STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

MEMORANDUM

TO: Health Officers

FROM: Courtney Lewis
Director, Center for Cancer Prevention & Control

DATE: August 26, 2015

RE: **Center for Cancer Prevention & Control – Revised Policies: Affordable Care Act Implementation for Direct Service Programs**

This memo is intended to provide clarity and revisions to program policy regarding the guidelines on how Center for Cancer Prevention & Control programs providing direct clinical services will operate with the implementation of the Affordable Care Act.

We remain focused on serving underserved populations in the state including low-income, uninsured or underinsured persons to bridge the gap in access to cancer screening, diagnostic and treatment services. We look forward to continuing our partnership with the local health departments in our efforts to refine policies addressing serving more low-income insured persons.

Guidelines for the programs listed below are included:

Breast & Cervical Cancer (Screening) Program
Breast & Cervical Cancer Diagnosis & Treatment Program
Maryland Cancer Fund
Cigarette Restitution Fund/Cancer Prevention, Education, Screening & Treatment Program

If you have any questions, please feel free to contact me at 410-767-0824 or by email at courtney.lewis@maryland.gov .

BREAST AND CERVICAL CANCER (SCREENING) PROGRAM

Program Operations

The program will continue to provide clinical services to eligible **uninsured and underinsured** clients.

Uninsured Client	Underinsured Client
• Does not have any health insurance	• Has Medicare Part A only • Has health insurance with a **deductible that has not been met** • Has health insurance with a **patient contribution amount** for applicable procedures to include **copays and co-insurance** Services covered by the insurer must be verified by acquiring the woman's Explanation of Benefits, which must be placed in the patient's chart as documentation. **The BCCP is a payor of last resort.**

Program staff should encourage potentially eligible clients to enroll into the Maryland Health Benefits Exchange during open enrollment periods, and into (expanded) Medicaid. Programs should implement processes established within their health department/hospital to refer patients to these programs.

- Program staff should encourage clients to apply through the Maryland Health Connection to determine eligibility and enroll in a plan. This includes enrollment of eligible clients into (expanded) Medicaid.
- Clients should visit **MarylandHealthConnection.gov** or call 1-855-642-8572 to find out which plan is right for them.

Clients that ***may be eligible*** for the Exchange or (expanded) Medicaid, ***but not enrolled*** in the Exchange or (expanded) Medicaid ***are allowed to enroll in the program*** should they meet program eligibility requirements.

Allowable Reimbursement

Uninsured Clients-Fee for Service

For clients **not** enrolled in the Exchange or (expanded) Medicaid, pay fee for service for screening/diagnostic services, up to the allowable Medicare/Medicaid reimbursement rate. Programs may reimburse for clinical services for an eligible client ***initiating an application*** for insurance at the time of their enrollment or recall to the program. If the client's health coverage is retroactive, the program may recoup funds for a paid service from a provider participating with the client's health insurance, per the health department's/hospital's established processes.

Insured Clients-Patient Contribution Amounts

Local programs will have **discretion to develop their own policies to allow reimbursement for co-insurance and copays**. Local programs may choose not to pay contribution costs for insured clients. **Local program policies must be applicable to all clients.**

Paying Patient Contributions

Patient Contribution	Reimbursement	Maximum Allowable
Co-insurance for applicable procedures	• Obtain the insurer's Explanation of Benefits (EOB). • Reimburse up to the allowable amount based on the BCCP Medicare/Medicaid Reimbursement Rates fee schedule	Reimburse up to the allowable amount based on the BCCP Medicare/Medicaid Reimbursement Rates fee schedule. *For high cost clients, consult with DHMH.*
Copays for applicable procedures	• Obtain the insurer's Explanation of Benefits (EOB). • Reimburse up to the allowable amount based on the BCCP Medicare/Medicaid Reimbursement Rates fee schedule	Reimburse up to the allowable amount based on the BCCP Medicare/Medicaid Reimbursement Rates fee schedule. *For high cost clients, consult with DHMH.*
Service fees for applicable procedures due to the patient's **deductible not being met**	• Obtain the insurer's Explanation of Benefits (EOB). • Reimburse up to the allowable amount based on the BCCP Medicare/Medicaid Reimbursement Rates fee schedule	Reimburse up to the allowable amount based on the BCCP Medicare/Medicaid Reimbursement Rates fee schedule until the deductible has been met.

