ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10537 SENATE HEALTH EDUCATION & SOCIAL SERVICES

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

§ 300k. Establishment of program of grants to States

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

(1) to screen women for breast and cervical cancer as a preventive health measure;

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

(3) to develop and disseminate public information and education programs for the detection and control of breast and cervical cancer;

(4) to improve the education, training, and skills of health professionals (including allied health professionals) in the detection and control of breast and cervical cancer;

(5) to establish mechanisms through which the States can monitor the quality of screening procedures for breast and cervical cancer, including the interpretation of such procedures; and

(6) to evaluate activities conducted under paragraphs (1) through (5) through appropriate surveillance or program-monitoring activities.

(b) Grant and contract authority of States.

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

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

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

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

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

(2) is made with respect to geographic areas in which there is--

(A) a substantial rate of mortality from breast or cervical cancer; or

(B) a substantial incidence of either of such cancers.

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

§ 300l. Requirement of matching funds

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

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

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

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

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

§ 300l-1. Requirement regarding medicaid

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

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

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

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

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

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

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

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

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

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

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

§ 300n. Additional required agreements

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

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

(1) will be made according to a schedule of charges that is made available to the public;

(2) will be adjusted to reflect the income of the woman involved; and

(3) will not be imposed on any woman with an income of less than 100 percent of the official poverty line, as established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981 [42 U.S.C. § 9902(2)].

(c) Statewide provision of services.

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

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

(3) Grants to tribes and tribal organizations.

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

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

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

(1) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

(2) by an entity that provides health services on a prepaid basis.

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 300n-2. Requirement of submission of application

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

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

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

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

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

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

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

§ 300n-4. Evaluations and reports

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

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

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

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

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

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

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

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

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

(d) Funding.

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

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

§ 300n-5. Funding for general program

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

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

# ALASKA STATE LEGISLATURE

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## SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

SENATOR LYDA GREEN, CHAIR

### COMMITTEE SCHEDULE

BUTROVICH 205

1:30 PM

Monday April 23

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

Bills Previously Heard/Scheduled

Wednesday April 25

+ Confirmation Hearings

Bills Previously Heard/Scheduled

+ indicates teleconference

= indicates bill previously heard/scheduled

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

Close

Received Thursday 3/29/01 from HCFA/CDC

**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

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.; Altvater, Kirk; Alvarez-Ott, Olga; Azzam, Ihsan; Blanchard, Judi; Bradt, Ellen; Bryant, Janice; Carter, Cathey; Carver, Christine; Clover, Cathy; Conn, Shirley; Craig, BJ; Deem, Vicki; Di Orio, Dolores; Diane Narkunas; Draper, Lee, BSN - SEARHC; Dulin, Stephanie; Erb, Julie; Ertel, 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; Luebbening, 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; Pettitt, 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; Thels, Ruth; Tilley, Kimberly; Tucker, Celeste; Ueda, Masao; Uyeda, Kit; Wake, Freddie; Walkington, Deb; Wallace, Cynthia; Zitka, kathleen; Baldwin, Barbara, MA; Blake, Margo C.; Brant, Viki L., MPA; Davies-Cole, John, PhD, MPH; Dexter, Diana; Gore, Anne M., MPH; Imanil, Venancio, Jr.; Muniz, Minnie Inzer, MEd; Myers, Mary Kay; Parker, Christine, MPH; Stoodt, Georjean; Wright, Moira; Buggage, Lynn; Callaghan, Carol, MPH; Fortune, Melody; Geadelmann, Jill Myers, BS, RN; Gugel, Donna; Kenney, MPH; Lawther, Greg; Leonard, Barbara A., MPH; Madigan, Shelly D.; Minami, Colleen; Moody, Conny, MBA; Ronan, Marianne, MPA; Slater, Jonathan S., PhD; Watts, Dena L.; Woodford, Mary Lou

**Cc:** Reynolds, Steven L.

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

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

>
> Cindy French
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> Sincerely,
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> 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 physicians plan-of-care, women who are determined to require only routine monitoring services for a precancerous breast or cervical condition (e.g., breast examinations and mammograms) are not considered to need treatment.

