

**SB**

**38**

**(File 2)**

# FISCAL NOTE

STATE OF ALASKA  
2001 LEGISLATIVE SESSION

Fiscal Note Number: I CORRECTED  
Bill Version: SB 38  
(S) Publish Date: 1/17/01

Revisor: Date/Time (Note if correction): \_\_\_\_\_ Dept. Affected: Health & Social Services  
Title: Relating to eligibility of certain women screened BRU: Medical Assistance Adm  
to have breast and cervical cancer for Medicaid Component: Medicaid State Programs  
Sponsor: Rules  
Requester: \_\_\_\_\_ Component Number: 967

## Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	589.2	636.3	687.2	742.2	801.6	865.7
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>589.2</b>	<b>636.3</b>	<b>687.2</b>	<b>742.2</b>	<b>801.6</b>	<b>865.7</b>

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ( )						
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FUND SOURCE	(Thousands of Dollars)					
1002 Federal Receipts	413.4	446.5	482.2	520.8	562.5	607.5
1003 GF Match	175.8	189.8	205.0	221.4	239.1	258.2
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
<b>TOTAL</b>	<b>589.2</b>	<b>636.3</b>	<b>687.2</b>	<b>742.2</b>	<b>801.6</b>	<b>865.7</b>

Estimate of any current year (FY2001) cost: 0.0

POSITIONS						
Full-time						
Part-time						
Temporary						

**ANALYSIS:** *(Attach a separate page if necessary)*

Legislation recently adopted by Congress creates a new Medicaid eligibility group for women diagnosed with cancer who were screened under the Breast and Cervical Cancer Detection Program funded through the Centers for Disease Control. Medicaid eligibility for these women lasts through treatment and includes all Medicaid covered services. The four grantees in Alaska diagnosed 39 women with breast cancer and 33 women with cervical cancer last year. Sixty-one percent of the breast cancer patients and eighteen percent of the cervical cancer patients were Alaska Native. Alaska Native women are not eligible for coverage under this option as they have creditable health insurance coverage as defined in the Public Health Service Act. Average Medicaid expenditures in FY 00 for women treated with these cancers were \$17,500 and \$12,100 respectively. Assumptions for this fiscal note were a federal match rate of 70.17 percent for FY02 (the State Children's Health Insurance match rate) and an eight percent growth rate for each succeeding year.

Prepared by: Nancy Weller, State Federal and Tribal Relations Phone 465-3355  
 Division: Medical Assistance Date/Time 1/5/01 2:42 PM  
 Approved by: Karen Gardner, State Auditor Date 1/8/01  
 Agency: Department of Health and Social Services

For distribution information, call the Governor's Legislative Office

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312

22-GH1073V  
Lauterbach  
4/30/01

**SENATE CS FOR CS FOR HOUSE BILL NO. 65( )**  
**IN THE LEGISLATURE OF THE STATE OF ALASKA**  
**TWENTY-SECOND LEGISLATURE - FIRST SESSION**

BY

Offered:  
Referred:

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

**A BILL**

**FOR AN ACT ENTITLED**

1 **"An Act relating to a new optional group of persons eligible for medical assistance who**  
2 **require treatment for breast or cervical cancer; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 \* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section  
5 to read:

6 **ADDITIONAL PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE.** (a) In  
7 addition to the other persons listed under AS 47.07.020(b), persons who have been diagnosed  
8 with breast or cervical cancer and who are eligible for coverage under 42 U.S.C.  
9 1396a(a)(10)(A)(ii)(XVIII) are eligible under AS 47.07.020(b) for medical assistance, subject  
10 to other provisions of AS 47.07.020.

11 (b) It is the intent of the legislature that not more than \$175,800 of general fund  
12 money be spent on services under (a) of this section for fiscal year 2002 and that not more  
13 than \$189,500 of general fund money be spent on services under (a) of this section for fiscal  
14 year 2003.

1 \* **Sec. 2.** The uncodified law of the State of Alaska is amended by adding a new section to  
2 read:

3 REPORT TO THE LEGISLATURE. The Department of Health and Social Services  
4 shall report to the legislature by the 30th day of the Second Regular Session of the Twenty-  
5 Second Alaska State Legislature and by the 30th day of the First Regular Session of the  
6 Twenty-Third Alaska State Legislature on the following matters:

7 (1) the environmental, behavioral, or genetic factors that have been associated  
8 with the onset of the types of breast or cervical cancer diagnosed in the persons eligible for  
9 services under sec. 1 of this Act in peer-reviewed clinical studies published in periodical  
10 medical literature that have postulated an association between one or more of these factors  
11 and an increase in the incidence of breast or cervical cancer; and

12 (2) recommendations, if any, about behavioral actions that may reduce the  
13 occurrence or likelihood of these types of breast or cervical cancers.

14 \* **Sec. 3.** This Act is repealed two years after the effective date of this Act.

15 \* **Sec. 4.** This Act takes effect immediately under AS 01.10.070(c).

Senator Lyda Green  
Alaska State Senate  
Juneau, Alaska

Dear Ms. Green,

It is a difficult thing for me to publicly testify in support of Senate Bill 38.. I am not afraid to testify; I have done it before. It brings to focus a personal experience that I am trying to put behind me.

A year and a half ago I went for a routine mammogram and my life changed completely. I had a lumpectomy followed by radiation. It sounds so easy to say, but it is definitely not an easy experience.

What I want to talk about today is what a diagnosis of cancer does to a person's emotional well being. I have always been a pretty level person, one who takes crisis, stress, and pressure in stride. I was in no way prepared for the emotional devastation a breast cancer diagnosis would bring me. It has taken me a year and a half of daily yoga, quitting a high pressure job for a half time one, and a lot of sleepless nights to begin to get back to "normal". After years of non use my tear ducts have had a real work out.

This experience has been hard on my family also. Seeing a woman who had always been a strong, positive person; one they had depended upon to be the level influence in their lives, become so emotionally and physically devastated was very difficult. Through it all I had tremendous support from a loving husband, all of my adult children, many friends and extended family; and thanks to their support and to good medical care, I am cancer free and nearly back to being the person I was.

What I simply cannot imagine is someone going through this without the support system I had. And I never had to think about the money! If I had had that added worry I would probably never have been able to come before you today to add my voice in support of this bill. I would just not have been strong enough emotionally. How someone can deal with all of the emotional and physical ups and downs of this disease and still have to worry about how to pay for treatment is something I cannot understand.

Thank you for considering this important legislation. It won't save women from breast or cervical cancer, but it will help them fight the tremendous battle that they must personally face.

Sincerely,



Sue Oliphant  
2155 Fritz Cove Road  
Juneau, AK 99801

(907) 789-1384  
suesandy@AK.net

Testimony of Kathleen A Coleman  
April 27, 2001

All the roads of my life have led me to this moment.

As an Environmental Scientist in New Mexico in the 1970s I was assigned to write a press release encouraging women to get mammograms. At that time early detection was the most accurate method for detecting for breast cancer. The odds of getting breast cancer in the life time of a women was 1 in 12 or 13. In the 1980s as a Health Physicist I made a presentation at a women's health forum at the Washington State Capitol encouraging women to get mammmograms, at that time breast cancer was identified as an epidemic. In the 1990s I administered Alaska's contract with the US FDA to assure standardized quality for mammograms. In this milliniem, mammograms are still the most reliable method to detect breast cancer, the odds of getting breast cancer in the lifetime of a woman has risen to 1 in 7 or 8.

For me, now breast cancer has a uniquely personal face to it. I have become one of those statistics. Before I left state government in 1998 an abnormality was detected on my mammogram. The radiologist said no additional action was required at that time but that I should continue with mammograms on a six month basis. When I left state service I took a different insurance policy. When the new policy arrived about a month after I left state service a rider had been placed on the policy stating the policy would never cover any breast issues.

Fast forward to summer 2000, under the Alaska Breast and Cervical Cancer Early Detection Program (BCCEDP), I was diagnosed with invasive ductal carcinoma—rather common breast cancer. The surgeon that performed the biopsy advised I had about three weeks to be on my way to some type of treatment. Without insurance I was abruptly alone in learning all there is to know about my disease, what treatments are available and how to finance those treatments. Without insurance I was not referred anywhere. This is clearly a position no one wants to find themselves in. I read everything on the web. Doctors charge \$250-\$500 to review the seven pages of lab work from my biopsy. I call every level of government and there is no financial assistance available to me. Some hospitals have charity programs for those with less than \$1500 worth of assets—including their cars. Generally hospitals do not make financial arrangements until the individual has a debt. When asked for estimates for their services, the hospitals give a broad range.

In Juneau, some women with breast cancer choose a mastectomy whether or not the severity of their disease warrants it. This is by far the least expensive option, radiation therapy that accompanies a lumpectomy is not available in Juneau. I choose a lumpectomy followed by six weeks of radiation therapy to be performed in Anchorage. In addition to financial arrangements for the hospital, additional financial arrangements need to be made for the surgeon, a radiation oncologist, a medical oncologist, xray, nuclear medicine, pathologist, housing and transportation.

I finished my radiation treatment January 30. I have every reason to believe this incidence of cancer is over for me. While concentrating on healing, having to put so much energy into figuring out a treatment plan and how to finance that treatment is a heavy additional burden for a cancer patient to carry. My bills are \$50,000. While the cancer is

over, it will be many, many years before all of the bills will be paid. It is my understanding SB 38 is not retroactive.

I was on the right track all those years ago encouraging women to get mammograms, as the state is right to offer the BCCEDP. But this only gets us part of the way there. For those of us that are uninsured this bill is the next critical step, authorized by the federal government the state may now provide the essential treatment.

I urge you to do everything possible to pass this bill into law.

**SITE: FAIRBANKS LIO**

**COMMITTEE: SHESS**

**DATE: 4/30/01**

**SUBJECT OF MEETING:**

**SB38:**

**UPDATE: #1**



# PLEASE SIGN IN

**PLEASE PRINT:**

**NAME**

**ADDRESS (MAILING & ZIP)**

**REPRESENTING**

**DO YOU WANT**

**TO TESTIFY?**

**Y or N**

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
Mary Louden Johnson		Fbx Breast Cancer Support Group	Y



# Alaska State Legislature

Please enter into the record my testimony to the HESS  
committee name

committee on SB 38, dated April 23, 2001  
bill/subject

I would like to make 4 points

- ① I support SB 38 & urge you to pass this bill. If you do not support this bill at least allow my verbal testimony & allow others from around the state the same. Written testimony DOES NOT allow for questions or discussion. It does not allow for an exchange of ideas.
- ② I strongly urge you to allow us verbal testimony on Monday of next week or at a future HESS meeting. There are options! You could AT LEAST allow 3 reps. from each area to speak!
- ③ This bill is a 70/30 (fed/state) cost projection. I am not thinking about SB 38 from an emotional place. I am thinking about \$ & saving lives. You have the op. to save Alaskan women or let them die.
- ④ I expect that you or one of your Staff members

Signed: will contact me. There are less than 20 days left -

Testifier let's not waste time.

VICTORIA SWANBERG, REP:SB

Representing (Optional)

PO BOX 92972 Anchorage, AK 99589

Address

254-4060

Phone No.



# Alaska State Legislature

Please enter into the record my testimony to the WCCF committee name

committee on SP38, dated SEP 27 2000,  
bill/subject

Committee memo

I urge you to pass SB38. If you were to hear testimony and look at the statistics - women, Alaskan women do need this funding. By you holding up this bill - women are doing who don't need to. I don't know if you can live with that thought - that I don't want. Therefore I urge you to pass this bill!

Thank you! Just so you know - I own a 3rd generation business and my family still lives in Alaska.

Signed: [Signature]  
Testifier

Representing (Optional)  
425 S. 15th St. Apt. 255A Anchorage 98148  
Address

[Blank]  
Phone No.



# Alaska State Legislature

Please enter into the record my testimony to the Hess  
 committee name  
 committee on SB38, dated April 23, 2001  
 bill/subject

(See attached letter :)

## Brief Summary Points:

We have the opportunity to allow Alaskan Women access to treatment they did not have before. - with a pricing that is manageable. A 70/30 match is unusual, compared to a 50/50 split.

TREATING cancer in the early stages will save the State money in the long run.

I support this bill and ask you to pass it.

Thank you - Michelle Dwyer

Signed: Michelle M. Dwyer  
 Testifier

Liana M. Craig Foundation  
 Representing (Optional)

PO Box 110674  
 Address

707. 560-7953  
 Phone No.

April 23, 2001

My name is Michelle Timpton and I am here on behalf of Diana Craig, who recently died from cervical cancer, at the age 28.

Diana was in a temporary - transitional period in her life at the time of diagnosis. And was without health insurance. She could have benefited from this program.

In order to receive treatment, she had to liquidate any meager assets to qualify for Medicaid.

I realize cancer treatment is complex & has other issues involved, <sup>but</sup> the bottom line is cost.

Cervical Cancer is treatable & preventable w/ early diagnosis & treatment. Cost costs everybody less when it is caught & treated in the early stage.

You have done a good job in securing screening / detection programs & now it ~~only~~ only makes sense to follow up w/ a treatment program.

This treatment program will save the state money in the long run. Since a person is diagnosed with any type of cancer, time is of the essence.

One way or another they will need treatment

So we can spare them the AGONY of the onset & progression of the disease w/ early detection, followed w/ treatment.

OR (still w/out ins)

we can allow it to progress & let it take the normal course that will w/out care manifest itself into an emergency which then falls back on to the state, costs 3 times as much had it have been dealt w/ at an early intervention.

SB 38 will Save Lives & Money.

I support SB 38 & ask you to pass this bill.

Thank you,  
Michelle Fingert  
U.M.C. Foundation  
907.360-9953



# Alaska State Legislature

Please enter into the record my testimony to the HESS committee name  
 committee on \_\_\_\_\_, dated APRIL 13 2001  
 bill/subject

I URGE YOU TO PASS THIS THROUGH LEGISLATION. IT IS A MISCONCEPTION TO BELIEVE THAT ONLY women who are on welfare or are very active are diagnosed with this disease. THAT IS NOT TRUE. THIS IS A VIABLE OPTION TO THESE WOMEN NOW. THE MONEY IS AVAILABLE. WE MUST SUPPORT THIS BILL. ALL WOMEN DESERVE THIS CHANCE NOW AT RECEIVING THIS FUNDING. WHERE THERE IS A NEED FOR SUPPORT, THERE IS A MARKET FOR TREATMENT. THIS 75/25 FEDERAL/STATE FUNDING SPLIT IS A GOOD DEAL AT THE MOMENT.

I URGE YOU TO PASS THIS BILL WITHOUT DELAY. BY DOING SO YOU WILL BE SAVING THESE WOMENS LIVES. EARLY DETECTION IS KEY AS

Signed: Nick Swamy  
 Testifier  
 \_\_\_\_\_  
 Representing (Optional)  
USOG MEMORIAL  
 \_\_\_\_\_  
 Address  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Phone No.



# Alaska State Legislature

(See reverse also)

Please enter into the record my testimony to the HESS committee name

committee on 5838-Privat. Health, dated 4-23-01  
bill/subject Cancer Treatment

My name is Carla Williams. I came to the LIO today to give verbal testimony at today's hearing, but we were denied this opportunity. I have, under separate cover, submitted testimony that supports that the 250% of poverty funding level is reasonable and necessary. The figures I used in this cost analysis were moderate to low.

Regarding the idea that people should not have any assets to qualify for this program I would like to remind the committee that in Ben Labby's Medicaid presentation a couple of weeks ago, Ben said that some of the more recent Medicaid programs were created so people didn't HAVE to spend down. I think that people are finally starting to realize that adding an ounce of compassion to these programs, saying that you

Signed: Carla Williams  
Testifier

(See reverse)

Representing (Optional)  
1300 W. SARAK PL Anchorage AK 99516  
Address

47-1776 7653 - Day 545-9666 Home 200  
Phone No.

don't have to lose absolutely everything and be totally destitute, is in the long run best for everyone.

As a Reach to Recovery volunteer, I visit women who have just had breast cancer surgery. After years of visits to their homes, I can assure the senators that I have never gone to the home of a poor woman who had a Cadillac in the driveway or new furniture.

If this bill is passed, 70% of the funds will come from the federal government, which is a good thing for the state and a good thing for women. Please don't start talking about taxes going up. There are a lot of federal programs, i.e. railroad spur to Anchorage downtown, building six marine centers or building a road to nowhere, that are directed to our state from the federal government and I've not heard a peep from the state legislators about these programs raising our taxes.

Here is something that will benefit our state by paying a \$400,000,000 a year, which will go directly into our economy to sectors and support staff. IT will help women who are in - to a large IT finishes something that was started in the '90s and



# Alaska State Legislature

Please enter into the record my testimony to the Senate HESS  
committee name

committee on SB 38, dated 4/23/01  
bill/subject

I am a nurse at a large Imaging Center in Anchorage, I coordinate the Anchorage Women's Breast Cancer Support Group - which has a membership of over 500 women with breast cancer and I am a member of the Alaska Breast Cancer Advocacy Partners - In short, I speak with a lot of women who have breast cancer

A very large part of my job involves interacting with women recently diagnosed with breast cancer. I help them find information + support, answer questions + direct women to other resources in the Anchorage community.

Women diagnosed with breast cancer through the Breast + Cervical Screening program have the same questions, fears + concerns as other women - with one notable exception - I worry about "how much will this cost" and "How can I pay for this"

There are no agencies that offer funds to women for cancer treatment. In some states - Tobacco money has been set aside for catastrophic health treatment - not here.

(continues)

Signed: Shelley M. Poolstige  
Testifier

Representing (Optional)  
2001 Dolly Korden Av. Anchorage AK 99516  
Address

907-345-6666  
Phone No.



# Alaska State Legislature

Please enter into the record my testimony to the Senate HESS  
committee name

committee on SB 38, dated 4/23/01  
bill/subject

The American Cancer Society provides some very limited funds for travel in order to access treatment and a few prescription drugs for treatment.

Certainly health providers + hospitals treat women regardless of their ability to pay - no one is turned away. However, these women are offered payment plans, their care is not necessarily donated. At a prior committee hearing we heard that these women are faced with bills from \$50,000-\$750,000 and higher. They have bills from the hospital, surgeon, anesthesia, oncologist, + radiation oncologist in addition to any co-existing medical treatment that is needed. These women must work out payment with all of these entities.

The women that I have met over the past 5 years from the grant program have primarily been single women or single parents working at jobs that don't offer an insurance plan. Some are married women where the primary wage earner has lost a job + therefore their insurance. They don't have retirement plans or other assets to tap into to pay for treatment. I think it has been established by others at previous hearings that these women don't really have an option to purchase insurance due to the high premiums charged for individual policies.

(continued)

Signed: Shelley Poolidge  
Testifier

Representing (Optional)

2001 Dolly Varden Av Anchorage, AK 99516  
Address

711-345-6666  
Phone No.



# Alaska State Legislature

Please enter into the record my testimony to the Senate HESS  
committee name

committee on SR 38, dated 4/23/01  
bill/subject

As a nurse, one of the greatest concerns is the women that choose sub-optimal treatment because of cost. In the last committee hearing, we heard from a woman Bernice Starkey, who chose lumpectomy for breast cancer, a surgery that removes only the cancerous lump. This surgery should be coupled with radiation therapy for treatment to be complete. Ms Starkey testified that she is aware of the need for radiation but simply can't afford the treatment. Ms Starkey's risk of a cancer recurrence is greater because of her sub-optimal treatment. If this cancer returns, treatment will be more difficult + more costly. I think it is a tragedy that women choose to forego standard treatment because they can't afford it.

In the early 90's - Alaska determined that this group of women were in need of assistance for breast + cervical cancer screening. It is logical to assume that this same group of women are also in need of cancer treatment assistance.

The cost is minimal when compared with the benefits.

Please Support SR 38

(end)

Signed: Shelley Prudig  
Testifier

Representing (Optional)

2001 Dolly Garden Av. Anchorage AK 99516  
Address

107-345-1044  
Phone No.



# Alaska State Legislature

Please enter into the record my testimony to the HESG  
committee name

committee on CR 35, dated 23 April 2001.  
bill/subject

SENATOR GREEN, CHAIR  
COMM MEMBERS SENATORS DAVIS, HALFORD, LEHMAN  
WARD AND WILKINS

IT IS UNFORTUNATE AND VERY DISCOURAGING THAT  
YOUR COMMITTEE DID NOT HAVE TIME TO ACCEPT  
PUBLIC TESTIMONY FROM THE ANCHORAGE  
ATTENDEES AT HEO ON APRIL 23RD. MANY  
BREAST CANCER SURVIVORS, FAMILY MEMBERS  
AND PROFESSIONALS WERE WILLING TO  
TESTIFY ON THIS CRITICAL ISSUE. TO BE DENIED  
THE OPPORTUNITY WAS A DISHEARTENING.  
THE FAILURE OF THIS COMMITTEE TO TAKE  
TIMELY ACTION ON THIS BILL HAS HAD A  
DEVASTATING IMPACT ON WOMEN WHO

Signed: Lil Sammie Oleson  
Testifier

CR 35 BREAST CANCER SURVIVORS  
Representing (Optional)

1317 CRESCENT AVE  
Address

907-452-2100  
Phone No.

7-101



# Alaska State Legislature

Please enter into the record my testimony to the \_\_\_\_\_  
committee name

committee on \_\_\_\_\_, dated \_\_\_\_\_  
bill/subject

ARE diagnosed with BREAST CANCER  
WHO ARE UNINSURED OR UNDERINSURED.  
POTENTIALLY they become candidates  
for the SUICIDE PREVENTION council.

EARLY detection REQUIRES EARLY  
INTERVENTION of medical treatment.

Signed: \_\_\_\_\_

Testifier

\_\_\_\_\_  
Representing (Optional)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone No.

14 2 1





SOA/HSS/MCFH, AK-BCCEDP  
3601 C Street, Suite 934  
Anchorage, AK 99503  
907-269-3400 Revised 03/20/2001  
Diagnostic Providers Page 1

**ANCHORAGE**

<b>#30, Alaska Diagnostic Laboratories</b> 4001 Dale St, Ste 105 Anchorage, AK 99508	Phone: 562-7208	Fax: 563-9070
<b>#31, Alaska Radiology Associates</b> 4001 Dale St, Ste 105 Anchorage, AK 99508	Phone: 563-3679	Fax: 563-9070
<b>#34, Alaska Regional Hospital Diagnostic Imaging</b> PO Box 143889 Anchorage, AK 99514	Phone: 264-1249	Fax: 264-1641
<b>#87, Alkray Radiology</b> POB 201024 Anchorage, Alaska 99508	Phone: (814) 864-9933	Fax: (814) 864-3394
<b>#35, David Anderson, MD</b> 2841 DeBarr Rd, Ste 42 Anchorage, AK 99508	Phone: 264-1204	Fax: 264-1995
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<b>#52, Laurie Bleicher, MD</b> 4001 Laurel #209 Anchorage, AK 99508	Phone: 561-2533	Fax: None
<b>#70, John DeKeyser, MD</b> 1200 Airport Hts, Ste 280A Anchorage, AK 99508	Phone: 264-2317	Fax: 264-2320
<b>#49, Roland Gower, MD</b> 2841 DeBarr Rd #41 Anchorage, AK 99508	Phone: 279-3564	Fax: 279-8600
<b>#47, Healthsouth Diagnostic</b> 4003 Lake Otis Pkwy #101 Anchorage, AK 99508	Phone: 562-6655	Fax: 563-6195
<b>#66, Imaging Specialists of Alaska</b> PO Box 140270 Anchorage, AK 99514	Phone: 264-1246	Fax: 279-8463

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907-269-3400 Revised 03/20/2001  
Diagnostic Providers Page 2

**ANCHORAGE (Cont'd)**

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<b>#88, George Stransky, MD</b> OB/GYN Associates 4231 Lake Otis Parkway Anchorage, Alaska 99508	Phone: 562-2965	Fax: 561-1257
<b>#80, James O'Malley, MD</b> 1200 Airport Heights Dr, Ste 220 Anchorage, Alaska 99508	Phone: 264-1580	Fax: 264-1589
<b>#48, Pathology Associates</b> PO Box 111565 Anchorage, AK 99511	Phone: 345-0004	Fax: 345-7783
<b>#64, Providence Alaska Medical Center</b> PO Box 196604 Anchorage, AK 99519	Phone: 261-3675	Fax: 261-3041
<b>#29, Providence Imaging Center</b> 3340 Providence Dr Anchorage, AK 99508	Phone: 261-4867	Fax: 261-4869
<b>#36, Judith Whitcomb, MD</b> 3300 Providence Dr, Ste 108 Anchorage, AK 99508	Phone: 563-3028	Fax: 563-0236
<b>#27, AK Women's Health Services Inc.</b> Jan Whitefield, MD 4115 Lake Otis Pkwy Anchorage, AK 99508	Phone: 563-7228	Fax: 563-6278
<b>#27, AK Women's Health Services Inc.</b> Jane Wiggins, MD 3260 Providence Drive, #522 Anchorage, AK 99508	Phone: 563-5151	Fax: 562-6995
<b>#37, Michelle Young, MD</b> POB 240687 Anchorage, AK 99524	Phone: 562-3055	Fax: 562-3056

SOA/HSS/MCFH, AK-BCCEDP  
3601 C Street, Suite 934  
Anchorage, AK 99503  
907-269-3400 Revised 03/20/2001  
Diagnostic Providers Page 3

**FAIRBANKS**

#56, James B. Borden, MD  
1867 Airport Way Suite 140A  
Fairbanks, AK 99701

Phone: 457-9355

Fax: 457-9356

#33, Breast Cancer Detection Center  
1905 Cowles St.  
Fairbanks, AK 99701

Phone: 479-3909

Fax: 479-2215

#73, Fairbanks Memorial Hospital  
Fiscal Services, attn: Anita  
1650 Cowles Street  
Fairbanks, AK 99701

Phone: 458-5305

Fax: 458-5324

#54, Richard Hutchison, MD  
1919 Lathrop, #101  
Fairbanks, AK 99701

Phone: 451-8775

Fax: 451-7716

#61, Arlene Kirschner, MD  
1919 Lathrop St, Ste 204  
Fairbanks, AK 99701

Phone: 474-4745

Fax: 474-4746

#76, Pathology Consultants  
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Fairbanks, AK 99701

Phone: 456-7767

Fax: 456-8050

#59, Radiology Consultants  
1867 Airport Way, Ste 130A  
Fairbanks, AK 99701

Phone: 452-6464

Fax: 452-1073

#75, Tanana Valley Clinic  
1001 Noble Street  
Fairbanks, AK 99701

Phone: 459-3500

Fax: 459-4994

**JUNEAU**

#62, Bartlett Regional Hospital  
3260 Hospital Drive  
Juneau, AK 99801

Phone: 586-8438

Fax: 463-4919

#67, Diagnostic Radiology Consultants  
3260 Hospital Drive  
Juneau, AK 99801

Phone: 463-5043

Fax: 463-5063

SOA/HSS/MCFH, AK-BCCEDP  
3601 C Street, Suite 934  
Anchorage, AK 99503  
907-269-3400 Revised 03/20/2001  
Diagnostic Providers Page 4

JUNEAU (Cont'd)

#41, William Palmer, MD  
3268 Hospital Dr, Ste E  
Juneau, AK 99801

Phone: 586-1895

Fax: 586-2595

#68, Southeast Alaska Pathology  
224 Fourth Street  
Juneau, AK 99801

Phone: 586-3282

Fax: 586-3284

#43, Nell Wagoner, MD  
3268 Hospital Dr, Ste B  
Juneau, AK 99801

Phone: 586-1717

Fax: 586-2677

KETCHIKAN

#12, Ketchikan General Hospital  
Attn: Billing  
PO Box 7798  
Ketchikan, AK 99901

Phone: 225-8015

Fax: 228-8368

#13, Donna Smith-Harrison, MD  
Southeast OB/GYN  
POB 7278  
Ketchikan, AK 99901

Phone: 225-6688

Fax: 247-6688

PALMER

#44, Jeff Hittson, MD  
PO Box 1966  
Palmer, AK 99645

Phone: 346-8255

Fax: 346-8255

#53, Mat-Su Radiology  
PO Box 600  
Palmer, AK 99645

Phone: 745-5731

Fax: 745-3536

#89, Valley Surgical Associates  
Michael Senta, MD  
561 So Denali, Suite D  
Palmer, Alaska 99645

Phone: 745-8100

Fax: 746-2655

SEWARD

#24, Providence Seward Medical Center  
Jim Sefton  
PO Box 365  
Seward, AK 99664

Phone: 224-5205

Fax: 224-7248

**SOLDOTNA**

#94, **John Nels Anderson** Phone: (907) 262-4161 Fax: (907) 262-1545  
265 Binkley  
Soldotna, AK 99669

#58, **Theodore Barton, MD** Fax: 262-5794  
Phone: 262-2602  
206 W. Rockwell, Suite 101  
Soldotna, AK 99669

#55, **Bobbie Behrens, MD** Phone: 262-2615 Fax: 262-8842  
35670 Kenai Spur Hwy  
Soldotna, AK 99669

#77, **Todd Boling, MD** Phone: 262-1443 Fax: 262-2423  
245 N Binkley #203  
Soldotna, AK 99669

#51, **Central Peninsula General Hospital** Phone: 262-8135 Fax: 262-0731  
250 Hospital Place  
Soldotna, AK 99669

#57, **Michael Flannery, MD** Phone: 262-6800 Fax: 262-9276  
170 E Corral  
Soldotna, AK 99669

#86, **Peninsula Pathology Institute** Phone: 262-3557 Fax: 262-6505  
35338 Kenai Spur Highway  
Soldotna, Alaska 99559

#65, **Joseph Sangster, MD** Phone: 262-1443 Fax: 262-2423  
245 N Binkley, #203  
Soldotna, AK 99669

**WASILLA**

#39, **Pamela Hill, MD** Phone: 373-0660 Fax: 373-0662  
950 Bogard Rd, Ste 230  
Wasilla, AK 99654

#40, **David Mayschak, MD** Phone: 376-7874 Fax: 373-7876  
935 West Point Dr, #101  
Wasilla, AK 99654

SOA/HSS/MCFH, AK-BCCEDP  
3601 C Street, Suite 934  
Anchorage, AK 99503  
907-269-3400 Revised 03/20/2001  
Diagnostic Providers Page 6

**WASILLA** (Cont'd)

**#46, Valley Hospital Association**  
950 S Bogard Rd, Ste 106  
Wasilla, AK 99654

Phone: 352-2814

Fax: 352-2815

**Washington**

**#79, Skagit Pathology, Inc.**  
1310 E. Division Street  
Mount Vernon, WA 98274

Phone: 360-424-6137

Fax: 360-416-2293

**#91, Dynacare Northwest, Inc.**  
1310 E Division Street  
Mt. Vernon, WA 98274

Phone: 360-424-6137

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SOA/HSS/MCFH, AK-BCCEDP  
3601 C Street, Suite 934  
Anchorage, AK 99503  
907-269-3400 Revised 03/20/2001  
Diagnostic Providers Page 7

**TOTAL NUMBER OF STATES AT:**

250% = 35  
 240% = 1  
 225% = 2  
 200% = 23  
 185% = 1

(Still a few missing, mainly US Territories)

State	Percentage of Poverty
Oklahoma	185
Alabama	200
Arizona	200
Arkansas	200
California	200
Connecticut	200
Florida	200
Georgia	200
Hopi Tribe	200
Idaho	200
Illinois	200
Kansas	200
Missouri	200
Montana	200
New Hampshire	200
North Carolina	200
North Dakota	200
Ohio	200
South Carolina	200
Texas	200
Virginia	200
Washington	200
West Virginia	200
Wyoming	200
Mississippi	225
Nebraska	225 <sup>1</sup>
Utah	240
Alaska	250
Cherokee Nation	250
DC	250
Delaware	250
Hawaii	250
Iowa	250

Louisiana	250
Maryland	250
Massachusetts	250
Michigan	250
Minnesota	250
NARA	250
Native American CHC	250
Navajo Nation	250
Nevada	250
New Hampshire	250
New Jersey	250
New Mexico	250
New York	250
North Slope	250
Oregon	250
Pennsylvania	250
Poarch Band of Creek Indians	250
Rhode Island	250
SEARHC	250
South Puget Intertribal	250
Southcentral Foundation	250
Tennessee	250
Vermont	250
Wisconsin	250
Colorado	250 <sup>2</sup>
Indiana	250 <sup>3</sup>
Maine	250 <sup>4</sup>
Kentucky	250 <sup>5</sup>

<sup>1</sup> Went from 200 – 250% last year, only ~1% are >200%.

