



Fiscal and Policy Options for the Every Woman Counts Program

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AN LAO REPORT

EXECUTIVE SUMMARY

Recently, there has been significant legislative and public interest in the state's Every Woman Counts (EWC) program for breast cancer early detection. This report: (1) provides background on the EWC program and other state breast cancer programs; (2) describes the recent history of the program, including caseload and funding trends as well as recent program changes; (3) describes the Governor's May Revision proposal for the program in 2010-11; (4) identifies fiscal and policy issues facing the Legislature with respect to EWC; (5) estimates costs for alternative eligibility and enrollment options; and (6) makes recommendations on the Governor's May Revision proposals and on transparency and oversight of the program.

As the Legislature considers issues related to EWC in the pending budget conference committee, we specifically recommend that it adopt a modified version of the Governor's cost containment proposals, consider redirecting existing funding for research to direct clinical services, and improve transparency and legislative oversight by requiring a formal budget estimate. In addition, we recommend the Legislature consider the long-term future of EWC in light of the passage of the federal Patient Protection and Affordable Care Act.

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BACKGROUND

The goal of the EWC program is to reduce the mortality and morbidity related to breast and cervical cancer. To achieve this goal, EWC offers free direct services including: (1) screening and diagnostic mammography; (2) clinical breast exams; (3) pelvic exams; (4) case management, including follow-up and referrals for abnormal screens; and (5) cervical cancer screening. The program delivers these direct services through a statewide network of medical providers who enroll women into the program and submit claims to EWC to be reimbursed for delivering the clinical services. The EWC also delivers various related public health services, such as education and outreach to underserved populations, a bilingual hotline, surveillance activities, and provider training. The program is administered by the state Department of Public Health (DPH).

Eligibility. The EWC program has somewhat different eligibility criteria for receiving breast and cervical cancer services. To be eligible for breast cancer services, a woman must be a resident of California, be at least 50 years of age, have income at or below 200 percent of the federal poverty level, and have no insurance coverage for these services. Similar criteria apply to eligibility for cervical cancer screening, except that women must be at least 25 years of age.

Funding Sources. The EWC program has been funded in recent years through three sources:

- A federal grant from the Centers for Disease Control and Prevention (CDC).
- The Breast Cancer Fund, which is derived from a two-cent tobacco tax imposed by 1993 state legislation. Monies

from the Breast Cancer Fund are allocated in equal parts to the Breast Cancer Control Account, or BCCA (which, in turn, is used in its entirety for the support of the EWC program) and to the Breast Cancer Research Account, or BCRA (which funds the California Breast Cancer Research Program [CBCRP], described below).

- Proposition 99, a 1988 ballot measure that imposed a 25-cent surtax on tobacco taxes. Only a portion of Proposition 99 funding is allocated to EWC. Most is used for the support of various other health, resources, and anti-tobacco programs.

Funding Levels. The funding allocated to EWC for the last three fiscal years from these funding sources, as well as the Governor's proposed funding level for 2010-11, is shown in Figure 1 (see next page).

As the figure shows, the amount of support EWC has received from the federal grant has been relatively flat in recent years. Support for EWC from both the BCCA and Proposition 99 has steadily declined over the years, due mainly to a decline in tobacco tax revenues tied to decreasing consumption of tobacco products.

Uses and Restrictions on Federal Funds. At least 60 percent of EWC's federal CDC grant must be spent on direct services. Direct services, as determined by federal authorities, include not only clinical services but also case management, referral, language interpretation, and transportation services for persons screened or receiving treatment for breast or cervical cancer.

After meeting this 60 percent obligation, remaining federal grant funds can be spent by EWC for program administration as well as public health functions, such as public information and outreach, data collection and analysis, quality improvement activities, public health surveillance, and evaluation of the effectiveness of the program.

Adjustments to Program Do Not Require Legislative Notice. The statute which created EWC provides the DPH with the statutory authority to make policy changes necessary to manage the program within the budgeted avail-

able resources. For example, the department is authorized to change who is eligible for EWC screening and services. While these provisions help to ensure that the program remains within its budgeted level, they do not require that DPH notify the Legislature when it makes such policy changes. For example, the Legislature might not have the opportunity to consider whether it wishes to augment funding levels for the program, or to consider alternative approaches to reduce program costs instead of ones instituted without notice by the DPH.

