MDHHS | Breast and Cervical Cancer Control Navigation Program

Michigan Department of Health & Human Services

Medicaid Treatment Act (MTA) Policy

AUGUST 2025

TABLE OF CONTENTS

I. Introduction

The Breast and Cervical Cancer Prevention and Treatment Act gives Michigan (MI) the opportunity to provide full medical coverage through Medicaid to eligible individuals who were screened for and diagnosed with breast or cervical cancer, including precancerous conditions, through the National Breast and Cervical Cancer Early Detection Program. MI's Breast and Cervical Cancer Control Navigation Program (BC3NP) Medicaid Treatment Act (MTA) Program provides MI residents meeting the eligibility criteria in this policy coverage for breast and cervical cancer treatment.

II. Eligibility Criteria for Program Enrollment

Eligibility criteria for enrollment in the BC3NP MTA program to receive cancer treatment are as follows:

A. Age and Income

- Age 21-64[1,2,3,5]
- Income ≤ 250 % Federal Poverty Level (FPL)[1,2,3,5]

NOTE: Clients receiving supplemental security income (SSI) are ineligible for BC3NP MTA.

B. Residency and Citizenship Status

- Current MI resident[3]
- Refer to the Michigan Department of Health and Human Services (MDHHS) Departmental Policy[4] for citizenship requirements.

C. Cancer Diagnosis

- Current breast or cervical cancer diagnosis requirement treatment[3,5]
- Qualifying breast diagnoses:
  - Invasive Breast Cancer including –
    - Inflammatory Breast Cancer
    - Phyllodes tumor
    - Paget's Disease of the Breast
  - Ductal Carcinoma in Situ (DCIS)
  - Lobular Carcinoma in Situ (LCIS)
- Qualifying cervical diagnoses:
  - Cervical Intraepithelial Neoplasia (CIN) 2
  - CIN 3
  - Carcinoma in Situ (CIS)
  - Invasive Adenocarcinoma
  - Invasive Squamous Cell Carcinoma

D. Insurance Requirements[3,5]

- Uninsured Clients: eligible to enroll in BC3NP MTA
- Underinsured Clients: may be eligible to enroll depending on type of insurance and coverage – See Table 1.

Table 1. MTA Eligibility Based on Insurance Status

Insurance Status		Eligible for MTA
Insurance is classified as **non-creditable**.[1,5,6]	Non-Creditable insurance coverage is defined as health insurance that contains a pre-existing condition exclusion, which either excludes treatment of breast or cervical cancer, or covers limited services, but not treatment for breast or cervical cancer. (§2701(c) of the Public Health Services Act, 42 U.S.C. §300gg(c).	**YES**, clients with non-creditable insurance are equivalent to uninsured.
Insurance **carrier has terminated coverage**.	Regardless of the client having started treatment and the insurance carrier having paid for part of their treatment, if the carrier terminates, the client's status has changed to uninsured. **Note**: The client cannot terminate insurance coverage after part of the treatment has been paid for by the carrier and be eligible.	**YES**, the client is now uninsured.
The insurance company has **not** paid for cancer treatment.	Clients enrolled in **Marketplace** private insurance: ▪ Deductible amount is not considered.	**YES**, but client **must dis-enroll** from Marketplace insurance.
	Clients enrolled in an **employer-sponsored** insurance plan: ▪ Individual insurance deductible is less than $1500. May be evaluated on case-by-case basis.	**YES**, but client **must dis-enroll** from employer insurance.
Exception	Clients enrolled in **employer-sponsored** insurance plan: ▪ Insurance deductible is greater than or equal to $1500.	**YES**, client **does not** have to dis-enroll from employer insurance and can enroll in BC3NP MTA at any time during cancer treatment.
	Clients enrolled in Healthy Michigan Plan (HMP) or another type of Medicaid.	**YES**, eligible to transfer to BC3NP MTA at any time during cancer treatment.

Final decision of client eligibility to enroll or re-enroll in MTA is determined by the BC3NP Director or Nurse Specialist.

III. Enrolling New Clients in BC3NP MTA

A. Who Enrolls Clients

New clients can be enrolled in BC3NP MTA only by a Local Health Department (LHD) Coordinator or designated LHD Program Staff.

Questions regarding client eligibility for the BC3NP MTA can be directed to:

- Medicaid Eligibility Quality Assurance Analyst
- Program Nurse Specialist
- Program Director

B. For Clients Ineligible for MTA

For clients not eligible or denied coverage through BC3NP MTA:

- The BC3NP coordinator or staff person will assist the client in obtaining cancer treatment through appropriate providers.

C. BC3NP Coordinator/Staff Responsibilities

- **Explain** MTA program requirements to the client to include:
  - BC3NP MTA eligibility criteria
    - See Appendix A
  - Duration of BC3NP MTA coverage
  - Yearly renewal of BC3NP MTA coverage
  - Criteria for termination of BC3NP MTA coverage
  - See Appendix E for additional information on MTA coverage
- **Obtain** required documentation to include:
  - Client's pathology report to confirm a breast or cervical cancer or cervical pre-cancerous condition.
  - Citizenship AND identity documentation as requested by MDHHS
    - See Appendix B
  - Citizenship and identity documentation are faxed with the application to the Medicaid Quality Analyst for review.
- **Complete** BC3NP MTA Application (DCH 1088) – See Appendix C

- Client completes all boxes top of form and signs name under the applicant's signature.
- BC3NP Coordinator/Staff member completes treatment begin date and end date (if known) on application and signs application.
  - See Appendix D

- **Fax (do not mail)** BC3NP MTA Application and copies of appropriate citizenship/identification documentation to Venetta Tucker, Medicaid Eligibility Quality Analyst at (517)241-0051.
  - **Do not** fax client's pathology report.
- **File original** BC3NP MTA Application, citizenship/identification documentation and a copy of the pathology report confirming breast/cervical cancer or cervical pre-cancerous condition in the client's chart at the BC3NP agency.
  - BC3NP MTA applications and all supporting documentation **must be retained for seven (7) years**.

