OCPP Oregon Center for Public Policy
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Issue Brief
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It Shouldn't Matter Who Paid for Screening

SB 891 fixes an eligibility rule that blocks Oregon women from treatment for breast and cervical cancer

Oregon's Breast and Cervical Cancer Medical Program (BCCM) lets women diagnosed with breast or cervical cancer enroll in Medicaid for treatment if they have limited income and no insurance. That's good policy. Women get timely, lifesaving treatment by means less costly than charity care, the most likely alternative.

Unfortunately, an unnecessarily restrictive eligibility rule blocks many low-income, uninsured women from the program. The rule bars women who would otherwise qualify for the BCCM if their screening and diagnostic services were not paid through a companion screening program, the Breast and Cervical Cancer Program (BCCP). So, for example, if the cancer sufferer receives her screening services from a doctor who is not part of the BCCP, pays for the services out of her own pocket, or gets diagnosed in an emergency room, she is ineligible for treatment under the BCCM.

Requiring women to be screened using BCCP funds is unfair and illogical. It rations treatment — with life-and-death consequences — on the basis of who undertakes the cancer screening, rather than just financial need.

SB 891 would open a way for women to receive treatment through the BCCM regardless of who provides their screening and diagnostic services. In doing so, the bill potentially would allow an estimated 128 more Oregon women to receive cancer treatment during an average month in the 2009-11 budget cycle and 400 more in the 2011-13 biennium.[1] Three-quarters of the money to pay for the expansion would come from the federal government.

A restrictive eligibility rule prevents some women from getting cancer treatment

Oregon's Breast and Cervical Cancer Medical Program complements the state's Breast and Cervical Cancer Program, a screening program for low- income, uninsured women.

Oregon's BCCM program allows women who qualify to enroll in Medicaid to obtain cancer treatment. To qualify, women must be uninsured, under age 65 and enrolled in the BCCP.[2] To be enrolled in the BCCP, in turn, requires family income of less than 250 percent of the federal poverty level.[3]

An additional requirement — the rule at issue — is that BCCP program funds must pay for all or part of a woman's screening and diagnostic costs.[4] This means that an Oregon woman diagnosed with breast or cervical cancer who otherwise meets the eligibility criteria for income, age and lack of insurance will be refused treatment if she is screened outside the BCCP. In other words, if

she chooses a doctor who is not part of the BCCP program, pays for the screening out of her own pocket, or gets diagnosed with cancer in an emergency room, for example, she is ineligible for treatment through the BCCM.

Because it is not adequately funded, the BCCP screening program reaches only a small proportion of eligible Oregonians — about 11 percent, or one in nine women. A proposed expansion would still leave two out of three eligible women unscreened.[5] Thus, it is inevitable that some low-income, uninsured Oregon women in need of breast or cervical cancer treatment will be diagnosed outside the BCCP screening program.

SB 891 should allow treatment regardless of who paid for screening

An easily implemented program change authorized by federal law would expand the eligibility rule in question and allow treatment regardless of who paid for the cancer screening, so long as a woman meets the remaining eligibility criteria.

The BCCM operates under federal rules that allow states an optional Medicaid eligibility category for women screened under the National Breast and Cervical Cancer Early Detection Program, of which Oregon's BCCP is a part.[6] Federal law requires that a woman be "screened under" the national screening program to be enrolled in Medicaid, but implementation guidelines offer states options for defining what counts as screening "under" the federal program.[7] Oregon currently uses the strictest definition, requiring that program funds pay for all or part of a woman's screening and diagnostic services. The least restrictive definition, by contrast, allows treatment regardless of who paid for the screening, so long as the provider is recognized by the BCCP and the woman meets the other eligibility criteria.

SB 891 would change existing statutory language defining who is eligible for the BCCM, instead simply recognizing BCCP eligibility criteria set by the Department of Human Services (DHS) through administrative rule. A woman would still have to be enrolled in the BCCP in order to receive treatment through the BCCM. Any licensed provider could, however, refer a patient to the BCCP for enrollment, provided she lacked insurance and met the income limit. Because Oregon allows presumptive eligibility for the BCCM, she could begin receiving treatment immediately, while her Medicaid paperwork is being processed.[8]

The bill does not explicitly require Oregon to adopt the least restrictive federal eligibility definition, leaving open the possibility that in the future eligibility could be restricted without a change in the statute. SB 891 would be improved if amended to explicitly mandate use of the least restrictive federal eligibility definition.

The change in eligibility criteria to the least restrictive definition would set Oregon alongside 14 other states currently using the more expansive criterion.[9] It would eventually allow twice as many Oregon women to obtain cancer treatment through the BCCM. In 2008, the BCCM had a caseload of about 350 women.[10] DHS estimates that changing to the least restrictive eligibility definition would expand the average monthly caseload during the 2009-11 budget cycle by 128 women and allow about 400 additional women access to treatment in an average month during the 2011-13 biennium.[11]

The federal government would pick up most of the cost and put money into Oregon's economy

As an incentive for states to participate, the federal government covers a larger share of costs for women enrolled in Medicaid through the BCCM than it does for standard Medicaid programs.

For every dollar Oregon spends on the BCCM in 2009, the federal government will add $2.80.[12] That is, the federal government will cover nearly three-quarters of the total cost.

DHS estimates that the expansion contemplated by SB 891 would cost Oregon $1.6 million in 2009-11 and $5 million when fully implemented in 2011-13. It would also bring into the state economy $4.5 million in new federal matching dollars in 2009-11 and $14.2 million in 2011-13.[13]

Conclusion

Oregon's current policy is unfair and illogical. It rations treatment — with life-and-death consequences —on the basis of who undertakes the cancer screening, not just the financial need of the patient.

