Every Woman's Life

Program Manual

A Virginia Department of Health Program

Recruitment

Priority Populations

Purpose: To define the program's priority populations to ensure providers concentrate their outreach/recruitment activities on women who are most in need of EWL services.

Responsible Person(s): Provider Site Coordinator or Designee

Revised Date: June 30, 2012

Policy:
EWL defines the priority populations as:

a. Minority Women – Providers are expected to enroll and screen racial and/or ethnic minority women (e.g., African American, Asian, Hispanic) at or above the rate proportional to the presence of minorities in their defined service area. According to recent Census data, 35% of Virginia residents claim racial/ethnic minority status. While white women are more likely than other racial/ethnic groups to be diagnosed with breast cancer, black women are more likely to die from the disease. Black women are also more likely to be diagnosed with breast cancer at a younger age and a later stage. Cervical cancer incidence rates are higher for black and Hispanic women as compared to white women. Mortality rates from cervical cancer for black and Hispanic women are almost double that of white women (Source: Virginia Cancer Registry 2003-2007 and the Centers for Disease Control).

b. Economically Deprived Women – Includes women who are at or below 100% of the federal poverty level. It has been well documented that economically deprived women have more barriers to accessing health care and preventive screenings than those of higher incomes. Studies by the American Cancer Society (ACS) have documented that mortality rates are higher for low income women diagnosed with breast cancer. A study from The National Cancer Institute (NCI) reports that cervical cancer continues to be a more serious threat to women with low incomes and educational levels. Women in high poverty census tracts were 20% more likely to be diagnosed with late-stage disease and a lower survival rate than women in census tracts with low poverty levels.

c. Never/Rarely Screened Women - Women who have never been screened or have not been screened in the past five years for cervical cancer. Research indicates that women who have not had a cervical cancer screening test in five or more years are more likely to be in the greatest need of medical care. For this reason, at least **20%** of all 40-64 year old women ***newly*** enrolled for cervical cancer screening should be women who have never had a cervical cancer screening test or have not had a cervical cancer screening test in the last 5 years. This indicator only applies to 40-64 year old women served with federal funds. Refer to the *Quality Assurance and Improvement Section; Federal Performance Indicators; #5.*

d. Women Over Age 50 – As age increases so does a woman's risk of breast cancer. About 1 out of 8 invasive breast cancers are found in women younger than 45, while about 2 out of 3 invasive breast cancers are found in women age 55 or older (Source: American Cancer Society).

The program expects providers to concentrate their outreach and recruitment efforts on the priority populations to ensure women with the greatest need receive EWL services. Women recruited within the priority population must meet all program eligibility requirements for enrollment.

Toll Free Referral Line

Purpose: To provide the number and intent of EWL's toll free referral line.

Responsible Person(s): EWL State Office

Effective Date: June 30, 2011

Policy:
A toll free line is answered by EWL State staff Monday-Friday during regular business hours (8am – 4pm). All calls are returned within a 48 hour time frame. The number for the toll free line is 1-866-395-4968 or 1-866-EWL-4YOU. The toll free line is only available to Virginia callers. Out-of-state callers or callers living in Virginia with an out-of-state cell phone number must call 804-864-8204 to reach the EWL referral line.

The toll free line receives many types of questions but the most frequently asked questions are from women and/or family members who are interested in EWL services. For callers that are requesting EWL services, a referral to the nearest EWL provider site is made. For callers not eligible for EWL services, community resources are provided.

Eligibility and Enrollment

Eligibility

Purpose: To define eligibility criteria for the EWL program.

Responsible Person(s): Provider Site Coordinator or Designee

Revised Date: June 30, 2018

Policy:
To enroll a woman as a participant in the Virginia EWL program the woman must be between 18-64 years of age, claim her primary residence in Virginia, have a gross household income that is 250% of the Federal Poverty Level or less, and have no health insurance or limited health insurance. Women aged 18-39 must be symptomatic for breast or cervical cancer, which includes, but is not limited to, an abnormal cervical cytology result or abnormal breast exam.

All women must be screened annually for eligibility prior to enrollment or re-enrollment into EWL. To receive EWL funded services, the following requirements must be met:[1]

1. Female gender (self-declared)
   a. Transgender women (male-to-female), *who have taken or are taking hormones* and meet all program eligibility requirements, are eligible to receive breast cancer screening and diagnostic services through EWL; therefore, EWL funds may be used to screen these transgender women. The Center of Excellence for Transgender Health and the World Professional Association for Transgender Health have developed consensus recommendations on preventive care services for the transgender population. Those recommendations include for "transwomen with past or current hormone use, breast-screening mammography in patients over age 50 with additional risk factors (e.g., estrogen and progestin use > 5 years, positive family history, BMI > 35)." These preventive care recommendations can be found at http://transhealth.ucsf.edu/trans?page=protocol-screening#S2X.

2. Age – must be age 18-64 (self-declared)
   a. EWL may serve eligible women over age 65 with state funds. Refer to the policy "Services for Women 65 Years of Age and Older" under the Services section.

3. Income must be 250% of the Federal Poverty Level or less (self-declared)
   a. **For eligibility purposes, the program uses an applicant's self-declared gross income to determine eligibility.** Gross income means income before any deductions such as income taxes, Social Security taxes, insurance premiums, charitable contributions and bonds. It includes the following: 1) monetary compensation for services, including wages, salary, commissions or fees, 2) net income from nonfarm self-employment, 3) net income from farm self-

[1] EWL providers may follow stricter eligibility guidelines, if funds are limited.

employment, 4) Social Security, 5) dividends or interest on savings or bonds or income from estates or trusts, 6) net rental income, 7) public assistance or welfare payments, 8) unemployment compensation, 9) government civilian employee or military retirement or pensions or veterans payments, 10) private pensions or annuities, 11) alimony or child support payments, 12) regular contributions from persons not living in the household, 13) net royalties, and 14) other cash income (includes cash amounts received or withdrawn from any source including savings, investments, trust accounts and other resources).

b. EWL providers may choose to verify and document income level if this practice coincides with their agency's policies and procedures.

4. Primary residence in Virginia (self-declared)
   a. EWL providers may choose to verify and document Virginia residence if this practice coincides with their agency's policies and procedures.

5. Uninsured or underinsured (self-declared) - Underinsured is defined as:

   a. Participation in the Medicaid Spend Down Program, if the woman has not met her "spend down amount" (amount a woman must pay out of pocket for medical expenses before Medicaid coverage begins)

   b. Health insurance that does not provide full health care coverage (e.g., Plan First Family Planning Services, and Governor's Access Plan (GAP))

The following women are **not** eligible for EWL services:

- Women who have health insurance (see exceptions listed under 5).
- Women who have Medicaid with full health care coverage.
- Women enrolled in Medicare with Medicaid as a supplement.
- Women who have Medicare Part A and Part B.
- Women who receive Social Security Disability benefits and Medicare Part A and B.
- Women who receive Social Security Disability benefits must receive benefits for two years before they are automatically eligible for Medicare Part A and B.
- Women who receive Supplemental Security Income (SSI) and Medicaid.

Women that are not U.S. citizens may receive EWL screening and follow-up services by an authorized EWL provider. However, these women will **not** be eligible for the Breast and Cervical Cancer Prevention and Treatment Act (Medicaid) if breast or cervical cancer or a pre-cancerous condition is diagnosed.

Funds can be used to cover screening for female-to-male transgender individuals who have not yet undergone complete hysterectomy or bilateral mastectomy.

Federal Poverty Guidelines

Purpose: To ensure the use of current Federal Poverty Guidelines for the purpose of enrolling financially eligible women.

Responsible Person(s): Provider Site Coordinator or Designee

Revised Date: June 30, 2016

Policy:
As required by law, an annual update to the Federal Poverty Guideline (FPG) is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the *Consumer Price Index for All Urban Consumers.*

Updates to the FPG are published in the *Federal Register* by the Department of Health and Human Services. EWL will officially adopt and release the FPG updates to providers at that time***.***

Client Participation Agreement

Purpose: To ensure that applicants provide accurate personal information to determine program eligibility, understand their responsibility as a EWL participant, and consent to all EWL services prior to receiving these services.

Responsible Person(s): Provider Site Coordinator or Designee

Revised Date: June 30, 2017

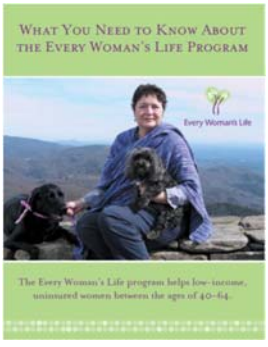
The Provider Site Coordinator or designee should obtain the client's written voluntary agreement to participate in the program by having the client carefully read and sign the Client Participation Agreement **prior** to receiving any EWL services**. (Attachment A).** The Client Participation Agreement must be signed each time a client's eligibility is determined (e.g., at the time new clients are enrolled, active clients are rescreened or inactive clients that change their status to active are re-enrolled).

For clients who do not understand the language of the Agreement, have language barriers or who have disabilities that impair communication, the Agreement must be read or interpreted to the client. Agreement to participate in the program must never be obtained in a manner that could be perceived as coercive.

For clients enrolled by phone, the Provider Site Coordinator or designee should read the entire form to the client and answer any questions. In the space reserved for the client's signature, write "Agreement by phone" and the date of the call. On the witness line, the Provider Site Coordinator or designee should sign and date the form.

The Agreement should be filed in the client's medical record. Providers are required to use the Client Participation Agreement designated in the manual. The client participation agreement should be maintained in the client's medical record and is reviewed at the time of a site visit. The form should be signed and dated by the client and witness.

The brochure or handout *"What you need to Know about Every Woman's Life"* should be provided and the contents explained to all clients at the time of enrollment or at the client's first clinic visit. This requirement also applies to clients enrolled by subcontractors.



Client Transfers

Purpose: To ensure that women transferring from another Breast and Cervical Cancer Early Detection Program (BCCEDP) are provided appropriate EWL services.

Responsible Person(s): Provider Site Coordinator or Designee

Revised Date: July 1, 2013

Policy:
The National BCCEDP (NBCCEDP) was created in response to the Breast and Cervical Cancer Mortality Prevention Act passed by Congress in 1990. The act established a program of cooperative agreements with states, tribes, and territories to increase the early detection of breast and cervical cancer among low income, uninsured, and underinsured women. Because this is a nationally-funded program, clients previously enrolled in a NBCCEDP screening program outside Virginia, but now living in Virginia, may be eligible for services under EWL. For example:

1. Women ages 40-64 previously enrolled in another BCCEDP who have recently relocated to Virginia and are requesting breast and cervical cancer screening services may be enrolled into EWL provided they meet the program's eligibility requirements and there are appointments available. Once eligibility is determined, complete the required client data collection forms (Client Eligibility Form, Breast and/or Cervical Screening and Diagnostic Forms) and submit for reimbursement once all screening and/or diagnostic results are received.

2. Women ages 18-64 in need of or receiving breast and cervical diagnostic services under the NBCCEDP who relocate to Virginia and need diagnostic work-up completed should be enrolled in EWL to complete the necessary diagnostic procedures. Provider Site Coordinators or their designee must verify these out-of-state transfers received services (e.g., screening and/or diagnostic) under another BCCEDP. Providers may use the *Client Transfer* form found in **Attachment B** for this purpose**.** File the form in the client's medical record. Provider Site Coordinators or their designee must complete the required client data forms (Client Eligibility Form and Breast and/or Cervical Screening and Diagnostic Forms) and submit for reimbursement once the diagnostic results are received. Women who transfer into EWL from another program and are in need of diagnostic services do <u>not</u> need to meet EWL income requirements since other programs may have higher income limits compared to Virginia. However, providers must document that these clients were receiving NBCCEDP screening and/or diagnostic services through another program prior to their relocation.

For women ages 18-39:

a. If the diagnostic work up rules out cancer, the woman should be referred to a health care provider for age appropriate health screenings and medical care. If the woman is 39 years of age and meets EWL eligibility requirements, she may be scheduled for EWL services so that she is enrolled in EWL by the time she turns age 40. This scenario is based on the assumption that appointment slots are available for women ages 40-49.

b. If breast or cervical cancer is diagnosed, the woman should be referred to Medicaid for medical assistance under the Virginia Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). Refer to the *Treatment Section – Breast and Cervical Cancer Prevention and Treatment Act.*

For women aged 40-64:

a. If the diagnostic work up rules out cancer, the woman may be enrolled for rescreening services 12 months following her initial screening date, if she meets EWL eligibility criteria and appointment slots are available (especially in the case of women ages 40-49).

b. If breast or cervical cancer is diagnosed, the woman should be referred to Medicaid for medical assistance under the Virginia BCCPTA. Refer to the *Treatment Section – Breast and Cervical Cancer Prevention and Treatment Act.*

3. Women who were previously diagnosed with cancer or a pre-cancerous condition while enrolled in another NBCCEDP funded program and in need of or receiving treatment, but are now a Virginia resident, are covered by the Virginia BCCPTA.

   a. Provider Site Coordinators or their designee must verify these out-of-state transfers are eligible for the Virginia BCCPTA. They may use the *Client Transfer* form found in **Attachment B** for this purpose**.** File the form in the client's medical record. **Do not send this form to the state EWL office.**

   b. The Client Eligibility and Breast/Cervical Screening and Diagnostic Forms do <u>not</u> have to be completed.

   c. Once the verification process is complete, Provider Site Coordinators or their designee must complete the Virginia BCCPTA enrollment form and submit the form to their local DSS Office. Refer to the *Treatment Section – Breast and Cervical Cancer Prevention and Treatment Act.*

Affordable Care Act

Purpose: To provide guidance on the impact of the Affordable Care Act (ACA) on EWL, to detail the expectations of EWL Providers to refer women to the health insurance marketplace and to track EWL clients who receive insurance through the ACA.

Responsible Person(s): Provider Site Coordinator or Designee

Revised Date: January 1, 2016

Policy:
Expanded insurance coverage resulting from the Affordable Care Act (ACA) may increase the number of people who have access to life-saving cancer screenings in Virginia. While this is encouraging, we understand that there is a great deal of uncertainty about the future. The CDC and the state EWL office are monitoring implementation of ACA and its impact to inform possible modifications to the program. Please communicate any new or ongoing issues that you are encountering as a result of ACA to the state EWL office. This information will be communicated to the CDC to help them inform decision makers on how the National Breast and Cervical Cancer and Early Detection Program (NBCCEDP) can best serve the public.

As before the ACA, EWL continues to play an important role in cancer screening for those in need. Per CDC guidance, programs should continue to screen program-eligible individuals until they are enrolled in and have access to services covered by insurance. Please refer to **Attachment C** for guidance on ACA messaging that can be used when communicating with the public and partners.

Eligibility for EWL remains the same. However, providers should keep the following guidance in mind as they operate their EWL programs:

- Eligibility for EWL remains self declared, unless a provider's organization requires documentation.

- As EWL providers enroll women, they should be encouraging them to sign up for health insurance coverage through the Health Insurance Marketplace (healthcare.gov or cuidadodesalud.gov).

- A larger emphasis is being placed on enrolling and screening women100% of the FPL and below. As of FY 16, the non-core indicator regarding women 100% of the federal poverty level was updated to reflect this emphasis. The non-core indicator now reads, "A minimum of 75% of women served will be at or below 100% of the Federal Poverty Level".

- When inactivating women because they have obtained insurance, EWL providers should inquire as to whether the insurance was obtained through the Affordable

Care Act. This information will be collected in the inactivation section of the EWL Eligibility Form.

Navigating Women to the Health Insurance Marketplace

As previously mentioned, EWL providers should encourage eligible women to sign up for insurance through the Health Insurance Marketplace. EWL providers are now required to indicate on client eligibility forms that women 101% - 200% FPL were encouraged to sign-up for insurance through the Marketplace and were referred to resources that can aid women in the enrollment process, either through their own organization or other resources.

EWL providers are encouraged to identify local resources that can aid EWL clients in enrolling for insurance through the Health Insurance Marketplace. A statewide resource that can be utilized by all EWL providers, is ENROLL Virginia!. ENROLL Virginia! is a nonpartisan, community-based effort to educate all Virginians about the new health insurance marketplace and provide free, unbiased assistance with the application and enrollment process. Their statewide toll-free phone system and website helps Virginians connect to resources across the state. In addition to helpful information on understanding the Health Insurance Marketplace, their website has an interactive map of local navigators, certified application counselors and trusted organizations that will help Virginians in all localities of the state apply for health coverage.

ENROLL Virginia!
Statewide Toll-Free:
1-888-392-5132

Click below for more information:
http://enroll-virginia.com/ev/enroll/Home

ATTACHMENT A

Every Woman's Life

Client Participation Agreement

Client Name (please print):_____

The Every Woman's Life program encourages and offers breast and cervical cancer screening to eligible women based on current screening recommendations. The goal of screening is to detect cancer in its earliest stage so that it can be treated. Screening for breast cancer involves a free breast examination and a breast X-ray called a mammogram. Screening for cervical cancer involves a free pelvic examination and Pap test. During the pelvic exam some cells will be taken from your cervix and sent to a lab to see if any abnormalities exist.

As a participant in the program:

- You will get the breast and cervical screening tests that are right for you based upon the current screening management guidelines.
- If you need more tests, your case manager will help you get these tests. Most of these tests will be at no cost to you, but you may need to pay for some tests not allowed by the program. Your case manager will work with other clinics to make sure you get all the tests that you need. Your case manager will explain any out of pocket costs for any services that might not be covered by the EWL program.
- If you are diagnosed with breast or cervical cancer you may be eligible to get your treatment paid for by Medicaid. Your case manager will assist you in completing the BCCPTA (Medicaid) application and forward the application to your local DSS office.
- You should come to all of your screening and follow up appointments. If you cannot make an appointment or no longer want to be in the program, you should call your case manager.

Agreement:

- I agree to get the screening tests and any other tests that I may need.
- I agree to keep all appointments. If I cannot come to an appointment, I will call my case manager.
- I confirm that the personal information that I have given is correct.
- I understand that my personal information is private and will be used to determine my eligibility for the program and by the case manager to help me get the tests that I need. My information may be shared with the local DSS office to process my Medicaid application and if I receive Medicaid I understand that my case manager may have access to my medical record to ensure that I have started treatment and to assess for any barriers related to my care and/or treatment. I understand that should I discontinue treatment or fail to start treatment, DSS may revoke my enrollment with Medicaid.
- I agree that my health information can be shared with the program.
- I understand that my participation is voluntary and that I may drop out of the program at any time. Should I decide to leave the program I will contact my case manager.

Client Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Every Woman's Life

Acuerdo de Participación de las Clientas

Nombre de la clienta (favor usa letra de molde): _____

El programa Every Woman's Life (EWL) promueve y ofrece evaluaciones de cáncer de mama y de cérvix a mujeres elegibles con base en las recomendaciones actuales para las evaluaciones. El objetivo de la evaluación es detectar el cáncer en su etapa más temprana para que pueda ser tratado. La evaluación del cáncer de mama consiste en un examen de mama gratuito y una radiografía de la mama llamada mamografía. La evaluación de cérvix consiste en un examen pélvico gratuito y una prueba de Papanicoláu. Durante el examen pélvico se tomará una muestra de algunas células de su cérvix y se enviarán al laboratorio para ver si existe alguna anomalía.

Como participante del programa:

- Usted recibirá evaluaciones para la mama y cérvix adecuadas para usted con base en los lineamientos actuales de manejo de las evaluaciones.
- Si necesita más pruebas, su administrador de caso le ayudará a obtenerlas. La mayoría de estas pruebas serán sin costo alguno para usted, pero es posible que sea necesario que usted pague por algunas pruebas que el programa no ofrece. Su administrador de caso trabajará con otras clínicas para asegurar que usted reciba todas las pruebas que necesita. Su administrador de caso le explicará cualquier gasto que usted deberá pagar de su propio bolsillo por cualquier servicio que podría no estar cubierto por el programa EWL.
- Si se le diagnostica cáncer de mama o de cérvix usted puede ser elegible para que su tratamiento sea pagado por Medicaid. Su administrador de caso le ayudará a completar la solicitud de BCCPTA (Medicaid) y enviar la solicitud a su oficina local de DSS.
- Usted debe presentarse a todas las evaluaciones y citas de seguimiento. Si no puede ir a una cita o ya no desea participar en el programa, deberá llamar a su administrador de caso.

Acuerdo:

- Acepto que se me hagan las pruebas de evaluación y cualquier otra prueba que pueda necesitar.
- Acepto ir a todas mis citas. Si no puede asistir a una cita, llamaré a mi administrador de caso.
- Confirmo que la información personal que he proporcionado es correcta.
- Entiendo que mi información personal es privada y será utilizada para determinar mi elegibilidad en el programa y por el administrador de caso para que me ayude a obtener las pruebas que necesito. Mi información puede ser compartida con la oficina de DSS local para tramitar mi solicitud de Medicaid y si recibo Medicaid entiendo que mi administrador de caso puede tener acceso a mi historia clínica para asegurarse que he comenzado el tratamiento y evaluar si hay alguna barrera relacionada con mi atención y/o tratamiento. Entiendo que si yo interrumpo o no comienzo el tratamiento, DSS puede revocar mi inscripción en Medicaid.
- Acepto que mi información de salud puede ser compartida con el programa.
- Entiendo que mi participación es voluntaria y que puedo dejar el programa en cualquier momento. Si decido dejar el programa me pondré en contacto con mi administrador de caso.

Firma de la cliente:_____ Fecha:_____

Firma del testigo:_____ Fecha:_____

ATTACHMENT B

Client Transfer

Purpose: This form is used to collect information on women transferring from another NBCCEDP funded program to the Virginia BCCEDP who are in need of diagnostic services or treatment under the Virginia Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

Instructions: The transferring program should enter all client information on the form. If certain client information (e.g., date treatment started) is not available at the time the form is completed, enter "unknown." Sign, date and FAX the completed form to the following provider site located in Virginia:

Provider Site Name:
Provider Site Contact Name:
Provider Site FAX #:

Transfer From: *(enter name of state, tribal organization, or territory)*	Transfer To: **Virginia**
Patient Information	
First Name:	Last Name:
Screening Date:	Screening Result:
Diagnosis Date:	Diagnosis:
Date Medicaid Eligible:	Date Treatment Started:
Screening Facility/Service Site: *(enter name of facility/service site where patient was screened)*	
Screening Facility/Service Site Contact Name:	
Screening Facility/Service Site Phone #:	

I certify that the above information is correct and the individual has been screened for breast or cervical cancer and found to need diagnostic procedures or treatment for breast or cervical cancer or a pre-cancerous lesion.

_____ Date_____
(Screening BCCEDP Representative's Signature)

_____ Date_____
(Screening BCCEDP Representative) - Please Print Full Name

Every Woman's Life
A Virginia Department of Health Program

ATTACHMENT C

Affordable Care Act (ACA) Messaging

Purpose: The information below should be used when communicating to the public and partners about the Every Woman's Life program and the ACA.

PUBLIC

- We know things are changing fast in the healthcare system, but Every Woman's Life [or local program name] is still here to help you get quality cancer screening and follow-up.
- Expanded insurance coverage resulting from the Affordable Care Act may increase the number of people who have access to life-saving cancer screens. If you can, you should sign up for coverage at healthcare.gov [or CuidadoDeSalud.gov] during open enrollment. Once on the website, select "Find Local Help" [or "Encuentre Ayuda Local"] if you need help completing the application process.
- If you are having problems getting screened, Every Woman's Life {or local program name] is a resource for you. We provide [list what you provide, examples are below]:
    - Patient Navigation services to help you find and receive the services you need.
    - Education so you understand why and when you should be screened and know what to expect from your provider.
    - Quality, free/low cost screening and follow-up if you are eligible for the program.
- [insert local organization name] Every Woman's Life program has not changed its eligibility criteria, however, it is possible that the program's eligibility criteria will change in the future as more people become insured.
- Let us know if you have any questions about your eligibility for [local program name].