<sup>2</sup> No income eligibility for Native American women living on reservations

<sup>3</sup> Legislature may require them to drop to 200% in order to include treatment

<sup>4</sup> Was 250% for 50-64, & 200% for 40-49, recently changed to be all 250%, as they could not meet target numbers

<sup>5</sup> <100% - services provided for free; 101% - 250% - services provided on a sliding fee scale.

**SITE: ANCHORAGE LIO**

**COMMITTEE:**

Senate H.E.S.S.

**DATE: 4-23-2001**

**SUBJECT OF MEETING:**

SB198/SB38/HB115

**UPDATE #:**



## PLEASE SIGN IN

**PLEASE PRINT:**

**NAME**

**ADDRESS (MAILING & ZIP)**

**REPRESENTING**

**DO YOU WANT  
TO TESTIFY?**

↓ **Y or N**

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? ↓ Y or N
Barbara M. DuBois	2500 Curlew Circle, Anchorage 99515	563 6538	U - SB 38
Iyllamae Olsonoski	1317 Crescent Ave, Anchorage 99508	563 6803	U - SB 38
Michelle Plimpton ✓	3136 E 16 <sup>th</sup> Ave, Anchorage 99508	222 2613	U - SB 38
Victoria Shaver ✓	PO Box 92972, Anchorage 99509	275 8763	U - SB 38
Carla Williams	13001 Norak Pl, Anchorage 99516	677 3032	U - SB 38
Linda Vlastuin	3601 C St, Anchorage 99503	269 3428	N - SB 38
Nicole Sweeny	6500 Meadow St, Anchorage 99507	344 9179	N - SB 38
Danielle Plimpton	341 W Tudor #105, Anchorage 99503	562 4334	N - SB 38
Erin Reinikka	425 S 156 th #233A, Seattle, WA 98148	206 431 8327	N - SB 38
Anne Gore	3700 Carleton, Anchorage 99517	248 7392	N - SB 38
3 observers			

**SITE: ANCHORAGE LIO**

**COMMITTEE:**

Senate H.E.S.S.

**DATE: 4-23-2001**

**SUBJECT OF MEETING:**

SB198/SB38/HB115

**UPDATE #:**



# PLEASE SIGN IN

*phone #s?*

**PLEASE PRINT:**

**NAME**

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**REPRESENTING**

**DO YOU WANT**

**TO TESTIFY?**

**Y or N**

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
Barbara M. DuBois	2500 Curlew Circle, Anchorage 99515		U - SB 38
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Carla Williams	13001 Norak Pl, Anchorage 99516		U - SB 38
Linda Vlastuin	3601 C St, Anchorage 99503		N - SB 38
Nicole Sweeny	6500 Meadow St, Anchorage 99507		N - SB 38
Danielle Plimpton	341 W Tudor #105, Anchorage 99503		N - SB 38
Erin Reinikka	425 S 156 th #233A, Seattle, WA 98148		N - SB 38
Anne Gore	3700 Carleton, Anchorage 99517		N - SB 38
3 observers			



*Carla Williams*  
*13001 Norak Place*  
*Anchorage, Alaska 99516*  
*907-345-8060*

April 22, 2001

Senate HESS Committee  
State Capitol  
Juneau, AK. 99801

Re: Written Testimony to 4/23/01 HESS Hearing on HR65-Breast and Cervical Cancer Treatment Bill

Dear Senators Green, Leman, Ward, Wilken, and Davis:


Please consider the following regarding the eligibility income level of 250% of the federal poverty level. It will be submitted as written testimony for the hearing on April 23<sup>rd</sup> at 1:30 p.m.

Attached are two income/expense scenarios, both based on a 47-year-old woman with no prior abnormal paps or mammograms. It is easy to understand why women are telling legislators that they cannot afford individual insurance coverage. Keep in mind that these typical expenses do not cover expenses such as auto accident deductibles, medical problems beyond colds/flu, emergency out-of-state travel expenses, and the numerous other unexpected financial obligations that arise over the course of a year.

The single woman in this analysis has less than \$100 of yearly disposable income remaining after expenses. The head of household woman has less than \$700. Insurance coverage of \$1,488 per year with a \$500 deductible is a minimum 80/20% basic coverage, with rates increasing for age and pre-existing conditions. Ms. Bernice Starkey testified in the Senate Labor Commerce Hearing on SB38 on March 1st that her insurance coverage would have cost \$320 per month or \$3,890 a year. Ms. Sue Ciccone testified that the cheapest insurance she could find, based on her conditions, was \$600 to \$800 per month or \$7,200 to \$9,600 a year, with a \$3,000 deductible.

These premiums exceed the single woman's disposable income, particularly if she has had prior medical conditions. "Prior medical conditions" can be as simple as a "suspicious biopsy." If the woman has had a previous cancer diagnosis, finding coverage is even more difficult, at any cost.

Sincerely,

  
Carla Williams

**Income and Expense Summary**  
**Single 47-year-old woman with no prior abnormal pap or mammogram**

Gross Pay	\$26,075	
Federal Tax	2830	
State ESC \$25,500 Max	133	
FICA Tax	1617	
Deductions	<u>\$4,580</u>	
Net Pay		<b>\$21,495</b>
Rent plus Utilities \$750/mo	9000	
Food \$75/wk	3900	
Car Payment \$190/mo	2280	
*Non-Food Expenses \$150/mo	1800	
Car Insurance \$110/mo	1320	
Gasoline \$20/wk	1040	
Laundry Expense \$10/wk	520	
Car Oil-Lube-Filter/License/IM/tire replacement \$35/mo	420	
Hair Expense \$35/mo	420	
Dentist with xrays and eye exam \$250	250	
Phone \$20/mo	240	
Yearly Medical Exam	120	
Prescriptions	<u>120</u>	
Total Expenses	\$21,430	
Net Pay less Expenses		<b>\$65</b>

**\*\* 80/20% Insurance with no pre-existing conditions**  
**Annual Out-of-Pocket \$2500 No Supplemental or Prescription**

Insurance Deductible \$500/yr	500	
Insurance Cost \$124/mo	<u>1488</u>	
Total Cost of Insurance Coverage		<b>\$1,488</b>

\* Examples of non-food expenses are clothes, shoes, winter gear, kitchen/bath supplies, entertainment, and non-prescription drugs.

\* \*Pre-existing conditions may increase the yearly premium dramatically or coverage may not be available at all.

**Income and Expenses Summary****Head of Household 47-year-old woman with no prior abnormal pap or mammogram  
and one dependent**

Gross Pay	\$35,150	
Federal Tax	3469	
State ESC Max \$25,500	133	
FICA Tax	2179	
Deductions	<u>\$5,781</u>	
<b>Net Pay</b>		<b>\$29,369</b>
Rent plus Utilities \$800/mo	9600	
Food \$120/wk	6240	
*Non-Food Expenses \$250/mo	3000	
Car Payment \$190/mo	2280	
Before/After School Child Care with Assistance \$185/mo	2220	
Car Insurance \$110/mo	1320	
Gasoline \$20/wk	1040	
Dentist with xrays and eye exam \$250 x2	500	
Hair Expense \$45/mo	540	
Laundry Expense \$10/wk	520	
Car Oil-Lube-Filter/License/IM/tire replacement \$35/mo	420	
School Supplies & Fees	300	
Prescriptions	250	
Phone \$20/mo	240	
Yearly Medical Exam \$120 x2	240	
Total Expenses	\$28,710	
Net Pay less Expenses		<b>\$659</b>

**\*\*80/20% Insurance with no pre-existing conditions  
Annual Out-of-Pocket \$2500 No Supplemental or Prescription**

Insurance Deductible \$500	500	
Insurance Cost \$124/mo \$2500 Annual Out of Pocket	1488	
Total Cost of Insurance Coverage		<b>\$1,488</b>

\* Examples of non-food expenses are clothes, shoes, winter gear, kitchen/bath supplies, entertainment, and non-prescription drugs.

\*\* Pre-existing conditions may increase the yearly premium dramatically or coverage may not be available at all.

## MEDICAID SERVICES AND GROUPS NOT IN CURRENT STATE LAW

### OPTIONAL SERVICES

- Chiropractic
- Case Management (for additional populations)
- Christian Science Nurses
- Christian Science Sanatorium
- Clinic services
- Community Supported living arrangements
- Adult dental services (preventive and restorative)
- Dentures
- Diagnostic services
- Emergency Hospital services (for hospitals not enrolled)
- Podiatry
- Preventive Services
- Private Duty Nursing
- Respiratory Therapy
- Screening services
- Home and community care for functionally disabled elderly
- Services of any type of practitioner licensed under state law
  - Psychologists and Psychological Associates
  - Licensed Clinical Social Workers
  - Marital and Family Therapists
  - Acupuncturists
  - Licensed Professional Counselors
  - Naturopaths

*Glaucoma*

### OPTIONAL GROUPS

- TB infected individuals
- Women diagnosed with breast or cervical cancer under the CDC Program
- Aged and disabled with incomes to 100% of the Federal Poverty level
- Expanded Working Disabled Option
- Medically Needy families and children
- Medically Needy Aged and Disabled
- Independent Foster Care Adolescents
- Presumptive eligibility for pregnant women
- Presumptive eligibility for children
- Other groups of low income people under a Demonstration Waiver
- Family Planning Waiver

### OTHER SERVICES OR GROUPS THAT HAVE BUDGETARY IMPLICATIONS BUT MAY NOT REQUIRE LEGISLATION

- Alzheimer's and other conditions for nursing facility /waiver admission
- 12 month continuous eligibility for children - *Denial, Kid Care*
- Non emergent transportation within communities of residence *Dr. a.u. serv. within community*
- School based services - *Health Care*
- Tobacco cessation services
- More liberal financial eligibility and coverage policies



# Health Care Financing Administration

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January 4, 2001

Dear State Health Official:

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA - the , (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 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 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 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 program to obtain timely access to treatment services. The BCCPTA allows States to provide coverage to these women under Medicaid. The following outlines the basic rules regarding the new eligibility option.

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

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

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

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 Medicaid 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, 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 is 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 medical practice. Such practice guidelines are located at the National Guideline Clearinghouse, Agency for Health Care Research and Quality: <http://www.ahrq.gov>. With respect to experimental treatments, States may cover experimental treatments although they are not required to do so. Furthermore, routine covered costs associated with the experimental intervention may be covered.

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

Under this option, states can certify entities that are eligible for payment under a state 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 are 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 optional categorically needy eligibility group and/or to provide presumptive eligibility. It must also 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 <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. The extent that these territories already receive the maximum federal payment permit the new law would not result in any additional federal funding. If the cap on federal payments has not been reached, federal funds at the enhanced matching rate could be available for the new eligibility group.

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

### Overview of Implementation

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

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

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

We encourage you to submit state plan amendments to your HCFA regional office as quickly as possible. HCFA staff will gladly offer technical assistance to any state that requests it. If you have questions about issues not addressed in this letter, please contact Marlene Jones at HCFA (410) 786-3290 for Medicaid-related issues and Steve Reynolds at CDC (770) 488-3075 for issues concerning NBCCEDP.

Sincerely,

/s/

Timothy M. Westmoreland  
Director

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### Footnotes:

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

(2) Public Law 106 - 554, included the Medicare, Medicaid and SCHIP Benefits

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

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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 Director  
 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.

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DRAFT

ATTACHMENT 2-2-A  
 PAGE 23b

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 XV of the Public Health Service Act in accordance with the requirements of section 15C 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 1920B (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. \_\_\_\_\_



Public Law 106-354  
106th Congress

An Act

To amend title XIX of the Social Security Act to provide medical assistance for certain women screened and found to have breast or cervical cancer under a federally funded screening program, to amend the Public Health Service Act and the Federal Food, Drug, and Cosmetic Act with respect to surveillance and information concerning the relationship between cervical cancer and the human papillomavirus (HPV), and for other purposes.

Oct. 24, 2000

[H.R. 4386]

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Breast and Cervical Cancer Prevention and Treatment Act of 2000".

Breast Cancer  
Prevention and  
Treatment Act of  
2000.  
42 USC 1305  
note.

SEC. 2. OPTIONAL MEDICAID COVERAGE OF CERTAIN BREAST OR CERVICAL CANCER PATIENTS.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

- (A) in subclause (XVI), by striking "or" at the end;
- (B) in subclause (XVII), by adding "or" at the end;

and

(C) by adding at the end the following:

"(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);".

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

"(aa) Individuals described in this subsection are individuals who—

- "(1) are not described in subsection (a)(10)(A)(i);
- "(2) have not attained age 65;
- "(3) have been screened for breast and 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 (42 U.S.C. 300k et seq.) in accordance with the requirements of section 1504 of that Act (42 U.S.C. 300n) and need treatment for breast or cervical cancer; and
- "(4) are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c))."

(3) **LIMITATION ON BENEFITS.**—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G)—

(A) by striking “and (XIII)” and inserting “(XIII)”; and  
 (B) by inserting “, and (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer” before the semicolon.

(4) **CONFORMING AMENDMENTS.**—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(A) in clause (xi), by striking “or” at the end;  
 (B) in clause (xii), by adding “or” at the end; and  
 (C) by inserting after clause (xii) the following:

“(xiii) individuals described in section 1902(aa),”.

(b) **PRESUMPTIVE ELIGIBILITY.**—

(1) **IN GENERAL.**—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920A the following:

“PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR CERVICAL  
 CANCER PATIENTS

“SEC. 1920B. (a) **STATE OPTION.**—A State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(aa) (relating to certain breast or cervical cancer patients) during a presumptive eligibility period.

“(b) **DEFINITIONS.**—For purposes of this section:

“(1) **PRESUMPTIVE ELIGIBILITY PERIOD.**—The term ‘presumptive eligibility period’ means, with respect to an individual described in subsection (a), the period that—

“(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(aa); and

“(B) ends with (and includes) the earlier of—

“(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

“(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

“(2) **QUALIFIED ENTITY.**—

“(A) **IN GENERAL.**—Subject to subparagraph (B), the term ‘qualified entity’ means any entity that—

“(i) is eligible for payments under a State plan approved under this title; and

“(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

“(B) REGULATIONS.—The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

“(C) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

“(c) ADMINISTRATION.—

“(1) IN GENERAL.—The State agency shall provide qualified entities with—

“(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

“(B) information on how to assist such individuals in completing and filing such forms.

“(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

“(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

“(B) inform such individual at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

“(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made.

“(d) PAYMENT.—Notwithstanding any other provision of this title, medical assistance that—

“(1) is furnished to an individual described in subsection (a)—

“(A) during a presumptive eligibility period;

“(B) by a entity that is eligible for payments under the State plan; and

“(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).”.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: “and provide for making medical assistance available to individuals described in subsection (a) of section 1920B during a presumptive eligibility period in accordance with such section”.

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(i) by striking “or for” and inserting “, for”; and

(ii) by inserting before the period the following:  
 “, or for medical assistance provided to an individual described in subsection (a) of section 1920B during a presumptive eligibility period under such section”.

(c) ENHANCED MATCH.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended—

(1) by striking “and” before “(3)”; and

(2) by inserting before the period at the end the following:  
 “, and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII)”.

(d) EFFECTIVE DATE.—The amendments made by this section apply to medical assistance for items and services furnished on or after October 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date.

Applicability.  
 42 USC 1396a  
 note.

Approved October 24, 2000.

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**LEGISLATIVE HISTORY—H.R. 4386 (S. 662):**

SENATE REPORTS: No. 106-323 accompanying S. 662 (Comm. on Finance).  
 CONGRESSIONAL RECORD, Vol. 146 (2000):

May 9, considered and passed House.

Oct. 4, considered and passed Senate, amended, in lieu of S. 662.

Oct. 12, House concurred in Senate amendment.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 36 (2000):

Oct. 24, Presidential statement.

Title 42. The Public Health and Welfare  
Chapter 6a. The Public Health Service  
**Preventive Health Measures with Respect to Breast and Cervical Cancers**  
42 U.S.C. § 300k (1996)

§ 300k. Establishment of program of grants to States

(a) In general. The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to States on the basis of an established competitive review process for the purpose of carrying out programs--

- (1) to screen women for breast and cervical cancer as a preventive health measure;
- (2) to provide appropriate referrals for medical treatment of women screened pursuant to paragraph (1) and to ensure, to the extent practicable, the provision of appropriate follow-up services;
- (3) to develop and disseminate public information and education programs for the detection and control of breast and cervical cancer;
- (4) to improve the education, training, and skills of health professionals (including allied health professionals) in the detection and control of breast and cervical cancer;
- (5) to establish mechanisms through which the States can monitor the quality of screening procedures for breast and cervical cancer, including the interpretation of such procedures; and
- (6) to evaluate activities conducted under paragraphs (1) through (5) through appropriate surveillance or program-monitoring activities.

(b) Grant and contract authority of States.

(1) In general. A state receiving a grant under subsection (a) may, subject to paragraphs (2) and (3), expend the grant to carry out the purpose described in such subsection through grants to, and contracts with, public or nonprofit private entities.

(2) Limited authority regarding other entities. In addition to the authority established in paragraph (1) for a State with respect to grants and contracts, the State may provide for screenings under subsection (a)(1) through entering into contracts with private entities that are not nonprofit entities.

(3) Payments for screenings. The amount paid by a State to an entity under this subsection for a screening procedure under subsection (a)(1) may not exceed the amount that would be paid under part B of title XVIII of the Social Security Act [42 U.S.C. § 1395j et seq.] if payment were made under such part for furnishing the procedure to a woman enrolled under such part.

(c) Special consideration for certain States. In making grants under subsection (a) to States whose initial grants under such subsection are made for fiscal year 1995 or any subsequent fiscal year, the Secretary shall give special consideration to any State whose proposal for carrying out programs under such subsection--

- (1) has been approved through a process of peer review; and

- (2) is made with respect to geographic areas in which there is--  
(A) a substantial rate of mortality from breast or cervical cancer; or  
(B) a substantial incidence of either of such cancers.

[(d)](c) Coordinating committee regarding year 2000 health objectives. The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a committee to coordinate the activities of the agencies of the Public Health Service (and other appropriate Federal agencies) that are carried out toward achieving the objectives established by the Secretary for reductions in the rate of mortality from breast and cervical cancer in the United States by the year 2000. Such committee shall be comprised of Federal officers or employees designated by the heads of the agencies involved to serve on the committee as representatives of the agencies, and such representatives from other public or private entities as the Secretary determines to be appropriate.

#### § 300l. Requirement of matching funds

(a) In general. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees, with respect to the costs to be incurred by the State in carrying out the purpose described in such section, to make available non-Federal contributions (in cash or in kind under subsection (b)) toward such costs in an amount equal to not less than \$1 for each \$3 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

(b) Determination of amount of non-Federal contribution.

(1) In general. Non-Federal contributions required in subsection (a) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(2) Maintenance of effort. In making a determination of the amount of non-Federal contributions for purposes of subsection (a), the Secretary may include only non-Federal contributions in excess of the average amount of non-Federal contributions made by the State involved toward the purpose described in section 1501 [42 U.S.C. § 300k] for the 2-year period preceding the first fiscal year for which the State is applying to receive a grant under such section.

(3) Inclusion of relevant non-Federal contributions for Medicaid. In making a determination of the amount of non-Federal contributions for purposes of subsection (a), the Secretary shall, subject to paragraphs (1) and (2) of this subsection, include any non-Federal amounts expended pursuant to title XIX of the Social Security Act [42 U.S.C. § 1396 et seq.] by the State involved toward the purpose described in paragraphs (1) and (2) of section 1501(a) [42 U.S.C. § 300k(a)].

#### § 300l-1. Requirement regarding medicaid

The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] for a program in a State unless the State plan under title XIX of the Social Security Act [42 U.S.C. § 1396 et seq.] for the State includes the screening procedures specified in subparagraphs (A) and (B) of section 1503(a)(2) [42 U.S.C. § 300m(a)(2)(A), (B)] as medical assistance provided under the plan.

§ 300m. Requirements with respect to type and quality of services

(a) Requirement of provision of all services by date certain. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees--

(1) to ensure that, initially and throughout the period during which amounts are received pursuant to the grant, not less than 60 percent of the grant is expended to provide each of the services or activities described in paragraphs (1) and (2) of section 1501(a) [42 U.S.C. § 300k(a)], including making available screening procedures for both breast and cervical cancers;

(2) subject to subsection (b), to ensure that--

(A) in the case of breast cancer, both a physical examination of the breasts and the screening procedure known as a mammography are conducted; and

(B) in the case of cervical cancer, both a pelvic examination and the screening procedure known as a pap smear are conducted;

(3) to ensure that, by the end of any second fiscal year of payments pursuant to the grant, each of the services or activities described in section 1501(a) [42 U.S.C. § 300k(a)] is provided; and

(4) to ensure that not more than 40 percent of the grant is expended to provide the services or activities described in paragraphs (3) through (6) of such section.

(b) Use of improved screening procedures. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that, if any screening procedure superior to a procedure described in subsection (a)(2) becomes commonly available and is recommended for use, any entity providing screening procedures pursuant to the grant will utilize the superior procedure rather than the procedure described in such subsection.

(c) Quality assurance regarding screening procedures. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that the State will, in accordance with applicable law, assure the quality of screening procedures conducted pursuant to such section.

§ 300n. Additional required agreements

(a) Priority for low-income women. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that low-income women will be given priority in the provision of services and activities pursuant to paragraphs (1) and (2) of section 1501(a) [42 U.S.C. § 300k(a)].

(b) Limitation on imposition of fees for services. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that, if a charge is imposed for the provision of services or activities under the grant, such charge--

- (1) will be made according to a schedule of charges that is made available to the public;
- (2) will be adjusted to reflect the income of the woman involved; and
- (3) will not be imposed on any woman with an income of less than 100 percent of the official poverty line, as established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981 [42 U.S.C. § 9902(2)].

(c) Statewide provision of services.

(1) In general. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that services and activities under the grant will be made available throughout the State, including availability to members of any Indian tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act [25 U.S.C. § 450b]).

(2) Waiver. The Secretary may waive the requirement established in paragraph (1) for a State if the Secretary determines that compliance by the State with the requirement would result in an inefficient allocation of resources with respect to carrying out the purpose described in section 1501(a) [42 U.S.C. § 300k(a)].

(3) Grants to tribes and tribal organizations.

(A) The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to tribes and tribal organizations (as such terms are used in paragraph (1)) for the purpose of carrying out programs described in section 1501(a) [42 U.S.C. § 300k(a)]. This title applies to such a grant (in relation to the jurisdiction of the tribe or organization) to the same extent and in the same manner as such title applies to a grant to a State under section 1501 [42 U.S.C. § 300k] (in relation to the jurisdiction of the State).

(B) If a tribe or tribal organization is receiving a grant under subparagraph (A) and the State in which the tribe or organization is located is receiving a grant under section 1501 [42 U.S.C. § 300k], the requirement established in paragraph (1) for the State regarding the tribe or organization is deemed to have been waived under paragraph (2).

(d) Relationship to items and services under other programs. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that the grant will not be expended to make payment for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to such item or service--

- (1) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or
- (2) by an entity that provides health services on a prepaid basis.

(e) Coordination with other breast and cervical cancer programs. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that the services and activities funded through the grant shall be coordinated with other Federal, State, and local breast and cervical cancer programs.

(f) Limitation on administrative expenses. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that not more than 10 percent of the grant will be expended for administrative expenses with respect to the grant.

(g) Restrictions on use of grant. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that the grant will not be expended to provide inpatient hospital services for any individual.

(h) Records and audits. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that--

(1) the State will establish such fiscal control and fund accounting procedures as may be necessary to ensure the proper disbursement of, and accounting for, amounts received by the State under such section; and

(2) upon request, the State will provide records maintained pursuant to paragraph (1) to the Secretary or the Comptroller of the United States for purposes of auditing the expenditures by the State of the grant.

(i) Reports to Secretary. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees to submit to the Secretary such reports as the Secretary may require with respect to the grant.

#### § 300n-1. Description of intended uses of grant

The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless--

(1) the State involved submits to the Secretary a description of the purposes for which the State intends to expend the grant;

(2) the description identifies the populations, areas, and localities in the State with a need for the services or activities described in section 1501(a) [42 U.S.C. § 300k(a)];

(3) the description provides information relating to the services and activities to be provided, including a description of the manner in which the services and activities will be coordinated with any similar services or activities of public and nonprofit private entities; and

(4) the description provides assurances that the grant funds will be used in the most cost-effective manner.

#### § 300n-2. Requirement of submission of application

The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless an application for the grant is submitted to the Secretary, the application contains the description of intended

uses required in section 1505 [42 U.S.C. § 300n-1], and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this title [42 U.S.C. § 300k et seq.].

#### § 300n-3. Technical assistance and provision of supplies and services in lieu of grant funds

(a) Technical assistance. The Secretary may provide training and technical assistance with respect to the planning, development, and operation of any program or service carried out pursuant to section 1501 [42 U.S.C. § 300k]. The Secretary may provide such technical assistance directly or through grants to, or contracts with, public and private entities.

(b) Provision of supplies and services in lieu of grant funds.

