SB

17

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB17
( ) Publish Date:

Revision Date/Time (Note if correction): 2/21/2003
Dept. Affected: Health & Social Services

Title: MEDICAID FOR BREAST AND CERVICAL CANCER
BRU: Medical Assistance
Component: Medicaid Services

Sponsor: DAVIS
Requester: SENATE (HES)
Component No.: 2077

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	970.0	1,108.8	1,265.6	1,442.6	1,642.5	1,867.8
Miscellaneous						
TOTAL OPERATING	**970.0**	**1,108.8**	**1,265.6**	**1,442.6**	**1,642.5**	**1,867.8**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts	687.5	785.8	896.9	1,022.4	1,164.0	1,323.7
1003 GF Match	282.5	323.0	368.7	420.2	478.5	544.1
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	**970.0**	**1,108.8**	**1,265.6**	**1,442.6**	**1,642.5**	**1,867.8**

Estimate of any current year (FY2003) cost: 847.3
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

This legislation continues the optional breast and cervical cancer Medicaid eligibility category, which is due to sunset June, 30, 2003.

In FY2002 Medicaid spent $584,364 ($403,032 Federal funds, $181,332 general funds) to pay for the treatment costs of 22 women diagnosed with breast cancer, 9 diagnosed with cervical cancer, and 13 with pre-cancerous cervical conditions. In future years we expect expenditures to grow at a rate typical of general Medicaid expenditures, but only a slight increase in the number of individuals taking advantage of this eligibility category. See our assumptions on the next page.

Prepared by: Kevin Henderson, Eligibility Program Officer — Phone 465-5821
Division: Medical Assistance — Date/Time 02/02/2003
Approved by: Joel S. Gilbertson, Commissioner — Date 02/24/2003
Agency: Department of Health and Social Services

STATE OF ALASKA
2003 LEGISLATIVE SESSION

BILL NO. SB1

ANALYSIS CONTINUATION

Assumptions used in making this fiscal note:

1. The number of women who have taken advantage of this program is lower that the numbers projected last year by the Division of Public Health. Part of the reason for the reduced number of eligibles is that Alaska Native women screened and diagnosed by the four tribal grantees are not applying for Medicaid. The number of anticipated recipients is expected to increase slightly. We assume a 5% increase in total recipients for each fiscal year.

2. To estimate future expenditures, we began by looking at the cost of services provided to women eligible under the breast and cervical cancer category in FY2002. The average cost per recipient in FY2002 was $24.0 for breast cancer, $4.9 for cervical cancer, and $.8 for precancerous cervical conditions. However, the trend for FY2003 appears to be 45% higher than FY2002. The program was new in FY2002, so we believe the FY2003 increase seen so far is due to the fact that current recipients have had time to move from needing treatment to actually being in or having received full treatment. We established a FY2003 base that is 45% higher than FY2002. Beginning with FY2004 we estimate that Medicaid expenditures in this category will grow at a rate of 10% per year, similar to the national average growth for Medicaid spending.

3. The enhanced federal match rate used is 70.87%.

Funding for this bill is in the Division's base budget, however the Governor's FY2004 Budget has not been finalized at this point.

ALASKA STATE LEGISLATURE

Senate
Health, Education &
Social Services
Committee
•
Senate
Labor & Commerce
Committee
•
Senate
State Affairs
Committee

While in Session
State Capitol
Juneau, Alaska 99801
(907) 465-3822
Fax: (907) 465-3756
•
While in Anchorage
716 West 4th Avenue
Anchorage, Alaska 99501
(907) 269-0144
Fax: (907) 269-0148

SENATOR BETTYE DAVIS

Senator_Bettye_Davis@legis.state.ak.us
www.akdemocrats.org

Memorandum

To:	Senator Fred Dyson, Chair Senate HESS Committee
From:	Senator Bettye Davis
Date:	January 31, 2003
RE:	Request for Hearing, SB 17

I respectfully request a hearing for Senate Bill 17.

I have attached the following:

- Current version of the bill
- Sponsor Statement
- Sectional Analysis
- Background material

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 7
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill 17

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

Sponsor Statement

Breast cancer is the most-diagnosed cancer in Alaska. One in seven Alaska women will be diagnosed with cancer in their lifetime.

In 1990, Congress enacted the Breast and Cervical Cancer Mortality Prevention Act. This act created the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), administered by the Centers for Disease Control (CDC). The program provides grants for screening exams to 1.8 million uninsured and underinsured women, who meet eligibility guidelines throughout the country each year including Alaska. The grantees provide clinical breast exams, pelvic exams, and mammograms.

Originally, federal money did not provide for follow-up treatment to diagnosed with cancer until the 2001 Breast and Cervical Cancer Prevention and Treatment Act, which allowed states to provide Medicaid coverage for those women who were diagnosed with cancer or pre-cancerous conditions through the program. The federal government pays 70% of treatment costs. In Alaska, there are currently four CDC grantees providing clinical breast exams, pelvic exams, and mammograms to medically under-served Alaskans meeting the requisite eligibility guidelines

In fiscal year 2001, the CDC grantees diagnosed 24 cases of breast cancer and 105 cases of cervical cancer in Alaska. At present 44 women are receiving treatments in this lifesaving program.

The Alaska State Legislature passed House Bill 65 in 2001, which enacted a temporary program for two years. Senate Bill House Bill 21 would make this life saving program permanent.

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

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State Capitol, Suite 7
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Sectional Analysis
Senate Bill 17

Section 1. Adds a new group of persons who are eligible for medical assistance under AS 47.07, known as the "Medicaid" program. The new group is confined to persons who are eligible for coverage under the specified federal law.

Section 2. Repeals the temporary law (sec.1, ch.33, SLA 2001) that added the same new group to coverage in the year 2001. The 2001 legislature put an application deadline in the 2001 law: two years after the effective date of the session law, which was June 26, 2001. That means that, after June 26, 2003, there can be no new applicants for Medicaid coverage for persons with breast or cervical cancer who are eligible under the specified federal law under unless the application period is extended by amending ch. 33, SLA 2001, or by passage of a bill like SB 17, which puts the new eligible group in the permanent statutes without an expiration date for either applications or for coverage. However, the coverage even under SB 17 is not necessarily permanent. State coverage of this group would expire if the federal law, 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII), is repealed or expires. Note the qualifying phrase at the end of section 1 of this bill ("...who are eligible for coverage under 42 U.S.C. [etc.]." If a person would no longer be covered under this federal law, they would no longer be covered under this state law.

Section 3. Provides that persons already covered under the temporary program enacted in 2001 do not have to reapply as new applicants under SB 17, but their cases would be subject to regular eligibility review on the same basis that the situations of other Medicaid recipients are subject to review.

Section 4. Keeps in place the regulations adopted for the temporary program enacted in 2001, subject to future amendment of the regulations by DHSS.

Section 5. Gives this Act an immediate effective date so that there would probably be no gap between the application deadline in ch. 33, SLA 2001 [June 26, 2003] and the effective date of SB 17.

Section 47.10.019 prohibits the courts from finding a minor to be a child in need of aid based solely on an allegation that the child's parent or guardian refuses to consent to the use of psychotropic drugs; or get a psychiatric evaluation or allow any psychiatric, behavioral or psychological treatment for the child.

Senator Bettye Davis

SENATE BILL 17

Medicaid coverage for persons diagnosed with breast or cervical cancer

Federal Law

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 disbursal 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].

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,

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

SECTION 1. SHORT TITLE.

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

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

42 USC 1396r–1b.

"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)".

Applicability. 42 USC 1396a note.

(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.

Approved October 24, 2000.

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.

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ALASKA NATIVE AND AMERICAN INDIAN DIRECT REIMBURSEMENT ACT OF 2000

Public Law 106–417
106th Congress

An Act

Nov. 1, 2000
[S. 406]

To amend the Indian Health Care Improvement Act to make permanent the demonstration program that allows for direct billing of medicare, medicaid, and other third party payors, and to expand the eligibility under such program to other tribes and tribal organizations.

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

Alaska Native and American Indian Direct Reimbursement Act of 2000.
25 USC 1601 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Alaska Native and American Indian Direct Reimbursement Act of 2000".

25 USC 1645 note.

SEC. 2. FINDINGS.

Congress finds the following:

(1) In 1988, Congress enacted section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645) that established a demonstration program to authorize 4 tribally-operated Indian Health Service hospitals or clinics to test methods for direct billing and receipt of payment for health services provided to patients eligible for reimbursement under the medicare or medicaid programs under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.), and other third party payors.

(2) The 4 participants selected by the Indian Health Service for the demonstration program began the direct billing and collection program in fiscal year 1989 and unanimously expressed success and satisfaction with the program. Benefits of the program include dramatically increased collections for services provided under the medicare and medicaid programs, a significant reduction in the turn-around time between billing and receipt of payments for services provided to eligible patients, and increased efficiency of participants being able to track their own billings and collections.

(3) The success of the demonstration program confirms that the direct involvement of tribes and tribal organizations in the direct billing of, and collection of payments from, the medicare and medicaid programs, and other third party payor reimbursements, is more beneficial to Indian tribes than the current system of Indian Health Service-managed collections.

(4) Allowing tribes and tribal organizations to directly manage their medicare and medicaid billings and collections, rather than channeling all activities through the Indian Health Service, will enable the Indian Health Service to reduce its administrative costs, is consistent with the provisions of the Indian Self-Determination Act, and furthers the commitment

of the Secretary to enable tribes and tribal organizations to manage and operate their health care programs.

(5) The demonstration program was originally to expire on September 30, 1996, but was extended by Congress, so that the current participants would not experience an interruption in the program while Congress awaited a recommendation from the Secretary of Health and Human Services on whether to make the program permanent.

(6) It would be beneficial to the Indian Health Service and to Indian tribes, tribal organizations, and Alaska Native organizations to provide permanent status to the demonstration program and to extend participation in the program to other Indian tribes, tribal organizations, and Alaska Native health organizations who operate a facility of the Indian Health Service.

SEC. 3. DIRECT BILLING OF MEDICARE, MEDICAID, AND OTHER THIRD PARTY PAYORS.

(a) PERMANENT AUTHORIZATION.—Section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645) is amended to read as follows:

"(a) ESTABLISHMENT OF DIRECT BILLING PROGRAM.—

"(1) IN GENERAL.—The Secretary shall establish a program under which Indian tribes, tribal organizations, and Alaska Native health organizations that contract or compact for the operation of a hospital or clinic of the Service under the Indian Self-Determination and Education Assistance Act may elect to directly bill for, and receive payment for, health care services provided by such hospital or clinic for which payment is made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (in this section referred to as the 'medicare program'), under a State plan for medical assistance approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (in this section referred to as the 'medicaid program'), or from any other third party payor.

"(2) APPLICATION OF 100 PERCENT FMAP.—The third sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) shall apply for purposes of reimbursement under the medicaid program for health care services directly billed under the program established under this section.

"(b) DIRECT REIMBURSEMENT.—

"(1) USE OF FUNDS.—Each hospital or clinic participating in the program described in subsection (a) of this section shall be reimbursed directly under the medicare and medicaid programs for services furnished, without regard to the provisions of section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) and sections 402(a) and 813(b)(2)(A), but all funds so reimbursed shall first be used by the hospital or clinic for the purpose of making any improvements in the hospital or clinic that may be necessary to achieve or maintain compliance with the conditions and requirements applicable generally to facilities of such type under the medicare or medicaid programs. Any funds so reimbursed which are in excess of the amount necessary to achieve or maintain such conditions shall be used—

"(A) solely for improving the health resources deficiency level of the Indian tribe; and

"(B) in accordance with the regulations of the Service applicable to funds provided by the Service under any contract entered into under the Indian Self-Determination Act (25 U.S.C. 450f et seq.).

"(2) AUDITS.—The amounts paid to the hospitals and clinics participating in the program established under this section shall be subject to all auditing requirements applicable to programs administered directly by the Service and to facilities participating in the medicare and medicaid programs.

Reports.

"(3) SECRETARIAL OVERSIGHT.—The Secretary shall monitor the performance of hospitals and clinics participating in the program established under this section, and shall require such hospitals and clinics to submit reports on the program to the Secretary on an annual basis.

"(4) NO PAYMENTS FROM SPECIAL FUNDS.—Notwithstanding section 1880(c) of the Social Security Act (42 U.S.C. 1395qq(c)) or section 402(a), no payment may be made out of the special funds described in such sections for the benefit of any hospital or clinic during the period that the hospital or clinic participates in the program established under this section.

"(c) REQUIREMENTS FOR PARTICIPATION.—

"(1) APPLICATION.—Except as provided in paragraph (2)(B), in order to be eligible for participation in the program established under this section, an Indian tribe, tribal organization, or Alaska Native health organization shall submit an application to the Secretary that establishes to the satisfaction of the Secretary that—

"(A) the Indian tribe, tribal organization, or Alaska Native health organization contracts or compacts for the operation of a facility of the Service;

"(B) the facility is eligible to participate in the medicare or medicaid programs under section 1880 or 1911 of the Social Security Act (42 U.S.C. 1395qq; 1396j);

"(C) the facility meets the requirements that apply to programs operated directly by the Service; and

"(D) the facility—

"(i) is accredited by an accrediting body as eligible for reimbursement under the medicare or medicaid programs; or

"(ii) has submitted a plan, which has been approved by the Secretary, for achieving such accreditation.

"(2) APPROVAL.—

Deadline.

"(A) IN GENERAL.—The Secretary shall review and approve a qualified application not later than 90 days after the date the application is submitted to the Secretary unless the Secretary determines that any of the criteria set forth in paragraph (1) are not met.

"(B) GRANDFATHER OF DEMONSTRATION PROGRAM PARTICIPANTS.—Any participant in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 1999 shall be deemed approved for participation in the program established under this section and shall not be required to submit an application in order to participate in the program.

"(C) DURATION.—An approval by the Secretary of a qualified application under subparagraph (A), or a deemed approval of a demonstration program under subparagraph (B), shall continue in effect as long as the approved applicant or the deemed approved demonstration program meets the requirements of this section.