IV. Arranging for Cancer Treatment of BC3NP MTA Clients

A. BC3NP Coordinator/Staff Responsibilities

- **Assist** client in:
  - Identifying/contacting appropriate Medicaid enrolled provider(s) (surgeons, medical oncologists and/or radiation oncologists) to provide breast or cervical cancer treatment.
  - Arranging for transportation to treatment (if needed).
    - See Appendix F
  - Identifying/contacting community resources and/or breast cancer nurse navigators in arranging for additional support as needed for treatment.
- **Notify** client's provider with date MTA begins for the client.

V. Duration/Termination of Medicaid Coverage for BC3NP MTA Clients

A. Client is eligible to receive BC3NP MTA coverage as long as they:

- Meet BC3NP age, income, insurance eligibility requirements **and**
- Are currently receiving breast or cervical cancer treatment **or**

- Are currently receiving follow-up care to monitor the effectiveness of treatment or care for a side effect related to treatment according to the client's health care provider.

B. Breast or cervical cancer treatment[7,8,9] is defined as the following:

- Breast or cervical cancer surgical procedures.
- Provision of chemotherapy/hormonal therapy/endocrine therapy to treat the breast or cervical cancer.
- Provision of radiation therapy to treat the breast or cervical cancer.
- Treatment of side effects relating to the type of breast or cervical cancer therapy received by the client.

C. Duration of MTA Treatment

- Length of treatment depends on the type of cancer diagnosed and cancer treatment.
    - See Appendix D.

D. MTA Coverage Termination

- MTA coverage will be terminated at any time if the client:
    - Turns 65 years old.
    - Reports income over 250% FPL.
    - Has obtained creditable insurance that covers cancer treatment.
    - Is eligible for Medicare Part A and Part B.
    - Is eligible for SSI.
    - Has completed breast/cervical cancer treatment and has returned to surveillance monitoring.
    - Cannot be located after attempt at contact.
    - Fails to comply with cancer treatment recommendations.
- **Notify** Venetta Tucker, MTA Eligibility Quality Analyst, via email with the client Medicaid ID number only and the reason for termination.
    - Venetta will inform the coordinator of MTA end date.
    - ALL breast and invasive cervical cancer clients are notified via letter from Venetta Tucker when the end date is determined.
    - Clients with CIN 2 or 3 are notified of both start and end dates for Medicaid when enrollment into the program is confirmed.

- **Contact** the client to inform them:
  - Reason BC3NP MA is terminated.
  - Date MTA coverage will end.
  - Additional resources that may assist her for other health related problems, enrollment in Marketplace insurance, applying for Health Michigan Plan, etc.

VI. Yearly Renewal (Redetermination) of BC3NP MTA Eligibility

A. What is Redetermination?

- Client eligibility for continued BC3NP MTA coverage is re-evaluated yearly by BC3NP coordinator/staff person to determine continued eligibility for the program.

B. Redetermination Report

- Anniversary Date
  - Each client has an anniversary date which is the first day of the month of the client's initial enrollment date into BC3NP MTA.
- Monthly, a Redetermination Report is sent to agencies responsible for renewing MTA clients enrolled in the program. The report lists MTA client name, Medicaid ID number and the due date for redetermination.

C. BC3NP Coordinator/Staff person responsibilities:

- **Review** list of client redeterminations sent to staff by BC3NP Program director or Nurse Specialist.
- **Contact**:
  - Clients listed on report.
    - Review continued eligibility for program and status regarding cancer treatment. See Appendix G.
    - If client is unable to be contacted, notify Venetta Tucker to terminate client's MTA coverage.
  - Client's treatment provider.
    - Obtain status of cancer treatment.
    - Document verbal conversation from provider in client's medical record or mail/fax Provider Request for Treatment Confirmation form for provider to complete.
      - See Appendix H.

- **Complete** BC3NP MTA application (DCH 1088).
    - The same application is used for new and renewing clients.
        - For renewing clients, document RENEWAL on top of the MTA application form.
    - Citizenship and identity information **are not** required for renewing clients unless a change in name or address has occurred during the past year.
    - **Application can be mailed** to the client if the client is unable to present in person to sign renewal application.
    - Fax completed application to Venetta Tucker at (517) 241-0051.

VII. BC3NP MTA Hearing/Appeal Rights

A. Appealing MTA Terminations

- Clients can appeal the discussion regarding MTA termination by requesting an administrative hearing before the Michigan Office of Administrative Hearing and Rules (MOAHR).
- The client needs to submit a written request for the appeal to MOAHR.
    - Address

      Michigan Office of Administrative Hearings and Rules
      611 W. Ottawa St.
      Ottawa Building, 2nd Floor
      P.O. Box 30695
      Lansing, MI 48909
    - Fax: (517) 335-6696
    - Email: moahr-ga@michigan.gov
- The client may select, at their discretion, legal counsel to represent them during the administrative appeal.
    - MOAHR will review the request and contact both the client and the BC3NP Director with notification of date and time of the hearing by the Administrative Law judge.
    - The client will be assigned a MOAHR docket number that is used on all correspondence with MOAHR and the client.

B. BC3NP Director responsibilities:

- Contact the BC3NP Coordinator who terminated the client's MTA and request the cancer treatment and other information on the client that determined their ineligibility for continued coverage through the BC3NP MTA.
- Provide a written summary of the reason(s) the BC3NP MTA coverage was discontinued for the client to the MOAHR Judge and the client.

