State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

August 1, 2011

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

Letter No.: 11-29

SUBJECT: ELIGIBILITY REDETERMINATION UNDER OTHER MEDI-CAL PROGRAMS FOR BENEFICIARIES TERMINATED FROM THE FEDERAL BREAST AND CERVICAL CANCER TREATMENT PROGRAM
(Ref: All County Welfare Directors Letters No. 01-36, 01-39, 02-12, 02-59 and 06-09 and 06-25).

This All County Welfare Directors Letter (ACWDL) supersedes and obsoletes ACWDL No. 06-25

This letter provides counties with instructions on the processing of the Breast and Cervical Cancer Treatment Program (BCCTP) cases that require an SB 87 process when a beneficiary is no longer eligible for federal full-scope or restricted-scope Medi-Cal benefits under BCCTP rules. ACWDL No. 06-09 dated February 24, 2006, provided an overview of BCCTP. Counties shall refer to ACWDL No. 06-09, regarding BCCTP eligibility requirements and aid codes for both federal and state-funded components. ACWDL 06-25 provided instructions on cases requiring a Medi-Cal redetermination (pursuant to SB 87), because the cases were referred from BCCTP to the county. ACWDL 06-25 is superseded and made obsolete by this letter, which provides the most current and correct instructions.

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BACKGROUND

The Department of Health Care Services (DHCS) has the statutory requirement to perform eligibility determinations for BCCTP applicants and beneficiaries under BCCTP rules. When a BCCTP beneficiary no longer meets the federal BCCTP requirements and is scheduled to be discontinued from BCCTP Medi-Cal, an eligibility review under other Medi-Cal programs must be completed before BCCTP Medi-Cal benefits can be discontinued. BCCTP does not have statutory authority to make redeterminations 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, 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 the SB 87 process, 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:

- She has turned 65 years of age.
- 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 (SOC));
        - Armed Forces insurance; or
        - A state health risk pool.
- She no longer needs treatment for breast and/or cervical cancer, as determined by her treating physician.

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

- Death,
- No longer a resident of California,
- Voluntary withdrawal from the Medi-Cal program,
- Failure to cooperate, or
- Fraud

BCCTP and County Coordination

When it is determined that a BCCTP beneficiary is no longer eligible for federal BCCTP Medi-Cal, 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 process is completed and reported to the Medi-Cal Eligibility Data System (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 send an Informational Notice, to inform the beneficiary that she will continue to receive full-scope, no SOC Medi-Cal, or restricted Medi-Cal, until the county makes a determination of her eligibility for any other Medi-Cal program, as well as the reason for the pending discontinuance. The notice 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 (See Enclosure1).

BCCTP is establishing four 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, beneficiaries determined no longer eligible for federal BCCTP Medi-Cal benefits will be placed in a corresponding interim aid code pending a county redetermination. Interim aid codes are in effect as of July 25, 2011. The counties will receive an "Exception Eligibles" (EE) tracking report on a monthly basis. The EE report is a tool for ensuring the interim BCCTP cases have a completed county eligibility determination. The EE report will show the number of months the beneficiaries have been in a BCCTP interim Medi-Cal aid code pending county redetermination.

During this state-to-county coordination period, if the woman being discontinued from federal BCCTP Medi-Cal (Aid Code 0P) 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 ensure 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). When the county makes a determination and a transaction is entered into MEDS, BCCTP will receive an alert advising that the county has taken action on the case. If the county determines the beneficiary is eligible for full-scope, no-SOC Medi-Cal under another program, she will be transferred from interim Medi-Cal coverage at the end of the month to the full scope Medi-Cal program 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, BCCTP will determine if the woman is eligible for the state-funded program. Upon BCCTP receiving the alert, a ten-day Notice of Action (NOA) will go out to the beneficiary informing them that they are being discontinued from Medi-Cal through BCCTP (See Enclosure 2).

IDENTIFYING THE BCCTP CASES ON 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. ACWDL No. 06-09 provided descriptions of all seven BCCTP aid codes. BCCTP beneficiaries, who will be discontinued from BCCTP benefits for the reasons identified above, and who will require a county Medi-Cal redetermination, are in the following three BCCTP aid codes:

- Aid Code 0P – Federal BCCTP eligibility determined, full-scope, no-SOC Medi-Cal.

- Aid Code 0U - 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.

- Aid Code 0V – Continuing Federal Restricted Services for those who were 0U eligibles, who have exhausted their period of state-funded cancer treatment services, but still need treatment and still meet all federal BCCTP requirements except for SIS.

