

**MAD-MR:** **EFF DATE: proposed**  
**MEDICAL ASSISTANCE PROGRAM ELIGIBILITY – QUALIFIED DISABLED INDIVIDUALS WHOSE**  
**INCOME EXCEEDS QMB AND SLIMB**  
**BENEFIT DESCRIPTION**  
**Tribal Consultation Version 9.18.13**

**TITLE 8 SOCIAL SERVICES**  
**CHAPTER 242 MEDICAL ASSISTANCE PROGRAM ELIGIBILITY - QUALIFIED DISABLED**  
**INDIVIDUALS WHOSE INCOME EXCEEDS QMB AND SLIMB**  
**PART 600 BENEFIT DESCRIPTION**

**8.242.600.1 ISSUING AGENCY:** New Mexico Human Services Department (HSD).  
[8.242.600.1 NMAC - Rp, 8.242.600.1 NMAC, 1-1-14]

**8.242.600.2 SCOPE:** The rule applies to the general public.  
[8.242.600.2 NMAC - Rp, 8.242.600.2 NMAC, 1-1-14]

**8.242.600.3 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.  
[8.242.600.3 NMAC - Rp, 8.242.600.3 NMAC, 1-1-14]

**8.242.600.4 DURATION:** Permanent.  
[8.242.600.4 NMAC - Rp, 8.242.600.4 NMAC, 1-1-14]

**8.242.600.5 EFFECTIVE DATE:** January 1, 2014, unless a later date is cited at the end of a section.  
[8.242.600.5 NMAC - Rp, 8.242.600.5 NMAC, 1-1-14]

**8.242.600.6 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*.  
[8.242.600.6 NMAC - Rp, 8.242.600.6 NMAC, 1-1-14]

**8.242.600.7 DEFINITIONS:** [RESERVED]

**8.242.600.8 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.  
[8.242.600.8 NMAC - N, 1-1-14]

**8.242.600.9 BENEFIT DESCRIPTION:** For Category 050, medicaid coverage is limited to payment of the medicare Part A premium. No medicaid card is issued.  
[8.242.600.9 NMAC - Rp, 8.242.600.9, 1-1-14]

**8.242.600.10 BENEFIT DETERMINATION:** Application for Category 050 is made on the assistance application form. Applications must be acted on and notice of action taken must be sent to the applicant within 45 days of *receipt of* the application.  
[8.242.600.10 NMAC - Rp, 8.242.600.10 NMAC, 1-1-14]

**8.242.600.11 INITIAL BENEFITS:** The effective date of eligibility for QD is based on the date of application and the date on which all eligibility criteria, including enrollment for medicare Part A, are met. Verification of the effective date of medicare Part A enrollment must be obtained from the social security administration (SSA). When the eligibility determination is made, notice of the approval or denial is sent to the applicant. If denied, this notice includes the reason for the denial and an explanation of rights to a hearing.  
[8.242.600.11 NMAC - Rp, 8.242.600.11 NMAC, 1-1-14]

**8.242.600.12 ONGOING BENEFITS:** A redetermination of eligibility must be made every 12 months.  
[8.242.600.12 NMAC - Rp, 8.242.600.12 NMAC, 1-1-14]

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**8.242.600.13 RETROACTIVE SSI 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 *who* 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” 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 NMAC. If the applicant’s countable income in a given month exceeds the applicable FBR, the applicant is not eligible for retroactive medicaid for that month. If the countable income is less than 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 for disability determination services (ISD 305) to the disability determination unit.

C. **Notice:**

(1) **Notice to applicant:** The applicant must be informed if eligibility in any of the retroactive months is denied.

(2) **Recipient responsibility to notify provider:** After the retroactive eligibility has been established, the ISS must notify the eligible recipient that he or she is responsible for informing all providers with outstanding bills of the retroactive eligibility determination. If the eligible recipient fails to 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 eligible recipient is responsible for payment of the bill.

[8.242.600.13 NMAC - Rp, 8.242.600.13 NMAC, 1-1-14]

**8.242.600.14 CHANGES IN ELIGIBILITY:** The case is closed when an eligible recipient becomes ineligible and is notified of the ineligibility in an advance notice. The case is closed in the month following the death of an eligible recipient.

[8.242.600.14 NMAC - Rp, 8.242.600.14 NMAC, 1-1-14]

**HISTORY OF 8.242.600 NMAC:**

**Pre-NMAC History:** The material in this part was derived from that previously filed with the State Records Center:

MAD Rule 842.00, Qualified Disabled Working Individuals, filed 10-11-90.

MAD Rule 842, Qualified Disabled Working Individuals, filed 6-30-92.

MAD Rule 842, Qualified Disabled Working Individuals, filed 9-26-94.

**History of Repealed Material:**

MAD Rule 842, Qualified Disabled Working Individuals, filed 9-26-94 - Repealed effective 2-1-95.

8.242.600 NMAC, Benefit Description, filed 9-15-13 - Repealed effective 1-1-14.