STATEMENT OF PAMA JOYNER
PROGRAM DIRECTOR OF THE
WASHINGTON BREAST AND CERVICAL HEALTH PROGRAM
WASHINGTON STATE DEPARTMENT OF HEALTH
BEFORE THE
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES

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Dear Chairman Waxman and Ranking Member Tom Davis,

Thank you for the opportunity to provide testimony on the experience of Washington State with our Washington Breast and Cervical Health Program (WBCHP) and that of other member states of the National Association of Chronic Disease Directors (NACDD) Breast and Cervical Cancer Council. My name is Pama Joyner and I have worked for the Washington State Department of Health (DOH) for eight years. I am the Acting Unit Director for the Cancer Prevention and Control Unit and Program Director for WBCHP. My responsibilities include providing leadership for program implementation; overall program focus and direction; and establishing and maintaining key stakeholder relationships.

Today I will provide information on current state-level program operations and challenges to states' ability to reach eligible women. Specifically, given that **early detection is the best way to reduce deaths from breast and cervical cancer,** grantees support a variety of strategies to reach underserved women. These strategies include program management, screening and diagnostic services, data management, quality assurance and quality improvement, evaluation, partnerships, professional development, and recruitment.

Washington's Breast and Cervical Cancer Health Program (WBCHP) enhances the overall health and well-being of Washington women

In Washington, our WBCHP not only saves lives, but also enhances the overall health and well-being of women who participate. Since the program's inception, WBCHP has offered vital services to thousands of Washington's most economically burdened women. It is a core value of the program that each woman enrolled receives state-of-the art screening, diagnostic and treatment services. The women's health examination provided at initial enrollment, and then repeated with each rescreening, is often the only primary care visit an enrollee receives.

Challenges: System and resource capacity is pressed to maintain existing service levels

An increasing number of women across the nation meet the eligibility requirements, yet system and resource capacity is pressed to even maintain existing service levels.

■ *Each state is only able to reach a fraction of the eligible population*

Nationally, the program is only able to reach 14.7% of the eligible uninsured and underinsured population for breast cancer and 6.7% for cervical cancer. In Washington we are reaching approximately 37% the eligible uninsured populations.

For example, the state of Virginia is able to screen 22% of its eligible uninsured population; Tennessee is screening approximately 11% of the eligible uninsured; in New York State they too are screening approximately 11% of their eligible population. Illinois, where there has recently been a substantial increase in state funding for their program, is still only able to screen 17% of its eligible population. In California, they are able to screen approximately 23%

of the eligible uninsured and underinsured population for breast cancer and just 8% for cervical cancer.

■ *States use a variety of strategies so that funding either meets screening goals or ensures services are available throughout the year*

Some states report they run out of funding before the end of the program year due to meeting their screening goals early. In other states, the program monitors enrollment and expenditures to ensure services are available all 12 months of the program year. Minnesota projects that they will run out of funds before the end of the current program year due to two principal causes: 1) They are screening significantly more women for cancer than anticipated; and, 2) a higher proportion of the women they are screening are uninsured which means that all of the diagnostic tests are paid for by the program. Such tests, over the past eight years, have become more costly.

California has experienced an increase in clinical demand resulting in the state allocation of tobacco tax revenues near the end of the fiscal year in order that all women seeking screening are served. Similar to Minnesota, the program reports the increased number of more costly diagnostic procedures leads to funds running out before the end of the program year.

In Virginia, a capped rate is paid for each woman screened, covering all screening and diagnostic procedures, plus any follow up. Providers contract to serve a specific number of women at the established capped rate. Virginia reports that many of their providers are cutting back clinic days/appointments since they have reached the number of women they were contracted to serve or are very near to reaching their contract goal. Just half-way through the current program year, several providers in Virginia are accepting only symptomatic women in order to prioritize their caseload.

In the state of New York, screening goals are established but funds may run out before the end of the program year due to screening in excess of the goal or from higher than anticipated costs for the women screened.

Texas fully expends their federal award each year. And, each year about half of their providers spend out their contracts before the end of the contract period. Most of their providers limit enrolling new clients before the end of the contract funding period and carefully schedule rescreening so that funds are available to pay for priority diagnostic services until the end of the contract period.

The state of Idaho reports that they carefully manage enrollment and screening to prevent over enrollment. However, their current screening numbers indicate that they will have to stop enrollment/screening before the end of the fiscal year and employ waiting lists statewide.

Maryland operates a decentralized program with funds allocated to local health jurisdictions. The state monitors expenditures of each jurisdiction and has the ability to shift funds between them when one might be running out of funds and another might not be spending funds fully. The primary cause for those local jurisdictions that run out of funds is due to over-enrollment.