The four new BCCTP interim aid codes, scope of coverage and descriptions are:

- Aid Code 0W - Transitional full-scope Medi-Cal coverage with no SOC to BCCTP beneficiaries terminated from aid code 0P because they have obtained age 65, acquire creditable health coverage, or are no longer in need of treatment for breast and/or cervical cancer.

- Aid Code 0X – Transitional restricted Medi-Cal *and* State-funded cancer treatment and related services to BCCTP beneficiaries terminated from aid code 0U because they have obtained creditable health coverage, but their out-of-pocket expenses for the health coverage will exceed $750 in the next twelve-month period and have not exhausted the 18 or 24 months of State-funded eligibility.
  Note: If the county does not make a determination before the end of the beneficiary's 18 months (for breast cancer) or 24 months (for cervical cancer) of State-funded eligibility, when State-funded eligibility ends the beneficiary will be placed into aid code 0L until the county makes a determination. (See aid code 0L description below).

- Aid Code 0Y - Transitional restricted Medi-Cal *and* State-funded cancer treatment and related services to beneficiaries terminated from aid code 0U because they have turned 65 years of age, have no creditable health coverage, and have not exhausted the 18 or 24 months of state-funded eligibility.
  Note: If the county does not make a determination before the end of the 18 or 24 months of State-funded eligibility, when State-funded eligibility ends, the beneficiary will be placed in aid code 0L, until the county makes a determination. (See aid code 0L description below).

- Aid Code 0L - Transitional, restricted Medi-Cal to beneficiaries:
  - Terminated from aid code 0U because they are no longer in need of treatment for breast and/or cervical cancer;
  - Terminated from aid code 0U because they acquired creditable health coverage, but their out-of-pocket expenses will *not* exceed $750 in the next 12 month period;
  - Terminated from aid code 0V because they have obtained age 65, acquire creditable health coverage, or are no longer in need of treatment for breast and/or cervical cancer;
  - Who have exhausted their 18 or 24 months of State-funded BCCTP coverage pending the county determination while in interim aid code 0X or 0Y.

BCCTP RESPONSIBILITIES

When BCCTP refers a case to the county, BCCTP shall:

1. Terminate the beneficiary from the BCCTP aid code;
2. Complete the MEDS transaction to place the beneficiary in the correct interim aid code;
3. Notify the county BCCTP liaison by facsimile with the BCCTP County Notification form when a BCCTP case requires a county redetermination under other Medi-Cal programs. If BCCTP staff has information that the beneficiary has an open Medi-Cal case at the county, such as Medi-Cal with a SOC 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 some or all of the following documents:

- BCCTP abbreviated application. (The screening and diagnosis to be blocked out).
- BCCTP Continuing Eligibility Redetermination Form if an Annual Redetermination was completed.
- BCCTP Rights and Responsibilities form.
- 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.
- MEDS screen showing "QE" screen if DRA has been met.
- Verification/documentation of immigration or citizenship status.
- Copy of Social Security card or other identification, if available.
- Health Insurance Questionnaire (DHS 6155), if available.
- BCCTP Medi-Cal Informing Notice advising her of her pending discontinuance from federal BCCTP Medi-Cal.

4. Determine if beneficiary is eligible for State-funded BCCTP;
5. Check MEDS for the county determination once an alert is received;
6. Send a ten-day NOA;
7. Place the beneficiary into the State-funded program on the first of the month following the termination of Medi-Cal benefits to ensure the beneficiary continues to have access to cancer-related treatment and services.
8. Send the beneficiary an Eligibility Letter to inform them of their BCCTP eligibility.

COUNTY RESPONSIBILITY

The county, upon receipt of a BCCTP case, must complete the eligibility review following the SB87 redetermination process. Unlike other Medi-Cal applicants, BCCTP applicants do not complete a standard Medi-Cal Statement of Facts form when they apply for Medi-Cal under BCCTP. 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 later in the letter) to obtain any additional information required to make an eligibility determination for other Medi-Cal programs.

When the county receives a BCCTP case for redetermination, the county shall:

1. Complete either a MEDS AP 18 or an AP 20 transaction to report the date the county received the case and started the redetermination process.

2. Ensure beneficiaries receive copies of the standard Medi-Cal information notices, including:

    - MC 007 (Medi-Cal General Property Limitation),
    - MC 219 (Rights and Responsibilities) and as appropriate,
    - DHS 7077 (Notice Regarding Standards for Medi-Cal Eligibility) and
    - DHS 7077A (Notice Regarding Transfer of Home for Both a Married and an Unmarried Applicant/Beneficiary).

