Breast Cancer Coverage File

PRESIDENT CLINTON AND FIRST LADY HILLARY RODHAM CLINTON PROMOTE SCREENINGS AND TREATMENT FOR BREAST, CERVICAL AND OTHER CANCERS
Highlights the Administration's Strong Record on Women and Children's Health
January 4, 2001

Today, President Clinton and First Lady Hillary Rodham Clinton will join advocates for women and families in a White House ceremony celebrating the enactment of the Breast and Cervical Cancer Act of 2000. The President will announce that the Health Care Financing Administration (HCFA) is releasing new guidance today to all 50 states advising them of how they can provide this important new health insurance option for thousands of low-income, uninsured women with breast cancer. President Clinton will also release an executive memorandum directing all Federal agencies to make at least four hours of leave available each year for employees to receive important health screenings for cancer and other preventable diseases. In addition, First Lady Hillary Rodham Clinton will highlight the recently enacted Children's Health Act of 2000, which promotes research on children's health issues, as the latest step in the Administration's strong record on women and children's health.

TREATMENT OPTIONS FOR LOW-INCOME UNINSURED WOMEN DIAGNOSED WITH BREAST OR CERVICAL CANCER ARE LIMITED. The National Breast and Cervical Cancer Early Detection Program provides breast and cervical cancer screening to over 360,000 women without access to these services annually. Although Federal government-sponsored screening programs make every effort to assist individuals diagnosed with disease to access treatment, thousands of women still face financial barriers to care, and those that receive some help frequently do not receive comprehensive coverage for services they need.

PRESIDENT CLINTON ENCOURAGES STATES TO PROVIDE NEW INSURANCE OPTION FOR VULNERABLE WOMEN WITH BREAST AND CERVICAL CANCER. Today, the President announced that HCFA is sending guidance to all 50 states encouraging them to take advantage of the Breast and Cervical Cancer Act of 2000. This new option, which costs $995 million over 10 years and was originally included in the President's FY 2001 Budget, will allow states to provide women diagnosed with cancer through the National Breast and Cervical Cancer Early Detection Program with access to insurance that covers critical treatment services. The guidance being issued today will clarify that the new law will:

- **Provide immediate, comprehensive health insurance to low-income, uninsured women diagnosed with breast and cervical cancer.** States have the option to provide the full Medicaid benefit package, at an enhanced Federal matching rate, to uninsured women diagnosed with breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program. They will be eligible for this benefit throughout the duration of their treatment, eliminating financial barriers to care for these women. These women will be able to access critical health care services necessary to treat their cancer, including radiation treatment, chemotherapy, as well as other health care services, such as basic laboratory and palliative care services, in order to provide a high quality standard of care to these patients.

- **Allow women to access life saving treatment without delay.** The guidance will make clear that states also have the option to allow health care providers and other qualified entities to provide critical health care services to women pending official enrollment in Medicaid, increasing the chances of survival for these women and allowing them to focus on fighting these terrible diseases – not about how they will pay for their care.

- **Result in increased state spending on breast and cervical cancer screening programs.** Some states currently supplement the Federal funds they receive for breast and cervical cancer with their own funds for diagnosis and treatment of these diseases. Estimates indicate that, under similar proposals, states would redirect these funds to supplement their investment in screening for breast and cervical cancer, resulting in a substantial increase in the number of mammograms and pap smears provided.

UNDETECTED AND UNTREATED CANCER CONTINUE TO HARM AMERICANS. Despite recent improvements in prevention and treatment, cancer remains the second leading cause of deaths in the United States. For women age 50-69, regular mammograms can reduce the chance of death from breast cancer by approximately 30 percent. Even in women age 40-50, regular mammograms can reduce mortality rates by approximately 17 percent. Because colorectal cancers grow slowly, early detection significantly increases survival. When detected early, the five-year survival rate is 90 percent. However, less than 40 percent of colorectal cancers are discovered at that stage. After the cancer has spread, the five-year survival rate drops to 65 percent. Preventive screenings and early detection, however, are not effective if patients cannot afford the treatment. Women without health insurance are 40 percent more likely to die from breast cancer than insured women since they are likely to get needed care.

PRESIDENT CLINTON TAKES NEW EXECUTIVE ACTION TO EXPAND ACCESS TO PREVENTIVE CARE FOR FEDERAL EMPLOYEES. Today, President Clinton will issue an executive memorandum that ensures that all 1.8 million Federal employees have access to leave benefits enabling them to access preventive screenings. This executive memorandum, which is another contribution towards the Administration's success in making the Federal government a model employer, will direct all Federal departments and agencies to:

- **Ensure that all Federal employees have at least four hours of leave available annually for preventive screenings.** The President will direct agencies to encourage employees to take advantage of screening programs and other preventive health services through options like promoting alternative work schedules; granting leave under the sick and annual leave programs; and granting excused absence to employees to participate in agency-sponsored preventive health activities. In addition, for employees with fewer than two weeks of accrued sick leave, agencies will provide up to four hours of excused absence each year, without loss of pay or charge to leave, for participation in preventive health screenings.

- **Develop and expand worksite health promotion and disease prevention programs.** Recognizing that the workplace is an effective place to provide information on preventive health care, the President will ask Federal agencies to develop or expand programs that help employees understand their risks for disease, obtain preventive health services, and make healthy lifestyle choices. Program information will be shared with the Office of Personnel Management, which will promote best practices.

PRESIDENT CLINTON AND FIRST LADY HILLARY CLINTON HIGHLIGHT NEW INVESTMENT IN RESEARCH AND TREATMENT FOR CHILDREN'S HEALTH. Today, the President and First Lady will highlight the importance of the Children's Health Act of 2000. This important legislation expands, and coordinates research, prevention, and treatment activities for conditions having a significant impact on children, including autism, diabetes, asthma, hearing loss, epilepsy, traumatic brain injury, infant mortality, lead poisoning, and oral health. The legislation establishes eight Centers of Excellence to promote research on the cause, diagnosis, early detection, prevention, and treatment of autism; promotes training of pediatric specialists; authorizes new research provisions, including a long-term child development study on environmental influences on children's health and a loan repayment program at NIH for health professionals doing pediatric research; and authorizes the Healthy Start program for the first time.

THE CLINTON-GORE ADMINISTRATION'S STRONG RECORD ON WOMEN'S HEALTH. The Clinton-Gore Administration has a strong record on women and children's health issues. The Clinton-Gore Administration has worked tirelessly to improve women's health, including ensuring the inclusion of women in clinical trials, more than doubling funding for breast cancer research, expanding Medicare coverage of mammograms, ending drive-through deliveries, and passing and reauthorizing the Violence Against Women Act (VAWA). The Administration has also taken strong steps to protect a woman's right to choose and promote women's reproductive health by securing historic increases in domestic and international family planning funding, providing contraceptive coverage to more than a million women covered by federal health plans, reversing the gag rule, and enacting the Freedom of Access to Clinic Entrances Act (FACE).

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

JAN 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)) and was also added by the BCCPTA. 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

---

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.

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

---

2 Public Law 106 - 554, including 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.

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

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,

Timothy M. Westmoreland
Director

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

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.

TN No._____ Approval Date:_____ Effective Date:_____

Supersedes
TN No._____

January 3, 2001

WOMENS HEALTH CARE EVENT

DATE:	**January 4, 2001**
LOCATION:	**The East Room**
BRIEFING:	**2:30 pm – 2:35 pm**
MEET &GREET:	**2:40 pm – 2:50 pm**
EVENT TIME:	**2:55 pm – 3:40 pm**
FROM:	**Chris Jennings**
	Mary Beth Cahill

I. PURPOSE

To celebrate the enactment of the Breast and Cervical Cancer Act of 2000 and announce new steps to help improve access to cancer screenings and treatments for low-income women and Federal employees.

