MEDICAID FOR BREAST AND CERVICAL CANCER

(FORMALLY KNOWN AS MEDICAID TREATMENT ACT)

Frequently Asked Questions

Effective September 1, 2007

Authorized by Health and Human Services Commission (HHSC)
and the
Department of State Health Services (DSHS)

Introduction

HB 1 and SB 10, passed by the 80th Texas Legislature, expand the DSHS Breast and Cervical Cancer Screening (BCCS) program as well as HHSC's Medicaid for Breast and Cervical Cancer (MBCC). With additional appropriations to DSHS ($5.2 million) and HHSC ($14.5 million), more women will have access to screening for breast and cervical cancer and to treatment under MBCC if they are diagnosed with one of these cancers. Section 16 of SB 10, the Medicaid Reform Act, directs HHSC to qualify any individual eligible for Medicaid and diagnosed with breast or cervical cancer, to receive treatment under Medicaid. This law took effect September 1, 2007.

Eligibility

Question 1. What are MBCC eligibility requirements?

Answer. In order to qualify for MBCC, a woman must meet the following eligibility requirements:

1. Diagnosed with a qualifying breast or cervical cancer by a BCCS contractor or by any medical provider, and in need of treatment as defined by BCCS policy; and
2. Have income at or below 200% Federal Poverty Income Guidelines, as defined by BCCS policy; and
3. Be a U.S. citizen or qualified alien; and
4. Be a Texas Resident; and
5. Not otherwise covered by a creditable health care coverage. The term "creditable coverage" means a woman cannot have a group health plan, benefits consisting of medical care under any hospital or medical service policy that covers breast/cervical cancer treatment, Medicare, Medicaid, armed forces insurance, or state health risk pool; and
6. Be under age 65.

Question 2. Will a woman who was diagnosed with a qualifying breast and/or cervical cancer prior to 9/1/07 by a medical provider who is not a BCCS contractor be eligible for MBCC?

Answer. The BCCS eligibility guidelines which allow screening by medical providers who are not BCCS contractors to be included under Title XV and thereby allowing a woman to be eligible for MBCC did not become effective until 9/1/07. In Texas, women diagnosed before this date by a provider who is not a BCCS contractor cannot be deemed screened under Title XV.

Question 3. Must a woman be uninsured for a specific length of time before she may be found eligible for MBCC?

Answer. No. There are no requirements imposed by federal law that a waiting period of prior uninsured status be imposed before a woman can become eligible for MBCC. States have no authority to impose waiting period requirements.

Question 4. What is a "creditable insurance"?

Answer. The term "creditable coverage" is defined under the Medicaid Reform Act to have the same meaning as "creditable coverage" for purposes of HIPAA, but without regard to a medical care program of the Indian Health Service or of a tribal organization. A woman having the following types of coverage would be considered to have creditable coverage and would, therefore, be ineligible for the new Medicaid provision:

- Health insurance coverage - benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.
- A group health plan
- Medicare
- Medicaid
- Armed forces insurance
- A state health risk pool

Question 5. Are there any circumstances where a woman with creditable coverage could be eligible for MBCC?

Answer. Yes. While the provision requires that a woman is "not otherwise covered under creditable coverage," we read that requirement to refer to creditable coverage for treatment of breast or cervical cancer (in light of the immediately preceding requirement referring to that treatment). There may be limited circumstances where a woman has creditable coverage, as defined above in Question 3, but she is not actually covered for treatment of breast or cervical cancer. For example, if a woman has creditable coverage but is in a period of exclusion (such as preexisting condition exclusion or an HMO affiliation period) for treatment of breast or cervical cancer, she is not considered covered for this treatment. If a woman who has creditable coverage exhausts her lifetime limit on all benefits under the plan or coverage or her yearly benefits for breast or cervical cancer treatment, she is not considered to have creditable coverage and is eligible for MBCC.

Question 6. Is Medicaid spend down a creditable insurance?

Answer. No.

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Question 7. What is meant by the term "need treatment"?

