Women’s Health Medicaid Program
WOMEN’S HEALTH MEDICAID PROGRAM

On October 24, 2000, President William Clinton signed into law the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354). This Act gives states the option to provide medical assistance through Medicaid to eligible women who are screened for and found to have breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

The Georgia Breast and Cervical Cancer Program has selected the Centers for Disease Control and Prevention Option 3 that includes women who are screened for breast and cervical cancer by any provider and/or entity that follows program guidelines.

Breast and Cervical Cancer Medicaid Treatment Program

Medicaid is a medical assistance program jointly financed by the federal and state government that helps to pay for some or all of the medical bills for those determined eligible for assistance. The Women’s Health Medicaid Program (WHMP) was established to provide access to treatment services to women eligible for the Breast and Cervical Cancer Program and have been diagnosed with breast or cervical cancer. Implementation of WHMP involves:

- The Department of Community Health’s (DCH) Division of Medical Assistance (DMA) Medicaid Program,
- The Department of Public Health (DPH), Breast and Cervical Cancer Program (BCCP) providers,
- The Right from the Start Medicaid Project (RSM)

  - Note: RSM is part of DCH and is affiliated with the Division of Family and Children Services, (DFACS).

Women’s Health Medicaid Program (WHMP) Eligibility Policy

Women’s Health Medicaid Program eligibility determination is a four-step sequential process involving Public Health BCCP providers, RSM, and Medicaid:

Step 1: Eligibility determination for BCCP (Public Health function);

Step 2: Presumptive eligibility determination for WHMP (Public Health function);

Step 3: Medicaid determination process (RSM function):

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Step 4: Care Management Organization (CMO) assignment (Medicaid function).

(1) Breast and Cervical Cancer Program Eligibility Determination

- The client must meet the Breast and Cervical Cancer Program eligibility requirements, which include residency, income, insurance status, and age (Section III Policy No. 1).

- Age Exception: When determining presumptive eligibility (PE) for WHMP, the Breast and Cervical Cancer Program age requirements are waived. For example, if a client is 19 years old, has breast cancer and meets all other Breast and Cervical Cancer Program requirements (residency, income, and insurance status), then she is to be declared “Breast and Cervical Cancer Program eligible” and an application for presumptive eligibility can be taken. For women aged 65 and older, refer them to the Social Security office to apply for Medicare, or to the Cancer State Aid Program if not eligible for Medicare.

- Men are not eligible for BCCP and, therefore, not eligible for the WHMP.

- Qualifying Diagnosis: A client must have a biopsy diagnosis of breast or cervical cancer that requires treatment. The “Certification of Diagnosis,” (Section VI, page 14) signed by the client’s physician, Public Health Nurse Colposcopist or a medically trained employee of the physician (i.e., RN, NP, or PA) designated to sign on his/her behalf, is the required documentation, and must be filed in the client’s Medical Record. The “Certification of Diagnosis” should be accompanied by a copy of the pathology report.

Qualifying breast and cervical diagnoses are as follows:

**Breast:**
- Ductal Carcinoma in Situ (DCIS)
- Lobular Carcinoma in Situ (LCIS)
- Invasive Breast Cancers

**Cervical:**
- Cervical Intraepithelial Neoplasia (CIN) II
- Cervical Intraepithelial Neoplasia (CIN) III
- Cervical Carcinoma in Situ
- Invasive Cervical Carcinoma

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BCCP Screening Providers

1. Public Health Departments and Contracted BCCP Providers

If a woman who participates in the Breast and Cervical Cancer Program and is diagnosed with breast or cervical cancer at a partner provider delivery site, she must go to the Breast and Cervical Cancer Program Provider with a Certification of Diagnosis signed by her physician or Public Health Nurse Colposcopist and a copy of the pathology report from the breast or cervical biopsy to apply for WHMP. Application for WHMP is called the "presumptive eligibility process." These women will have had BCCP data forms (3152, 3154B, etc.) submitted when receiving screening and diagnostic services.

2. Non- BCCP Providers

Women who are not screened in the Breast and Cervical Cancer Program but are diagnosed with breast or cervical cancer by an outside physician may be referred to a BCCP provider for the WHMP presumptive eligibility application process. The referring physician must complete a Certification of Diagnosis, which the applicant takes to the Breast and Cervical Cancer Program provider along with a copy of the pathology report from the breast or cervical biopsy. Since this client was not enrolled in the BCCP for screening and/or diagnostics, do not submit the BCCP data forms.

- Once it is determined that the woman is eligible for Breast and Cervical Cancer Program, no further assessment of income, or citizenship such as a birth certificate is needed to complete the presumptive eligibility application.