"(d) EXAMINATION AND IMPLEMENTATION OF CHANGES.—

"(1) IN GENERAL.—The Secretary, acting through the Service, and with the assistance of the Administrator of the Health Care Financing Administration, shall examine on an ongoing basis and implement—

"(A) any administrative changes that may be necessary to facilitate direct billing and reimbursement under the program established under this section, including any agreements with States that may be necessary to provide for direct billing under the medicaid program; and

"(B) any changes that may be necessary to enable participants in the program established under this section to provide to the Service medical records information on patients served under the program that is consistent with the medical records information system of the Service.

"(2) ACCOUNTING INFORMATION.—The accounting information that a participant in the program established under this section shall be required to report shall be the same as the information required to be reported by participants in the demonstration program authorized under this section as in effect on the day before the date of enactment of the Alaska Native and American Indian Direct Reimbursement Act of 1999. The Secretary may from time to time, after consultation with the program participants, change the accounting information submission requirements.

"(e) WITHDRAWAL FROM PROGRAM.—A participant in the program established under this section may withdraw from participation in the same manner and under the same conditions that a tribe or tribal organization may retrocede a contracted program to the Secretary under authority of the Indian Self-Determination Act (25 U.S.C. 450 et seq.). All cost accounting and billing authority under the program established under this section shall be returned to the Secretary upon the Secretary's acceptance of the withdrawal of participation in this program.".

(b) CONFORMING AMENDMENTS.—(1) Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended by adding at the end the following:

"(e) For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645).".

(2) Section 1911 of the Social Security Act (42 U.S.C. 1396j) is amended by adding at the end the following:

"(d) For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this title, see

section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645).".

25 USC 1645 note.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2000.

Effective dates. 25 USC 1645 note.

SEC. 4. TECHNICAL AMENDMENT.

(a) IN GENERAL.—Effective November 9, 1998, section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645(e)) is reenacted as in effect on that date.

(b) REPORTS.—Effective November 10, 1998, section 405 of the Indian Health Care Improvement Act is amended by striking subsection (e).

Approved November 1, 2000.

LEGISLATIVE HISTORY—S. 406:

HOUSE REPORTS: No. 106–818, Pt. 1 (Comm. on Resources).
SENATE REPORTS: No. 106–152 (Comm. on Indian Affairs).
CONGRESSIONAL RECORD:
Vol. 145 (1999): Sept. 15, considered and passed Senate.
Vol. 146 (2000): Oct. 17, considered and passed House.

○

Senator Bettye Davis

SENATE BILL 17

Medicaid coverage for persons diagnosed with breast or cervical cancer

CDC Fact Sheet

The National Breast and Cervical Cancer Early Detection Program

The **National Breast and Cervical Cancer Early Detection Program** helps low-income, uninsured, and underserved women gain access to lifesaving early detection screening programs for breast and cervical cancers.

Many deaths from breast and cervical cancers—which will occur disproportionately among women who are uninsured or underinsured—could be avoided by increasing cancer screening rates among all women at risk. Mammograms and Papanicolaou (Pap) tests are underused by women who have less than a high school education, are older, live below the poverty level, or are members of certain racial and ethnic minority groups.

Studies show that early detection of breast and cervical cancers saves lives. Timely mammography screening among women aged 40 or older could prevent 15% to 30% of all deaths from breast cancer. Detection and treatment of precancerous lesions found during a Pap test can actually prevent cervical cancer, as well as find cervical cancer at an early stage when it is most curable.

Mammography is the best available method to detect breast cancer in its earliest, most treatable stage—an average of 1 to 3 years before the woman can feel the lump. Women aged 40 years of age and older should have routine mammograms every 1 to 2 years.

Cervical cancer screening using the Pap test detects not only cancer but also precancerous lesions. Women should begin getting a Pap test with the onset of sexual activity, but no later than 18 years of age.

The Facts

Breast Cancer

Except for skin cancer, breast cancer is the most commonly diagnosed cancer among American women.

—

It is second to lung cancer as the leading cause of cancer-related death.

—

In 2002, an estimated 203,500 new cases will be diagnosed among women.

—

In 2002, an estimated 39,600 women will die of this disease.

—

If detected early, the 5-year survival rate for localized breast cancer is 96%.

Cervical Cancer

The incidence of invasive cervical cancer has gone down significantly over the last 40 years, in large part because of screening for and treatment of precancerous cervical lesions.

—

In 2002, an estimated 13,000 new cases will be diagnosed.

—

In 2002, an estimated 4,100 women will die of this disease.

—

Routine screening for cervical cancer can prevent the disease.

Source: American Cancer Society, *Cancer Facts and Figures 2002.*

CDC SAFER·HEALTHIER·PEOPLE™

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention

CDC Activities Target Early Detection

To help improve access to early detection screening for breast and cervical cancers for underserved women, Congress passed the Breast and Cervical Cancer Mortality Prevention Act of 1990, which created the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP). This program, currently funded at $192.6 million, provides both screening and diagnostic services, including

- Clinical breast exams
- Mammograms
- Pap tests
- Surgical consultation
- Diagnostic testing for women whose screening outcome is abnormal

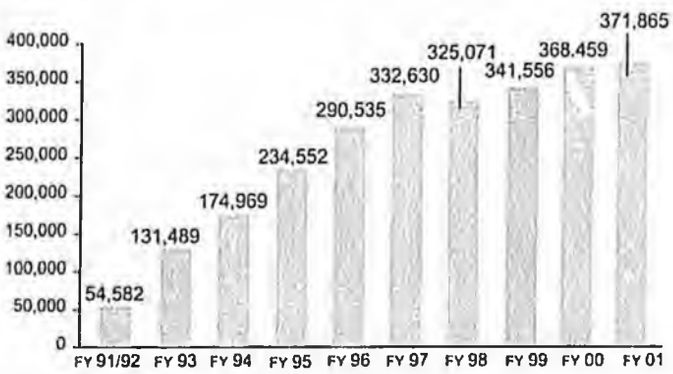
Over the last 12 years, the Program has grown and is now in all 50 U.S. States, 6 U.S.Territories, the District of Columbia, and 14 American Indian/Alaska Native organizations.

To date, it has

- Screened almost 1.5 million women.
- Provided more than 3.5 million screening exams.
- Diagnosed more than 9,000 breast cancers; 48,170 precancerous cervical lesions; and 831 cervical cancers.

The NBCCEDP is improving health care for underserved women through outreach, public and professional education, improved access to services, diagnostic evaluation, case management, treatment services, and quality assurance measures. Examples of the Program's work are provided in the following sections.

Number of Women Served by the NBCCEDP, 1991–2001



Total number of women ever served = 1,440,455.
Served indicates that a woman received at least one Program Pap, mammogram, or clinical breast exam in the fiscal year.
Source: Minimum Data Elements through 09/30/2001 paid with NBCCEDP funds, National Breast & Cervical Cancer Early Detection Program.

Coalitions and Partnerships: Reaching Underserved Women

CDC funds a network of partners to develop interventions that increase access to and use of screening services among underserved women. Many state programs have joined with nontraditional partners, including Native American tribal leaders, councils on aging, and church groups to offer education and outreach in community settings. The range of community partners and intervention strategies has expanded screening services to women on American Indian reservations and in rural and inner-city areas. For example—

With added support from Avon and the Susan G. Komen Foundation, the South Puget Intertribal Planning Agency's Native Women's Wellness Program has steadily increased its outreach to women in the five tribal communities in Washington state. Native American outreach workers and tribal health care providers have built a level of trust with the women in the community and are highly respected among this group. Their work continues to steadily increase the number of women screened through this program.

Public Education and Outreach: Eliminating Barriers to Access

The NBCCEDP supports a variety of organizations to develop and implement effective outreach programs. These programs help women overcome barriers to screening, including fear of a cancer diagnosis, lack of transportation and child care, linguistic and cultural differences, and lack of physician referral. With CDC's leadership, significant progress has been made in teaching women about the benefits of screening and early detection. For example—

California Department of Health's Every Woman Counts Program launched the nation's first statewide Asian language breast cancer hotline, providing information in Chinese (Mandarin and Cantonese dialects), Korean, and Vietnamese languages (English and Spanish were already offered). A public awareness campaign "Every Woman Counts...Every Year!" ran radio and print public service announcements in Mandarin, Cantonese, Korean, and Vietnamese publicizing the available hotline. The number of calls to the hotline increased more than 200%.

Professional Education: Enhancing Health Care at the Source

Through professional education services, the NBCCEDP's state, territorial, and tribal programs educate a wide range of health care professionals—including physicians, nurses, radiology technologists, and cytologists—on the key roles they play in the early detection of breast and cervical cancers. For example—

Alabama's Breast and Cervical Cancer Early Detection Program (ABCCEDP) produces multiple professional education conferences by satellite every year. In September 2001, they aired a video conference on the Alabama Medicaid Breast and Cervical Cancer Treatment Program. The satellite broadcast reached hundreds of health professionals with information about the treatment program. The ABCCEDP continues to receive inquiries for information on this broadcast.

Screening, Tracking, Follow-Up, and Case Management

The NBCCEDP provides national guidance on screening tec. .iques, diagnostic skills, and case management to ensure current techniques and best practices are used. Case management consists of making sure a woman is screened, rescreened, accesses appropriate follow-up care if she has an abnormal test result, and receives appropriate treatment if she is diagnosed with cancer. Case managers also may help women navigate the health care system (e.g., make sure transportation is available, work with physicians to obtain free or reduced-cost services). For example—

Case managers with the Missouri Department of Health and Senior Services' Breast and Cervical Cancer Control Program (BCCCP) collaborate with organizations to provide resources and support for individuals and their families affected by breast cancer. In one instance, a case manager helped a woman who was unemployed and depressed and who needed chemotherapy. The BCCCP case manager sought help from several organizations, including the Breast Cancer Foundation of the Ozarks, which paid the woman's rent and utilities for 3 months. The American Cancer Society provided a wig and other types of support. The woman finished treatment and is doing well in her own home. Through the work of the Missouri BCCCP case manager, the woman received much needed support during a difficult time.

Quality Assurance for Screening and Follow-Up

Health agencies that participate in the NBCCEDP use mammography facilities certified by the American College of Radiology and Cytology and laboratories that follow the Clinical Laboratory Improvement Amendments of 1988. CDC provides screening and diagnostic guidelines to all programs and helps them evaluate their clinical services. With CDC's guidance, all programs develop strategies to ensure that all women receive the best care possible. For example—

Oregon's Breast and Cervical Cancer Early Detection Program has created a database that tracks and documents communication between state and local providers to ensure that women needing diagnostic evaluation receive quality care. Annual chart reviews are done to validate data previously reported to the state by local providers. The Oregon Program has also developed a case management handbook that provides standardized guidance information on the expectations and basic elements of case management. This helps to ensure the consistency and quality of services provided throughout Oregon's decentralized state health care system.

Enhancing Treatment Services

In 2000, the Breast and Cervical Cancer Treatment and Prevention Act was passed to help provide treatment to women enrolled in the NBCCEDP and who are diagnosed with a breast or cervical cancer or precancer. This landmark legislation gives states the option to provide Medicaid coverage for treatment services to women enrolled in the NBCCEDP who have been diagnosed with cancer or precancerous lesions. CDC's partnership with the Centers for Medicare and Medicaid Services has helped states receive approval from the U.S. Department of Health and Human Services for the Medicaid option in their state. (For a current list of approved states, see the NBCCEDP Web site at http://www.cdc.gov/cancer/nbccedp/law106-354.htm.)

CDC's Research Activities

CDC conducts research to develop more effective strategies to improve the communication, education, outreach, and outcomes of its breast and cervical cancer control activities. Examples include the following:

- ***Mammography Rescreening Rates and Risk Factor Assessments***—This four-state study is designed to obtain scientifically valid and statistically precise estimates of mammography rescreening rates among the NBCCEDP enrollees and identify factors that influence rescreening behavior. The study also looks at why women do not return for rescreening. Data collection is complete and data analysis is underway. Results are expected in early 2003.

- ***Breast Cancer Data Quality and Patterns of Care Study***—This study will sample female patients in seven states and the District of Columbia who received a diagnosis of localized breast cancer in 1997 and 1998 to determine quality of data collected and patterns of care (PoC) received. It will compare data newly collected from medical records with data routinely collected for central cancer registries. Information on the first course of treatment, health insurance type, stage of cancer at diagnosis, and other data will be compared. Results from CDC's PoC are expected by December 2005. This study is part of the larger CONCORD study, which is looking at differences in cancer survival between the United States, Canada, and European countries.

- ***Case-Control Study of Mammography Efficacy***—This is an adjunct to a large, multi-center, case-control study of risk factors for breast cancer among women aged 35 to 64 years of age. This part of the study is designed to assess the efficacy of screening mammography. Because the assessment of efficacy depends on the accuracy of women's self-reported mammography histories, an initial validation study to compare self-reported mammography history with provider records has been done. CDC is working with the University of Pennsylvania on this project.

- ***Cervical Cancer Screening Policy: Clinical and Economic Outcomes***—This study will conduct quantitative evaluation of cervical cancer screening policies and practices involving low-income women enrolled in the NBCCEDP. Decision-analysis, cost-effectiveness, and cost-utility modeling will be done using the NBCCEDP data. CDC is working with the University of California.

- ***2000 National Health Interview Survey***—An analysis is being done of year 2000 National Health Interview Survey cancer data on breast cancer screening among American women. This CDC survey collects information from a representative sample of U.S. women. The data provide important insights into differences in breast cancer screening practices in different populations.

- ***Economic Barriers to Preventive Cancer Screening***—This study will use data from the Behavioral Risk Factor Surveillance System to look at how income, insurance status, and the perception of cost as a barrier to medical care affects the probability of getting screened for breast and cervical cancers. The study will also look at the role of the NBCCEDP in changing behaviors of uninsured women toward accessing breast and cervical cancer screening services.

Future Directions

By raising awareness about the importance of early detection and providing access to screening services, the NBCCEDP is estimated to reach approximately 18% of women 50 years of age and older who are eligible for the Program. CDC will continue working with an array of partners to increase access to breast and cervical cancer early detection and treatment services, to develop effective strategies to improve rescreening rates among women enrolled in the program, and to implement proven public education and outreach strategies to improve access to screening for women who have rarely or never been screened. Research will continue to develop innovative strategies to ensure timely and high quality clinical services and access to treatment for women with a cancer or precancer diagnosis.