C. MOAHR Hearing Date

- The MOAHR hearing is conducted via a three-way conference call between the judge, the BC3NP Director and the client.
- The participants are sworn in by the judge prior to the hearing.
- Each participant presents a summary of the case.
- A time period for final questions is given by the judge.
- Hearing is recessed and judge will issue a final verdict within 30 days to uphold the MTA termination or re-instate the client's coverage based on the information presented during the hearing.

VIII. MDHHS BC3NP MTA Contact Staff

- Venetta Tucker, tuckerv@michigan.gov
  Medicaid Eligibility Quality Assurance Analyst
  Phone: (517)241-8682, Fax: (517) 241-0051

- Kanika Lewis, lewisk27@michigan.gov
  BC3NP Medicaid Case Manager
  Phone: (517) 614-5057, Fax: (517) 763-0290

- Marisa McClean, mccleanm1@michigan.gov
  BC3NP Medicaid Case Manager
  Phone: (517) 243-8246, Fax: (517) 763-0290

- E.J. Siegl, siegle@michigan.gov
  BC3NP Director
  Phone: (517) 614-9307, Fax: (517) 763-0290

References

1. Breast and Cervical Cancer Prevention and Treatment Act of 1999. CRPT-106hrpt486-pt1.pdf (govinfo.gov).
2. Breast and Cervical Cancer Mortality Prevention Act of 1990 Amendment to Public Law 106-354, Breast and Cervical Cancer Prevention and Treatment Act of 2000. Public Law 106-354 106th Congress (cdc.gov).
3. Michigan Breast and Cervical Cancer Control Navigation Program Eligibility Criteria. Breast & Cervical Cancer Control Navigation Program (BC3NP). Breast & Cervical Cancer Control Navigation Program (BC3NP) (michigan.gov).
4. Michigan Department of Health and Human Services. Citizenship/Non-Citizen Status. CITIZENSHIP/NON-CITIZEN STATUS (michigan.gov).
5. Centers for Medicare & Medicaid Services. Implementation Guide: Medicaid State Plan Eligibility Individuals Needing Treatment for Breast or Cervical Cancer. IG-S58-Individuals Needing Treatment for Breast or Cervical Cancer.
6. Title 42 – The Public Health and Welfare. Chapter 6A, Subchapter XXV – Requirements Relating to Health Insurance Coverage. U.S.C. Title 42 - THE PUBLIC HEALTH AND WELFARE (govinfo.gov).
7. National Comprehensive Cancer Network Clinical Practice Guidelines for Breast Cancer. Version 4.2025. https://www.nccn.org/professionals/physician_gls/PDF/breast.pdf.
8. National Comprehensive Cancer Network Clinical Practice Guidelines for Cervical Cancer. Version 4.2025. https://www.nccn.org/professionals/physician_gls/pdf/cervical.pdf.
9. National Cancer Institute – Cervical Cancer Treatment – Health Professional Version. Updated May 13, 2025. https://www.cancer.gov/types/cervical/hp/cervical-treatment-pdq#_85.

APPENDIX A

MTA Eligibility Application Checklist

STEPS REQUIRED TO COMPLETE APPLICATION	✓
EXPLAIN MTA program requirements to client: ▪ BC3NP MTA eligibility criteria (age, income, insurance, current treatment) ▪ Duration of MTA coverage ▪ Yearly renewal of MTA coverage on anniversary date ▪ Criteria for termination of BC3NP MTA	
OBTAIN required documents ▪ Client's pathology report confirming cancer diagnosis ▪ Citizenship and identity documentation	
COMPLETE BC3NP MTA Application (DCH 1088) entering treatment begin dates and end dates ▪ End dates based on diagnosis are in Appendix D.	
Fax the following to Venetta Tucker (FAX: 517-241-0051): ▪ Application ▪ Proof of citizenship ▪ Photo identity document ▪ **Do NOT fax pathology report.**	

APPENDIX B

MTA Citizenship and Identity Documentation Requirements

Citizenship and Identity Documentation Requirements for BC3NP MTA Enrollment

Eligibility requirements for BC3NP MTA include verification of the client's citizenship and identity by producing any **ONE** of the following documents **for each type of identification**:

Citizenship Documentation

- U.S. Passport
- Certificate of Naturalization
- Certificate of U.S. citizenship
- Birth certificate
- Report or certification of birth abroad of a US citizen
- U.S. Citizen ID card
- Adoption papers
- Military record if it shows state born
- Voter ID Card
- Enhanced Michigan Driver's License

Identity Documentation - (Photo ID)

- Driver's License/Photo ID Card
- U.S. Passport
- School Photo ID
- Federal, state, or local government ID
- U.S. military ID card

NOTE: If the client cannot obtain the required citizenship / identity documentation:

- Inform the client that they have **15 calendar days** to produce the missing citizenship or identity documentation.
- Inform Venetta Tucker, Medicaid Quality Analyst, that documentation verifying client citizenship and/or identity will be forthcoming; client unable to obtain it at the time the application was signed.
- If unable to obtain documentation during that time or if the client requires assistance in obtaining supporting documents (e.g., a copy of their birth certificate), notify BC3NP Nurse Specialist or Director.

