Breast and Cervical Cancer Early Detection Program

and

Colorectal Cancer Control Program

Report for Program Year

2017-2018

New York State Department of Health

Cancer Services Program

TABLE OF CONTENTS

Additional and related information is available from the New York State Department of Health (NYSDOH) at: http://www.health.ny.gov/cancerservicesprogram

Persons interested in obtaining additional information about this report should contact the NYSDOH Cancer Services Program at:

Bureau of Cancer Prevention and Control
New York State Department of Health
Riverview Center, Room 350
Albany, NY 12204-0678
Telephone: (518) 474-1222
Fax: (518) 473-0642
Email: canserv@health.ny.gov

Persons interested in locating the Cancer Services Program in their area should call the toll-free Referral Line at 1-866-442-CANCER (2262).

EXECUTIVE SUMMARY

The New York State Department of Health (NYSDOH) Cancer Services Program (CSP) provides breast, cervical, and colorectal cancer screening and diagnostic services for uninsured and underinsured people in New York State (NYS) and promotes awareness about and access to cancer screening for all New Yorkers. This work is done by a network of contractors that conduct public education and targeted outreach to enroll eligible New Yorkers into the program for services. The contractors enter into agreements with health care providers and clinical laboratories in their service areas to provide breast, cervical and colorectal cancer screening and diagnostic services. Since 2013, CSP contractors also educate individuals about and make referrals to the New York State of Health, the State's health plan marketplace. This report, which is required as part of Section 2408 of the Public Health Law, focuses on the program's breast, cervical and colorectal cancer screening services across NYS.

Over 15,900 women are newly diagnosed with breast cancer and about 2,540 die from the disease each year in NYS.[1] Cervical cancer is diagnosed in about 855 women and about 275 women die from the disease each year in NYS. For colorectal cancer, there are approximately 8,980 new cases every year and over 3,000 deaths annually.[1] An increase in timely, age-appropriate screening could prevent many of these deaths by detecting cancer early when it is most treatable.

From April 1, 2017 through March 31, 2018, 26,124 eligible adults were screened for breast, cervical, or colorectal cancer through the CSP with 22,029 mammograms, 20,055 clinical breast exams, 6,379 Pap tests, 4,236 high-risk human papillomavirus (HPV) tests, 5,363 FIT/FOBT Kits (stool-based colorectal cancer screening tests), and 305 screening colonoscopies provided. Over the course of this same 12-month period, the CSP identified 164 individuals with breast cancer, three with cervical cancer, 111 with precancerous cervical dysplasia, 12 with colorectal cancer, and 265 with precancerous colorectal polyps. A total of 215 people were newly enrolled in the Medicaid Cancer Treatment Program – 177 for breast cancer treatment, 22 for cervical cancer treatment, 13 for colorectal cancer treatment, and 3 for prostate cancer treatment.

Mammograms (an x-ray of the breast) for breast cancer screening, Pap tests with or without the HPV test for cervical cancer screening, and stool-based testing and direct visualization exams such as a colonoscopy for colorectal cancer, are all highly effective cancer screening tools. These cancer screening tools are not used enough in some subsets of the population, with too many deaths still occurring from breast, cervical, and colorectal cancer among those who are uninsured and underinsured, geographically and culturally isolated, older, medically underserved or racial, ethnic and cultural minorities.[2] The goal

[1] New York State Cancer Registry, 2019. *Cancer Incidence and Mortality for New York State, 2012-2016*. http://www.health.ny.gov/statistics/cancer/registry/vol1/v1rnys.htm

[2] National Cancer Institute, 2008. *National Cancer Institute Cancer Fact Sheets: Cancer Health Disparities*. http://www.cancer.gov/cancertopics/factsheet/disparities/cancer-health-disparities

of the CSP is to improve access to and increase use of cancer screening services for these underserved populations and improve the quality of care received in NYS.

This report provides information about the breast, cervical, and colorectal screening and diagnostic services offered to eligible adults by CSP contractors for the period from April 1, 2017 through March 31, 2018 (program year 2017-2018). During this period, there were 35 CSP contractors with agreements with over 5,000 health care providers, facilities and clinical laboratories, providing screening services in every NYS county and New York City borough.

PROGRAM DESCRIPTION

OVERVIEW

The New York State Department of Health (NYSDOH) Cancer Services Program (CSP) oversees the delivery of comprehensive breast, cervical and colorectal cancer screening and diagnostic services to eligible uninsured and underinsured people in NYS through local screening program contractors. CSP contractors conduct outreach, public education, data management, case management and quality assurance activities and develop relationships with regional providers (e.g., hospitals, clinics, laboratories) who offer screening and diagnostic services.

CSP contractors and their partners also help individuals diagnosed with breast, cervical or colorectal cancer to quickly obtain their cancer treatment through the NYS Medicaid Cancer Treatment Program (MCTP), if they are eligible. Although the CSP contractors do not oversee the delivery of prostate cancer screening services based on population-based screening guidelines, men screened or diagnosed with prostate cancer in NYS through CSP-participating providers are eligible for treatment coverage through the MCTP. Eligible individuals may receive full Medicaid coverage during their cancer treatment.

NYS started the full roll out of the Affordable Care Act and Medicaid expansion in 2013. At that time, CSP contractors began educating clients about the New York State of Health (NYSoH), working with local in-person assistors and navigators to help enroll them in public health insurance programs or qualified health plans. As a result, many uninsured individuals obtained health insurance, reducing the number of people eligible for the CSP.

During program year 2017-2018, the CSP had a combined state and federal annual budget of approximately $19 million, which included support for screening, diagnostic, and case management services, and surveillance and data management. The CSP receives federal funds from the Centers for Disease Control and Prevention (CDC) for breast and cervical cancer screening as part of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), and funds for colorectal cancer screening as part of the National Colorectal Cancer Control Program.

ELIGIBILITY CRITERIA

To access screening, diagnostic and case management services through the CSP, individuals must meet program eligibility criteria which include health insurance status, income, age and other personal criteria such as cancer risk status.

The eligible population for breast and cervical cancer screening through the CSP includes women who are uninsured or underinsured (defined as those financially unable to meet their co-payments or deductibles or whose insurance does not provide coverage for breast and/or cervical cancer screenings), and who have household incomes at or below 250 percent of the federal poverty level (FPL). Those ages 40 years and older are eligible for clinical breast exams, mammograms, Pap tests and high-risk HPV tests and any associated diagnostic testing.

Women ages 18 to 39 years who are deemed at high-risk for, or who have clinically significant findings for, breast cancer are eligible for CSP services. Multiple factors determine risk for breast cancer, including, but not limited to, a personal or family history of breast, ovarian or other cancers, the age at which a family member was diagnosed with a particular cancer, or a personal history of chest irradiation for treatment of lymphoma during adolescence or young adulthood. The CSP follows guidance from the CDC that those eligible for the CSP be offered a CBE as part of breast cancer screening. While CBEs are not recommended screening by the United States Preventive Services Task Force, the CDC's guidance acknowledges that this access should be offered to the uninsured because in many cases these exams may be their only access to a medical provider.

The CSP reimburses fecal tests (FIT or FOBT) as the method for screening adults ages 50 and older who are at average risk for colorectal cancer and who have not received a test during the previous 10 months. Both FIT (Fecal Immunochemical Test) and high-sensitivity FOBT (Fecal Occult Blood Test) check for the presence of occult, or hidden, blood in the stool and are initiated by the client at home. Adults at increased or high-risk, or those with clinically significant signs and symptoms of colorectal cancer should not receive a FIT or FOBT kit and may be eligible for a CSP-funded screening colonoscopy after undergoing prior approval. Individuals are considered high-risk when they have either a family history of familial adenomatous polyposis, family history of hereditary non-polyposis colon cancer, a personal history of inflammatory bowel disease, a personal history of chronic ulcerative colitis, or a personal history of Crohn's disease. Individuals are considered increased risk if they have a personal history of single small (<1cm) pre-cancerous polyp, personal history of large (1cm+), multiple, or pre-cancerous polyp with dysplasia or villous changes, a personal history of colorectal cancer, or a family history of colorectal cancer or pre-cancerous polyps in one 1st degree relative before the age of 60 or two or more 1st degree relatives at any age. Adults ages 50 to 64 who are symptomatic for colorectal cancer may be eligible for a diagnostic colonoscopy; these symptoms must be assessed by a NYS-licensed health care provider to aid in the determination of CSP eligibility. Individuals presenting with: 1) an abdominal mass, 2) a rectal (not pelvic) mass, 3) prolonged rectal bleeding with bowel change, 4) persistent rectal bleeding, or 5) non-specific symptom strongly suggesting CRC, are also ineligible for FIT/FOBT-based testing and instead are referred for a diagnostic colonoscopy.

PRIORITY POPULATIONS

CSP contractors focus their activities on priority populations – subsets of the program-eligible population who are affected by breast, cervical or colorectal cancer more so than others, or who are medically unserved or underserved and lack adequate health care options. Individuals who are medically unserved or underserved include, but are not limited to, those who experience more difficulty receiving services due to their sex, race, ethnicity, disability, sexual orientation, gender identity, geographic location, income status, cultural beliefs, or ability to read or write.

The CSP provides screening mammograms to women ages 40 years and older, but identifies women ages 50 years and older as the priority population due to the increased risk of breast cancer with increasing age. Another priority for the CSP is to provide Pap tests to women who are rarely (screened more than five years ago) or who have never been screened for cervical cancer.

While CSP eligibility for colorectal cancer screening includes adults ages 50 and older, the CSP priority population is those between the ages of 50-64 years. A focus on this population is supported by the CDC and recognizes that the risk of colorectal cancer increases with increasing age.

CASE MANAGEMENT

Case management has been an important part of the CSP since the federal law for the NBCCEDP was reauthorized to include this component in 1998. Clients found to have abnormal screenings are provided with case management services to ensure that they receive timely diagnosis, appropriate follow-up care and access to necessary treatment.

Case management increases client adherence to screening, diagnostic and treatment services, and ensures they receive support to obtain needed services. The CSP requires a direct, personal level of support be available to assist clients to address difficulties that might delay or prevent their care. Barriers to care may include transportation, child or elder care, language and cultural barriers, fear and misunderstanding of clinical recommendations, and issues related to the emotional burden of cancer.

QUALITY ASSURANCE

In 1998, the CSP began monitoring clinical performance and outcomes among providers offering clinical services through the program to ensure receipt of quality clinical services. These quality assurance (QA) efforts have since become a model recognized by the CDC; many other states have adopted similar QA activities.

The QA team reviews data reported on a monthly basis and works with contractors and providers to determine reasons for any unusual data patterns. The findings may require a more extensive review, including review of medical records, and may result in the development of a corrective action plan. The quality improvement activities developed as part of these corrective action plans potentially reach beyond those women enrolled in the CSP; improvements in technique or processes benefit both the uninsured and insured served by these providers. The CSP QA activities not only result in improved quality of clinical care, but also help raise awareness of CSP goals, increase participation by the providers and facilities and improve access for clients.