For more information or additional copies of this document, please contact:
Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion
Division of Cancer Prevention and Control
Mail Stop K-64, 4770 Buford Highway, NE, Atlanta, GA 30341-3717
(770) 488-1751 • Voice Information System 1 (888) 842-6355 • Fax (770) 488-1760
cancerinfo@cdc.gov • http://www.cdc.gov/cancer

Senator Bettye Davis

SENATE BILL 17

Medicaid coverage for persons diagnosed with breast or cervical cancer

FAQs

BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000

On January 4, 2001, the Centers for Medicare and Medicaid Services (CMS), formerly 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.

Below are the first series of answers that respond to some of the questions about the BCCPTA. CMS 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 (As mandated by PL 106-354.):

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.

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

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 physicians 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 redetemination 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 women 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 screened again under a CDC program and found to be in need of treatment for 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, CMS 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 http://www.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 medical 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 HIS 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 the service of 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. CMS 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.

Senator Bettye Davis

SENATE BILL 17

Medicaid coverage for persons diagnosed with breast or cervical cancer

Alaska Statistics

Sen. Davis

Report to the Legislature
In Accordance with Chapter 33, SLA 2001
By the Department of
Health and Social Services

OVERVIEW OF THIS REPORT

AS 47.07.020(b) requires that the Department of Health and Social Services report to the Legislature by the 30th day of the Second Regular Session of the Twenty Third Alaska State Legislature on the following matters:

1. **Factors associated with the onset of breast or cervical cancer;**
2. **Information from Alaska-specific sources regarding risk factors associated with the onset of breast or cervical cancer;**
3. **Recommendations about behavioral actions that may reduce the occurrence or likelihood of these types of breast or cervical cancer;**
4. **Costs per person paid for by the State associated with treatment assistance, and total medical costs per person, whether paid for by the State or not.**

This report addresses these requirements.

DETAILED INFORMATION

AS 47.07.020(b), Section 2 (1): The environmental, behavioral, or genetic factors that have been associated with the onset of breast or cervical cancer in peer-reviewed clinical studies published in periodical medical literature that have postulated an association between one or more of these factors and an increase in the incidence of breast or cervical cancer.

An extensive literature search was conducted in 2002 and updated in early 2003 to comply with Section 2 (1). The text below summarizes the information from documents referenced at the end of this report. These documents describe the risk and protective factors generally agreed upon by the majority of scientists and medical practitioners, thus representing sound modern scientific research practices. This list does not include any factors generally agreed to be inconclusive or controversial.

Breast Cancer

Most scientists agree that these **risks and associated factors** increase the odds of having breast cancer.

- Increasing age: Women over age 50 have a higher risk of breast cancer and it continues to increase with age. Age is the only identifiable risk factor in the majority of cases diagnosed.
- Younger than average age at menarche: Women who had their first period at an early age have a higher risk of breast cancer.
- Older age at first birth: Women who give birth to their first child at a later age have a higher risk of breast cancer. The risk increases incrementally with age.
- Older than average age at menopause: Women who go through menopause later have a higher risk of breast cancer.
- Number of births: Women who have fewer than 2 children have a higher risk of breast cancer *but a lower risk of cervical cancer.*
- Post-menopausal hormones: Women who take post-menopausal hormones for an extended period of time have a higher risk of breast cancer.
- Benign breast disease: Women who have benign breast conditions, especially hyperplasia have an increased risk of breast cancer.
- Family history: Women who have a mother or sister with breast cancer have a higher risk of the disease, especially if the relative was diagnosed at a young age.
- Known genetic predisposition: Genetic mutation is proven in only 5-10% of cases.
- Significant radiation exposure: "Significant" exposure would be considered repeated chest X-rays in childhood or radiation therapy for cancer as in leukemia.

Protective factors:

- Breast feeding: Women who breast feed for at least one year combined over all pregnancies have a lower risk of breast cancer.
- Weight: Women who maintain a healthy weight have a lower risk of breast cancer, especially if they are post-menopausal.
- Exercise: Women who exercise regularly or who perform manual labor have a lower risk of breast cancer.
- Alcohol: Women who have less than 1 drink a day have a lower risk of breast cancer (This association has been shown to be weak).
- Eating vegetables: Women who eat at least 3 servings of vegetables a day have a lower risk of breast cancer (This association is believed to be weak and nonspecific).

Cervical Cancer

Most scientists agree that these **risks and associated factors** increase the risk of cervical cancer:

- Smoking cigarettes: Women who smoke have a higher risk of cervical cancer.
- Sex at an early age: Women who have sex for the first time at an early age have a higher risk of cervical cancer. "Early age" normally refers to puberty, when there is rapid cellular division of the cervix making it vulnerable to infection. Because numerous factors can affect the onset of pubertal changes (e.g., ethnicity, weight,

amount of physical exercise) "early age" can vary widely in a population. Sexual molestation or abuse must not be overlooked or minimized when considering age of first vaginal intercourse.

- Sexually transmitted disease or infection: Women exposed by their partners to sexually transmitted disease or infection have a higher risk of cervical cancer, especially if infected by specific virulent strains of the human papillomavirus (HPV).
- Number of births: Women who give birth to two or more children have a higher risk of cervical cancer *but a lower risk of breast cancer.*
- Poor nutrition: Dietary deficiencies, especially of folates, and Vitamins A, C, & E contribute to risk. (This is considered a weak associated factor).

Protective factors:

- Pap smears: Women who have regular Pap smears have a lower risk of cervical cancer. This test finds cells that may turn into cancer. If the cells are found early, a woman can be treated for a pre-cancerous condition before cervical cancer develops.
- Limited number of sexual partners: Women with few sexual partners in their lifetime have a lower risk of cervical cancer.
- Condoms and diaphragms: Women who utilize barrier methods of contraception every time they have sex, have a lower risk of cervical cancer, even though these methods do not always protect against HPV.
- Nutritional supplementation: Therapeutic levels of beta carotene, folates, and Vitamins A & E have been found helpful in reversing CIN.

AS 47.07.020(b), Section 2 (2): Summary information from the Alaska Cancer Registry and other Alaska-specific sources available to the department regarding risk factors for breast and cervical cancer.

The Alaska Cancer Registry and the American Cancer Society/Alaska concur with the factors listed above as presented in peer-reviewed medical periodicals. There are no additional or differing Alaska-specific risk factors for women and the incidence or prevalence of breast or cervical cancer.

AS 47.07.020(b), Section 2 (3): Recommendations, if any, about behavioral actions that may reduce the occurrence or likelihood of these types of breast or cervical cancer.

Experts generally agree that most breast cancer risk factors relate to cumulative lifetime exposure to estrogen, both endogenous (produced or synthesized within the body) and exogenous (introduced from outside the body, such as from food sources). Alterations of these factors are associated with both risks and benefits. While experts agree that the following activities may reduce the occurrence or likelihood of breast cancer, it is imperative to note that only about one-third of women diagnosed with breast cancer have any acknowledged risk factor. Without clear knowledge of risk and cause, it is difficult to isolate preventive activities. Research continues, but the lack of hard data on risk

reduction must be mentioned here. Nonetheless, activities thought to reduce the risk of breast cancer include:

1. Maintaining a healthy body weight
2. Consuming 5 servings a day of fruits and vegetables
3. Not smoking
4. Getting regular exercise
5. Getting regular mammograms. "Regular" has been defined by the National Cancer Institute as women in their 40's being screened every 1-2 years with mammography; women aged 50 and over being screened every year; and women who are at higher risk than average should seek expert medical advice about whether they should begin screening before age 40 and the frequency of screening.
6. Treating high-risk women with Tamoxifen. "High-risk" women (women with hyperplasia or who test positive for the breast cancer gene) participating in research trials using the drug Tamoxifen prophylactically have demonstrated a reduced incidence of cancer than would otherwise be expected. Tamoxifen has no prophylactic benefit for non-high-risk women.

Cervical cancer rates are higher among older women; however, cervical intraepithelial neoplasia (CIN), the precursor lesion to cervical cancer, most often occurs among younger women. Experts agree that infection with certain strains of HPV is one of the strongest risk factors for cervical cancer and CIN. Experts also agree that one of the most important things women, especially younger women, can do to reduce their risk of cervical cancer is to receive regular screening with a Pap test. Early detection and treatment of CIN is nearly 100% effective in stopping progression to cervical cancer.[3] Thus, activities thought to reduce the risk of cervical cancer include:

1) Getting regular Pap smears
2) Postponing initial sexual activity and limiting the number of sexual partners
3) Engaging in safe sexual activity

Programs that Provide Information to the Public in Support of these Recommendations

The Department of Health and Social Services houses numerous programs that address these preventive activities and educate the public about reducing risk factors to improve overall health.

Breast Cancer prevention and education services by state programs

Breast & Cervical Health Check (BCHC)

Housed in the Section of Maternal Child & Family Health, BCHC encourages all women to receive appropriate breast screening. BCHC-eligible women (as determined by age and income) are actively assisted in receiving screening through a wide network of medical providers. BCHC reimburses providers and radiologic facilities for breast screening and diagnostic services.

"Take Heart Alaska" and "Eat Smart Alaska"

These programs are housed in the Section of Community Health and Emergency Medicine (CHEMS) of the Dept. of Health and Social Services. They promote a preventive approach to chronic disease by emphasizing heart health and advocating for individual and community-based commitment to healthier lifestyles and nutritious dietary choices. CHEMS services seek to improve access to preventive services for all Alaskans.

The Family and Community Nutrition Program

The Section of the Maternal, Child & Family Health Program (MCFH) houses the Family and Community Nutrition Program (FCNP). It works primarily toward reducing dietary risk for chronic diseases among Alaskans. FCNP also works on other nutrition issues affecting Alaskans, such as food access and availability.

The Alaska Diabetes Prevention and Control Program

Located in the Section of Epidemiology, the Diabetes Program works to reduce the burden of diabetes (Type II Diabetes is caused by sedentary lifestyle) by providing public education and information, developing community based diabetes programs, and translating research into clinical practice by providing professional education programs. Research now indicates that Type II diabetes can often be preventable by improved general nutrition, maintenance of normal weight, and adequate physical activity, things which also reduce risk for many other chronic diseases, including cancer.

"5 A Day for Better Health"

This MCFH program is part of a nationwide nutrition campaign to encourage Americans to eat 5 or more servings of fruits and vegetables every day for better health. The "5 A Day" campaign distributes recipes, brochures and other materials throughout Alaska promoting integration of more fruits and vegetables into every day's diet. In rural Alaska, the campaign has been adapted to become "The Alaskan Way to 5 A Day" and promotes canned and frozen fruits and vegetables consumption as well as appropriate traditional Native foods.

The Alaska Tobacco Prevention and Control Program

The Tobacco Prevention and Control Program strives to reduce the overall mortality and morbidity caused by active tobacco use, passive exposure to tobacco, and the effects these two factors have in Alaska. Located in CHEMS, the program cooperates with local communities, statewide partners, and national organizations, to eliminate exposure to environmental tobacco smoke, promote cessation among youth and adults, reduce initiation among youth, and identify and eliminate disparities.

Alaskans Promoting Physical Activity

This CHEMS program strives to improve health fitness and quality of life for all Alaskans by influencing policies, physical and social environments, and personal behaviors through health promotion, education, and advocacy efforts.

Cervical Cancer prevention and education services by state programs

Breast & Cervical Health Check (BCHC)

BCHC is housed in the Section of Maternal Child & Family Health and encourages all women to receive appropriate screening. It assists BCHC-eligible women (as determined by age and income) to receive screening through BCHC, providing payment for professional services and laboratory fees. In addition to those Pap smears provided by BCHC clinicians throughout the state (5,000 per year), the Section of Public Health Nursing provides an additional 6,000 Pap screenings annually Public Health Centers statewide.

The Teen Abstinence Education Program

Housed in the Section of Maternal, Child & Family Health, the Teen Abstinence Education Program supports sexual abstinence as a positive and healthy choice for teens through support for abstinence education in six school districts – Juneau, Sitka, Mat-Su, Kodiak, Fairbanks and Kenai. This abstinence education training is offered to high school peer educators, who then deliver a series of five lessons to junior high students. To make the most of limited dollars, the training is offered to the largest school districts in the state. The Anchorage School District has chosen not to avail themselves of this opportunity as school staff have stated that other curricula and activities currently offered promote abstinence. Unfortunately, this program has suffered loss of staff due to funding reductions in 2002.

Family Planning Program

Family planning services are provided to sexually active teens and low-income women at Alaska Public Health Centers. Services provided include: a comprehensive medical history and physical examination (with breast examination and Pap smear), counseling regarding abstinence and methods of contraception, and information about reducing the risk of sexually transmitted infections. Approximately 3000 breast examinations and 6000 Pap tests were provided in 2002. Family planning clinics also participate in the CDC-funded National Infertility Prevention Project and offer pregnancy services such as preconceptional counseling, pregnancy testing and prenatal referral.

Sexually transmitted disease (STD) program

The Section of Epidemiology provides case surveillance of STDs to monitor trends and detect potential outbreaks; provides information, technical assistance, and other capacity building services to educators, members of the public, medical and other health service providers; and (in collaboration with Public Health Laboratory) provides screening for STDs in Public Health Centers and private non-profit agencies statewide. The diagnosis of HPV infection is primarily a clinical one: a physician diagnoses and may treat HPV if detected at examination. Because HPV infection is not vaccine-preventable, there is no State-funded prevention activity against HPV except general education on STD reduction.

Other sources of data and information: In addition to the above-noted programs, CHEMS maintains the Behavior Risk Factor Surveillance System. The System provides information on behavioral risks in Alaska and data for interventions to reduce risky behaviors. The Alaska Cancer Registry maintains a listing of newly diagnosed cancer cases and pertinent data about that cancer.

AS 47.07.020(b), Section 2 (4): To the extent that the information is available to the department in the billings submitted for assistance under Section 1 of this Act, the cost per person paid for by the State under Section 1 of this Act during the fiscal year preceding the date of the report and total medical costs per person for the fiscal year preceding the date of the report, whether paid for by the State or not; the information provided in the department's report under this paragraph shall be provide separately for each person who received assistance under Section 1 of this Act, but the information shall be presented in a manner that does not allow identification of this person.

Medicaid payments for this program for the period July 1, 2001 – June 30,, 2002 totaled $584,364. This amount includes both state general fund dollars and federal dollars. The federal dollars amounted to 70.4% of the total paid amount, or $411,382--- state general fund dollars equaled 29.6%, or $172,982.

