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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH PROMOTION
ANALYSIS

BILL #: HB 1355

RELATING TO: Medicaid/Breast or Cervical Cancer

SPONSOR(S): Representative(s) Gannon & others

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH PROMOTION
(2) HEALTH & HUMAN SERVICES APPROPRIATIONS
(3) COUNCIL FOR HEALTHY COMMUNITIES
(4)
(5)

I. SUMMARY:

HB 1355 provides for a new optional eligibility category under the Florida Medicaid program for women under age 65, with income at or below 250 percent of the federal poverty level, and who have been screened for breast and cervical cancer by a "qualified entity" under the auspices of the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program and meet specific requirements relating to the need for treatment and lack of coverage for such treatment. Specifically defines "qualified entity." Specifies that no assets test be part of eligibility, provides for a presumptive eligibility period, and provides for duration of eligibity.

The bill's effective date is July 1, 2001.

A complete fiscal impact is not available for the bill. The treatment cost for county health department clients under the bill is estimated at $998,515, of which $309,540 would be the state's share, while the treatment cost for community health center clients is estimated at $1,785,756, of which $696,445 would be state share. There is no estimate of the number of women whose need for treatment is identified by other community-based providers.

The Governor's Legislative Budget Request for fiscal year 2001-2002 contains $12.9 million for Medicaid breast and cervical cancer treatment. While not included in the House of Representatives budget proposal, HB 1807, this funding is included in the Senate budget proposal.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes [x]	No []	N/A []
5.	Family Empowerment	Yes [x]	No []	N/A []

For any principle that received a "no" above, please explain:

In providing for a new optional eligibility category under the Florida Medicaid program, the bill expands the current scope of the program.

B. PRESENT SITUATION:

The American Cancer Society estimates that in 2001, nearly 1,270,000 new cancer cases will be diagnosed in the United States, including 39,700 in Florida. Of these, an estimated 13,000 new cases of breast and cervical cancer will be diagnosed in Florida. Approximately 3,000 Florida women will die of these cancers despite the fact that earlier detection and treatment of these diseases could substantially decrease mortality. These deaths occur disproportionately among members of racial and ethnic minority and low-income groups, particularly African-American women.

Research indicates that regular mammography and clinical breast exams can reduce breast cancer mortality by 30 percent among women 50 years and older. Mortality due to cervical cancer is totally preventable if caught early.

Medicaid

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The federal government, the state, and the counties jointly fund the program. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration (AHCA) is the single state agency responsible for the Florida Medicaid program. The Department of Children and Family Services is responsible for determining Medicaid eligibility and managing Medicaid eligibility policy, with approval of any changes by AHCA.

The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S. Section 409.903, F.S., specifies categories of individuals who are required by federal law to be covered, if determined eligible, by the Medicaid Program (mandatory coverage groups). Section 409.904, F.S., specifies categories of individuals who the federal government gives state Medicaid programs the choice of covering (optional coverage groups). Section 409.905, F.S., specifies the medical and other services that the federal government requires a state Medicaid program to provide. Section 409.906, F.S., specifies the medical and other services the state may provide under the state Medicaid plan.

Medicaid is an entitlement program. Federal laws and regulations require that states make all Medicaid services available to all categorically eligible recipients regardless of diagnosis. If the Medicaid recipient is a child, however, Medicaid is required to provide additional services (which may not be available to adult Medicaid recipients and which may not include services typically covered under a state's Medicaid program) to treat an illness identified through health screening.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (the Act)(Public Law 106-354) amended Title XIX of the Social Security Act to allow states to serve, as an optional coverage group, uninsured women under age 65 who are identified through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program and are in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer. The Act allows states to claim enhanced federal funding at the Title XXI (State Children's Health Insurance Program) rate, which is 69 percent federal and 31 percent state, compared to the typical Title XIX (Medicaid) rate, which for Florida is 54 percent federal and 46 percent state. The Act also allows states to extend presumptive eligibility to applicants in order to ensure that needed treatment begins as early as possible. The Act has an effective date of October 1, 2000.

There is no income or asset limitation for Medicaid coverage under the Act. Since the optional Medicaid coverage group is limited to women who have been screened under the National Breast and Cervical Cancer Early Detection Program federal screening program, income and asset standards under that program would become those for the optional Medicaid coverage group. In addition, a woman: must be under 65 years of age; may not have other health care coverage; and may not be Medicaid-eligible under another category. States are not permitted to implement more restrictive Medicaid financial eligibility criteria for this program.