(1) In general. Upon the request of a State receiving a grant under section 1501 [42 U.S.C. § 300k], the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the State in carrying out such section and, for such purpose, may detail to the State any officer or employee of the Department of Health and Human Services.

(2) Corresponding reduction in payments. With respect to a request described in paragraph (1), the Secretary shall reduce the amount of payments under the grant under section 1501 [42 U.S.C. § 300k] to the State involved by an amount equal to the costs of detailing personnel (including pay, allowances, and travel expenses) and the fair market value of any supplies, equipment, or services provided by the Secretary. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

#### § 300n-4. Evaluations and reports

(a) Evaluations. The Secretary shall, directly or through contracts with public private entities, provide for annual evaluations of programs carried out pursuant to section 1501 [42 U.S.C. § 300k]. Such evaluations shall include evaluations of the extent to which States carrying out such programs are in compliance with section 1501(a)(2) [42 U.S.C. § 300k(a)(2)] and with section 1504(c) [42 U.S.C. § 300n(c)].

(b) Report to Congress. The Secretary shall, not later than 1 year after the date on which amounts are first appropriated pursuant to section 1509(a) [42 U.S.C. § 300n-5(a)], and annually thereafter, submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report summarizing evaluations carried out pursuant to subsection (a) during the preceding fiscal year and making such recommendations for administrative and legislative initiatives with respect to this title [42 U.S.C. § 300k et seq.] as the Secretary determines to be appropriate, including recommendations regarding compliance by the States with section 1501(a)(2) [42 U.S.C. § 300k(a)(2)] and with section 1504(c) [42 U.S.C. § 300n(c)].

§ 300n-4a. Supplemental grants for additional preventive health services

(a) Demonstration projects. In the case of States receiving grants under section 1501 [42 U.S.C. § 300k], the Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to not more than 3 such States to carry out demonstration projects for the purpose of--

(1) providing preventive health services in addition to the services authorized in such section, including screenings regarding blood pressure and cholesterol, and including health education;

(2) providing appropriate referrals for medical treatment of women receiving services pursuant to paragraph (1) and ensuring, to the extent practicable, the provision of appropriate follow-up services; and

(3) evaluating activities conducted under paragraphs (1) and (2) through appropriate surveillance or program-monitoring activities.

(b) Status as participant in program regarding breast and cervical cancer. The Secretary may not make a grant under subsection (a) unless the State involved agrees that services under the grant will be provided only through entities that are screening women for breast or cervical cancer pursuant to a grant under section 1501 [42 U.S.C. § 300k].

(c) Applicability of provisions of general program. This title [42 U.S.C. § 300k et seq.] applies to a grant under subsection (a) to the same extent and in the same manner as such title applies to a grant under section 1501 [42 U.S.C. § 300k].

(d) Funding.

(1) In general. Subject to paragraph (2), for the purpose of carrying out this section, there are authorized to be appropriated \$ 3,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 1998.

(2) Limitation regarding funding with respect to breast and cervical cancer. The authorization of appropriations established in paragraph (1) is not effective for a fiscal year unless the amount appropriated under section 1510(a) [42 U.S.C. § 300n-5(a)] for the fiscal year is equal to or greater than \$ 100,000,000.

§ 300n-5. Funding for general program

(a) Authorization of appropriations. For the purpose of carrying out this title [42 U.S.C. § 300k et seq.], there are authorized to be appropriated \$ 50,000,000 for fiscal year 1991, such sums as may be necessary for each of the fiscal years 1992 and 1993, \$ 150,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 1998.

(b) Set-aside for technical assistance and provision of supplies and services. Of the amounts appropriated under subsection (a) for a fiscal year, the Secretary shall reserve not more than 20 percent for carrying out section 1507 [42 U.S.C. § 300n-3].

# ALASKA STATE LEGISLATURE



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(907) 465-3805 Fax

## SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE SENATOR LYDA GREEN, CHAIR

### COMMITTEE SCHEDULE

BUTROVICH 205

1:30 PM

#### Monday April 23

- + Continuation of Discussion on Medicaid Directions
- + SB 198 STATEWIDE SUICIDE PREVENTION COUNCIL (Halford)
- + SB 38 MEDICAL ASSISTANCE: BREAST/CERVICAL CANCER (Governor)
- + HB 115 EMERGENCY COMMITMENT ORDERS & TREATMENT (Kapsner)

Bills Previously Heard/Scheduled

#### Wednesday April 25

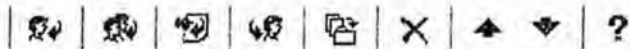
- + Confirmation Hearings

Bills Previously Heard/Scheduled

+ indicates teleconference

= indicates bill previously heard/scheduled

SENATOR LOREN LEMAN, VICE-CHAIR  
SENATOR JERRY WARD, SENATOR GARY WILKEN, SENATOR BETTYE DAVIS



Close

From: Gore, Anne M

To: Diven, Mary R

Cc:

Subject: FW: BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000

Sent: 3/29/01 9:29 AM

Importance: Normal

Received Thursday  
3/29/01 from HCFA/CDC

HCFA/CDC - frequently asked questions/answers

-----Original Message-----

From: NCCD/DCPC Cancer Inquiries [SMTP:nccdcpcinfo@cdc.gov]

Sent: Thursday, March 29, 2001 9:14 AM

To: Abraham, Isasmu Dr.; Altwater, Kirk; Alvarez-Ott, Olga; Azzam, Ihsan; Blanchard, Judi; Bradt, Ellen; Bryant, Janice; Carter, Cathey; Carver, Christine; Clover, Cathy; Conn, Shirley; Craig, BJ; Deem, Vicki; Di Orto, Dolores; Diane Narkunas; Draper, Lee, BSN - SEARHC; Dulin, Stephanie; Erb, Julie; Ertell, Anne; Ferrell Stewart, Jennifer; Fields, Cheryl; Foss, Mary Ann; Green, Joanne; Hasvold, Cindy; Heilman, Nancy Jane; Hoelscher, Catherine, MS; Howerton, Dawn; Imanil, Venancio; Jensen, Ruth; Johnson, Gayle; Judy Hannan; Judy Pilts Reed; Kunz, Karen; Lamb, Deleen; Lawson, Hershel; Lopez, Kerri; Lord, Kelly; Luebbing, Mary Pat; Martin, Lori; McAnarney, Karen; Mercier, Leeann; Mielcarek, Beth; Mirabassi, Janice; Mitchner, Julia; Mooman, Candace; Ochoa, Ted; Olsen, Jennifer; Owl Wiggins, Elizabeth; Patterson, Tina; Pennington, Deborah; Pettitt, Steve L; Reece, Donald; Reichert, Jeannie M., RN - Manillaq; Rexroat, Mary; Riggsbee, Lucie; Ronan, Laura; Rosemarie McIntyre; Ruan, Gale; Scepka, Jean; Schmidt, Kate; Schmidt, Norma; Schultz, Ruth; Schwab, Victoria; Siegl, E.J.; Simmons, Donna; Slagle, Ella Kay; Susanne Pickering; Theis, Ruth; Tilley, Kimberly; Tucker, Celeste; Ueda, Masao; Uyeda, Kit; Wake, Freddie; Walkington, Deb; Wallace, Cynthia; Zilka, Kathleen; Baldwin, Barbara, MA; Blake, Margo C.; Brant, Viki L., MPA; Davies-Cole, John, PhD, MPH; Dexter, Diana; Gore, Anne M., MPH; Imanil, Venancio, Jr.; Muniz, Minnie Inzer, MEd; Myers, Mary Kay; Parker, Christine, MPH; Stoodt, Georjean; Wright, Moira; Buggage, Lynn; Callaghan, Carol, MPH; Fortune, Melody; Geadelmann, Jill Myers, BS, RN; Gugel, Donna; Kenney, MPH; Lawther, Greg; Leonard, Barbara A., MPH; Madigan, Shelly D.; Minami, Colleen; Moody, Conny, MBA; Ronan, Marianne, MPA; Slater, Jonathan S., PhD; Watts, Dena L.; Woodford, Mary Lou

Cc: Reynolds, Steven L.

Subject: BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000

> BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000

>

> On January 4, 2000, the Health Care Financing Administration (HCFA)

> provided initial guidance to State Health Officials to assist with

> implementing the provisions of the Breast and Cervical Cancer Prevention

> and Treatment Act (BCCPTA). 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.

>

> In the attached document you will find a series of frequently asked

> questions and answers about the treatment act. HCFA and CDC will release

> additional guidance as needed and as it becomes available. Please contact

> your program consultant, Cindy French, or Steve Reynolds with any

> questions.

>

> For more information, visit our Web site at:

> <http://www.cdc.gov/cancer/nbccedp/law106-354.htm>

>

> <<Medicaid CDC final fnrv1strdBCQA.doc>>

>

- >
- > Cindy French
- > 770-488-3156
- >
- > Steve Reynolds
- > 770-488-3075
- >
- > Sincerely,
- >
- > Margaret Brome
- > Acting Assistant Branch Chief
- > Program Services Branch
- >  [Medicaid CDC final fnrv1strdBCQA.doc](#)

## **BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000**

On January 4, 2000, the Health Care Financing Administration (HCFA) provided initial guidance to State Health Officials to assist with implementing the provisions of the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). 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 precancerous conditions and early stage cancer.

Below are the first series of answers that respond to some of the questions about the BCCPTA. HCFA and CDC are committed to providing timely responses to important issues and will release additional guidance as needed and as it becomes available.

### **ELIGIBILITY**

**Question 1. What are the eligibility requirements for the new optional eligibility group for women who need treatment for breast or cervical cancer?**

**Answer.** In order to qualify under this new optional category, a woman must meet the following eligibility requirements:

1. The woman must have been screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service (PHS) Act, and found to need treatment for either breast or cervical cancer (including a precancerous condition);
2. She does not otherwise have creditable coverage, 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 described in any of the mandatory Medicaid categorically needy eligibility groups; and
3. She is under age 65. (As mandated by PL 106-354.)

**Question 2. Must a woman be uninsured for a specific length of time before she may be found eligible for Medicaid under this new option?**

**Answer.** No. There are no requirements imposed by federal law that there be a waiting period of prior uninsurance before a woman can become eligible for Medicaid under this new option, and no authority for states to impose such requirements. In addition, if she were insured but her creditable coverage were to end, the woman could become immediately eligible for coverage under Medicaid assuming she satisfied all other eligibility criteria.

**Question 3. What is meant by the term "creditable coverage"?**

**Answer.** The term "creditable coverage" is defined under the new Act to have the same meaning as "creditable coverage" for purposes of HIPAA. A woman having the following types of coverage would be considered to have creditable coverage and would, therefore, be ineligible for the new Medicaid option:

- A group health plan
- Health insurance coverage - *benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.*
- Medicare
- Medicaid
- Armed forces insurance
- A medical care program of the Indian Health Service (IHS) or of a tribal organization
- A state health risk pool

**Question 4. Are there any circumstances where a woman with creditable coverage could be eligible for the new Medicaid option?**

**Answer.** Yes. While the new option requires that a woman is "not otherwise covered under creditable coverage," we read that requirement to refer to creditable coverage for treatment of breast or cervical cancer (in light of the immediately preceding requirement referring to that treatment). There may be limited circumstances where a woman has creditable coverage, as defined above in Question 3, but she is not actually covered for treatment of breast or cervical cancer. For example, if a woman has creditable coverage but is in a period of exclusion (such as a preexisting condition exclusion or an HMO affiliation period) for treatment of breast or cervical cancer, she is not considered covered for this treatment. If a woman who has creditable coverage exhausts her lifetime limit on all benefits under the plan or coverage, including treatment for breast or cervical cancer, she is not considered covered for this treatment. In these types of circumstances, the woman may be eligible for the new Medicaid option, assuming that she meets all other eligibility criteria.

(NOTE: The reference to "not otherwise covered" in the eligibility criteria for this new group is different than under the State Children's Health Insurance Program (SCHIP) eligibility criteria. While the statute also provides that a child is ineligible for SCHIP if covered by a group health plan or health insurance coverage, unlike the new Medicaid option the SCHIP eligibility exclusion is not connected to coverage for a specific condition.)

*(Question 37 addresses the treatment of creditable coverage that may be available/unavailable to American Indians and Alaska Natives (AI/AN) through a medical care program of the IHS or AI/AN tribal organization.)*

**Question 5. Is a woman who has limited coverage, such as limited drug coverage or limits on the number of outpatient visits or high deductibles, eligible for the new Medicaid option?**

**Answer.** No. In order to qualify for this new Medicaid option, a woman must not be otherwise covered under creditable coverage. According to the HIPAA rules defining creditable coverage, most health insurance, including insurance that may have limits on benefits or have high deductibles, is considered creditable coverage. However, there are certain types of coverage that are not considered creditable coverage. A woman who may have one of these types of coverage may be eligible for the new Medicaid option assuming that she meets all other eligibility criteria:

- Limited scope coverage such as those which only cover dental, vision, or long term care.
- Coverage for only a specified disease or illness.

**Question 6. What does it mean that an individual not have "attained age 65"? What if she turns age 65 during her period of coverage?**

**Answer.** The statute uses the term "attained age 65". A woman attains age 65 on the date of her 65th birthday. If the woman turns age 65 during her period of coverage her eligibility will terminate as of the date of her birthday. Her coverage may continue to the end of the month or quarter to the extent that it is the usual and customary practice of the state to pay for coverage through a capitated payment on a monthly or quarterly basis. Similarly, to the extent that it is usual and customary for payment to be due at the onset of a particular service, such as payment for inpatient hospital services upon admission to the hospital, she is entitled to the full service. Further, at attainment of age 65, the state must explore other categories of Medicaid coverage and should assist the individual to continue coverage under Medicare.

**Question 7. Who is considered to have been "screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program?"**

**Answer.**

1. Women are considered screened under the CDC program if their clinical services were provided all or in part by CDC Title XV funds. CDC Title XV grantees are those entities receiving funds under a cooperative agreement with CDC to support activities related to the National Breast and Cervical Cancer Early Detection Program.

In addition, CDC allows Title XV grantees the flexibility to extend the definition of screened under the CDC program to include one or both of the following two options:

2. Women who are screened under a state Breast and Cervical Cancer Early Detection Program in which their particular clinical service was not 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, and the service was within the scope of a grant, sub-grant or contract under that state

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provider agreements

program and the CDC Title XV grantee has elected to include such screening activities by that provider as screening activities pursuant to CDC Title XV.

3. Women who are screened by any other provider and/or entity and the 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 to low-income women, but does not receive funds from the CDC Title XV grantee to support these services, the CDC Title XV grantee would have the option of including these providers' screening activities as part of their overall screening program. The CDC Title XV grantee may require any provider deemed part of the overall screening program to follow program guidelines.

The programs operating in states under the CDC program will provide Medicaid agencies with verification that a woman was screened under the CDC program. A list of state contacts for the CDC National Breast and Cervical Cancer Early Detection Program can be found at web site: <http://www.cdc.gov/cancer/nbccedp/contacts.htm>.

**Question 8. Does a woman have to have been screened for both breast and cervical cancer and found to be in need of treatment before she can be found eligible for Medicaid?**

**Answer.** No. A woman does not have to have been screened for both breast and cervical cancer as a condition of eligibility for Medicaid. Either screen would satisfy the screening requirement.

**Question 9. What is meant by the term "need treatment"?**

**Answer.** The term "need treatment" means that, in the opinion of the woman's treating health professional that the diagnostic test following a breast or cervical cancer screen indicates that the woman is in need of cancer treatment services. These services include diagnostic services that may be necessary to determine the extent and proper course of treatment, as well as definitive cancer treatment itself. Based on the physician's plan-of-care, women who are determined to require only routine monitoring services for a precancerous breast or cervical condition (e.g., breast examinations and mammograms) are not considered to need treatment.

**Question 10. Is there any income test under Medicaid for women under this new eligibility group?**

**Answer.** No. There are no Medicaid income or resource limitations imposed by federal law for this new Medicaid eligibility group, and no authority for states to impose such limitations.

**Question 11. Can a state impose Medicaid asset /eligibility standards on women whose eligibility is based on this new option?**

**Answer.** No. Asset related questions would be appropriate as part of the Medicaid application process only to the extent necessary to determine if the individual is otherwise eligible for Medicaid.

**Question 12. Can a state limit Medicaid eligibility to certain subcategories of women (e.g., women of a certain age, certain geographic residences, or with certain types of cancers or disease severity)?**

**Answer.** No. States must cover all eligible women and may not limit coverage to sub-populations.

### **ELIGIBILITY PERIOD**

**Question 13. If a state elects to expand Medicaid eligibility to include this new optional group, what is the effective date of the coverage available to this group?**

**Answer.** Medicaid eligibility can be effective as early as the first day of the quarter in which the state Medicaid agency submits an approvable state plan amendment to HCFA and the state implements the expansion or a later date specified in the state plan amendment.

**Question 14. When does a woman's eligibility under this new option begin?**

**Answer.** 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 eligibility requirements under the state plan (including having been screened and diagnosed).

**Question 15. When would a woman's eligibility under this new option end?**

**Answer.** A woman determined eligible under this option would continue to be eligible as long as she is receiving treatment for breast or cervical cancer, is under age 65, and is not otherwise covered under creditable insurance coverage. A state may presume that a woman is receiving such treatment during the duration of the period established by her treating health professional in her plan of care. If that period extends beyond a year (or a shorter period at state option), the state must confirm eligibility consistent with standard Medicaid redetermination requirements. Care and services under this new option should be consistent with optimal standards of practice for items and services available under the state plan. The state may use utilization management techniques such as prior approval to monitor care and ensure that it is medically necessary and used efficiently.

**Question 16a. Is a woman limited to one period of eligibility? What happens if a woman goes through treatment for breast or cervical cancer, and then two years after treatment is completed has a recurrence and needs treatment for breast or cervical cancer again?**

**Answer.** No. A woman is not limited to one period of eligibility. A new period of eligibility and coverage would commence each time a woman is screened under a CDC program and found to need treatment for breast or cervical cancer, and meets all other eligibility criteria.

**Question 16b. If a woman is treated for breast or cervical cancer during her first period of eligibility and is subsequently determined to have cancer that has spread to other parts of her body, would she be covered?**

**Answer.** Yes. If the recurrent metastasized cancer is either a known or presumed complication of breast or cervical cancer, and the woman is still in her first period of eligibility, i.e., she is still receiving treatment for the initial breast or cervical cancer diagnosis, she would continue to be eligible for additional treatment. If, however, her first treatment period is over and her Medicaid eligibility has been terminated, she must be recertified as eligible for the CDC program to renew her Medicaid eligibility for the treatment of recurrent breast or cervical cancer.

### **COVERAGE**

**Question 17. What is the scope of coverage under this option?**

**Answer.** During the period of eligibility, a woman is entitled to full Medicaid coverage as specified in the state plan. Coverage is not limited to treatment of breast or cervical cancer (including a precancerous condition).

**Question 18. Can states employ utilization management techniques to determine coverage limits and if so, are there relevant practice standards that can be used to assist states to carry out utilization management activities?**

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

**Question 19. May a state cover experimental treatments?**

**Answer.** Yes. States may cover experimental treatments although they are not required to do so. Routine covered costs associated with the experimental intervention may also be covered.

### **PRESUMPTIVE ELIGIBILITY**

**Question 20. What is presumptive eligibility?**

**Answer.** Presumptive eligibility is a Medicaid option that allows states to enroll women in Medicaid 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. Election of presumptive eligibility provides states the opportunity to offer immediate health care coverage to women likely to be Medicaid eligible, before there has been a full Medicaid eligibility determination.

**Question 21. Is presumptive eligibility mandatory for this group?**

**Answer.** No. Presumptive eligibility is a state option.

**Question 22. When does presumptive eligibility begin?**

**Answer.** Presumptive eligibility begins on the date that a qualified entity determines that the woman appears to meet the eligibility criteria for this new Medicaid option. Federal financial participation (FFP) is allowed for services provided during this presumptive eligibility period regardless of whether the woman is later found eligible for Medicaid.

**Question 23. When does presumptive eligibility end?**

**Answer.** 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.

For example, if a woman is found presumptively eligible on April 1 and files her application before May 31, her presumptive eligibility would continue until her eligibility is determined. If the woman fails to apply, her eligibility would cease on May 31.

**Question 24. Which types of entities can be a qualified entity for purpose of presumptive eligibility?**

**Answer.** State Medicaid agencies can certify entities that are eligible for payments under the 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.

**Question 25. What if the entity does not participate in Medicaid as a health provider or on some other basis? For example, what if a community volunteer group wants to make presumptive eligibility services?**

**Answer.** If the entity receives payment as either a provider or administrative contractor under the state Medicaid plan, the entity could be qualified as long as the Medicaid agency also determines that the entity is capable of making presumptive eligibility determinations.

**Question 26. Can presumptive eligibility determinations be performed at outstationed eligibility locations? Can the full application be filed at an outstationed site?**

**Answer.** Yes. States are generally required to have outstation locations at federally qualified health centers and disproportionate share hospitals. At its option, a state may expand the types of entities that are used in its outstationing program. Outstation activities may be performed by state eligibility workers, by employees of a provider or contractor, or by volunteers.

If a state that arranges with an entity to perform outstation functions determines that the entity is capable of making presumptive eligibility determinations, the state can expand its agreement with the entity to make presumptive determinations for women applying under this new category. In addition, the state can use the outstation location to accept full Medicaid applications from presumptively eligible women. Outstation workers who are not public employees of the agency that makes eligibility determinations can only do initial processing of full Medicaid applications.

For example, a state has an agreement with its federally qualified health centers (FQHC) to conduct outstationing activities. The health centers also are part of the state's early detection coalition under Title XV and offer both cervical cancer and breast cancer screening. A state that adopts presumptive eligibility may enter into an agreement with the FQHCs to make presumptive eligibility determinations and perform outstationed enrollment activities for presumptively eligible women.

**Question 27. Must a full Medicaid eligibility determination be completed in order to establish presumptive eligibility?**

**Answer.** No. Presumptive eligibility is designed to permit temporary Medicaid coverage while a complete eligibility determination is conducted. Presumptive eligibility permits rapid access to health care for women found through screening to need cancer treatment. To streamline this process, at the point that presumptive eligibility is being determined, a presumptive eligibility provider need to determine only that the woman has been screened under the state's breast and cervical cancer detection program (as defined by the state) and needs treatment, is under age 65, and has neither Medicaid nor any other form of individual or group health insurance. For women who meet these rapid criteria, coverage on a presumptive basis can begin. The state will provide qualified entities with application forms and information on how to assist such individuals in completing and filing such forms. This will enable the qualified entity to assist a presumptively eligible woman in applying for formal coverage and to help her collect and provide the state agency with needed information to determine eligibility, including income and resource information, and other information related to residency and legal status.

**Question 28. Are state administrative expenditures for a presumptive eligibility program eligible for a federal match?**

**Answer.** Yes. Expenditures for presumptive eligibility activities, including payments to the qualified entity for the administrative costs of making presumptive determinations and providing application assistance would be allowable administrative costs under Medicaid and federal financial participation would be available at the 50% rate. Expenditures for providing services to presumptive eligibles under this category are eligible for the enhanced federal matching rate.

**Question 29. Can provider taxes or donations be used to support the state share of a presumptive eligibility program?**

**Answer.** Provider taxes that meet the requirements of §1903(w) of the Social Security Act may be used to support the state share of a presumptive eligibility program. Furthermore, §1903(w) of the Act provides an exception to the otherwise restrictive rules governing provider-related donations, by considering as permissible provider donations made by a hospital, clinic, or similar entity for the direct costs of state or local agency personnel who are stationed at the facility to determine eligibility of individuals for Medicaid or to provide outreach services to eligible Medicaid individuals. Thus, under the statutory exception, donations made by a hospital, clinic, or similar entity to cover the direct costs of a state or local agency worker stationed at such facility could be used to support the state share of a presumptive eligibility program. It must be noted that this exception applies to the costs of state or local agency workers (i.e., outstationed state employees) and is not applicable to costs incurred by provider personnel. Under the latter arrangement, an in-kind donation made by the provider would be subject to the very restrictive bona fide provider-related donation statutory provisions and would more than likely not be considered a permissible source of state share." Donations by health providers to cover the direct costs associated with presumptive eligibility would be permissible as a form of Medicaid outreach in accordance with the requirements of 42 C.F.R. §433.66 (b)(2). A state could report these provider donations as a state expenditure for purposes of claiming the federal administrative match.

**Question 30. Must a state enter into presumptive eligibility agreements with all entities that are eligible to receive federal payments under Medicaid and are capable of carrying out presumptive eligibility services?**

**Answer.** No. A state may select among qualified presumptive eligibility providers. However, HCFA and the CDC encourage states to elect presumptive eligibility as a means of promoting access to rapid coverage, which is essential to treatment. Furthermore, we encourage states that elect to use presumptive eligibility to make decisions about presumptive eligibility sites through closely coordinated efforts among the state Medicaid agency, the state agency that administers the early detection program, and community breast and cervical cancer coalitions. This will best ensure the availability of presumptive eligibility and enrollment assistance at a sufficient number of locations to ensure that the purposes of this Act are achieved.

**Question 31. Were a state to offer presumptive eligibility, would the state be required to do so on a statewide basis?**

**Answer.** Yes. Presumptive eligibility is part of the state plan and must be made available on a statewide basis.

#### **CITIZENSHIP AND ALIENAGE**

**Question 32. Does this new eligibility option amount to a "federal means tested public benefit"?**

**Answer.** Yes. Medicaid is a federal means tested public benefit.

**Question 33. Are qualified aliens and non-qualified aliens eligible for the new Medicaid option?**

**Answer.** 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.hhs.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). 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.

**Question 34. What does the term "emergency medical condition" mean?**

**Answer.** 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.

**Question 35. Would treatment for breast and cervical cancer (including treatment for a precancerous condition) be classified as coverage for an "emergency medical condition?"**

**Answer.** 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.

#### **TREATMENT OF TERRITORIES**

**Question 36. Does the new law apply to the United States territories?**

**Answer.** Yes. 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**

**Question 37. Since medical care furnished by the Indian Health Service (IHS) or AI/AN tribal organizations is treated as “creditable coverage” under the PHS Act, how does this affect AI/AN women?**

**Answer.** Medical care programs of the IHS or of a tribal organization is creditable coverage under §2701(c) of the PHS Act; however not all AI/AN women are covered under such programs (in this case, for breast or cervical cancer treatments). Some AI/AN women may not have access to coverage under such programs at all: for example, women who do not live on a reservation or near an IHS facility. States are encouraged to work with IHS and tribal organizations to ensure that AI/AN women screened under the CDC program who lack such coverage are enrolled in Medicaid.

Furthermore, some AI/AN women who have creditable coverage through IHS may not be covered under that creditable coverage (*refer to questions 3 through 5 for a detailed explanation of creditable coverage*) with respect to treatment for breast or cervical cancer. If the State eligibility worker (or the qualified entity that performs presumptive eligibility) determines that the AI/AN woman lacks coverage for breast and cervical cancer treatment through the IHS or tribal organization, that AI/AN woman can be included in the new Medicaid eligibility group. Such a determination should be based on a documented refusal or inability by IHS or tribal organization to provide (or continue to provide) treatment for breast or cervical cancer. States should consult and work with IHS and tribal organizations to understand when such a determination is appropriate, and to streamline documentation requirements.

**Question 38. What type of coordination should states engage in with the IHS and tribes and tribal organizations?**

**Answer.** States should ensure that the IHS and tribal health programs that participate in the CDC early detection program are fully involved in the planning process regarding implementation and coordination between the state’s early detection program and the expanded Medicaid eligibility option.

**Question 39. Are the IHS or tribal health programs administered by Indian tribal organizations eligible to receive Medicaid payments for the breast and cervical cancer treatment they furnish to Medicaid-eligible women?**

**Answer.** Yes. IHS and tribal health programs would be eligible for payment for covered services to the same extent as they would be eligible for payment for any other covered Medicaid service.

### **FEDERAL FINANCIAL PARTICIPATION**

**Question 40. What level of enhanced FFP is available to states that elect to add coverage under this option? How can a state find out what its enhanced match rate will be?**

**Answer.** 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 Act. That rate is published annually in the Federal Register, and is posted on the web site at <http://aspe.os.dhhs.gov/health/fmap.htm>.

**Question 41. When is the enhanced federal matching rate available for Medicaid expenditures on the new eligibility group?**

**Answer.** The new law has an effective date of October 1, 2000. In order to be eligible for payment under this new Act, a state or territory must submit a state plan amendment (SPA) electing this optional categorical needy eligibility group and/or to provide presumptive eligibility. A SPA can be effective back to the first day of the quarter in which it is submitted. Funding for this group would be available back to the effective date of the SPA. Attached is a state plan preprint that should be used by states electing these new options.

