Size	133%	138%	190%	200%	240%	250%	300%
1	$1,735.00	$1,800.00	$2,478.00	$2,609.00	$3,130.00	$3,261.00	$3,913.00
2	$2,345.00	$2,433.00	$3,349.00	$3,525.00	$4,230.00	$4,407.00	$5,288.00
3	$2,954.00	$3,065.00	$4,220.00	$4,442.00	$5,330.00	$5,553.00	$6,663.00
4	$3,564.00	$3,698.00	$5,091.00	$5,359.00	$6,430.00	$6,698.00	$8,038.00
5	$4,173.00	$4,330.00	$5,962.00	$6,275.00	$7,530.00	$7,844.00	$9,413.00
6	$4,783.00	$4,963.00	$6,833.00	$7,192.00	$8,630.00	$8,990.00	$10,788.00
7	$5,393.00	$5,595.00	$7,703.00	$8,109.00	$9,730.00	$10,136.00	$12,163.00
8	$6,002.00	$6,228.00	$8,574.00	$9,025.00	$10,830.00	$11,282.00	$13,538.00
+1	$609.00	$633.00	$871.00	$916.00	$1,100.00	$1,146.00	$1,375.00

General Categories

Category 031 covers newborn babies born to mothers eligible for and receiving New Mexico Medicaid at the time of the birth and born to mothers deemed to have been eligible for receiving New Mexico Medicaid at the time of the birth. Emergency Medical Services for Non-Citizens (EMSNC) qualify as receipt of Medicaid for the mother. The babies are eligible for 12 months starting with the month of birth if the infant continues to reside in New Mexico.

Foster Care and Adoption Subsidy

Categories 017, 037, 046, 047, 066, and 086 provide Medicaid for children in state substitute care programs and in adoption subsidy situations. The Children, Youth and Families Department make eligibility determinations for these categories. To be eligible based on income, a child in a substitute care placement must have an income below the maximum AFDC standard of need for one person.

Supplemental Security Income (SSI)

Categories 001, 003, and 004 – The Social Security Administration determines eligibility for these categories. SSI provides cash benefits and Medicaid provides health care coverage for eligible individuals under aged (Category 001), blind (Category 003), or disabled (Category 004).

The maximum monthly income benefits provided under this program are $994 for an individual and $1,491 for a couple. If the applicant is a minor child, a certain portion of the parents' income is considered available to the child. Resource limits are $2,000 for an individual and $3,000 for a couple. A burial fund of up to $1,500 is excludable.

Medicaid Extension

Designated as Categories 001, 003 and 004 - Section 503.Title V of Public Law 94-566 continues Medicaid coverage for persons who lose eligibility for SSI and Medicaid solely due to Social Security cost-of-living increases. The "Pickle Amendment" extends coverage to people who meet SSI eligibility criteria when Social Security cost-of-living increases are disregarded.

Public Law 100-203 extends Medicaid eligibility to widow(er)s between the ages of 60 and 64 who lose SSI eligibility due to receipt of or an increase in early widow(er)'s Title II benefits. Eligibility terminates when the individual becomes eligible for Medicare Part A.

Public Law 99-243, Section 6 extends Medicaid eligibility to certain disabled adult children (DACs) who lose SSI eligibility due to receipt of, or increase in, Title II DAC benefits.

The Omnibus Budget Reconciliation Act of 1990 extends Medicaid coverage to certain disabled widow(er)s and disabled surviving divorced spouses who lose SSI eligibility due to receipt of, or

increase in, disabled widow(er)'s/disabled surviving divorced spouse's Title II benefits. Medicaid eligibility terminates when the individual becomes eligible for Medicare Part A.

The state has also opted to extend Medicaid eligibility to non-institutionalized individuals who lose SSI eligibility because the amount of their initial Title II benefit exactly equals the income ceiling for the SSI program.

Individuals who lose SSI eligibility for other reasons may qualify for up to two (2) months of extended Medicaid eligibility to give them an opportunity to apply under one of the other categories of coverage.

Children's Medical Services

Category 007-The purpose of the Children's Medical Services program is to maximize the health and wellbeing of New Mexico's children with or at risk for, chronic illness or disability, and who are under the age of 21 years; and also for adults with cystic fibrosis - by assuring that community-based, coordinated, culturally competent, family-centered preventive, diagnostic, treatment and family support services are accessible. Administration and enforcement are the responsibility of the Public Health Division of the Department of Health.

Institutional Care Medicaid

Categories 081 (aged), 083 (blind), and 084 (disabled) provide Medicaid to individuals requiring institutional care in nursing facilities (NFs) designated as High NFs or Low NFs; Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID); and who are in acute care hospitals. These individuals must meet all SSI eligibility criteria except income. As of January 1, 2026, the maximum allowable countable income limit is $2,982 per month. (Persons with less than $50 in income must apply for SSI). The resource limit for single individuals for this program is $2,000.

For married applicants, special income and resource rules apply. An amount up to $162,660 of the couple's resources can be protected for the non-institutionalized spouse when one member of the couple begins institutionalization for a continuous period of at least 30 days on or after January 1, 2026. Different resource criteria apply depending on when the applicant is institutionalized.

