

Breast and Cervical Cancer Early Detection Program Report

**New York State Department of Health
Cancer Services Program**

Report for Program Year

2015-2016

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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) facilitates access to breast, cervical and colorectal cancer screening and diagnostic services for uninsured and underinsured women and men in New York State (NYS) and promotes awareness about and access to cancer screening for all New Yorkers. This work is provided through a network of contractors that conduct public education and targeted outreach to enroll eligible New Yorkers into the program for receipt of services. The contractors enter into agreements with health care providers and clinical laboratories in their service areas for the provision of breast, cervical and colorectal cancer screening and diagnostic services. Since NYS's full implementation of the Affordable Care Act and Medicaid expansion in 2013, CSP contractors also educate about and make referrals to the New York State of Health, the State's health plan marketplace. This report, which is required pursuant to Section 2408 of the Public Health Law, focuses on the program's provision of breast and cervical cancer screening services across NYS.

Over 15,750 women are newly diagnosed with breast cancer and approximately 2,550 die from the disease annually in NYS.¹ Cervical cancer is diagnosed in about 840 women in NYS each year and approximately 270 women die from the disease 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, 2015 through March 31, 2016, 27,251 eligible women were screened for cancer through the CSP with approximately 25,683 mammograms, 23,434 clinical breast exams, 7,538 Pap tests, and over 5,140 high-risk human papillomavirus (HPV) tests. Over the course of this same 12-month period, the CSP identified 246 individuals with breast cancer, 3 with cervical cancer and 149 with precancerous cervical dysplasia. A total of 247 clients were enrolled in the Medicaid Cancer Treatment Program for breast or cervical cancer treatment.

Mammograms for breast cancer screening and the Pap test with or without the HPV test for cervical cancer screening are highly effective cancer screening tools. Virtually all cervical cancer cases are caused by HPV infections, which can cause cervical cell abnormalities. The Pap test detects cervical cell abnormalities that could become cervical cancer without proper treatment. The HPV test looks for the presence of HPV strains.

These cancer screening tools are underused in some subsets of the population, with a disproportionate number of deaths from breast and cervical cancer occurring among women who are uninsured and underinsured, geographically and culturally isolated, older, medically underserved or racial, ethnic and

¹ New York State Cancer Registry, 2017. *Cancer Incidence and Mortality for New York State, 2011-2015*. <http://www.health.ny.gov/statistics/cancer/registry/vol1/v1rnys.htm>

cultural minorities.² The goal of the CSP is to improve access to and utilization of cancer preventive services for these underserved populations and improve the quality of care received in NYS.

This report provides information about the breast and cervical cancer early detection and diagnostic services offered to eligible clients by CSP contractors for the period from April 1, 2015 through March 31, 2016 (program year 2015-2016). During this period, there were 36 CSP contractors with agreements with over 5,600 health care providers, facilities and clinical laboratories, providing screening services in every NYS County and New York City borough.

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

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 women and men in NYS through local screening program contractors. CSP contractors conduct outreach, public education, data management and quality assurance and develop relationships with regional providers (e.g., hospitals, clinics, laboratories) who offer screening and diagnostic services.

CSP contractors and their partners also assist individuals diagnosed with breast, cervical or colorectal cancer to obtain prompt, comprehensive treatment through the NYS Medicaid Cancer Treatment Program (MCTP), if 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 for the duration of their cancer treatment.

NYS proceeded with full implementation of the Affordable Care Act and Medicaid expansion in 2013. At this time, CSP contractors began educating clients about the New York State of Health (NYSoH), working with local in-person assistors and navigators to facilitate enrollment 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 2015-2016, the CSP had a combined state and federal annual budget of approximately \$22 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).

ELIGIBILITY CRITERIA

In order to access screening, diagnostic and case management services through the CSP, individuals must meet program eligibility criteria which include client 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). Women 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 appropriate mammography or other diagnostic testing. Multiple factors determine a woman's risk for breast cancer, including, but not limited to, a personal or family history of breast, ovarian and 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.

PRIORITY POPULATIONS

CSP contractors focus their activities on priority populations – subsets of the program-eligible population who are disproportionately affected by breast, cervical or colorectal cancer or who are medically underserved or underserved and lack adequate health care options. Individuals who are medically underserved or underserved include, but are not limited to, those who experience barriers to services due to sex, race, ethnicity, disability, sexual orientation, gender identity, geographic location, socioeconomic status, cultural isolation, low literacy or language.

The CSP provides screening mammograms to women ages 40 years and older, but identifies women ages 50 years and older as a priority population for mammography screening 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 5 years ago) or never screened for cervical cancer.

CASE MANAGEMENT

Case management has been an integral part of the CSP since the federal legislation 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 clients receive support to obtain needed services. The CSP requires a direct, personal level of support be available to assist clients to address barriers 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 psychosocial 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 that women receive 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 CSP 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 uninsured and insured women 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.

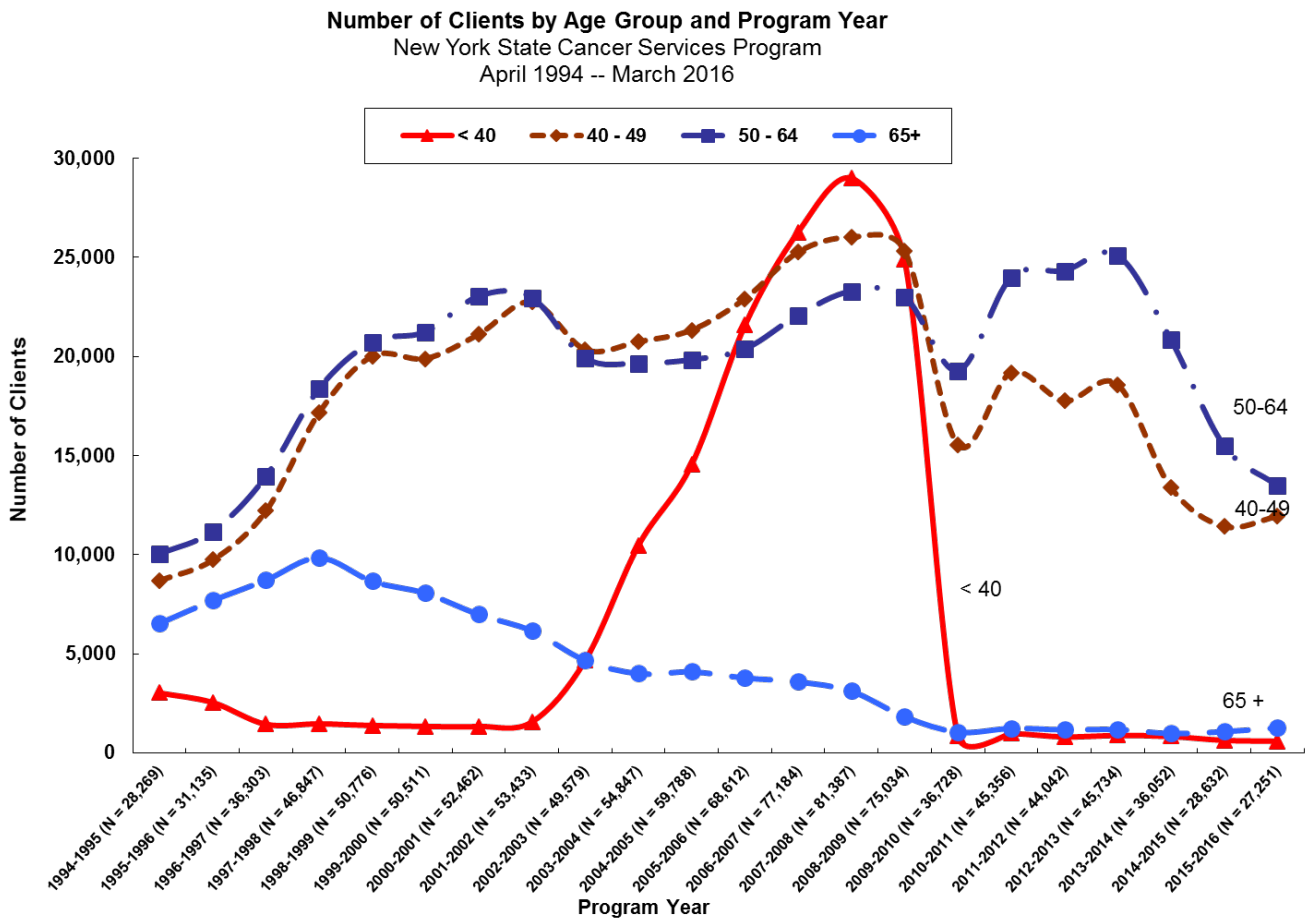
PROGRAM OUTCOMES

This section summarizes the breast and cervical cancer screening and diagnostic services provided through the CSP, screening test results and final diagnoses determined for program year 2015-2016.

