



California
Department of
Health Services

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Department of Health Services



ARNOLD SCHWARZENEGGER
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TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 06-25
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIASONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

SUBJECT: ELIGIBILITY DETERMINATION UNDER OTHER MEDI-CAL PROGRAMS
FOR BENEFICIARIES TERMINATED FROM THE FEDERAL BREAST
AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP)
(Ref: All County Welfare Directors Letters No. 01-36, 01-39, 02-12, 02-59
and 06-09)

This letter provides counties with instructions on the processing of BCCTP cases that require an SB 87 redetermination when a beneficiary is no longer eligible for federal full-scope or restricted-scope Medi-Cal benefits under BCCTP rules. All County Welfare Directors Letter (ACWDL) No. 06-09 dated February 24, 2006, provided an overview of the BCCTP. Counties shall refer to ACWDL No. 06-09 regarding BCCTP eligibility requirements and aid codes for both federal and State-funded components.

The California Department of Health Services has the statutory authority to complete eligibility determinations for BCCTP applicants under BCCTP rules. When a BCCTP beneficiary no longer meets the federal BCCTP requirements and is scheduled to be discontinued from her BCCTP Medi-Cal eligibility, an eligibility review under other Medi-Cal programs must be completed before her BCCTP Medi-Cal benefits can be discontinued. The BCCTP does not have statutory authority to make determinations of eligibility for any other Medi-Cal program. Therefore, when BCCTP determines that a woman is no longer eligible for Medi-Cal under the federal BCCTP rules, the BCCTP staff will discontinue her from BCCTP Medi-Cal and place her in an interim Medi-Cal aid code (to be discussed later in this ACWDL) pending the county completion of redetermination, as required by Welfare and Institutions (W&I) Code, Section 14005.37.

A woman becomes ineligible for federal BCCTP Medi-Cal benefits under any of the following circumstances:

1. She has turned 65 years of age.
2. She has obtained creditable insurance coverage, as determined by BCCTP.

A woman having the following types of coverage would be considered to have creditable coverage and would therefore be ineligible for BCCTP Medi-Cal.

- A group health plan
 - Health insurance coverage – benefits consisting of medical care (provided 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.
 - Medicare
 - Medi-Cal (full-scope, no share-of-cost)
 - Armed Forces insurance
 - A state health risk pool
3. She no longer needs treatment for breast and/or cervical cancer, as determined by her treating physician.

Only those cases where the woman is determined by BCCTP staff to no longer meet the federal BCCTP eligibility criteria will be referred to the counties. There are certain reasons for discontinuance from BCCTP Medi-Cal that do not require a redetermination by the county. As indicated in Sections 14005.37 and 14005.39, these exceptions are:

- Death
- Moved out of state
- Voluntary withdrawal from the Medi-Cal program
- Failure to cooperate or fraud

BCCTP and County Coordination

When the BCCTP beneficiary is determined no longer eligible for federal BCCTP Medi-Cal, BCCTP staff will send a Notice of Action (NOA) to inform her of this, as well as the reason for the discontinuance. (See Attachments 1, 2, 3 and 4). The NOA will advise the BCCTP beneficiary that she will continue to receive full-scope, no-cost

Medi-Cal or restricted Medi-Cal on an interim basis until the county makes a determination of her eligibility for any other Medi-Cal program. The beneficiary will continue to receive full-scope, no-cost Medi-Cal benefits or restricted benefits until the county social services agency completes a redetermination of her eligibility under other Medi-Cal programs. The NOA also includes language to advise her that, during the county's redetermination, she will be asked by the county to provide additional information on income, resources and family composition.

During the State-to-County coordination period, the beneficiary will continue to receive the same level of Medi-Cal benefits (full-scope or restricted) as she was receiving under BCCTP until an SB 87 Redetermination is reported to MEDS. A woman discontinued from full-scope federal BCCTP Medi-Cal will continue to receive full-scope benefits on an interim basis; whereas, a woman without satisfactory immigration status who is discontinued from restricted BCCTP Medi-Cal benefits will continue to receive federal emergency and pregnancy-related services and State-only long-term care services.