By removing Oregon's restrictive statutory language, SB 891 opens the way for more low-income, uninsured women to receive the treatment they need for breast or cervical cancer, while pumping millions of federal dollars into the state economy. The bill is good public policy, and it could be made even better by amending it to explicitly adopt the least restrictive federal eligibility standard.

When it comes to providing treatment for low-income, uninsured women with breast or cervical cancer, it shouldn't matter who paid for their screening services.

Endnotes

[1] Email message from Lynn Read, Deputy Administrator, Division of Medical Assistance Programs, Department of Human Services (DHS), to Joy Margheim, OCPP, March 20, 2009.

[2] DHS, *Breast and Cervical Cancer Medical Program Manual,* available at www.dhs.state.or.us/spd/tools/program/bccm.htm; Breast and Cervical Cancer Prevention and Treatment Act of 2000, PL 106-354, section 2(a)(2)(aa). Women not covered for the needed treatment count as uninsured. Someone insured under a group plan that does not cover the necessary treatment or who is in a period of exclusion or has exhausted her lifetime limit on benefits, for example, could qualify for treatment. Centers for Medicare and Medicaid Services (CMS), Technical Policy Questions and Guidance, Breast and Cervical Cancer Prevention and Treatment Act of 2000, not dated, available at www.cms.hhs.gov/MedicaidSpecialCovCond/Downloads/TechnicalPolicyQuestionsandGuidance.pdf.

[3] DHS, Oregon Breast and Cervical Cancer Program, "Breast and Cervical Cancer Program (BCCP) Eligibility Guidelines," available at www.oregon.gov/DHS/ph/bcc/index.shtml.

[4] DHS, Oregon Breast and Cervical Cancer Program, *Guidebook for Providers,* September 2008, p. 23, available at www.oregon.gov/DHS/ph/bcc/docs/BCC_Program_Manual.pdf.

[5] See Oregon Center for Public Policy, *SB 892 Promises to Save Women's Lives,* April 9, 2009.

[6] Breast and Cervical Cancer Prevention and Treatment Act of 2000, PL 106-354, section 2(a)(2)(aa). See CMS, Medicaid Special Coverage Conditions, Breast and Cervical Cancer: Prevention and Treatment, www.cms.hhs.gov/MedicaidSpecialCovCond/02_BreastandCervicalCancer PreventionandTreatment.asp.

[7] Letter from Timothy M. Westmoreland, Director, Center for Medicaid and State Operations, to State Health Officials, January 4, 2001, available at www.cms.hhs.gov/MedicaidSpecialCovCond/downloads/CMSO-LetterBreast&CervicalCancerPrevention&TreatmentAct.pdf. States select from 3 categories to define whether a woman has been "screened under the program." Category 1 considers women eligible only if program funds paid for all or part of their services; category 2 includes women who were screened by a *provider* who receives program funds, regardless of whether the women's screening was covered by program funds; category 3 covers women screened by any provider recognized by the state. All states must treat women in category 1, but they can expand eligibility by adding categories 2 and/or 3.

[8] ORS 414.536; DHS, *Breast and Cervical Cancer Medical Program Manual.*

[9] Email message from Suzan K. Stecklein, CMS, to Joy Margheim, OCPP, August 8, 2008, and OCPP analysis of state program web sites. Here, states choosing options 1 and 3 or 1, 2, and 3 are all counted as having chosen the least restrictive option.

[10] DHS, *Fall 2008 Forecast,* September 2008, pp. C-21-22, available at www.oregon.gov/DHS/data/forecasts/2008/fall_08_01.pdf; DHS, OHP managed care enrollment reports, www.oregon.gov/DHS/healthplan/data_pubs/enrollment/main.shtml. According to the fall 2008 forecast, the caseload was 355 in March 2008; the average of caseload figures reported in DHS enrollment reports for January through November 2008 is 356.

[11] Email message from Lynn Read, Deputy Administrator, Division of Medical Assistance Programs, DHS, to Joy Margheim, OCPP, March 20, 2009.

[12] Technical Policy Questions and Guidance, Breast and Cervical Cancer Prevention and Treatment Act of 2000, www.cms.hhs.gov/MedicaidSpecialCovCond/Downloads/TechnicalPolicyQuestionsandGuidance.pdf. For 2009, the enhanced FMAP rate is 73.72 percent. The standard federal medical assistance percentage was 62.45 for 2009, but the American Recovery and Reinvestment Act of 2009 (ARRA) temporarily increased standard state FMAP rates by 6.2 percent for 2009 and 2010. States with large increases in their unemployment rate will receive an additional increase. The ARRA increases do not affect the enhanced FMAP rate for the BCCM. Federal Financial Participation in State Assistance Expenditures (FMAP), Fiscal Year 2009 Table, aspe.os.dhhs.gov/health/fmap09.htm; U.S. Department of Health and Human Services, "$15 Billion in Medicaid Relief Headed to States: Federal Medical Assistance Percentage (FMAP)," www.hhs.gov/recovery/programs/medicaidfmap.html; Center on Budget and Policy Priorities, *American Recovery and Reinvestment Act of 2009: State-by-State Estimates of Key Provisions Affecting Low- and Moderate-Income Individuals,* updated March 3, 2009, available at www.cbpp.org/files/1-22-09bud.pdf; American Recovery and Reinvestment Act of 2009, H.R. 1, 111th Cong., section 5001.

[13] DHS, 2009-11 Agency Request Budget, Division of Medical Assistance Programs, "Budget Summary," available at www.oregon.gov/DHS/aboutdhs/budget/09-11budget/arb/dmap_summary.pdf; Email message from Lynn Read, Deputy Administrator, Division of Medical Assistance Programs, DHS, to Joy Margheim, OCPP, March 20, 2009.

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