2198 – WOMEN'S HEALTH MEDICAID

POLICY STATEMENT

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 provides Medicaid coverage to women diagnosed and who are in need of treatment for breast or cervical cancer and/or precancerous conditions of the breast or cervix. This coverage is provided under the Women's Health Medicaid class of assistance.

BASIC CONSIDERATIONS

Effective July 1, 2001 the Department of Community Health (DCH) began implementation of the Women's Health Medicaid (WHM) class of assistance (COA) for women who are in need of treatment for breast and cervical cancer, including pre-cancerous conditions and early stage cancer.

Public Health or one of its partner affiliates completes the breast and/or cervical cancer screening in accordance with the Center for Disease Control (CDC) guidelines established under Title XV.

To be eligible under the WHM COA an A/R must meet the following conditions:

- Screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program in accordance with Title XV guidelines, and diagnosed and found to be in need of treatment for breast or cervical cancer or a precancerous condition of the breast or cervix.

- Have no creditable health coverage, including health insurance, Medicare and/or Medicaid.

  EXCEPTION: There may be limited circumstances where the A/R has creditable coverage but is in a period of exclusion such as a pre-existing condition or where life time limits have been exhausted. In these situations, the A/R is considered uninsured.

- Is under age 65.

- Is a U.S. citizen or a lawfully admitted immigrant.

  NOTE: A/R's who do not meet the citizenship requirement may qualify for this COA using EMA criteria. EMA is not completed as part of the PE process.

BASIC CONSIDERATIONS (cont.)

Other Eligibility Factors

In order to be considered for the WHM COA, the A/R's income must be under 200% of the Federal Poverty Level, as required by the Title XV program. This screening of income is completed during the Presumptive Eligibility process by the local public health department.

The A/R must be a Georgia resident.

A/R's approved for this COA are entitled to the full range of Medicaid covered services. Eligibility for coverage ends when the A/R's course of treatment is completed or they no longer meet eligibility requirements (for example, they have attained the age of 65 or obtained creditable health coverage) or they become eligible under another Medicaid COA.

Eligibility begins the month of application if the A/R meets all eligibility criteria. Retroactive Medicaid is available provided the A/R has an affirmative diagnosis of breast or cervical cancer or pre-cancer and meets all other eligibility criteria in the prior month(s) requested.

PROCEDURES

Process/Implementation

This program involves the Department of Community Health, Division of Public Health and the Right from the Start Medicaid Project. The eligibility determination is a two-pronged process consisting of a presumptive eligibility determination and a determination of eligibility for regular categories of Medicaid.

Presumptive Eligibility Process

Women who have received a diagnosis or suspect they have cervical or breast cancer must apply initially through the local public health department. Public health or one of its partner affiliates will complete the breast and/or cervical cancer screening procedures in accordance with CDC guidelines established under Title XV.

If the woman meets all of the guidelines set forth by Title XV, public health will take a Presumptive Eligibility application. This consists of completing an application, interviewing the woman and determining eligibility in accordance with the basic eligibility criteria.

PROCEDURES (cont.)

Presumptive Eligibility Process (cont.)

As part of the Presumptive Eligibility determination process, health department personnel are required to complete the DMA-632W Eligibility Determination for Women's Health Medicaid Program; Form 216, citizenship affidavit, DMA-285, Health Insurance Questionnaire; and the DMA-634W, Notice of Action.

NOTE: The DMA-285 is completed by the health department as part of the PE application. Any coverage that pays the cost of cancer treatment would make her ineligible. Limited scope coverage such as vision or dental coverage would not. The DMA-634W is only completed if the application is denied.

If the A/R is determined eligible, they will be given temporary Medicaid certification forms. The A/R will have immediate access to health care and the full range of Medicaid covered services until the plastic Medicaid card is received. The A/R is also given a Notice of Action form advising of approval and a list of cancer specialists in their area.

Public Health departments will enter the eligibility information directly into the Georgia Medicaid Management Information System (GAMMIS) if the application is approved and the A/R will receive a plastic Medicaid card. A/R's eligible under this COA are assigned to one of the Care Management Organizations (CMOs) serving their area. There are no co-payments in the WHM program.

If the A/R is determined to be ineligible for the program, public health gives a Notice of Action advising of ineligibility, an application for the State Cancer Aid Program and a list of cancer specialists in their area.

PROCEDURES (cont.)

Eligibility Determination

Public Health will forward to local RSM Project staff copies of all applications, approved or denied, for review and to determine the A/R's ongoing eligibility under the WHM COA or any other potential Medicaid COA such as RSM or Low Income Medicaid.

If continued eligibility is determined for WHM or RSM COA, state RSM Project staff have the responsibility for ongoing case maintenance. If the A/R is potentially eligible for another Family Medicaid COA, the local RSM Project staff will complete the eligibility determination if there is no active FS or TANF case. If there is an active FS or TANF case, the application will be sent to the county DFCS office for processing of the Family Medicaid. If the A/R appears to be potentially eligible for an ABD COA, the application will be forwarded to the appropriate county DFCS office.

WHM cases are reviewed for continuing eligibility one year after approval by the RSM Project Arrowhead Team. The A/R is mailed a cover letter, a Review Form, a Physician's Treatment form, and a list of all RSM Project offices for contact information. The A/R is given approximately 30 days to return her information to the Arrowhead office. Once the information is returned, the Arrowhead Team completes the eligibility review.

If a WHM case has been denied or closed within the 3 prior months, the A/R can reapply with an RSM Project worker using the form 94. In addition to the 94, the A/R must submit a physician's statement of treatment or a certificate of diagnosis. Either of these must be less than 30 days old. The RSM worker will screen on GHP to verify previous receipt of WHM. If the A/R does not show on GHP, a copy of the original presumptive WHM application must be obtained before the reapplication can be completed.

Reports

When an A/R is found to be ineligible by local RSM Project staff, the A/R is sent appropriate notification. Appeal rights are applicable when eligibility for continued Medicaid is denied. Appeals and all inquiries pertaining to Women's Health Medicaid cases should be directed to the RSM Project at 1-800-809-7276 or to the local RSM Project supervisor. Refer to Appendix B-Hearings.

Reports	Presumptive **WHM** reports are available at www.mmis.georgia.gov. Detailed instructions can be found in Appendix J.