Payor of Last Resort

REVISED GUIDANCE (August 2015)

BCCP should always be the payor of last resort for insured clients. If a client has other insurance, that insurance is primary and the provider must bill the primary insurance first. After obtaining the insurer's Explanation of Benefits and determining the patient responsibility amount for allowable services, BCCP may pay the provider the amount that is the patient's responsibility as long as:

- the ***BCCP payment*** to the provider does not exceed the program allowable rate **and**
- the combined payment of the primary plan and BCCP does not exceed the provider's charge.

Unallowable Reimbursement

Do not pay **premiums** for clients with insurance, including those insured through the Exchange.

BREAST AND CERVICAL CANCER DIAGNOSIS & TREATMENT PROGRAM

Program Operations

The program will continue to serve eligible uninsured and underinsured clients.

Uninsured Client	Underinsured Client
• Does not have any health insurance	• Has any health insurance with a **deductible that has not been met** • Has any health insurance with a **patient contribution amount** for applicable procedures to include **copays and co-insurance** Services covered by the insurer must be verified by acquiring the client's Explanation of Benefits. **The BCCDTP is a payor of last resort.**

- The program will encourage enrollment into the Maryland Health Benefits Exchange for potentially eligible clients during open enrollment periods. Program staff will also encourage enrollment of potentially eligible clients into (expanded) Medicaid.
  - The program will encourage clients to apply through the Maryland Health Connection to determine eligibility and enroll in a plan. This includes enrollment of eligible clients into (expanded) Medicaid.
  - Clients should visit **MarylandHealthConnection.gov** or call 1-855-642-8572 to find out which plan is right for them.

- Clients that ***may be eligible*** for the Exchange or (expanded) Medicaid, ***but not enrolled*** in the Exchange or (expanded) Medicaid ***can enroll in the program*** should they meet program eligibility requirements.

Allowable Reimbursement

Uninsured Clients-Fee for Service

For clients **not** enrolled in the Exchange or (expanded) Medicaid, the program pays fee for service for diagnostic/treatment services, up to the allowable Medicaid reimbursement rate. The program may reimburse for clinical services for an eligible client ***initiating an application*** for insurance at the time of their enrollment or recertification to the program.

Insured Clients-Patient Contribution Amounts

Patient Contribution	Reimbursement
Deductible, co-insurance and copays for applicable procedures for patients with any insurance.	Obtain the insurer's Explanation of Benefits (EOB).

Unallowable Reimbursement

BCCDTP **will not pay premiums** for clients with insurance, including those insured through the Exchange.

MARYLAND CANCER FUND

Program Operations

The program will continue to serve eligible **uninsured and underinsured** clients.

Uninsured Client	Underinsured Client
• Does not have any health insurance	• Has health insurance with a **deductible that has not been met** • Has health insurance with a **patient contribution amount** for applicable procedures to include **copays and co-insurance** Services covered by the insurance must be verified by acquiring the client's Explanation of Benefits, and must be placed in the client's chart as documentation. **The MCF is a payor of last resort.**

Grantees should encourage potentially eligible clients to enroll into the Maryland Health Benefits Exchange during open enrollment periods, and into (expanded) Medicaid. Grantees may implement processes established within their health department/hospital to refer patients to these programs.

- Grantees should encourage clients to apply through the Maryland Health Connection to determine eligibility and enroll in a plan. This includes enrollment of eligible clients into (expanded) Medicaid.
- Clients should visit **MarylandHealthConnection.gov** or call 1-855-642-8572 to find out which plan is right for them.

Clients that ***may be eligible*** for the Exchange or (expanded) Medicaid, ***but not enrolled*** in the Exchange or (expanded) Medicaid ***are allowed to enroll in the program*** should they meet program eligibility requirements.

Allowable Reimbursement

Uninsured Clients-Fee for Service

For clients **not** enrolled in the Exchange or (expanded) Medicaid, pay fee for service for screening/diagnostic services, up to the allowable Medicare/Medicaid reimbursement rate. Programs may reimburse for clinical services for an eligible client ***initiating an application*** for insurance at the time of their enrollment or recall to the program. If the client's health coverage is retroactive, the program may recoup funds for a paid service from a provider participating with the client's health insurance, per the health department's/hospital's established processes.

