

ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10535 SENATE HEALTH EDUCATION & SOCIAL SERVICES

education and outreach; professional education; quality assurance and improvement; surveillance; and, partnership development and community involvement for cancer control, chronic disease control or other relevant areas.

7. Source Data for Matching Requirement

Identify and describe:

- a. Maintenance of Effort (MOE) - The average amount of non-Federal dollars expended for breast and cervical cancer programs and activities made by a State/territory/tribe for the two year period preceding the first Federal fiscal year of the program funding for breast and cervical cancer early detection activities. This amount will be used to establish the maintenance of effort baseline for current and future match requirements;
- b. State/territory/tribe allowable sources of matching funds for the program and the estimated amounts from each;
- c. Procedures for documenting the value of non-cash matching funds;
- d. Procedures for documenting the actual amount of match received.

8. Budget with Justification

- a. Provide a detailed budget request and complete line item justification (for both Federal and non-Federal funds) of all proposed operating expenses consistent with the program activities described in this announcement. Not less than 60 percent of Federal funds will be expended for screening, tracking, follow-up and other support services such as case management. Not more than 10 percent of Federal funds will be expended for administrative expenses. A detailed line-item breakdown of the 60/40 distribution should be incorporated into the budget.
- b. The applicant should submit a Screening and Diagnostic Worksheet that details the projected number of women screened, the reimbursement rate provided for each service, and the overall projected clinical costs. A sample Screening and Diagnostic Worksheet is included in the NBCCEDP PPM.
- c. To request new direct-assistance assignees, include:
 - (1) number of assignees requested;
 - (2) description of the position and proposed duties;

- (3) ability or inability to hire locally with financial assistance;
- (4) justification for request;
- (5) organizational chart and name of intended supervisor;
- (6) opportunities for training, education, and work experiences for assignees; and
- (7) description of assignee's access to computer equipment for communication with CDC (e.g., personal computer at home, personal computer at workstation, shared computer at workstation on site, shared computer at a central office).

F. Submission and Deadline

Submit the original and two copies of the completed application Form PHS-5161-1 (OMB Number 0937-0189). Forms are in the application kit. On or before May 26, 1999, submit the application to:

Mildred S. Garner, Grants Management Officer, Grants Management Branch, Procurement and Grants Office, Centers for Disease Control and Prevention (CDC), 2920 Brandywine Road, Room 3000, Atlanta, GA 30341.

1. Deadline: Applications will be considered as meeting the deadline if they are either:

- a. Received on or before the stated deadline date; or
- b. Sent on or before the deadline date and received in time for orderly processing. (Applicants must request a legibly dated U.S. Postal Service postmark or obtain a legibly dated receipt from a commercial carrier or the U.S. Postal Service. Private metered postmarks shall not be acceptable proof of timely mailing.)

2. Late Applications: Applications which do not meet the criteria in 1(a) or 1(b), above, are considered late applications, will be returned to the applicant.

G. Evaluation Criteria (100 Points)

Each application will be evaluated individually against the following criteria by an independent review group appointed by CDC.

1. Background and Need (10 points)

The extent of the disease burden and the need among the priority populations as measured by:

- a. The State/territorial/tribal breast and cervical cancer age-adjusted mortality rates averaged more than five years and ranking nationally;

- b. The disease burden, including the incidence rates of breast and cervical cancer by age, race and ethnicity (where available);
- c. The number of uninsured women by race/ethnicity who are 18-39, 40-49, 50-64, 65+ years;
- d. The unmet screening needs of uninsured and under-insured women;
- e. Existing access and barriers to early detection services, (e.g., social, financial, geographic).

2. Implementation Plan (50 points)

The degree of comprehensiveness and quality of the Work Plan in relation to:

- a. The applicant's proposed work plan that includes overall goals for the program and program components, describes performance indicators related to goals and details measurable, time phased and realistic objectives for each program component. (10 Points)
- b. Proposed public education, information, and outreach strategies that are likely to increase the number of low income, uninsured women that are screened and rescreened. (10 points)
- c. Proposed professional education strategies that are likely to effect the health care providers knowledge, attitudes, and behaviors in such a way

that more women in the target audience are screened and rescreened appropriately. (10 points).

- d. Proposed a service delivery program that provides quality screening, rescreening and diagnostic services, according to established standards, and a proactive tracking, follow-up and case management system. (10 points)
- e. Proposed surveillance and evaluation strategies that appear to use reliable data and program results to measure program effectiveness and to facilitate program planning, development, and implementation, and to enhance program goals and objectives. (10 points)

3. Partnership Development and Community Involvement (10 points)

The feasibility and extent of the applicant's proposal to develop and maintain collaborative partnerships with other Federal, State and local programs, territories, tribes and voluntary, professional, and private-sector agencies. The extent of involvement of a broad-based coalition that advises and supports the program. The extent to which letters of support reflects assistance from key partners, participants, and community leaders.

4. Management and Organizational Structure (15 points)

The feasibility and appropriateness of the applicant's management plan that describes the development of qualified and diverse technical, program, and administrative staff, organizational relationships including lines of authority, internal and external communication systems, and a system for sound fiscal management.

5. Capability for Program Implementation (15 points)

The extent to which the applicant appears likely to be successful in implementing the proposed activities as measured by:

- a. Accomplishments by comprehensive-funded States and tribes in implementing a breast and cervical cancer early detection program as required through previous funding agreements. These accomplishments should be evaluated in terms of the number of women screened, the number of services provided, and the number of cancers detected.
- b. Accomplishments by capacity-funded States in establishing a comprehensive public health infrastructure to support a breast and cervical cancer early detection program.
- c. Relevant past experiences of unfunded applicants

in conducting breast and cervical cancer early detection programs.

6. Budget and Justification (Not Weighted)

The extent to which the proposed budget is adequately justified, reasonable, and consistent with this program announcement.

7. Human Subject (Not Weighted)

Whether or not exempt from the DHHS regulations, does the application adequately address the requirement of 45 CFR Part 46 for the protection of human subjects? Recommendations on the adequacy of protections include:

(1) protections appear adequate and there are no comments to make or concerns to raise, or (2) protections appear adequate, but there are comments regarding the protocol, or (3) protections appear inadequate and the Objective Review Group (ORG) has concerns related to human subjects, or (4) disapproval of the application is recommended because the research risks are sufficiently serious and protection against risks are inadequate as to make the entire application unacceptable.

H. Other Requirements

Technical Reporting Requirements

Provide CDC with the original plus two copies of:

1. Semiannual progress reports are required and must be

submitted no later than 30 days after each semiannual reporting period. The semiannual progress reports must summarize the following: (1) major accomplishments including information on women screened; (2) problems encountered in program implementation; and (3) efforts or proposed strategies to resolve problems. All manuscripts published as a result of the work supported in part or whole by the cooperative agreement will be submitted with the progress reports.

2. An annual financial status report (FSR) must be submitted no later than 90 days after the end of each budget period.
3. The final financial status report and progress report is required no later than 90 days after the end of the project period.

Send all reports to:

Nealean K. Austin, Grants Management Specialist
Grants Management Branch, Procurement and Grants
Office, Centers for Disease Control and Prevention
(CDC), Room 3000, 2920 Brandywine Road, Atlanta, GA
30341.

The following additional requirements are applicable to this program. For a complete description of each, see Attachment I in application package.

AR-1

Human Subjects Requirement

AR-2	Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research
AR-7	Executive Order 12372 Review
AR-9	Paperwork Reduction Act Requirements
AR-10	Smoke-Free Workplace Requirements
AR-11	Healthy People 2000
AR-12	Lobbying Restrictions

I. Authority and Catalog of Federal Domestic Assistance Number

This program is authorized under sections 1501, 1502, 1507 and 1509 [42 U.S.C. 300k, 42 U.S.C. 300l, and 42 U.S.C. 300n-3] of the Public Health Service Act, as amended. The Catalog of Federal Domestic Assistance number is 93.919.

