



Breast and Cervical Cancer Advisory Council Meeting
November 28, 2011
9:00 a.m. - 12:00 p.m.



Agenda Item	Discussion	Action Items
Welcome and Introductions	Dr. Caroline Peck will be replacing Dr. Lyman as the Co-Chair due to his upcoming retirement.	
Announcements and Co-Chair Comments	n/a	
California Department of Public Health	<p>Meeting was called to order at 9:34 a.m.</p> <p>State of the State - The California Department of Public Health (CDPH) has a new administration. The CDPH director is Ron Chapman who is the former health officer for Solano County. He is assisted by Daniel Kim, Deputy Director of Operations and Kathleen Billingsley, Chief Deputy Director, who both came on in July. Fiscal Year (FY) 2011-12 budget was signed on time.</p> <p>Federal Budget Update - The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) may change in the next grant cycle. The Center for Disease Control and Prevention (CDC) is thinking of a new way of doing business as shown by the President's FY 2012 budget. The CDC is interested in an integrated approach to address chronic diseases and their risk factors. The Chronic Disease Control Branch (CDCB) within CDPH has a number of CDC grant programs such as heart disease and stroke, arthritis, diabetes, comprehensive cancer, colorectal, and breast and cervical cancer.</p> <p>This effort is being spearheaded by Dr. Ursula Bauer. A Funding Opportunity Announcement (FOA) for a coordinated chronic disease grant was released by the CDC to increase coordination and collaboration, efficiency and effectiveness of chronic disease programs. The deliverables for this grant are to create a statewide chronic disease plan and to build a statewide coalition. . CDPH received a grant award for \$1.9M per year for three years. The CDCB is currently setting up an</p>	



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	<p>infrastructure to integrate these chronic disease programs. CDC would like a focus on three areas which are being referred to as “buckets”. The first area is policy, the second area is health care systems, and the third is community clinical linkages. How programs will look in the future remains to be seen. . In 2013, there may be an integrated FOA released by the CDC where all chronic disease programs will be applying within the same FOA. Up to this point every program has been applying independently.</p> <p>CDS has applied for the NBCCEDP every 5 years. CDC may not have the program focus on screening so much in the future. Program may be asked to focus more on health education and outreach to get people screened. This is mixed in with the Health Care Reform (HCR) in 2014 when people will have more access to health insurance. California serves undocumented immigrants that will not be eligible for HCR and the program is trying to make the point to CDC and California administration that we will still need programs that provide quality clinical services to this population after 2014. This is a period of great uncertainty about what will happen at the federal level as this is an election year.</p> <p>NBCCEDP will have a FOA that will be coming out this spring and Cancer Detection Section (CDS) will inform the council at the next meeting what CDC’s direction will be and how many years the FOA will be for. It will be business as usual until we hear otherwise.</p> <p>Federal Fiscal Year 2012 Budget: When the bill passed to raise the debt ceiling, \$900B in cuts was also agreed to that would take effect over 10 years and it would include \$12B in 2012. As of now, there is no budget for FY 2012. Two continuing resolutions have been passed, one through November and the second one through mid-December. There are likely to be more short term resolutions. As the super committee was not able to come to a resolution, trigger cuts will begin in 2013 and it is unclear what will happen in FY 2012. CDC has informed the program that there will be flat funding this year, but CDS will have to wait until a budget decision or year-long continuing resolution is passed to know for sure. There was about a three percent decrease in federal funding for this fiscal year.</p>	
<p>Breast and Cervical Cancer Treatment Program</p>	<p>39,483 applications have been received since program inception. Of those 25,542 were for breast cancer treatment, 13,768 were for cervical cancer treatment and 173 for both. Five most common diagnosed breast cancers have remained</p>	<p>The Council would like to see what is going on with invasive which would include the lobular</p>



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	<p>consistent over the past 10 years. Rankings have changed over the years. Cervical cancer diagnoses have remained consistent over the last 10 years and have not changed.</p> <p>EWC continues to bring in the most applicants to BCCTP. Forty-eight percent of total cases were enrolled from women screened in EWC.</p> <p>BCCTP cases by county - LA has largest enrollment for BCCTP. Approximately 37 percent of all cases come from LA County.</p> <p>Percentage of women treated by BCCTP and incidence rates by county - for some counties the comparison is close but not for all counties. This comparison includes the BCCTP Medi-Cal population and the Medi-Cal population that is not covered by BCCTP.</p> <p>Impact of EWC suspension on BCCTP enrollment - Applications initially decreased when EWC was suspended. Enrollment in BCCTP has recovered and more people have enrolled in BCCTP.</p> <p>From 2002-2009, 10 percent of all breast cancers in California were represented by BCCTP. In 2002, it was 18 percent, but that is likely attributable to BCCTP receiving a client from the Breast Cancer Treatment Fund.</p>	<p>and the ductal together and the non-invasive which would include the comedo type and the non-comedo type together. Instead of five categories, the Council would like to see three categories. This would show whether the screening component of EWC is effective by looking to see if there is a reduction in metastatic and an increase in non-invasive. If this is the case the Council thinks there should be publicity around this success.</p>
<p>Cancer Detection Section Updates</p>	<p>Reporting Updates</p> <p><u>Quarterly Report</u> – This update includes the first report for FY 2011-12. The report was released late to include a full quarter report. The report includes data from July 1, 2011 through September 30, 2011. Total unique EWC recipient ID number is 59,312 with expenditures estimated at \$5.4 million for all services. This report can be found on the CDS website. Program activities are also included in the report.</p> <p><u>Core Program Performance Indicators (CPPIs)</u> – The most recent report was from October 1, 2010 through March 31, 2010. This update is a follow up to an action item from the previous Council meeting and will focus on cervical cancer, starting with the federal subset. All CPPIs were met except for the percent of abnormal Cervical tests with complete follow up. The goal of this indicator is greater than or equal to 90 percent and EWC reached 82 percent. Overall, EWC is doing well. Seventy-seven percent of the non-federal subset conducted complete follow up on</p>	