3. Make an eligibility determination for all other Medi-Cal programs using the SB 87 process;

4. Report the eligibility to MEDS. If the beneficiary is found eligible for full-scope no SOC Medi-Cal, after the county completes the eligibility review;

5. Use the MEDS AP 34 or EW 34 transaction to report the denial if the beneficiary is found ineligible for Medi-Cal;

6. Issue a NOA to approve or discontinue regular Medi-Cal to the beneficiary.

   NOTE: There will not be any special transaction entries required to change a BCCTP interim aid code to another Medi-Cal program aid code because the county's transaction on the outcome of the eligibility determination will automatically terminate the beneficiary's interim aid code benefits. Therefore, it is important the county's determination be reported to MEDS timely and correctly.

COUNTY REDETERMINATION (SB 87) PROCESS

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. 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 an *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 telephone contact 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 discontinuance of Medi-Cal benefits.

If the beneficiary does not respond to the county within 20 days of the date the county mailed the form, the county shall send the beneficiary a NOA stating that her Medi-Cal eligibility has been discontinued.

If the county receives incomplete information within 20 days, the county shall attempt to contact the beneficiary either by telephone or in writing to request the information and/or verification. For written contact the county may use a second MC 355 form with a ten-day due date. If the beneficiary does not comply within the ten days, the county shall send a ten-day discontinuance NOA, which clearly explains the reason for the discontinuance.

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, 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 provided 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 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.

EXAMPLE OF PROCESS

The following example illustrates a seamless eligibility determination process for county and State-funded BCCTP staff.

During the annual redetermination, a BCCTP beneficiary has been determined to have creditable health coverage and not eligible for full-scope Medi-Cal benefits under aid code 0P. However, the beneficiary's estimated out-of-pocket expenses for the next 12 months will exceed $750, she would be eligible for State-funded BCCTP coverage if she is not eligible for other full-scope, no SOC Medi-Cal benefits.

1. BCCTP Eligibility Specialist (ES) completes MEDS online transaction on June 18, 2011, and places the beneficiary into interim aid code 0W effective July 1, 2011, pending the county's determination under all other Medi-Cal programs;

2. BCCTP ES sends referral to the County on June 20, 2011;

3. County receives the referral packet on July 1, 2011, and completes MEDS transaction to show application pending status;

4. County receives the EE-BCCTP Report showing the beneficiary interim aid code status;

5. County completes the SB 87 process on August 20 2011, and finds beneficiary not eligible for other full-scope, no SOC Medi-Cal;

6. County performs a MEDS transaction on August 20, 2011, to deny on MEDS. This transaction automatically terminates BCCTP interim aid code and sends a ten-day NOA, effective August 31, 2011, (denial action will generate a worker alert to BCCTP ES);

7. BCCTP ES receives MEDS worker alert on August 21, 2011, and verifies the county's action on MEDS on August 22, 2011;

8. BCCTP ES completes MEDS online transaction to place beneficiary into aid code 0R, effective September 1, 2011.

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, including the right to aid paid pending an appeal, if the hearing is requested within ten days of the notice or before the termination takes effect. If the woman files an appeal on the BCCTP Medi-Cal discontinuance, the BCCTP ES 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 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 2011.
- County receives BCCTP case file and completes AP 18: June 2011.
- County approves full scope, no SOC Medi-Cal: August 2011.
- Next Annual Redetermination is due: July 2012.

Managed Care

The full-scope BCCTP Medi-Cal eligibles (aid code 0P) have voluntary optional enrollment in a two-plan or geographic managed care county. The Medi-Cal Managed Care Division has established 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**.**

DHCS wants to provide a seamless transition for beneficiaries determined no longer eligible for full-scope, no SOC Medi-Cal benefits under federal BCCTP rules. BCCTP and County Coordination will provide uninterrupted cancer treatment and related services to beneficiaries, who are found ineligible for full-scope, no SOC Medi-Cal due to change in their circumstances, but qualify under the State-funded BCCTP. If counties have questions regarding this ACWDL, please contact Ms. Portia High at (916) 552-9386 or email her at portia.high@dhcs.ca.gov. If counties have case-specific questions, counties may contact the BCCTP staff assigned to the case.