II. BACKGROUND

Today, you and the First Lady will be joined by advocates for women and families in a White House ceremony celebrating the enactment of the Breast and Cervical Cancer Act of 2000. You will announce new steps your Administration is taking to help ensure this important legislation can be properly administered to help thousands of low-income, uninsured women with breast cancer without delay, and you will release an Executive Memorandum to all Federal agencies to help eliminate barriers to preventive care. In addition, the First Lady will highlight the recently enacted Children's Health Act of 2000, which makes a multi-million dollar investment in research on children's health issues.

Encouraging States To Provide New Insurance Option For Vulnerable Women With Breast And Cervical Cancer. Today you will announce that the Health Care Financing Administration is sending guidance to all 50 states encouraging them to take advantage of a new Medicaid option that allows states to provide low-income, uninsured women access to critical treatment services. This new option costs $990 million over 10 years and was included in your FY 2001 Budget to:

- Provide comprehensive health insurance to low-income, uninsured women diagnosed with breast and cervical cancer. States have the option to provide the full Medicaid benefit package to uninsured women diagnosed with breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program for the duration of their treatment. These women will be able to access critical health care services necessary to treat their cancer, including radiation treatment, chemotherapy, and other health care services.

- Allow women to access life saving treatment without delay. States also have the option to allow health care providers and other qualified entities to provide critical health care services to women pending official enrollment in Medicaid, increasing the chances of survival for these women and allowing them to focus on fighting these terrible diseases – not about how they will pay for their care.
- Increase state spending on breast and cervical cancer screening programs. Some states currently supplement the Federal funds they receive for breast and cervical cancer with their own funds for diagnosis and treatment of these diseases. Estimates by the Congressional Budget Office indicate that, under similar proposals, states would redirect these funds to supplement their investment in screening for breast and cervical cancer, resulting in a substantial increase in the number of mammograms and pap smears provided.

Taking New Executive Action To Eliminate Barriers To Preventive Screenings For Federal Employees. The Federal government currently provides employees with considerable flexibility in scheduling their work hours around medical needs, including routine examinations and preventive screenings. Many agencies offer creative, effective employee health programs that provide opportunities for employees to take advantage of preventive health screenings at work. Today, you will take the next step to eliminate barriers to preventive screenings for Federal employees by releasing an Executive Memorandum directing all Federal agencies to:

- Review existing policies to ensure that Federal employees can take advantage of screening programs and other preventive health programs. This Executive Memorandum includes flexible options to encourage preventive health screenings, such as: promoting alternative work schedules, which allow for a variety of working arrangements tailored to fit the needs of individual employees; granting leave under the sick and annual leave programs; and granting excused absence to employees to participate in agency sponsored preventive health activities.
- Ensure all employees have at least four hours of leave for preventive screenings each year. For employees with fewer than two weeks of accrued sick leave, you will direct each department and agency to provide up to four hours of excused absence each year, without loss of pay or charge to leave, for participation in preventive health screenings for these individuals.

Highlighting New Investment In Research And Treatment For Children's Health. Today, you and the First Lady will highlight the importance of the Children's Health Act of 2000, which expands, intensifies, and coordinates research, prevention, and treatment activities for diseases and conditions having a disproportionate or significant impact on children. This legislation establishes eight Centers of Excellence to promote research on the cause, diagnosis, early detection, prevention, control, and treatment of autism; promotes training of pediatric specialists; authorizes new research provisions, which will increase our understanding of children's health, including a long-term child development study on environmental influences on children's health and a loan repayment program at NIH for health professionals conducting pediatric research; and authorizes the Healthy Start program for the first time.

III. PARTICIPANTS

Briefing:
Jake Siewert
Melanne Verveer
Chris Jennings
Mary Beth Cahill
Loretta Ucelli
Heather Hurlburt
Heather Howard

Meet and Greet Participants:
The First Lady
Secretary Donna Shalala
Director Janice Lachance
Tonia Conine, Breast Cancer Survivor
Approximately 19 women and children health advocates *(see attached list)*

Program Participants:
YOU
The First Lady
Tonia Conine, Breast Cancer Survivor

Tonia Conine is 42-years-old and from Oklahoma City. She was diagnosed with breast cancer through the CDC Early Prevention Program in March of 2000. Tonia did not have health insurance and could not receive it through her employer, but her income was too high to qualify her for Medicaid coverage. She went to her doctor and told him that she could not afford to be treated. He performed the necessary surgery for free and she went into debt for the costs associated with the follow-up care she needed (about $6,000 – which she is paying off on a monthly basis). She is now in remission, and supports the CDC law because she does not want another woman to have to go through what she has gone through.

IV. PRESS PLAN

Open

V. SEQUENCE OF EVENTS

- **YOU** will greet meet and greet participants in the Blue Room.
- **YOU** will be announced into the East Room accompanied by the First Lady and Tonia Conine.
- The First Lady will make brief remarks and introduce Tonia Conine.
- Tonia Conine will make brief remarks and introduce **YOU**.
- **YOU** will make remarks, work a ropeline and depart.

VI. REMARKS

To be provided by speechwriting

VII. ATTACHMENTS

Meet and greet participants

Meet and Greet Participants

Stephenie Foster, GSA
Pat Reuss, Women's Legal Defense Fund
Kate Michelman, NARAL
Marcia Greenburger, National Women's law Center
Duffy Campbell, National Women's Law Center
Gloria Feldt, Planned Parenthood
Jody Rabham, National Council of Jewish Women
Fran Visco, President, National Breast Cancer Coalition
Joanne Howes, Bass and Howes
Dorian Goldman, Irvin Goldman Family Foundation, National Breast Cancer Coalition
Marlene McCarthy, Director, Rhode Island National Breast Cancer Coalition
Dr. Dileep Bal, President, American Cancer Society
Dr. Gerald Woolam, Former President, American Cancer Society
Dan Smith, American Cancer Society
Jonathan Shestack, Cure Autism Now
Marina Weiss, March of Dimes
Jo Merrill, March of Dimes
Mary and David Busby, FRAXA Research Foundation
Katie Clapp, President FRAXA Research Foundation

CDC Breast Cancer Coverage File

DRAFT: PRESIDENT CLINTON ANNOUNCES NEW INSURANCE OPTION FOR VULNERABLE WOMEN WITH BREAST AND CERVICAL CANCER
February 4, 1999

Today, in his weekly radio address, President Clinton will announce that the budget he will release on Monday will include a new Medicaid option to provide needed insurance coverage to the thousands of uninsured women with breast and cervical cancer detected by Federally supported screening programs. This $220 million investment over 5 years will help eliminate the current and frequently overwhelming financial barriers to treatment. The Vice President and the First Lady, national leaders in the prevention, diagnosis, and treatment of breast cancer, strongly advocated for this initiative, which has been endorsed by the National Breast Cancer Coalition and other cancer groups. Similar legislation has received broad, bipartisan support in the Congress under the leadership of the late Senator Chafee, Senator Mikulski, and Representatives Eshoo and Lazio.

TREATMENT OPTIONS FOR LOW-INCOME UNINSURED WOMEN DIAGNOSED WITH BREAST OR CERVICAL CANCER ARE LIMITED. The National Breast and Cervical Cancer Early Detection Program provides breast and cervical cancer screening to over 360,000 women without access to these services annually. Typically, Federal government-sponsored screening programs make every effort to assist individuals diagnosed with disease to access treatment. However, thousands of women still face financial barriers to care, and those that receive some help frequently do not receive comprehensive coverage for services they need.

- **Early detection saves lives.** An estimated 2 million American women will be diagnosed with breast or cervical cancer in this decade, and half a million women will lose their lives to these diseases. According for the Centers for Disease Control, approximately 15 to 30 percent of all deaths from breast cancer among women over the age of 40 and virtually all deaths from cervical cancer could have been prevented with early screening. When breast cancer is diagnosed early, the 5 year survival rate is 97 percent; but when it is diagnosed after it has spread, the 5 year survival rate is only 21 percent.