J. Where to Obtain Additional Information

To receive additional written information and to request an application kit, call 1-888-GRANTS4 (1-888-472-6874). You will be asked to leave your name and address and will be instructed to identify the Announcement number of interest. If you have questions after reviewing the contents of all the documents, business management technical assistance may be obtained from:

Nealean K. Austin, Grants Management Specialist
 Grants Management Branch, Procurement and Grants Office
 Announcement 99052

Centers for Disease Control and Prevention (CDC)
Room 3000, 2920 Brandywine Road, Atlanta, GA 30341,
telephone (770)-488-2754, E-mail address NEA1@CDC.GOV

For program technical assistance, contact:

Amy Harris, Acting Manager, Policy Development and
Administrative Coordination, Program Services Branch,
Division of Cancer Prevention and Control, National
Center for Chronic Disease Prevention and Health
Promotion, Centers for Disease Control and Prevention
(CDC), 4770 Buford Highway, NE., Mailstop K-57,
Atlanta, GA 30341-3724, telephone (770) 488-4880, fax
(770) 488-4727, or

See also the CDC home page on the Internet:

<http://www.cdc.gov> or <http://www.cdc.gov/cancer> for a copy
of the PPM.

Addendum 1

Background

Breast Cancer

In the United States, approximately 500,000 women will die this decade from breast and cervical cancer. Among women, breast cancer accounts for 29 percent of all new cancer cases and is the second leading cause of cancer related deaths. An estimated one of every eight women in the United States will develop breast cancer in her lifetime. In 1998, the American Cancer Society estimates that 178,700 women will be diagnosed with invasive breast cancer and 43,500 women will die of this disease. Death rates from the disease are highest among women aged 40 or more years, and among black women as compared to white women for those aged less than 70 years.

It is not currently known how to prevent breast cancer from occurring. Thus, detecting carcinoma of the breast at an early stage is the key to more treatment options, improved survival, and decreased mortality. Research has shown that the use of mammography can reduce the mortality due to breast cancer among women 50 years and older by 30 percent.

The percent of women who are regularly screened for breast cancer decreases with age. The baseline data on mammography use from the 1994 National Health Interview Survey show that only 60.6 percent of women 50 years and older reported having received a mammogram within the past two years. This proportion was lower for racial and ethnic minority women, for women who had less than a high school education, for women who were over age 65 years, and for women who were living below the poverty level. In Healthy People 2000, the Public Health Service (PHS) recommended that by the year 2000, 60 percent of women aged 50 years and older should receive a mammogram every two years.

Cervical Cancer

The overall incidence of invasive cervical cancer has decreased steadily over the last several decades. As Pap screening has become more prevalent, carcinoma in situ of the cervix is now more frequent than invasive cancer, particularly in women under 50 years of age. In 1997, invasive cervical cancer was diagnosed in approximately 14,500 women, and carcinoma in situ was diagnosed in about 65,000 women, and about 4,800 women died of cervical cancer.

The primary goal of cervical cancer screening is to increase

detection and treatment of precancerous cervical lesions and thus prevent the occurrence of cervical cancer. Although no clinical trials have studied the efficacy of Papanicolaou (Pap) test in reducing cervical cancer mortality, experts agree that it is an effective technology. Since the introduction of the Pap test in the 1940s, cervical cancer mortality rates have decreased by 75 percent.

In 1991, the PHS established that by the year 2000, 85 percent of women should be receiving a Pap test within the preceding one to three years. Baseline data on the use of the Pap test from the 1987 National Health Interview Survey (NHIS) showed that only 65 percent of women aged 18 years and older reported having received a Pap test within the past three years. As with mammography screening, this proportion was lower for racial and ethnic minority women, for women who had less than a high school education, for women who were over age 75 years, and for women who had low incomes.

Attachment 1

AR-1

Human Subjects Requirements

If a project involves research on human subjects, assurance (in accordance with Department of Health and Human Services Regulations, 45 CFR Part 46) of the protection of human subjects is required.

In addition to other applicable committees, Indian Health Service (IHS) institutional review committees also must review the project if any component of IHS will be involved with or will support the research. If any American Indian community is involved, its tribal government must also approve that portion of the project applicable to it.

Unless the grantee holds a Multiple Project Assurance, a Single Project Assurance is required, as well as an assurance for each subcontractor or cooperating institution that has immediate responsibility for human subjects.

The Office for Protection from Research Risks (OPRR) at the National Institutes of Health (NIH) negotiates assurances for all activities involving human subjects that are supported by the Department of Health and Human Services.

AR-2

Requirements for Inclusion of Women and Racial and Ethnic Minorities in Research

It is the policy of the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) to ensure that individuals of both sexes and the various racial and ethnic groups will be included in CDC/ATSDR-supported research projects involving human subjects, whenever feasible and appropriate. Racial and ethnic groups are those defined in OMB Directive No. 15 and include American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander. Applicants shall ensure that women, racial and ethnic minority populations are appropriately represented in applications for research involving human subjects. Where clear and compelling rationale exist that inclusion is inappropriate or not feasible, this situation

must be explained as part of the application. This policy does not apply to research studies when the investigator cannot control the race, ethnicity, and/or sex of subjects. Further guidance to this policy is contained in the Federal Register, Vol. 60, No. 179, pages 47947-47951, and dated Friday, September 15, 1995.

AR-7

Executive Order 12372 Review

Applications are subject to Intergovernmental Review of Federal Programs, as governed by Executive Order (E.O.) 12372. The order sets up a system for State and local governmental review of proposed Federal assistance applications. Applicants should contact their State single point of contact (SPOC) as early as possible to alert the SPOC to prospective applications and to receive instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC for each State affected. (The application kit contains a current list of SPOCs.) SPOCs who have recommendations about the State process for applications submitted to CDC should send them, in a document bearing the program announcement number, no more than 60 days after the application deadline date, to:

Nealean K. Austin, Grants Management Specialist
Grants Management Branch, Procurement and Grants Office
Announcement Number 99052
Centers for Disease Control and Prevention, Room 3000
2920 Brandywine Road
Atlanta, GA 30341

Indian tribes must request tribal government review of their applications.

If Indian tribes are eligible for the program, change the sentence about SPOC recommendations as follows:

SPOCs or tribal governments that have recommendations about an application submitted to CDC should send them, in a document bearing the program announcement number, no more than 60 days after the application deadline date, to:

Nealean K. Austin, Grants Management Specialist
Grants Management Branch, Procurement and Grants Office
Announcement Number 99052
Centers for Disease Control and Prevention, Room 3000
2920 Brandywine Road
Atlanta, GA 30341

CDC does not guarantee to accept or justify its nonacceptance of recommendations that are received more than 60 days after the application deadline.

AR-9

Paperwork Reduction Act Requirements

Projects that involve data collection from 10 or more persons and that are funded by grants and cooperative agreements will be subject to review and approval by the Office of Management and Budget (OMB).

AR-10

Smoke-Free Workplace Requirements

CDC strongly encourages all recipients to provide a smoke-free workplace and to promote abstinence from all tobacco products. Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities that receive Federal funds in which education, library, day care, health care, or early childhood development services are provided to children.

AR-11

Healthy People 2000

CDC is committed to achieving the health promotion and disease prevention objectives of "Healthy People 2000," a national activity to reduce morbidity and mortality and improve the quality of life. For a copy of "Healthy People 2000" (Full Report: Stock No. 017-001-00474-0) or "Healthy People 2000" (Summary Report: Stock No. 017-001-00473-1), write or call:

Superintendent of Documents

Government Printing Office

Washington, DC 20402-9325

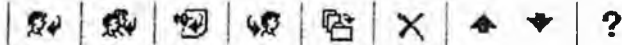
Telephone (202) 512-1800

AR-12

Lobbying Restrictions

Applicants should be aware of restrictions on the use of HHS funds for lobbying of Federal or State legislative bodies. Under the provisions of 31 U.S.C. Section 1352 (which has been in effect since December 23, 1989), recipients (and their subtier contractors) are prohibited from using appropriated Federal funds (other than profits from a Federal contract) for lobbying congress or any Federal agency in connection with the award of a particular contract, grant, cooperative agreement, or loan. This includes grants/cooperative agreements that, in whole or in part, involve conferences for which Federal funds cannot be used directly or indirectly to encourage participants to lobby or to instruct participants on how to lobby.

In addition, the FY 1998 Department of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act (Public Law 105-78) states in Section 503 (a) and (b) that no part of any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress or any State legislature, except in presentation to the Congress or any State legislature itself. No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.



Close

From: Gore, Anne M
 To: Diven, Mary R
 Cc:
 Subject: FW: BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000
 Sent: 3/29/01 9:29 AM
 Importance: Normal

**Received Thursday
 3/29/01 from HCFA/CDC**

HCFA/CDC - frequently asked questions/answers

---Original Message---


From: NCCD/DCPC Cancer Inquiries [SMTP:nccdcpcinfo@cdc.gov]
 Sent: Thursday, March 29, 2001 9:14 AM

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

Cc: Reynolds, Steven L.