WOMEN SCREENED THROUGH THE CANCER SERVICES PROGRAM

The number of women screened for breast and/or cervical cancer through the CSP has varied through the years since the program's inception in 1994. Figure 1 provides information about the number of women screened for breast and/or cervical cancer from 1994 through the 2015-2016 program year. The total number of women screened reached a high of over 81,000 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. The number of women screened by the program then increased by over 8,000 between the 2009-2010 and the 2010-2011 program years. In the 2011-2012 program year, the total number of women screened declined by 1,300 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 women screened has decreased during each of the past three program years, from 36,052 in program year 2013-2014 to 28,632 in program year 2014-2015 and 27,251 in program year 2015-2016. This decrease is primarily due to implementation of the Affordable Care Act and Medicaid expansion, resulting in a reduction in the number of individuals eligible for the CSP.

Figure 1



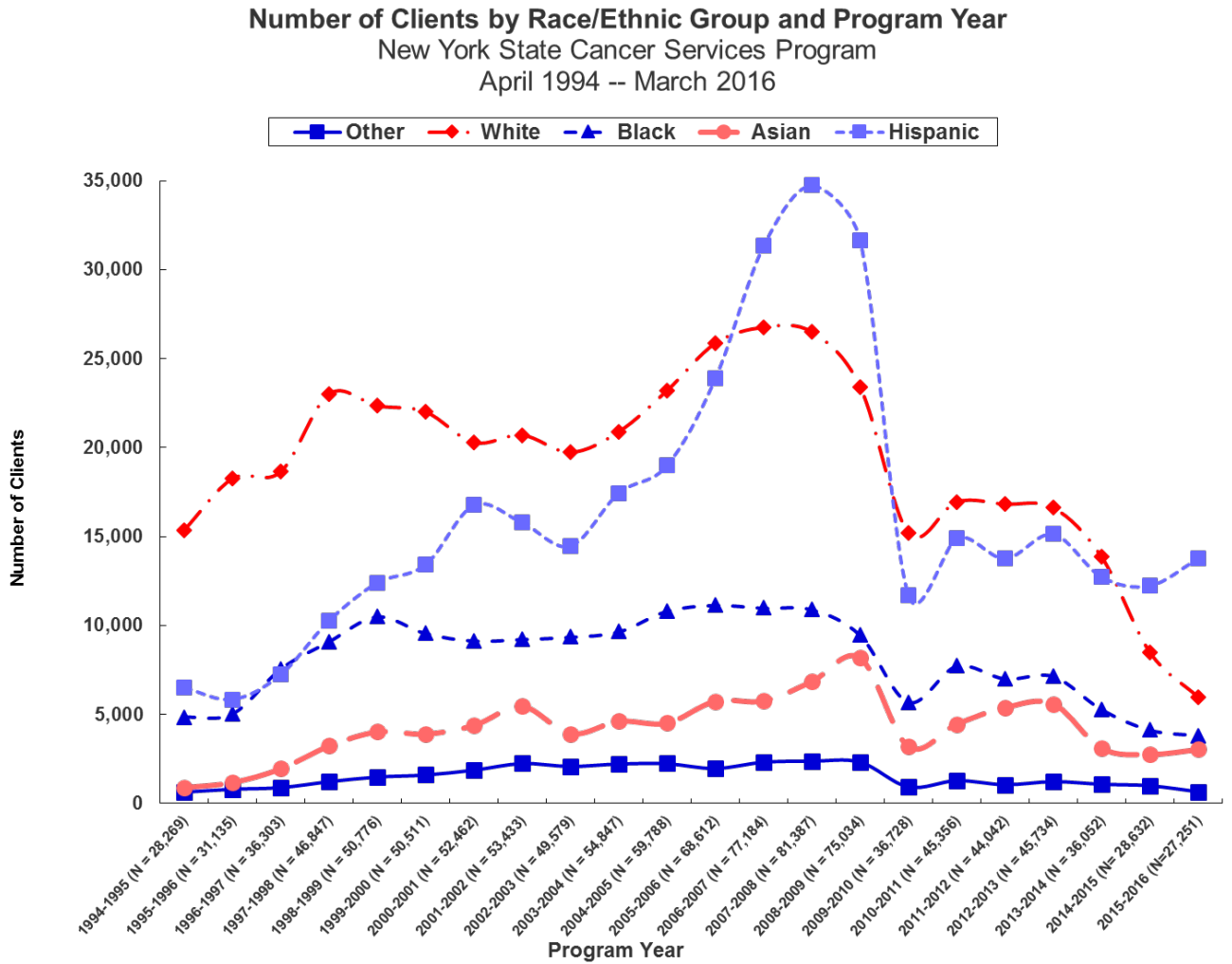
Changes in eligibility criteria for the program can explain most of the variation seen within age-specific groups of women across the 22 program years. The initial increase among younger women was due to the expansion of the number of women 18 to 39 years of age served by the program. A sharp decline 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 women 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 women 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 priority population of women 50 to 64 years of age. Since the 2009-2010 program year, women in the 50 to 64 age group represent the largest group of clients served. This is a reflection of the greater emphasis on the priority population of women 50 to 64 years of age, and changes in the program eligibility criteria beginning in the 2009-2010 program year.

Despite the decreasing numbers of women screened by the CSP, the number of women screened during the period covered by this report continues to be a small proportion of the estimated low-income, uninsured women in NYS who are eligible for services. The number of women ages 40 to 64 screened through the CSP in the 2015-2016 program year represented 18.5 percent (25,397/137,466) of the estimated eligible population of women 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 21.0 percent (13,468/63,992) for those ages 50 to 64 for the 2015-2016 program year.

The racial and ethnic distribution of women screened through the CSP is shown in Figure 2. In the 2015-2016 program year, 50.5 percent of women screened identified as Hispanic, 22.0 percent identified as white, 14.0 percent identified themselves as Black, 11.2 percent identified as Asian, and 2.4 percent identified as other races. The number of Hispanic women screened through the CSP increased dramatically until the 2007-2008 program year when approximately 35,000 Hispanic women were screened (42.7 percent of all women screened that year). The number of Hispanic women then declined to approximately 12,000 Hispanic women screened in the 2014-2015 program year (42.7 percent of all women screened that year). Due to a recent decline in the proportion of white women screened (from 38.5 percent in program year 2013-2014 to 22.0 percent in program year 2015-2016), Hispanic women again represented the largest proportion of clients being served by the CSP in program year 2015-2016, representing 50.5 percent of all clients screened.