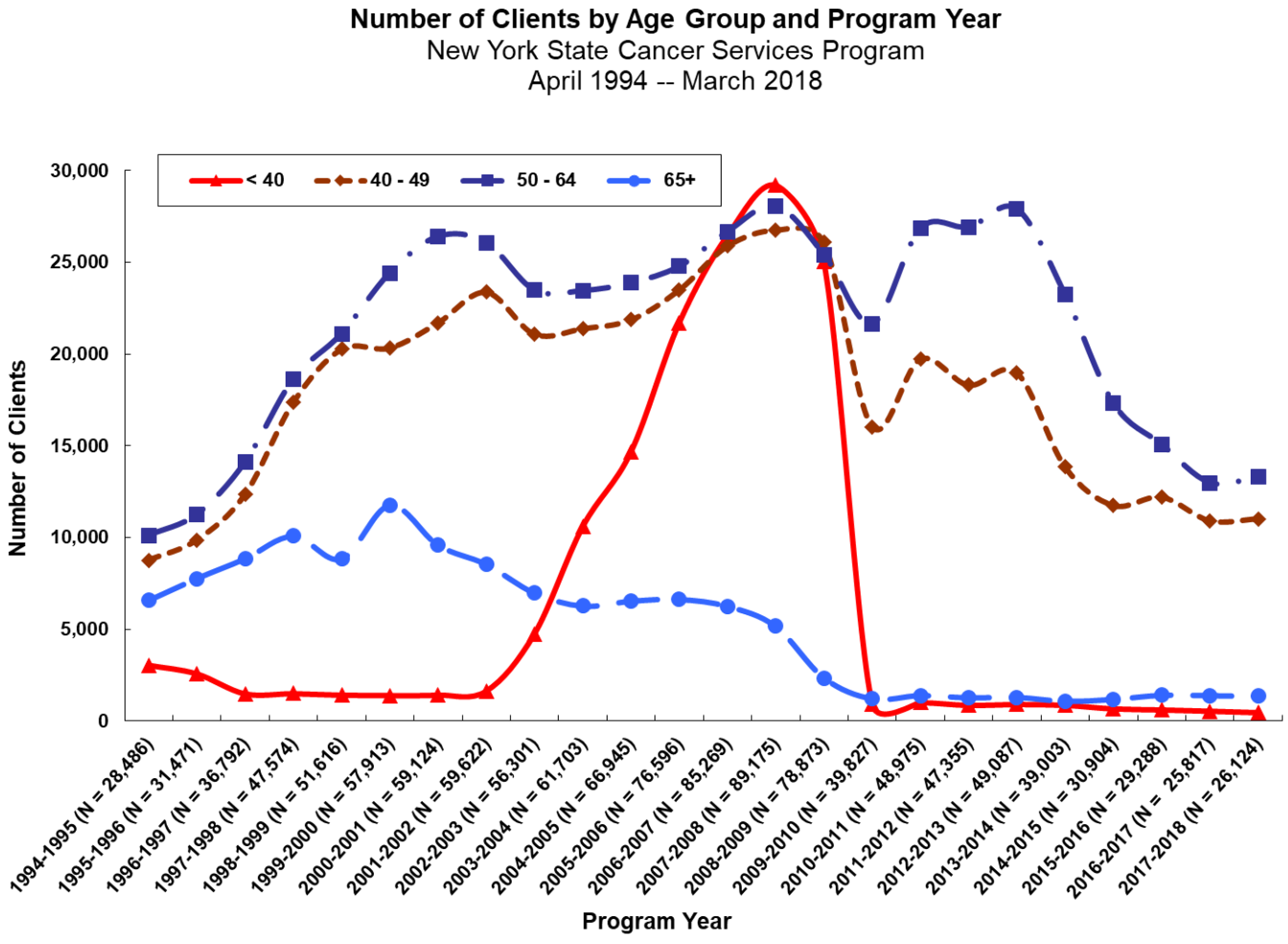
SCREENINGS, DIAGNOSTICS, AND OUTCOMES

TRENDS SINCE PROGRAM INCEPTION

CLIENTS SERVED

The number of clients screened for breast, cervical, and/or colorectal cancer through the CSP has varied through the years since the program's start in 1994. Figure 1 provides information about the number of clients screened from 1994 through the 2017-2018 program year. The total number of clients screened reached a high of over 89,000 in the 2007-2008 program year, but declined in the following two program years due to changes in program eligibility criteria, a loss of high volume providers downstate that focused primarily on screening women younger than age 40, and QA activities that identified two large CSP contractors that were misinterpreting program eligibility criteria and screening clients who were not eligible for CSP services.

Figure 1



The number of clients screened by the program increased by over 9,000 between the 2009-2010 and the 2010-2011 program years. In the 2011-2012 program year, the total number of clients screened declined by 1,620 compared to the 2010-2011 program year but increased again in the 2012-2013 program year by about 1,700 clients. Most recently, the number of clients screened went from 39,003 in program year 2013-2014 to 25,817 in program year 2016-2017 but seems to have stabilized with 26,124 clients screened in program year 2017-2018. These numbers primarily reflect more people having health insurance as a result of the Affordable Care Act and Medicaid expansion, resulting in a reduction in the number of individuals eligible for the CSP.

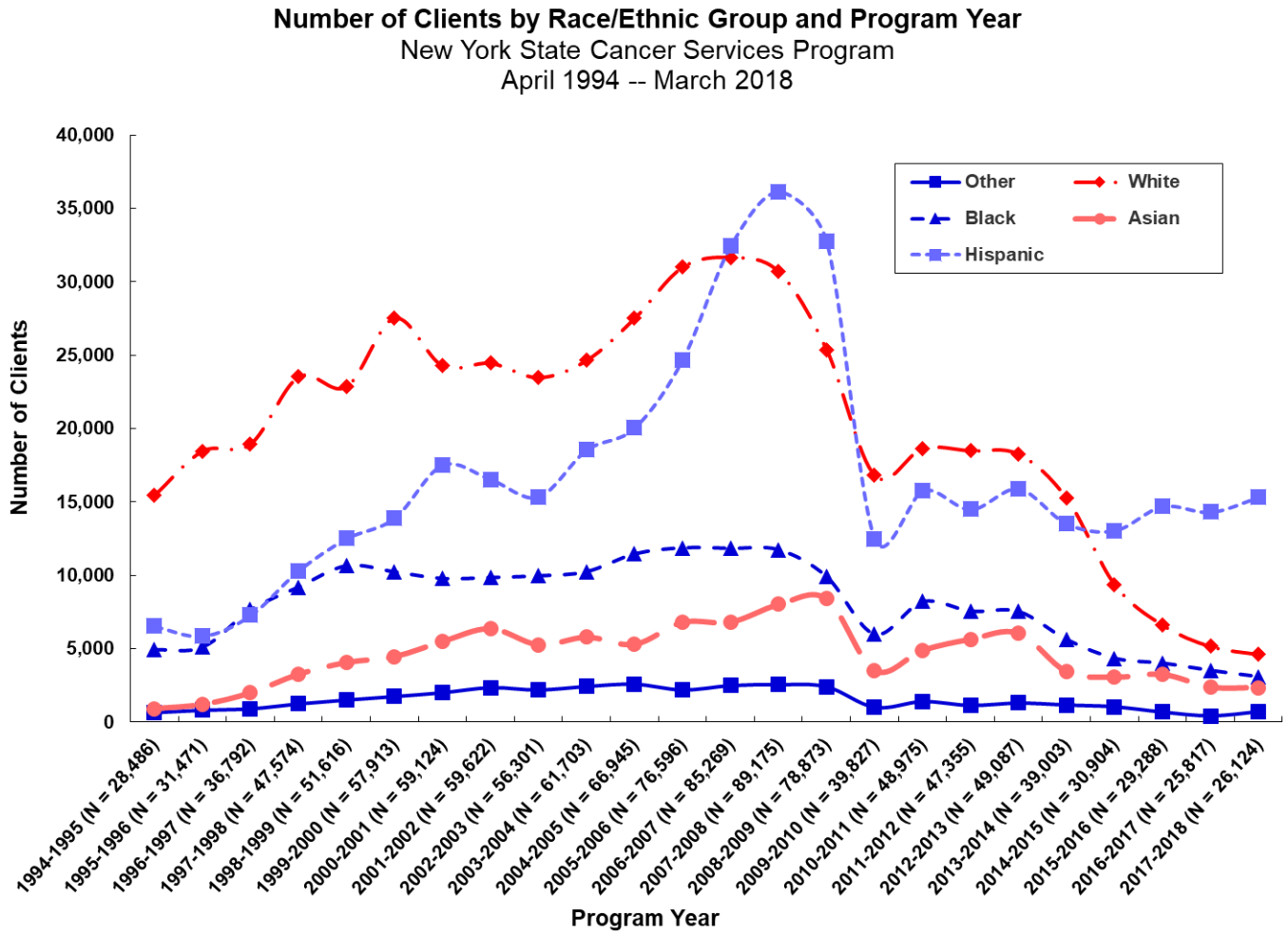
Changes in eligibility criteria for the program can explain most of the variation seen within age-specific groups of clients across the 24 program years. The initial increase among younger individuals was due to the expansion of the number of women 18 to 39 years of age served by the program. A sharp decline in this age group occurred in the 2009-2010 program year when the eligibility criteria for the program changed again to focus recruitment on the priority population of clients 50 to 64 years of age, while other providers, such as family planning providers and federally qualified health centers, continued to provide recommended cancer screenings to women in younger age groups in NYS. The gradual decrease in clients ages 65 and older was due to changes in Medicare Part B coverage in January 1998 to include annual mammograms and the increased focus on the CSP priority population of women 50 to 64 years of age. Since the 2009-2010 program year, clients in the 50 to 64 age group represent the largest group of clients served, reflecting the intended emphasis on the priority population.

Despite the reduced number of clients screened by the CSP in more recent years, the number of clients screened continues to be a small proportion of the estimated low-income, uninsured individuals in NYS who are eligible for the CSP. The number of clients ages 40 to 64 years screened through the CSP in the 2017-2018 program year represented only 10.8 percent (24,310 /225,718) of the estimated eligible population of individuals ages 40 to 64 who are uninsured and at or below 250 percent of FPL in NYS.[3] The percent of the eligible population screened was only 12.2 percent (13,291 /109,232) for those ages 50 to 64 for the 2017-2018 program year.