See next page for specific dollar amounts per individual case.

Breast and Cervical Cancer Program
Financial Information 7/1/01 to 6/30/02

Recipient	Total Billed Amount	Total Paid Amount
1	$607.85	$521.86
2	$1,000.00	$431.24
3	$103,976.45	$57,634.03
4	$167,962.79	$95,514.37
5	$3,689.50	$3,051.88
6	$3,868.19	$2,481.74
7	$89,341.14	$23,453.92
8	$3,892.80	$1,897.29
9	$107.99	$105.99
10	$18,077.14	$7,528.94
11	$111,821.87	$40,247.08
12	$7,908.40	$4,202.43
13	$9,056.84	$5,593.44
14	$1,186.00	$1,029.88
15	$64,425.77	$19,440.81
16	$4,460.65	$2,140.69
17	$283.00	$274.23
18	$22,396.87	$6,252.46
19	$7,161.44	$4,077.21
20	$89,491.26	$43,505.59
21	$75.00	$53.11
22	$2,656.90	$1,464.04
23	$14,331.23	$6,541.00
24	$35,066.34	$14,874.27
25	$57,944.39	$23,881.07
26	$1,463.00	$670.49
27	$87,539.39	$51,549.83
28	$2,759.81	$1,352.08
29	$10,279.25	$3,078.70
30	$1,472.78	$1,055.61
31	$79,668.14	$23,883.43
32	$2,978.11	$1,718.94
33	$130,680.02	$49,033.26
34	$1,352.00	$568.26
35	$533.99	$422.57
36	$56,311.67	$21,193.02
37	$7,239.45	$4,897.84
38	$96,747.95	$37,306.64
39	$2,574.75	$1,064.50
	$11,624.84	$10,692.60

40		
41	$1,651.00	$482.20
42	$1,350.00	$431.24
43	$10,667.92	$7,116.45
44	$2,758.29	$1,647.99
Total	**$1,330,442.17**	**$584,364.19**

*This data represents Medicaid claims only.

Documents used in compiling this report:

Centers for Disease Control and Prevention (CDC) and the National Institutes of Health/National Cancer Institute. Cancer information for health professionals. Accessed at: html://www.cancer.gov/cancerinfo/pdq/prevention/breast/healthprofessional, AND html://www.cancer.gov/cancerinfo/pdq/prevention/cervical/healthprofessional, AND html://www.cancer.gov/cancerinfo/pdq/genetics/breast-and-ovarian, on Jan. 16, 2003.

Harvard Center for Cancer Prevention. Resources for professionals and "Your Cancer Risk". Accessed at: html://www.hsph.harvard.edu/cancer/publications/index.html on Jan. 16, 2003.

Susan G. Komen Foundation. Risk factors for breast cancer. Accessed at: html://www.komen.org/bci/abc/dc/dc_index.asp, on Jan. 16, 2003.

Saslow, D, et al. (2002). American Cancer Society guideline for the early detection of cervical neoplasia and cancer. *CA: A Cancer Journal for Clinicians*, 52(6):342-362.

Vogel, V. (2001). Reducing the risk of breast cancer with Tamoxifen in women at increased risk. *Journal of Clinical Oncology*, 19(90001):87-92.

Wright, T. et al. (2002). 2001 Consensus guidelines for the management of women with cervical cytological abnormalities. *JAMA*, 287(16): 2120-2129.

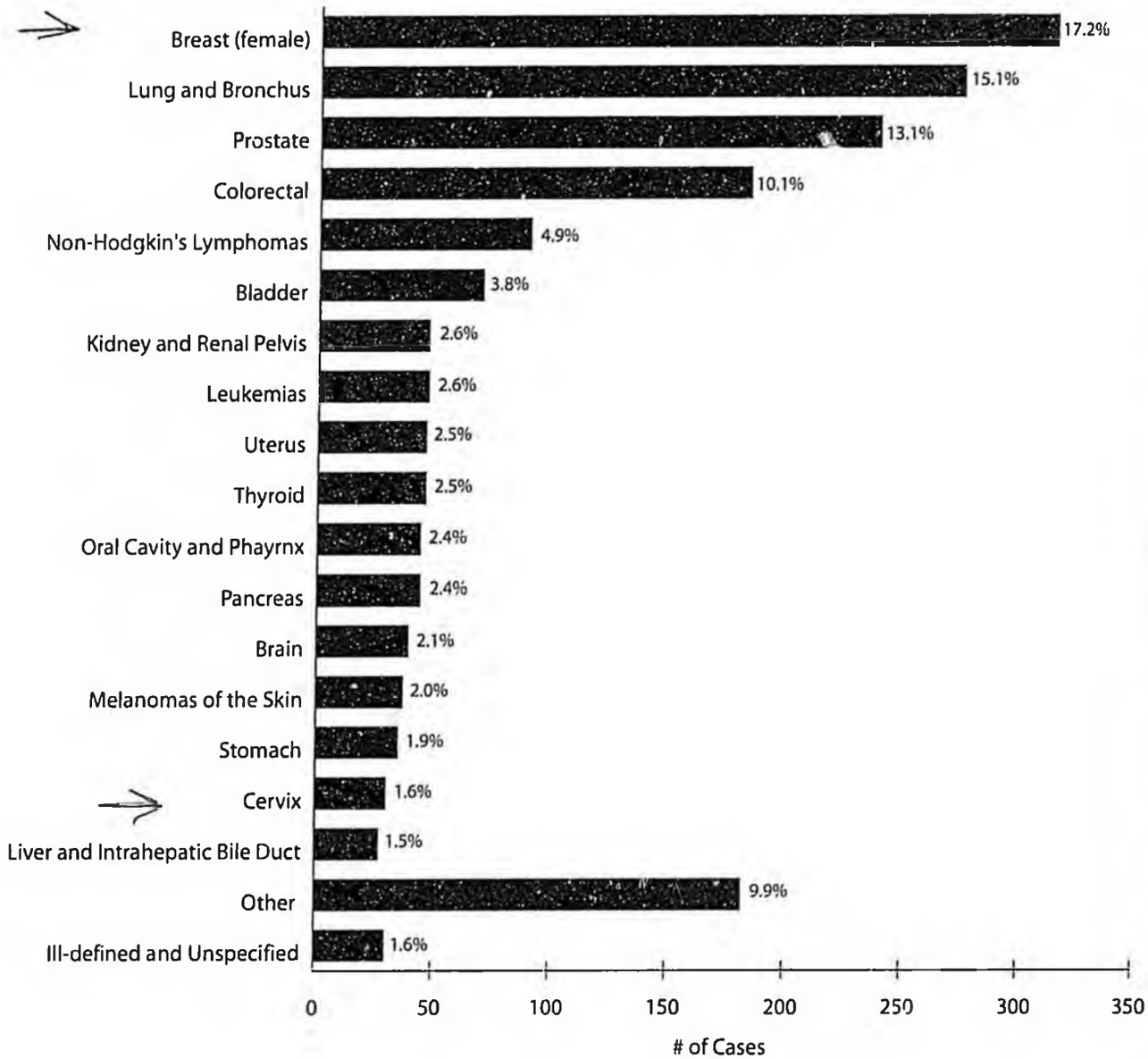
Highlights

The Alaska Cancer Registry is pleased to release its *1998 Annual Report,* which provides statewide cancer statistics for both incidence and mortality. Highlights from findings from this report are summarized below:

- During 1998, there were 1,827 new cases of invasive cancers diagnosed among Alaska residents. The 1998 age-adjusted incidence rate was 413.5 new cases per 100,000 residents.
- Cancers of the breast, lung and bronchus, prostate, and colorectal accounted for 55.7% of all newly diagnosed 1998 cancers in Alaska residents.
- The incidence rate for all cancers in Alaska was 16% higher for males than females.
- The five most commonly diagnosed cancers among Alaska men, which consisted of 63.5% of total male cancers, were: prostate (26.3%), lung (16.9%), colorectal (8.9%), urinary bladder (6%) and non-Hodgkin's lymphoma (5.4%).
- The five most commonly diagnosed cancers among Alaska women, which consisted of 68.3% of total female cancers, were cancers of the breast (34.4%), lung (13.2%), colorectal (11.2%), uterus (5%) and non-Hodgkin's lymphoma (4.5%).
- Of all the cancers diagnosed in 1998, 85.4% were in Alaskans 45 years of age or older; 65.4% were in Alaskans 55 years of age or older.
- In 1998, a total of 649 Alaska residents died as a result of cancer (25.2% of all Alaska resident deaths). Cancer was the leading cause of death in Alaska. The 1998 age-adjusted mortality rate for Alaska residents was 161.7 cancer deaths per 100,000 residents.
- The mortality rate for all cancers was 28% higher for males than females.
- Lung cancer was the most common cause of cancer death among Alaskans. There were 195 lung cancer deaths in 1998, or 30% of all cancer deaths. Lung cancer was the leading cause of death among both men (30.9%) and women (29.1%).
- Of the total cancer deaths, 77% were of Alaskans 55years of age or older; 54.5% were of Alaskans 65 years of age or older.

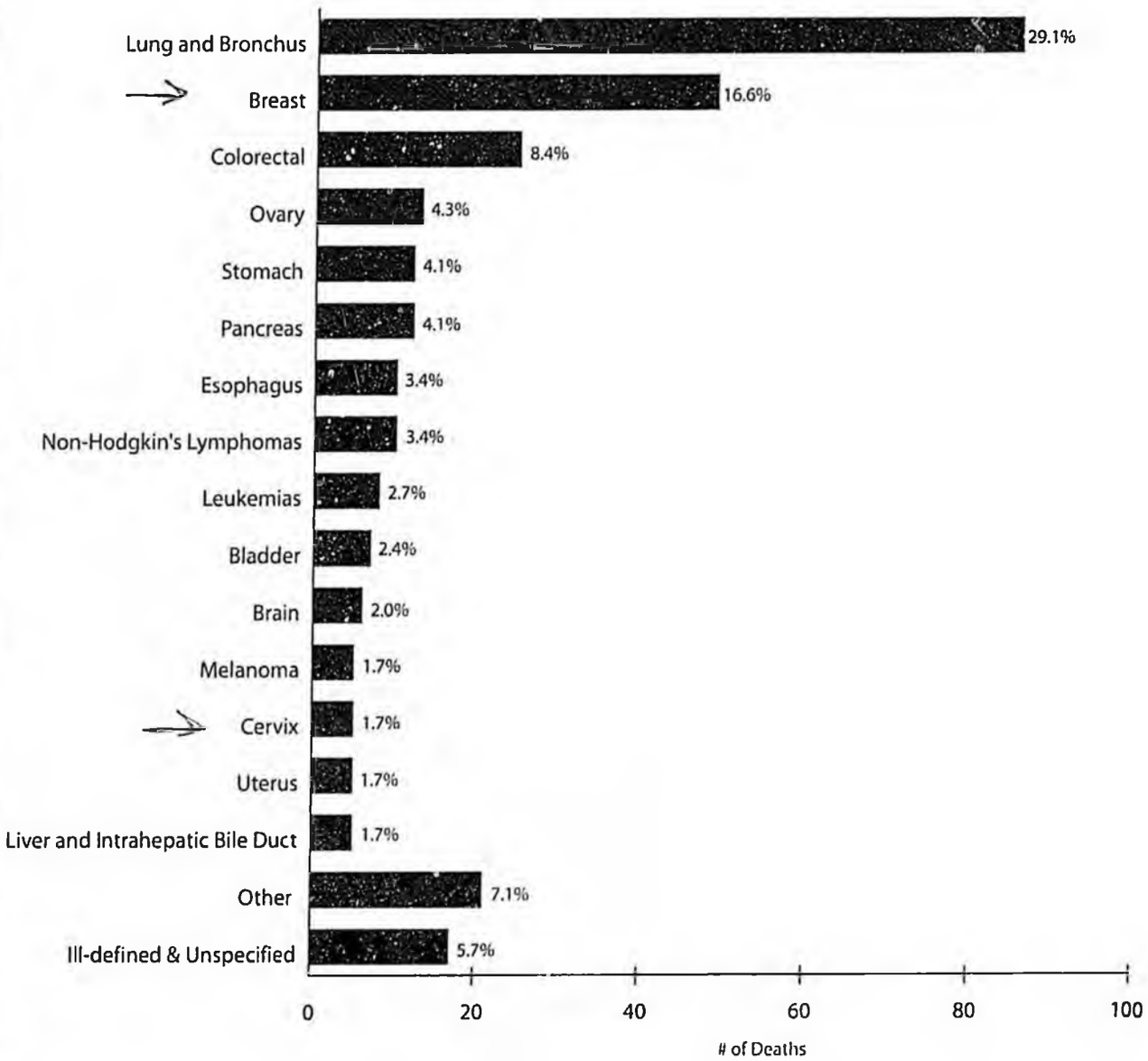
Percent of Cancer Cases by Site

1998 Invasive Cancer Cases (n=1827) - Alaska Residents



Percent of Female Cancer Deaths by Site

1998 Female Cancer Deaths (n=296) - Alaska Residents



Breast (female)

Data Definition: Incidence data were obtained from the Alaska Cancer Registry using primary site ICD-O-2 codes C50.0 - C50.9, and excluding morphology codes 9590-9989. Mortality data were obtained from Alaska State death certificates using the underlying cause of death ICD-9 codes 174.0 - 174.9.