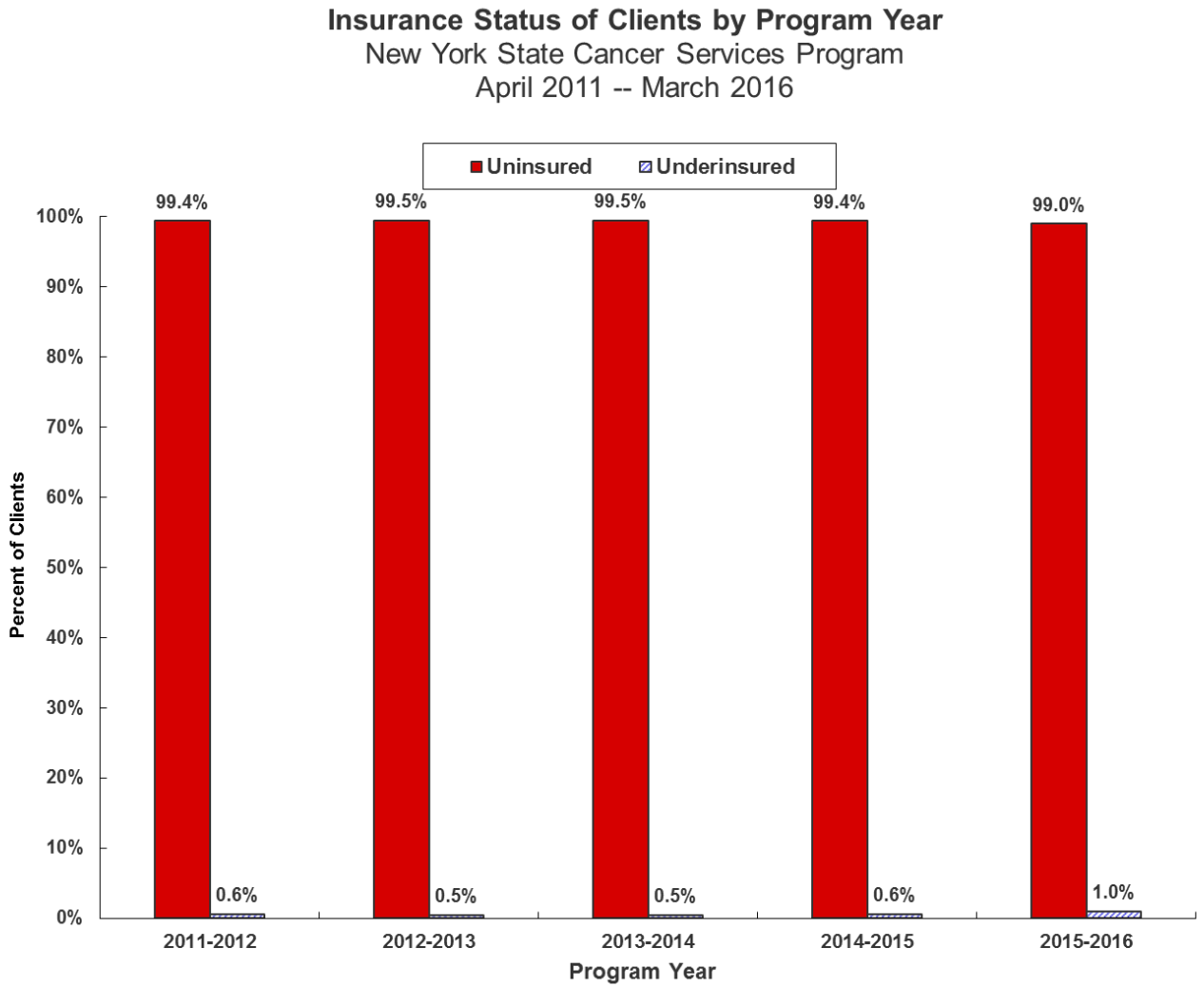
³ United States Census Bureau, 2017. *Small Area Health Insurance Estimates, 2015*.
<https://www.census.gov/programs-surveys/sahie.html>

Figure 2



Although the CSP screens women who are either uninsured or underinsured, the vast majority of the women screened through the program are uninsured (Figure 3). In the 2015-2016 program year, approximately 99.0 percent of women screened did not have health insurance.

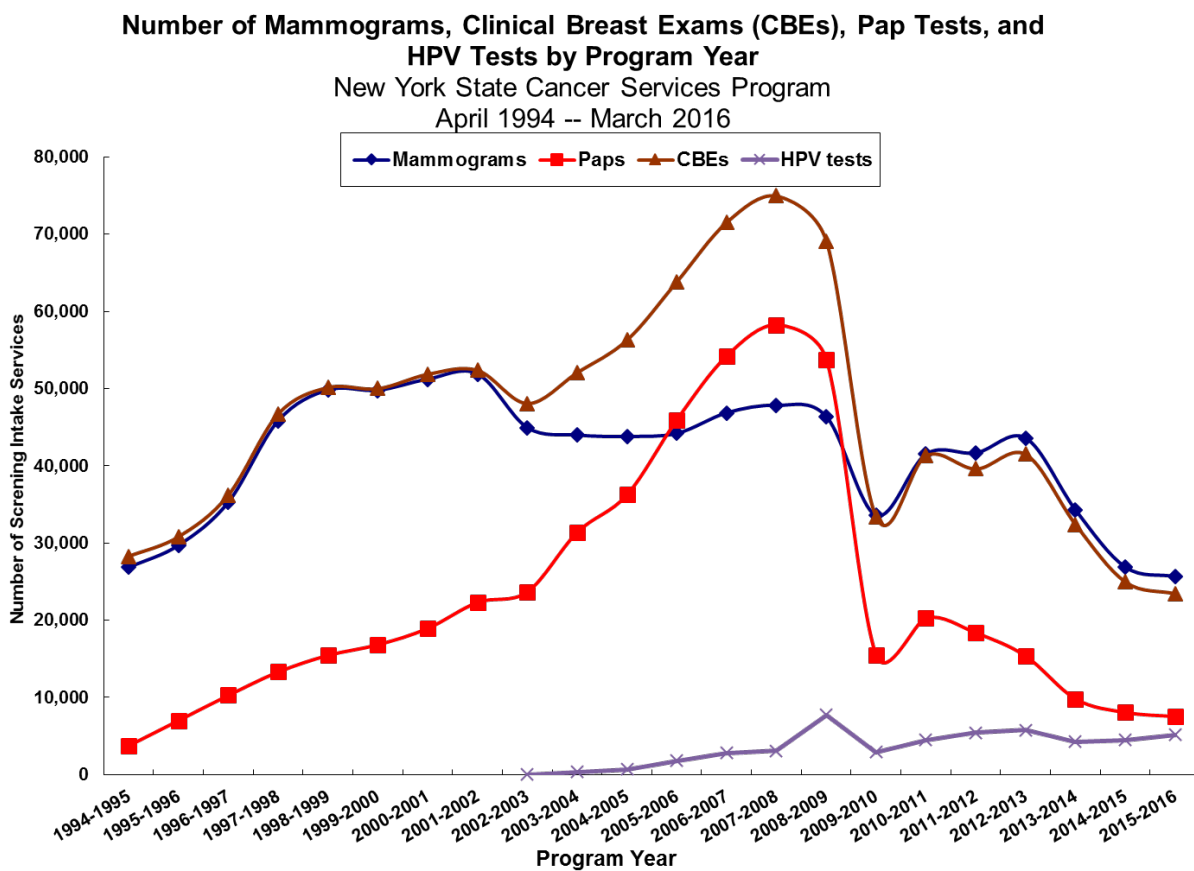
Figure 3



BREAST AND CERVICAL CANCER SCREENING SERVICES

The CSP provided over 905,360 mammograms, over 1,018,800 clinical breast exams (CBEs), over 506,330 Pap tests, and approximately 49,000 high-risk HPV tests to low income, uninsured and underinsured women since its inception in 1994 (Figure 4). The HPV tests represent a combination of screening, surveillance and reflex tests performed after an abnormal Pap test. In the 2015-2016 program year, 25,683 mammograms, 23,434 CBEs, 7,538 Pap tests, and 5,142 high-risk HPV tests were provided. The majority of HPV tests provided were co-tests performed at the same time as the Pap test.

Figure 4



The CSP provides screening mammograms to women ages 40 years and older, but identifies women ages 50 years and older as a high priority group for mammography screening due to increased breast cancer incidence in older women. The CSP goal is to provide at least 75 percent of screening mammograms to women ages 50 years and older. In the 2015-2016 program year, 56.2 percent of women who received screening mammograms were in this age group. Another priority for the CSP is to provide Pap tests to women who are rarely (screened more than 5 years ago) or never screened for

cervical cancer. The program goal is to provide at least 20 percent of initial program-funded Pap tests to women who meet these criteria. In the 2015-2016 program year, 45.4 percent of women met this criteria.

BREAST CANCER SCREENING RESULTS

The CSP follows guidance from the CDC that women 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 uninsured women because in many cases these exams may be a woman’s only access to a medical provider. An abnormal CBE result is defined as having a mass or other finding in the breast. Figure 5 illustrates the age-specific percentages of abnormal CBEs in the 2015-2016 program year. Overall, the percentage of abnormal CBEs among all clients screened in this program year was 8.5 percent, but this percentage was 95.5% among clients under 40 years of age (Figure 5). This is explained, in part, by the fact that, beginning in 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 5

