Calendar No. 641

106TH CONGRESS, *2d Session* | SENATE | REPORT 106–323

BREAST AND CERVICAL CANCER TREATMENT ACT

JUNE 27, 2000.—Ordered to be printed

Mr. ROTH, from the Committee on Finance, submitted the following

REPORT

[To accompany S. 662]

[Including cost estimate of the Congressional Budget Office]

The Committee on Finance, to which was referred the bill (S. 662) to amend title XIX of the Social Security Act to provide medical assistance for certain woment screened and found to have breast cancer under a federally funded screening program, having considered the same, reports favorably thereon with an amendment and recommends that the bill (as amended) do pass.

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I. SUMMARY AND BACKGROUND

A. SUMMARY

S. 662, as reported by the Committee on Finance, creates a new option for states to extend Medicaid eligibility to individuals receiv-

ing a cancer diagnosis through the Centers for Disease Control's Breast and Cervical Cancer Early Detection Program.

B. Background and Reasons for Legislation

Nearly 10 years ago, Congress created the National Breast and Cervical Cancer Early Detection Program, through the Centers for Disease Control, to help lower-income women receive the early detection services that are the best protection against breast and cervical cancer. This important program has served more than a million women in subsequent years. However, the screening program does not include a treatment component. Instead, women who receive cancer diagnoses must rely on informal networks of donated care.

S. 662 fulfills a promise made nearly 10 years ago. The federal government will continue to help lower-income, uninsured women access needed preventive health care services. But now the federal commitment will not stop with screening. If problems are found, the federal government will work with the states to provide necessary treatment services to women facing cancer diagnoses.

S. 662 makes treatment available to eligible women through the Medicaid program. There are very valid concerns about creating disease-specific Medicaid eligibility categories. However, S. 662 deals with a thoroughly unique set of circumstances. The new Medicaid eligibility category created in S. 662 is specifically linked to a unique and existing federal screening program, and shall not be viewed as a precedent for extending Medicaid eligibility body-part by body-part.

C. Legislative History

Senator John Chafee introduced S. 662 on March 18, 1999, and then on July 27th he chaired a Finance Committee Health Subcommittee hearing on the bill. At the hearing, witnesses from the health policy, medical, advocacy, and beneficiary communities discussed the pressing need for a treatment component to supplement the CDC screening programs.

On June 14, 2000, the Finance Committee ordered S. 662, the Breast and Cervical Cancer Treatment Act, reported favorably, as amended by the Chairman's mark, by a voice vote.

II. EXPLANATION OF THE BILL

A. Coverage as Optional Categorically Needy Group

Current law

The requirements of federal law, coupled with decisions by individual states in structuring their Medicaid programs, determine who is eligible for Medicaid in a given state. In general, federal law places limits on the categories or groups of individuals that can be covered and establishes specific eligibility rules for each category. Within these parameters, states are given additional options. Medicaid is also a means-tested entitlement program. To qualify, applicants' income and resources must be within certain limits, most of which are determined by states, again within federal statutory parameters. Moreover, states have flexibility in defining countable income and resources.

States must provide Medicaid coverage to certain groups and have the option of covering others. Examples of major mandatory eligibility groups relevant to individuals targeted by S. 662 (i.e., non-institutionalized adult females) include: (1) persons who would be eligible for cash assistance under former rules of the Aid to Families with Dependent Children (AFDC) program (in effect on July 16, 1996, as adjusted) even if they do not qualify for cash grants under the new Temporary Assistance for Needy Families (TANF) program, (2) disabled individuals receiving supplemental security income (SSI) and/or state supplemental payments (except in those states that use more restrictive disability or income standards for determining Medicaid eligibility for such persons), (3) individuals qualifying for transitional medical assistance for up to 12 months after Medicaid eligibility is lost due to increases in hours of employment, support payments or earned income, and (4) pregnant women who are in families with income up to 133 percent of the federal poverty level.

Examples of major optional coverage groups relevant to S. 662 include: (1) pregnant women in families with income between 133 percent and 185 percent of the federal poverty level, and (2) persons qualifying as "medically needy," that is, those who fall into one of Medicaid's categorical coverage groups and meet the (usually higher) income and resource requirements for medically needy coverage. States may further expand eligibility through waivers of federal rules, or use of existing provisions that permit changes in income and resource standards or calculation methods.