APPENDIX C

Breast and Cervical Cancer Treatment Program (MTA) Application (DCH 1088)

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT PROGRAM

APPLICATION FOR MEDICAID

Last Name	First Name	Middle Initial

Address	Apt. or Lot Number

City	State	Zip Code	County	Birthdate (MM/DD/YYYY)
	MI			

Social Security Number	Phone Number (Area Code, Number)	Treatment Begin Date	Treatment End Date	Do you intend to stay in Michigan?
				☐ YES ☐ NO

Are you a United States citizen? (If NO, attach a copy of USCIS status.)
☐ YES ☐ NO

Racial /Ethnic Heritage: _____

A-Asian or Pacific Islander; B-Black or African American (Non-Hispanic); E-Other Race or Ethnicity; H-Hispanic; I-Native American / American Indian / Alaskan Native J-Native Hawaiian; O-Caucasian/White (Non-Hispanic); Z-Mutually Defined or Multiracial

Do you have health insurance? ☐ YES ☐ NO

If YES, name of insurance company

Policy Number

ACKNOWLEDGEMENTS

This is your copy of your rights and responsibilities as an applicant for or beneficiary 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 the Breast and Cervical Cancer Prevention and Treatment Program (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 Local Public Health agency may use necessary medical information 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 this application is only for Medicaid coverage under the 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 DHS-1171 to apply for cash benefits, food assistance, day care assistance or other services at the local Department of Human Services (DHS) office.

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 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 DHS 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 Health and Human Services. You will be notified of your rights if your application is denied for any reason.

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 — SIGN HERE

Date — DATE

I certify that this applicant meets all eligibility criteria for the BCCPT program. Case Manager/Breast and Cervical Cancer Control Program (BC3NP) Coordinator Signature

Date

Printed Case Manager/BC3NP Coordinator Name

Telephone Number

Citizenship documentation attached? ☐ YES ☐ NO

Identity documentation attached? ☐ YES ☐ NO

FAX APPLICATION AND DOCUMENTATION TO **VENETTA TUCKER: (517) 241-0051**

Authority: Social Security Act XIX, Public Law 106-354.
Completion: Is Voluntary, but is required if Medical Assistance Program Payment is desired.
DCH-1088 (08/08) Previous editions are obsolete.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

APPENDIX D

MTA Breast and Cervical Treatment Start/End Dates

Guidelines for Determining Breast and Cervical Cancer Treatment Start and End Dates

Table 1. Breast Cancer Treatment Start and End Dates

Breast Cancer Diagnosis	Treatment Options	MBCIS Treatment Start Date	MTA Application Start Date	MTA Application End Date
LCIS	A. Observation ONLY after biopsy confirming diagnosis. No further surgery scheduled AND client NOT eligible for targeted drug.	Date of biopsy confirming a qualifying cancer or pre-cancerous lesion diagnosis	1st of the month cancer diagnosed from biopsy.	**End date is 2 months (60 days) from MTA start date if no targeted drug therapy is prescribed.**
	B. Targeted drug therapy to decrease the incidence of subsequent breast cancers (requires oncology consult visit).	Date of oncology consult visit AND verification client has the prescribed targeted drug therapy medication for treatment.	1st of the month cancer diagnosed from biopsy.	**No set end date.** MTA continues until targeted drug therapy is completed.
	C. Bilateral prophylactic total mastectomy without axillary node dissection.	Date of biopsy confirming cancer diagnosis.	1st of the month cancer diagnosed from biopsy.	**No set end date.** MTA continues until therapy is completed.
DCIS	A. Breast-conserving surgery (lumpectomy) without lymph node surgery and radiation therapy with or without targeted drug therapy.	Surgery date. If targeted drug therapy is prescribed prior to surgery, then record oncology consult date.	1st of the month cancer diagnosed from biopsy.	**No set end date.** MTA continues until targeted drug therapy is completed or resolution of sides effects (if any) from radiation or targeted therapy.

Table 1. Breast Cancer Treatment Start and End Dates

Continued

Breast Cancer Diagnosis	Treatment Options	MBCIS Treatment Start Date	MTA Application Start Date	MTA Application End Date
DCIS	B. Total mastectomy with or without sentinel node biopsy with or without reconstruction and targeted therapy.	Surgery date. If chemotherapy/targeted drug therapy is prescribed prior to surgery, then record oncology consult date.	1st of the month cancer diagnosed from biopsy.	**No set end date.** MTA continues until chemotherapy/targeted drug therapy is completed.
Invasive Breast Cancer	A. Breast-conserving surgery with axillary node staging and radiation therapy with or without chemotherapy and/or targeted therapy.	Surgery date. If chemotherapy/targeted drug therapy is prescribed prior to surgery, then record oncology consult date.	1st of the month cancer diagnosed from biopsy.	**No set end date.** MTA continues until chemotherapy/targeted drug therapy is completed.
	B. Mastectomy (FIRST) with axillary node staging with or without reconstruction followed by radiation, chemotherapy, and/or targeted therapy.	Surgery date. If chemotherapy/targeted drug therapy is prescribed prior to surgery, then record oncology consult date.	1st of the month cancer diagnosed from biopsy.	**No set end date.** MTA continues until radiation, chemotherapy and/or targeted drug therapy is completed OR breast reconstruction is completed.
	C. Neoadjuvant therapy (targeted therapy or chemotherapy PRIOR to surgery to shrink tumors).	Date of oncology consult visit. Need verification client has the prescribed drug therapy.	1st of the month cancer diagnosed from biopsy.	**No set end date.** MTA continues until targeted therapy and/or chemotherapy is completed.

