CANCER SERVICES PROGRAM OPERATIONS MANUAL

2017

New York State Department of Health

Cancer Services Program

Your partner for cancer screening, support and information

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Chapter 1: CSP Program Overview

The Cancer Services Program (CSP) oversees the delivery of comprehensive breast, cervical, and colorectal cancer screening and diagnostic services to eligible uninsured and underinsured individuals in New York State through local cancer screening program contractors. Each individual cancer screening program contractor ("Contractor") develops relationships with regional providers (e.g.: hospitals, clinics, health care providers) and community-based organizations to collaboratively conduct outreach to priority populations, provide screening, diagnostic, and case management services, quality assurance, public education, and data management, as well as other activities outlined in this manual. The contractor and its partners also help individuals diagnosed with breast, cervical, colorectal, or prostate cancer obtain prompt, comprehensive treatment through the New York State (NYS) Medicaid Cancer Treatment Program (MCTP), if eligible. Eligible individuals may receive full Medicaid coverage for the duration of their cancer treatment. The New York State Department of Health (NYSDOH) does not support routine, population-based screening for prostate cancer. However, men screened for, and/or diagnosed with, prostate cancer through participating providers are eligible for treatment coverage through the MCTP.

A. NYSDOH CSP Definitions

CSP Contractor ("contractor")

A contractor is the legal entity with which NYSDOH enters into a contract to coordinate, implement, and manage a local CSP across its entire service area. NYSDOH funds contractors across the state to promote evidence-based cancer screening at the population level and provide appropriate screening services to eligible populations. NYSDOH CSP contractors hold responsibility for all contract activities outlined in Chapter 2 (Required Activities and Standards), including those performed by subcontractors. Contractors ensure all required activities and contractual obligations are met in a timely manner and are the primary contact for the NYSDOH. Contractors receive a combination of funding from the federal Centers for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and from NYS to reimburse health care providers for eligible clinical services. CSP Contractors provide services in every county of New York State.

CSP Partners ("partners")

Contractors are expected to accomplish required activities through development of relationships with community organizations and health care providers located throughout the service area. Partners work with CSP contractors to implement the required contract activities and to provide and promote utilization of cancer screening services at the population level and among eligible populations. Community partners can identify barriers to services for their local population and design effective strategies to overcome these barriers. Community partners are more likely to support interventions they, themselves, have helped develop.

Partners can help contractors reach their goals by:

1: expanding and maximizing resources
2: coordinating program activities
3: identifying approaches and resources to overcome obstacles to the provision of cancer screening and diagnostic follow-up for the CSP priority populations
4: using their relationships to identify, educate, and move community members to cancer screening services
5: promoting the delivery of breast, cervical, and colorectal cancer screening

Partners include:

- community organizations, such as service clubs, senior services programs, libraries, faith-based organizations, community centers and chambers of commerce
- healthcare providers in a variety of settings (hospitals, community health centers, local health departments, federally qualified health centers, clinics, family planning providers, primary care providers, specialists
- local businesses (media representatives, beauty salons and barbershops)
- health-related organizations (American Cancer Society, Avon Foundation, Susan G Komen for the Cure)
- public service representatives (elected officials, local health departments)

Partners assist with implementation of required activities as appropriate to the mission and role of their organizations. Partners may provide a valuable source of services, promote the screening programs, and add in-kind resources.

CSP Providers ("providers")

CSP providers are defined as health care providers who have been credentialed and approved by the NYSDOH CSP to provide screening and diagnostic services to CSP clients. CSP contractors are responsible for recruiting providers that adequately address the local CSP's needs for breast, cervical, and colorectal cancer screening, diagnostic services, and treatment and referral. To facilitate referral to the MCTP for prostate cancer patients, contractors should also recruit health care providers and facilities that screen and/or diagnose men.

Please see CSP Operations Manual, Chapter 2 (Required Activities and Standards) for additional information about provider credentialing and requirements of CSP providers.

CSP Clients ("clients")

CSP clients are defined as eligible women and men who receive at least one CSP-reimbursed breast, cervical, or colorectal cancer screening or diagnostic service.

In general, the eligible populations screened through the local CSP (and for whose clinical services the NYSDOH CSP reimburses) include women age 40 and over and men age 50 and over, who are uninsured or underinsured. As defined by NYS Public Health Law 2405.1, these are persons who are age-appropriate for breast, cervical, and/or colorectal cancer screening and who have inadequate access and/or financial resources to obtain cancer screening and detection services. This includes persons who lack health insurance, persons whose health insurance coverage is inadequate, or those who cannot meet their deductible or cost-sharing obligations for the purpose of accessing coverage under their health insurance.

Please see CSP Operations Manual Chapter 3 (Eligibility) for guidance in determining CSP client eligibility.

CSP Priority Population ("priority population")

The "priority population" refers to sub-groups of the eligible population who are disproportionately affected by breast, cervical, or colorectal cancers and who, as a result, are of special concern to the NYSDOH. These populations are the focus of outreach, recruitment, and screening efforts. Priority populations include:

- uninsured and underinsured persons aged 50 – 64
- women age 40 and over who are rarely or never screened for cervical cancer – defined as those who have never had Pap tests or who have not had Pap tests within the past five years
- the medically unserved or underserved including, but not limited to, individuals who experience barriers to services due to race, ethnicity, disability, sexual orientation, gender identity, socio-economic status, cultural isolation, and/or geographic location

CSP Contractor Staff

Personnel who perform one or more of the key staffing functions under the NYSDOH CSP contract are considered "CSP contractor staff". CSP contractors are required to hire, train, and retain staff to perform, or subcontract for the provision of, the key staffing functions: program coordination, public education and targeted outreach, case management, intake/eligibility, data management, and fiscal management. Contractors may subcontract components of the scope of work (e.g.: public education and targeted outreach), but it is required that the contractor maintain at least 51% of the infrastructure contract within the grantee organization. The lead organization (contractor) will have overall responsibility for all contract activities, including those performed by subcontractors, and will be the primary contact for the NYSDOH.