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

- > BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000
- >
- > On January 4, 2000, the Health Care Financing Administration (HCFA)
- > provided initial guidance to State Health Officials to assist with
- > implementing the provisions of the Breast and Cervical Cancer Prevention
- > and Treatment Act (BCCPTA). The new option allows states to provide full
- > Medicaid benefits to uninsured women under age 65 who are identified
- > through the Centers for Disease Control and Prevention's (CDC) National
- > Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in
- > need of treatment for breast or cervical cancer, including pre-cancerous
- > conditions and early stage cancer.
- >
- > In the attached document you will find a series of frequently asked
- > questions and answers about the treatment act. HCFA and CDC will release
- > additional guidance as needed and as it becomes available. Please contact
- > your program consultant, Cindy French, or Steve Reynolds with any
- > questions.
- >
- > For more information, visit our Web site at:
- > <http://www.cdc.gov/cancer/nbccedp/law106-354.htm>
- >
- > <<Medicaid CDC final fnrv1strdBCQA.doc>>
- >

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

BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000

On January 4, 2000, the Health Care Financing Administration (HCFA) provided initial guidance to State Health Officials to assist with implementing the provisions of the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). The new option allows states to provide full Medicaid benefits to uninsured women under age 65 who are identified through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer.

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

ELIGIBILITY

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

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

1. The woman must have been screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service (PHS) Act, and found to need treatment for either breast or cervical cancer (including a precancerous condition);
2. She does not otherwise have creditable coverage, as the term is used under the Health Insurance Portability and Accountability Act (HIPAA) (§2701(c) of the PHS Act (42 U.S.C. 300gg(c)); and she must not be described in any of the mandatory Medicaid categorically needy eligibility groups; and
3. She is under age 65. (As mandated by PL 106-354.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Answer.

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

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

2. Women who are screened under a state Breast and Cervical Cancer Early Detection Program in which their particular clinical service was not paid for by CDC Title XV funds, but the service was rendered by a provider and/or an entity funded at least in part by CDC Title XV funds, and the service was within the scope of a grant, sub-grant or contract under that state

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

3. Women who are screened by any other provider and/or entity and the CDC Title XV grantee has elected to include screening activities by that provider as screening activities pursuant to CDC Title XV. For example, if a family planning or community health center provides breast or cervical cancer screening or diagnostic services to low-income women, but does not receive funds from the CDC Title XV grantee to support these services, the CDC Title XV grantee would have the option of including these providers' screening activities as part of their overall screening program. The CDC Title XV grantee may require any provider deemed part of the overall screening program to follow program guidelines.

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

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

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

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

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

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

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

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

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

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

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

ELIGIBILITY PERIOD

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

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

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

Answer. A woman's eligibility for coverage under this new option begins up to three months prior to the month in which she applied for Medicaid, if as of this earlier date, she would have met relevant eligibility requirements under the state plan (including having been screened and diagnosed).

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

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

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

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

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

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

COVERAGE

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

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

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

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

Question 19. May a state cover experimental treatments?

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

PRESUMPTIVE ELIGIBILITY

Question 20. What is presumptive eligibility?

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

cancer. Election of presumptive eligibility provides states the opportunity to offer immediate health care coverage to women likely to be Medicaid eligible, before there has been a full Medicaid eligibility determination.

Question 21. Is presumptive eligibility mandatory for this group?

Answer. No. Presumptive eligibility is a state option.

Question 22. When does presumptive eligibility begin?

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

Question 23. When does presumptive eligibility end?

Answer. Presumptive eligibility ends on the earlier of the following two dates: the date on which a formal determination is made on the woman's application for Medicaid; or, in the case of a woman who fails to apply for Medicaid following the presumptive eligibility determination, the last day of the month following the month in which presumptive eligibility begins.

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

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

Answer. State Medicaid agencies can certify entities that are eligible for payments under the state's Medicaid program that the state determines are capable of making presumptive eligibility determinations. A certified entity can enroll women who appear to be eligible in Medicaid on a temporary basis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CITIZENSHIP AND ALIENAGE

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

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

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

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

Women who do not meet the immigration-related eligibility criteria may still be able to receive Medicaid coverage related to an "emergency condition", other than services related to an organ transplant. Section 1903(v) of the Act permits states to obtain federal match for services related to an "emergency medical condition" when furnished to an otherwise eligible individual.

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

Answer. The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (A) placing the patient's health in serious jeopardy; (B) serious impairment of bodily functions, or (C) serious dysfunction of any bodily part.

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

Answer. Breast or cervical cancers may be identified at various stages. Some women in need of treatment for breast or cervical cancer will have an emergency condition. As with other examples of emergency medical conditions, medical judgement and the facts of a particular case will form the basis for identifying those conditions in screened women that amount to an emergency medical condition.

TREATMENT OF TERRITORIES

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

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

TREATMENT OF AMERICAN INDIAN AND ALASKA NATIVE (AI/AN)WOMEN

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

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

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

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

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

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

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

FEDERAL FINANCIAL PARTICIPATION

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

Answer. The federal matching rate for the new eligibility group is equal to the enhanced federal medical assistance percentage (FMAP) used in the State Children's Health Insurance Program (SCHIP) (described in §2105(b) of the Act. That rate is published annually in the Federal Register, and is posted on the web site at <http://aspe.os.dhhs.gov/health/fmap.htm>.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPLICATION AND ENROLLMENT

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

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

Question 49. Must there be a written application?

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

Question 50. How quickly must the application be processed?

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

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

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

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

GENERAL STATE IMPLEMENTATION

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICAID SERVICES AND GROUPS NOT IN CURRENT STATE LAW

OPTIONAL SERVICES

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

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

OPTIONAL GROUPS

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

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

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



Alaska State Legislature

Please enter into the record my testimony to the SENATE HESS
committee name
 committee on SB38, dated 4/30/01
bill/subject

Testimony for SB38

I support the passage of SB38. To go even further, I support implementation of insurance for every resident in this state equivalent to that of elected officials. I would think there could be some option for people to buy in to a program with their permanent fund dividends to allow this.

In my previous employment with this state, people frequently came to the LIO office seeking financial assistance for their medical bills. These people had worked their whole lives at jobs without insurance. They had worked hard and saved their money. They had acquired a home and, in some cases, other possessions which made them ineligible for public assistance. I know of one case, in Wasilla, a woman had to chose between making her house payments or purchasing her prescriptions drugs, costing \$600 per month, to prolong her life while she suffered from breast cancer. She choose the house payment and death.

Cancer has certainly touched each one of your lives and you know how costly it can be. My mother, a small business owner, was able to purchase and pay for her own insurance. She had cervical cancer and died from pancreatic cancer. There were still many bills due to the illness. My daughter, on the other hand, has been a practicing alcoholic for the majority of her adult life. She has been diagnosed with a tumor in her cervix that has

Signed: Mary A. Fureheim
Testifier

leg
Representing (Optional)

1001 E. PULLMAN, WASILLA 99654
Address

(907) 316-5742
Phone No.



Alaska State Legislature

PAGE 2

Please enter into the record my testimony to the SENATE HESS
 committee name
 committee on SB 38 , dated 4/30/01
 bill/subject

invaded her bladder. I am very grateful she is eligible for state assistance. Even though she chose to live in this manner and acquired nothing she receives excellent medical assistance. In response to a statement from a member of the Senate HESS committee, my mother had two sexual partners in her life, the man who raped her at 14 and my father and did not smoke. My daughter has been with the same man for 11 years. My hope is the senator will check factual data regarding this disease before making such statements in the future.

But, what about the Alaskan with no insurance? They are forced to liquidate assets as well as suffer through a physical and emotional trauma.

I do not ask you on the Senate HESS committee to vote for this bill. I simply request you vote to move it out of committee. Put a do not pass on it if it is objectionable to you but please move it forward to give these people who are affected by this legislation a chance. Thank you.

Signed: Mary O. Gustafson
 Testifier

 Representing (Optional)

 Address

 Phone No.

To Alaska State Legislature

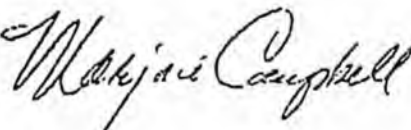
Re: SB 38 and HB 65

I am a retired State of Alaska public servant and, like hundreds of other Alaskan employees both past and present, including past and present elected officials, I enjoy the privilege and security of having health insurance. Next month I have an appointment for a mammogram and a pap test. But if I were one of the many woman in Alaska who have no health insurance and no financial reserves to cover large unexpected medical expenses I probably would not even have bothered to make an appointment for screening knowing that if the results were bad there would be nothing I could do about it.

