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**BREAST AND CERVICAL CANCER MEDICAID**  
**MA-3250 BREAST AND CERVICAL CANCER MEDICAID**  
**REVISED 11/01/09 – CHANGE NO. 14-09**

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**I. BACKGROUND**

The federal Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 amended Title XIX of the Social Security Act to give States enhanced matching funds to provide Medicaid eligibility to a new group of individuals previously ineligible under any Medicaid program.

The North Carolina General Assembly approved funding for this option in Senate Bill 1005.

In North Carolina the program is known as Breast and Cervical Cancer Medicaid (BCCM). This coverage group is authorized in the MAF aid program/category with the classification code as "W." The woman receives a gray Medicaid card giving her access to covered services provided under the Medicaid program.

The Breast and Cervical Cancer Control Program (BCCCP) is a screening service for the early detection of breast and cervical cancer. The local health departments, some community health centers, or other designated medical facilities are screening providers for the BCCCP. These providers complete the application for women that have been enrolled, screened and determined to need treatment for breast or cervical cancer. The BCCCP screening providers fax and mail the application to the local Department of Social Services.

Title XV (Public Law 101-354) precludes men from being eligible to receive screening and/or diagnostic services through BCCCP. Therefore, men may not be considered screened under BCCCP and are ineligible for Medicaid coverage for breast cancer.

Below are the guidelines the women have to meet to be enrolled and screened for breast or cervical cancer by the local screening providers under the BCCCP.

1. Be at or below 250% of the current Federal Poverty Level.
2. Not enrolled in Medicare Part B, and/or not authorized for Medicaid.
3. The woman must **not** have any creditable medical insurance coverage, including Medicare and/or Medicaid.

These are not the eligibility requirements for BCCM.

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**II. ELIGIBILITY REQUIREMENTS FOR BREAST AND CERVICAL CANCER MEDICAID (BCCM)**

**The applicant must meet all the following requirements to be eligible for Breast and Cervical Cancer Medicaid.**

- A.** The woman must be enrolled and screened for breast or cervical cancer through the BCCCP. BCCCP must determine that she needs treatment for either breast or cervical cancer including pre-cancerous conditions and early stage cancer.

Women who have moved to N.C. from another state and were enrolled in the BCCCP screening program in another state and women who are referred from a private physician must be enrolled, screened and found to need treatment for either breast or cervical cancer by BCCCP.

- B.** The woman must **not** have any creditable medical insurance coverage, including Medicare and/or Medicaid.

Do not authorize the woman for BCCM if she is eligible for another Medicaid benefit. If the woman is potentially eligible for MAF-M (medically needy), authorize her for MAF-M if her medical expenses to meet the deductible have been incurred as of the date of the BCCM application.

The following types of coverage are creditable medical insurance coverage:

1. A group medical plan,
2. Medical insurance coverage, which is benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical services plan contract, or HMO organization contract offered by a medical insurance issuer,
3. Medicare A and/or B,
4. Medicaid,
5. Armed forces insurance,
6. A state medical risk pool.

A woman with creditable medical insurance coverage is ineligible for BCCM. However, if the insurance coverage consists solely of limited benefits such as accidents or limited-scope dental, vision, or long term-care she may be eligible for BCCM. There may also be limited circumstances where a woman has major medical insurance, but she is not actually covered for treatment of breast or cervical cancer.

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**(II.B.)**

In this situation, she would meet the requirement for having no creditable medical insurance coverage.

**C.** The woman must be age 18 through 64.

**D.** The woman must meet other general eligibility requirements for Medicaid.

1. Be a citizen of the U.S. or be an alien who meets the criteria contained in MA-3332, US Citizenship Requirements and/or MA-3330, Alien Requirements.

NOTE: If the woman is an alien limited to emergency medical care only, she may still be able to receive Medicaid coverage related to an "emergency condition," other than services related to an organ transplant. Breast or cervical cancers may be identified at various stages.

2. Be a resident of North Carolina as defined in MA-3335, State Residence.
3. Not be an inmate of a public institution. Refer to MA-3360, Living Arrangement.
4. Not be in an institution for mental diseases. However, individuals under age 21 receiving inpatient psychiatric care or individuals ages 21 to 65 in the medical/surgical unit of the state mental hospitals are eligible for assistance. Refer to MA-3360, Living Arrangement.
5. Not be authorized for Medicaid in another assistance category, county, or state. Refer to MA-3230, Eligibility of Individuals under 21, MA-3335, State Residence, and MA-3340, County Residence. Refer to V.B.
6. Furnish a Social Security number or apply for a number. Refer to MA-3355, Enumeration Procedures.
7. Cooperate with the local child support enforcement agency in establishing paternity and securing medical and child support for any child who is currently receiving Medicaid. Refer to MA-3365, Child Support.