PARTNERS

- Expanded insurance coverage resulting from the Affordable Care Act may increase the number of people who have access to life-saving cancer screenings and other clinical preventive services.
- However, barriers to quality cancer screening remain. Barriers including lack of awareness of screening, among others, will prevent some from taking advantage of screening, even though they have insurance.
- Collaboration among the public health, clinical, and business communities is essential.
- We want you to know that Every Woman's Life [or local program name] is still here to promote and provide access to quality cancer screening.
- [insert local organization name] Every Woman's Life program has not changed its eligibility criteria; however, it is possible that the program's eligibility criteria will change in the future.

Services

Client Education

Purpose: To ensure that all clients enrolled in EWL receive age appropriate health information emphasizing the importance and purpose of regular breast and/or cervical screening exams as well as healthy lifestyle behaviors.

Responsible Person(s): Provider Site Case Managers, Clinicians, or Designee

Revised Date: June 1, 2017

Policy:

Client education is an essential and fundamental component of the EWL program. Health information provided during the clinic visit assists clients in making positive lifestyle choices and decisions, and provides critical information about the importance of routine cancer screening exams. Case managers, clinicians or their designee should:

1. Provide information that is culturally and linguistically appropriate and understandable for visually/hearing impaired women, about the purpose of clinical breast exams, screening mammograms and/or cervical cancer screening tests when they enroll in the program. Emphasis should be placed on the message that routine screening lowers mortality from breast cancer and decreases a woman's chances of developing invasive cervical cancer.

2. Provide information on other age-appropriate cancer screenings (e.g., colorectal screening over age 50) to women enrolled in the program.

Case Managers, clinicians or their designee should also provide health information on key topics which encourage a healthy lifestyle (e.g., low fat/salt diet, increased activity) to women enrolled in the program to lower the risk of chronic diseases, such as heart disease, high blood pressure and diabetes. Client education should be clearly documented in the medical record and is reviewed at the time of a medical record review.

Additionally, other appropriate health education information (e.g., STDs) should be provided to promote safe and healthy lifestyle practices and behaviors.

Cervical Services – Age 18-39

Purpose: To ensure 18-39 year old women with high-grade cervical abnormalities receive appropriate cervical diagnostic services through EWL.

Responsible Person(s): Provider Site Clinicians

Revised Date: June 30, 2018

Policy:
The EWL program provides cervical diagnostic services (e.g., colposcopy) to eligible women between the ages of 18-39 that are referred to the program as a result of an abnormal cervical screening result. Women within this age range are typically screened through family planning clinics or other health care providers and referred to the EWL program. The EWL program **does not** cover routine cervical screening services for this age group. Additionally, cervical tests for this age group should follow the recommendation and management guidelines of the ASCCP.

Women enrolled into the EWL program for diagnostic services should have documentation of a pelvic exam in the medical record. The pelvic exam includes a gynecologic history, counseling and expectations, external exam (inspection of clitoris, labia, and vaginal opening), speculum exam (vaginal inspection and specimen collection), bimanual exam (check of tubes, ovaries and uterus), and rectal exam. If the pelvic exam is performed by a non-EWL Clinician, the EWL Coordinator and/or Case Manager should request the documentation and file it in the EWL medical record. The documentation should be recorded on the Cervical Screening/Diagnostic form.

EWL providers that are faced with limited appointments for women within this age range and need to prioritize services should use the priority listing below to schedule appointments.

Cervical abnormalities that warrant cervical diagnostic and case management services include **(In order of priority)**:

1. Squamous Cell Carcinoma
2. Atypical Glandular Cells (AGC)
3. High-Grade SIL (HSIL)
4. Atypical Squamous Cells - Cannot Exclude High Grade Squamous Intraepithelial Lesion (ASC-H)*
5. Atypical Squamous Cells – Cannot Exclude High Grade SIL (ASC:H) and High Grade Squamous Intraepithelial Lesion (HSIL) in women 21-24
6. Low-Grade Squamous Intraepithelial Lesion (LSIL) for women with no HPV test or +HPV*
7. Atypical Squamous Cells of Undetermined Significance (ASCUS) with +HPV*
8. Women age 30 and older with a negative cytology screening result and +HPV 16/18
9. Women age 30 and older with an unsatisfactory screening result and +HPV

An abnormal cervical screening test result requires follow-up. *Refer to the policy - Managing Women with an Abnormal Cervical Screening Result*.

Please refer to the current ASCCP Guidelines for management options for women 21-24 or women who are pregnant. **Note:** In order to invoice for state funds, question #12 – "Was the client referred for immediate cervical diagnostic work-up for final diagnosis?" **must** be checked ***"yes"*** on the *Cervical Screening and Diagnostic Form,* a diagnostic procedure must be performed and recorded under the *Diagnostic Procedures* section **and** the funding source for the diagnostic procedure **must** be EWL.

Breast Services – Age 18-39

Purpose: To ensure 18-39 year old women with breast symptoms receive appropriate diagnostic services through EWL.

Responsible Person(s): Provider Site Clinicians

Revised Date: June 30, 2018

Policy:
The EWL program provides breast diagnostic services (e.g., ultrasound, additional mammogram views, and biopsy) to eligible women between the ages of 18-39 that are symptomatic for breast cancer. Symptomatic is defined as the presence of:

1. A discrete palpable mass
2. Bloody or serous nipple discharge
3. Nipple or areolar scaliness, skin changes
4. Skin dimpling, retraction, or inflammation
5. Asymmetric thickening/nodularity

A clinical breast examination (CBE) must be performed and documented in the medical record to confirm the presence of breast symptoms. The presence of symptoms must be confirmed by a Clinician for women who self-report an issue. EWL clinicians or non-EWL clinicians may perform the CBE. If a non-EWL clinician performs the CBE and refers the woman to a EWL provider, the provider site clinician/case manager must obtain the results of the exam and record the information on the screening/diagnostic form. This does not negate the EWL Clinician's option to perform another CBE if warranted.

Once a CBE is performed and confirms the presence of breast symptoms (e.g., discrete palpable mass, nipple discharge, skin changes, scaliness or dimpling), the client must be referred for further diagnostic work-up. For the purpose of the program, a diagnostic mammogram is not viewed as a stand-alone for diagnostic work-up. An ultrasound will be needed in most cases as well and is the preferred first modality of evaluation for women under age 40 years. *Refer to the guidelines –Current NCCN Breast Cancer Screening and Diagnosis Guidelines.* These Guidelines can be found at *www.nccn.org*.

Women within this age group that have received an abnormal imaging result are also eligible to receive breast diagnostic services. Results warranting additional diagnostic services includes:

A. BIRADS – 0: Additional imaging evaluation and/or comparison to prior mammograms is needed
B. BIRADS – 3: Probably benign finding
C. BIRADS – 4: Suspicious abnormality
D. BIRADS – 5: Highly suggestive of malignancy
E. BIRADS – 6: Known biopsy – proven malignancy

Refer to the policy – Managing Abnormal Breast Results.

Women within this age range are typically screened through family planning clinics or other health care providers and referred to the EWL program.

The EWL program **does not** cover routine breast screening services, such as a screening mammogram, for a*symptomatic* women between the ages of **18-39**, even if they are considered to be at high risk (e.g., women who have a personal history of breast cancer, test positive for the BRCA1 or BRCA2 mutation, or have a first degree relative with pre-menopausal breast cancer). Mammogram results must be reported using the American College of Radiology Breast Imaging Reporting and Database System (BI-RADS). Facilities should be accredited by the ACR if performing mammography, breast Ultrasound, and breast MRI.

Note: In order to invoice for state funds, question #11 – "Are additional breast procedures needed for final diagnosis?" **must** be checked ***"yes"*** on the *Breast Screening and Diagnostic Form,* a diagnostic procedure **must** be performed and recorded under the *Diagnostic Procedures* section **and** the funding source for the diagnostic procedure must be EWL.

Cervical Services – Age 40-64

Purpose: To ensure that eligible women are provided cervical cancer screening and clinical pelvic examinations.

Responsible Person(s): Provider Site Clinicians and Case Managers

Revised Date: June 30, 2016

Policy:
The EWL program promotes a gynecological exam, which includes an annual pelvic exam. A cervical cancer screening test should be offered and performed based upon the current ASCCP management guidelines recommendation. The pelvic exam includes a gynecologic history, counseling and expectations, external exam (inspection of clitoris, labia, and vaginal opening), speculum exam (vaginal inspection and specimen collection), bimanual exam (check of tubes, ovaries and uterus), and rectal exam. The primary purpose of the cervical cancer screening test is to identify pre-cancerous and cancerous cervical lesions at an early stage. Clinicians should obtain a cervical cancer screening test from women who have an intact cervix. The screening test can be the conventional slide or liquid-based cervical cytology method (ThinPrep or SurePath).

Cervical Cancer Screening Intervals – Conventional or Liquid-Based

The screening interval for cervical cancer screening is every **three years** with cytology alone for women age 21 and over or **every five years** with cytology and HPV testing (co-testing) for women age 30 and over.[1] Please note that while the guidelines recommend screening at age 21, the EWL program only provides routine screening to this age group (40-64).

Refer to **Attachment A** for the EWL Cervical Cancer Screening Guidelines. To ensure the cervical screening intervals are followed, providers should review a client's medical record and the current ASCCP management guidelines.

Reporting Cervical Cancer Screening and Diagnostic Test Results
Cervical cancer screening and diagnostic test results can be reported using the Bethesda System 2001 or Lower Anogenital Squamous Terminology (LAST). The Bethesda System defines cytology specimen adequacy for interpretation as either:

- Satisfactory,
- Specimen processed and examined, but unsatisfactory for evaluation of epithelial abnormality because of (specify reason),
- Unsatisfactory

Possible results with the Bethesda System include:

- Negative for intraepithelial lesion or malignancy
- Epithelial cell abnormalities
- Glandular cell abnormalities.

The LAST system is an alternative to the Bethesda System that was recently developed to provide consistent terminology for both cytology and histology across all lower genital epithelial tissues (vulva, vagina, cervix, anus, and penis). It is expected that most labs will transition to the LAST System over the next few years. The LAST terminology similarly identifies specimens as normal or epithelial cell abnormalities but uses fewer categories. The recommended LAST terminology (cytology and histology) for HPV-associated squamous lesions of the lower anogenital tract is:

- Low-grade Squamous intraepithelial lesion (LSIL)
- High-grade Squamous intraepithelial lesion (HSIL)
    - HSIL may be sub-classified as CIN II, CIN II,III or CIN III. (The sub-classification is useful in determining management of results in young women, but not in women age 40 and over.) [2]

Whether reported in Bethesda System terminology or LAST terminology, the specific cytology screening results will determine what additional procedures are needed.

Cervical Cancer Screening Following a Hysterectomy

The presence of a cervix can be determined on physical exam. EWL funds **can** be used to pay for an initial examination (i.e., pelvic exam) to determine if a woman has a cervix. EWL funds **cannot** be used to pay for cervical cancer screening in women with complete hysterectomies (i.e., those without a cervix), unless the hysterectomy was performed due to cervical neoplasia (precursors to cervical cancer) or invasive cervical cancer. EWL funds **can** be used to pay for cervical cancer screening in women that self-report they do not know the reason for the hysterectomy (e.g., uterine versus cervical cancer) and no medical record is readily available to document the reason. If screening is performed for this reason, it should be clearly documented in the medical record.

For women with a total hysterectomy and a history of invasive cervical cancer, cervical cancer screening with cytology alone should continue every three years until the patient is no longer eligible for EWL services (e.g., age 65 and over). The client should then continue screening as a Medicare eligible client *(American College of Obstetricians and Gynecologists, Practice Bulletin 2012)*.

Women with a partial hysterectomy (cervix intact) and a history of cervical neoplasia should continue routine cervical cancer screening following either a post treatment surveillance period or spontaneous resolution of cervical neoplasia. The surveillance period for post treatment or spontaneous resolution of cervical neoplasia (CIN 2, 3) consists of co-testing (cervical cytology with high-risk HPV DNA testing) at 12 and 24 months *(ASCCP.)* After the surveillance period routine screening should continue for 20 years *(American College of Obstetricians and Gynecologists)*.

Additional information on ASCCP's guidelines for cervical cancer screening following a hysterectomy can be found in the following study in the *Journal of Lower Genital Tract Disease*, http://journals.lww.com/jlgtd/PublishingImages/ASCCP%20Guidelines.pdf#zoom=80.

Abnormal Cervical Cancer Screening Test Result

An abnormal cervical screening test result requires follow-up. *Refer to the policy - Managing Women with an Abnormal Cervical Screening Result*.

The EWL provider and sub-contractor(s) must contract with facilities that meet EWL quality standards and requirements; specifically cytology laboratories which have current Clinical Laboratory Improvement Amendments of 1988 (CLIA) certification.

[1] U.S. Preventive Services Task Force (USPSTF), 2012

[2] Darragh TM, Colgan TJ, Thomas Cox J, Heller DS, Henry MR, Luff RD, McCalmont T, Nayar R, Palefsky JM, Stoler MH, Wilkinson EJ, Zaino RJ, Wilbur DC; Members of the LAST Project Work Groups. Int J Gynecol Pathol. 2013 Jan;32(1):76-115. doi: 10.1097/PGP.0b013e31826916c7. Erratum in: Int J Gynecol Pathol. 2013 Mar;32(2):241. Int J Gynecol Pathol. 2013 Jul; 32(4):432

Breast Services – Age 40-64

Purpose: To ensure women between the ages of 40-64 are provided clinical breast exams and annual screening mammograms.

Responsible Person(s): Provider Site Clinicians

Revised Date: June 30, 2018

Policy:
The primary purpose of regular breast cancer screening is to detect pre-cancerous or cancerous lesions at the earliest stage and refer promptly for treatment to achieve better outcomes. The clinical breast examination and screening mammogram are two important tests used in breast cancer screening. Refer to **Attachment A** for EWL Breast Cancer Screening Guidelines.

Clinical Breast Examination
The Clinical Breast Examination (CBE) is an important contribution to breast cancer screening. The CBE can detect some cancers not found by mammography, though this happens infrequently. The more important role of the CBE is that it provides the clinician an opportunity to educate the client about breast health, normal breast composition, and the importance of regular check-ups and breast imaging.

Clinicians should perform and document at least one CBE annually on all clients enrolled in EWL and document the findings in the medical record and on the screening/diagnostic form. The presence of symptoms must be confirmed by a Clinician for women who self-report an issue. If a non-EWL clinician performs the CBE and refers the woman to a EWL provider for breast screening, the provider site clinician/case manager must obtain the results of the exam, file it in the medical record, and record the information on the screening/diagnostic form. This does not negate the EWL Clinician's option to perform another CBE if warranted. The CBE should consist of a review of the client's clinical history, a visual inspection, and physical examination. For CBE core competencies, refer to **Attachment B**.

Screening Mammogram
Enrolled women should receive an annual screening mammogram performed by a Radiological Technologist certified in mammography and read by a Radiologist meeting qualifications of the Mammography Quality Standards Act (MQSA). The interval between screening mammograms should not be less than 12 months. Mammogram results must be reported using the American College of Radiology Breast Imaging Reporting and Database System (BI-RADS). Facilities should be accredited by the ACR if performing mammography, breast Ultrasound, and breast MRI.

If a woman receives an abnormal CBE and/or screening test result, policies for follow-up of abnormal breast cancer screening results must be followed. Additionally, the

current NCCN clinical practice guidelines are to be followed for managing breast cancer screening and diagnosis. *Refer to Services Section; Managing Women with an Abnormal Breast Screening Result.*

Digital Mammography

Digital mammography is an allowable procedure. EWL authorized providers may reimburse for this procedure at the digital mammography Medicare reimbursement rate.

Screening Mammograms after Mastectomy

Women who have had a total, modified radical or radical mastectomy for breast cancer need no further routine screening mammograms of the affected side (or sides, if both breasts are removed); they should have an annual physical exam. Screening mammograms should be continued on the unaffected breast each year since women who have had one breast cancer are at a higher risk of developing a new cancer of the other breast.

Women who have had a breast removed by total, modified radical or radical mastectomy and reconstructed (rebuilt) with silicone gel or saline implants do not need routine mammograms; they should have an annual physical exam.

Women who have had a subcutaneous mastectomy have enough breast tissue left behind to warrant a yearly screening mammogram.

Implants

Women who have had breast implants due to augmentation or cosmetic reasons should receive routine mammography screenings. Breast MRI to assess implant ruptures is not covered.

Breast MRI Screening

EWL funds may be used to reimburse for screening Breast MRI when performed in conjunction with a mammogram when the established CDC criteria has been met. **ALL** requests for breast MRI screening must be reviewed and pre-approved for reimbursement by the State office.

When submitting requests to the state office, fax the client's medical record documentation (i.e. office note, imaging and pathology reports and risk model assessment) to the attention of the Chronic Disease Clinical Coordinator and email a brief synopsis of the request. Please do not email any patient identifiable information (i.e. name). Please complete an appropriate risk model such as the Tyrer-Cuzick assessment for any client deemed high risk prior to submitting your request.

Breast MRI is not recommended as part of breast cancer screening for women at average risk. There is insufficient evidence to recommend for or against MRI screening in women with a lifetime risk of 15-20%, heterogeneously or extremely dense breast on mammography and women with a personal history of breast cancer including DCIS. Breast MRI screening is not recommended for women at <15% lifetime risk. Breast MRI

should not be used as a substitute for biopsy. Breast MRI cannot be reimbursed by EWL to assess the extent of disease in women who have already been diagnosed with breast cancer. Breast MRI is rarely indicated in the evaluation of an abnormal mammogram.

Breast MRI should never be done alone as a breast cancer screening tool. For further review of the screening requirements, refer to the current VABCCEDP Allowable Procedures and Relevant CPT codes and fees listing.

Quality Standards for Mammography Facilities

The provider and sub-contractor(s) must contract with facilities that meet EWL quality standards and requirements; mammography facilities which meet the Mammography Quality Standard Act (MQSA) criteria and have current FDA approval.

Managing Abnormal Cervical Results

Purpose: To ensure women receive appropriate diagnostic and follow-up services through EWL.

Responsible Person(s): Provider Site Clinicians and Case Managers

Revised Date: June 30, 2018

Policy:
The management of women with abnormal cervical cancer screening test results relies on a body of scientific literature that is constantly growing and changing. EWL establishes clinical policies and protocols following standards established by nationally recognized organizations such as the American Society of Colposcopy and Cervical Pathology (ASCCP), and the American College of Obstetrics and Gynecology (ACOG). All clinical policies and procedures are reviewed and approved annually by the EWL Medical Advisory Committee.

For the clinical management of abnormal cervical screening results, follow the current *American Society of Colposcopy and Cervical Pathology's 2012 Consensus Guidelines.* The ASCCP guidelines can be found at *www.asccp.org*.

Case management services are required for the following abnormal cervical screening results:

1. Squamous Cell Carcinoma
2. Atypical Glandular Cells (AGC)
3. High-Grade SIL (HSIL)
4. Atypical Squamous Cells - Cannot Exclude High Grade Squamous Intraepithelial Lesion (ASC-H)*
5. Atypical Squamous Cells – Cannot Exclude High Grade SIL (ASC:H) and High Grade Squamous Intraepithelial Lesion (HSIL) in women 21-24
6. Low-Grade Squamous Intraepithelial Lesion (LSIL) for women with no HPV test or +HPV*
7. Atypical Squamous Cells of Undetermined Significance (ASCUS) with +HPV*
8. Women age 30 and older with a negative cytology screening result and +HPV 16/18
9. Women age 30 and older with an unsatisfactory screening result and +HPV

**Please refer to the ASCCP Guidelines for management options for pregnant women and women ages 21-24 as the treatment options may vary for this group.*

LEEP or Conization

The use of LEEP or conization of the cervix may be performed as a *diagnostic* procedure based on ASCCP recommendations and algorithms.

1. LEEP or conization as a diagnostic procedure may be ordered for women with an abnormal cervical cancer screening result, with an unsatisfactory colposcopy or cervical stenosis.

2. If the LEEP or conization procedure yields a positive biopsy result for HSIL, CIN II or CIN III and the procedure serves as the diagnostic and treatment procedure, the client should be referred to Medicaid for retroactive Medicaid coverage under the BCCPTA. In this case, the LEEP or conization results should be recorded on the data form as both the diagnostic and treatment procedure, if no additional treatment is planned.

3. If the LEEP or conization procedure yields a positive biopsy result for HSIL, CIN II, or CIN III and the client needs additional treatment, a referral should be made to Medicaid for treatment under the BCCPTA.

A LEEP may also be performed as treatment. For purposes of the EWL program, NBCCEDP (EWL) funds **cannot** be used to pay for any form of treatment including a LEEP. A LEEP performed as a diagnostic procedure is covered when the above criterion is applied. If a definitive diagnosis of pre-cancer or cancer has been confirmed, it is not appropriate to perform the LEEP and identify it as a diagnostic for the purpose of receiving reimbursement when in actuality; the procedure was performed as treatment. A LEEP performed as treatment must be paid for by another funding source, (i.e., Medicaid).

Use of HPV Testing

HPV DNA testing is allowable only as described in current ASCCP and/or ACOG guidelines. Results generated by or available following non-guideline use of HPV DNA testing should not influence care provided under the auspices of this program.

HPV testing is not recommended for routine screening in women aged 21-29. (HPV testing, may, however, be used in women 25 and older who have an ASC-US Pap, or in co-testing for follow-up of women 25 and older who have had a prior abnormal Pap result - per ASCCP guidelines.) Having an HPV vaccination does not change screening recommendations. Women who have been vaccinated against HPV still need to follow the screening recommendations for their age group.

Managing Abnormal Breast Results

Purpose: To ensure women receive appropriate diagnostic and follow-up services through EWL.

Responsible Person(s): Provider Site Clinicians and Case Managers

Revised Date: June 30, 2017

Policy:
The management of women with abnormal screening mammogram and/or clinical breast exam test results relies on a body of scientific literature that is constantly growing and changing. EWL establishes clinical policies and protocols following standards established by nationally recognized organizations such as the National Comprehensive Cancer Network (NCCN) and the American College of Radiology. All clinical policies and procedures are reviewed and endorsed annually by the EWL Medical Advisory Committee.

For the clinical management of abnormal CBE and/or breast screening results, follow the current NCCN *Breast Cancer Screening and Diagnosis Guidelines***.** These guidelines can be found at *www.nccn.org*. Case management services *are required* for the following abnormal breast CBE or mammography screening results:

1. Clinical breast exam that is abnormal or suspicious for cancer. This includes the clinical categories of:
    A. Discrete palpable mass
    B. Bloody or serous nipple discharge
    C. Nipple or areolar scaliness, skin changes
    D. Skin dimpling, retraction or inflammation
    E. Asymmetric thickening/nodularity

2. Abnormal mammography results for the following American College of Radiology categories:
    A. BIRADS – 0: Additional imaging evaluation and/or comparison to prior mammograms is needed
    B. BIRADS – 3: Probably benign finding
    C. BIRADS – 4: Suspicious abnormality
    D. BIRADS – 5: Highly suggestive of malignancy
    E. BIRADS – 6: Known biopsy – proven malignancy

Services – Age 65 and Older

Purpose: To ensure that women aged 65 and older receive services, if eligible.

Responsible Person(s): Provider Site Case Manager or Designee

Revised Date: June 30, 2011

Policy:
Women aged 65 and older that are eligible to receive Medicare benefits, but not enrolled, should be encouraged to enroll.

Women aged 65 and older that do not qualify for Medicare may be eligible to receive EWL program screening and diagnostic services provided they meet the program's eligibility criteria. This includes women who:

1. Are not eligible to receive Medicare Part A or B

2. Receive Medicare Part A but cannot afford the premium to enroll in Medicare Part B

These women may receive EWL services using state funds. Refer to the *Reimbursement Section; Reimbursement for EWL Program Services* policy for invoice instructions.

Due to limited state funds, providers are encouraged to limit EWL services to symptomatic women over the age of 65.

Women 65 and older diagnosed with pre-cancer or cancer of the breast or cervix **may not** be eligible for Medicaid through the BCCPTA because of their age.

Women that are enrolled in Medicare Part A and Part B
*are **not** eligible for EWL services.*

Rescreening

Purpose: To ensure that women are provided breast and cervical cancer screening tests according to EWL program screening guidelines following their initial screening examinations.