Please see CSP Operations Manual Chapter 2 (Required Activities and Standards) for additional information about key staff and functions.

NYSDOH CSP Staff

The NYSDOH CSP staff provide oversight and guidance to CSP contractors through programmatic, administrative, clinical, and fiscal monitoring as well as technical assistance, public and provider education regarding cancer prevention and early detection, and assistance implementing effective outreach to the eligible priority populations. Additionally, NYSDOH CSP staff work with CSP contractor staff to ensure individuals with abnormal screening results receive follow up and case management as needed, and that the local CSP provides quality clinical services; this is accomplished through credentialing activities and a quality assurance program. The NYSDOH Cancer Screening Research and Evaluation Unit (aka "Data Unit") provides data management support and monitors and assesses program data for NYSDOH CSP staff and CSP contractors.

NYSDOH CSP Regional Managers work with CSP contractors to provide oversight, monitoring, and technical assistance on all aspects of contract implementation and management. *CSP Regional Managers are the first point of contact for all contract questions, including billing, vouchers, eligibility, reimbursement, work plans, budgets, reporting requirements, and implementation of all required activities.* NYSDOH CSP staff are substantially involved in the program activities, above and beyond routine grant monitoring.

NYSDOH CSP staff activities include, but are not limited to:

- establishing program policies and guidelines
- collaboration with national and state-wide partners and organizations to promote and provide comprehensive, guideline-concordant breast, cervical, and colorectal cancer screening activities among age-appropriate populations in the state
- facilitating the exchange of information and coordination, collaboration, and service integration between contractors and chronic disease counterparts
- provision of ongoing guidance, consultation, and technical assistance to support planning, implementation, monitoring, and evaluation of the activities listed within the scope of work
- monitoring contractor progress in implementation of the Program, and working with contractors through email, conference calls, and site visits, as well as review of progress reports and other data reports to support program progress and improvement
- convening training, capacity-building exercises, meetings, web forums, conference calls, and site visits with contractors
- providing relevant research findings, scientific research, public health recommendations, and up-to-date clinical guidelines related to the program's scope of work
- design, implementation, and evaluation of screening promotion and screening provision activities

- provision of strategies to work effectively with health care systems and other organizations to improve the implementation of activities
- use of clinical data submissions to develop regular data monitoring feedback reports that support data use for quality assurance, program improvement, and program monitoring and evaluation
- using quarterly progress reports, monthly data submissions, and other reports to evaluate, monitor, and report on progress toward meeting performance standards

The NYSDOH CSP staff directs the activities of the CSP and are available to contractors as a resource. The CSP Regional Manager is the first level of support for contractor staff and providers. Email general questions about the CSP to CanServ@health.ny.gov. See the tables below for information on specific inquiry types.

Program Website and E-mail addresses	
CSP (CanServ)	CanServ@health.ny.gov
Claim for Payment (CFP) submissions	BCPCCM@health.ny.gov
Credentialing	CSPCredentialing@health.ny.gov
**Data Unit	CSPData@health.ny.gov
Fiscal Unit	DCDPFiscal@health.ny.gov
Web Address	www.health.ny.gov/cancerservicesprogram

**The following requests and questions should be submitted via email to the Data Unit

1 All data requests (using the electronic Data Request Form)
2 Data system access unrelated to new or departing CSP contractor staff (as those are managed via the CSP Contact Update Form)
3 Problems with the data system
4 How to use the data system
5 Screening Intake Form (SIF) questions
6 Site Code questions
7 Data correction questions
8 Insurance denial form questions

Cancer Survivorship

Due to early detection and improved treatments, it is estimated that over 1 million New Yorkers have survived cancer. A cancer survivor is defined as an individual living with

cancer, from the time of diagnosis through the remaining years of life. Numerous organizations offer services for cancer survivors, their caregivers, and their families – these services address a wide range of issues including medical, emotional, psychosocial, and financial needs. These supportive services are offered in a variety of formats across NYS. To learn more, please refer to the Community Programs List on the New York State Department of Health website.

B. The NYS Medicaid Cancer Treatment Program (MCTP)

In addition to screening services, the local CSP secures provision of diagnostic and case management services, and helps eligible women and men diagnosed with cancer to obtain Medicaid coverage through the NYS MCTP. Since 2002, the MCTP has provided full Medicaid coverage for the entire period of cancer treatment to eligible women and men diagnosed with breast cancer and to women diagnosed with cervical cancer or a pre-cancerous breast or cervical condition. The Federal government and NYS administer funding for the MCTP for women diagnosed with breast or cervical cancer. In 2006, the NYS legislation that created this program was expanded to cover treatment for colorectal and prostate cancers and pre-cancerous colorectal or prostate conditions. Coverage for colorectal cancer began April 1, 2007 and coverage for prostate cancer began October 1, 2007. The NYSDOH CSP does not provide reimbursement for prostate cancer screening or diagnostic services, nor does it support routine, population-based prostate cancer screening. However, the local CSP can enroll eligible men (men who are screened and/or diagnosed with prostate cancer by a current CSP-credentialed provider and who are in need of prostate cancer treatment) in the MCTP. See Chapter 7, Attachment 7-I.

