TITLE 8 SOCIAL SERVICES
CHAPTER 291 MEDICAID ELIGIBILITY - AFFORDABLE CARE
PART 410 GENERAL RECIPIENT REQUIREMENTS

8.291.410.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA).
[8.291.410.1 NMAC - Rp, 8.291.410.1 NMAC, 10/1/2017; A, 7/1/2024]

8.291.410.2 SCOPE: The rule applies to the general public.
[8.291.410.2 NMAC - Rp, 8.291.410.2 NMAC, 10/1/2017]

8.291.410.3 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 or by state statute. See Section 27-1-12 et seq., NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.291.410.3 NMAC - Rp, 8.291.410.3 NMAC, 10/1/2017; A, 7/1/2024]

8.291.410.4 DURATION: Permanent.
[8.291.410.4 NMAC - Rp, 8.291.410.4 NMAC, 10/1/2017]

8.291.410.5 EFFECTIVE DATE: October 1, 2017, unless a later date is cited at the end of a section.
[8.291.410.5 NMAC - Rp, 8.291.410.5 NMAC, 10/1/2017]

8.291.410.6 OBJECTIVE: The objective of this rule is to provide eligibility guidelines when determining eligibility for the medical assistance division (MAD) medical assistance programs (MAP) and other health care programs it administers. Processes for establishing and maintaining this category of eligibility are found in the affordable care general provision chapter located at 8.291.400 NMAC through 8.291.430 NMAC.
[8.291.410.6 NMAC - Rp, 8.291.410.6 NMAC, 10/1/2017]

8.291.410.7 DEFINITIONS: Refer to 8.291.400.7 NMAC.
[8.291.410.7 NMAC - Rp, 8.291.410.7 NMAC, 10/1/2017]

8.291.410.8 MISSION: [~~To transform lives. Working with our partners, we design and deliver innovative, high-quality health and human services that improve the security and promote independence for New Mexicans in their communities.~~] We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.
[8.291.410.8 NMAC - Rp, 8.291.410.8 NMAC, 10/1/2017; A, 1/1/2022]

8.291.410.9 GENERAL RECIPIENT REQUIREMENTS: To be eligible for MAP, applicants or recipients must meet specific requirements as outlined in this part.
[8.291.410.9 NMAC - Rp, 8.291.410.9 NMAC, 10/1/2017]

8.291.410.10 USE OF SOCIAL SECURITY NUMBER: Refer to 8.200.410.10 NMAC.
[8.291.410.10 NMAC - Rp, 8.291.410.10 NMAC, 10/1/2017]

8.291.410.11 AGE: The age of the applicant recipient is verified to determine if [~~he or she is~~] they are under or over the specified age limit.

A. Age of child: Verification of age, including self-attestation of an applicant or recipient under 21 years of age is mandatory for MAP enrollment.

B. Age of adults: Age of an applicant or recipient 21 years of age or older is verified if questionable.

C. Documents that can be used to verify age can be found in 8.100.130 NMAC.

[8.291.410.11 NMAC - Rp, 8.291.410.11 NMAC, 10/1/2017; A, xx/xx/xxxx]

8.291.410.12 RELATIONSHIP: Verification of relationship is mandatory, see 8.291.410.20 NMAC

A. Documents that can be used to verify relationship can be found at 8.100.130 NMAC.

B. The documentary evidence must contain the names of related individuals in question.

(1) If the relative is other than a parent, the relationship must be traced if questionable.

(2) In situations in which both parents are living in the home and the father's paternity has not been established by operation of law or determined through court order, it will be necessary to establish the relationship of the applicant or recipient under 21 years of age to the father by completion of the [~~HSD~~] HCA child support enforcement division (CSED) acknowledgment of paternity packet.

(3) If the child is living with a relative, it will be necessary to establish the relationship of the absent parents. A CSED acknowledgement of paternity will be an acceptable means of establishing relationship.