**NOTE:** There is no income or asset test for this Medicaid coverage group. The a/r meets the Medicaid income and asset test based on eligibility for BCCCP.

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**III. POLICY FUNDMENTALS AND/OR RULES FOR BCCM**

**A. Aid Program/Category and Medicaid Classification**

The woman is authorized in the MAF aid program/category with one of the following classifications:

1. **W-** Citizen receiving full coverage.
2. **T-** Qualified alien receiving full coverage.
3. **U-** Qualified alien eligible for emergency services only.
4. **V-** Non-qualified alien eligible for emergency services only.

This coverage group (BCCM) does not require the woman to have an eligible child for her to be eligible for Medicaid.

**B. Date of Application**

The date of application is the date that a "complete" application is received from a BCCCP screening provider in the agency. This may be by fax or mail.

1. A complete application is one that meets the following criteria:
  - a. The information is legible.
  - b. DMA-5079 is signed and dated by the applicant and BCCCP screening provider.
  - c. Section I and the name, mailing address, social security number and date of birth of applicant are completed on the DMA-5079.
  - d. DMA-5081, Verification of Screening and Diagnosis for Breast and Cervical Cancer Medicaid is completed and signed by a physician, including patient's name, date of diagnosis, estimated length of treatment.
2. Each county should establish a fax/mail in log to register and track incomplete as well as complete applications. Refer to MA-3207, Receiving Mail In Applications for an example of a mail in log which may be adapted.

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**REISSUED 11/01/09 – CHANGE NO. 14-09****(III.)****C. Certification Period**

The certification period for this coverage group is based on the woman's course of treatment for cancer as established by a physician and approved by the Division of Public Health (DPH). A DMA-5081, Verification of Screening and Diagnosis for Breast and Cervical Cancer Medicaid, must be completed by a physician giving an estimated length of treatment.

The certification period may be up to 12 months. Even if the course of treatment is estimated by the physician to be more than 12 months, the certification period for Medicaid coverage can be no longer than 12 months.

If the course of treatment is estimated to be less than 12 months, the certification period must be the actual number of months the DPH states on the DMA-5081.

A review is completed at the end of the certification period to determine if she continues to be eligible for BCCM. Refer to V.C. for redetermination procedures.

1. The certification period begins with the first day of the application month the woman is found to meet all eligibility requirements for BCCM.
2. The certification period ends on the last day of:
  - a. The twelfth month, or
  - b. The last month of the estimated period of treatment stated on the DMA-5081.
3. A redetermination is completed at the end of the certification period.
4. The eligibility period ends after the woman's first follow-up visit when the DPH determines her course of treatment is completed, or it has been determined the woman no longer meets the criteria for this eligibility category.

For example, the woman turned 65 years old or has obtained major medical insurance coverage. Terminate the woman's BCCM case after she has been evaluated for any other Medicaid program and timely notice has been given. See V.

5. A woman is not limited to one period of eligibility. A new period of eligibility and coverage would occur each time a woman is screened through BCCCP and is found to need treatment of breast or cervical cancer.

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**(III.)**

**D. Retroactive Coverage**

The applicant may request up to 3 months of retroactive coverage under BCCM. Retroactive coverage only applies if as of the earlier date, the woman met eligibility requirements. This includes having been screened and found to need treatment for breast or cervical cancer in the retroactive month.

The retroactive months are separate from the ongoing certification period.

**E. Covered Services and Medicaid ID Card**

1. Coverage is not limited to only treatment of breast or cervical cancer. The woman is eligible for all Medicaid covered services. Refer to MA-5100, Medicaid Covered Services.
2. Recipients will receive a gray Medicaid identification card.
3. Refer to MA-3505, Medicaid ID Card, for procedures on returned Medicaid cards.

**F. Child Support Referrals**

Referral to Child Support Enforcement is not required unless the woman is a caretaker of children receiving Medicaid. If a woman is approved for MAF-W who has children receiving Medicaid, complete a referral on the child's case and send to Child Support Enforcement.

If a child of the MAF-W recipient is approved for Medicaid, complete a referral on the child's case and send to Child Support Enforcement.

A referral screen is displayed only when the woman is between 18 and 21 years of age for the BCCM case. Do not send a referral on this case to Child Support since there are no children in the MAF-W case.

