MEDICAID ELIGIBILITY – GENERAL RECIPIENT POLICIES
RECIPIENT RIGHTS AND RESPONSIBILITIES

INDEX

This page intentionally left blank.

MEDICAID ELIGIBILITY – GENERAL RECIPIENT POLICIES
RECIPIENT RIGHTS AND RESPONSIBILITIES

TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT POLICIES
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, 1-1-14]

8.200.430.2 SCOPE: The rule applies to the general public.
[8.200.430.2 NMAC - Rp, 8.200.430.2 NMAC, 1-1-14]

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, 1-1-14]

8.200.430.4 DURATION: Permanent.
[8.200.430.4 NMAC - Rp, 8.200.430.4 NMAC, 1-1-14]

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, 1-1-14]

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, 1-1-14]

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.
[8.200.430.8 NMAC - N, 1-1-14]

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 medicaid health care programs, 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 8.100.130.11 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 medicaid, cash assistance, supplemental nutrition assistance program (SNAP) and low income home energy assistance (LIHEAP) application or a medicaid-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 medical assistance division (MAD) 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 medicaid 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 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 QMB category of eligibility is approved. When QMB is approved, the cost of the premium for Part A will be covered by medicaid.

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 medicaid 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, 1-1-14]

8.200.430.10 FREEDOM OF CHOICE: Except when specifically waived from MAD, an eligible recipient has the freedom to obtain medical and behavioral health services from a MAD provider of his or her choice.
[8.200.430.10 NMAC - Rp, 8.200.430.10 NMAC, 1-1-14]

8.200.430.11 RELEASE OF INFORMATION: By signing the medicaid application, an applicant or a re-determining eligible recipient gives HSD explicit consent to release information to applicable state or federal agencies, medical or behavioral health providers, or an HSD designee when the information is needed to provide, monitor, or approve medicaid services. Medical 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, 1-1-14]

8.200.430.12 RIGHT TO HEARING: An applicant or an eligible recipient is entitled to adequate notice of state agency actions and for an opportunity to have an impartial review of those decisions at an administrative hearing. This includes any action to deny or terminate medicaid or another health care program's eligibility or deny, terminate, suspend or reduce a medicaid covered service [42 CFR Section 431.220(a)(1)(2)].

A. Adequate notice rules regarding medicaid eligibility are detailed at 8.100.180 NMAC. Fair hearing rules regarding medicaid eligibility are detailed at 8.100.970 NMAC.

B. Adequate notice and recipient hearing rules regarding MAD covered services are detailed in 8.352.2 NMAC.
[8.200.430.12 NMAC - Rp, 8.200.430.12 NMAC, 1-1-14]

8.200.430.13 ASSIGNMENT OF SUPPORT: As a condition of MAD 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 responsibility to identify and collect from primarily responsible third parties and recipient responsibility to cooperate with HSD to uncover such payments. Medicaid is the payer of last resort. If other third party resources are available, these health care resources must be used before medicaid. As a condition of medicaid eligibility, an applicant assigns his or her rights to medical 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 a 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 medicaid 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-determininationn of eligibility for medicaid services, 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 medical 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 medicaid 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 medicaid 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 medicaid is limited to applicable copayments required under the HMO or plan and to medicaid 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 medical or behavioral health condition of the HMO or plan subscriber.

(b) Medical 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 medicaid 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 medical and behavioral health expenses and lost income; payments for medical and behavioral health expenses may be made as medical 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 medical 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 medical 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 medical, behavioral health or dental expenses; for purposes of medical 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 medical, 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 medical 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, 1-1-14]

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

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

(1) obtain medical 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 medical 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 medicaid services. The eligible recipient child maintains medicaid 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 medicaid services for one year and until full restitution has been made to HSD. The eligible recipient child maintains medicaid eligibility provided all other eligibility criteria are met.

[8.200.430.14 NMAC - Rp, 8.200.430.14 NMAC, 1-1-14]

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 medicaid eligibility card and evidence of any other health insurance to a medicaid 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 medicaid 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 medicaid services on the date services are furnished.

(2) When a provider bills medicaid and the claim is denied, the provider cannot bill the eligible recipient. Exceptions exist for denials caused by medicaid ineligibility or by an eligible recipient's failure to furnish medicaid 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 providers of this eligibility determination. When an individual receives retro medicaid eligibility, the now-eligible recipient must notify all of his or her medicaid 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 medicaid 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, 1-1-14]

8.200.430.16 ELIGIBLE RECIPIENT FINANCIAL RESPONSIBILITIES:

A. A medicaid provider agrees to accept the amount paid as payment in full with the exception of co-payment amounts required in certain medicaid 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 medicaid eligibility identification before the receipt of a medicaid service and as a result the provider fails to adhere to medicaid 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 provider. An individual is financially responsible for services received if he or she was not eligible for medicaid services on the date services are furnished.