Responsible Person(s): Provider Site Case Manager or Designee

Revised Date: June 30, 2018

Policy:
Priority for EWL program services should be given to eligible women previously enrolled and screened through the program. Providers must reach a rescreen target goal of ≥65%, which means at least 65% of women who received a screening mammogram in any given year should return within 12-18 months for their next screening mammogram. For yearly screening mammograms, there must be at least 12 months between screening tests.

Providers should also ensure that women who have completed treatment under the Breast and Cervical Cancer Prevention Treatment Act (BCCPTA) be contacted and re-enrolled (if eligible) into EWL to resume regular cancer screenings.

If a woman is in a follow up cycle that overlaps with her re-screening date, the EWL provider site may submit the invoice and indicate “rescreen” on the diagnostic form. As these cases arise, please contact the state office for guidance.

Clients should be notified of a rescreen at least a month in advance. It is acceptable if the EWL provider site chooses to notify a client more frequently than one month. The rescreen notification including the method of notification should be clearly documented in the EWL medical record. This documentation is reviewed at the time of a medical record review.

The current USPSTF guidelines recommend biennial screening mammography for women aged 50 to 74 years. While EWL continues to provide screening annually, it is acceptable for an EWL provider or subcontractor to follow these guidelines with their EWL patients. If the decision is made to follow the USPSTF guidelines, the EWL Provider Site Coordinator should notify the State Office so rescreen monitoring can be managed appropriately.

Referrals

Purpose: To ensure that all clients enrolled in EWL receive the appropriate referrals based on their medical, social and economic needs.

Responsible Person(s): Provider Site Case Managers, Clinicians, or Designee

Revised Date: June 30, 2018

Policy:

The provider site case manager, clinician or designee must broker both medical and supportive referrals to optimize a client's health outcomes. During the referral and appointment phase of the clinic visit, case managers, clinicians, or their designee should:

1. Set an appointment for a screening mammogram if the exam is not performed on site. If an appointment cannot be set, at a minimum a referral for a screening mammogram should be provided. Contact information for the screening mammography site (e.g., facility and contact name and phone number), travel directions and procedural directions to prepare for the screening mammogram should be provided in writing to the client. Document the screening mammogram referral/appointment in the client's medical record.

2. Provide referrals and, if possible, establish appointments for additional diagnostic procedures for clients with abnormal screening results to ensure they receive timely and appropriate breast and cervical diagnostic services. Case managers should provide information explaining the need for the additional diagnostic tests and any procedural directions in writing to increase a client's level of understanding. All referrals should be documented in the client's medical record. Any delays in service or scheduling should be clearly documented in the medical record. An extensive delay in scheduling services is unacceptable and should not occur regularly.

3. Provide other social or supportive referrals (e.g., transportation to/from medical appointments) to ensure clients with abnormal screening or diagnostic results receive the recommended services. These referrals should be documented in the client's care plan and address those needs identified in the client's needs assessment.

4. Provide referrals for other medical or cancer screening services (e.g., colorectal screening) that are age appropriate and identified as needed. Document all referrals in the client's medical record.

5. Refer tobacco users to the Quit Now Virginia toll free phone service (1-800-QUIT-NOW). Depending on the client's stage of change they may receive Quit Now Virginia brochure that explains the health benefits of quitting and the services

available through the Quit Now Virginia line to help clients successfully quit, including referrals to community resources and comprehensive counseling. A list of materials for each stage of change are listed below:

a) Pre-Contemplators (not thinking) – provide Quit Now Virginia brochure.

b) Contemplators (thinking) – provide Quit Now Virginia brochure.

c) Preparation (planning) – provide Quit Now Virginia brochure and, **upon a client's consent**, a e-Referral (**Attachment C**) to Quit Now Virginia. The e-Referral will initiate a call from the Quit Now staff to the client.

EWL Provider Site Coordinators or their designee can order Quit Now Virginia materials (e.g., wallet cards, brochures, posters) by completing the enclosed Quit Now Order form (**Attachment D**) and faxing it to 804-864-7748.

6. Provide referrals and/or educational materials that will promote and encourage a healthy lifestyle (e.g., low fat diet, increased physical activity) to women enrolled in the program to lower the risk of chronic diseases, such as overweight/obesity, heart disease, stroke, high blood pressure and diabetes. Document all referrals in the client's medical record.

7. Provide information regarding the Health Insurance Market Place to all eligible client's and document as a "referral" on the eligibility form.

Cancellation of Services

Purpose: To ensure continuity of care for all EWL enrolled women after a provider ceases to be an authorized EWL provider.

Responsible Person(s): Provider Site Coordinator or Designee

Revised Date: June 30, 2018

Policy:
EWL providers may cancel an existing contract upon 30 days written notice to the State EWL office. Any contract cancellation notice does not relieve the provider of the obligation to deliver and/or perform all outstanding orders issued prior to the effective date of cancellation.

Upon termination of the contract, the provider is responsible for facilitating continuity of care for clients enrolled into the EWL program during their contracted period. This includes:

1. The completion of any outstanding diagnostic and follow-up work-up that is in progress at the time the contract is terminated.

2. Written notification to all enrolled clients that their status as an EWL provider has ended, and good faith efforts to transfer management of the client's care to another EWL provider (if possible) or to arrange for health care services outside of the EWL network of providers.

3. The transfer of program records (with client consent) to the new health care provider.

4. The submission of all screening cycle data (including follow-up and diagnostic testing) for all clients enrolled during the contract period. The EWL provider site and the state office will agree upon a final closing date for submitting all EWL related documents to the Data Manager or Data Entry Clerk.

ATTACHMENT A

EWL Cancer Screening Guidelines

Breast	EWL Protocol[*1]	Cervical	EWL Protocol[*2]
Age to start mammography screening	• Target population is 50-64 ➢ 40-49, if slots available ➢ More than 80% of screening mammograms must be provided to women over age 50	**Age to start screening**	• Target population is 50-64 ➢ 40-49, if slots available ➢ A minimum of 20% newly enrolled women who receive a Pap test will meet the criteria for having been never or rarely screened
Intervals of screening – previous mammogram normal	• Annual • At least 65% of EWL patients should be rescreened annually	**Intervals of screening – previous cytology normal**	• Every three years with cytology alone for women age 21 and over or every five years with cytology and HPV testing (co-testing) for women age 30 and over *Routine Screening is limited to women age 40-64.
Above average risk?	• Not currently assessing risk	**Pelvic Exam**	• Mandatory - part of EWL physical exam
Age to stop screening	• Program does not enroll women over the age of 65.	**Age to stop screening**	• Program does not enroll women over the age of 65.
Clinical breast exam	• Mandatory-part of the EWL physical exam	**HPV DNA for screening**	• Reimbursable if done in conjunction with cytology every **five** years *HPV should not be performed on women under age 30
Teach Self breast exam (BSE)	• Optional	**If hysterectomy was indicated for :** • Benign reasons (i.e. treating uterine fibroids):	• No screening • unless cervical remnants are present
Digital Mammography	• Optional • Reimbursable		
MRI for screening average risk women	• Not reimbursable unless performed in conjunction with a mammogram and after review by the state office	**If hysterectomy was indicated as treatment for:** • CIN I, II, III/CIS • Cancer indications	• The surveillance period for post treatment or spontaneous resolution of cervical neoplasia (CIN 2, 3) consists of co-testing (cervical cytology with high-risk HPV DNA testing) at 12 and 24 months *(ASCCP)* After the surveillance period routine screening should continue for 20 years *(ACOG)*. • Invasive cervical cancer - cervical cancer screening with cytology alone should continue every three years indefinitely *(ACOG)*.

Source:
[*1]U.S. Preventive Services Task Force (USPSTF) 2002
[*2] U.S. Preventive Services Task Force (USPSTF) 2012

ATTACHMENT B

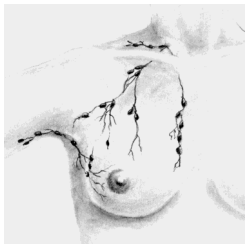
Core Competencies of Clinical Breast Examination

HISTORY

Cancer Detection Programs:
Every Woman Counts

- Health history questions regarding age, family history, personal history, reproductive history
- Review patient's concerns or symptoms
- Assess actual and perceived risk

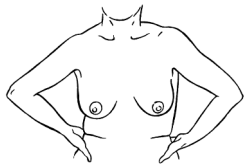
LYMPH NODE EXAM



Clavicular
Palpate deep above & below the clavicle
Axillary
Palpate in a diamond pattern

- Deep at the apex
- Medially along pectoralis muscle
- Laterally along subscapular muscle
- High under humeral head

VISUAL INSPECTION



In sitting position check for:

- Symmetry
- Skin changes
- Nipple changes
- Dimpling
- Venous Pattern

PATIENT POSITIONING

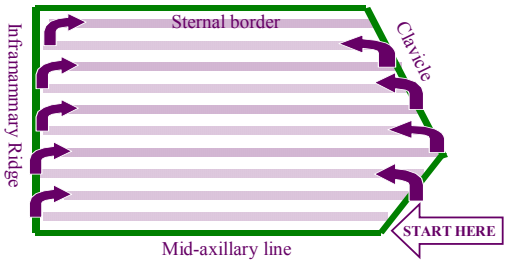
Cahan

- Hip elevated 90°
- Knees flexed
- Support lower back or shoulder
- Elbow - 90° angle, back of hand on forehead

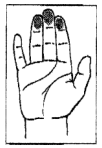
Supine

- Elbow - 90° angle

PERIMETER & PATTERN
(VERTICAL STRIP)



PALPATION



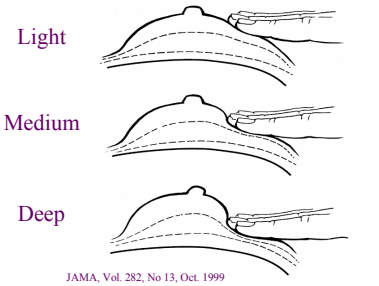
JAMA, Vol. 282, No 13, Oct. 1999

Pads of three middle fingers

Dime size circles

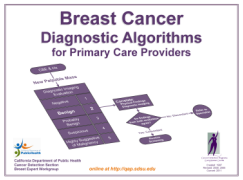
Slide or walk between palpations without lifting fingers

PRESSURE



JAMA, Vol. 282, No 13, Oct. 1999

PLAN OF ACTION & PATIENT ED



- Determine next steps for abnormal results
- Stress importance of adherence to f/u
- Emphasize rescreening
- Impart cultural sensitivity
- Discuss/teach BSE

DOCUMENTATION

- Patient concerns
- Exam findings
- Plan of action
- Referrals made
- Patient education
- Results notification (tests/procedures)

Discreet Mass

- ✓Location
- ✓Size
- ✓Shape
- ✓Margins
- ✓Mobility
- ✓Consistency
- ✓Tenderness

For more professional education information log on to: qap.sdsu.edu

ATTACHMENT C

QUIT NOW VIRGINIA TOBACCO CESSATION QUITLINE

Three Clicks & Done!

The Tobacco Control Program (TCP) is pleased to announce that the new Quit Now Virginia Web Portal for Patient e-Referrals is now live!

It is our goal to provide the technical assistance needed to include referral services into your practice. The TCP regional coordinators are available with support and technical assistance for your implementation of the referral services in three easy steps: ASK, ADVISE & REFER.

You may access the web portal at
https://www.wellbeingenroll.net/Providerreferral/Default.aspx?clientName=Virginia

For more information, visit
http://www.vdh.virginia.gov/tobacco-free-living/quitline-e-referral-service/

ATTACHMENT D

Material Request Form

1-800-Quit Now / 1-800-784-8669

Quitnow.net/Virginia

Quit Now Virginia
Tobacco User Quitline

Contact Information (Please Print)

Name _____

Organization Name _____

_____

Mailing address _____

City_____, VA Zip_____

Phone number_____

Email address_____

Material Description	**Quantity**
• Quit Now Brochure- English (100 per pkg.)	_____
• Quit Now Brochure- Spanish (100 per pkg.)	_____
• Quit Now Patient Referral Note Pad	_____
• Quit Now Palm Cards (100 per pkg.)	_____
• 1-800-Quit Now Note Pad (referral sites only)	_____
• Poster (English)	_____
• Poster (Spanish)	_____

***Maximum orders: Brochures- 200 / Note pads- 5 / Posters-3/ Palm cards -100**

For Additional Services, Information or Interest- Check the circle:

◯ **To become a Quitline Referral site**

◯ **To become a Tobacco Free Worksite**

◯ **To host a Tobacco Control related presentation**

◯ **Interested in a local or state tobacco coalition**

◯ **Tobacco Control Regional Coordinator contact information**

Fax or Email completed form to: Tobacco Control Program, Quit Now Virginia

Rita.Miller@vdh.virginia.gov Fax: 804-864-7205

Please allow up to one (1) week for delivery

For Office use only: Date filled_____

Case Management

Case Management Needs Assessment

Purpose: To ensure that all clients with an abnormal breast and cervical screening result are evaluated for barriers to follow-up care.

Responsible Person(s): Provider Site Case Managers

Effective Date: June 30, 2018

Policy:
The needs assessment is an effective tool that can be used to identify barriers that may prevent clients from receiving the services they need. The needs assessment can reveal a client's individual strengths as well as medical, psychological, financial, legal, and social needs.

Upon notification of a client's abnormal breast and/or cervical screening result, the case manager must interview the client within 5 business days of receipt to identify if any barriers are present and, if present, to discuss and offer options and services that are individualized to meet the client's needs. If the client is enrolled in EWL for the purpose of further diagnostics, the needs assessment must be completed prior to the initiation of the diagnostic procedure. The case manager is ultimately responsible for ensuring the needs assessment and care plan is completed within the allotted timeframe regardless of a sub-contractor.

Any identified barriers must be documented on the Case Management Needs Assessment and Care Plan form (**Attachment A)** or documented on the needs assessment form that is approved by the case manager's agency. Any forms used by the individual agency must accompany the components of the form provided by the State office. **The needs assessment is to be signed and dated on the day it is completed.** Multiple or varying dates should not be documented on the needs assessment or care plan. The needs assessment should not be completed without the client's input. The needs assessment may be obtained telephonically by reviewing the questions with client and the case manager must still sign and date the form. The needs assessment is reviewed at the time of a medical record review and should be signed and dated by the case manager and filed in the client's medical record.

If the needs assessment identifies barriers to care, a case management care plan is required and should be completed at the time of the needs assessment. In contrast, if no barriers are identified a case management care plan is not needed. The needs assessment and care plan should be completed by the case manager or coordinator that has been assisting the client.

If a EWL provider opts to use their own needs assessment and care plan form, it must meet the above requirements.

Case Management Care Plan

Purpose: To ensure that all clients identified as having barriers to follow-up care receive a care plan that promotes self-determination, independence, and empowerment and facilitates and ensures appropriate follow-up.

Responsible Person(s): Provider Site Case Managers

Effective Date: June 30, 2018

Policy:
One of the essential roles and responsibilities of the case manager is to arrange for and coordinate the appropriate services to meet the needs and health goals of the client with identified barriers. This includes the development and implementation of a care plan that involves the client, caregiver, and/or family to identify and access the resources that are necessary to meet the client's needs. The case manager is responsible for identifying resources based on the client's needs and advocating on behalf of the client to ensure all needed services and follow-up care is received.

The Case Management Needs Assessment and Care Plan form **(Attachment A)** or a care plan that is approved by the case manager's agency can be used to address issues and barriers to follow-up care and establish a mutually acceptable action plan with the client, caregiver, or family member. The ultimate goal of the individualized care plan is to incorporate the client's choices and preferences for the service arrangements being developed and empower the client to ensure they are involved in all aspects of their care.

The care plan should be developed within 5 business days of receiving the abnormal finding or prior to the initiation of the first diagnostic test. The care plan should be completed at the same time as the needs assessment. The care plan should be reassessed and updated periodically or when the client's circumstances change. If the Needs Assessment does not identity any barriers, the care plan is not needed. The case manager should sign and date the form and file it in the client's medical record. The care plan is reviewed at the time of a site visit. The case manager is ultimately responsible for ensuring the needs assessment and care plan is completed within the allotted timeframe regardless of a sub-contractor. If a EWL provider opts to use their own needs assessment and care plan form, it must meet the above requirements. Multiple or varying dates should not be documented on the needs assessment or care plan.

The case manager should monitor all case management services and changes in the client's needs and ensure that all services specified in the care plan are received and the client's needs are fully met. .

Tracking System

Purpose: To ensure that all clients receive appropriate and timely screening, diagnostic and follow-up services.

Responsible Person(s): Provider Site Case Managers

Effective Date: June 30, 2018

Policy:
Tracking screening and diagnostic services throughout a client's cycle, starting with the initial screening examination or test, through a final diagnosis and referral and initiation of treatment, if indicated, and later rescreening at appropriate intervals, is essential and ensures women receive the timely, appropriate, and complete care they need. Both human resources (e.g., case managers) and technical systems (e.g., tickler systems) are required to effectively track the delivery of care to clients. The timely identification of clients screened and their test results is important in coordinating screening and diagnostic services.

To meet the program's expectations, case managers should establish and maintain a client tracking system that will:

1. Collect, edit, and manage information to track a client's receipt of screening and diagnostic services and, when appropriate, treatment referrals through the initiation of treatment,

2. Be compatible with the resources and capabilities of their agency,

3. Ensure client confidentiality (this includes emailing EWL patient data), and

4. Be efficient. Case managers should periodically review and assess the client tracking system to determine its effectiveness. An efficient client tracking system will prevent incomplete follow-up and unnecessary delays, and reduce duplication of services.

Client tracking systems may consist of a tickler file (3x5 cards), notebook system, or more sophisticated computerized system. Regardless of the client tracking system chosen, it must be realistic, easy to use, and compatible with agency resources. The tracking system is reviewed at the time of a site visit. Appropriate tracking will assist the Case Manager with adhering to the mandated Federal Performance Indicators related to rendering timely services.

Other methods or tools that can be used to supplement and support the client tracking system include physician prompts, automated client reminder systems, and client reminder cards.

Tracking and Follow-Up

Purpose: To ensure all EWL enrolled women receive timely and appropriate care and minimize the number of women who are lost to follow-up or refuse services.

Responsible Person(s): Provider Site Case Managers

Revised Date: June 30, 2018

Policy:
A critical component of case management is to ensure that women receive timely notification of their screening/diagnostic results, and timely and appropriate rescreening, diagnostic and/or treatment services. For this reason, providers are expected to maintain an efficient tracking system that will enable them to track client results, notify clients of tests results, and follow-up with clients with abnormal results. Refer to **Attachment B** for a diagram that delineates the tracking and follow-up process for abnormal results. Documentation of all procedures and test results should be clearly filed in the client's medical record (i.e., pathology reports, colposcopy reports, etc.).

Notification of Normal Screening Results
Providers should communicate normal cervical screening test results or any normal diagnostic result to clients in writing or by telephone within **10** business days of receipt and clearly document the notification in the record. Documentation of receipt should be clearly documented in the client record.

The case manager should initial and date the notification. Documentation to support receipt of result and client notification is reviewed at the time of a medical record review. Providers are **not** required to notify the client of normal screening mammography results since mammography providers are required to notify clients within 30 days under MQSA regulations enacted by the FDA.

Notification of Abnormal Screening and/or Diagnostic Results
Providers should notify a client of an abnormal screening or diagnostic test result within **5** business days of receipt and clearly document the notification in the client's record. Documentation of receipt should be clearly documented and filed in the client record. Receipt of the abnormal test /procedure result is reviewed at the time of a medical record review and should be clearly identified in the medical record. As a reminder, a needs assessment should be completed within 5 business days of receipt of an abnormal result. If any barriers are identified, a care plan is required.

Result Notification Process
Three attempts to notify the client should be made by phone on three separate days and times. If unsuccessful, a letter should be sent and a copy of the letter should be filed in the medical record. If there is no response to the letter, a certified letter should be sent to the client and a copy of the certified letter should be filed in the medical record. All efforts to contact the client as well as follow-up recommendations should be

clearly documented in the client's medical record. All entries should be signed and dated by the Case Manager and filed in the client's medical record. All contact efforts and documentation to support client notification is reviewed at the time of a site visit.

All abnormal screening/diagnostic test results should be communicated to the client within 5 business days of receipt of the test result. Test results may be communicated by phone, in writing, or computer accessed. Test result notification should be clearly documented in the client record and must be legible. This documentation is reviewed at the time of a site visit. If the information is documented electronically, the EWL provider site is responsible for having the documentation readily available at the time of a medical record review. This includes printing electronic documentation and submitting for a medical record review.

Follow-up for Rescreening

Providers are expected to develop and implement a client reminder system to facilitate the tracking of women previously screened. The client reminder system should capture mammography and cervical cancer screening examinations and should follow the program's defined screening and management guidelines. Women that are eligible for rescreen services should be notified and reminded they need to return for rescreening at least one month in advance of the rescreen due date. Notification of rescreen should be clearly documented in the client's record.

For clients that do not respond, at least three reminder attempts on three separate dates and times should be made and documented. Once a rescreen appointment is established, providers may choose to remind clients at different intervals prior to the actual rescreen appointment to reduce no-show rates. Clients that do not respond to the rescreen reminders, refuse services or fail to show for the rescreen appointment may be inactivated after three attempts to contact the client have been made and documented; one of which should be a certified letter. All efforts to contact the client should be signed and dated by the Case Manager and clearly documented in the record. All contact efforts and documentation to support client notification of rescreening is reviewed at the time of a medical record review.

Follow-up for Diagnostic Services

Securing diagnostic services for uninsured women can sometimes be challenging. For clients in need of additional diagnostic procedures, providers are expected to track test results to ensure they receive the recommended care in a timely manner. The coordinator and/or case manager may require follow up with subcontracted providers to stress the importance of timely scheduling if services are delayed. Providers are expected to work with each client so they understand the need for follow-up and know where and how to access these services. As a reminder, a needs assessment should be completed prior to the performance of any diagnostic service performed due to an abnormal result.

Clients that refuse a diagnostic procedure or do not respond to three attempts (made on separate dates and times) to schedule a diagnostic procedure or fail to show for three

scheduled diagnostic appointments may be inactivated after three attempts have been made and documented. One of the attempts should be a certified letter and it should explain the importance of the follow up and include the risks associated with failure to follow up. In addition, the client should be advised that failure to follow up may result in inactivation from the EWL program. The inactivation date and reason should be documented on the eligibility form and submitted to the Data Entry Clerk at the state office. All contact efforts (including type of contact) along with documentation to support client notification of diagnostic test results is reviewed at the time of a site visit and should be legibly documented in the medical record.

Inactivating Patients

Patients should be inactivated immediately if they are deceased, have private insurance, Medicaid (includes BCCPTA), Medicare, have moved, refused services, are over age or income or lost to follow up. If a client is inactivated, the inactivation date and reason should be recorded on the EWL eligibility form and submitted to the Data Entry Clerk at the state office.. Providers who have stricter internal policies may follow their facility policies. Attempts to reach a client should be varied and include methods such as telephone, email, fax, text messaging, regular or certified mail, or a home visit. Attempts must be made at various times of the day and various days of the week and documented in the client record. All entries should be legible, signed and dated by the Case Manager or Coordinator.

Lost to Follow-Up

A client may be deemed 'lost-to-follow-up' in situations where the Case Manager has lost contact or communication with the client in order to complete mandated follow up procedures/ or yearly screenings. A client is not considered lost to follow up until at least a minimum of three separate contact attempts on separate dates and times have been made to contact the client. For example, 3 phone calls on separate dates/times, certified letter or consideration of a home visit. If all contact attempts are unsuccessful and clearly documented in the record, the client is considered to be lost to follow up and is inactivated (refer to inactivating patients section). All entries should be legible, signed and dated by the Case Manager. At least one of these contact attempts should be a registered or certified letter if the follow up is for diagnostic purposes. The letter should explain the importance of follow up care and the risk associated with failure to follow up. The client should be advised that failure to comply may result in an inactivation with the EWL program. A copy of the letter should be filed in the medical record. This documentation is reviewed at the time of a medical record review.

a. For diagnostic follow ups- the letter should describe abnormal results, outcome of not following up with recommendations, **and that the record will be closed / inactivated within 2 weeks (give specific date) if there is no response from the client.**

b. For yearly screenings: a written reminder should be sent to clients regarding the importance of yearly screenings.