C. Public Health Insurance Programs

The NYSDOH places a high priority on identifying individuals who may be eligible for health insurance through the Health Benefit Exchange, referred to as "the New York State of Health™" (NYSOH). This ensures clients can have access to a primary care physician and payment source for all their health care needs. Many CSP clients may be eligible for additional health care benefits if they are referred to, and enrolled in, public and commercial insurance programs. Local CSPs are required to help identify these individuals during the process of determining eligibility for the CSP, and to provide them with current information about the NYSOH. This includes directing individuals to In-Person Assistors and Certified Application Counselors in their area for possible enrollment. Please see CSP Operations Manual Chapter 3 (Eligibility) for details on this process.

D. NYS Tobacco Control Integration

The NYSDOH Bureau of Tobacco Control (BTC) implements evidence-based and promising strategies to prevent and reduce tobacco use. The BTC has worked to effectively increase access to cessation services and motivate smokers to try to quit through implementation of a multi-pronged cessation approach in NYS.

Effective April 1, 2010, as required by the CDC, the NYSDOH requires local CSPs to implement activities to ensure all CSP clients, at the time of intake, are assessed for smoking status and, if applicable, referred to the NYS Smokers' Quitline **1-866-NY-QUITS** (1-866-697-8487).

Chapter 2 – Required Activities & Standards

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Chapter 2: Required Activities and Standards

A. Scope of Work – Required Activities

The NYSDOH CSP contracts with organizations to coordinate, implement, and manage breast, cervical, and colorectal cancer screening and diagnostic services to eligible persons in communities across the state.

Contractors must hire staff and/or enter into subcontract(s), per guidelines, to implement all required activities. The contractor is the primary point of contact with the NYSDOH CSP and is responsible for ensuring implementation of all required activities and program guidelines. Activities specific to the local implementation of the required activities are developed annually through the work plan process. Work plans are routinely reviewed and revised in collaboration with contractor staff and the CSP Regional Manager (see "Reporting Requirements and Contract Monitoring" in this chapter for more information). Contractors are required to execute and manage the activities listed below under the guidance of the NYSDOH CSP.

Program Management and Leadership

The contractor will have overall responsibility for all contract activities and will be the primary contact for the NYSDOH. The contractor will coordinate and administer the program to ensure the implementation of all required activities and timely completion of contractual obligations. The contractor will also ensure that any barriers to implementation of the required activities are promptly addressed to reduce potential adverse effects on program performance. In addition, the contractor will:

- serve as the point of contact with community members, providers, partners, and other organizations in the service region
- manage the day-to-day operations of the local screening program
- monitor, review, and revise activities according to monthly performance measure reports, budget monitoring tools, and other performance indicators
- submit, in a timely manner, complete and accurate annual work plans, budgets, semi-annual reports, and other deliverables, as required by the NYSDOH
- ensure a qualified staffing structure, addressing all functions as described in the Required Staff and Key Functions sections below. Establish systems to recruit, hire, and train staff in a timely manner
- ensure sufficient Designated Qualified Entities (DQEs) in the service area to meet the needs of the client population. DQEs are individuals

authorized to complete applications for enrollment in the Medicaid Cancer Treatment Program (MCTP)

- submit, within one week of start or termination, contact information for key staff as requested by NYSDOH to ensure the CSP database, the toll-free recruitment phone line database, and the public website are accurate and up-to-date. NYSDOH maintains this information to facilitate communication with, and between, contractors, as well as to provide contact information for statewide promotion of the program as conducted by NYSDOH
- ensure all staff participate in NYSDOH and NYSDOH-sponsored trainings and contractor meetings as directed
- implement referral systems whereby clients are directed from CSP contractors to Health Benefit Exchange navigators or certified application counselors for possible enrollment in public and commercial insurance programs; and (for clients not eligible for public or commercial insurance programs), referral from navigators or certified application counselors to the CSP participating providers for needed cancer screening or diagnostic services
- collect and submit, via a performance management tracking system, information and data regarding program implementation and short- and long-term outcomes as required by NYSDOH. When available, the performance management tracking system will be provided by NYSDOH
- under the direction of NYSDOH, participate in and/or coordinate planning and implementation of local sustainability activities aimed at increasing public support for the local screening program. This includes, but is not limited to: media/promotional activities (letters to the editor, newspaper articles, etc.) and educational visits to inform community members and decision makers about the impact of cancer, the unmet need for cancer screening, and how the local program addresses the problem in the community
- under the direction of NYSDOH, oversee the implementation of policy, systems, and environmental change strategies to promote cancer screening among age-appropriate populations across the state
- under the direction of NYSDOH, oversee and coordinate close-out activities at the end of the contract period to ensure smooth transition of clients and continuity of their care, as well as complete final data management and provider reimbursement

Partnering, Coordination, and Collaboration

The contractor will build and maintain collaborative relationships with health, human service, education, and other community organizations to provide and promote

utilization of cancer screening services at the population level and among the eligible populations throughout the service region. The contractor will:

- collaborate with, and actively engage, organizations and individuals throughout the service region with the knowledge, skills, and resources to reach the eligible and priority populations to assist in implementing all required activities. Such organizations should include key strategic partners (e.g.: American Cancer Society, Susan G. Komen for the Cure, local health departments, NYS Cancer Consortium members, health care systems and providers) and may include public and private businesses, service and social groups, faith-based organizations, non-profit organizations, medical institutions, medical care providers, mobile mammography van providers, government agencies, media, Federally Qualified Health Centers, worksites, groups serving individuals with cancer and their families, cancer survivor organizations and others
- develop and implement a plan to regularly communicate with partners and providers about program services and operations. Such communication may be in writing, via phone, webinar, and in-person meetings
- engage partners to assess needs, conduct education, and develop, implement, and evaluate comprehensive plans for outreach and in-reach recruitment activities to build demand for, and provide screening services to, eligible priority populations throughout the service region
- ensure development of relationships between providers and community organizations to establish referrals for client services not reimbursed through the CSP (e.g.: child care, transportation, medical equipment)
- over the course of the grant period, and under the guidance of NYSDOH:
    - collaborate with, and actively engage, partners to increase awareness of effective policy, systems and environmental (PSE) change intervention approaches, such as those outlined in the Centers for Disease Control and Prevention's (CDC) *Guide to Community Preventive Services* (www.thecommunityguide.org) that support cancer screening promotion and provision activities
    - facilitate planning processes to identify, develop and plan PSE interventions that build demand for cancer screening, especially among priority populations throughout the service region and
    - ensure active contractor, partner, and provider support for the NYS Comprehensive Cancer Control Plan goals and activities, collaborate with other organizations on common goals regarding cancer prevention and detection. The NYS Cancer Control Plan is accessible online at www.nyscancerconsortium.org

Public Education, Targeted Outreach and In-Reach

The contractor will engage partners to implement evidence-based or evidence-informed strategies to promote the program, build public demand for cancer screening services, and identify eligible clients in priority populations throughout the service region. In addition, the contractor will ensure, and coordinate implementation of, client-oriented screening interventions and strategies as outlined in the CDC's *Guide to Community Preventive Services* (www.thecommunityguide.org) and the National Cancer Institute's *Cancer Control PLANET* (cancercontrolplanet.cancer.gov). The contractor will also:

- use data to identify and locate eligible priority populations throughout the service region to target and prioritize public education, outreach, and in-reach efforts. It is expected that at least 75% of clients screened through the program will be aged 50 through 64
- ensure implementation of effective strategies for educating members of priority populations about the importance of early detection and screening for breast, cervical, and colorectal cancer
- ensure delivery of clear and consistent messages about breast, cervical, and colorectal cancer screening to increase the public demand for cancer screening and promote the availability of the local screening program. Such messages should include use of traditional and digital media, letters to the editor, etc. and be written at appropriate reading levels for those with low health literacy skills; messaging should be created using guidance, review, and approval from NYSDOH
- collaborate with patient navigators, community health workers, peer educators or other partners to provide one-on-one education to increase knowledge or influence attitudes and beliefs regarding the need for cancer screening
- ensure collaboration with community partners to offer and/or provide community groups and organizations with group education sessions regarding the need for screening, intention to be screened, risk/health benefits of screening and appropriate screening intervals
- ensure building and development of strong relationships with local media organizations
- coordinate partner participation in promotion and outreach activities (e.g. Main Streets Go Blue, cancer awareness month activities and other community events) as provided and directed by NYSDOH
- coordinate education of local decision makers, community leaders and members of the public. Provide data, facts, and client/personal stories for use by partners in these activities
- work with partners to enlist businesses and employers throughout the service region to promote cancer screening

- recruit community programs working with cancer survivors to encourage survivors to be screened
- ensure collaboration with existing chronic disease programs in the service region to conduct joint outreach and recruitment, and to promote clinical preventive services
- ensure implementation of cancer screening and/or (where available) mobile mammography events to increase access to cancer screening, diagnosis and treatment services
- ensure implementation of in-reach strategies within and among participating health care systems and providers to identify individuals in need of breast, cervical, and/or colorectal cancer for potential enrollment in the program. Examples of in-reach strategies are listed in #7 below

Provision of Health Services: Screening, Diagnostic and Case Management Activities

The contractor will develop a network of medical care providers throughout the service region to provide eligible women and men with comprehensive, guideline-concordant breast, cervical and/or colorectal cancer screening and diagnostic services and, when necessary, ensure access to treatment services. The contractor will:

- recruit and maintain a comprehensive provider network able to provide high quality, evidence-based breast, cervical, and colorectal cancer screening services to the eligible population throughout the service region
- ensure written provider agreements are obtained from all network providers within two months of initiation of contract and by April 1 of each grant year thereafter (see Attachment 2VI and 2VII). As part of this process, secure assurance and commitment from clinical providers to accept the rates in the Maximum Allowable Reimbursement Schedule (MARS) (see Chapter 6) as payment in full for services rendered
- on an ongoing basis, ensure there are sufficient numbers and types of providers in the network to meet the needs of the eligible population for comprehensive and timely cancer screening and diagnostic services
- as directed by NYSDOH, ensure network providers are licensed and appropriately qualified and credentialed, without license restrictions related to providing cancer screening services
- establish and monitor systems for:
    - conducting intake activities and program eligibility assessment for new clients for guideline-concordant breast, cervical, and colorectal cancer screening. This may be accomplished through a centralized, decentralized, or combined centralized and decentralized intake model. In a centralized intake model, lead organization staff identify potential

clients and act as the first point of contact, assess eligibility, conduct client intake, complete intake forms, schedule appointments, and conduct other related administrative tasks. In a decentralized intake model, client identification, eligibility assessment, intake, form completion, scheduling and other administrative tasks take place at many different sites, including the lead organization, individual providers, partner organizations, etc. Intake systems will include provisions to ensure client information and signed consent forms as required by NYSDOH are obtained prior to the provision of services. Eligibility assessment systems will include documentation that eligibility criteria have been reviewed for each client. It is expected that at least 75% of clients screened through the program will be aged 50 through 64