With the exception of the medically needy and special categories for pregnant women, all of the above groups have access to the full range of Medicaid benefits offered in a state. States may specify a narrower set of benefits for the medically needy, within federal parameters. Persons who qualify as pregnant women are limited to pregnancy-related benefits during the period of pregnancy (and for 60 days postpartum).

In general, Medicaid beneficiaries are permitted to have other forms of health insurance. When a Medicaid beneficiary has other insurance, Medicaid becomes the secondary payer and would, for example, cover cost-sharing obligations under the primary insurance plan, and would also pay for Medicaid covered services not offered by the primary insurance plan. In some circumstances, Medicaid pays the premiums required for other insurance.

The Breast and Cervical Cancer Mortality Prevention Act of 1990 (P.L. 101–354) authorized the Centers for Disease Control and Prevention (CDC) to begin a national program to increase screening services for all women, with priority given to low-income women. The CDC's National Breast and Cervical Cancer Early Detection Program (Public Health Service Act, Title XV) was reauthorized through FY2003 by P.L. 105–340. States are required to contribute $1 for every $3 of federal grant funds. To receive a grant, states must cover specified screening services under Medicaid. The specified screening services for breast cancer are physical breast examination and mammography; for cervical cancer, pelvic examination and pap smear. If a superior screening procedure becomes available and is recommended for use, the superior procedure is to be utilized. The law for this program does not specify financial eligibility standards. Cost-sharing can be imposed on a sliding scale based on

income only for women above 100% of FPL. If the woman is covered by other health benefits programs (e.g., private insurance, Medicare, Medicaid) that pay for these screening services, that other program is the first payer. The upper payment limit for covered screening services is the Medicare rate.

Explanation of provision

S. 662 would establish a new optional categorically needy coverage group under Medicaid. Eligible individuals are those women who are under age 65, have been screened under the Centers for Disease Control's Breast and Cervical Cancer Early Detection Program, and need treatment for breast or cervical cancer. In addition, such individuals must not otherwise be eligible for Medicaid under a mandatory coverage group and must not have other creditable health insurance coverage (as defined in Section 2701(c) of the Public Health Service Act).

This definition of creditable health insurance coverage does not include state programs to provide treatment services to women diagnosed with breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program. As a result, women currently eligible for state-funded treatment programs will not be disqualified from receiving Medicaid services under this legislation.

As of March 1999, the upper income eligibility level in most states (45 of 50) for individuals screened under the CDC program was 200 to 250 percent of the federal poverty level.

Medicaid coverage would be limited to medical assistance provided during the period in which the individual requires breast or cervical cancer treatment.

Reason for change

Since its inception in 1990, the Center for Disease Control's National Breast and Cervical Cancer Early Detection Program has provided screening services to more than a million women across the country. In the process, more than 6,000 cases of breast cancer and 500 cases of cervical cancer have been detected. Currently, women facing these diagnoses have to rely upon informal systems of donated care to meet the costs associated with treating their disease. S. 662 will give the states the option of making women diagnosed through the CDC screening programs eligible for Medicaid, bypassing the need to rely on informal systems of care.

B. Presumptive Eligibility

Current law

Medicaid law stipulates that state Medicaid plans must provide safeguards to assure that eligibility is determined in a manner consistent with simplicity of administration and in the best interests of beneficiaries. Regulations further specify that state Medicaid agencies must establish and inform applicants of time limits for determining eligibility and must determine eligibility within those limits, except in unusual circumstances. The largest permissible time limits are 90 days for disability-based applications and 45 days for other applications. The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant.

Currently, states have the option of extending what is known as "presumptive eligibility" to two categories of Medicaid beneficiaries—pregnant women and children under 19 years of age. Presumptive eligibility allows such individuals whose family income appears to be below the state's Medicaid income standards to enroll temporarily in Medicaid, until a final formal determination of eligibility is made. The primary purpose of this option is to make needed services immediately available to these specified groups. Presumptive eligibility has been permitted for pregnant women since 1986, and for children under 19 since 1997.