The racial and ethnic groups of clients screened through the CSP are shown in Figure 2. The number of Hispanic clients screened through the CSP increased dramatically until the 2007-2008 program year when approximately 36,000 Hispanic clients were screened (40.5 percent of all clients screened that year). The number of Hispanic clients then declined to approximately 13,000 Hispanic clients screened in the 2014-2015 program year, which represented 42.3 percent of all clients screened that year because of decreases in the total number of clients screened. Due to a recent decline in the number of white clients screened (from 18,268 in program year 2013-2014 to 4,626 in program year 2017-2018), Hispanic clients again represented the largest proportion of clients served by the CSP in program year 2017-2018, representing 58.7 percent of all clients screened. In the 2017-

[3] United States Census Bureau, 2019. *Small Area Health Insurance Estimates, 2017.* https://www.census.gov/programs-surveys/sahie.html

Figure 2

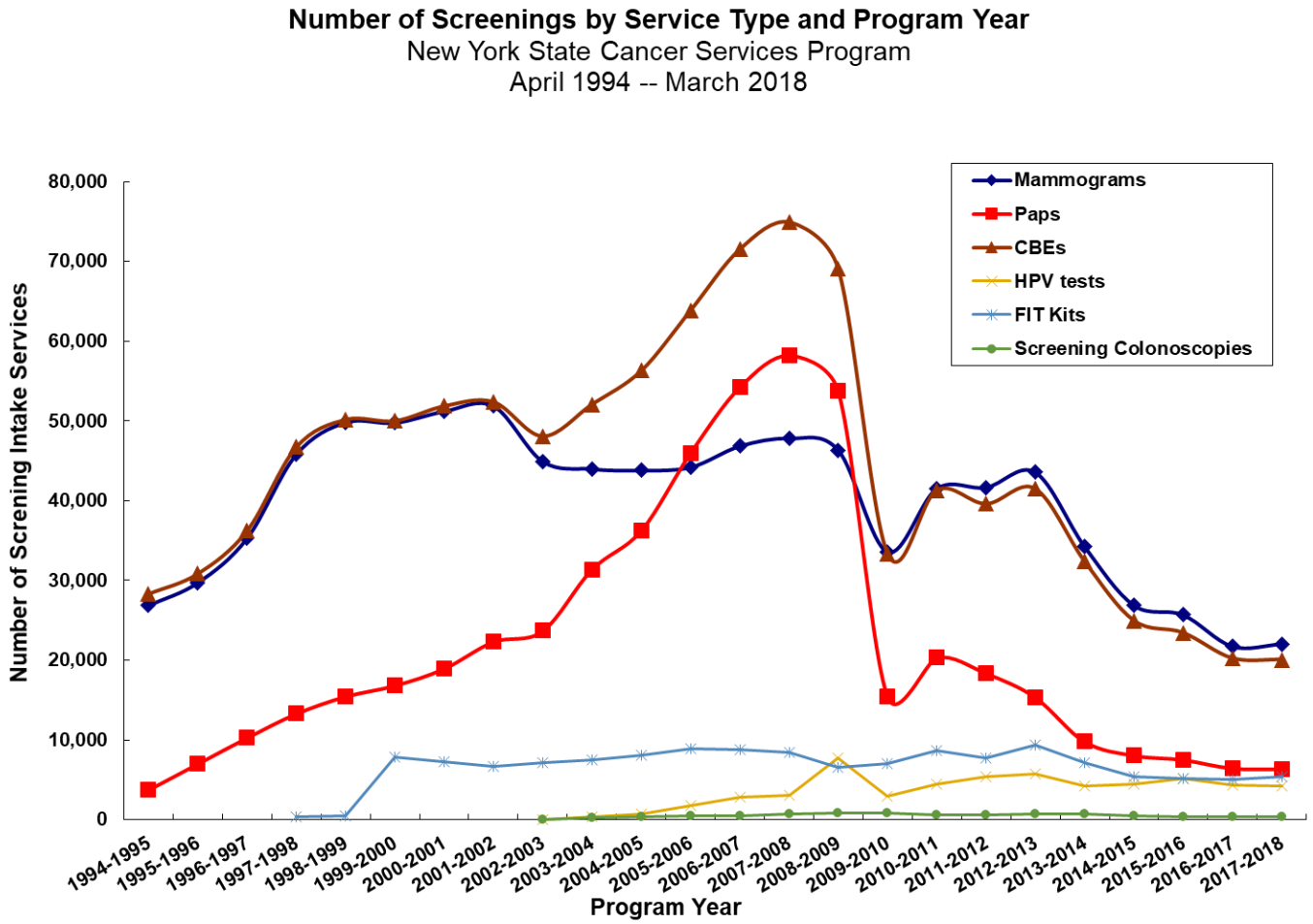


2018 program year, 58.7 percent of clients screened identified as Hispanic, 17.7 percent identified as white, 11.9 percent identified as Black, 9.0 percent identified as Asian, and 2.7 percent identified as other races.

SCREENING SERVICES PROVIDED

The CSP has provided more than 949,130 mammograms, 1,059,100 clinical breast exams (CBEs), 519,170 Pap tests, 57,600 high-risk HPV tests, 138,600 FOBT/FIT kits, and 8,100 screening colonoscopies to low income, uninsured and underinsured individuals since its start in 1994 (Figure 3). In the 2017-2018 program year, 22,029 mammograms, 20,055 CBEs, 6,379 Pap tests, 4,236 high-risk HPV tests, 5,363 FOBT/FIT kits, and 305 screening colonoscopies were provided. The majority of HPV tests provided were co-tests performed at the same time as the Pap test.

Figure 3

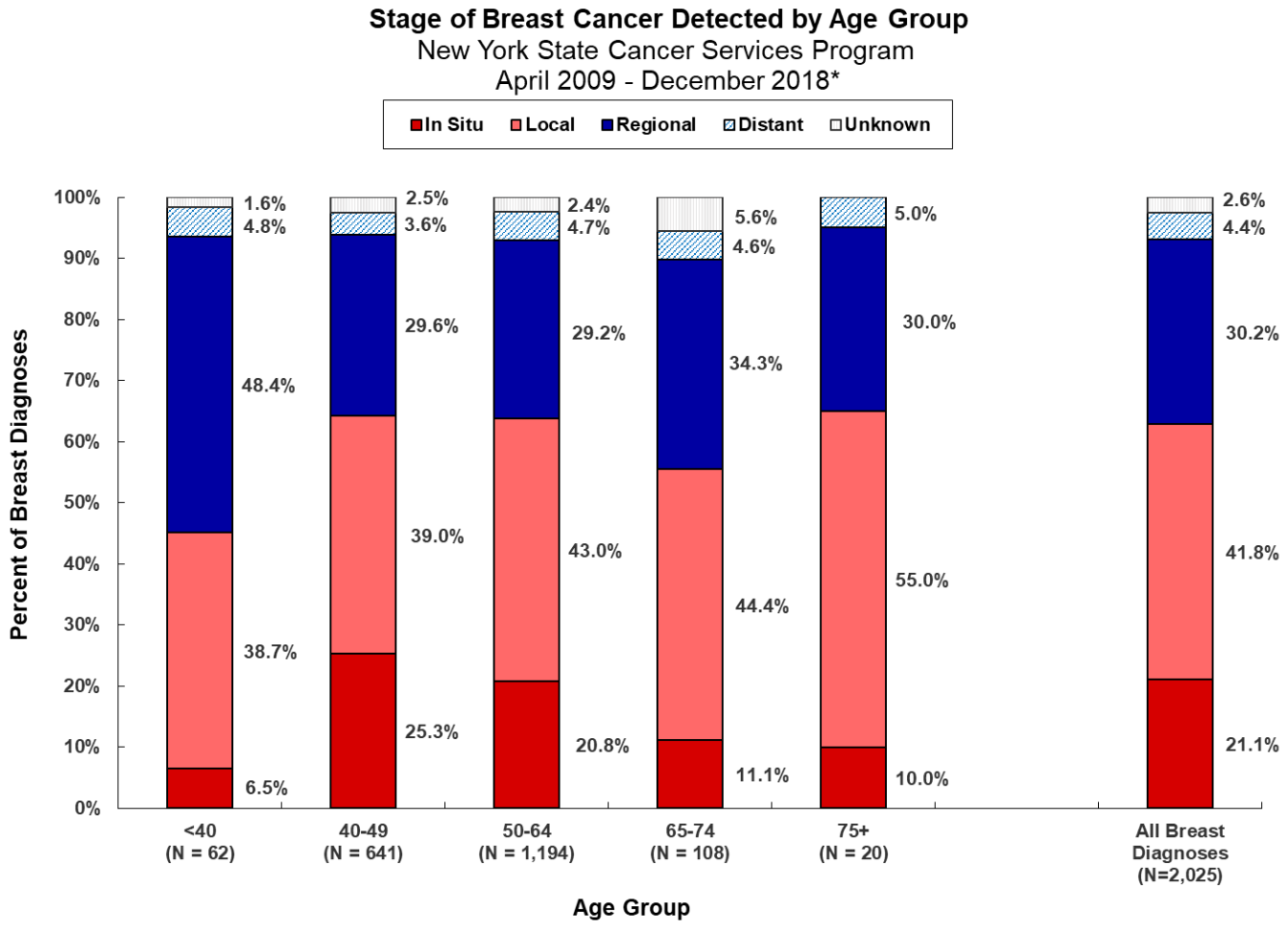


CANCERS DETECTED

Since the program's inception, a total of 7,169 breast cancer diagnoses were detected, yielding an overall detection rate of 7.55 cases per 1,000 women screened. The detection rate is determined by dividing the total number of cases of breast cancer found among those screened by the total number of women screened during the same time period.

Identification of breast cancer at an early stage when it is most treatable and the survival rate is more favorable is a primary goal of the CSP. Staging of cancers diagnosed through the CSP between April 2009 and December 2018, and the percent of women with early stage disease varied by age group are presented in Figure 4. Overall, the percent of clients diagnosed early with in situ or a localized stage of breast cancer was 62.0 percent. The lower percent of early diagnoses in younger women may again be related to the CSP eligibility criteria, which allow women under age 40 to have screening mammograms only if they are symptomatic or considered to be at increased risk for breast cancer.

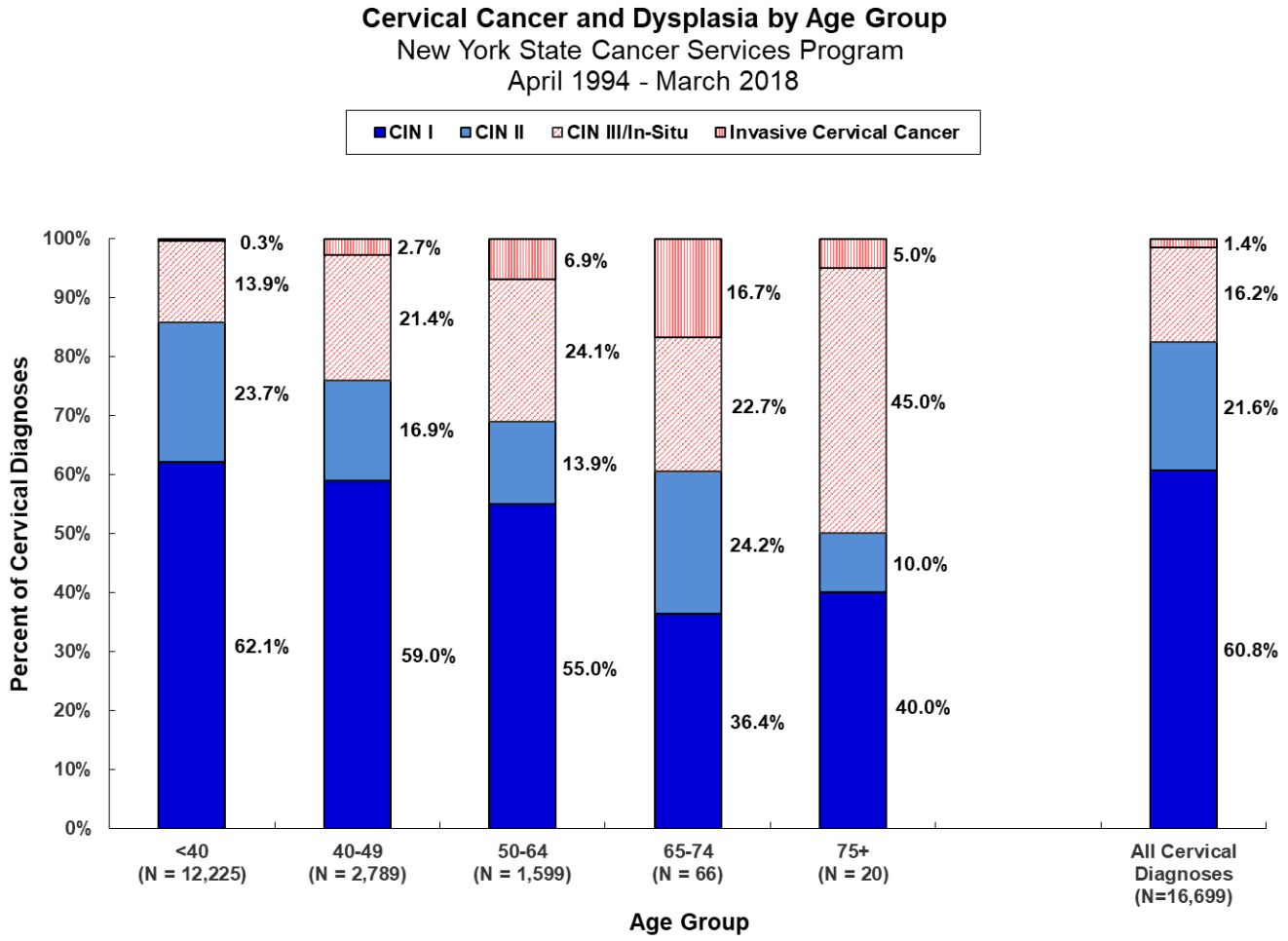
Figure 4



*Limited to program years where breast cancer diagnoses were matched with the NYS Cancer Registry for reporting to CDC, to ensure consistent information on breast cancer stage. An "unknown" diagnosis refers to cases where staging was not performed or stage information is unavailable for any reason.