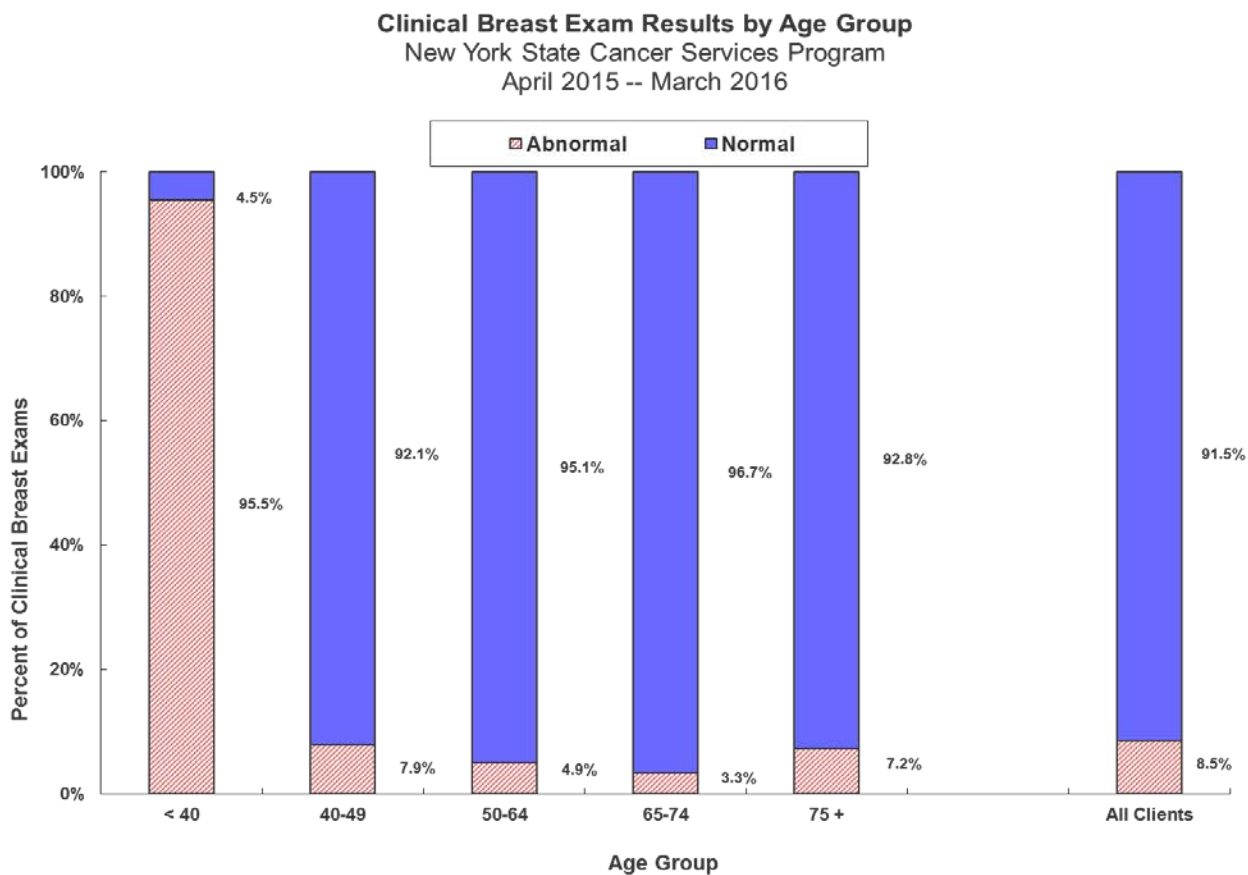
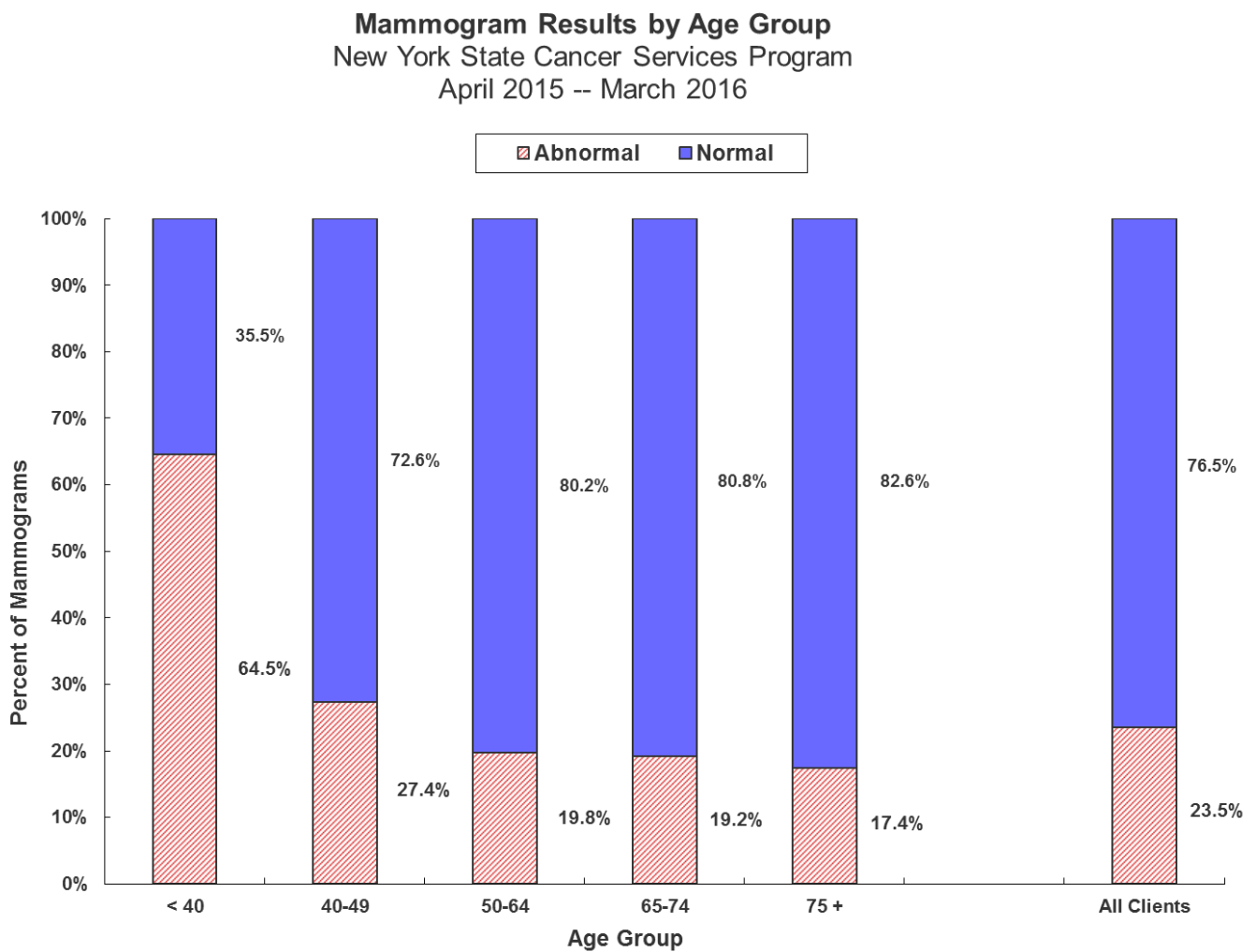


Figure 6 illustrates the age-specific percentages of abnormal mammograms in the 2015-2016 program year. Abnormal mammograms include those that had results of “assessment incomplete”, “suspicious abnormality” or “highly suggestive of malignancy.” Overall, the percentage of abnormal mammograms among all clients screened in the program was 23.5 percent during the 2015-2016 program year. The percent of abnormal mammograms varied by age, and was lowest among women in the 75 and older and 65 to 74 age range. Younger women aged less than 40 had approximately two to three times as many abnormal findings as women in other age groups. As with the CBE findings, this is likely due to the fact that 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.