BCCTP staff will notify the county BCCTP contact person via facsimile with the Breast and Cervical Cancer Treatment Program County Notification form (Attachment 5) when a BCCTP case requires a county redetermination under other Medi-Cal programs. If BCCTP staff has information that the beneficiary already has an opened Medi-Cal case at the county, such as Medi-Cal with a share-of-cost or emergency/pregnancy-related Medi-Cal, BCCTP staff will include the county case information on the County Notification form with the county case number and worker code showing on MEDS to facilitate the county redetermination process as the county case worker may not be aware of the change in the BCCTP beneficiary's circumstances that generated the BCCTP discontinuance. BCCTP staff will send a copy of the case record by regular mail. The BCCTP case file may contain the following documents:

1. BCCTP application. (The screening and diagnosis to be blocked out).
2. BCCTP Continuing Eligibility Redetermination Form if an Annual Redetermination was completed.
3. BCCTP Rights and Responsibilities form.
4. Statement of Citizenship, Alienage, and Immigration Status form (MC 13), if applicant did not declare she was born in the U.S. or U.S. territory.
5. Verification/documentation of immigration status.

6. Copy of Social Security card or other identification, if available.
7. Health Insurance Questionnaire (DHS 6155).
8. BCCTP Medi-Cal NOA advising her of her discontinuance from federal BCCTP Medi-Cal.

The BCCTP is establishing three interim aid codes and women will remain in the appropriate interim aid code until the county makes an eligibility determination. Until the BCCTP interim aid codes are operational, federal BCCTP beneficiaries who are being discontinued will continue in the same BCCTP aid code, pending the outcome of the county's eligibility determination. Once the BCCTP interim aid codes are operational, those beneficiaries determined no longer eligible for federal BCCTP or restricted Medi-Cal benefits will be placed in a corresponding interim aid code pending a county determination. The "Exception Eligibles" tracking report to counties on a monthly basis is a tool for ensuring that the interim BCCTP cases have a completed county eligibility determination. The Exception Eligibles report will be broken out to show the number of months the beneficiaries have been in a BCCTP interim Medi-Cal aid code pending county redetermination. BCCTP will issue another ACWDL to provide counties with information of these interim aid codes, county exception eligible reports and any worker alerts.

During this State-to-County coordination period, if the woman being discontinued from federal BCCTP Medi-Cal (Aid Code ØP) appears eligible for State-funded BCCTP coverage, BCCTP staff will concurrently determine her eligibility under the State-funded component pending the outcome of the county's Medi-Cal eligibility review. This concurrent review process will assure that a determination will be made if she is eligible under the State-funded BCCTP component so she may continue to receive cancer treatment without any break in coverage, if not eligible under any other Medi-Cal program. Unlike full-scope or restricted Medi-Cal, State funded BCCTP will only provide breast and/or cervical cancer treatment and related services (limited to 18 months for breast cancer and 24 months for cervical cancer). If the county determines the beneficiary is eligible for full-scope, no-SOC Medi-Cal under another program, she will be terminated from interim Medi-Cal coverage at the end of the month and will not be placed into State-funded BCCTP. If the county determines that she is eligible for another Medi-Cal program, but with a limited scope of coverage or a SOC, she may be determined eligible for the State-funded program if she meets all State-funded eligibility criteria.

Identifying the BCCTP cases on the Medi-Cal Eligibility Data System (MEDS)

BCCTP aid codes are the responsibility of the State. BCCTP eligibility information is available in the MEDS secondary screens: MEDS Q1, Q2 or Q3 screens. ACWDL No. 06-09 provided descriptions of all seven BCCTP aid codes. The BCCTP beneficiaries who will be discontinued from BCCTP benefits for the reasons identified above and who require a county Medi-Cal redetermination are in the following three BCCTP aid codes:

1. Aid Code ØP – Federal BCCTP eligibility determined, full-scope, no-SOC Medi-Cal.
2. Aid Code ØU - Federal/State-funded – Restricted Medi-Cal Services and State-funded Cancer Treatment and Related Services for women without Satisfactory Immigration Status (SIS) – redetermination does not include the State-funded services.
3. Aid Code ØV – Continuing Federal Restricted Services for those who were ØU eligibles, but have exhausted their period of State-funded cancer treatment services, but still need treatment and still meet all federal BCCTP requirements except for SIS.

When the county receives a BCCTP case for redetermination, the county must complete either a MEDS AP 18 or AP 20 transaction to report the date the county received the case and started the redetermination process. There will not be any special transaction entries required to change a BCCTP interim aid code to another Medi-Cal program aid code. If the beneficiary is found eligible for regular Medi-Cal after the county completes the eligibility review, the county will report the eligibility to MEDS as any other newly determined eligible beneficiary is being reported. If the beneficiary is found ineligible for Medi-Cal, the county will use the MEDS AP 34 or EW 34 transaction to report the outcome. The county's determination of eligibility or ineligibility must be reported to MEDS online or through batch transaction so that the beneficiary's eligibility status is reported correctly. The county must issue a NOA to approve or deny regular Medi-Cal to the beneficiary.