Table 2. Cervical Cancer Treatment Start and End Dates

Cervical Cancer Diagnosis	Treatment Options	MBCIS Treatment Start Date	MTA Application Start Date	MTA Application End Date
CIN 2 (pre-cervical cancer)	A. Surgical procedure (LEEP, conization)	Date of surgical procedure (LEEP, cone) post-biopsy.	1st of the month treatment is scheduled.	**End date is 2 months (60 days) post-procedure.** This includes the month of LEEP/cone and one-month post-procedure. Can be extended, if dysplasia is observed.
CIN 3/CIS	A. Surgical procedure (LEEP, conization).	Date of surgical procedure (LEEP, cone) post-biopsy.	1st of the month treatment is scheduled.	**Last day of month 6 months post-treatment.** Can be extended.
	B. Hysterectomy for CIN3/CIS if dysplasia involves margin.	Date of surgical procedure (LEEP, cone) post-biopsy.	1st of the month treatment is scheduled.	**Last day of month 6 months post-treatment.** Can be extended.
Invasive Cervical Cancer Adenocarcinoma or Squamous Cell Carcinoma	A. Hysterectomy May include chemotherapy and/or radiation therapy, if needed.	Date of surgical procedure (LEEP, cone) post-biopsy.	1st of the month cancer diagnosed from biopsy.	**No set end date.** MTA continues until treatment completed per surgeon or oncologist.

APPENDIX E

Resources for Clients New to BC3NP MTA

Breast & Cervical Cancer Control Navigation Program (BC3NP)
Medicaid Coverage for Treatment

You have been awarded **Medicaid** through the Breast & Cervical Cancer Control Navigation Medicaid Treatment Act Program (BC3NP MTA). Your award letter will come from the Michigan Department of Health & Human Services (MDHHS).

The following information covers important information about this program.

BC3NP Medicaid Benefits:

- The BC3NP MTA is a special Medicaid program. You are eligible for the program if you are:
  - Currently receiving cancer treatment.
  - Are under age 65.
  - Meet the BC3NP income requirements.
  - Live in Michigan.

- Your award is straight Medicaid (Fee for Service). Your coverage is not part of a Health Maintenance Organization (HMO).
- You are entitled to full Medicaid coverage for services in addition to coverage for cancer treatment.
- Because this is a special Medicaid program **ALL** questions about your *eligibility for the program* should be directed to the BC3NP staff member listed at the end of this document.
- For questions about your *Medicaid coverage for tests or procedures or billing* please call the Medicaid Recipient Hotline (800-642-3195). The BC3NP staff member cannot answer questions about Medicaid coverage for tests or procedures nor approve any tests or procedures you may require for your care.

What services may be covered?

Below are services that Medicaid may cover when medically necessary. When making your appointment, please verify that the provider will accept Medicaid. You should not be asked to pay for services or copays. If asked for a co-pay or any form of payment, please contact us.

- Ambulance transportation
- Chiropractic
- Dental
- Doctor visits
- Emergency services
- Family planning
- Hearing and speech services
- Home health care
- Hospice care
- Inpatient and outpatient hospital care
- Lab
- Medical supplies
- Mental health services
- Non-emergency medical transportation
- Nursing home care
- Personal care services
- Physical and occupational therapy
- Podiatry
- Pregnancy care (prenatal, delivery, postpartum)
- Prescribed medications
- Private duty nursing
- Substance use disorder treatment
- Surgery
- Vision
- X-ray

Breast & Cervical Cancer Control Navigation Program (BC3NP)
Medicaid Coverage for Treatment

Length of Time for Medicaid Coverage

- Your Medicaid coverage is in effect for one year after your application is received by Medicaid if you are diagnosed with breast cancer or invasive cervical cancer.
- If you are diagnosed with a pre-cervical cancer (CIN 2 or CIN 3/CIS) your Medicaid coverage will be effective for 3 months. If you require further treatment beyond 3 months we can extend your Medicaid coverage.
- You will be informed of your renewal month or when your Medicaid will end at the time of enrollment.

Transportation Reimbursement for Travel To and From Cancer Treatment

- Medicaid will reimburse you for travel to and from cancer treatment if needed. Reimbursement cannot be provided for travel to non-medical appointments.
- You will receive a copy of the Medical Transportation form when you receive your Medicaid approval letter for coverage.
- The Medical Transportation form contains directions for completion and when the form must be returned.
- Completed forms can be mailed or faxed to Venetta Tucker.
    - Mailing Address: Venetta Tucker, BCCP, 400 S. Pine Street, Lansing, MI 48393
    - Fax: 517-241-0051.
- Reimbursement may take up to 4 – 6 weeks to be received.
- For questions about a missing reimbursement, please contact your BC3NP staff member with the following information to track your reimbursement:
    - Medicaid ID Number.
    - Time frame covering the reimbursement (beginning date to ending date).
    - How many forms were sent with the reimbursement.
    - Date forms were mailed to Venetta Tucker.

Annual Renewal Process:

BC3NP staff will contact you at least once each year to re-verify your eligibility for Medicaid through BC3NP MTA. To remain eligible, you must:

- Meet the BC3NP income guidelines.
- Be under age 65.
- Not receiving Medicare, Social Security Income (SSI) or Social Security Disability Insurance (SSDI).
- Be currently receiving cancer treatment. Treatment may include one or more of the following services: surgery, cancer drug therapy (chemotherapy or other drugs used to treat your cancer), radiation therapy, monitoring of side effects (relating to the type of cancer therapy given).
- Currently be living in Michigan.

Your Responsibility:

You must contact the BC3NP staff for any of the following reasons:

- If your income, address, or telephone number changes.
- If you obtain any other insurance, including Medicare.
- When you have finished the treatment services listed above.
- If you have questions about your eligibility or award.

Breast & Cervical Cancer Control Navigation Program (BC3NP)
Medicaid Coverage for Treatment

Additional Information:

1) Switching insurance coverage: Sometimes, clients in our program become eligible for some type of disability income and may become eligible for SSI or Medicare.
   - **If you are awarded SSI or Medicare,** please contact us right away.
   - Because of program requirements, BC3NP Medicaid coverage ends once you are eligible to receive SSI or Medicare. This is important for you to know so that you can sign up for all parts of Medicare that you need including prescription coverage (Part D).

