



Breast and Cervical Cancer Advisory Council Meeting
May 21, 2012
10:00 a.m. - 3:00 p.m.
American River Room 74.718



Agenda Item	Discussion	Action Items
Welcome and Introductions	<p>In attendance:</p> <p>BCCAC Members: Larry Wagman, Michael Policar, Susan Shinagawa, Diane Carr, Joan Bloom, Claire Mills, Beverly Rodriguez</p> <p>CDPH Staff: Dr. Caroline Peck, Monica Brown, Stephanie Roberson, Enrique Ramirez, Katie Owens, La Roux Pendleton, Joanne Wellman.</p> <p>DHCS Staff: Terri Stratton, Marin Deen, Kathleen Yelle, Carmen Alexander</p> <p><u>Introduction of New Staff</u> - Monica Brown is the new Research Scientist Supervisor I who is overseeing the Evaluation and Research Unit. She previously worked for the California Cancer Registry. Enrique Ramirez is the new Staff Services Manager I, who is overseeing the Fiscal and Legislation Unit. He previously worked at the Department of Health Care Services (DHCS) with Audits and Investigations.</p>	
Announcements and Co-Chair Comments	<p>Every Woman Counts (EWC) is scheduled to be transferred over to DHCS on July 1, 2012. California Department of Public Health (CDPH) and DHCS staff are working to make a the smooth transition.</p> <p>The transition of EWC from CDPH to DHCS has been in progress for the last year, but Cancer Detection Section (CDS) found out about it in January 2012.</p>	Send Council DHCS organization chart when it becomes available
California Department of Public Health	<p>State of the State – Budget cuts are focused on the General Fund (GF), but no cut to EWC GF are anticipated. In the Estimates Package, EWC asked for the amount of funding needed for the next fiscal year based on projections of caseload. For fiscal year (FY) 2012-13, EWC is asking for \$10.3 million (M) in GF.</p> <p>EWC just received its award notification for its federal program, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). EWC is getting roughly</p>	



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	<p>the same amount it received last year. EWC applied for \$9M, but received \$6.87M, which is \$74K less than the previous year. The EWC support budget will be reduced by \$74K, and the funding that pays for clinical services will remain the same. The Center for Disease Control and Prevention (CDC) informed EWC that they performed well. No state that applied for \$9M received that amount. The funding amount is more of a reflection of the federal budget situation.</p> <p>Federal Budget – It is unlikely that there will be a FY 2013 federal budget until after the general election. EWC will receive funding for NBCCEDP. The funding for NBCCEDP will be included in a continuous resolution that will be passed after October 1, 2012.</p> <p>Coordinated Chronic Disease Grant – CDPH will be developing a chronic disease state plan, identifying opportunities for collaboration, setting priorities for the state, and working with local health departments and various stakeholders. EWC was specifically called out by CDC to participate. CDPH will have an interagency agreement with DHCS to maintain the collaboration.</p> <p>Transition of EWC from CDPH to DHCS – CDS learned late last year that the Governor was proposing to move EWC from CDPH to DHCS. The rationale behind the decision is that DHCS has a lot of experience running health plans, and EWC is a limited benefit health plan. CDPH has been working with DHCS to make sure there is a smooth transition. EWC will be housed in the Division for Medi-Cal Benefits, Waivers Analysis, and Rates. No determination has been made about who will be chief of EWC. DHCS is undergoing reorganization to accommodate this and other programs that will be transitioning.</p> <p>The area of risk with the transition is maintaining the ability to meet CDC requirements. The Council is concerned with maintaining strategic integrity of the program when it transitions over to DHCS. There is a good foundational understanding of public health among DHCS leadership. The transition has been described as a lift and shift. EWC will be its own branch. The Council believes DHCS leadership needs to be tasked with ensuring the strategic integrity of EWC. The recommendation to the Council is to weigh in on the type of person that should be the chief of EWC.</p>	<p>The Council will write a letter to DHCS leadership and task them with maintaining the strategic integrity of EWC upon its transition to the department. Dr. Wagman will call Neal Kohatsu and Vanessa Baird. He will also communicate with DHCS Legislative and Governmental Affairs.</p>
<p>Breast and Cervical Cancer</p>	<p>Breast and Cervical Cancer Treatment Program Report</p>	