County Eligibility Determination Process

The county, upon receipt of a BCCTP case, must complete the eligibility review within 60 days. The 60-day period begins from the date BCCTP staff sends the BCCTP Notification via facsimile. Unlike other Medi-Cal applicants, the BCCTP applicants do

not complete a standard Medi-Cal Statement of Facts form when they apply for Medi-Cal under BCCTP. The BCCTP applicants complete an abbreviated BCCTP Internet-based application and a modified BCCTP Rights and Responsibilities form at an enrolling provider's office. Because BCCTP has no income or resource requirement, and the beneficiary's household composition information is not obtained with the application, the beneficiary's BCCTP case file contains limited information that the county can use to complete the eligibility review. Counties shall use the SB 87 process identified below to obtain any additional information required to make an eligibility determination for other Medi-Cal programs.

During the county eligibility redetermination process, counties must ensure that these beneficiaries receive copies of the standard Medi-Cal information notices, including the MC 007 (Medi-Cal General Property Limitation), MC 219 (Rights and Responsibilities) and as appropriate, the DHS 7007 (Notice Regarding Standards for Medi-Cal Eligibility) and DHS 7007A (Notice Regarding Transfer of Home for Both a Married and an Unmarried Applicant/Beneficiary), so that they have necessary information about property and spenddown.

The county will require additional contacts with the beneficiary to obtain information to complete their eligibility review. If counties have specific case questions or need additional information from BCCTP, they should contact the BCCTP staff assigned to the case. The BCCTP staff email address and telephone number can be located on the BCCTP County Notification form. All BCCTP Medi-Cal cases referred to the county for a Medi-Cal determination must be redetermined under the SB 87 three-step process, as outlined in ACWDL 02-59 and summarized below. Counties must follow each step sequentially until the beneficiary's continued Medi-Cal eligibility or ineligibility is accurately determined.

Step One- *Ex parte* Review

The first step in the SB 87 process is the *ex parte* review, without beneficiary contact. This review involves evaluation of all sources of information available to the county to make a Medi-Cal redetermination. All information sources reasonably available to the county include information from BCCTP, Medi-Cal, Food Stamps, General Relief/Assistance, Foster Care, and California Work Opportunity and Responsibility to Kids case files of the beneficiary or any one of his or her immediate family members, which are open or were closed within the last 45 days. The counties are also to use, if appropriate, other sources of relevant information, including MEDS and the Income Eligibility Verification System.

If the *ex parte* review proves to be inadequate to complete the Medi-Cal determination, the county is required to complete Step Two.

Step Two- Direct Contact

If the Medi-Cal determination cannot be established by *ex parte review*, the county must attempt to contact the beneficiary by telephone. The beneficiary's telephone number is displayed on the MEDS address inquiry screen, as well as on other documentation contained in the BCCTP case file. When contacting the beneficiary, the county should remind the beneficiary that her regular Medi-Cal eligibility is being redetermined and more information is needed to complete the eligibility review. The county should further inform the beneficiary that her continued eligibility for Medi-Cal can be established under various avenues of eligibility, including an allegation of disability (refer to ACWDL 01-36).

If telephone contact with the beneficiary results in the establishment of continued Medi-Cal eligibility, then Step Three is not required. If the telephone contact with the beneficiary does not result in eligibility for the Medi-Cal program, and all avenues to continue Medi-Cal have not been exhausted (including any allegation of disability), then Step Three is required.

Step Three-The Request for Information Form (MC355)

The county shall send the beneficiary an MC 355, which asks for information to establish continued Medi-Cal eligibility after the *ex parte* review, and states that telephone contacts have been unsuccessful. The county shall highlight on the form only the information needed to complete the eligibility determination. The beneficiary must have 20 days to respond to the Request for Information Form.

If the beneficiary returns the completed MC 355 within 20 days and the county determines the beneficiary is eligible or ineligible for regular Medi-Cal benefits, the county shall send the appropriate NOA to the beneficiary regarding the approval or denial of Medi-Cal benefits.

If the beneficiary does not return the completed form to the county within 20 days of the date the county mailed the form, the county must send the beneficiary a NOA stating that her Medi-Cal eligibility has been denied. The county shall notify the BCCTP staff via email or telephone of the denial so that the BCCTP staff may discontinue the beneficiary's interim Medi-Cal benefits with a timely NOA.