1998 Alaska Residents
Incidence and Mortality Summary by Sex
rates per 100,000 population age-adjusted to 1970 U.S. population

Incidence	Female
In situ cancer	66
Invasive cancer	315
Incidence rate*	122.1
1998 U.S. rate*	118.1

*Excludes in situ cases

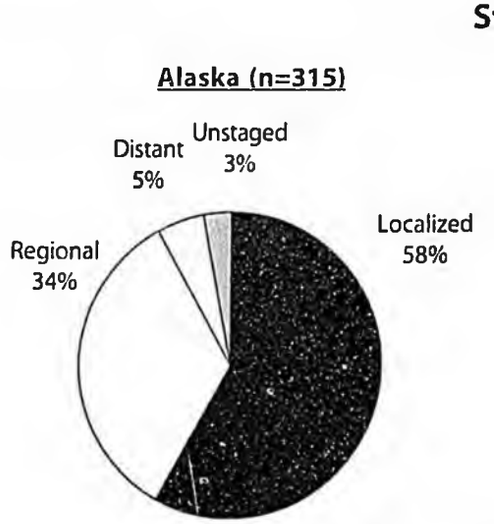
Mortality	Female
Deaths	49
Mortality rate	21.3
1998 U.S. rate	22.7

Invasive Breast Cancer by Borough/Census Area

Aleutians East	1	Kenai Peninsula	26	Skagway-Hoonah-Angoon	0
Aleutians West	3	Ketchikan Gateway	8	Southeast Fairbanks	7
Anchorage	144	Kodiak Island	11	Valdez-Cordova	5
Bethel	3	Lake and Peninsula	0	Wade Hampton	0
Bristol Bay	0	Matanuska-Susitna	30	Wrangell-Petersburg	4
Denali	2	Nome	4	Yakutat	0
Dillingham	5	North Slope	1	Yukon-Koyukuk	5
Fairbanks North Star	38	Northwest Arctic	0	Unknown	0
Haines	1	Prince of Wales-Outer Ketchikan	0		
Juneau	12	Sitka	5		

Stage at Diagnosis

Alaska (n=315)



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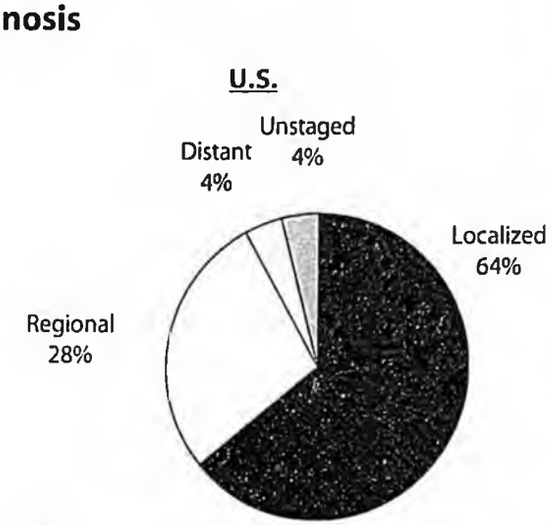


5 year Survival (U.S., 1998)
All Stages 85.5% Localized 96.4%

Cervix

Data Definition: Incidence data were obtained from the Alaska Cancer Registry using primary site ICD-O-2 codes C53.0 - C53.9,and excluding morphology codes 9590-9989. Mortality data were obtained from Alaska State death certificates using the underlying cause of death ICD-9 codes 180.0 - 180.9.

1998 Alaska Residents
Incidence and Mortality Summary by Sex
rates per 100,000 population age-adjusted to 1970 U.S. population

Incidence	Female
Invasive cancer	30
Incidence rate	10.1
1998 U.S. rate*	7.5

*Excludes in situ cases

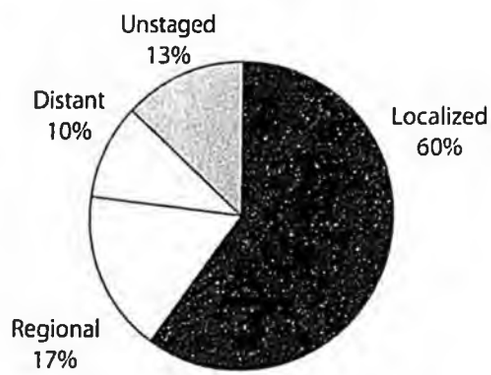
Mortality	Female
Deaths	5
Mortality rate	1.6
1998 U.S. rate	2.5

Cervical Cancer by Borough/Census Area

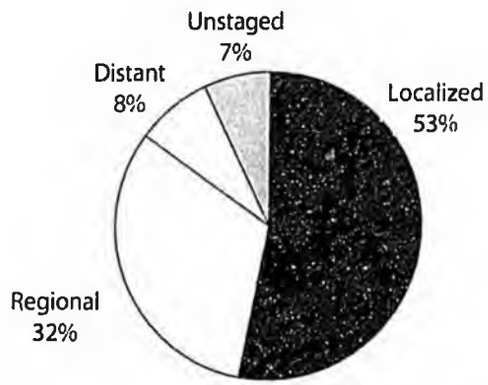
Aleutians East	**0**	**Kenai Peninsula**	**0**	**Skagway-Hoonah-Angoon**	**1**
Aleutians West	**0**	**Ketchikan Gateway**	**2**	**Southeast Fairbanks**	**1**
Anchorage	**10**	**Kodiak Island**	**3**	**Valdez-Cordova**	**0**
Bethel	**0**	**Lake and Peninsula**	**0**	**Wade Hampton**	**1**
Bristol Bay	**0**	**Matanuska-Susitna**	**3**	**Wrangell-Petersburg**	**2**
Denali	**0**	**Nome**	**0**	**Yakutat**	**0**
Dillingham	**0**	**North Slope**	**0**	**Yukon-Koyukuk**	**0**
Fairbanks North Star	**3**	**Northwest Arctic**	**1**	**Unknown**	**0**
Haines	**0**	**Prince of Wales-Outer Ketchikan**	**3**		
Juneau	**0**	**Sitka**	**0**		

Stage at Diagnosis

Alaska (n=30)



U.S.



5 year Survival (U.S., 1998)
All Stages 69.9% Localized 91.9%

Table 1. Age Distribution of Invasive Cancers - Alaska, 19988

	All Ages	45-49		50-54		55-59		60-64		65-69		70-74		75-79		80-84		85+	
Site of Cancer	#	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Liver and Intrahepatic Bile Duct	27	4	14.8	2	7.4	3	11.1	4	14.8	2	7.4	6	22.2	1	3.7	1	3.7	1	3.7
Liver	23	4	17.4	1	4.3	3	13.0	3	13.0	2	8.7	5	21.7	1	4.3	1	4.3	1	4.3
Intrahepatic Bile Duct	4	0	0.0	1	25.0	0	0.0	1	25.0	0	0.0	1	25.0	0	0.0	0	0.0	0	0.0
Gallbladder	5	0	0.0	0	0.0	0	0.0	1	20.0	1	20.0	2	40.0	0	0.0	0	0.0	0	0.0
Other Biliary	5	0	0.0	1	20.0	1	20.0	1	20.0	0	0.0	1	20.0	1	20.0	0	0.0	0	0.0
Pancreas	44	1	2.3	4	9.1	7	15.9	8	18.2	9	20.5	6	13.6	2	4.5	0	0.0	3	6.8
Retroperitoneum	1	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Peritoneum, Omentum and Mesentery	3	0	0.0	0	0.0	1	33.3	0	0.0	0	0.0	1	33.3	0	0.0	0	0.0	0	0.0
Other Digestive Organs	4	0	0.0	0	0.0	0	0.0	0	0.0	1	25.0	0	0.0	1	25.0	1	25.0	0	0.0
Respiratory System	297	14	4.7	27	9.1	32	10.8	41	13.8	55	18.5	53	17.8	43	14.5	10	3.4	6	2.0
Nose, Nasal Cavity and Middle Ear	3	0	0.0	0	0.0	0	0.0	0	0.0	2	66.7	0	0.0	0	0.0	0	0.0	0	0.0
Larynx	13	1	7.7	2	15.4	4	30.8	1	7.7	0	0.0	1	7.7	3	23.1	0	0.0	0	0.0
Lung and Bronchus	275	13	4.7	24	8.7	28	10.2	39	14.2	52	18.9	52	18.9	38	13.8	9	3.3	6	2.2
Pleura	6	0	0.0	1	16.7	0	0.0	1	16.7	1	16.7	0	0.0	2	33.3	1	16.7	0	0.0
Trachea, Mediastinum and Other Respiratory Organs	0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Bones and Joints	3	1	33.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Soft Tissue including Heart	18	1	5.6	0	0.0	0	0.0	2	11.1	0	0.0	2	11.1	1	5.6	0	0.0	0	0.0
Skin excluding Basal and Squamous	46	6	13.0	4	8.7	7	15.2	6	13.0	4	8.7	4	8.7	2	4.3	0	0.0	0	0.0
Melanomas of the Skin	37	5	13.5	3	8.1	6	16.2	5	13.5	4	10.8	1	2.7	2	5.4	0	0.0	0	0.0
Other Non-Epithelial Skin	9	1	11.1	1	11.1	1	11.1	1	11.1	0	0.0	3	33.3	0	0.0	0	0.0	0	0.0
Breast	318	69	21.7	41	12.9	37	11.6	31	9.7	18	5.7	23	7.2	20	6.3	19	6.0	3	0.9
Female Genital System	105	15	14.3	21	20.0	8	7.6	10	9.5	7	6.7	7	6.7	4	3.8	4	3.8	4	3.8
Cervix	30	5	16.7	4	13.3	2	6.7	1	3.3	0	0.0	2	6.7	0	0.0	0	0.0	2	6.7
Corpus and Uterus, NOS	46	6	13.0	9	19.6	4	8.7	7	15.2	6	13.0	4	8.7	3	6.5	2	4.3	0	0.0
Corpus	46	6	13.0	9	19.6	4	8.7	7	15.2	6	13.0	4	8.7	3	6.5	2	4.3	0	0.0
Uterus, NOS	0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Ovary	24	3	12.5	8	33.3	2	8.3	1	4.2	0	0.0	1	4.2	0	0.0	2	8.3	1	4.2
Vagina	1	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	100.0
Vulva	3	1	33.3	0	0.0	0	0.0	1	33.3	0	0.0	0	0.0	1	33.3	0	0.0	0	0.0
Other Female Genital Organs	1	0	0.0	0	0.0	0	0.0	0	0.0	1	100.0	0	0.0	0	0.0	0	0.0	0	0.0

Table 2-c. Female Cancer Incidence and Mortality by Site - Alaska, 1998

	INCIDENCE					MORTALITY				
Site of Cancer	# of Cases	Rate per 100,000	95% CL Lower	95% CL Upper	94-98 US Rate	# of Cases	Rate per 100,000	95% CL Lower	95% CL Upper	94-98 US Rate
Other Biliary	4	n/c	n/c	n/c	0.9	1	n/c	n/c	n/c	0.4
Pancreas	16	7.2	4.0	12.2	7.8	12	5.9	3.0	10.6	7.2
Retroperitoneum	0	n/c	n/c	n/c	0.4	0	n/c	n/c	n/c	0.1
Peritoneum, Omentum and Mesentery	1	n/c	n/c	n/c	0.7	0	n/c	n/c	n/c	0.2
Other Digestive Organs	2	n/c	n/c	n/c	0.3	0	n/c	n/c	n/c	0.1
Respiratory System	126	**62.7**	51.9	75.1	44.0	88	**44.5**	35.5	55.2	35.0
Nose, Nasal Cavity and Middle Ear	2	n/c	n/c	n/c	0.4	1	n/c	n/c	n/c	0.1
Larynx	2	n/c	n/c	n/c	1.4	1	n/c	n/c	n/c	0.5
Lung and Bronchus	121	**60.6**	50.0	72.9	43.5	86	**43.6**	34.6	54.2	34.3
Pleura	1	n/c	n/c	n/c	0.3	0	n/c	n/c	n/c	0.1
Trachea, Mediastinum and Other Respiratory Organs	0	n/c	n/c	n/c	0.1	0	n/c	n/c	n/c	0.1
Bones and Joints	1	n/c	n/c	n/c	0.8	1	n/c	n/c	n/c	0.3
Soft Tissue including Heart	12	4.3	2.1	8.2	2.2	2	n/c	n/c	n/c	1.2
Skin excluding Basal and Squamous	14	**4.5**	2.3	8.3	12.1	5	2.3	0.7	5.7	1.8
Melanomas of the Skin	11	**3.3**	1.5	6.6	11.7	5	2.3	0.7	5.7	1.5
Other Non-Epithelial Skin	3	n/c	n/c	n/c	1.2	0	n/c	n/c	n/c	0.3
Breast	315	122.1	108.0	137.7	114.3	49	21.3	15.5	28.9	24.2
Female Genital System	105	41.1	33.1	50.6	47.1	24	11.3	7.1	17.3	14.1
Cervix	30	10.1	6.6	15.2	7.7	5	1.6	0.5	4.5	2.7
Corpus and Uterus, NOS	46	19.9	14.3	27.1	21.9	5	3.0	1.0	7.0	3.3
Corpus	46	19.9	14.3	27.1	21.0	1	n/c	n/c	n/c	1.7
Uterus, NOS	0	n//c	n/c	n/c	0.3	4	n/c	n/c	n/c	1.6
Ovary	24	**8.5**	5.3	13.4	14.5	13	6.2	3.2	10.9	7.5
Vagina	1	n/c	n/c	n/c	0.6	0	n/c	n/c	n/c	0.2
Vulva	3	n/c	n/c	n/c	1.7	0	n/c	n/c	n/c	0.3
Other Female Genital Organs	1	n/c	n/c	n/c	0.6	1	n/c	n/c	n/c	0.2
Male Genital System	n/a	n/a	n/a	n/a	0.0	n/a	n/a	n/a	n/a	n/a
Prostate	n/a	n/a	n/a	n/a	0.0	n/a	n/a	n/a	n/a	n/a
Testis	n/a	n/a	n/a	n/a	0.0	n/a	n/a	n/a	n/a	n/a
Penis	n/a	n/a	n/a	n/a	0.0	n/a	n/a	n/a	n/a	n/a
Other Male Genital Organs	n/a	n/a	n/a	n/a	0.0	n/a	n/a	n/a	n/a	n/a
Urinary System	28	12.0	7.8	17.9	14.0	9	4.2	1.9	8.4	4.1
Urinary Bladder	15	6.8	3.7	11.7	7.6	7	3.7	1.5	7.9	1.7
Kidney and Renal Pelvis	13	5.2	2.7	9.4	6.6	2	n/c	n/c	n/c	2.3
Ureter	0	n/c	n/c	n/c	0.3	0	n/c	n/c	n/c	0.1
Other Urinary Organs	0	n/c	n/c	n/c	0.2	0	n/c	n/c	n/c	0.0

Bold numbers indicate rate differrent than U.S. rate.
Note: Rate is not calculated (n/c) where number is less than 5.

