

TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT RULES
PART 430 RECIPIENT RIGHTS AND RESPONSIBILITIES

8.200.430.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.200.430.1 NMAC - Rp, 8.200.430.1 NMAC, 1/1/2014]

8.200.430.2 SCOPE: The rule applies to the general public.
[8.200.430.2 NMAC - Rp, 8.200.430.2 NMAC, 1/1/2014]

8.200.430.3 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 NMSA 1978, Section 27-1-12 et seq.
[8.200.430.3 NMAC - Rp, 8.200.430.3 NMAC, 1/1/2014]

8.200.430.4 DURATION: Permanent.
[8.200.430.4 NMAC - Rp, 8.200.430.4 NMAC, 1/1/2014]

8.200.430.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.200.430.5 NMAC - Rp, 8.200.430.5 NMAC, 1/1/2014]

8.200.430.6 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*.
[8.200.430.6 NMAC - Rp, 8.200.430.6 NMAC, 1/1/2014]

8.200.430.7 DEFINITIONS: [RESERVED]

8.200.430.8 [~~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.~~] [RESERVED]
[8.200.430.8 NMAC - N, 1/1/2014; A, xx-xx-xx]

8.200.430.9 RECIPIENT RIGHTS AND RESPONSIBILITIES:

A. An individual has the right to apply for medicaid and other health care programs HSD administers regardless of whether it appears he or she may be eligible.

(1) Income support division (ISD) determines eligibility for the medical assistance division's medical assistance programs (MAP), unless otherwise determined by another entity as stated in 8.200.400 NMAC. A decision shall be made promptly on applications in accordance with the timeliness standards set forth in 8.100.130 NMAC.

(2) Individuals who might be eligible for supplemental security income (SSI) are referred to the social security administration (SSA) office to apply.

B. Application: A paper or electronic application is required from the applicant, an authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant may complete a joint MAP, cash assistance, supplemental nutrition assistance program (SNAP) and low income home energy assistance (LIHEAP) application or a MAP-only application.

(1) The following do not require an application unless a re-determination is due in that month or the following month, as applicable:

(a) switching from one of the medical assistance for women, children (MAWC) and families MAP categories to another;

(b) switching between medicaid and refugee medical assistance; and

(c) switching to or from one of the long term care medicaid categories.

(2) Medicare savings programs (MSP):

(a) A MAP eligible recipient receiving full benefits is automatically deemed eligible

for MSP when she or he receives free medicare Part-A hospital insurance; the eligible recipient does not have to apply for medicare MSP;

(b) When an individual is not eligible for free medicare Part A hospital insurance, a separate application for the MAP qualified medicare beneficiary (QMB) eligibility category 040 is required. Individuals must apply for medicare Part A with the SSA. This is called, “conditional Part A” because they will receive medicare Part A on the condition that the MAP QMB category of eligibility is approved. When QMB is approved, the cost of the premium for Part A will be covered by MAD.

C. Responsibility in the application or recertification process: The applicant or the re-determining eligible recipient is responsible for providing verification of eligibility. Refer to 8.100.130 NMAC.

(1) An applicant or an eligible recipient's failure to provide necessary verification results in MAP ineligibility.

(2) An applicant or a re-determining eligible recipient must give HSD permission to contact other individuals, agencies, or sources of information which are necessary to establish eligibility.

[8.200.430.9 NMAC - Rp, 8.200.430.9 NMAC, 1/1/2014; A, 10/15/2014]

8.200.430.10 FREEDOM OF CHOICE: Except when specifically waived from MAD, an eligible recipient has the freedom to obtain physical and behavioral health services from a MAD provider of his or her choice.

[8.200.430.10 NMAC - Rp, 8.200.430.10 NMAC, 1/1/2014; A, 10/15/2014]

8.200.430.11 RELEASE OF INFORMATION: By signing the MAP application, an applicant or a re-determining eligible recipient gives HSD explicit consent to release information to applicable state or federal agencies, physical or behavioral health providers, or an HSD designee when the information is needed to provide, monitor, or approve MAD services. Physical and behavioral health information is confidential and is subject to the standards for confidentiality per 8.300.11 NMAC.