C. The following relatives are within the fifth degree of relationship:

(1) father (biological or adoptive);

(2) mother (biological or adoptive);

(3) grandfather, great grandfather, great great grandfather, great great great grandfather;

(4) grandmother, great grandmother, great great grandmother, great great great grandmother;

(5) spouse of child's parent (stepparent);

(6) spouse of child's grandparent, great grandparent, great great grandparent, great great great grandparent (step grandparent);

(7) brother, half-brother, brother-in-law, step-brother;

(8) sister, half-sister, sister-in-law, step-sister;

(9) uncle of the whole or half blood, uncle-in-law, great uncle, great great uncle;

(10) aunt of the whole or half blood, aunt-in-law, great aunt, great great aunt;

(11) first cousin and spouse of first cousin;

(12) son or daughter of first cousin (first cousin once removed);

(13) son or daughter of great aunt or great uncle (first cousin once removed) and spouse; or

(14) nephew or niece and spouses.

D. Effect of divorce or death on relationship: A relationship based upon marriage, such as the "in-law" or "step" relationships, continues to exist following the dissolution of the marriage by divorce or death.

[8.291.410.12 NMAC - Rp, 8.291.410.12 NMAC, 10/1/2017; A, xx/xx/xxxx]

8.291.410.13 IDENTITY: Refer to 8.200.410.12 NMAC.

[8.291.410.13 NMAC - Rp, 8.291.410.13 NMAC, 10/1/2017]

8.291.410.14 CITIZENSHIP/NON-CITIZEN STATUS: Refer to 8.200.410.12 NMAC.

[8.291.410.14 NMAC - Rp, 8.291.410.14 NMAC, 10/1/2017; A, 1/1/2022]

8.291.410.15 RESIDENCE: To meet MAP requirements for eligibility, applicants or recipients must be living in New Mexico on the date of application or final determination of eligibility and have demonstrated an intention to remain in the state.

A. Establishing residence: Residence in New Mexico is established by living in the state and carrying out the types of activities associated with day-to-day living, such as occupying a home, enrolling child(ren) in school, getting a state driver's license, or renting a post office box. An applicant or recipient who is homeless is considered to have met the residence requirements if he or she intends to remain in the state.

B. Recipients receiving benefits out-of-state: Applicants or recipients who receive financial or medical assistance in another state which makes residence in that state a condition of eligibility are considered residents of that state until the ISD office receives verification from the other state agency indicating that it has been notified by an applicant or recipient of the abandonment of residence in that state.

C. Applicants or recipients court ordered into full or partial responsibility of the state children youth and families department (CYFD): When CYFD places an applicant or recipient in a new state of residence, the new state of residence is responsible for the provision of medicaid; however, New Mexico must provide limited coverage for services that are part of the New Mexico MAD benefit package and not available in the new state of residence.

D. Abandonment: Residence is not abandoned by temporary absences. Temporary absences occur when applicants or recipients leave New Mexico for specific purposes with time-limited goals. An applicant or recipient may be temporarily absent from the state is the person intends to return when the purpose of the absence has been accomplished, unless another state has determined [~~he or she is~~] they are a resident there for the purposes of MAP enrollment. Residence is considered abandoned when the applicant or recipient leaves New Mexico for any of the following reasons:

(1) intends to establish residence in another state;

(2) for no specific purpose with no clear intention of returning;

(3) applies for financial, food or medical assistance in another state which makes residence in that state a condition of eligibility; or

(4) for more than 30 calendar days, without notifying [~~HSD of his or her~~] HCA of their departure or intention of returning.

E. Dispute in residency: If there is a dispute in state residency, the applicant or recipient may be considered a resident in the state in which [~~he or she is~~] they are physically located.

F. Evidence of immigration status may not be used to determine that an individual is not a state resident per 42 CFR. 435.956 (c)(2).

[8.291.410.15 NMAC - Rp, 8.291.410.15 NMAC, 10/1/2017; A, xx/xx/xxxx]

8.291.410.16 NON-CONCURRENT RECEIPT OF ASSISTANCE: A MAP applicant or recipient receiving medicaid in another state is not eligible for MAP enrollment in accordance with 8.200.410 NMAC.