Table 3-b. Cancer Mortality by Race for Selected Sites - Alaska, 1996-1998

	Total			White			AK Native			Asian-Pacific Islander			Black			
Site of Cancer	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	1994-98 U.S. Rate
All Sites	167.3	(1,915)	159-175	163.8	(1,423)	155-173	217.2	(389)	119-306	80.6 *	(46)	57-113	203.4	(54)	148-274	166.2
Stomach	6.4 **	(79)	5-8	3.9 ***	(32)	2-5	18.8 *	(39)	13-26	n/c	(6)		n/c	(<5)		4.0
Colorectal	15.3	(166)	13-18	13.5 **	(110)	11-16	26.9 *	(47)	19-36	n/c	(<5)		n/c	(7)		16.9
Pancreas	8.9	(101)	7-11	8.3	(72)	6-10	14.7 *	(26)	9-22	n/c	(<5)		n/c	(<5)		8.3
Lung	51.7	(572)	47-56	50.1	(429)	45-55	66.3 *	(112)	54-80	19.8 *	(11)	9-41	74.6	(19)	43-122	48.7
Breast (female)	21.6	(143)	18-26	22.6	(109)	18-28	21.1	(24)	13-32	n/c	(<5)		n/c	(7)		24.2
Prostate	15.8 *,2	(68)	12-22	17.4	(55)	13-24	13.6	(10)	6-26		(0)		n/c	(<5)		23.7
Non-Hodgkin's Lymphoma	6.7	(81)	5-8	7.4	(67)	5-10	5.2	(10)	2-10	n/c	(<5)		n/c	(<5)		6.9

Unknown race = 3 deaths

Rates per 100,000 population age-adjusted to 1970 U.S. population

* Significantly different from U.S. and Alaska

** Significantly different from U.S.

*** Significantly different from Alaska

Note: Rate is not calculated (n/c) where number is less than 10
Cells with fewer than 5 cases are not presented.

Table 4-a. Cancer Incidence by Borough/Census Area for Selected Sites Alaska, 1996-1998

	All Cancers Combined			Lung			Colorectal			Breast			Prostate			Non-Hodgkin's Lymphoma		
	Rate per 100,000	(# of) Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of) Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI
U.S. 1994-1998	400.5			56.1			43.9			114.3			142.0		16.1			
Alaska, 1996-1998	409.7	(5,242)	397-421	67.5**	(780)	62-72	45.1	(527)	41-49	118.1	(864)	109-127	129.0	(673)	124-145	17.0	(238)	15-19
Aleutians East	233.3	(10)	99-2,893	n/c	(<5)			(0)		n/c	(<5)		n/c	(<5)		n/c	(<5)	
Aleutians West	454.5	(34)	268-760	154.7**	(10)	62-377	n/c	(5)		n/c	(5)		n/c	(<5)		n/c	(<5)	
Anchorage	411.3	(2,133)	392-431	61.9	(290)	54-70	40.2	(189)	34-47	127.5	(388)	114-142	152.0***(293)		134-172	18.3	(107)	14-22
Bethel	245.2*	(72)	190-312	45.3	(12)	23-80	73.4**	(20)	44-115	60.9	(10)	28-118	n/c	(<5)		n/c	(<5)	
Bristol Bay	n/c	(5)		n/c	(<5)			(0)			(0)			(0)			(0)	
Denali	389.3	(15)	179-872	n/c	(<5)			(0)		n/c	(6)		n/c	(<5)		n/c	(<5)	
Dillingham	454.3	(40)	317-641	n/c	(9)		n/c	(9)		n/c	(6)		n/c	(<5)		n/c	(<5)	
Fairbanks North Star	416.3	(607)	380-454	65.4	(83)	51-82	43.7	(57)	32-58	119.9	(97)	95-150	116.8	(74)	90-152	13.1	(24)	8-21
Haines	382.1	(29)	252-574	n/c	(5)		n/c	(<5)		n/c	(<5)		n/c	(5)		n/c	(<5)	
Juneau	386.3	(275)	339-438	59.6	(37)	41-83	28.9	(18)	16-47	100.1	(48)	72-138	148.3	(42)	105-204	17.2	(11)	8-32
Kenai Peninsula	436.1	(491)	396-479	96.4*	(101)	78-118	31.0***	(34)	21-44	121.6	(73)	94-155	134.3	(68)	103-175	17.7	(21)	10-29
Ketchikan Gateway	404.4	(168)	343-475	70.4	(28)	46-105	31.0	(14)	16-56	95.8	(22)	58-154	121.8	(21)	74-192	n/c	(5)	
Kodiak Island	530.1*	(129)	433-646	85.3	(18)	47-146	64.2	(13)	32-120	258.1*	(32)	170-387	158.2	(17)	89-273	n/c	(<5)	
Lake and Peninsula	378.2	(14)	202-670	n/c	(<5)		n/c	(<5)		n/c	(<5)			(0)			(0)	
Matanuska-Susitna	462.3*	(515)	420-508	61.4	(67)	47-80	54.5	(54)	40-73	132.9	(82)	103-169	126.8	(62)	95-170	26.3**	(29)	17-40
Nome	370.6	(75)	288-471	88.4	(15)	49-148	83.0*	(17)	46-138	n/c	(9)		n/c	(<5)		n/c	(<5)	
North Slope	305.3	(43)	213-433	n/c	(8)		74.3	(10)	32-156	n/c	(5)		n/c	(<5)			(0)	
Northwest Arctic	349.5	(41)	246-489	n/c	(6)		99.5*	(11)	48-191	n/c	(<5)		n/c	(<5)		n/c	(<5)	
Prince of Wales-Outer Ketchikan	388.6	(56)	277-541	n/c	(9)		151.6*	(14)	77-276	n/c	(<5)		n/c	(6)		n/c	(<5)	
Sitka	376.0	(92)	300-467	66.0	(15)	36-113	67.7	(17)	38-114	n/c	(8)		104.6	(10)	48-204	n/c	(<5)	
Skagway-Hoonah-Angoon	334.4	(35)	226-485	n/c	(<5)		n/c	(<5)		n/c	(6)		n/c	(6)		n/c	(<5)	
Southeast Fairbanks	429.0	(61)	319-570	n/c	(6)		n/c	(<5)		n/c	(9)		n/c	(9)		n/c	(<5)	
Valdez-Cordova	407.3	(103)	326-505	52.3	(13)	26-97	54.9	(12)	26-103	126.9	(18)	69-220	164.7	(19)	97-271	n/c	(6)	
Wade Hampton	358.3	(43)	256-497	120.1**	(13)	63-218	n/c	(5)		n/c	(<5)		n/c	(<5)			(0)	
Wrangell-Petersburg	365.7	(75)	285-467	72.5	(14)	39-130	n/c	(<5)		131.3	(16)	73-237	135.2	(12)	69-251	n/c	(<5)	
Yakutat	974.0*	(15)	505-1,872	n/c	(<5)			(0)		n/c	(<5)		n/c	(<5)			(0)	
Yukon-Koyukuk	384.0	(60)	290-500	n/c	(6)		105.3*	(16)	59-175	n/c	(7)		n/c	(8)		n/c	(<5)	

Unknown Borough/Census Area = 6 cases.

Rates per 100,000 population age-adjusted to 1970 U.S. population.

*Significantly different from U.S. and Alaska.

**Significantly different from U.S.

***Significantly different from Alaska.

Notes: Rate not calculated (n/c) where number is less than 10.

Cells with fewer than 5 cases are not presented.

Table 4-b. Cancer Mortality by Borough/Census Area for Selected Sites Alaska, 1996-1998

	All Cancers Combined			Lung			Colorectal			Breast			Pancreas		
	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI	Rate per 100,000	(# of Cases)	95% CI
U.S. 1994-1998	166.2			48.7			16.9			24.2			8.3		
Alaska, 1996-1998	167.3	(1,915)	159-175	51.7	(572)	47-56	15.3	(166)	13-18	21.6	(143)	18-25	8.9	(101)	7-11
Aleutians East	n/c	(9)		n/c	(<5)			(0)		n/c	(<5)			(0)	
Aleutians West	n/c	(7)		n/c	(<5)			(0)		n/c	(<5)		n/c	(<5)	
Anchorage	166.4	(754)	154-179	49.0	(216)	42-56	14.1	(58)	10-18	20.7	(60)	15-27	7.4	(34)	5-10
Bethel	161.4	(44)	116-219	53.4	(14)	29-91	n/c	(7)		n/c	(<5)		n/c	(<5)	
Bristol Bay	n/c	(<5)		n/c	(<5)			(0)			(0)			(0)	
Denali	n/c	(<5)		n/c	(<5)			(0)			(0)			(0)	
Dillingham	161.6	(13)	83-295	n/c	(<5)		n/c	(<5)			(0)			(0)	
Fairbanks North Star	154.6	(197)	132-180	44.0	(53)	32-59	9.4	(12)	4-18	31.0	(22)	18-49	14.3	(15)	8-24
Haines	138.6	(10)	65-281	n/c	(5)			(0)			(0)		n/c	(<5)	
Juneau	158.4	(102)	127-194	48.8	(29)	32-71	n/c	(8)		n/c	(<5)		n/c	(9)	
Kenai Peninsula	205.7	(216)	178-237	68.4*	(73)	53-87	20.0	(19)	11-32	35.4	(19)	20-57	10.2	(10)	4-20.1
Ketchikan Gateway	127.0	(52)	94-170	36.0	(14)	19-63	n/c	(7)		n/c	(<5)		n/c	(<5)	
Kodiak Island	123.1	(26)	76-193	n/c	(9)		n/c	(<5)		n/c	(<5)		n/c	(<5)	
Lake and Peninsula	n/c	(8)		n/c	(<5)			(0)			(0)		n/c	(<5)	
Matanuska-Susitna	168.5	(177)	143-198	50.4	(53)	37-67	12.0	(13)	6-23	26.9	(14)	14-47	8.7	(10)	4-18
Nome	210.0	(39)	147-291	86.3	(15)	47-145	n/c	(5)			(0)		n/c	(<5)	
North Slope	186.9	(21)	110-302	n/c	(7)		n/c	(<5)		n/c	(<5)		n/c	(<5)	
Northwest Arctic	212.7	(27)	135-328	n/c	(6)		n/c	(<5)		n/c	(<5)		n/c	(<5)	
Prince of Wales-Outer Ketchikan	112.1	(16)	58-212	n/c	(<5)		n/c	(<5)			(0)			(0)	
Sitka	119.7	(27)	78-178	n/c	(9)		n/c	(<5)		n/c	(<5)		n/c	(<5)	
Skagway-Hoonah-Angoon	133.8	(13)	69-245	n/c	(<5)		n/c	(<5)		n/c	(<5)			(0)	
Southeast Fairbanks	198.7	(20)	119-315	n/c	(<5)		n/c	(<5)			(0)			(0)	
Valdez-Cordova	153.2	(32)	102-223	n/c	(9)		n/c	(<5)		n/c	(<5)		n/c	(<5)	
Wade Hampton	228.8	(25)	146-350	91.1	(10)	42-182	n/c	(<5)			(0)			(0)	
Wrangell-Petersburg	169.2	(34)	116-245	53.2	(10)	25-106	n/c	(<5)		n/c	(<5)		n/c	(<5)	
Yakutat	n/c	(7)		n/c	(<5)			(0)			(0)			(0)	
Yukon-Koyukuk	193.1	(28)	127-283	79.3	(10)	35-139	n/c	(<5)		n/c	(<5)		n/c	(<5)	

Unknown Borough/Census Area = 6 deaths.

Rates per 100,000 population age-adjusted to 1970 U.S. population.

*Significantly different from U.S. and Alaska.

Notes: Rate not calculated (n/c) where numbers are less than 10.

Cells with fewer than 5 deaths are not presented.

Senator Bettye Davis

SENATE BILL 17

Medicaid coverage for persons diagnosed with breast or cervical cancer

Press Releases

United States Department of Health Human Services

News Release

FOR IMMEDIATE RELEASE
Wednesday, Jan. 29, 2003

Contact: HHS Press Office
(202) 690-6343

HHS TO PROPOSE INCREASED FUNDING FOR CANCER SCREENING

President Bush will propose a $10 million increase in funding for breast and cervical cancer screening to help low-income and underserved women, HHS Secretary Tommy G. Thompson said today.

The proposed increase is for the National Breast and Cervical Cancer Early Detection Program, administered by Centers for Disease Control and Prevention (CDC), which provides screening services, including clinical breast examinations, mammograms, pelvic examinations and Pap tests, to underserved women. It also funds post-screening diagnostic services, such as surgical consultation and biopsy, to ensure that women with abnormal results receive timely and adequate referrals.

"Together, breast and cervical cancer take the lives of more than 40,000 American women each year," Secretary Thompson said. "These deaths occurred disproportionately among low-income women and women who belong to racial or ethnic minorities. By increasing screening rates for at-risk women, we can save lives."

HHS' fiscal year 2004 budget will request an additional $10 million for this program, bringing the total requested funding to $211 million. The additional funding would allow the program to provide an additional 32,000 procedures, for a total of 562,000 procedures. The increase also will support efforts to increase education and outreach programs for women and health care providers, to improve quality assurance measures for screening and to improve access to screening and follow-up services.

In addition, HHS has approved Medicaid plan amendments for 49 states and the District of Columbia that allow their state Medicaid programs to provide health coverage to women without health insurance who are diagnosed with cancer through the free CDC screening program. This coverage helps to ensure that women receive appropriate care and treatment as quickly as possible, when the odds for a successful recovery are greatest.

The National Breast and Cervical Cancer Early Detection Program was established by the Breast and Cervical Cancer Mortality Prevention Act of 1990. Since its creation, the program has provided more than 3 million screening examinations and diagnosed more than 12,000 breast cancers and 800 invasive cervical cancers. The program operates in all 50 states, the District of Columbia, six U.S. territories and 12 American Indian and Alaska Native organizations.

More information about the CDC screening program is available at http://www.cdc.gov/cancer/nbccedp/. Details about this Medicaid option are available at http://www.cms.hhs.gov/bccpt/.

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Note: All HHS press releases, fact sheets and other press materials are available at *http://www.hhs.gov/news*.

Last Revised: January 30, 2003

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KTUU.COM

Anchorage, AK

Dave Steward / KTUU

Breast cancer survivor Denise Otter says the program helped enormously.