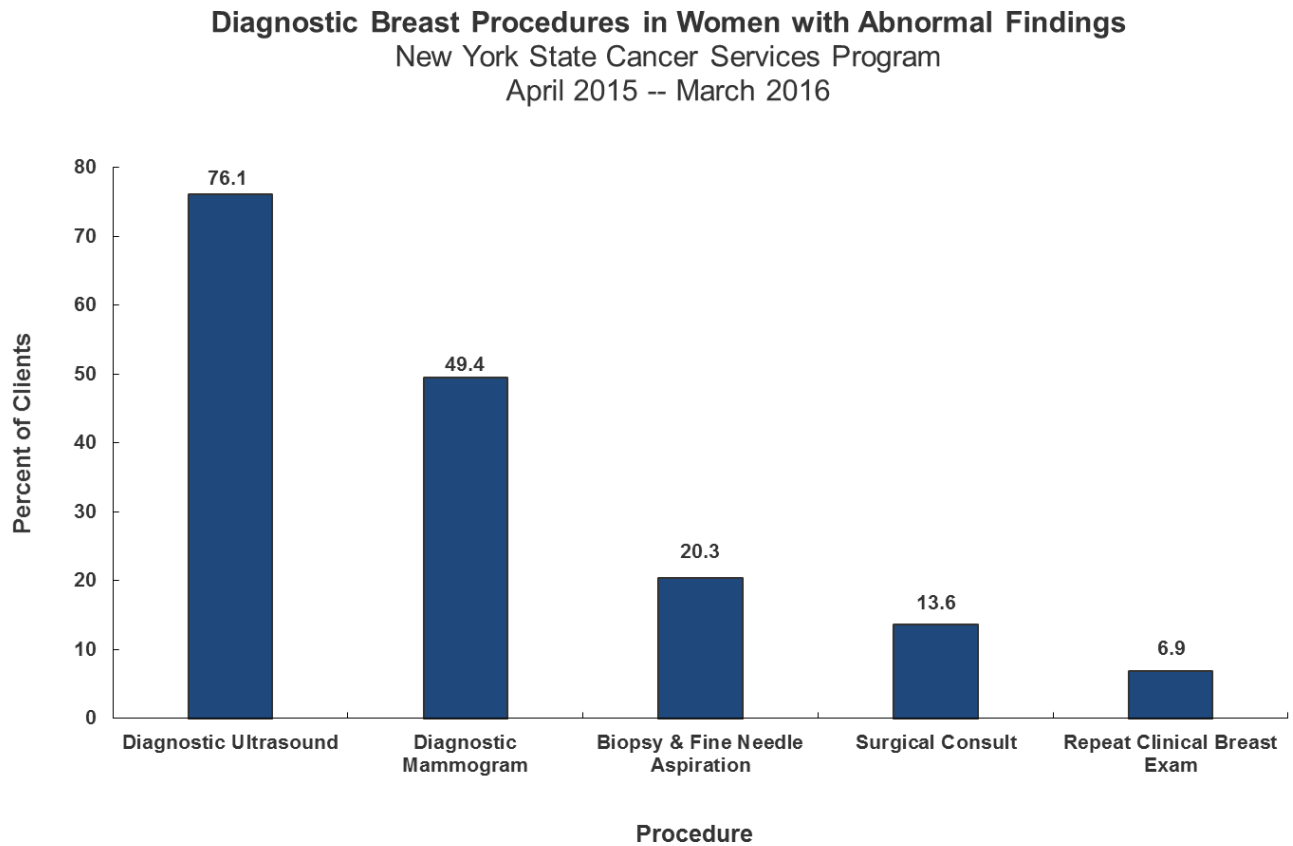
Figure 6



BREAST CANCER SCREENING 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 2015-2016 program year, 83.9 percent of abnormal breast cancer screenings had timely follow-up. Figure 7 illustrates the most common diagnostic procedures provided through the CSP to women with abnormal findings. During the 2015-2016 program year, 76.1 percent of women with abnormal findings received ultrasounds and 49.4 percent received diagnostic mammograms.

Figure 7

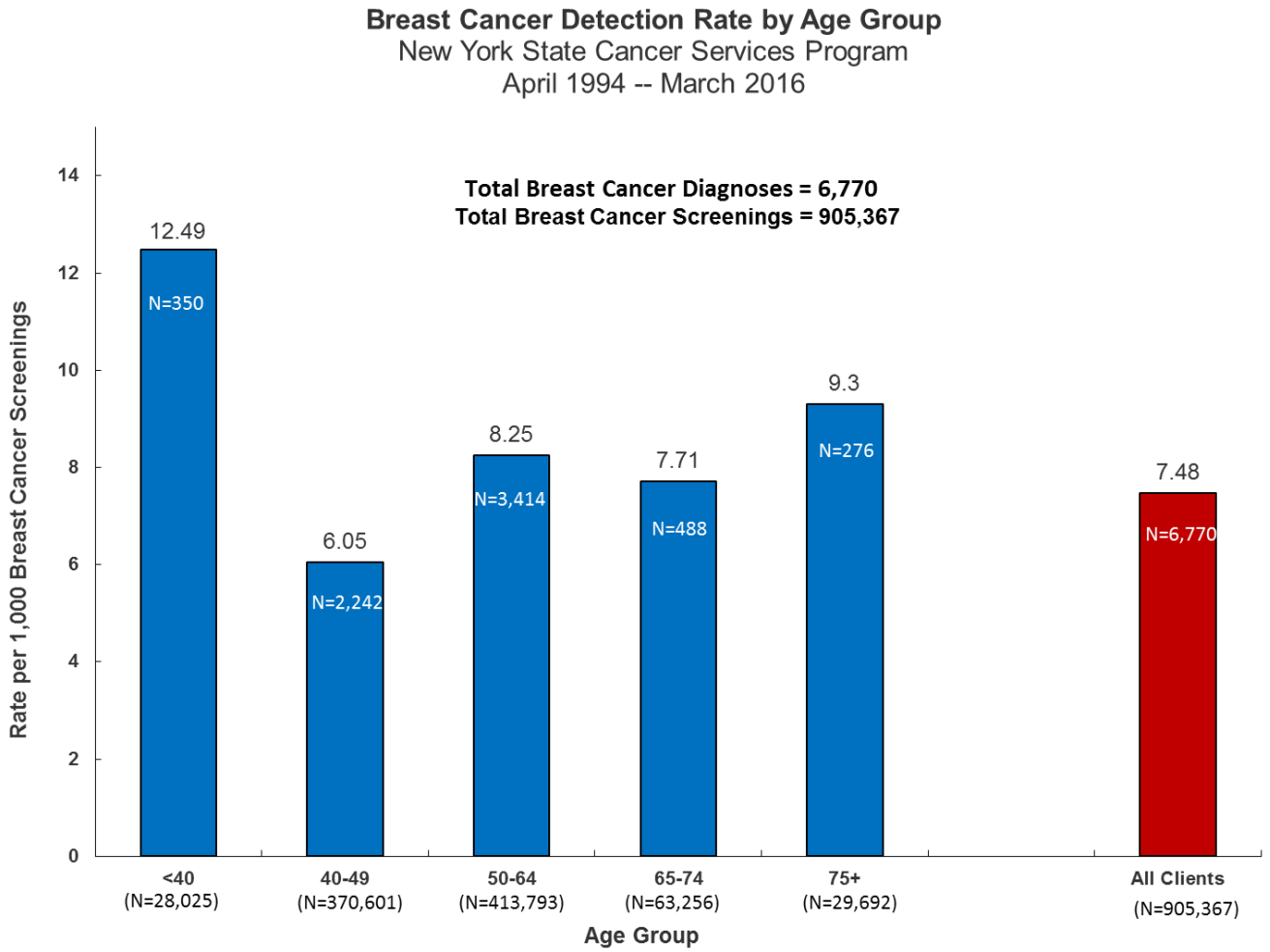


BREAST CANCER DETECTION

During the 2015-2016 program year, a total of 246 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 through the CSP, representing an overall breast cancer detection rate of 9.6 cases per 1,000 women screened through the CSP during the program year. Figure 8 shows how the detection rate for breast cancer varied by age for cases diagnosed between the 1994-1995 and 2015-2016 program years; 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 of breast cancer with age in the general population, with the highest incidence in women 75 to 79 years of age.⁴

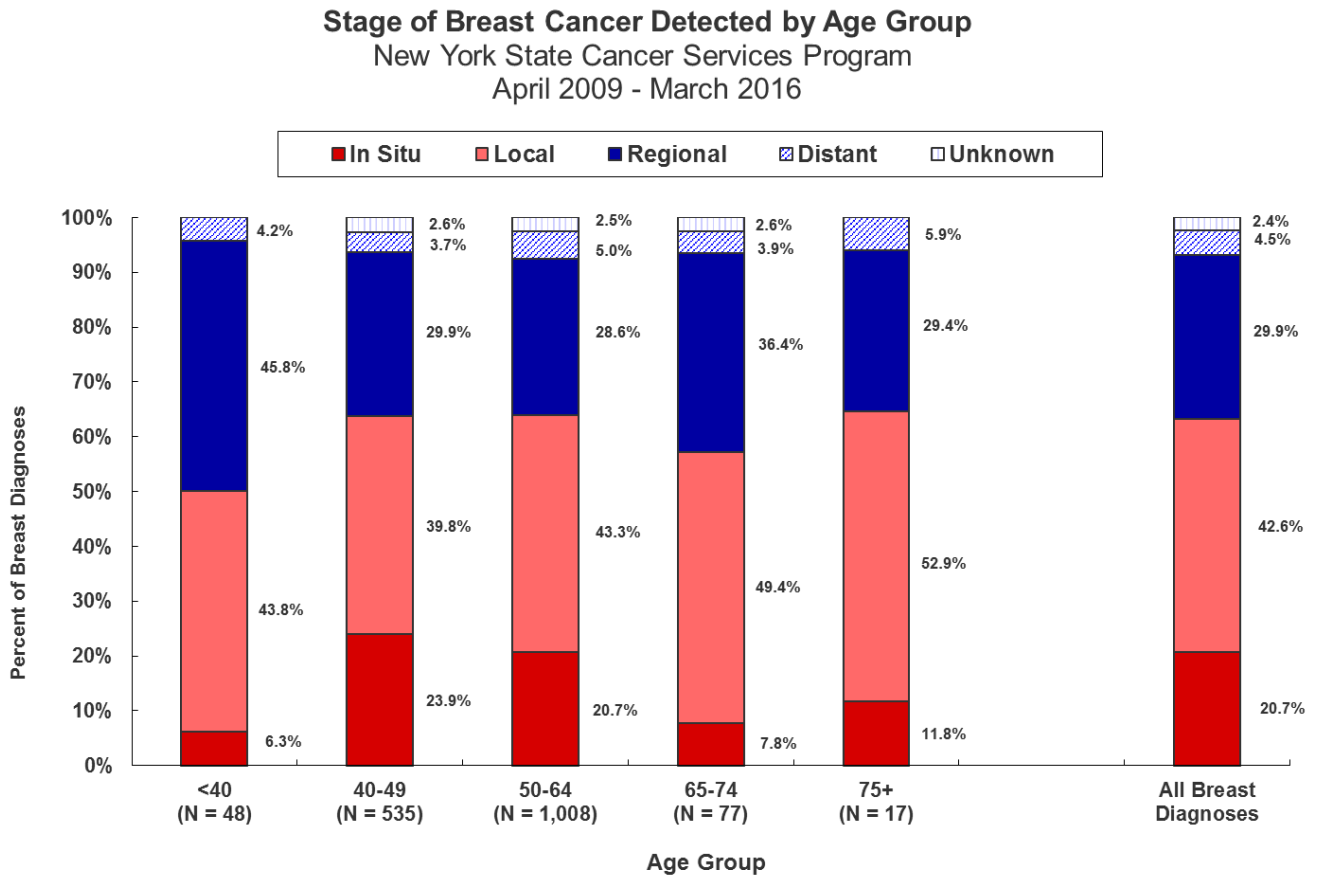
⁴ New York State Cancer Registry, 2017. *Female Breast Cancer Incidence and Mortality by Age Group, New York State, 2011-2015*. <https://www.health.ny.gov/statistics/cancer/registry/table6/tb6breastnys.htm>