A client may be deemed lost to follow up if the client did not return phone calls, respond to letters, refused services (refer to refused services section), or registered or certified

letter was not accepted. Clients should be informed that if they wish to re-enroll with the EWL program they may do so if they meet program eligibility at the time.

Refused Services

A client may be deemed 'refused services' in situations where the Case Manager has been in contact with the client, either through phone calls or in response to letters being sent and the client has:

1. Refused the diagnostic/screening services or refused treatment.
2. Missed her appointment for more than 3 times.
3. Cancelled and rescheduled her appointment several times such that it has been greater than 2 months since the initial abnormal screening date, scheduled yearly screening or diagnostic follow up.
4. Not followed through with her diagnostic/screening appointment or treatment plan.

Clients deemed as refusing services should be inactivated and notified of the inactivation. The inactivation reason and date should be recorded on the EWL eligibility form and submitted to the Data Entry Clerk at the state office. All attempts to contact the client on various dates and times should be legibly documented, signed and dated in the client's medical record. Clients should be informed that if they wish to re-enroll with the EWL program they may do so if they meet program eligibility at the time.

Clients deemed as refusing services pertaining to treatment should be inactivated and the local DSS office should be informed of the client's refusal if a BCCPTA application was submitted (refer to the BCCPTA section of the manual).

Case Management

Purpose: A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

Responsible Person(s): Provider Site Case Managers

Effective Date: June 30, 2017

Policy: Case management serves as a means of achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation.

Case Manager Role:

- The case manager helps clients to schedule appointments, receive timely follow up services, assess barriers, develop a care plan, find resources and referrals when needed and facilitates connection with services.
- The case manager notifies the client of abnormal results, ensures that the client understands the results and facilitates the next steps in the care process.
- The case manager discusses management options with the client's clinician when the current recommended NCCN and ASCCP guidelines are not being followed. Clinical justification for non-adherence must be clearly documented in the medical record.
- The case manager is responsible for reviewing and adhering to the EWL policy manual, VABCCEDP allowable procedures/CPT codes fees listing, the EWL newsletter, electronic communications sent by State office, the NCCN and ASCCP management guidelines and other documents provided by State office.
- The case manager manages complex situations/findings and includes the client in the decision making process. In other words, the case manager is expected to identify and address any complications or barriers to care and devise a corrective action plan to promote client compliance.
- The case manager monitors and tracks the client's clinical status throughout the course of EWL enrollment regardless of services provided by sub-contracted providers.
- The case manager ensures that treatment has started; not just surgical consultation.
- The case manager is responsible for the accuracy of the EWL medical record documentation. If a screening / diagnostic procedure or diagnosis is documented on the EWL form, the documentation in the medical record should correspond and vice-versa. Remember, if it is not documented, it is considered not done.
- The case manager may assist the client with the BCCPTA application if she has been diagnosed with Cancer while <u>not</u> enrolled in EWL, meets eligibility criteria, and she received screening/diagnostics from a EWL contracted provider. The

Case Manager does not invoice for this client and does not use a screening slot. However, the eligibility and screening & diagnostic forms must be completed and submitted to the State office.

- The case manager should follow a client to the point of treatment. The treatment status and start date should be recorded on the screening/diagnostic form.

ATTACHMENT A

Every Woman's Life

CASE MANAGEMENT NEEDS ASSESSMENT AND CARE PLAN

Client Name:	DOB:
Day Phone:	Alternate Contact Person: Phone No:
Case Manager Name: Provider Name:	Form Completion Date:
Abnormal Breast Result (date and result):	Abnormal Cervical Result (date and result):

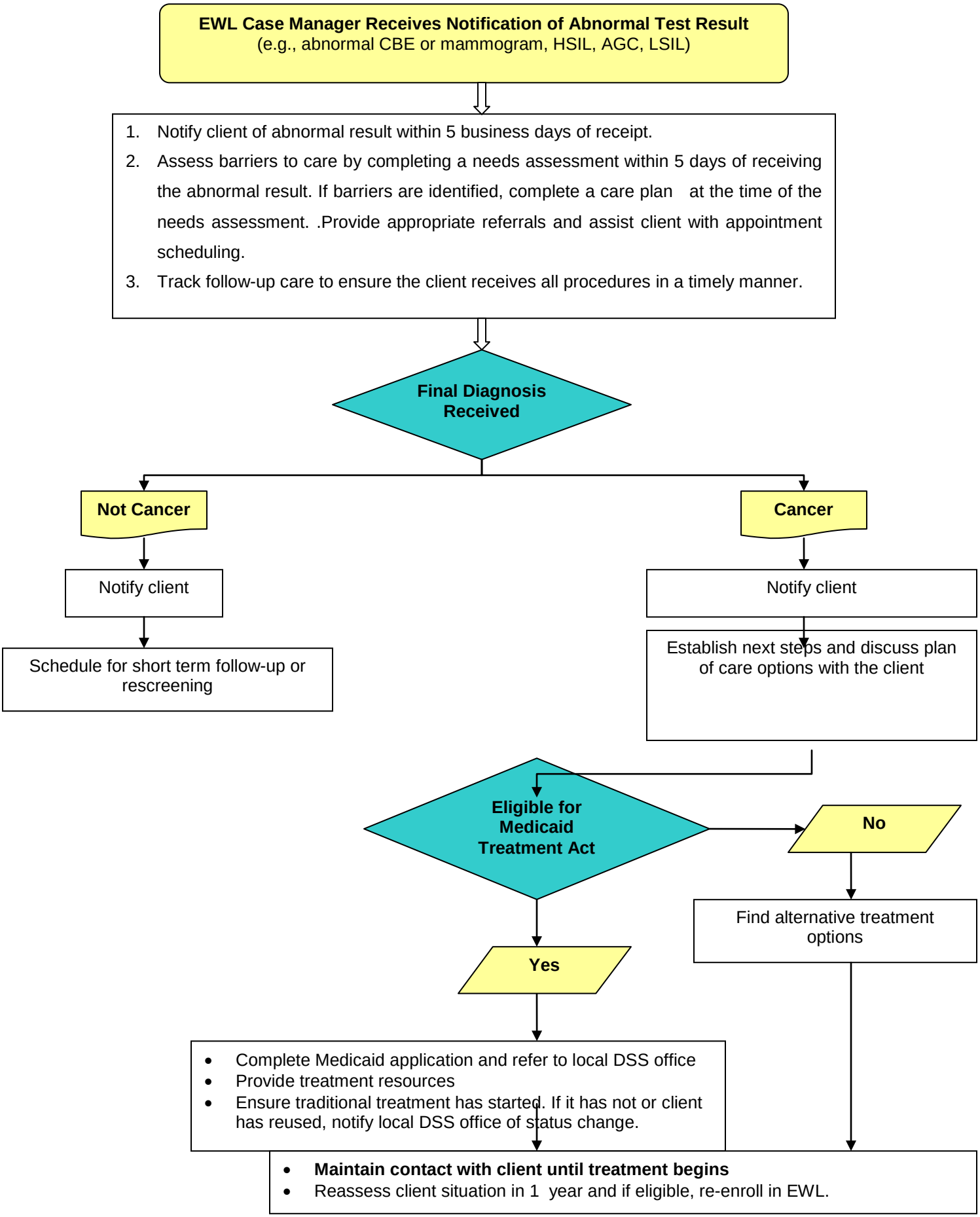
NEEDS ASSESSMENT *	
I feel that I will *not* have the support of my family and/or friends if I need it.	☐ Yes ☐ No
I may have problems getting to follow-up appointments if they are recommended for me.	☐ Yes ☐ No
If follow-up tests/services are recommended for me, I may need help in understanding them.	☐ Yes ☐ No
Are there other issues that would prevent you from receiving follow-up care?	☐ Yes ☐ No If yes, explain:_____ _____ _____ _____

***A "YES" answer in any category requires a care plan.**

CARE PLAN				
	Problem	**Plan**	**Client Contacts***	**Outcome**
☐	Inadequate social support			
☐	Lacks access to services			
☐	Lacks understanding of services needed			
☐	Other issues			

*** Record date and type of contact (1-telephone, 2-office visit, 3-home visit, 4-mail, 5-certified mail, 6-email, 7-text message**

ATTACHMENT B


EWL Case Manager Receives Notification of Abnormal Test Result
(e.g., abnormal CBE or mammogram, HSIL, AGC, LSIL)
1. Notify client of abnormal result within 5 business days of receipt.
2. Assess barriers to care by completing a needs assessment within 5 days of receiving the abnormal result. If barriers are identified, complete a care plan at the time of the needs assessment. .Provide appropriate referrals and assist client with appointment scheduling.
3. Track follow-up care to ensure the client receives all procedures in a timely manner.
Final Diagnosis Received
Not Cancer
Notify client
Schedule for short term follow-up or rescreening
Cancer
Notify client
Establish next steps and discuss plan of care options with the client
Eligible for Medicaid Treatment Act
No
Find alternative treatment options
Yes
Complete Medicaid application and refer to local DSS office
Provide treatment resources
Ensure traditional treatment has started. If it has not or client has reused, notify local DSS office of status change.
Maintain contact with client until treatment begins
Reassess client situation in 1 year and if eligible, re-enroll in EWL.

Data Collection, Reporting & Retention

Data Collection Forms

Purpose: To identify the data collection forms that must be accurately completed for each client enrolled into EWL.

Responsible Person(s): Provider Site Coordinator or Designee

Revised Date: June 30, 2018

Policy:
The EWL client data forms collect critical demographic and clinical information on each client enrolled and served through the program. Data fields listed on the forms are required by CDC for national reporting purposes, and are often referred to as the Minimum Data Elements (MDEs).

The EWL program requires that providers complete and submit data forms for each client served. The forms include the Eligibility Form plus the Breast Screening and Diagnostic Form and/or Cervical Screening and Diagnostic Form. To view the client data forms and instruction sheets refer to **Attachment A**.

Providers must ensure the accuracy and completeness of all client data submitted. For information on how to submit the client data forms and receive payment for services provided, refer to the section - *Reimbursement.*

Data form documentation should correlate with actual medical record findings. This documentation is verified during a site visit review (onsite or desk).

Reporting Requirements

Purpose: To define the EWL reporting requirements that provider sites must comply with to maintain authorization.

Responsible Person(s): Provider Site Coordinator or Designee

Revised Date: June 30, 2016

Policy:
All of the following reporting requirements must be submitted to the state EWL program by the specified deadline date:

1. Monthly Screening Log – This report captures the EWL providers' self reported new and re-screens each month during the grant period. Provider sites must complete and email the monthly screening log for the previous month by the 5th day of each month to the state EWL program. Refer to **Attachment B** for the Monthly Screening Log form. Retain Monthly Screening Logs for the current and previous year then recycle.

2. Annual Renewal Application – Provider sites are required to submit a renewal application annually that includes provider contact information, the provider's defined service area and service capacity as well as a corrective action plan for any deficiencies identified during the previous grant year. Provider sites must submit the renewal application electronically to the state EWL program by the deadline date. There are typically four one-year renewals attached to each *Request for Proposal (RFP)* cycle. Retain a copy of the Annual Renewal Application for the entire five-year RFP cycle then destroy by shredding or pulping. The EWL provider site performance indicator results and clinical site visit findings are reviewed and taken into account when determining renewal and award allocation.

3. Match Report – Provider sites are required to match $1 of nonfederal resources for every $3 of federal funds they receive. Matching funds may be cash, in-kind, or donated services, or equipment. Matching funds may not include (1) payment for treatment services or the donation of treatment services, (2) services assisted or subsidized by the Federal government, or (3) the indirect or overhead costs of an organization. All costs used to satisfy the matching requirement must be documented by the provider and will be subject to audit. There is no match requirement for state funds. The match report documents the provider's cash and in-kind donations and must be completed and electronically submitted by July 31st to the State EWL program. Refer to **Attachment C** for the Matching Funds Form. Retain a copy of the annual Matching Funds Form for the entire five-year RFP cycle than destroy by shredding or pulping.

Medical Record Management

Purpose: To delineate the composition, retention and disposition of the client medical record.

Responsible Person(s): Provider Site Coordinator or Designee

Revised Date: June 30, 2018

Policy:
The provider must maintain a permanent client medical record that is in compliance with JCAHO quality assurance guidelines for documentation. Electronic records are acceptable as medical records and must be readily available at the time of a site visit and must be printed and copied for a medical record review. The record should include all relevant clinical documents, including but not limited to, copies of the clinical breast exam, pelvic exam, cervical cytology and screening mammogram results, pathology reports and copies of the results of any diagnostic work-up performed. EWL records should also include documentation of EWL related forms and documentation to support client notification (e.g. telephone log, progress notes, etc.). EWL providers should follow the medical record documentation policies endorsed by their agency/organization.

Providers must follow the conditions for records retention and disposition of client medical records outlined under the provisions of the *Virginia Public Records Act, Sections 42.1-76, et. Seq. of the Code of Virginia*. Adult client medical records should be retained for at least 6 years after the date of last treatment then destroyed by shredding or pulping. For more information on record retention and disposition visit: http://www.lva.virginia.gov/agencies/records/.

The provider must have an organized and secure client record system that is readily accessible and available to the client upon request with a signed release of information, and to the state EWL office for examination within a reasonable time. When information is requested, providers should release only the specific information requested. Upon request, clients transferring to another provider or out-of-state program must be provided with a copy or summary of their record to expedite continuity of care.

EWL program information (eligibility, demographic, and clinical information) on women enrolled and served through EWL must be submitted to the EWL state office. Program information that is not submitted to the state EWL office must be filed in the client's medical record or in the case of an electronic record the information must be filed in a separate EWL program record or scanned into the patients electronic record. This includes the following EWL program forms:

1. Client Participation Agreement,
2. Client Needs Assessment and Care Plan (if applicable),
3. Client Transfer Form (if applicable),

4. BCCPTA Medicaid Application (if applicable).

The provider must maintain client/record confidentiality in accordance with state and federal laws, rules, and regulations. The provider and all sub-contractors should conform to all relevant rules and regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Print & Save

Form Reset

Every Woman's Life
A Virginia Department of Health Program

Client Eligibility Form

Revised 04/24/2014

PERSONAL INFORMATION			
Last Name	**First Name**	**MI**	**Maiden Name**
SSN (or alien ID)	**Birth Date**	**Age**	
Address		**City**	
County	**State** **Zip**	**Home Phone**	
Work Phone	**Cell Phone**	**Best Time to Call:**	

1. What is your household income before taxes? $ /Year

2. How many people live on this income? (including yourself)

3. Do you have Medicaid? ___Yes ___No **Medicare?** ___Yes ___No ➔**If YES** ___Part A or ___Part B

4. Private insurance? ___Yes ___No **ACA Insurance?** ___Yes ___No ➔**If YES, has deductible been met?** ___Yes ___No

5. Do you now smoke cigarettes? ___Every day ___Some days ___Not at all ___Don't know ___Don't want to answer

6. Are you planning, thinking, or not thinking about quitting smoking in the next 30 days?
___Planning ___Thinking ___Not thinking ___Don't want to answer

7. What is the highest grade of school you completed? ___<9th ___Some high school ___High school graduate or equivalent ___Some college or higher ___Don't know ___Don't want to answer

QUESTIONS FOR NEW EWL CLIENTS ONLY

8. How did you hear about the Every Woman's Life program? ☐Brochure ☐Community Health Worker ☐Family/Friend ☐Health Fair ☐Internet/Web ☐Radio/TV/Newspaper ☐Other:_____

9. Ethnicity: ☐Hispanic ☐Non Hispanic

10. Do you describe yourself as: (check ALL that apply) ☐White ☐Black/African American ☐Asian ☐American Indian/Alaskan Native ☐Native Hawaiian/ Pacific Islander ☐Other: _____

11. What language do you speak every day?_____

12. Have you ever had a pap test? ___Yes ___No ___Unknown
➔If YES, when was your last Pap test? (month/year) or ☐More than 5 years ago

13. Have you ever had a mammogram? ___Yes ___No ___Unknown
➔If YES, when was your last mammogram? (month/year) or ☐More than 5 years ago

PROVIDER SITE USE ONLY: Admin. Site:_____ Case Manager: _____
14. Enrollment Site: _____ **15.** Enrollment Date: _____
16. Client Status: Active – check one: ___ New Patient ___ Rescreen
17. Inactive: ___ Medicaid ___ Medicare ___ Private Insurance ___ ACA Insurance ___ Other _____ **18.** Effective Date _____
19. If eligible, client referred to Health Insurance Market Place ___ Yes ___ No **20.** Date of Referral _____
21. Detail: Previous Breast Cancer ___L Br ___R Br Hysterectomy for: Cervical Cancer ___ Non Cancer ___ Unknown ___
22. ___ Cervical record only, no breast form submitted ___ Breast record only, no cervical form submitted
23. Client offered Virginia Quit Line information? ___ Yes ___ No Client offered other tobacco resources? ___ Yes ___ No

*****Note: For questions 1 through 23, please refer to the Client Eligibility Form Instruction Sheet for guidance and additional information.**

Formulario de requisitos
La Vida de Toda Mujer - Departamento de Salud de Virginia

Revised 06/23/2014

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INFORMACIÓN PERSONAL			
Apellido	**Nombre**	**Inicial del segundo nombre:**	**Apellido de soltera**
Núm. de Seguro Social (o identificación de extranjero)	**Fecha de nacimiento**	**Edad**	
Dirección	**Ciudad / pueblo**	**Condado**	
Estado	**Código postal**	**Teléfono de la casa**	
Teléfono del trabajo	**Celular**	**Mejor hora para llamar:**	

1. ¿Cuál es el ingreso de su hogar antes de descontarle los impuestos? $ /Año

2. ¿Cuántas personas viven de este ingreso? (incluyéndose a sí misma) -

3. ¿Recibe usted Medicaid? ___ Sí ___ No **Medicare?** ___ Sí ___ No ➔ **Si marcó el "Sí,** ___Parte A o ___Parte B

4. ¿Seguro Privado? ___ Sí ___ No **ACA Seguro** ___ Sí ___ No ➔ **Si marcó el "Sí, se ha alcanzado el deducible del seguro?** ___Sí ___No

5. Actualmente, ¿fuma cigarrillos? ___ Todos los días ___ Algunos días ___ Nada ___ No sé ___ No quiero contestar

6. ¿Planea, piensa (o no piensa) en dejar de fumar en los próximos 30 días? ___ Estoy planificando dejar de fumar ___ Estoy pensando en dejar de fumar ___ No estoy pensando en dejar de fumar ___ No quiero contestar

7. ¿Cual es el nivel más alto de estudios que cursó? ___ Media incompleta ___ secundaria incompleta ___ Media o secundaria incluyendo mi bachillerato escolar ___ Educación universitaria o superior ___ No sé ___ No quiero contestar

PREGUNTAS PARA LAS CLIENTES NUEVAS SOLAMENTE

8. ¿Cómo se escucho' del programa "La Vida de Toda Mujer"? ___ folleto ___ trabajador/a de salud ___ familia/amigo/a ___ feria sobre la salud ___ la Internet/la Web ___ radio/ televisión/ periódico ___ otro

9. Origen étnico: ___ hispano ___ no hispano ___ desconocido

10. ¿Se describe usted como…? (marque TODAS las que aplican) ___ blanca ___ negra/afroamericana ☐ asiática ___ nativoamericana/ indígena de Alaska ___ indígena de Hawaii/ de las islas pacíficas ___ desconocida

11. ¿Qué idioma habla usted a diario?

12. ¿Le han hecho alguna vez una prueba del Papanicolau? ___ Sí ___ No ___ No Sé
➔ **Si marcó el "Sí, ¿cuándo fue su último Papanicolau? (mes/año)** ___ hace más de 5 años ___ no lo sé

13. ¿Le han hecho alguna vez una mamografía? ___ Sí ___ No ___ No Sé
➔ **Si marcó el "Sí, ¿cuándo fue su última mamografía? (mes/año)** ☐ hace más de 5 años ☐ no lo sé

PROVIDER SITE USE ONLY: Admin. Site:_____ Case Manager: _____
14. Enrollment Site: _____ **15.** Enrollment Date: _____
16. Client Status: Active – check one: ___ New Patient ___ Rescreen
17. Inactive: ___ Medicaid ___ Medicare ___ Private Insurance ___ ACA Insurance ___ Other _____ **18.** Effective Date _____
19. If eligible, client referred to Health Insurance Market Place ___ Yes ___ No **20.** Date of Referral _____
21. Detail: Previous Breast Cancer ___L Br ___R Br Hysterectomy for: Cervical Cancer ___ Non Cancer ___ Unknown ___
22. ___ Cervical record only, no breast form submitted ___ Breast record only, no cervical form submitted
23. Client offered Virginia Quit Line information? ___ Yes ___ No Client offered other tobacco resources? ___ Yes ___ No

*****Note: For questions 1 through 23, please refer to the Client Eligibility Form Instruction Sheet for guidance and additional information.**

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Breast Screening and Diagnostic Form Every Woman's Life - Virginia Department of Health

Revised 04/02/2018

Form Reset

Last Name	First Name	MI	Maiden Name
Admin Site	**__ New Screen __ Follow-Up __ Rescreen**		**SSN (or alien ID)**

1. Indication for initial mammogram **(This includes refused mammograms)**:
   - __ Routine screening mammogram
   - __ Initial mammogram performed to evaluate symptoms, abnormal CBE result, or previous abnormal mammogram result
   - __ Initial mammogram done by a non-program funded provider, client referred in for diagnostic evaluation: Date of referral _____
   - __ Initial mammogram not done. Client only received CBE or proceeded directly for other imaging or diagnostic work-up: Date of Referral _____
     Why was a mammogram not done? __ Refused __ Not Needed __ Needed but not performed

CLINICAL BREAST EXAM (CBE) (*Required*)

2. Does the client have any abnormal breast symptoms? __ Yes __ No
3. Did the client have a CBE? __ Yes __ No
4. CBE date: _____ (mm/dd/yyyy)
5. What were the CBE results?
   - __ Normal exam
   - __ Benign finding (fibrocystic changes, diffuse lumpiness or nodularity)
   - __ Discrete palpable mass*****
   - __ Bloody or serous nipple discharge*****
   - __ Nipple or areolar scaliness*****
   - __ Skin dimpling or retraction*****
   - __ Previous normal CBE (past 12 months)– CBE not done
   - __ CBE not performed, other or unknown reason
   - __ Refused
6. Was the CBE paid by EWL? __ Yes __ No

*** Requires further diagnostic evaluation.**

MAMMOGRAM (*Required*)

7. Mammogram type: __ Screening __ Diagnostic __ Unilateral __ Bilateral
8. Mammogram date: _____ (mm/dd/yyyy)
9. What were the mammogram results?
   - __ Negative
   - __ Benign finding
   - __ Probably benign*
   - __ Suspicious abnormality*
   - __ Highly suggestive of malignancy*
   - __ Assessment is incomplete (BI-RADS 0)- Additional Imaging Required*
   - __ Assessment is incomplete (BI-RADS 0)- Film Comparison Required *
   - __ Unsatisfactory, film cannot be interpreted (Repeat Mammogram)
   - __ Unknown, presumed abnormal, from non-program funded source
10. Was the mammogram paid by EWL? __ Yes __ No
11. Where was the mammogram performed? _____
12. Additional breast procedures needed for final diagnosis? __ Yes __ No

*** Requires further diagnostic evaluation.**

DIAGNOSTIC PROCEDURES (*If applicable*)

13. Additional Mam Views: __ Yes __ No
__ Unilateral __ Bilateral
Procedure date _____
Procedure Site _____
- __ Negative
- __ Benign findings
- __ Probably benign
- __ Suspicious abnormality
- __ Highly suggestive of malignancy
- __ Unsatisfactory
- __ Assessment Incomplete
- __ Refused

