An individual is eligible for limited* Medicaid coverage when all of the following conditions are met:

- The individual must have been diagnosed as HIV positive.

- The income of the individual, his spouse and his dependent children who live with him must meet the income limits detailed in Chapter 10.

- He must be ineligible for any other Medicaid full-coverage group or be eligible as a Medically Needy client who has not met his spenddown.

* Medicaid coverage is limited to payment for medications listed on the current WV ADAP Formulary for HIV/AIDS treatment.

Except for acceptance of the initial OFS-2 Medicaid and the 2-page ADAP applications, this coverage group is administered by BMS. Potential eligibility for or receipt of Medicare, Part D, does not affect the application or referral process for ADAP eligibility determination. For special communication between the Worker and BMS, refer to Chapter 1.

If the client becomes eligible under any other coverage group or meets his spenddown, the Worker must notify BMS immediately by memorandum and must specify the beginning date of Medicaid eligibility.

G. WV CHILDREN'S HEALTH INSURANCE PROGRAM (WV CHIP)

WV CHIP is not Medicaid. See Chapter 7 for WV CHIP policy.

H. WOMEN WITH BREAST OR CERVICAL CANCER (BCC)

Income: N/A **Assets: N/A**

A woman is eligible for BCCSP Medicaid if she is diagnosed with a breast or cervical cancer or certain pre-cancerous conditions, regardless of income. She must also be receiving active treatment for her diagnosis and currently enrolled in the Breast and Cervical Cancer Screening Program through a screening provider to be eligible for this type of Medicaid coverage.

1. Eligibility Requirements

A woman who meets the following requirements may be eligible for full-coverage Medicaid:

- She has been diagnosed with breast or cervical cancer through the Centers for Disease Control (CDC) program administered by the Office of Maternal, Child and Family Health.

- She has no medical insurance or insurance that meets an exception listed in Chapter 7, Appendix A under Excepted Insurance Benefits. No penalty applies for discontinuing insurance.

- There may be limited situations in which a woman with creditable coverage can receive BCC coverage. Examples include, but are not limited to, no coverage for breast or cervical cancer, periods of exclusion, such as for a preexisting condition, or having exhausted lifetime or annual benefits for all services or for breast or cervical cancer.

- She is under age 65.

- She is not eligible for Medicaid under any of the following Mandatory Categorically Needy coverage groups:

  - AFDC Medicaid
  - Deemed AFDC Medicaid
  - Transitional Medicaid
  - Qualified Child Medicaid
  - Poverty-Level Pregnant Woman
  - Poverty-Level Child
  - SSI Medicaid
  - Deemed SSI Medicaid

Medicaid eligibility begins up to three months prior to the month of application, providing she would have met the eligibility criteria, and concludes when the cancer treatment ends or when she is no longer eligible. For example, she attains age 65 or obtains creditable insurance. Coverage is not limited to charges related only to cancer treatment, and there is no limit to the number of eligibility periods for which a woman may qualify.

Recipients are screened for eligibility for other mandatory Medicaid coverage groups, and, if found eligible, are approved for the other group. Failure to apply for Medicaid or to assist in the eligibility determination process results in case closure.

NOTE: Eligibility for any optional coverage group does not apply, and there is no spenddown provision.

2. Application Process

The application process is as follows:

- A woman is screened at a Breast and Cervical Cancer Screening Program site. If diagnosed with breast or cervical cancer, she is given a CDC Certificate of Diagnosis and completes form DFA-BCC-1.

- The DFA-BCC-1 form is forwarded by the CDC facility to the DHHR office in the county in which the applicant resides. The Worker enters the information in RAPIDS to issue a medical card, provided all eligibility criteria described above are met.

- If information provided on the DFA-BCC-1 indicates that the woman is not income or asset eligible for any other mandatory Medicaid coverage group, no action is taken, but the decision must be recorded in RAPIDS.

- If **the information indicates the woman** may be eligible under one of the mandatory coverage groups listed **in item 1** above, the Worker contacts the woman, arranges for an interview, and requests any additional information required to determine eligibility.

- If the woman is determined Medicaid eligible for a mandatory coverage group, the Worker closes the BCC AG and approves the new coverage group.

- If **ineligible** for a mandatory Medicaid coverage group, the woman remains in the BCC group and the Worker records the results of the determination process in RAPIDS.

- If **the woman or a representative** fails to apply within 30 days, or she fails to cooperate in determining eligibility for **a** mandatory Medicaid coverage group, the BCC case is closed.

NOTE: BCC recipients are not required to cooperate with BCSE unless they become eligible for another mandatory coverage group. Women who would be eligible for another mandatory group, except for failure to cooperate with BCSE, are not eligible for BCC.

3. Redetermination Process

An annual redetermination for BCC and Medicaid eligibility is required. OMCFH is responsible for providing a BCC Medicaid Continuation Form to verify continuing treatment and for assuring that a new completed DFA-BCC-1 is mailed to the local DHHR office.

If changes have occurred which indicate the woman may be eligible for one of the Medicaid groups listed above, the Worker must schedule an interview to complete a Medicaid application. The BCC case remains open while the determination is being made. Failure to complete or cooperate in the Medicaid application process will result in closure of the BCC case.

If determined eligible for another Medicaid group, the Worker closes the BCC coverage and takes action to approve the woman for the appropriate Medicaid coverage group.

If it appears there have been no significant changes and the woman continues to meet all other BCC requirements, no action is taken in RAPIDS. The Worker files the forms in the case record and makes appropriate cases comments.

4. Data System Coding and Communications with Breast and Cervical Cancer Program (BCCSP)

To insure that needed services are not delayed after approval for BCC and that BCCSP has current information about individuals who are closed or denied, the Worker must follow the procedures outlined below:

- **Follow RAPIDS instructions for coding BCC using PRD-38**
- **Print the ACCH screen, which must include the BCC applicant's name**

- **Write the status of the case on the bottom of the printout. Examples include, but are not limited to, approved for BCC, needs CDC certificate or ineligible for BCC as eligible for another mandatory coverage group.**

- **Fax the printout, along with the CDC certificate of diagnosis and the BCC Medicaid application, to the attention of: BCCSP at (304) 558-7164 or mail to the Office of Maternal, Child and Family Health (OMCFH), ATTN: BCCSP, 350 Capitol Street, Room 427, Charleston, WV 25301-3715.**

Notify BCC by fax or mail of any BCC client's name, demographic change or death.