- **Uninsured women with breast and cervical cancer face barriers to receiving lifesaving treatment.** In fact, women who are uninsured are 40 percent more likely to die from breast cancer than those with insurance. Not only are these women less likely to be screened, but the course of treatment they elect is often affected by their ability to pay for services. As Dr. Stanley Klausner testified to the House Commerce Committee, women with breast cancer may choose mastectomies over less radical surgery because they know that they cannot afford the chemotherapy and radiation that follow less aggressive treatment.

- **Finding treatment for women without other options diverts scarce resources from crucial screening activities.** The time and effort required to ensure that low-income, uninsured women with cancer receive the lifesaving treatment they need diverts scarce program resources from critical screening activities and reduces the number of women being screened. Because the implicit cross-subsidy of care for the uninsured continues to erode with the advent of managed care and other cost control efforts, identifying sources of free or low-cost care for these women is becoming steadily more difficult.

PRESIDENT CLINTON ANNOUNCES NEW INITIATIVE TO NEW INSURANCE OPTION FOR VULNERABLE WOMEN WITH BREAST AND CERVICAL CANCER. Today, the President announced that his FY 2001 budget will invest $220 million over 5 years in a new Medicaid option that allows states to provide low income, uninsured women with access critical treatment services. It will:

- **Provide comprehensive health insurance to low income, uninsured women diagnosed with breast and cervical cancer.** States will have the option to provide the full Medicaid benefit package to uninsured women diagnosed with breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program for the duration of their treatment, eliminating financial barriers to care for these women. These women will be able to access critical health care services necessary to treat their cancer, including radiation treatment, chemotherapy, as well as other health care services, such as basic laboratory and palliative care services, in order to provide a high quality standard of care to these patients.

- **Allow women to access life saving treatment without delay.** States would also have the option to allow health care providers and other qualified entities to provide critical health care services to women pending official enrollment in Medicaid, increasing the chances of survival for these women and allowing them to focus on fighting these terrible diseases – not about how they will pay for their care.

- **Result in increased state spending on breast and cervical cancer screening programs.** Some states currently supplement the Federal funds they receive for breast and cervical cancer with their own funds for diagnosis and treatment of these diseases. Estimates by the Congressional Budget Office indicate that, under similar proposals, states would redirect these funds to supplement their investment in screening for breast and cervical cancer, resulting in a substantial increase in the number of mammograms and pap smears provided.

BUILDS ON THE CLINTON-GORE ADMINISTRATION'S LONGSTANDING COMMITMENT TO FIGHTING BREAST AND CERVICAL CANCER. The Clinton-Gore Administration has responded to the significant threat posed by breast and cervical cancer with increased efforts in research, prevention and treatment. Fighting the spread of this disease has been a high priority for both Vice President Gore and First Lady Hillary Clinton.

Vice President Al Gore successfully fought for historic increases in funding for breast cancer research, prevention and treatment at the National Cancer Institutes during the Clinton-Gore Administration. He has also advocated for access to cancer clinical trials for new cancer drugs *for* Medicare beneficiaries as Medicare currently does not cover these cutting edge treatments. In 1997, Vice President Gore unveiled the Cancer Genome Anatomy Project, an effort to unravel the genetics of cancer which will help scientists develop new treatments that more effectively target cancer. This effort has already more than doubled its original goals. He has also advocated for legislation that prevents employers and health insurers from discriminating on the basis of genetic information. Studies show that a leading reason that women choose not to take genetic tests for breast cancer is fear that this information will be used against them.

First Lady Hillary Clinton championed budget increases for the National Cancer Institute and other agencies to support research on breast cancer detection, treatment, and cures; launched the Medicare Mammography Campaign to urge older women to get mammograms and to promote the use of Medicare coverage for mammography, implemented by the Clinton Administration; helped develop and implement the National Action Plan on Breast Cancer, a public-private partnership coordinated at the Department of Health and Human Services; advocated for legislation pending before the Congress to ensure that women who have mastectomies are entitled to sufficient hospital stays from their HMOs.

During the Clinton Administration, funding for breast and cervical cancer research, prevention and treatment increased from approximately $283 million in FY 1993 to $623 million in FY 2000. President Clinton enacted the Mammography Quality Standards Act to ensure the quality of mammograms. Finally, the President's Medicare reform plan would eliminate all cost sharing for mammograms and pap smears, which should increase the number of older women using these critical services.

QUESTIONS AND ANSWERS ON NEW MEDICAID OPTION FOR WOMEN WITH BREAST AND CERVICAL CANCER

Q: How can you justify providing automatic Medicaid eligibility for women diagnosed with breast or cervical cancer when you've consistently rejected providing Medicaid eligibility for people with HIV and AIDS? Didn't the Vice President pledged to work on this over two years ago?

A: This new option does not provide automatic Medicaid eligibility for any woman with breast or cervical cancer. It provides states with a new option to close treatment gaps by providing Medicaid coverage to uninsured, low-income women with cancer identified through the National Breast and Cervical Cancer Early Detection Program.

When the Federal government sponsors screening efforts to identify a disease, we make every effort possible to assist individuals in accessing care to treat it. However, Federally supported screening program for breast and cervical cancer has no treatment component – forcing uninsured women to negotiate a complicated patchwork of charity care or forgo treatment altogether. Many of these women are single adults aged 40 to 50 (those women most likely to develop cancer) who are unable to qualify for Medicaid but too young to be covered under Medicare. This new policy ensures that these women are able to access the treatment they need, regardless of income.

Currently, individuals diagnosed with HIV and AIDS through Federally supported screening programs are able to access treatment through the Ryan White / ADAP program, which provides care to low income individuals infected with HIV nationwide. The Clinton-Gore Administration has a longstanding commitment to this program, increasing its funding by X percent since 1993, for a total funding level in 2000 of Y and have proposed an increase of $125 million in the FY 2001 budget. In addition, the new Work Incentives Improvement Act creates a new Medicaid buy-in demonstration to help people with a specific physical or mental impairment, such as HIV or AIDS, that is expected to lead to a severe disability without medical assistance, and HCFA is actively working with states to develop a waiver model through which individuals with HIV and AIDS can be enrolled in Medicaid.

Q: Right now, states have their own systems of treatment for uninsured women with breast and cervical cancer. Won't this new proposal just substitute Federal for state funds?

A: The current system of treatment for uninsured women with breast and cervical cancer is a confusing patchwork of charity care and programs with limited state and private funding. The reason this new Medicaid option is necessary is because the state systems of care for these women are clearly inadequate and under-funded.

Q: These screening programs are often not available state-wide. What about those uninsured women whose cancer is not diagnosed through a Federal program? What happens to them?

A: When President Clinton took office, the National Breast and Cervical Cancer Early Detection Program was operational in only 6 states. Now, it's up and running in all 50. All states have the opportunity to design their screening programs as they see fit, and we will continue to support states in their efforts to expand these programs and implement them state-wide.

In addition, the Clinton-Gore Administration continues to work to provide new, comprehensive, affordable health insurance options to low income Americans. In his FY 2001 budget, the President proposed to invest $110 billion over 5 years to: (1) provide a new, affordable health insurance option for families; (2) accelerate enrollment of uninsured children eligible for Medicaid and S-CHIP; and (3) expand health insurance options for Americans facing unique barriers to coverage. The President's budget also proposes $125 million – a down payment on a $1 billion investment over 5 years – to strengthen programs that provide health care directly to the uninsured.

Q: States are doing everything possible to decrease their Medicaid costs. What makes you think that states are going to take this new option, especially since there is no enhanced match associated with the proposal?