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	<p>abnormal tests.</p> <p><u>Rarely vs. Never Screened for Cervical Cancer</u> – This report is another follow up item that was requested in the previous Council meeting. The indicator goal is greater than or equal to 20 percent. Rarely screened is having a previous Pap test more than five years ago. For the federal subset, never screened is 15 percent, and non-federal is 13.9 percent. Combined all enrolled providers statewide is 15.3 percent. The difference between the federal and the non-federal subset is not statistically significant. For rarely screened, 5.8 percent for the federal and 9.1 percent for the non-federal subset, and for both it is 9.1 percent. The difference here is statistically significant. EWC is doing better with never screened than with rarely screened.</p> <p>Response to Audit</p> <p>The Bureau of State Audits last published update was March 20, 2011. There were several outstanding items including the ability to track spending. In response, CDS has implemented activities as described in the initial audit response: added percent effort to contract scope of work activities, implemented a time study and required detail for line items invoiced. In addition, CDS participates in the Estimates process to provide the Legislature with projections of caseload and associated costs. To address the finding of duplicate enrollment CDS is looking into a single point of enrollment/identity (SPE/I) model to enroll women into EWC. A system development notice (SDN) was submitted to facilitate this change with the Medi-Cal fiscal intermediary (FI), but there is currently a moratorium on SDNs as the Medi-cal FI has undergone a change recently. Regarding the issue of program transparency, CDS is promulgating regulations. CDS will get input from the Council in advance in an informal manner before the official public comment period.</p> <p>Policy updates</p> <p><u>Single Point of Enrollment/Identity (SPE/I)</u> - CDS had addressed concerns raised in the last Council meeting about using the EWC Consumer 800 number as the sole means to enroll women into EWC. The purpose of SPE/I from the auditors view point was to design a system that would eliminate duplicate enrollments, and be able to track caseload better so as not to be subject to duplicate billing. One proposed solution was to utilize the 800 number as the single point of enrollment. Feedback from the last meeting reinforced concerns with this method. At this time,</p>	<p>The Council would like to know the impact of HPV testing. Has this been cost effective? Has this proved to be a successful in cervical cancer outcomes?</p>
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	<p>CDS is not sure how it will be implemented but will still need to make sure every woman has only one recipient identification number in her lifetime. The program is planning to use unique identifiers to ensure that a woman is not being reenrolled or has multiple identification numbers within the system in order to track for quality control purposes and prevent duplicate billings. CDS is exploring alternative methods which also require SDNs. EWC is looking internally at controls that can be created in DETEC (EWC's data collection and reporting system) that will allow CDS to uniquely identify women without using the 800 number as the single point of enrollment/identity.</p> <p><u>Future Challenges</u> - EWC has been participating in the Estimates process and reported the Low Income Health Program (LIHP) as a future fiscal issue. CDS is being asked to estimate the impact on the EWC enrollment. LIHP is a Medi-Cal waiver that is being implemented as a part of HCR to expand Medi-Cal to cover people who are up to 133 percent of the federal poverty level (FPL) and in the secondary program, up to 200 percent FPL. LIHP is for under and un-insured individuals throughout the state who are legally documented residents. CDS has to determine what percent of EWC caseload is up to 133 percent and 200 percent FPL, and are undocumented to determine who of the EWC patient population would be potential enrollees into LIHP. There are ten legacy counties with managed care plans already through Medi-Cal. They are the first set of programs enrolling individuals who are up to 133 percent FPL. Four of those 10 are enrolling individuals up to 200 percent FPL. As of August of this year, approximately 196,000 individuals have been enrolled. CDS is working with Department of Health Care Services (DHCS) to determine what the total enrollment will be. Estimates on their website suggest 500,000 will be enrolled by the end of December 2013, before full implementation of HCR occurs in 2014. Each county has control over enrollment caps, and can decide at what FPL they are enrolling individuals. The Department of Finance is looking for CDS to provide projections on estimated savings as a result of this program. Initial estimates are that 12-14 percent of EWC's caseload is undocumented residents who are not eligible for LIHP.</p> <p><u>Digital mammography (DM) Sunset</u> – This was included as part of the quarterly report to the legislature. Cost of DM is higher than film mammography (FM) and there is likely to be increased costs to the program once the bill sunsets. Unless the sunset date or rates change, the effect on the program will be an approximately \$3.7 million increase in screening costs. This information will be included in the Estimates process as a fiscal impact, and CDS will request funding to cover</p>	<p>CDS to find the sponsor AB 359 and send to the Council. The Council asked if there was</p>
