SECTION 8 MEDICAL BENEFITS FOR TREATMENT

8.0 MEDICAL BENEFITS FOR PERSONS WITH BREAST OR CERVICAL CANCER

The federal Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354) and State Public Act 92-47 authorized the State to extend medical assistance eligibility and full medical benefits to otherwise uninsured individuals under the age of 65 who are diagnosed through IBCCP screening with breast or cervical cancer, including precancerous cervical conditions. The Illinois Department of Healthcare and Family Services (HFS) administers these services under Medical Benefits for Persons with Breast or Cervical Cancer. Effective October 1, 2007, eligibility for benefits included women with incomes over 250% Federal Poverty Level (FPL) as long as they meet other eligibility criteria and are referred to HFS through the IBCCP network. Prior to October 1, 2007, only women with incomes at or below 250% FPL were eligible.

8.1 MEDICAL BENEFITS FOR TREATMENT ELIGIBILITY

A.) Medical benefits are available to women who were **screened or diagnosed through IBCCP and have verified that they do not have insurance** and need treatment for breast or cervical cancer or a precancerous cervical condition.

> **NOTE:** Effective September 1, 2006, IBCCP Lead Agencies may refer women who are screened and diagnosed by medical providers not on contract with IBCCP to HFS for medical benefits coverage (See Sections 8.6 – 8.9).
>
> Effective October 1, 2007, eligibility for medical benefits included uninsured and underinsured women regardless of income.

1.) Precancerous cervical conditions in this Program that are defined as needing treatment based on confirmed **diagnostic** testing include:

a) Cervical Intraepithelial Neoplasia, grade 3 (CIN 3);

b) Severe dysplasia of the cervix;

c) High-Grade Squamous Intraepithelial Lesion (HSIL);

d) Atypical glandular cells (AGC) with a suspicion of adenocarcinoma in situ.

B.) Additional HFS eligibility requirements include:

1.) No health insurance or health insurance that does not cover breast or cervical cancer treatment, for example:

a) Limited scope of coverage such as those which only cover dental, vision, or long term care. This includes cancer policies that cover only cancer diagnosis, regardless of any service or monetary limits set by the policy; or

b) Coverage for only a specified disease or illness.

2.) Pre-existing condition limitations that exclude treatment for breast or cervical cancer;

3.) Younger than 65 years of age;

4.) United States citizen or otherwise meets immigration status requirements for medical benefits. If qualifying as a legal permanent resident (LPR), the individual must be a LPR for 5 years. If an immigrant does not have legal permanent residency, but has documentation (bank statement, tax return, etc.) to prove they have resided in the United States for more than five years, individual case review will be given by HFS.

a) **Exemptions** to LPR requirements include but may not be limited to granting asylum to people who are already in the United States and are unwilling or unable to return to their home country because of persecution or well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.

b) Client status will be evaluated on a case-by-case basis

5.) Have or have applied for a Social Security number;

6.) Is ineligible for any other medical assistance;

7.) Resident of Illinois; and

8.) Continued need of treatment for breast or cervical cancer or a

precancerous cervical condition.

C.) Women in need of treatment are referred, by IDPH through IBCCP Lead or Consortia Agencies, that in the opinion of the treating physician they require therapy directed toward cure or palliation of breast or cervical cancer. This includes recurrent metastasized cancer that is a known or presumed complication of breast or cervical cancer and complications resulting from the treatment modalities themselves.

- Treatment includes diagnostic services that may be necessary to determine the extent and proper course of treatment.

Note: Women who require routine screening (e.g., Pap tests or mammograms) **are not** considered to need treatment. HFS will cancel medical eligibility for women who do not require treatment for breast or cervical cancer at the time of recertification.

8.2 MEDICAL BENEFITS FOR TREATMENT APPLICATION PROCESS

The application process to determine eligibility for enrollment in the Medical Benefits for Persons with Breast or Cervical Cancer Program, when there is a diagnosis made by an IBCCP contracted medical provider, is a cooperative endeavor between the Department of Healthcare and Family Services (HFS) under the Breast and Cervical Cancer Eligibility Unit (BCCEU) and IBCCP staff. An overview of the IBCCP application process for women screened and diagnosed by IBCCP follows (See also Appendix D):

A.) The IBCCP Case Manager:

1.) Identifies a client needing medical benefits for treatment for breast or cervical cancer or treatment for the precancerous conditions listed in 8.1;

2.) Completes the Health Benefits for Persons with Breast or Cervical Cancer Certification Form (Appendix D);

3.) Faxes the above form along with the current IBCCP Eligibility Determination Form to the BCCEU at (217) 557-3524;

4.) Notifies the client to expect a telephone call or letter from HFS, if the client has no telephone.