Funding Source: __ EWL __ Other

14. Ultrasound: __ Yes __ No
Procedure date _____
Procedure site: _____
- __ Negative
- __ Benign Finding
- __ Probably Benign
- __ Highly suggestive of malignancy
- __ Known Biopsy- proven malignancy
- __ Suspicious abnormality
- __ Refused

Funding Source: __ EWL __ Other

15. Film Comparison for final diagnosis:
__ Yes __ No
Procedure date _____
Procedure site: _____
- __ Negative
- __ Benign findings
- __ Probably benign
- __ Suspicious abnormality
- __ Highly suggestive of malignancy
- __ Unsatisfactory
- __ Refused

Funding Source: __ EWL __ Other

16. Fine Needle/ Cyst Aspiration: __ Yes __ No
Procedure date _____
Procedure site: _____
- __ Not suspicious for cancer
- __ Suspicious for cancer
- __ No fluid/tissue collected
- __ Refused

Funding Source: __ EWL __ Other

17. Biopsy/ Lumpectomy: __ Yes __ No
Type of biopsy: __ Excisional __ Non Excisional
Procedure date _____
Procedure site: _____
- __ Normal breast tissue
- __ Hyperplasia
- __ Other benign changes
- __ Atypical Ductal Hyperplasia
- __ DCIS
- __ LCIS
- __ Invasive cancer
- __ Refused

Funding Source: __ EWL __ Other

18. Repeat CBE __ Yes __ No
Procedure date _____
Procedure site: _____
- __ Normal (WNL)
- __ Benign finding
- __ Discrete palpable mass
- __ Bloody or serous nipple discharge
- __ Nipple or areolar scaliness
- __ Skin dimpling or retraction
- __ Refused

Funding Source: __ EWL __ Other

19. Surgical Consult: __ Yes __ No
Procedure date _____
Procedure site: _____
- __ Biopsy/FNA
- __ No intervention at this time-routine FU
- __ Not done/other unk reason
- __ Short term FU
- __ Surgery or treatment recommended
- __ Ultrasound recommended
- __ Refused

Funding Source: __ EWL __ Other

WORK UP STATUS (*Required*)

20. What is the work up status?
- __ Work-up complete
- __ Short- term follow-up
  __ 3 mon __ 6 mon __ 9 mon
- __ Irreconcilable
- __ Deceased
- __ Client lost to follow-up
- __ Workup refused

21. Date of final diagnosis:

22. Final Diagnosis:
- ☐ Breast cancer not diagnosed
- ☐ Invasive breast cancer
- ☐ Ductal carcinoma in situ
- ☐ Lobular carcinoma in situ
- ☐ Reoccurrence of prior breast cancer

TREATMENT STATUS (*Required*)

23. What is the status of breast cancer treatment?
- __ Treatment started
- __ Client lost to follow-up
- __ Treatment refused
- __ Treatment not recommended

24. Date of treatment status:

25. Was the client enrolled in Medicaid for treatment?
__ Yes __ No
If no, why not? _____

Form Completed by:

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Cervical Screening and Diagnostic Form

Every Woman's Life - Virginia Department of Health *Revised 04/02/2018*

Form Reset

Last Name	First Name	MI	Maiden Name
Admin Site	__ New Screen __ Follow-Up __ Rescreen		**SSN (or alien ID)**

PAP TEST AND PELVIC EXAM *(Required)*

1. Indication for Pap Test:
   - __ Routine Pap Test
   - __ Client under surveillance for a previous abnormal test
   - __ Pap Test done by a non-program funded provider, client referred in for diagnostic evaluation. Date of referral: _____
   - __ Pap Test not done. Client proceeded directly for diagnostic work-up or HPV test

     Why was a pap test not done? __ Refused __ Not Needed __ Needed but not performed

2. Pelvic exam date: _____ (mm/dd/yyyy)
3. Pap test date: _____ (mm/dd/yyyy)
   __ 3 year (without HPV test) __ 5 year (with HPV test)
4. What were the Pap test results?
   - __ Negative (for intraepithelial lesion or malignancy)
   - __ ASC-US*
   - __ LGSIL*
   - __ ASC-H*
   - __ HGSIL*
   - __ Squamous cell carcinoma*
   - __ Abnormal Glandular Cells (AGC)*
   - __ Results unknown, presumed abnormal, from non-program funded sources
   - __ Other result: _____

*** May require further diagnostic evaluation.**

5. Cervix present? __ Yes (Cervical) __ No (Vaginal)
6. Specimen type: __ Conventional __Liquid based __Other
7. Specimen adequacy? __ Satisfactory __ Unsatisfactory- Repeat Pap Required
8. Was the Pelvic exam paid by EWL? __ Yes __ No
9. Was the Pap test paid by EWL? __ Yes __ No
10. HPV Test Result?
    __ Positive* __Negative __Not Done
11. HPV test date: _____ (mm/dd/yyyy)
12. Was the HPV test paid by EWL? __ Yes __ No
13. Where was the Pap test/Pelvic exam performed?
    Facility/Clinic: _____
14. Was the client referred for **immediate** cervical diagnostic workup to reach a final diagnosis? __Yes __ No

***May require further diagnostic evaluation.**

DIAGNOSTIC PROCEDURES *(if applicable)*

15. Colposcopy without Biopsy:
    __Yes __ No
    Procedure date _____
    Procedure Site: _____
    Results:
    - __ Negative (WNL)
    - __ Inflammatory Reaction Changes
    - __ Other abnormality
    - __ Unsatisfactory
    - __ Refused

    Funding Source: __ EWL __Other

16. Colposcopy-directed Biopsy/ECC: __Yes __No
    Procedure date _____
    Procedure site: _____
    Results:
    - __ Adenocarcinoma
    - __ CIN I
    - __ CIN II
    - __ CIN III/ CIS
    - __ Invasive Carcinoma
    - __ Negative (WNL)
    - __ Other **non-cancerous** abnormality
    - __ Refused

    Funding Source: __ EWL __ Other

17. Other Procedure #1:
    ☐ Yes ☐ No
    Procedure date _____
    - __ ECC
    - __ LEEP
    - __ Cone
    - __ Other: _____

    Procedure site: _____
    Results:
    - __ Adenocarcinoma
    - __ CIN I
    - __ CIN II
    - __ CIN III/ CIS
    - __ Invasive Carcinoma
    - __ Negative (WNL)
    - __ Other **non-cancerous** abnormality
    - __ No tissue present ***(ECC only)***
    - __ Refused

    Funding Source: __ EWL __ Other

18. Other Procedure #2:
    __ Yes __ No
    Procedure date _____
    - __ ECC
    - __ LEEP
    - __ Cone
    - __ Other: _____

    Procedure site: _____
    Results:
    - __ Adenocarcinoma
    - __ CIN I
    - __ CIN II
    - __ CIN III/ CIS
    - __ Invasive Carcinoma
    - __ Negative (WNL)
    - __ Other **non-cancerous** abnormality
    - __ No tissue present ***(ECC only)***
    - __ Refused

    Funding Source: __ EWL __ Other

WORK-UP STATUS *(Required)*

19. What is the status of the final diagnosis?
    - __ Work-up complete
    - __ Short- term follow-up
      - __ 3 mon __ 6 mon __9 mon
      - __ 12 mon
    - __ Irreconcilable
    - __ Deceased
    - __ Client lost to follow-up
    - __ Workup refused

20. Date of final diagnosis: (mm/dd/yyyy)

21. Final Diagnosis:
    - __ Normal/Benign Reaction/Inflammation
    - __ HPV/Condylomata/Atypia
    - __ CIN I/ Mild Dysplasia (biopsy diagnosis)
    - __ CIN II/ Moderate Dysplasia (biopsy diagnosis) §
    - __ CIN III/ Severe Dysplasia/ Carcinoma in situ (Stage 0) § (biopsy diagnosis)
    - __ Invasive Cervical Carcinoma (biopsy diagnosis) §
    - __ Other: _____
    - __ Low grade SIL (biopsy diagnosis) §
    - __ High grade SIL (biopsy diagnosis) §

§ **Requires Treatment**

TREATMENT STATUS *(Required)*

22. What is the status of cervical cancer treatment?
    - __ Treatment started
    - __ Client lost to follow-up
    - __ Treatment refused
    - __ Treatment not recommended

23. Date of treatment status: (mm/dd/yyyy)

24. Was the client enrolled in Medicaid for treatment?
    __Yes __ No
    If no, why not?
    _____

Form Completed by: _____

Client Eligibility Form Instruction Sheet

Please use this form to refer to the numbered fields on the Client Eligibility Form. These instructions offer clarification and guidance for completing those fields. Questions 1-13 should be filled out by the *client.* Contact the EWL Data Manager if you have additional questions.

1. Household Income
- Report the annual household income as the total combined gross income of all persons, including the client, living in the same household, regardless of whether or not the client is a dependent.
- If the client is unemployed and has no income, enter "0". Refer to the current Federal Poverty Guidelines for income thresholds.

2. Number of People: Report the total number of all persons in the household including the client.

3. Medicaid/Medicare
- Report whether or not the client has medical coverage through Medicaid or Medicare.
- A woman may be eligible if she has Medicaid Part A *only*.

4. Insurance Status
- Report whether or not the client has medical coverage through a private insurer.
- Indicate whether the private insurance was obtained from the Affordable Care Act (ACA) by checking (✓) "Yes" or "No" to ACA Insurance.
- A woman may be eligible if she has private insurance but can not meet her deductible or if the insurance does not cover necessary breast and cervical screening services.

5. Smoke Cigarettes: If the client is a current smoker, indicate how often.

6. Quitting smoking
- If the client is a current smoker, indicate whether they are interested in quitting.
- This question is used to help determine the client's readiness to change (Not thinking = Pre-contemplation; Thinking = Contemplation; Planning = Preparation) and will be used to refer the client to the Virginia Quit Line.

7. Education Level: Report the highest level of school that the client completed.

8. Referral Source
- Report how the client heard about EWL. This section is important to help the program better target its outreach efforts.
- For sites that are conducting outreach via other organizations, please write the name of the organization after "Other".

9. and 10. Hispanic Ethnicity and Race
- Ethnic identification refers to whether or not the client is of Spanish, Hispanic, or Latina origin.
- Both are separate questions: for instance, a client who reports being Hispanic or Latina can also be White or Black.
- Encourage clients to report on ***both*** race and ethnic origin. The client is permitted to record more than one racial group.
- If a client does not know their own race, please leave this box blank.

11. Language Spoken: Report what language the client primarily speaks every day. This information is used to conduct effective outreach programs as well as customize client education and health brochures.

12. and 13. Screening History
- Ask the client if or when she last had a mammogram or Pap test prior to being enrolled in the program.
- Ask the client if she can recall the month and year, or just year, of her last Pap or mammogram. If the client cannot recall an approximate date but indicates that it was more than five years ago, check (✓) the box "more than 5 years ago".
- Make every effort to collect at least the year of the last Pap test as this is used to determine rates of women never or rarely screened for cervical cancer.

14. Enrollment Site
- Enrollment Site is the site where you enrolled the client. This is typically a clinic, local health department, or hospital.
- Do not use a temporary outreach site (e.g., church, salon, work place) as an enrollment site -- instead refer to the site where the case manager, health educator, or outreach/enrollment coordinator works from permanently.

15. Enrollment Date: Enrollment Date refers to the date when the client was enrolled as a new client. For clients who are returning as rescreens, indicate the date when her eligibility was re-assessed.

16. and 17. Client Status
- Indicate the client's status – active or inactive. If "active", indicate if the client is receiving screening services for the first time (e.g., New Screen) or is returning for rescreening services (e.g., Rescreen).
- If "inactive", list the reason why the client is no longer active (e.g., enrolled in Medicaid, Medicare, over age, insured by the Affordable Care Act or has obtained private insurance through another source). If the client has been "Lost to follow-up", "Moved", or "Refused Care" mark "Other" and list reason.
- Note: A client should be inactivated if there is no response to appointments made for rescreen or diagnostic services after reasonable attempts have been made to contact the client.

18. Effective Date: If the client has been inactivated, record the date of the status change.

19. Health Insurance Marketplace Referral:
- Women who are between 101% to 200% of the federal poverty level may be eligible to receive health insurance. Indicate if the client was referred to health insurance market place.
- A woman may still qualify for EWL services if she is unable to meet her deductible or if breast/cervical services are not covered.

20. Date of Referral: Document the date that the client was referred to the Health Insurance Market Place

21. Detail: Provide further detail of a client's health history by indicating if the client has previously been diagnosed with breast cancer, or if she has had a hysterectomy due to cancer or non cancerous reasons (this section should only be filled out for active clients).

22. Forms Submitted
- If a client did not receive both breast and cervical services, one of these boxes should be checked.
- If a client only received cervical services, check (✓) the box that indicates "cervical record only, no breast form being submitted", and submit the Eligibility and Cervical Screening and Diagnostic Form.
- If a client only received breast services, check (✓) the box that indicates "breast record only, no cervical form being submitted", and submit the Eligibility and Breast Screening and Diagnostic Form.

23. Virginia Quit Line Referral:
- Indicate if the client was offered Virginia Quit Line materials
- Indicate if the client was offered other tobacco resources.
- Even if a client refuses the referral materials please check "Yes" the referral materials were offered
- A client should still be offered Virginia Quit Line information even if she indicates "not thinking about quitting smoking in the next 30 days".

Breast Screening and Diagnostic Form Instruction Sheet

Please use this form to refer to the numbered fields on the Breast Screening and Diagnostic Form. These instructions offer clarification and guidance for completing those fields. Contact the EWL Data Manager if you have additional questions.

1. Indication for Mammogram

- Report the reason for performing the *current* mammogram.
- If client was referred for diagnostic procedures, include the referral date (date client referred into the program for diagnostic evaluation) - this will be used to calculate time from screening to dx.
- If client did **Not** receive an initial mammogram and proceeded directly to other imaging or diagnostic work-up or only received a CBE, **include the referral date** (date client referred into the program or date of first diagnostic procedure; whichever occurs first), and indicate whether it was "Not needed", "Refused", or if the mammogram was "Needed but not performed".

Note: Mammogram information (questions 7-12) needs to be provided even if it was done by a non-program funded provider.

2. Breast Symptoms: Indicate if the client has any abnormal breast symptoms by checking (✓) "Yes" or "No" for new screens, follow-ups, and rescreens.

3. and 4. CBE Performed and Date: Indicate if the CBE was performed by checking (✓) "Yes" or "No" and enter the date when performed.

5. CBE Result

- Select *Normal* to indicate a normal, within normal limits (WNL), or a negative CBE.
- Select *Benign* when CBE findings are not a concern for cancer.
- If the CBE is abnormal and suspicious for breast cancer, select the appropriate result, all results with an asterisk (*) next to it requires further diagnostic work.
- Note: If you obtain **more than one** CBE result or **different** results in each breast, record the **worse** of the two findings. If the CBE result is **abnormal** (as indicated by an *) immediate diagnostic procedures are needed even if **CURRENT** screening or diagnostic mammogram result is negative or benign.

6. CBE Paid: Indicate "Yes" if the CBE was fully or partially paid for by EWL funds.

7. Mammogram Type: Typically, a client who is asymptomatic and has no breast history will have what is referred to as a "Screening" mammogram. In other cases, when the client is symptomatic or she is considered at risk, according to her health or family history, the initial mammogram ordered is "diagnostic" rather than screening. If a diagnostic mammogram was done, indicate whether it was unilateral or bilateral.

8. and 9. Mammogram Date and Result: Enter the date when the mammogram was *performed*.

- Select *Assessment Incomplete- Additional Imaging Required* (BI-RADS 0) if the radiologist is recommending additional imagery be performed before arriving at a final interpretation.
- All results with an asterisk (*) next to it requires further diagnostic work.
- Note: If you obtain **more than one** mammogram result or **different** results in each breast, record the **worse** of the two findings.

10. and 11. Mammogram Paid and Location: Indicate "Yes" if the mammogram was fully or partially paid for by EWL funds and document the location (subcontractor) where the mammogram was performed.

12. Workup Recommendation: Specify if the radiologist recommended additional breast procedures based on the mammogram and/or CBE finding. **If there is an abnormal result (*) from either a CBE or mammogram, additional diagnostic work-up is required.** If the recommendation is for short-term follow-up—i.e., repeat the mammogram in six months—enter "NO" for question #12.

13-19. Diagnostic Procedures:

- Indicate which diagnostic test was performed, the procedure date, the procedure site (subcontractor), result, and funding source for the test.
- If a test was cancelled or not performed because the client refused or did not show for her appointment, indicate the test as "refused" **and** include a note as to why the client did not complete the tests.
- Note: Film comparisons should only be documented in cases when a mammogram result is recorded as BI-RADS 0 (Assessment is incomplete). Film comparisons done as part of standard imaging evaluation or as a routine radiologic review of previous films should not be reported.

20. Work-Up Status

- "Work-up complete" should **Only** be marked if diagnostic procedures were performed.
- If the recommendation is for short-term follow-up, check (✓) the short- term follow up box and indicate whether 3, 6, or 9 month follow up was recommended. Short-term follow-up should only be documented if the clinician intends to perform a diagnostic procedure after the short-term follow-up has elapsed and **NOT** in situations where the clinician intends to assess the general condition of the patient.
- Note: If short-term follow-up is indicated, work-up complete, date of final diagnosis (date of last diagnostic procedure), and final diagnosis ("breast cancer not diagnosed") should be marked.
- A response of "irreconcilable" will be used for those cases, which after clinical review, it is determined that there is no sufficient way to document the clinical scenario on the EWL data form. Please call the State office **before** checking Irreconcilable.
- If a test was cancelled or not performed because the client refused or did not show for her appointment, indicate the work-up-status as "Workup refused" **and** include a note as to why the client did not complete the tests.
- A response of "deceased" will be used in cases where the clinical work up could not be completed because the client had passed away.

21. Final Diagnosis Date: If more than one diagnostic procedure was performed, the date of final diagnosis should be reported as the date of the final imaging procedure that provided the definitive diagnosis.

22. Final Diagnosis: Indicate whether the client was diagnosed with breast cancer or not.

23. Treatment Status: The treatment section is for breast cancer treatment only. Include a note if treatment was not started and provide the reason.

24. Treatment Status Date

- Report the date treatment was started. NOTE: Oftentimes it may be a lumpectomy performed in the course of an excisional biopsy. Report the date of treatment as the date when the biopsy/lumpectomy was performed.
- For both "Client Lost to Follow-Up" and "Treatment Refused", enter the date in which policy guidelines have been satisfied (e.g. date after three different attempts to contact the client have been made).
- If treatment is not recommended, enter the date that both the clinician and the patient jointly agree not to pursue treatment (e.g. end stage cancers)

25. Medicaid Enrollment: If the client was diagnosed with breast cancer, and not enrolled in Medicaid, indicate why in the space provided.

Additional Notes

- If the mammogram is unsatisfactory, you should submit the Screening and Diagnostic Form with the unsatisfactory finding. The mammogram should be repeated and a new form submitted to the State office. This will help in tracking the number of unsatisfactory results.
- The person who signs the form is the individual responsible for the information in the form and must be able to provide follow up information if requested by the State office.

Cervical Screening and Diagnostic Form Instruction Sheet

Please use this form to refer to the numbered fields on the Cervical Screening and Diagnostic Form. These instructions offer clarification and guidance for completing those fields. Contact the EWL Data Manager if you have additional questions.

1. Indication for Pap test

- Report the reason for performing the *current* Pap test.
- If client was referred for diagnostic procedures, include the referral date- this will be used to calculate time from screening to dx.
- If a Pap test was not done and client proceeded to diagnostics or an HPV test, indicate the reason ("Refused", "Not needed" or if "Needed but not performed").

  Note: If the client is referred to EWL for diagnostic evaluation for a cervical problem on the basis of an abnormal Pap test by an outside provider, obtain and record the results of the Pap test, date it was performed, location, and indicate that the Pap test was not paid by EWL.

2. and 3. Pelvic Exam and Pap test Dates: Enter the dates when these procedures were performed.

- List the dates that the pelvic exam and pap test were performed.
- Indicate whether the Pap test was a 3 year test (without an HPV test) or a 5 year (with an HPV test)

4. Pap test Result

- Select *Negative (for intraepithelial lesion….)* when there is no cellular evidence of neoplasia or for other identified organisms or non-neoplastic findings.
- Select *Atypical squamous cells of undetermined significance (ASC-US)* when more testing is needed to determine if the abnormal cells represent Infection, irritation or pre-cancer.
- An example of *Other* Pap test Result is "other malignant neoplasm". This category is for forms of cancer that only rarely affect the cervix, such as malignant melanoma, sarcomas, and lymphoma.
- All results with an asterisk (*) next to it may require further diagnostic evaluation

5. Cervix Present: This indicates if the specimen was taken from the cervix or from the vaginal area. For women who have an intact cervix, the specimen will generally come from the cervix. EWL does not reimburse Pap tests for women who have had a hysterectomy unless the hysterectomy was due to cervical cancer or dysplasia.

6. Specimen Type: Select type of specimen used ("Conventional, "Liquid based" or "Other").

7. Specimen Adequacy: Select adequacy of Pap test. Note: If the Adequacy is **unsatisfactory**, repeat the Pap test.

8. and 9. Pelvic exam and Pap test Paid: Indicate whether these procedures were fully or partially paid for by EWL funds by checking "Yes".

10. and 11. HPV Test Result and Date

- Report the test result of high risk HPV Strains 16 or 18 only. Reimbursement of screening for low risk HPV types is **not** permitted.
- Enter the date when this procedure was performed.

12. HPV test Paid: Indicate whether the HPV test was paid for by EWL funds by checking "Yes".

13. Pap test / Pelvic exam Location: Document the location (subcontractor) where the Pap test was performed.

14. Workup Recommendation: Specify if the clinician recommended workup to reach a final dx based on the Pap test and/or HPV test results. The clinician should follow the guidelines for recommended work-up for an abnormal Pap test, as provided by EWL. If the recommendation is for short-term follow-up—i.e., repeat the Pap test in six months—enter "NO".

15-18. Diagnostic Procedures: Indicate which diagnostic test was performed, the procedure date, the procedure site (subcontractor), result, and funding source for the test. If a test was cancelled or not performed because the client refused or did not show for her appointment, indicate the test as "refused" and include a note as to why the client did not complete the tests.

Note: Endometrial biopsy may be reported under the "Other Procedure" section. Endometrial biopsy may be performed to evaluate the presence of atypical glandular cells or adenocarcinoma. Typically, an endometrial biopsy is performed to evaluate the uterus lining for the presence of cancer or pre-cancerous cells.

19. Work-Up Status

- If the recommendation is for short-term follow-up, check (✓) the short- term follow up box & indicate whether it's 3, 6, 9, or 12 months.
- If short-term follow-up is indicated, work-up complete, date of final diagnosis (date of last diagnostic procedure), and final diagnosis must be checked (✓).
- A response of "irreconcilable" will be used for those cases, which after clinical review, it is determined that there is no sufficient way to document the clinical scenario on the EWL data form. Please call the State office before checking "Irreconcilable".
- If a test was cancelled or not performed because the client refused or did not show for her appointment, indicate the work-up status as "refused" and include a note as to why the client did not complete the tests.
- A response of "deceased" will be used in cases where the clinical work-up could not be completed because the client passed away.

20. Final Diagnosis Date: If more than one diagnostic procedure was performed, the date of final diagnosis should be reported as the date of the procedure that provided the definitive diagnosis.

21. Final Diagnosis:

- For a final diagnosis of squamous cell carcinoma or cervical adenocarcinoma, it is important to know if the pathologist reported the carcinoma **in situ or invasive.** This will assist in determining which final diagnosis to select.
- A final diagnosis must be indicated on the form when a diagnostic procedure has been performed for an abnormal Pap test result.

22. Treatment Status:

- Treatment status is required for a diagnosis of CIN II, CIN III, Invasive Cervical Carcinoma, Low Grade SIL, and High Grade SIL. If treatment was not started include a note as to why the client did not have treatment initiated.
- LEEP and Cone procedures may also be used as a form of treatment and should be documented as such. Do Not mark "Treatment not recommended, pending or unknown" if treatment was done during one of these procedures check (✓) "Treatment started".