Figure 1
Funding History for the Every Woman Counts Program

(In Millions)

Revenue Source	2007-08	2008-09	2009-10	2010-11 (Proposed)	
				January	May
Proposition 99	\$30.8	\$26.6	\$22.1	\$22.1	\$22.1
Breast Cancer Control Account	17.2	19.3	26.6 ^a	14.0	12.3
Federal CDC grant funds	5.7	5.7	6.3	6.3	7.2
Total Available Revenues	\$53.7	\$51.6	\$55.0	\$42.4	\$41.6

^a Includes a one-time augmentation to pay for excess clinical claims.

CDC = Centers for Disease Control and Prevention.

HOW EWC INTERACTS WITH OTHER STATE AND PRIVATE PROGRAMS

The EWC program is one of several state health programs for women, as there are also private organizations devoted to breast cancer research and treatment activities. As we discuss below, some of these programs interact with EWC, while others carry out complementary activities.

Medi-Cal Fiscal Intermediary. Medi-Cal is a program that provides comprehensive health insurance to low-income, aged, and disabled persons in California. The EWC program is adminis-

tered by the DPH, but the program makes payments to EWC providers through Medi-Cal's fiscal intermediary, a contractor that processes claims for the Medi-Cal Program. In the budget year, the state will be transitioning from the current contractor to a new one, resulting in some additional costs to the state related to the transition.

Family Planning Access to Care and Treatment. The state Family Planning Access to Care and Treatment (Family PACT) program provides

birth control and various other types of family planning services for certain youth and women not enrolled in Medi-Cal. Many younger low-income women in California are eligible to receive cervical cancer screening through Family PACT, and in fact do so. As a result, the majority of the services delivered through EWC are related to screening and diagnosis of breast cancer rather than cervical cancer.

Breast and Cervical Cancer Treatment Program (BCCTP). The Department of Health Care Services (DHCS) administers a BCCTP within Medi-Cal that interacts extensively with EWC. Eligibility for the programs is similar, and there is a federal requirement that women must receive diagnostic testing for breast cancer through the EWC program in order to receive treatment through the BCCTP. This requirement that women go through an EWC provider in order to enroll in the BCCTP is set in federal law and cannot be modified without federal approval.

Breast Cancer Research Program. As mentioned above, part of the monies from the BCRA are used to support the CBCRP, which is ad-

ministered by the University of California (UC). Approximately \$11.2 million is currently proposed for the research program from the BCRA for the budget year. About 30 percent of these research funds are currently awarded within the UC or the California State University systems, while the rest is awarded to private universities, private research institutes, national laboratories, and community-based organizations. According to research program officials, \$2.5 million of the 2010-11 funds would be spent to continue ongoing projects that were initiated in prior years.

Private Research Funding. There are many other organizations that provide funding for breast cancer research, including a number that serve women in California. A search of the National Cancer Institute database indicates that breast cancer research is currently funded in the amount of \$600 million annually, with \$74 million allocated to researchers in California. Susan G. Komen for the Cure, another organization that funds breast cancer research, indicates that it intends to spend \$200 million annually on breast cancer research nationwide for the next decade.

RECENT DEVELOPMENTS IN THE EWC PROGRAM

The EWC Caseload Trends. Caseload and total support for the EWC program, by funding source, is shown in Figure 2 (see next page). As the figure shows, caseload for the EWC program has been steadily increasing over the last decade. Even though the overall revenues the state collects through Proposition 99 have been steadily declining, the EWC program nonetheless received Proposition 99 augmentations through 2007-08 in amounts that were sufficient to fully fund program caseload.

Costs Outpaced EWC's Budget. In 2008-09, the EWC program experienced rapid caseload growth, leading to an unexpected increase in costs for clinical claims that outpaced the funding budgeted for the program. In May 2009, the DPH requested and received approval from the Legislature to use \$13.8 million in unspent BCCA funds from prior years for a one-time augmentation to offset these costs.

This one-time augmentation, however, did not address an underlying mismatch between program costs (which remain high due to caseload demands) and revenues (which were declining due to a drop-off in Proposition 99 funding). Program costs and caseload continued to rise faster than expected. In order to avoid a forecasted \$12 million shortfall in 2009-10, DPH took action to contain costs by administratively instituting two major policy changes effective January 1, 2010: (1) a temporary freeze on new enrollment in the program, and (2) a permanent increase in the minimum age eligibility for breast cancer screening services from age 40 to age 50.

Impacts of Current-Year Policy Changes.

The policy changes have had several impacts. The temporary freeze in enrollment has meant that some women seeking screening services have not been able to obtain no-cost EWC services. This situation has resulted in some women not receiving screening services. Others continued to receive these services but either paid the costs out of pocket or received care from physicians who were not compensated for their services.