2) American Cancer Society Cancer Resource Network: American Cancer Society (ACS) offers personal counseling and information on treatment options and extra services to help you while you are in treatment. Call 1-800-227-2345 if you are interested in services offered by ACS.

3) Talk to your Doctor about Genetic counseling/testing. This may be a covered service under your Medicaid.

Questions About Program Eligibility or Renewals Contact:
Questions About Medicaid Coverage for Tests/Procedures or Billing
• Call the Medicaid Recipient Hotline (800-642-3195). • The BC3NP staff member listed above cannot answer questions about Medicaid coverage for tests or procedures nor approve any tests or procedures you may require for your care.

APPENDIX F

BC3NP Medical Verification for Transportation Forms (MSA 4674 and DHS 5330) and Instructions for Completion

Instructions for MTA Clients Requiring Reimbursement for Transportation

Effective 9/16/2021

BC3NP Medicaid Treatment Act (MTA) Program clients requesting transportation reimbursement must complete the following 2 forms to receive reimbursement for transportation:

- Medical Transportation Statement (MSA-4674)
- Medical Verification for Transportation Form (DHS-5330)

INSTRUCTIONS FOR FORM COMPLETION

1. Venetta Tucker, Medicaid Quality Analyst, will mail the MSA-4674 (Medical Transportation Statement) to the client with the client's renewal letter.
   - The form contains directions for completion and when the form must be returned.
   - Client to mail form to: Attention: Venetta Tucker, BC3NP, 400 S. Pine Street, 5th Floor, Lansing, MI 48933.

2. BC3NP Coordinator
   a. Yearly, at the time of the client's renewal, complete the Medical Verification for Transportation form (DHS-5330)
   b. Coordinator fills in the Client's Name, Date of Birth, Medicaid ID #, and Address.
   c. Completion of medical questions A-G on the form.
      - BC3NP Coordinator can ask the client the questions or
      - Mail the application to the client with instructions to complete A-G

3. Required Signatures
   a. BC3NP MTA has been granted an exception from Medicaid so BC3NP coordinators can sign the Verification for Transportation form in place of the client's medical provider.
   b. Under Medical Provider Name: enter N/A.
   c. Under Medicaid Enrolled Provider Signature: cross out and enter BC3NP MTA Enrollment Coordinator and sign your name.
   d. Under Patient's or Representative's Signature: Client signs in this box and provides signature date.
   e. Under MDHHS Specialist Name: Venetta Tucker will sign the form when she receives it. Fax the form along with the renewal application to Venetta Tucker at 517-241-0051.

4. Form Retention
   - The original signed form (like the client's MTA applications) should be kept in the client's file for seven (7) years.

MEDICAL TRANSPORTATION STATEMENT
Michigan Department of Health and Human Services

Case Name:
Case Number:
Date:
MDHHS Office:
Co: District: Section: Unit: Worker:
Specialist / ID: /
Phone:
Fax:
Individual ID:

If you do not understand this, call an MDHHS office in your area.
MDHHS employees are prohibited by law from providing legal advice.
Si Ud. no entiende esto, llame a su oficina local del MDHHS.
La ley prohíbe a los empleados de MDHHS proporcionar asesoría legal.
اذا واجهت صعوبة في فهم هذا الطلب، فاتصل بمكتب MDHHS المحلي في منطقتك.
يحرّم القانون على موظفي MDHHS إعطاء النصيحة القانونية.

ENTER ADDRESSEE NAME
ENTER ADDRESSEE CARE OF
ENTER ADDRESSEE PO BOX OR STREET
ENTER ADDRESSEE CITY/STATE/ZIP

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

AUTHORITY: Title XIX of the Social Security Act.

COMPLETION: Is voluntary but required if payment from applicable programs is sought.

SIGMA Doc Code	SIGMA Doc Unit	SIGMA Doc ID

☐ One-time appointment ☐ On-going appointments

SECTION I - MDHHS Specialist Completes Only **ONE** medical provider and **ONE** transporter per form.

Beneficiary Name	Beneficiary Street Address	Apt. No.	City	State	Zip Code

Phone No.	Medicaid ID No.	Level of Care Code	TOA

Directions to the House

Special Instructions (Disabled, wheelchair, car seats, etc.)

Medical Provider Name	NPI No.	Medical Provider Street Address	Suite	Phone No.

City	State	ZIP Code

SECTION II - Transportation Provider

Transportation Provider Name	Soc. Sec. No. or TIN No.

Provider Street Address	City	State	Zip Code	Phone No.

SECTION III - Transportation Record (Provider / Transporter / Beneficiary Complete):

Appointment Date	Appointment Time	Departure Date and Time	Return Date and Time	Round Trip Miles	Attendant Initials	Medical Provider's Signature
TOTAL					I certify that I provided attendant service on the date(s) above.	I certify that I am a Medicaid enrolled provider and that I provided a medical service on the appointment date(s) above.

Beneficiary Signature	Date

Transporter Signature	Date
I certify that I provided the above service(s) and did not receive any other payment for the transportation. I am not aware that the passenger received any other payment for this transport. Any third-party payment received but not indicated on this form must be reported to the Michigan Medicaid Program.	