[8.200.430.11 NMAC - Rp, 8.200.430.11 NMAC, 1/1/2014; A, 10/15/2014]

8.200.430.12 RIGHT TO HEARING: An applicant or an eligible recipient is entitled to adequate notice of a HSD adverse action regarding his or her termination or re-categorization of his or her MAP category of eligibility. The applicant or re-determining eligible recipient has specific rights and responsibilities when requesting a HSD administrative hearing. A HSD administrative hearing affords the applicant or re-determining eligible recipient the opportunity to have an impartial review of these decisions. See 8.352.2, 8.100.180 and 8.100.970 NMAC for a detailed description of these rights, responsibilities and the HSD administrative hearing process. 8.352.2 NMAC further details the rights, responsibilities and the HSD administrative hearing process for other adverse actions MAD, its utilization review contractor or a HSD contracted managed care organization (MCO) may initiate (42 CFR Section 431.220(a)(1)(2)).

[8.200.430.12 NMAC - Rp, 8.200.430.12 NMAC, 1/1/2014; A, 10/15/2014]

8.200.430.13 ASSIGNMENT OF SUPPORT: As a condition of MAP eligibility, HSD requires an applicant or a re-determining eligible recipient to assign his or her medical care support rights to HSD for medical support and any third party payments. The assignment authorizes HSD to pursue and make recoveries from liable third parties (42 CFR 433.146; NMSA 1978 27-2-28 (G)).

A. **Assigning medical support rights:** The assignment to HSD of an eligible recipient’s rights to medical support and payments occurs automatically under New Mexico law when the applicant or the re-determining eligible recipient signs the application.

B. **Third party liability (TPL):** This section describes HSD’s responsibility to identify and collect from primarily responsible third parties and the eligible recipient’s responsibility to cooperate with HSD to uncover such payments. MAD is the payer of last resort. If other third party resources are available, these health care resources must be used before MAD makes a reimbursement. As a condition of MAP eligibility, an applicant assigns his or her rights to physical and behavioral health support and payments to HSD and promises to cooperate in identifying, pursuing, and collecting payments from these resources. Third party resources include the gross recovery by eligible recipient, including personal injury protection benefits, before any reduction in attorney’s fees or costs, obtained through settlement or verdict, for personal injury negligence or intentional tort claims or actions, up to the full amount of MAD payments for treatment of injuries causally related to the occurrence that is the subject of the claim or action.

(1) **Required TPL information:** During the initial determination or re-determination of eligibility for MAP enrollment, ISD must obtain information about TPL from either the applicant or the re-

determining eligible recipient.

(a) HSD is required to take all reasonable measures to determine the legal liability of third parties, including health insurers in paying for the physical and behavioral health services furnished to an eligible recipient (42 CFR 433.138(a)).

(b) HSD uses the information collected at the time of determination in order for MAD to pursue claims against third parties.

(2) Availability of health insurance: If an applicant or an eligible recipient has health insurance, the applicant or the eligible recipient shall notify ISD. ISD must collect all relevant information, including name and address of the insurance company; individuals covered by the policy, effective dates, covered services, and appropriate policy numbers.

(a) An applicant or an eligible recipient with health insurance coverage or coverage by a health maintenance organization (HMO) or other managed care plan (plan) must be given a copy of the TPL recipient information letter.

(b) If there is an absent parent, ISD may request the absent parent's name and social security number (SSN).

(c) ISD must determine if an absent parent, relative, applicant or any member of the household is employed and has health insurance coverage.

(3) Eligible recipients with health insurance coverage: An applicant or an eligible recipient must inform his or her MAD providers of his or her TPL. An applicant or an eligible recipient must report changes to or terminations of insurance coverage to ISD. If an applicant or an eligible recipient has health coverage through an HMO or plan, payment from MAD is limited to applicable copayments required under the HMO or plan and to MAD covered services documented in writing as exclusions by the HMO or plan.

(a) If the HMO or plan uses a drug formulary, the medical director of the HMO or plan must sign and attach a written certification for each drug claim to document that a pharmaceutical product is not covered by the HMO or plan. The signature is a certification that the HMO or plan drug formulary does not contain a therapeutic equivalent that adequately treats the physical or behavioral health condition of the HMO or plan subscriber.

(b) Physical and behavioral health services not included in the HMO or plan are covered by MAD only after review of the documentation and on approval by MAD.

