TITLE 8 SOCIAL SERVICES
CHAPTER 290 MEDICAID ELIGIBILITY - HOME AND COMMUNITY-BASED SERVICES WAIVER (CATEGORIES 090, 091, 092, 093, 094, 095 AND 096)
PART 600 BENEFIT DESCRIPTION

8.290.600.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.290.600.1 NMAC - Rp, 8.290.600.1 NMAC, 1/1/2019; A, 7/1/2024]

8.290.600.2 SCOPE: The rule applies to the general public.
[8.290.600.2 NMAC - Rp, 8.290.600.2 NMAC, 1/1/2019]

8.290.600.3 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 (HCA) pursuant to state statute. See Section 27-2-12 *et seq.*, NMSA 1978. 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.
[8.290.600.3 NMAC - Rp, 8.290.600.3 NMAC, 1/1/2019; A, 7/1/2024]

8.290.600.4 DURATION: Permanent.
[8.290.600.4 NMAC - Rp, 8.290.600.4 NMAC, 1/1/2019]

8.290.600.5 EFFECTIVE DATE: January 1, 2019, or upon a later approval date by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.
[8.290.600.5 NMAC - Rp, 8.290.600.5 NMAC, 1/1/2019]

8.290.600.6 OBJECTIVE: The objective of this rule is to provide eligibility criteria for the medical assistance division (MAD) programs.
[8.290.600.6 NMAC - Rp, 8.290.600.6 NMAC, 1/1/2019]

8.290.600.7 DEFINITIONS: See Section 8.290.400.7 NMAC.
[8.290.600.7 NMAC - Rp, 8.290.600.7 NMAC, 1/1/2019]

8.290.600.8 [RESERVED]

8.290.600.9 BENEFIT DESCRIPTION: Eligible recipients are eligible for specified services available under the particular waiver and ancillary services available under the general medicaid program. See specific program policy sections for covered services.
[8.290.600.9 NMAC - Rp, 8.290.600.9 NMAC, 1/1/2019]

8.290.600.10 BENEFIT DETERMINATION: Application for the waiver programs is made using the [~~HSD~~] HCA 100 application. Upon notification by the appropriate program manager that an unduplicated recipient (UDR) is available for waiver services, applicants are registered on the income support division (ISD) eligibility system. Applications must be acted upon and notice of approval, denial, or delay sent out within 45 calendar days from the date of application, or within 90 calendar days if a disability determination is required from the disability determination unit (DDU). The eligible recipients must assist in completing the application, may complete the form themselves, or may receive help from a relative, friend, guardian, or other designated representative.

A. Representatives applying on behalf of individuals: If a representative makes application on behalf of the eligible recipient, that representative will continue to be relied upon for information regarding the eligible recipient's circumstances. The ISD caseworker will send all notices to the eligible recipient in care of the representative.

B. Additional forms: The following forms are also required as part of the application process:

(1) the eligible recipient or representative must complete and sign the primary freedom of choice (PFOC) form at the time of allocation; and

(2) the eligible recipient or representative must sign the applicant's statement of understanding at the time waiver services are declined or terminated.

C. Additional information furnished during application: The ISD caseworker provides an explanation of the waiver programs, including, but not limited to, income and resource limits and possible alternatives, such as institutionalization. The ISD caseworker refers potentially eligible recipients to the social security administration to apply for supplemental security income (SSI) benefits. If a disability decision by the DDU is required, but has not been made, the ISD caseworker must follow established procedures to refer the case for evaluation.
[8.290.600.10 NMAC - Rp, 8.290.600.10 NMAC, 1/1/2019]

8.290.600.11 INITIAL BENEFITS:

A. The application process begins once the letter of allocation and the medicaid application for assistance are received by ISD. Once ISD has confirmed the applicant/recipient meets all eligibility criteria, the application can be approved effective the first month for which an approved level of care has been established. Medicaid eligibility covers acute and ancillary medicaid services that are effective immediately on the first day of the first month of medicaid eligibility. Home and community-based waiver services are prospective and are only available once the individual services plan (ISP) or comprehensive care plan (CCP) is approved and implemented. Following initial approval, waiver services must be provided when appropriate to eligible waiver recipients within 90 calendar days of approval. Medicaid eligibility under the waiver program is contingent on the receipt of waiver services. If an applicant/recipient is transitioning from one home and community-based services (HCBS) waiver program to another, ISD must be contacted to coordinate the start date based on the month the ISP or CCP is established for the new program. This is to ensure there is no interruption in services for the recipient.