A: We think that the states are just as interested as we are in providing new coverage options to these women. The success of the S-CHIP program is the best example of states' readiness to take advantage of new options to provide access to health care for low income individuals. In addition, we are prepared to do everything possible to help states take advantage of this new opportunity.

MEDICAID COVERAGE FOR BREAST CANCER

+ KENNEDY - ESHOO (RECONSTRUCTIVE BREAST)

Schedule Proposal April 7, 1997

__Accept __Regret __Pending

TO: Stephanie Streett
Patti Solis Doyle

FROM: Gene Sperling
Maria Echaveste
Melanne Verveer
Betsy Myers

REQUEST: For the President and First Lady to participate in a South Lawn event with breast cancer advocates in town May 2nd and 3rd for the National Breast Cancer Coalition conference.

PURPOSE: (1) To highlight the President's great list of accomplishments in fighting breast cancer and his numerous FY 98 budget proposals addressing women's health generally.

(2) To take a leadership role in supporting breast cancer initiatives pending on the Hill and to help generate momentum behind passage of these measures.

(3) To highlight the First Lady's continued commitment to increasing the awareness of the importance of mammograms and to introduce a new PSA with the First Lady on mammograms.

BACKGROUND: The President and First Lady have taken a strong leadership role in fighting breast cancer throughout the Administration. Congress has joined the Administration in fighting this disease with a long list of legislative proposals that address several injustices in the health care system experienced by breast cancer patients, including drive through mastectomies. The President has already expressed support to end drive through mastectomies and he has indicated to women members of Congress that he would like to do a breast cancer event to back some of their other proposals.

At this event, attended by hundreds of survivors who all have dealt with the problems addressed by the legislation, he could call for passage of legislation to be determined; and further emphasize his commitment to increasing research dollars to fight breast cancer and women's health generally. Since the President took office, funding for breast cancer research, prevention and treatment has nearly doubled, from about $276 million in FY 1993 to over $500 million in the President's FY 1998 budget.

In addition, the First Lady would introduce her newest PSA, which highlights Medicare coverage of mammograms for women 65 and older; and challenge the private sector to join in this important education effort.

This event, attended by the President and First Lady, would be a powerful message near Mothers Day on how this Administration has made the fight against breast cancer a top priority.

DATE AND TIME: May 2nd and 3rd, when 600-700 breast cancer advocates are in Washington for a National Breast Cancer Coalition conference.

DURATION: 45 minutes

LOCATION: Greeting in Oval for special guests.
Event on South Lawn.

PARTICIPANTS: The audience would be women health care advocates, breast cancer survivors, persons from the medical community and the more than 500-600 advocates in town for the National Breast Cancer Coalition conference.

OUTLINE OF EVENTS: Oval Office greeting
Introduction of President by survivor on South Lawn
President's speech and introduction of the First Lady
First Lady's Speech

REMARKS REQUIRED: To be provided by Women's Office and Speechwriting

MEDIA COVERAGE: Open.

RECOMMENDED BY: Gene Sperling, Maria Echaveste, Melanne Verveer, Betsy Myers, Chris Jennings

CONTACT: Mary Dixon, 6-7300

ORIGIN OF PROPOSAL: Betsy Myers, 6-7300

Breast Cancer and Medicaid Coverage File

MEMORANDUM

April 16, 1998

TO: Chris and Jen

FR: Sarah B.

RE: Expanding Medicaid to Women in CDC Breast Cancer Screening Program

The National Breast Cancer Coalition has called to ask for the Administration to support legislation that would extend Medicaid coverage to women who have been diagnosed as having breast or cervical cancer by having been screened by the National Breast and Cervical Cancer Early Detection Program run by the CDC. The bill is scheduled to be introduced next Wednesday by Senators D'Amato, Snowe, Miluski, and Moynihan as well as Representative Kennelly and possibly others on the House side.

The CDC program, started in 1990, will receive $140 million in 1997 to screen low-income women (up to 250 percent of poverty) for breast and cervical cancer. So far it has screened over 500,000 women, found over 32,218 abnormal mammograms, and diagnosed 2,918 cases of breast cancer. Of those who have been diagnosed, 2,327 were under the age of 65 and therefore ineligible for Medicare. It has also provided 612,008 Pap tests and 24,434 were abnormal and 19,166 cases of cervical cancer were diagnosed.

How Women Diagnosed With Cancer Currently Receive Treatment

While there are currently no funds available in this program to treat women diagnosed with cancer, most of the women who have been diagnosed up to now have received treatment. In fact, CDC's data shows that 96 percent of positively diagnosed women have received treatment, usually in a timely manner. States have cobbled together various ways to extend treatment for these women. Because of the popularity of the CDC program, there have been private donations from organizations such as the Susan B. Komen Foundation as well as local efforts to raise money for these programs, such as Sororities and local businesses holding fundraisers, or providers agreeing to treat these women.

However, there are adverse consequences from this piecemeal approach. First, the states and the program itself are spending an inordinate amount of resources finding treatment for women with cancer. In fact, many doubt that as the program grows it will not be able to find a way to identify funds for all of women who need treatment. Moreover, a recent MMWR report released by CDC noted that some providers and many women have been reluctant to participate in the program because they fear they will not be able to pay for treatment if cancer is identified.

Legislative Proposal

This legislation provides Medicaid coverage for women who are diagnosed with breast or cervical cancer through the NBCCP program. This would be a state option and would allow the state to make treatment available during a period of presumptive eligibility. This proposal was passed through the Senate Finance Committee in June 1997. However, no action was taken in the House and the bill died in Committee. As you may recall, the National Breast Cancer Coalition did ask us to support this late in the balanced budget process. However, their request came during the final days of negotiations, and we were able to say no on the basis that we were not supporting any new provisions at that time because it would undermine the deal. The proposal has been scored by CBO as costing $100 million over five years.

Pros/Cons

Extending Medicaid coverage to these women would certainly ensure a more stable funding source to ensure that the women who enter this program receive treatment. CDC believes that it would free up many resources that are currently spent trying to find treatment for the women identified. There is also some precedence for this. Apparently, (I am still checking out) in 1993, we enacted the Tuberculuous Optional Benefit Program, which allowed states the option of expanding Medicaid to people with TB.

However, you are obviously well aware of the implications for the Medicaid program and the extent to which this would create a precedent to open up Medicaid disease by disease. While most of CDC's programs focus on education and outreach rather than screening for chronic diseases that sometimes require long term follow up care, there are other programs, such as cardiovascular and diabetes, that could benefit from a link to the Medicaid program. There are also other Federal programs, such as Ryan White, that expend a great deal of resources treating people with HIV/AIDS. While Ryan, unlike the CDC program, does not have any legislative barriers to providing treatment, clearly they could help more people if they could guarantee Medicaid as the payor of care. Moreover, there are many others diseases that do not have specific Federal public health programs associated with them but still would benefit from extending Medicaid. The current controversy over whether to extend Medicaid to people with HIV at an earlier stage in their disease is currently the most visible example.

There is also the question of whether it is good public policy to extend Medicaid only to women who have participated in a particular Federal program. While the CDC program does have a presence in all fifty states, it is certainly not available to all women who fit the income criteria. This policy would extend Medicaid to some women with breast cancer who are in a certain income bracket but not others who are at the same or perhaps at an even lower income bracket. The NBCC and CDC have explored (although I believe only briefly) other ways of assuring treatment for women in this program. One idea is to expand the funding for the program to assure treatment services. The program is currently not equipped to provide breast cancer treatment and while they could develop links to local providers, CDC is not currently equipped to be a payor for these women. That being said, there are probably creative ways that could be explored to create a more stable source of funding. The NBCC is interested in the Medicaid option in part because it is a stable source of funding that does not fall under discretionary caps.