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<p>Treatment Program</p>	<p>Since October of last year, there has been an additional 1900 applications submitted. Approximately 1400 applications submitted with breast cancer, approximately 500 applications submitted with cervical cancer, and two applications came in with diagnosis of breast and cervical cancer.</p> <p>Previously there was a chart in the report of the five highest incidences of type of breast cancer, and the Council asked for it to be condensed to three and to present a historical picture. The chart in the report shows by year, from the beginning of the program through December 2011, the incidence of non-invasive ductal cancer with comedo and non-comedo grouped together. It also shows invasive cancer with ductal and lobular, grouped together. Metastatic cancers are also included. A column for all other cancers is also shown. The goal was to see if there was a downward trend in number of cases coming in of women who have invasive or metastatic cancers to determine if the screening program has been effective. By looking at figures, it appears that there has been a decrease, over time, in invasive and metastatic cancers. From 2002, there is a general trend of non-invasive cancers going from 18 percent of the caseload to 24 percent of the caseload. Combined invasive and metastatic cancers have declined significantly from 72 percent of caseload to about 61 percent. There is some variation among years, but in general there appears to be a trend.</p> <p>Cervical cancer – There is not a significant difference in prior reports and percentages are roughly the same as they have been in the past.</p> <p>Forty eight percent of the women who are enrolled in the Breast and Cervical Cancer Treatment Program (BCCTP) are screened by EWC. Twenty-two percent of BCCTP enrollments come from private providers which indicate there is awareness of BCCTP outside of EWC providers.</p>	<p>The Council wants a list of what is included in the “all other cancer” category and see it broken down by invasive, non-invasive and metastatic.</p> <p>For cervical cancer, the Council would like to see CIN II, II and High Grade Squamous Cell Intraepithelial cancers collapsed. They would also like other cervical cancers to be listed out.</p> <p>The Council would like to know if the BCCTP Cases by County chart is representative of the percent eligible population by those counties. They would also like to know if the distribution is representative of the eligible population with</p>
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<p>Cancer Detection Section Updates</p>	<p>Policy Updates</p> <p><u>Impact of Low Income Health Program on EWC</u> – The impact of the Low Income Health Program (LIHP) was taken into account in the Estimates package. Until January 2014, Medi-Cal is implementing LIHP, which is the bridge to health care reform, 1115 Waiver. Currently ten counties have enrolled into LIHP. LIHP will be expanded as other counties enroll. LIHP is voluntary from the county’s perspective in terms of if they want to participate, how much funding they want to commit, and who they want to cover.</p> <p>Even with the implementation of LIHP and ultimately Health Care Reform, the EWC program will be necessary because the legislature understands that there will be women who will need access to clinical services who are not eligible for LIHP, the Health Benefit Exchange, or extended Medi-Cal services. In FY 2012-13, approximately 52,000 of the EWC population will go into LIHP.</p> <p>EWC Provider Billing and Clinical Tool Update</p> <p><u>New Mobile Application for Breast Cancer Diagnostics Algorithms</u> - There is a new mobile application for the Breast Diagnostic Algorithms. Interlinks are embedded and will take users to an algorithm based on specific abnormalities. These interlinks are also incorporated into the webpage that is used by regional contractors.</p> <p><u>New Case Management CPT Code for Abnormal Records</u> - There has been a change in case management claim procedures and codes used for billing. EWC was alerted by DHCS that the CPT codes that have been used to bill case management since 2002, CPT 99358 and 99359, were not HIPAA compliant. Also, other programs were accessing that code and did not like the fixed rate. It was determined it was not an appropriate code based on HIPAA guidance and compliance and correct use of the code. The correct code is going to be changed from a dual system to a health care common procedure code system level two, which are not direct service codes, such as mammograms and office visits, for example. This is a T code and EWC is proposing to change it to a T1017-targeted case management code and eliminate a code for normal screening results effective July 1, 2012. EWC will continue to pay for abnormal cases only. Abnormal cases</p>	<p>regard to race/ethnicity.</p>
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include any instance of a provider's decision for immediate workup. In the description of the code, it states each 15 minutes. EWC has to be clear with providers that this code can only be billed once per woman per year, even if the appointment takes longer than 15 minutes. This is a minor policy change. EWC plans to send letters to primary care providers, and regional contractors will be alerted during the upcoming conference. The policy change will also be included in the Medi-Cal bulletin that is posted on the Medi-Cal website, and in the Medi-Cal manual.