Original signed by Robert Sugawara, Assistant Chief for

René Mollow, MSN, RN, Chief
Medi-Cal Eligibility Division

Enclosures

BREAST AND CERVICAL CANCER TREATMENT PROGRAM
Informational Notice

Notice Date:
Case Tracking No.:
Elig.Specialist (ES):
ES Telephone:
ES Fax Telephone:
ES Work Hours:
Notice for:

The Breast and Cervical Cancer Treatment Program (BCCTP) provides no-cost Medi-Cal benefits for women who are California residents, under age 65, citizens/nationals of the United States or have satisfactory immigration status, and have been diagnosed with, and are in need of treatment for, breast and/or cervical cancer, but do not have adequate health care coverage. You have been getting Medi-Cal benefits under BCCTP at no cost to you.

BCCTP has determined that

_____ You have adequate health coverage (can include Medicare).

_____ You are 65 years of age as of __.

_____ You no longer need treatment for breast and/or cervical cancer.

Due to the above reason you are no longer eligible for Medi-Cal through BCCTP; however, Medi-Cal rules require that a redetermination of your eligibility under other Medi-Cal programs be made before we can change or stop your Medi-Cal benefits. While your eligibility for another Medi-Cal program is being determined by the county, **you will continue to get the same Medi-Cal benefits through the BCCTP.**

The county social services office in your county of residence, _____, will see if you are eligible for another Medi-Cal program. Because other Medi-Cal programs have different eligibility rules from BCCTP, the county will ask you for information on your income, family size and any resource or property that you may have. BCCTP is also sending a copy of your file to the county to help with the review process. The county will make a separate determination based on the information you provide to them and notify you in writing of your eligibility or ineligibility for another Medi-Cal Program.

If you have any questions regarding your eligibility for Medi-Cal, please contact your county social services agency at _____for more information.

You will also receive an official discontinuance Notice of Action (NOA) from BCCTP when the county completes their determination. If the county finds you are not eligible for another Medi-Cal program, or if you are eligible for another Medi-Cal program with a share of cost and you have not previously been in the state-funded BCCTP, BCCTP will review your case to see if you are eligible for the state-funded BCCTP. The state-funded BCCTP provides breast and cervical cancer treatment and related services only for 18 months for breast cancer and/or 24 months for cervical cancer.

If you have questions about this notice, please contact your BCCTP worker within 15 working days.

Do not throw your plastic Benefits Identification Card (BIC) away. You still need your BIC to get health care services for as long as you are eligible for Medi-Cal. Always show your BIC to your medical provider whenever you need care.

The statutes that require this action are Sections 14007.71 and 14019 of the Welfare and Institutions Code.

State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

BREAST AND CERVICAL CANCER TREATMENT PROGRAM
Discontinuance of Medi-Cal benefits

Notice Date:
Case Tracking No.:
Elig.Specialist (ES):
ES Telephone:
ES Fax Telephone:
ES Work Hours:
Notice for:

Effective _____, your Medi-Cal coverage under the Breast and Cervical Cancer Treatment Program (BCCTP) will be discontinued.

The reason for the discontinuance is:

_____ You have adequate health coverage (can include Medicare).

_____ You are 65 years of age as of __.

_____ You no longer need treatment for breast and/or cervical cancer.

Medi-Cal rules require that, before your coverage is stopped, a determination must be made under all other Medi-Cal programs. We forwarded a copy of your BCCTP case record to your local county Medi-Cal office for a Medi-Cal eligibility determination. BCCTP continued to give you Medi-Cal coverage while the county made an eligibility determination. The county has completed the eligibility review and informed you of the outcome of their Medi-Cal review. If you have any questions regarding the county's Medi-Cal eligibility determination, please contact your county social services agency for more information.

If you are determined ineligible for another Medi-Cal program, or if you are eligible for another Medi-Cal program with a share of cost and you have not previously been in the state-funded BCCTP, your case will be reviewed by BCCTP to see if you are eligible for the state-funded BCCTP. The state-funded BCCTP provides breast and cervical cancer treatment and related services only for 18 months for breast cancer and/or 24 months for cervical cancer. You will receive a separate notice regarding your state-funded BCCTP eligibility.

If you have questions about this notice, please contact your BCCTP worker within 15 working days.

Do not throw your plastic Benefits Identification Card (BIC) away. You still need your BIC to get health care services for as long as you are eligible for Medi-Cal. Always show your BIC to your medical provider whenever you need care.

Please see the enclosed important information about your hearing rights.

The statutes that require this action are Sections 14005.37 and 14007.71 of the Welfare and Institutions Code.