(c) An applicant or an eligible recipient covered by an HMO or plan is responsible for payment of medical services obtained outside the HMO or plan and for medical services obtained without complying with the rules or policies of the HMO or plan.

(d) An applicant or an eligible recipient living outside an HMO or plan coverage area may request a waiver of the requirement to use HMO or plan providers and services. The applicant or the eligible recipient for whom a coverage waiver is approved by MAD may receive reimbursement for expenses which allow him or her to travel to an HMO or plan participating provider, even when the provider is not located near the applicant or the eligible recipient's residence.

(4) Potential health care resources: ISD must evaluate the presence of a TPL source if certain factors are identified during the MAD eligibility interview.

(a) When the age of the applicant or the eligible recipient is over 65 years old medicare must be explored. A student, especially a college student, may have health or accident insurance through his or her school.

(b) An application on behalf of deceased individual must be examined for "last illness" coverage through a life insurance policy.

(c) Certain specific income sources are indicators of possible TPL which include:

(i) railroad retirement benefits and social security retirement or disability benefits indicating eligibility for Title XVIII (medicare) benefits;

(ii) workers' compensation (WC) benefits paid to employees who suffer an injury or accident caused by conditions arising from employment; these benefits may compensate employees for physical and behavioral health expenses and lost income; payments for physical and behavioral health expenses may be made as physical and behavioral health bills are incurred or as a lump sum award;

(iii) black lung benefits payable under the coal mine workers' compensation program, administered by the federal department of labor (DOL), can produce benefits similar to railroad retirement benefits if the treatment for illness is related to the diagnosis of pneumoconiosis; beneficiaries are reimbursed only if services are rendered by specific providers, authorized by the DOL; black lung payments are made monthly and physical and behavioral health expenses are paid as they are incurred; and

(iv) Title IV-D support payments or financial support payments from an absent parent may indicate the potential for physical and behavioral health support; if a custodial party does not have health insurance that meets a minimum standard, the court in a divorce, separation or custody and support proceeding may order the parent(s) with the obligation of support to purchase insurance for the eligible recipient child (45 CFR 303.31(b)(1); NMSA 1978, Section 40-4C-4(A)(1)); insurance can be obtained through the parent's employer or union (NMSA 1978, Section 40-4C-4(A)(2)); parents may be ordered to pay all or a portion of the physical and behavioral health expenses; for purposes of physical and behavioral health support, the minimum standards of acceptable coverage, deductibles, coinsurance, lifetime benefits, out-of-pocket expenses, co-payments, and plan requirements are the minimum standards of health insurance policies and managed care plans established for small businesses in New Mexico; see New Mexico insurance code.

(d) An applicant or an eligible recipient has earned income: Earned income may indicate physical, behavioral health and health insurance made available by an employer.

(e) Work history or military services: Work history may indicate eligibility for other cash and physical and behavioral benefits. Previous military service suggests the potential for veterans administration (VA) or department of defense (DOD) health care, including the civilian health and the medical program of the United States (CHAMPUS), for individuals who reside within a 40-mile radius of a military health care facility. An applicant or an eligible recipient who is eligible for DOD health care must obtain certification of non-availability of medical services from the base health benefits advisor in order to be eligible for CHAMPUS.

(f) An applicant or an eligible recipient's expenses show insurance premium payments: Monthly expense information may show that the applicant or the eligible recipient pays private insurance premiums or is enrolled in an HMO or plan.

(g) The applicant or the eligible recipient has a disability: Disability information contained in applications or brought up during interviews may indicate casualties or accidents involving legally responsible third parties.

(h) The applicant or the eligible recipient has a chronic disease: Individuals with chronic renal disease are probably entitled to medicare. Applications for social security disability may be indicative of medicare coverage.

(5) Communicating TPL information: Information concerning health insurance or health plans is collected and transmitted to MAD by ISD, child support enforcement division (CSED), SSA, and the children, youth and families department (CYFD).