[8.291.410.16 NMAC - Rp, 8.291.410.16 NMAC, 10/1/2017]

8.291.410.17 APPLICATIONS FOR OTHER BENEFITS: As a condition of eligibility, a MAP applicant or recipient must take all necessary steps to obtain any benefits [~~he or she is~~] they are entitled to in accordance with 8.200.410 NMAC.

[8.291.410.17 NMAC - Rp, 8.291.410.17 NMAC, 10/1/2017; A, xx/xx/xxxx]

8.291.410.18 APPLICATIONS (42 CFR 435.907):

A. Basis and implementation. In accordance with section 1413(b)(1)(A) of the Affordable Care Act, [~~HSD will~~] the HCA must accept an application from the applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603, or family, as defined in section 36B(d)(1) of the Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant, and any documentation required to establish eligibility:

(1) Via the internet web site;

(2) By telephone;

(3) Via mail;

(4) In person; and

(5) Through other commonly available electronic means.

B. The application must be:

(1) The single, streamlined application for all insurance affordability programs or

(2) An alternative single, streamlined application for all insurance affordability programs, which may be no more burdensome on the applicant than the application described in Paragraph (1) of Subsection B of 8.291.410.18 NMAC. [~~HSD~~] HCA uses the [~~HSD~~] HCA 100 and MAD 100 application forms, and Your Eligibility System NM (Yes NM).

C. For individuals applying, or who may be eligible, for assistance on a basis other than the applicable modified adjusted gross income (MAGI) standard in accordance with 42 CFR435.911 [~~HSD~~] the HCA will use an application described in Subsection B of 8.291.410.18 NMAC and supplemental forms to collect additional information needed to determine eligibility on such other basis.

D. [~~HSD~~] The HCA may not require an in-person interview as part of the application process for a determination of eligibility using MAGI-based income.

E. Limits on information: [~~HSD~~] The HCA will only require an applicant to provide the information necessary to make an eligibility determination or for a purpose directly connected to the administration of the state plan.

F. [~~HSD~~] The HCA accepts on applications electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission.

[8.291.410.18 NMAC - Rp, 8.291.410.18 NMAC, 10/1/2017; A, xx/xx/xxxx]

8.291.410.19 Periodic renewal of medicaid eligibility (42 CFR 435.916):

A. Renewal of individuals whose medicaid eligibility is based on MAGI.

(1) Except as provided in Subsection D of 8.291.410.19 NMAC, the eligibility of medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months, and no more frequently than once every 12 months. The other adults category is renewed once every six months for renewals initiated on or after January 1, 2027, except for native americans who are renewed once every 12-months.

(2) Renewal on basis of information available to [~~HSD~~] HCA. [~~HSD~~] HCA will make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to [~~HSD~~] HCA, including but not limited to information accessed through any data bases accessed by [~~HSD~~] HCA under 42 CFR 435.948, 435.949 and 435.956. If the [~~HSD~~] HCA is able to renew eligibility based on such information, [~~HSD~~] HCA will notify the individual:

(a) Of the eligibility determination, and basis; and

(b) That the individual must inform the [~~HSD~~] HCA, through any of the modes permitted for submission of applications under 42 CFR 435.907(a) and Subsection A of 8.291.410.18 NMAC, if any of the information contained in such notice is inaccurate, but that the individual is not required to sign and return such notice if all information provided on such notice is accurate.

(3) Use of a pre-populated renewal form. If [~~HSD~~] HCA cannot renew eligibility in accordance with Paragraph (2) of Subsection A of 8.291.410.19 NMAC, [~~HSD~~] HCA will:

(a) Provide the individual with:

(i) A renewal form containing information available to [~~HSD~~] HCA that is needed to renew eligibility.

