January 4, 2001

Dear State Health Official:

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA - the Act) (Public Law 106-354) amends Title XIX of the Social Security Act to give States enhanced matching funds to provide Medicaid eligibility to a new group of individuals previously not eligible under the program. The new option allows states to provide full Medicaid benefits to uninsured women under age 65 who are identified through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer. The Act also allows states to extend presumptive eligibility to applicants in order to ensure that needed treatment begins as early as possible. The Act has an effective date of October 1, 2000.

The Health Care Financing Administration (HCFA) and CDC are committed to facilitating states' efforts to improve access to needed breast and cervical cancer treatment for uninsured women identified under the NBCCEDP as needing such treatment. This letter is a first step in support of that commitment. It provides a brief overview of CDC's NBCCEDP program and outlines the basic provisions of the new Medicaid coverage option.

Overview of CDC's National Breast and Cervical Cancer Early Detection Program (CDC Program)

During 2001, almost 50,000 women are expected to die from breast or cervical cancer in the United States despite the fact that earlier detection and treatment of these diseases could substantially decrease this mortality. Many of these deaths, which will occur disproportionately among women of racial and ethnic minority and low?income groups, could be avoided by making cancer screening services available to all women at risk. Recognizing the value of screening and early detection, Congress passed the Breast and Cervical Cancer Mortality Prevention Act of 1990. This Act established the NBCCEDP, which authorizes CDC to promote breast and cervical cancer screening and to pay for screening services for eligible women.

The NBCCEDP operates in all 50 states, the District of Columbia, 6 U.S. Territories, and 12 American Indian/Alaska Native organizations. Through cooperative agreements with state and territorial Health Departments, the District of Columbia Health Department, and American Indian/Alaskan Native Health Agencies, CDC's NBCCEDP builds the infrastructure for breast and cervical cancer early detection by supporting public and provider education, quality assurance, surveillance, and evaluation activities critical to achieving maximum utilization of the Program's screening, diagnostic and case management services.

Screening services provided by the NBCCEDP include clinical breast examinations, mammograms, pelvic examinations, and Papanicolaou (Pap) tests. Screening services also include diagnostic services, such as surgical consultation and biopsy to ensure that all women with abnormal screening results receive timely and adequate diagnostic evaluation and treatment referrals. The law does not, however, allow CDC to pay for treatment services for women who are diagnosed with breast or cervical cancer.

As a condition of participation in the CDC program, 42 U.S.C.300n(a) requires states to agree that low-income women will be given priority in the provision of services. Over the

past 10 years, the NBCCEDP has provided more than 2 million screening exams to underserved women, including older women, women with low incomes, and women of racial and ethnic minority groups. The program has diagnosed more than 8,600 breast cancers, over 39,000 pre-cancerous cervical lesions, and 660 cervical cancers. The overall goal of the NBCCEDP is to reduce mortality from breast and cervical cancers, and the success of this effort hinges on the identification and treatment of pre-cancerous conditions and early stage cancers.

Medicaid Program Requirements

It is difficult for many uninsured women who are screened and diagnosed through the CDC program to obtain timely access to treatment services. The BCCPTA allows States to provide coverage to these women under Medicaid. The following outlines the basic rules regarding the new eligibility option.

Eligibility. The BCCPTA adds a new optional categorically needy eligibility group (Section 1902(a)(10)(A)(ii)(XVIII), which is comprised of individuals described in §1902(aa)). In order to qualify under this new optional category, the Act requires that a woman will need to meet the following eligibility requirements:

1. The woman must have been screened for breast or cervical cancer[1] under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service (PHS) Act, and found to need treatment for either breast or cervical cancer; and
2. She must be uninsured, that is, she must not otherwise have creditable coverage (including current enrollment in Medicaid), as the term is used under the Health Insurance Portability and Accountability Act (HIPAA) (§2701(c) of the PHS Act (42 U.S.C. 300gg(c)), and she must not be eligible under any of the mandatory Medicaid eligibility groups. There is no requirement that there be a waiting period of prior uninsurance before a woman who has been screened under the CDC program can become eligible for Medicaid under this new option; and
3. She must be under age 65.

Breast and cervical cancer treatment programs have varied from state to state. Some states have run programs separate from Title XV and may wish to combine those programs with Title XV. It is anticipated that variations among states will continue and programs will continue to evolve.

We have been advised by CDC that a woman has been "screened under the program" if she comes under any of the following three categories:

1. CDC Title XV funds paid for all or part of the costs of her screening services.
2. The woman is screened under a state Breast and Cervical Cancer Early Detection Program in which her particular clinical service has not been paid for by CDC Title XV funds, but the service was rendered by a provider and/or an entity funded at least in part by CDC Title XV funds; the service was within the scope of a grant, sub-grant or contract under that State program; and the State CDC Title XV grantee has elected to include such screening activities by that provider as screening activities pursuant to CDC Title XV.