MSA-4874 (Rev. 10-17) Previous edition obsolete. 1

Case Name	Case Number	Specialist

SECTION IV - Local MDHHS Specialist & Manager Complete

A) ___ Miles X $____ (Appropriate mile-age rate)	$	D) Lodging	$	G) Total Auth (Lines A through F)	$	
B) Lift/Medivan Base Rate	$	E) Meals	$	MDHHS Specialist's Signature		Date
C) Fees and Tolls	$	F) Attendant(s)	$	MDHHS Manager's Signature		Date
Is the transportation provider CHAMPS enrolled? Yes ☐ No ☐ Not Applicable ☐						

SECTION V - Local MDHHS Office Use Only

Audited and Approved by:				Date
Budget Fiscal Year	Unit	Accounting Template	Department Object	Amount $

Instructions for MSA-4674 (Medical Transportation Statement)

- Use this form for 5 or less trips made in a month. Use 1 medical provider per form and 1 transportation provider per form.
- This form must be returned to the MDHHS local office within **90 calendar days** from the last date of service to authorize payment for medical transportation.

SECTION I:
- The MDHHS Specialist completes this section.

SECTION II:
- The transportation provider completes this section.
- Leave this section BLANK if the beneficiary drives themselves OR if the beneficiary wishes to receive the transportation payment directly.

SECTION III - Transportation Record:
Transporter:
- Enter the following for each appointment / visit: date, departure time, return time, number of miles traveled (round trip) and the attendant initials, if medically necessary.
- If SECTION III was completed, then only that transporter may sign at the bottom of this section.
- By signing this form, I certify that I provided the stated service(s) and did not receive any other payment for this transportation. I am not aware that the passenger received any other payment for this transport. Any third party payment received but not indicated on this form must be reported to the Michigan Medicaid Program.

Medical Provider (or their designee):
- Confirm the date(s) and time(s) of appointment(s) and sign your name to verify that the medical visit did occur.

Beneficiary:
- Sign the form to certify you received the transportation on the dates identified.

SECTION IV:
- The MDHHS Specialist calculates the transportation payment and signs their name and dates.
- The MDHHS Manager reviews the entire form and signs their name and dates, approving the payment.
- The local office must then submit this form to the appropriate MDHHS Accounting Service Center within 10 business days of receipt of the form.
- Transportation providers must be CHAMPS enrolled to receive mileage reimbursement from Medicaid for medical transportation services.

SECTION V:
- The local MDHHS office completes this section.

COPY DISTRIBUTION:
Original: • Mail or give this copy to the **Beneficiary** for completion by the Beneficiary, medical provider and the transporter.
• **Return to MDHHS Specialist** for completion. Forward to the local MDHHS Accounting Unit for payment processing.
Copy 1: • Local MDHHS Case File copy.
Copy 2: • Give this copy to the Transporter Provider.

MSA-4674 (Rev. 10-17) Previous edition obsolete. 2

Case Name:
Case Number:
Date:
MDHHS Office:
Specialist / ID: /
Phone:
Fax:
Individual ID:

STATE OF MICHIGAN
Department of Health and Human Services

If you do not understand this, call an MDHHS office in your area.
MDHHS employees are prohibited by law from providing legal advice.
Si usted no entiende esto, llame a una oficina de MDHHS en su área.
La ley prohíbe a los empleados de MDHHS proporcionar asesoría legal.
إذا واجهت صعوبة في فهم هذا الطلب، فاتصل بمكتب MDHHS الموجود في منطقتك.
يحرّم القانون على موظفي MDHHS إعطاء النصيحة القانونية.

ENTER ADDRESSEE NAME
ENTER ADDRESSEE CARE OF
ENTER ADDRESSEE PO BOX OR STREET
ENTER ADDRESSEE CITY/STATE/ZIP

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

MEDICAL VERIFICATION FOR TRANSPORTATION

INSTRUCTIONS: To be completed annually by a physician (MD or DO). Please print or type.

Medical Provider:
Providers must be Medicaid enrolled. An addressed, prepaid envelope is enclosed for your convenience.

You are hereby authorized to release the information requested below to the Michigan Department of Health and Human Services.

Patient's Name		Patient's Birthdate		Medicaid ID #	
Patient Street Address		Apt/Suite / City		State	Zip Code
Preferred Contact Number					
☐ A	Does the patient have a chronic ongoing illness which may require multiple visits to a provider? ▶ ☐ YES ☐ NO				
☐ B	If yes to line A, what is the illness?				
☐ C	Estimated number of office or clinic visits ____ times per ☐ week ☐ month ☐ quarter ☐ Other (Please Specify)		Will this change? ☐ YES, When? ____ (Date) ☐ NO		
☐ D	Patient's current status: ☐ Non-ambulatory ☐ Walks with assistive device(s) ☐ Walks without restrictions ☐ Limited mobility with assistive device(s) (relies on wheeled mobility) ☐ Walks without assistive devices				
☐ E	Does the patient need special transportation? If Yes, indicate mode of transportation needed (e.g., van with wheelchair lift, ambulance, etc.) ☐ YES ☐ NO ▶				
☐ F	Does someone need to accompany the patient to the medical appointment? ☐ YES ☐ NO ▶	If yes, who / why?			
☐ G	Other (Explain)				
Medical Provider Name		National Provider Identifier (NPI)		Provider's Phone No.	
Street Address (No., Street, Bldg.)	Suite	City	State	ZIP Code	
Medicaid-enrolled Provider Signature				Signature Date	
MDHHS Specialist Name (Print or type)				Signature Date	
MDHHS Specialist Signature		I certify that the beneficiary meets requirements as listed in the Medicaid Provider Manual to receive Medicaid non-emergency medical transportation.			
Patient's or Representative's Signature				Signature Date	

DHS-5330 (Rev. 3-17) Previous edition may be used.

APPENDIX G

BC3NP MTA Client Status Update

Breast and Cervical Cancer Control Navigation Program

Breast and Cervical Cancer Control Navigation Program
Medicaid Treatment Program

Dear BC3NP Medicaid Participant,

You are enrolled in a special Medicaid Program through the Breast and Cervical Cancer Control Navigation Program (BC3NP). Each year, we need to re-evaluate if you are still eligible to receive Medicaid coverage through our program.

