TITLE 8 SOCIAL SERVICES
CHAPTER 234 MEDICAID ELIGIBILITY - SSI INELIGIBILITY - DUE TO INCOME OR RESOURCES FROM AN ALIEN SPONSOR
PART 600 BENEFIT DESCRIPTION

8.234.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.234.600.1 NMAC - Rp, 8.234.600.1 NMAC, 1-1-14]

8.234.600.2 SCOPE: The rule applies to the general public.
[8.234.600.2 NMAC - Rp, 8.234.600.2 NMAC, 1-1-14]

8.234.600.3 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.
[8.234.600.3 NMAC - Rp, 8.234.600.3 NMAC, 1-1-14]

8.234.600.4 DURATION: Permanent.
[8.234.600.4 NMAC - Rp, 8.234.600.4 NMAC, 1-1-14]

8.234.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.234.600.5 NMAC - Rp, 8.234.600.5 NMAC, 1-1-14]

8.234.600.6 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 Chapter 8.100 NMAC, *General Provisions for Public Assistance Programs.*
[8.234.600.6 NMAC - Rp, 8.234.600.6 NMAC, 1-1-14]

8.234.600.7 DEFINITIONS: [RESERVED]

8.234.600.8 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.
[8.234.600.8 NMAC - N, 1-1-14]

8.234.600.9 BENEFIT DESCRIPTION: Under the eligibility Category 034, an eligible recipient receives the full range of medicaid covered services.
[8.234.600.9 NMAC - Rp, 8.234.600.9 NMAC, 1-1-14]

8.234.600.10 BENEFIT DETERMINATION:

A. Income support division (ISD) determines initial and ongoing eligibility.

B. Up to three months of retroactive medicaid coverage is provided to an applicant who has received a medicaid covered service during the retroactive period and who would have met applicable eligibility criteria had they applied earlier. Eligibility for each retroactive month is determined separately. An application for retroactive medicaid enrollment must be made within 180 calendar days from the date of the medicaid application.
[8.234.600.10 NMAC - Rp, 8.234.600.10 NMAC, 1-1-14]

8.234.600.11 INITIAL BENEFITS:

A. **Move during eligibility determination:** If an applicant moves to another county while the eligibility determination is pending, the county ISD office in which the application was originally registered shall transfer the case to the new responsible office.

B. **Delays in eligibility determination:** If an eligibility determination is not made within the time limit, the applicant is notified in writing of the reason for the delay. This notice also informs the applicant or re-determining recipient of the right to request an administrative hearing.
[8.234.600.11 NMAC - Rp, 8.234.600.11 NMAC, 1-1-14]

8.234.600.12 PERIODIC REDETERMINATIONS OF ELIGIBILITY:

A. A re-determination of eligibility is made every 12 months.

B. All changes that may affect eligibility must be reported within 10 calendar days from the date of the change as detailed in 8.200.430 NMAC.

[8.234.600.12 NMAC - Rp, 8.234.600.12 NMAC, 1-1-14]

8.234.600.13 SSI RETROACTIVE BENEFIT COVERAGE: Up to three months of retroactive medicaid coverage can be furnished to applicants who have received medicaid covered services during the retroactive period and would have met applicable eligibility criteria had they applied during the three months prior to the month of application [42 CFR 435.914].

A. **Application for retroactive benefit coverage:** Application for retroactive medicaid can be made by checking "yes" in the "application for retroactive medicaid payments" box on the application or re-determination of eligibility for medical assistance (MAD 381) form or by checking "yes" to the question "does anyone in your household have unpaid medical expenses in the last three months?" on the application for assistance (ISD 100 S) form. Applications for retroactive supplemental security income (SSI) medicaid benefits for recipients of SSI must be made by 180 days from the date of approval for SSI. Medicaid covered services which were furnished more than two years prior to approval are not covered.

B. **Approval requirements:** To establish retroactive eligibility, the income support specialist (ISS) must verify that all conditions of eligibility were met for each of the three retroactive months and that the applicant received medicaid covered services. Eligibility for each month is approved or denied on its own merits.

(1) Applicable benefit rate: The federal benefit rate (FBR) in effect during the retroactive months based on the applicant's living arrangements is applicable for retroactive medicaid eligibility determinations. See 8.200.520.10 NMAC. If the applicant's countable income in a given month exceed the applicable FBR, the applicant is not eligible for retroactive medicaid for that month. If the countable income is less that the FBR, the applicant is eligible on the factor of income for that month. A separate determination must be made for each of the three months in the retroactive period.

(2) Disability determination required: If a determination is needed of the date of onset of blindness or disability, the ISS must send a referral to disability determination services (ISD 305) to the disability determination unit.

C. **Notice:**

(1) Notice to applicant: The applicant must be informed if any of the retroactive months are denied.

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the ISS must notify the recipient that he or she is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the recipient does not inform all providers and furnish verification of eligibility which can be used for billing and the provider consequently does not submit the billing within 120 days from the date of approval of retroactive coverage, the recipient is responsible for payment of the bill.

[8.234.600.13 NMAC - Rp, 8.234.600.13 NMAC, 1-1-14]

HISTORY OF 8.234.600 NMAC:

History of Repealed Material:

8.234.600 NMAC, Benefit Description, filed 9-3-13 - Repealed effective 1-1-14.