(ii) At least 30 days from the date of the renewal form to respond and provide any necessary information through any of the modes of submission specified in 42 CFR 435.907(a) and 8.291.410.18(A) NMAC and to sign the renewal form in a manner consistent with 42 CFR 435.907(f) and Subsection F of 8.291.410.18 NMAC.

(iii) Notice of the [~~HSD~~] HCA decision concerning the renewal of eligibility.

(b) Verify any information provided by the beneficiary in accordance with 42 CFR 435.945 through 435.956.

(c) Reconsider in a timely manner the eligibility of an individual who is terminated for failure to submit the renewal form or necessary information, if the individual subsequently submits the renewal form within 90 days after the date of termination without requiring a new application;

(d) Not require an individual to complete an in-person interview as part of the renewal process.

B. Redetermination of individuals whose medicaid eligibility is determined on a basis other than modified adjusted gross income: [~~HSD~~] HCA will redetermine the eligibility of medicaid beneficiaries excepted from modified adjusted gross income per 42 CFR 435.603, for circumstances that may change, at least every 12 months. [~~HSD~~] HCA will make a redetermination of eligibility in accordance with the provisions of Paragraph (2) of Subsection A of 8.291.410.19 NMAC, if sufficient information is available to do so. [~~HSD~~] HCA adopts the procedures described at 42 CFR 435.916(a)(3) for individuals whose eligibility cannot be renewed in accordance with Paragraph (3) of Subsection A of 8.291.410.19 NMAC.

(1) [~~HSD~~] HCA will consider blindness as continuing until the reviewing physician under 42 CFR 435.531 determines that a beneficiary's vision has improved beyond the definition of blindness contained in the plan; and

(2) [~~HSD~~] HCA will consider disability as continuing until the review team, under 42 CFR 435.541, determines that a beneficiary's disability no longer meets the definition of disability contained in the plan.

C. Procedures for reporting changes: [~~HSD~~] HCA has procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility and that such changes may be reported through any of the modes for submission of applications described in 43 CFR 435.907(a) and Subsection A of 8.291.410.18 NMAC.

D. [~~HSD~~] HCA action on information about changes: Consistent with the requirements of 42 CFR 435.952, [~~HSD~~] HCA will promptly redetermine eligibility between regular renewals of eligibility described in Subsections B and C of 8.291.410.19 NMAC whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility. Auto renewal is only applicable to the following medicaid categories: working disabled individuals, qualified medicare beneficiaries, specified low income medicare beneficiary, qualified individuals, parent caretaker, pregnant women, children's medicaid, children's health insurance program (CHIP), pregnancy related services, other adult and family planning.

(1) For renewals of medicaid beneficiaries whose financial eligibility is determined using MAGI-based income, the agency must limit any requests for additional information from the individual to information relating to such change in circumstance.

(2) If [~~HSD~~] the HCA has enough information available to it to renew eligibility with respect to all eligibility criteria, the [~~HSD~~] HCA will begin a new 12-month renewal period [~~.~~] except for the other adults category which will begin a new six-month renewal period. Native Americans on the other adults category will begin a new 12-month renewal period.

(3) If [~~HSD~~] HCA has information about anticipated changes in a beneficiary's circumstances that may affect [~~his or her~~] their eligibility, [~~HSD~~] HCA will redetermine eligibility at the appropriate time based on such changes.

E. [~~HSD~~] HCA will request from beneficiaries only the information needed to renew eligibility. Requests for non-applicant information must be conducted in accordance with 42 CFR 435.907.

F. Determination of ineligibility and transmission of data pertaining to individuals no longer eligible for medicaid.

(1) Prior to making a determination of ineligibility, [~~HSD~~] HCA will consider all bases of eligibility, consistent with 42 CFR 435.911.

(2) For individuals determined ineligible for medicaid, the agency must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200.

G. Any renewal form or notice will be accessible to persons who are limited english proficient and persons with disabilities, consistent with 42 CFR 435.905.