**Question 42. What level of FFP is available to States for providing case management as a medical service under the BCCPTA? What level of FFP is available to States for providing case management as an administrative activity?**

**Answer.** State Medicaid expenditures are generally claimed under two categories: medical assistance (that is, medical services) and administrative expenditures. The federal matching rate for medical assistance expenditures, referred to as the federal medical assistance percentage (FMAP), is generally the same for all types of medical services, but varies by state in accordance with a statutorily prescribed formula. The FFP for States' administrative expenditures is the same for all States, but varies by the type of administrative expenditure.

Under the BCCPTA, covered medical services provided to the new eligibility group, including services case management, are matched at an enhanced FMAP. That rate is published annually in the Federal Register, and is posted on the web site at <http://aspe.os.dhhs.gov/health/fmap.htm>.

**Question 43. Is there any aggregate upper limit on the availability of federal funds for this new eligibility group?**

**Answer.** No. This is a Medicaid benefit and there is no aggregate upper limit on the federal funds available to furnish coverage to individuals eligible under this new eligibility group.

**Question 44. What financial obligations for medical assistance will a state incur under the Act?**

**Answer.** A state is responsible for its share of covered medical assistance consistent with the enhanced federal matching rate. Because the enhanced federal matching rate is significantly higher than the standard Medicaid federal matching rate, a state's financial responsibility for expansions authorized by the BCCPTA will be significantly lower than under the standard program. States will be able to obtain access to the enhanced federal matching in advance of actual expenditures, pursuant to the normal Medicaid funding mechanism.

**Question 45. Can Medicaid require cost sharing from women eligible in the new eligibility group?**

**Answer.** Yes, for non-pregnant women over age 20, but cost sharing is limited to deductibles, coinsurance copayments or similar charges that do not exceed the nominal amounts set forth in federal Medicaid regulations. Under these requirements, for non-institutional services, any deductible cannot exceed \$2.00 per month per family for each period of Medicaid eligibility, coinsurance may not exceed 5 percent of the payment the state makes for the services, and the maximum copayment for a single service would be \$3.00. For institutional services, cost sharing may not exceed 50 percent of the payment made by the state for the first day of institutional care. Only one of these types of charges can be imposed for each service, and there must also be a cumulative maximum amount for all deductible, coinsurance or copayment charges.

**Question 46. If a state were to impose cost-sharing requirements (to the extent permitted under Medicaid law and regulation) on individuals in this new eligibility group, would cost sharing amounts count toward the state share?**

**Answer.** No. Beneficiary cost sharing is not considered part of the state match for expenditures under Title XIX but an applicable credit that reduces state expenditures. Beneficiary cost-sharing revenues collected by the state must be applied to offset, that is to reduce overall federally matchable Medicaid expenditures. Such revenues effectively reduce both the state and federal shares of allowable Title XIX expenditures, and both state and federal governments would be credited with their respective share of these cost sharing funds. Cost sharing collected and retained by providers would not count as expenditures or revenues to the state.

For example, if the total expenditure for a beneficiary is \$20,500 and the state collects \$500 in cost sharing, the expenditure allowable for Title XIX purposes would be \$20,000. If the state's enhanced FMAP was 65%, the federal government would pay the state \$13,000 and net state responsibility would be \$7,000.

**Question 47. How will states report their expenditures related to the new law?**

**Answer.** HCFA is currently revising the form HCFA-64, Medical Assistance Expenditures by Type of Service for the Medical Assistance Program, to include a new Column (e) specifically dedicated to reporting these expenditures. We are currently reprogramming the MBES/CBES automated reporting system (Medicaid Budget Expenditure System/State Children's Health

Insurance Program Budget Expenditure System) to incorporate this change. We expect this change to be completed in time for the states to use this in reporting their first quarter fiscal year 2001 expenditure report which is due January 30, 2001. We will also be sending detailed reporting instructions to the states.

### **APPLICATION AND ENROLLMENT**

**Question 48. What are the basic elements of an application under this new option? How simple can it be?**

**Answer.** The basic elements of an application under this new option can be simple. The individual must provide a social security number and information about her health insurance and citizenship/alienage status. The application must notify the individual about her rights and responsibilities and must be signed. No verification is required under federal law except alien status if the woman is not a citizen. The application must contain sufficient information to determine if an individual is described in the mandatory Medicaid categorical eligibility groups. However, the application could be structured to avoid asking for unnecessary information. If, for example, an individual is not pregnant, does not have dependent children, and is not disabled, no additional income or asset information needs to be collected, since the woman has no relationship to one of the mandatory categorical eligibility groupings. If the information on the application indicates that the individual is not likely to be in a mandatory Medicaid group, the state does not have to perform a full determination for those groups. However, if a short application that is expressly designed for this new option would not collect enough information to allow the state to actually determine her eligibility under all other mandatory Medicaid coverage groups, the application must say so and must inform the woman of her right to file a full application.

**Question 49. Must there be a written application?**

**Answer.** Yes. Medicaid requires that there be a written application and that the final determination be made by the agency which determines Medicaid eligibility. An outstationed enrollment provider that performs outstationing functions for this newly eligible category of women can receive and initially process applications but cannot make the final determination. However, the final determination can be made at the outstationed enrollment provider site if it is done by a State employee from the agency that makes Medicaid eligibility determinations.

**Question 50. How quickly must the application be processed?**

**Answer.** Applications must be processed within 45 days, barring unusual circumstances.

**Question 51. What if a woman who applies is determined not to meet the qualifications of this new option?**

**Answer.** If the information on the application is sufficient to determine her eligibility under some or all relevant categories, the state must make this determination before denying coverage.

If the application does not permit a determination under all relevant categories, the applicant must be notified and given the opportunity to submit the additional information required to make a determination under other categories.

### **GENERAL STATE IMPLEMENTATION**

**Question 52. Is the expansion of Medicaid eligibility authorized by the new law mandatory or optional for states?**

**Answer.** The new Medicaid eligibility group is optional for states.

**Question 53. If a state wishes to expand Medicaid eligibility to include the new eligibility group authorized by the new law, what is the state required to do? Must a state plan amendment be submitted? What must the state do to add presumptive eligibility for the group?**

**Answer.** In order to be eligible for payment under this new Act, the state or territory must submit a state plan amendment electing this optional categorical eligibility group and/or providing presumptive eligibility. Attached is a state plan preprint that should be used by states electing these new options.

**Question 54. Can states offer targeted case management for women with breast and cervical cancer?**

**Answer.** Yes. A state can develop a targeted case management program under its Medicaid state plan for women with breast and cervical cancer. Such a program would be designed to assist the target population in accessing needed medical, social, educational, and other services. States can find additional information on targeted case management at §1915(g) of the Act and §4302 of the state Medicaid Manual. States also may wish to consult the National Association of Social Workers' Standards for Social Work Case Management, June, 1992, or the Case Management Society of America's Standards of Practice for Case Management, 1995.

**Question 55. Can a state require a beneficiary under this benefit to enroll in a managed care organization or managed care entity?**

**Answer.** Yes. By electing in its state plan to do so, a state may require beneficiaries to enroll in managed care arrangements to obtain coverage. To the extent consistent with usual and customary practices, a state could contract with full-service managed care organizations or managed care entities that specialize in the management of breast and cervical cancer patients and receive payments on a global basis. Those arrangements must ordinarily permit eligible individuals a choice of managed care entities. Furthermore, such arrangements must either include the full range of Medicaid coverage, or must be coordinated with other arrangements to furnish beneficiaries the full range of Medicaid coverage.

In the event that a state decides to use managed care arrangements for breast and cervical cancer patients, we urge state Medicaid agencies and state health agencies to collaborate in developing standards and contractual specifications for participation by either full service or specialty MCOs. At a minimum such standards should address the following issues: enrollment; scope of coverage; case management; provider network capabilities; geographic and service timeline access; cultural competence and language access; quality improvement; data; and external review. MCOs that participate in breast and cervical cancer treatment must meet all standards applicable to MCOs under the Medicaid program.

**Question 56. Is breast reconstructive surgery a covered service under the new Medicaid option?**

**Answer.** Reconstructive breast surgery may be provided as an optional service under the Medicaid program. If a state elects this option, women eligible for breast cancer treatment through the new Medicaid option can receive breast reconstructive surgery as defined in the state's Medicaid plan.

**Question 57. Are men diagnosed with breast cancer eligible for this Medicaid benefit?**

**Answer.** No. Title XV (Public Law 101-354) precludes men from being eligible to receive screening and/or diagnostic services through the CDC NBCCEDP; therefore, men may not be considered screened under the program.

## MEDICAID SERVICES AND GROUPS NOT IN CURRENT STATE LAW

### OPTIONAL SERVICES

Chiropractic  
Case Management (for additional populations)  
Christian Science Nurses  
Christian Science Sanatorium  
Clinic services  
Community Supported living arrangements  
Adult dental services (preventive and restorative)  
Dentures  
Diagnostic services  
Emergency Hospital services (for hospitals not enrolled)  
Podiatry  
Preventive Services  
Private Duty Nursing  
Respiratory Therapy  
Screening services  
Home and community care for functionally disabled elderly  
Services of any type of practitioner licensed under state law

- Psychologists and Psychological Associates
- Licensed Clinical Social Workers
- Marital and Family Therapists
- Acupuncturists
- Licensed Professional Counselors
- Naturopaths

### OPTIONAL GROUPS

TB infected individuals  
Women diagnosed with breast or cervical cancer under the CDC Program  
Aged and disabled with incomes to 100% of the Federal Poverty level  
Expanded Working Disabled Option  
Medically Needy families and children  
Medically Needy Aged and Disabled  
Independent Foster Care Adolescents  
Presumptive eligibility for pregnant women  
Presumptive eligibility for children  
Other groups of low income people under a Demonstration Waiver  
Family Planning Waiver

### OTHER SERVICES OR GROUPS THAT HAVE BUDGETARY IMPLICATIONS BUT MAY NOT REQUIRE LEGISLATION

Alzheimer's and other conditions for nursing facility /waiver admission  
12 month continuous eligibility for children  
Non emergent transportation within communities of residence  
School based services  
Tobacco cessation services  
More liberal financial eligibility and coverage policies

**The National Breast and Cervical Cancer  
Early Detection Program**

**Program Announcement 99052**

**Alaska's Proposal**

Project Period: 9/30/00 – 9/29/01

Submitted By:

State of Alaska  
Department of Health & Social Services  
Division of Public Health  
Section of Maternal, Child and Family Health  
1231 Gambell Street  
Anchorage, AK 99501

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<b>APPLICATION FOR FEDERAL ASSISTANCE</b>		<b>2. DATE SUBMITTED</b> May 26, 2000	Applicant Identifier
<b>1. TYPE OF SUBMISSION:</b> Application <input type="checkbox"/> Construction <input type="checkbox"/> Preapplication <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction <input type="checkbox"/> Non-Construction		<b>3. DATE RECEIVED BY STATE</b> March 30, 2000	State Application Identifier
		<b>4. DATE RECEIVED BY FEDERAL AGENCY</b>	Federal Identifier
<b>5. APPLICANT INFORMATION</b>			
Legal Name: <b>STATE OF ALASKA</b> Department of Health & Social Services		Organizational Unit: Division of Public Health Section of Maternal, Child & Family Health	
Address (give city, county, state, and zip code) 1231 Gambell Street Anchorage, AK 99501		Name and telephone number of the person to be contacted on matters involving this application (give area code) Pam Muth, MPH, Chief Section of Maternal, Child & Family Health (907) 269-3400	
<b>6. EMPLOYER IDENTIFICATION NUMBER (EIN):</b> 9   2   -   6   0   0   1   1   8   5		<b>7. TYPE OF APPLICANT: (enter appropriate letter in box)</b> <input checked="" type="checkbox"/> A	
<b>8. TYPE OF APPLICATION:</b> <input type="checkbox"/> New <input checked="" type="checkbox"/> Continuation <input type="checkbox"/> Revision If Revision, enter appropriate letter(s) in box(es) <input type="checkbox"/> <input type="checkbox"/> A Increase Award B Decrease Award C Increase Duration D Decrease Duration Other (specify) _____		A. State H. Independent School District B. County I. State Controlled Institution of Higher Learning C. Municipal J. Private University D. Township K. Indian Tribe E. Interstate L. Individual F. Intermunicipal M. Profit Organization G. Special District N. Other (Specify)	
<b>10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:</b> 9   3   -   9   1   9		<b>9. NAME OF FEDERAL AGENCY:</b> Centers for Disease Control and Prevention	
TITLE: National Breast & Cervical Cancer Early Detection Program		<b>11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:</b> Alaska Breast & Cervical Cancer Early Detection Program	
<b>12. AREAS AFFECTED BY PROJECT (cities, states, etc.):</b> State of Alaska			
<b>13. PROPOSED PROJECT:</b> Start Date: 9/30/99 Ending Date: 9/29/04		<b>14. CONGRESSIONAL DISTRICTS OF:</b> a. Applicant: Alaska Congressional District b. Project: Alaska	
<b>15. ESTIMATED FUNDING:</b>		<b>16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?</b>	
a. Federal	\$ 1,837,492	a. YES THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON: DATE:	
b. Applicant	\$ 0	b. NO <input checked="" type="checkbox"/> PROGRAM IS NOT COVERED BY E.O. 12372	
c. State	\$	<input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
d. Local	\$		
e. Other	\$ 824,401		
f. Program Income	\$ 0	<b>17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?</b>	
g. TOTAL	\$ 2,661,893	<input type="checkbox"/> Yes If "Yes" attach an explanation. <input checked="" type="checkbox"/> No	
<b>18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.</b>			
a Typed Name of Authorized Representative Karen Perdue		b Title Commissioner Department of Health & Social Services	c Telephone Number (907) 465-3030
Signature of Authorized Representative <i>Karen Perdue</i>			e Date Signed 5/19/2000

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 0318-0044

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. BCCEDP		\$ 350,000	\$	\$ 1,837,492	\$ 824,401	\$ 2,661,893
2.						
3.						
4.						
5. TOTALS		\$ 350,000	\$	\$ 1,837,492	\$ 824,401	\$ 2,661,893

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1) 40%	(2) 60%	(3) Total	(4) Match	
a. Personnel	\$ 290,943	\$ 186,233	\$ 477,176	\$	\$ 477,176
b. Fringe Benefits	87,283	55,870	143,153		143,153
c. Travel	41,115	10,260	51,375		51,375
d. Equipment					
e. Supplies					
f. Contractual	44,000	937,674	981,674		981,674
g. Construction					
h. Other	84,861		84,861	824,401	909,262
i. Total Direct Charges (sum of 6a - 6h)	548,202	1,190,037	1,738,239	824,401	2,562,640
j. Indirect Charges	99,253		99,253		99,253
k. TOTALS (sum of 8i and 8j)	\$ 647,455	\$ 1,190,037	\$ 1,837,492	\$ 824,401	\$ 2,661,893
7. Program Income	\$	\$	\$	\$	\$

**SECTION C - NON-FEDERAL RESOURCES**

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. BCCEDP	0	0	0 824,401	0 824,401
9.				
10.				
11.				
12. TOTALS (sum of lines 8 and 11)	0	0	0 824,401	0 824,401

**SECTION D - FORECASTED CASH NEEDS**

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	0 1,837,492	0 459,373	0 459,373	0 459,373	0 459,373
14. Non-Federal	824,401	206,100	206,100	206,100	206,101
15. TOTAL (sum of lines 13 and 14)	0 2,661,893	0 665,473	0 665,473	0 665,473	0 665,474

**SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT**

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. Breast and Cervical Cancer Early Detection	0 1,837,492	0 1,837,492	0 1,837,492	0 1,837,492
17.				
18.				
19.	0 1,837,492	0 1,837,492	0 1,837,492	0 1,837,492
20. TOTALS (sum of lines 16 - 19)				

**SECTION F - OTHER BUDGET INFORMATION**

(Attach additional Sheets If Necessary)

21. Direct Charges: \$1,738,239	22. Indirect Charges: 16% Personnel + Fringe Benefits = \$99,253
23. Remarks	

### CHECKLIST

**Public Burden Statement:** Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate, or any other aspect of this collection of information, including suggestions for reducing this burden, to the OS Reports Clearance Officer, ASMB/Budget/DIOR, Room 503H, HHH Bldg., 200 Independence Ave., S.W., Washington, D.C. 20201.

**NOTE TO APPLICANT:** This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last page of the signed original of the application. This page is reserved for CDC staff use only.

Type of Application:     NEW             Noncompeting Continuation     Competing Continuation     Supplemental

**PART A:** The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

- |  | Included                            | NOT<br>Applicable |
|--|-------------------------------------|-------------------|
| 1. Proper Signature and Date for Item 18 on SF 424 (FACE PAGE) ..... | <input checked="" type="checkbox"/> |                   |
| 2. Human Subjects Certification, when applicable (45 CFR 46) .....   | <input type="checkbox"/>            | <b>XX</b>         |

**PART B:** This part is provided to assure that pertinent information has been addressed and included in the application.

- |   | YES                      | NOT<br>Applicable |
|---|--------------------------|-------------------|
| 1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required? .....                             | <input type="checkbox"/> | <b>XX</b>         |
| 2. Has the appropriate box been checked for item # 16 on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100) ..... | <b>XX</b>                |                   |
| 3. Has the entire proposed project period been identified in item # 13 of the FACE PAGE? .....  | <b>XX</b>                |                   |
| 4. Have biographical sketch(es) with job description(s) been attached, when required? .....   | <b>XX</b>                |                   |
| 5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) been completed and included? .....  | <b>XX</b>                |                   |
| 6. Has the 12 month detailed budget been provided? .....  | <b>XX</b>                |                   |
| 7. Has the budget for the entire proposed project period with sufficient detail been provided? .....  | <input type="checkbox"/> | <b>XX</b>         |
| 8. For a Supplemental application, does the detailed budget address only the additional funds requested? .....  | <input type="checkbox"/> | <b>XX</b>         |
| 9. For Competing Continuation and Supplemental applications, has a progress report been included? .....   | <b>XX</b>                |                   |

**PART C:** In the spaces provided below, identify the applicant organization's administrative official to be notified if an award is made and the individual responsible for directing the proposed program/project.

Name, title, organization, address, E-mail address (if any), FAX, and telephone number of the administrative official to be notified if an award is to be made.

Orlando Moskito  
Revenue Unit Supervisor  
Dept. of Health & Social Services  
P.O. Box 110650  
Juneau, Alaska 99811-0650/(907) 465-3131

Name, title, organization, address, E-mail address (if any), FAX, and telephone number of the program director/project director/principal investigator designated to direct the proposed project or program.

Pam Muth, Chief  
Section of Maternal, Child, & Family Health  
1231 Gambell Street  
Anchorage, Alaska 99501 / (907) 269-3400

APPLICANT ORGANIZATION'S 2-DIGIT OHHS EIN III already assigned

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SOCIAL SECURITY NUMBER

5	0	3	-	8	4	-	6	4	6	5
---	---	---	---	---	---	---	---	---	---	---

HIGHEST DEGREE EARNED

MPH
-----

(OVER)

## **NEW OR SIGNIFICANTLY REVISED INFORMATION**

The program anticipated increasing the percent of Alaska Natives served from 1.5% to 10% by December 31, 2000. It is unlikely this projection will be reached, primarily because the program has not yet been in a position to work with Native health agencies. During the past year, the program has had to define and clarify its policies and procedures. The program has been diligent in its commitment to complete this undertaking before working with new screening providers. We anticipate establishing partnerships with Native health agencies within the next year. The percent of Alaska Natives served by the program should increase to the 10% goal by 12/2001.

The program projected adding screening providers in three communities that already had screening providers, and in seven additional communities that did not have screening providers. The timeline for accomplishing this has been pushed back because, again, the program had to define and clarify its policies and procedures before working with new providers. We should begin adding new providers by July 2000 and reach our projected goal by the end of FY2001.

The program will continue to strive to improve the rate of appropriate follow-up of abnormal CBEs toward 100%. According to the most recent MDE submission, we are making progress toward that goal (58.6 % to 63.6%), however, it is unlikely we will reach 100% by September 30, 2000. Rates are monitored on a semi-annual basis in conjunction with MDE submissions.

The program budgeted to screen 4,500 women in FY 2000 while the projected timeline for reaching this figure was not until December 31, 2001. The program is steadily increasing the numbers of women screened and should reach its projection as planned.

The program has found that having a large statewide coalition does not efficiently or effectively support program services. The program, therefore, has moved in the direction of working with community-based groups on a regional basis. This information was included in the April 2000 progress report to PGO and is discussed in further detail under section 3 of this continuing grant application, Partnership Development and Community Involvement.

Case management initiatives will be expanded beyond the description in the FY2000 application and are addressed in the attached plan. Related to this issue, the program has found that at this time, the only tribal grantee with which we have a need to coordinate services to women screened is SEARHC. We are working to coordinate services on an ongoing basis and will work toward establishing a memorandum of agreement. At this time, there is no apparent need for this type of collaboration with the other tribal grantees.

The public health nursing position to be funded half-time by the program has not been filled. The position is still being negotiated and hiring for that position is dependent, in part, upon action that must be taken by Public Health Nursing. The budgeted Administrative Clerk II position has not yet been filled; however, we anticipate filling the position by the end of FY2000.

### Rescreening Operational Plan and Protocol

Each woman who is enrolled in AK-BCCEDP must be tracked and recalled for an annual Pap test, pelvic exam, CBE, and, if she is 50 to 64 years old, a mammogram. Each provider is responsible to maintain a system for identifying and notifying AK-BCCEDP clients who are due

for clinical breast and pelvic exams, mammograms, and Pap tests. AK-BCCEDP will pay for annual rescreening [including screening mammography (for all women age 50 to 64 and 10% of women age 40 to 49), clinical breast exam (CBE), Pap test, and pelvic exam] that occurs no sooner than eleven (11) months from the service date of the previous annual screening. Contact must be made with the program consultant if annual screening needs to take place sooner than eleven months from the previous annual screening.

To assist with client recall, each provider will receive from the AK-BCCEDP a monthly list of clients who are due for annual screenings, approximately one (1) month before these clients are due to be rescreened. For example, in May 2000, the AK-BCCEDP will send the provider a list of clients due for annual screening in June 2000. If the client does not return for rescreening, she will not be on the list again in subsequent years.

#### Minimum Requirements for Recalling Clients

1. The screening provider sends personalized reminders to clients three to six weeks before the anniversary date of the previous year's exam.
2. If no appointment has been made, call the client one to four weeks prior to the screening anniversary date and schedule an appointment if the client agrees to rescreening. Verification of the woman's continuing eligibility should be made during this call. If the client is no longer eligible, refer her to other resources for ongoing screening and follow-up.
3. Make a second telephone call within three weeks after the annual screening date if no appointment has been scheduled or if the client has failed to keep a scheduled appointment.

If no appointment has been made, or if the client has failed to keep a scheduled appointment, record your attempts to contact the client in the client's medical record.

### **PROGRESS REPORT**

A. Management. The Alaska BCCEDP changed management in February 1999. One of the primary activities following the change, and of this grant year, has been to develop, define and clarify policies and procedures for the program. This has been a major undertaking, but one which has significantly improved the program. We have also had many personnel management challenges in the program to include staff vacancies. In addition, the program has been laying the groundwork necessary to increase screening and diagnostic services in both communities currently without participating screening providers and in communities with screening providers but not enough to serve to the potentially eligible population. We plan to increase the number of women screened to 4,500 by December 31, 2001. The program had to delay plans to add new screening providers because the program lacked clear, consistent, documented policies and procedures that needed to be developed before adding new providers. During this grant year the following has occurred or been accomplished:

- Increased the number of diagnostic providers who have agreements with program by five
- Revised program Policies and Procedures Manual for providers. Task included having to develop and define many policies and procedures contained therein.
- The program's women's health nurse practitioner (NP) position was vacant for six months (10/99-3/00) resulting in some program activity deadlines being pushed back. Priority for the NP consultant's time will be re-convening the Clinical Advisory Committee, participating in the overall quality assurance process, monitoring and addressing abnormal clinical breast exam (CBE) follow-up needs, implementing new cervical cancer and case management policies, and improving the overall quality of, and standardizing, CBE techniques.

- The program's public education/marketing position was vacant for three months (11/99-2/00). Several major activities have been undertaken and/or achieved since filling that position (see Public Education, Information and Outreach).
- The program Accounting Technician position was vacant for three months (8/99-11/99) during a state hiring freeze and following the implementation of a new system for program billing. Program billing got two or more months behind. The Accounting Technician position was filled in November 1999 and program bills are now typically processed within one week of their receipt in the billing office.
- The program Public Health Nurse liaison position (half-time) and Administrative Clerk II position remain vacant. The program is taking steps to fill the clerk position. The nursing position is still being negotiated and hiring for that position is dependent, in part, upon action that must be taken by Public Health Nursing.

### B. Surveillance

Women Screened. From 3/95-9/30/99, the AK-BCCEDP screened a total of 8,748 women. The following tables show the breakdown of enrolled women by age group, race and ethnicity. The number of new women enrolled increased from 1,840 in year four to 2,276 in year 5 (FY99). The majority of women served by the program continue to be white, non-Hispanic women. Sixty-nine percent of screening mammograms go to women ages 50-64. Based on our data runs, the program is now almost meeting the 75% minimum for screening mammograms and we are continuing to work with providers on this issue. The number of women receiving initial mammograms has steadily increased each year, from 24 in FY95 to 1,524 in FY99.

Age of Enrolled Women 3/95 – 9/30/99

Age Group	Frequency	Percent
<20	357	4
20-29	1951	22
30-39	2198	25
40-49	2187	25
50-64	1769	20
>65	286	3

Race and Ethnicity of Enrolled Women 3/95 – 9/30/99

Race	Hispanic	Non-Hispanic	Unknown	Total
AK Native/ Am Ind (1.6%)	9	122	7	138
Asian/Pacific Island (5.2%)	16	430	9	455
African American (6.7%)	36	539	7	582
White (79.3%)	614	6180	147	6941
Other (3.4%)	228	58	12	298
Unknown (3.8%)	33	46	255	334
Total (100%)	936 (11%)	7375 (84%)	437 (5%)	8748

Insurance Status. The AK-BCCEDP collects information on insurance status as part of its eligibility determination process. Currently, eligibility forms are retained by the provider in the enrolled woman's medical chart and are reviewed during monitoring site visits. This information is not reported to AK-BCCEDP at this time. Information concerning insurance status, however, is often obtained by the program through the AK-BCCEDP billing office through the routine submission of bills by providers seeking reimbursement for services. In March 2000, we began to enter insurance information into the database used for bill processing. The program receives notification from providers when women have met or not met their deductible, when Medicaid has paid all or a portion of a bill, or when providers make a special notation that a patient does or

does not have insurance. Because we have only very recently begun to enter this information, we are unable to break out screening by insurance status at this time.

Rescreening. The formula for the rescreening rates was the one detailed in the handouts provided to the program managers at their annual meeting in 2/17/00.

Race and Ethnicity of Rescreened Women. For the period 3/93-12/97, rescreening of women has occurred most among the white, non-Hispanic women enrolled in the program. This is to be expected as they are the largest group of women enrolled. A breakdown by age group is provided below describing rescreened women.

Race/Ethnicity of Rescreened Women	40-49 years	50-64 years
White	87.5%	76%
Black	6.25%	10%
Asian	6.25%	6%
Alaska Native/American Indian	N/A	2%
Other	N/A	4%
Unknown	N/A	2%
Non-Hispanic	87.5%	13%
Hispanic	6.25%	82%
Unknown	6.25%	5%

Abnormal Findings. Abnormal findings are reported for the period 3/95 - 9/30/99.

Mammograms. Abnormal findings include all women with a finding of probably benign short-term follow-up indicated, highly suspicious, suspicious for malignancy and assessment incomplete (BIRADS 3, 4, 5 or 6). As expected, women with abnormal screening mammogram findings are more likely to be older women (50-59), the percentage increasing with increasing age. One-fourth of women with abnormal mammogram results reported never having a mammogram. Race and ethnicity of abnormal mammograms reflect percentages similar to that over the overall population screened.

Clinical Breast Exams. The following tables give the breakdown of results for clinical breast exams by age and race.

**CBE Results by Age Group, 3/95 - 9/30/99**

Result	<20	20-29	30-39	40-49	50-64	>64	Total
Normal/ Benign	161 (3%)	1125 (18%)	1425 (23%)	1659 (27%)	1518 (25%)	210 (3%)	6098
Abnormal Suspicious	4 (1%)	36 (9%)	106 (28%)	134 (35%)	87 (23%)	11 (3%)	378

**CBE Result by Race, 3/95 - 9/30/99**

Result	White	Black	Asian	AK Native	Other	Unknown	Total
Normal/ Benign	4807 (79%)	416 (7%)	287 (5%)	88 (2%)	300 (5%)	200 (3%)	6098
Abnormal Suspicious	320 (85%)	24 (6%)	6 (2%)	7 (2%)	8 (2%)	13 (3%)	378

Eighty-nine percent (89%) of abnormal suspicious CBEs are among non-Hispanic women. Only 6% of abnormal suspicious CBEs are in Hispanic women which is consistent with our overall program demographics.