A total of 16,699 cervical cancer and dysplasia diagnoses were detected between 1994 and 2018, yielding an overall detection rate of 32.2 cases per 1,000 women screened. The detection rate is determined by dividing the total number of cases of cervical cancer and/or dysplasia diagnoses found among those screened by the total number of women screened during the same time period. The percent of clients diagnosed with invasive cervical cancer is very small; less than two percent of abnormal Pap tests were determined to be invasive cervical cancer between 1994 and 2018 (Figure 5). The higher detection rate of invasive cervical cancer in women 65 to 74 years of age is consistent with the incidence (or number of new cases) of cervical cancer in the general population,

Figure 5



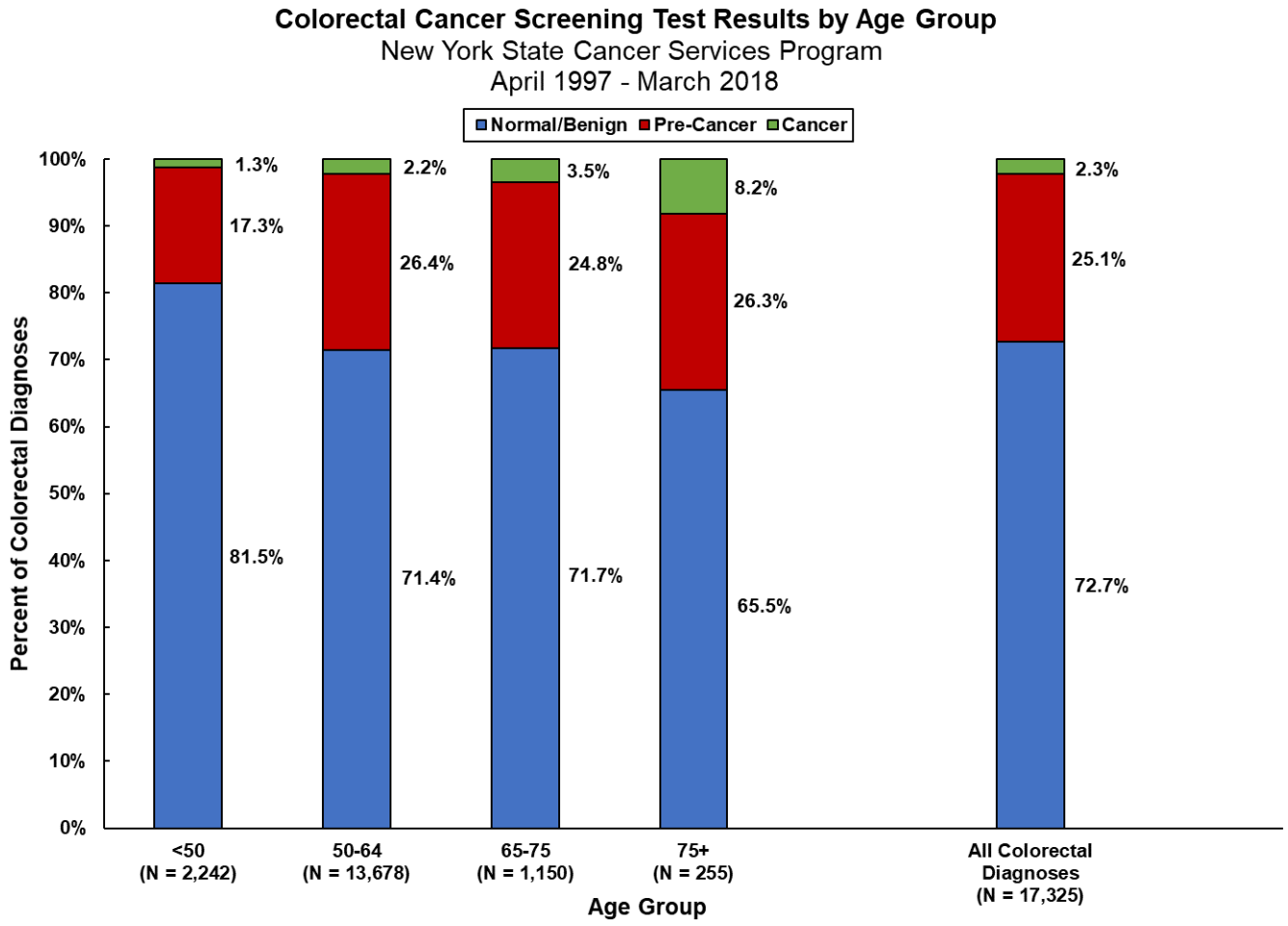
where incidence rates generally increase with age.[4] The higher number of precancerous cases in younger women may be due to patterns of enrollment prior to the 2009-2010 program year, where younger women with abnormal Pap tests were more likely to be enrolled in the CSP for additional follow-up.

The CSP has provided more than 145,000 colorectal cancer screening services to low-income, uninsured and underinsured men and women since program coverage for colorectal services began in 1997. Of these, over 138,000 were FIT/FOBT kit developments and over 8,000 were screening colonoscopies. Figure 6 shows how the diagnosis of colorectal cancer and pre-cancer varies by age group between program years 1997-1998 and 2017-2018. A total of 4,736 colorectal cancer and pre-cancer diagnoses were detected between 1997 and 2018. The higher rate of

[4] New York State Cancer Registry, 2019. *Cervical Cancer Incidence and Mortality by Age group, New York State, 2012-2016.* https://www.health.ny.gov/statistics/cancer/registry/table6/tb6cervixnys.htm

colorectal cancer in individuals 65 years of age and older is consistent with the incidence (or number of new cases) of colorectal cancer in the general population, where incidence rates generally increase with age.[5]

Figure 6



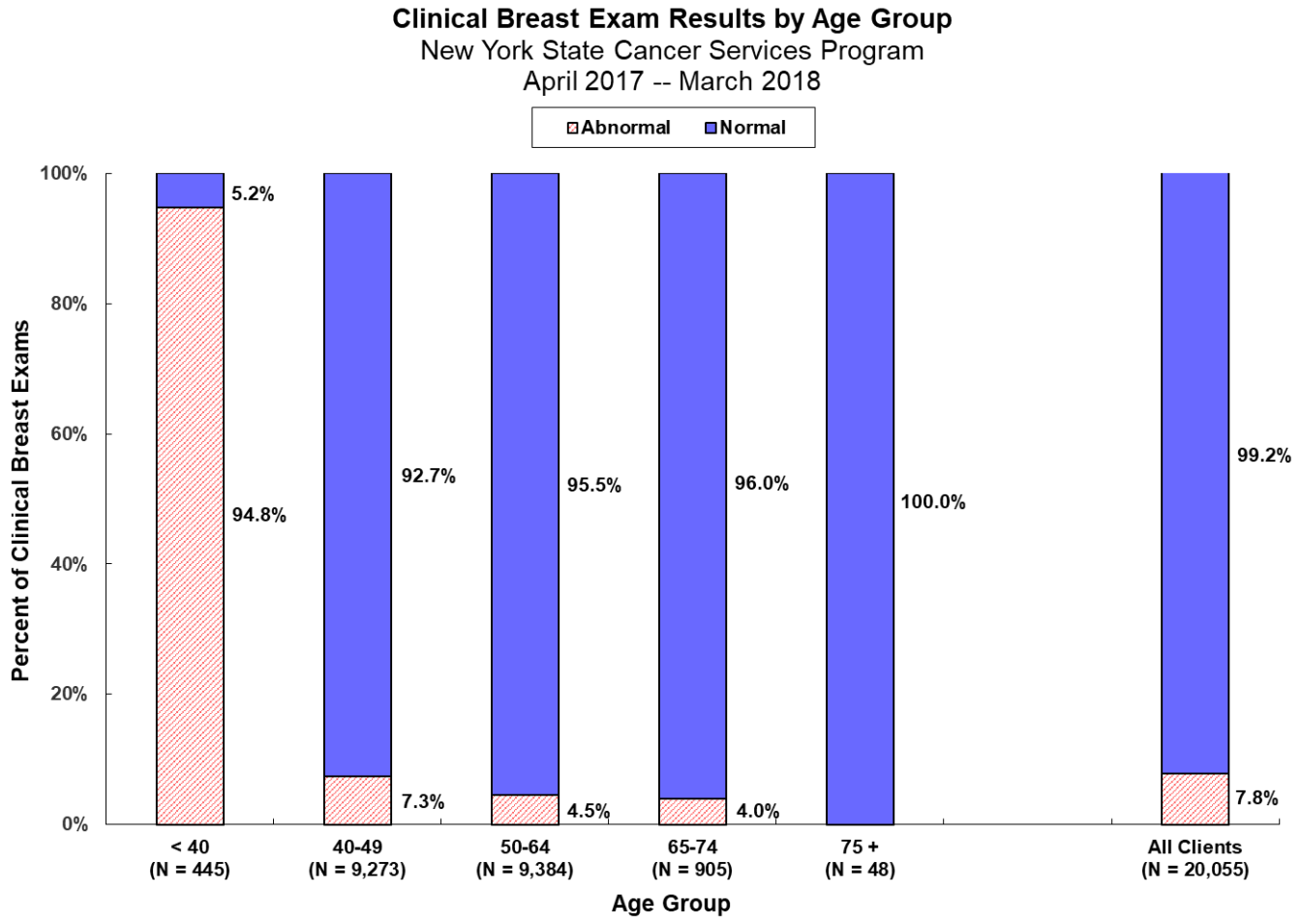
[5] New York State Cancer Registry, 2019. *Colorectal Cancer Incidence and Mortality by Age group, New York State, 2013-2017.* https://www.health.ny.gov/statistics/cancer/registry/table6/tb6colorectalnys.htm