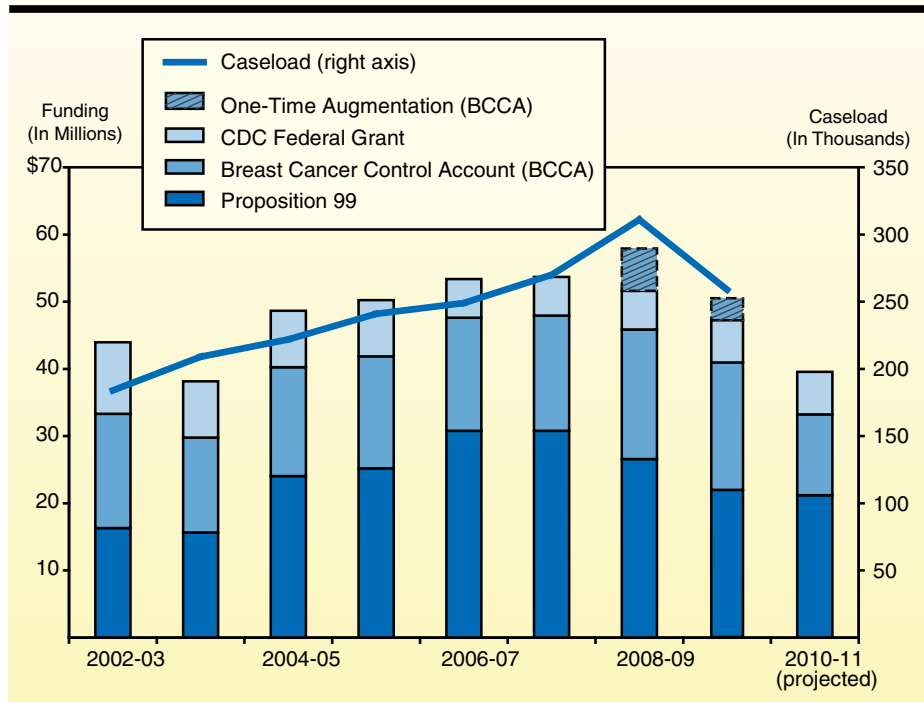
Additionally, the implementation of these two policy changes means that some women who are not currently enrolled in EWC, but who may receive an abnormal screen through

another means or be symptomatic for breast cancer, cannot enroll in EWC to receive follow-up diagnostic testing. As noted above, this testing is required in order to enroll in BCCTP. Thus, these changes have effectively closed the pathway to diagnosis and treatment for anyone not currently enrolled in EWC. The DHCS has reported a small decrease in new enrollment for BCCTP that has been attributed to the recent policy changes in EWC.

Audit of Program Under Way. Unlike many caseload-driven state programs, EWC does not provide the Legislature with a regularly updated estimate of caseload, cost projections, and proposed policy changes. Also, as we noted earlier, the statute which created EWC authorizes the administration to modify the program to manage within the available budgeted resources without advance notification to the Legislature.

Figure 2

Caseload and Funding History for the Every Woman Counts Program



Thus, the Legislature was not made aware at the time the 2009-10 budget for EWC was passed that mid-year policy adjustments to limit enrollment and eligibility would be needed. As a result of concerns about this situation, the Legislature requested that that Bureau of State Audits (BSA) investigate several issues related to cost, caseload trends, and the operational efficiency of EWC. The BSA is currently completing an audit of the program that is scheduled to be released on June 10, 2010.

The Office of State Audits and Evaluations, a separate audit agency under the direction of the Department of Finance, released an audit on May 25, 2010 that confirmed that DPH does not have adequate processes in place to monitor or project current and future obligations of resources. In addition, the audit found that the department could take steps to improve fiscal oversight of the program, such as improving coordination with Medi-Cal and implementing policies and procedures to ensure that fund condition statements are accurately prepared and supported.

GOVERNOR'S MAY REVISION PROPOSALS FOR EWC

Budget Proposal. The Governor's January budget proposed \$42.4 million in funding for EWC, as shown in Figure 1. The May Revision proposes \$41.6 million for EWC, an amount which reflects a reduction of \$1.7 million in funding from the BCCA due to lower-than-expected revenues in that account. The DPH proposes to absorb this reduction by reducing state operations funding for professional education and regional contractors, an approach that would have no further impact to EWC's ability to pay clinical claims.