In past program years, Ohio ran out of funds before the end of the program year. Learning from past funding cycles, it developed strategies to better estimate screening projections, closely monitored expenditures and had to stop screening around March or April. Further impacting the Ohio program and other states are increased costs for diagnostic services and more clients requiring those procedures. For the coming program year (2008 – 2009) Ohio will for the first time have state funds to assist the program in not running out of resources before the end of the program year.

■ *Waiting lists can be useful, but they also have drawbacks.*

Waiting lists are a good indication of program need. However, many programs are uncomfortable in creating waiting lists as there is a sense that eligible women are being promised services the program may not be able to deliver. In Washington State, when screening resources were limited to federal and state funding only, wait lists were instituted. At one point, more than 1,000 women across the state were waiting for screening services. We were able to stop having waiting lists upon receiving grant awards from the Susan G. Komen for the Cure to support breast screening services.

In Virginia, providers have begun to maintain waiting lists. The program currently projects there are approximately 100 women waiting for services. Florida reports similar numbers at some of its screening sites by the end of the program year.

In Tennessee, there is no waiting list. The program projects it will need to stop screening mid-May and plans to ask women to call back after the start of the new program year, July 1, 2008.

New York's program assures that women are not turned away for services by securing additional state funds to assure payment to service providers.

Before receiving a significant increase in state funds, Illinois maintained waiting lists and implemented a policy that prioritized services for women reporting symptoms, thus asymptomatic women only were placed on the waiting list. These waiting lists (per Lead Agency) were generally fewer than 100 women.

Ohio, too, developed and continues to maintain a waiting list. Currently there are less than 100 women on the list in two out of eleven regions in the state. The reason for the waiting list is not due to lack of funding, but to staffing/appointment limitations.

■ *New technologies and increased health costs impact the ability to maintain or increase screening numbers*

New technologies and increasing health costs impact a program's ability to increase screening numbers. Level funding year after year is recognized as a cut, resulting in fewer women screened.

Each state manages increasing costs with different strategies. In California the reimbursement rates are tied to Med-Cal, the state Medicaid system, realizing some cost savings over the standard practice of reimbursing at Medicare rates. This strategy is becoming less effective, as California reports that without a significant increase to Med-Cal rates in several years – rates are the lowest in the nation – makes it very difficult for the program to recruit and retain providers. Furthermore, the state has seen a 55% increase in the number of women screened since 1999, whereas the costs for screening have increased by 142%.

In Virginia, because it uses a capped system, the impact is not as great as in other states as the excess financial burden has fallen onto the provider. However, many of those providers have begun to push back and ask for a higher capped rate.

Texas, too, has experienced significant cost increases related to new technologies. The program reports that from 1999 to 2005 new patient office visits increased by 27%, whereas established patient office visits increased by 40%. Screening mammograms went up 29% and conventional Pap tests 106%.

In Maryland, some radiology facilities have stopped participating in the program as they have switched to digitized mammography and will not accept conventional mammography reimbursement rates for the service.

Washington State experienced a 72% increase in screening and diagnostic costs between 1999 and 2005. Costs are higher for first-time enrollees to this program. Over 70% of the pre-cancerous conditions and cancers diagnosed in the program have been in newly enrolled women. Previously screened women most often have normal screening results that end up being less costly. These are typical screening outcomes for most programs.

Other operational costs continue to increase while funding remains relatively flat impacting a program's ability to maintain or increase its screening numbers. Tennessee experienced a significant cost increase when decentralizing its program. A greater demand for services was created (more eligible women became aware of the program) which impacted costs in other areas of the program. This included advertising the service, providing timely and adequate services, and supporting access to treatment services for those women diagnosed with cancer. All of these are activities required to meet the performance measures of the program.

Ohio reports that multiple factors impact their ability to maintain and/or increase their screening numbers. While clinical services alone has increased almost 20% in the last 3 years another substantial increase in costs are in the area of program infrastructure necessary to support the enrollment and screening of clients. This includes staff costs and the associated costs of "doing business." Unlike the larger health care arena, where staffing and infrastructure costs are shared across many funding sources or payers, state programs are finding it more and more difficult to maintain, let alone increase their screening numbers, when funding levels remain flat.

■ *Additional funds and provider capacity would allow states to screen more women*

Increasing financial resources to screen more women is necessary but having provider capacity to screen more women is critical. Many programs rely on local public health agencies and/or the network of community health clinics in their state. Other programs use these systems but also contract with individual providers or private large clinic systems.