BREAST CANCER

SCREENING SERVICES AND OUTCOMES

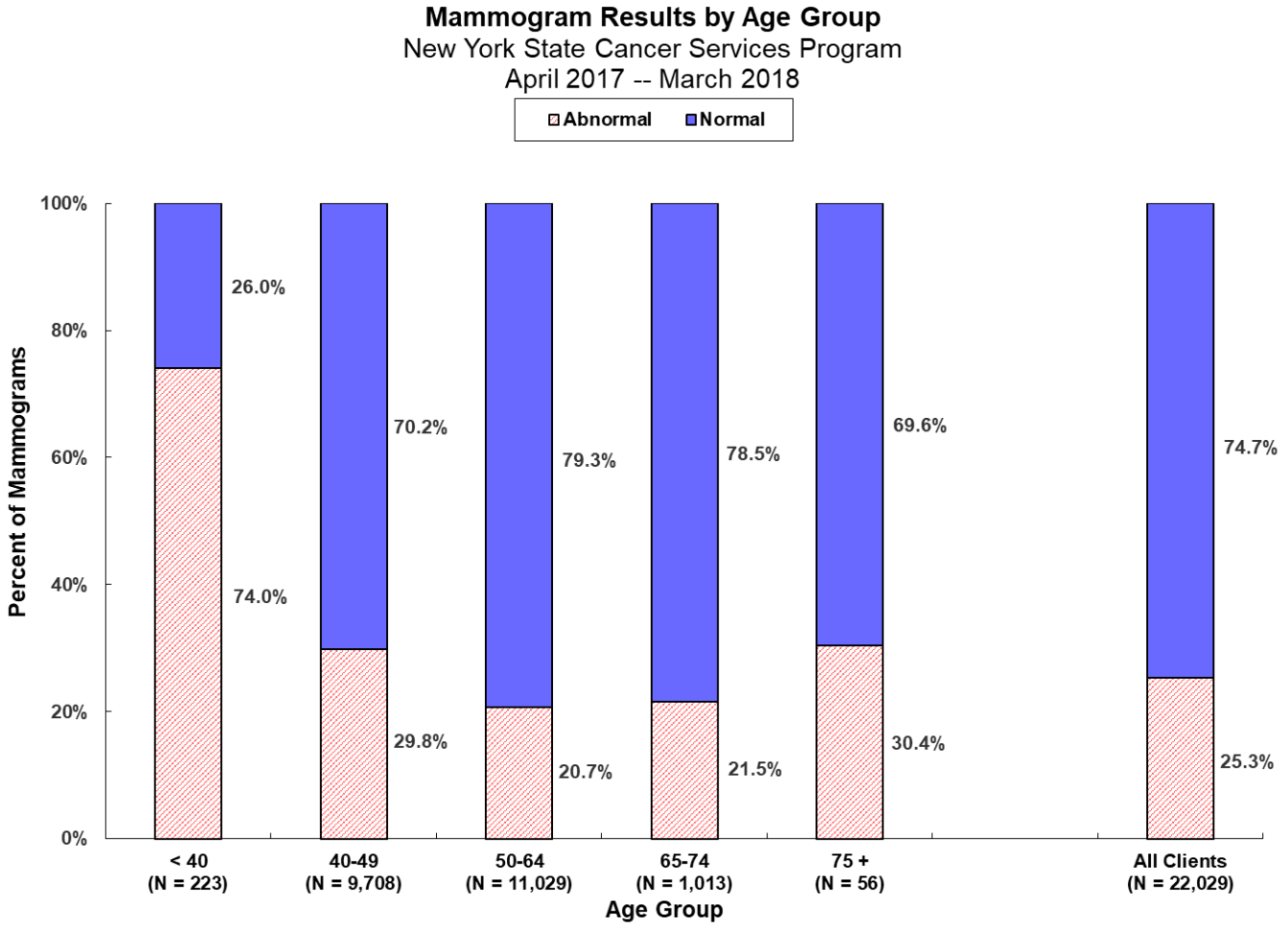
An abnormal CBE result is defined as having a mass or other finding in the breast. Figure 7 illustrates the age-specific percentages of abnormal CBEs in the 2017-2018 program year. Overall, the percentage of abnormal CBEs among all clients screened was 7.8 percent. Of the 445 women under the age of 40, 94.8 percent of them had abnormal CBEs. In comparison, the age group with the greatest number of clients, 9,384 in the 50-64 age range, had only 4.5 percent with abnormal CBEs. This is likely because, as of 2009, clients ages 18 to 39 years old were only eligible to receive breast cancer screening through the CSP if they were at increased risk or symptomatic for breast cancer.

Figure 7



In the program year, 55.0 percent of women who received screening mammograms were over the age of 50, the priority population for the CSP. Figure 8 illustrates the age-specific percentages of abnormal mammograms in the program year. Abnormal mammograms include those that had results of "assessment incomplete", "suspicious abnormality" or "highly suggestive of malignancy." Overall, the percentage of abnormal mammograms among all clients screened in the program was 25.3 percent. The percent of abnormal mammograms varied by age and was lowest among the 11,029 women aged 50 to 64 years at 20.7 percent. The 223 women aged less than 40 years had approximately two to three times as many abnormal findings as women in other age groups at 74.0 percent. As with the CBE findings, this is likely because women less than 40 years of age are eligible to receive a mammogram through the CSP only if they are at increased risk or are symptomatic for breast cancer.

Figure 8



DIAGNOSTIC FOLLOW-UP

Women with abnormal findings on breast screenings (either CBEs or mammograms) are referred for diagnostic services through case management. The program goal is to provide timely diagnostic follow-up (defined as a final diagnosis determination within 60 days of the date of screening) for at least 75 percent of abnormal breast screenings.

During the 2017-2018 program year, 79.8 percent of abnormal breast cancer screenings had timely follow-up. The most common diagnostic procedures provided through the CSP to women with abnormal findings were diagnostic ultrasounds (80.2% of women with abnormal findings) and diagnostic mammograms (50.9%).

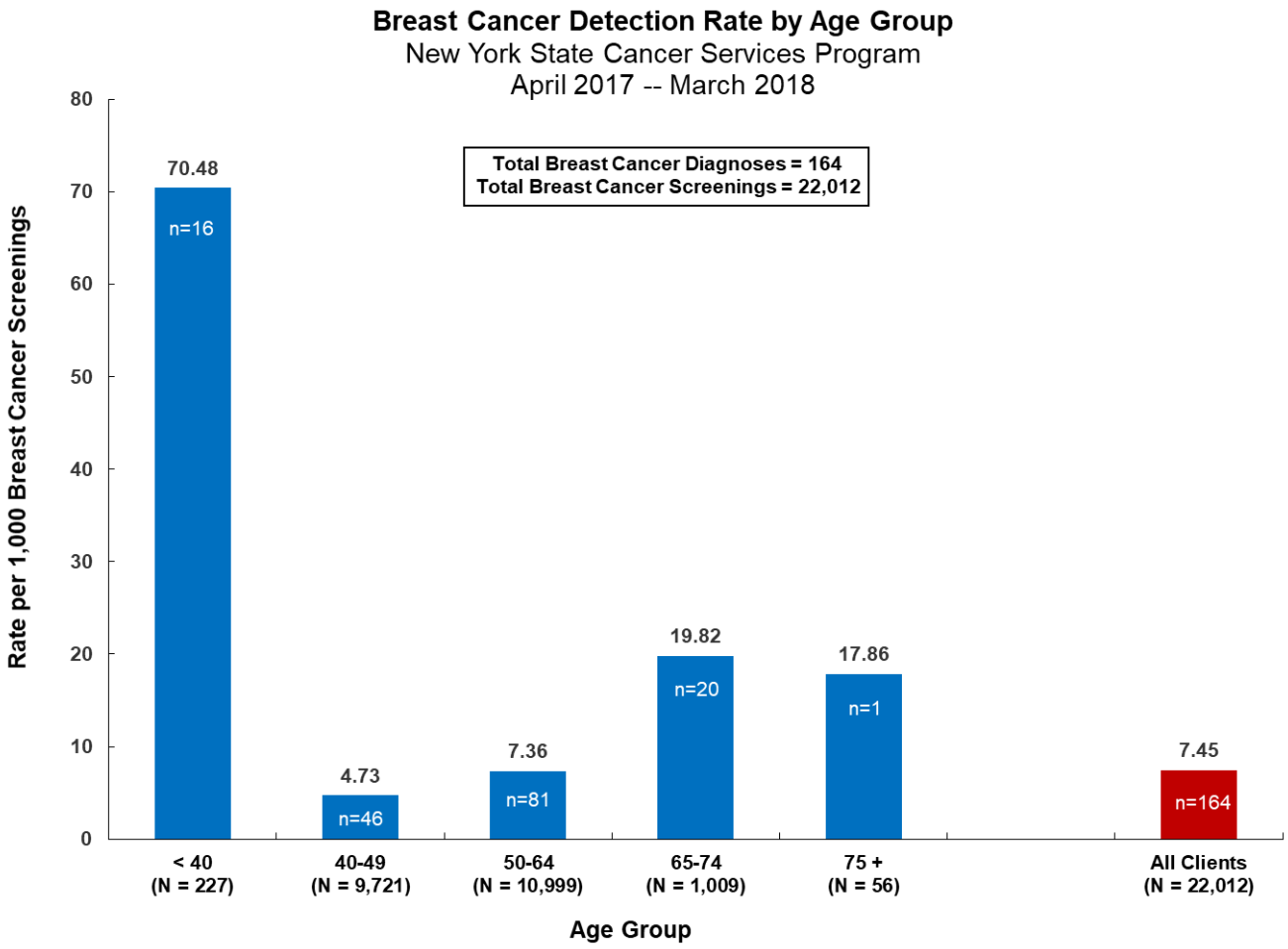
CANCERS DETECTED

A total of 164 cases of breast cancer, including invasive breast cancer, lobular carcinoma in situ (LCIS), ductal carcinoma in situ (DCIS) and all other carcinoma in situ, were diagnosed among women screened through the CSP during the 2017-2018 program year. This represents a breast cancer detection rate of 7.45 cases per 1,000 women screened.

Figure 9 shows how the detection rate for breast cancer varied by age for cases diagnosed in the 2017-2018 program year; rates were highest among the youngest and oldest age groups. The relatively high detection rate of breast cancer among women under age 40 years can be explained by the CSP's eligibility criteria, which allow younger women to receive mammograms through the CSP only if they are at increased risk or symptomatic for breast cancer. The higher detection rate for breast cancer among the older age group is consistent with the increasing incidence (or number of new cases) of breast cancer with age in the general population, with the highest incidence rate in women 75 to 79 years of age.[6]

[6] New York State Cancer Registry, 2019. *Female Breast Cancer Incidence and Mortality by Age Group, New York State, 2012-2016.* https://www.health.ny.gov/statistics/cancer/registry/table6/tb6breastnys.htm

