

**TITLE 8 SOCIAL SERVICES**  
**CHAPTER 281 MEDICAID ELIGIBILITY - INSTITUTIONAL CARE (CATEGORIES 081, 083 and 084)**  
**PART 600 BENEFIT DESCRIPTION**

**8.281.600.1 ISSUING AGENCY:** New Mexico Human Services Department.  
[8.281.600.1 NMAC - Rp, 8 NMAC 4.ICM.000.1, 4/1/2009]

**8.281.600.2 SCOPE:** The rule applies to the general public.  
[8.281.600.2 NMAC - Rp, 8 NMAC 4.ICM.000.2, 4/1/2009]

**8.281.600.3 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 human services department pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).  
[8.281.600.3 NMAC - Rp, 8 NMAC 4.ICM.000.3, 4/1/2009]

**8.281.600.4 DURATION:** Permanent.  
[8.281.600.4 NMAC - Rp, 8 NMAC 4.ICM.000.4, 4/1/2009]

**8.281.600.5 EFFECTIVE DATE:** ~~[February 1, 1995, unless a later date is cited at the end of a section.]~~  
January 1, 2019, or upon approval by the federal centers for medicare and medicaid services (CMS), unless a later date is cited at the end of the section.  
[8.281.600.5 NMAC - Rp, 8 NMAC 4.ICM.000.5, 4/1/2009; A, xx/xx/xxxx]

**8.281.600.6 OBJECTIVE:** The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.  
[8.281.600.6 NMAC - Rp, 8 NMAC 4.ICM.000.6, 4/1/2009]

**8.281.600.7 DEFINITIONS:** [RESERVED]

**8.281.600.8** [RESERVED]

**8.281.600.9 BENEFIT DESCRIPTION:** Applicant/recipient who is eligible for institutional care medicaid is eligible to receive the full range of medicaid-covered services, unless coverage is restricted due to transfer of asset penalties.  
[7/1/00; 8.281.600.9 NMAC - Rp, 8 NMAC 4.ICM.600, 4/1/2009]

**8.281.600.10 BENEFIT DETERMINATION:**

**A.** ~~[Application for institutional care medicaid is made using the application/redetermination of eligibility for medical assistance of aged, blind and disabled individuals (form MAD 381)]~~ Application for institutional care medicaid is made using the HSD 100 application. Completed applications must be acted upon and notice of approval, denial, or delay sent out within 45 days from the date of registration. The ISD worker explains time limits to the applicant and informs him or her of the date by which the application should be processed.

**B. Representatives applying on behalf of individuals:** If a representative makes application on behalf of an institutionalized individual, the representative is relied upon for information. The ISD worker sends all notices to the applicant/recipient in care of the representative. If the individual who makes an application is an employee of the institution, the ISD worker contacts the applicant's family or other involved individuals. The ISD worker focuses on the applicant/recipient's current circumstances and on past circumstances which may provide clues to existing or potential resources.  
[7/1/00; 8.281.600.10 NMAC - Rp, 8 NMAC 4.ICM.620, 4/1/2009; A, xx/xx/xxxx]

**8.281.600.11 INITIAL BENEFITS:**

**A.** For an applicant/recipient who loses SSI eligibility after entering an institution, the institutional care medicaid application date is the first day of the month of SSI termination, or the month the application is received by the ISD worker, whichever is earlier.

**B. Notice of determination:** Applicants eligible for institutional care medicaid are notified of the

approval and advised of the amount, if any, of the medical care credit. Applicants who are ineligible are notified of the denial and provided with an explanation of appeal rights.  
[8.281.600.11 NMAC - Rp, 8 NMAC 4.ICM.623, 4/1/2009]

**8.281.600.12 ONGOING BENEFITS:** A complete redetermination of eligibility must be performed by the ISD worker for each open case at least annually. ~~[The redetermination includes contact with the recipient, representative or if applicable, the institution's contact person.]~~

**A. Regular reviews:** For each regular yearly review, the ISD worker must determine:

(1) whether medical care credit payments are up to date; an overdue balance may indicate a change in circumstances that is unreported, particularly where rental property is involved; and

(2) whether the deposit to the recipient's personal fund is consistently no more than the applicable personal needs allowance amount per month; a larger deposit may indicate an increase in income that is unreported or a previously unidentified source of income.

**B. ~~Additional reviews:~~** ~~Additional reviews are scheduled by the ISD worker depending upon the nature of the recipient's income, resources or medical condition. The following situations may require more frequent review:~~

~~(1) social security cost of living increases;~~

~~(2) VA cost of living increases;~~

~~(3) rental income which is sporadic and requires review every three months; or~~

~~(4) level of care changes and determinations; the end date on the abstract must be posted for follow up; the utilization review contractor confirmation form, notice of level of care certification period, is valid for 60 days for high level nursing facility (NF) or low level NF starting from the date on the form.]~~ Level of care reviews are required to be completed at least annually. Level of care determinations are made by the utilization review contractor or a member's selected or assigned managed care organization.

