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**501.01 Introduction**

(Rev. 03/01/19)

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA) allows states to provide full Medicaid benefits to uninsured individuals who are found in need of treatment for breast cancer, cervical cancer, or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia), including cancer that has originated in or metastasized to the breast or cervix. This coverage group is known as the Breast and Cervical Cancer Program (BCCP), and was first implemented October 1, 2001.

The BCCP is a non-MAGI category, and does not follow MAGI methodology. There is no resource requirement for BCCP.

**501.02 BCCP Forms**

(Rev. 04/01/15)

The following forms are required to apply for BCCP coverage:

1. The Healthy Connections Application, DHHS Form 3400
   1. Form 3400 must be completed and signed by the applicant.
2. The Breast and Cervical Cancer Program Application Addendum, [DHHS Form 913-A](http://medsweb.scdhhs.gov/EligibilityForms/FM%20913-A.pdf)
   1. Form 913-A must be completed by the South Carolina Department of Health and Environmental Control (SCDHEC), or any other provider who is providing the diagnosis, and signed by the applicant.
   2. The worker must complete the first page of the Non-MAGI Workbook with the applicant’s budget group information. In the Notes and Documentation section, the worker must include the following information:
      1. Family size,
      2. Income limit,
      3. Gross family income, and
      4. Eligibility status.
3. The Addendum for Specialty Programs, DHHS Form 3400-A
   1. Form 3400-A must be completed and signed by the applicant if the applicant needs to be assessed under a different program, such as Aged, Blind, Disabled (ABD).

**501.03 Eligibility Criteria**

South Carolina covers two categories of patients that may be covered by the BCCP. The categories include the Non-Best Chance Network Patient and the Best Chance Network Patient. Both options are explained below.

501.03.01 Non-Best Chance Network and Best Chance Network Patient

(Rev. 03/01/19)

Patients of the Non-Best Chance Network (non-BCN) are individuals, who have been diagnosed by a non-BCN provider and found in need of treatment for breast cancer, cervical cancer, or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia), including cancer that has originated in or metastasized to the breast or cervix. The following criteria must be met:

* The patient must be under age 65;
* The patient must meet South Carolina state residency, United States citizenship, and identity requirements (refer to MPPM 102.03 and 102.04.01 and 102.04.02);
* The patient must have been screened for breast cancer, cervical cancer, diagnosed, and found in need of treatment for breast cancer, cervical cancer, or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia), including cancer that has originated in or metastasized to the breast or cervix;
* The patient must not have other insurance coverage that would cover treatment for breast cancer, cervical cancer, or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia), including Medicare Part A or B;
  + Note: It must be determined if an applicant has creditable health coverage. Eligibility workers must check the [DHHS Form 3400](https://www.scdhhs.gov/sites/default/files/Form%203400%20Application.pdf), Healthy Connections Application for Medicaid and/or Affordable Health Coverage, appropriate review forms, and the TPL Policy Inquiry on MMIS for any indication of creditable health coverage at approval, review, or in an ex parte determination.
* Must not be eligible for another full coverage Medicaid eligibility group.
* Family income is at or below 200% of the Federal Poverty Level (FPL) (Refer to MPPM 103.08)

Note: Eligibility workers must check the Healthy Connections Application, [DHHS Form 3400](https://www.scdhhs.gov/sites/default/files/Form%203400%20Application.pdf), appropriate review forms, and the TPL Policy Inquiry on MMIS for any indication of creditable health coverage at approval, review, and in an ex parte determination.

Patients of the Best Chance Network (BCN) are individuals diagnosed by a BCN provider and found in need of treatment. They must meet all of the criteria listed above as well as the two additional criteria below:

* The patient must be aged 40 – 64; and
* The patient must have been screened, diagnosed, and found in need of treatment for breast cancer, cervical cancer, or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia), including cancer that has originated in or metastasized to the breast or cervix, under the Best Chance Network program.