[8.200.430.13 NMAC - Rp, 8.200.430.13 NMAC, 1/1/2014; A, 10/15/2014]

8.200.430.14 ELIGIBLE RECIPIENT RESPONSIBILITY TO COOPERATE WITH ASSIGNMENT OF SUPPORT RIGHTS:

A. Cooperation: As a condition of MAP eligibility, an applicant or an eligible recipient must cooperate with HSD to:

(1) obtain physical and behavioral health support and payments for his or herself and other individuals for whom he or she can legally assign rights;

(2) pursue liable third parties by identifying individuals and providing information to HSD;

(3) cooperate with CSED to establish paternity and medical support as appropriate, see 8.50.105.12 NMAC;

(4) appear at a state or local office designated by HSD to give information or evidence relevant to the case, appear as a witness at a court or other proceeding or give information or attest to lack of information, under penalty of perjury;

(5) refund HSD any money received for physical or behavioral health care that has already been paid; this includes payments received from insurance companies, personal injury settlements, and any other liable third party; and

(6) respond to the trauma inquiry letter that is mailed to an eligible recipient (42 CFR 433.138(4)); the letter asks an eligible recipient to provide more information about possible accidents, causes of accidents, and whether legal counsel has been obtained (42 CFR 433.147; 45 CFR 232.42, 232.43; NMSA 1978 27-2-28(G)(3)).

B. Good cause waiver of cooperation: The requirements for cooperation may be waived by HSD if it decides that the applicant or the eligible recipient has good cause for refusing to cooperate. Waivers can be obtained for cooperating with CSED. The applicant or the eligible recipient should request a good cause waiver from CSED per 8.50.105.14 NMAC.

C. Penalties for failure to cooperate:

(1) When the parent, the specified relative or legal guardian fails or refuses to cooperate, the parent or specified relative will not be eligible for MAD services. The eligible recipient child maintains MAP eligibility provided all other eligibility criteria are met.

(2) When the parent or the specified relative fails or refuses to refund payments received from insurance or other settlement sources, such as personal injury case awards, he or she is not eligible for MAD services for one year and until full restitution has been made to HSD. The eligible recipient child maintains MAP eligibility provided all other eligibility criteria are met.

[8.200.430.14 NMAC - Rp, 8.200.430.14 NMAC, 1/1/2014; A, 10/15/2014]

8.200.430.15 ELIGIBLE RECIPIENT RESPONSIBILITY TO GIVE PROVIDER PROPER IDENTIFICATION AND NOTICE OF ELIGIBILITY CHANGES:

A. An eligible recipient is responsible for presenting a current MAP eligibility card and evidence of any other health insurance to a MAD provider each time service is requested.

(1) An eligible recipient is responsible for any financial liability incurred if he or she fails to furnish current MAP eligibility identification before the receipt of a service and as a result the provider fails to adhere to MAD rules, such as a failure to request prior approval. If this omission occurs, the settlement of claims for services is between the eligible recipient and the provider. An individual is financially responsible for services received if he or she was not eligible for MAD services on the date services are furnished.

(2) When a provider bills MAD and the claim is denied, the provider cannot bill the eligible recipient. Exceptions exist for denials caused by MAP ineligibility or by an eligible recipient's failure to furnish MAP identification in a timely manner.

(3) If an eligible recipient fails to notify the provider that he or she has received services that are limited by time or amount, the eligible recipient is responsible for payment of the service prior to rendering the service if the provider made reasonable efforts to verify whether the eligible recipient has already received services.

B. Notification of providers following retroactive eligibility determinations: If an eligibility determination is made, the eligible recipient is responsible for notifying MAD providers of this eligibility determination. When an individual receives retro MAP eligibility, the now-eligible recipient must notify all of his or her MAD providers of his or her change of eligibility. If the eligible recipient fails to notify the provider and the provider can no longer file a claim for reimbursement, the eligible recipient becomes the responsible payer for those services.

C. Notification if an eligible recipient has private insurance: If an eligible recipient is covered under a private health insurance policy or health plan, he or she is required to inform his or her MAD providers of the private health coverage, including applicable policy numbers and special claim forms.

[8.200.430.15 NMAC - Rp, 8.200.430.15 NMAC, 1/1/2014; A, 10/15/2014]

8.200.430.16 ELIGIBLE RECIPIENT FINANCIAL RESPONSIBILITIES:

A. A MAD provider agrees to accept the amount paid as payment in full with the exception of co-payment amounts required in certain MAP eligibility categories (42 CFR 447.15). Other than the co-payments, a provider cannot bill an eligible recipient for any unpaid portion of the bill (balance billing) or for a claim that is not paid because of a provider administrative error or failure of multiple providers to communicate eligibility information. A native American eligible recipient is exempt from co-payment requirements.