[8.281.600.12 NMAC - Rp, 8 NMAC 4.ICM.624, 4/1/2009; A, xx/xx/xxxx]

**8.281.600.13 RETROACTIVE BENEFIT COVERAGE:** Up to three 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 months prior to the month of application [42 CFR Section 435.914]. Retroactive medicaid coverage is provided in accordance with 8.200.400.14 NMAC.

~~[A. Application for retroactive benefit coverage: Application for retroactive medicaid can be made by checking "yes" in the "application for retroactive medical payments" box on the application/redetermination of eligibility for medical assistance of aged, blind and disabled individuals (form MAD 381) or by checking "yes" to the question on "does anyone in your household have unpaid medical expenses in the last three months?" on the application for assistance (form ISD 100). Applications for retroactive medicaid benefits must be made within 180 days from the date of application for assistance. Medicaid covered services which were furnished more than two years prior to application are not covered.~~

~~[B. Approval requirements: To establish retroactive eligibility, the ISD worker must verify that all conditions of eligibility were met for each of the three 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 eligibility system or on the retroactive medicaid eligibility authorization (form ISD 333).~~

~~[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 ISD worker 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.]~~

[8.281.600.13 NMAC - Rp, 8 NMAC 4.ICM.625, 4/1/2009; A, xx/xx/xxxx]

**8.281.600.14 CHANGES IN ELIGIBILITY:**

**A.** The following procedures apply when an institutional care medicaid recipient leaves an institution:

(1) the recipient is notified in writing that his/her eligibility for institutional care medicaid

has terminated;

- (2) the institutional care medicaid case is closed;
- (3) the recipient is screened for other medicaid program eligibility; or
- (4) the recipient is referred to the social security administration for determination of

eligibility for SSI benefits if appropriate; if a recipient dies in an institution, the case is closed the following month.

**B. Discharge status:** Discharge status continues after the UR contractor determines that there is no medical necessity for a high NF or low NF placement. Discharge status does not apply to an acute care placement. After placement in discharge status, the recipient continues to be eligible for institutional care medicaid since he/she still requires institutional care.

(1) Abstract submission: Discharge status requires a new abstract be submitted at regular intervals. The institution must attach verification to the abstract that adequate placement has been and is being sought.

(2) Case closure: The ISD worker takes no action to close a case until the recipient is actually discharged from the institution. If the recipient is transferred from high NF to low NF, medicaid coverage is not interrupted, unless the recipient is ineligible for other reasons.

[8.281.600.14 NMAC - Rp, 8 NMAC 4.ICM.630, 4/1/2009]

### **HISTORY OF 8.281.600 NMAC:**

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

ISD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 12/29/1983.

ISD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 8/11/1987.

MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 2/5/1988.

MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 2/25/1988.

MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 6/1/1988.

MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 1/31/1989.

MAD Rule 380.0000, Medical Assistance for Persons Requiring Institutional Care, filed 6/21/1989.

MAD Rule 880.0000, Medical Assistance for Persons Requiring Institutional Care, filed 3/21/1990.

MAD Rule 880, Medical Assistance for Persons Requiring Institutional Care, filed 5/3/1991.

MAD Rule 880, Medical Assistance for Persons Requiring Institutional Care, filed 6/12/1992.

MAD Rule 880, Medical Assistance for Persons Requiring Institutional Care, filed 11/16/1994.

MAD Rule 882, Resources - Medical Assistance for Persons Requiring Institutional Care, filed 3/9/1993.

MAD Rule 882, Resources - Medical Assistance for Persons Requiring Institutional Care, filed 11/16/1994.

MAD Rule 882, Resources, filed 12/29/1994.

MAD Rule 883, Income - Medical Assistance for Persons Requiring Institutional Care, filed 3/18/1993.

MAD Rule 883, Income - Medical Assistance for Persons Requiring Institutional Care, filed 11/16/1994.

MAD Rule 883, Income, filed 12/29/1994.

MAD Rule 885, Medical Care Credit, filed 11/16/1994.

MAD Rule 888, Medicare Catastrophic Coverage Act of 1988 Regarding Transfers of Assets, filed 3/10/1994.

MAD Rule 888, Transfers of Assets, filed 12/27/1994.

MAD Rule 889, Spousal Impoverishment, filed 8/17/1992.

MAD Rule 889, Spousal Impoverishment, filed 2/17/1994.

### History of Repealed Material:

MAD Rule 880, Medical Assistance for Persons Requiring Institutional Care, filed 11/16/1994 - Repealed effective 2/1/1995.

MAD Rule 882, Resources, filed 12/29/1994 - Repealed effective 2/1/1995.

MAD Rule 883, Income, filed 12/29/1994 - Repealed effective 2/1/1995.

MAD Rule 885, Medical Care Credit, filed 11/16/1994 - Repealed effective 2/1/1995.

MAD Rule 888, Transfers of Assets, filed 12/27/1994 - Repealed effective 2/1/1995.

MAD Rule 889, Spousal Impoverishment, filed 2/17/1994 - Repealed effective 2/1/1995.

8 NMAC 4.ICM.600, Benefit Description, filed 12/30/1994 - Repealed effective 4/1/2009.