Cost Containment Proposals. In order to reduce costs in EWC, the May Revision proposes to maintain eligibility in the program at 50 years of age and older on a permanent basis, and to continue the freeze on all new enrollment. Under the administration's budget proposal, the freeze on enrollment would stay in place until savings are realized from some proposed new cost containment measures that would take effect July 1, 2010.

One of these new measures would implement a tiered case management payment system

to achieve projected annual savings of \$9.8 million upon full implementation. Currently, EWC providers are paid \$50 for follow-up case management and reporting related to each screening exam, whether the results of the exam are normal or abnormal. Under the new tiered system, providers would be paid \$10 for follow-up case management and reporting related to normal screens. However, they would be paid the greater amount of \$50 in the subset of cases in which a screen showed evidence of abnormalities. The state would save money on provider payments because it would pay these higher costs for only a select number of cases.

The administration also proposes to limit screening mammograms for women participating in EWC to once every two years instead of the current practice of providing them once each year. This change is expected to result in savings of \$2.4 million annually upon its full implementation.

The DPH has projected that it would take from 6 months to 24 months to fully implement its cost containment proposals. That is because, as the program currently operates, there is a

significant lag in time between when the clinical services are delivered and when the claims related to those services are paid. Also, the administration indicates it would take some time to modify the information technology and claims processing systems, and to train providers on the mammogram screening change.

This means that the full potential savings from these changes could not be achieved in 2010-11. As a result, the administration's budget proposal assumes that the enrollment freeze is kept in place until savings from the new measures can be achieved.

Correction in Claims Processing Costs.

The May Revision proposal also reflects a cost increase of approximately \$1.6 million related to transition to a new fiscal intermediary for the

Medi-Cal Program, through which claims are paid to EWC providers. However, the budget was not augmented for this cost increase. Instead, the administration assumed there would be additional offsetting savings from the freeze on enrollment discussed above.

In response to inquiries about this item, DPH later stated that this proposed \$1.6 million adjustment was technically incorrect and should not have been added as a separate cost. The DPH states that the actual increase related to the transition to a new fiscal intermediary is \$350,000, and the DPH now proposes to absorb this smaller increase in costs within its existing proposed state support budget, leaving more funding available for clinical claims.

ASSESSING THE GOVERNOR'S PROPOSAL AND AVAILABLE POLICY OPTIONS

Fiscal and Policy Choices. The Legislature faces a number of important policy questions, with corresponding fiscal implications, with respect to the EWC program.

- What is the appropriate minimum age for eligibility for the program, and what are the costs of various eligibility options? (See the box on page 12 for a discussion of recent findings regarding the need for routine mammography in women age 40 to 49.)
- What is the benefit of preserving the public health components of the EWC program such as education, provider training, and surveillance as compared to preserving direct clinical services?
- What types of information does the Legislature need to make sound decisions about the program now and in the future?
- How much oversight does the Legislature wish to exercise over the operation of the program, such as eligibility and implementation of cost-cutting measures? Or, does it prefer to continue to delegate authority to the DPH to manage the program within a set budget?

Several Alternatives Exist for Modifying EWC Eligibility. The Legislature has considered various options for changing the eligibility rules for EWC. The Assembly version of the budget redirects \$36 million in Proposition 99 funding

in order to reopen the program to all women 40 years of age and over. Because these monies would otherwise have been used to offset General Fund costs for Medi-Cal, this action results in an equivalent increase in General Fund costs in the Medi-Cal budget. The Senate version of the budget augments EWC funding by \$25 million from the General Fund (which was done to send this item to the Budget Conference Committee). The Assembly also adopted a modified form of one of the Governor’s cost containment proposals (which we describe in more detail below) to partly offset the costs of reopening EWC enrollment. However, the Senate did not hear any of the May Revision cost containment proposals.

As it discusses these matters in conference, the Legislature has various approaches to consider, including if it wishes to reverse, or partly reverse, the current restrictions in program eligibility that have been implemented by the administration. In Figure 3 we show the Governor’s May Revision proposal for EWC eligibility and enrollment (Option 1) and three alternatives

(Options 2, 3, and 4) which provide various ways to loosen current eligibility rules. The figure also shows the additional costs compared to the Governor’s May Revision proposal, and how these costs could be lowered by implementing cost containment measures we recommend below.