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

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

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

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

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

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

## ELIGIBILITY PERIOD

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

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

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

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

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

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

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

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

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

**Answer.** Yes. If the recurrent metastasized cancer is either a known or presumed complication of breast or cervical cancer, and the women is still in her first period of eligibility, i.e., she is still receiving treatment for the initial breast or cervical cancer diagnosis, she would continue to be eligible for additional treatment. If, however, her first treatment period is over and her Medicaid eligibility has been terminated, she must be 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 no 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 continuos eligibility for children
Non emergent transportation within communities of residence
School based services
Tobacco cessation services
More liberal financial eligibility and coverage policies

# The National Breast and Cervical Cancer Early Detection Program

**Program Announcement 99052**

Alaska's Proposal

Project Period: 9/30/00 – 9/29/01

Submitted By:

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

## Table of Contents

OMB Approval No. 0348-0043

**APPLICATION FOR FEDERAL ASSISTANCE**

2. DATE SUBMITTED: May 26, 2000

Applicant Identifier:

1. TYPE OF SUBMISSION:
- Application: [ ] Construction [ ] Non-Construction
- Preapplication: [ ] Construction [X] Non-Construction

3. DATE RECEIVED BY STATE: March 30,2000

State Application Identifier:

4. DATE RECEIVED BY FEDERAL AGENCY:

Federal Identifier:

5. APPLICANT INFORMATION

Legal Name:
STATE OF ALASKA
Department of Health & Social Services

Organizational Unit:
Division of Public Health
Section of Maternal, Child & Family Health

Address (give city, county, state, and zip code)
1231 Gambell Street
Anchorage, AK 99501

Name and telephone number of the person to be contacted on matters involving this application (give area code)
Pam Muth, MPH, Chief
Section of Maternal, Child & Family Health (907) 269-3400

6. EMPLOYER IDENTIFICATION NUMBER (EIN): 92-6001185

7. TYPE OF APPLICANT: (enter appropriate letter in box) [A]
- A. State
- B. County
- C. Municipal
- D. Township
- E. Interstate
- F. Intermunicipal
- G. Special District
- H. Independent School District
- I. State Controlled Institution of Higher Learning
- J. Private University
- K. Indian Tribe
- L. Individual
- M. Profit Organization
- N. Other (Specify)

8. TYPE OF APPLICATION:
[ ] New [X] Continuation [ ] Revision

If Revision, enter appropriate letter(s) in box(es) [ ] [ ]
A Increase Award B Decrease Award
C Increase Duration D Decrease Duration
Other (specify)

9. NAME OF FEDERAL AGENCY:
Centers for Disease Control and Prevention

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 93-91 9

TITLE: National Breast & Cervical Cancer Early Detection Program

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Alaska Breast & Cervical Cancer Early Detection Program

12. AREAS AFFECTED BY PROJECT (cities, states, etc.):
State of Alaska

13. PROPOSED PROJECT:

| Start Date | Ending Date |
|---|---|
| 9/30/99 | 9/29/04 |

14. CONGRESSIONAL DISTRICTS OF:

| a. Applicant | b. Project |
|---|---|
| Alaska Congressional District | Alaska |

15. ESTIMATED FUNDING:

| | | |
|---|---|---|
| a. Federal | $ | 1,837,492 |
| b. Applicant | $ | 0 |
| c. State | $ | |
| d. Local | $ | |
| e Other | $ | 824,401 |
| f. Program Income | $ | 0 |
| g. TOTAL | $ | 2,661,893 |

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?
- a. YES THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON: DATE:
- b. NO [X] PROGRAM IS NOT COVERED BY E.O. 12372
- [ ] OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?
[ ] Yes If "Yes" attach an explanation. [X] No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

| a Typed Name of Authorized Representative | b Title | c Telephone Number |
|---|---|---|
| Karen Perdue | Commissioner Department of Health & Social Services | (907) 465-3030 |

Signature of Authorized Representative: [signature]

e Date Signed: 5/19/200

Previous Editions Not Usable

Standard Form 424 (REV 4-88)

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OMB Approval No. [illegible]-0044