Pap Tests. Abnormal Pap test results (final diagnosis of high grade SIL and squamous cell cancer combined) reflect the race, ethnicity and age percentages of all women screened in the program. The rate of abnormal Pap tests decreases with increasing age, from 31% for women under 30 to 15% for women 50-64.

The mean time elapsed from screening to diagnosis for Pap tests is 45 days, and for screening mammograms is 49 days. The mean time elapsed from diagnosis of cervical dysplasia or cancer to treatment is 24.5 days, and for diagnosis of breast cancer to treatment is 38 days. Forty-one breast cancers and eight cervical cancers have been detected through the program since 1995.

#### C. Partnership Development and Community Involvement

Partnership development is now more purposefully focused on matching local resources to the service needs of program women. As availability of services varies by state geographic region, the program has started working with local grass roots service provider groups. In order to expand screening activity statewide we are developing tools and protocols for initiating services in new communities as well as expanding services in existing communities, assessing diagnostic capacity, resources, and referral patterns. During this year, we have accomplished the following:

- The Matanuska-Susitna Agency Partnership has recruited diagnostic specialists in preparation for the increased need for program women who will be entering the program with newly recruited screening providers in the summer of 2000. Several providers have expressed interest in becoming screening providers for the program.
- In the Central Kenai area similar efforts are being initiated under leadership of community members in partnership with the program. Kenai-area activity has included assessment of community resources and the need for additional screening and diagnostic providers.
- In Anchorage, the program is formalizing partnerships by facilitating agreements between outreach and screening providers, formalizing partnerships with other funding agencies for screening mammography for women 40-49, and monitoring the effectiveness and efficiency of rotating consultants for diagnostic services. As program case management services develop and expand, the value of these partnerships will grow.
- In Southeast Alaska we have collaborated with tribal grantee, SEARHC, and Public Health Nursing to ensure non-beneficiaries (non-Natives) living in major SE Alaska communities (Juneau, Ketchikan) and some remote SE communities have access to breast and cervical screening services. We continually work together to ensure that services are not duplicated and are coordinated. The programs have worked together on several outreach and public education efforts, as well as professional education opportunities.

#### D. Professional Education.

The program has moved away from its tradition of offering one large statewide conference on breast and cervical cancer early detection issues as a means of delivering professional education to providers to offering opportunities more targeted to improving specific skills and knowledge of our screening providers. Activities and plans in place include promotion of self-study on *Follow up of Abnormal CBE and Mammographic Findings* and *Mammacare* training. We also

plan to provide focus group training to state staff and grantee outreach staff before the end of the year. Program nurses provide ongoing technical assistance to screening providers on program policies and procedures and clinical guidelines. During this year we have also:

- Surveyed providers on program satisfaction and professional education needs.
- Held quarterly teleconferences for screening providers on program policy updates and issues.
- Coordinated downlink sites and disseminated information on satellite broadcasts relevant to BCCEDP.
- Determined abnormal CBE follow-up as the professional education priority for program providers this year. To date, 12 screening sites and 18 non-screening providers have requested 53 *Follow up* self-study manuals indicated an intended viewing audience of 59.
- Developed a booth for the Alaska Nursing Association, Alaska Nurse Practitioner, and Issues in Women's Health conferences to promote the self study packet, *Followup of Abnormal CBE and Mammographic Findings*.
- Put plans for *Mammacare* CBE training in place. Program nurse practitioner will become a certified trainer by 9/30/2000; instruction will be offered to program screening providers.

#### E. Quality Assurance and Improvement

Experts in the management of breast and cervical disease have been selected and retained on contract to advise the program on complex medical management issues.

Clinical guidelines of the AK-BCCEDP will be reviewed and revised with input from a reorganized Clinical Advisory Committee (CAC). The committee will convene by June 2000 and complete a review of current guidelines by September 30, 2000. Updated guidelines will be completed by December 2000 and printed and distributed to all program providers as soon as possible after that date. The CAC will continue to meet at least semi-annually to address other program concerns, with priority given to implementation of the cervical cancer screening policy and appropriate abnormal CBE follow-up.

A complete revision of the site review and monitoring process is currently underway. Routine site reviews were postponed during the last year while the program undertook a major review of policies, procedures and processes. A plan for biennial reviews was initiated in April 2000. New providers will have a site review after their first year of participation and biennially thereafter. Site monitoring reviews will continue with priority for immediate review of sites with the greatest need for technical assistance. Additional accomplishments during this grant year include:

- New guidelines and tools for conducting a screening provider site visit are being developed; adjusted time for completion 11/00.
- Program consultants continue to offer technical assistance to providers where needs have been identified through MDEs or upon provider request.
- Contract ANP protocols and contract being developed to review abnormal CBEs at all sites.
- Diagnostic reports are monitored for consistency with data reported by screening providers
- Data reports are developed and distributed to screening providers as a means for providing feedback on program enrolled women (e.g. numbers screened, percents of abnormal results, percents of mammograms to women 50-64)

#### F. Public Education, Information and Outreach.

During this grant year the program has accomplished the following:

- Conducted a review of the literature on one-to-one outreach interventions; developed request for proposal (RFP) for Breast and Cervical Outreach Demonstration Projects. Projects are scheduled to begin in August 2000 in applicant communities where BCCEDP services exist.
- Negotiated, implemented and monitored grant with YWCA ENCOREplus program. Provided technical assistance to increase the numbers of women recruited in the Anchorage area and to recruit more women ages 50 to 64.
- In-progress assessment of the 800 line as an enrollment method.
- Developed new marketing materials, established relationships with other agencies that serve low-income populations, and decided on a new program name, Breast and Cervical HEALTH CHECK. Working on new program logo. Advertised program in screening communities statewide (posters, coupons, newspaper ads).
- Pilot project in Central Kenai Peninsula has reliably evaluated personal door to door recruitment during the past year. Impact to date:
  - increase in #s program women ages 40-49 & 50-64 who were screened from prior to the project to after project implementation
  - increase in % of program screened women ages 50-64 receiving screening mammography to over 80%
  - able to evaluate outreach efforts reliably

#### G. Screening, Referral, Tracking, Follow-Up

One of the major challenges in this area is the lack of secure funding for diagnostic and treatment services not covered by the BCCEDP. We continue to pursue partnerships to ensure diagnostic and treatment services are available to women screened through the program. A variety of donated resources, pro bono work or extended payment arrangements are used to cover costs not covered by the BCCEDP.

- The program developed a protocol for referral, tracking and follow-up of abnormal results by providers. Follow up of abnormal screening results is done monthly per program protocol developed 1/00; protocols are revised as needed
- Program consultants track women with abnormal results monthly to promote timely and appropriate diagnosis & treatment of all abnormal screening results by providers
- Clinical forms have been revised to be more user-friendly and capture new MDE requirements
- Program services have been coordinated with Public Health Nursing family planning services

#### H. Evaluation

The program has not developed a new plan or significantly modified the current plan to assess the implementation and effectiveness of each program component.

## Alaska Breast and Cervical Health Check Case Management Plan

### Goal

Alaska BCHC's case management goal is to assure continuous improvement in the status of the medical outcomes of all program clients with abnormal screening results, as well as all those diagnosed with breast or cervical cancer. The measure of success will be that all women will complete diagnostic services within 60 days of an abnormal screening result and women diagnosed with cancer will initiate treatment within 60 days.

### Background and Assessment

Alaska BCHC staff have worked diligently over the past 18 months to improve the quality of reporting and recording of provider-client data to ensure accurate clinical findings are entered in the CaST database. Part of this important exchange between the program staff and provider network has been an improved understanding of the importance of the role of follow-up and care coordination in assisting women to access needed services. The ability to generate an accurate estimate of the number of women who will need case management services depends on accurate data sources. Criteria for case management clients has not yet been finalized. However, staff discussion indicates a consensus that priority case management populations would include those with highly suspect CBE, mammography, or Pap results; women who have missed needed diagnostic or rescreening appointments; and women needing short term follow-up. Case closure criteria would also be data dependent and will be enhanced by "cleaning up" some remaining inconsistencies in our data for "lost to follow up" and "refused" clients.

The cumulative MDE data on mammograms indicate a relatively high percentage of missing (15.3) or pending (1.2) status of final diagnosis. The cumulative percentage refused (9.5) and lost to follow-up (4.7) seem to be improving per the most recent data submission (4.8 and 4.0 respectively), but are still well above the expected minimum of 2-3%. Similarly, MDE Pap screening data for 4/98-3/99 indicate higher than expected lost to follow-up percentages (7.4;  $\leq 3$  expected) and a percentage of complete follow-up (89.5) that is a near miss ( $\geq 90$  expected).

### Implementation

Locally based clinical providers will be expected to provide case management enhancement of their current follow-up and tracking efforts. BCHC staff will assist by providing guidance on policy, technical assistance, systems development, enhanced data and tracking reports, needs assessment and intake criteria, resource directories, revised forms/consents, and financial assistance. Information is currently being collected on payment options, amounts, and allowable services. One model under consideration is that of the Alaska Division of Medical Assistance, which is a fee for service model covering screening, initial assessment, care plan development, re-assessment, and a per month fee for active "care coordination services".

State program staff responsible for oversight of the case management plan is primarily the program coordinator, with assistance from the clinical nurse consultant for quality assurance and monitoring processes, data manager for evaluation component, regional

program consultants for site work, review and technical assistance. The outreach coordinator is developing a model for community resource inventory which, when expanded to a statewide inventory will assist in locating and directing clients to care givers. Attention to services for disabled women will be given special emphasis.

An ambitious timeline has been developed with the detailed workplan. Work is in progress on case management definitions, provider needs assessment, and estimation of staff capacity and number of patients in need. Tools and forms will be developed and tested later this year. Evaluation/monitoring and billing systems will be pretested and redesigned in early 2001, with implementation scheduled for fall, 2001.

Monitoring and evaluation of the success of the case management effort will be done through analysis of CaST data and site review. The expected number of cases compared to the actual number of cases, the number/percent of women completing their recommended follow-up for diagnosis or treatment initiation, and the expected reduction in the number/percent of women lost to follow-up will be monitored on a regular basis.

**AK-BCCEDP Case Management Work Plan – Systems Level**

**Case Management Goal:** To assure continuous improvement in the status of the medical outcomes of all program clients with abnormal screening results, as well as all those diagnosed with breast or cervical cancer.

**Measure of Success:** Women will complete diagnostic services within 60 days of an abnormal screening result; women diagnosed with cancer will initiate treatment within 60 days.

**Goal for process of assessment:** To determine the extent of the program's need for case management and the availability of resources needed to implement planned case management services.

**Objective 1:** Beginning 1/27/00 and continuing on an ongoing basis, program staff will define the target client population with potential need for case management to enable timely access into diagnostic, treatment, and re-screening services.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Define eligibility and case closure criteria for case management clients and set appropriate protocol based on past two years of program data.	In Progress	MDEs	5/11/00 & ongoing	Clinical QA Coordinator – CK
B. Assess the extent of the program's need for case management based on CaST data and selected chart audit results based on criteria developed in protocol above.	In Progress	CaST data	05/01/00	Data Manager Program Coordinator – SCB Clinical QA Coordinator – CK
C. Work with program site case managers to develop estimates of time and cost for case management services based on established eligibility criteria and current client utilization of existing services.	In Progress	CaST data	6/11/00 & ongoing	Data Manager Program Coordinator – SCB Clinical QA Coordinator – CK

**Objective 2:** Beginning 9/30/99 and continuing on an ongoing basis, program staff will inventory existing case management resources available to the program from regional social and health care agencies.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Review the Alaska Department of Community and Economic Development's community profiles to develop a resource list of program service delivery areas by geographic region.	In Progress	Local and state data	5/26/00	Health Planner – MB Pub.Ed. Coordinator – LS
B. Identify key players for social service referrals and other case management needs in partnership with local service delivery providers including public health centers.	In Progress	N/A	5/26/00	Health Planner – MB Pub.Ed. Coordinator – LS
C. Assess the diagnostic and treatment capacity by geographic region	In Progress	CaST data Local & state data	Ongoing	Program Coordinator – SCB Data Manager

D. Inventory existing site case manager resources available to the program; evaluate current skill and expertise level of site case managers.	In Progress		7/31/00	Program Coordinator – SCB Program Consultants SSB & SH
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Goal for process of planning: To assure that resources are in place prior to implementing the case management system at a client level.

Objective 1: Beginning 9/30/99 and continuing on an ongoing basis, program staff will assess adequacy of provider staff at each site to deliver quality case management services for all program eligible women.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. With the estimate of the number of women at each site who will need case management, develop skills and task list for site case managers.	In Progress	CaST data	9/1/00	Program Coordinator – SCB Clinical QA Coordinator – CK
B. Develop training and skills enhancement plan for each site.	In Progress	N/A	05/01/2001	Health Planner – MB Program Coordinator – SCB
C. Develop protocol and program materials defining both systems level and client level accountability and reporting requirements for case management services.	In Progress	N/A	02/01/01 & ongoing	Clinical QA Consultant – CK Program Coordinator – SCB Program Consultants – SSB & SH
Design protocols and tools to document: <ul style="list-style-type: none"> <li>• Needs assessment</li> <li>• Individual case management plan</li> <li>• Completion of case management</li> <li>• Refusal of care</li> <li>• Referral Form</li> <li>• Follow-Up Form</li> <li>• Lost to follow up</li> <li>• Assurance of confidentiality &amp; consent to participate in case management</li> </ul>	In Progress	N/A	07/11/00 & ongoing	Clinical QA Consultant – CK Program Coordinator – SCB Program Consultants SSB & SH
E. Continue to develop a marketing plan by geographic region to continue recruiting diagnostic and treatment providers	In Progress	N/A	03/01/00 & ongoing	Pub Ed Coordinator-LS
F. Develop a plan for AK-BCCEDP staff to assure case management services at sites found to have inadequate resources.	In Progress	N/A	07/11/00	Program Coordinator –SCB Clinical QA Coordinator – CK

Goal for process of coordination: To optimize services available to the client by developing and coordinating standardized sy avoid duplication of services at the local level.

Objective 1: Beginning 9/30/99 and continuing on an ongoing basis, program staff will establish formal and informal agreem maximize availability and access to necessary diagnostic, treatment, and support services.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Working with local partnerships and providers determine the needs for formal agreements.	In Progress	N/A	9/30/99 & on-going	Program Coordinator – SCB Health Planner – MB
B. Work with local service providers to establish community partnerships to assist in the coordination of services and reduce duplication of services.	In Progress	N/A	6/11/01	Health Planner – MB
C. Develop a standardized client referral tool and algorithm of the referral process for each identified program service delivery area to assure reliable tracking of clients.	In Progress	N/A	8/31/00	Clinical QA Coordinator – CK
D. Define role of provider and program staff in facilitating coordination of all case management activities between providers and in the management of the referral tracking system.	In Progress	N/A	8/31/00	Program Coordinator – SCB

Goal for the process of monitoring: To provide ongoing re-assessment of the case management system and, when appropriate management and operational plan.

Objective 1: Program staff will implement a case management monitoring plan by 1/1/02

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Develop a case management quality-monitoring plan.	In Progress	CaST data	11/15/00	Clinical QA Coordinator – CK
B. Monitor the number of case management clients who fail to receive case management services according to the plan.	In Progress	CaST data	4/1/02 & semi-annually thereafter	Program Coordinator – SCB Data Manager
C. Review trends of the failed cases for evaluation and modification of current case management systems and plan.	In Progress	CaST data	7/1/02	Program Coordinator – SCB Data Manager Clinical QA Coordinator- CK
D. Modify current systems and plan based on trends identified.	In Progress	CaST data	7/01/02	Program Coordinator – SCB Data Manager Clinical QA Coordinator- CK
E. Apply evaluation results to redesign of the system and perating plan.	In Progress	CaST data	7/1/02	Program Coordinator – SCB Data Manager Clinical QA Coordinator- CK

Goal for process of resource development: To develop adequate provider resources at both local and state level to maximize diagnostic, and treatment services.

Objective 1: Beginning 9/30/99 and continuing on an ongoing basis, program staff in collaboration with site case managers, diagnostic and treatment services available in all program service areas.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Hire marketing and public education staff person.	Complete 2/7/00	N/A		Program Coordinator – SCB
B. Develop and implement marketing plan. Market the program.	In Progress	N/A	3/24/00 & monthly thereafter	Pub Ed Coordinator – LS
C. Recruit and establish agreements with diagnostic providers.	In Progress	N/A	5/1/00 & monthly thereafter	Program Coordinator – SCB
D. Recruit and provide continuing support to gratis treatment providers.	In Progress	N/A	5/1/00 & monthly thereafter	Program Coordinator – SCB
E. Develop and maintain a statewide directory of resources by geographic region utilizing current annual "Provider Update" tool.	In Progress	N/A	5/1/00 & monthly thereafter	Program Coordinator – SCB

Objective 2: Staff will implement a reimbursement system for case management by 8/31/00.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Develop a case management budget for the program based on estimated number of women eligible for case management at each site and estimated cost of serving each woman.	In Progress	CaST data	9/1/00	Program Coordinator – SCB
B. Select reimbursement mechanism.	In Progress	Billing data	5/1/00	Program Coordinator – SCB
C. Design algorithm and specify necessary elements for processing & paying a case management bill.	In Progress	Billing data	6/1/00	Program Coordinator – SCB
D. Program staff will develop and document a reimbursement protocol & system for case management	In Progress	Billing data	7/1/00	Program Coordinator – SCB

**Objective 1:** By 10/1/01 program staff will implement an evaluation process that includes the use of MDEs, client and provider satisfaction surveys to measure the adequacy of individual case management services.

**Goal for the process of evaluation:** To evaluate the effectiveness of the case management system and its sustaining ability to assure timely and high quality case management services that positively impact the program MDEs, providers, and clients.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Identify criteria to be included in the evaluation including outcome measures of the adequacy of individual case management service.	In Progress	CaST data	11/1/00 & on-going	Clinical QA Coordinator – CK
B. Design a protocol and process for submission and quality assessment of case management tools and activities documented by the tools.	In Progress	N/A	11/1/00 & on-going	Clinical QA Coordinator – CK
C. Design tool & process to capture desired information including client satisfaction survey.	In Progress	N/A	11/1/00 & on-going	Clinical QA Coordinator – CK
D. Assess timeliness and adequacy of individual case management services using MDEs, needs assessment, referral systems, and documentation of refused care & lost to follow up tools.	In Progress	CaST data	11/01/01	Data Manager
E. Assess numbers of providers leaving the program because of new requirements.	In Progress	N/A	8/31/01	Program Coordinator – SCB
F. Assess provider satisfaction with case management using survey.	In Progress	Satisfaction Survey	1/15/02	Program Coordinator – SCB
G. Assess number of case managed women entering a re-screening cycle.	In Progress	MDE's	11/01/02	Data Manager
H. Assure continued assessment of need for, and provision of, training	In Progress	CaST data	7/01/01	Program Coordinator – SCB Program Consultant – SSB Clinical QA Consultant – CK Data Manager

**AK-BCCEDP Case Management Work Plan—Client Level**

**Case Management Goal:** To assure continuous improvement in the status of the medical outcomes of all program clients with abnormal screening results, as well as all those diagnosed with breast or cervical cancer.

**Measure of Success:** Women will complete diagnostic services within 60 days of an abnormal screening result; women diagnosed with cancer will initiate treatment within 60 days.

**Goal for process of assessment:** To determine the extent of each client's need for case management and the availability of resources needed to implement planned case management services at each provider site.

**Objective 1:** By 9/1/00, based on the definition of the target client population with potential need for case management, each provider will assess the characteristics and numbers of individuals in the program who are at risk for, or have not achieved timely access to diagnostic, treatment, and re-screening services.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Develop a risk assessment tool based on eligibility and case closure criteria for case management of clients.	In Progress	CaST Data	6/30/00 and monthly thereafter	Program Coordinator – S. Burn. Clinical QA Coordinator - C.K. Program Consultants-S.B. & S.A.H.
B. Assess the extent of each provider's skills and knowledge for assessing clients' needs for diagnostic, treatment and essential support services.	In Progress	N/A	8/31/01 & annually thereafter	Program Coordinator – S. Burn. Clinical QA Coordinator - C.K.
C. Develop guidelines and process for re-assessment of client's continued need for case management or criteria for closure of case.	In Progress	N/A	8/31/01 & biannually thereafter	Program Coordinator – S. Burn. Clinical QA Coordinator - C.K. Program Consultants-S.B. & S.A.H.

**Goal for process of planning:** To develop standardized care plans to assure that each client's individual short term and long term needs for receiving diagnostic, treatment, and re-screening services are met in a consistent and timely manner.

**Objective 1:** By 10/1/01 the designated site case manager for each provider site will have in place an individualized care plan for each client assessed and found to be in need of case management services

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Provide training and ongoing technical assistance in use of the risk assessment tool and standardized sample case management plans that set goals, activities, time elements, and clearly designate responsibility for each element.		CaST Data	9/1/00 On-going	Program Coordinator – S. Burn. Clinical QA Coordinator - C.K. Program Consultants-S.B. & S.A.H.
B. Implement the state level plan for case management at provider sites without resources to provide case management services.		N/A	8/31/00	Program Coordinator – S. Burn. Clinical QA Coordinator - C.K.
C. Provide local sites with a tool to document referrals, follow up, and revisions of case management plans.		N/A	8/31/00	Program Coordinator – S. Burn. Clinical QA Coordinator - C.K.

**Goal for process of coordination:** To optimize coordination of services and resources between provider and regional helper agencies to assure that resources meet clients' needs while reducing duplication of effort.

**Objective 1:** Beginning 9/30/99 program staff & site case managers will work with local providers, coalitions and public health centers to coordinate and maintain resources and support services to meet client needs as specified in the client case management care plan.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Establish formal and informal agreements to maximize availability and access to necessary diagnostic, treatment and support services.	In Progress	N/A	10/01/99 and monthly thereafter	Program Coordinator—S.Burn. Program Consultants-S.B. & S.A.H.
B. Provide active assistance in reviewing the case management process at provider sites to ensure all clients receive the services identified in their case management plan.	In Progress	N/A	10/01/99	Program Coordinator—S.Burn. Program Consultants-S.B. & S.A.H.
C. Guide site case managers in appropriate documentation needed to coordinate services in each client's case management plan.		N/A	10/1/99	Program Coordinator—S.Burn. Program Consultants-S.B. & S.A.H.
D. Provide training and technical assistance for site case managers to assure appropriate use of tracking tools, and timely and reliable tracking of clients.		CaST Data	10/1/99	Program Coordinator—S.Burn. Program Consultants-S.B. & S.A.H.

**Goal for the process of monitoring:** To provide ongoing re-assessment of case management operating plan and, when appropriate, to modify the program's case management operating plan to assure each client receives appropriate, timely services.

By 11/1/01 site case managers will review each client's needs and re-assess the quality of care and timeliness of services provided based upon that review.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Review CaST data and individual case management plans of clients receiving case management with the site case managers on at least a monthly basis.		CaST Data	11/01/01 and monthly thereafter	Clinical QA Coordinator - C.K. Program Consultants - S.B. & S.A.H.
3. Re-assess and re-design the individual case management care plan if necessary.		N/A	11/01/01	Clinical QA Coordinator - C.K. Program Consultants - S.B. & S.A.H.

Goal for process of resource development: To increase the client's ability to use support, diagnostic, and treatment services in an appropriate and timely manner.

Objective 1: By 11/1/00 site case managers will document the knowledge, skills and support offered to clients to promote their self-sufficiency and self-determination.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Training and ongoing technical assistance will be provided to assure site case managers understand and follow expected protocols.		CaST Data	11/01/01 and monthly thereafter	Clinical QA Coordinator – C.K. Program Consultants – S.B. & S.A.H.
B. Case management plans, involving the client at every step, will be signed and dated by both the client and the case manager.		N/A	11/01/01 and monthly thereafter	Site Case Managers
C. Conduct annual inventory of resources available and utilized by clients.		N/A	11/01/01	Clinical QA Coordinator – C.K. Program Consultants – S.B. & S.A.H., Site Case Managers

Goal for the process of evaluation: To evaluate whether clients receive diagnostic, treatment and rescreening services in a timely and appropriate manner according to program protocol.

Objective 1: By 12/1/01 program staff will review outcome measures of the adequacy of individual case management services.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Monthly review of site specific CaST data and submitted case management plans, adequacy will be assessed based on timeliness of access to diagnostic and treatment services.	In Progress	CaST Data	11/01/01 and monthly thereafter	Program Coordinator – S. Burn. Clinical QA Coordinator – C.K. Data Manager
B. All clients will have their case management plan reviewed for quality, appropriateness and timeliness of services accessed following closure of their case.	In Progress	CaST Data	Biennial site visits	Clinical QA Coordinator – C.K. Program Consultants—S.B. & S.A.H.
C. Client satisfaction will be reviewed following closure of every case.	In Progress	CaST Data	Monthly	Clinical QA Coordinator – C.K. Program Consultants—S.B. & S.A.H.
D. Documented refused care & lost to follow up clients will have their medical records reviewed during each standard QA site visit.	In Progress	CaST Data	Biennial site visits	Clinical QA Coordinator – C.K. Program Consultants—S.B. & S.A.H.
E. Provide feedback to site case managers on the quality of services and performance	In Progress	CaST Data	4/01/02 & biannually thereafter	Program Coordinator – S. Burn. Data Manager Clinical QA Coordinator—C.K. Program Consultants—S.B. & S.A.H.

## Overview of Cervical Cancer Operational Plan for Alaska BCHC

### Background / Data Review and Assessment

The Alaska BCHC's improved infrastructure and support for providers has resulted in an increase of women served over the past 18 months, or since the program was moved to the Maternal, Child, and Family Health section. Considerable attention has been devoted to improving the quality of clinical breast examination and follow-up. The program is now moving to develop a more comprehensive and standardized quality assurance plan. MDE data indicate increases can be anticipated for both breast and cervical screening: Paps (04/98-03/99) 3,830; projected (04/99-03/00) 4,000; and screening mammogram results (04/98-03/99) 1,647; projected (04/99-03/00) 1,800.

The Alaska BCHC serves women aged 18-64 who are un- or underinsured and have incomes <250% of the Federal Poverty Level (FPL). Review of MDE data through 9/30/99 show that of women 50-64 years of age, only 36% have received a program funded Pap test. The ethnicity of women with abnormal Pap tests reflects the demographics of our program enrollment.

Cervical cancer mortality rates in Alaska are low relative to other states. For the five year period of 1992-96 the average annual mortality rate for Alaska was 1.8 per 100,000 women - the fourth lowest among the 50 states (SEER, 1999). Only a decade earlier (1986-87), Alaska's cervical cancer mortality rate was tenth highest in the nation at 3.8 per 100,000 (MMWR 1992:41;SS-2). Continued improvement in cervical cancer mortality is especially marked among Alaska Natives. Between 1980 and 1998, the cervical cancer mortality rate for Alaska Natives declined by 87%. By 1993-97, the average annual cervical cancer mortality rate for Alaska Native women was 2.5 per 100,000 and, while higher than the non-Native rate for that time period, was not statistically different. Only three cervical cancer deaths occurred among Alaska Natives during 1994 to 1998, preventing calculation of a reliable mortality rate -- but the continued decline in mortality due to cervical cancer indicates that this racial disparity for cervical cancer mortality in Alaska may have been eliminated (Schoellhorn, unpublished, 2000).

### Background / Data Review for Women Rarely or Never Screened

Alaska Behavioral Risk Factor Surveillance System (BRFSS) data for 1998 indicate that 96.9% of women have ever had a Pap test, and 92.3% have had a Pap test in the last five years. Women reporting lower incomes and fewer years of education report lowest rates of Pap screening within the last five years. By age, the lowest rates of Pap screening within the last five years occur in the 60-64 yr. (17.5%) and over 65 yr. old (15.6%) age groups. Women who are retired or unable to work report having received the least screening in the last three years. Racial pattern data obtained for blacks from BRFSS may be skewed by small sample size. "Other" race reports a high rate of recent Pap screening, possibly because of access to Native Health Corporation services by Alaska Native populations. State race-specific data show that Alaska Natives report the highest rates of Pap test screening in the past three years and, consistent with that, the "Other" group is the most likely to have been screened in the last three years.

Of the women that have received pap tests through our program, 3.5% (206 of 5,865) have never had a Pap test and an additional 10 % (575 of 5,591) received their last Pap test five or more years ago. Only 1.2% of women said they did not know or did not indicate they had ever had a Pap test and another 7% said they had had a Pap but did not recall when the last one occurred. Women received both Pap and breast screening on entrance into the program 35% of the time. Only 13.9% of our program clients have received three annual Pap screenings where the results were all Negative/WNL.