Figure 8



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. Overall, the percent of clients diagnosed early with in situ or a localized stage of breast cancer was 63.3 percent between the 2009-2010 and 2015-2016 program years, and the percent of women with early stage disease varied by age group (Figure 9). 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 9*

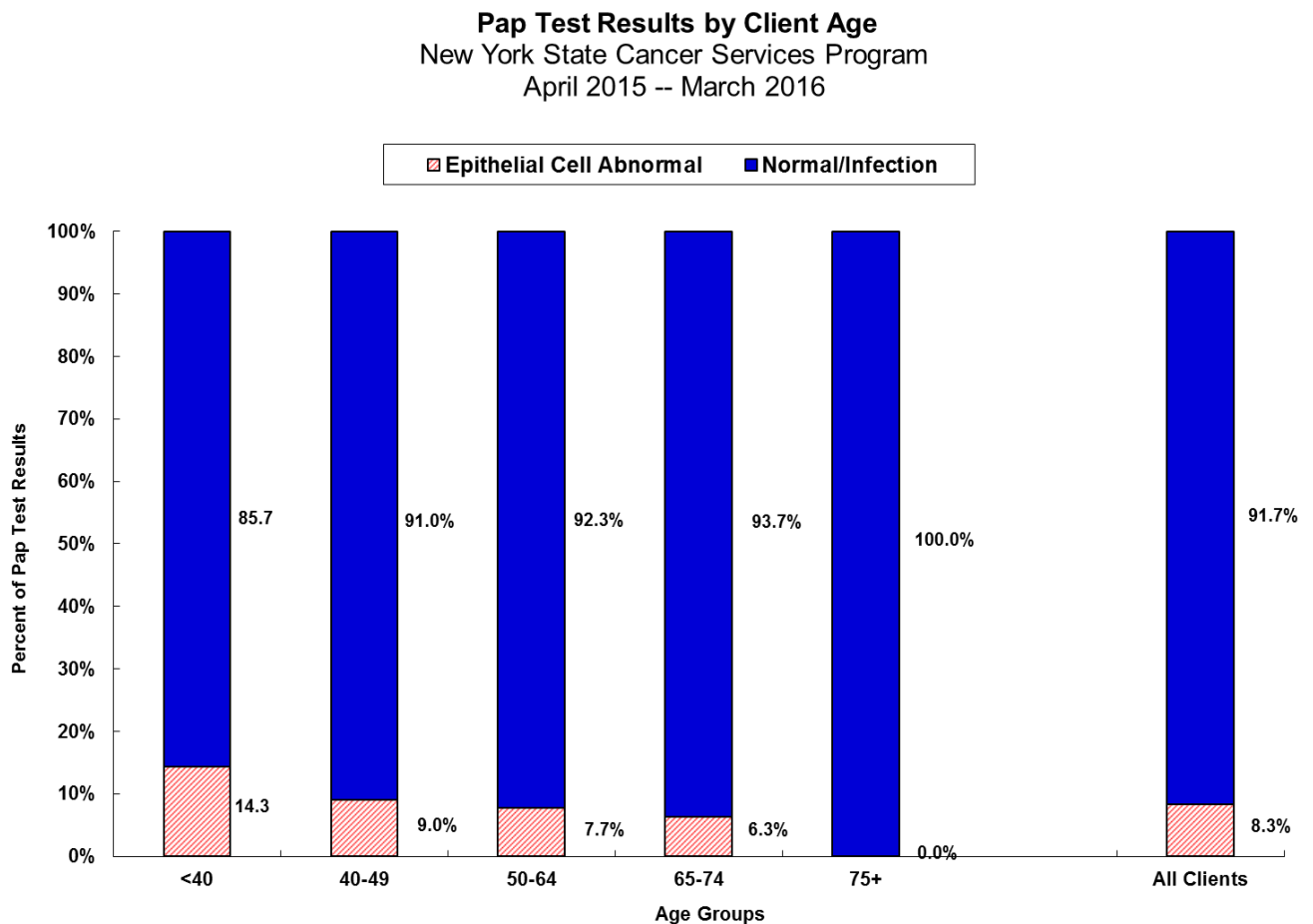


*Note: Figure 9 is limited to program years where breast cancer diagnoses were matched with the NYS Cancer Registry for reporting to CDC, to ensure consistent information on breast cancer stage. An “unknown” diagnosis refers to cases where staging was not performed or stage information is unavailable for any reason.

CERVICAL CANCER SCREENING RESULTS

The percentage of abnormal Pap test results among all women screened through the CSP was 8.3 percent for program year 2015-2016. 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. The youngest women 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 performed as part of the screening process (screening and surveillance HPV tests), 10.9% of tests detected the presence of HPV in program year 2015-2016. Because HPV infection is the main risk factor for the development of cervical cancer, the results of both the Pap and HPV test are used to determine the appropriate diagnostic services, treatment and re-screening recommendations.