In FY 2007, Washington State screened 2,000 more than FY 2006. Our goal is to screen an additional 2,000 more women in FY 2008. With just 10% more funding each year we could continue to increase these numbers over the next four years and reach 41% of the eligible uninsured population by FY 2012. At this point we would need to assess the current provider network capacity and begin to identify and secure contracts with other providers.

The Missouri program states that with additional financial resources they believe they could increase the number of women they screen by 5 to 10% more if they can get more providers.

New Hampshire just started receiving state funds to support their screening program. They believe with more financial resources they could screen 25 to 35% of their eligible population.

In Virginia, if more funding resources were available they could immediately screen 35 to 50% more women and work toward increasing the overall percentage of the eligible population screened over time. The program notes however this also will require strengthening their provider network and capacity.

Tennessee projects they could handle at least 25 to 35% more women than they currently screen, whereas New York, Maryland and Florida all state they could screen between 25 and

35% of the eligible population if financial resources were available. California believes that to sustain good quality care for all eligible women, the program could expand its service delivery system by 5% annually, about 145,000 more women each year.

An assessment would need to be done to determine what the existing service delivery system in each state could handle. Planning would also be needed to incrementally expand services based on the number of new providers in which each state could secure agreements or contracts.

■ *Low reimbursement rates serve as a disincentive to program participation*

In 2006, Washington's Medical Advisory Committee (MAC) successfully intervened when a contracted local radiology practice refused to perform stereotactic breast biopsies due to low reimbursement rates, resulting in women from five counties traveling up to 100 miles to access services. The MAC wrote a letter to this practice explaining the reasoning behind the reimbursement policy and the impact of their decision on the community. After receiving two letters, the practice agreed to continue contracting with WBCHP to provide these services. DOH plans to use this strategy in the future as reimbursement policies continue to impact access to clinical services.

California reports that some providers have voluntarily left the program due to Medi-Cal (Medicaid) rates. Virginia reports its providers are having difficulty negotiating contracts with their subcontractors, impacting their client's ability to access mammograms and diagnostic tests. This situation is tied to drops in Medicare reimbursement rates. Florida reports it is having difficulty keeping providers in some areas of the state due to reimbursement rates.

In New York, oncologists and surgeons in certain geographic areas of the state will not participate in the Medicaid program or no longer accept Medicaid clients for cancer treatment due to low reimbursement rates. In the northern part of the state, the reimbursement issue is especially troublesome, as the only Oncology practice refuses to accept Medicaid clients. As a necessity, clients travel outside the county to receive their vital cancer treatment. Furthermore, oncologists are unable to purchase many of the cancer drugs they administer to clients for prices less than the Medicare amounts. Clients transitioned to the state Medicaid program who are terminally ill are transferred to Social Security due to disability and their cancer drugs are paid for by Medicare.

There is a perception by providers that if they accept one Medicaid client they will need to open their door to all Medicaid clients.

Texas routinely hears from its contractors that they have trouble finding providers who will accept the screening program's Medicare reimbursement rates. A new provider signed on for the current program year, and after two months, terminated the contract as the medical community in that service area would not accept clients for diagnostic procedures or cancer treatment services. Idaho, too, reports problems are encountered when trying to access diagnostic tests, surgical consults, and cancer treatment services.

In Ohio, the program is starting to hear from providers that are limiting the number of Medicaid and/or Medicare clients they will take on during the program year. In addition, Ohio reports providers are frustrated services cannot be reimbursed due to NBCCEDP program policies for procedures covered by Medicaid and/or Medicare.

Transition to Treatment Program: In Washington we find that regardless of the total number of women screened (increasing number each year), the percentage of women diagnosed

with cancer each year is 1.5% of the total number screened. Many of the other states report this same type of trend.

Private/Local Partnerships: For grantees fortunate to have state and private resources there is greater flexibility to maintain or increase the number of women screened each year. A few states receive direct funding from affiliates of the Susan G. Komen for the Cure® and from their local American Cancer Society in their state. Many other states have providers who receive grants from affiliates of the Susan G. Komen for the Cure® and, in many instances, these services are coordinated with the state program. However, there remain a number of grantees who operate their programs with federal funds only, or with limited additional resources. These programs continue to struggle with maintaining or increasing screening rates when funding remains flat.

Summary

Early detection is the best way to reduce deaths from breast and cervical cancer.

Access to screening, diagnostic services and treatment is critical for all women regardless of income, education, race or ethnicity. However, women with low incomes are less likely to receive cancer screening and are more likely to be diagnosed with more advanced disease than higher-income women.

To reach these underserved women, all grantees support a variety of strategies, including program management, screening and diagnostic services, data management, quality assurance and quality improvement, evaluation, partnerships, professional development, and recruitment.