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TITLE 8 SOCIAL SERVICES
CHAPTER 245 MEDICAID ELIGIBILITY - SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMB) (CATEGORY 045)
PART 600 BENEFIT DETERMINATION

8.245.600.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.245.600.1 NMAC - Rn, 8 NMAC 4.SMB.000.1, 12/1/09]

8.245.600.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.245.600.2 NMAC - Rn, 8 NMAC 4.SMB.000.2, 12/1/09]

8.245.600.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.245.600.3 NMAC - Rn, 8 NMAC 4.SMB.000.3, 12/1/09]

8.245.600.4 DURATION: Permanent
[2/1/95; 8.245.600.4 NMAC - Rn, 8 NMAC 4.SMB.000.4, 12/1/09]

8.245.600.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[2/1/95; 8.245.600.5 NMAC - Rn, 8 NMAC 4.SMB.000.5 & A, 12/1/09]

8.245.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[2/1/95; 8.245.600.6 NMAC - Rn, 8 NMAC 4.SMB.000.6, 12/1/09]

8.245.600.7 DEFINITIONS: [RESERVED]

8.245.600.8 MISSION: To reduce the impact on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[8.245.600.8 NMAC - N, 12/1/09]

8.245.600.9 BENEFIT DESCRIPTION: Most individuals 65 or older receive free medicare part A. Those who do not receive free part A can voluntarily enroll for hospital insurance coverage and pay the monthly premium. Medicaid does not pay the medicare part A monthly premium for this category of recipients. Voluntary enrollees for premium/conditional medicare part A must enroll for supplementary medical insurance, medicare part B, and pay that premium also. After an application for SLIMB benefits is approved, medicaid begins to pay the medicare part B premium. Applicants/recipients eligible for medicaid coverage under another medicaid category may also be eligible for SLIMB. SLIMB eligibility allows the state to receive federal matching funding for the purchase of medicare part B. Since payment of the medicare part B premium is the only benefit, no medicaid card is issued and there is no interaction with the medicaid claims processing contractor.
[2/1/95; 8.245.600.9 NMAC - Rn, 8 NMAC 4.SMB.600 & A, 12/1/09]

8.245.600.10 BENEFIT DETERMINATION: Application for SLIMB is made on the assistance application form. Applications are acted on and notice of action taken is sent to the applicant within 45 days of the application. Determination of SLIMB eligibility for current recipients of medicaid is made without a separate application. Recipients of supplemental security income (SSI) or qualified medicare beneficiaries are not eligible for SLIMB.
[2/1/95; 8.245.600.10 NMAC - Rn, 8 NMAC 4.SMB.620 &A, 12/1/09]

8.245.600.11 INITIAL BENEFITS: Eligibility begins the month the case is approved. When an eligibility determination is made, notice of the approval or denial is sent to the applicant. If the application is denied, this notice includes the recipient's right to request a hearing.
[2/1/95; 8.245.600.11 NMAC - Rn, 8 NMAC 4.SMB.623, 12/1/09]

8.245.600.12 ONGOING BENEFITS: A redetermination of eligibility is made every 12 months.
[2/1/95; 8.245.600.12 NMAC - Rn, 8 NMAC 4.SMB.624 & A, 12/1/09]

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

A. Application for retroactive benefit coverage: Application for retroactive medicaid is made by checking "yes" to the question on the application form about having unpaid medical bills in the three months prior to application for assistance. Applications for retroactive medicaid benefits must be made no later than 180 days from the date of application for assistance.

B. Approval requirements: To establish retroactive eligibility, the ISD worker must verify that all conditions of eligibility were met for each of the three retroactive months. Each month must be approved or denied on its own merit. In certain cases this may involve using the federal benefit rate (FBR) in effect during the retroactive months based on the applicant's living arrangement. See 8.200.520 NMAC, *Income Standards*.

C. Benefit coverage: Retroactive benefits in this category of eligibility are limited to the payment of the medicare part B premium only.

D. Disability determination required: If a determination is needed as of the date of onset of blindness or disability, the ISD caseworker must send a referral to the disability determination unit. Medical records for the requested months of determination must accompany the referral.

E. Notice:

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

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the ISD worker must notify the recipient that he/she is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the recipient does not inform all providers and furnish verification of eligibility which can be used for billing and the provider consequently does not submit the billing within 120 days from the date of approval of retroactive coverage, the recipient is responsible for payment of the bill.
[2/1/95; 8.245.600.13 NMAC - Rn, 8 NMAC 4.SMB.625 & A, 12/1/09]

8.245.600.14 CHANGES IN ELIGIBILITY: A case is closed, with provision of advance notice, whent the recipient becomes ineligible. If a recipient dies, the case is closed the following month.
[2/1/95; 8.245.600.14 NMAC - Rn, 8 NMAC 4.SMB.630, 12/1/09]

HISTORY OF 8.245.600 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center: MAD Rule 843, Specified Low Income Medicare Beneficiaries, filed 9/26/94.

History of Repealed Material: MAD Rule 843, Specified Low Income Medicare Beneficiaries, filed 9/26/94 - Repealed effective 2/1/95.