B.) BCCEU staff contacts the client by telephone or letter and collects information

about legal status and insurance coverage.

- If the BCCEU staff is unable to reach the client after three attempts, the IBCCP Case Manager will be contacted for assistance.

C.) BCCEU staff mails or faxes a completed application to the client for signature (with a request for verifications, if necessary) and return to the HFS central BCCEU.

- BCCEU staff notifies the IBCCP Case Manager when the application is sent to the client.

D.) The IBCCP Case Manager contacts the client to offer assistance with completion of the HFS application, including information verification. If the client does not have telephone service, the IBCCP Case Manager may schedule a time when the client and staff at BCCEU can discuss the forms and determine eligibility at the Case Manager's work site.

1.) Upon receipt of the signed application, HFS will finalize the determination of eligibility and either:

a) Enroll the client with HFS and mail an approval notice to the client; or
b) Determine the client to be ineligible and send a Notice of Denial, explaining the reason for denial and options for appeal, to the client.
c) BCCEU staff will notify the IBCCP Case Manager of approval or denial, including the reason for denial, of the application.

2.) If the client is found ineligible due to failure to supply complete information, the IBCCP Case Manager will assist the client with submission of the necessary information to complete the application within 60 days of the date of the Notice of Denial.

- If 60 days have elapsed since the date of the Notice of Denial, a new application must be processed with re-submission of the Health Benefits for Persons with Breast or Cervical Cancer Certification Form and the IBCCP Eligibility Determination Form to the BCCEU at HFS.

3.) If the client is found ineligible or declines enrollment with HFS, the IBCCP Case Manager will assist the client in finding treatment utilizing alternative funding sources (See 5.12).

4.) Eligibility for medical assistance through the Medical Benefits for Persons with Breast or Cervical Cancer Program can begin no earlier than the month in which the client was screened through IBCCP. (HFS can backdate coverage up to three months prior to the month of application as long as the expanded eligibility was in effect for the backdated months and the client meets all eligibility criteria during those months.)

8.3 MEDICAL BENEFITS FOR TREATMENT RECERTIFICATION

Breast Cancer: HFS requires yearly recertification for clients diagnosed with breast cancer. Clients receiving Tamoxifen or one of the newer therapeutic medications will continue to receive services for as many as five years as long as the annual recertification forms are completed and returned.

Cervical Cancer: HFS requires recertification no less than every six months. Clients will continue to receive services as long as the recertification forms are completed and returned. **Follow-up Pap tests alone are not sufficient to continue receiving HFS medical services.**

Process: HFS sends a recertification notice to the client with a Physician Statement which must be signed and returned. If the Physician Statement indicates care is no longer needed, then HFS cancels the woman's medical case. If the Physician Statement is not returned within a predetermined time frame established by HFS, the IBCCP Case Manager is contacted by BCCEU to ask for assistance to intervene with the medical provider to respond. The client's case is terminated when no response from the medical provider or client is received. The IBCCP Case Manager is critical in the recertification process to ensure treatment continues when necessary.

IBCCP may also be contacted if the client has moved and left no forwarding address. HFS medical benefits will be discontinued unless written notification from the client is received by HFS.

8.4 OTHER MEDICAL BENEFITS FOR TREATMENT INFORMATION

A.) Services include all comprehensive medical benefits including physician services, inpatient and outpatient hospital care, pharmacy and much more. If a person is already receiving medical assistance from HFS, this Program does not provide any additional benefits.

B.) Only HFS approved medical providers will be reimbursed through the Medical Benefits for Persons with Breast or Cervical Cancer Program. To enroll as a medical provider with HFS, the provider may contact the Provider Participation Unit at (217) 782-0538 or visit the HFS provider Web site at www.hfs.illinois.gov/enrollment/.

C.) Treatment includes diagnostic services that may be necessary to determine the extent and proper course of treatment. For specific information about what Medical benefits for Persons with Breast or Cervical Cancer covers, please refer to the provider handbooks. Information on the handbooks can be obtained from the Illinois Department of Healthcare and Family Services website, www.hfs.illinois.gov/handbooks/.

D.) **Co-payments –** Clients may be required to make a co-payment for services once they have been approved for the HFS Treatment Act Program. Co-payment requirements have been in place for several years. They are relatively low and many medical providers do not charge for them. The medical providers charge the co-pay and HFS will deduct the co-pay from the rate they pay for the service. There are no co-pays for services that require a doctor's order such as labs, radiology, therapies, etc.

The rates are as follows: $2.00 for an office visit or a nurse practitioner, doctor, or dentist; $3.00 for brand name drugs (no co-pay for generic drugs); and $0-$3.00 per day for a hospital stay which can vary by hospital.