(1) An eligible recipient is responsible for any financial liability incurred if he or she fails to furnish current MAP eligibility identification before the receipt of a MAP service and as a result the provider fails to adhere to MAD reimbursement rules, such as a failure to request prior approval. If this omission occurs, the settlement of claims for services is between the eligible recipient and the MAP provider. An individual is financially responsible for services received if he or she was not eligible for MAD services on the date services are furnished.

(2) When a provider bills MAD and the claim is denied, the provider cannot bill the eligible recipient. Exceptions exist for denials caused by MAP ineligibility or by an eligible recipient's failure to furnish MAP identification at the time of service.

(3) If an eligible recipient fails to notify a provider that he or she has received services that are limited by time or amount, the eligible recipient is responsible to pay for services if, before furnishing the services, the provider makes reasonable efforts to verify whether the eligible recipient has already received services.

B. Failure of an eligible recipient to follow his or her privately held health insurance carrier's requirements: An eligible recipient must be aware of the physician, pharmacy, hospital, and other providers who participate in his or her HMO or other managed care plan. An eligible recipient is responsible for payment for

services if he or she uses a provider who is not a participant in his or her plan or if he or she receives any services without complying with the rules, policies, and procedures of his or her plan.

C. Other eligible recipient payment responsibilities: If all the following conditions are met before a MAD service is furnished, the eligible recipient can be billed directly by a MAD provider for services and is liable for payment:

- (1) the eligible recipient is advised by a provider that the particular service is not covered by MAD or is advised by a provider that he or she is not a MAD provider;
- (2) the eligible recipient is informed by a provider of the necessity, options, and charges for the services and the option of going to another provider who is a MAD provider; and
- (3) the eligible recipient agrees in writing to have the service provided with full knowledge that he or she is financially responsible for the payment.

D. ~~Children's health insurance program (CHIP) and working disabled individuals (WDI) co-payments: It is the eligible recipient's responsibility to pay the co-payment to the MAD provider.~~

~~(1) Children's health insurance program (CHIP) co-payment requirement: Eligible recipients or members whose benefits are determined using criteria for CHIP are identified by their category of eligibility. The following co-payments apply to CHIP eligible recipients or members:~~

- ~~(a) \$2 per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;~~
- ~~(b) \$5 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;~~
- ~~(c) \$5 per dental visit, unless all the services are preventive services;~~
- ~~(d) 25 per inpatient hospital admission unless the hospital is receiving the eligible recipient or member as a transfer from another hospital;~~
- ~~(e) \$3 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and~~
- ~~(f) \$8 for non-emergent use of the ED.~~

~~(2) Working disabled individual's copayment requirements (WDI): Eligible recipients or members whose benefits are determined using criteria for WDI are identified by their MAP category of eligibility. The following co-payments apply to WDI eligible recipients or members:~~

- ~~(a) \$3 per prescription applies to prescription and non-prescription drug items unless the co-payment for unnecessary drug utilization is assessed;~~
- ~~(b) \$7 per outpatient visit, including physician or other practitioner visits, therapy sessions, and behavioral health service sessions;~~
- ~~(c) \$7 per dental visit, unless all the services are preventive services;~~
- ~~(d) \$30 per inpatient hospital admission unless the hospital is receiving the eligible recipient or member as a transfer from another hospital;~~
- ~~(e) \$3 per prescription applies for unnecessary use of a brand name drug, unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply; and~~
- ~~(f) \$8 for non-emergent use of the ED.~~

E. Co-payment responsibilities: The provider is responsible for understanding and applying the rules for co-payment including when to contact the payer to determine if a co-payment is applicable for the service for the specific eligible recipient or member.