The NBCC is coming into town in early May and they believe (from Audrey Haynes) that the First Lady may do something on their behalf while they are in town. How do we want to respond both to their request for support as they unveil the legislation next week as well as when (and if) the First Lady chooses to do something when they are in town? You should note that this issue is one of the three highest priorities for the NBCC. The first two are eliminating genetic discrimination and expanding coverage of cancer clinical trials. We have supported legislation and been highly visible on both of these issues and, as you well know, went out of our way to develop a cancer clinical trials proposal that was acceptable to the group.

PRESIDENT CLINTON AND FIRST LADY HILLARY RODHAM CLINTON PROMOTE SCREENINGS AND TREATMENT FOR BREAST, CERVICAL AND OTHER CANCERS
Highlights the Administration's Strong Record on Women and Children's Health
January 4, 2001

Today, President Clinton and First Lady Hillary Rodham Clinton will join advocates for women and families in a White House ceremony celebrating the enactment of the Breast and Cervical Cancer Act of 2000. The President will announce that the Health Care Financing Administration (HCFA) is releasing new guidance today to all 50 states advising them of how they can provide this important new health insurance option for thousands of low-income, uninsured women with breast cancer. President Clinton will also release an executive memorandum directing all Federal agencies to make at least four hours of leave available each year for employees to receive important health screenings for cancer and other preventable diseases. In addition, First Lady Hillary Rodham Clinton will highlight the recently enacted Children's Health Act of 2000, which promotes research on children's health issues, as the latest step in the Administration's strong record on women and children's health.

TREATMENT OPTIONS FOR LOW-INCOME UNINSURED WOMEN DIAGNOSED WITH BREAST OR CERVICAL CANCER ARE LIMITED. The National Breast and Cervical Cancer Early Detection Program provides breast and cervical cancer screening to over 360,000 women without access to these services annually. Although Federal government-sponsored screening programs make every effort to assist individuals diagnosed with disease to access treatment, thousands of women still face financial barriers to care, and those that receive some help frequently do not receive comprehensive coverage for services they need.

PRESIDENT CLINTON ENCOURAGES STATES TO PROVIDE NEW INSURANCE OPTION FOR VULNERABLE WOMEN WITH BREAST AND CERVICAL CANCER. Today, the President announced that HCFA is sending guidance to all 50 states encouraging them to take advantage of the Breast and Cervical Cancer Act of 2000. This new option, which costs $995 million over 10 years and was originally included in the President's FY 2001 Budget, will allow states to provide women diagnosed with cancer through the National Breast and Cervical Cancer Early Detection Program with access to insurance that covers critical treatment services. The guidance being issued today will clarify that the new law will:

- **Provide immediate, comprehensive health insurance to low-income, uninsured women diagnosed with breast and cervical cancer.** States have the option to provide the full Medicaid benefit package, at an enhanced Federal matching rate, to uninsured women diagnosed with breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program. They will be eligible for this benefit throughout the duration of their treatment, eliminating financial barriers to care for these women. These women will be able to access critical health care services necessary to treat their cancer, including radiation treatment, chemotherapy, as well as other health care services, such as basic laboratory and palliative care services, in order to provide a high quality standard of care to these patients.

- **Allow women to access life saving treatment without delay.** The guidance will make clear that states also have the option to allow health care providers and other qualified entities to provide critical health care services to women pending official enrollment in Medicaid, increasing the chances of survival for these women and allowing them to focus on fighting these terrible diseases – not about how they will pay for their care.

- **Result in increased state spending on breast and cervical cancer screening programs.** Some states currently supplement the Federal funds they receive for breast and cervical cancer with their own funds for diagnosis and treatment of these diseases. Estimates indicate that, under similar proposals, states would redirect these funds to supplement their investment in screening for breast and cervical cancer, resulting in a substantial increase in the number of mammograms and pap smears provided.

UNDETECTED AND UNTREATED CANCER CONTINUE TO HARM AMERICANS. Despite recent improvements in prevention and treatment, cancer remains the second leading cause of deaths in the United States. For women age 50-69, regular mammograms can reduce the chance of death from breast cancer by approximately 30 percent. Even in women age 40-50, regular mammograms can reduce mortality rates by approximately 17 percent. Because colorectal cancers grow slowly, early detection significantly increases survival. When detected early, the five-year survival rate is 90 percent. However, less than 40 percent of colorectal cancers are discovered at that stage. After the cancer has spread, the five-year survival rate drops to 65 percent. Preventive screenings and early detection, however, are not effective if patients cannot afford the treatment. Women without health insurance are 40 percent more likely to die from breast cancer than insured women since they are likely to get needed care.

PRESIDENT CLINTON TAKES NEW EXECUTIVE ACTION TO EXPAND ACCESS TO PREVENTIVE CARE FOR FEDERAL EMPLOYEES. Today, President Clinton will issue an executive memorandum that ensures that all 1.8 million Federal employees have access to leave benefits enabling them to access preventive screenings. This executive memorandum, which is another contribution towards the Administration's success in making the Federal government a model employer, will direct all Federal departments and agencies to:

- **Ensure that all Federal employees have at least four hours of leave available annually for preventive screenings.** The President will direct agencies to encourage employees to take advantage of screening programs and other preventive health services through options like promoting alternative work schedules; granting leave under the sick and annual leave programs; and granting excused absence to employees to participate in agency-sponsored preventive health activities. In addition, for employees with fewer than two weeks of accrued sick leave, agencies will provide up to four hours of excused absence each year, without loss of pay or charge to leave, for participation in preventive health screenings.

- **Develop and expand worksite health promotion and disease prevention programs.** Recognizing that the workplace is an effective place to provide information on preventive health care, the President will ask Federal agencies to develop or expand programs that help employees understand their risks for disease, obtain preventive health services, and make healthy lifestyle choices. Program information will be shared with the Office of Personnel Management, which will promote best practices.

PRESIDENT CLINTON AND FIRST LADY HILLARY CLINTON HIGHLIGHT NEW INVESTMENT IN RESEARCH AND TREATMENT FOR CHILDREN'S HEALTH. Today, the President and First Lady will highlight the importance of the Children's Health Act of 2000. This important legislation expands, and coordinates research, prevention, and treatment activities for conditions having a significant impact on children, including autism, diabetes, asthma, hearing loss, epilepsy, traumatic brain injury, infant mortality, lead poisoning, and oral health. The legislation: establishes eight Centers of Excellence to promote research on the cause, diagnosis, early detection, prevention, and treatment of autism; promotes training of pediatric specialists; authorizes new research provisions, including a long-term child development study on environmental influences on children's health and a loan repayment program at NIH for health professionals doing pediatric research; and authorizes the Healthy Start program for the first time.

THE CLINTON-GORE ADMINISTRATION'S STRONG RECORD ON WOMEN'S HEALTH. The Clinton-Gore Administration has a strong record on women and children's health issues. The Clinton-Gore Administration has worked tirelessly to improve women's health, including ensuring the inclusion of women in clinical trials, more than doubling funding for breast cancer research, expanding Medicare coverage of mammograms, ending drive-through deliveries, and passing and reauthorizing the Violence Against Women Act (VAWA). The Administration has also taken strong steps to protect a woman's right to choose and promote women's reproductive health by securing historic increases in domestic and international family planning funding, providing contraceptive coverage to more than a million women covered by federal health plans, reversing the gag rule, and enacting the Freedom of Access to Clinic Entrances Act (FACE).

DRAFT File Breast Cancer: CDC

THE NATIONAL BREAST AND CERVICAL CANCER CONTROL PROGRAM (NBCCP)

The NBCCP Program

- **In 1990, Congress enacted the National Breast and Cervical Cancer Control Program** (NBCCP) into law (P.L. 101-354), enabling states to provide screening services for breast and cervical cancer to women with no other source of payment for such services.