Presumptive Eligibility Determination

If the woman is eligible for the Breast and Cervical Cancer Program, the BCCP Program provider determines presumptive eligibility for the WHMP. Presumptive eligibility (PE) is a Medicaid process that allows states to enroll women in Medicaid for a limited period of time while full Medicaid applications are filed and processed and final eligibility is determined by RSM. The presumptive eligibility procedure facilitates prompt enrollment and timely health care coverage to women likely to be Medicaid eligible before the full Medicaid eligibility review has been completed.

1. Presumptive Eligibility Providers

a. Public health departments
b. Grady Memorial Hospital

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c. Community Health Centers (CHCs) that have been trained to conduct Presumptive Eligibility.

All clients must go to a Breast and Cervical Cancer Program provider to apply for presumptive eligibility. It is the Breast and Cervical Cancer Program provider’s responsibility to determine program eligibility and Presumptive Eligibility for Women’s Health Medicaid.

2. A woman determined eligible for the WHMP is entitled to Medicaid covered services (not limited to cancer related treatment) which may include physician office visits, prescription drugs, inpatient and outpatient hospital services and home health or hospice services.

3. WHMP eligible women must receive treatment from physicians that participate in the Georgia Medicaid program. The Breast and Cervical Cancer Program provider may provide a list of local physicians and their respective CMO affiliation(s) to WHMP eligible women.

4. Access to health care begins as soon as presumptive eligibility is determined. When cancer treatment is complete, the patient is no longer eligible to receive medical services paid for by the Women’s Health Medicaid Program.

Note: Completion of treatment is a decision made by the treating physician. Case management, to include Medicaid notification of treatment completion, is a function of the designated CMO.

5. The Breast and Cervical Cancer Program eligible woman must meet the following requirements for determination of presumptive eligibility for the WHMP:

6. Must not have health insurance that covers the cost of cancer treatment; specifically, the client must lack creditable coverage as defined by Medicaid (see discussion on creditable healthcare coverage that follows).

7. Must be a resident of any county in Georgia and a United States citizen or legal immigrant. The applicant’s statement of citizenship/legal immigrant status is acceptable. Verification of citizenship/legal immigrant status should not be requested and is not required. If the applicant does present proof of status at the presumptive eligibility interview, make copies and with one retained in the presumptive eligibility file and one sent to the local RSM outreach worker.

o Must be less than 65 years of age.

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May be eligible for retroactive coverage based on the date of diagnosis and the date the presumptive eligibility application was taken. **RSM will determine whether the woman qualifies for retroactive coverage.**

May be eligible to participate in the WHMP more than one time if she has a re-current or new cancer of the breast or cervix and continues to meet eligibility requirements for the Breast and Cervical Cancer Program and for the Women’s Health Medicaid. (Note: A new application must be completed and submitted whenever there is a break in Medicaid service.)

For more information regarding the Women’s Health Medicaid Program, please review the Department of Community Health’s Presumptive Eligibility ACA WHM manual for this program. Information regarding application forms, processing completed applications, and contact information will be located in this manual.

To obtain a copy of the DCH WHM Presumptive Manual please go to [www.mmis.georgia.gov](http://www.mmis.georgia.gov),

- Select Provider Information
- Scroll down to and select Provider Manuals,
- Click on “Presumptive Eligibility Medicaid ACA WHM”

Following completion the WHM application:

- Complete the DPH **“Women’s Health Medicaid Applicant Data Form”**
- Fax ONLY this form and a copy of the Certificate of diagnosis to the BCCP State Office. **FAX #: 404-463-8954**

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Certification of Diagnosis

Client Name: ____________________________________________________________

Client SS #: ____________________________________________________________

Clinic Name: ____________________________________________________________

Diagnosis (Biopsy) Date: ____________________________________________________

Diagnosis: ________________________________________________________________

Stage of cancer (if available): ______________________________________________

Physician's Signature: ______________________________________________________

Please attach a copy of the pathology report confirming this diagnosis

Instructions: Purpose of this Form – This form is required to refer women to the
Women’s Health Medicaid Program for treatment of breast or cervical cancer/pre-
cancer.

Completion of this Form – The physician or a medically trained employee of the
physician (i.e., RN, NP, or PA) designated to sign on behalf of the physician must
complete this form and send it with the client to the health department or other qualified
Georgia Breast & Cervical Cancer Program provider for presumptive eligibility
determination. The Breast and Cervical Cancer Program provider places this form in
the client’s record.