On April 23 I watched Senator Green try to dismiss this bill as quickly as possible. She said she didn't understand why breast and cervical cancer should be selected out from a host of other illnesses for follow-up care. I have no objections to Senator Green expanding the list of illnesses to be covered, but in the meantime for about the same price it costs us to keep a senator in Juneau we could begin to make sense of the screening program by providing necessary follow-up for the needy. And the reason breast and cervical cancer has been specified in this bill is because the \$585,000 offered by the federal government was not designated to be used for a triple bypass. Senator Green said she was not without a heart, but if she fails to support this bill it will reflect an unconscionable partisan political act.

Also on April 23 I was disturbed by the inference of Senator Leman that perhaps cervical cancer should not be covered because a few of these cases of cancer might be the result of the persons behavior. He preferred to spend the money on education. Education is good and if 100% effective would eliminate most of our behavior related costly diseases such as lung cancer, diabetes and heart disease. In the meantime I hope we are living in a country where we strive to act in a humane and caring way. Senator Leman also said that to his knowledge follow-up treatment was already available to everybody in Alaska. This is not true. Emergency room treatment is available to everybody but that is quite different than someone looking for recommended follow-up care after being told their screening results are suspicious of cancer. Because the cost to the State is only \$175,000 I sincerely hope that this bill will receive that humane and caring support.

Marjorie Campbell
4365 Wickersham Way
Wasilla, Ak. 99654



Tel: 376-5437
E-mail: marji@matnet.com

Senator Lyda Green
Alaska State Senate
Juneau, Alaska

Dear Ms. Green,

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

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

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

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

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

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

Sincerely,



Sue Oliphant
2155 Fritz Cove Road
Juneau, AK 99801

(907) 789-1384
suesandy@AK.net

Testimony of Kathleen A Coleman
April 27, 2001

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

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

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

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

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

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

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

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

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

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

April 22, 2001

Senate HESS Committee
State Capitol
Juneau, AK. 99801

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

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

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

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

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

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

Sincerely,


Carla Williams

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

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

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

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

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

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

Income and Expenses Summary

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

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

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

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

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

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

April 2, 2001

Senator Green
HESS Committee
State Capitol, Room 125
Juneau, AK 99801-1182

Dear Senator Green:

This letter is in regards to Diana Marie Craig, who worked with many of you in the 20th Alaska State Legislature. In writing to you, I am carrying out her wishes. You see, at age 28, on July 8, 2000, Diana died of Cervical Cancer. If she were alive today, she would have been sitting there with you discussing SB 38/HB65, regarding Medical Assistance for Breast/Cervical Cancer.

On February 22, 2001, the Alaska Legislature awarded Diana an honorary citation for her years of involvement in the State and Federal Senate as well as her other life accomplishments. Diana was a promising public servant, teacher, debate coach and more. She was an upstanding citizen, loving daughter, granddaughter, and friend. Because there was no an Early Detection Program, she died of undiagnosed cervical cancer.

In short, I think by sharing her story you will agree that her death is a direct result of the lack of a state medical system for the uninsured.

In 1999, at the end of her University career, she began having female problems. She sought treatment through "school insurance" at a university health center in Oregon. It was there that the false diagnosis started. The Health Center reassured her the cramping and bleeding, was nothing more than stress and sent her away with Advil. She was away from her home state, she was dealing with her father's terminal cancer diagnosis, and she was in the masters program. She was to return in 3 months after the problem "corrected" itself. She graduated and with degree in hand, she was ready to start her new career as a teacher. However, that problem still hadn't "corrected" itself so upon her return to Alaska, she sought out another medical institution and got a similar response. She was told because she was only 26, cancer was not a reality for her and that without proof of insurance the tests were too costly to run. No exploratory testing was done, and a Pap smear exam postponed - even though she had been bleeding constantly for many months.

They told her when she had "insurance in September, from teaching, they could do an exploratory surgery and take care of it." Waiting for insurance was too long to wait. The local health clinic told her she did not qualify for their treatment program. Diana constantly sought medical treatment for one year, but was denied due to lack of insurance.

After a year, Diana's condition became unbearable, and she had lost so much strength and blood that she could no longer walk up a flight of stairs. Eating, sleeping, walking were suddenly feats in themselves. Finally her mother's physician, as a favor, saw her and allowed her to pay for an appointment without proof of insurance. Upon obtaining her medical history, he immediately did a full exam. He immediately referred her to an emergency room where she would be met by a gynecologist. What he found was horrendous: 25 & 18-cm tumors on each ovary. She told him she did not have insurance, and he thanked her for her honesty. This issue had to be addressed. It was now an emergency situation.

Diana died because she didn't have insurance and because the providers who saw her thought of money before they did her life. Repeatedly, they told her when she had insurance, they would do exploratory testing. They knew exploratory testing was needed! They even stated early on "There is a slight possibility for the tumors to be malignant."

Studies show cervical cancer can be prevented if caught in the early stages. Diana's could have been diagnosed in the early stages FOUR TIMES:

- September 1999 University Health Center (Oregon)
- January 1999 University Health Center (Oregon)
- May 1999 Non-Profit Health Clinic (Alaska)
- June 1999 Private Hospital Clinic (Alaska)

Four times she was told she was too young and because she did not have insurance they would not run any tests. Without insurance, they were hesitant to give her basic medical care, much less do exploratory surgery. One provider even told her, "You don't want the financial burden of the debt from the surgery..."

Death is not an option. This is why SB 38 must pass. Diana asked us to make sure other young women do not have to suffer like she did. This is why we are writing you and it is why we support SB 38. People do not have insurance for a lot of different reasons. Not all people seeking assistance are the "stereotypical" recipient living off the system waiting for someone to take care of them. Diana was not. Diana graduated from college with little, if any debt. She was financially responsible. She was striving to be a better person, she had just started her own business, and was just starting out in her career as a teacher. This was a transitional phase. This should not cost her life.

Had a program been in place to pay for exploratory testing on her first, second, or third visit, Diana might be alive today. This would have given us (her family & friends) options to raise money... and time TO SAVE our friend.

Please support SB38/HB65 for early detection of breast and cervical cancer.

If anyone would like to discuss this issue further please contact me at (907) 360-9953 or at plimpton@chugach.net. More information can be found at www.dianamcraig.org

Sincerely,

Michelle Plimpton

Also Signing this letter:

Victoria Shaver, Anchorage Alaska
Andy & Peggy Ammann, Anchorage Alaska,
Marie Barker, Anchorage Alaska
Rosie Stauffer, Anchorage Alaska
Janet Craig, Anchorage Alaska
Nicole Sweeney, Anchorage Alaska
Erica Reinikka, Seattle Washington
Steven & Mary Craig, Anchorage Alaska
Tony & Anita Fleming, Anchorage Alaska
Maybelle Benedict, Chickaloon Alaska
Amy Hanable, Tualatin Oregon
Michelle Hansberry Keizer Oregon
Ranada Young, Salem Oregon
Ray & Linda Craig, Palmer Alaska
Rita Reinikka, Anchorage Alaska

Daniel Wilman, Anchorage, Alaska
Scott & Terry Sliter, Eagle River, Alaska
Loanna Haseltine, Paris France
Linda Plimpton, Anchorage Alaska
Aaron Sweeney, Anchorage Alaska
Jennifer Reynolds, San Francisco CA
Danielle Plimpton, Anchorage Alaska
Cari Craig, Palmer Alaska
Paulette Farmer, Anchorage Alaska
Vicky & Robert Shaver, Anchorage Alaska
Cy & Lilly Plimpton, Anchorage Alaska
Joanne & Eric Reinikka, Federal Way WA
Erin Reinikka, Seattle Washington
Tristan Allen, Anchorage Alaska
Jennifer Snyder, Anchorage Alaska
Diana's Friends

Cc.