**G. Transportation**

Breast and Cervical Cancer Medicaid recipients are eligible for Medicaid funded transportation services.

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**(III.)****H. Copayment**

Copayments are the same as other Medicaid programs. There is no co-payment for women under age 21. For women age 21 and over, refer to MA-3540, Medicaid Covered Services.

**I. Managed Care**

These recipients are ineligible for managed care.

**J. Federally Recognized Indian Tribes**

Medical care programs of the Indian Health Service (IHS) or of a tribal organization are sometimes considered creditable coverage under the Public Health Act. However, not all women are covered under such programs. In North Carolina, Medicaid is considered the primary payer when Indian Health Services is involved. Therefore, even if the woman can use IHS, she is eligible for BCCM.

**K. Automated Inquiry and Match Procedures**

Reaction to the BENDEX, BEER, FRR, and ESC/UI and other reports are not required unless the woman goes into another Medicaid program.

This coverage group is excluded from COLA since there is no income or asset test for BCCM.

**L. Appeals/Hearing Request**

BCCM applicants/recipients have the same right to request a hearing as other Medicaid a/r's. Refer to MA-3430, Notice and Hearings Process, for procedures on appeals.

**IV. BCCCP SCREENING PROVIDER PROCEDURES FOR BCCM**

**A.** County health departments, some community medical centers and other medical facilities that are contracted to perform screening by BCCCP will be responsible for insuring that the following forms are completed, faxed and mailed to the county dss.

1. DMA-5079, Application, (Figure 1)

Each question guides the screening provider to continue with the next question or to stop because the woman is ineligible for BCCM. The applicant

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## (IV.A.1.)

signs and dates this form on page 2. The screening provider that is completing the form for the applicant also signs and dates the application.

2. DMA-5081, Verification of Screening and Diagnosis for Breast and Cervical Cancer Medicaid (Figure 2).

A physician completes and signs this form.

- B.** DMA-5087, Health Department Check List for Breast and Cervical Cancer Medicaid, is a checklist for the BCCCP screening provider to use as a tool to ensure the county dss receives all the necessary information needed to determine Medicaid coverage. (Figure 3).
- C.** A “Rights and Responsibilities” form is attached to the back of the DMA-5079. This form must be given to the applicant.
- D.** The BCCCP providers must inform the applicant that the county dss will notify her of a decision within 45 days of receipt of the application.
- E.** The BCCCP screening providers must use a fax cover sheet that has a statement about confidentiality if this language is not currently on the fax cover sheet. Example: This facsimile and any files transmitted with it are confidential and intended solely for the use of the individual or entity to which they are addressed. If you have received the fax in error please notify the sender, delete and destroy this message and its attachments.

**V. COUNTY DSS PROCEDURES****A. Determine Eligibility**

Once the county dss receives the DMA-5079 and DMA-5081 from the BCCCP screening providers, the following will occur:

1. DSS reviews the DMA-5079, Breast and Cervical Cancer Medicaid Application and the DMA-5081, Verification of Screening and Diagnosis for Breast and Cervical Cancer Medicaid for completion. See III.B. for definition of a complete application. Each county should establish a fax/mail in log to register and track incomplete as well as complete applications. Refer to MA-3207, Receiving Mail In Applications for an example of a mail in log, which may be adapted.
2. If the application is complete, DSS completes a name search in EIS to determine if the woman has a current Medicaid case. If the woman does not have an individual ID number, then assign an ID. Refer to EIS-1056,

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Common Name Database. BCCM applications are included in the county's Application Management Report and the Report Card.

The county keys the DSS-8124 using the date of application as the date a "complete" application was received in the county dss, whether faxed or mailed.

3. DSS determines if the applicant is eligible for BCCM or another Medicaid aid program/category. If the woman is a qualified alien, DSS must verify the alien document and date of admission into the U.S. by accessing SAVE. The date of Medicaid eligibility can be no earlier than the first day of the month of her diagnosis, as stated on the DMA-5081. Retroactive coverage of three months is allowed. (Refer to V.B. for determining eligibility under another aid program/category.)
4. DSS faxes the DMA-5081 to the MEU of DMA. DMA faxes the DMA-5081 to the North Carolina Division of Public Health. DPH reviews the DMA-5081 to determine the Medicaid certification period for the woman. DPH then faxes the DMA-5081 determination to DMA. The DMA-5081 determination is faxed to DSS no later than one working day after receipt. If more than 12 months is given for her length of treatment, then only a 12 month certification period is given. At the end of the certification period, DSS completes a review to determine her ongoing eligibility.
5. Complete the DSS-8125 'authorized representative' field on page 2 with the name and address of the BCCCP Coordinator. This generates a copy of the approval notice to the BCCCP Coordinator. This assists the BCCCP Coordinator in ensuring treatment occurs or other funding is identified.