Group fights for Medicaid cancer funding

Joy Mapaye

Anchorage, Alaska, Jan. 26 - A local advocacy group for breast cancer is fighting to keep Medicaid funding for Alaska's breast and cervical cancer treatment program. It's funding that ends this summer.

That funding is scheduled to end this June, which is why the group says it's trying to get the word out as quickly as possible. What's at stake is a treatment program that allows low-income Alaskan women with breast cancer or cervical cancer to get access to Medicaid funds for treatment.

Candidates for the program have been screened and diagnosed, by a Centers for Disease Control screening program to get the funds. From July 2001 to June 2002, Medicaid paid treatment costs for 44 women.

Federal funds make up about 70 percent of this money, with the state chipping in about 30 percent. Last year, the total amount Alaska spent on funding was about $175,000.

"It's helped me enormously," said breast cancer survivor Denise Otter. "I've used the program for a month, before I was eligible with insurance through my employer."

"This program allows low-income women, who have been diagnosed through the screening program, to get that treatment quickly," said Carla Williams, the president of Alaska Breast Cancer Advocacy Partners.

The group says an estimated 69 women will qualify and need breast cancer treatment in fiscal year 2003.

There are two bills in the Legislature to help restore funding, one in the House and one in the Senate. It's still early for those bills so the group is just waiting to see what happens.

Web posted Thursday, January 16, 2003

Women's increased cancer coverage to end

Democrats file bills to make coverage permanent

By TIMOTHY INKLEBARGER
JUNEAU EMPIRE © 2003

A program providing breast and cervical cancer treatment for women who lack health insurance could come to an end this year unless the Legislature extends the program.

A bill passed in 2001 took advantage of a federal program extending Medicaid coverage of breast and cervical cancer. That program increased the income limit from 72 percent of the federal poverty rate to 250 percent.

The program provides about 70 percent funding from the federal government.

In fiscal year 2002, 44 of 54 eligible recipients took advantage of the program for a total cost of $584,364, according to the state Department of Health and Social Services. The state pitched in about $174,300.

Then-Gov. Tony Knowles filed a bill in 2001 to take advantage of the federal program, calling it "must have" legislation. But it hit a snag in the Senate with lawmakers who opposed expanding Medicaid and choosing diseases that are eligible for coverage.

The bill was stalled by Wasilla Republican Lyda Green, former chairwoman of the Senate Health and Social Services committee.

At the time, then-U.S. Sen. Frank Murkowski, an Alaska Republican, sent a letter to all Alaska lawmakers calling on them to support the bill.

"I recognize that there are concerns about creating disease-specific Medicaid eligibility categories. However, this legislation deals with a thoroughly unique set of circumstances ... and should not be viewed as a precedent for extending Medicaid body-part by body-part," Murkowski wrote.

The bill was approved by the committee, but Green placed a two-year sunset on the program, which is set to expire this June.

Green, a survivor of breast cancer, told The Associated Press in March of 2001: "These are not easy decisions. These are very, very tough policy calls."

She did not return calls to the Empire by its midday deadline today.

Bills have been prefiled by Democrats in the House and the Senate to make the coverage permanent. It is uncertain whether any lawmakers will oppose the measure. Similar bills introduced last session to remove the sunset did not make it to a floor vote.

Sen. Fred Dyson, an Eagle River Republican, will sit as chairman of the Senate Health and Social Services Committee this session. While serving in the state House in 2001, Dyson was one of five Republican lawmakers in the 40-member body who voted against the bill. Dyson was unavailable for comment for this article.

Murkowski's support in 2001 for providing coverage, however, could persuade lawmakers who oppose expanding Medicaid.

Murkowski spokesman John Manly said he was unsure if the governor supported such a bill but added: "In light of the governor's and first lady's interest in this issue over the years ... I anticipate that he will be in support of this bill."

Rep. Beth Kerttula, a Juneau Democrat and co-author of the House bill to make the program permanent, said she expects that most Democrats and many Republicans in the House will sign on to the bill.

As the recently appointed minority whip of the House, Kerttula has the responsibility to line up the vote within the Democratic caucus.

Meanwhile, breast and cervical cancer advocacy groups in Alaska are gearing up for a heavy lobbying effort on the issue this session.

Carla Williams, president of the Anchorage-based Alaska Breast Cancer Advocacy Partners, said the group plans trips to the Legislature and will engage in a postcard-writing campaign to elected officials.

The organization plans to send out hundreds of postcards across the state calling on people to support the bill.

"Discontinuing treatment would be devastating for those women who are trying to get well and fight this disease," Williams said.

Timothy Inklebarger can be reached at timothyi@juneauempire.com.

Senator Bettye Davis

SENATE BILL 17

Medicaid coverage for persons diagnosed with breast or cervical cancer

Positive Support

The National Breast Cancer Coalition's (NBCC) SCORECARD on State Participation in the Breast and Cervical Cancer Treatment Program

Preamble: State Scorecard
(as of January 27, 2003)

Purpose

National Breast Cancer Coalition (NBCC) grassroots advocates played a pivotal role in the enactment of the Breast and Cervical Cancer Treatment Act (P.L. 106-354). This important legislation established a program, available to all states, that provides breast and cervical cancer treatment coverage to low-income, uninsured women.

States must take certain steps to "opt into" the new treatment program in order to participate. This state scorecard tracks the steps that states have taken to implement it. The scorecard also describes the Act and explains where the policy idea behind the law came from; how the law was enacted; what states generally need to do to participate in the program; and what work still needs to be done.

This scorecard is a snapshot of state action as it stands at the moment.

The Act

On October 24, 2000, the Breast and Cervical Cancer Treatment Act (P.L. 106-354) was signed into law. This Act gives states the option of providing Medicaid coverage to low-income, uninsured women, under 65 years of age, who have been screened and diagnosed through the Breast and Cervical Cancer Early Detection Program (BCCEDP), and are in need of breast or cervical cancer treatment. Each state that opts in receives an enhanced match from the federal government, equal to its Children's Health Insurance Program match, which will help fund 65%-83% of the total program cost. Participating states may choose to extend a presumptive eligibility procedure to applicants in order to facilitate prompt enrollment and immediate access to treatment.

Origin of the Policy

For years, NBCC was concerned that the Breast and Cervical Cancer Mortality Prevention Act (PL 101-354) authorized the Centers for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) to provide free screening services for low-income women with no health insurance, but failed to cover any treatment. As a result, many women diagnosed with cancer under the NBCCEDP found themselves scrambling to find ways to pay for their treatment. Over the years, volunteers helped these women find treatment coverage through charitable contributions, but this system was often unreliable and rapidly deteriorating.

The idea for a potential solution to this problem came from the National Breast Cancer Coalition through its grassroots network. NBCC recognized the need for women diagnosed through the NBCCEDP to gain access to guaranteed treatment and suggested Medicaid as a possible source to cover the cost of their treatment. This idea launched what was to become the Breast and Cervical Cancer Treatment Act.

The National Breast Cancer Coalition's (NBCC) SCORECARD on State Participation in the Breast and Cervical Cancer Treatment Program

The Road to Enactment

From 1997 until the Treatment Act became law, NBCC focused its efforts on implementing a treatment component for the federal screening program. From developing the strategy, successfully urging the Administration to include funding for the bill in the President's fiscal year 2001 budget, persuading an overwhelming majority of members of Congress to cosponsor the Breast and Cervical Cancer Treatment Act, convincing Committees to hold hearings and markups, to persuading Congressional leaders to bring the bill to the floor, NBCC led the fight to bring this law to life.

While rapid state action and overwhelming support in Congress (the bill passed 421-1 in the House of Representatives, and unanimously in the Senate) may suggest that the steps above were accomplished easily, that is far from the case. Rather, passage of this important Act was an uphill battle. It took four long years to get this bill passed, and during that time NBCC's grassroots faced many setbacks – some that seemed insurmountable. NBCC's success in ensuring that low-income women diagnosed with breast cancer have access to the treatment they deserve demonstrates the power of strategic and tireless grassroots advocacy.

Process for State Participation in the Treatment Program

Since the bill was signed into law, NBCC's attention and efforts have been focused on working with individual states to ensure that they take up the new Medicaid option. NBCC's grassroots network has been working with their Members of Congress, Governors, state legislators, CDC's Early Detection Program officials, and State Medicaid Directors on engaging states in the implementation process. This far-reaching initiative has revealed that while the key steps in the process are similar for all states, no two states share the same story.

Any state that elects to participate in the new Medicaid option, and if so desired, the presumptive eligibility option, must submit an amended state Medicaid plan to the Center for Medicare and Medicaid Services (CMS) (formerly called the Health Care Financing Administration) for its approval. Only when a state's amended state Medicaid plan is approved by CMS has it completed the steps it needs to receive its enhanced federal share of payment for program costs.

In addition, all states must provide funding to cover the state share of program costs. Most states will need to appropriate new funding, while a few states may initially be able to use funding already allocated to the state health or Medicaid Department.
For some states, an amendment to the state Medicaid plan and the allocation of funding are the only requirements to participate in the new option. States that opt in this way are considered to have opted in administratively, since the Governor could approve the policy without having to sign authorizing legislation that would need to pass through the state legislature. However, most states must enact authorizing legislation in order to opt in to the treatment program.

The National Breast Cancer Coalition's (NBCC) SCORECARD on State Participation in the Breast and Cervical Cancer Treatment Program

State Action

In only a year since the enactment of the Treatment Act, almost every state has committed to adopting the treatment option. Many public policy and public health officials, and leaders in local and national healthcare communities have commented that this progress is unique. For example, the Federal Funds Information for States (FFIS) noted that states were taking on the Medicaid option at "a historically rapid rate," and attributed this phenomenon partly to "coordinated efforts by breast cancer survivors and their allies to persuade state officials to adopt it." The National Breast Cancer Coalition's incredible grassroots advocates have been credited numerous times as the primary leaders of this effort.

To date, United States Department of Health and Human Service's Secretary Tommy Thompson has approved **48** states' proposals to amend their state Medicaid plans to expand coverage to uninsured women diagnosed with breast or cervical cancer. NBCC commends Secretary Thompson and the CMS officials for their support and strong encouragement to the states to participate in the Treatment Program.

NBCC applauds the many states that quickly implemented the treatment program. The Coalition urges other states to follow suit so women will access to the treatment option as soon as possible.

Continuing Efforts

It is important that, while we celebrate the passage of the Breast and Cervical Cancer Treatment Act and the rapid progress we are making in encouraging state participation in this program, we do not lose sight of the fact that this is only a first step. While the Breast and Cervical Cancer Treatment Act provides coverage for underserved women screened who qualify for the NBCCEDP, there are many other women who still do not have access to early detection and treatment services. We must continue to work together to ensure that all women who are diagnosed with breast cancer have access to the high quality treatment they deserve.

NBCC's grassroots advocates will remain diligent in their efforts to ensure that if a state has opted into the program, the program continues to thrive in future years, and that cuts are not made to the critical treatment benefits the women in that state will now receive.

The National Breast Cancer Coalition's (NBCC) SCORECARD on State Participation in the Breast and Cervical Cancer Treatment Program

Steps that states must take to participate ("opt into") the Treatment Program:
There are two ways for a state to begin implementation of the Treatment Program. A state can either enact authorizing legislation or opt in administratively. In either case, states must also allocate funding for their share of program costs. Next, all states must submit an amended Medicaid plan to the Center for Medicaid and Medicare Services (CMS) (*formerly called the Health Care Financing Administration (HCFA)*) for its approval. These amended plans inform CMS how a state will run the Treatment Program. Finally, upon CMS approval of its state plan amendment, a state may begin participating in the Treatment Program.

(1) Legislation enacted = legislation authorizing participation in the Treatment Program passed in the state legislature and was signed by the governor.

Funding approved = the state has allocated funding for its share of the Treatment Program costs. To see the amount and source of the funding allocated by the state, look in either the authorizing legislation or within the general budget bill.

(2) Amended plan submitted = the state submitted an amended state Medicaid plan to CMS for its approval.

(3) Participating in treatment program = CMS approved the state Medicaid plan amendment. Therefore, the state has completed all steps required to accept the new Medicaid option and can begin participating in the Treatment Program.

State	(1) Legislation enacted/ funding approved	(2) Amended plan submitted	(3) Participating in treatment program
Alabama	✓	✓	✓
Alaska	✓	✓	✓
Arizona	✓	✓	✓
Arkansas	✓	✓	✓
California	✓	✓	✓
Colorado	✓	✓	✓
Connecticut	✓	✓	✓
Delaware		✓	✓
Florida	✓	✓	✓
Georgia	✓	✓	✓
Hawaii	✓	✓	✓
Idaho	✓	✓	✓
Illinois	✓	✓	✓
Indiana	✓	✓	✓
Iowa	✓	✓	✓
Kansas	✓	✓	✓
Kentucky	✓	✓	✓
Louisiana	✓	✓	✓
Maine	✓	✓	✓
Maryland	✓	✓	✓
Massachusetts	✓		
Michigan	✓	✓	✓
Minnesota	✓	✓	✓
Mississippi	✓	✓	✓
Missouri	✓	✓	✓
Montana	✓	✓	✓
Nebraska	✓	✓	✓
Nevada	✓	✓	✓
New Hampshire	✓	✓	✓
New Jersey	✓	✓	✓
New Mexico	✓	✓	✓
New York	✓	✓	✓
North Carolina	✓	✓	✓
North Dakota	✓	✓	✓
Ohio	✓	✓	✓
Oklahoma	✓		
Oregon	✓	✓	✓
Pennsylvania	✓	✓	✓
Rhode Island	✓	✓	✓
South Carolina	✓	✓	✓
South Dakota	✓	✓	✓
Tennessee			✓
Texas	✓	✓	✓
Utah	✓	✓	✓
Vermont	✓	✓	✓
Virginia	✓	✓	✓
Washington	✓	✓	✓
West Virginia	✓	✓	✓
Wisconsin	✓	✓	✓
Wyoming	✓	✓	✓

Nancy Murkowski

Nancy Gore Murkowski is a life-long Alaskan. Born in Nome, where her father was the Federal Judge for the Territory of Alaska, she was raised in and attended school in Ketchikan. She attended Willamette University in Salem, Oregon, and graduated with a Bachelor of Arts degree from San Jose State University in California.