Pete Kelly
Loren Leman
Jerry Ward
Bettye Davis
Alan Austerman
John Cowdery
Dave Donley
Johnny Ellis
Kim Elton
Rick Halford
Lyman Hoffman
Pete Kelly
Georgianna Lincoln
Donald Olson
Drue Pearce
Randy Phillips
Robin Taylor
Gene Therriault
John Torgerson
Gary Wilken

Diana Craig's Brief Medical Timeline:

1998

- September Noticed first abnormal menstruation. Monthly cycle did not stop.
- October Made appointment at University Health Center (In Oregon). Diagnosis: Stress [Dealing with her Father's Terminal Cancer Diagnosis, Being away from home in Alaska, and being in the Masters Program] They were not able to do vaginal exam/pap – due to blood. Take Advil for cramping. Come back in 3 Months.

1999

- January Appointment with the same health center at the University. They told her bleeding was normal in individuals under stress.
- February Bleeding had not stopped. Noted heavier cramping and golf ball size clots. Returned for a brief visit to AK for Grandmas 80th, birthday. Family noticed a problem.
- May Returned to Alaska with degree & teaching certification. Went to Anchorage Non-Profit health clinic for further treatment- Told she did not qualify for their program.
- June Sought treatment at a local hospital clinic (Alaska), by a nurse practitioner who never referred her to an actual physician. Told she could not do an exam. Told she could possibly have tumors. The Nurse Practitioner agreed that it was likely that it could be stress causing the bleeding or fibroid tumors.
- July (1st Wk) It was recommended that she have a sonogram but Diana did not have enough money up front. She was having a hard time moving around, walking up stairs, driving a car and remembering things. Physically failing each week.
- July (2nd Wk) Hormone treatment. A lot of Iron to replace blood loss. The nurse practitioner did say she was highly anemic. She suggested exploratory surgery if she could afford it, but could also do hormone therapy until September when she would possibly have a teaching position and therefore health insurance. Family & Friends begged her to seek different opinion.
- August 3rd First visit with actual physician and first vaginal exam. She almost passed out: Blood loss overwhelming. Physician responded: how were these tumors missed? Option: go to emergency room now. Gynecologist: examined, tested and determined the cancer had Metastasized. At that point they could not do surgery yet due to the need for multiple blood transfusions. (The physician wondered how she survived this long on a "half a tank" of blood. He said if the cancer didn't kill her, the organ failure would have!) Her body was carrying the tumors as a pregnancy and the uterus was trying to deliver the masses inside the body along with massive blood loss.
- August 5th 1 year after symptoms and countless attempts to receive medical care Diana severed the "perceived financial ties" to her family and liquidated her meager savings. Which opened the door to Medicaid and the University of Washington medical team; of surgeons to perform a 5-hour surgery to remove the 18 & 25 cm. tumors found on each ovary and perform a partial hysterectomy while removing massive Ascites fluid. Prognosis: Quality of Life. Nothing more could be done.
- August 6th Very forgiving, positive and vowed to make it a good fight! Up and walking.
- August 7th Emergency procedures done to remove blood clots in lungs.

Shunt funneled into vein in arm, up to neck over into heart.

August 10th First Round Chemo Treatment: Allergic reaction. Nursing team did not believe she had Anaphylactic shock.

September Chemo in Anchorage every 3 weeks. Going well No problems to report.

2000

January Second procedure to relieve veins in arms, port-a-catheter inserted into chest.

February(2nd Wk)Change in chemo side effects. Uncontrollable vomiting daily, so she made an appointment with her oncologist. He reassured her she was fine. The constant pain was in her head. He could look into some more treatments or getting her to U of W around the third week of the month. After two weeks of vomiting she could no longer wait and called University of Washington. Her surgeon sent for her immediately. Vomiting for more than 24 hrs was ABNORMAL she was to come immediately. At this point she was no longer vomiting stomach bile, she was vomiting feces and other abnormal vile fluids. Which would explain the sight and smell.

February (3rd Wk)Emergency visit. Cat scan. Showed Tumor had been growing and intestine and bowels closed shut. Colostomy performed. Diagnosis: The Oncologist in Anchorage waited too long to assist her and now there was nothing they could do. Tumor spread to other distant regions. Constant pain.

March Started new chemotherapy; her body had grown resistant to the chemicals. New chemo didn't work.

March Chemotherapy Drug Taxol splashed into her eyes. Nurse did not follow procedures and bag burst open.

May Growing weaker, not able to eat much. Sleeping mostly. Constant Pain

June Constant pain, increased medicine, increased sleep, change in personality.

June 28 Kidney failure & Abnormally low blood pressure. Delusions

July 3rd Emergency room, complete organ failure. Delusions

July 8th Died

Subject: SB 38/Senate HESS hearing

Date: Mon, 23 Apr 2001 10:25:21 -0000

From: "Anne Gore" <agore@gci.net>

To: <Senator_Bettye_Davis@legis.state.ak.us>

Dear Senator Davis -

I write to you today not as a constituent (I live in west Anchorage) but as a woman concerned about breast & cervical cancer in Alaska.

SB 38 - the Breast & Cervical Cancer Treatment bill will be heard today in Senate HESS. I know that this bill has strong opposition by many members of this committee, but knowing your sound and strong record of support for women and children, I plead with you today to be a "voice of reason" for this bill. Please do what you can to move this bill from HESS so that it can continue to be heard elsewhere in the Senate.

A few facts about the bill:

Eleven years ago, George Bush Senior signed into law the Breast & Cervical Cancer Mortality Act of 1990. This bill provided (and continues to provide) funding to the Centers for Disease Control and Prevention which in turn provides the oversight to individual states and their breast & cervical cancer screening efforts. 2001 now finds every state in the Union with a Breast & Cervical Cancer Early Detection Program, in addition, there are 6 US Territories and 12 Tribal Grantees funded (3 of which are in Alaska).

The goal of the National Breast & Cervical Cancer Early Detection program is to reach out to medically underserved women and provide Pap tests, pelvic exams clinical breast exams, and mammograms to women at no cost. Women of low income and women of racial and ethnic minority are the target populations for this screening program, as they have the highest morbidity and mortality rates from these diseases.

The State of Alaska has had its Breast & Cervical Early Detection Program (called "Breast & Cervical Health Check") in place since 1995. Since that time over 11,000 individual women have been screened for cancer by BCHC, over 17,000 Pap tests have been provided and over 8,000 mammograms to women in throughout the state who might have otherwise gone without these life saving early detection services.

However, the program is not perfect, at the state, or national level. Recognizing that, Congress passed, and Bill Clinton signed into law the "Breast and Cervical Cancer Treatment Act of 2000." This important piece of legislation recognized that screening and diagnosis of cancer was not enough. Without providing treatment to the women it screened and diagnosed, the original legislation passed in 1990 was incomplete. The Breast & Cervical Cancer Treatment Act of 2000 was passed **unanimously** by the US Senate, and by a vote of 421-1 in the House. The reason the bill enjoyed such support was for the reason stated above: the original legislation was incomplete. Many argued in the House and Senate that "we were setting ourselves up to now have to cover medical costs body part-by-body part. If breast and cervical cancer today, then Alzheimers tomorrow, and lung cancer the next day." The fact remains however, that breast cancer is a leading cause of death in American women, cervical cancer is nearly curable when detected early, and both cancers are relatively easy, and inexpensive to detect. That is why the original legislation was passed in 1990! There are **NO** other federally funded cancer screening programs in the United States.

I recently heard one of your colleagues in the House ask the same question that had been voiced during the national debates "Well, if we pay for breast cancer today, will we have to pay for lung cancer when the tobacco advocates come knocking?" The answer is NO. Again, there are no other screening and diagnosis programs in the United States that have federal financial support and oversight like the National Breast & Cervical Cancer Early Detection Program.

In Alaska, passage of this legislation means that 42 women, screened and diagnosed with cancer by the State of Alaska's Breast & Cervical Cancer Early Detection Program would have access to treatment for their cancer. There is a 70/30 federal/state split, our cost would be only \$170,000.

I urge you to move this bill out of HESS today. Even if it moves out with a "No Rec" it is still moving, and will give others the chance to hear, and speak to it in other committees.

Thank you for your time, and attention to this bill. Thank you for your continual championing of causes for Alaska's women.

Best regards,

Anne Gore

p.s. I wish I could testify on this bill. However I work for the Dept. of Health and Social Services and it would be a conflict of interest. I'm writing to you today on my day off, as a private citizen.

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Best regards,

Anne Gore

p.s. I wish I could testify on this bill. However I work for the Dept. of Health and Social Services and it would be a conflict of interest. I'm writing to you today on my day off, as a private citizen.

