INDEX

8.232.600 BENEFIT DESCRIPTION

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TITLE 8 SOCIAL SERVICES
CHAPTER 232 MEDICAID ELIGIBILITY - CHILDREN UNDER 19: 185 PERCENT OR 235 PERCENT OF POVERTY GUIDELINES - CATEGORY 032
PART 600 BENEFIT DESCRIPTION

8.232.600.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.232.600.1 NMAC - Rn, 8 NMAC 4.KID.000.1, 7/1/04]

8.232.600.2 SCOPE: The rule applies to the general public
[2/1/95; 8.232.600.2 NMAC - Rn, 8 NMAC 4.KID.000.2, 7/1/04]

8.232.600.3 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; 8.232.600.3 NMAC - Rn, 8 NMAC 4.KID.000.3, 7/1/04]

8.232.600.4 DURATION: Permanent
[2/1/95; 8.232.600.4 NMAC - Rn, 8 NMAC 4.KID.000.4, 7/1/04]

8.232.600.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[2/1/95; 8.232.600.5 NMAC - Rn, 8 NMAC 4.KID.000.5, 7/1/04]

8.232.600.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[2/1/95; 8.232.600.6 NMAC - Rn, 8 NMAC 4.KID.000.6, 7/1/04]

8.232.600.7 DEFINITIONS: [RESERVED]

8.323.600.8 MISSION: To reduce the impact of poverty 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.
[8.323.600.8 NMAC - N/E, 10/1/09]

8.232.600.9 BENEFIT DESCRIPTION: A recipient who is eligible for medicaid under this category is eligible to receive the full range of medicaid-covered services. SCHIP recipients have copayment responsibilities, with a family maximum amount. It is the responsibility of the family to track and total the copayments made. Once the family yearly maximum amount has been paid by the family via copayments on medicaid covered services, the recipient must notify the medical assistance division. The first month that copayments are not required by the recipient is the month following the month in which it has been verified by the medical assistance division that the maximum amount has been met. If the determination is made after the twenty-fifth (25th) of the month, the change is made effective the second month after the request. No retroactive eligibility for the met copayment maximum" criteria is allowed. Subsequent to establishing that the copayment maximum amount has been met, the family is not responsible for payment of copayments for the remainder of that calendar year. Effective, July 1, 2000, Native American recipients under SCHIP are exempt from making copayments for medicaid-covered services.
[2/1/95; 3/1/99; 7/1/00; 8.232.600.9 NMAC - Rn, 8 NMAC 4.KID.600, 7/1/04]

8.232.600.10 BENEFIT DETERMINATION:

A. Eligibility for the application month and for each month between the application month and the month of approval must be determined in its own right.

B. Processing time limit: All applications must be processed within forty-five (45) days from the date of application. The time limit begins on the day the signed application is received. Applications must be acted upon and notice of approval, denial or delay sent out within the required time limit. The ISS explains the time limit and that the applicant may request an administrative hearing if the application pends longer than the time limit allows.

[2/1/95; 8.232.600.10 NMAC - Rn, 8 NMAC 4.KID.620, 7/1/04]

8.232.600.11 INITIAL BENEFITS: Notices of eligibility determinations are automatically generated and mailed to applicants/recipients.

A. **Move during eligibility determination:** If an applicant moves to another county while the eligibility determination is pending, the county income support division (ISD) office in which the application was originally registered transfers 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/recipient of the right to request an administrative hearing.

[2/1/95; 8.232.600.11 NMAC - Rn, 8 NMAC 4.KID.623, 7/1/04]

8.232.600.12 ONGOING BENEFITS: Periodic reviews are conducted every twelve (12) months. Those cases that have been certified in the last six (6) months, prior to the effective date of this regulation, shall have their eligibility extended for an additional six (6) months.

[2/1/95; 8.232.600.12 NMAC - Rn, 8 NMAC 4.KID.624 & A, 7/1/04; A, 7/1/06]

8.232.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three (3) months of retroactive medicaid coverage can be furnished to applicants/recipients who have received medicaid-covered services during the retroactive period and would have met applicable eligibility criteria had they applied during the three (3) months prior to the month of application [42 CFR Section 435.914] Retroactive medicaid for children 0 – 5 years of age applying the $750 earned income disregard or child care deduction in Paragraph (3) of Subsection A of 8.232.500.12 NMAC cannot be approved prior to August 1, 2006.

A. **Application for retroactive benefit coverage:** Application for retroactive medicaid can be made by checking "yes" to the question "does anyone in your household have unpaid medical expenses in the last three (3) months?" on the application for assistance (ISD 100 S) form or by checking "yes" to the question "does anyone have any unpaid medical bills from the past three months?" on the application for medical assistance for children and pregnant women (MAD 023) form. Applications for retroactive medicaid benefits must be made no later than 180 days from the date of application for assistance. Medicaid-covered services which were furnished more than two (2) years prior to application are not covered.

B. **Approval requirements:** To establish retroactive eligibility, the income support division worker must verify that all conditions of eligibility were met for each of the three (3) retroactive months and that the applicant received medicaid-covered services. Each month must be approved or denied on its own merits. Retroactive eligibility can be approved on either the ISD2 system or on the retroactive medicaid eligibility authorization (ISD 333) form.

C. **Notice:**

(1) **Notice to applicant:** The income support division worker must inform the applicant if any of the retroactive months are denied.

(2) Recipient responsibility to notify provider: After the retroactive eligibility has been established, the income support division 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; 4/1/95; 7/1/95; 8.232.600.13 NMAC - Rn, 8 NMAC 4.KID.625 & A, 7/1/04; A, 8-1-06]

8.232.600.14 CHANGES IN ELIGIBILITY:

A. **Eligibility termination when age limit reached:** If a recipient's eligibility ends because he/she turns 19 years of age and the recipient is receiving inpatient services in an acute care hospital on the date he/she turns 19 years of age, the recipient's eligibility continues until the end of that admission. If the recipient is an inpatient in a free-standing psychiatric facility or other residential facility, the recipient's eligibility continues until the end of the month in which the recipient turns 19 years of age. The income support division worker verifies that the closure is caused by the recipient's turning 19 years of age and terminates medicaid eligibility at the end of the applicable time period.

B. **Ongoing eligibility:** A redetermination of eligibility is made every 12 months. Changes in eligibility status will be effective the first day of the following month.

C. **Continuous eligibility:** Eligibility will continue for the 12-month certification period, regardless of changes in income. This provision applies even if it is reported that the family income exceeds the applicable federal income poverty guidelines. The 12 months of continuous medicaid starts with the month of approval or redetermination and is separate from any months of presumptive or retroactive eligibility. This provision does not apply when there is a death of a household member, the member or the family moves out of state or the child turns 19 years of age.

[2/1/95; 4/1/95; 6/30/98; 8.232.600.14 NMAC - Rn, 8 NMAC 4.KID.630 & A, 7/1/04; A, 7/1/06; A/E, 10/1/09; A, 10/30/09; A, 11/1/11]

HISTORY OF 8.232.600 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center.
ISD 290.1000, Medical Assistance for Woman and Children, filed 11/13/84.
ISD FA 830, Medical Assistance for Woman and Children and AFDC Related Groups, filed 2/10/88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups, filed 8/11/88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9/8/88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 9/30/88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12/1/88.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3/31/89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6/8/89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12/28/89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 12/29/89.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 3/1/91.
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6/5/92.