Note: An applicant is not eligible for BCCP coverage if otherwise covered under creditable coverage. In this case, creditable coverage is an insurance policy that provides coverage for the treatment of breast or cervical cancer. Eligibility workers must check the [DHHS Form 3400](https://www.scdhhs.gov/sites/default/files/Form%203400%20Application.pdf), Healthy Connections Application, appropriate review forms, and the TPL Policy Inquiry on MMIS for any indication of creditable health coverage at approval, review, and in an ex parte determination. If an applicant has creditable coverage but has exhausted the lifetime limits on all benefits under the plan, the applicant is not considered to have creditable coverage and could be Medicaid eligible under the BCCP program. Once coverage is reinstated, the eligibility worker should verify the reinstatement of coverage and close the case.

501.03.02 Special Situations

(Rev. 04/01/15)

* **Other Treatment**

First time applicants who meet the eligibility criteria, have completed treatment of breast or cervical cancer, and need or are receiving treatment for metastasis to other organs secondary to breast or cervical cancer may be approved.

* **New South Carolina Residents**
  + An applicant qualified for a program under the BCCPTA in another state and found to be in need of treatment for breast and/or cervical cancer conditions will be considered for eligibility in South Carolina’s BCCP. If an applicant was screened in a different state, the applicant does not need to be screened again in South Carolina.
  + Workers should follow the steps below to determine eligibility for a new state resident:
    - After an applicant submits Form 3400, ask for documentation from the applicant’s initial consultation with a provider in South Carolina.

Ask the applicant for a copy of records, detailing the applicant’s former coverage.

* + - Send Form 913-A to the applicant to complete with the provider, and send the applicant the Medicaid Eligibility Checklist, Form 1233, if more information is needed.
    - If copies of the records are received, do not deny BCCP coverage while awaiting the return of Form 913-A or any requested information. If the applicant does not return Form 913-A or any requested information, send the applicant a 10-day notice to close the case. Once all the relevant information has been received, continue eligibility.
* Non-Citizen Applicants

Non-citizen applicants, who are residents of South Carolina, found in need of treatment for breast cancer, cervical cancer, or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia) may be eligible for BCCP. If the applicant is approved, coverage will continue as long as eligibility criteria are met and the beneficiary is receiving treatment.

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| --- |
| Procedure for Approving Non-Citizen Individuals for Emergency Services in PCAT 71 |
| MEDS Procedure: |
| MEDS Procedure for Approving Non-Citizen Individuals for Emergency Services in PCAT 71:  On HMS06- Set the US Citizenship Indicator to “N”  On ELD00- Set the Citizenship Pass/Fail to “Fail”  On ELD02- Set the Service Type to “E”  Note: Non-citizen beneficiaries in PCAT 71 will not receive a Medicaid card, nor will they be sent an approval notice. The eligibility worker must manually send an approval notice. |

**501.04 Budgeting and Resources**

The BCCP is a non-MAGI category, and does not follow MAGI methodology. There is no resource requirement for BCCP.

To determine an applicant’s total countable monthly income, add together:

* The monthly gross earned income (minus the Earned Income Standard Work Deduction MPPM 501.04.02) and
* The monthly gross unearned income (minus the appropriate Child Support Deduction MPPM 501.04.03),
* Then deduct the appropriate child/dependent care deduction (MPPM 501.04.04).

501.04.01 Verification and Documentation of Income

The applicant’s statement of the amount of gross monthly household income as documented on the application is sufficient verification. The applicant’s income should only be verified if determining eligibility for another Medicaid category.

501.04.02 Earned Income Standard Work Deduction

A standard work deduction of $100 is applied to the determined monthly gross earned income.

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| **Example:** Ms. Allen earns $1,000 per month.  $1,000 Earned income  -100 Earned income disregard  $900 Net Earned income |

501.04.03 Child Support Deduction

If the applicant’s income is within the FPL guidelines after applying the standard work deduction, the eligibility worker may proceed with the eligibility determination.