Reporting Updates

Quarterly Report – The quarterly report reflects program activity from July 1, 2011 through the end of the third quarter, March 31, 2012. As of that date, the number of EWC recipients, which include women who have received at least one service, was 189,721. The total number of claims was 549,454. Expenditures came in at \$21.9M. We are at about 60 percent of projected caseload for the fiscal year. We are at about 53 percent of projected expenditures. Several months after the fiscal year ends, providers will still be billing for services provided, so it will be a while before we have the full picture of caseload and expenditures for this fiscal year. The next report is due August 15, which will include a complete report of data through June 30. .

Bureau of State Audits Audit Response – EWC gives semi-annual progress reports to the Bureau of State Audits (BSA), and they in turn issue a report on their interpretation of our progress. The last report came out in January and there are two outstanding items, and one of them is regulations. In past meetings, EWC has reported on the promulgating of regulations, but that process has been put on hold due to the transition to DHCS.

The other outstanding item is EWC contracts. EWC provided a response stating it was doing everything it could to monitor expenditures in contracts by making the scope of work more detailed and including more quantification, asking for more detail in invoices, requiring progress reports, and administering site reviews. However, the auditors concluded that EWC did not substantiate the claim that the resolution for the recommendation was fully implemented. DHCS is conducting their own review of the audit findings and this item was not a concern, and they will be involved in providing BSA a response.



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	<p><u>Annual Report</u> – The statute that provides for the report is Revenue & Taxation Code 304061.6 (f). In FY 2009-10, the program served just over 210,000 women. Approximately 80 percent were for breast cancer services and 20 percent were for cervical cancer services. Thirty-two percent of women served for breast cancer services were ages 40-49, and 67 percent were over age 50. For cervical cancer services, 14 percent were ages 25-39, 31 percent were ages 40-49, and 55 percent were over age 50. Compared to 2008-09, the numbers of women served were down for breast services due to policy changes and program closure. The primary ethnic group served in the program is Hispanic women, followed by Asian Pacific Islanders, non-Hispanic whites, African Americans, and others, which include mixed race and race unknown. Presumably, the racial ethnic distribution among the EWC population may reflect the relationship with providers. It could also be the only source of screening for the Hispanic women, while African American women may have access to resources or know of other resources.</p> <p>The majority of breast cancer screening and diagnostic services performed were mammograms at 88 percent, followed by clinical breast exams and other diagnostic services. For cervical cancer screening the majority of services performed were Pap tests, with only 0.4 percent going toward diagnostic services. The stage at diagnosis compares the EWC population to the general cancer population in California and comes from cancer registry data. EWC women had fewer diagnoses at the local stage versus more at regional and distant stages. However, the comparison with cancer registry data may not be truly equal. This is the entire state of California being compared to women in a program that are of low socioeconomic status. The distribution of race/ethnicity is not the same. The next comparison will be more equal in the next annual report. For cervical cancer diagnoses, EWC women were diagnosed more often with local and regional disease than the rest of state, but less often with distant disease.</p> <p>Of women diagnosed with breast and cervical cancer from EWC, 75 percent of the breast cancers received treatment from BCCTP, whereas for cervical cancer, 63 percent received treatment through BCCTP compared to 24 and 33 percent respectively of women who received treatment through other health care services.</p> <p>FY 2010-11 preliminary statistics include serving 191,000 women with 154,600 for breast cancer services and 87,900 for cervical cancer services. In comparison to</p>	
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FY 2008-09 our numbers are still down for breast cancer screening in younger women and women over age 50. The aftermath of program changes are still being felt.

Federal Grant Core Program Performance Indicator (CPPI) Success – CPPIs are program measures for screening of Pap tests and mammograms. Majority of women should be rarely or never screened, and we have met that. We have also met the percent of women that should be screened over age 50. For cervical cancer diagnostics, EWC met all CPPIs. For breast cancer measures, EWC has met CPPIs despite program changes.

Budget Updates

Estimates Package FY 2012-13 – EWC is spending within its means. EWC estimates it will spend \$41.6M in claims, and it currently has \$45.1M in local assistance funding. In the EWC May Revise Estimates Package, it was asked to estimate 2012-13 expenditures on clinical claims. The estimate was \$40M, with \$10.3M being requested from GF, and the rest of the money will come from all other funding sources (BCCA, Prop 99, Federal Grant). The total amount being requested for local assistance is \$44.8M. A percent change methodology was used to generate the estimate in caseload and expenditures for FY 2012-13. For FY 2011-12, 79 percent of total funds are spent on clinical claims. The cost of state operations is under 15 percent. For FY 2012-13, 80 percent of funds will be spent on clinical claims. EWC will be reducing the cost of state operations in FY 2012-13. For FY 2011-12, the total funding amount is about \$53M, and for FY 2012-13 total funding amount is about \$50M.