# BUDGET INFORMATION - N -Construction Programs

## SECTION A - BUDGET SUMMARY

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

## SECTION B - BUDGET CATEGORIES

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

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## SECTION C - NON-FEDERAL RESOURCES

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

## SECTION D - FORECASTED CASH NEEDS

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

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

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

## SECTION F - OTHER BUDGET INFORMATION

(Attach additional Sheets if Necessary)

21. Direct Charges: $1,738,239

22. Indirect Charges: 16% Personnel + Fringe Benefits = $99,253

23. Remarks

# CHECKLIST

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

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

Type of Application: ☐ NEW ☒ Noncompeting Continuation ☐ Competing Continuation ☐ Supplemental

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

| | Included | NOT Applicable |
|---|---|---|
| 1. Proper Signature and Date for Item 18 on SF 424 (FACE PAGE) | ☒ | |
| 2. Human Subjects Certification, when applicable (45 CFR 46) | ☐ | ☒ |

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

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

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

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

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

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

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

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (if already assigned)

SOCIAL SECURITY NUMBER: 503-84-6465

HIGHEST DEGREE EARNED: MPH

(OVER)

## NEW OR SIGNIFICANTLY REVISED INFORMATION

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

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

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

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

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

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

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

Rescreening Operational Plan and Protocol

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

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

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

Minimum Requirements for Recalling Clients

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

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

## PROGRESS REPORT

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

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

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

B. Surveillance

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

**Age of Enrolled Women 3/95 – 9/30/99**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Partnership Development and Community Involvement

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

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

D. Professional Education.

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

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

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

E. Quality Assurance and Improvement

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

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

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

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

F. Public Education. Information and Outreach.

During this grant year the program has accomplished the following:

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

G. Screening. Referral. Tracking. Follow-Up

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

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

H. Evaluation

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

## Alaska Breast and Cervical Health Check Case Management Plan

Goal

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

Background and Assessment

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

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

Implementation

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

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

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

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

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

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

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

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

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

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

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

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

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

| | | | | |
|---|---|---|---|---|
| D. Inventory existing site case manager resources available to the program; evaluate current skill and expertise level of site case managers. | In Progress | | 7/31/00 | Program Coordinator – SCB<br>Program Consultants SSB & SH |

Goal for process of **planning**: To assure that resources are in place prior to implementing the case management system at a client level.

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

| Activities | Status | Data | Time Frame for Assessing Progress | Staff Responsible |
|---|---|---|---|---|
| A. With the estimate of the number of women at each site who will need case management, develop skills and task list for site case managers. | In Progress | CaST data | 9/1/00 | Program Coordinator – SCB<br>Clinical QA Coordinator – CK |
| B. Develop training and skills enhancement plan for each site. | In Progress | N/A | 05/01/2001 | Health Planner – MB<br>Program Coordinator – SCB |
| C. Develop protocol and program materials defining both systems level and client level accountability and reporting requirements for case management services. | In Progress | N/A | 02/01/01 & ongoing | Clinical QA Consultant – CK<br>Program Coordinator – SCB<br>Program Consultants – SSB & SH |
| Design protocols and tools to document:<br>• Needs assessment<br>• Individual case management plan<br>• Completion of case management<br>• Refusal of care<br>• Referral Form<br>• Follow-Up Form<br>• Lost to follow up<br>• Assurance of confidentiality & consent to participate in case management | In Progress | N/A | 07/11/00 & ongoing | Clinical QA Consultant – CK<br>Program Coordinator – SCB<br>Program Consultants SSB & SH |
| E. Continue to develop a marketing plan by geographic region to continue recruiting diagnostic and treatment providers | In Progress | N/A | 03/01/00 & ongoing | Pub Ed Coordinator-LS |
| F. Develop a plan for AK-BCCEDP staff to assure case management services at sites found to have inadequate resources. | In Progress | N/A | 07/11/00 | Program Coordinator –SCB<br>Clinical QA Coordinator – CK |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Overview of Cervical Cancer Operational Plan for Alaska BCHC

Background / Data Review and Assessment

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

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

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

Background / Data Review for Women Rarely or Never Screened

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

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

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

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

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

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

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

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

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

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

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

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

| | | | |
|---|---|---|---|
| a. On-going review of current program data and progress toward objectives. Plans will be revised as appropriate. | Program MDE | On-going | Program coord., Clinical nurse cons., Regional reps., Data analyst, Epidemiologist |