Under Option 3, eligibility in EWC would not be open to all women ages 40 to 49, but women in this age range who have an abnormal screen or are symptomatic for breast cancer would be permitted to enroll and receive *diagnostic services only* (not routine screening services). This approach would allow these women to receive a diagnosis through EWC that, in turn, would allow them to obtain treatment through the BCCTP. The costs associated with such a policy change cannot be estimated precisely, since it is unknown how many women ages 40 to 49 would access screening services from providers other than EWC that may lead to a need for diagnostic services. The estimated cost of this policy change shown above is based on the cost for diagnostic services for women ages 40 to 49 under the old

Figure 3
Eligibility Options and LAO Estimates of Associated Costs for 2010-11

(In Millions)

Option	Additional Cost to Restore Enrollment	Savings From LAO Proposed Cost Containment Measures	Net Additional Cost of Option
1. Adopt the Governor’s proposal to continue enrollment freeze and allow new enrollment of women over 50 years of age as savings from cost containment are realized.	—	—	—
2. Maintain eligibility at 50 and older without restricting new enrollment.	\$9.0	\$9.2	—
3. Maintain eligibility at 50 and older without restricting new enrollment, and allow women 40 and older who are symptomatic to enroll to receive diagnostic services.	14.9	9.2	\$5.7
4. Expand eligibility to all women 40 and older without restricting new enrollment.	33.7	13.7	20.0

eligibility rules when women ages 40 to 49 could receive screening services.

Possible Modification to Tiered Case Management Proposal. The latter three options shown in Figure 3 that relax EWC current eligibility rules also include cost containment proposals that could result in some offsetting savings. Our cost containment proposals are essentially a variation of the permanent cost containment measures proposed by the administration in the May Revision.

Our analysis indicates that the proposed tiered case management payment system could be modified to make no payment at all to provid-

ers for follow-up on normal screens, as opposed to the \$10 payment proposed by the administration. (A normal screen should not require follow-up beyond notification to a patient that a test was normal.) The DPH estimates that our proposed approach would save an additional \$2.5 million annually that could be redirected to pay for a reversal of the current restrictions on eligibility. Thus, the total cost savings upon full implementation of this modified tiered case management payment system would be \$12.3 million annually (\$9.8 million plus an additional \$2.5 million).

Some significant savings from these measures could be obtained in 2010-11. The DPH

ROUTINE MAMMOGRAPHY SCREENING FOR WOMEN AGES 40 TO 49: A SUBJECT OF CONTROVERSY

Over the past year, there has been significant controversy over whether routine mammography screening is appropriate for all women ages 40 to 49. New analyses of the cost and benefits of routine screening have questioned the basis for recommending it for women in this age group. Below, we provide some background on this topic for legislative consideration.

Guidelines for Screening. There are many organizations that produce guidelines for mammography screening, including the American Cancer Society, the American College of Obstetricians and Gynecologists, and the American College of Physicians. In addition, the U.S. Preventative Services Task Force (USPSTF) issues recommendations about mammography screenings. There is little agreement among the differing sets of guidelines as to whether routine screening is appropriate for all women ages 40 to 49.

What Is USPSTF and What Did It Recommend? The USPSTF is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. Recently, the USPSTF updated its recommendations relating to when women under 50 should seek screening. The USPSTF had previously recommended routine screening on a biennial basis (meaning, at least once every two years) for all women ages 40 to 49. The updated recommendation states that women should start routine biennial screenings at age 50, and that the choice to screen before this time should be decided by a woman and her doctor. The USPSTF further recommends that screening before the age of 50 be an individualized decision based on a woman's unique set of risk factors and preferences.

estimates that 75 percent of the \$12.3 million in projected tiered case management savings for the modified proposal we described (\$0 for normal screens, and \$50 for abnormal) could be achieved in the budget year if eligibility were to be maintained at 50 years of age (as shown in Options 2 and 3). This equates to \$9.2 million in savings that could be achieved in the budget year. We estimate that \$13.7 million in savings from these cost containment measures would be achieved if the program were to be reopened to women ages 40 to 49 as reflected in Option 4. However, the DPH estimates that no savings related to the transition to biennial mammogram

screenings would be achieved in the budget year, because time is needed to make the necessary system modifications and to train providers on the policy change.

Public Health Goals May Outweigh Need for Direct Services in Future Years. In addition to other factors, the Legislature should consider the future role of EWC in light of passage of the federal Patient Protection and Affordable Care Act (PPACA). This new federal law will make comprehensive health insurance far more accessible to the population currently served by the program and thereby reduce the need for the component of EWC that pays for screening

What Was the Rationale for the New Recommendations? In assessing the updated USPSTF recommendation, it is important to understand that while screening is beneficial for women whose cancer is detected early, it can also cause harm. The USPSTF recommendations are based on its assessment of net benefit—identified benefits minus identified harms. Routine screening is intended to catch the development of disease early enough for treatment to be beneficial. However, screening can lead to harms such as incorrect diagnosis; unnecessary diagnostic tests and treatment; anxiety, psychological harm, and lost productivity; and unnecessary radiation exposure from the X-rays used in mammography. On balance, routine screening is usually recommended for a population if the benefits outweigh the harms.