  - recalling existing clients for rescreening at appropriate intervals

- ensure a method for CSP contractor distribution and/or participating provider provision of high sensitivity fecal immunochemical test (FIT) kits for colorectal cancer. Selected kits must be available in the U.S. and have published data for the highest sensitivity and specificity for detection of colon cancer for individuals at average risk (no known risk factors) for CRC. See Chapter 4 for a list of fecal tests with published data. As an alternate to FIT, a high-sensitivity guaiac fecal occult blood test with similar published data can be used and reimbursed.
- ensure proper medical oversight for CSP contractor provision of FIT test kits for colorectal cancer screening, including establishment of standing medical orders for FIT kit distribution, development, and (if applicable) follow-up. A sample template for a standing order is attached as Attachment 4-VI in Chapter 4.
- report the results of screening and diagnostic testing to NYSDOH in a timely manner as outlined in the Program Performance Measures section of this manual
- refer clients in need of treatment for breast, cervical, or colorectal cancer for enrollment in the MCTP. Refer men who meet program eligibility criteria and who were screened and/or diagnosed with prostate cancer by network providers for enrollment in the MCTP. It is expected that 100% of MCTP-eligible clients will be enrolled in MCTP. Note: the NYSDOH does not currently support routine, population-based screening for prostate cancer and does not, therefore, reimburse for prostate cancer screening
- ensure women and men with abnormal screening results are assessed for the need for case management services and ensure such services are provided to those in need. Case management involves working with partners and community resources to assist clients in overcoming barriers to timely diagnostic and treatment services. Case management may be accomplished

through a centralized process (contract organization hires dedicated case management staff), a decentralized process (contract organization works with staff of network providers), or a combination of both. Case management activities include:

- ensure women and men in need of follow up receive comprehensive, coordinated care in a timely manner, as indicated in the Program Performance Measures and based on their individual needs
- ensure development and implementation of individual written care plans, including periodic reassessment and follow-up of the client's needs throughout the duration of care, with evaluation for client satisfaction
- development of relationships with community organizations that provide resources addressing barriers individuals may encounter during diagnosis, evaluation and treatment
- ensure network providers are committed to treat women and men diagnosed with breast, cervical, or colorectal cancer (or pre-cancerous cervical lesions) who do not qualify for MCTP, regardless of the client's ability to pay
- ensure only eligible clients receive program services; clearly communicate program eligibility guidelines to all providers in the network
- participate in all quality assurance, data collection, and reporting requirements set by NYSDOH; cooperate fully with the NYSDOH quality assurance team to identify providers with potential quality concerns, explore reasons for unusual data patterns, and remediate providers' clinical and/or data reporting deficiencies in a timely manner
- as directed by NYSDOH, promptly communicate program changes (e.g. eligibility, guidance, practices, and policies), professional development opportunities, and other program service issues to clinical providers, laboratories, imaging facilities and partners
- ensure providers submit all required forms, data, and records in a timely manner
- ensure qualified personnel are available to provide clinical oversight for the interpretation of reports and medical records, conduct risk assessment to determine client eligibility, and ensure adherence to guideline-concordant care

Data Management

Since data management is integral to monitoring and evaluating the program, the contractor will oversee the collection of all data required by NYSDOH. The contractor will:

- use NYSDOH forms and on-line, secure data system* to ensure timely collection of all NYSDOH-required data and associated documentation (e.g.

client demographics, screening and diagnostic services information, treatment information) for clients screened by participating providers and for whom reimbursement is requested

- ensure timely submission of all required client data via the NYSDOH on-line secure data system*, consistent with the NYSDOH 90-day reimbursement policy (as described in this chapter)
- ensure sufficient staff are trained to enter and manage clinical data on the data system. Participation in NYSDOH-sponsored data training is required for all new staff, and for experienced staff as necessary or as directed by NYSDOH
- conduct timely training and follow up with participating providers as needed to ensure timely and appropriate submission of all required forms and data
- promptly obtain missing or corrected information from providers, and forward that information to NYSDOH

*Note: The NYSDOH maintains a secure, web-based, real-time data entry system, referred to as "the data system". Contractors enter screening, diagnostic, treatment, and demographic information into this system for women and men who are provided with screening services. This web-based system facilitates timely provider reimbursement and patient tracking and follow up, improves the quality of data collected, and helps reinforce program procedures. On-line data queries and reports are available for contractors' use to monitor performance.

Fiscal Management

The contractor will be responsible for all fiscal management activities. The contractor will:

- within the funding amounts set by NYSDOH, establish fiscal and operational systems to ensure clinical and laboratory services are provided throughout the full program year. This may be done by establishing monthly client volumes for provision of services by participating network providers
- monitor the infrastructure budget to ensure funds are expended in an appropriate manner; prepare and submit budget modifications if necessary and in accordance with NYSDOH practices
- on a monthly basis, prepare the budget report of expenditures (BSROE) and submit vouchers to NYSDOH to ensure prompt reimbursement to sub-contractors/vendors; per the State Claims Processing Required Supporting Documentation Guidance", provide back-up documentation for voucher expenditures. Such documentation may include copies of receipts, invoices, bills, payroll records, etc. to substantiate personal and other-than-personal charges

- respond to inquiries from participating providers to reconcile payment for services rendered
- for underinsured clients, ensure all providers are aware of, and conform to, client eligibility, data submission, and billing guidelines in accordance with the CSP Operations Manual Chapter 3
- *Component A Grantees only:* on a monthly basis, prepare and submit clinical service vouchers to NYSDOH and HRI to ensure prompt reimbursement to health care providers and clinical laboratories for clinical services rendered, per the MARS
- *Component A Grantees only:* ensure systems are in place to receive reimbursement from NYSDOH and HRI for clinical and laboratory services; process and send checks (with appropriate documentation of the eligible services rendered) to credentialed providers and clinical laboratories within 14 to 21 business days after receiving payment from NYSDOH and/or HRI

Patient Navigation and In-reach*

**Required for* Component B contractors serving Bronx, Brooklyn, Queens, Staten Island, Manhattan and the Hudson Valley (Westchester, Rockland, Putnam, Ulster, and Dutchess), *optional for* Component A contractors.