3. The woman is screened by any other provider and/or entity and the state CDC Title XV grantee has elected to include screening activities by that provider as screening activities pursuant to CDC Title XV. For example, if a family planning or community health center provides breast or cervical cancer screening or diagnostic services, the state would have the option of including the provider's screening activities as part of overall CDC Title XV activities.

As long as the screening was performed by a provider under the state's Breast and Cervical Cancer Early Detection Program as defined above, the woman meets the Medicaid eligibility requirement. The programs operating in states under the CDC program will be able to provide Medicaid agencies with verification that the woman was screened under the CDC program.

In the context of BCCPTA, a woman is considered to "need treatment" if, in the opinion of the individual's treating health professional (i.e., the individual who conducts the screen or any other health professional with whom the individual consults), the screen (and diagnostic evaluation following the clinical screening) indicates that the woman is in need of treatment services. These services include diagnostic services that may be necessary to determine the extent and proper course of treatment, as well as treatment itself.

In addition to meeting these criteria, the woman will also need to meet any other general coverage requirements applicable to Medicaid beneficiaries (e.g., state residency and citizenship or immigration status). There are no Medicaid income or resource limitations imposed by federal law for this new Medicaid eligibility group[2], and no authority for states to impose such limitations.

Eligibility Period. As with other mandatory and optional eligibility categories, under §1902(a)(34) of the Act, a woman's eligibility for coverage under this new option begins up to three months prior to the month in which she applied for Medicaid, if as of this earlier date, she would have met relevant program requirements as described in the eligibility section of this letter. Her eligibility for coverage ends when her course of treatment is completed, or the state has determined that she no longer meets the criteria for this eligibility category (for example, because she has attained age 65 or has creditable coverage) and has determined in accordance with 42 C.F.R. §435.916 that she does not remain eligible for Medicaid under an alternate eligibility category.

A woman is not limited to one period of eligibility. A new period of eligibility and coverage would commence each time a woman who has been screened under the CDC program has been found to need treatment of breast or cervical cancer, and meets other eligibility criteria.

Coverage. A woman whose eligibility is based on this new option is entitled to full Medicaid coverage; coverage is not limited to coverage for treatment of breast and cervical cancer.

As is the case with Medicaid coverage in general, states may use administrative methods, such as prior review and approval requirements, to ensure that services furnished to women under this new option are medically necessary. Services furnished under this new option should be, to the maximum extent possible, consistent with optimal standards of practice. Such practice guidelines are located at the National Guideline Clearinghouse, Agency for Health Care Research and Quality: http://www.ahrq.gov. With respect to experimental

treatments, States may cover experimental treatments although they are not required to do so. Furthermore, routine covered costs associated with the experimental intervention may be covered.

Presumptive Eligibility. Presumptive eligibility is a Medicaid option that allows states to enroll Medicaid applicants for a limited period of time before full Medicaid applications are filed and processed, based on a determination by a Medicaid provider of likely Medicaid eligibility. States have the option to use the presumptive eligibility procedure to facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer.

Under this option, states can certify entities that are eligible for payment under a state's Medicaid program that the state determines are capable of making presumptive eligibility determinations. A certified entity can enroll women who appear to be eligible in Medicaid on a temporary basis.

Presumptive eligibility begins on the date that a qualified entity determines that the woman appears to meet the eligibility criteria described above. Presumptive eligibility ends on the earlier of the following two dates: the date on which a formal determination is made on the woman's application for Medicaid; or, in the case of a woman who fails to apply for Medicaid following the presumptive eligibility determination, the last day of the month following the month in which presumptive eligibility begins. Federal financial participation is allowed for services provided during this presumptive eligibility period regardless of whether or not the woman applies for Medicaid or is later found eligible for Medicaid.

Citizenship and Alienage. The usual rules which govern citizenship and alienage apply to the new optional Medicaid eligibility group. In general, to be eligible for Medicaid an individual must either be a citizen or a qualified alien. (See the web site at http://aspe.hss.gov/hsp/immigration/restrictions-sum.htm for a definition of "qualified alien" and a discussion of the restrictions on immigrants receiving federal public benefits, including Medicaid, and for a list of exceptions to these restrictions.) Most states have elected to provide Medicaid to qualified aliens. However, many qualified aliens who arrived in the United States after August 21, 1996 are barred from receiving Medicaid for 5 years beginning with their date of entry with a qualified alien status. The 5 year bar does not apply to certain refugees, asylees, and certain other groups. Otherwise eligible qualified aliens who are subject to the 5 year ban as well as otherwise eligible non-qualified aliens may receive Medicaid coverage for treatment of an emergency medical condition but not including organ transplants and transplant-related services.

Women who do not meet the immigration-related eligibility criteria may still be able to receive Medicaid coverage related to an "emergency condition", other than services related to an organ transplant. Section 1903(v) of the Act permits states to obtain Federal match for services related to an "emergency medical condition" when furnished to an otherwise eligible individual. The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (A) placing the patient's health in serious jeopardy; (B) serious impairment of bodily functions, or (C) serious dysfunction of any bodily part.