23. Treatment Status Date

- Report the date treatment was started.
- For both "Client Lost to Follow-Up" and "Treatment Refused", enter the date in which policy guidelines have been satisfied (e.g. date after three different attempts to contact the client have been made).
- If treatment is not recommended, enter the date that both the clinician and the patient jointly agree not to pursue treatment (e.g. end stage cancers)
- Note: If a LEEP or CONE procedure is used as a treatment method, document the start date of the most recent procedure.

24. Medicaid Enrollment: If the client was diagnosed with pre-cancer or cervical cancer and not enrolled in Medicaid, indicate why in the space provided.

Additional Notes

- If more than one result or final diagnosis is reported—different findings on the colposcopy or biopsy—report the worse of the two findings.
- The person who signs the form is the individual responsible for the information on the form and must be able to provide follow up information if requested by the State office.

ATTACHMENT B

Monthly Screening Log

Provider Site:

(1) Fill in the number of federal and state screenings you were awarded for FY 2018-19 in the boxes to the right. **Federal** **State**

(2) Enter the number of new screens and re-screens each month for federal and state

(3) The Total, Cumulative Total, and Percent Screened will be **automatically** calculated for you.

(4) Enter the date you submit this screening log to VDH

(5) Submit the screening log by the 5th day of each month

(6) Email your screening log to kim.jefferson@vdh.virginia.gov

FEDERAL

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	TOTAL
# New Screens												0
# Rescreens												0
Total (AUTO Calc)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0
Cumulative Total (AUTO Calc)	0	0	0	0	0	0	0	0	0	0	0	0
Percent Screened (AUTO Calc)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Date Submitted												

STATE

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	TOTAL
# New Screens												0
# Rescreens												0
Total (AUTO Calc)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0
Cumulative Total (AUTO Calc)	0	0	0	0	0	0	0	0	0	0	0	0
Percent Screened (AUTO Calc)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Date Submitted												

ATTACHMENT C

Every Woman's Life Program
Matching Funds Form
Fiscal Year 2018-2019

Non-federal matching funds in the amount of $1 for every $3 of federal funds awarded is required. Matching funds may be cash, in-kind, or donated services or equipment. Matching funds may not include (1) payment for treatment services or the donation of treatment services, (2) services assisted or subsidized by the Federal government, or (3) the indirect or overhead costs of an organization. All costs used to satisfy the matching requirement must be documented by the provider and will be subject to audit. Please provide in the table below your **actual** matching funds for FY 2018-19 (June 30, 2018 – June 29, 2019) by **July 31, 2019.**

Provider Name_____

NON-FEDERAL CASH RESOURCES AND AMOUNTS:

Source	**Actual Amount For FY 2018-19**
• Cash donations	$
• Community fund-raising	$
• Other grants or awards *(e.g., Komen, Avon).* **Specify each grant individually and the dollar amount received.**	$

NON-FEDERAL NON-CASH RESOURCES AND AMOUNT:

Source	**Actual Amount For FY 2018-19**
• Donated vehicles and equipment *(e.g., vans for transportation, laboratory equipment, computers)*	$
• Donated clinical services *(e.g., professional salaries)*	$
• Donated non-clinical services *(e.g., clerical salaries)*	$
• Donated supplies *(e.g., educational materials, promotional materials)*	$
• Donated media time *(e.g., television, radio, print)*	$
• Donated professional time *(e.g., service on coalitions, advisory committees, advertising/marketing consultation)*	$

Every Woman's Life

A Virginia Department of Health Program

Reimbursement

Reimbursement for EWL Services

Purpose: To define the payment policy for screening, diagnostic, and other related services provided under the auspices of the EWL program.

Responsible Person(s): Provider Site Coordinator or Designee

Revised Date: June 30, 2017

Policy:

The EWL provider will receive compensation for breast and cervical cancer screening and related services in the form of a per person capitation rate. The capitation rate is calculated using historical EWL procedural data (e.g., type and number of screening and diagnostic procedures performed) times the actual costs for procedures, which is based on current Virginia Medicare reimbursement rates, plus case management fees for women with abnormal screening results.

The EWL provider will have a formal agreement in place with each sub-contractor providing EWL services that outline reimbursement rates and procedures allowed as part of the partnership. This should be updated annually and signed by both parties. The terms of the formal agreements should align with the current VABCCEDP allowable Procedures and Relevant CPT Codes and Fees list.

For services supported through federal funds, the current capitation rate for a 12-month contract year is $375 per woman aged 40-64. For counties and cities located in the northern Virginia area[1], the capitation rate is $405 per woman aged 40-64. The capitation rate includes the cost of providing breast and cervical cancer screening services, including short-term follow-up visits that occur within 12 months of the initial screening exam, plus the cost of approved diagnostic tests for the percentage of women who will need them. The capitation rate also supports case management services for managing women with abnormal breast and cervical screening results.

For services supported through state funds, the current capitation rate for a 12-month contract year is $455 per woman aged 18-39. For counties and cities located in the northern Virginia area, the capitation rate is $495 per woman aged 18-39. The capitation rate includes the cost of providing approved breast or cervical cancer diagnostic services, including any short-term follow-up visits that occur within 12 months of the initial diagnostic exam. The capitation rate also supports case management services for managing women with abnormal breast or cervical screening results.

[1] Northern Virginia cities and counties include: Cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park, and the counties of Arlington, Fairfax, Loudoun, and Prince William.

To receive the approved capitation rate, EWL providers must submit an original invoice plus the required data forms for each client (e.g., Client Eligibility Form, Breast Screening & Diagnostic Form, and Cervical Screening & Diagnostic Form). If a client only received cervical services, check the box that indicates "cervical record only, no breast form being submitted", and submit the Eligibility and Cervical Screening and Diagnostic Form. If a client only received breast services, check the box that indicates "breast record only, no cervical form being submitted", and submit the Eligibility and Breast Screening and Diagnostic Form. Screening information must be complete and all diagnostic information must be entered, if diagnostic tests were performed.

A copy of the Invoice/Client Screening List can be found in **Attachment A**. Refer to the **Data Collection, Retention and Reporting** section for the required client data forms.

Upon receipt of the invoice/client data packet, the EWL Data Manager will review the data forms for accuracy and completeness and will contact the provider site by fax or telephone to request any missing information. Provider sites must respond to all requests for missing information in a timely manner. If missing information is not provided, invoices will be adjusted accordingly to reflect clients not approved for payment. The EWL Program Director or designee will approve the invoice within 3 calendar days of its receipt, and forward to the agency Business Unit for payment processing. The approved number of clients will be emailed to the provider site. When a client(s) is denied for payment the reason for denial will be faxed.

Providers that fail to submit the required data and request payment for a client within **90 calendar days** of the date of the client's last screening exam (e.g., CBE, cervical cancer screening test, screening mammogram) will forfeit the right to payment.

It is expected that providers will submit an invoice/client data packet monthly, and adhere to the following goals for submission:

Quarter	Date	Invoice Goal	Client Data Goal
2nd quarter	**12/31**	**25% of total award**	**25%**
3rd quarter	**3/31**	**50% of total award**	**50%**
4th quarter	**6/29**	**100% of total award***	**75%**
	8/31	**----------**	**100%**

* Close out procedures issued each year during the month of June will include data form submission and reimbursement instructions that will vary from the standard reimbursement policy and procedure.

Procedure:

1. Complete all information on the required data forms, which include the Client Eligibility Form, Breast Screening and Diagnostic Form, and/or Cervical Screening and Diagnostic Form.

2. Customize the EWL invoice with your organization's letterhead.

3. Complete an invoice for federal services, if requesting payment for clients aged 40-64. See **Attachment A – FEDERAL SCREENING INVOICE.**

   A. Ideally, the approved capitation rate will be paid for clients that have received a clinical breast exam, screening mammogram, cervical cancer screening test and pelvic exam, unless the procedure is marked – refused, not needed, or done recently. Some clients may not need all four screening exams each year, however, in order to receive payment the client must have at least received a screening mammogram. For example, a client that receives a cervical cancer screening test and clinical breast exam but no screening mammogram will not be reimbursed. Exception: The capitation rate will be approved for clients that received a screening mammogram elsewhere, and were referred into the EWL program for breast or cervical diagnostic testing to rule out cancer.

   B. If a woman is in a follow up cycle that overlaps with her re-screening date, the EWL provider site may submit the invoice and indicate "rescreen" on the diagnostic form. As these cases arise, please contact the state office for guidance.

4. Complete an invoice for state services, if requesting payment for clients aged 18-39. See **Attachment A – STATE SCREENING INVOICE.**

   A. Providers will **not** receive the capitation rate for clients that receive a clinical breast exam to rule out the need for additional diagnostic testing. Providers will ***only*** receive the capitation rate for clients that received diagnostic tests to rule out cervical or breast cancer.

   B. Reimbursement for symptomatic women that receive a diagnostic procedure(s) for an abnormal cervical screening result and later return within the same fiscal year and need a diagnostic procedure(s) for an abnormal breast screening result or vice versa will be handled on a case-by-case basis. Contact the state EWL Data Manager for these types of cases.

   C. Symptomatic women age 40-49 may be submitted on a state invoice under the following circumstance:

      a. The provider is attempting to meet the 50 and over mammogram screening indicator.

b. The provider and/or state EWL office is attempting to spend down funds for the current year (prior approval for this reason is needed by the state EWL office).

In both situations above, the women must meet the requirements of a symptomatic woman listed in the Services Section – Refer to *Cervical Services for Women Age 18-39 and Breast Services for Women Age 18-39.*

D. Eligible women aged 65 and older may be submitted on a state screening invoice.

E. EWL eligible woman 50 and over may be submitted on a state invoice if prior approval has been given by the state EWL Office.

5. Include the following information on the invoice:
   A. Invoice date

   B. Federal tax ID#

   C. Invoice # (state and federal screening invoice numbers must be different)

   D. Contract #

   E. Provider site name

   F. Amount of funds requested:
      i. List the number of clients you are requesting payment for and the requested amount in the appropriate space.

      ii. For other related services (e.g., travel) that have been pre-approved, providers should enter the total dollar amount requested in the row marked “other” and a description of the request, and attach any supporting documentation.

   G. Organization name and address where payment should be mailed

6. Complete the Client Screening List. Enter the invoice date and invoice number. List the client name and screening date of service, and number the client list. Attach clients 40-64 years of age to the **Federal Screening Invoice**; clients 18-39 years of age to the **State Screening Invoice.** Exception: providers may also submit symptomatic women age 40-49 on a state invoice – refer to #4C.

7. Group follow-ups by age (e.g., 18-39 or 40-64) and list them on the Follow-Up Client Screening List. Attach this list to the Federal or State Screening Invoice, depending on the age group.

    A. The Follow-Up Client Screening List should not be submitted to the state EWL office on a blank invoice marked "NA".

8. **Mail** the completed invoice/client data packet to:

Virginia Department of Health
Every Woman's Life
ATTENTION: DATA MANAGER
109 Governor Street, 9th Floor
Richmond, Virginia 23219

9. Maintain a record of invoices approved by the EWL State Office for the current and two preceding fiscal years for reference and/or audit purposes.

ATTACHMENT A

Insert Provider Letterhead

Invoice Date: _____ Federal Tax ID#_____
Invoice #_____ Contract #_____
Submitted by: _____
Provider Site Name

TO: Virginia Department of Health
Virginia Every Woman's Life (EWL)
109 Governor Street, 9th Floor, East
Richmond, Virginia 23219
Attention: Data Manager

FEDERAL SCREENING INVOICE

Reimbursement is requested for expenses incurred for:

Expense	**Description**	**Amount Requested**	**FOR STATE USE ONLY**	
			Amount Approved	**State Approval**
Breast & Cervical Services	Screening, diagnostic and follow-up services (list clients and service dates on Client Screening List)	# Clients_____ $_____	# Clients_____ $_____	
Other		$	$	

Send the approved amount to (*enter address in the space below*):

Client Screening List – Federal

Invoice Date: _____ Invoice #_____

Screening data is submitted for payment on the following EWL clients (**list clients paid with federal funds**):

No.	Client Name	Screening Date of Service	STATE USE ONLY Approved

Client Screening List – Follow-Up

No.	Client Name	Screening Date of Service	STATE USE ONLY Approved

Insert Provider Letterhead

Invoice Date: _____ Federal Tax ID#_____
Invoice #_____ Contract #_____
Submitted by: _____
Provider Site Name

TO: Virginia Department of Health
Virginia Every Woman's Life (EWL)
109 Governor Street, 9th Floor, East
Richmond, Virginia 23219
Attention: Data Manager

STATE SCREENING INVOICE

Reimbursement is requested for expenses incurred for:

Expense	**Description**	**Amount Requested**	**FOR STATE USE ONLY**	
			Amount Approved	**State Approval**
Breast & Cervical Services	Diagnostic and follow-up services (list clients and service dates on Client Screening List)	# Clients_____ $_____	# Clients_____ $_____	
Other		$	$	

Send the approved amount to (*enter address in the space below*):

Client Screening List – State

Invoice Date: _____ Invoice #_____

Screening data is submitted for payment on the following EWL clients (**list clients paid with <u>state funds</u>**):

No.	Client Name	Screening Date of Service	STATE USE ONLY Approved

Client Screening List – Follow-Up

No.	Client Name	Screening Date of Service	STATE USE ONLY Approved

Treatment

Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

Purpose: To define who is eligible for medical assistance under the BCCPTA and the referral procedure.

Responsible Person(s): Provider Site Coordinator or Case Manager

Revised Date: June 30, 2018

Policy:
Women who are screened and/or diagnosed with breast or cervical cancer or a pre-cancerous condition, and certified as needing treatment by an EWL provider, may be eligible for payment of that treatment by Medicaid under the **Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).**

Pre-cancerous conditions of the breast and cervix are those that are defined by a health care professional as needing treatment. Pre-cancer of the breast may be defined by a biopsy or histology finding of atypia where excision is recommended. Other lesions where excision may be considered due to pre-cancer risk are ductal carcinoma-in-situ (DCIS), lobular carcinoma-in-situ (LCIS), radial sclerosing lesions/radial scar, atypical lobular hyperplasia, atypical ductal hyperplasia, flat epithelial atypia, spindle cell lesion, granular cell tumors and mucin containing lesions.

Benign or suspected Phyllodes Tumor and Papillary Lesions may require excision but do not constitute an immediate referral to the BCCPTA for Medicaid. Refer to the VABCCEDP Allowable Procedures and Relevant CPT Codes and Fees list for reimbursement of an excisional biopsy. Malignant tumors should be referred to the BCCPTA for Medicaid.

Surgical biopsy can also be considered if a core needle biopsy does not explain the imaging findings (discordant). Pseudoangiomatous stromal hyperplasia (PASH) is a benign histology and is not considered a pre-cancerous condition; excision is not warranted unless discordant from the mammographic finding.

Pre-cancer of the cervix may be defined by a biopsy result of HSIL, CIN 2 (moderate dysplasia), and CIN 3 (severe dysplasia). **CIN I does not constitute a referral to the BCCPTA. Vaginal Intraepithelial neoplasia does not constitute a referral to the BCCPTA.**

A Treatment is defined as the “initiation or start” of treatment. As an example, treatment may consist of surgery or chemotherapy/radiation. Treatment is **not** defined as the

Source: http://www.dss.virginia.gov/benefit/medicalassistance/manual.cgi
TN # 95; Categorically Needy Groups; MO3-Medical Covered Groups, MO320.312, pages 69-72/ 3/11

surgical consultation date or BCCPTA application date. VABCCEDP (EWL) funds **cannot** be used to reimburse any form of treatment. The health care professional must determine when the course of treatment is completed. Some clients will have a very short course of treatment while others may have a prolonged course of treatment.

Women that are eligible for referral for medical assistance under the BCCPTA include:

1. Women who are screened and diagnosed with breast or cervical cancer or a precancerous condition by an EWL provider.

2. Women who are screened by an EWL provider but later diagnosed with breast or cervical cancer or a pre-cancerous condition by a non-EWL provider.

3. Women who are screened by a non-EWL provider or seen by a non-EWL provider because of a symptom that is suspicious for cancer and referred to an EWL provider who later diagnoses breast or cervical cancer or a pre-cancerous condition.

4. Women who are diagnosed with breast or cervical cancer or a pre-cancerous condition through another state's Breast and Cervical Cancer Early Detection Program and relocate to Virginia before treatment started or during treatment.

5. Women previously enrolled under the BCCPTA and upon re-enrollment into EWL are subsequently diagnosed with breast or cervical cancer or a pre-cancerous condition may be eligible for re-enrollment in Medicaid for the new cancer even if it is a recurrence of the previous cancer.

6. Women who reside in northern Virginia (the cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park and the counties of Arlington, Fairfax, Loudoun and Prince William) who are screened and diagnosed with breast or cervical cancer or a pre-cancerous condition through the DC Centers for Disease Control and Prevention's "Project Wish" program and meet the requirements of the BCCPTA covered group. These women will receive a Virginia BCCPTA application form from the DC provider and will be instructed to submit the application directly to the local department of social services in their home locality.

7. Women who were not enrolled in EWL at the time of their screening/diagnosis, but had at least one screening or diagnostic service done by a provider who was participating in EWL at the time, and currently meets EWL eligibility (age, income, insurance status). In these situations , EWL Coordinators should; 1) confirm that a screening and/or diagnosis was done by a provider that participated in EWL at the time of the service; 2) submit BCCPTA application to local DSS; and 3) submit completed eligibility and diagnostic

Source: http://www.dss.virginia.gov/benefit/medicalassistance/manual.cgi
TN # 95; Categorically Needy Groups; MO3-Medical Covered Groups, MO320.312, pages 69-72/ 3/11

form to EWL central office. In these cases, a slot will not be used and the EWL provider will not be reimbursed.

Women who are **not eligible** for referral include:

1. Women who have received a diagnosis for breast or cervical cancer or pre-cancerous condition and were not screened or diagnosed by an EWL provider for that condition.

2. Women that are incarcerated.

3. Women who do not have a breast or cervical cancer or pre-cancerous diagnosis.

Additionally, women referred to Medicaid for enrollment into the BCCPTA must meet Medicaid's non-financial eligibility requirements, including:

1. Must be age 18-64.

   a. Women age 65 and older may qualify for another Medicaid covered group for aged individuals if they meet Medicaid income guidelines (80% FPL) and do not exceed the resource limit of $2,000.

2. Must be a Virginia resident.

3. Must be a US citizen or meet alien requirements:

   a. Documentation of citizenship and identity is required for Medicaid applicants and recipients who claim to be U.S. citizens. The Department of Medical Assistance Services completes a data match with the Social Security Administration (SSA) in order to obtain citizenship and identity verification. Local Department of Social Services eligibility workers will enroll the woman in Medicaid while the match is being completed. If the data match fails to provide verification, the individual may be required to provide documentation of citizenship and identity in order for Medicaid coverage to continue.

   b. Women who are **not** U.S. citizens will require further evaluation by the DSS and may not be eligible for treatment under the BCCPTA. Many qualified aliens who arrived in the U.S. after August 21, 1996 have been banned from receiving Medicaid for 5 years beginning with their date of entry. The five-year ban does not apply to certain refugees, asylees, and certain other groups.

4. Must **not** be eligible for Medicaid under another mandatory covered group. Women who receive SSI, are pregnant, or have a child under the age of 18 living

Source: http://www.dss.virginia.gov/benefit/medicalassistance/manual.cgi
TN # 95; Categorically Needy Groups; MO3-Medical Covered Groups, MO320.312, pages 69-72/ 3/11

with them will require further evaluation by DSS. These women may be eligible to receive medical assistance under Medicaid's Low-Income Families with Children (LIFC), Medically Indigent (MI) Pregnant Women, FAMIS Plus, or SSI. If the woman does **not** qualify for any of these covered groups she may qualify for medical assistance under the BCCPTA.

5. Must **not** have creditable health insurance coverage. Creditable health insurance includes:
    a. A group health plan
    b. Health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan or health maintenance organization contract offered by a health insurance issuer
    c. Medicare
    d. Medicaid
    e. Armed forces insurance
    f. A medical care program of the Indian Health Service or tribal organization
    g. A state health risk pool

    Health insurance that does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits is still considered creditable health insurance. Similarly, if a woman has creditable health insurance, but a high deductible, she is **not eligible** for enrollment under the BCCPTA covered group.

    Women who have non-creditable health insurance, which includes a disease specific policy (e.g., cancer policy) or dental, vision, or prescription only policies with no other coverage **may be eligible** for medical assistance under the BCCPTA.

In all cases, the final determination of Medicaid eligibility will be made by DSS.

The EWL provider should ensure that women who are <u>not</u> eligible for medical assistance under the BCCPTA receive appropriate treatment services. The provider should explore community resources, such as charity care, faith-based organizations, and health institutions that serve indigent populations to ensure treatment services are provided.

<u>Notification of BCCPTA Eligibility</u>
DSS will **not** notify EWL providers when a case has been approved or denied. DSS will send notices to the individual who is requesting benefits or the individual's authorized representative, but <u>not</u> the EWL provider. To verify if a EWL client is the recipient of Medicaid, you can call the toll free Medicall numbers (800-884-9730 or 800-772-9996) and follow the prompts. Note: you must be a Medicaid provider with a provider number

Source: http://www.dss.virginia.gov/benefit/medicalassistance/manual.cgi
TN # 95; Categorically Needy Groups; MO3-Medical Covered Groups, MO320.312, pages 69-72/ 3/11

to access the Medicall system. For information regarding Medicaid eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification information, visit https://www.virginiamedicaid.dmas.virginia.gov/wps/portal and follow the enrollment instructions to access the system.

Annual Renewal

The DSS will re-determine Medicaid eligibility on an annual basis. At the time of the annual re-determination, the woman must provide a statement from her health care professional verifying continued treatment for breast and/or cervical cancer is necessary. The determination of continuing treatment is at the decision of the treating provider. The determination of continuing treatment is not a decision of the EWL Coordinator/Case Manager although they can assist the client with the request if needed. For example, contact the treating provider office if the client is having difficulty getting the form signed in a timely manner.

Entitlement

Women will receive full Medicaid coverage (i.e., coverage is not limited to the treatment of breast and cervical cancer) for as long as they are in cancer treatment. Medicaid coverage may begin on the first day of the application month or up to 3 months prior to the month of application providing all Medicaid eligibility criteria are met.

A co-pay is associated with Medicaid services and women are responsible for paying the co-pay, which is dependent upon the type of service they receive. For example, for an inpatient hospital stay the co-pay is $100.00 per admission and $1.00 per clinic visit.

Procedure:

The following procedures must take place once a woman is diagnosed with breast or cervical cancer or a pre-cancerous condition and is certified as needing treatment by an EWL health care professional:

1. Complete the BCCPTA Medicaid Application Form **(Attachment A).** The EWL client and coordinator/case manager must sign and date the form. A copy of the signed form should be filed in the client's medical record. The form is reviewed at the time of a medical record audit.

2. The coordinator/case manager will immediately forward the completed BCCPTA Medicaid application form to the county or city DSS office where the woman resides. A copy of the form should be maintained in the client's medical record and is subject to review at the time of a site visit. Ownness to submit the form to the local DSS office should not be displaced to the client.

Source: http://www.dss.virginia.gov/benefit/medicalassistance/manual.cgi
TN # 95; Categorically Needy Groups; MO3-Medical Covered Groups, MO320.312, pages 69-72/ 3/11

3. Upon completion and submission of the BCCPTA application, **the coordinator/case manager will maintain contact with the woman to ensure that treatment has begun** and that any barriers to receiving treatment are addressed. Documentation of treatment should be noted in the medical record. If the client fails to initiate or refuses treatment, the DSS office must be notified and the client informed that her Medicaid may be revoked.

4. The coordinator/case manager must re-assess the woman's eligibility for re-enrollment into the EWL program when cancer treatment is completed. This is typically done within 1 year of initiating treatment.