- **The program is administered by the Centers for Disease Control** (CDC), and works in partnership with local health agencies and community partners, providing education, follow-up, and diagnostic services. NBCCP serves older women, women with low income, uninsured or underinsured women, and women of racial/ethnic minority groups who qualify.

- **In 1997, Congress appropriated $140 million for NBCCP.**

- **Not all state programs are fully functioning.** Nevertheless, the NBCCP has a presence in all 50 states, the District of Columbia, and 13 American Indian/Alaska Native organizations.

The Women Receiving Screening Services

By September, 1997, the NBCCP program had provided mammography screening to:

- 506,673 women aged 40 years and older.

- Found that 32,218 (6.5%) mammograms were abnormal.

- Diagnosed 2,918 cases of breast cancer.

- **Of those diagnosed with breast cancer, 2,327 were under 65 years of age, and therefore ineligible for Medicare.**

A "Cruel Irony": No Coverage for Treatment

- **2.6 million women are living with breast cancer:** every 3 minutes another woman is diagnosed and every 11 minutes another woman dies of breast cancer. There is no cure or known cause for breast cancer.

- **The NBCCP program as enacted provides funding only for mammography screening.** Only recently did CDC agree to cover diagnostic services—services necessary to determine whether or not a woman has breast cancer. But there is no federal funding or

program for treating the 2,327 who have been screened and diagnosed with breast cancer. This is a cruel and heartbreaking irony.

- **The sad truth is that treatment is provided in an ad-hoc and unreliable manner.** Although health agencies at the state level have found creative ways to help women find treatment, these networks are overloaded and breaking down. Women are forced to rely on charity care, donated services, bake sales, and in some cases dwindling state funds in order to pay for their treatment.

- **As the program reaches out to screen more women, these pieced-together networks are breaking down.**

- **The lack of financial support for treatment is hurting the NBCCP Program.** Time and effort required to arrange for treatment services diverts resources away from screening activities. As a result fewer women are being screened—the program serves only 12% to 15% of age-eligible, uninsured women nationally.

A Long-term Solution: Covering Treatment Costs

- **The National Breast Cancer Coalition believes that women shouldn't have to hold bake sales in order to fund treatment.** The NBCCP program is inadequate and has stranded the women it set out to serve, that is, those with no other source of payment. It is irresponsible of the federal government to enact a federal program that does not guarantee to women who have been screened and found to have breast cancer—the resources to get appropriate treatment.

- **Medicaid is the answer.** Congress should allow states the option of providing Medicaid coverage to women who have participated in the NBCCP program and have been diagnosed with breast cancer.

- **There is a precedent for covering participants in the NBCCP program under Medicaid.** In 1993, Congress created the Tuberculous Optional Benefit Program, making individuals who are infected with tuberculosis eligible for Medicaid.

- **The budgetary implication of covering women participants under Medicaid is a small cost to pay to save lives.** It is estimated that this provision would increase Medicaid costs by $100 million over five years.

- **The Senate Finance Committee supports the National Breast Cancer Coalition effort.** In June, 1997, the Senate passed a provision which would provide Medicaid coverage for women who had been diagnosed with breast or cervical cancer through the NBCCP program. But no action was taken by the House and the provision died in Committee review.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control
and Prevention (CDC)

Memorandum

Date March 26, 1998

From Rosemarie Henson, M.P.H., M.S.S.W., Chief, Program Services Branch, DCPC, CDC

Subject Re: Multi-Site Case Study Results

To Partners of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

Please find attached the MMWR article on *Results from a Multi-site Case Study* component of the *Follow-up and Treatment Services in the National Breast and Cervical Cancer Early Detection Program.*

HIV Counseling and Testing — Continued

ing that persons who receive preliminary results understand the meaning of the result and prefer rapid testing (*4*). When additional rapid tests become available for use in the United States, the PHS will re-evaluate algorithms using specific combinations of two or more rapid tests for screening and confirming HIV infection.

References

1. Kamb ML, Bolan G, Zenilman J, et al. Does HIV/STD prevention counseling work? Results from a multi-center randomized trial (Project Respect) [Abstract 0134] In: Program and abstracts of the International Congress of Sexually Transmitted Diseases. Seville, Spain: Association for Research in Clinical Microbiology, 1997:83.
2. CDC. HIV counseling and testing in publicly funded sites: 1995 summary report. Atlanta: US Department of Health and Human Services, CDC, September 1997.
3. George JR, Schochetman G. Detection of HIV infection using serologic techniques in AIDS testing: a comprehensive guide to technical, medical, social, legal, and management issues. 2nd ed. Schochetman G, George JR, eds. New York: Springer-Verlag, 1994.
4. Kassler WJ, Dillon BA, Haley C, Jones WK, Goldman A. On-site, rapid HIV testing with same-day results and counseling. AIDS 1997;11:1045–51.
5. CDC. Interpretation and use of the Western blot assay for serodiagnosis of human immunodeficiency virus type 1 infections. MMWR 1989;38(suppl 7):S4–S8.
6. Stetler HC, Granade TC, Nuñez CA, et al. Field evaluation of rapid HIV serologic tests for screening and confirming HIV-1 infection in Honduras. AIDS 1997;11:369–75.
7. Kassler WJ, Haley C, Jones WK, Gerber AR, Kennedy EJ, George JR. Performance of a rapid, on-site human immunodeficiency virus antibody assay in a public health setting. J Clin Microbiol 1995;33:2899–902.

Strategies for Providing Follow-Up and Treatment Services In the National Breast and Cervical Cancer Early Detection Program — United States, 1997

The Breast and Cervical Cancer Mortality Prevention Act of 1990* authorized CDC to establish the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) to increase screening services for women at low income levels who are uninsured or underinsured (*1*). Although the NBCCEDP covers most diagnostic services that women need after receiving an abnormal mammography or Papanicolaou (Pap) test result, the program does not reimburse for breast biopsies. In addition, the Act prohibits the use of NBCCEDP funds for cancer treatment. Participating health agencies must ensure that NBCCEDP clients receive timely, appropriate diagnostic and treatment services. In 1996, CDC began a case study to determine how early detection programs in seven participating states (California, Michigan, Minnesota, New Mexico, New York, North Carolina, and Texas) identified resources and obtained diagnostic and treatment services. This report summarizes the results of the study (*2*), which indicate that respondents in these states reported that treatment had been initiated for almost all NBCCEDP clients in whom cancer was diagnosed. However, respondents also considered the strategies used to obtain these services as short-term solutions that were labor-intensive and diverted resources away from screening activities.

In the seven states, NBCCEDP-sponsored screening services had been provided for ≥3 years, and breast cancer had been diagnosed in ≥60 women. The states were se-

*Public Law 101-354.

National Breast and Cervical Cancer Early Detection Program — Continued

lected to provide a range of geographic locations, a combination of urban and rural populations, and racial/ethnic diversity among program clients. Researchers conducted semi-structured interviews with 192 persons affiliated with the seven state programs. Of these interviewees, 120 (63%) were providers of screening, diagnostic, and/or treatment services; 58 (30%) were state program staff; and 14 (7%) were coalition members. Interviews included topics such as guidelines related to diagnostic and treatment services, strategies used to obtain and pay for services, level of effort required to secure these services, and changes in strategies over time. Each interview was tape recorded and transcribed. Using a systematic scheme derived from the research questions, three researchers coded the same transcripts until an inter-rater agreement of 80% was reached. Thereafter, all transcripts were coded independently. Coding results were entered into text analysis software that sorts text from transcripts into sets of information, themes, and evidence relevant to the specific research questions (*3*). The results reflect a synthesis of the interviewees' responses.

