Michigan Department of Community Health

MDCH

Beneficiary Eligibility Bulletin

Distribution: Beneficiary Eligibility 01-03

Issued: October 1, 2001

Subject: Breast and Cervical Cancer Prevention and Treatment Program

Effective: October 1, 2001

Programs Affected: Medicaid

Recent federal legislation allows states the option of Medicaid coverage for females between the ages of 18 through 64 years who are participants in the Breast and Cervical Cancer Control Program (BCCCP). Medicaid coverage will allow participants to receive treatment for breast and/or cervical cancer after screening and diagnosis through the BCCCP.

For purposes of Medicaid eligibility, Michigan will use the eligibility determination of the BCCCP. This will allow women on limited incomes, without insurance coverage, or who have insufficient insurance coverage to receive medical treatment for breast and/or cervical cancer or a pre-cancerous condition.

Manual Maintenance

Retain this bulletin until further notice.

Questions

Any questions regarding this bulletin should be directed to: Eligibility Policy Section, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979. Questions and policy clarifications should be directed to (517) 241-7185.

Approved

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Medical Services Administration

BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT

LEGAL BASIS

SOCIAL SECURITY ACT, 42 USC 300 K et. seq.

DCH Appropriations Act

APPLICATION USED

Breast and Cervical Cancer Prevention and Treatment Program (DCH-1088)

TARGETED POPULATION

The population to be served are women:

- age 18 through 64,
- who have been screened for breast and/or cervical cancer under the Centers for Disease Control and Prevention early detection program established under Title XV of the Public Health Service Act, and
- who have been diagnosed with breast or cervical cancer or pre-cancerous condition as determined through the Title XV screening process.

EXCLUDED PERSONS

The beneficiary must not have creditable insurance coverage that covers treatment for breast and/or cervical cancer. Creditable coverage is, but is not limited to: Medicaid, Medicare, Armed Forces insurance, group health plan, state health risk pool, medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract.

EVS IDENTIFIER

BCCPTP program code “O” with scope/coverage of 1F or 1E and a worker load number of (to be determined).

NON-FINANCIAL FACTORS

In addition to meeting the age, screening and condition criteria identified above, the beneficiary must meet all non-financial factors in Chapter IV.

FINANCIAL FACTORS

Medicaid eligibility is based on the BCCPTP income standards and consistent with the Centers for Disease Control (CDC) guidelines.

There is no asset test.

GROUP COMPOSITION

Group composition consists of the beneficiary, the spouse, and their dependent children under the age of 18 years living in the home.

BUDGETING

There is no budget requirement for the Medicaid agency. Medicaid will use the certification of the BCCCP agency.

INCOME VERIFICATION

Income eligibility is determined by the BCCCP.

BEGIN DATE OF ELIGIBILITY

For Medicaid coverage, the begin date is the first day of the month in which eligibility is found, beginning with the month of application.

For retroactive Medicaid, eligibility can begin up to three months prior to the month of application. A retro-Medicaid application must be filed for each month requested. The beneficiary must meet program requirements for each month that retro-medical coverage has been requested.

Individuals who have been screened and diagnosed under the BCCCP program and need to receive cancer or pre-cancerous treatment may apply for Medicaid coverage under this program.

CONTINUING ELIGIBILITY

Medicaid eligibility must be reviewed yearly. A completed and signed application by both the beneficiary and BCCCP agency must be filed with the Medicaid agency. The application must certify the beneficiary continues to meet all financial and non-financial eligibility factors and continues to receive treatment for cancer or a pre-cancerous condition.

END DATE OF ELIGIBILITY

A beneficiary remains eligible for Medicaid until:

- the course of treatment has ended as determined by the BCCCP agency, or
- she no longer meets the eligibility criteria for this program (such as, has obtained creditable insurance coverage; attained age 65).

The BCCCP agency will notify the appropriate Medicaid agency when the treatment course has ended.

Adverse action notices will be issued in compliance with DCH Hearing Policy.