5. DSS will require the woman to complete a re-determination form after 1 year. The coordinator/case manager may need to assist the woman with communicating with the physician's office in order to get the form completed in a timely manner. However, the re-determination is made by a treating health care provider and not the coordinator/case manager.

6. When asked for the Medicaid enrollment date by central office, the coordinator/case manager will provide the actual date notification was received and not the Medicaid retro-active eligibility date.

For guidance on women diagnosed with breast or cervical cancer or a pre-cancerous condition that are transferring to Virginia refer to the *Eligibility & Enrollment Section – Client Transfers.*

For more detailed information on the Medicaid BCCPTA Policy, refer to **Attachment B.** For Frequently Asked Questions related to the BCCPTA, refer to **Attachment C.** For consultation on specific cases, contact the state EWL office.

Source: http://www.dss.virginia.gov/benefit/medicalassistance/manual.cgi
TN # 95; Categorically Needy Groups; MO3-Medical Covered Groups, MO320.312, pages 69-72/ 3/11

ATTACHMENT A

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application

AGENCY USE ONLY

DATE RECEIVED:

CASE NAME/NUMBER:

LOCALITY: | WORKER

Please complete all sections. If you need assistance, please contact an eligibility worker at your local Department of Social Services.

1. IDENTIFYING INFORMATION

LAST NAME: FIRST NAME: MI: SOCIAL SECURITY NUMBER:

ADDRESS: CITY: STATE: ZIP: STATE OF RESIDENCE:

MAILING ADDRESS (If different): CITY: STATE: ZIP: HOME PHONE #: DAYTIME PHONE #:

2. ADDITIONAL INFORMATION

RACE: ☐ WHITE ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC ☐ OTHER

MARITAL STATUS: ☐ NEVER MARRIED ☐ DIVORCED ☐ MARRIED ☐ WIDOWED ☐ SEPARATED

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

U. S. CITIZEN? YES ☐ NO ☐ IF NO, ALIEN NUMBER: _____

DO YOU RECEIVE SSI? YES ☐ NO ☐ ARE YOU PREGNANT? YES ☐ NO ☐ DO YOU HAVE A CHILD(REN) UNDER AGE 19 LIVING WITH YOU? YES ☐ NO ☐

DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐ IF YES, COMPANY NAME: _____

POLICY #: _____ EFFECTIVE DATE: _____ TYPE OF COVERAGE: _____

DID YOU RECEIVE MEDICAL CARE IN ANY OF THE THREE MONTHS BEFORE THIS APPLICATION? YES ☐ NO ☐ IF YES, LIST MONTHS: _____

3. BCCPTA CERTIFICATION

I CERTIFY THAT THE ABOVE NAMED INDIVIDUAL IS A VIRGINIA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (BCCEDP) PARTICIPANT (TITLE XV) AND IS ELIGIBLE FOR MEDICAID UNDER THE BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000.

SCREENING DATE: _____ DIAGNOSIS DATE: _____ FACILITY/SERVICE SITE: _____ PHONE #: _____

SIGNATURE OF BCCEDP CASE MANAGER: _____ DATE: _____

YOUR RIGHTS AND RESPONSIBILITIES

By signing below, I agree to the following:
I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs or disability consistent with state and federal law and to file a complaint if I feel I have been discriminated against.
- Have my eligibility for Medicaid benefits determined within 10 working days of receipt of my application at my local department of social services.
- Appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application; (2) denied benefits from the Medicaid program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid benefits.

I have the responsibility to:

- Not purposely withhold information, or give false information and understand if I do so my Medicaid coverage may be denied or ended.
- Report any changes in information provided on this form within 10 days to my local department of social services.
- Cooperate with a review of my Medicaid eligibility by Quality Control and understand that refusing to cooperate will make me ineligible for Medicaid until I cooperate with a review.

I further understand and agree that:

- This application is used only to apply for Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act coverage group and that in order to apply under other coverage groups I must complete another application.
- The Department of Medical Assistance Services and the Department of Social Services are authorized to obtain any verification necessary to establish my eligibility for Medicaid.
- The Department of Medical Assistance Services has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by me.
- Each provider of medical services may release any medical records pertaining to any services received by me.
- I am assigning my rights to medical support and other third party payments to the Department of Medical Assistance Services in order to receive benefits from the Medicaid program.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information or fail to report a change promptly or on purpose I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud. I understand that my signature on this application signifies, under penalty of perjury, that I am a U.S. citizen or alien in lawful immigration status.

_____ _____

Signature or Mark **Date**

_____ _____

Witness/Authorized Representative **Date**

Commonwealth of Virginia Voter Registration Agency Certification

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Please check only one)

❑ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.

❑ Yes, I would like to apply to register to vote. (please fill out the voter registration application form)

❑ No, I do not want to register to vote.

If you do not check any box, you will be considered to have decided **not to** register to vote at this time. Applying to register to vote or declining to register to vote will not affect the assistance or services that youwill be provided by this agency. If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

If you believe that someone has interfered with your right to register or to decline to register tovote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with:Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, phone (804) 864-8901.

_____ _____ _____

Applicant Name **Signature** **Date**

(For agency use only)

Voter Registration form completed: ❑ Yes ❑ No
Voter Registration form given to applicant for later mailing (at applicant's request): ❑

_____ _____

Agency Staff Signature Date

ATTACHMENT B

M0320.312 BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA)

A. Policy

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services, including long-term care (LTC) (see Chapter M14) for certain women with breast and cervical cancer. Virginia chose to cover this group beginning July 1, 2001.

Women eligible for the BCCPTA program must be age 18 through 64. They must have been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program (BCCEDP) and referred to LDSS for a Medicaid eligibility determination. These women must not have creditable health insurance coverage for treatment of breast or cervical cancer. *Virginia's BCCEDP program, Every Woman's Life, is administered by the Virginia Department of Health.*

Through an agreement between Virginia and the District of Columbia (D.C.), residents of northern Virginia (the cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park and the counties of Arlington, Fairfax, Loudoun and Prince William) are allowed to be screened and diagnosed for breast or cervical cancer and pre-cancerous conditions through the DC Center for Disease Control and Prevention's "Project Wish" program. Women who are screened and certified as needing treatment for breast or cervical cancer through Project Wish may be eligible for Virginia Medicaid, provided they meet the requirements of the BCCPTA covered group. These women will receive a Virginia BCCPTA application form from the DC providers and will be instructed to submit the application directly to the local department of social services in their home locality.

Women diagnosed with cancer by a provider who is not operating under the BCCEDP are not eligible in this covered group.

B. Nonfinancial Eligibility

1. Required Nonfinancial Requirements

BCCPTA women must meet the following Medicaid nonfinancial requiremen in chapter M02:

- citizenship/alien status;
- Virginia residency;
- Social Security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

In addition, BCCPTA women must not be eligible for Medicaid under the following mandatory categorically needy covered groups:

- LIFC;
- MI Pregnant Women;
- FAMIS Plus (MI Child Under Age 19);
- SSI recipients.

2. Creditable Health Insurance Coverage

BCCPTA women must not have creditable health insurance coverage. Creditable health insurance coverage includes:

- a group health plan;
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- Medicare;
- Medicaid;
- armed forces insurance a medical care program of the Indian Health Service (IHS) or of a tribal organization;
- a state health risk pool.

There may be situations where a woman has creditable health insurance coverage as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits, *or the woman may have a high deductible. The woman is not eligible for Medicaid in the BCCCPTA covered group because she has creditable health insurance.*

C. Financial Eligibility

There are no Medicaid financial requirements for the BCCPTA covered group. The BCCEDP has income and resource requirements that are used to screen women for this program.

Women requesting Medicaid coverage of LTC services must provide verification of their resources and income and must meet all the LTC eligibility requirements in chapter M14.

D. Application Procedures

The application procedures for women who meet the BCCPTA non-financial requirements have been streamlined to facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer. In addition to the nonfinancial information required to evaluate eligibility in the BCCPTA covered group, the following information is needed for enrollment in Medicaid:

- name,
- address,
- sex and race,
- date of birth,
- country of origin and entry date, if an alien.

Women who meet the description of individuals in the LIFC, MI Pregnant Women, FAMIS Plus, or SSI recipients covered groups must complete the appropriate Medicaid application for the covered group and must have a Medicaid eligibility determination completed prior to determining their eligibility in the BCCPTA covered group. If not eligible in the LIFC, MI

Pregnant Women, FAMIS Plus, or SSI recipients covered groups, then determine their eligibility in the BCCPTA covered group.

1. Application Form

This covered group has a special application, BCCPTA Medicaid Application (form #032-03-384), that must be initiated by a BCCEDP provider, *including those affiliated with Project Wish operating in the District of Columbia.* The application includes the BCCEDP certification of the woman's need for treatment and the information needed to determine the nonfinancial eligibility in the BCCPTA covered group. Appendix 7 to subchapter M0120 contains a sample of the BCCPTA Medicaid Application form.

If eligibility in another Medicaid covered group must first be determined, the applicant must be given the appropriate Medicaid application.

2. Application Processing Time Frames

BCCPTA Medicaid applications filed by women who do not meet the description of an individual in the LIFC, MI Pregnant Women, FAMIS Plus, or SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by women who meet the description of an individual in the LIFC, MI Pregnant Women, FAMIS Plus, or SSI recipients covered groups must be processed as soon as possible, but no later than 45 calendar days of the agency's receipt of the signed application.

3. Notices

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a "Notice of Action on Medicaid", form #032-03-008, on the 10th day stating why action has not been taken, specifying what information is needed and a deadline for submitting the information.

E. Entitlement

1. Entitlement Begin Date

Eligibility under this covered group is met the beginning of the month the screening is completed if the woman later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for her breast and/or cervical cancer.

Eligible BCCPTA women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month.

2. Retroactive Entitlement

Retroactive coverage is applicable to this covered group if the individual was screened by a medical provider operating under the BCCEDP and diagnosed as needing treatment for breast or cervical cancer in the retroactive month(s).

F. Enrollment

The aid category for BCCPTA women is "066".

G. Benefit Package

The BCCPTA group is a full-benefit covered group. All Medicaid-covered services are available to BCCPTA enrollees, including long-term care in a facility or in a community-based care waiver.

H. Renewal

Annual renewal requirements are applicable to the BCCPTA covered group. At the time of the annual renewal, the recipient must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. The BCCPTA Redetermination (form #032-03-653) is used for the renewal. See M1520.200 for renewal requirements.

ATTACHMENT C

Medicaid FAQ Sheet

1. **If a woman has private health insurance would she be eligible for the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)?**

Answer: Medicaid states that the woman must not have creditable health insurance coverage for the treatment of breast or cervical cancer. Creditable health insurance coverage includes:

- group health plan
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer
- Medicare
- Medicaid
- armed forces insurance
- a medical care program of the Indian Health Service or of a tribal organization
- state health risk pool

There may be situations where a woman has creditable health insurance as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits. These women would not be eligible for coverage under the BCCPTA because they have creditable coverage. If a woman has creditable coverage, but a high deductible, she is still not eligible for treatment under the BCCPTA.

If a woman has a disease specific policy (e.g., dental, cancer, prescription, or vision only policy), but no other coverage, it is not considered creditable health insurance; the woman is eligible for treatment under the BCCPTA.

2. **Are women who move to Virginia and participated in the NBCCEDP program in another state eligible for the BCCPTA?**

Answer: Yes. Since the EWL program is part of the national BCCEDP, women receiving Medicaid under the Medicaid Treatment Act in other states, territories, tribal organizations or the District of Columbia can continue to receive these benefits in Virginia. Even though other states, territories, tribal organizations and the District of Columbia may have different program eligibility criteria (e.g., income $\leq$ 250%), and follow different Medicaid eligibility criteria, women transferred into Virginia will continue to be eligible for treatment. In contrast, women receiving treatment under the BCCPTA in Virginia that move to another state may not be eligible for the BCCPTA in that state under their policy.

To initiate the transfer, EWL programs should verify, and if possible receive documentation, that the woman was enrolled in a NBBCEDP program and was receiving treatment under this state/program. Once this is verified, the EWL provider will need to complete a Medicaid application and forward it to their local Department of Social Services (DSS) office. Once treatment ends, the woman, if

eligible for EWL, may be re-screened through the program. Women who are not eligible for EWL should be referred to other community resources for their routine cancer screening.

3. **When a woman that is currently receiving treatment under the BCCPTA no longer meets EWL's income guidelines is she still eligible to receive Medicaid?**

Answer: At this time, yes. However, Medicaid may change their annual redetermination policy in the future to include not only a physician statement that continued treatment is needed but also financial eligibility determination.

4. **Do we have presumptive eligibility in Virginia?**

Answer: Virginia does not have presumptive eligibility. Virginia has streamlined the eligibility process for the BCCPTA. Medicaid has an application and certification to determine if the individual meets the requirements of the BCCPTA covered group.

5. **Are women who received treatment for breast and/or cervical cancer through the BCCPTA eligible for re-entry into BCCPTA if complications arise from their previous treatment?**

Answer: If a woman is no longer under treatment and has been discharged from Medicaid, she is not eligible for re-entry into Medicaid for complications related to her treatment. She should apply for 'regular' Medicaid.

6. **Is reconstructive surgery covered under the BCCPTA?**

Answer: If a Medicaid provider obtains preauthorization for the surgery and determines it to be medically necessary it will be covered. To obtain preauthorization, the Medicaid provider will need to submit the required paperwork.

7. **Is the cost of a wig allowable under the BCCPTA?**

Answer: No, the BCCPTA does not cover the cost of a wig since it is considered a 'cosmetic' expense.

8. **Do women enrolled in Every Woman's Life and trying to enter Medicaid for treatment need to provide proof of citizenship and identify?**

Answer: Yes; documentation of citizenship and identity is required for Medicaid applicants and recipients who claim to be U.S. citizens. The Department of Medical Assistance Services completes a data match with the Social Security Administration (SSA) in order to obtain citizenship and identity verification. Local

Department of Social Services eligibility workers will go ahead and enroll the woman in Medicaid while the match is being completed. If the data match fails to provide verification, the individual may be required to provide documentation of her citizenship and identity in order for her Medicaid coverage to continue. The individual will be notified by DSS if she is required to provide documentation.

9. Do the Medicaid citizenship and identity requirements mean that aliens (not being able to provide proof of citizenship) are no longer eligible for the BCCPTA?

Answer: Documentation of citizenship and identity is required for Medicaid applicants and recipients who claim to be U.S. citizens. Non-citizens who are in this country legally have always been required to provide immigration documentation. If a non-citizen is screened and diagnosed through the EWL program and needs Medicaid, as long as she is a qualified alien eligible for full Medicaid benefits, she will be eligible.

10. Will DSS notify case managers when the final determination for BCCPTA eligibility is made?

Answer: This is not a feasible practice for DSS. However, they have provided some important resources in their response below that will assist you when a client fails to respond to your follow up calls for information.

"Medicaid policy requires notification to the applicant by local social service departments when enrollment is complete. Providers have access to a DMAS electronic system that allows them to see what benefits a Medicaid recipient who presents for services has as well as a toll-free provider hotline through DMAS when they have any questions about an individual's eligibility. With the number of providers, it is not feasible for DSS staff, whose primary responsibility is to address client needs, to notify providers when an individual qualifies for a service through Medicaid enrollment given the services already available to providers."

For Medicaid eligibility information, EWL providers are encouraged to visit the DMAS website, https://www.virginiamedicaid.dmas.virginia.gov/wps/portal*. Additionally, there are two toll free Medicall numbers (800-772-9996 or 800-884-9730) to call for eligibility information. To access the Medicall system, you must be a Medicaid provider with a provider number.*

11. Is it the responsibility of EWL providers to notify DSS if a client who has been approved for BCCPTA decides not to become a Medicaid recipient?

Answer: No, if a client has been approved for BCCPTA but decides to decline Medicaid services she will need to directly notify DSS of her decision.

Medicaid FAQ Sheet

12. Is there a co-pay for Medicaid services?

Answer: Yes. Most Medicaid recipients other than pregnant women and children have co-pays for the Medicaid services they receive. Clients are responsible for the co-pay. Below is a list of co-pays for specific services:

a. Inpatient hospital $100 per admission
b. Outpatient hospital $ 3.00 per visit
c. Clinic visit $1.00 per visit
d. Physical office visit $1.00 per visit
e. Other physician visit $3.00 per visit
f. Eye Exam $1.00 per exam
g. Prescriptions $1.00 and $3.00
h. Home health visit $3.00 per visit
i. Rehabilitation service $3.00 per visit

Emergency Services are never subject to co-pays.

13. Does retroactive coverage under the BCCPTA only include the cost of diagnostics related to the breast and cervical cancer diagnosis or does it include all medical expenses (diabetes, heard disease, etc.) that are incurred by the woman?

Answer: Retroactive coverage includes all Medicaid covered services received during the three months prior to the month the Medicaid application was filed. If the woman already paid for a service Medicaid would have covered the provider may bill Medicaid and then reimburse the woman. Medicaid does not reimburse recipients for services, only providers.

14. When completing a Medicaid application for clients enrolled with state funding, what date do we enter for the screening date at the bottom of the application? Is it the date of the abnormal cervical cancer screening test or the date of EWL enrollment?

Answer: It is the date of the cervical cancer screening test.

15. Are the race and marital status fields required fields on the Medicaid application form?

Answer: Yes, race and marital status information is collected and reported to the Centers for Medicare and Medicaid Services.

Medicaid FAQ Sheet

16. Is there an annual re-enrollment into BCCPTA?

Answer: Yes, clients enrolled under the BCCPTA must complete a re-determination form, which is available at their local DSS office. They can either have the treating physician complete the certification section of the form or have the physician verify in writing that they continue to receive treatment for breast and cervical cancer.

17. How long does a legal resident need to work before they can be eligible for the BCCPTA?

Answer: One of the requirements to receive "full Medicaid benefits" is that the individual must have worked at least 40 qualifying quarters since being in the U.S. Legal residents who do not meet this work requirement will be deemed an "unqualified alien" by DSS and Medicaid payment will be limited to treatment for emergency services.

18. What is Plan First?

Answer: Plan First is a Medicaid program that provides an annual physical exam, cervical cancer screening, lab services, contraceptives, and family planning education and counseling services to eligible women (and men) through the family planning office visit. Women with an abnormal cervical cancer screening result or breast exam may be referred to EWL for further testing under the EWL state program. Women enrolled in Plan First qualify for EWL since Plan First does not provide full health care coverage. These women are considered underinsured.

19. Are incarcerated women eligible for Medicaid treatment under the BCCPTA?

Answer: No, as long as a woman is incarcerated she is ineligible for Medicaid in ANY covered group.

20. Who should we contact with BCCPTA-related questions?

Answer: For DSS related questions (e.g., questions about the BCCPTA application form or DSS eligibility worker decisions/actions) contact the DSS program consultant that is assigned to your regional office (see attached listing). For BCCPTA/EWL policy-related questions, contact the State EWL office.

21. Are the women who are enrolled under the BCCPTA most likely to receive care under a fee for service plan or managed care plan?

Answer: Women enrolled under the BCCPTA are currently excluded from managed care. They can only receive care from fee for service providers.

Medicaid FAQ Sheet

22. Can a woman be re-enrolled into Medicaid who was previously enrolled and then dropped out because she received health insurance through a job, only to later lose their health insurance because of job loss?

Answer: Yes, if a woman no longer has health insurance because of a job loss she can be re-enrolled into Medicaid.

23. Does DSS need to be notified if a woman enrolled into the BCCPTA refuses treatment?

Answer: Yes, if a woman refuses treatment, the provider must contact DSS to let them know. The woman will no longer be eligible for the BCCPTA and DSS will determine if she is eligible for any other groups. Prior to contacting DSS, providers should explain to the client that refusing treatment will make them ineligible for the BCCPTA. This interaction should be clearly documented in the clients medical record.

Revised 6/1/2015

ATTACHMENT D

VDSS Medical Assistance Program Consultants Assignments

Effective 4-5-2018

CENTRAL		EASTERN		NORTHERN		PIEDMONT		WESTERN	
Central Regional Office		Eastern Regional Office		Northern Regional Office		Piedmont Regional Office		Western Regional Office	
Niani V. Wynn 804-662-9756 Phone 804-819-7114 Fax niani.v.wynn@dss. virginia.gov		Johnical Haynes 757-985-4707 Phone 757-455-0840 Fax 757 618-2339 Cell johnical. haynes@dss.virginia.gov		Don McBride 540-347-6326 Phone 540-347-6331 Fax donald.mcbride@dss.virginia.gov		Julia Viet Clingempeel 540-204-9644 Phone 561-7536 Fax 540-580-3863 Cell julia.viet@dss.virginia.gov		Sandra Blevins 276-676-5639 Phone 276- 676-5621 Fax sandra.w.blevins@dss. virginia.gov	
AGENCY	**FIPS**	**AGENCY**	**FIPS**	**AGENCY**	**FIPS**	**AGENCY**	**FIPS**	**AGENCY**	**FIPS**
Amelia	7	Accomack	001	Alexandria	510	Albemarle	003	*Bristol*	*520*
Buckingham	29	Brunswick	025	Arlington	013	Alleghany/Covington	005/580	*Bland*	*021*
Caroline	33	Chesapeake	550	Clarke	043	Amherst	009	*Buchanan*	*027*
Charles City	36	Dinwiddie	053	Culpeper	047	Appomattox	011	*Carroll*	*035*
Chesterfield/Col. Heights	041/570	Franklin City	620	FairfaxCo/FallsChurch/FairfaxCity	059/610/600	Bath	017	*Dickenson*	*051*
Cumberland	49	Gloucester	073	Fauquier	061	Bedford Co/City	019/515	*Floyd*	*063*
Essex	57	Greensville/Emporia	081/595	Frederick	069	Botetourt	023	*Galax*	*640*
Fluvanna	65	Hampton	650	Fredericksburg	630	Campbell	031	*Giles*	*071*
Goochland	75	Isle of Wight	093	Greene	079	Charlotte	037	*Grayson*	*077*
Hanover	85	James City Co.	095	Harrisonburg-Rockingham	660/165	Charlottesville	540	*Lee*	*105*
Henrico	87	Mathews	115	King George	099	Craig	045	*Montgomery*	*121*
Hopewell	670	Newport News	700	Loudoun	107	Danville	590	*Norton*	*720*
King and Queen	97	Norfolk	710	Louisa	109	Franklin County	067	*Patrick*	*141*
King William	101	Northampton	131	Madison	113	Halifax	083	*Pulaski*	*155*
Lancaster	103	Portsmouth	740	Manassas City	683	Henry-Martinsville	089/690	*Radford*	*750*
Lunenburg	111	Prince George	149	Manassas Park	685	Highland	091	*Russell*	*167*
Middlesex	119	Southampton	175	Orange	137	Lynchburg	680	*Scott*	*169*
New Kent	127	Suffolk	800	Page	139	Mecklenburg	117	*Smyth*	*173*
Northumberland	133	Surry	181	Prince William	153	Nelson	125	*Tazewell*	*185*
Nottoway	135	Sussex	183	Rappahannock	157	Pittsylvania	143	*Washington*	*191*
Petersburg	730	Virginia Beach	810	Shenandoah	171	Roanoke City	770	*Wise*	*195*
Powhatan	145	Williamsburg	830	Spotsylvania	177	Roanoke Co-Salem	161/775	*Wythe*	*197*
Prince Edward	147	York/Poquoson	199/735	Stafford	179	Rockbridge-BuenaVista-Lexington	163/530/678		
Richmond City	760			Warren	187	Shenandoah Valley(Staunton/Augusta	/Waynesboro 015/790/820		
Richmond County	159			Winchester	840				
Westmoreland	193								

DBHDS	
FACILITY	**FIPS**
Southwestern VA Trng Ctr	984
Southeastern VA Trng Ctr	985
Northern VA Trng Ctr	986
Southside VA Trng Ctr	989
Western State Hospital	991
Southwestern VA. MH Inst	992
Piedmont Geriatric Hosp	993
Eastern State Hospital	994
Hiram Davis Med Ctr	996
Catawba Hospital	997

Revised 04/2018 MAU

Quality Assurance and Improvement

Federal Performance Indicators

Purpose: To define the performance indicators used to measure a provider's performance over a period of time.