Respondents described several strategies used to ensure necessary diagnostic and treatment services for women screened through the NBCCEDP. State-level strategies in all states included 1) computerized tracking and follow-up systems that used program surveillance data to identify and manage clients in need of diagnostic and treatment services; 2) provisions in contracts requiring screening providers to arrange for diagnostic follow-up and treatment before screening women; and 3) arrangements with provider groups and state professional associations for free or reduced-cost services for NBCCEDP clients. All states also had access to public or private funds to help support services not covered by the program; such revenue sources included state appropriations from general or tobacco tax revenues or funds from private foundations. These funds were available primarily for breast diagnostic services.

Local strategies tailored to the needs of individual clients were used to obtain diagnostic and treatment services. Common strategies reported by respondents included the following: providers billed public or private insurance plans; providers or local health departments helped clients apply for public assistance programs; providers referred clients to public hospitals; county indigent-care funds and hospital community-benefit programs financed services; clients received services through individually negotiated payment plans; and clients paid reduced or full fees for services.

Respondents strongly supported the continued growth of NBCCEDP and its goals but expressed several concerns. First, considerable time and effort were involved in developing and maintaining systems for diagnostic follow-up and treatment. Second, the process of identifying available resources within states for diagnostic and treatment services was considered labor-intensive. Third, the lack of coverage for diagnostic and treatment services negatively affected recruitment of providers and restricted the number of women screened. Fourth, respondents believed that an increasing number of physicians will not have the autonomy, because of changes in the health-care system, to offer free or reduced-fee services to NBCCEDP clients.

Respondents reported that arrangements for treatment were made for almost all NBCCEDP clients who received a diagnosis of breast cancer or invasive cervical cancer. Respondents stated that some women experienced time delays between screening, definitive diagnosis, and initiation of treatment. State program officials reported that, according to 1992–1998 surveillance data, small numbers of clients in whom cancer was diagnosed (i.e., from three to 13 women in each state) subsequently refused

National Breast and Cervical Cancer Early Detection Program — Continued

treatment. Because these clients were not interviewed, it could not be determined whether financial barriers contributed to their decisions to refuse treatment or their loss to follow-up.

Respondents were concerned that the NBCCEDP did not provide funding for all diagnostic procedures and treatment for the diseases for which clients were being screened; approaches for delivering services were fragmented; and the process of obtaining resources required substantial effort at the state, local, and provider levels. Respondents reported that the continuation of every strategy for diagnostic and treatment services beyond the next few years is uncertain.

Reported by: PM Lantz, PhD, Univ of Michigan School of Public Health, Ann Arbor. LE Sever, PhD, Battelle, Centers for Public Health Research and Evaluation, Seattle, Washington. Program Svcs Br, Office of the Director, Div of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: During July 1991–March 1997, the NBCCEDP provided 576,408 mammograms to women aged ≥40 years, and 3409 cases of breast cancer were diagnosed. During this same period, the program provided 732,754 Pap tests; 23,782 cases of cervical intraepithelial neoplasia and 303 cases of invasive cervical cancer were diagnosed. These totals included women referred to the program for diagnostic evaluation of an abnormal screening result. The NBCCEDP internal estimates suggested that during this period only 12%–15% of uninsured women aged 40–64 years in the United States had been screened by the program (CDC, unpublished data, 1997).

Screening alone does not prevent cancer deaths; it must be coupled with timely and appropriate diagnostic and treatment services. The Congressional mandate for NBCCEDP requires grantees to take all appropriate measures to ensure provision of services required by women who have abnormal screening results. CDC provides funds for case management to help these women access health-care services. To increase the comprehensive nature of the program, CDC recently approved the use of NBCCEDP funds for breast biopsies.

The results of this study indicate that state health departments and their partners in the seven states had developed a wide range of strategies for diagnostic and treatment services in the absence of program resources. However, the time and effort required to arrange and maintain these services diverted resources away from screening activities.

This study was subject to at least two limitations. First, the results were based solely on the experience and opinions of informed professionals affiliated with the program and did not include the perspectives of NBCCEDP clients. Second, the results may not reflect the program experiences in other states. Case-study methods, however, are an appropriate and well-accepted approach to gaining in-depth understanding of complex programs in real-life situations (4). The validity of the findings was enhanced by developing standard instruments to guide the semi-structured interviews, protecting the confidentiality of respondents' remarks, using interview transcripts for data analysis rather than relying on interviewer notes, and obtaining feedback concerning state summary reports from respondents.

As more women are screened by the NBCCEDP, a greater burden will be placed on participating health agencies, providers, and other partners to obtain resources for breast and cervical cancer treatment. Case-management services will continue to be essential in helping underserved women overcome financial, logistical, and other bar-

National Breast and Cervical Cancer Early Detection Program — Continued

riers to receiving these services. Other long-term solutions to ensure that women in the program receive necessary treatment services are being pursued.

References

1. Hanson RM, Wyatt SW, Lee NC. The National Breast and Cervical Cancer Early Detection Program: a comprehensive public health response to major health issues for women. J Public Health Management and Practice 1996;2:36–47.
2. Lantz PM, Macklem DJ, Hare M, Richardson LC, Sever LE, Orians CE. Follow-up and treatment issues in the National Breast and Cervical Cancer Early Detection Program: results from a multiple-site case study—final report. Baltimore: Battelle, Centers for Public Health Research and Evaluation, 1997.
3. Miles MB, Huberman MA. Qualitative data analysis: an expanded sourcebook. 2nd ed. Thousand Oaks, California: Sage, 1994.
4. Yin RK. Case study research: design and methods. Sage: Newbury Park, 1989.

Notice to Readers

World Health Day — April 7, 1998

"Invest in the Future: Support Safe Motherhood" is the theme in the United States for World Health Day, April 7, 1998. In the United States, this day will focus on the continued importance of maternal health and opportunities to improve this aspect of women's health. Although the risk for women dying from pregnancy has decreased substantially during the past 50 years, the maternal mortality ratio for the nation has not decreased since 1982 (*1*). Approximately 50% of pregnancy-related deaths remain preventable (*2*), and the extent of morbidity associated with pregnancy is often unrecognized.

Safe motherhood begins before pregnancy with healthy lifestyles that include good nutrition, physical activity, preconception care, and avoidance of harmful substances. Safe motherhood continues with planned pregnancies; early, quality prenatal care; knowledge of warning signs of problems; and the delivery of a healthy, full-term baby with the minimum of necessary interventions. Postpartum support for women and their families in a positive, nurturing environment also is important.

In 1998, in the United States, women can plan, carry, and deliver a pregnancy more safely than in the past. However, additional efforts need to be taken to make safe motherhood a reality for all women. Improved public health surveillance, prevention research, and prevention programs are needed to continue improving the health of women before, during, and after pregnancy and delivery. Examples include new surveillance methods to monitor and understand pregnancy complications; prevention research on the essential content of prenatal care; and prevention programs to ensure the adequate intake of folic acid by women of reproductive age to prevent neural tube defects (*3*).

The World Health Day Advisory Committee of the American Association for World Health coordinates World Health Day activities in the United States. Additional information about special events and resource materials about World Health Day 1998 are available from the American Association for World Health, 1825 K Street, N.W., Suite 1208, Washington, DC 20006; e-mail: AAWHstaff@aol.com; or from the World-Wide Web site: http://www.aawhworldhealth.org.

105TH CONGRESS
2D SESSION

S. _____

IN THE SENATE OF THE UNITED STATES

Mr. D'AMATO introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To amend title XIX of the Social Security Act to provide breast and cervical cancer treatment services to certain women screened and found to have breast or cervical cancer under a Federal screening program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION. 1. OPTIONAL MEDICAID COVERAGE OF CDC-SCREENED BREAST OR CERVICAL CANCER PATIENTS.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(1) in subclause (XIII), by striking "or" at the end;

(2) in subclause (XIV), by adding "or" at the end; and

(3) by adding at the end the following:

"(XV) who are described in subsection (aa)(1) (relating to certain CDC-screened breast or cervical cancer patients);".