Regional Contractor Update

Regional Conference – May 30-31. An overview of the agenda was provided.

Consumer 800 Number Update - Cancer Prevention Institute of California (CPIC) is the contractor that administers the EWC consumer 800 number. CPIC is staffed with telephone information specialists who pre-qualify women for eligibility into EWC. Major highlights in recent annual report show from July 2010 - June 2011 CPIC answered about 19,000 calls. Sixty-five percent of calls were for screening and 69 percent of those were pre-qualified for enrollment into EWC. More calls



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	<p>were received when services were restored. The breakdown for how callers knew about the consumer 800 number include: 30 percent from health professionals, 16 percent had previous knowledge of the program, 14 percent from organizations and community groups, and 13 percent from the internet.</p>	
<p>USPSTF New Cervical Cancer Screening Guidelines</p>	<p>New Cervical Cancer Screening Guidelines were released in March. From the mid-1940s to the mid-1980s, women were told to get Pap tests once a year. After that time, recommendations were based on personal risk. If you had few risk factors you could stretch out intervals to every three years. In 2003, the risk of significant cervical abnormality was three years after the onset of intercourse. The recommendation was to wait to screen women three years after first sexual encounter. The next big change came in 2009. The American College of Obstetricians and Gynecologists (ACOG) recommendation was for women to start having Pap tests at age 21, every two years from ages 21-29 and every three years from ages 30-65. Once a women reached age 65 or 70, if there were three negative screenings in prior 10 years, then there was no need to get screened for the remainder of the lifetime. The evolution of cervical cancer screening is that it's starting a little later and ending earlier, with wider screening intervals. The exceptions were women with high risk, and they are still being recommended for annual screening.</p> <p>United States Preventive Services Task Force changed their recommendation and provided two alternatives. One is cytology (Pap Test). Women between the ages of 21-65 should get a Pap test every three years, or alternatively get co-testing, which is cytology and HPV testing, which is recommended for women over the age of 30. If both cytology + HPV testing are negative, the recommended screening interval is 5 years.</p> <p>The American Cancer Society, the American Society of Colposcopy and Cervical Pathology, and the American Society of Clinical Pathology came out with another recommendation for guidelines. For women under the age of 21, no screening is recommended. For women ages 21-29, screen ever three years. For women ages 30-65, cytology + HPV every five years or cytology alone every three years is recommended. This group identified a preferred approach, which are the cytology + HPV over cytology alone. Their rationale is they believe there is better sensitivity</p>	



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	<p>and negative predictive value.</p> <p>These guidelines establish a standard of care for the nation. The Office of Family Planning (OFP) will be doing provider education, updating clinical practice guidelines, and hosting a webinar to increase awareness of new guidelines. OFP will also be issuing report cards to providers on their average screening intervals. OFP will be developing a program on how to educate consumers on how to tailor their intervals based on guidelines.</p>	
Council Discussion	n/a	

Council Members	Attendance	
	Present	Absent
Lawrence Wagman	√	
Diane Carr	√	
Rev. Tammie Denyse		√
Lydia Howell	√	
Marion Kavanaugh-Lynch		√
Claire Mills	√	
Michael Policar	√	
Sandra Robinson		√
Beverly Rodriguez	√	
Susan Shinagawa	√	

State staff	Attendance	
	Present	Absent
Caroline Peck, CDCB, Branch Chief, CDS Acting Chief	√	
Stephanie Roberson, CDS, Acting Chief	√	
Katie Owens, CDS, Chief, Clinical and Provider Services Unit	√	
Enrique Ramirez, CDS, Fiscal and Legislation Unit Chief	√	
Monica Brown, CDS, Chief, Evaluation and Research Unit	√	
Joanne Wellman, CDS, Chief, Health Education and Communication Unit	√	
La Roux Pendleton, CDS, Fiscal & Legislation Unit	√	
Kathleen Yelle, Manager, BCCTP	√	
Carmen Alexander, Manager BCCTP	√	



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Carol Somkin		√				
Joan R. Bloom	√					