REPORTING CHANGES

Changes in address, insurance coverage, or death of the beneficiary are to be reported to the DCH worker within 10 days of the change.

COVERAGES

A BCCPTP beneficiary is entitled to full Medicaid coverage. Undocumented immigrants are entitled to emergency services only.

INTERACTION WITH OTHER PROGRAMS

Medicaid coverage is limited to the adult female beneficiary. This does not preclude other household members from receiving Medicaid under other programs for which they qualify.

Children's Special Health Care Services (CSHCS)

A beneficiary may receive services from CSHCS and BCCPTP Medicaid simultaneously.

Spenddown Beneficiaries

A beneficiary on a Medicaid spenddown would not be considered as having creditable coverage and may be eligible under BCCPTP.

State Medical Program (SMP)

SMP does not qualify as a creditable coverage. Beneficiaries eligible for BCCPTP will not be eligible for SMP.

MIChild

MIChild is considered creditable coverage. Beneficiaries eligible for MIChild will not be eligible for BCCPTP.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

MEDICAID

BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT PROGRAM

Last Name	First Name	Middle Initial

Address	Apt.

City	State MI	Zip Code	County	Birthdate

Social Security Number	Phone Number	Date Treatment Began

Race (optional) Circle One: Black/African American White Hispanic Alaskan Native American Indian Asian/Pacific Other

Are you a United States citizen? Yes No If No, please attach a copy of INS card.	Do you intend to stay in Michigan? Yes No

Do you have health insurance? Yes No If yes, name of company:_____

Policy Number: _____

ACKNOWLEDGEMENTS

This is your copy of your rights and responsibilities as an applicant for or recipient of Medicaid benefits. By signing the application you acknowledge that you understand your rights and responsibilities and that you are applying only for Medicaid through BCCPTP.

I agree to the release of information and supporting proof in order to evaluate and verify eligibility. I agree that the Department of Community Health (DCH) or Family Independence Agency (FIA) may use necessary medical infomation about me, including any information about HIV or AIDS, to determine eligibility for a specific program or for other administrative purposes. I understand that these agencies will maintain confidentiality according to federal requirements at 42 CFR 431.300 - 431.307 and any other applicable federal and state laws and regulations.

I understand that when the DCH pays the cost of medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to the department. Payment of any recovery under such right is to be made directly to the State of Michigan, DCH, or its agent.

I understand that if I get more benefits than I am entitled to through my fault, I may have to repay any extra benefits received.

I understand that this application is only for Medicaid coverage under the Breast and Cervical Cancer Prevention and Treatment Program (BCCPTP). I understand that if found not eligible for health benefits under the BCCPTP, I may be eligible for Medicaid benefits on some other basis. I understand I have the right to complete the FIA-1171 to apply for cash benefits, Food Stamps, Day Care assistance or other services at the local FIA office.

Neither the DCH nor FIA will discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, disability or political beliefs.

I understand that I must report changes, such as name, address, Medicaid program participation, or health insurance coverage, within 10 days of the change.

I understand that computer cross-checking may be used to verify information I have provided on this application.

If you would like help with the pursuit of financial or medical support, contact your local FIA office.

If you need help with reading or writing to complete this application, under the Americans with Disabilities Act, you are invited to make your needs known to your local treatment program case manager.

You have the right to appeal a decision by the Department of Community Health. You will be notified of your rights if your application is denied for any reason.

PLEASE SIGN YOUR APPLICATION:

I certify under penalty of perjury that the information on the application is true, complete, and accurate to the best of my knowledge. I understand that any misrepresentation of the facts means that benefits may be taken away. I authorize the state to verify the information on this application.

_____ _____

Applicant's Signature Date

I certify that this applicant meets all eligibility criteria for the BCCPTP program.

_____ _____

Case Manager/BCCCP Coordinator Signature Date

_____ _____

Printed Case Manager/BCCCP Coordinator Name Telephone Number

This form is issued under authority of Social Security Act XIX, Public Law 106-354. Completion is voluntary.

DCH-1088 9/2001 (W) You must complete this form if you want to be considered for Medicaid coverage.