11/20

Breast + Cervical

Jennifer Katz

Cap shouldn't apply to

intent - if ♀ are screened
they are presumed eligible
- don't make new category ♀ medically needed ♀

HCFA's counsel -- doesn't think HCFA has discretion
1902 will fix - (for disability)

Legis. clarified → covered for all services under Medicaid once they become eligible

Cap { HCFA counsel - Then subject to 133% income limit (of TANF payment limits)
- This is very limit - Then they would have to certified eligible for Medicaid
presume eligible for temporary period of time

intent of bill - all ♀ ~~diagnosed~~ screened + diagnosed presumed eligible

Andy Schneider for analysis, whom they are pointing to HCFA counsel

CAP.

Breast + Cervical Cancer Treatment

11/17
Tim Westmoreland

OMB + Senior HHS understand that
☆ have to get guidance out by Jan 20 at ...

legislation is self implementing - states can send us bills soon
haven't told them how to do it

~~haven't diagnosed~~ only diagnosed through program
referral through program
being listed in outreach materials in referral system

↤ mention to Jeanne
Call Mary Beth

☆ want to make sure it happens
+ that we get ~~the~~ credit

Sara Rosenbaum - GW
Lisa Zagner - sen Edwards
email to Jenny
resume
Sarah Cieran 326-8763
714-7703

From the Desk Of...
Jennifer L. Katz, J.D.
Senior Manager, Government Relations
National Breast Cancer Coalition
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Phone: (202) 973-0595
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To: Heather Howard

From: Jennifer Katz

Pages: 2 (including cover) **Date:** November 30, 2000

Phone: (202) 456-7263 **Fax:** (202) 456-2878

Re:

[redacted]

1. The original purpose of the 133 percent limit was to constrain states from setting high income levels for their medically needy. (Note that the 133 percent is not to the FPL, but to the much lower TANF payment amounts). Since the Reagan years, HCFA has interpreted 1903(f)(1) to apply to optional categorically needy (OCN) groups in 1902(a)(10)(A)(ii). Faced with this interpretation, Congress has carved out statutory exceptions (in 1903(f)(4)) for mandatory as well as optional categorically needy groups like pregnant women and working disabled individuals. HCFA is, in effect, reconsidering its interpretation in a proposed rule published October 31. This proposed rule will be of great help to OCN eligibility groups that are not exempted from the 133 percent limit in (f)(4), by allowing states to exempt them through the use of less restrictive income methodologies. My view, however, is that both (f)(1) and the saving proposed rule are irrelevant to the new group of women in need of treatment for breast or cervical cancer.

Like every other OCN group, this new group is entitled to the same Medicaid benefits package that the state makes available to it mandatory eligibles (that's presumably the reason the group was written into this part of the statute). Unlike every other OCN group, however, this new group is not subject to either an income or resource test. The statute is amazingly clear; you're eligible if: (1) you're not receiving Medicaid as a mandatory eligible, (2) you're under 65, (3) you've been screened under the CDC program and need treatment, and (4) you don't have creditable coverage. There's no reference whatsoever to meeting any income or resource standards and there is no reason for HCFA to impute such standards, as the 1903(f)(1) interpretation above would do. Congress knows how to write income and resource eligibility criteria (e.g., "family income less than or equal to 250 percent of the federal poverty level") and how to give states the authority to establish such standards. It didn't do so, and neither should HCFA.

[redacted]

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To: Heather Howard

From: Jennifer Katz

Pages: 2 (including cover) **Date:** November 29, 2000

Phone: (202) 456-7263 **Fax:** (202) 456-2878

Re: Memo on Implementation of the Breast and Cervical Cancer Treatment Act

Heather
Excuse my scribble on this memo
Give me a call and we can talk further
Jennifer

Donald Schriber

Steve Reynolds → Cathy Cahill

Ultimately: Deputy Sec.

Tim Westmoreland Jeffrey Lovelend

fax to Tim: 410 786 0025

1. The original purpose of the 133 percent limit was to constrain states from setting high income levels for their medically needy. (Note that the 133 percent is not to the FPL, but to the much lower TANF payment amounts). Since the Reagan years, HCFA has interpreted 1903(f)(1) to apply to optional categorically needy (OCN) groups in 1902(a)(10)(A)(ii). Faced with this interpretation, Congress has carved out statutory exceptions (in 1903(f)(4)) for mandatory as well as optional categorically needy groups like pregnant women and working disabled individuals. HCFA is, in effect, reconsidering its interpretation in a proposed rule published October 31. This proposed rule will be of great help to OCN eligibility groups that are not exempted from the 133 percent limit in (f)(4), by allowing states to exempt them through the use of less restrictive income methodologies. My view, however, is that both (f)(1) and the saving proposed rule are irrelevant to the new group of women in need of treatment for breast or cervical cancer. Like every other OCN group, this new group is entitled to the same Medicaid benefits package that the state makes available to it mandatory eligibles (that's presumably the reason the group was written into this part of the statue). Unlike every other OCN group, however, this new group is not subject to either an income or resource test. The statute is amazingly clear; you're eligible if: (1) you're not receiving Medicaid as a mandatory eligible, (2) you're under 65, (3) you've been screened under the CDC program and need treatment, and (4) you don't have creditable coverage. There's no reference whatsoever to meeting any income or resource standards and there is no reason for HCFA to impute such standards, as the 1903(f)(1) interpretation above would do. Congress knows how to write income and resource eligibility criteria (e.g., "family income less than or equal to 250 percent of the federal poverty level") and how to give states the authority to establish such standards. It didn't do so, and neither should HCFA.

2. My copy of the enrolled bill shows a new clause (4) being added to the first sentence of 1905(b) that specifies that the CHIP enhanced match rate is the FMAP for the costs of services to this eligibility group. There's no allotment, cap, or other limitation in sight, either within the new clause (4) or within the cross-referenced section 2105(b). I can't find any reference to an allotment, cap, or other limitation in the CBO estimate either. Again, there's no basis for HCFA to impute such a cap. Congress knows how to write an allotment cap if it wants to: see the third sentence of 1905(b).

3. The policy stinks, but the language is clear: you're not eligible if you are "otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act." This same PHS Act reference appears in CHIP (see 2110(c)(2)). Congress could have said "under creditable coverage, as defined by the Secretary." It didn't. The term means what section 2701(c) and implementing regulations say it means. I did not follow HIPAA and its implementation closely, but a quick skim of section 2701(c) indicates that it is fairly detailed; it gives the Secretary some discretion in regulations implementing its provisions relating to group health plans, but where those regulations are and whether they could help solve this problem I'm unable to say.

Income testing/Application forms - defeats purpose supposed to be seamless!

Lawyers serve as front for H&S workman All work for Howard Raab

Chief gen. counsel @ HCFA (formerly Canton)

rely on Reg. don't go back to do legis.

re-certif. every 12 mo.

why don't they come up w/ lang?

I said we don't have discretion to do this w/out 1902(R)(2) reg.

confident this reg will be fixed

Could drop coverage, and next day re elig for Medicaid