MEDICAID ELIGIBILITY – CHILDREN UNDER 19 – 235 PERCENT OR LOWER OF FEDERAL POVERTY GUIDELINES
BENEFIT DESCRIPTION
Tribal Consultation Version 9.18.13

TITLE 8 SOCIAL SERVICES
CHAPTER 232 MEDICAID ELIGIBILITY - CHILDREN UNDER 19 - 235 PERCENT OR LOWER OF FEDERAL POVERTY GUIDELINES
PART 600 BENEFIT DESCRIPTION

8.232.600.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.232.600.1 NMAC - Rp, 8.232.600.1 NMAC, 1-1-14]

8.232.600.2 SCOPE: The rule applies to the general public
[8.232.600.2 NMAC - Rp, 8.232.600.2 NMAC, 1-1-14]

8.232.600.3 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.
[8.232.600.3 NMAC - Rp, 8.232.600.3 NMAC, 1-1-14]

8.232.600.4 DURATION: Permanent.
[8.232.600.4 NMAC - Rp, 8.232.600.4 NMAC, 1-1-14]

8.232.600.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.232.600.5 NMAC - Rp, 8.232.600.5 NMAC, 1-1-14]

8.232.600.6 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 8.100 NMAC, *General Provisions for Public Assistance Programs*.
[8.232.600.6 NMAC - Rp, 8.232.600.6 NMAC, 1-1-14]

8.232.600.7 DEFINITIONS: [RESERVED]

8.232.600.8 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.
[8.232.600.8 NMAC - Rp, 8.232.600.8 NMAC, 1-1-14]

8.232.600.9 BENEFIT DESCRIPTION:

A. An eligible recipient child of an assistance unit with income less than 185 percent federal poverty level (FPL) guidelines receives the full range of medicaid services. No copayments are required of this eligibility category.

B. An eligible recipient child of an assistance unit with income that is greater than 185 percent and less than 235 percent of the FPL receives the full range of medicaid services. This eligibility category is known as the children's health insurance program (CHIP). Copayments are required for this eligibility category pursuant to 8.200.430 NMAC.

C. Applications received on or after January 1, 2014 for Category 032 will be evaluated for an Affordable Care Act category.

[8.232.600.9 NMAC - Rp, 8.232.600.9 NMAC, 1-1-14]

8.232.600.10 BENEFIT DETERMINATION:

A. A child may have a presumptive eligibility determination made by a MAD approved provider. Refer to 8.200.400.12 NMAC.

B. ISD determines initial and ongoing eligibility.

[8.232.600.10 NMAC - Rp, 8.232.600.10 NMAC, 1-1-14]

8.232.600.11 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.

[8.232.600.11 NMAC - Rp, 8.232.600.11 NMAC, 1-1-14]

8.232.600.12 ONGOING BENEFITS:

A. A redetermination of eligibility is made every 12 months.

B Continuous eligibility for a child is established at a 12-month period of eligibility for a child under age 19. Changes in family income are disregarded.

C. 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.

D. Recipients of Category 032 with a re-determination date of March 31, 2014 or prior will be re-determined for this category using existing Category 032 policy. Recipients with a re-determination date of April 1, 2014 or later will be re-determined for an Affordable Care Act category. Category 032 ends March 31, 2015.

[8.232.600.12 NMAC - Rp, 8.232.600.12 NMAC, 1-1-14]

8.232.600.13 RETROACTIVE BENEFIT COVERAGE: Up to three months of retroactive medicaid coverage can be furnished to an applicant or recipient who has 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 can be made 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 or ISDSP 101) 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 or MADSP 048) 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 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 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 eligibility system or on the retroactive medicaid eligibility authorization (MAD 333) form.

C. **Notice to applicant:** The income support division worker must inform the applicant if eligibility for any of the retroactive months is denied. Recipient responsibility to notify provider: After the retroactive eligibility has been established, the income support division worker 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.

[8.232.600.13 NMAC - Rp, 8.232.600.13 NMAC, 1-1-14]

8.232.600.14 CHANGES IN ELIGIBILITY:

A. **Eligibility termination when age limit reached:** If a recipient’s eligibility ends because he or she turns 19 years of age and the recipient is receiving inpatient services in an acute care hospital on the date he or 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 ISD 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 re-determination 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 FPL guidelines. The 12 months of continuous medicaid starts with the month of approval or re-determination 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.
[8.232.600.14 NMAC - Rp, 8.232.600.14 NMAC, 1-1-14]

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.

History of Repealed Material:
MAD Rule 830, Medical Assistance for Women and Children and AFDC - Related Groups; filed 6-5-92 - Repealed effective 2-1-95.
8.232.600 NMAC, Benefit Description, filed 6-16-04 - Repealed effective 1-1-14.