#### Background / Data Review Re: Decreasing Over-screening Among Enrolled Women

We use the patient reminder system in CaST that provides annual and short term follow-up reminders. The reminder lists are sent to our providers. These reminder/recall systems are currently capable of accepting modification to generate recall data for Pap test cycles other than on an annual basis and on a result-dependent basis. Providers have their own recall systems that may require modification to incorporate the new guidelines. Questions have arisen as to whether or not women will continue to come for annual breast screening when Pap screening is not offered or encouraged as appropriate for them.

Hysterectomy is reported on 19% of program clients compared to 14.4% statewide (BRFSS data). Of the program clients, 2% of the reported hysterectomies were in women with a history of cervical cancer; 3% were in women with a history of severe cervical dysplasia. The program has had a policy of not encouraging Pap smears for women with previous hysterectomy for non-cancerous reasons but has continued to pay providers for Pap smears when the client is uncertain as to reason for hysterectomy, or for provider discretionary reasons. The program also pays for an initial exam to determine whether or not a woman has a cervix. The program has collected hysterectomy data but will be adding a question to specifically address whether or not the woman has an intact cervix.

There are 18 women who are currently in the program who have returned for a fourth Pap after having three normal Paps by our providers. There are 91 women who have received three normal Pap tests who will not be eligible for a fourth. There are 656 women who have had two normal Paps who may need to be counseled about not returning on an annual basis if their next test is normal. The program has only been screening for five years, so we are only now at a point where we can begin to monitor over-screening.

The program's clinical guidelines will be updated to include recommendations for Pap screening on a result-driven basis. Key experts from the clinical advisory committee will be called upon to assist the program in re-educating providers about the change in policy and practice. Program eligibility and screening forms will be revised to assist providers in identifying women who are not in need of Pap screening due to having had three consecutive normal results in the last 5-year period.

**Revised Cervical Cancer Screening Policy Workplan  
Alaska BCHC (Rev. 05/08/00)**

**Program Goal:** Increase cervical cancer screening for AK-BCHC program eligible women who have never or rarely received screening.

**Measure of Success:** At least 20% of new program clients will meet the criteria of having been never or rarely screened for cervical cancer.

**Objective 1A:** By 10/01/2000, staff will develop a plan and timeline for identifying and reaching program eligible women who have never or rarely been screened for cervical cancer.

Activities	Data	Time Frame to Assess Progress	Staff Member(s) Responsible
a. Review and document current program capacity and activities to identify and screen never and rarely screened program eligible women.	Program	12/00	Clinical nurse consultant, Data analyst, Program coordinator
b. Review program data to determine the number & percent of women never and rarely screened (current and new enrollees).	Program Minimum Data Elements (MDE), BRFSS	12/00	Data analyst
c. Review program and other data to identify high-risk populations or geographic areas.	Program MDE, Cancer Registry, Mortality, BRFSS	12/00	Epidemiologist
d. Assess the need for intensified outreach, specific strategies, and screening efforts to reach identified sub-populations.		12/00	Epidemiologist, Data analyst
e. Conduct key informant interviews, focus groups or surveys to determine women's reasons for rare or never screening		02/00	Marketing analyst, Regional reps.
f. Meet with providers to identify key contacts for outreach into identified sub-populations and elicit assistance from those key contacts		02/00	Regional reps., Clinical nurse consultant, Program coordinator
g. Develop and pretest program materials for outreach to the rarely or never screening population		03/00	Marketing consultant

**Objective 1B:** By 10/01/2001, staff will implement the program plan to identify, reach, and screen program eligible women who have never or rarely been screened for cervical cancer.

a. On-going review of current program data and progress toward objectives. Plans will be revised as appropriate.	Program MDE	On-going	Program coord., Clinical nurse cons., Regional reps., Data analyst, Epidemiologist
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**Program Goal:** Implement the revised cervical cancer screening policy. Decrease over screening among enrolled women (10/01/01).

**Measure of Success:** At least 75% of program clients with three consecutive, normal Pap tests within a 5 year period are transitioned to a 3-year cervical re-screening interval.

**Objective 2A:** By 01/01/2001, staff will develop draft cervical cancer screening policy and plan for dissemination to program providers.

Activities	Data	Time Frame to Assess Progress	Staff Member Responsible
a. BCHC Clinical Advisory Committee to review, revise, recommend cervical cancer screening policy, define clinician discretion, incorporate into guidelines.		10/00	Clinical nurse consultant

b. Identify key supporters willing to work with Project Staff to assist with provider education and implementation of this policy.		11/00	Project Coordinator, Clinical nurse consultant, Regional reps.
c. Develop a plan and timeline for dissemination of the policy to providers.		11/00	Project Coordinator, Clinical nurse consultant
d. Review program materials and program contracts to determine need for revisions due to policy/procedural change.		02/01	Project coordinator, Marketing consult., Outreach coordinator

Objective 2B: By 10/01/2001, staff will coordinate the dissemination, training on and implementation of the revised cervical cancer plan.

a. Disseminate policy to providers.		04/01	Clinical nurse cons.,
b. Monitor provider feedback and requests for assistance in implementing the policy.		On-going	Clinical nurse cons., Outreach coord., Regional reps.
c. Assess success of strategies implemented; revise as necessary.		On-going	Project coordinator, Clinical nurse cons.
d. Develop plan to evaluate impact of policy on the return rate of women needing breast screening but not Pap/pelvic under the Program's guidelines.		09/01	Clinical nurse cons., Data analyst, Regional reps.

Objective 2C: By 10/01/2001, staff will coordinate efforts to inform/educate program eligible women of the revised cervical cancer screening policy.

a. Develop and disseminate client messages and qualitatively analyze effectiveness of messages and programs used.		04/01	Marketing cons., Project coordinator, Data analyst
b. Ongoing assessment of success of strategies as implemented. Revise as necessary.		On-going	Project coordinator

Objective 2D: By 10/01/2001, staff will coordinate efforts for a program review of clinical systems to determine frequency at which program providers are scheduling Pap tests for NBCCEDP-enrolled women.

a. Develop and document plans to promote provider compliance with new policy.	Program	01/01	Data analyst, Clinical nurse cons., Regional reps.
b. Review and document aggregate program data to identify provider agencies that have historically provided Pap tests to women after documentation of three consecutive, normal, annual results.	Program	06/01	Data analyst
c. Meet with providers to discuss, reinforce scientific basis for, and encourage compliance with policy.		06/01	Project coordinator, Clinical nurse cons., Regional reps.
d. Develop a method to identify individual clinicians within provider agencies.		09/01	Data analyst
e. Assess progress toward meeting objective.	Program, site visits	On-going	Project coordinator

**Objective 2E:** By 10/01/2001, staff will review and revise the current reminder/recall system and educate contractors to ensure that eligible women are reminded of appointments at the appropriate intervals.

a. Review/revise current reminder policies and procedures as needed.		06/01	Project coordinator
b. Review/revise program materials as needed.		06/01	Outreach coord., Regional reps
c. Develop standardized cue cards and reminder cards for use by providers to emphasize recommended Pap screening schedule.		06/01	Outreach coord., Marketing consultant
d. Review and document program data regarding the Project's rescreening rate.	Program MDE	04/01	Data analyst, Regional reps.
e. Test modified reminder/recall system to ensure clients will be recalled at the appropriate intervals.	IMS	09/01	Project coordinator, Data analyst, Regional reps.
f. Ongoing review of rescreening rates, program materials, reminder/recall systems with revision as necessary.	Program	On-going	

**Program Goal 3:** Implement the policy on screening women with hysterectomy for reasons unrelated to cancer (10/01/00)

**Measure of Success:** No more than 2% of program clients with absent cervix due to non-cancer related hysterectomy will receive Pap screening

**Objective 3:** By 10/01/01, systems to monitor compliance with the Project's hysterectomy policy will be reviewed and revised as necessary.

Activities	Data	Time Frame to Assess Progress	Staff Member Responsible
a. Current program policy will be reviewed to assure consistency with CDC policy.		10/00	Project coordinator
b. Clinical Advisory Committee will review and revise clinical guidelines as necessary to clarify policy for providers.		10/00	Clinical nurse consultant
c. Assure billing edits are accurate and effective.	Program records	On-going	Data analyst, Billing clerk, Data entry clerk
d. Review CaST data	CaST	10/01/01	Data analyst

v. 05/08/00

**BUDGET JUSTIFICATION**  
9/30/2000 – 9/29/2001

**PERSONNEL**

40% Distribution: \$290,943  
60% Distribution: \$186,233  
TOTAL: \$477,176

	<u>Position Title/Name</u>	<u>Annual Salary</u>	<u>% Time</u>	<u>Months</u>	<u>Amount Requested</u>
1.	Program Director Linda Vlastuin	\$68,496	50%	12	0
2.	Program Coordinator Sandy Burnham	\$56,388	100% (40%)	12	\$56,388
3.	Clinical Consultant/QA/NP Chris Knutson	\$55,788	15% (40%) 35% (60%)	12	\$ 8,368 \$19,526
4.	Liaison/Clinical/Prof Ed Sally Bowers	\$54,420	25% (40%) 75% (60%)	12	\$13,605 \$40,815
5.	Liaison/Clinical Sherrell Holtshouser	\$55,650	25% (40%) 75% (60%)	12	\$13,913 \$41,738
6.	Outreach/Coalition Micki Boling	\$51,971	75% (40%) 25% (60%)	12	\$38,978 \$12,993
7.	Public Ed/Outreach/Mktg Lisa Simono	\$47,760	75% (40%) 25% (60%)	12	\$35,820 \$11,940
8.	Programmer/Analyst Grace Reynolds	\$52,824	25% (40%) 75% (60%)	12	\$13,206 \$39,618
9.	Admin Clerk II Jeanne Della-Maggiore	\$27,060	75% (40%) 25% (60%)	12	\$20,295 \$ 6,765
10.	PHN/NP Liaison Vacant	\$51,352 (6 mos)	(40%) 50% (60%)	12	\$12,838
11.	Admin Clerk III Sue Layton	\$32,952	100% (40%)	12	\$32,952
12.	Admin Clerk II Vacant	\$ 26,604	100% (40%)	12	\$26,604
13.	Accounting Technician I Julie Bristol	\$30,814	100% (40%)	12	\$30,814

**FRINGE BENEFITS**  
(\$ Amount x .30)

40% Distribution \$87,283  
60% Distribution \$55,870  
**TOTAL** \$143,153

Personnel: Administration  
\$290,943 x 30% = \$87,283  
Personnel: Outreach/Screening/Referral/Follow-up  
\$186,233 x 30% = \$55,870

**INDIRECT COST**

40% Distribution \$ 99,253

\$620,329 x 16% = \$99,253

The indirect rate used by the State of Alaska is approximately 16% of personnel costs and fringe benefits.

**TRAVEL**

40% Distribution: \$41,115  
60% Distribution: \$10,260  
**TOTAL** \$51,375

**Out of State**

(40% Distribution) Total \$12,075

<u>Conference/Meeting</u>	<u># Personnel</u>	<u>\$/Person/Trip</u>	<u>Total Cost</u>
Chronic Disease Conference	1	\$1,725	\$1,725

1 trip x \$1,000 r/t airfare x 1 person = \$1,000

5 days per diem x \$42/day x 1 person = \$210

4 nights lodging x \$110/night x 1 person = \$440

Shuttle, airport parking, mileage @ \$75

One Program staff will travel to CDC sponsored Chronic Disease Conference in Atlanta, GA.

**NTC Conference**

2	\$1,725	\$3,450
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1 trip x \$1,000 r/t airfare x 2 people = \$2,000

5 days per diem x \$42/day x 2 people = \$336

4 nights lodging x \$110/night x 2 people = \$660

Shuttle, airport parking, mileage @ \$75

Two Program staff will attend one National Training Center training as required by CDC.

**Program Directors' Meeting**

1 (x 2trips)	\$1,725	\$3,450
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2 trips x \$1,000 r/t airfare x 1 person = \$2,000

10 days per diem x \$42/day x 1 person = \$420

8 nights lodging x \$110/night x 1 person = \$880

Shuttle, airport parking, mileage @ \$75/trip

Program Coordinator will travel to lower 48 to two CDC Program Directors meetings.

**Data Managers**

1	\$1,725	\$1,725
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1 trip x \$1,000 r/t airfare x 1 person = \$1,000

5 days per diem x \$42/day x 1 person = \$210

4 nights lodging x \$110/night x 1 person = \$440  
 Shuttle, airport parking, mileage @ \$75  
 Data manager will travel to lower 48 for CDC mandated data managers' meeting.

**Cancer Control Conference** 1 \$1,725 \$1,725

1 trip x \$1,000 r/t airfare x 1 person = \$1,000  
 5 days per diem x \$42/day x 1 person = \$210  
 4 nights lodging x \$110/night x 1 person = \$440  
 Shuttle, airport parking, mileage @ \$75  
 One Program staff will travel to lower 48 for CDC required cancer control conference.

**Cervical Cancer Public Education Conference** 1 \$1,725 \$1,725

1 trip x \$1,000 r/t airfare x 1 person = \$1,000  
 5 days per diem x \$42/day x 1 person = \$210  
 4 nights lodging x \$110/night x 1 person = \$440  
 Shuttle, airport parking, mileage @ \$75

**In State - Staff** (40% Distribution) Total \$29,040

<u>Outreach/Screening</u>	<u>No. of</u>	<u>Cost per</u>	
<u>Referral/Follow-up</u>	<u>Personnel</u>	<u>Person/Trip</u>	<u>Total Cost</u>
<b>Various Locations</b>	2	\$726	\$29,040

20 trips x \$350 average r/t airfare x 2 people = \$14,000  
 3 days per diem x \$42/day x 2 people x 20 trips = \$5,040  
 2 nights lodging x \$100/night x 2 people x 20 trips = \$8,000  
 Rental car, airport parking, etc @\$50/person x 20 = \$2,000

**Justification**

To be used by the Program Coordinator, Clinical Liaisons and Outreach personnel to enroll providers, conduct site quality assurance reviews, technical assistance and individual client case management at screening sites. Trips will require two people. New sites may require two trips during their first year of screening for the program.

**In State - Patient** (60% Distribution) Total \$10,260

<u>Patient</u>	<u># Clients</u>	<u>\$/Person/Trip</u>	<u>Total Cost</u>
<b>Rural Areas</b>	15	\$684	\$10,260

1 trip x \$400 r/t airfare per patient x 15 patients = \$6,000  
 2 days per diem x \$42/day x per patient x 15 trips = \$1,260  
 2 nights lodging x \$100/night x per patient x 15 trips = \$3,000

**Justification**

The Program is expanding into rural areas of the State and patient travel will be needed to obtain diagnostic services.

**CONTRACTUAL**

40% Distribution: \$ 44,000  
 60% Distribution: \$ 937,674  
**TOTAL** \$ 981,674

Clinical Services (60% Distribution) Total \$675,287

4,500 Clients x \$150 per client = \$675,287

Payments to screening and diagnostic providers for procedures. Screening and diagnostic calculation worksheet estimates a higher cost per woman than the program has ever experienced in the past. We estimate cost per woman for clinical services to be \$150 per woman. Based on historical program data, cost for clinical services per woman has been \$135.

Eligibility Determination/Follow-up/Supplies (60% Distribution) Total \$135,000

4,500 clients at \$30/client = \$135,000

Payment to screening providers for above services.

Case Management (60% Distribution) Total \$ 86,387

Payment for case management services per case management plan.

Outreach/Follow-up (40% Distribution) Total \$24,000

(60% Distribution) Total \$36,000

Grant to YWCA for recruiting women, determining eligibility, and conducting follow-up in the Anchorage area.

Medical Consultation (40% Distribution) Total \$ 5,000

(60% Distribution) Total \$ 5,000

50 hours x \$200/hour = \$10,000

Contract with women's health specialist for consultation on pap smear follow-up/cervical diagnostic services and provider training. Contract previously approved.

Billing Database Maintenance and Updating (40% Distribution) Total \$ 5,000

Contract with programmer to provide maintenance and updates on customized billing database as needed by the program. Contract previously approved.

Professional Education (40% Distribution) Total \$10,000

5 trainer/speakers x \$2,000 per speaker = \$10,000

(Includes airfare, lodging, per diem and/or honorarium)

Provide continuing education and skills building opportunities on breast and cervical cancer screening to medical providers statewide by providing speakers for 5 statewide professional conferences including the Alaska Nurse Practitioners Association, Alaska Medical Association, Radiology Associates, Physicians Assistants, and Mammography Technology Associates.

OTHER

40% Distribution: \$ 84,861

60% Distribution: \$ \_\_\_\_\_

TOTAL \$ 84,861

In State Travel (40% Distribution) Total \$3,804

<u>Conference/Meeting</u>	<u>No. of Personnel</u>	<u>Cost per Person/Trip</u>	<u>Total Cost</u>
<b>BCCEDP Medical Advisory Committee Meeting</b>	<b>6</b>	<b>\$634</b>	<b>\$3,804</b>

1 trip x \$400 average r/t airfare x 6 people = \$2,400  
 2 days per diem x \$42/day x 6 people x 1 trip = \$504  
 1 night lodging x \$100/night x 6 people x 1 trip = \$600  
 Cab, airport parking, etc. @\$75 each = \$300

Justification

Travel for six BCCEDP Medical Advisory Committee members to travel to Anchorage for one Medical Advisory Committee meeting to revise protocols.

Advertising/Marketing (40% Distribution) Total \$40,000

Television/radio adds to broadcast Public Service Announcements, adds on city buses, statewide and local newspaper adds in 19 communities for outreach and public education.

Average expense = 19 Communities x \$2,105 per community

Printing (40% Distribution) Total \$20,835

Poster/display board for program \$500

Orientation packets for screening & diagnostic providers. \$2.50/packet x 200 packets = \$500

Marketing packets for screening providers. \$2.50/packet x 200 packets = \$500

Updated clinical guidelines for medical providers. \$3/booklet x 1,000 booklets = \$3,000

Resource guide. \$1/booklet x 2500 booklets = \$2,500

Client reminder cards for follow-up screening services. .30¢/card x 5,000 cards = \$1,500

Program forms (eligibility, data reporting, Vouchers). \$1250 per quarter x 4 quarters = \$5,000

Program handout to explain program to enrolled women. .50 x 5000 = \$2,500

Direct mailing event stuffers 60,000@.025 each = \$1,500

Posters, sticky pads, gift certificates \$3,335

Postage (40% Distribution) Total \$10,122

Provider orientation packets. \$3/packet x 200 packets = \$600

Marketing packets. \$3/packet x 200 packets = \$600

Resource Guides. .75¢/booklet x 2,500 booklets = \$1,875

Clinical Guidelines. \$2.50/booklet x 1,000 booklets = \$2,500

Mailing program forms to providers. \$250 per quarter x 4 quarters = \$1,000

Policy and procedure manuals. \$5/manual x 200 manuals = \$1,000

Postage for mailing program posters, brochures, etc. = \$2,547

**Telephone** (40% Distribution) Total \$ 3,000

Medical Advisory Committee

4 teleconference meetings per year x 2 hours per meeting x \$200 hour = \$1,600

Screening Provider Teleconference

4 teleconference meetings per year x 1 hour per meeting x \$200 hour = \$800

1-800 Telephone Line for Client Outreach

\$50 per month x 12 months = \$600

**Supplies** (40% Distribution) Total \$5,000

Purchase file folders, envelopes, pocket folders, mailing boxes, etc. = \$3,000

Purchase self-study materials and videos for medical providers = \$2,000

**Miscellaneous** (40% Distribution) Total \$2,100

Conference participation fees 2 @ \$250 = \$500

Staff training. \$200 per training x 8 staff = \$1,600. Provide job related professional education to BCCEDP staff.

**Total Grant 40/60 Summary**

40% (includes \$99,253 in administrative costs) \$ 647,455 (35%)

60% \$1,190,037 (65%)

**Total Request** \$1,837,492 (100%)

**Unobligated Funds**

The program anticipates having approximately \$350,000 in unobligated funds at the close of FY 2001 (October 29, 2000). This is the result of: several staff vacancies during the year, a delay in enrolling new providers and conducting site visits, coalition activities that were not conducted because of a change in direction with those plans, and because we have not yet achieved our goal of screening 4,500 women per year (targeted for December 2001). We have also made an effort to work with the American Cancer Society and YWCA ENCORE Plus program to fund screening mammograms for women 40-49, so we have had a reduction of program funded mammograms for that age group. This effort was initiated in order to work toward the CDC requirement of 90% of program funded mammograms going to women age 50-64.

**MAINTENANCE OF EFFORT**  
**9/30/2000 – 9/29/2001**

**Personnel:** \$ 20,892  
 This represents a portion of the salaries (including benefits of the following state employees who are actively involved in this project.

Pam Muth, MPH Section Chief	15%	\$14,302
Jay Newgaard, Admin. Assistant	10%	\$ 6,590

**Equipment:** \$132,249  
 This represents the State's cost for the computer hardware/software Necessary to conduct BCCEDP's activities and LAN support.

**Contractual:** \$ 25,939  
 Telephone costs to support BCCEDP's activities.

**TOTAL STATE SUPPORT** \$179,080

**SUMMARY OF MATCH**

<u>Category</u>	<u>Amount</u>
Public Health Nursing – Women's Health Services	\$263,398
Alaska Run For Women	\$ 49,500
Donated Mammograms – Providence Imaging Center	\$ 5,000
Donated Mammograms – Alaska Regional Hospital	\$ 5,000
Donated Mammograms – Health South Diagnostics	\$ 5,000
Donated Mammograms – Breast Cancer Detection Center	\$213,888
Uncompensated Care – Medical Providers	\$225,000
Breast Cancer Focus Inc. – Education	\$57,615
<b>Total</b>	<b>\$824,401</b>

SCREENING AND DIAGNOSTIC WORK-UP CALCULATIONS SHEET

CALCULATIONS INPUT

NUMBER OF WOMEN SCREENED

New Screens: mammograms	1,200
Subsequent mammograms	600
Total mammograms	1,800

Number of screening CBE's	1,800
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New Screens: PAPs	2,500
Subsequent PAPs	2,000
Total PAPs	4,500

New office visits	2,560
Subsequent office visits	2,250
Total office visits	4,810

AK-BCCEDP	Cost of each procedure
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\$	67.81
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\$	14.60
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New Pt	\$	143.88
Established Pt	\$	81.56

ASSUMPTIONS REGARDING RATES OF ABNORMALS AND PROCEDURES

Rate of abnormal mammograms new (5-10%)	5.3%
Rate of abnormal mammograms - subsequent	3.6%
Rate of abnormal CBE's (with normal mammogram)	8.0%
Rate of ASCUS Paps	6.0%
Rate of LSIL Paps	3.0%
Rate of HGSIL and SqCa Paps	1.0%

Rate of each procedure following an abnormal mammogram

Diagnostic Mam (add'l mam views)	56%
Ultrasound	31%
FNA	9%
Biopsy (non excisional)	9%
Excisional biopsy	19%
Surgical consult	30%
Pathology charges: breast	

Cost of each procedure	
\$	79.33
\$	80.35
\$	97.30
\$	372.89
\$	403.60
\$	103.23
\$	86.97

Rate of each procedure following an abnormal CBE (with normal mam)

Diagnostic Mam (add'l mam views)	33%
Ultrasound	50%
FNA	7%
Biopsy (non exc.)	0%
Excisional biopsy	7%
Surgical Consult	93%

Rate of each procedure following ASCUS Pap smear

Colpo-directed Biopsy	15%	\$ 117.75
Colposcopy alone	5%	\$ 91.12
Repeat Pap smears	100%	\$ 28.93
Pathology charges: cervical		\$ 86.97

Rate of each procedure following LSIL Pap smear

Colpo-directed Biopsy	35%	\$ 117.75
Colposcopy alone	15%	\$ 91.12
Repeat Pap smears	100%	\$ 28.93
Pathology charges: cervical		\$ 86.97

Rate of each procedure following HGSIL and SqCa Pap smear

Colpo-directed Biopsy	90%	\$ 117.75
Colposcopy alone	10%	\$ 91.12
Repeat Pap smears	100%	\$ 28.93
Pathology charges: cervical		\$ 86.97

CALCULATIONS USING ABOVE RATES

Total abnormal mams	85.2
Total abnormal CBE's (normal Mam)	144
Total ASCUS Paps	270
Total LSIL Paps	135
Total HGSIL and SqCa Paps	45

TOTAL NUMBERS AND COSTS OF SCREENING AND DIAGNOSTIC PROCEDURES

Mammogram	1,800	\$ 122,058	14.6%
Pap smears	4,500	\$ 65,700	7.9%
Office visits	4,810	\$ 551,843	66.2%
Colposcopy/biopsy	128.25	\$ 15,101	1.8%
Colposcopy alone	38.25	\$ 3,485	0.4%
Diagnostic Mam (add'l mam views)	95	\$ 7,555	0.9%
Ultrasound	98	\$ 7,907	0.9%
FNA	18	\$ 1,727	0.2%
Biopsy (non excisional)	8	\$ 2,859	0.3%
Excisional biopsy	26	\$ 10,602	1.3%
Repeat pap smear	450	\$ 13,019	1.6%
Surgical consult	159	\$ 16,463	2.0%
Pathology; breast	52	\$ 4,495	0.5%
Pathology; cervical	128	\$ 11,154	1.3%
TOTALS	12,311	\$ 833,968	100%

Appendices

Alaska BCCEDP CPT Codes for 2000

DESCRIPTION OF SERVICE	CPT CODE	AK FEE 2000	TECH-NICAL	PROFES-SIONAL
<b>CERVICAL</b>				
<b>Screening</b>				
Pap Smear, reported in Bethesda System	88164	\$14.60		
<b>Diagnostics</b>				
Pap Smear, reported in Bethesda System requiring interpretation by physician	88141	28.93		
Colposcopy Biopsy Interpretation	88305	86.97	36.90	50.07
Colposcopy without Biopsy (surgical procedure only)	57452	91.12		
Colposcopy with Biopsy and/or endocervical curettage (surgical procedure only)	57454	117.75		
<b>OFFICE VISITS</b>				
New Patient - Office Visit (10 minutes face to face)	99201	46.12		
New Patient - Office Visit (20 minutes face to face)	99202	71.28		
New Patient - Office Visit (30 minutes face to face)	99203	99.89		
New Patient - Office Visit (45 minutes face to face)	99204	143.88		
New Patient - Office Visit (60 minutes face to face)	99205	177.95		
Established Patient - Office Visit (5 minutes face to face)	99211	23.07		
Established Patient - Office Visit (10 minutes face to face)	99212	38.82		
Established Patient - Office Visit (15 minutes face to face)	99213	52.97		
Established Patient - Office Visit (25 minutes face to face)	99214	81.56		
Established Patient - Office Visit (40 minutes face to face)	99215	121.35		
Consultation Visit - 15 minutes face to face with patient	99241	63.23		
Consultation Visit - 30 minutes face to face with patient	99242	103.23		
Consultation Visit - 40 minutes face to face with patient	99243	131.26		
<b>PREVENTIVE MEDICINE SERVICES</b>				
New Patient - Initial Preventive Medicine Visit, 40-64 Years	99386	104.48		
New Patient - Initial Preventive Medicine Visit, 65 - Years	99387	120.87		
Established Patient - Periodic Preventive Medicine Visit, 40-64 Years	99396	99.89		
Established Patient - Periodic Preventive Medicine Visit, 65 - Years	99397	109.88		

Alaska BCCEDP CPT Codes for 2000

DESCRIPTION OF SERVICE	CPT CODE	AK FEE 2000	TECH-NICAL	PROFES-SIONAL
<b>BREAST</b>				
<b>Screening</b>				
Screening mammogram	76092	\$67.81	\$46.12	\$21.69
<i>Diagnostics</i>				
Diagnostic/Follow-up- Unilateral Mammogram	76090	79.33	49.19	30.14
Diagnostic/Follow-up- Bilateral Mammogram	76091	97.62	60.49	37.13
Stereotactic localization for breast biopsy, each lesion, radiological supervision and interpretation	76095	424.91	331.91	93.00
Preoperative placement of needle localization wire, breast, radiological supervision and interpretation	76096	92.85	60.49	32.37
Radiological examination, surgical specimen	76098	29.39	19.59	9.79
Ultrasound - Echography, Breasts(unilateral or bilateral) B -scan and/or real time image documentation	76645	80.35	49.19	31.16
Ultrasonic guidance for cyst aspiration, radiological supervision and interpretation	76938	109.99	71.06	38.93
Ultrasonic guidance for needle biopsy, radiological supervision and interpretation	76942	110.42	71.06	39.36
Aspiration of Cyst of Breast (surgical procedure only)	19000	70.12		
Aspiration of Cyst of Breast, Additional	19001	40.36		
Biopsy of breast; needle core (surgical procedure only)	19100	134.36		
Incisional biopsy of breast.	19101	372.89		
Excision of cyst, fibroadenoma, or other benign or malignant tumor aberrant breast tissue, duct lesion or nipple lesion	19120	403.60		
Excision of breast lesion identified by pre-operative placement of radiological marker - single lesion	19125	440.47		
Excision of breast lesion identified by pre-operative placement of radiological marker - each additional lesion	19126	188.43		
Preoperative placement of needle localization wire, breast	19290	157.03		
Surgical Tray. Reimbursed only in conjunction with 19101, 19120, 19125, 19126, 76095	A4550	19.04		
Fine Needle Aspiration with/without preparation of smears	88170	97.30	21.01	76.29
Evaluation of Fine Needle Aspiration	88172	70.26	31.62	38.65
Interpretation and Report of Fine Needle Aspiration	88173	112.44	32.05	80.40
Breast biopsy interpretation	88305	86.97	36.90	50.07

Appendix A: Screening & Diagnostic CPT Code/Rate List

Billing Code: 4163-18-P


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Disease Control and Prevention  
[Program Announcement 99052]

Cooperative Agreement for 1999 National Breast and Cervical  
Cancer Early Detection Program  
Notice of Availability of Funds

A. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 1999 funds for a cooperative agreement program for the National Breast and Cervical Cancer Early Detection Program. This program addresses the "Healthy People 2000" priority area(s) related to cancer.