If, during the eligibility review, the beneficiary alleges to have a disability, the county shall refer to policy directives outlined in ACWDL 02-59 and in Medi-Cal Eligibility Procedures Manual, Article 22, C-9, on reexaminations, redeterminations, and reevaluations for disability allegations and referrals to the State Programs Disability and Adults Program Division (SP-DAPD). ACWDLs 01-36 and 02-40 provide counties with instructions on disability linkage to Medi-Cal through SP-DAPD when no other linkage to the Medi-Cal program exists and when the individual alleges to have a disability during an SB 87 redetermination process. The beneficiary must be placed in aid code 6J, 6R, 5J, or 5R, as appropriate, while the disability claim is pending. Counties shall notify BCCTP staff of the individual's disability case status (approval or denial) as well as update MEDS with the disposition of the case.

State Hearings and Appeals

All beneficiaries in these three federal BCCTP Medi-Cal aid codes have the same hearing and appeal rights as any other Medi-Cal beneficiary. If the woman files an appeal on the BCCTP Medi-Cal discontinuance, the BCCTP Eligibility Specialist will prepare the position statement. If an individual is denied Medi-Cal based on the county's determination and she files an appeal, the county will need to prepare the position statement.

Medi-Cal Annual Redetermination Dates

If a former BCCTP beneficiary is being added to an existing Medi-Cal Family Budget Unit (MFBU), the Annual Redetermination date for this individual is the same redetermination date as the other members in the MFBU. For all other BCCTP women who are determined eligible for Medi-Cal, the Annual Redetermination date will be 12 months from the month the county completes the redetermination under another Medi-Cal program. For example:

- BCCTP beneficiary placed in interim Medi-Cal aid code: June 2006.
- County receives BCCTP case file and completes AP 18: June 2006.
- County approves no-cost Medi-Cal: August 2006.
- Next Annual Redetermination is due: July 2007.

Managed Care


The full-scope BCCTP Medi-Cal eligibles (aid code ØP) have voluntary optional enrollment in a two-plan or geographic managed care county. BCCTP is working with the Medi-Cal Managed Care Division to establish a voluntary enrollment option for the

full-scope interim Medi-Cal aid code used for BCCTP discontinuances to ensure continuity of care for those who are currently enrolled into a Medi-Cal managed care health plan. This means that, if a full-scope BCCTP beneficiary voluntarily enrolled into a managed care health plan before her discontinuance from BCCTP Medi-Cal benefits, she will continue to access health care from her enrolled health plan during the interim period. For the beneficiaries who reside in a county under the County Organized Health System (COHS), they will access health care under the county's COHS.

County and State coordination on these cases will ensure seamless transition of eligible women from federal BCCTP to regular Medi-Cal or to State-funded BCCTP, as appropriate. If counties have questions regarding this ACWDL or changes to the BCCTP County Liaison List, please contact Ms. Barbara Rodriguez at (916) 552-8090 or brodrigu@dhs.ca.gov. Case-specific questions must be directed to the BCCTP staff assigned to the case.

Original signed by

Maria Enriquez, Chief
Medi-Cal Eligibility Branch

Enclosures 

BREAST AND CERVICAL CANCER TREATMENT PROGRAM COUNTY NOTIFICATION-MEDI-CAL DETERMINATION

Instructions: Complete each space or box. If information does not pertain to this case, indicate with N/A.

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| To: County: _____ Medi-Cal Liaison Name: _____ Liaison Telephone: _____ Fax Number: _____ E-mail Address: _____ | From: State department of Health Services Breast and Cervical Cancer Treatment Program Eligibility Specialist (ES): _____ ES Telephone: _____ ES Fax Number: _____ ES E-mail Address: _____ | | |
| BCCTP Beneficiary Information | | | |
| | | | |
| Name | Phone number () | Alternate/Message phone number () | |
| Address (number, street) | City | ZIP code | |
| Authorized representative <input type="checkbox"/> Yes <input type="checkbox"/> No | AR name | AR phone number () | Beneficiary's primary language |
| Case Documents in Referral Packet: | | | |
| <input type="checkbox"/> BCCTP Application or BCCTP Addendum Application for Signature <input type="checkbox"/> Statement of Citizenship, Alienage, and Immigration Status (MC13) <input type="checkbox"/> Medi-Cal Rights, Responsibilities and Declarations (MC210BC) <input type="checkbox"/> Identifications <input type="checkbox"/> Social security card <input type="checkbox"/> Immigration documents <input type="checkbox"/> Other Health Coverage Information (DHS 6155) <input type="checkbox"/> Last Notice of Action <input type="checkbox"/> Case details <input type="checkbox"/> Other _____ | | | |
| Reason for Federal BCCTP discontinuance: | | | |
| <input type="checkbox"/> Beneficiary has turned 65 years of age on _____. <input type="checkbox"/> Beneficiary has obtained creditable insurance coverage _____. <input type="checkbox"/> Beneficiary no longer needs treatment for breast and/or cervical cancer _____. <input type="checkbox"/> Other _____ | | | |