TOTAL NUMBER OF STATES AT:

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

(Still a few missing, mainly US Territories)

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

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

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

² No income eligibility for Native American women living on reservations

³ Legislature may require them to drop to 200% in order to include treatment

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

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

**Correspondence
in Support of
Senate Bill 38**

Submitted by Senator Bettye Davis
Senate HESS
April 23, 2001

Elizabeth Balstad

8451 valley Blvd. Apt. B
Juneau, Alaska 99801
907-790-2374
ewebetcha@gci.net

April 23, 2001

Dear Senate Member,

I was recently sent an e-mail asking me to express my support of senate bill 38, providing care funds for breast and cervical cancer patients. I certainly support the efforts of the USA on behalf of people who can not afford insurance.

I will go one step further, to tell you I am a licensed insurance agent in Alaska. While I do not sell life/health policies currently, I am working towards an additional licensing in this area.

You may find it interesting to know that as a former resident of Minnesota, I am appaled at the lack of legislation supporting that insurance companies provied as mandatory coverage immunizations for children, and annual or rated every 5 year exams for cancer screenings for men and women. These coverages are mandated in states such as Minnesota, where we lived one year ago in April of 2000.

Also, just an FYI, the poverty level is a joke. Unless you are single and can live in a tent, no one can live on what is called poverty level. To provide care to women who meet a guideline such as 250% under the poverty level is riduclous.

There are many women out there living by barely making ends meet and supporting children that men have refused to support. The inability of our system to help these people leaves these children in jepordy.

I am hardly a "bleeding heart liberal", but I do feel that our system as a whole should work better. It would be nice to see our leaders working together for the benefit of all instead of the "me first" or "I will if you'll do this" attitude.

Bottom line: Please support bill # 38.

Thank you,

Liz Balstad

Sincerely,

Signature

Subject: Support of SB38

Date: Thu, 29 Mar 2001 15:56:56 -0900

From: Kattaryna Stiles <swingkatt@alaska.com>

Please support SB38 to help women with breast and cervical cancer. It's the right thing to do. Your conscience will thank you and so will I.

Kattaryna Stiles

Subject: priority1a-2001 Form Results

Date: Sat, 31 Mar 2001 00:32:28 -0600

From: form_engine@formsite.com

To: Senator_Bettye_Davis@legis.state.ak.us

Dear Senator,

I support SB38, the Breast and Cervical Cancer Treatment Bill, and I urge you to convince your colleagues in the HESS Committee to pass this legislation out of committee.: This is an important issue. Please pay attention. Your sisters, mothers, daughters, grandmothers -- and constituents -- are counting on you.

Name: Billie Johnston
Mailing Address: 3443 Wiley Post Lp. S.
City: Anchorage
My Alaska Zip Code: 99517
My Email Address: djohnston@gci.net

Click the link below to view results in original form

<http://www.formsite.com/app/FormSite?FormId=ESR&ResultNbr=1140891&UserNbr=38235&FormNbr=1140891>

SECURE LINK: Click the secure link below to view results in original form

<https://www.formsite.com/app/FormSite?FormId=ESR&ResultNbr=1140891&UserNbr=38235&FormNbr=1140891>

FormSite.com RELEASES NEW VERSION 3/23/01

Major features include:

- 1.) help text can be specified for each question. A "?" icon is placed next to the question and when clicked pops up a window with your additional help text in it.
- 2.) The width, in columns, can now be specified for the "grid" presentation of radio/check questions. The default is 6 columns which can now be overridden.
- 3.) We now accept American Express in addition to Visa and Master card.
- 4.) Major look and feel changes to the site. If you have comments on the latest features email them to randy@formsite.com

Check out the FormSite.com Staff Freebie picks:

<http://www.formsite.com/forms/freestuff.html>

#####

Subject: SB 38 & HB 65

Date: Mon, 02 Apr 2001 11:16:50 -0800

From: "Mary Menne" <MaryM@apiai.com>

To: <Senator_Bettye_Davis@legis.state.ak.us>, <Senator_Gary_Wilken@legis.state.ak.us>, <Senator_Jerry_Ward@legis.state.ak.us>, <Senator_Loren_Leman@legis.state.ak.us>

Dear Senators -

This e-mail is in support of SB 38 & HB 65 to help women with breast and/or cervical cancer.

As a 13 year survivor of breast cancer, I have had to opportunity to offer encouragement and support to persons that have been diagnosed with breast cancer and were without medical insurance. Thus, their choices to live or die should not be dependent upon any given financial situation. The best medical care should be available to all, regardless of their insurance/financial status.

Thank you for listening.

One of the survivors, Mary L. Menne

Subject: priority1a-2001 Form Results
Date: Mon, 2 Apr 2001 18:27:28 -0500
From: form_engine@formsite.com
To: Senator_Bettye_Davis@legis.state.ak.us

Dear Senator,

I support SB38, the Breast and Cervical Cancer Treatment Bill, and I urge you to convince your colleagues in the HESS Committee to pass this legislation out of committee.:

Name: Rosemary A> Tucker
Mailing Address: 2807 Aspen Drive
City: Anchorage
My Alaska Zip Code: 99517
My Email Address: rtucker@anhc.org

Click the link below to view results in original form

<http://www.formsite.com/app/FormSite?FormId=ESR&ResultNbr=1146657&UserNbr=38235&FormNbr=1146657>

SECURE LINK: Click the secure link below to view results in original form

<https://www.formsite.com/app/FormSite?FormId=ESR&ResultNbr=1146657&UserNbr=38235&FormNbr=1146657>

FormSite.com RELEASES NEW VERSION 3/23/01

Major features include:

- 1.) help text can be specified for each question. A "?" icon is placed next to the question and when clicked pops up a window with your additional help text in it.
- 2.) The width, in columns, can now be specified for the "grid" presentation of radio/check questions. The default is 6 columns which can now be overridden.
- 3.) We now accept American Express in addition to Visa and Master card.
- 4.) Major look and feel changes to the site. If you have comments on the latest features email them to randy@formsite.com

Check out the FormSite.com Staff Freebie picks:
<http://www.formsite.com/forms/freestuff.html>

#####

Subject: POM - Public Opinion Message

Date: Mon, 2 Apr 2001 17:01:21 -0700

From: "Erica Reinikka" <Erica_Reinikka@usw.salvationarmy.org>

To: Senator_Pete_Kelly@legis.state.ak.us, Senator_Loren_Leman@legis.state.ak.us,
Senator_Jerry_Ward@legis.state.ak.us, Senator_Bettye_Davis@legis.state.ak.us,
Senator_Alán_Austerman@legis.state.ak.us, Senator_John_Cowdery@legis.state.ak.us,
Senator_Dave_Donley@legis.state.ak.us, Senator_Johnny_Ellis@legis.state.ak.us,
Senator_Kim_Elton@legis.state.ak.us, Senator_Rick_Halford@legis.state.ak.us,
Senator_Lyman_Hoffman@legis.state.ak.us, Senator_Georgianna_Lincoln@legis.state.ak.us,
senator_donald_olson@legis.state.ak.us, Senator_Drue_Pearce@legis.state.ak.us,
Senator_Randy_Phillips@legis.state.ak.us, Senator_Robin_Taylor@legis.state.ak.us,
Senator_Gene_Therriault@legis.state.ak.us, Senator_John_Torgerson@legis.state.ak.us,
Senator_Gary_Wilken@legis.state.ak.us

Good afternoon,

I support SB38, the Breast & Cervical Cancer Treatment Bill and I urge you to convince your colleagues in the HESS Committee to pass this legislation out of committee. Thank you for your support!