(2) When a provider bills medicaid and the claim is denied, the provider cannot bill the eligible recipient. Exceptions exist for denials caused by medicaid ineligibility or by an eligible recipient's failure to furnish medicaid 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 service is furnished, the eligible recipient can be billed directly by a medicaid 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 medicaid or is advised by a provider that he or she is not a medicaid 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 medicaid 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 medicaid provider.

(1) WDI co-payment requirements are the following:

(a) $7 per outpatient physician visit to a physician or other practitioner, dental visit, therapy session, or behavioral health service session;

(b) $20 per emergency room (ER) visit;

(c) $28 for non emergent use of the ER;

(d) $30 per inpatient hospital admission;

(e) $5 per drug item (does not apply if the $8 co-payment for a brand name drug is assessed); and

(f) $8 for a brand name drug when there is a less expensive therapeutically equivalent drug on the preferred drug list (PDL) unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.

(2) CHIP co-payment requirements are the following:

(a) $5 per outpatient physician visit to a physician or other practitioner, dental visit, therapy session, or behavioral health service session;

(b) $15 per ER visit;

(c) $50 for non emergent use of the ER;

(d) $25 per inpatient hospital admission;

(e) $2 per drug item (does not apply if the $5 co-payment for a brand name drug is assessed); and

(f) $5 for a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.

E. The following exemptions from co-payment responsibilities for WDI and CHIP eligible recipients apply:

(1) native Americans;

(2) family planning services, procedures, drugs, supplies, and devices;

(3) medicare cross over claims including claims from medicare advantage plans;

(4) preventive services regardless of age (well child checks, vaccines, preventive dental cleanings/exams, etc.);

(5) prenatal and postpartum care and deliveries, and prenatal drug items;

(6) provider preventable conditions;

(7) psychotropic drug items are exempt from the brand name co-payment (only the regular pharmacy co-payment applies);

(8) when the maximum family limit has been exceeded;

(9) all services rendered by an Indian health services facility (IHS), 638 facility, or urban Indian facility regardless of race code; and

(10) federal match 3 for categories 071 and 400 through 421 are exempt because these are presumptively eligible children.

F. Brand name drug: A $3 co-payment for a brand name drug applies to MAD eligible recipients, except for WDI and CHIP, which have higher co-payment amounts, when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.

G. Non emergent use of the ER: For non emergent use of the ER, the co-payment varies by the federal poverty level (FPL). These co-payment amounts apply to MAD eligible recipients except for WDI which has

a higher co-payment amount. The co-payments for non emergent use of the ER are the following:

(1) $8 if 150 percent of the FPL or below; and

(2) $50 if greater than 150 percent of the FPL.

H. The following are exempt from the non emergent use of the ER and brand name drug co-payment:

(1) native Americans;

(2) medicare cross over claims including claims from medicare advantage plans;

(3) psychotropic drug items;

(4) foster care and adoption categories (Categories 014, 017, 037, 046, 047, 066, and 086); and

(5) institutional care categories (Categories 081, 083, and 084).

I. Co-payment maximum: The aggregate amount of cost sharing imposed for all individuals in the family as applied during the quarterly period is five percent of countable family income.

[8.200.430.16 NMAC - Rp, 8.200.430.16 NMAC, 1-1-14]

8.200.430.17 RESTITUTION:

A. A medicaid 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 recipient will be initiated.

B. The restitution bureau of HSD is responsible for the tracking and collection of overpayments made to medicaid recipients, vendors, and medicaid 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, 1-1-14]

8.200.430.18 ELIGIBLE RECIPIENT RESPONSIBILITY TO ENROLL IN AVAILABLE EMPLOYER-BASED GROUP HEALTH PLAN OR OTHER INSURANCE PLANS: Effective July 01, 1998, HSD no longer accepts referrals to the health insurance premium payment (HIPP) program. HIPP is only available to participants active on HIPP as of July 01, 1998 who have continued to maintain their eligibility for the program. This program will end January 31, 2014.

[8.200.430.18 NMAC - Rp, 8.200.430.18 NMAC, 1-1-14; A, 2-14-14]

8.200.430.19 REPORTING REQUIREMENTS: A medicaid 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. **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:** 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.

[8.200.430.19 NMAC - N, 1-1-14]

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

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

(3) Personal representative: An adult designated in writing who is authorized to represent the estate of the eligible recipient.

B. **Basis for defining the group:** A medicaid 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 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 medicaid 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 an Indian, 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 medicaid 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 personal 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 personal 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, a personal 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 medicaid 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 medicaid on behalf of the eligible recipient. The personal 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 medicaid 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 personal representative.

(4) MAD, or its designee, will send notice of recovery to the probate court, when applicable, and to the eligible recipient's personal 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 an administrative hearing; and
(h) the method by which an affected person may obtain a 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 personal representative or successor in interest to notify other individuals who would be affected by the proposed recovery.

(6) The personal 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.

[8.200.430.20 NMAC - N, 1-1-14]

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 12-30-94.

History of Repealed Material:
8.200.430 NMAC, Recipient Rights and Responsibilities, filed 12-13-2000 - Repealed effective 1-1-14.