(b) GROUP AND BENEFIT DESCRIBED.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following:

"(aa)(1) Individuals described in this paragraph are individuals not described in subsection (a)(10)(A)(i) who—

"(A) have not attained age 65;

"(B) have been diagnosed with breast or cervical cancer through participation in the program to screen women for breast and cervical cancer conducted by the Director of the Centers for Disease Control and Prevention under title 15 of the Public Health Service Act (42 U.S.C. 300k et seq.);

"(C) satisfy the income and resource eligibility criteria established by such Director for participation in such program; and

1 "(D) do not otherwise have health insurance
2 coverage, including coverage through eligibility for
3 medical assistance under the State plan under this
4 title.
5 "(2) For purposes of subsection (a)(10), the term
6 'breast or cervical cancer-related services' means services
7 that are medically necessary or appropriate for the treat-
8 ment of breast or cervical cancer and complications arising
9 from such treatment.".
10 (c) PRESUMPTIVE ELIGIBILITY.—
11 (1) IN GENERAL.—Title XIX of the Social Se-
12 curity Act is amended by inserting after section
13 1920A the following:
14 "PRESUMPTIVE ELIGIBILITY FOR CERTAIN CDC-
15 SCREENED BREAST OR CERVICAL CANCER PATIENTS
16 "SEC. 1920B. (a) A State plan approved under sec-
17 tion 1902 may provide for making breast or cervical can-
18 cer-related services available to an individual described in
19 described in section 1902(aa)(1) (relating to certain CDC-
20 screened breast or cervical cancer patients) during a pre-
21 sumptive eligibility period.
22 "(b) For purposes of this section:
23 "(1) The term 'breast or cervical cancer-related
24 services' has the meaning given such term in section
25 1902(aa)(2).

1 "(2) The term 'presumptive eligibility period'
2 means, with respect to an individual described in
3 subsection (a), the period that—
4 "(A) begins with the date on which a
5 qualified entity determines, on the basis of pre-
6 liminary information, that the individual is eli-
7 gible under the State plan for breast or cervical
8 cancer-related services, and
9 "(B) ends with (and includes) the earlier
10 of—
11 "(i) the day on which a determination
12 is made with respect to the eligibility of
13 such individual for such services under the
14 State plan, or
15 "(ii) in the case of such an individual
16 who does not file an application by the last
17 day of the month following the month dur-
18 ing which the entity makes the determina-
19 tion referred to in subparagraph (A), such
20 last day.
21 "(3)(A) Subject to subparagraph (B), the term
22 'qualified entity' means any entity that—
23 "(i)(I) is eligible for payments under a
24 State plan approved under this title and pro-

1 vides breast or cervical cancer-related services;
2 and
3 "(ii) is determined by the State agency to
4 be capable of making determinations of the type
5 described in paragraph (2)(A).
6 "(B) The Secretary may issue regulations fur-
7 ther limiting those entities that may become quali-
8 fied entities in order to prevent fraud and abuse and
9 for other reasons.
10 "(C) Nothing in this section shall be construed
11 as preventing a State from limiting the classes of en-
12 tities that may become qualified entities, consistent
13 with any limitations imposed under subparagraph
14 (B).
15 "(c)(1) The State agency shall provide qualified enti-
16 ties with—
17 "(A) such forms as are necessary for an appli-
18 cation to be made by an individual described in sub-
19 section (a) for breast or cervical cancer-related serv-
20 ices under the State plan, and
21 "(B) information on how to assist such individ-
22 uals in completing and filing such forms.
23 "(2) A qualified entity that determines under sub-
24 section (b)(2)(A) that an individual described in sub-

1 section (a) is presumptively eligible for breast or cervical
2 cancer-related services under a State plan shall—
3 "(A) notify the State agency of the determina-
4 tion within 5 working days after the date on which
5 determination is made, and
6 "(B) inform such individual at the time the de-
7 termination is made that an application for breast or
8 cervical cancer-related services under the State plan
9 is required to be made by not later than the last day
10 of the month following the month during which the
11 determination is made.
12 "(3) In the case of an individual described in sub-
13 section (a) who is determined by a qualified entity to be
14 presumptively eligible for breast or cervical cancer-related
15 services under a State plan, the individual shall apply for
16 such services under such plan by not later than the last
17 day of the month following the month during which the
18 determination is made.
19 "(d) Notwithstanding any other provision of this title,
20 breast or cervical cancer-related services that—
21 "(1) are furnished to an individual described in
22 subsection (a)—
23 "(A) during a presumptive eligibility pe-
24 riod,

1 "(B) by a entity that is eligible for pay-
2 ments under the State plan; and
3 "(2) are included in the care and services cov-
4 ered by a State plan;
5 shall be treated as breast or cervical cancer-related serv-
6 ices (as so defined) provided by such plan for purposes
7 of section 1903(a)(8).".
8 (2) CONFORMING AMENDMENTS.—
9 (A) Section 1902(a)(47) (42 U.S.C.
10 1396a(a)(47)) is amended by inserting before
11 the semicolon at the end the following: "and
12 provide for making breast or cervical cancer-re-
13 lated services (as defined in section
14 1902(aa)(2)) available to individuals described
15 in section 1920B(a) during a presumptive eligi-
16 bility period in accordance with such section".
17 (B) Section 1903(u)(1)(D)(v) (42 U.S.C.
18 1396b(u)(1)(D)(v)) is amended—
19 (i) by striking "or for" and inserting
20 ", for"; and
21 (ii) by inserting before the period the
22 following: ", or for breast or cervical can-
23 cer-related services (as defined in section
24 1902(aa)(2)) provided to an individual de-
25 scribed in section 1920B(a) during a pre-

1 sumptive eligibility period under such sec-
2 tion".
3 (d) ENHANCED MATCH. -Section 1903(a) of the So-
4 cial Security Act (42 U.S.C. 1396b(a)) is amended—
5 (1) in paragraph (7), by striking the period and
6 inserting "; plus"; and
7 (2) by adding at the end the following:
8 "(8) an amount equal to 90 per centum of the
9 sums expended during such quarter which are at-
10 tributable to the furnishing of breast or cervical can-
11 cer-related services (as described in section
12 1902(aa)(2)) to individuals described in section
13 1902(aa)(1).".
14 (e) LIMITATION ON BENEFITS.—Section 1902(a)(10)
15 (42 U.S.C. 1396a(a)(10)) is amended in the matter follow
16 ing subparagraph (F)—
17 (1) by striking "and (XIII)" and inserting
18 "(XIII)"; and
19 (2) by inserting before the semicolon at the end
20 the following: ", and (XIV) the medical assistance
21 made available to an individual described in sub-
22 section (aa)(1) who is eligible for medical assistance
23 only because of subparagraph (A)(ii)(XV) shall be
24 limited to medical assistance for breast or cervical

1 cancer-related services (as described in subsection
2 (aa)(2))".
3 (f) CONFORMING AMENDMENTS.—
4 (1) Section 1905(a) (42 U.S.C. 1396d(a)) is
5 amended—
6 (A) in clause (x), by striking "or" at the
7 end;
8 (B) in clause (xi), by adding "or" at the
9 end;
10 (C) by inserting after clause (xi) the fol-
11 lowing:
12 "(xii) individuals described in section
13 1902(aa)(1),";
14 (D) by striking "and" at the end of para-
15 graph (26);
16 (E) by redesignating paragraph (27) as
17 paragraph (28); and
18 (F) by inserting after paragraph (26) the
19 following:
20 "(27) breast or cervical cancer-related services
21 described in section 1902(aa)(2); and".
22 (g) EFFECTIVE DATE.—The amendments made by
23 this section apply to medical assistance furnished on or
24 after October 1, 1998, without regard to whether or not

1 final regulations to carry out such amendments have been
2 promulgated by such date.