If the applicant’s income is not within the FPL guidelines after applying the standard work deduction, the eligibility worker should provide the applicant with the Medicaid Eligibility Checklist, [DHHS FM 1233](http://medsweb.scdhhs.gov/EligibilityForms/FM1233-ME.pdf). The eligibility worker should include questions on the Checklist regarding the child support deduction and the child/dependent care deduction.

The child support deduction amounts to $50 for applicants who receive child support. To apply the child support deduction, deduct $50 if the applicant receives child support.

501.04.04 Child/Dependent Care Deduction

To determine the amount of the deduction, deduct a dependent care expense of up to $200 per month, per child under age 12 or incapacitated adult, reduced by the amount of ABC Childcare Assistance. This deduction is allowed if the parent or caretaker relative is employed or attending school. School attendance must be verified. The deduction is allowed for any income in the budget group, regardless of the type or ownership of income.

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| Example #1: Ms. Cartwright attends school. The only income in the home is child support received by her three sons of $500 each. She pays $80 per week childcare for her 3-year-old son, Adam.  $80 x 4.33 = $346.40  $346.40 > $200 maximum allowable deduction  $1,500.00 child support  - 50.00 child support deduction  $1,450.00 net child support  $1,450.00 net child support  - 200.00 childcare deduction  $1,250.00 net monthly income |
| Example #2: Mr. Briggs attends school. He earns $300 per month from his part-time job. He and his two children receive $500 each in SSA survivor’s benefits for a total of $1,500. Daycare costs are $40 per week for each of his two children.  $40 x 4.33 = $173.20  $173.20 < $200 maximum allowable deduction per child.  $300.00 earned income  -100.00 earned income disregard  $200.00  +1,500.00 unearned income  $1,700.00  -346.40 childcare deduction ($200 max. per child)  $1,353.60 monthly net income |

**501.05 Effective Date of Application and Retroactive Coverage**

The effective date of the application is the date the application is received by DHHS. Eligibility can begin up to three (3) months before the effective date. Refer to MPPM 101.05 for additional information about Retroactive coverage.

**501.06 Eligibility Review**

(Rev. 04/01/15)

Eligibility is reviewed annually for beneficiaries with breast cancer, cervical cancer, and is reviewed every six (6) months for pre-cancerous lesions (CIN 2/3 or atypical hyperplasia). Coverage continues as long as the eligibility criteria is met and the beneficiary is receiving treatment. Once a year, a review form is mailed to the beneficiary and must be returned for coverage to continue.

Hormonal cancer therapy is limited to a five (5) year course of treatment. However, if a recipient’s hormonal therapy treatment has been extended beyond five years, the worker should complete a review, attain documentation indicating therapy has been extended, and verify the beneficiary remains in treatment. Once this information is verified, BCCP coverage can continue. If a case was closed due to the five-year limitation, the case may be reopened.

**501.07 Termination of Coverage**

Eligibility for coverage under the BCCP must be terminated for the following reasons:

* The beneficiary’s course of treatment is completed. DHHS must be notified within 10 days after treatment ends.
* The beneficiary has completed five (5) years of hormonal cancer therapy for breast cancer.
* The beneficiary is no longer receiving treatment for breast cancer or cervical cancer.
* The beneficiary requests termination.
* The beneficiary reaches age 65. (Coverage terminates at the end of the month in which their 65th birthday occurs.)
* The beneficiary dies.
* The beneficiary becomes eligible for Medicare.
* The beneficiary becomes eligible for a mandatory Medicaid program, in which case the eligibility category must be changed to the new coverage group.
* The beneficiary moves to another state.
* The beneficiary fails to complete the re-determination process.
* The beneficiary becomes covered under creditable insurance.
* The beneficiary does not meet one of the eligibility requirements listed in MPPM [501.03](#MPPM_501_03).

An ex parte determination must be made to determine if the beneficiary qualifies for coverage under another program. A 10-day advance notice must be provided before eligibility is terminated.

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