Figure 9



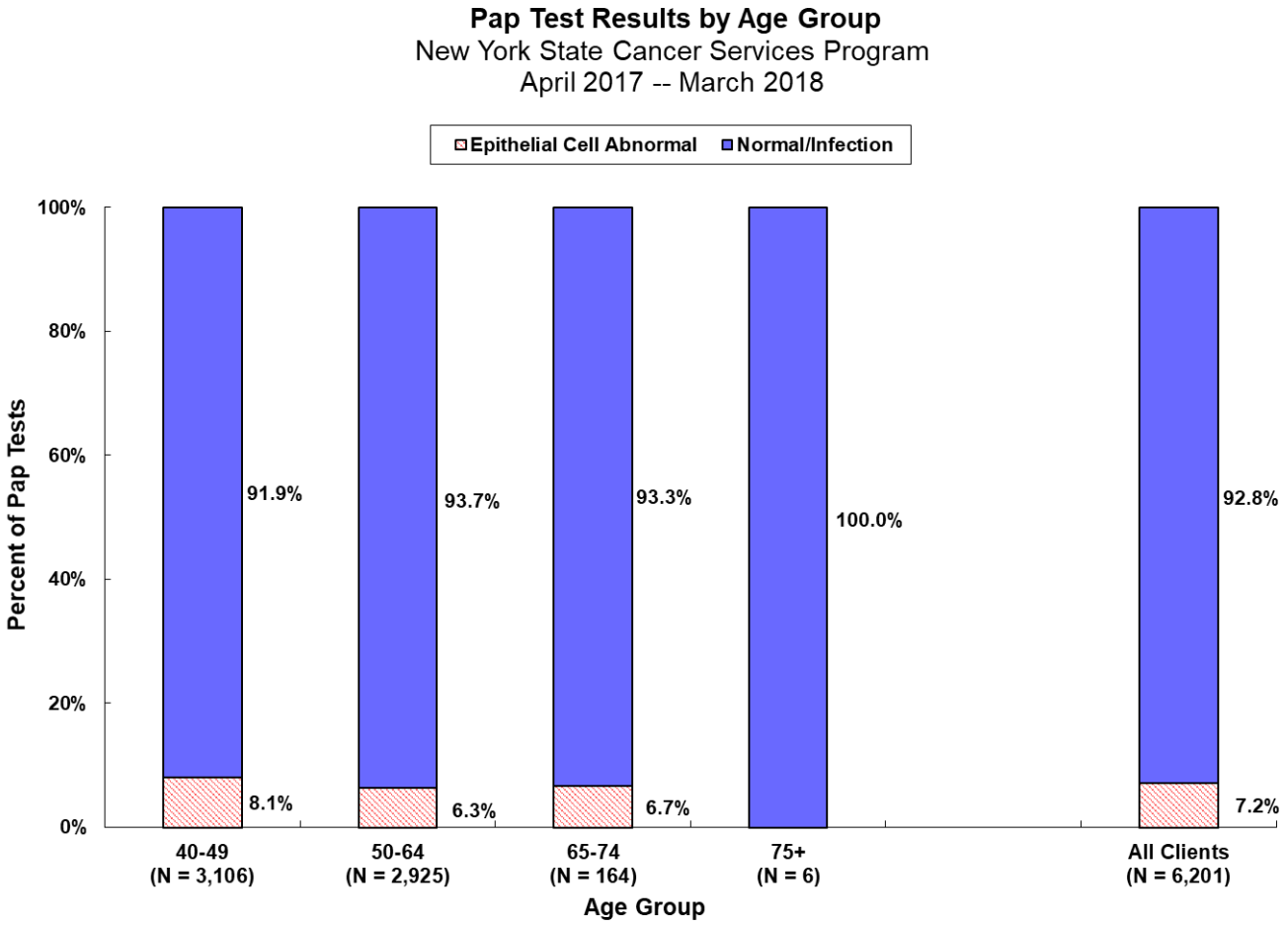
CERVICAL CANCER

SCREENING SERVICES AND OUTCOMES

A CSP priority is to provide screenings to women rarely or never screened for cervical cancer. In the program year 2017-2018, 49.1 percent of women met that criteria, far exceeding the program goal of 20 percent. The percentage of abnormal Pap test results among all women screened through the CSP was 7.2 percent for program year. Abnormal Pap test results can include any of the following: atypical squamous cells of undetermined significance (ASC-US), low-grade squamous intraepithelial lesions (LSIL) including HPV changes, high-grade squamous intraepithelial lesions (HSIL), atypical squamous cells of undetermined significance - cannot exclude HSIL (ASC-H), atypical glandular cells – all subcategories (AGC), squamous cell cancer or other results.

Figure 10 illustrates how the percentage of abnormal Pap test results varied with age. Women aged 40-49 were slightly more likely to have abnormal findings than women 50 to 64 and 65 to 74 years of age. For high-risk HPV tests

Figure 10



performed as part of the screening process (screening and surveillance HPV tests), 11.5% of tests detected the presence of HPV in program year (data not shown). Because HPV infection is the main risk factor for the development of cervical cancer, the HPV test results are used to help determine the appropriate diagnostic services, treatment and re-screening recommendations.

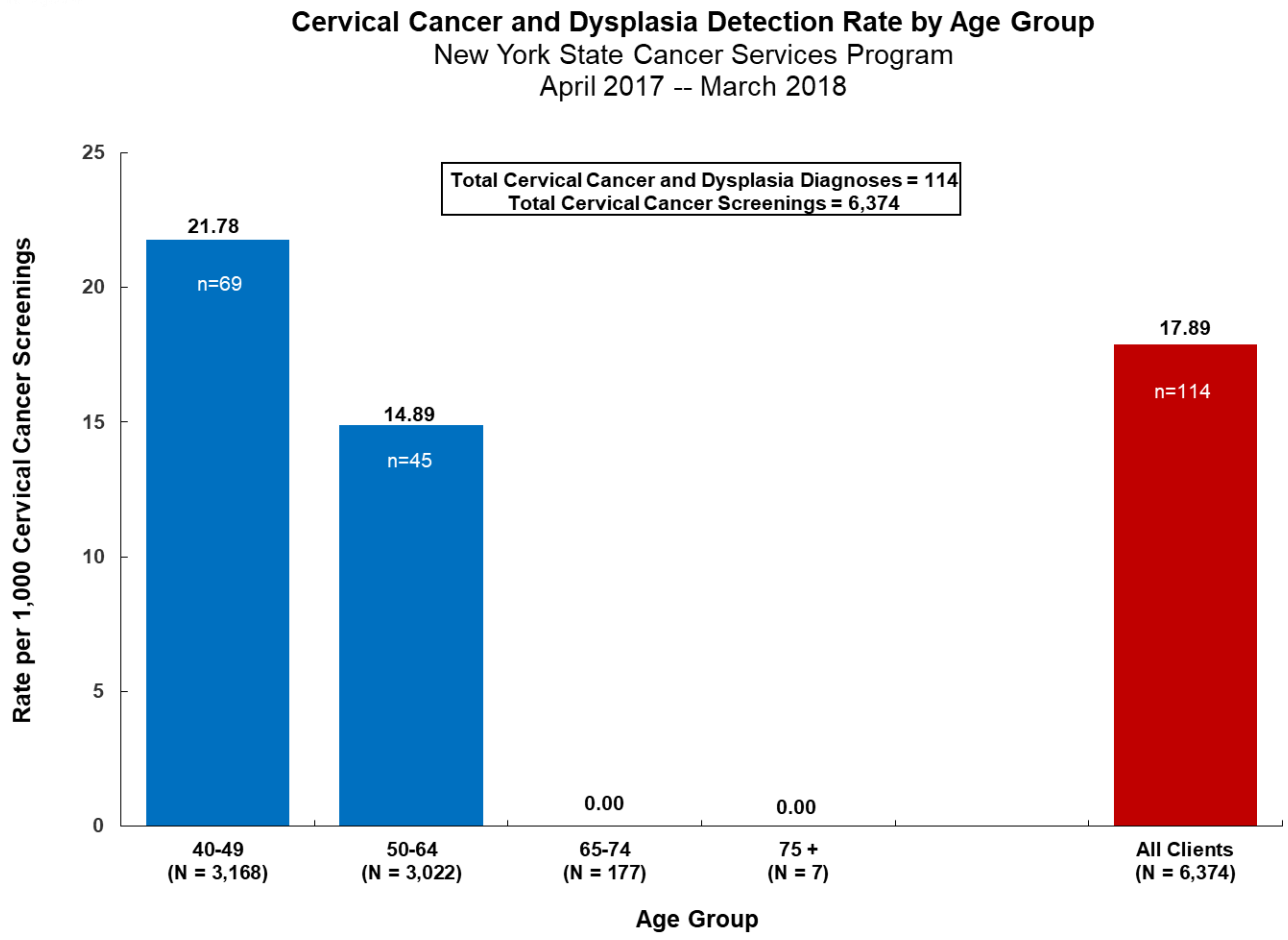
DIAGNOSTIC FOLLOW-UP

Women with abnormal pap tests and/or abnormal high-risk HPV tests are referred to diagnostic services. The program goal is to provide timely diagnostic follow-up (defined as a final diagnosis determination within 90 days of the date of screening) for at least 75 percent of the abnormal cervical cancer screenings provided through the CSP. During the 2017-2018 program year, 83.0 percent of abnormal cervical cancer screenings had timely follow-up. The most common diagnostic procedures provided for women with abnormal cervical cancer screenings in the program year were colposcopies with biopsies (82.9% of women with abnormal cervical cancer screenings) and gynecological consults (62.8%).

CANCERS AND DYSPLASIAS DETECTED

Among those screened through the CSP in the 2017-2018 program year, three cases of invasive cervical cancer and 111 cases of cervical intraepithelial neoplasia (CIN) were diagnosed. The overall rate of invasive cervical cancer and dysplasia (defined as CIN I or worse [including CIN I, CIN II, CIN III - carcinoma in situ]) was 17.89 cases per 1,000 women screened. Figure 11 shows how the detection rates of cervical cancer and dysplasia vary by age for cases diagnosed in the program year.

Figure 11



SCREENING SERVICES AND OUTCOMES

In the 2017-2018 program year, 5,342 kits were developed and 306 screening colonoscopies were performed through the CSP. The percentage of abnormal FIT/FOBT test results among all clients screened through the CSP was 6.4 percent. Figure 12 illustrates a very slight variation of abnormal FIT/FOBT test results across age groups. The percentage of positive FIT/FOBT tests varied by sex, with 5.6% of tests among women having abnormal findings and 9.3% of tests among men having abnormal findings (data not shown).

Figure 13 illustrates the variation of screening colonoscopy results across age groups for those who were considered at increased or high-risk for colorectal cancer. In the 2017-2018 program year, only 306 clients in these age categories met the risk criteria and received a screening colonoscopy.