The purpose of this program is to establish a State/territorial/tribal comprehensive public health approach to reduce breast and cervical cancer morbidity and mortality through screening, tracking, follow-up and case management, public education, information, and outreach, professional education, quality assurance and improvement, surveillance, evaluation, partnership development and community involvement. The program is established to eliminate disparity and provide comprehensive breast and



cervical cancer screening services for all women at or below 250 percent of the official poverty line as established by the Director of the Office of Management and Budget (OMB) and revised by the Secretary of DHHS in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1991 [Section 1504(b)(3) of the PHS Act, as amended]. Criteria for priority populations are uninsured or under-insured older women who are racial, ethnic and cultural minorities, such as American Indians, Alaska Natives, African-Americans, Hispanics, Asian/Pacific Islanders; Lesbians; women with disabilities; and for women who live in hard-to-reach communities in urban and rural areas. Priority populations, as defined above, will be used throughout this document.

*Outreach  
minis - Encore  
don-t-don - Low income  
coupons - 700 codes  
Asian*



**B. Eligible Applicants**

Assistance will be provided only to the official health departments of States and Territories or their bona fide agents or instrumentalities and to Indian Tribal governments (including Indian Tribes, Tribal organizations, Alaska Natives and Urban Indian organizations, hereafter referred to as Tribes). This includes the Commonwealth of Puerto Rico, the Federated States of Micronesia, Guam, and the Republic of the Marshall Islands, and federally recognized tribes.

1. The following States and territories are excluded:
  - a. American Samoa, California, Colorado, Maryland,

Michigan, Minnesota, Missouri, New Mexico, North Carolina, South Carolina, Texas, and West Virginia, which were funded in August 1997, under Program Announcement 718 entitled National Breast and Cervical Cancer Early Detection Program.

- b. Alabama, Commonwealth of the Northern Mariana Islands, Delaware, Hawaii, Idaho, Indiana, Kentucky, Mississippi, Montana, Nevada, New Hampshire, North Dakota, Republic of Palau, South Dakota, Tennessee, Virgin Islands, Virginia, Washington, DC, and Wyoming, which were funded in September of 1996, under Program Announcement 623 entitled 1996 National Breast and Cervical Cancer Early Detection Program.

2. The following Tribes are excluded:

- a. Consolidated Tribal Health Project, Inc., CA, and Southeast Regional Health Consortium, AK, which were funded August 1997, under Program Announcement 718 entitled National Breast and Cervical Cancer Early Detection Program.
- b. Hopi tribe, AZ; Native American Rehabilitation Association of the NW, OR; Indian Community Health Service; AZ; and the Navajo Division of Health, AZ, which were funded in September of 1996, under Program Announcement 623 entitled 1996 National

Breast and Cervical Cancer Early Detection  
Program.

States currently receiving CDC funds under Program Announcement 321 and 474, entitled Early Detection and Control of Breast and Cervical Cancer, are eligible to apply for funding under this announcement. Tribes currently receiving CDC funds under Program Announcement 442, entitled Early Detection Program American Indian Initiative, are eligible to apply for funding under this announcement. Additionally, Puerto Rico, currently funded under Program Announcement 425, entitled Capacity Building for Core Components of Breast and Cervical Cancer Prevention and Control, is eligible to apply under this announcement.

C. Availability of Funds

1. Approximately \$53,000,000 is available in FY 1999 to fund approximately 23 States. It is expected that the average award will be \$2,100,000, ranging from \$1,000,000 to \$4,500,000.
2. Approximately \$3,500,000 is available in FY 1999 to fund approximately 12 Tribes/Territories. It is expected that the average award will be \$300,000, ranging from \$200,000 to \$500,000.

It is expected that the awards will begin on September 30, 1999, and will be made for a 12-month budget period within a

project period of up to five years. Funding estimates may change.

Continuation awards of funded projects within an approved project period will be made on the basis of satisfactory progress and the availability of funds.

#### Direct Assistance

You may request Federal personnel, equipment, or supplies as direct assistance, in lieu of a portion of financial assistance.

#### Use of Funds

1. Not less than 60 percent of cooperative agreement funds will be expended for screening, tracking, follow-up, and the provision of appropriate support services such as case management. The remaining 40 percent will be expended to support public education, information, and outreach; professional education; quality assurance and improvement; surveillance; program evaluation; partnership development and community involvement.  
[Section 1503(a)(1) and (4) of the PHS Act, as amended].
2. Cooperative agreement funds will not be expended to provide inpatient hospital or treatment services.  
[Section 1504(g) of the PHS Act, as amended.] Also, cooperative agreement funds will not be used for the

specific diagnostic procedure of Loop Electrosurgical Excisional Procedure (LEEP).

3. Not more than 10 percent of funds will be expended annually for administrative expenses. These administrative expenses are in lieu of and replace indirect costs. [Section 1504(f) of the PHS Act, as amended.]

Note: Treatment is defined as any medical or surgical intervention recommended by a clinician, and provided for the management of a diagnosed condition.

4. Matching funds are required from non-Federal sources in an amount not less than \$1 for each \$3 of Federal funds awarded under this program. [Section 1502 (a) and (b) of the PHS Act, as amended.]
5. Costs used to satisfy matching requirements are subject to the same prior approval requirements and rules of allowability as those which govern project costs supported by Federal funds. (OMB Circular A-87 "Cost Principles for State, Local and Indian Tribal Governments" and PHS Grants Policy Statement, Section 6).
6. All costs used to satisfy matching requirements must be documented by the applicant and will be subject to audit.

### Recipient Financial Participation

Recipient financial participation is required for this program in accordance with the authorizing legislation. Section 1502(a) and (b) (1), (2), and (3) of the PHS Act, as amended, requires matching funds from non-Federal sources in an amount not less than \$1 for each \$3 of Federal funds awarded under this program. However, The Omnibus Territories Act requires DHHS to waive matching fund requirements for Guam, U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands. The matching funds may be in cash or its equivalent in-kind or donated services, including equipment, fairly evaluated. The contributions may be made directly or through donations from public or private entities. Public Law 93-638 authorizes tribal organizations contracting under the authority of Title I and compacting under the authority of Title III to use funds received under the Indian Self-Determination Act as matching funds.

In States/territories/tribes, non-Federal funds from a variety of sources may presently be used to support one or more of the breast and cervical cancer early detection activities described in this program announcement.

Maintenance of Effort (MOE) - The average amount of non-Federal dollars expended for breast and cervical cancer programs and activities made by a State/territory/tribe for

the two year period preceding the first Federal fiscal year of the program funding for breast and cervical cancer early detection activities. Supplantation of existing program efforts funded through other Federal or non-Federal sources is not allowable. Applicants may also include, as State/territory/tribe matching funds, any non-Federal amounts expended pursuant to Title XIX of the Social Security Act for the screening, tracking, follow-up and case management of women for breast and cervical cancer. Matching funds may not include: (1) the payment for treatment services or the donation of treatment services; (2) services assisted or subsidized by the Federal government; or (3) the indirect or overhead costs of an organization.

#### D. Program Requirements

In accordance with Public Law 101-354:

1. States, territories and tribes are required to implement all the following program components:
  - a. States and tribes presently receiving comprehensive funding: All program components should be operational at this time.
  - b. Territory presently receiving capacity funding: Comprehensive breast and cervical cancer screening, follow-up, tracking services and other support services such as a case management should

be initiated within the first twelve months of the first budget year. The capacity building program components (not the screening, tracking, follow-up and case management systems) should be fully operational at this time.

- c. Territories/tribes not presently receiving capacity funds and applying for comprehensive funding: The application should outline plans for the operation of all program components. The screening, tracking, follow-up and case management systems should be initiated within twelve months of the award date. [Section 1503 (a) (1) and (3) of the PHS Act, as amended.]
2. If a new or improved, and superior, screening procedure becomes widely available and is recommended for use, this superior procedure will be utilized in the program. [Section 1503(b) of the PHS Act, as amended.]
  3. An award may not be made unless the State/Territorial Medicaid Program provides coverage for:
    - a. In the case of breast cancer, a clinical breast examination and screening mammography.
    - b. In the case of cervical cancer, both a pelvic examination and Pap test screening. [Section 1502A of the PHS Act, as amended.]

For those Territorial Departments of Health not

receiving Medicaid, this program requirement would be non-applicable.

4. In 1993, Congressional amendments to the National Breast and Cervical Cancer Early Detection Program included the following changes:
  - a. The amount paid by a State/territory/tribe for a screening procedure may not exceed the amount that would be paid under part B of title XVIII of the Social Security Act (Medicare) [Section 1501(b)(3) of the PHS Act, as amended].
  - b. All facilities conducting mammography screening procedures funded by the Program must meet the regulations for mammography quality assurance developed by the Food and Drug Administration (FDA), most recently reauthorized and finalized October 31, 1998.
  - c. For cervical cancer activities, facilities will meet the standards and regulations developed by the Health Care Financing Administration (HCFA) implementing the Clinical Laboratory Improvement Amendments (CLIA) of 1988.
5. In 1998, Reauthorization language for the National Breast and Cervical Cancer Early Detection Program included the following change:
  - a. States/territories/tribes may enter into contracts .

with public and non-profit private entities and through contracts with public and private entities to provide screening, tracking, follow-up, and case management services, as well as for public education, information, and outreach activities, professional education activities, establish mechanisms to monitor quality of screening procedures, and to evaluate such activities. If a non-profit private entity and a private entity that is not a non-profit entity both submit applications to a State/tribe/territory, the State/tribe/territory may give priority, based on a competitive review process, to the application submitted by the non-profit private entity in any case in which the State/tribe/territory determines that the quality of such application is equivalent to the quality of the application submitted by the other private entity [Section 1501(b) of the PHS Act, as amended].

In accordance with Section 1504 (c) (2) of the PHS Act, as amended, CDC may waive the requirements for specific services/activities if it is determined that compliance by the State/territory/tribe would result in an inefficient allocation of resources with respect to carrying out a comprehensive breast and cervical cancer early detection

program (as described in Section 1501(a)). A request from the recipient outlining appropriate and detailed justification would be required before the waiver is approved.

In conducting activities to achieve the purpose of this program, the recipient will be responsible for the activities under "Recipient Activities", and CDC will be responsible for conducting activities under "CDC Activities".

#### Recipient Activities

1. Establish a system for screening and rescreening women for breast and cervical cancer as a preventive health measure. [Section 1501(a)(1) of the PHS Act, as amended.]

This program is to increase the access to and use of screening services for breast and cervical cancer among all women with emphasis being given to identified priority populations as described under the "Purpose" section.

- a. Ensure that screening and rescreening procedures are available for both breast and cervical cancer and provided to women participating in the program, including a clinical breast exam, mammography, pelvic exam, and Pap smear.

[Section 1503(a)(2)(A) and (B).]

b. Screening services should be made available according to the following guidelines:

(1) Provide priority for screening, tracking, follow-up and other support services such as case management to women who are low-income and uninsured or under-insured. [Section 1504(a) of the PHS Act, as amended.]

An award may not be made under this announcement unless the State/territory/tribe involved agrees to give priority to the provision of screening, tracking, follow-up, and other support services such as case management to low-income women who are underserved or uninsured.

Note: Low income is defined as at or below 250 percent of the official poverty line. The official poverty line is established by the Director of the OMB and revised by the Secretary of the DHHS in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1991 [Section 1504(b)(3) of the PHS Act, as amended.]

(2) Establish breast and cervical cancer screening services throughout the

State/territory/tribe. [Section 1504(c)(1) of the PHS Act, as amended.]

Funds may not be awarded under this announcement, unless the State/territory/tribe involved agrees that services and activities will be made available throughout the State, territory, or tribe, including availability to members of any Indian tribe or tribal organization (as such terms are defined in Section 4 of the Indian Self-Determination and Education Assistance Act).

- (3) Provide allowances for items and services reimbursed under other programs. [Section 1504(d)(1) and (2) of the PHS Act, as amended.]

Funds may not be awarded under this announcement, unless the State/territory/tribe involved agrees that funds will not be expended to make payment for any item or service that will be paid or can reasonably be expected to be paid by:

(a) Any State/territory/tribe compensation program, insurance policy, or Federal or State/territory/tribe health benefits program.

(b) An entity that provides health services on a prepaid basis.

(4) Establish a schedule of fees/charges for services. [Section 1504(b)(1), (2), and (3) of the PHS Act, as amended.]

Funds may not be awarded under this announcement unless the State/territory/tribe involved agrees that if charges are to be imposed for the provision of services or program activities, the fees/charges for allowable screening and diagnostic evaluation will be:

(a) Made according to a schedule of fees that is made available to the public. [Section 1504(b)(1) of the PHS Act, amended.]

(b) Adjusted to reflect the income of the woman screened. [Section 1504(b)(2) of the PHS Act, as amended.]

(c) Totally waived for any woman with an income of less than 100 percent of the official poverty line.

Additionally, the schedule of fees/charges should not exceed the maximum allowable charges established by the Medicare Program administered by the Health Care Financing Administration (HCFA). Fee/charge schedules should be developed in accordance with guidelines described in the interim final rule (42 CFR Parts 405 and 534) which implements Section 4163 of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508) which provides limited coverage for screening mammography services.

**Breast Health:** The most important risk factors for breast cancer are being female and older age. Priority for mammograms should be given to eligible women 50 years and older not enrolled in Medicare Part B previously screened in the NBCCEDP. Specific policies that outline eligibility criteria and authorize screening and diagnostic services are provided in the NBCCEDP PPM.

**Cervical Health:** Women who are 18 years and

older, with an intact cervix, are eligible for an annual Pap test and pelvic examination. While the incidence of precancerous lesions are higher among younger women, older women have higher rates of invasive cancer and cervical cancer mortality and are less likely to be screened regularly. Hence, programs should provide a balanced distribution in the ages of women receiving Pap tests. Women who have had a total hysterectomy; that was performed for cervical neoplasia are eligible to receive Pap screening. Priority for Pap tests should be given to eligible women previously screened in the NBCCEDP. The following exception applies:

After a woman has had three consecutive, normal, annual examinations, the Pap test may be performed less frequently at the discretion of her health care provider.

For diagnostic services following an abnormal screening result, cooperative agreement funds may be

expended for colposcopy,  
colposcopy-directed biopsy, and  
endocervical curettage.

2. Provide appropriate referrals for medical treatment of women screened in the program and ensure, to the extent practicable, the provision of appropriate and timely diagnostic and treatment services. [Section 1501(a)(2) of the PHS Act, as amended.]

A system for providing the appropriate and timely diagnostic and treatment services for women whose screening test results are abnormal or suspicious is an essential component of any comprehensive breast and cervical cancer early detection program. Priority for diagnostic services should be given to women provided a screening procedure by the program who have abnormal screening results. The implementation plan and budget for diagnostic services should reflect the projected number of women to be screened by the program annually and the estimated number of abnormal screening exams expected. Programs are encouraged to use the Screening and Diagnostic Worksheet included in the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Policies and Procedures Manual (PPM) to report their projections.

3. Develop, implement and maintain a proactive system for the timely and appropriate tracking, follow-up, and case management of women with abnormal or suspicious screening tests [Section 1501(a)(6) of the PHS Act, as amended].

Systems should include the regular updating of information on local resources available in the community to which health care providers can refer women for additional diagnostic procedures, as well as treatment services. Clients in need of treatment services should be assisted with obtaining eligibility for public-supported third party reimbursement programs or private donated services.

Tracking the women screened is essential to identify those women who have abnormal results and ensure they receive appropriate and timely follow-up for short-interval rescreening, diagnostic procedures, and treatment. Tracking also includes reminders and outreach to women with normal or benign results to return for timely rescreening. A proactive tracking system is one that can be effectively integrated into the State/territory/tribe health care delivery system. The tracking system should provide women with a unique identification number and to document the outcome of

individual screening tests, regardless of the screening cycle or site. It should also provide information on needed diagnostic follow-up. Confidentiality of a woman's clinical procedure results must be assured. To meet the intent of Pub. L. 101-354 in ensuring the appropriate follow-up of women with abnormal screening results, the State/territory/tribe tracking and follow-up system must include information on screening location (e.g., county, city), demographic characteristics (e.g., race, date of birth), and screening procedures and results (e.g., mammography, Pap tests) for all women in the program. For women identified with abnormal screening results, information on diagnostic procedures (e.g., colposcopy) and final diagnoses, treatment (e.g., date initiated), and stages of cancer must be included.

4. Develop and disseminate public information, education and outreach programs for the early detection and control of breast and cervical cancer. [Section 1501 (a) (3) of the PHS Act, as amended.]

Public information, education, and outreach include the systematic design and sustained delivery of clear and consistent health messages to women using a variety of methods and strategies that contribute to the early detection of breast and cervical cancer. Successful

public education and outreach programs are those that increase women's knowledge, and ultimately have an impact on attitudes and screening behavior.

Public information, education, and outreach activities should increase the number of women screened especially those who are identified as priority populations as defined in the "Purpose" section.

State/territory/tribe and local programs should clearly demonstrate, through evaluation, the relationship of public information, education, and outreach strategies to the number of women screened through the program.

The program should develop a plan that defines the scope (content, priority populations, methods, strategies outcomes, resources) of the public information, education, and outreach efforts.

5. Improve the education, training, and skills of health professionals (including allied health professionals) in the detection and control of breast and cervical cancer. [Section 1501(a)(4) of the PHS Act, as amended.]

The purpose of professional education activities is to affect health care providers' knowledge, attitudes, and behaviors to ultimately result in more women, who are identified as priority populations as defined in the

"Purpose" section, in the intended audience being screened appropriately.

Professional education refers to the education of physicians, nurses, case managers, cytotechnologists, radiologists, radiologic technologists, health educators, outreach workers, support staff members, and other health professionals. It includes preprofessional, postgraduate, and continuing education. Professional education includes developing knowledge, attitudes, and skills to enable professionals to perform their jobs more effectively. It involves the identification of resources and needs and planning, implementing, and evaluating training for the health care provider. Professional education includes promoting the development and implementation of systems of health care delivery that provide positive clinical outcomes for patients, as well as the development and dissemination of clear recommendations and guidelines.

A plan should be developed that defines the scope (i.e., content, provider populations, strategies, methods, outcomes, resources) of professional education, including a prioritized list of professional groups to be trained.

Training should be based on adult learning principles with a focus on skill-based training.

6. Establish mechanisms through which the State/territory/tribe can monitor the quality of screening procedures for breast and cervical cancer, including the interpretation of such procedures.

[Section 1501(a) (5) of the PHS Act, as amended.]

Cooperative agreement funds may not be awarded [under Section 1501 of the PHS Act, as amended, Pub. L. 101-354] unless the State/territory/tribe involved agrees to assure that the State/territory/tribe will, in accordance with applicable law, assure the quality of screening procedures conducted pursuant to Section 1503 (c) of the PHS Act, as amended.

- a. Develop and implement a quality assurance and improvement system for breast cancer screening.

The mammography services provided to women screened in the program must be conducted in accordance with the following guidelines issued by the Secretary of the Department of Health and Human Services.

- (1) All facilities conducting mammography screening procedures funded by the program must meet the requirements for mammography

quality assurance developed by the Food and Drug Administration (FDA), most recently Reauthorized and finalized October 31, 1998.

(2) Radiologists participating in the program will record their findings using the second edition American College of Radiology (ACR) Breast Imaging Reporting and Data System (BI-RADS). The BI-RADS' reporting categories are as follows: (1) Negative; (2) Benign finding; (3) Probably benign finding -- short interval follow-up suggested; (4) Suspicious finding; (5) Highly suggestive of malignancy; (6) Assessment incomplete -- additional imaging evaluation needed.

(3) A report of the results of a mammogram performed through this program will be placed in a woman's permanent medical records that are maintained by her health care provider.

b. Develop and implement a quality assurance and improvement system for cervical cancer screening. The laboratory services provided to women for cytological screening must be conducted in accordance with the following guidelines issued by the Secretary of the Department of Health and Human Services.

- (1) All facilities providing laboratory services will meet the standards and regulations promulgated by the Health Care Financing Administration (HCFA) under the Clinical Laboratory Improvement Act (CLIA) of 1988.
- (2) All cervical cytology interpretation is required to be done on the premises of a qualified laboratory.
- (3) A report of the results of a Pap test performed through this program will be placed in the woman's permanent medical records that are maintained by her health care provider.
- (4) Pathologists participating in the program will record their Pap test findings using the Bethesda System which specifies specimen adequacy and incorporates these categories:
  - (1) Within Normal Limits; (2) Infection/Inflammation/Reactive Changes; (3) Atypical squamous cells; (4) Low Grade Squamous Intra epithelial Neoplasia (SIL); (5) High Grade SIL; (6) Squamous Cell Carcinoma; (7) Atypical glandular cells; (8) Other.

In addition to using only MQSA and CLIA certified providers, quality assurance and improvement efforts

should include use of:

- (1) an active medical advisory group;
- (2) established clinical guidelines; and,
- (3) a system that assures that abnormal screening results are followed-up and that rescreening occurs.

7. Establish mechanisms which enhance the State/territory/tribe cancer surveillance system (i.e., linkage to the Central Cancer Registry and other databases) and facilitate program planning and evaluation. [Section 1501(a)(5) of the PHS Act, as amended.]

Monitoring the distribution and determinants of breast and cervical cancer incidence and mortality is necessary to effectively plan, implement, and evaluate a comprehensive early detection program. Linkages and coordination with State/territory/tribe vital statistics, the Central Cancer Registry, the Behavioral Risk Factor Surveillance System and other State/territory/tribe and local surveys are needed to evaluate the status of a program's goals and objectives.

- a. To do this, surveillance systems should be established or enhanced which will:

- (1) Collect Statewide/territory/tribal population-based information on the demographics, incidence, staging at diagnosis, and mortality from breast and cervical cancer.
  - (2) Identify segments of the population at higher risk for disease and for the failure to be screened.
  - (3) Identify factors contributing to the disease burden, such as behavioral risk factors and limited or inequitable access to early detection and treatment services.
  - (4) Monitor the number and characteristics of women screened in the program and the outcome of screening by analyzing data from the State/territory/tribe tracking and follow-up system.
  - (5) Monitor screening resources, including the number of available mammography facilities, cytology laboratories, and providers of cervical cancer screening.
  - (6) When appropriate, develop linkages between the above-mentioned data bases.
- b. Measuring the effectiveness of program activities to modify the screening behavior of women and the

effect on morbidity and mortality is important for the identification of successful intervention strategies for the early detection of breast and cervical cancer. Equally important is the evaluation or the assessment of factors that contributed to the successful or unsuccessful establishment and implementation of program activities.

The design of each program component should ensure that there can be meaningful evaluation. The evaluation plan should assess the implementation and effectiveness of each program component. At a minimum, the evaluation plan should identify those program activities that will be evaluated, the objectives to be measured, how they will be measured, the proposed program time-lines, and resources needed. In addition to evaluating progress in meeting goals and objectives, the program should develop performance indicators to use as a measure of program improvement and resource management and allocation.

Note: Indicator is defined as a performance measure used to track critical processes over time to signify progress toward a particular goal or outcome of the program.

8. Ensure the coordination of services and program activities with other similar programs and establish a broad-based coalition to advise and support the program. [Section 1504(e) of the PHS Act, as amended.] Coordination with other similar programs maximizes the availability of services and program activities, promotes consistency in screening procedures and educational messages, and reduces duplication. An award may not be made under this program announcement unless the State/territory/tribe agrees that the services and activities provided in this program are coordinated with other Federal, State/territory/tribe, and local breast and cervical cancer early detection programs through the development of collaborative partnerships. [Section 1504(e) of the PHS Act, as amended.]

The success of a comprehensive breast and cervical cancer early detection program is improved by broad-based support in the community and active public and private sector involvement. Partnership development with a broad range of stakeholders, including consumers, brings valuable knowledge, skills, and financial resources to the program, and provides access to, and information about, populations of women who have been missed by traditional health service systems.

Linkages should be established with federally funded programs such as the Regional Offices of the National Cancer Institute/Cancer Information Service (NCI/CIS), the Health Resources and Services Administration (HRSA) community/migrant health centers, Title X Family Planning programs, State Offices for Aging and Minority Health, the Indian Health Service (IHS) and the Medicare Program of the Health Care Financing Administration (HCFA).

Linkages and active collaboration are strongly encouraged with private sector organizations such as the American Cancer Society (ACS), the Young Women's Christian Association (YWCA), the Susan G. Komen Breast Cancer Foundation, the National Breast Cancer Coalition (NBCC), the National Alliance of Breast Cancer Organizations (NABCO), the American Association of Retired Persons (AARP), local medical and nursing societies professional organizations, private physicians, survivors of breast and cervical cancer, local women's support groups, community leaders, managed care organizations, and other agencies and businesses in the community that provide health care and related support services to women.

9. Develop a work and management plan for the implementation of a comprehensive breast and cervical

cancer screening program.

The success of a comprehensive breast and cervical cancer early detection program is increased by the existence of a comprehensive, integrated, and realistic plan to address these diseases among all women, with emphasis given to women identified as priority populations under the "Purpose" section. All program components of the comprehensive program should be addressed.

A work plan should include goals, measurable objectives, strategies proposed to attain the goals and performance indicators (if applicable). The goals in the work plan should relate to the State, territory, or tribe Year 2000 Objectives and to the State, territory, and tribe Cancer Control Plan.

The management plan should reflect the development of qualified and diverse technical, program, and program/administrative staff, appropriate organizational relationships including lines of authority, adequate internal and external communication systems, and a system for sound fiscal management.

10. Representation or attendance at CDC sponsored trainings, meetings, site visits, and conferences.

## CDC Activities

1. Convene a workshop of the funded Programs every one to two years for information-sharing and problem-solving and hold a Program Director's meeting at least once a year.
2. Provide consultation and technical assistance to plan, implement, and evaluate each component as described under Recipient Activities above, to include:
  - a. Practical application of Public Law 101-354, including amendments to the law;
  - b. Design and implementation of each program component (screening, tracking, follow-up and support services such as case management; public education and outreach; professional education; partnership development and community involvement; quality assurance and improvement; surveillance; and evaluation);
  - c. Interpretation of current scientific literature related to the early detection of breast and cervical cancer;
  - d. Nationally recognized clinical and quality assurance guidelines for the assessment and diagnosis of breast and cervical cancer;
  - e. Evaluation of each program component through the analysis and interpretation of program outcomes,

screening data, and surveillance data;

f. Overall operational planning and program management.

3. Provide training opportunities on selected topics to State, territorial and tribal program staff through the National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control's National Training Center.
4. Conduct site visits to assess program progress and mutually resolve problems, as needed, and/or coordinate reverse site visits to CDC in Atlanta, Georgia.

**G. Application Content**

Use the information in the Program Requirements, Other Requirements, and Evaluation Criteria sections to develop the application content. Your application will be evaluated on the criteria listed, so it is important to follow them in laying out your program plan. The application, including budget, justification and appendices, should be no more than 125 double-spaced unbound pages, printed on one-side of 8 ½ x 11" paper, suitable for photocopying, with one inch margins, and 12 point font.

**1. Executive Summary**

The applicant should provide a clear, concise one or two page written summary to include: (1) the need for

goals, measurable, time-phased, and realistic objectives, and strategies to attain the goals for: (1) the overall program and (2) specific program components as described under the Recipient Activities. Project the number of women to be screened and rescreened annually by age, racial and ethnic groups, and areas or locality in the State/territory/tribe. [Section 1505(2) of the PHS Act, as amended.] Estimate the number of abnormal screening exams expected annually.

Applicants are encouraged to include a completed Screening and Diagnostic Worksheet (sample included in the NBCCEDP PPM) in their application.