For pregnant women and children, current law defines the period of presumptive eligibility, entities qualified to determine presumptive eligibility, and administrative requirements for state Medicaid agencies and qualified entities that make such determinations. The period of presumptive eligibility begins with the date on which a qualified entity determines, on the basis of preliminary information, that the applicant's income does not exceed the applicable income standard. The period ends with the earlier of either: (a) the day on which the final eligibility determination is made, or (b) for those beneficiaries who fail to submit an application, the last day of the month following the month in which the qualified entity established presumptive eligibility. Qualified entities include Medicaid providers; Head Start programs; Women, Infants and Children (WIC) supplemental nutrition programs; and agencies that determine eligibility for subsidized child care. Finally, state Medicaid agencies must provide qualified entities with the necessary forms for application, and information on how to assist individuals in completing applications. In turn, qualifying entities must notify the state Medicaid agency of presumptive eligibility determinations within 5 working days, and inform applicants that formal application is required within a specified time frame using an appropriate form.

Payments for covered items and services provided to beneficiaries during the period of presumptive eligibility will be matched at the applicable federal medical assistance percentage for those items and services.

Explanation of provision

S. 662 includes the option of extending presumptive eligibility to individuals qualifying for Medicaid under the new optional coverage group. With one exception, the rules governing presumptive eligibility are the same as those already specified in current law for pregnant women and children under 19 years of age. In S. 662, qualifying entities for determining presumptive eligibility would be limited to Medicaid providers only.

Reason for change

Presumptive eligibility would give states the option to ensure that no time lag exists between a diagnosis received through the CDC screening program and Medicaid eligibility for treatment.

C. Enhanced Match

Current law

Medicaid is a federal-state matching program. The federal share of a state's payments for Medicaid benefits is called the federal medical assistance percentage (FMAP). The FMAP for a given state is determined by a formula that considers the state's per capita income compared to the national average. The law establishes a minimum FMAP of 50 percent and a maximum of 83 percent. The federal share of Medicaid payments for benefits is higher in poor states. In FY2000, FMAPs range from 50 percent to 76.8 percent.

The law provides some exceptions to the FMAP for Medicaid benefits. For example, family planning services (instruction in contraceptive methods and family planning supplies) are federally matched at a 90 percent rate. Benefits provided to children who qualify for Medicaid via an expansion of eligibility under the State Children's Health Insurance Program are matched at an enhanced rate that can range from 65 percent to 85 percent. Medicaid services received through an Indian Health Service facility are fully funded by the federal government with no state share.

With specific exceptions, Medicaid administrative expenses are generally matched at the rate of 50 percent.

Explanation of provision

The Chairman's mark makes a change to S. 662 to fit within the budget reserve account of $250 million over 5 years included in the concurrent resolution on the budget for fiscal year 2001. S. 662 as introduced stipulates that states would receive a federal matching rate equal to 75 percent for activities related to offering, arranging and furnishing medical assistance to individuals eligible under the new optional categorically needy group. However, S. 662 is scored by the Congressional Budget Office as costing $360 million over 5 years. The Chairman's mark uses the enhanced matching rate structure used for the state children's health insurance program, which averages a 68 to 32 percent match rate (compared to the Medicaid average match of 57 to 43 percent). This model, with an October 1, 2000 start date, is scored at $250 million over 5 years.

Reason for change

The enhanced match rate included in the bill is intended to give states a financial incentive to take up the new option to extend Medicaid eligibility to women receiving breast or cervical cancer diagnoses through CDC's screening program.

D. Effective Date

All amendments made by S. 662 apply to medical assistance provided on or after October 1, 2000, without regard to whether final regulations to carry out these amendments have been promulgated by that date.

III. BUDGET EFFECTS OF THE BILL

In compliance with sections 308 and 403 of the Congressional Budget Act of 1974, and paragraph 11(a) of Rule XXVI of the Standing Rules of the Senate, the following letter has been received

from the Congressional Budget Office on the budgetary impact of the legislation:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 20, 2000.

Hon. WILLIAM V. ROTH, Jr.
Chairman, Committee on Finance,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 662, the Breast and Cervical Cancer prevention and Treatment Act of 2000.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Eric Rollins (for federal costs) and Leo Lex (for impacts on state and local governments).

Sincerely,

STEVEN LIEBERMAN
(For Dan L. Crippen, Director).