The USPSTF found that the benefits of routine screening are similar for women in the 40 to 49 age group and women in the 50 to 59 age group, in terms of reduced mortality from breast cancer. However, the USPSTF found that women ages 40 to 49 are much more likely than their counterparts ages 50 to 59 to experience the harms related to screening described above. The harm an individual woman between the ages of 40 and 49 may experience is partially based on subjective factors, such as how concerned a woman is about her risk for breast cancer. This is why the USPSTF recommends that screening be an individualized decision between a provider and a patient for this younger age group.

Thus, if Every Woman Counts eligibility were designed to align with USPSTF recommendations, the program would not be restricted to women age 50 and over. Rather, the program would allow enrollment of women under 50 who decided with their provider that mammography screening was appropriate for them.

and related health services. However, the other public health components of EWC described earlier in this report, such as efforts to provide

education and outreach about breast and cervical cancer to underserved populations, may still be warranted in the future.

ANALYST'S RECOMMENDATIONS

We recommend the Legislature adopt a modified version of the Governor's cost containment proposals, consider redirecting existing funding for research to direct clinical services, and improve transparency and legislative oversight by requiring the administration to prepare a formal budget estimate for the EWC program, and consider the long-term future of EWC in light of the federal health care reform act..

Modify Cost Containment Proposals. We believe that both the administration's cost containment proposals (tiered case management payments and biennial screening) are reasonable, but we recommend adopting the modified tiered case management system we described earlier. Under our approach, no payments would be made to providers for follow-up on normal screens, as opposed to the \$10 payment proposed by DPH. This approach would result in state savings of \$9.2 million in the budget year if eligibility for the program were maintained at 50 years of age. In our view, this approach to achieving savings is a reasonable one.

Temporarily Redirect Existing Funds From Research to Direct Services. If the Legislature wishes to augment funding for EWC, we recommend redirecting funding from the CBCRP on a temporary basis for this purpose. Given the state's current severe fiscal difficulties and the increasing demand for EWC services, we believe it is reasonable for the Legislature to redirect funding from new and ongoing research on a temporary basis in order to provide effective,

evidence-based clinical services. Our proposed approach would require statutory changes.

Improve Transparency and Legislative Oversight by Requiring an Estimate. In response to legislative concerns about the budgeting problems that have occurred in the EWC program, Assembly Budget Subcommittee No. 1 on Health and Human Services adopted proposed trailer bill language that would require the administration to prepare a formal budget estimate package for EWC in the future. We concur with the need for more detailed information about the program. Accordingly, we recommend that the Legislature require DPH to provide, by January 10 and May 14 annually, an estimate of the caseload and projected costs of the program. The estimate should also identify the policy changes that may be implemented if the DPH projects that funding is inadequate. In addition, the estimate should include fiscal and programmatic details regarding the public health services provided through the program, such as outreach and education, data collection, surveillance, and evaluation.

The Legislature may wish to also adopt budget bill language requiring notification in advance to the Legislature whenever the administration has projected that a projected shortfall will occur in the program. The budget bill language should also provide for notification in advance to the Legislature before any policy changes to the program are implemented to address such a shortfall in program funding.

We believe that the estimate should provide a level of information adequate to facilitate legislative oversight of the program. In addition, we believe an estimate will provide valuable information to the Legislature as it thinks through how state health programs will change in response to federal health care reform.

Consider Long-Term Future of EWC. As mentioned above, many of the women currently served by EWC will have access to low-cost health insurance beginning in 2014 as a result

of the federal PPACA. These changes should dramatically reduce demand for EWC direct care services. Over the next several years, we recommend the Legislature consider how best to change this as well as other disease-specific state programs in response to the new federal legislation. For example, the Legislature should consider how EWC enrollees may be transitioned into more comprehensive health insurance, and reassess which public health services the state should still provide.

LAO Publications

This report was prepared by Lisa Murawski and reviewed by Shawn Martin. The Legislative Analyst's Office (LAO) is a nonpartisan office which provides fiscal and policy information and advice to the Legislature.

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