The Health Care Financing Administration has been advised by Centers for Disease Control and Prevention (CDC) that a woman will meet the eligibility criteria of having been "screened under the program" if she comes under any of the following three categories:

1. CDC Title XV funds paid for all or part of the costs of her screening services.

2. The woman is screened under a state Breast and Cervical Cancer Early Detection Program in which her particular clinical service has not been paid for by CDC Title XV funds, but the service was rendered by a provider or an entity funded at least in part by CDC Title XV funds; the service was within the scope of a grant, sub-grant, or contract under that State program; and the State CDC Title XV grantee has elected to include such screening activities by that provider as screening activities pursuant to CDC Title XV.

3. The woman is screened by any other provider and/or entity and the state CDC Title XV grantee has elected to include screening activities by that provider as screening activities pursuant to CDC Title XV. For example, if a family planning or community health center provides breast or cervical cancer screening or diagnostic services, the state would have the option of including the provider's screening activities as part of overall CDC Title XV activities.

As long as the screening was performed by a provider under the state's Breast and Cervical Cancer Early Detection Program as defined above, the woman meets the Medicaid eligibility requirement. The programs operating in states under the CDC program will be required to provide Medicaid agencies with verification that the woman was screened under the CDC program.

Federal Clarification

As indicated in the above summary, it is less than clear which screening activities fall under the auspices of the new federal law. The federal government has recognized the need for some clarity on this issue. On January 4, 2001, in a letter to State Health Officials, the federal Health Care Financing Administration (HCFA) announced that, for purposes of the Breast and Cervical Cancer Prevention and Treatment Act of 2000, states may consider women to have been "screened under the program" and therefore be eligible for treatment benefits, if they are screened at a family planning or community health center – even where the center is not officially part of the state's Title XV screening program.

The Breast and Cervical Cancer Early Detection Program

Congress passed the Breast and Cervical Cancer Mortality Prevention Act in 1990. This Act established the National Breast and Cervical Cancer Early Detection Program ("screening program"), which authorizes CDC to promote breast and cervical cancer screening and to pay for screening services for eligible women. The screening program builds the infrastructure for breast and cervical cancer early detection by supporting public and provider education, quality assurance, surveillance, and evaluation activities critical to achieving maximum utilization of the program's screening, diagnostic, and case management services. Screening services provided by the program include clinical breast examinations, mammograms, pelvic examinations, and Papanicolaou (Pap) tests. Screening services also include diagnostic services, such as surgical consultation and biopsy, to ensure that all women with abnormal screening results receive timely and adequate diagnostic evaluation and treatment referrals. The law does not, however, allow CDC to pay for treatment services for women who are diagnosed with breast or cervical cancer.

In Florida, this screening program operates in 20 counties, generally through county health departments. According to the Department of Health, the program has been restricted to counties in which local resources to provide follow-up treatment are available. Since 1994, the program has screened 12,000 women for breast cancer and approximately 10,000 women for cervical cancer. The program is currently screening approximately 4,000-6,000 women per year. Approximately 1 percent of the women screened have indications of breast or cervical cancer. The department reports that CDC funds will be available to expand the screening program once Medicaid funds are available to provide care for women requiring follow-up.

Neither the Breast and Cervical Cancer Mortality Prevention Act of 1990 nor the Breast and Cervical Cancer Prevention and Treatment Act of 2000 specify income levels for participation. The Department of Health, however, applies a sliding fee scale to the screening program under which women between 100 and 200 percent of the federal poverty level pay a percentage of the cost of their screening. Women over 200 percent of the federal poverty level are eligible to be screened, but are required to pay the full fee for the screening. Department of Health staff report that the majority of women screened under the program have incomes around 150 percent of the federal poverty level. Although the sliding fee scale guidelines for the screening program are in place statewide, counties implementing the program use differing mechanisms to verify income. In some counties, income is entirely self-declared, while in others, income verification is required. There is no asset limit under the program.

The Definition of *Creditable Coverage*

Section 2701(c) of the federal Public Health Services Act defines "creditable coverage" as follows:

The term *Creditable Coverage* includes only those coverages required to be included as such under Section 2701(c) of the Public Health Services Act, and shall exclude those coverages that are permitted to be excluded under Section 2701(c). Solely for purposes of illustration and not in limitation of the foregoing, *Creditable Coverage* generally includes periods of coverage under an individual or group health plan (including Medicare, Medicaid, governmental and church plans) that are not followed by a Significant Break in Coverage and excludes coverages for liability, limited scope dental or vision benefits, specified disease, and/or other supplemental type benefits.