Withdrawal/denial notices must be manual as denials are completed on the DSS-8124 Application and the 'authorized representative' field is not available for the application screen. Send a copy of the notice to the BCCCP Coordinator.

Once the case is approved in EIS, a gray Medicaid ID card will be mailed to the recipient.

**B. Eligible Under Another Medicaid Aid Program/Category**

1. When Section III of the DMA-5079 is completed by the screening provider, the woman may be eligible for another Medicaid program. If a woman is eligible for another Medicaid program she is ineligible for Breast and Cervical Cancer Medicaid. Review the application to see under which aid program/category she may be eligible.

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(V.B.1.)

- a. Determine if more verification is needed to determine eligibility in another aid program/category. If more information is needed to determine eligibility for another Medicaid program, send a DMA-5097/5097S, Request for Information. The BCCCP Coordinator remains a resource for any requested information.
  - b. Calculate earned and unearned income and resources. Document the verification on the application. Determine in which Medicaid program she is eligible according to her verified income and resources. If verification is not received and it appears a/r has a deductible, then authorize Medicaid under BCCM.
2. If the woman is potentially eligible for Medicaid with a deductible, authorize her for MAF-M if her medical expenses meeting her deductible have been incurred as of the date of the BCCM application.
  3. If the woman is a qualified alien, verify the authenticity of the alien document, and the date of admission using SAVE, Systematic Alien Verification for Entitlement Program.
  4. If the woman states she is disabled but not receiving disability, process the application for BCCM. Advise the applicant to apply for MAD-90. Once she is approved for Medicaid for the Disabled, close the Breast and Cervical Cancer Medicaid. Ensure there are no gaps in eligibility coverage.

**C. Redetermination Process**

1. The monthly Case Management Report, DHREJ CASE MANAGEMENT REPORT, displayed in XPTR contains BCCM cases whose certification period is expiring. The message displays on the report three months prior to the last month of the certification period. There is also a special review message that displays two months prior to the month of the 65<sup>th</sup> birthday.
2. Appointment notices will not be generated.
3. Before the end of the certification period, initiate the review process by mailing the DMA-5079, Breast and Cervical Cancer Medicaid Application, to the recipient and the DMA-5081R, Recertification for Continuing BCCM Eligibility, to the BCCCP screening provider. The BCCCP screening provider will assist you in getting the physician to complete the form if ongoing treatment is still needed.

(V.C.3.)

4. If the DMA-5081R indicates a need for additional treatment, fax the form to MEU (919-715-0801) to send to DPH. DPH will determine if treatment meets criteria and establish needed months for eligibility. MEU will fax the form to the county. Upon receipt of the DMA-5079, Breast and Cervical Cancer Medicaid Application and completed DMA-5081R, Recertification for Continuing BCCM Eligibility, complete the review. If she is still receiving treatment for cancer, key the new certification period into EIS. Key the BCCCP Coordinator name and address into the 'authorized representative' field on the DSS-8125 to ensure a copy of the approval notice is sent to the BCCCP coordinator.
5. If she is no longer receiving treatment for cancer, terminate case in EIS after evaluating for any other Medicaid aid program/category based on information in record. Send a timely notice of termination. This notice can be automated. To notify the BCCCP Coordinator use the 'authorized representative' field for terminations.

#### **D. Changes in Situation**

The recipient is to report any changes in her situation within 10 calendar days to the county department of social services.

1. **Attained Age 65**

If a woman turns 65 during her period of Medicaid coverage, her eligibility terminates at the end of the month of her 65<sup>th</sup> birthday. A message will display on the Case Management Report in XPTR two months prior to the month of her 65<sup>th</sup> birthday. Before terminating, explore other categories of Medicaid coverage. The IMC is to assist the individual in getting coverage under Medicare. A timely notice is to be sent to terminate her assistance if she is ineligible for any other Medicaid program.

2. **No Longer Needs Treatment for Cancer**

A woman determined eligible under this option remains eligible as long as she receives treatment for breast or cervical cancer. Presume that a woman is receiving such treatment during the duration of the period established by her physician and DPH. If it is reported that the woman is no longer in need of treatment for cancer, she is no longer eligible for BCCM.

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Evaluate eligibility for other Medicaid programs. If she is eligible for another Medicaid aid program/category, process the case. If she is ineligible for other coverage, terminate the case after the timely notice.