- (1) Co-payments are not applied when one or more of the following conditions are met:
 - (a) the service is a Medicare claim or Medicare advantage claim, or follows other insurer payment, so the payment is therefore toward a deductible, co-insurance, or co-payment determined by the primary payer;
 - (b) the eligible recipient or member is a native American;
 - (c) the service is rendered by an Indian health service (IHS), tribal 638, or urban Indian facility regardless of the race of the eligible recipient or member;
 - (d) the service is for an eligible recipient enrolled in hospice;
 - (e) the recipient is under age 21 and has only presumptive eligibility (PE) at the time of service;
 - (f) the maximum family out-of-pocket cost sharing limit has been reached;
 - (g) the service was rendered prior to any eligibility being established including when eligibility is retroactively established to the time period of the service;
 - (h) the eligible recipient or member is in foster care or has an adoption category of

eligibility;

- ~~(i) the eligible recipient or member resides in a nursing facility or a facility for individuals with intellectual disabilities (ID), has a level of care determination or nursing facility care, or other residential care, or for community benefits, or for a home and community based services waiver;~~
- ~~(j) the service is not for a MAP category of eligibility such as the department of health children's medical services program;~~
- ~~(k) the service is a provider preventable condition or is solely to treat a provider preventable condition; or~~
- ~~(2) the eligible recipient, member or service is exempt from co-payment as otherwise described in these rules.~~
- ~~(3) Other than a co-payment for non-emergent use of the emergency department (ED) or for unnecessary use of a brand name drug, co-payments are not applied when the services are one of the following:~~
 - ~~(a) family planning services, procedures drugs, supplies, or devices;~~
 - ~~(b) preventive services (well child checks, vaccines, preventive dental cleanings/exams, periodic health exams) unless treatment is rendered; or~~
 - ~~(c) prenatal and postpartum care and deliveries, and prenatal drug items.~~
- ~~(4) Unnecessary use of a brand named drug:~~
 - ~~(a) If in the prescriber's estimation, the alternative drug item available on the PDL is either less effective for treating the eligible recipient's condition, or would have more side effects or higher potential for adverse reactions, the co-payment is not applied.~~
 - ~~(b) If the prescriber has stated the brand name is medically necessary and therefore the claim is billed with a dispense as written indicator, the co-payment is not applied unless the reason for the brand being medically necessary is something other than the generic form is anticipated to have more side effects or adverse reactions, or would be less effective in treating the eligible recipient~~
 - ~~(c) The unnecessary utilization of a brand name drug shall not apply to legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions. Minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.~~
- ~~(5) Unnecessary use of the ED: the unnecessary utilization of an ED is when an eligible recipient presents to an emergency room for service when the condition of the eligible recipient is not an emergency medical condition and the hospital determines the condition does not require emergency treatment after considering the medical presentation of the eligible recipient, the age of the eligible recipient, alternative providers that may be available in the community at the specific time of day, and other relevant factors. The co-payment is assessed when the eligible recipient is told that the condition does not require emergency treatment and the eligible recipient still chooses to continue with the treatment in the ED. A hospital provider must determine the eligible recipient is using the ED for a non-emergent service and apply co-payments to non-emergent use of the ED according to the definition as stated in this paragraph.] [Medicaid recipients may be responsible to pay co-payments as outlined in 8.302.2 NMAC.](#)~~

[8.200.430.16 NMAC - Rp, 8.200.430.16 NMAC, 1/1/2014; A, 10/15/2014; A, xx-xx-xx]

8.200.430.17 RESTITUTION:

A. A MAP eligible recipient must return overpayments or medical payments received from liable third parties to the applicable medical service provider or to MAD. If payments are not returned or received, recoupment proceedings against the eligible recipient will be initiated.

B. The restitution bureau of HSD is responsible for the tracking and collection of overpayments made to MAP eligible recipients, vendors, and MAD providers. See Section OIG-940, RESTITUTIONS. The MAD third party liability unit is responsible for monitoring and collecting payments received from liable third parties. See 8.302.3 NMAC.

[8.200.430.17 NMAC - Rp, 8.200.430.17 NMAC, 1/1/2014; A, 10/15/2014]

8.200.430.18 REPORTING REQUIREMENTS: ~~[An eligible recipient is required to report certain changes which might affect his or her eligibility. The following changes must be reported to ISD within 10 calendar days from the date the change occurred pursuant to 8.200.400 NMAC, 8.200.410 NMAC, and 8.200.420 NMAC.]~~

[A medicaid eligible recipient is required to report certain changes which might affect his or her eligibility to ISD within 10 calendar days from the date the change occurred. A timely change that is reported within 10 calendar days that may result in a more beneficial medicaid eligibility category shall be evaluated in the month the change](#)

occurred. An untimely change that is reported after 10 calendar days that may result in a more beneficial medicaid eligibility category shall be evaluated in the month the change was reported. A reported change that does not result in the same or a more beneficial medicaid category is considered an adverse action and is applied prospectively in accordance with 8.100.180.10 NMAC. The following changes must be reported to ISD:

A. Living arrangements or change of address: Any change in where an eligible recipient lives or gets his or her mail must be reported.