- b. Describe the State/territory/tribe's: (1) health care delivery system; (2) proposed Statewide/territorial/tribal screening system; (3) proposed proactive tracking and follow-up system for women requiring diagnostic procedures and medical treatment not provided by the program; and (4) proposed tracking and follow-up system for women screened and rescreened by the program; and (5) proposed support services such as case management [Section 1501(a) (1) and (2) of the PHS Act, as amended.]
- c. For those applicants previously receiving National

Breast and Cervical Cancer Early Detection Program Cooperative Agreement funding, describe, in detail, the operational plan related to rescreening efforts (including staff responsible for oversight, the process to monitor rescreening rates and the system to assess the strategies used) and rescreening protocol (including a systematic and comprehensive reminder system). Include the calculation of mammography and cervical cancer rescreening rates for clinical services previously provided to eligible enrolled NBCCEDP women.

- d. Document available resources in the State/territory/tribe for the payment or reimbursement of breast and cervical cancer screening, including the Medicaid Program. [Section 1504 (d) of the PHS Act, as amended.]
- e. Describe the ability to establish a screening program that meets FDA regulations for mammography screening; uses the American College of Radiology Breast Imaging Reporting and Data System (BI-RADS); meets the standards and regulations of the Clinical Laboratory Improvement Act (CLIA) for cervical cancer screening; and, uses the Bethesda System.

- f. Provide a projected timetable for program implementation that displays dates for the accomplishment of specific proposed activities.
- g. Describe the current or proposed plan for evaluating (1) the program's progress in meeting specific objectives outlined in the implementation plan by program component area, and (2) overall success based on performance indicators established by the applicant. Describe the types of indicators to be used to assess outcomes that will occur as a result of this funding. Baseline measures should be identified and assessed to allow for comparisons after implementation has begun. Specify the kind of data/performance indicator that will be used, how the data will be obtained, how information will be used to improve the overall efficiency and effectiveness of the program, as well as individual program components, who is responsible for each evaluation task, and a timeline for accomplishing each evaluation task.
- h. Describe how the State/territory/tribe will assure that funds will be used in a cost-effective manner. [Section 1505 (4) of the PHS Act, as amended.]

#### 4. Partnership Development and Community Involvement

The applicant should describe:

- a. How the program will develop linkages and coordinate with other Federal, State and local programs, voluntary and professional organizations, private physicians, and mammography facilities and other groups, agencies, and businesses in the community that provide health care and related support services to women.  
[Section 1504(e) of the PHS Act, as amended.]
- b. The current or proposed broad-based coalitions that will advise and support the breast and cervical cancer early detection program, including the identification of current members or proposed representatives, their charge, and their proposed roles and responsibilities. Specific subcommittees of the coalition should be described (e.g., Medical Advisory, public information education and outreach, and professional education).
- c. Letters of support (dated within the last three months) from key partners, participants, and community leaders should be included in the application.

## 5. Management and Organizational Structure

The applicant should submit a Management plan. This plan should include a description of the structure to ensure the implementation of a comprehensive breast and cervical cancer program that includes development of qualified and diverse technical, program, and administrative staff, organizational relationships including lines of authority, internal and external communication systems, and a system for sound fiscal management. The information should also include the following:

- a. A copy of the organizational chart indicating the placement of the proposed program in the department/organization.
- b. Documentation of available resources in the State/territory/tribe for the payment or reimbursement of breast and cervical cancer screening, including the Medicaid and Medicare Programs. [Section 1504 (d) of the PHS Act, as amended.]
- c. The proposed schedule of fees and charges for breast and cervical cancer screening and diagnostic services, consistent with maximum Medicare reimbursement rates, and include a description of its use in the program. In

States/territories/tribes where there are multiple Medicare rates and a single reimbursement rate is being proposed, the applicant must provide justification for approval. [Section 1504 (b) of the PHS Act, as amended.]

6. **Capability for Program Implementation**

The applicant should describe proposed activities as measured by:

- a. Accomplishments of an existing breast and cervical cancer early detection program funded by CDC or relevant past experiences funded by other sources:

- (1) States Currently Receiving CDC Comprehensive Funds:

Accomplishments in establishing a comprehensive breast and cervical cancer early detection program, including the total number, age and racial/ethnic distribution of women screened; percent of abnormal findings by age and race/ethnicity; rate of cancer age adjusted or age-group specific; follow-up time between screening and diagnosis and between diagnosis and treatment initiation; and, percent of women who are routinely rescreened by the program.

Accomplishments in establishing an infrastructure to support a breast and cervical cancer screening program and in resolving program challenges, such as mammography screening for Medicare Part B unenrolled women 50 years and older, the timely follow-up of women with abnormal screening and diagnostic results, or the use of the American College of Radiology BI-RADS by radiologists to report mammogram results.

(2) Territory currently receiving CDC Capacity Building Funds: Accomplishments in establishing a comprehensive infrastructure to support a breast and cervical cancer screening program including screening, tracking, follow-up and case management information, public education and outreach, professional education, quality assurance and improvement, surveillance, and partnership development and community involvement.

(3) Territories/Tribes not currently Receiving CDC Breast and Cervical Cancer Funds: Relevant past experiences of the applicant in conducting screening, tracking, follow-up, case management; public information,

education and outreach; professional education; quality assurance and improvement; surveillance; and, partnership development and community involvement for cancer control, chronic disease control or other relevant areas.

7. Source Data for Matching Requirement

Identify and describe:

- a. Maintenance of Effort (MOE) - The average amount of non-Federal dollars expended for breast and cervical cancer programs and activities made by a State/territory/tribe for the two year period preceding the first Federal fiscal year of the program funding for breast and cervical cancer early detection activities. This amount will be used to establish the maintenance of effort baseline for current and future match requirements;
- b. State/territory/tribe allowable sources of matching funds for the program and the estimated amounts from each;
- c. Procedures for documenting the value of non-cash matching funds;
- d. Procedures for documenting the actual amount of match received.

8. Budget with Justification

- a. Provide a detailed budget request and complete line item justification (for both Federal and non-Federal funds) of all proposed operating expenses consistent with the program activities described in this announcement. Not less than 60 percent of Federal funds will be expended for screening, tracking, follow-up and other support services such as case management. Not more than 10 percent of Federal funds will be expended for administrative expenses. A detailed line-item breakdown of the 60/40 distribution should be incorporated into the budget.
- b. The applicant should submit a Screening and Diagnostic Worksheet that details the projected number of women screened, the reimbursement rate provided for each service, and the overall projected clinical costs. A sample Screening and Diagnostic Worksheet is included in the NBCCEDP PPM.
- c. To request new direct-assistance assignees, include:
  - (1) number of assignees requested;
  - (2) description of the position and proposed duties;

- (3) ability or inability to hire locally with financial assistance;
- (4) justification for request;
- (5) organizational chart and name of intended supervisor;
- (6) opportunities for training, education, and work experiences for assignees; and
- (7) description of assignee's access to computer equipment for communication with CDC (e.g., personal computer at home, personal computer at workstation, shared computer at workstation on site, shared computer at a central office).

F. Submission and Deadline

Submit the original and two copies of the completed application Form PHS-5161-1 (OMB Number 0937-0189). Forms are in the application kit. On or before May 26, 1999, submit the application to:

Mildred S. Garner, Grants Management Officer, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 2920 Brandywine Road, Room 3000, Atlanta, GA 30341.

1. Deadline: Applications will be considered as meeting the deadline if they are either:

- a. Received on or before the stated deadline date; or
- b. Sent on or before the deadline date and received in time for orderly processing. (Applicants must request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or the U.S. Postal Service. Private metered postmarks shall not be acceptable proof of timely mailing.)

2. Late Applications: Applications which do not meet the criteria in 1(a) or 1(b), above, are considered late applications, will be returned to the applicant.

#### G. Evaluation Criteria (100 Points)

Each application will be evaluated individually against the following criteria by an independent review group appointed by CDC.

##### 1. Background and Need (10 points)

The extent of the disease burden and the need among the priority populations as measured by:

- a. The State/territorial/tribal breast and cervical cancer age-adjusted mortality rates averaged more than five years and ranking nationally;

- b. The disease burden, including the incidence rates of breast and cervical cancer by age, race and ethnicity (where available);
- c. The number of uninsured women by race/ethnicity who are 18-39, 40-49, 50-64, 65+ years;
- d. The unmet screening needs of uninsured and underinsured women;
- e. Existing access and barriers to early detection services, (e.g., social, financial, geographic).

2. Implementation Plan (50 points)

The degree of comprehensiveness and quality of the Work Plan in relation to:

- a. The applicant's proposed work plan that includes overall goals for the program and program components, describes performance indicators related to goals and details measurable, time phased and realistic objectives for each program component. (10 Points)
- b. Proposed public education, information, and outreach strategies that are likely to increase the number of low income, uninsured women that are screened and rescreened. (10 points)
- c. Proposed professional education strategies that are likely to effect the health care providers knowledge, attitudes, and behaviors in such a way

that more women in the target audience are screened and rescreened appropriately. (10 points).

- d. Proposed a service delivery program that provides quality screening, rescreening and diagnostic services, according to established standards, and a proactive tracking, follow-up and case management system. (10 points)
- e. Proposed surveillance and evaluation strategies that appear to use reliable data and program results to measure program effectiveness and to facilitate program planning, development, and implementation, and to enhance program goals and objectives. (10 points)

3. Partnership Development and Community Involvement (10 points)

The feasibility and extent of the applicant's proposal to develop and maintain collaborative partnerships with other Federal, State and local programs, territories, tribes and voluntary, professional, and private-sector agencies. The extent of involvement of a broad-based coalition that advises and supports the program. The extent to which letters of support reflects assistance from key partners, participants, and community leaders.

4. Management and Organizational Structure (15 points)

The feasibility and appropriateness of the applicant's management plan that describes the development of qualified and diverse technical, program, and administrative staff, organizational relationships including lines of authority, internal and external communication systems, and a system for sound fiscal management.

5. Capability for Program Implementation (15 points)

The extent to which the applicant appears likely to be successful in implementing the proposed activities as measured by:

- a. Accomplishments by comprehensive-funded States and tribes in implementing a breast and cervical cancer early detection program as required through previous funding agreements. These accomplishments should be evaluated in terms of the number of women screened, the number of services provided, and the number of cancers detected.
- b. Accomplishments by capacity-funded States in establishing a comprehensive public health infrastructure to support a breast and cervical cancer early detection program.
- c. Relevant past experiences of unfunded applicants

in conducting breast and cervical cancer early detection programs.

6. Budget and Justification (Not Weighted)

The extent to which the proposed budget is adequately justified, reasonable, and consistent with this program announcement.

7. Human Subject (Not Weighted)

Whether or not exempt from the DHHS regulations, does the application adequately address the requirement of 45 CFR Part 46 for the protection of human subjects? Recommendations on the adequacy of protections include: (1) protections appear adequate and there are no comments to make or concerns to raise, or (2) protections appear adequate, but there are comments regarding the protocol, or (3) protections appear inadequate and the Objective Review Group (ORG) has concerns related to human subjects, or (4) disapproval of the application is recommended because the research risks are sufficiently serious and protection against risks are inadequate as to make the entire application unacceptable.

H. Other Requirements

Technical Reporting Requirements

Provide CDC with the original plus two copies of:

1. Semiannual progress reports are required and must be

submitted no later than 30 days after each semiannual reporting period. The semiannual progress reports must summarize the following: (1) major accomplishments including information on women screened; (2) problems encountered in program implementation; and (3) efforts or proposed strategies to resolve problems. All manuscripts published as a result of the work supported in part or whole by the cooperative agreement will be submitted with the progress reports.

2. An annual financial status report (FSR) must be submitted no later than 90 days after the end of each budget period.
3. The final financial status report and progress report is required no later than 90 days after the end of the project period.

Send all reports to:

Nealean K. Austin, Grants Management Specialist  
Grants Management Branch, Procurement and Grants  
Office, Centers for Disease Control and Prevention  
(CDC), Room 3000, 2920 Brandywine Road, Atlanta, GA  
30341.

The following additional requirements are applicable to this program. For a complete description of each, see Attachment I in application package.

AR-1

Human Subjects Requirement

AR-2	Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research
AR-7	Executive Order 12372 Review
AR-9	Paperwork Reduction Act Requirements
AR-10	Smoke-Free Workplace Requirements
AR-11	Healthy People 2000
AR-12	Lobbying Restrictions

I. Authority and Catalog of Federal Domestic Assistance  
Number

This program is authorized under sections 1501, 1502, 1507 and 1509 [42 U.S.C. 300k, 42 U.S.C. 300l, and 42 U.S.C. 300n-3] of the Public Health Service Act, as amended. The Catalog of Federal Domestic Assistance number is 93.919.

J. Where to Obtain Additional Information

To receive additional written information and to request an application kit, call 1-888-GRANTS4 (1-888-472-6874). You will be asked to leave your name and address and will be instructed to identify the Announcement number of interest. If you have questions after reviewing the contents of all the documents, business management technical assistance may be obtained from:

Nealean K. Austin, Grants Management Specialist  
Grants Management Branch, Procurement and Grants Office  
Announcement 99052

Centers for Disease Control and Prevention (CDC)  
Room 3000, 2920 Brandywine Road, Atlanta, GA 30341,  
telephone (770)-488-2754, E-mail address NEA1@CDC.GOV

For program technical assistance, contact:

Amy Harris, Acting Manager: Policy Development and  
Administrative Coordination, Program Services Branch,  
Division of Cancer Prevention and Control, National  
Center for Chronic Disease Prevention and Health  
Promotion, Centers for Disease Control and Prevention  
(CDC), 4770 Buford Highway, NE., Mailstop K-57,  
Atlanta, GA 30341-3724, telephone (770) 488-4880, fax  
(770) 488-4727, or

See also the CDC home page on the Internet:

<http://www.cdc.gov> or <http://www.cdc.gov/cancer> for a copy  
of the PPM.

## Addendum 1

### Background

#### Breast Cancer

In the United States, approximately 500,000 women will die this decade from breast and cervical cancer. Among women, breast cancer accounts for 29 percent of all new cancer cases and is the second leading cause of cancer related deaths. An estimated one of every eight women in the United States will develop breast cancer in her lifetime. In 1998, the American Cancer Society estimates that 178,700 women will be diagnosed with invasive breast cancer and 43,500 women will die of this disease. Death rates from the disease are highest among women aged 40 or more years, and among black women as compared to white women for those aged less than 70 years.

It is not currently known how to prevent breast cancer from occurring. Thus, detecting carcinoma of the breast at an early stage is the key to more treatment options, improved survival, and decreased mortality. Research has shown that the use of mammography can reduce the mortality due to breast cancer among women 50 years and older by 30 percent.

The percent of women who are regularly screened for breast cancer decreases with age. The baseline data on mammography use from the 1994 National Health Interview Survey show that only 60.6 percent of women 50 years and older reported having received a mammogram within the past two years. This proportion was lower for racial and ethnic minority women, for women who had less than a high school education, for women who were over age 65 years, and for women who were living below the poverty level. In Healthy People 2000, the Public Health Service (PHS) recommended that by the year 2000, 60 percent of women aged 50 years and older should receive a mammogram every two years.

#### Cervical Cancer

The overall incidence of invasive cervical cancer has decreased steadily over the last several decades. As Pap screening has become more prevalent, carcinoma in situ of the cervix is now more frequent than invasive cancer, particularly in women under 50 years of age. In 1997, invasive cervical cancer was diagnosed in approximately 14,500 women, and carcinoma in situ was diagnosed in about 65,000 women, and about 4,800 women died of cervical cancer.

The primary goal of cervical cancer screening is to increase

detection and treatment of precancerous cervical lesions and thus prevent the occurrence of cervical cancer. Although no clinical trials have studied the efficacy of Papanicolaou (Pap) test in reducing cervical cancer mortality, experts agree that it is an effective technology. Since the introduction of the Pap test in the 1940s, cervical cancer mortality rates have decreased by 75 percent.

In 1991, the PHS established that by the year 2000, 85 percent of women should be receiving a Pap test within the preceding one to three years. Baseline data on the use of the Pap test from the 1987 National Health Interview Survey (NHIS) showed that only 65 percent of women aged 18 years and older reported having received a Pap test within the past three years. As with mammography screening, this proportion was lower for racial and ethnic minority women, for women who had less than a high school education, for women who were over age 75 years, and for women who had low incomes.

## Attachment 1

### AR-1

#### Human Subjects Requirements

If a project involves research on human subjects, assurance (in accordance with Department of Health and Human Services Regulations, 45 CFR Part 46) of the protection of human subjects is required.

In addition to other applicable committees, Indian Health Service (IHS) institutional review committees also must review the project if any component of IHS will be involved with or will support the research. If any American Indian community is involved, its tribal government must also approve that portion of the project applicable to it.

Unless the grantee holds a Multiple Project Assurance, a Single Project Assurance is required, as well as an assurance for each subcontractor or cooperating institution that has immediate responsibility for human subjects.

The Office for Protection from Research Risks (OPRR) at the National Institutes of Health (NIH) negotiates assurances for all activities involving human subjects that are supported by the Department of Health and Human Services.

### AR-2

#### Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research

It is the policy of the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) to ensure that individuals of both sexes and the various racial and ethnic groups will be included in CDC/ATSDR-supported research projects involving human subjects, whenever feasible and appropriate. Racial and ethnic groups are those defined in OMB Directive No. 15 and include American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander. Applicants shall ensure that women, racial and ethnic minority populations are appropriately represented in applications for research involving human subjects. Where clear and compelling rationale exist that inclusion is inappropriate or not feasible, this situation

must be explained as part of the application. This policy does not apply to research studies when the investigator cannot control the race, ethnicity, and/or sex of subjects. Further guidance to this policy is contained in the Federal Register, Vol. 60, No. 179, pages 47947-47951, and dated Friday, September 15, 1995.

AR-7

#### Executive Order 12372 Review

Applications are subject to Intergovernmental Review of Federal Programs, as governed by Executive Order (E.O.) 12372. The order sets up a system for State and local governmental review of proposed Federal assistance applications. Applicants should contact their State single point of contact (SPOC) as early as possible to alert the SPOC to prospective applications and to receive instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC for each State affected. (The application kit contains a current list of SPOCs.) SPOCs who have recommendations about the State process for applications submitted to CDC should send them, in a document bearing the program announcement number, no more than 60 days after the application deadline date, to:

Nealean K. Austin, Grants Management Specialist  
Grants Management Branch, Procurement and Grants Office  
Announcement Number 99052  
Centers for Disease Control and Prevention, Room 3000  
2920 Brandywine Road  
Atlanta, GA 30341

Indian tribes must request tribal government review of their applications.

If Indian tribes are eligible for the program, change the sentence about SPOC recommendations as follows:

SPOCs or tribal governments that have recommendations about an application submitted to CDC should send them, in a document bearing the program announcement number, no more than 60 days after the application deadline date, to:

Nealean K. Austin, Grants Management Specialist  
Grants Management Branch, Procurement and Grants Office  
Announcement Number 99052  
Centers for Disease Control and Prevention, Room 3000  
2920 Brandywine Road  
Atlanta, GA 30341

CDC does not guarantee to accept or justify its nonacceptance of recommendations that are received more than 60 days after the application deadline.

#### AR-9

##### Paperwork Reduction Act Requirements

Projects that involve data collection from 10 or more persons and that are funded by grants and cooperative agreements will be subject to review and approval by the Office of Management and Budget (OMB).

#### AR-10

##### Smoke-Free Workplace Requirements

CDC strongly encourages all recipients to provide a smoke-free workplace and to promote abstinence from all tobacco products. Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities that receive Federal funds in which education, library, day care, health care, or early childhood development services are provided to children.

#### AR-11

##### Healthy People 2000

CDC is committed to achieving the health promotion and disease prevention objectives of "Healthy People 2000," a national activity to reduce morbidity and mortality and improve the quality of life. For a copy of "Healthy People 2000" (Full Report: Stock No. 017-001-00474-0) or "Healthy People 2000" (Summary Report: Stock No. 017-001-00473-1), write or call:

Superintendent of Documents

Government Printing Office

Washington, DC 20402-9325

Telephone (202) 512-1800

AR-12

### Lobbying Restrictions

Applicants should be aware of restrictions on the use of HHS funds for lobbying of Federal or State legislative bodies. Under the provisions of 31 U.S.C. Section 1352 (which has been in effect since December 23, 1989), recipients (and their subtier contractors) are prohibited from using appropriated Federal funds (other than profits from a Federal contract) for lobbying congress or any Federal agency in connection with the award of a particular contract, grant, cooperative agreement, or loan. This includes grants/cooperative agreements that, in whole or in part, involve conferences for which Federal funds cannot be used directly or indirectly to encourage participants to lobby or to instruct participants on how to lobby.

In addition, the FY 1998 Department of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act (Public Law 105-78) states in Section 503 (a) and (b) that no part of any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress or any State legislature, except in presentation to the Congress or any State legislature itself. No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

AMENDMENT

OFFERED IN THE SENATE

TO: SCS CSHB 65( ), Draft Version "F"

1 Page 2, line 11:

2 Delete "and"

3

4 Page 2, line 13:

5 Delete "."

6 Insert "; and

7 (3) to the extent that the information is available to the department in the  
8 billings submitted for assistance under sec. 1 of this Act, the cost per person paid for by the  
9 state under sec. 1 of this Act during the fiscal year preceding the date of the report and the  
10 total medical costs per person for the fiscal year preceding the date of the report, whether paid  
11 for by the state or not; the information provided in the department's report under this  
12 paragraph shall be provided separately for each person who received assistance under sec. 1  
13 of this Act, but the information shall be presented in a manner that does not allow  
14 identification of the person."



# Alaska State Legislature

Please enter into the record my testimony to the SENATE HESS  
 committee name  
 committee on SB38, dated 4/30/01  
 bill/subject

### Testimony for SB38

I support the passage of SB38. To go even further, I support implementation of insurance for every resident in this state equivalent to that of elected officials. I would think there could be some option for people to buy in to a program with their permanent fund dividends to allow this.

In my previous employment with this state, people frequently came to the LIO office seeking financial assistance for their medical bills. These people had worked their whole lives at jobs without insurance. They had worked hard and saved their money. They had acquired a home and, in some cases, other possessions which made them ineligible for public assistance. I know of one case, in Wasilla, a woman had to chose between making her house payments or purchasing her prescriptions drugs, costing \$600 per month, to prolong her life while she suffered from breast cancer. She chose the house payment and death.

Cancer has certainly touched each one of your lives and you know how costly it can be. My mother, a small business owner, was able to purchase and pay for her own insurance. She had cervical cancer and died from pancreatic cancer. There were still many bills due to the illness. My daughter, on the other hand, has been a practicing alcoholic for the majority of her adult life. She has been diagnosed with a tumor in her cervix that has

Signed: Mary A. Fulkerson  
 Testifier

leg  
 Representing (Optional)

1001 E. PULLMAN, WASILLA 99654  
 Address

(907) 316-5742  
 Phone No.



# Alaska State Legislature

PAGE 2

Please enter into the record my testimony to the SENATE HESS  
 committee name  
 committee on SB 38 , dated 4/30/01  
 bill/subject

invaded her bladder. I am very grateful she is eligible for state assistance. Even though she chose to live in this manner and acquired nothing she receives excellent medical assistance. In response to a statement from a member of the Senate HESS committee, my mother had two sexual partners in her life, the man who raped her at 14 and my father and did not smoke. My daughter has been with the same man for 11 years. My hope is the senator will check factual data regarding this disease before making such statements in the future.

But, what about the Alaskan with no insurance? They are forced to liquidate assets as well as suffer through a physical and emotional trauma.

I do not ask you on the Senate HESS committee to vote for this bill. I simply request you vote to move it out of committee. Put a do not pass on it if it is objectionable to you but please move it forward to give these people who are affected by this legislation a chance. Thank you.

Signed: *Nancy A. Furdess*  
 Testifier

Representing (Optional)

Address

Phone No.

To Alaska State Legislature

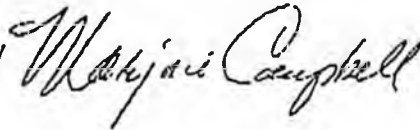
Re: SB 38 and HB 65

I am a retired State of Alaska public servant and, like hundreds of other Alaskan employees both past and present, including past and present elected officials, I enjoy the privilege and security of having health insurance. Next month I have an appointment for a mammogram and a pap test. But if I were one of the many woman in Alaska who have no health insurance and no financial reserves to cover large unexpected medical expenses I probably would not even have bothered to make an appointment for screening knowing that if the results were bad there would be nothing I could do about it.

On April 23 I watched Senator Green try to dismiss this bill as quickly as possible. She said she didn't understand why breast and cervical cancer should be selected out from a host of other illnesses for follow-up care. I have no objection to Senator Green expanding the list of illnesses to be covered, but in the meantime for about the same price it costs us to keep a senator in Juneau we could begin to make sense of the screening program by providing necessary follow-up for the needy. And the reason breast and cervical cancer has been specified in this bill is because the \$585,000 offered by the federal government was not designated to be used for a triple bypass. Senator Green said she was not without a heart, but if she fails to support this bill it will reflect an unconscionable partisan political act.

Also on April 23 I was disturbed by the inference of Senator Leman that perhaps cervical cancer should not be covered because a few of these cases of cancer might be the result of the persons behavior. He preferred to spend the money on education. Education is good and if 100% effective would eliminate most of our behavior related costly diseases such as lung cancer, diabetes and heart disease. In the meantime I hope we are living in a country where we strive to act in a humane and caring way. Senator Leman also said that to his knowledge follow-up treatment was already available to everybody in Alaska. This is not true. Emergency room treatment is available to everybody but that is quite different than someone looking for recommended follow-up care after being told their screening results are suspicious of cancer. Because the cost to the State is only \$175,000 I sincerely hope that this bill will receive that humane and caring support.

Marjorie Campbell  
4365 Wickersham Way  
Wasilla, Ak. 99654



Tel: 376-5437  
E-mail: marji@matnet.com

**SENATE COMMITTEE REPORT  
First Committee of Referral**

\*\*\* CORRECTED REPORT \*\*\*

DATE: 1/16/01

FURTHER: HESS  
Finance

Date of 5-Day Notice: 1/24/01  
(in accordance with Uniform Rule 23)

DATE TURNED  
IN TO OFFICE: 3/12/01

Labor and Commerce Committee considered

SENATE BILL NO. 38

MEDICAL ASSISTANCE: BREAST/CERVICAL CANCER

"An Act relating to a new optional group of persons eligible for medical assistance who require treatment for breast or cervical cancer; and providing for an effective date."

and recommends:

- be replaced with \_\_\_\_\_ CS \_\_\_\_\_ (\_\_\_\_\_)
- adopt previous \_\_\_\_\_ CS \_\_\_\_\_ (\_\_\_\_\_)
- attached amendment(s)
- adopt Letter of Intent by \_\_\_\_\_ Committee
- further referral to \_\_\_\_\_ Committee

Senate Bill:

same title

new title

House Bill:

same title

technical title

new: SCR # \_\_\_\_\_

**NEW FISCAL NOTE(S):**

Department	Date	Fiscal	Zero	FN#

**PREVIOUS FISCAL NOTE(S):**

Department	Date	Fiscal	Zero	FN#
DH + SS	1/8/01	589.2		1

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
<i>Wm. Custer</i>			✓	
<i>Drew D. Heman</i>			✓	
<i>[Signature]</i>			✓	
<i>Bette Davis</i>	✓			
CHAIR: <i>Paul E. Kelly</i>			✓	

**SENATE COMMITTEE REPORT  
First Committee of Referral**

DATE: 1/16/01

FURTHER: HESS  
Finance

Date of 5-Day Notice: 1-24-01  
(in accordance with Uniform Rule 23)

DATE TURNED  
IN TO OFFICE: 2-15-01

Labor and Commerce Committee considered

SENATE BILL NO. 38

"An Act relating to a new optional group of persons eligible for medical assistance who require treatment for breast or cervical cancer; and providing for an effective date."

and recommends:

- be replaced with \_\_\_\_\_ CS \_\_\_\_\_ (\_\_\_\_\_)
- adopt previous \_\_\_\_\_ CS \_\_\_\_\_ (\_\_\_\_\_)
- attached amendment(s)
- adopt Letter of Intent by \_\_\_\_\_ Committee
- further referral to \_\_\_\_\_ Committee

**Senate Bill:**

- same title
- new title

**House Bill:**

- same title
- technical title
- new: SCR # \_\_\_\_\_

**NEW FISCAL NOTE(S):**

Department	Date	Fiscal	Zero	FN#

**PREVIOUS FISCAL NOTE(S):**

Department	Date	Fiscal	Zero	FN#
DH&SS	1/8/01	589.2		1

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
<i>[Signature]</i>			✓	
<del><i>[Signature]</i></del>				
<i>[Signature]</i>			✓	
<i>[Signature]</i>			✓	
<i>[Signature]</i>			✓	
CHAIR <i>[Signature]</i>			✓	