[8.291.410.19 NMAC - N, 10/1/2017; A, xx/xx/xxxx]

8.291.410.20 VERIFICATION METHODS: Verification will be obtained through various methods. Not all methods will necessarily be used in each case. This section details the specific types of methods to be used in establishing the applicant or recipient's eligibility.

A. Prior case data not subject to change: Verification of an eligibility factor not subject to change, which previously has been verified and accepted, will not be subject to re-verification. The caseworker shall not ask an applicant or recipient for verification of any eligibility factors which have previously been established through documents in [~~HSD's~~] HCA's possession and are not subject to change. Such factors include U.S. citizenship, birth date, relationship and enumeration.

B. Electronic data: Every applicant or recipient shall be informed that the information provided is subject to verification through state, federal and contracted data systems. The caseworker shall not require further verification of such information unless it is disputed by the applicant or recipient, or the information is otherwise questionable as defined in 8.100.130 NMAC.

C. Self-attestation is the information that an applicant or recipient reports on an application and is certifying as true and correct to the best of their knowledge.

D. Documentary evidence is the primary source of verification for information not established in prior case information or electronic source data. Obtaining necessary verification through documentary evidence readily available to the applicant or recipient shall always be explored before collateral contacts or sworn statements are used. Documentary evidence consists of a written confirmation of a household's circumstances. Acceptable verification is not limited to any single type of document. The types of documents which may be accepted as verification are specified under the sections pertaining to verification methods later in this chapter. The caseworker shall provide applicants or recipients with receipts for verification documents provided subsequent to the interview.

E. Collateral contact is defined at 8.100.130 NMAC.

F. Sworn statement is defined at 8.100.130 NMAC.

[8.291.410.20 - Rp, 8.291.410.19, 10/1/2017; A, xx/xx/xxxx]

8.291.410.21 VERIFICATION STANDARDS: Below is a list of standards [~~HSD~~] HCA will utilize to determine eligibility for MAP categories defined at 8.291.400.10 NMAC. If verification cannot be confirmed utilizing the various methods described in each section of this rule, [~~HSD~~] HCA may request additional information. If information is provided and becomes questionable as defined at 8.100.130 NMAC, then additional documentation must be provided as described by 8.100.130 NMAC.

A. Income: Verification of income is mandatory for ACA related MAP and [~~HSD~~] HCA will utilize electronic sources and documents provided by the applicant or recipient to verify [~~his or her~~] their income. Examples of acceptable documentation can be found at 8.100.130 NMAC.

B. Residency: Self attestation is an acceptable form of verification of residency.

C. Age: Self attestation is an acceptable form of verification of age.

D. Enumeration: [~~HSD~~] HCA will utilize electronic sources to verify an applicant or recipient's enumeration.

E. Citizenship: [~~HSD~~] HCA will utilize electronic sources to verify an applicant or recipient's citizenship.

F. Immigration status: [~~HSD~~] HCA will utilize electronic sources to verify an applicant or recipient's immigration status.

G. Relationship: Self attestation is an acceptable form of verification of relationship.

H. Receipt of other benefits: [~~HSD~~] HCA will utilize electronic sources to verify an applicant or recipient's receipt of other benefits.

[8.291.410.21 - Rp, 8.291.410.20, 10/1/2017; A, xx/xx/xxxx]

8.291.410.22 VERIFYING FINANCIAL INFORMATION (42 CFR 435.948):

A. [~~HSD~~] HCA will request the following information relating to financial eligibility from other agencies in the state and other states and federal programs to the extent [~~HSD~~] HCA determines such information is useful to verifying the financial eligibility of an individual.

(1) Information related to wages, net earnings from self-employment, unearned income and resources from the state wage information collection agency (SWICA), the internal revenue service (IRS), the social security administration (SSA), the agencies administering the state unemployment compensation laws, the state-administered supplementary payment programs under section 1616(a) of the Act, and any state program administered under a plan approved under Titles I, X, XIV, or XVI of the Act; and

(2) Information related to eligibility or enrollment from the supplemental nutrition assistance program (SNAP), the state program funded under Part A of Title IV of the Act, and other insurance affordability programs.