Responsible Person(s): Provider Site Coordinator or Designee

Revised Date: June 30, 2018

Policy:
In addition to observational site visits, there are five core performance indicators that are used to monitor a provider's performance to ensure quality services are delivered in a timely and efficient manner. The indicators focus on client recruitment, completeness of work-up, timeliness of diagnosis, and timeliness of treatment. Providers must meet the performance indicators. The indicators are tracked and reported quarterly to EWL providers for informational, educational and quality improvement purposes. Additionally, there are three non-core performance indicators that are routinely tracked to ensure the program is reaching and serving women within the priority population. Meeting the performance indicators does not supersede the results or findings of an observational or problem focused site visit.

The **core** performance indicators are listed below:

1. **Work-Up Completed**

Performance Indicator	Minimum Standard
▪ If there is an abnormal breast cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.	▪ A minimum of 90% of records will be complete.
▪ If there is an abnormal cervical cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.	▪ A minimum of 90% of records will be complete.

2. **Screening to Diagnosis**

Performance Indicator	Minimum Standard
▪ If there is an abnormal breast cancer screening result, the time between the abnormal screening test result and final diagnosis will be no longer than 60 days. For women referred into the program for diagnostic evaluation after an abnormal screen received outside of the program, the interval will begin on the referral date for diagnostic testing, rather than the date of the initial outside screen.	▪ No more than 25% of records will indicate a timeframe of greater than 60 days between an abnormal breast cancer screening test result or referral date and the final diagnosis.

▪ If there is an abnormal cervical cancer screening result*, the time between the abnormal screening test result and final diagnosis will be no longer than 90 days. For women referred into the program for diagnostic evaluation after an abnormal screen received outside of the program, the interval will begin on the referral date for diagnostic testing, rather than the date of the initial outside screen. **Defined as squamous cell cancer, atypical glandular cells (AGC), high grade SIL, LSIL, ASC-H, result unknown and presumed abnormal, positive cervical cytology result from a non-program funded source, and any cervical cytology result [ASCUS, LSIL], which is marked as needing diagnostics.*	▪ No more than 25% of records will indicate a timeframe of greater than 90 days between an abnormal cervical cancer screening test result or referral date and the final diagnosis.

3. Treatment Started

Performance Indicator	Minimum Standard
▪ If there is a final diagnosis of breast cancer, appropriate treatment will be initiated.	▪ A minimum of 90% of records will indicate treatment was initiated.
▪ If there is a final diagnosis of CIN II, CIN III/CIS or invasive cancer, appropriate treatment will be initiated.	▪ A minimum of 90% of records will indicate treatment was initiated.

4. Diagnosis to Treatment

Performance Indicator	Minimum Standard
▪ If there is a final diagnosis of breast cancer or a pre-cancerous condition, the time between cancer diagnosis and initiation of treatment will be no longer than 60 days.	▪ No more than 20% of records will indicate a timeframe of greater than 60 days between a final diagnosis and the initiation of treatment.
▪ If there is a final diagnosis of cervical dysplasia or pre-cancer (i.e. CIN II, CIN III/CIS), the time between diagnosis and the initiation of treatment will be no longer than 90 days.	▪ No more than 20% of records will indicate a timeframe of greater than 90 days between a final diagnosis of cervical dysplasia or pre-cancer (i.e. CIN II, CIN III/CIS) and initiation of treatment.
▪ If there is a final diagnosis of invasive cervical cancer, the time between diagnosis and initiation of treatment will be no longer than 60 days.	▪ No more than 20% of records will indicate a timeframe of greater than 60 days between final diagnosis of invasive cervical cancer and the initiation of treatment.

5. Mammograms Over 50

Performance Indicator	Minimum Standard
▪ The majority of screening mammograms provided should be to women between 50 and 64 years of age.	▪ A minimum of 80% of screening mammograms provided to program eligible women who are 40 to 64 years of age must be provided to women over age 50.

The three additional **non-core** indicators include:

6. Re-Screen (non-core)

Performance Indicator	Minimum Standard
▪ The provider will give priority to eligible women ages 50-64 previously enrolled and screened through EWL.	▪ A minimum of 65% of women screened in any given year should return within 12-18 months after their last mammogram screening. There must be at least 12 months between mammogram screening tests for the screening to be considered a rescreen. Note: Clients with abnormal mammogram results or diagnosed with breast cancer are not included in the calculation of the rescreen rate.

7. Very Low-Income Women Served (non-core)

Performance Indicator	Minimum Standard
▪ The provider will give priority to eligible very low-income women that are defined as having an annual gross income at or below 100% of the Federal Poverty Level.	▪ A minimum of 75% of women served will be at or below 100% of the Federal Poverty Level.

8. Minority Women Served (non-core)

Performance Indicator	Minimum Standard
▪ The provider will give priority to eligible minority women (e.g., African American, Latino, Asian etc.) that claim a non-Caucasian racial and ethnic status.	▪ Providers will serve a higher percentage of minority women that is proportionate for their service area.

State Performance Indicators

Purpose: To define the performance indicators used to measure a provider's performance over a period of time.

Responsible Person(s): Provider Site Coordinator or Designee

Effective Date: June 30, 2006
Revised Date: June 30, 2010

Policy:
There are four performance indicators that are used to monitor a provider's performance to ensure quality services are delivered in a timely and efficient manner. The indicators focus on completeness of work-up, timeliness of diagnosis, and timeliness of treatment. Providers must meet the four performance indicators. The four indicators are tracked and reported quarterly to EWL providers for informational, educational and quality improvement purposes.

The four performance indicators are listed below:

1. **Work-Up Completed**

Performance Indicator	Minimum Standard
▪ If there is an abnormal breast cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.	▪ A minimum of 90% of records will be complete.
▪ If there is an abnormal cervical cancer screening result or a diagnostic workup is planned, a final diagnosis will be recorded.	▪ A minimum of 90% of records will be complete.

2. **Referral to Diagnosis**

Performance Indicator	Minimum Standard
▪ If there is an abnormal breast cancer screening result, the time between the referral date and final diagnosis will be no longer than 60 days.	▪ No more than 25% of records will indicate a timeframe of greater than 60 days between the referral date and the final diagnosis.
▪ If there is an abnormal cervical cancer screening result*, the time between the referral date and final diagnosis will be no longer than 90 days. **Defined as squamous cell cancer, atypical glandular cells (AGC), high grade SIL, LSIL,*	▪ No more than 25% of records will indicate a timeframe of greater than 90 days between the referral date and the final diagnosis.

ASC-H, result unknown and presumed abnormal, positive cervical cytology result from a non-program funded source, and any cervical cytology result [ASCUS, LSIL], which is marked as needing diagnostics.	

3. Treatment Started

Performance Indicator	Minimum Standard
▪ If there is a final diagnosis of breast cancer, appropriate treatment will be initiated.	▪ A minimum of 90% of records will indicate treatment was initiated.
▪ If there is a final diagnosis of CIN II, CIN III/CIS or invasive cancer, appropriate treatment will be initiated.	▪ A minimum of 90% of records will indicate treatment was initiated.

4. Diagnosis to Treatment

Performance Indicator	Minimum Standard
▪ If there is a final diagnosis of breast cancer or a pre-cancerous condition, the time between cancer diagnosis and initiation of treatment will be no longer than 60 days.	▪ No more than 20% of records will indicate a timeframe of greater than 60 days between a final diagnosis and the initiation of treatment.
▪ If there is a final diagnosis of cervical dysplasia or pre-cancer (i.e. CIN II, CIN III/CIS), the time between diagnosis and the initiation of treatment will be no longer than 90 days.	▪ No more than 20% of records will indicate a timeframe of greater than 90 days between a final diagnosis of cervical dysplasia or pre-cancer (i.e. CIN II, CIN III/CIS) and initiation of treatment.
▪ If there is a final diagnosis of invasive cervical cancer, the time between diagnosis and initiation of treatment will be no longer than 60 days.	▪ No more than 20% of records will indicate a timeframe of greater than 60 days between final diagnosis of invasive cervical cancer and the initiation of treatment.

Observational Site Visit / Medical Record Review

Purpose: To ensure consistent and optimum health care is delivered through EWL.

Responsible Person(s): Quality Assurance/Improvement (QA/I) Nurse and Provider Site Coordinator or Designee

Revised Date: June 30, 2018

Policy:
Monitoring and assessing clinical services are important components of quality assurance/improvement and can ultimately help a program meet and/or exceed customer expectations and program outcomes. The purpose of the routine observational site visit is to:

1. Asses the accessibility and quality of services provided,

2. Evaluate clinic flow and efficiency,

3. Train providers on program policies, procedures and protocols,

4. Conduct a medical record review to compare and verify actual care provided to outcomes reported,

5. Provide technical assistance to help providers enhance systems to improve care,

6. Solicit general feedback, and

7. Negotiate an action plan in response to any proposed recommendations.

The information gathered during an observational site visit, desk review or self audit provides a comprehensive assessment of EWL services that will identify potential problems and problem-prone aspects of care as well as effective strategies for improving services.

A desk medical record review or site visit will be conducted every three years for each authorized EWL provider. The medical record review will be conducted to evaluate adherence to established program policy, clinical and case management protocols. The review can help determine whether an identified problem is related to the delivery of care or data collection and reporting. For the medical record review, the State office will generate a random list of records, which will include clients who received a diagnostic work-up. EWL provider sites should have a copy of the client's medical record readily available at the time of a site visit, including electronic record documentation and if requested, mail records to State office upon request. During a site visit, the EWL Coordinator should be prepared to provide an overview of their EWL program structure

challenges/barriers and a tour of the facility where services are rendered (when permissible).

In addition to the observational visit, EWL providers may be required to complete an annual self audit using an automated tool each fiscal year. During each grant year, providers will be contacted by the state office to complete the audit tool using a specific EWL client identified by the state. To access the EWL audit tool, click http://www.surveygizmo.com/s3/540292/EWL-Audit-Tool.

Findings from the desk review, observational site visit and self audit tool will be utilized when determining award allocation. Providers that are required to submit a corrective action plan are expected to incorporate strategies to improve their EWL program in order to maintain program compliance. Any provider submitting a corrective action plan but not adhering to it or does not show improvement in the next review cycle is subject to a decreased award allocation.

Procedure:

1. For on-site visits, the provider site director and/or the coordinator will be contacted at least 15 business days prior to the site visit when feasible to schedule the visit. Any visit that is scheduled less than 15 days in advance shall be agreed upon by the site coordinator.

2. A list of medical records to be reviewed at the time of the visit will be faxed with the confirmation within 7-10 days in advance of the site visit.

3. For a desk medical record review, the provider site coordinator will be contacted and advised a desk review is being requested. The list of medical records to be reviewed along with a confirmation letter of the request will be faxed to the coordinator at least 10 business days prior to the due date. Copies of the requested records should be mailed to the Chronic Disease Clinical Coordinator at central office. A copy of the entire record should be submitted. Failure to submit the entire medical record may result in the citation of documentation errors. Providers will not be contacted and asked to submit missing documentation during the course of the audit as this defeats the purpose of the audit process.

4. The QA/I Nurse will use the observational site visit or medical record review and medical record review tools to gather relevant information.

5. Within 30 business days of the completed site visit, the QA/I Nurse will submit a written summary to the provider director and/or coordinator that lists their strengths, findings of the review and any recommendations for improvement.

5. Within 30 business days of receiving the written summary and recommendations, the provider coordinator or designee will submit a written response that details their plans to address the recommendations.

6. Within 30 business days of receipt of the provider's improvement plan, the QA/I Nurse will approve the plan or negotiate changes if necessary.

7. Progress on the improvement plan will be tracked and will remain in effect until the provider meets program standards or the QA/I Nurse is satisfied with the provider's performance.

Problem-Focused Visit

Purpose: To provide a collaborative approach to problem solving and program improvement to enhance and strengthen the quality of services delivered through EWL.

Responsible Person(s): EWL State Team and Provider Site Coordinator or Designee

Revised Date: June 30, 2017

Policy:
A problem-focused site visit/call may occur when a specific problem has been identified by the EWL state office or the provider. The site visit/call will be scheduled to discuss a specific area(s) in need of improvement and to collaboratively develop an action plan to improve provider performance. Site visits/calls may be initiated when problems are identified through the Quarterly Performance Indicator Report (QPIR), medical record desk review, self audit tool or observational site visits. Other tracking reports or programmatic issues, such as a customer service or communication problem, may also generate a provider site visit/call. Problem-focused site visits/calls may be initiated by the provider site to solicit technical assistance/guidance on a particular issue/problem.

The purpose of the site visit/call is to allow state and provider site staff an opportunity to clarify the scope of the problem and its primary or root causes, and brainstorm options for resolving the problem to ensure the program complies with all program standards and expectations. A quality improvement model such as *FOCUS on Quality* and tools such as the *fishbone diagram* may be used to assess quality and plan strategies to improve outcomes. The problem-focused site visit/call will include the state EWL team and key provider site personnel such as the Director (or designee), Coordinator, Case Manager(s), Fiscal Administrator, and any other staff directly affiliated with the EWL program.

Procedure:

1. The state EWL office will coordinate a mutually agreeable date, time and place of the site visit/call through the provider site coordinator or designee.

2. At least 7-10 calendar days prior to the visit/call, an agenda and any supporting documentation will be faxed or electronically sent to the provider/state.

3. During the site visit/call, participants will discuss the problem, strategize and formulate practical solutions, and develop an improvement plan.

4. Within 30 business days of the site visit/call, the Provider Site Coordinator or designee will submit the improvement plan to the designated state EWL staff person and list the following for each issue identified:

    a. Specific goals, objectives and activities to improve performance

b. Staff person(s) responsible for implementing the activities

c. Realistic timeline for the completion of each objective/activities

d. Reporting times to document progress on established goals

5. Within 30 business days of receipt of the improvement plan, the state EWL office will review, finalize and approve the plan.

6. Progress on the improvement plan will be tracked and will remain in effect until the provider meets program standards or the state EWL office is satisfied with the providers' performance. The state office reserves the right to adjust the provider's award allocation until program standards have been met.

ATTACHMENT A

Attachment A **Established: 2/1/2015**

Virginia Department of Health
Every Woman's Life Program
Corrective Action Plan

Actions to be Taken When a Corrective Action Plan following a Site Visit is Required

1. Definition of a Corrective Action Plan: A corrective action plan is a document describing step by step how a specific situation will be changed to better meet the performance goals of the program.
    a. *Components of a action plan:*
        i. A clear statement of the problem that has been identified.
        ii. A statement of the desired situation going forward.
        iii. A listing of specific steps that need to be taken to move from the problematic to the desired state. Each step should list the specific person who is responsible for completing the step, and a due date of when this work should be completed.
    b. *Submission of a corrective action plan:*
        i. Submit the action plan within 30 calendar days of receipt of the EWL site visit summary report to the EWL Chronic Disease Clinical Coordinator (CDCC) at the State office. Any delays and requests for an extension must be communicated to the CDCC within 7 days of the deadline. The circumstances surrounding the request will determine the level of extension.
        ii. Submit the report in a Word document and include your provider site information (i.e., administrative name, etc.) in the report. The report must be signed and dated by the EWL Program Coordinator.
        iii. A special template is not required for the report but it must be legible and contain all the components of an action plan.
        iv. Do not include any identifiable patient/client information in your report.
        v. Address all issues identified in the site visit Corrective Action Plan section of the EWL medical record review findings.
        vi. Do not copy and paste the language listed in the summary report provided by the CDCC. Any reports submitted that have duplicated the language verbatim without providing action details on behalf of the provider site will be returned for corrections and re-submission.
        vii. Contact Sharon Slade, RN, BSN, EWL, Chronic Disease Clinical Coordinator at 804-864-7882 for direct questions. Mail reports to the attention of Sharon Slade, CDCC at: VDH- 109 Governor Street, 9th floor, Richmond, VA 23219.

2. Below are examples of possible issues that might be identified by the CDCC with examples of a corrective action plan response.

    - Example #1: The example illustrates findings by the CDCC as reported to the provider site coordinator in the summary and/or medical record review findings. In addition, an example of an acceptable versus unacceptable response is provided.

Case Management Finding:	The client had a biopsy confirmed diagnosis of CIN II but did not receive any form of treatment.
Corrective Action Plan:	"The coordinator and/or case manager will follow up with providers and/or subcontractors to ensure the current ASCCP and NCCN guidelines are being followed. The coordinator and/or case manager will advocate on the client's behalf and document clinical reasons treatment is not provided if indicated by the guidelines".
Provider Site Acceptable Response:	An example of an acceptable corrective action might state, "The EWL coordinator will send correspondence to the business manager of _____ sub-contracted practice by _____ (date) reminding providers of EWL's requirement to follow the current ASCCP and NCCN guidelines regarding screening, diagnostics and/or treatment. When the current management guidelines are not followed, the coordinator and/or case manager will contact the provider as an advocate for the client to discuss clinical rationale for not following the recommended screening, diagnostic or treatment guidelines and clearly document the clinical rationale in the client's EWL medical record".
Provider Site Unacceptable Response:	An unacceptable corrective action response is to copy and paste the state corrective action plan verbatim OR to state, "The doctor made the decision to proceed as indicated". While that may be the case, this response does not provide any corrective action to the identified problem.

    - Example #2: The example illustrates findings by the CDCC as reported to the provider site coordinator in the summary and/or medical record review findings. In addition, an example of an acceptable versus unacceptable response is provided.

Case Management Finding:	The client had an abnormal breast or cervical screening or diagnostic result and a needs assessment was not completed or was untimely.

Corrective Action Plan:	"The case manager will complete the needs assessment when notification of a client's abnormal breast and/or cervical screening result is received. The needs assessment must be completed within 5 business days of receipt. If any barriers are identified, a care plan must be completed within 5 business days of the needs assessment. It is strongly recommended that the needs assessment and care plan are completed simultaneously. The document must be filed in the client's record".
Provider Site Acceptable Response:	An example of an acceptable corrective action might state, "A needs assessment form will be placed in each EWL client record and flagged with a red post it by the administrative assistant at the time a client is enrolled into EWL. The case manager will complete the needs assessment with the client during enrollment either telephonically or in person if an abnormal result is already known. If an abnormal result is determined later in the process, the case manager will complete the needs assessment at the time contact is made to notify the client of the abnormality. To monitor quality assurance of the process, a designated staff member will review all EWL records flagged with a red post it weekly to ensure completion has occurred within 5 business days".
Provider Site Unacceptable Response:	An unacceptable corrective action response is to copy and paste the state corrective action plan finding verbatim OR to state, "A needs assessment will be completed within 5 days".

Staffing


BREAST AND CERVICAL CANCER
SCREENING
SAVES
LIVES
BREAST AND CERVICAL CANCER

EWL Provider Site Staff

Purpose: To delineate the roles, responsibilities and qualifications of EWL provider site staff.

Responsible Person(s): Provider Site Director, Administrator and Coordinator

Effective Date: June 30, 2018

Policy:
There are three primary staffing roles associated with EWL that are essential to the coordination and delivery of program services. They include a Coordinator, Case Manager, and Clinician. Trained, qualified staff to fulfill all three roles is required to ensure quality services are delivered in a timely and appropriate manner.

The Coordinator provides oversight for EWL services and serves as the official point of contact for the -program. The Coordinator may also function in the role of case manager if he/she meets the staffing qualifications of a case manager or is a health care professional with experience and/or knowledge of women's health. If the Coordinator is unavailable or on extended leave (more than 15 business days), the state office should be notified of the absence and provided a temporary point of contact in the Coordinator's absence. Providers must continue to ensure that all EWL requirements and needs of the client are met. The Coordinator is responsible for assuring:

a. All provider site staff affiliated with EWL is in compliance with EWL program policies and procedures.

b. All provider site staff affiliated with the program receives information/materials disseminated from the State EWL office in a timely manner. Likewise, EWL provider sites are expected to respond to State EWL office requests within the requested time frame.

c. The screening goal is met and all screening and non-screening funds are spent by the designated time frame.

d. Screening/re-screening services are accomplished in a timely and efficient manner.

e. All core performance indicators are met or exceeded.

f. All client data is submitted in a timely manner and invoices are submitted to the State EWL office monthly. Failure to submit monthly invoices may affect the state office ability to yield a feasible sample for conducting medical record reviews. If this occurs, the provider site will be counseled on the matter and if not corrected, the provider site award allocation may be affected.

g. All reporting and data requirements are met.

h. All staff changes and contact information is reported to the State EWL office within 7 calendar days of the change.

The Case Manager(s) should be an RN, MD, PA, NP or LCSW with a Virginia license in good standing with their respective Board. The Case Manager meeting these credentials may also serve as the Coordinator. If the Case Manager is unavailable or on extended leave (more than 15 business days), the state office should be notified of the absence and provided a temporary point of contact. In the Case Manager's absence, Providers must continue to ensure that all EWL requirements and needs of the client are met. The Case Manager is responsible for:

a. Coordinating care for all EWL clients with an abnormal CBE, screening or diagnostic result and appropriate and timely follow up care until a final diagnosis is made.:

   i. Completing a client needs assessment to identify any client barriers, such as transportation, scheduling, and lack of understanding of the nature or purpose of a follow-up procedure.

   ii. Developing a comprehensive care plan and providing appropriate referrals for clients with identified needs to remove service barriers so the client can take action on recommendations and receive the follow-up procedures they need.

b. Ensuring all clients who require treatment receive assistance with completion of the BCCPTA application and are followed through the initiation of treatment. Upon treatment completion, re-assess the client to see if she meets EWL eligibility criteria and if so, re-enroll into the program to receive appropriate screening services.

c. Ensuring all women receive the appropriate breast and cervical re-screening notification and services through the use of client tracking and reminder systems.

d. Providing age appropriate referrals for other medical or cancer screening services as well as referrals to promote and encourage a healthy lifestyle.

Providers must also have access to licensed and trained Clinician(s) or subcontract for the services they provide. Clinicians obtain or review current health history, provide the physical assessment, order screening and diagnostic studies, make the final diagnosis, and oversee the clinical care of EWL clients according to established clinical guidelines. Clinicians may assist with collecting and recording clinical information on the EWL data collection forms. **Providers must ensure clinician availability to avoid any lengthy delays (i.e., more than 30 calendar days) in service delivery**. If a provider anticipates a clinician shortage or is faced with an unexpected vacancy they should

make every effort to fill the shortage in a timely manner to avoid any disruption in service. Any unusual disruptions in service or extended delay of service should be communicated to the state EWL office.

Providers should also designate a Director, Administrator, and Fiscal/Billing Coordinator. Official correspondence, including contract notifications, renewals, modifications, and program policy changes will be sent to the Director. The Administrator and Fiscal/Billing Coordinator, in collaboration with the Coordinator, will ensure subcontractors are paid for services rendered in a timely manner, and track and reconcile program expenditures to ensure all screening and non-screening funds are spent.

Training and Technical Assistance

Purpose: To ensure the EWL provider site workforce has the necessary knowledge, skills and attitudes to perform their jobs competently and with sensitivity for diverse client cultures.

Responsible Person(s): Provider Site Director, Administrator and Coordinator

Effective Date: June 30, 2017

Policy:
To maintain a qualified and competent workforce, EWL will periodically assess learning needs through provider performance, surveys and training evaluations, and require that all staff affiliated with the program receive training that is appropriate to their role. Training requirements include:

a. Coordinators or substitute designees are required to attend all mandatory EWL conference calls, webinars and face-to-face meetings. Attendance will be tracked by the State EWL Office.

b. Clinicians are required to attend clinical trainings related to their area of expertise to ensure quality care is provided to EWL enrollees and to maintain licensure.

EWL provider site staff must have Internet access and the ability to participate in multimedia training events using technology such as polycom, web casts, webinars etc.

Technical assistance on program policies and procedures is available to providers by the State EWL office during regular business hours (8am-5pm, Monday-Friday). Additionally, the State EWL office will maintain an up-to-date web site with information on training events, recruitment materials, manuals, facts sheets, reports, tools and other information to assist providers with day-day operations.

www.vdhlivewell.com/ewl