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Women’s Health Medicaid Applicant Data Form

For BCCP Provider Clinic to Complete
Fax completed form to the Public Health State Office
Fax Number: 404-463-8954

PLEASE PRINT

District#: ____________ County Name: ____________

CHD# / Clinic # where patient’s application was made: ____________

BCCP Provider Clinic Name: ____________

Person Completing Form: ____________

Telephone # of Person Completing Form: ____________ Ext.: ____________

Patient Information

1. Last Name: ____________ 2. First Name: ____________ 3. MI: ____________

4. Social Security #: ____________

5. Date of Birth: ____________ Phone No. ____________

6. Patient’s County of Residence: ____________

7. Family Size: ____________

8a. Family Monthly Income: ____________ OR 8b. Family Yearly Income: ____________

9. Type of Diagnosis:
   - 9a. Breast
   - 9b. Cervical
   - CIN II
   - CIN III
   - Carcinoma

10. Date of Diagnosis (Biopsy) [From Certification of Diagnosis]: ____________

11. Effective Date for Services (From Form – DMA 632-W): ____________

12. Is Applicant a BCCP Patient? □ Yes □ No

13. Approved for Women’s Health Medicaid: □ Yes □ No
   - If no, give reason for denial if known:
     - □ Age ≥ 65
     - □ Citizenship
     - □ Other
     - □ Health Insurance

Patient requests to have an American Cancer Society Patient Navigator contact her to provide additional post-hospital care resources. Yes □ No □

14. For State Office Use Only: ____________

Comments: ____________

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Resumption of WHM following:

- End of SSI Medicaid or other Medicaid category the client may have been placed on following initial enrollment in WHM.
  or
- Client's failure to respond to annual renewal

DCH and ARROWHEAD strongly encourage the client or her physician to contact ARROWHEAD directly regarding WHM loss or changes.

However, if the individuals contact DPH (Qualified Provider – QP) rather than ARROWHEAD, DPH can either assist the individual directly or have her contact ARROWHEAD. If the last known Medicaid case is about to end, or has ended within the last three (3) months, do not do a PE WHM application, allow ARROWHEAD to re-determine WHM eligibility.

When these individuals change Medicaid categories, a Statement of Treatment form is required in order for ARROWHEAD to determine WHM eligibility. The treating physician is required to complete the Statement of Treatment form in order to re-instate her WHM coverage.

The following form should be completed by the treating physician when a previously active WHM beneficiary's case was closed because she was approved for another Medicaid category. For example, the client is eligible to receive SS which has its own Medicaid category. In this situation, the patient may later become eligible for disability and is able to receive Social Security which does not have a Medicaid category plus the client must be deemed disabled for 2 years before she will be eligible for Medicare. Since she is no longer receiving SSI, the SSI Medicaid category closes and she will have no insurance coverage. If the client meets WHM eligibility requirements, she may resume WHM coverage following approval from ARROWHEAD after review of the physician's completed Statement of Treatment form.

Another example occurs when the client does not complete the annual renewal forms that are sent from ARROWHEAD each year during her birth month. If ARROWHEAD does not receive the completed renewal forms, the client's Medicaid case will close (the renewal forms are sent to the address that ARROWHEAD has on file and cannot be forwarded). Again, the re-instatement process requires the Statement of Treatment form to be completed.

The Statement of Treatment form does not replace the "Certificate of Diagnosis" which is required for the initial enrollment into the WHM program. The Statement of Treatment form is required for ARROWHEAD to determine her current eligibility for continued Medicaid coverage and to expedite her WHM re-enrollment.

For more information, please review the Department of Community Health's Presumptive Eligibility ACA WHM manual for this program.
Physician's Statement of Treatment for WHM

The physician or a medically authorized personnel of the physician (i.e., RN, NP or PA) designated to sign on his/her behalf, must complete this form. This physician should be the physician treating the patient for her breast and/or cervical cancer.

<table>
<thead>
<tr>
<th>Patient's Full Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Patient's Gender</td>
<td>Female, Male</td>
</tr>
<tr>
<td>Clinic Name</td>
<td></td>
</tr>
<tr>
<td>Diagnosis Date</td>
<td></td>
</tr>
<tr>
<td>Diagnosis (choose one or both if applicable)</td>
<td>Breast Cancer, Cervical Cancer</td>
</tr>
<tr>
<td>Printed Name of Physician</td>
<td></td>
</tr>
</tbody>
</table>

I certify that the above patient (One must be selected)

- is currently under my care for the treatment of breast and/or cervical cancer. Medication therapy (example: such as taking Tamoxifen, Anmedex, etc. or in close monitoring), is considered as being in treatment for cancer. The customer must have a diagnosis of breast and/or cervical cancer or a pre-cancerous condition (ex. CIN II, III) that requires treatment.

- is NOT currently under my care for the treatment of breast and/or cervical cancer.

I certify that the above information is correct regarding my patient. By signing below, I am either a physician or a medically authorized personnel of the physician listed above.

Physician Signature or Authorized Personnel | Title | Date

Address:

City: State: Zip Code:

Phone:

The form may be submitted either by fax, scanned into an Email:

| Worker's Name |  |
| Worker's Phone Number |  |
| Fax number |  |
| Email address | womenshealth@dch.ga.gov |

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