B. To the extent that the information identified in Subsection A of 8.291.410.22 NMAC is available through the electronic service established in accordance with 8.291.410.23 NMAC [~~HSD~~] HCA will obtain the information through such service.

C. [~~HSD~~] HCA will request the information by SSN, or if an SSN is not available, using other personally identifying information in the individual's account, if possible.

[8.291.410.22 NMAC - N, 10/1/2017; A, xx/xx/xxxx]

8.291.410.23 VERIFICATION OF INFORMATION THROUGH AN ELECTRONIC SERVICE (42 CFR 435.949(a) and (b)): The federal government will establish an electronic service through which [~~HSD~~] HCA may verify certain information with, or obtain such information from, federal agencies and other data sources, including SSA, the department of treasury, and the department of homeland security. To the extent that information related to eligibility for medicaid is available through the electronic service, [~~HSD~~] HCA must obtain the information through such service.

[8.291.410.23 NMAC - N, 10/1/2017; A, xx/xx/xxxx]

8.291.410.24 USE OF INFORMATION AND REQUESTS OF ADDITIONAL INFORMATION FROM INDIVIDUALS (42 CFR 435.952):

A. [~~HSD~~] HCA will promptly evaluate information received or obtained by it in accordance with regulations per 42 CFR 435.940 through 435.960 to determine whether such information may affect the eligibility of an individual or the benefits to which [~~he or she is~~] they are entitled.

B. If information provided by or on behalf of an individual (on the application or renewal form or otherwise) is reasonably compatible with information obtained by [~~HSD~~] HCA in accordance with 42. CFR 435.948, 435.949 or 435.956 [~~HSD~~] HCA will determine or renew eligibility based on such information.

C. An individual must not be required to provide additional information or documentation unless information needed by the agency [~~HSD~~] HCA in accordance with 42 CFR 435.948, 435.949 or 435.956 cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as provided in the verification plan described in 8.291.410.24 NMAC with information provided by or on behalf of the individual.

(1) Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold.

(2) If information provided by or on behalf of an individual is not reasonably compatible with information obtained through an electronic data match, [~~HSD~~] HCA must seek additional information from the individual including:

(a) A statement which reasonably explains the discrepancy; or

(b) Other information (which may include documentation), provided that documentation from the individual is permitted only to the extent electronic data are not available and establishing a data match would not be effective, considering such factors as the administrative costs associated with establishing and using the data match compared with the administrative costs associated with relying on paper documentation, and the impact on program integrity in terms of the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage.

(c) [~~HSD~~] HCA must provide the individual a reasonable period, defined as 10 calendar days, to furnish any additional information required under Subsection C of 8.291.410.24 NMAC.

(3) Exception for special circumstances. [~~HSD~~] HCA must establish an exception to permit, on a case-by-case basis, self-attestation of individuals for all eligibility criteria when documentation does not exist at the time of application or renewal, or is not reasonably available, such as in the case of individuals who are homeless or have experienced domestic violence or a natural disaster. This exception does not apply if documentation is specifically required under title XI or XIX, such as requirements for verifying citizenship and immigration status.

D. [~~HSD~~] HCA may not deny or terminate eligibility or reduce benefits for any individual on the basis of information received in accordance with regulations under 42 CFR 435.940 through 435.960 of this subpart unless [~~HSD~~] HCA has sought additional information from the individual in accordance with Subsection C of 8.291.410.24 NMAC and provided proper notice and hearing rights to the individual.

[8.291.410.24 NMAC - N, 10/1/2017; A, xx/xx/xxxx]

8.291.410.25 VERIFICATION PLAN: [~~HSD~~] HCA has a verification plan describing the verification policies and procedures to implement the provisions set forth in 42 CFR 435.940 through 435.956 and 8.100.130 and 8.291.410 NMAC. The state verification plan is posted on the [~~HSD~~] HCA website.