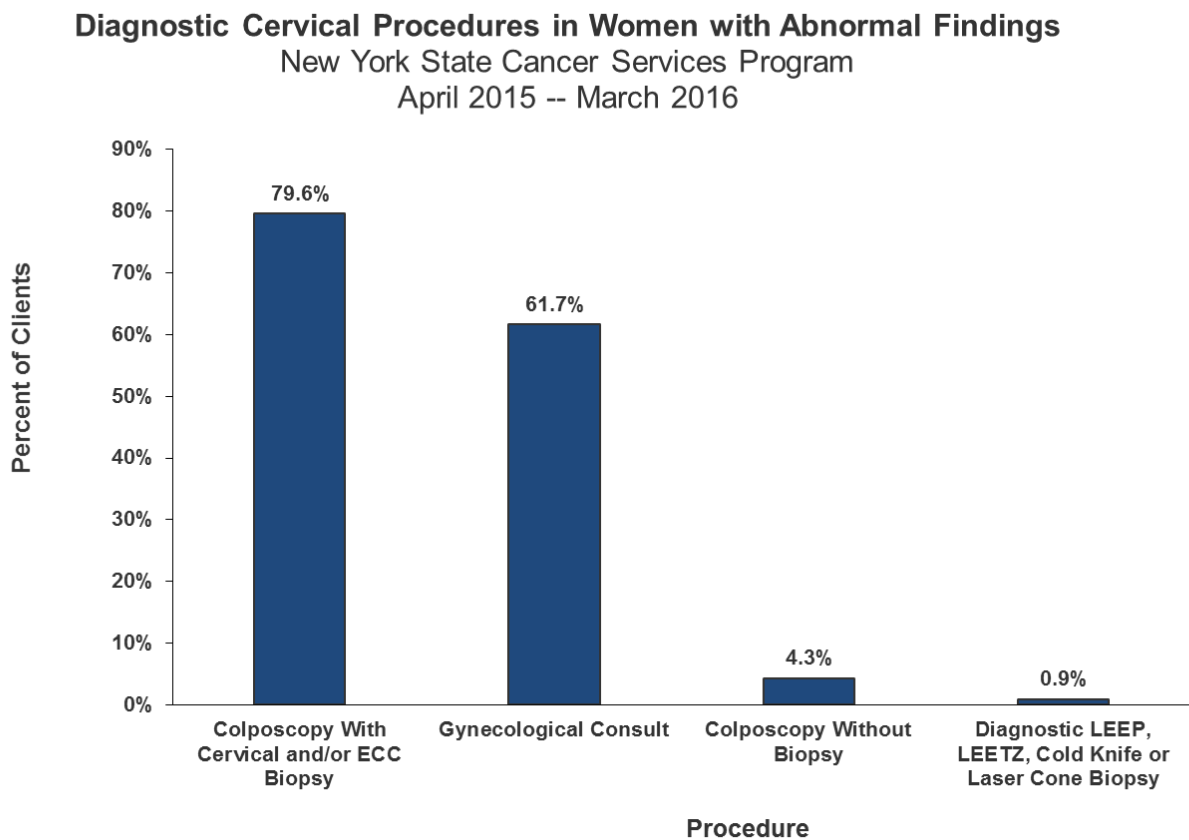
Figure 10



CERVICAL CANCER 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 2015-2016 program year, 82.4 percent of abnormal cervical cancer screenings had timely follow-up. Figure 11 displays the most common diagnostic procedures provided for women with abnormal cervical cancer screenings. In the 2015-2016 program year, 79.6 percent of women who had abnormal cervical cancer screenings had colposcopies with biopsies, and 61.7 percent had gynecological consults.

Figure 11



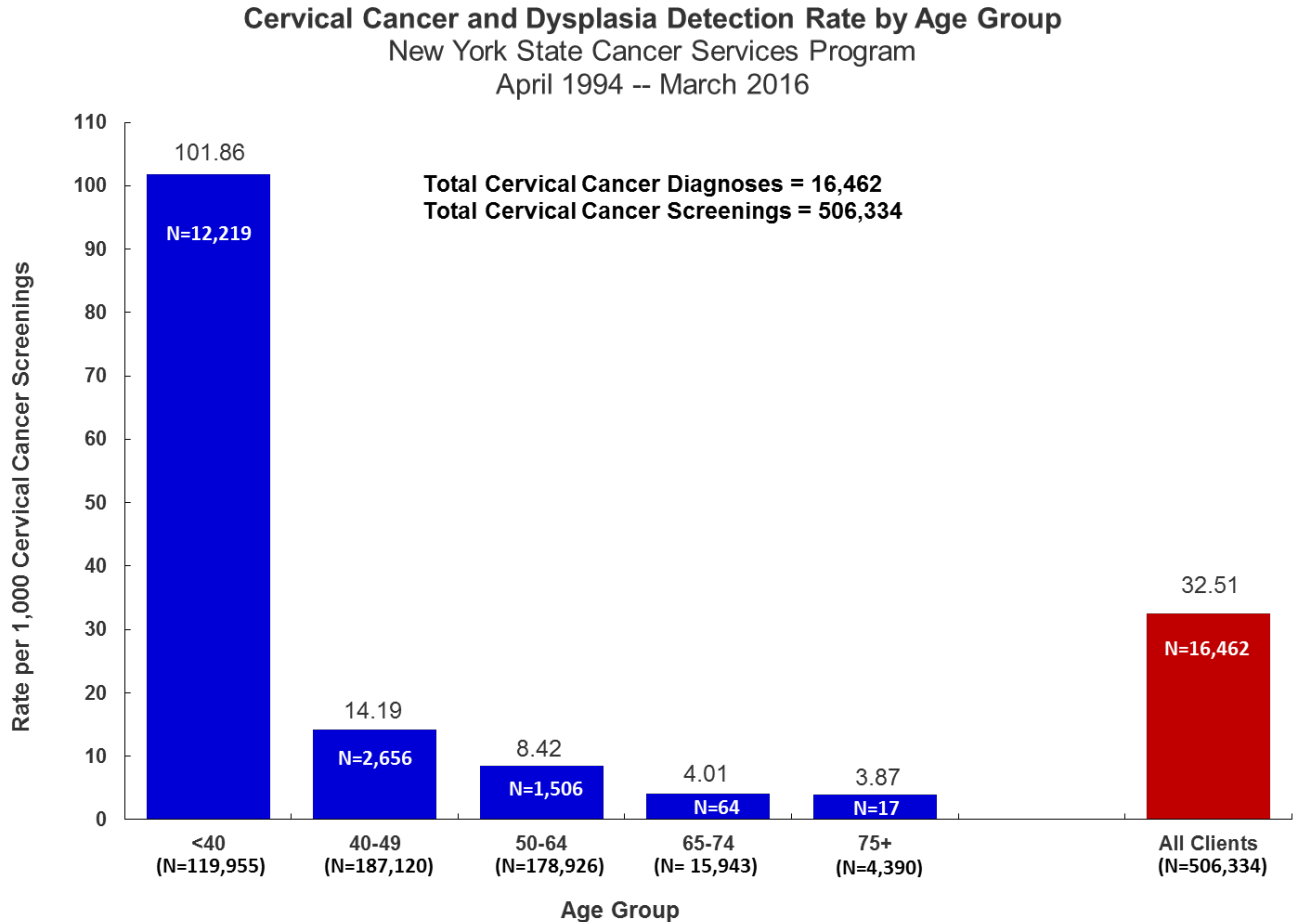
CERVICAL CANCER AND DYSPLASIA DETECTION

In the 2015-2016 program year, a total of 3 cases of invasive cervical cancer and 145 cases of cervical intraepithelial neoplasia (CIN) were diagnosed through the CSP. 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 19.6 cases per 1,000 women screened for program year 2015-2016.

Figure 12 shows how the detection rates of cervical cancer and dysplasia vary by age for cases diagnosed between the 1994-1995 and 2015-2016 program years. The high detection rate for women under age 40 years 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.