Component B contractors are required to implement patient navigation strategies to identify individuals in need of screening for breast, cervical, and/or colorectal cancer. The Component B contractor will:

- ensure implementation of in-reach strategies among health care providers to identify individuals in need of screening for breast, cervical, and colorectal cancer for potential enrollment in the program. In-reach strategies will include:
- establishing a system for querying health systems' electronic database to identify current patients in need of guideline-concordant breast, cervical, and/or colorectal cancer screening
- establish a mechanism for contacting identified patients regarding needed cancer screenings, providing patient education about the importance of cancer screening and helping them to obtain screening appointments
- promoting the use of cancer screening reminder and recall systems via telephone, mail, or electronic reminders to prompt eligible adults to participate in cancer screening
- promoting the use of health communication strategies to promote cancer prevention and early detection to their eligible patient populations
- promote office-based policies and practice-based system changes designed to support comprehensive cancer screening

- using program data, provide assessment and feedback to health care providers to support comprehensive cancer screening to eligible patient populations
- build relationships within and outside the health system, and with partners, to provide information about the patient navigation function
- maintain ongoing communication with system providers, non-system providers, and other partners to identify patients "at risk" due to barriers to care
- identify patient navigation staff who will:
    - help patients understand recommended follow-up of abnormal screening results, treatment referrals, and general preventive health behaviors
    - contact patients who are at risk for missing screening, follow up, or treatment appointments
    - facilitate access to obtaining insurance coverage or a sliding fee scale for medical appointments
    - communicate with providers about unique patient needs such as language and/or cultural barriers, handicap access, etc.
    - ensure availability of appropriate information in the patient's medical record during scheduled appointments
    - help patients understand and navigate the health care system

B. Required Staff and Key Functions

Contractors will ensure a staffing plan and infrastructure that fully addresses the lead organization's ability to implement all required activities as defined in the Scope of Work above. The staffing plan should also address staff recruitment, training, and retention practices. Contractor staff and subcontractors should have the appropriate education and professional credentials and competencies to effectively carry out the required activities. At the lead organization/contractor, staff should be at a level to effect decision-making related to the contract. Salaries should be commensurate with the level of education and experience of the positions. *Note: if a vacancy occurs (resignation, medical/maternity leave, etc.) the lead organization is responsible to cover extended absences and ensure contract work is completed.* Staff fulfilling the roles of Program Coordinator and other key functions must have the ability to serve and travel to all areas of the service region.

The staffing plan is expected to include the following required Program Coordinator position, as well as positions that fulfill the functions below. One appropriately qualified

staff person may be responsible for multiple functions, but all functions should be addressed.

Required Staff

1: Program Coordinator

Required for both Component A and Component B contractors. This individual should have a function within the contractor organization that reflects professional and leadership status. The Program Coordinator will serve as the primary point of contact with NYSDOH and is expected to attend all trainings and meetings convened by NYSDOH. This individual will also serve as the primary point of contact for all subcontractors, partners, and providers for all contract activities and communications. In addition, the Program Coordinator will ensure all required activities as listed in the Scope of Work are implemented, and will have primary responsibility for all activities listed in the *Program Management* and *Leadership and Partnering, Coordination and Collaboration* sections of this manual. The Program Coordinator should demonstrate the ability to motivate and inspire others, convey knowledge and enthusiasm for the program to partners, communicate effectively within the community and with regional and state partners, and plan and implement effective activities to promote and provide breast, cervical, and colorectal cancer screening.

a. **For Component A Grantees:** the contractor will employ a professional position, recommended at a minimum of .50 FTE, for the Program Coordinator; exceptions to the recommended minimum FTE will be considered with appropriate justification

b. **For Component B Grantees:** the contractor will employ a professional position, recommended at a 1.0 FTE, for the Program Coordinator; exceptions to the recommended minimum FTE will be considered with appropriate justification.

Key Functions

1: Public Education and Targeted Outreach (PETO) and In-reach

Staff in this capacity serve as the liaison between community members, hard-to-reach members of the priority populations, and participating providers. These individuals work to increase the numbers of women and men who seek breast, cervical, and colorectal cancer screening by developing and implementing evidence-based and evidence-informed public education programs. Staff should have the ability to communicate clearly and effectively, both verbally and in writing, with members of the public and professional audiences about complicated health issues. These individuals should have sufficient knowledge about, and experience with, the community they serve to identify local resources that can address barriers to

screening, establish relationships with agencies and organizations to reach priority populations, and conduct other needed activities to reach the eligible and priority populations.

2: Case Management

Case management staff implement protocols and processes to ensure clients with abnormal screening results receive timely follow up for necessary diagnostic services, as outlined in the Program Performance Measures. These individuals work with clients, partners, health care providers, and other community resources to assist women and men to overcome identified barriers to care. They help clients obtain and keep scheduled diagnostic appointments, access diagnostic evaluation, and if needed, obtain treatment. They may also provide clinical oversight for the interpretation of reports/medical records, conduct risk assessment for eligibility and clinical appropriateness, and ensure adherence to NYSDOH policies and guideline-concordant cancer screening. Case management may be conducted by the contractor organization, by network providers, or a combination of both.