Kind Regards,
Erica Reinikka

Erica L. Reinikka
425 South 156th Street, Apt 233-A
Seattle, WA 98148
206-431-8327

Subject: SB 38**Date:** Tue, 3 Apr 2001 22:28:15 -0500**From:** "Plimpton, Michelle M (VECO)" <PlimptMM@bp.com>**To:** "Senator Lyda Green" <Senator_Lyda_Green@legis.state.ak.us>

CC: "Senator Loren Leman" <Senator_Loren_Leman@legis.state.ak.us>,
 "Senator Johnny Ellis" <Senator_Johnny_Ellis@legis.state.ak.us>,
 "Senator Robin Taylor" <Senator_Robin_Taylor@legis.state.ak.us>,
 "Senator Alan Austerman" <Senator_Alان_Austerman@legis.state.ak.us>,
 "Senator Kim Elton" <Senator_Kim_Elton@legis.state.ak.us>,
 "Senator John Cowdery" <Senator_John_Cowdery@legis.state.ak.us>,
 "Senator Georgianna Lincoln" <Senator_Georgianna_Lincoln@legis.state.ak.us>,
 "Senator Gene Therriault" <Senator_Gene_Therriault@legis.state.ak.us>,
 "Senator Bettye Davis" <Senator_Bettye_Davis@legis.state.ak.us>,
 "Senator Rick Halford" <Senator_Rick_Halfordn@legis.state.ak.us>,
 "Senator Donald Olson" <Senator_Donald_Olson@legis.state.ak.us>,
 "Senator John Torgerson" <Senator_John_Torgerson@legis.state.ak.us>,
 "Senator Dave Donley" <Senator_Dave_Donley@legis.state.ak.us>,
 "Senator Lyman Hoffman" <Senator_Lyman_Hoffman@legis.state.ak.us>,
 "Senator Drue Pearce" <Senator_Drue_Pearce@legis.state.ak.us>,
 "Senator Jerry Ward" <Senator_Jerry_Ward@legis.state.ak.us>,
 "Senator Pete Kelly" <Senator_Pete_Kelly@legis.state.ak.us>,
 "Senator Randy Phillips" <Senator_Randy_Phillips@legis.state.ak.us>,
 "Senator Gary Wilken" <Senator_Gary_Wilken@legis.state.ak.us>,
 "Michelle Plimpton" <plimpton@chugach.net>

Dear Senator Green:

Please read the attached letter I have written on behalf of my friend, Diana Craig. It is in regards to SB38/HB65, Medical Assistance for Breast and Cervical Cancer. I strongly urge you and other members of the Senate & HESS Committee to support this bill for early detection of breast and cervical cancer. Diana Craig died in July 2000, in part because she was unsuccessful in obtaining adequate medical care and diagnosis because she lacked health insurance.

Diana could have undeniably benefited from this type of temporary assistance program. We must realize, not everyone is blessed with a continual health insurance plan. It is in situations such as this, where temporary assistance could have made a difference between life and death. It would have allowed her family and friends time to seek alternative measures to save her life.


Thank you for your consideration of supporting SB38/HB65.

Sincerely,

Michelle Plimpton

907.762-1173 Work
 907.360-9953 Home

<<Plimpton SB 38 Letter .doc>>

 <u>Plimpton SB 38 Letter .doc</u>	Name: Plimpton SB 38 Letter .doc Type: Winword File (application/msword) Encoding: base64 Download Status: Not downloaded with message
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Subject: SB 38**Date:** Wed, 04 Apr 2001 21:00:16 -0800**From:** "Thomas K. Hunt and Sharon W. Smith" <smunt@gci.net>**To:** Senator Loren Leman <"Senator Loren Leman"@legis.state.ak.us>,
Senator Lyda Green <"Senator Lyda Green"@legis.state.ak.us>,
Senator Jerry Ward <"Senator Jerry Ward"@legis.state.ak.us>,
Senator Bettye Davis <"Senator Bettye Davis"@legis.state.ak.us>,
Senator Gary Wilken <"Senator Gary Wilken"@legis.state.ak.us>

I am a physician working with underserved, uninsured patients at the Community Health Center in Anchorage. I have diagnosed women with breast and cervical cancer using the CDC's screening program. Please pass SB 38 so that I may obtain treatment for these disadvantaged women. You know how very expensive medical care is today, and without help these women will not receive treatment. I am sure you are aware that the bulk of the money to fund this program will come from the federal government. Just stop and think how good you will feel about yourself, and your decision if you save just one of these lives! Please help me continue to care for these women who deserve medical care every bit as much as you or I do!

Thank you for your attention. I look forward to the hearing on this bill.

Sharon Smith, MD, MPH

Subject: Support SB38, HB65 adn SB15

Date: Thu, 05 Apr 2001 09:40:26 -0600

From: Deborah Craig <deborahLC@gci.net>

To: Senator_Loren_Leman@legis.state.ak.us, Senator_Jerry_Ward@legis.state.ak.us,
Senator_Bettye_Davis@legis.state.ak.us, Senator_Gary_Wilken@legis.state.ak.us,
Senator_Gene_Therriault@legis.state.ak.us, Senator_Rick_Halford@legis.state.ak.us,
Senator_Drue_Pearce@legis.state.ak.us, Senator_Randy_Phillips@legis.state.ak.us

Senator Loren Leman
Senator Jerry Ward
Senator Bettye Davis
Senator Gary Wilken
Senator Gene Therriault
Senator Bettye Davis
Senator Rick Halford
Senator Drue Pearce
Senator Randy Phillips

Dear Sirs and Madams,

I am writing to express my support for Senate Bill 38 and its companion in the House, House Bill 65, allowing Alaska to opt into Medicaid to gain federal dollars to treat uninsured women who have been diagnosed with breast or cervical cancer (diagnosed by the Center for Disease Control's screening program).

I am also writing to support Senate Bill 15, an attempt to restore some fairness in the insurance industry. It's ludicrous that we eliminate options for pregnancy termination, at the same time not supporting prevention oriented mechanisms to control family size.

Thank you,

Deborah Craig

19 Year Alaska Resident

Subject: Breast Cancer-SB 38

Date: Tue, 10 Apr 2001 06:11:40

From: "sarah scanlan" <sarahscanlan@hotmail.com>

To: Senator_Lyda_Green@legis.state.ak.us, Senator_Loren_Leman@legis.state.ak.us,
Senator_Jerry_Ward@legis.state.ak.us, Senator_Gary_Wilken@legis.state.ak.us,
Senator_Bettye_Davis@legis.state.ak.us

CC: Senator_Georgianna_Lincoln@legis.state.ak.us, Senator_Drue_Pearce@legis.state.ak.us

Chair Green, Vice Chair Leman, and Senators Ward, Wilken, and Davis,

As with many other Alaskans, I am writing to ask for your support of SB 38. There comes a point in time when good public policy is simply an issue of common sense decision making. This is clearly one of them--1 in 8 Alaskan women will be diagnosed with breast cancer, and the lives of loved ones will be saved because you will have made the right public policy decision.

I am another one of the women you are hearing from urging you to move this bill. I spent the first two months in my run for the Senate seat last summer receiving daily radiation treatments for breast cancer. I was one of the lucky ones; I had good cobra coverage. We must provide that safety net for the many other women who will be diagnosed in the coming months, and who will be grateful to you for having the foresight to set aside the \$175,000 Alaska is required to put up to match the waiting federal dollars.

This is one of those issues which should move forward without debate or deliberation, won't bankrupt our State, and for which many affected families and Alaskans will be grateful for each of you having done the right thing.

I urge you to begin increasing the public's faith in this system to do the right thing. Thank you for this opportunity to comment.

Get your FREE download of MSN Explorer at <http://explorer.msn.com>

Subject: SB 38

Date: Thu, 12 Apr 2001 13:12:41 -0800

From: "Mary Ideran" <awrc@ak.net>

To: <Senator_Betty_Davis@legis.state.ak.us>

I keep hearing wonderful things about all your hard work. I know how difficult it can be to be the lone voice on such important issues. Keep it up. Many depend on you to fight the fight! Thank you.

Mary Ideran

Executive Director

Subject: SB 38

Date: Thu, 12 Apr 2001 13:43:26 -0800

From: cms@gci.net

To: Senator_Bettye_Davis@legis.state.ak.us

Senator Davis: I wanted to thank you for your efforts regarding the breast and cervical cancer coverage. With the national and state governments efforts to push back the clock on many social issues it gives me hope that we have people such as yourself that have a world view. We need you to keep up the fight. Don't let it get you down. Good will prevail. If I can help you in any way let me know.

Charles M. Springer

PO Box 230490

Anchorage, AK 99523

THANKS

Subject: THANKS

Date: Thu, 12 Apr 2001 14:09:31 -0800

From: "Payton-Hewlett, Marjorie" <PNMAP@matsu.alaska.edu>

To: "Senator_Bettye_Davis@legis.state.ak.us" <Senator_Bettye_Davis@legis.state.ak.us>

Bettye,

Thanks for your help on SB 38. I appreciate your positive work and voice with this issue.