Insured Clients-Patient Contribution Amounts

Patient Contribution	Reimbursement	Maximum Allowable
Co-insurance and copays for applicable procedures	• Obtain the insurer's Explanation of Benefits (EOB). • Reimburse up to the allowable Medicaid reimbursement rate	Reimburse up to the allowable Medicaid reimbursement rate.
Service fees for applicable procedures due to the patient's **deductible not being met**	• Obtain the insurer's Explanation of Benefits (EOB). • Reimburse up to the allowable Medicaid reimbursement rate	Pay fee for service until the deductible has been met

Unallowable Reimbursement

Do not pay **premiums** for clients with insurance, including those insured through the Exchange**.**

CIGARETTE RESTITUTION FUND / CANCER PREVENTION, EDUCATION, SCREENING & TREATMENT PROGRAM

Program Operations

The program will continue to provide clinical services and now patient navigation services to eligible clients, **uninsured and underinsured,** as identified by the local program in their grant award. The CPEST is a payor of last resort.

CPEST Program staff should encourage potentially eligible clients to enroll into the Maryland Health Benefits Exchange during open enrollment periods, and into (expanded) Medicaid. Programs may implement processes established within their health department/hospital to refer patients to these programs.

- Program staff should encourage clients to apply through the Maryland Health Connection to determine eligibility and enroll in a plan. This includes enrollment of eligible clients into (expanded) Medicaid.
- Clients should visit **MarylandHealthConnection.gov** or call 1-855-642-8572 to find out which plan is right for them.

Clients who ***may be eligible*** for the Exchange or (expanded) Medicaid, ***but not enrolled*** in the Exchange or (expanded) Medicaid ***are allowed to enroll in the CPEST program*** should they meet program eligibility requirements.

The CPEST programs should contact clients well in advance of their recall due date to assess for current eligibility and should encourage potentially eligible clients to enroll in the Exchange. If clients are not enrolled in the Exchange by the time their recall is due, they are eligible to receive program services if all other program eligibility requirements are met.

Allowable Reimbursement

Uninsured Clients-Fee for Service

For clients **not** enrolled in the Exchange or (expanded) Medicaid, pay fee for service for screening/diagnostic services, up to the allowable Medicare/Medicaid Reimbursement rate. Programs may reimburse for clinical services for an eligible client ***initiating an application*** for insurance at the time of their enrollment or recall to the CPEST program. If the client's health coverage is retroactive and covers the CPEST services, the CPEST program may recoup funds for a paid service from a provider participating with the client's health insurance, per the health department's/hospital's established processes.

Insured Clients-Patient Contribution Amounts

Local programs will have **discretion to develop their own policies to allow CPEST reimbursement for "contribution amounts", that is co-insurance, copays, and deductibles, incurred as part of screening, diagnostic, and/or treatment services**. Local programs may choose not to pay contribution costs for insured clients. **Local program policies must be applicable to all clients.**

Paying Patient Contribution Amounts

Patient Contribution	Reimbursement	Maximum Allowable
Co-insurance for applicable procedures	• Obtain the insurer's Explanation of Benefits (EOB). • Reimburse up to the allowable amount based on the CPEST Medicare/Medicaid Reimbursement Rates fee schedule	Reimburse up to the allowable amount based on the CPEST Medicare/Medicaid Reimbursement Rates fee schedule. *For high cost clients, consult with DHMH.*
Copays for applicable procedures	• Obtain the insurer's Explanation of Benefits (EOB). • Reimburse up to the allowable amount based on the CPEST Medicare/Medicaid Reimbursement Rates fee schedule	Reimburse up to the allowable amount based on the CPEST Medicare/Medicaid Reimbursement Rates fee schedule. *For high cost clients, consult with DHMH.*
Service fees for applicable procedures due to the patient's **deductible not being met**	• Obtain the insurer's Explanation of Benefits (EOB). • Reimburse up to the allowable amount based on the CPEST Medicare/Medicaid Reimbursement Rates fee schedule	Pay fee for service until the deductible has been met

Payor of Last Resort

REVISED GUIDANCE (August 2015)

CPEST should always be the payor of last resort for insured clients. If a client has other insurance, that insurance is primary and the provider must bill the primary insurance first. After obtaining the insurer's Explanation of Benefits and determining the patient responsibility amount for allowable services, CPEST may pay the provider the amount that is the patient's responsibility as long as:

- the ***CPEST payment*** to the provider does not exceed the program allowable rate **and**
- the combined payment of the primary plan and CPEST does not exceed the provider's charge.

Unallowable Reimbursement

Do not pay **premiums** for clients with insurance, including those insured through the Exchange**.**