[8.291.410.25 NMAC - N, 10/1/2017; A, xx/xx/xxxx]

8.291.410.26 TIMEFRAME FOR DISPOSITION: An applicant or recipient is given a timeframe to provide necessary verification in order for ISD to process an application within the timeframe set forth in this section. This requirement pertains to requests for verification for initial applications as well as for verification for ongoing eligibility. ISD shall make an eligibility decision within three working days of the receipt of all necessary verification.

A. The application disposition deadline for MAP is 45 days from the date of application.

(1) Day one: the date of application is the first day.

(2) No later than day 44, or by the preceding work day if day 44 falls on a weekend or holiday:

(a) if verification provided establishes eligibility or ineligibility; or

(b) if the day following day 44 is not a work day, then decision must be made earlier than day 44 to allow for mailing on or before the deadline.

(3) No later than day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is not provided until day 42 - 44.

(4) Day 45 by the next work day if day 45 falls on a weekend or holiday, if needed verification is provided on day 45, or is not provided.

(5) After day 45:

(a) When an applicant or recipient requests one or more 10-calendar day extensions of time to provide needed verification. An applicant or recipient is entitled to receive up to three 10- calendar day extensions of time upon request.

(b) The eligibility decision must be made as soon as possible and within three working days of receipt of all necessary verification.

B. Tracking the application processing time limit: The application processing time limit begins on the day the signed application is received in the ISD county office.

C. Delayed determination: If an eligibility determination is not made within the required application processing time limit, the applicant or recipient shall be notified in writing of the reason for the delay and that the applicant or recipient has the right to request a [~~HSD~~] HCA administrative hearing regarding ISD's failure to act within the time limit.

D. Extensions of time: Up to three 10-calendar day extensions for providing verification shall be granted at the applicant or recipient's request. The extension begins at the end of the application processing time period or at the end of the previous extension.

E. Lack of verification: If verification needed to determine eligibility is not provided and no extension of time is requested, the application will be denied on the 45th day after the application date or by the next work day if 45th day falls on weekend or holiday.

F. Per 42 CFR 435.912(c)(3) the determination of eligibility for any medicaid applicant may not exceed:

(1) [~~ninety~~] 90 days for applicants who apply for medicaid on the basis of disability; and

(2) [~~forty-five~~] 45 days for all other medicaid applicants.

G. Per 42 CFR 435.912(g) [~~HSD~~] HCA may not use the time standards cited at Subsection F of 8.291.410.26 NMAC:

(1) as a waiting period before determining eligibility; or

(2) as a reason for denying eligibility (because it has not determined eligibility within the time standards.

H. Case documentation (42 CFR 435.914).

(1) [~~HSD~~] HCA includes in each applicant's case record facts to support the agency's decision on the application.

(2) [~~HSD~~] HCA disposes of each application by a finding of eligibility or ineligibility, unless:

(a) there is an entry in the case record that the applicant voluntarily withdrew the application, and that [~~HSD~~] HCA sent a notice confirming the decision;

(b) there is a supporting entry in the case record that the applicant has died; or

(c) there is a supporting entry in the case record that the applicant cannot be located.

[8.291.410.26 - Rp 8.291.410.21, 10/1/2017; A, xx/xx/xxxx]

8.291.410.27 HCA action on updated address information (42 CFR 435.919(f)):

A. Updated address information received from a third party:

(1) The HCA must have a process in place to regularly obtain updated address information from reliable data sources and to act on such updated address information in accordance with Subsection B and C of 8.291.410.27 NMAC.

(2) The HCA may establish a process to obtain updated address information from other third-party data sources and to act on such updated address information in accordance with Subsection B and C of 8.291.410.27 NMAC.

(3) Reliable data sources include:

(a) Mail returned to the HCA by the United States Postal Service (USPS) with a forwarding address;

(b) The USPS national change of address (NCOA) database;

(c) The HCA's contracted managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), primary care case managers (PCCMs), and PCCM entities, provided the MCO, PIHP, PAHP, PCCM, or PCCM entity received the information directly from or verified it with the beneficiary; and

(d) Other data sources identified by the HCA and approved by the secretary.