3. Becomes Pregnant

If a woman becomes pregnant, evaluate the case for Medicaid for Pregnant Women. Transfer the MAF-W to MPW if the recipient is eligible for MPW. If treatment for cancer has been terminated and the recipient is not eligible for MPW or any other Medicaid aid program/category, terminate the Medicaid coverage for Breast and Cervical Cancer. Send a timely notice.

4. Eligible for Other Medicaid Programs

a. If a woman begins to receive Social Security Disability, she may become eligible for another Medicaid aid program/category. Terminate BCCM and give adequate notice unless the woman has a deductible. If she has a deductible, send a timely notice. Approve the Medicaid for the Disabled by entering an administrative application. Refer to the EIS Manual for procedures in completing the DSS-8125.

b. If a woman has children, she may become eligible for another Medicaid aid program/category as a caretaker relative. Refer to [MA-3235](#), Caretaker Relative Eligibility. At the end of the adequate notice, transfer the BCCM case to another MAF category. Refer to the EIS Manual for allowable transfer codes.

c. If a woman is no longer able to work or her income is terminated and she has children, she may be eligible for another Medicaid aid program/category. Transfer the BCCM case at the end of the adequate notice to MAF-C. Refer to the EIS Manual for allowable transfer codes.

5. Obtains Health Insurance

If a woman obtains **or it is discovered that she has** creditable medical health insurance, she is no longer eligible for Breast or Cervical Cancer Medicaid. Ensure the insurance coverage will cover breast or cervical cancer treatments. Refer to II. B. above for definition of creditable coverage. Evaluate for all other Medicaid programs. If ineligible for all other Medicaid programs, **start the process** to terminate coverage. **Follow procedures in [MA-3510, Third Party Recovery](#) for entering insurance information.**

6. Moves to a Different County

Refer to [MA-3340](#), County Residence, for transfer procedures.

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7. Moves Out of State

If the recipient moves out of North Carolina, terminate the Medicaid coverage for this program. Send an adequate notice or a timely notice. Refer to MA-3430, Notice and Hearings Process, to determine which is correct in this situation.

8. Enters a Long Term Care Facility

Refer to MA-3325, Long-Term Care Budgeting, if the woman enters a long-term care facility. Compute a patient monthly liability, and enter into EIS. Advise the woman to apply for Medicaid for the Disabled.

**E. Disability**

Advise the applicant to apply for Medicaid for the Disabled if she alleges she has a disability but has not been determined disabled by Social Security Disability. Work with the BCCCP Coordinator to get her to apply for SSA disability.

1. Approve the woman for Breast and Cervical Cancer Medicaid if she is eligible while she is waiting on the approval of the disability.
2. If the disability is approved, close the BCCM with the appropriate notice.

**F. Children in the Home**

If the woman applying for BCCM indicates she has young children in the home under the age of 19 and it appears they may be eligible for NCHC or Medicaid, mail a DMA-5063, N.C. Health Check/Health Choice for Children Application, to the woman.

If the BCCM recipient is the caretaker of children receiving Medicaid, a referral to Child Support Enforcement is required.

**G. Terminated From Another Program**

If a woman is being terminated from Medicaid in any program and was previously enrolled, screened and determined to need treatment by a BCCCP screening provider, the county dss is to do the following.

1. Determine if the woman continues to be eligible for BCCM during the certification period established for BCCM.

(V.G.)

2. If the DMA-5081 indicates the woman's estimated length of treatment is still ongoing, transfer the case to BCCM for the months remaining in the length of treatment.

**Example:** The county dss has a Medicaid case and a change in situation occurs making the recipient no longer eligible for regular Medicaid coverage. In the Medicaid case record, it is indicated the recipient was screened under BCCCP and found to need treatment for breast and cervical cancer.

#### **H. Non-U.S. Citizens and Emergency Medical Services**

1. Women who do not meet the citizenship/alienage eligibility criteria may still be able to receive Medicaid coverage related to an "emergency condition."
2. When the county receives an application for emergency medical services, review the application to see if she is potentially eligible under BCCM. If the applicant has breast or cervical cancer and currently receives treatment for cancer, the county DSS must contact the local health department to see if the woman was screened through BCCCP. If so, indicate this on the MA-3330 Figure 7 sent to DMA.
3. If a non-qualified alien has been screened by the BCCCP and determined to need treatment for cancer, she may be eligible under BCCM for certain dates of coverage if it is determined she has a medical emergency. Medicaid may not be authorized until after the emergency service has occurred.