After being approved, a patient liability or "Patient Pay Amount" is calculated and is paid to the nursing facility to defray the cost of institutional care. A certain portion of the recipient's income may be kept for personal needs allowance ($97); non-covered medical expenses, remedial medical expenses, Medicare premiums and other monthly health insurance premiums. There is also a potential allowance for support of a spouse and any minor children in the home.

Home and Community Based Waivers

Category 090 HIV/AIDS
Category 091 Disabled and Elderly-Age 65 or older
Category 092 Brain Injury
Category 093 Disabled and Elderly- Blind
Category 094 Disabled and Elderly- Disabled
Category 095 Medically Fragile
Category 096 Developmentally Disabled

Recipients in these programs are persons who qualify both financially and medically for institutional care but remain in the community. The Department of Health or Aging and Long-Term Services Department must determine that adequate care can be provided to the individual in the community at a lesser cost than in an institutional setting. Income and resource limits are the same as for Institutional Care Medicaid.

Qualified Medicare Beneficiaries (QMBs)

Category 041(over 65) Category 044 (under 65) entitles individuals to payment of Medicare premiums as well as the deductible and coinsurance amounts on Medicare-covered services. To be eligible, the applicant must already have, or be conditionally eligible for Medicare Part A (Hospital Insurance). To be eligible, their income must be below 100% of the Federal Poverty Level Guidelines. Income limits are $1,305 for an individual and $1,763 for a married couple.

QMB is the only category that will pay the Medicare Conditional Part A premium.

Specified Low-Income Medicare Beneficiaries (SLIMBs)/ Qualified Individuals 1 (QI1s)

Category 042 and Category 045 entitles individuals to payment of their Medicare Part B premiums. To be eligible, the applicant must already have Medicare Part A (Hospital Insurance). Income is below 120% of the Federal Poverty Level Guidelines. Countable monthly income must be at least $1,305 but no more than $1,565 for an individual and at least $1,763 but no more than $2,115 for an applicant with an ineligible spouse when income is deemed.

The SLIMB category was expanded to cover an additional group of individuals known as Qualified Individuals 1 (QI1's), if their income is between 120-135% of the Federal Poverty Level Guidelines. Countable monthly income must be at least $1,565 but no more than $1,761 for an individual and at least $2,115 but no more than $2,380 for an applicant with an ineligible spouse when income is deemed.

Payment of the Medicare Part B premium is the only benefit. No Medicaid card is issued.

Effective January 1, 2021, the resource limit for QMB, SLIMB and QI1's will no longer be required for eligibility determination.

Qualified Disabled Working Individuals (QD)

Category 050 entitles individuals to payment of their **Medicare Part A** Premium if their income is below 200% of the Federal Poverty Level Guidelines. Countable monthly income must be less than $2,609 for an individual and must be less than $3,525 for an applicant with an ineligible spouse when income is deemed. The resource limit for QD's is $4,000 for an individual and $6,000.

To Qualify for QD the individual needs to meet the follow:

1. Must be under age 65.
2. lose entitlement to free Medicare Part A due to substantial gainful employment.
3. continue to meet the Social Security Administration (SSA) disability criteria; and
4. be enrolled for premium Part A Medicare.

Working Disabled Individuals (WDIs)

Category 074 covers disabled working individuals, who, because of earnings, do not qualify for Medicaid under any other programs. Individuals must meet the Social Security Administration's (SSA) criteria for disability without regard to "substantial gainful activity". The program also covers those individuals with a recent attachment to the workforce. An individual is considered to have recent attachment to the workforce if he/she 1) has enough earnings in a quarter to meet the SSA's definition of a qualifying quarter, or 2) has lost SSI and Medicaid due to the initial receipt of Social Security Disability Insurance (SSDI) benefits, until Medicare entitlement.

Medical Assistance for Refugees

Category 049 provides Medicaid coverage for low-income refugees. Coverage is limited to a maximum of twelve-months from the date the individual enters the U.S. There are 4 scenarios under which Refugee Medical Assistance can be approved:

1. Applicant meets AFDC standard of need when the earned income disregard is applied;
2. Applicant meets all criteria for refugee cash assistance but wishes to receive only refugee medical assistance;
3. Four month refugee medical assistance extension when eligibility for refugee cash assistance is lost due to earned income;
4. Spend-down (Category 059).

Breast or Cervical Cancer

Category 052 covers women who are under 65 years of age, uninsured, and 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 New Mexico Department of

Health is responsible for verifying that women referred for treatment have met screening requirements that include an income test of 250% of the Federal Poverty Level Guidelines and diagnostic testing by a contracted CDC provider that results in a diagnosis of breast or cervical cancer, including pre-cancerous conditions.

Emergency Medical Services for Non-Citizens

Category 085 provides coverage of emergency services for certain non-citizens who are undocumented or who do not meet the qualifying immigration criteria and meet all eligibility criteria for an existing Medicaid category except for their non-citizen status. The non-citizen must receive emergency medical services and be referred to the local Income Support Division (ISD) office by the provider. Coverage is available only for emergencies approved by the UR contractor and only for the duration of the specific emergency.