Cancer State Aid Facility Contact – Duties

1. Manages all correspondence related to the Facility/Provider Participation Agreement/Contract with the Cancer State Aid Program and the Department of Public Health's Office of Contracts Administration.
2. Assists resolution of incomplete Participation Agreements, supporting documentation and required exhibits.

Cancer State Aid Facility Patient Contact/Coordinator (CSA-P) – Duties

The facility designates the staff member who will serve as the Cancer State Aid (CSA) Patient Contact or Coordinator (CSA-P). This person facilitates communication between the participating provider/facility and the patient.

It is also the responsibility of the facility's designated CSA-P to verify that the patient is not eligible for Medicaid or any category of Medicare and does not have other creditable insurance coverage prior to submission of an enrollment application to the program.

The facility's CSA-P performs the following functions:

1. Reviews all program materials at the beginning of each fiscal year (July 1st), understands the guidance and forms, and asks for CSA assistance as needed.
2. Manages, prepares, verifies that all sections of the current year application forms are fully completed, verifies that all required materials are attached and submits all CSA patient applications from their facility. Applications that are incomplete or submitted on any part of past year forms will be returned to the facility causing delays in approval and enrollment dates.
3. Eligibility for the CSA is determined by the facility CSA-P through review of appropriate financial and medical information provided by the patient and the patient's medical care provider. This information must meet the CSA eligibility criteria.
4. The CSA-P should become familiar with the various categories of Medicaid Eligibility to enable appropriate recommendations for application to Medicaid, and achievement of the most accurate assessment of patients' eligibility for CSA.
5. Maintains files of financial and medical records that support the patient's eligibility for CSA; this supporting documentation may be requested during an annual program audit or another time when a need to validate patient eligibility has been identified.
6. Serves as the point of contact for patients enrolled through their facility and CSA;
7. Provides information and assistance to patients who wish to apply for CSA through their facility;
8. Receives and manages all patient related correspondence with CSA;
9. Immediately notifies CSA of changes in patient financial or medical eligibility;
10. Provides enrollment information and appropriate updates to the facility's CSA Billing Contact.

Training for the facility's CSA-P is provided by the Cancer State Aid Program. To schedule financial and medical eligibility training, please contact the CSA Nurse Consultant at 404-657-6635.

Cancer State Aid Facility Billing/Claims/Refunds Contact (CSA-C) – Duties

The facility designates the staff member who will serve as the Cancer State Aid Facility Billing/Claims/Refunds Contact (CSA-C). This person facilitates communication between CSA, the participating provider/facility and the patient on topics related to CSA reimbursement of claims for eligible cancer treatment services.

The facility's CSA-C performs the following functions:

1. Reviews all program materials at the beginning of each fiscal year (July 1st), understands the guidance and forms, and asks for CSA assistance as needed.
2. Manages and prepares all patient service claims; and ensures that submitted claims include the complete required documentations prior to submission for reimbursement by the CSA;
3. Maintains records/files that support reimbursements or refunds of the patient's treatment services or claims;
4. Manages all correspondence related to CSA billing/claims/refunds;
5. Shares appropriate updates with the facility's CSA Patient Contact (CSA-P).

Additional Information (for CSA-P and CSA-C)

Prior to submission of claims to CSA for payment, the CSA-C at the facility should perform a Medicaid verification or check to ensure that the patient has not become eligible for Medicaid.

a. Performance of the Medicaid check prior to submission of claims will assist assurance that the payments made to the facility will not need to be refunded at a later date.

b. Performance of Medicaid checks will ensure that the facility submits the claims for payment to the patient's current coverage provider. And will ensure that the facility receives appropriate payments in a timely manner without unnecessary delays. Cancer State Aid will only provide payments for treatments related to the cancer diagnosis, while Medicaid and Medicare will reimburse services provided for other medical conditions in addition to cancer care.

1. It is the responsibility of the CSA-C to implement use of current fiscal year billing materials provided by CSA. Claims for reimbursement calculated and/or submitted using outdated materials cannot be processed and will be returned for corrections causing payment delays.
2. Brief descriptions and eligibility guidance for all categories of Medicaid coverage may be found at http://dch.georgia.gov/applying-medicaid.
3. For those patients who are eligible for Medicare Part A (hospitalization or in-patient service coverage), the facility's CSA-P must determine if it is likely that the patient will also be eligible for Medicare Parts B, C or D.

   The following descriptions of the different categories of Medicare coverage will be helpful in determining patient eligibility. Additional information may be found at http://www.cms.hhs.gov/MedicareGenInfo/ and http://www.medicare.gov/Publications/Pubs/pdf/02110.pdf (large file, longer download)

   Medicare is a health insurance program for:
   - people age 65 or older,
   - people under age 65 with certain disabilities, and
   - people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

   a. **Medicare Part A – Hospital Insurance** - Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover **inpatient** care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

   b. **Medicare Part B – Medical Insurance** - Most people pay a monthly premium for Part B. Medicare Part B (Medical Insurance) helps cover doctors' services and **outpatient** care. It also

covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

*Please note that eligible patients who do not sign up for Part B when they first become eligible will pay a monthly penalty should they choose to enroll in Part B of Medicare at a later date**.**

c. **Medicare Part C – Medicare Advantage Plans (like an HMO or PPO)**
A health coverage choice run by private companies approved by Medicare Includes Part A, Part B, and usually other coverage including prescription drugs

d. **Medicare Part D – Medicare Prescription Drug Coverage**
May help lower your prescription drug costs and help protect against higher costs in the future. Private companies provide this insurance coverage. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

4. Patients who are eligible for Part B and/or other parts of Medicare and have difficulty meeting the financial demands of paying the premiums and co-payments for that coverage should apply for Medicaid's "**Qualified Medicare Beneficiary**" program. http://dch.georgia.gov/medicaid

e. Qualified Medicare Beneficiaries (QMB) are defined as: Aged, blind or disabled individuals who have Medicare Part A (hospital) insurance, and have income less than 100 percent of the federal poverty level and limited resources. Medicaid will pay the Medicare premiums (A&B), coinsurance and deductibles only.

QMB Income Limits	QMB Resource Limits
Individual - $978 per month ($11,736 per year) Couple - $1,313 per month ($15,756 per year)	Individual - $7,080 Couple - $10,620

Effective 3-1-2013

f. Facilities' Cancer State Aid Patient Contact (CSA-P) in charge of applications to Cancer State Aid should assess the patients' likelihood of becoming eligible for the QMB program using the income and resource limits of the QMB program.

g. Patients who are highly likely to be eligible for the QMB program must be provided information to assist their application for Medicare and QMB enrollment.

h. Patients are expected to accept all Medicare coverage for which they are eligible. Those applicants who cannot pay the Medicare premiums and copayments should apply for Medicaid's QMB coverage. Applicants to the Cancer State Aid Program who are denied QMB coverage must submit a copy of the denial letter from Medicaid with their application to Cancer State Aid.

i. Patients who declined any part of Medicare coverage, and are in need of coverage for cancer treatment may still apply for CSA. These patients may be provided limited CSA program coverage and will be evaluated on a case by case basis for CSA enrollment. Any CSA coverage offered will only continue until the patient is again eligible to apply for Medicare benefits or the defined CSA benefit period for which they are approved. At that time they should also apply for Medicaid's QMB program if needed.

*Training for the facility's CSA-C is provided by the Cancer State Aid Program. To schedule CSA claims training, please contact the CSA Claims Team Leader; phone 404-657-2570.