3: Intake/Eligibility

Staff responsible for intake and eligibility are the first point of contact for potential clients. These individuals determine client eligibility for breast, cervical, and colorectal screening and/or diagnostic services. They work with network providers to make appropriate cancer screening appointments for eligible clients and complete required NYSDOH intake/eligibility forms, and may provide initial data management. In addition, Intake/Eligibility staff communicate client information to Case Management staff to ensure timely follow-up of screening results. They may also contact clients referred by PETO staff, partners, and the statewide hotline to determine eligibility for the program. The Intake/Eligibility function may be accomplished through a centralized process (lead organization hires dedicated staff) or a decentralized process (lead organization works with network providers' staff), or a combination of both processes.

4: Data Management

Data management staff will collect, maintain, and submit data deliverables required by NYSDOH. These individuals use a web-based, secure database, provided by NYSDOH, to enter all required client- and service-related data. They ensure the security and confidentiality of collected data, establish systems to ensure timely receipt of client and service data from network providers, review and assess the completeness, accuracy and timeliness of data received, and communicate with network providers to obtain inadequate or missing data. Data management staff also serve as the point of contact for all data-related communication between NYSDOH and the lead organization.

5: Fiscal Management

Fiscal management staff routinely monitor infrastructure and clinical and laboratory service budgets to ensure funds are expended as per contract guidelines and that expenditures do not exceed allocated amounts, and conduct oversight of subcontractors. These individuals are responsible for ensuring there are sufficient infrastructure and clinical and laboratory services funds to support the program throughout the entire contract period. Fiscal management staff also prepare and submit vouchers on a monthly basis, ensure that submitted vouchers reflect actual and appropriate costs, and are accompanied by necessary and sufficient back-up documentation to substantiate the costs. Fiscal management staff prepare and submit budget modifications as necessary, maintain accounts receivable, prepare the budget statement report of expenditures, and assist the Program Coordinator in monitoring of clinical services expenditures. These individuals also respond to inquiries from providers to reconcile payments for services rendered and communicate with providers to ensure they are aware of which services are eligible for reimbursement. **For Component A Grantees only**, fiscal management staff are responsible for ensuring providers are reimbursed in a timely manner for services rendered, and for processing provider payments.

6: Clinical Care Coordinator

(Required for Component B Grantees only, optional for Component A Grantees.) Staff in this capacity hold responsibility for overseeing the clinical work of the Case Managers. They provide clinical oversight for interpretation of reports and medical records, provide guidance to intake/eligibility staff for risk assessment, eligibility, and clinical appropriateness for screening, and ensure adherence to guideline-concordant care. They oversee systems in place to ensure timely follow-up for clients with abnormal screening results as indicated in the Program Performance Measures. In addition, staff in this capacity provide training for new Case Managers, assist in the interpretation of NYSDOH policies and guidelines, and assist the Program Coordinator with credentialing and quality assurance activities.

7: Patient Navigation

(Required for Component B Grantees only, optional for Component A Grantees.) Patient Navigators work within health care systems, in collaboration with providers and community organizations, to identify individuals in need of breast, cervical, and/or colorectal cancer screening and assist them in receiving such services. These individuals develop and implement in-reach strategies within the health care system to approach members of eligible priority populations, and recruit them for program enrollment. Patient Navigators help clients understand the importance of preventive health services, the need for guideline-concordant screening, and follow-up of abnormal screening results. Patient Navigators also assess clients' barriers to health care, and coordinate health care system and community resources to address clients' needs. Patient navigation may be conducted by the lead organization, by providers within the health system, or a combination of both.

C. Provider Credentialing

All health care providers must be credentialed by the NYSDOH CSP in order to be reimbursed for services provided to CSP clients. All contractors must participate in the credentialing process. Contractors are required to submit the names, license numbers, practice locations, and other requested information to NYSDOH CSP annually, to allow for provider credentialing activities by the NYSDOH CSP.

Any new providers added during the contract year must be credentialed by NYSDOH CSP before a site code is assigned. This process usually takes approximately 10 business days to complete. Site codes are assigned to each CSP provider to track services provided. The codes are entered into the data system to identify where services took place, and to reimburse providers. Contractors must contact the CSP with requests for new site codes, or with changes to existing ones. See Attachments 2-I and 2-II for detailed instructions regarding site codes.

A provider with a license restriction, or who becomes subject to any disciplinary action taken by a government program, hospital, managed care organization, or licensing authority (including, but not limited to, an active or stayed suspension or restriction of provider's or practitioner's license or certification) will be reviewed by NYSDOH CSP to determine if the restriction is related to services provided through the CSP or constitutes fraud or malpractice. If the restriction involves one of these areas, the NYSDOH CSP will send the provider a letter notifying him/her that s/he is prohibited from participation in the CSP. The provider will also be notified of the opportunity to appeal this decision by submitting a request for appeal to a NYSDOH review panel.

D. Requirements for Clinical Service Providers

The contract with NYSDOH requires contractors, or subcontractors on behalf of the local CSP, to obtain annual provider agreements with providers offering clinical services to CSP clients. Component B contractors are required to use the agreement provided as Attachment 2-VI; the agreement must contain the Participating Provider Requirements for Component B participating providers listed below. A sample provider agreement (Attachment 2-VII) is also provided for Component A contractors to use with participating providers. Component A provider agreements must also contain the Participating Provider Requirements referenced in the section below.