Figure 12

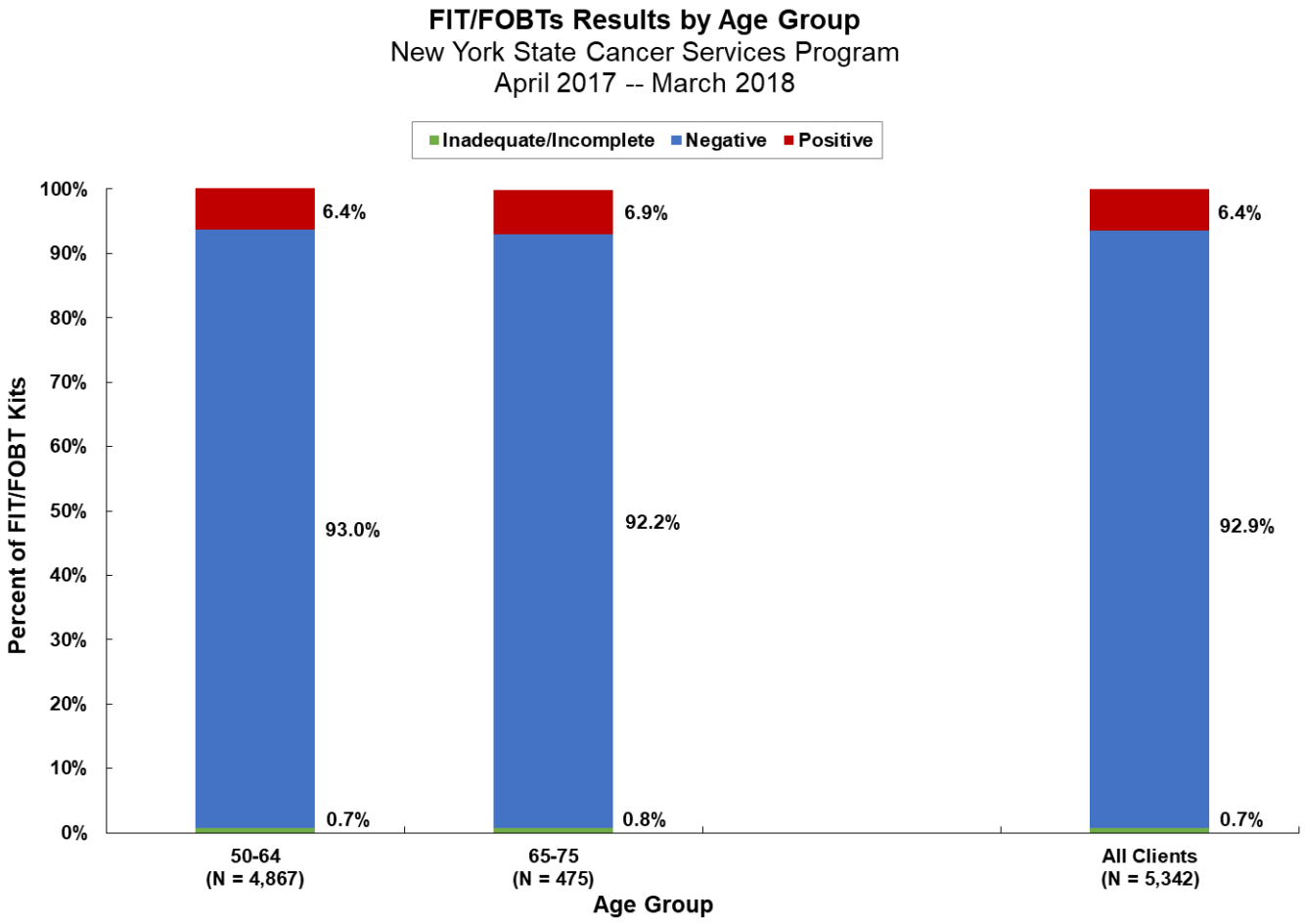
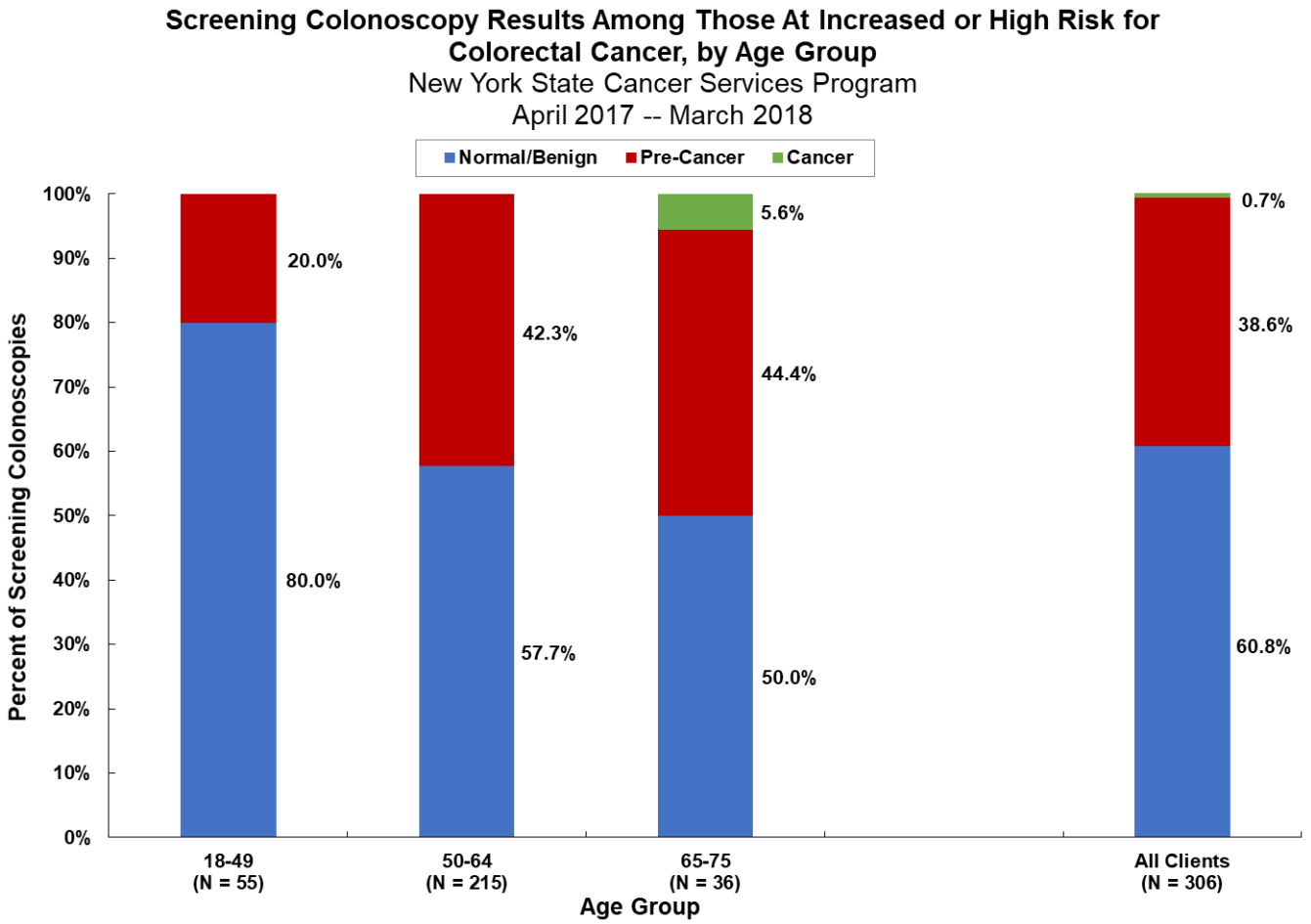


Figure 13

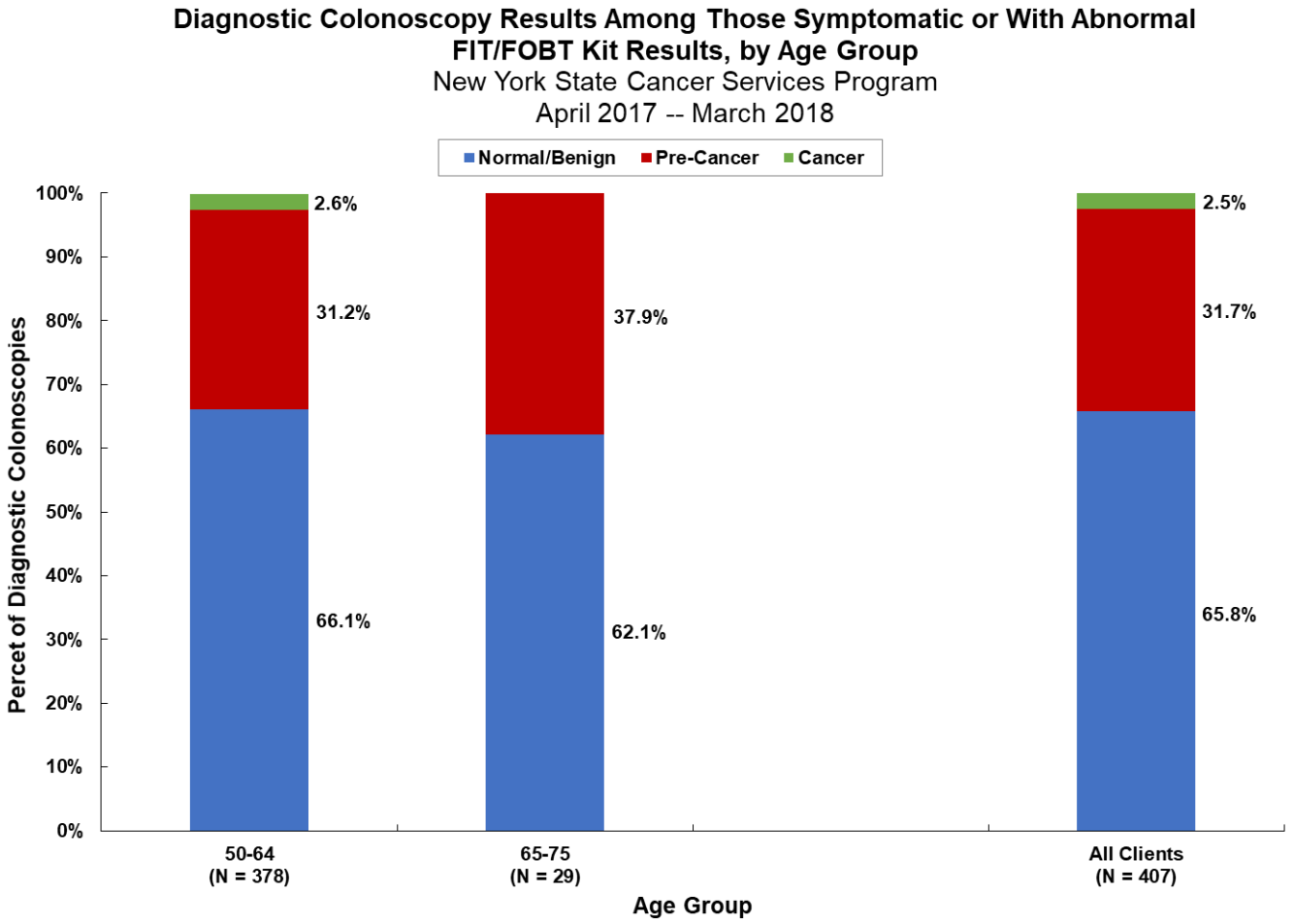


DIAGNOSTIC FOLLOW-UP

Individuals presenting with symptoms and those who were average risk but who had an abnormal finding on their initial FIT/FOBT are referred for a diagnostic colonoscopy. The program goal is to provide timely diagnostic follow-up, defined as follow-up within 90 days from the initial screening date for at least 75 percent of CSP clients with an abnormal screening result. During the 2017-2018 program year, 72.8% of abnormal colorectal cancer screenings had timely follow-up.

Among clients with abnormal FIT/FOBT results or those who were symptomatic, the most common diagnostic colorectal procedures were medical consults (83.1%) and colonoscopy with biopsy or removal of tumors/polyps (55.7%). Clients who received a diagnostic colonoscopy due to an abnormal FIT/FOBT result and those who were symptomatic had similar rates of diagnostic colorectal procedure types and polyp detection. A total of 10 cancers (2.5% of diagnoses) and 129 pre-cancers (31.7%) were diagnosed by diagnostic colonoscopy in the program year. Figure 14 illustrates the variation of diagnostic colonoscopy results by age group.