B. Household size: Any change in the household size must be reported. This includes the death of an individual included in the either or both the assistance unit and budget group.

C. Enumeration: Any new social security number must be reported.

D. Income: Except for continuous eligibility in 8.200.400 NMAC any increase or decrease in the amount of income or change in the source of income must be reported.

E. Resource: Resources only apply to non-modified adjusted gross income (MAGI) medicaid categories. Any change in what an eligible recipient owns must be reported. This includes any property the eligible recipient owns or has interest in, cash on hand, money in banks or credit unions, stocks, bonds, life insurance policies or any other item of value.

[8.200.430.18 NMAC - Rp, 8.200.430.18 NMAC, 1/1/2014; A, 2/14/2014; 8.200.430.18 NMAC - Rn & A, 8.200.430.19 NMAC, 10/15/2014; A, xx-xx-xx]

8.200.430.19 MAD ESTATE RECOVERY: HSD is mandated to seek recovery from the estates of certain individuals up to the amount of medical assistance payments made by the HSD on behalf of the individual. See Social Security Act Section 1917 (42 USC 1396p(b) and NMSA 1978, Section 27-2A-1 et seq. "Medicaid Estate Recovery Act").

A. Definitions used in MAD estate recovery:

(1) **Authorized representative:** The individual designated to represent and act on the eligible recipient's behalf. The eligible recipient or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the member.

(2) **Estate:** Real and personal property and other assets of an individual subject to probate or administration pursuant to the New Mexico Uniform Probate Code.

(3) **Medical assistance:** Amounts paid by HSD for long term care services including related hospital and prescription drug services.

B. Basis for defining the group: A MAP eligible recipient who was 55 years of age or older when medical assistance payments were made on his or her behalf for nursing facilities services, home and community based services, and related hospital and prescription drug services are subject to estate recovery.

C. The following exemptions apply to estate recovery:

(1) Qualified medicare beneficiaries, specified low-income beneficiaries, qualifying individuals, and qualified disabled and working individuals, are exempt from estate recovery for the receipt of hospital and prescription drug services unless they are concurrently in a MAP nursing facility category of eligibility or on a home and community based services waiver; this provision applies to medicare cost-sharing benefits (i.e., Part A and Part B premiums, deductibles, coinsurance, and co-payments) paid under the medicare savings programs.

(2) Certain income, resources, and property are exempted from MAD estate recovery for native Americans:

(a) interest in and income derived from tribal land and other resources held in trust status and judgment funds from the Indian claims commission and the United States claims court;

(b) ownership interest in trust or non-trust property, including real property and improvements;

(i) located on a reservation or near a reservation as designated and approved by the bureau of Indian affairs of the U.S, department of interior; or

(ii) for any federally-recognized tribe located within the most recent boundaries of a prior federal reservation; and

(iii) protection of non-trust property described in Subparagraphs (a) and (b)

is limited to circumstances when it passes from a native American to one or more relatives, including native Americans not enrolled as members of a tribe and non-native Americans such as a spouse and step-children, that their culture would nevertheless protect as family members; to a tribe or tribal organization; or to one or more native

Americans;

(c) income left as a remainder in an estate derived from property protected in Paragraph (2) above, that was either collected by a native American, or by a tribe or tribal organization and distributed to native Americans that the individual can clearly trace the income as coming from the protected property;

(d) ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources resulting from the exercise of federally-protected rights, and income either collected by a native American, or by a tribe or tribal organization and distributed to native Americans derived from these sources as long as the individual can clearly trace the ownership interest as coming from protected sources; and

(e) ownership interest in or usage of rights to items, not covered by Subparagraphs (a) through (d) above, that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

D. Recovery process: Recovery from an eligible recipient's estate will be made only after the death of the eligible recipient's surviving spouse, if any, and only at a time that the eligible recipient does not have surviving child who is less than 21 years of age, blind, or who meet the SSA definition of disability.

