TITLE 8 SOCIAL SERVICES
CHAPTER 252 MEDICAID ELIGIBILITY - BREAST AND CERVICAL CANCER PROGRAM (CATEGORY 052)
PART 400 RECIPIENT POLICIES

8.252.400.1 ISSUING AGENCY: New Mexico Human Services Department.
[8.252.400.1 NMAC - N, 7/1/2002]

8.252.400.2 SCOPE: The rule applies to the general public.
[8.252.400.2 NMAC - N, 7/1/2002]

8.252.400.3 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 NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991)
[8.252.400.3 NMAC - N, 7/1/2002]

8.252.400.4 DURATION: Permanent
[8.252.400.4 NMAC - N, 7/1/2002]

8.252.400.5 EFFECTIVE DATE: July 1, 2002, unless a later date is cited at the end of a section.
[8.252.400.5 NMAC - N, 7/1/2002]

8.252.400.6 OBJECTIVE: The objective of these regulations is to provide eligibility policy and procedures for the medicaid program.
[8.252.400.6 NMAC - N, 7/1/2002]

8.252.400.7 DEFINITIONS: [**RESERVED**]

8.252.400.8 [[~~**RESERVED**~~]] **MISSION:** To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

8.252.400.9 BREAST AND CERVICAL CANCER (BCC) - Category 052: The human services department (HSD) is the single state agency designated to administer the medicaid program in New Mexico. The department of health (DOH) and the HSD are charged with developing and implementing a program for uninsured women under the age of 65 years, who have met screening criteria as set forth in the centers for disease control and prevention's (CDC) national breast and cervical cancer early detection program (NBCCEDP). The DOH is responsible for verifying that women referred for treatment have met screening requirements that include an income test of [~~250%~~] two hundred and fifty percent of the federal poverty guidelines, and diagnostic testing by a contracted CDC provider resulting in a diagnosis of breast or cervical cancer including pre-cancerous conditions. Women who have met CDC screening criteria and identified as needing treatment for a diagnoses of breast or cervical cancer, including pre-cancerous conditions will be referred for treatment that includes the completion of a medicaid application for the BCC program. The Breast and Cervical Cancer Prevention and Treatment Act allows states to extend presumptive eligibility to applicants in order to ensure that needed treatment begins as early as possible.
[8.252.400.9 NMAC - N, 7/1/2002; A, xx/xx/xxxx]

8.252.400.10 BASIS FOR DEFINING THE GROUP: Women who have been determined as having met CDC program screening requirements will be identified and referred for treatment. Public Law 106-354 does not provide eligibility for men diagnosed with cancer.
[8.252.400.10 NMAC - N, 7/1/2002]

8.252.400.11 GENERAL RECIPIENT REQUIREMENTS: Eligibility for the breast and cervical cancer program is always prospective. Women must meet, or expect to meet all medicaid and CDC financial and non-financial eligibility criteria in the month for which determination of eligibility is made.
[8.252.400.11 NMAC - N, 7/1/2002]

8.252.400.12 ENUMERATION: A woman must furnish her social security account number. Medicaid eligibility is denied or terminated for a woman who fails to furnish her social security number. If a woman does not have, a valid social security number, she must apply for one as a condition of medicaid eligibility. Presentation of the application for a social security number, or proof that an application has been made at a social security administration office, meets this requirement. A woman must provide her social security account number upon receipt of the number from SSA but no later than her next recertification.
[8.252.400.12 NMAC - N, 7/1/2002]

8.252.400.13 CITIZENSHIP: Refer to medical assistance program manual Section MAD 412, 412.1, and 412.2 (Section 11 of 8.200.410 NMAC). Women who do not meet citizenship eligibility criteria may be eligible to receive coverage for emergency services under the emergency medical services for undocumented ~~[aliens (EMSA)]~~ non-citizens (EMSNC) program.
[8.252.400.13 NMAC - N, 7/1/2002; A, xx/xx/xxxx]

8.252.400.14 RESIDENCE: To be eligible for medicaid, a woman must be physically present in New Mexico on the date of application or final determination of eligibility, and must have intent to remain in the state.

A. Establishing residence: Residence in New Mexico is established by living in the state and carrying out the types of activities normally indicating residency, such as occupying a home, enrolling child (ren) in school, getting a state driver's license, or renting a post office box. A woman who is homeless is considered to have met the residence requirements if she intends to remain in the state.