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

S.662—Breast and Cervical Cancer Prevention and Treatment Act of 2000

Sumary: S. 662 would allow states to receive federal Medicaid funds for providing medical care to low-income women who have been screened under a Centers for Disease Control and Prevention (CDC) screening program and found to have breast or cervical cancer. CBO estimates that S. 662 would increase direct spending by $250 million over the 2000–2005 period. Since this bill would affect direct spending, pay-as-you-go-procedures would apply.

S. 662 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). A new coverage option in the bill would allow states to increase spending in their Medicaid programs for the treatment of breast and cervical cancer. CBO estimates that the state portion of Medicaid expenditures for this optional coverage would total $107 million over the 2000–2005 period.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 662 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in millions of dollars—					
	2000	2001	2002	2003	2004	2005
CHANGES IN DIRECT SPENDING						
Estimated budget authority	0	15	35	50	65	85
Estimated outlays	0	15	35	50	65	85

Basis of estimate: S. 662 would give states the option of providing Medicaid coverage to women who have been screened under the CDC's National Breast and Cervical Cancer Early Detection Program and found to have breast or cervical cancer. States would receive an enhanced federal Medicaid match rate for services provided to women who become eligible for Medicaid under the bill.

(This enhanced federal match rate, which is already used for services provided under the State Children's Health Insurance Program, averages about 70 percent, compared to 57 percent for the regular match rate.) Federal Medicaid funds would be available beginning in fiscal year 2001.

Under current law, women with breast and cervical cancer are eligible for Medicaid only if they fall into an existing eligibility category. The principal eligibility categories for low-income women are pregnancy, and welfare-related or disability-related coverage (which is largely based on receipt of either Temporary Assistance for Needy Families or Supplemental Security Income). If a women is found to have breast or cervical cancer, does not have health insurance, and does not qualify for Medicaid, she either pays for the treatment with her own funds, receives treatment through a state, local, or privately funded program, receives charity care, or goes without treatment.

The Congress created the National Breast and Cervical Cancer Early Detection Program in 1990 and appropriated $166 million for the program for fiscal year 2000. The funds support screening activities in all 50 states, in the District of Columbia and U.S. territories, and for several American Indian/Alaska Native organizations. States set their own income eligibility levels, at or below 250 percent of the federal poverty line. Most states have set eligibility criteria at about 200 percent of poverty. The CDC estimates that the program currently screens about 15 percent of the eligible population. Program funds are not available for treating breast and cervical cancer.

The bill's effect on federal Medicaid spending depends on the number of women who would receive Medicaid-funded treatment as a result of the bill, the cost of the treatment, and the number of states that would choose the option. The following discussion focuses on the estimate for breast cancer treatment, which accounts for over 90 percent of the estimated costs of the bill. A brief discussion of the cost of cervical cancer treatment can be found at the end of the section.

Number of beneficiaries.—The states provided 224,000 mammograms with funds available under the CDC screening program in 1998. Some states currently supplement the CDC screening funds with their own funds for screening, diagnosis, and treatment. Under the bill, CBO expects that the number of mammograms under the CDC program would rise to 540,000 by 2005, as states that fund diagnosis and treatment services redirect their funds to suplement the screening funds in the CDC program. Because participation in that program would provide access to federal Medicaid funds for diagnosis and treatment of breast cancer, states would have an incentive to redirect their own funds into the CDC screening program.

Of women screened for breast cancer by the CDC program since its inception, about 0.5 percent, or 5 per 1,000, have been found to have breast cancer. Another 7 percent have had abnormal screens that required additional diagnosis and perhaps minor treatment. CBO assumes that the same incidence of cancer and other abnormal results would continue under the bill, resulting in the identification of about 2,700 new cancers and 36,000 abnormal mammograms each year by 2005.

In addition to these new cases, CDC reports that it has already diagnosed over 5,800 breast cancers. CBO anticipates that about 2,400 of these women would receive coverage under the bill if states adopt the option.