Breast or cervical cancers may be identified at various stages. Some women in need of treatment for breast or cervical cancer will have an emergency condition. As with other

examples of emergency medical conditions, medical judgement and the facts of a particular case will form the basis for identifying those conditions in screened women that amount to an emergency medical condition.

Requirement to Submit a State Plan Amendment. In order to be eligible for payment under this new Act, a state or territory must submit a state plan amendment electing this optional categorically needy eligibility group and/or to provide presumptive eligibility. We enclose state plan preprint language that should be used by states electing these new options.

Matching Rate. The Federal matching rate for the new eligibility group is equal to the enhanced Federal Medical Assistance Percentage (FMAP) used in the State Children's Health Insurance Program (SCHIP) (described in §2105(b) of the Social Security Act (the Act)). That rate is published periodically in the Federal Register, and is posted on web site http://aspe.os.dhhs.gov/health/fmap.htm.

Participation of Territories. Territories that operate Medicaid programs (Puerto Rico, Virgin Islands, American Samoa, Guam and the Northern Marianas Islands) may choose this new option. However, federal payments to those territories are capped by statute. To the extent that these territories already receive the maximum federal payment permitted, the new law would not result in any additional federal funding. If the cap on federal payments has not been reached, federal funds at the enhanced matching rate could be available for the new eligibility group.

Treatment of American Indian and Alaska Native (AI/AN) Women. Under Section 2701(c) of the Public Health Service Act, a medical care program of the Indian Health Service (IHS) or an Indian tribal organization is considered creditable coverage, as the term is used under HIPAA. But not all AI/AN women are "covered under" this creditable coverage. The term "covered under" implies reasonable access to such a program. In consultation with IHS and the tribes, we intend to develop standards to determine whether individuals are "covered under" such a program.

Overview of Implementation

Successful implementation of the new benefit will require a coordinated effort between state Medicaid and public health agencies. State breast and cervical cancer programs have been in place for several years so they may be able to provide to state Medicaid agencies important data on the numbers of women screened and diagnosed within a state.

At the federal level, HCFA will be working closely with CDC to help facilitate implementation of the new coverage group. To assist states as they move forward, we are developing the state plan materials, instructions and more detailed questions and answers regarding the new benefit.

We believe that states will be able to design application procedures that are simple and that are closely tied to the case management services offered by most state breast and cervical cancer programs. A simple process will help ensure that women with cancer receive the treatment they need.

We encourage you to submit state plan amendments to your HCFA regional office as quickly as possible. HCFA staff will gladly offer technical assistance to any state that requests it. If

you have questions about issues not addressed in this letter, please contact Marlene Jones at HCFA (410) 786-3290 for Medicaid-related issues and Steve Reynolds at CDC (770) 488-3075 for issues concerning NBCCEDP.

Sincerely,

/s/

Timothy M. Westmoreland
Director

Footnotes:
(1) A woman is considered to have been screened under the CDC program and eligible for the new Medicaid optional group if she has received a screening mammogram, clinical breast exam, or Pap test; or she has received diagnostic services following an abnormal clinical breast exam, mammogram, or Pap test; and she has received a diagnosis of breast or cervical cancer or of a pre-cancerous condition of the breast or cervix as the result of the screening or diagnostic service.

(2) Public Law 106 - 554, included the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 which, at section 710, provides a technical correction that the limitation under section 1903 (f) of the Social Security Act which limits federal matching funds to individuals with incomes below 133 1/3% of the payment ordinarily made under the former Aid to Families with Dependent Children (AFDC) program to a family of the same size does not apply to this eligibility group. The effective date of the technical correction is October 1, 2000. States may cover all women who are screened through the CDC program and determined eligible for the new Medicaid option regardless of income.

Enclosure

cc:
HCFA Regional Administrators
HCFA Associate Regional Administrators for Medicaid and State Operations
Centers for Disease Control and Prevention Grantees
Nancy Lee - Centers for Disease Control and Prevention
Steve Reynolds - Centers for Disease Control and Prevention
Kathy Cahill - Centers for Disease Control and Prevention
Don Shriber - Centers for Disease Control and Prevention, State Chronic Disease Directors
Lee Partridge - Director, Health Policy Unit, American Public Human Services Association
Joy Wilson - Director, Health Committee, National Conference of State Legislatures
Matt Salo - Director of Health Legislation, National Governors' Association
Heather Mizeru - Director of State Affairs, National Association of Community Health Centers, Inc.

DRAFT

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STATE:_____

Citation Group Covered

B. Optional Coverage Other Than the Medically Needy (Continued)

1902 (a) (10) (A)
(ii) (XVIII) of the Act ____[24]. Women who:

a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;

b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;

c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and

d. have not attained age 65.

1920B of the Act ____ [25]. Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) the Act related to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.