B. Recipients receiving benefits out-of-state: A women who receives medical assistance in another state is considered a resident of that state until the income support division (ISD) staff receives verification from the other state agency indicating that it has been notified by the woman of the abandonment of residence in that state.

C. Abandonment: Residence is not abandoned by temporary absences. Temporary absences occur when a woman leaves New Mexico for specific purposes with time-limited goals. Residence is considered abandoned when any of the following occurs:

(1) a woman leaves New Mexico and indicates that she intends to establish residence in another state;

(2) a woman leaves New Mexico for no specific purpose with no clear intention of returning;

(3) a woman leaves New Mexico and applies for financial, food or medical assistance in another state.

[8.252.400.14 NMAC - N, 7/1/2002]

8.252.400.15 NON-CONCURRENT RECEIPT OF ASSISTANCE: A woman may not be receiving assistance in another medicaid category.
[8.252.400.15 NMAC - N, 7/1/2002]

8.252.400.16 SPECIAL RECIPIENT REQUIREMENTS: A woman must have been screened and diagnosed with breast or cervical cancer or a pre-cancerous condition by a provider of the centers for disease control and prevention's (CDC) national breast and cervical cancer early detection program and be in need of treatment. Women identified as in need of treatment, will be given an application that includes the DOH's CDC contracted provider referral for treatment form. The DOH is responsible for verifying the referring physician is a contracted CDC provider.
[8.252.400.16 NMAC - N, 7/1/2002]

8.252.400.17 AGE: To be eligible for this category, a woman must be under 65 years of age. Medicaid eligibility ends the last day of the month a woman turns 65 years of age.
[8.252.400.17 NMAC - N, 7/1/2002]

8.252.400.18 THIRD PARTY LIABILITY: A woman must be uninsured.

A. A woman is considered uninsured when her health insurance policy has lifetime limits and she has exhausted those limits or, she is denied coverage due to a pre-existing condition.

B. Women with high deductibles, or limits on coverage, such as the limit of doctor visits or drug coverage that have not been exhausted are considered insured.

C. There is no penalty for dropping insurance.

[8.252.400.18 NMAC - N, 7/1/2002]

8.252.400.19 PRESUMPTIVE ELIGIBILITY: A woman may be eligible to receive medicaid services from the date the presumptive eligibility determination is made until the end of the month following the month in which the determination was made, for a period of up to 60 days. The purpose of the presumptive eligibility is to allow medicaid payment for health care services furnished to a woman while her application for medicaid is being processed. Only one presumptive eligibility period is allowed per twelve-month period. The period of presumptive eligibility begins when an approved presumptive eligibility provider establishes eligibility. Presumptive eligibility criteria are a simplified version of Category 052 eligibility requirements.

A. Processing presumptive eligibility information: The medical assistance division (MAD) authorizes certain providers to make presumptive eligibility determinations. The provider must notify MAD through its claims processing contractor of the determination within 24 hours of the determination of presumptive eligibility.

B. Provider responsibility: The presumptive eligibility provider must process both presumptive eligibility as well as an application for medical assistance for the woman.

C. Provider eligibility: Entities who may participate must be a CDC Title XV grantees are those entities receiving funds under a cooperative agreement with CDC to support activities related to the national breast and cervical cancer detection program.

[8.252.400.19 NMAC - N, 7/1/2002]

8.252.400.20 RECIPIENT RIGHTS AND RESPONSIBILITIES: A woman or her representative is responsible for establishing her eligibility for medicaid. As part of this responsibility, the woman must provide required information and documents, or take the actions necessary to establish eligibility. Failure to do so must result in a decision that eligibility does not exist. A woman must also grant the human services department (HSD) permission to contact other persons, agencies or sources of information necessary to establish eligibility. See 8.200.430 NMAC, *Recipient Rights and Responsibilities* for specific information.

[8.252.400.20 NMAC - N, 7/1/2002]

8.252.400.21 REPORTING REQUIREMENTS: A woman [~~and/or~~] or any other responsible party must:

A. report any changes in circumstances, which may affect the woman's eligibility within [~~ten (10)~~] 10 days of the date of the change to the county ISD office;

B. the ISD worker must evaluate the effect of the change and take any required action as soon as possible; however, the action must take effect no later than the end of the month following the month in which the change took place.

[8.252.400.21 NMAC - N, 7/1/2002]

HISTORY OF 8.252.400 NMAC: [RESERVED]