8.5 TERMINATION FROM MEDICAL BENEFITS FOR TREATMENT

The client, medical provider and IBCCP Case Manager are notified in writing by HFS when the former IBCCP client's HFS medical benefits are cancelled. The final date of coverage is provided.

Clients who remain eligible for IBCCP services can enroll in the Program again following termination of their HFS cases. Effective October 1, 2007, eligibility included women with incomes over 250% Federal Poverty Level who do not have insurance and who wish to continue receiving service through IBCCP. Prior to October 1, 2007, only women with incomes at or below 250% FPL were eligible.

8.6 MEDICAL BENEFITS FOR PERSONS WITH BREAST AND CERVICAL CANCER EXPANSION

Effective September 1, 2006 the State of Illinois expanded health insurance for low-income women with breast or cervical cancer or precancerous cervical conditions to include women diagnosed by medical providers not on contract with the Illinois Breast and Cervical Cancer Program (IBCCP). Effective October 1, 2007, eligibility included women with income over 250% Federal Poverty Level who meet all other eligibility criteria. The process for referring the woman to the Illinois Department of Healthcare and Family Services (HFS) by medical providers not on contract with IBCCP is as follows:

1. A woman is diagnosed by a medical provider and found to have breast or cervical cancer or one of the precancerous cervical conditions listed below or is in continued need of treatment for breast or cervical cancer or a precancerous cervical condition.
   - Cervical Intraepithelial Neoplasia, grade 3 (CIN 3);
   - Severe dysplasia of the cervix;
   - High-Grade Squamous Intraepithelial Lesion (HSIL);
   - Atypical glandular cells (AGC) with a suspicion of adenocarcinoma in situ.

2. The woman meets the following additional criteria:
   - Illinois resident
   - Age 19 through 64
   - U.S. citizen or qualified immigrant
   - Has no form of insurance that would pay for her medical benefits for treatment services.
3. The medical provider **completes, dates, and signs** Section 1 of the "Application for Health Benefits for Persons with Breast or Cervical Cancer" for HFS medical benefits for treatment. (Appendix D)

4. The medical provider is to attempt to assess the income and assist the client to complete the applicant portion, Section 2, **and** the Cornerstone Consent Form. (Appendix D)

5. The medical provider submits Sections 1 and 2 with as much supporting information and documentation as possible to the IBCCP Lead Agency assigned to serve the client's community. Medical providers who do not submit the information will be contacted by telephone by the IBCCP Lead or Consortia Agency to obtain the information. Direct contact with the client by telephone will be necessary for those instances where the medical provider is unable to obtain the information. **All forms requiring signature must be properly signed and dated before further processing of the "Application for Health Benefits for Persons with Breast or Cervical**

Cancer" can occur. Medical providers who do not provide signed and dated information will be contacted by the IBCCP agency staff to obtain the necessary signature.

Items noted with a star (☆) on the "Application for Health Benefits for Persons with Breast or Cervical Cancer" are mandatory items that must be provided by the client. **Items marked with a ☆**, except the Citizenship and residency information, **are the minimum items required for IBCCP** to make the determination of whether the client qualifies for referral to HFS. The following items must be included with the application for consideration.

- Client's address and contact information including home phone.
- Pathology report demonstrating breast cancer or cervical cancer or specific precancerous cervical condition as listed in 8.6.1.
- Verification of current treatment received within the last 3 months.
- "Cornerstone Consent Form" signed by the client and a witness and dated.
- Copy of the driver's license or other document verifying the client's age.
- Proof of income as described in the application.
- Copy of the front and back of the insurance card, if applicable.
- Proof of citizenship or qualified immigration status as described in the application.

If the medical provider and IBCCP are not able to obtain the documents, HFS will request citizenship and immigration status information including the Alien Registration number from the client.

6. The IBCCP Lead Agency staff will review the "Application for Health Benefits for Persons with Breast or Cervical Cancer" and enclosures to determine whether the client qualifies for referral to HFS.

7. If a woman meets the criteria for referral to HFS, IBCCP will complete and sign Section 3. (Appendix D) The IBCCP Lead Agency will mail or fax Sections 1, 2 and 3 of the "Application for Health Benefits for Persons with Breast or Cervical Cancer" to the BCCEU at HFS. Please note that a man diagnosed with breast cancer qualifies for treatment if he meets all of the above criteria. Although the male client cannot be enrolled in IBCCP, it is acceptable for the Lead Agency to assist the client in completing the RTTA application and process it according to the above protocol.

8. If an individual does not meet the criteria for referral to HFS, the IBCCP Lead Agency notifies the individual and the medical provider within 1 business day by

telephone. This contact will be followed by written notice to the patient and the medical provider. (See IBCCP Denial of Application, 8.7).