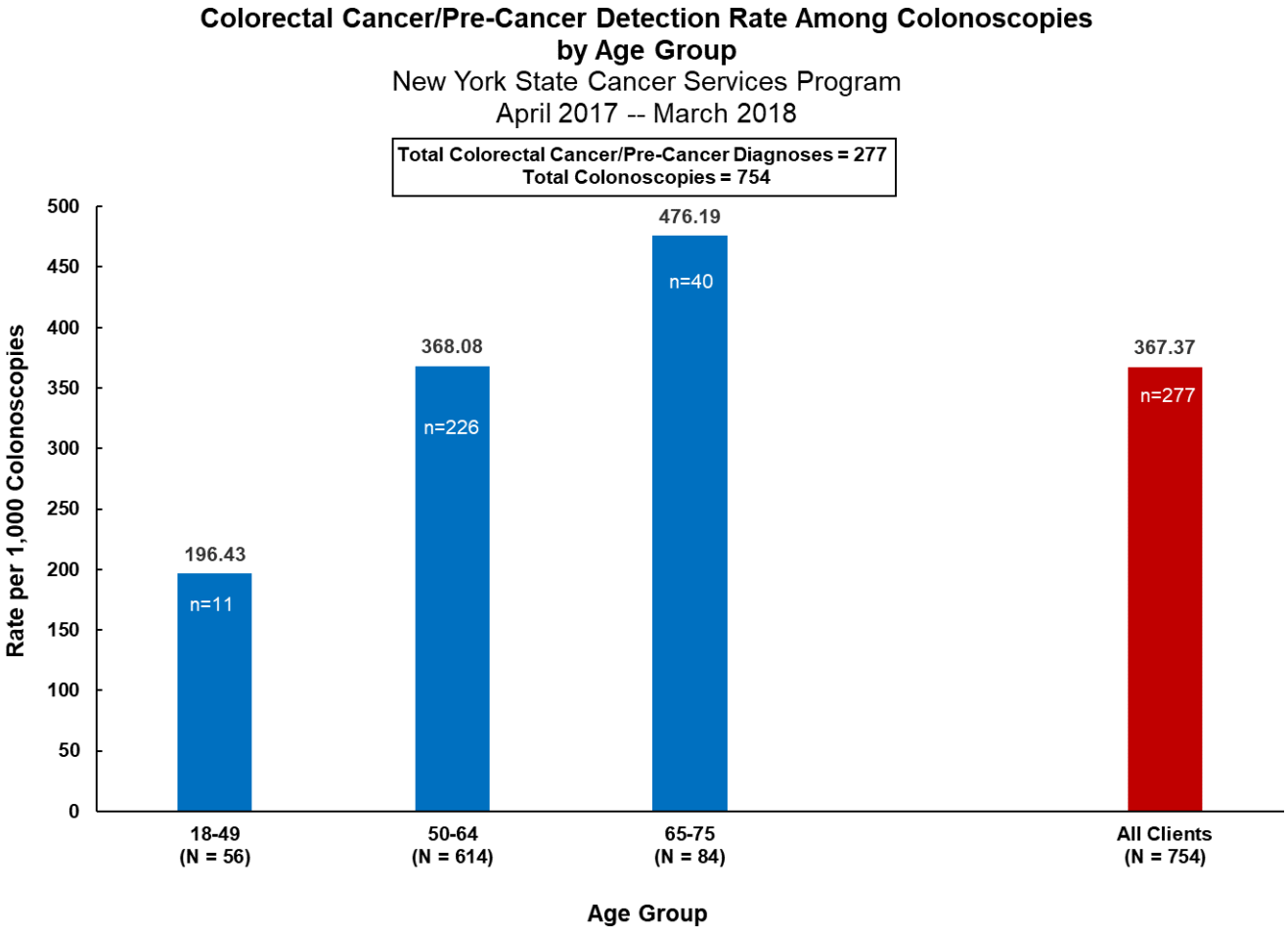
Figure 14



CANCERS DETECTED

During the 2017-2018 program year, 12 cases of colorectal cancer were diagnosed (2 from screening colonoscopy and 10 from diagnostic colonoscopy), representing a cancer detection rate of 1.68 cases per 1,000 clients screened. Both cases were among clients 65-74 years of age. A total of 118 cases of pre-cancer were diagnosed by screening colonoscopy, yielding a pre-cancer detection rate of 385.62 cases per 1,000 clients. Figure 15 depicts how cancer and pre-cancer detection varied by age group.

Figure 15



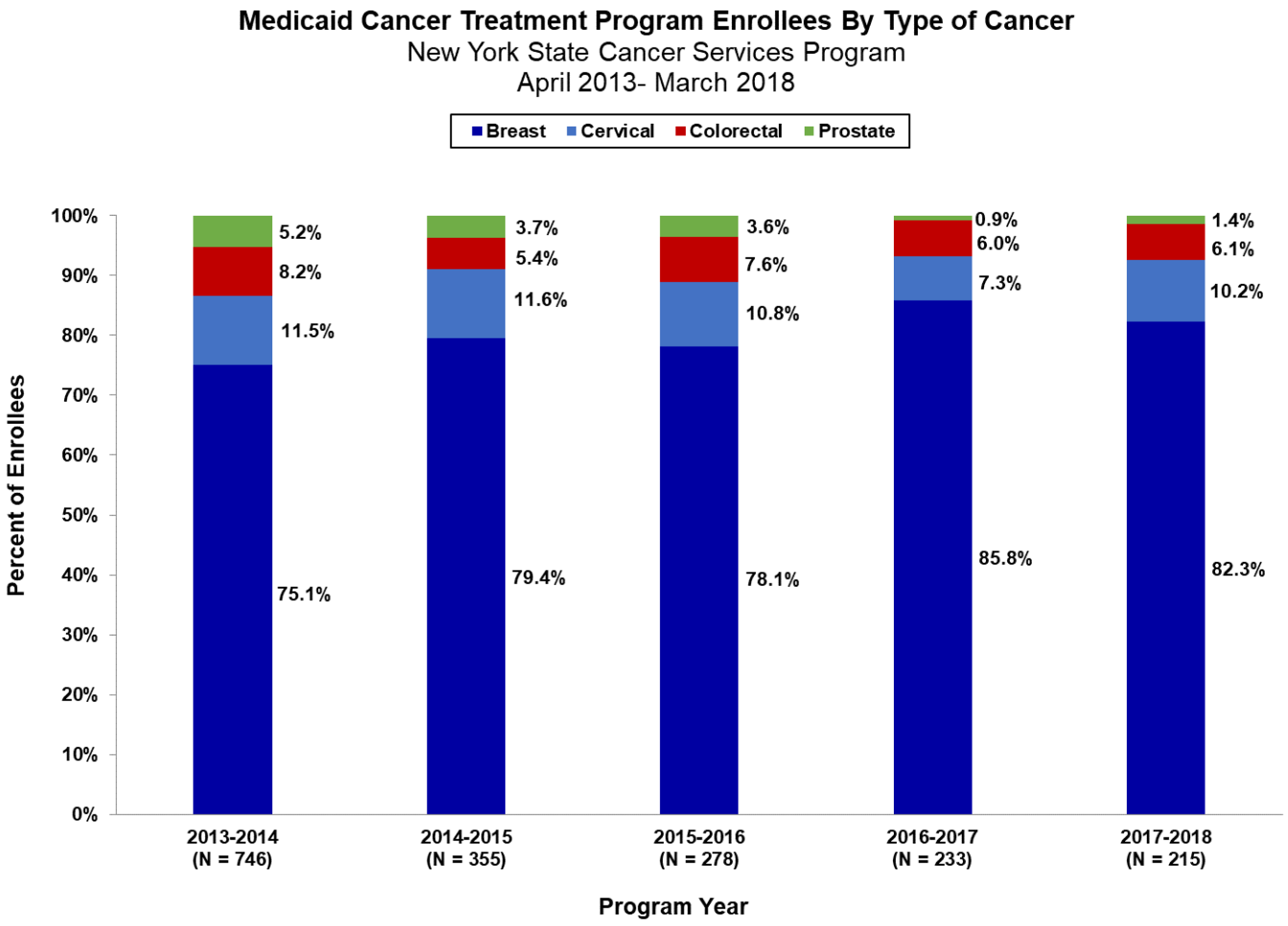
ENROLLMENT IN THE MEDICAID CANCER TREATMENT PROGRAM (MCTP)

The CSP actively follows eligible clients diagnosed with cancer or precancerous conditions requiring treatment for enrollment in the Medicad Cancer Treatment Program (MCTP), with a program goal of at least 90 percent of MCTP-eligible clients enrolled. Figure 16 presents the number of enrollees in the MCTP by type of cancer and program year. More than 200 CSP clients received cancer treatment through the MCTP yearly over the past 3 years.

During the 2017-2018 program year, 93.6 percent (n=215) of MCTP-eligible clients diagnosed through the CSP were enrolled in the MCTP. Enrollment was slightly lower compared to the previous program year (n=233) and comprised of 82.3% (n=177) for breast cancer, 10.2% (n=22) for precancerous cervical dysplasia, 6.1% (n=13) for colorectal cancer, and 1.4% (n=3) for prostate cancer treatment, respectively.

In addition to new enrollees in the MCTP, eligible clients are also recertified for additional years of coverage. During the 2017-2018 program year, almost 58 percent of clients were recertified for a second year of coverage, approximately 38 percent were enrolled for a third year, almost 16 percent for a fourth year, and slightly over 12 percent for a fifth year. Applications for enrollment are processed quickly; on average, final determinations of eligibility for coverage are provided within four to six days.

Figure 16



CONCLUSION

The NYS CSP provides critical cancer preventive services to eligible uninsured and underinsured individuals across every area of NYS and ensures they receive all follow-up care necessary in a timely manner and access to needed treatment. During the 2017-2018 program year, over 5,000 providers and health care facilities offered breast, cervical and colorectal cancer screening and diagnostic services through the CSP. From April 1, 2017 through March 31, 2018, 26,124 eligible adults were screened for cancer through the CSP with 22,029 mammograms, 20,055 clinical breast exams, 6,379 Pap tests, 4,236 high-risk human papillomavirus (HPV) tests, 5,363 FIT/FOBT Kits, and 305 screening colonoscopies provided. During this same 12-month period, the CSP identified 164 individuals with breast cancer, three with cervical cancer, 111 with precancerous cervical dysplasia, 12 with colorectal cancer, and 265 with precancerous colorectal polyps. A total of 215 clients were enrolled in the Medicaid Cancer Treatment Program, 177 for breast cancer treatment, 22 for cervical cancer treatment, 13 for colorectal cancer treatment, and 3 for prostate cancer treatment.

In the program year covered by this report, the CSP continued to experience the impact of the Affordable Care Act and Medicaid expansion, with a reduced number of eligible, uninsured women and men being screened as compared to prior years. This reduction is likely a reflection of both a decrease in the number of clients eligible for CSP services due to the increased number of adults obtaining health insurance and the transition time required for CSP contractors to modify their usual patterns of partner and provider engagement to better identify areas in their communities where the remaining uninsured and underinsured are located. This latter point is supported by the data estimates shared in this report that in the 2017-2018 program year, the number of adults ages 40 to 64 screened through the CSP represented only 10.8 percent (24,310 /225,718) of the estimated eligible population of individuals ages 40 to 64 who are uninsured and at or below 250 percent of FPL in NYS.[7] Future efforts will look at the geographic distribution of the remaining uninsured and specific population demographics. Along with the continued need for screening services for the uninsured and underinsured, an ongoing role of the CSP will be to promote cancer screening among the newly insured and work with community and health care partners to improve processes aimed at increased screening and timely follow up. This point acknowledges the fact that having insurance does not guarantee a person will be up-to-date with recommended cancer screenings.

[7] United States Census Bureau. *Small Area Health Insurance Estimates, 2016.* https://www.census.gov/programs-surveys/sahie.html