Federal Poverty Level

The federal Department of Health and Human Services annually updates the federal poverty guidelines used as the basis for eligibility for a variety of federal and state programs. These data, generally referred to as the "federal poverty level," are published in the Federal Register. As published on February 16, 2001, the federal poverty level for the indicated family sizes and percentage levels of poverty for the year 2001 are as follows:

Size of Family Unit	100% of FPL	200% of FPL	250 % of FPL
1	$8,590	$17,180	$21,475
2	$11,610	$23,220	$29,025
3	$14,630	$29,260	$36,575
4	$17,650	$35,300	$44,125

C. EFFECT OF PROPOSED CHANGES:

HB 1355 provides for a new optional eligibility category under the Florida Medicaid program for women under age 65, with income at or below 250 percent of the federal poverty level, and who have been screened for breast and cervical cancer by a “qualified entity” under the auspices of the federal Centers for Disease Control and Prevention breast and cervical cancer early detection program and meet specific requirements relating to the need for treatment and lack of coverage for such treatment. Specifically defines “qualified entity.” Specifies that no assets test be part of eligibility, provides for a presumptive eligibility period, and provides for duration of eligibility.

The bill’s effective date is July 1, 2001.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 409.904, F.S., relating to optional eligibility under Florida’s Medicaid program, to add as a new subsection (9) optional eligibility for women who meet the following criteria:

- Are under age 65;
- Have an income at or below 250 percent of the federal poverty level; and
- Have been screened for breast and cervical cancer under the CDC breast and cervical cancer early detection program established under Title XV of the Public Health Service Act, in accordance with the requirements of that act, and needs treatment for breast and cervical cancer and is not otherwise covered under “creditable coverage” under he Public Health Services Act (as that term is defined in the PRESENT SITUATION of this analysis.)

The bill indicates that for purposes of this subsection, “qualified entity” includes a county public health department, a community health center, and any community-based service delivery system that provides breast and cervical cancer screening services. The bill also specifies: that an asset

test is not required for determining eligibility; a presumptive eligibility period; and duration of eligibility.

Section 2. Provides for a July 1, 2001, effective date.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

County Health Department Clients

The Agency for Health Care Administration just revised its costs estimates relating to the proposed treatment program. The Medicaid cost of treating a woman with breast cancer is $9,167 annually. The cost of treating a woman with cervical cancer is $10,195 annually.

The Agency for Health Care Administration has estimated that the annual caseload for the program will be 35 individuals with cervical cancer and 70 individuals with breast cancer in the first year of the program. This estimate was based on the number of women the Department of Health has identified in prior years through its screening programs as having either of these two diseases. The agency estimates that the first-year Medicaid cost of the expanded eligibility would be $998,515, of which $309,540 would be the state's share.

This revised estimate is considerably less than the $12 million plus estimate included in the Governor's Legislative Budget Request. The revised figures are also much more in line with comparable estimates of the American Cancer Society and the Congressional Budget Office, according to the agency.

Community Health Center Clients

Information from the Florida Association of Community Health Centers indicates that in calendar year 1999, community health centers had the following results from breast and cervical cancer:

	Primary Diagnosis	Secondary Diagnosis	Total
Abnormal breast findings	322	156	478
Abnormal cervical findings	1,031	293	1,324

According to the Department of Health, it can safely be assumed that 10 percent of women with abnormal screening results will require treatment. Based on this assumption, and using the revised Medicaid cost information from above, the treatment costs for these women would be $1,785,756, of which $696,445 would be state share.

Clients of Other Community-Based Providers

The bill is non-specific as to community-based providers. There is no estimate of the number of women who might be screened annually by such providers, and no way to calculate potential treatment costs associated with women whose positive screening results indicate a need for treatment.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

To the extent that local government health care programs, or local health care programs funded by local government, are providing breast and cervical cancer treatment services that meet the requirements of this bill, those women whose screening results indicate the need to cancer treatment could avail themselves of services made available under Medicaid under this bill. This could result in a reduction in expenditures for local governments, to the extent the local governments absorb any of these treatment costs currently.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Those low-income women in need of treatment services for breast and cervical cancer will have greatly improved chances of ready access to appropriate care.

The bill will provide funding for care that is currently being rendered by medical providers as uncompensated care.

D. FISCAL COMMENTS:

Staff at the agency believe that the caseload in the program may grow in subsequent years, since providers who have historically provided uncompensated care to these women will have an incentive to refer newly-diagnosed uninsured women to screening programs in order to gain Medicaid coverage and treatment.

In addition, if the Department of Health expands screening efforts, additional Medicaid caseload would probably result.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

On page 1, line 31, the bill refers to "county public health department." The preferred term is "county health department."

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH PROMOTION:

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