**Program Goal:** Implement the revised cervical cancer screening policy. Decrease over screening among enrolled women (10/01/01).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

v. 05/08/00

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

**PERSONNEL**

| | |
|---|---|
| **40% Distribution:** | **$290,943** |
| **60% Distribution:** | **$186,233** |
| **TOTAL** | **$477,176** |

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

**FRINGE BENEFITS** — **40% Distribution $87,283**
**($ Amount x .30)** — **60% Distribution $55,870**
**TOTAL $143,153**

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

**INDIRECT COST** — **40% Distribution** — **$ 99,253**
$620,329 x 16% = $99,253
The indirect rate used by the State of Alaska is approximately 16% of personnel costs and fringe benefits.

**TRAVEL**

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

**Out of State** — **(40% Distribution) Total $12,075**

| Conference/Meeting | # Personnel | $/Person/Trip | Total Cost |
|---|---|---|---|
| **Chronic Disease Conference** | 1 | $1,725 | $1,725 |

1 trip x $1,000 r/t airfare x 1 person = $1,000
5 days per diem x $42/day x 1 person = $210
4 nights lodging x $110/night x 1 person = $440
Shuttle, airport parking, mileage @ $75
One Program staff will travel to CDC sponsored Chronic Disease Conference in Atlanta, GA.

**NTC Conference** — 2 — $1,725 — $3,450
1 trip x $1,000 r/t airfare x 2 people = $2,000
5 days per diem x $42/day x 2 people = $336
4 nights lodging x $110/night x 2 people = $660
Shuttle, airport parking, mileage @ $75
Two Program staff will attend one National Training Center training as required by CDC.

**Program Directors' Meeting** — 1 (x 2trips) — $1,725 — $3,450
2 trips x $1,000 r/t airfare x 1 person = $2,000
10 days per diem x $42/day x 1 person = $420
8 nights lodging x $110/night x 1 person = $880
Shuttle, airport parking, mileage @ $75/trip
Program Coordinator will travel to lower 48 to two CDC Program Directors meetings.

**Data Managers** — 1 — $1,725 — $1,725
1 trip x $1,000 r/t airfare x 1 person = $1,000
5 days per diem x $42/day x 1 person = $210

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

| | | | |
|---|---|---|---|
| **Cancer Control Conference** | 1 | $1,725 | $1,725 |

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

| | | | |
|---|---|---|---|
| **Cervical Cancer Public Education Conference** | 1 | $1,725 | $1,725 |

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

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

| Outreach/Screening Referral/Follow-up | No. of Personnel | Cost per Person/Trip | Total Cost |
|---|---|---|---|
| **Various Locations** | 2 | $726 | $29,040 |

20 trips x $350 average r/t airfare x 2 people = $14,000
3 days per diem x $42/day x 2 people x 20 trips = $5,040
2 nights lodging x $100/night x 2 people x 20 trips = $8,000
Rental car, airport parking, etc @$50/person x 20 = $2,000
Justification
To be used by the Program Coordinator, Clinical Liaisons and Outreach personnel to enroll providers, conduct site quality assurance reviews, technical assistance and individual client case management at screening sites. Trips will require two people. New sites may require two trips during their first year of screening for the program.

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

| Patient | # Clients | $/Person/Trip | Total Cost |
|---|---|---|---|
| **Rural Areas** | 15 | $684 | $10,260 |

1 trip x $400 r/t airfare per patient x 15 patients = $6,000
2 days per diem x $42/day x per patient x 15 trips = $1,260
2 nights lodging x $100/night x per patient x 15 trips = $3,000
Justification
The Program is expanding into rural areas of the State and patient travel will be needed to obtain diagnostic services.

CONTRACTUAL

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

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

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

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

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

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

Payment to screening providers for above services.

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

Payment for case management services per case management plan.

**Outreach/Follow-up** **(40% Distribution) Total $24,000**
**(60% Distribution) Total $36,000**

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

**Medical Consultation** **(40% Distribution) Total $ 5,000**
**(60% Distribution) Total $ 5,000**

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

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

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

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

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

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

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

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

**OTHER**

| | |
|---|---|
| **40% Distribution:** | **$ 84,861** |
| **60% Distribution:** | **$ _____** |
| **TOTAL** | **$ 84,861** |

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

| Conference/Meeting | No. of Personnel | Cost per Person/Trip | Total Cost |
|---|---|---|---|
| **BCCEDP Medical Advisory Committee Meeting** | 6 | $634 | $3,804 |

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

Justification

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

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

Television/radio adds to broadcast Public Service Announcements, adds on city buses, statewide and local newspaper adds in 19 communities for outreach and public education.
Average expense = 19 Communities x $2,105 per community

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

Poster/display board for program $500

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

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

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

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

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

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

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

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

Posters, sticky pads, gift certificates $3,335

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

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

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

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

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

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

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

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

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

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

Screening Provider Teleconference
4 teleconference meetings per year x 1 hour per meeting x $200 hour = $800

1-800 Telephone Line for Client Outreach
$50 per month x 12 months = $600

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

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

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

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

Conference participation fees 2 @ $250 = $500

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

| **Total Grant 40/60 Summary** | |
|---|---|
| **40% (includes $99,253 in administrative costs)** | **$ 647,455 (35%)** |
| **60%** | **$1,190,037 (65%)** |
| **Total Request** | **$1,837,492 (100%)** |

**Unobligated Funds**

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

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

**Personnel:** $ 20,892

This represents a portion of the salaries (including benefits of the following state employees who are actively involved in this project.

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

**Equipment:** $132,249

This represents the State's cost for the computer hardware/software Necessary to conduct BCCEDP's activities and LAN support.

**Contractual:** $ 25,939

Telephone costs to support BCCEDP's activities.

**TOTAL STATE SUPPORT** $179,080

## SUMMARY OF MATCH

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

# SCREENING AND DIAGNOSTIC WORK-UP CALCULATIONS SHEET

## CALCULATIONS INPUT

| NUMBER OF WOMEN SCREENED | | AK-BCCEDP Cost of each procedure |
|---|---|---|
| New Screens: mammograms | 1,200 | |
| Subsequent mammograms | 600 | |
| Total mammograms | 1,800 | $ 67.81 |
| Number of screening CBE's | 1,800 | |
| New Screens: PAPs | 2,500 | |
| Subsequent PAPs | 2,000 | |
| Total PAPs | 4,500 | $ 14.60 |
| New office visits | 2,560 | New Pt $ 143.88 |
| Subsequent office visits | 2,250 | Established Pt $ 81.56 |
| Total office visits | 4,810 | |

ASSUMPTIONS REGARDING RATES OF ABNORMALS AND PROCEDURES

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

| Rate of each procedure following an abnormal mammogram | | Cost of each procedure |
|---|---|---|
| Diagnostic Mam (addt'l mam views) | 56% | $ 79.33 |
| Ultrasound | 31% | $ 80.35 |
| FNA | 9% | $ 97.30 |
| Biopsy (non excisional) | 9% | $ 372.89 |
| Excisional biopsy | 19% | $ 403.60 |
| Surgical consult | 30% | $ 103.23 |
| Pathology charges: breast | | $ 86.97 |

| Rate of each procedure following an abnormal CBE (with normal mam) | |
|---|---|
| Diagnostic Mam (addt'l mam views) | 33% |
| Ultrasound | 50% |
| FNA | 7% |
| Biopsy (non exc.) | 0% |
| Excisional biopsy | 7% |
| Surgical Consult | 93% |

| | | |
|---|---|---|
| Rate of each procedure following ASCUS Pap smear | | |
| Colpo-directed Biopsy | 15% | $ 117.75 |
| Colposcopy alone | 5% | $ 91.12 |
| Repeat Pap smears | 100% | $ 28.93 |
| Pathology charges: cervical | | $ 86.97 |
| Rate of each procedure following LSIL Pap smear | | |
| Colpo-directed Biuopsy | 35% | $ 117.75 |
| Colposcopy alone | 15% | $ 91.12 |
| Repeat Pap smears | 100% | $ 28.93 |
| Pathology charges: cervical | | $ 86.97 |
| Rate of each procedure following HGSIL and SqCa Pap smear | | |
| Colpo-directed Buipsy | 90% | $ 117.75 |
| Colposcopy alone | 10% | $ 91.12 |
| Repeat Pap smears | 100% | $ 28.93 |
| Pathology charges: cervical | | $ 86.97 |

CALCULATIONS USING ABOVE RATES

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

TOTAL NUMBERS AND COSTS OF SCREENING AND DIAGNOSTIC PROCEDURES

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

# Appendices

# Alaska BCCEDP CPT Codes for 2000

| DESCRIPTION OF SERVICE | CPT CODE | AK FEE 2000 | TECH-NICAL | PROFES-SIONAL |
|---|---|---|---|---|
| **CERVICAL** | | | | |
| Screening | | | | |
| Pap Smear, reported in Bethesda System | 88164 | $14.60 | | |
| *Diagnostics* | | | | |
| Pap Smear, reported in Bethesda System requiring interpretation by physician | 88141 | 28.93 | | |
| Colposcopy Biopsy Interpretation | 88305 | 86.97 | 36.90 | 50.07 |
| Colposcopy without Biopsy (surgical procedure only) | 57452 | 91.12 | | |
| Colposcopy with Biopsy and/or endocervical curettage (surgical procedure only) | 57454 | 117.75 | | |
| **OFFICE VISITS** | | | | |
| New Patient - Office Visit (10 minutes face to face) | 99201 | 46.12 | | |
| New Patient - Office Visit (20 minutes face to face) | 99202 | 71.28 | | |
| New Patient - Office Visit (30 minutes face to face) | 99203 | 99.89 | | |
| New Patient - Office Visit (45 minutes face to face) | 99204 | 143.88 | | |
| New Patient - Office Visit (60 minutes face to face) | 99205 | 177.95 | | |
| Established Patient - Office Visit (5 minutes face to face) | 99211 | 23.07 | | |
| Established Patient - Office Visit (10 minutes face to face) | 99212 | 38.82 | | |
| Established Patient - Office Visit (15 minutes face to face) | 99213 | 52.97 | | |
| Established Patient - Office Visit (25 minutes face to face) | 99214 | 81.56 | | |
| Established Patient - Office Visit (40 minutes face to face) | 99215 | 121.35 | | |
| Consultation Visit - 15 minutes face to face with patient | 99241 | 63.23 | | |
| Consultation Visit - 30 minutes face to face with patient | 99242 | 103.23 | | |
| Consultation Visit - 40 minutes face to face with patient | 99243 | 131.26 | | |
| **PREVENTIVE MEDICINE SERVICES** | | | | |
| New Patient – Initial Preventive Medicine Visit, 40-64 Years | 99386 | 104.48 | | |
| New Patient – Initial Preventive Medicine Visit, 65 – Years | 99387 | 120.87 | | |
| Established Patient – Periodic Preventive Medicine Visit, 40-64 Years | 99396 | 00 89 | | |
| Established Patient – Periodic Preventive Medicine Visit, 65 – Years | 99397 | 109.88 | | |

# Alaska BCCEDP CPT Codes for 2000

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

Billing Code: 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 99052]

Cooperative Agreement for 1999 National Breast and Cervical Cancer Early Detection Program

Notice of Availability of Funds

A. Purpose

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

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

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

B. Eligible Applicants

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

1. The following States and territories are excluded:

   a. American Samoa, California, Colorado, Maryland,

Breast and Cervical Cancer Early Detection Program.

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

C. Availability of Funds

1. Approximately $53,000,000 is available in FY 1999 to fund approximately 23 States. It is expected that the average award will be $2,100,000, ranging from $1,000,000 to $4,500,000.

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

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

# CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

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

B. Eligible Applicants

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1. The following States and territories are excluded:

   a. American Samoa, California, Colorado, Maryland,

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

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

2. The following Tribes are excluded:

a. Consolidated Tribal Health Project, Inc., CA, and Southeast Regional Health Consortium, AK, which were funded August 1997, under Program Announcement 718 entitled National Breast and Cervical Cancer Early Detection Program.

b. Hopi tribe, AZ; Native American Rehabilitation Association of the NW, OR; Indian Community Health Service; AZ; and the Navajo Division of Health, AZ, which were funded in September of 1996, under Program Announcement 623 entitled 1996 National

Breast and Cervical Cancer Early Detection Program.