In 1974, Nancy helped found the Breast Cancer Detection Center of Alaska in Fairbanks, which provides free- or low-cost breast examinations and mammograms for women throughout Alaska. She has been an active fundraiser for that Center, hosting eight charity fishing tournaments to aid the facility. (See below) In 1998, she won the sixth annual Action for Cancer Awareness Award from the Cancer Research Foundation of America for her efforts. She was the 1996 recipient of the Georgetown University Lombardi Cancer Center's "Symbol of Caring" award for her work in this area, is a member of the Congressional Families for Breast Cancer Awareness, and is Honorary Chair of the Alaska Breast Cancer Coalition. She also serves on the Executive Board of the Congressional Families for Cancer Awareness Foundation.

Nancy and Frank Murkowski have been the Honorary Alaska State Chairmen of the Red Ribbon Campaign, an anti-drug abuse program, for several years. She is a former Chairman for the Congressional Families for Drug Free Youth.

Nancy is also a member of the Senate Spouses Red Cross Unit and the Pioneers of Alaska, Auxiliary 4. An active fundraiser in the Washington, D.C. area, she was Chairman for the 1997 March of Dimes gala in Washington, was Chairman for the 1993 Ambassadors Ball to benefit the National Multiple Sclerosis Society in Washington, Co-Chairman of the CARE Ball for 2000 and 2001 and was a member of the Medical Affairs Development Council at the University of Washington.

Nancy and Frank have a home in Fairbanks, six children and 12 grandchildren.

Breast Cancer Detection Center of Alaska

Frank and Nancy Murkowski are pioneers in efforts to fight cancer in Alaska.

In 1974, Mrs. Murkowski was one of three women who formed the non profit Breast Cancer Detection Center of Alaska, first housed in an old bank building donated by the senator when he was President of Alaska National Bank of the North in his hometown of Fairbanks. Initially, the center, from a single X-ray machine, provided low- or no-cost mammograms for anyone who could visit the northcentral Alaska location. Initially the center provided about 2,000 mammograms a year to women from up to 80 Alaska villages.

Eight years ago, the Murkowskis sponsored their first charity fishing tournament to raise money, first to replace the center's aging X-ray machine, and in later years to buy a mobile van and equip it with a new X-ray machine -- the Mollie -- so that women on the road system in central Alaska could obtain mammograms. And then two years ago the event raised enough money to buy a third (mobile) machine -- the Sophie - that can be packed in air freight crates and resembled to allow mammogram testing in tiny Alaska villages served only by small commuter airlines.

The Murkowskis in the event's first eight years have raised more than $1.8 million, more than $1.6 million for the operation of the Fairbanks center. The center now serves about 2,500 women a year in more than 81 villages throughout the state. In years when the event has raised more than $250,000 for the Fairbanks center, excess money has been donated to cancer and health groups statewide. The following groups have received donations from the event: 2002 -- Sunshine Health Clinic of Talkeetna, $20,000; Providence Hospital in Anchorage, $25,000 and the Southeast Alaska Cancer and Wellness Foundation of Juneau, $20,000; 2001 -- the ACS Mammogram Assistance Program, $20,000; the First City Council on Cancer in Ketchikan, $25,000; the Hospice Home Care of Juneau, $10,000; 2000 -- Ketchikan General Hospital, $20,000; Bering Straits Womens Group, $5,000; and Craig Community Foundation, $3,000.

Frank and Nancy Murkowski in 2001 also donated $80,000 for detection and treatment of breast cancer and other forms of cancer in Alaska -- money derived not from the Waterfall fishing event, but was raised during the celebration of Murkowski's 20th anniversary in the U.S. Senate in February 2001 in Anchorage. The money was donated to both Providence Foundation to be used in providing cancer treatments for those in need at Providence Alaska Medical Center in Anchorage and to the Breast Cancer Detection Center of Alaska in Fairbanks.

The Murkowskis say they work so hard to raise money to fight breast cancer because Alaska has the second highest breast cancer death rate in the nation -- about 50 women every year. With one in eight women diagnosed with breast cancer in Alaska yearly -- about 200 new cases a year -- early detection is especially vital. And early detection is especially difficult in Alaska where most of the state's 228 rural villages have clinics that contain no mammogram X-ray equipment.

Prostate Cancer Testing

The Senator and Nancy Murkowski in 1999 also served as honorary leaders in an effort to encourage men to have prostate cancer examinations and women to have breast cancer exams.

The effort, centered around Father's Day observances, noted that Prostate cancer is one of the most treatable cancers when detected early and is one of the easiest cancers to detect through regular screenings. Nevertheless, prostate cancer is the second leading cancer killer of American men and will affect one in every five men sometime in their lifetime. In Alaska, according to the American Cancer Society, 200 men and women were diagnosed with prostate and breast cancer in 1998, with the diseases claiming nearly 50 men and 100 women in 1998.

Frank Murkowski urged Alaskans, especially men over age 50, to get a prostate exam, which includes both a PSA (prostate specific antigen test) and a digital rectal exam yearly. He also urged women over age 40 to have mammograms every year or two, while women 50 and over are urged to have the exams yearly. Legislative Changes:

In 1998, Senator Murkowski sponsored legislation, with former Sen. Al D'Amato, R-N.Y., that allowed physicians and not insurance companies to determine the length of stay for breast cancer mastectomy patients in hospitals. The bill, that was included in the final appropriations bill for that year, also ensured that mastectomy patients could have access to reconstructive surgery and the right for additional consultations with doctors to be covered by health insurance.

Prior to the bill, Murkowski said, some HMOs and other insurance plans didn't adequately cover reconstructive surgery nor were allowing long enough stays in the hospital after the operations. At the time, some companies required doctors to discharge mastectomy patients within 24 hours of surgery. The bill overrode that requirement. It also required companies nationwide to pay for secondary consultations often needed since patients should receive pathology, radiology and

oncology consults prior to and after mastectomies.

The bill also required coverage for breast reconstruction which was vital because many women could not afford the roughly $15,000 cost of reconstructive surgery following mastectomies without adequate insurance benefits. Nationwide, before the change only 23 percent of women with breast cancer were undergoing full reconstructive surgeries after mastectomies -- only 3.4 percent of the women in Alaska being able to afford the costs.

The Senator accomplished that legislation after winning additional money from the military's medical budget for breast cancer medical research in prior years.

In 2000, Murkowski also co-authored the Breast and Cervical Cancer Prevention and Treatment Act that passed that year. The measure guarantees that low-income women across the nation, including in Alaska, who were diagnosed with breast or cervical cancer under a special federal screening program created years earlier will receive follow-up medical treatment under the states' Medicaid programs, if needed.

The law actually changes the income formulas for women under the Medicaid program -- the program that provides health care nationwide for low income people -- to allow states to extend Medicaid coverage to slightly higher income poor women diagnosed with cancer under the 1990's federal screening program. The change, which involved adding $200 million in federal Medicaid funding nationwide to pay for the formula change, had the effect of helping thousands of low-income women get medical care for the cancer found during the screening program, including 42 women in Alaska.

PO Box 101299
Anchorage, AK 99510
Tel: 907.222.3600

FRANK H. MURKOWSKI
ALASKA

COMMITTEES:

CHAIRMAN
ENERGY AND NATURAL RESOURCES

FINANCE
VETERANS' AFFAIRS
INDIAN AFFAIRS

United States Senate
WASHINGTON, DC 20510-0202
(202) 224-6665
(202) 224-5301 FAX

222 WEST 7TH AVENUE, BOX 1
ANCHORAGE, AK 99513-7570
(907) 271-3735

101 12TH AVENUE, BOX 7
FAIRBANKS, AK 99701-6278
(907) 456-0233

P.O. BOX 21647
JUNEAU, AK 99802-1647
(907) 586-7400

130 TRADING BAY ROAD, SUITE 350
KENAI, AK 99611-7716
(907) 283-5808

109 MAIN STREET
KETCHIKAN, AK 99901-6489
(907) 225-6880

851 E. WESTPOINT DRIVE, SUITE 307
WASILLA, AK 99654-7142
(907) 376-7665

April 26, 2001

The Honorable Senator Rick Halford
President, Alaska State Senate
State Capitol
Juneau, AK 99801-1182

The Honorable Representative Brian Porter
Speaker of the Alaska House of Representatives
State Capitol
Juneau, AK 99801-1182

Dear Senator Halford and Representative Porter:

As you know, I have traditionally given great deference to the work of Alaska's state legislature, and it is not my custom to become involved with its activities. I believe it is my duty to respond to the state's concerns and calls for help--rather than to interject myself into internal debates. However, the needs of a small number of Alaskan women force me to diverge from my common practice. It is a very important priority for me to see that Alaska Senate Bill 38, extending Medicaid coverage to a few uninsured low income Alaskan women with breast or cervical cancer, is passed by the legislature before the end of this legislative session.

In 1990, Congress recognized the importance of screening and early detection--establishing the National Breast and Cervical Cancer Early Detection Program. This program provided screenings to uninsured, low income women across the country. Unfortunately, for those women who were diagnosed with cancer, the program failed to provide insurance coverage that would have allowed them to receive medical treatment.

Last year, Congress enacted the Breast and Cervical Cancer Prevention and Treatment Act, legislation I co-wrote. This law fulfilled Congress' 1990 commitment to the victims of these cancers by permitting states to extend Medicaid coverage to cover the costs of treating these illnesses which, untreated, are almost always fatal. We will continue to help lower-income, uninsured women access needed preventive health care services. But now our commitment will not stop with a screening. If problems are found, the federal government will work with the state to provide necessary treatment services to women facing cancer diagnoses. But to accomplish this, the state legislature must adopt SB 38. For this, I need your

immediate help.

I recognize that there are concerns about creating disease-specific Medicaid eligibility categories. However, this legislation deals with a thoroughly unique set of circumstances. The new Medicaid eligibility category is specifically linked to a unique and existing federal screening program, and should not be viewed as a precedent for extending Medicaid eligibility body-part by body-part. Additionally, Medicaid coverage would only be available during the period in which the individual requires breast or cervical cancer treatment.

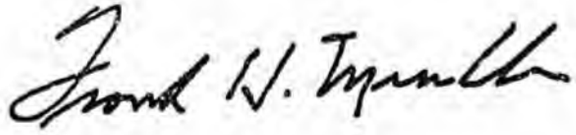
As you know, I am very sensitive to the costs associated with the Medicaid program in Alaska. In 1997, I was able to change the federal government's Medicaid formula to enable the state to bear a smaller share of Medicaid costs. This saved the state approximately $100 million over three years. Just last year, I won an additional $200 million of federal dollars--a 20 percent increase above the previous adjustment--to expand our state's Medicaid program over the next five years. As a result, In FY 2002 alone, the state will receive an additional $40 million from my legislation.

The cost of extending Medicaid coverage to the estimated 42 eligible women diagnosed under the CDC program in 2002 will be $175,800, as the federal government will pay for 70.17% of total expenditures. In light of these facts, I strongly believe that the state can afford to extend Medicaid coverage to these women--and can use these additional funds to accomplish this goal.

We must work quickly to ensure that the state extends coverage to these women. We have the money, and there certainly is a need. While this is a small segment of Alaska's population, it is our duty to heed their call for help. It must be recognized that Alaskan women have the second highest rate of breast cancer in the nation. With such an epidemic in our state, I would hate for Alaska to stand out as one of the few states that fail to provide this life-or-death benefit.

Please feel free to call me or my staff if we can provide you with any additional information or to discuss the merits of this legislation. Together, we can ensure that needy women in Alaska receive the care and coverage they deserve.

Sincerely,



Frank H. Murkowski
United States Senator

cc: All Members of the Alaska State Legislature

FRANK H. MURKOWSKI
ALASKA

COMMITTEES:

RANKING MEMBER
ENERGY AND NATURAL RESOURCES

FINANCE
VETERANS' AFFAIRS
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130 TRADING BAY ROAD, SUITE 350
KENAI, AK 99611-7716
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540 WATER STREET, SUITE 101
KETCHIKAN, AK 99901-6378
(907) 225-6880

851 EAST WESTPOINT DRIVE, SUITE 307
WASILLA, AK 99654-7142
(907) 376-7665

May 20, 2002

Mr. Richard A. Benavides
Legislative Aide
Office of Senator Bettye Davis
State Capitol
Juneau, AK 99801-1182

Dear Richard:

Thank you for contacting me regarding the Breast and Cervical Cancer Act. I appreciate your interest in seeing that this program continues.

In December of 2001, we did amend the original law to extend the benefit to Native women. Otherwise, no other changes were made or are planned to be made.

Thank you again for contacting me and for all that you are doing for Alaska.

Sincerely,

Frank H. Murkowski
United States Senator

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 7
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Sectional Analysis
Senate Bill 17

Section 1. Adds a new group of persons who are eligible for medical assistance under AS 47.07, known as the "Medicaid" program. The new group is confined to persons who are eligible for coverage under the specified federal law.

Section 2. Repeals the temporary law (sec.1, ch.33, SLA 2001) that added the same new group to coverage in the year 2001. The 2001 legislature put an application deadline in the 2001 law: two years after the effective date of the session law, which was June 26, 2001. That means that, after June 26, 2003, there can be no new applicants for Medicaid coverage for persons with breast or cervical cancer who are eligible under the specified federal law under unless the application period is extended by amending ch. 33, SLA 2001, or by passage of a bill like SB 17, which puts the new eligible group in the permanent statutes without an expiration date for either applications or for coverage. However, the coverage even under SB 17 is not necessarily permanent. State coverage of this group would expire if the federal law, 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII), is repealed or expires. Note the qualifying phrase at the end of section 1 of this bill ("...who are eligible for coverage under 42 U.S.C. [etc.]." If a person would no longer be covered under this federal law, they would no longer be covered under this state law.

Section 3. Provides that persons already covered under the temporary program enacted in 2001 do not have to reapply as new applicants under SB 17, but their cases would be subject to regular eligibility review on the same basis that the situations of other Medicaid recipients are subject to review.

Section 4. Keeps in place the regulations adopted for the temporary program enacted in 2001, subject to future amendment of the regulations by DHSS.

Section 5. Gives this Act an immediate effective date so that there would probably be no gap between the application deadline in ch. 33, SLA 2001 [June 26, 2003] and the effective date of SB 17.