9. Eligibility for medical assistance through the Medical Benefits for Persons with Breast or Cervical Cancer Program expansion can begin no earlier than the 1st of the month in which the client began the screening process with her medical provider not on contract with IBCCP. In no case can eligibility begin more than three months prior to the month in which HFS receives the application.

   Example: Client referral to HFS was submitted on January 10, 2007. Screening services were initiated with the medical provider on October 20, 2006. The approval from HFS will indicate an effective date of October 1, 2006.

Referral of Women Currently Receiving Medical Benefits for Treatment

Women previously diagnosed by a medical provider not on contract with IBCCP who are currently receiving treatment through other charitable sources are also eligible for the "Healthcare Benefits for Women Diagnosed with Breast or Cervical Cancer" expansion. Sections 1 and 2 of the "Application for Health Benefits for Persons with Breast or Cervical Cancer" must be completed, signed, and submitted to IBCCP as noted herein with all the necessary supporting documents for determination of qualification for referral to HFS. Information on those clients who are approved will then be forwarded to HFS with Section 3 completed by the IBCCP Lead Agency staff as noted above.

Services provided before September 1, 2006 to women with income up to and including 250% FPL cannot be reimbursed; however, services provided to such women after September 1, 2006 may qualify for reimbursement to the medical provider by HFS as long as the client is referred by IBCCP and HFS enrolls the client for coverage on the date the service is provided.

Services provided to women with incomes over 250% FPL prior to the effective date of October 1, 2007 cannot be reimbursed. Services provided after October 1, 2007 may qualify for reimbursement to the medical provider by HFS as long as the client applies through IBCCP and is referred to HFS for coverage on the date the service is provided.

HFS can backdate coverage up to three months prior to the month of application as long as the expanded eligibility was in effect for the backdated months and the client meets all eligibility criteria during those months.

8.7 APPLICATIONS NOT APPROVED FOR REFERRAL TO HFS

In the event, the client does not want to provide the information necessary to determine eligibility; she will not be eligible for HFS medical benefits. If the woman is determined by the IBCCP Agency staff to not meet the eligibility requirements for referral to HFS, all forms must be copied for the IBCCP expansion file and the original is returned to the medical provider. The medical provider and client will be contacted by the IBCCP Lead Agency staff by telephone within 24 hours of determination of the client's determination as eligible for IBCCP or did not meet the guidelines for acceptance to IBCCP. Women who cannot be reached by telephone will also receive a copy of the "HFS Health Benefits Referral Denial Notice" with a cover letter. The letter is to be sent by certified mail to document receipt. A copy of the notification information sent to the client and to the medical provider must be maintained in the IBCCP files.

"Health Benefits Referral Denial Notice" (Appendix D) that the client does not qualify for referral to HFS and therefore, will not be receiving medical benefits for treatment through HFS. The medical provider will also be notified to help the client identify sources for charity care.

8.8 HFS RESPONSIBILITY FOR APPLICATIONS

HFS will contact the client to obtain any of the information needed that IBCCP is not required to obtain. This includes copies of Alien Registration Cards, birth certificates, passports, certificate of naturalization or certificate of citizenship. Per the rules and regulations governing HFS, the staff at BCCEU will evaluate all information submitted regarding the woman's application to determine eligibility for HFS services.

HFS will send written notice of its decision (approval or denial) on the "Application for Health Benefits for Persons with Breast or Cervical Cancer" to the client and Lead Agency. If the application was incomplete and the client was denied by HFS for failing to provide necessary information, the IBCCP Lead Agency may assist the client in appealing the denial within 60 days of the date of the Notice of Denial.
Clients who are denied due to reasons other than an incomplete application also have 60 days to appeal the decision to HFS and request a hearing to review the decision. IBCCP Lead and Consortia Agency staff members are unable to assist with this process.

8.9 MEDICAL BENEFITS FOR TREATMENT RECERTIFICATION

The client's eligibility will be reviewed at least once each year by HFS staff. As a part of the HFS eligibility recertification process, the treating medical provider will be asked whether the client continues to need treatment for breast or cervical cancer. When it has been

determined by the client's treating medical provider that she no longer requires such treatment, or if she otherwise does not qualify for the Program, her coverage will be cancelled by HFS.

HFS will notify the client and the respective IBCCP Lead Agency of the client's termination from Medical Benefits for Persons with Breast or Cervical Cancer. The client may appeal this decision. If the client prevails in the appeal, she will be reenrolled with HFS.

Clients who have been cancelled from HFS and who may be eligible for IBCCP are encouraged to re-enroll in IBCCP for ongoing screening services. Women who are eligible for Family Planning or other programs are to be referred to those agencies.

Clients who were referred through a private medical provider, not on contract with IBCCP can be enrolled in IBCCP if the medical provider is willing to sign a contract OR the woman is willing to see a contracted medical provider.