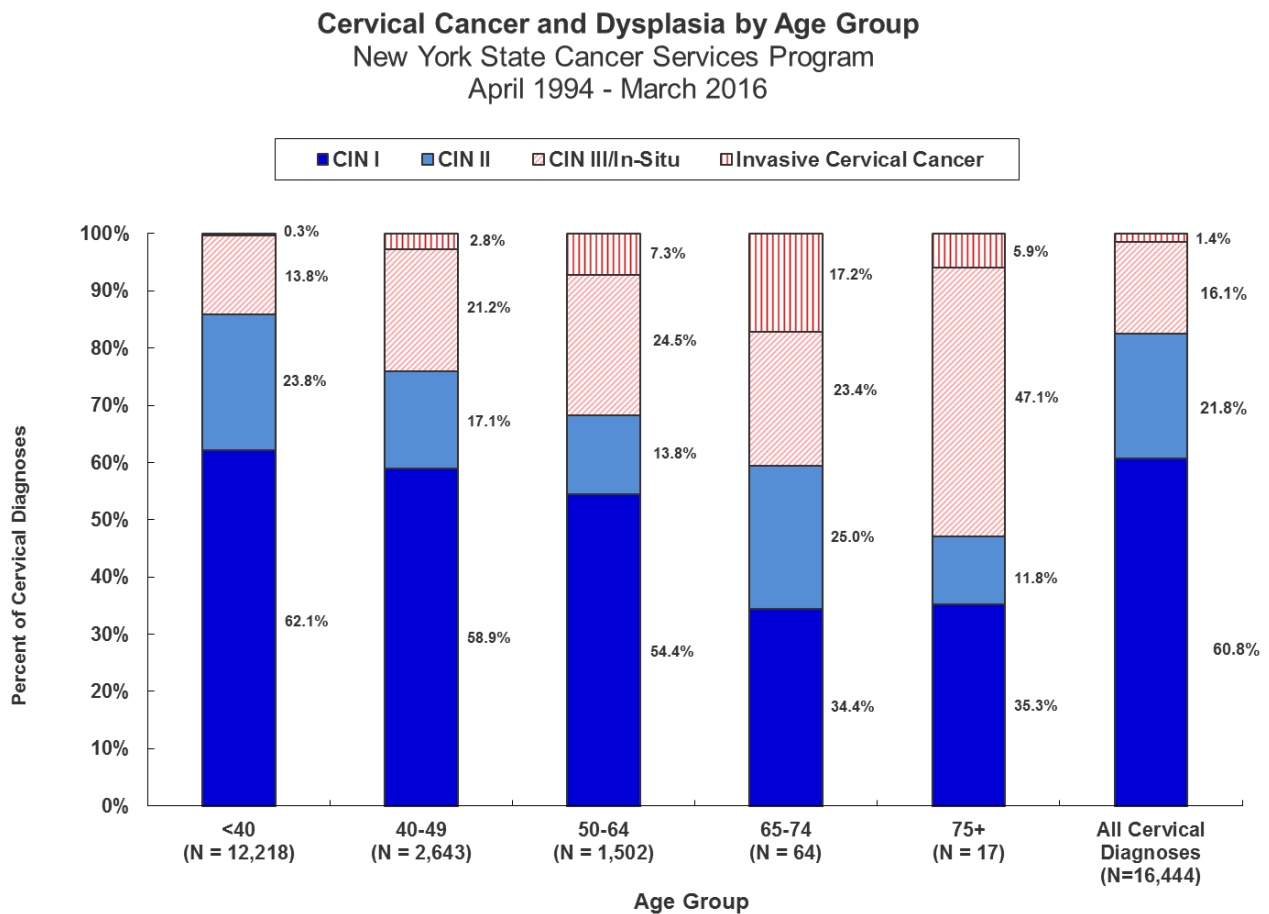
Figure 12

N=2,576



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 during the period between the 1994-1995 and 2015-2016 program years (Figure 13). The higher detection rate of invasive cervical cancer in women 65 to 74 years of age is consistent with the incidence of cervical cancer in the general population, where incidence generally increases with age.⁵ As noted above, 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.

Figure 13



⁵ New York State Cancer Registry, 2017. *Cervical Cancer Incidence and Mortality by Age group, New York State, 2011-2015.*
<https://www.health.ny.gov/statistics/cancer/registry/table6/tb6cervixnys.htm>

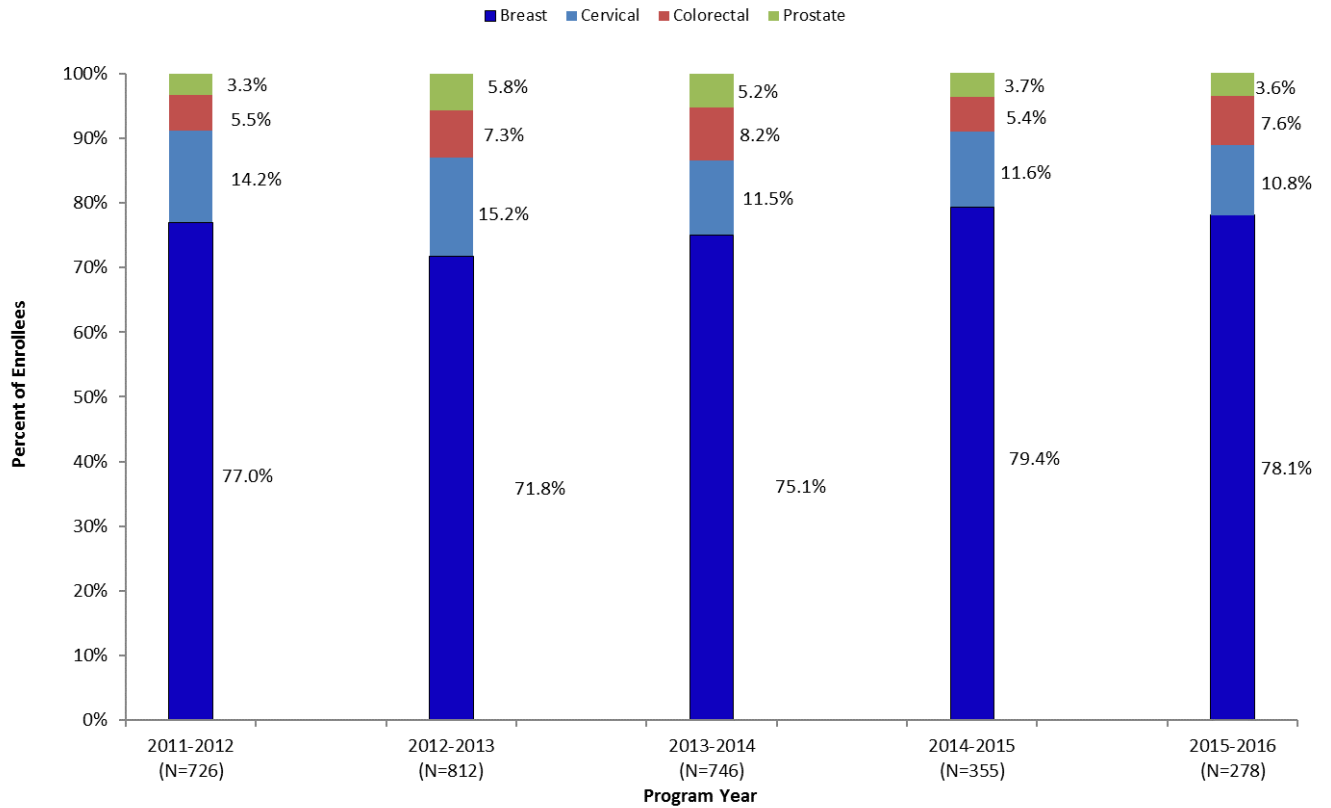
Due to the small number of invasive cervical cancer cases, staging information is not described in detail in this report. Overall, a total of 36 invasive cervical cancer cases were diagnosed between April 2009 and March 2016 and were matched with the cancer registry to obtain staging data. Of the 36 invasive cervical cancer cases, approximately 80.6% of cases were diagnosed with in situ, localized, or regional disease, and only 16.7% were diagnosed at a late stage (distant). For the remaining cases (approximately 2.7%), staging was not performed or stage information was not available.

CANCER TREATMENT: MEDICAID CANCER TREATMENT PROGRAM (MCTP)

The CSP actively follows eligible clients diagnosed with cancer or precancerous conditions requiring treatment for enrollment in the MCTP, with a program goal of at least 90 percent of MCTP-eligible clients enrolled. During the 2015-2016 program year, 96.2 percent of MCTP-eligible women diagnosed with breast or cervical cancers or precancerous conditions through the CSP were enrolled in the MCTP. Figure 14 presents the number of enrollees in the MCTP by type of cancer and program year. In the 2015-2016 program year, the overall number of MCTP enrollees (n=278) for all cancer types was slightly lower compared to the previous program year (n=355). In the 2015-2016 program year, the percentage of enrollees with a diagnosis of breast cancer was 78.1% (n=217), while the percentage of enrollees with a diagnosis of cervical cancer or precancerous cervical dysplasia was 10.8% (n=30). The percent of enrollees with a diagnosis of breast cancer has generally increased over the past 5 years, which is likely explained by the increased focus on the priority population of women ages 50 to 64 years and the higher incidence of breast cancer with increasing age.

Figure 14

Medicaid Cancer Treatment Program Enrollees By Type of Cancer New York State Cancer Services Program April 2011- March 2016



In addition to new enrollees in the MCTP, eligible clients are also recertified for additional years of coverage. Almost 55 percent of clients are recertified for a second year of coverage, approximately 37 percent are enrolled for a third year, almost 16 percent for a fourth year and slightly over 10 percent for a fifth year of MCTP coverage. Applications for enrollment are processed quickly; on average, final determinations of eligibility for coverage are provided within four to six days.

CONCLUSION

The NYS CSP provides critical cancer preventive services to eligible uninsured and underinsured individuals across every area of NYS and ensures women receive all follow-up care necessary in a timely manner and access to needed treatment. During the 2015-2016 program year, over 5,600 providers and health care facilities offered breast and cervical cancer screening and diagnostic services through the CSP. From April 1, 2015 through March 31, 2016, 27,251 eligible women were screened for cancer through the CSP with approximately 25,683 mammograms, 23,434 clinical breast exams, 7,538 Pap tests, and over 5,140 high-risk HPV tests. Over the course of this same 12-month period, the CSP identified 246 individuals with breast cancer, 3 with cervical cancer and 149 with precancerous cervical dysplasia. A total of 247 clients were enrolled in the MCTP for breast or cervical 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 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 women and men 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 2015-2016 program year, the number of women ages 40 to 64 screened through the CSP represented 18.5 percent (25,397/137,466) of the estimated eligible population of women ages 40 to 64 who are uninsured and at or below 250 percent of FPL in NYS.⁶ 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, a future 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.

⁶ United States Census Bureau. *Small Area Health Insurance Estimates, 2015*.
<https://www.census.gov/programs-surveys/sahie.html>