Answer. A woman is considered to "need treatment" if, in the opinion of the woman's treating health professional, the screening and diagnostic evaluations indicate that the woman is in need of cancer treatment services. These services may include diagnostic services that are necessary to determine the extent and proper course of treatment, as well as definitive cancer treatment itself. Women who are determined to require only routine monitoring services for a pre-cancerous breast or cervical condition (e.g., breast examinations and mammograms) are not considered to need treatment.

Question 8. When would a woman's eligibility under MBCC end?

Answer: A woman determined eligible under MBCC would continue to be eligible as long as she is receiving treatment for breast or cervical cancer, is under age 65, is a resident of the State of Texas and is not otherwise covered under creditable insurance. In Texas, the Health and Human Services Commission (HHSC) is responsible for continued eligibility and re-determination requirements.

Question 9. What is presumptive eligibility?

Answer. Presumptive eligibility is a Medicaid option that allows states to enroll women in Medicaid for a limited period of time before a full Medicaid application is processed, based on a determination by a Medicaid provider of likely Medicaid eligibility. Under presumptive eligibility, coverage begins the day after diagnosis.

Question 10. If the woman has a social security card for the purposes of work only, is she considered a citizen?

Answer. No.

Question 11. Are qualified and non-qualified aliens eligible for the Medicaid services?

Answer: HHSC is responsible for alienage determination. The rules that govern citizenship and alienage apply to women eligible under MBCC. Non-qualified aliens may receive Medicaid coverage for treatment of an emergency medical condition. Again, HHSC is responsible for making the determination based on the application provided by the contractor/provider and certification of an emergency condition from a Medicaid provider. The BCCS contractor should complete the medical assistance form and forward it to DSHS so that HHSC can then determine Medicaid eligibility. In this case, the woman would not be presumed eligible for services.

Question 12. If the woman has submitted the documents to become a citizen; however, the citizenship is still pending is she eligible?

Answer. She is not eligible unless she has a qualifying alien status. Alien eligibility depends on a number of factors including entry date, status and the type of immigration card held. There are also exceptions made for military connection and certain groups of entrants. HHSC must see a copy of the alien registration card and validate it using an electronic interface that HHSC has with US Citizenship and Immigration Services (USCIS). HHSC must complete the determination of qualifying status before certifying the woman. Non-citizens cannot be presumptively eligible.

Question 13. Does MBCC require proof of U.S. citizenship?

Answer. Yes. As part of the eligibility determination process for MBCC, the BCCS contractor will screen for U.S. citizenship. If the contractor is uncertain whether a woman meets citizenship and alienage status, the completed medical assistance form (Form 1034) should be forwarded to DSHS so that HHSC can process and determine MBCC eligibility. When citizenship and alienage is in question, the woman is not presumptively eligible.

Question 14. What happens if there is uncertainty about a client's legal immigration status?

Answer. If the contractor is uncertain about the client's immigration status, they must complete and forward the medical assistance application (Form 1034) to DSHS so that HHSC can process and determine MBCC eligibility. Attach a copy of the woman's immigration card, if available. She will have to provide it for the determination to be completed.

Question 15. Is there an age requirement for services under MBCC?

Answer. The woman must not have reached her 65th birthday. The contractor will follow BCCS program eligibility guidelines.

Question 16. Is there a minimum residency requirement?

Answer. The woman must be a resident of Texas. There are no minimum residency requirements. If the woman states she is from another state and visiting Texas, she would not be eligible for Medicaid services.

Question 17. Does MBCC require proof of income? What constitutes proof?

Answer. If eligible for services under the BCCS program, a woman does not have to re-verify income to receive benefits under MBCC. Income is documented by the BCCS contractors who help women apply for MBCC.

Question 18. What supporting documentation should be attached to the Form 1034?

Answer. A pathology report of a biopsy-confirmed qualifying diagnosis and U.S. citizenship and identification documents should be attached to the Form 1034.

Question 19. For auditing purposes, what documentation /proofs are required to be in the patient's clinic record?