Marjorie A. Payton-Hewlett
Student Services Manager
Matanuska Susitna College
PO Box 2889
Palmer, Alaska 99645

<<Payton-Hewlett, Marjorie A. (E-mail).vcf>>

Payton-Hewlett, Marjorie <PNMAP@matsu.alaska.edu> Manager Student Services
--

Subject: Appreciation

Date: Thu, 12 Apr 2001 14:24:47 -0800

From: Jim Sanders <Jim_Sanders@labor.state.ak.us>

Organization: Alaska Department of Labor and Workforce Development

To: Senator_Bettye_Davis@legis.state.ak.us

Senator Davis - Thank you for your hard work on SB 38. As a husband, the father of two daughters and someone who cares about providing adequate health care for all Alaskans, thank you for fighting for this important issue. Jim Sanders

Subject: Voice of reason

Date: Thu, 12 Apr 2001 15:38:10 -0800

From: "NANCY SANDERS" <afnls@uaa.alaska.edu>

Organization: University of Alaska Anchorage School of Nursing

To: Senator_Bettye_Davis@legis.state.ak.us

Dear Representative Davis,

I am so glad you are in Juneau as one of the representatives from Anchorage. I know that you have been working hard to advocate for women who are uninsured or underinsured in the issue of getting treatment for diagnosed breast or cervical cancer. It does not make any sense that hearings on SB 38 are being blocked. Thank you for being a voice of reason and advocating for women.

Keep up the good work,

Nancy Sanders

Nancy L. Sanders, PhD, RN, CTN <afnls@uaa.alaska.edu>

Subject:

Date: Fri, 13 Apr 2001 01:42:16 +0000

From: mclain.karen@att.net

To: Senator_Bettye_Davis@legis.state.ak.us

Dear Senator Davis,

I really appreciate your efforts to try to get a hearing on SB38 for breast cancer and cervical cancer coverage. I know it can be frustrating to try to do the right thing sometimes when you come up against a brick wall.

Please keep up the good work on behalf of your constituents.

Karen McLain
Anchorage AK 99503

thanks

Subject: thanks

Date: Thu, 12 Apr 2001 21:51:57 -0800

From: "Allison Mendel" <aem@gci.net>

To: <Senator_Bettye_Davis@legis.state.ak.us>

Thank you for your continuing great work in a very hostile environment, especially on hate crimes and medicaid funding for breast and cervical cancer. Eventually the voices of reason and compassion will prevail, even if not this year.

Allison Mendel

Subject: SB 38

Date: Fri, 13 Apr 2001 06:14:36 -0800

From: "JACKIE PFLAUM" <afjsp@uaa.alaska.edu>

Organization: University of Alaska Anchorage

To: Senator_Bettye_Davis@legis.state.ak.us

thanks for all your continuing support on SB 38. I am so glad there is at least one champion in the senate HESS committee.

Subject: SB38

Date: Fri, 13 Apr 2001 09:24:29 -0700

From: Barbara_Gill/AK/ACS/US@cancer.org

To: Senator_Bettye_Davis@legis.state.ak.us

THank you for your support and efforts to move this important bill forward. We encourage all to lend their support to help get this funding for all women who qualify for current BHP programs. If any of these women are diagnosed with breast cancer today they go home to die because they have no resources for threatment.. We should be able to assist these under-served women, who are mothers and grandmothers, with screening and also a means of having the disease treated

Again, thank you.

Barbara J Gill
Community Cancer Control Manager/Quality of Life
Northwest Division, American Cancer Society, Alaska Area

Cheers to YOU!

Subject: Cheers to YOU!

Date: Fri, 13 Apr 2001 14:14:07 EDT

From: PSlisz68@aol.com

To: Senator_Bettye_Davis@legis.state.ak.us

Senator Davis:

I have been following SB 38 and I want to applaud your efforts in supporting this bill. We need people in Juneau, like you, that are persistent in their efforts to try and pass bills that make sense and are to the benefit of Alaskans. Again thank you and please keep up the good fight.

Pauline Slisz
UAA MSW Student

thank you!

Subject: thank you!

Date: Fri, 13 Apr 2001 14:06:20 -0700

From: "Katherine Davey" <Katherine.Davey@ppfa.org>

Organization: Planned Parenthood of Alaska

To: <Senator_Bettye_Davis@legis.state.ak.us>

Senator Davis,

I just want to thank you for the work you do to support women's health issues in our legislature. It seems to be a particularly hostile year and I appreciate your willingness to speak out in support of SB 38, and other legislation that supports women's health. Please know that your voice echoes the interests of many women, men and families in Alaska - people whose interests are not being served by our supermajority.

Thank you,

Katherine

Katherine L. Davey
4880 Newcastle Way
Anchorage, AK 99503
907-563-5245
Katherincinalaska@yahoo.com

Thank you

Subject: Thank you

Date: Fri, 13 Apr 2001 15:11:36 -0800

From: Bill Bear <bearair@alaska.net>

To: <Senator_Bettye_Davis@legis.state.ak.us>

Senator Davis, thank you for your efforts on behalf of women everywhere. Please continue the good fight to help the women of Alaska who don't have the means to help themselves.

Peggy Bear, Wasilla

Bear Air
PO Box 875493
Wasilla AK 99687

907 373-3373
888 430-3373
www.alaska.net/~bearair

THANK YOU!!

Subject: THANK YOU!!

Date: Fri, 13 Apr 2001 19:05:21 -0800

From: "Dale Kelley" <drkelley@alaska.net>

To: <Senator_Bettye_Davis@legis.state.ak.us>

Dear Senator Davis,

I want to thank you so very much for your fine work in support of SB 38. Your continued courage in working for women's health as well as the hate crime legislation is an inspiration to all of us who stand for justice on many levels.

I can only begin to imagine the difficult position you are repeatedly in - as well as Johnny Ellis and others - in the present political climate in Juneau. Please know that there are many of us "out here" who support your efforts and draw much hope from your efforts.

It has been a pleasure to meet you at different times in these past years - and I couldn't have been happier over your election victory.

I have worked hard with Pat Abney on her last campaigns, and have also appreciated your support with Alaskans Against the Death Penalty. I was pleased to be with you at AADP's last awards banquet, where I was grateful to receive the spiritual leadership award, along with the awards received by Gov. Knowles and several others.

On those discouraging days, please know that lots of good energy and prayers are being sent your way!

Most sincerely,

Rev (Ms) Dale Kelley

Soldotna United Methodist Church

Subject: SB 38

Date: Mon, 16 Apr 2001 09:53:48 -0800

From: "sherry koogler" <sherrill_k@hotmail.com>

To: Senator_Bettye_Davis@legis.state.ak.us

I understand that you have worked very hard in your support of SB 38. I also support this bill and find it hard to believe that Senator Green so vehemently opposes assisting poor women with breast cancer pay medical bills. Thank you for yur support on this very important matter. Sherrill Koogler MSW student

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Subject: SB 38

Date: Mon, 16 Apr 2001 14:55:28 -0500

From: "Wilson, Margaret" <mwilson@tananachiefs.org>

To: <Senator_Betty_Davis@legis.state.ak.us>

Thank you for leading the charge on SB38. As an Alaska Native woman, I am glad that there are caring people such as you who are not afraid to stand up and be counted. Please, don't waver in your stand. Margaret Wilson

Subject: SB 38

Date: Tue, 17 Apr 2001 06:23:45 -0800

From: "Marilyn Walsh Kasmar" <akpca@alaska.net>

Organization: Alaska Primary Care Association, Inc.

To: <Senator_Betty_Davis@legis.state.ak.us>

Dear Senator Davis.

I'm writing to thank you for your work on SB 38.

As you know there are many who share your concern for women who have no access to treatment once they are diagnosed with breast or cervical cancer. I can't imagine what it must be like to get that kind of news, and have no options for paying for treatment. I hope I never have to find out.

I want you to know that there are many people on many fronts who appreciate your support for this bill.

Sincerely,

Marilyn Walsh Kasmar, RNC, MBA

Executive Director

Alaska Primary Care Association

908 West Northern Lights Blvd., Suite 202

Anchorage, AK 99508

907.272.6131 phone

907.274.6131 fax

akpca@alaska.net

<http://www.alaskapca.org>

Marilyn Walsh Kasmar <akpca@alaska.net>

Alaska Primary Care Association

Subject: Sb 38

Date: Wed, 18 Apr 2001 12:28:31 -0700 (PDT)

From: Deborah Kamholz <mspygmies@yahoo.com>

To: Senator_Bettye_Davis@legis.state.ak.us

Dear Senator Davis,

Thank you so much for your help SB 38 for breast and cervical cancer coverage.

You are a Blessing to those of us supporting this bill.

Keep up the good work,

Sincerely,

Deborah Kamholz

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