Enclosed in this mailing are the following:

- Application
- Eligibility Form (on the back of this letter)
- Release of Information

PLEASE COMPLETE **ALL HIGHLIGHTED AREAS** ON THESE FORMS. All three forms **MUST** be returned using the self-addressed stamped envelope by _____.

If you DO NOT return the documents listed by THE DATE ABOVE, your Medicaid coverage in our program will be DISCONTINUED.

If you meet our eligibility requirements, we will automatically renew your Medicaid coverage.

If you DO NOT meet the eligibility requirements, you will receive a letter from Medicaid stating this along with information about other health insurance options.

If you decide you no longer want or need our BC3NP Medicaid coverage, please mail a written letter stating you wish to have your coverage discontinued using the self-addressed stamped envelope enclosed with this mailing.

If you have any questions, please contact me.

Thank you,

Breast and Cervical Cancer Control Navigation Program
Medicaid Treatment Program

Medicaid Renewal Eligibility Form

1. Changes to insurance status and/or government assistance should be reported immediately. **Please check the box for ALL that apply:**

- ☐ I have enrolled in Medicare this year.
- ☐ I am receiving Social Security benefits.
- ☐ I have acquired new insurance privately or through an employer.
- ☐ None of these are true.

2. **Please complete the highlighted areas below.** We will review the following information to determine if you are still eligible for this program. This will include contacting your healthcare provider to verify your cancer treatment plan.

Total Household Income Per Year (AGI)	$	Number of people in the household supported by the reported income	

Current Cancer Treatment – Please **CIRCLE TREATMENT** you are receiving:

- Anastrozole (Arimidex) – Exemestane – Letrozole (Femara) – Herceptin – Tamoxifen
- Chemotherapy – Radiation
- Upcoming Surgery – Reconstruction
- Follow-up Monitoring (Imaging, bloodwork, and/or office visits multiple times a year)
- Treatment of side effects from cancer treatment - e.g. Lymphedema Care
- Other treatment plans/medications not listed or comments about care (LIST BELOW):

- **Back to Routine Care (annual screenings ONLY)**

Provider **FIRST AND LAST NAME** for Cancer Treatment	Provider **PHONE NUMBER**

MDHHS | Breast and Cervical Cancer Control Navigation Program

Breast and Cervical Cancer Control Navigation Program (BC3NP)
RELEASE OF INFORMATION

I UNDERSTAND THAT:

- I am currently enrolled in a special Medicaid program through the Breast and Cervical Cancer Control Navigation Program (BC3NP).
- Yearly redetermination will be made to verify my eligibility to continue in the program.
- My cancer provider will be contacted to verify that I am still receiving cancer treatment.
- Any personal information obtained about me will be kept private and confidential.
- By signing this form, I authorize you to release confidential health information to the providers/agencies listed below.
- The purpose of this release of information is to allow my cancer provider to release information about me to the BC3NP Medicaid Case Manager listed below.
- I have the right to revoke this authorization, in writing, at any time.

I GIVE PERMISSION AND AGREE TO:

- Allow my cancer provider/agency listed below to provide the BC3NP Medicaid Case Manager listed below with information about me, including, but not limited to, my name and address and current cancer treatment,

_____ [Agency/Provider for Cancer Treatment)

_____BC3NP Medicaid Case Manager Name
_____ [Address]
_____ [City, State, ZIP]
_____ [Phone]
_____ [Fax]

I have been able to ask questions about the Breast and Cervical Cancer Control and Navigation Medicaid Treatment Program and this form and have been given answers to my questions. Based on my understanding of the information, I give permission for my cancer provider listed above to forward my information to _____ [BC3NP Medicaid Case Manager] as part of my verification of continued enrollment in this program.

_____

Signature of client Date

_____

Signature of person obtaining release of information Date

Client Information

Last Name: _____ **First Name:** _____

Phone Number: _____

Email: _____

CONTENTS OF THIS FORM REMAIN IN EFFECT ONE YEAR FROM DATE SIGNED

March 2025

APPENDIX H

Provider Request for Treatment Confirmation

STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

Date: [ ]

Dear Provider

Your patient, [ ], DOB [ ], Medicaid Beneficiary ID: [ ] is enrolled in a special Medicaid treatment program through the Breast and Cervical Cancer Control Navigation Program (BC3NP). To receive Medicaid coverage through this program the client must meet the BC3NP eligibility criteria for age (21-64), income (≤ 250% Federal Poverty Guidelines) and actively receiving cancer treatment or is receiving follow-up care for side effects related to cancer treatment. Yearly, we need to verify that the client is still receiving cancer treatment or follow-up care so her Medicaid can continue.

Please complete the information below and send to our secure fax line: **517-763-0290**. If you have any questions, please contact one of us below. Thank you.

E.J. Siegl, BSN, OCN, MA, CBCN
BC3NP Director/
Medicaid Case Manager
siegle@michigan.gov
(517) 614-9307

Kanika S. Lewis, MPH, MSW, RN
BC3NP Nurse Specialist/
Medicaid Case Manager
lewisk27@michigan.gov
(517) 614- 5057

Verification of Cancer Treatment	
❑ Client is actively receiving cancer treatment for: ❑ Breast Cancer ❑ Cervical Cancer ❑ CIN III/CIS ❑ CIN II	❑ Client has completed cancer treatment and can return to routine or surveillance screening. Date Treatment Completed:
❑ Client requires follow-up care for side effects / other issues post cancer treatment. Describe follow-up required by client:	

Provider Name: _____ Date:_____

Signature: _____ Phone: _____

Additional Comments: