

BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000

On January 4, 2001, the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) provided initial guidance to State Health Officials to assist with implementing the provisions of the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). The provision 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 a series of questions and answers that respond to some of the issues that have been raised regarding the BCCPTA. CMS and CDC are committed to providing timely responses to important issues and will release additional guidance as needed and as it becomes available. Unless otherwise specified, the term "state" refers to the State Medicaid Agency.

Listed below are commonly used acronyms used in this section.

AI/AN	American Indian and Alaska Native
BCCEDP	Breast and Cervical Cancer Early Detection Program
BCCPT	Breast and Cervical Cancer Prevention and Treatment
BCCPTA	Breast and Cervical Cancer Prevention and Treatment Act
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
FFP	Federal Financial Participation
FPL	Federal Poverty Level
IHS	Indian Health Services
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
PE	Presumptive Eligibility
PHS	Public Health Service

ELIGIBILITY

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

Answer. In order to qualify under this optional category, a woman must meet the following eligibility requirements (As mandated by PL 106-354.):

1. The woman must have been screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service (PHS) Act, and found to need treatment for either breast or cervical cancer (including a precancerous condition);

2. She does not otherwise have creditable coverage, as the term is used under the Health Insurance Portability and Accountability Act (HIPAA) (§2701(c) of the PHS Act (42 U.S.C. 300gg(c)) but without regard to a medical care program of the IHS or of a tribal organization; and she must not be described in any of the mandatory Medicaid categorically needy eligibility groups; and

3. She is under age 65.

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

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 provision, 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 Act to have the same meaning as "creditable coverage" for purposes of HIPAA, but without regard to a medical care program of the IHS or of a tribal organization. A woman having the following types of coverage would be considered to have creditable coverage and would, therefore, be ineligible for the new Medicaid provision:

- 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 state health risk pool

Question 4. Are there any circumstances where a woman with creditable coverage could be eligible for this Medicaid provision?

Answer. Yes. While the provision 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 or her yearly benefits for breast or cervical cancer treatment, she is not considered to have creditable coverage and is eligible for Medicaid under BCCPTA. If a woman is insured but is limited to inpatient hospital services (for example, she is enrolled in Medicare Part A, but not Part B), she is still able to receive treatment for her breast or cervical cancer in the hospital setting, i.e., the treatment would be included within the scope of the inpatient hospital services and she would therefore be considered to have creditable coverage. In these types of circumstances, the woman may be eligible for the Medicaid provision, assuming that she meets all other eligibility criteria.

(NOTE: The reference to "not otherwise covered" in the eligibility criteria for this 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 provision the SCHIP eligibility exclusion is not connected to coverage for a specific condition.)

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 Medicaid provision?

Answer. No. In order to qualify for this Medicaid provision, 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 Medicaid provision 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.(Required) 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. (Optional) 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. (Optional) 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. If a woman eligible under the BCCPTA moves to another state, must she be rescreened?

Answer. No. A woman who has been screened in one state's NBCCEDP may be eligible for the Medicaid BCCPTA provision in a second state where she has applied, even if the second state has more restrictive screening criteria. For example, in instances where a woman moves from a state that has selected screening options 1, 2, and 3 (see question 7) to encompass the broadest possible screening provider base, to another state that has the most restrictive screening provider base (option 1), she would still be considered "screened under the program" and eligible for all benefits. Likewise, each state's income and age screening criteria varies under the NBCCEDP. As long as the second state has implemented the BCCPTA eligibility provision, and the woman meets all of the BCCPTA criteria, she would be covered by Medicaid in the second state.

Question 10. What is meant by the term "need treatment"?

Answer. The term "need treatment" means that, a CDC 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. 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 11. Is there any income test under Medicaid for women under this eligibility group?

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

Question 12. Can a state impose Medicaid asset standards on women whose eligibility is based on this provision?

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 13. 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 14. If a state elects to expand Medicaid eligibility to include this 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 CMS and the state implements the expansion or a later date specified in the state plan amendment.

Question 15. When does a woman's eligibility under this provision begin?

Answer. A woman's eligibility for coverage under this provision 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 16. What is the start date of eligibility for a woman covered under this provision?

Answer. States have discretion in defining this term. States may choose to establish the date of eligibility as the date of screening, date of diagnosis, or at some other point.

Question 17. The statute states that a woman is eligible for Medicaid under BCCPTA as long as she “requires treatment for breast or cervical cancer”. What is meant by the term “requires treatment”?

Answer. The term “requires treatment” relates to duration of treatment for purposes of the BCCPTA. States have the flexibility to define what constitutes “requires treatment.” States may establish reasonable limits or guidelines for determining when breast or cervical cancer treatment is completed and the person is no longer eligible for Medicaid under the BCCPTA.

Question 18. When would a woman's eligibility under this provision end?

Answer. A woman determined eligible under this provision would continue to be eligible as long as she needs treatment for breast or cervical cancer, is under age 65, and is not otherwise covered under creditable insurance coverage. A state may presume that a woman is receiving such treatment during the duration of the period established by her treating health professional in her plan of care. If that period extends beyond a year (or a shorter period at state option), the state must confirm eligibility consistent with standard Medicaid redetermination requirements. Care and services under this new provision 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 19a. 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 19b. If a woman is treated for breast or cervical cancer during her first period of eligibility and is subsequently determined to have cancer that has spread to other parts of her body, would she be covered?

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

COVERAGE

Question 20. What is the scope of coverage under this provision?

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

Question 21. 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 provision are medically necessary. Care and services furnished under this provision 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 22. 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 23. 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 24. Is presumptive eligibility mandatory for this group?

Answer. No. Presumptive eligibility is a state option.

Question 25. 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 Medicaid provision. 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 26. 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 27. 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 28. 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 determinations?

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 29. 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 30. 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 31. 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 32. 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 determinations 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 33. Must a state enter into presumptive eligibility agreements with all entities that are eligible to receive federal payments under Medicaid and are capable of carrying out presumptive eligibility services?

Answer. No. A state may select among qualified presumptive eligibility providers. However, CMS and the CDC encourage states to elect presumptive eligibility as a means

of promoting access to rapid coverage, which is essential to treatment. Furthermore, we encourage states that elect to use presumptive eligibility to make decisions about presumptive eligibility sites through closely coordinated efforts among the state Medicaid agency, the state agency that administers the early detection program, and community breast and cervical cancer coalitions. This will best ensure the availability of presumptive eligibility and enrollment assistance at a sufficient number of locations to ensure that the purposes of this Act are achieved.

Question 34. 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 35. Does this provision amount to a “federal means tested public benefit”?

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

Question 36. Are qualified aliens and non-qualified aliens eligible for the new Medicaid option?

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

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

Question 37. 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 38. Would treatment for breast and cervical cancer (including treatment for a precancerous condition) be classified as coverage for an "emergency medical condition?"

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

TREATMENT OF TERRITORIES

Question 39. 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 provision. 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 40. 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 provision.

Question 41. 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 (FFP)

Question 42. What level of enhanced FFP is available to states that elect to add coverage under this provision? 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 43. 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.

Question 44. What level of FFP is available to States for providing case management as a medical service under the BCCPTA? What level of FFP is available to States for providing case management as an administrative activity?

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

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

Question 45. 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 46. 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 47. Can Medicaid require cost sharing from women eligible in the new eligibility group?

Answer. Yes, for non-pregnant women over age 18 or at state option age 19, 20 or 21, but cost sharing is limited to deductibles, coinsurance copayments or similar charges that do not exceed the nominal amounts set forth in federal Medicaid regulations. Under these requirements, for non-institutional services, any deductible cannot exceed \$2.00 per month per family for each period of Medicaid eligibility, coinsurance may not exceed 5 percent of the payment the state makes for the services, and the maximum copayment for a single service would be \$3.00. For institutional services, cost sharing may not exceed 50 percent of the payment made by the state for the first day of institutional care. Only one of these types of charges can be imposed for each service, and there must also be a cumulative maximum amount for all deductible, coinsurance or copayment charges.

Question 48. 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 49. How will states report their expenditures related to the law?

Answer. CMS has revised the form CMS-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 have reprogrammed the MBES/CBES automated reporting system (Medicaid Budget Expenditure System/State Children's Health Insurance Program Budget Expenditure System) to incorporate this change. This change was completed in time for the states to report their first quarter fiscal year 2001 expenditure report which was due January 30, 2001. We have also sent detailed reporting instructions to the states.

APPLICATION AND ENROLLMENT

Question 50. What are the basic elements of an application under this provision? 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 51. 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 52. How quickly must the application be processed?

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

Question 53. What if a woman who applies is determined not to meet the qualifications of this provision?

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

Answer. This Medicaid eligibility group is optional for states.

Question 55. If a state wishes to expand Medicaid eligibility to include this eligibility group authorized by the 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 Act, the state or territory must submit a state plan amendment electing this optional categorical eligibility group and/or providing presumptive eligibility.

Question 56. 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 57. 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 58. Is breast reconstructive surgery a covered service under this Medicaid provision?

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

Question 59. 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.