(1) Estate recovery is limited to payments for applicable services received on or after October 1, 1993; except that recovery also is permitted for pre-October 1993 payments for nursing facility services received by a MAP recipient who was 65 years of age or older when such nursing facility services were received.

(2) A recovery notice will be mailed to the authorized representative or next of kin upon the eligible recipient's death informing him or her about the amount of claim against the estate and provide information on hardship waivers and hearing rights.

(3) It is the family or authorized representative's responsibility to report the eligible recipient's date of death to the ISD office within 10 calendar days after the date of death.

E. Eligible recipient rights and responsibilities:

(1) At the time of application or re-certification, the authorized representative must be identified or confirmed by the applicant or eligible recipient or his or her designee.

(2) Information explaining estate recovery will be furnished to the applicant or eligible recipient, his or her personal representative, or designee during the application or re-certification process. Upon the death of the MAP eligible recipient, a notice of intent to collect (recovery) letter will be mailed to the eligible recipient's personal representative with the total amount of claims paid by MAD on behalf of the eligible recipient. The authorized representative must acknowledge receipt of this letter in the manner prescribed in the letter within 30 calendar days of the date on the letter.

(3) During the application or re-certification process for] MAP eligibility, the local county ISD office will identify the assets of an applicant or the eligible recipient. This includes all real and personal property which belongs in whole or in part to the applicant or eligible recipient and the current fair market value of each asset. Any known encumbrances on the asset should be identified at this time by the applicant or the eligible recipient or his or her authorized representative.

(4) MAD, or its designee, will send notice of recovery to the probate court, when applicable, and to the eligible recipient's authorized representative or successor in interest. The notice will contain the following information:

- (a) statement describing the action MAD, or its designee, intends to take;
- (b) reasons for the intended action;
- (c) statutory authority for the action;
- (d) amount to be recovered;
- (e) opportunity to apply for the undue hardship waiver;
- (f) procedures for applying for a hardship waiver and the relevant timeframes

involved;

(g) explanation of the eligible recipient's personal representative's right to request a HSD administrative hearing; and

(h) the method by which an affected person may obtain a HSD administrative hearing and the applicable timeframes involved.

(5) Once notified by MAD, or its designee, of the decision to seek recovery, it is the responsibility of the eligible recipient's authorized representative or successor in interest to notify other individuals who would be affected by the proposed recovery.

(6) The authorized representative will:

- (a) remit the amount of medical assistance payments to HSD or its designee;
- (b) apply for an undue hardship waiver; (see Paragraph (2) of Subsection F below);

or

- (c) request an administrative hearing.

F. Waivers:

(1) For a general waiver, HSD may compromise, settle, or waive recovery pursuant to the Medicaid Estate Recovery Act if it deems that such action is in the best interest of the state or federal government.

(2) Hardship provision: HSD, or its designee, may waive recovery because recovery would work an undue hardship on the heirs. The following are deemed to be causes for hardship:

(a) the deceased recipient's heir would become eligible for a needs-based assistance program such as medicaid or temporary assistance to needy families (TANF) or be put at risk of serious deprivation without the receipt of the proceeds of the estate;

(b) the deceased eligible recipient's heir would be able to discontinue reliance on a needs-based program (such as medicaid or TANF) if he or she received the inheritance from the estate;

(c) the deceased recipient's assets which are subject to recovery are the sole income source for the heir;

(d) the homestead is worth 50 percent or less than the average price of a home in the county where the home is located based on census data compared to the property tax value of the home; or

(e) there are other compelling circumstances as determined by HSD or its designee.
[8.200.430.19 NMAC - N, 1/1/2014; 8.200.430.19 NMAC - Rn & A, 8.200.430.20 NMAC, 10/15/2014]

8.200.430.20 [RESERVED]

[8.200.430.20 NMAC - N, 1/1/2014; Repealed, 10/15/2014]

HISTORY OF 8.200.430 NMAC: The material in this part was derived from that previously filed with the State Records Center:

8 NMAC 4.MAD.430, Recipient Policies, Recipient Rights and Responsibilities, filed 12/30/1994.

History of Repealed Material:

8.200.430 NMAC, Recipient Rights and Responsibilities, filed 12/13/2000 - Repealed effective 1/1/2014.