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	<p>additional costs. There has not been a significant increase in the proportion of DM to FM claims after implementation of Assembly Bill 359. CDS may see more providers billing for DM after the sunset date as they will be able to claim full reimbursement for DM.</p> <p><u>Effect of Case Management Fee Structure Change</u> – CDS did a comparison of six month intervals between January and June of 2009 and 2011. CDS saw the same rate of data submission when looking at billing at unique offices. There was a slight increase of abnormal cases reported in 2011, but there was no significant change in data submission. The new case management fee structure has been an effective cost containment strategy and has not affected data submission. CDS is concerned that with less incentive to report normal screening outcomes that providers may increase reporting on abnormal screening outcomes to get the \$50 fee. The program will continue to track billing behavior.</p> <p>Regional Contractor Update</p> <p>CDS is in the process of executing new contracts with the regions. All 10 regions have contracts that are in the process of being approved. CDS was able to increase the contract amounts for this contract cycle. The six regions that the California Health Collaborative covers have been consolidated into one contract and have separate deliverables for each region.</p> <p>Budget Updates</p> <p>For FY 2011-12, 79 percent of the EWC budget was spent on clinical claims, which includes all four fund sources (BCCA, federal grant, Prop 99, and General Fund). Seven percent goes to local assistance contracts.</p> <p>Nine percent was spent on salaries and operating expenses. Six percent was spent on support contracts.</p> <p>There was a 3.2 percent decrease in the federal grant. CDS is applying the decrease to State operations.</p> <p>There will be fiscal challenges beginning this year with processing costs. DHCS has acquired a new FI that processes and pays EWC clinical claims. Additional costs are associated with contract turnover and enhancements to the processing of</p>	<p>something that could be done to extend the sunset date, and CDS informed them that it could be through the legislative process. The Council thought there may be value in exploring this as an option.</p>
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<p>clinical claims. EWC estimates costs will quadruple in this fiscal year, and future fiscal years for claims processing. CDS is in the process of determining which contracts will be eliminated or reduced to cover this increase in costs from their State operations budget for this fiscal year, and may reduce support contracts for next fiscal year. In prior years EWC used local assistance funds to pay for processing costs to free up local assistance dollars to screen more women. This was the strategy that was employed prior to the implementation of the Estimates process.</p> <p>Workgroup Updates</p> <p><u>Cervical Cancer Screening and Follow-up Curriculum</u></p> <p>The development of this curriculum was part of the CDC workplan and the result of a provider needs assessment conducted a few years ago. The goal of the curriculum is to offer a comprehensive overview of cervical cancer with an emphasis on the workup of abnormal cytological findings. Live trainings of the curriculum will be conducted and continuing medical education (CME) credits will be given for participants who enroll in the training. Trainings will be offered in all 10 regions. In the future, CDS plans to record the training and conduct it as a webinar and hopefully, CME credits can be given for the webinar.</p> <p><u>Provider Evaluation Workgroup</u></p> <p>This workgroup was created as a continuous quality assurance measure to assure the quality of care provided to women. Providers are to provide a complete set of data on each woman served, but the reality is different. There are discrepancies in the data submission rates and the billing behavior. Average data submission is 75 percent. Fourteen percent of providers report less than 50 percent of their required data. Twenty-two percent of providers report between 50-75 percent of required data. Fifty-one percent of providers report more than 75 percent of their required data. Fourteen percent submit no data and this can occur for a variety of reasons. Providers who are deficient in submitting complete data are informed of their deficiencies in data submission and asked to submit an action plan on how they will correct their deficiencies. The workgroup is collaborating with staff promulgating regulations to include language that allows EWC to disenroll providers who are continuously delinquent with submitting complete data.</p>



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Council Discussion	n/a
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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		√
Carol Somkin		√
Joan R. Bloom	√	

State staff	Attendance	
	Present	Absent
Caroline Peck, CDCB Branch Chief	√	
Katie Owens, CDS Acting Chief	√	
Stephanie Roberson, CDS Assistant Chief	√	
Betsy Barnhart, CDS Fiscal and Legislation Unit Chief		√
Manuel Chavez, BCCTP	√	
Kathleen Yelle, Manager, BCCTP	√	
Kristine Selmar, CDS, Chief, Administration Unit	√	
Joanne Wellman, CDS, Chief, Health Education and Communication Unit	√	
La Roux Pendleton, CDS, Fiscal & Legislation Unit	√	
Carmen Alexander, Manger, BCCTP		√