B. In-state address changes: The following actions are required when the HCA receives updated in-state address information for a beneficiary.

(1) If the information is provided by a reliable data source, the HCA must:

(a) accept the information as reliable;

(b) update the beneficiary's case record; and

(c) notify the beneficiary of the update.

(2) If the information is provided by a data source not described in Paragraph (3) of Subsection A of 8.291.410.27 NMAC, the HCA must check the HCA's medicaid enterprise system (MES) and the most recent address information received from reliable data sources to confirm the accuracy of the information.

(3) If the updated address information is confirmed, the HCA must accept the information as reliable.

(4) If the updated address information is not confirmed by the MES or a reliable data source, the HCA must make a good-faith effort, as described in Subsection E of 8.291.410.27 NMAC, to contact the beneficiary to confirm the information.

(5) If the HCA is unable to confirm the updated address information, the HCA may not update the beneficiary's address in the case record or terminate the beneficiary's coverage for failure to respond to a request to confirm their address or state residency.

C. Out-of-state address changes: The following actions are required when the HCA receives updated out-of-state address information for a beneficiary:

(1) The HCA must make a good-faith effort, as described in Subsection E of 8.291.410.27 NMAC, to contact the beneficiary to confirm the information or obtain information on whether the beneficiary continues to meet the HCA's state residency requirement.

(2) If the HCA is unable to confirm that the beneficiary continues to meet state residency requirements, the HCA must provide advance notice of termination and fair hearing rights.

(D) Whereabouts unknown: The following actions are required when beneficiary mail is returned to the HCA with no forwarding address:

(1) The HCA must check the HCA's MES and the most recently available information from reliable data sources for additional contact information. If updated in-state address information is available from such a reliable data source, then accept the information as reliable.

(2) If updated address information cannot be obtained and confirmed as reliable, the HCA must make a good-faith effort, as described in Subsection E of 8.291.410.27 NMAC, to contact the beneficiary to obtain updated address information.

(3) If the HCA is unable to identify and confirm the beneficiary's address and the beneficiary's whereabouts remain unknown, the HCA must take appropriate steps to move the beneficiary to a fee-for-service delivery system, or to terminate or suspend the beneficiary's coverage.

(4) If the HCA elects to terminate or suspend coverage the HCA must send notice to the beneficiary's last known address or via electronic notification no later than the date of termination or suspension and provide notice of fair hearing rights.

(5) If whereabouts of a beneficiary whose coverage was terminated or suspended in accordance become known within the beneficiary's eligibility period, as defined at 42 CFR 435.916(b), the HCA:

(a) Must reinstate coverage back to the date of termination without requiring the individual to provide additional information to verify their eligibility, unless the HCA has other information available to it that indicates the beneficiary may not meet all eligibility requirements.

(b) May begin a new eligibility period if the HCA has sufficient information available to it to renew eligibility with respect to all eligibility criteria without requiring additional information from the beneficiary

E. A good-faith effort to contact a beneficiary: A good-faith effort includes:

(1) at least two attempts to contact the beneficiary;

(2) use of two or more modalities (such as, mail, phone, email);

(3) a reasonable period of time between contact attempts; and

(4) at least 30 calendar days for the beneficiary to respond to confirm updated address information. If the HCA does not have the information necessary to make at least two attempts to contact a beneficiary through two or more modalities, the HCA must make a note of that fact in the beneficiary's case record.

HISTORY OF 8.291.410 NMAC:

History of Repealed Material:
8.291.410 NMAC, General Recipient Requirements, filed 9/17/2013 - Duration expired 12/31/2013.
8.291.410 NMAC, General Recipient Requirements, filed 12/17/2013 – Repealed effective 10/1/2017.

NMAC History:
8.291.410 NMAC, General Recipient Requirements, filed 12/17/2013 was replaced by 8.291.410 NMAC, General Recipient Requirements effective 10/1/2017.