Cost of treatment—Based on data from a large health maintenance organization, CBO has estimated the average cost of breast cancer treatment by age and year since diagnosis. In the first year after diagnosis, CBO estimates that cancer treatment would cost about $20,000. In subsequent years, CBO estimates about $6,000 a year in ongoing care costs, until the last year of a patient's life, when costs total about $33,000. CBO used information from the National Cancer Institute's Surveillance, Epidemiology, and End Results Program to estimate age-specific mortality rates from the time of diagnosis.

For women who have an abnormal mammogram, but who are not ultimately diagnosed with cancer, CBO estimates average treatment costs of about $2,000 in the year after the mammogram for follow-up diagnostic and treatment services.

The costs discussed above are for cancer treatment only and are expressed in fiscal year 2001 dollars. Because the bill would extend full Medicaid coverage during the time the woman needs cancer treatment, CBO added about $1,000 a year to the costs of cancer treatment (one-third of the average per capita Medicaid costs for adults) to determine total Medicaid costs for women newly eligible because of the bill. CBO expects that the average annual cost of treatment would rise at the same rate as the Consumer Price Index for medical care (CPI–M)

State participation.—In 2001, CBO anticipates, that states with 25 percent of potential Medicaid costs would choose to cover breast cancer patients screened through the CDC program in their Medicaid programs. By 2005, CBO projects that proportion would rise to 50 percent.

Cervical cancer.—The costs of cervical cancer treatment under the bill stem principally from treatment of pre-cancerous conditions since screening often results in an abnormal finding at an early stage of the disease. CBO anticipates that about 120 new cases of cervical cancer would be diagnosed each year under the screening program, with average annual treatment costs similar to the treatment costs for breast cancer. CBO expects about 10,000 abnormal pap smears each year, with treatment costs averaging $1,000 to $2,000. In total, CBO estimates that treatment of cervical cancer under the bill would cost $15 million over the 2000–2005 period.

Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that are subject to pay-as-you-go procedures are shown in the following table. (S. 662 would not affect receipts.) For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By fiscal year, in millions of dollars—										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	15	35	50	65	85	105	120	145	165	190
Changes in receipts	Not applicable.										

Intergovernmental and private-sector impact: S. 662 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act. The bill would allow states to increase spending in their Medicaid programs for the treatment of breast and cervical cancer. CBO estimates that the state portion of Medicaid expenditures for this optional coverage would total $107 million over the 2000–2005 period.

State spending for the treatment of breast and cervical cancer among certain women who would otherwise be ineligible for Medicaid would qualify for a 70 percent federal match on average. Some states may already be covering this type of treatment in state-funded public health programs. In those cases, the federal matching funds would allow states to increase their overall level of spending for existing programs or to redirect a portion of their current spending to screening or other state programs.

Previous CBO estimate: On November 10, 1999, CBO estimated that section 2 of H.R. 1070, as ordered reported by the House Committee on Commerce on October 28, 1999, would increase federal Medicaid spending by $205 million over the 2000–2004 period. The provisions of that section are almost identical to those in S. 662, except for the federal match rate that would apply to Medicaid services provided under the new state option. Under H.R. 1070, the federal match rate would be 75 percent or the state's regular rate, whichever is higher. Since the federal match rate under S. 662 would generally be lower (70 percent, on average), CBO assumed that state participation in the new Medicaid option would also be lower. CBO's estimate for S. 662 also incorporates more recent data on the CDC screening program, new projections for the CPI–M, and budgetary effects in 2005.

Estimate prepared by: Federal costs: Eric Rollins; impact on State, local, and tribal governments: Leo Lex; impact on the private sector: Rekha Ramesh.

Estimate approved by: Robert A. Sunshine, Assistant Director for Budget Analysis.

IV. VOTE OF THE COMMITTEE

In compliance with section 133 of the Legislative Reorganization Act of 1946, the Committee states that S. 662, as amended by the Chairman's mark, was ordered reported favorably by a voice vote, a quorum being present.

V. REGULATORY IMPACT

In compliance with paragraph 11(b) of Rule XXVI of the Standing Rules of the Senate, the Committee states that the legislation will not significantly regulate any individuals or businesses, will not impact the personal privacy of individuals, and will result in no significant additional paperwork. The regulatory impact of the bill on the government will be limited to the need for the Health Care Financing Administration to develop regulations for the implementation of the new state option.

This new option set forth in the bill will not impose a federal intergovernmental mandate on state, local, or tribal governments.