Answer. BCCS requires documentation of the qualifying diagnosis and Form 1034 to be included in the client health or case management record.

Question 20. Can a woman who was diagnosed after 9/1/07, but who did not meet financial eligibility requirements as set by BCCS or had creditable insurance coverage at the time of diagnosis, qualify for MBCC if at a later time she is subsequently determined to meet financial requirements or loses insurance coverage?

Answer. Yes, if she now meets other eligibility requirements and needs treatment for her cancer, she may be eligible for MBCC coverage.

Question 21. Can the contractor receive an electronic copy of the application (Form 1034)?

Answer. HHSC does not plan to make the copy available electronically.

Question 22. Where can a woman call to ask specific questions regarding her MBCC coverage, application, or for information on how to apply for benefits?

Answer. If she is currently receiving MBCC or has questions regarding an application she submitted, she can call 1-800-248-1078. For information on how to apply for MBCC, she can call 2-1-1 (Option 2) or her local Health and Human Services Commission office.

Coverage

Question 1. What is the scope of coverage under MBCC?

Answer. During the period of eligibility, a woman is entitled to full Medicaid coverage as specified in the state plan. Coverage is not limited to treatment of breast or cervical cancer (including pre-cancerous condition).

Question 2. What is the effective date of MBCC coverage?

Answer. If the file date and the diagnosis date fall within the same month, then the Medical Effective Date (MED) will be the same as the diagnosis date. If the Form 1034 file date and the diagnosis date are in separate months, then the MED will default to the first day of the month in which the form was filed. If the client provides verification of unpaid bills with dates of service that occurred in a previous month, but on or after the date of diagnosis, then the eligibility date can be adjusted to be the date of the diagnosis.

Question 3. Are medical bills unrelated to the cancer diagnosis covered by MBCC?

Answer. Yes. The woman is enrolled in Medicaid; any service she receives is eligible for full Medicaid benefits covered under the Texas Medicaid program. All eligible medical bills are covered from the date of diagnosis. Dependent medical bills are not covered under the program, only the BCCS client's medical bills.

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Question 4. Are follow-up visits covered as part of treatment? For example, after chemotherapy and radiation or after Leep or Cryotherapy, a woman is given instructions to follow-up every 3 months with her oncologist for two years. During that time, follow-up mammograms or pap tests are also ordered.

Answer. If the patient's treating physician determines that the patient is still in active treatment, surveillance and monitoring visits, mammograms and pap tests would be covered services by Medicaid. Once active treatment is completed, screening mammograms and pap tests would be considered routine screening services and can be covered by the BCCS program.

Question 5. Is hormone (anti-estrogen) therapy a Medicaid covered service?

Answer. Hormone (anti-estrogen) therapy is a standard part of treatment for women with estrogen receptor-positive breast cancer. The two main types of hormone therapy are 1) selective estrogen receptor modulators like Tamoxifen and 2) aromatase inhibitors like Arimidex and Femara. Typically, hormone therapy is provided following the end of the first phase of treatment, which may include surgery, radiation, and chemotherapy.

For women with estrogen receptor-positive tumors, hormone (anti-estrogen) therapy following completion of the first phase of treatment is regarded as part of ongoing, active treatment. The Medicaid program regards this use of hormone (anti-estrogen) therapy as medically necessary and is a covered service.

Question 6. What pre-cancerous and cancer conditions are covered by MBCC?

Answer. The BCCS program considers the following biopsy-confirmed diagnoses: a) Cervical includes CIN III, severe cervical dysplasia, cervical carcinoma in–situ, invasive cervical cancer; b) Breast includes ductal carcinoma in-situ, and invasive breast cancer as qualifying diagnoses for MBCC eligibility. (Qualifying Diagnosis Information).

Question 7. How does HHSC go about paying previous unpaid medical bills?

Answer. After submission of the Form 1034, providers should submit prior unpaid medical bills to HHSC. The woman needs to inform HHSC of unpaid bills. HHSC will request verification if coverage is needed and bills were not submitted by the provider.