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

C. Availability of Funds

1. Approximately $53,000,000 is available in FY 1999 to fund approximately 23 States. It is expected that the average award will be $2,100,000, ranging from $1,000,000 to $4,500,000.

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

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

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

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

**Direct Assistance**

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

**Use of Funds**

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

2. Cooperative agreement funds will not be expended to provide inpatient hospital or treatment services. [Section 1504(g) of the PHS Act, as amended.] Also, cooperative agreement funds will not be used for the

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

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

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

4. Matching funds are required from non-Federal sources in an amount not less than $1 for each $3 of Federal funds awarded under this program. [Section 1502 (a) and (b) of the PHS Act, as amended.]

5. Costs used to satisfy matching requirements are subject to the same prior approval requirements and rules of allowability as those which govern project costs supported by Federal funds. (OMB Circular A-87 "Cost Principles for State, Local and Indian Tribal Governments" and PHS Grants Policy Statement, Section 6).

6. All costs used to satisfy matching requirements must be documented by the applicant and will be subject to audit.

**Recipient Financial Participation**

Recipient financial participation is required for this program in accordance with the authorizing legislation. Section 1502(a) and (b)(1), (2), and (3) of the PHS Act, as amended, requires matching funds from non-Federal sources in an amount not less than $1 for each $3 of Federal funds awarded under this program. However, The Omnibus Territories Act requires DHHS to waive matching fund requirements for Guam, U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands.

The matching funds may be in cash or its equivalent in-kind or donated services, including equipment, fairly evaluated. The contributions may be made directly or through donations from public or private entities. Public Law 93-638 authorizes tribal organizations contracting under the authority of Title I and compacting under the authority of Title III to use funds received under the Indian Self-Determination Act as matching funds.

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

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

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

D. Program Requirements

In accordance with Public Law 101-354:

1. States, territories and tribes are required to implement all the following program components:

   a. States and tribes presently receiving comprehensive funding: All program components should be operational at this time.

   b. Territory presently receiving capacity funding: Comprehensive breast and cervical cancer screening, follow-up, tracking services and other support services such as a case management should

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

c. Territories/tribes not presently receiving capacity funds and applying for comprehensive funding: The application should outline plans for the operation of all program components. The screening, tracking, follow-up and case management systems should be initiated within twelve months of the award date. [Section 1503 (a)(1) and (3) of the PHS Act, as amended.]

2. If a new or improved, and superior, screening procedure becomes widely available and is recommended for use, this superior procedure will be utilized in the program. [Section 1503(b) of the PHS Act, as amended.]

3. An award may not be made unless the State/Territorial Medicaid Program provides coverage for:

a. In the case of breast cancer, a clinical breast examination and screening mammography.

b. In the case of cervical cancer, both a pelvic examination and Pap test screening. [Section 1502A of the PHS Act, as amended.]

For those Territorial Departments of Health not

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

4. In 1993, Congressional amendments to the National Breast and Cervical Cancer Early Detection Program included the following changes:

   a. The amount paid by a State/territory/tribe for a screening procedure may not exceed the amount that would be paid under part B of title XVIII of the Social Security Act (Medicare) [Section 1501(b)(3) of the PHS Act, as amended].

   b. All facilities conducting mammography screening procedures funded by the Program must meet the regulations for mammography quality assurance developed by the Food and Drug Administration (FDA), most recently reauthorized and finalized October 31, 1998.

   c. For cervical cancer activities, facilities will meet the standards and regulations developed by the Health Care Financing Administration (HCFA) implementing the Clinical Laboratory Improvement Amendments (CLIA) of 1988.

5. In 1998, Reauthorization language for the National Breast and Cervical Cancer Early Detection Program included the following change:

   a. States/territories/tribes may enter into contracts

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

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

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

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

**Recipient Activities**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Adjusted to reflect the income of the woman screened. [Section 1504(b)(2) of the PHS Act, as amended.]