VI. CHANGES IN EXISTING LAW

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law opposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1905(a), to—

(i) * * *

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) (or, in the case of individuals described in section 1905(a)(i), to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) * * *

* * * * * * *

(XVI) who are employed individuals with a medically improved disability described in section 1905(v)(1) and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, only if the State provides medical assistance to individuals described in subclause (XV); **[**or**]**

(XVII) who are independent foster care adolescents (as defined in section 1905(w)(1)), or who are within any reasonable categories of such adolescents specified by the State; *or*

(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);

* * * * * * *

(G) that, in applying eligibility criteria of the supplemental security income program under title XVI for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving supplemental security income, the State will disregard the provisions of subsections (c) and (e) of section 1613;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII of individuals eligible therefore (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, of the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing , or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason for this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available to medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited

to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1905(p)(1) who is only entitle to medical assistance because the individual is such a beneficary shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3)), subject to the provisions of subsection (n) and section 1916(b), (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10) require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A), as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover to the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1906 shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amounts, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2)), [and (XIII)] (*XIII*) the medical assistance made available to an individual described in subsection (z)(1) who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2)*, and (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer*;

* * * * * * *

(47) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920 and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with

such section *and provide for making medical assistance available to individuals described in subsection (a) of section 1920B during a presumptive eligibility period in accordance with such section*:

* * * * * * *

(aa) Individuals described in this subsection individuals who—

(1) are not described in subsection (a)(10)(a)(i);

(2) have not attained age 65;

(3) have been screened for breast and cervical concern under the Centers for Disease Control and Prevention breast and cervical cancer early detection program established under title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) in accordance with the requirements of section 1504 of that Act (42 U.S.C. 300n) and need treatment for breast or cervical cancer; and

(4) are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act (45 U.S.C. 300gg(c)).

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * * * *

(u)(1)(A) * * *

* * * * * * *

(D)(i) * * *

* * * * * * *

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)) **[**or for**]**, *for* items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section, *or for medical assistance provided to an individual described in subsection (a) of section 1920B during a presumptive eligibility period under such section.*

* * * * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' servcies, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to in-

dividuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

(i) * * *

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(xi) individuals described in section 1902(z)(1), [or]

(xii) employed individuals with a medically improved disability (as defined in subsection (v)), *or*

(xiii) individuals described in section 1902(aa),

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for mental diseases);

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(b) Subject to section 1933(d), the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capital income of such State bears to the square of the per capital income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum, [and] (3) for purposes of this title and title XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent*, and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII).* The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4o of the Indian Health Care Improvement Act). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures (other than expenditures under section 1923) described in subsection (u)(2)(A) or subsection (u)(3) for the State for a fiscal year, and that do not exceed the amount of the State's allotment under section 2104 (not taking into account reductions under section 2104(d)(2)) for the fiscal year reduced by the amount of any payments made under section 2105 to the State from such allotment for such fiscal year, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b).

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PRESUMPTIVE ELIGIBILITY FOR CHILDREN

SEC. 1920A. * * *

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PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST AND CERVICAL CANCER PATIENTS

SEC. 1920B. (a) STATE OPTION.—A State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(aa) (relating to certain breast and cervical cancer patients) during a presumptive eligibility period.

(b) DEFINITIONS.—For purposes of this section:

(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term "presumptive eligibility period" means, with respect to an individual described in subsection (a), the period that—

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(aa); and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(2) QUALIFIED ENTITY.—

(A) IN GENERAL.—Subject to subparagraph (B), the term "qualified entity" means any entity that—

(i) is eligible for payments under a State plan approved under this title; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

(B) REGULATIONS.—The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

(C) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

(c) ADMINISTRATION.—

(1) IN GENERAL.—The State agency shall provide qualified entities with—

(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

(B) information on how to assist such individuals in completing and filing such forms.

(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual de-

scribed in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

(B) inform such individual at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made.

(d) PAYMENT.—Notwithstanding any other provision of this title, medical assistance that—

(1) is furnished to an individual described in subsection (a)—

(A) during a presumptive eligibility period;

(B) by a entity that is eligible for payments under the State plan; and

(2) is included in the care and services covered by the State plan;

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).

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