B. Notice of determination: Applicants determined to be ineligible for waiver services are notified of the reason for the denial and provided with an explanation of appeal rights.

C. Applicants determined to be eligible for waiver services are notified of the approval.
[8.290.600.11 NMAC - Rp, 8.290.600.11 NMAC, 1/1/2019]

8.290.600.12 ONGOING BENEFITS:

A. A complete redetermination of eligibility must be performed annually by the ISD caseworker for each open case.

B. ~~[Level of care determinations are made by the utilization review contractor or a member's selected or assigned managed care organization, as applicable to the centennial care, community benefit program. Level of care reviews are required to be completed at least annually except for certain community benefit members whose chronic condition is not expected to improve. These individuals may be eligible for an ongoing nursing facility (NF) level of care (LOC). To qualify for ongoing NF LOC, the community benefit member must have met a NF LOC for the previous three years. The ongoing NF LOC status must be reviewed and approved annually by the managed care organization's medical director and must be supported in documentation by the member's physician. The complete criteria for an ongoing NF LOC can be found in the New Mexico medicaid nursing facility level of care criteria and instructions document]~~ Level of care determinations are made by the member's selected or assigned managed care organization or by New Mexico medicaid's designated third party assessor or utilization review contractor. Level of care reviews are required to be completed annually for home and community-based waiver programs.

C. 90 day reconsideration period: ~~[HSD]~~ HCA will reconsider in a timely manner the waiver eligibility of an individual who is terminated for failure to submit the renewal form or necessary information, if the individual subsequently submits the renewal form within 90 days after the date of termination without requiring a new application per 42 CFR 435.916(C)(iii).
[8.290.600.12 NMAC - Rp, 8.290.600.12 NMAC, 1/1/2019; A, xx/xx/xxxx]

8.290.600.13 RETROACTIVE BENEFITS: Eligibility for these categories is prospective so retroactive coverage is not available in accordance with 8.200.400.14 NMAC.
[8.290.600.13 NMAC - Rp, 8.290.600.13 NMAC, 1/1/2019]

8.290.600.14 CHANGES IN ELIGIBILITY: If the eligible recipient ceases to meet any of the eligibility criteria, the case is closed following provision of advance notice as appropriate. See Section 8.200.430.9 NMAC and following subsections for information about notices and hearing rights.

A. Non-provision of waiver services: To continue to be eligible for waiver services, an eligible recipient must be receiving waiver services, early and periodic screening, diagnostic and treatment (EPSDT) benefits or managed care services, other than case management, (42 CFR Section 435.217). If at any time waiver

services are no longer being provided (e.g., a suspension) and are not expected to be provided for 90 consecutive days, the recipient is **ineligible** for the waiver category and the case must be closed after appropriate notice is provided by the ISD caseworker.

B. Admission to a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF-IID): If an eligible waiver recipient enters an acute care hospital, a nursing facility, or an ICF-IID and remains for more than 90 consecutive days, the waiver case must be closed and an application for institutional care medicaid (ICM) must be processed. The eligible recipient is not required to complete a new application if the periodic review on the waiver case is not due in either the month of entry into the institution or the following month. If the waiver recipient is institutionalized within less than 90 consecutive days and still receives waiver services within that time frame, the waiver case is not closed and an application for ICM need not be processed.

C. Reporting changes in circumstances: The primary responsibility for reporting changes in the eligible recipient's circumstances rests with the eligible recipient or [~~his/her~~] their representative. At the initial eligibility determination and all on-going eligibility redeterminations, the ISD caseworker must explain the reporting responsibilities requirement to the eligible recipient or [~~his/her~~] their representative and document that such explanation was given. In the event that waiver services cease to be provided, the case manager or the waiver program manager (or designee) must immediately notify the income support division office of that fact by telephone. The telephone call is to be followed by a written notice to the ISD caseworker.

[8.290.600.14 NMAC - Rp, 8.290.600.14 NMAC, 1/1/2019; A, xx/xx/xxxx]

HISTORY OF 8.290.600 NMAC:

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

MAD Rule 898, Transfers Of Assets, 12/29/1994.

History of Repealed Material:

8.290.600 NMAC - Benefit Description, filed 4/12/2002 Repealed effective 1/1/2019.