Participating Provider Requirements (CSP Component A Providers)

Providers of screening and/or diagnostic services in the New York State Department of Health Cancer Services Program (PROVIDERS), agree to:

1. Abide by the applicable provisions of the New York State Department of Health Cancer Services Program (STATE) Operations Manual, including, but not limited to: clinical guidelines, eligibility criteria, and case management sections.

2. Provide clients of the CSP (STATE) with the same quality of care as afforded to any other patients in their care.

3. Request reimbursement for clinical services ONLY for clients who meet the eligibility criteria as defined in the (STATE) CSP Operations Manual.

4. Treat the STATE as the payor of last resort. All Providers agree to first bill client's other insurance and/or third party payor for services provided through the STATE. Provider further agrees that it must submit accurate information of services performed to the CONTRACTOR for the STATE and may not submit claims for reimbursement directly to the State.

5. Accept reimbursement rates established by the STATE as payment in full for all services that are covered by the STATE. Providers agree not to charge clients for the difference between the STATE reimbursement rate and the Provider's usual fees. Under no circumstances shall Providers bill CSP clients for services that are covered by the STATE.

6. Promptly refer CSP clients for all needed and appropriate diagnostic and treatment services without consideration of their ability to pay. This assurance includes any and all necessary services NOT covered by the STATE.

7. Obtain signed written consent from all CSP clients for the provision of clinical services and release of their medical information to the relevant other entities participating in their care and the New York State Department of Health for the purposes of case management, tracking and reimbursement, in addition to any other consents or authorizations the Providers may obtain or which may be required by law to obtain.

8. Submit accurate demographic, screening, diagnostic treatment and other data required by the STATE in a timely manner to the STATE contractor and in the format required by the STATE. The Provider agrees that the reimbursement for clinical services will not be provided by the STATE to the STATE contractor for reimbursement to the Provider until data have been accepted and approved on the CSP data system.

9. The State CONTRACTOR agrees to pay providers for clinical services accepted and approved on the CSP data system in accordance with the approved reimbursement schedule.

10. Maintain adequate medical, business, financial, personnel, and other records which may be applicable to the CSP (STATE). Providers agree to provide the (STATE) CSP access to medical, including original mammograms, consents, business, and personnel, financial, and other records, which may be relevant to the Cancer Services Program for purposes of inspection, auditing and copying.

11. Ensure that all licensed health care professionals are appropriately licensed to practice their profession in the State of New York, and maintain the appropriate credentials for the services that they are providing. Maintain all applicable provider, office based surgery and/or facility credentials, certifications, licenses, operating certificates, and/or approvals required by law and necessary to perform and bill for CSP services and facility fees, including, but not limited to, approvals for laboratory, mammography, office-based surgery and diagnostic and treatment services.

12. Immediately notify the CSP (i) if Provider's or Practitioner's license to practice or certification to operate in any state, certification(s) to prescribe medication, if applicable, or staff privileges at any hospital, if applicable, are voluntarily surrendered, restricted temporarily or permanently reclassified, suspended, or revoked for any reason; and (ii) if Provider or Practitioner is indicted or convicted of a criminal offense, regardless of the nature of the offense, or if the Provider or Practitioner becomes subject to any disciplinary action taken by a government program, hospital, managed care organization or licensing authority, including, but not limited to an active or stayed suspension or restriction of Provider's or Practitioner's license or certification.

13. Provide all information necessary to comply with the credentialing and recredentialing activities, and further, to provide such information within a reasonable time period.

14. Cooperate fully with CSP quality assurance efforts including participating in discussions to explore reasons for unusual data patterns, and agree to undertake any proposed remediation plans to any clinical and/or data reporting deficiencies in a timely manner.

15. The CSP (STATE) reserves the right to discontinue any service Providers from participation in the CSP for any reason.

16. Paragraphs ten and fourteen of these Participating Provider Requirements shall survive termination of the AGREEMENT.

Participating Provider Requirements (CSP Component B Providers)

Providers of screening and/or diagnostic services in the New York State Department of Health Cancer Services Program (PROVIDERS) agree to:

1. Abide by the applicable provisions of the New York State Department of Health Cancer Services Program (STATE) Operations Manual including, but not limited to: clinical guidelines, eligibility criteria, and case management sections.

2. Provide clients of the CSP (STATE) with the same quality of care as afforded to any other patients in their care.

3. Request reimbursement for clinical services ONLY for clients who meet the eligibility criteria as defined in the (STATE) CSP Operations Manual.

4. Treat the STATE as the payor of last resort. All Providers agree to first bill client's other insurance and/or third-party payor for services provided through the STATE. Provider further agrees that it must submit accurate information of services performed to the Contractor for the STATE and may not submit claims for reimbursement directly to the STATE.

5. Accept reimbursement rates established by the STATE as payment in full or all services that are covered by the STATE. Providers agree not to charge clients for the difference between the STATE reimbursement rate and the Provider's usual fees. Under no circumstances shall Providers bill CSP clients for services that are covered by the STATE.

6. Promptly refer CSP clients for all needed and appropriate diagnostic and treatment services without consideration of their ability to pay. This assurance includes any and all necessary services NOT covered by the STATE.

7. Obtain signed written consent from all CSP clients for the provision of clinical services and release of their medical information to the relevant other entities participating in their care and the New York State Department of Health for the purposes of case management, tracking and reimbursement, in addition to any other consents or authorizations the Providers may obtain or which may be required by law to obtain.

8. Submit accurate demographic, screening, diagnostic, treatment and any other data required by the STATE in a timely manner to the STATE contractor and in the format required by the STATE. The Provider agrees that the reimbursement for clinical services will not be provided by the STATE to Provider until data have been accepted and approved on the CSP data system.

9. The STATE or its fiscal agent thereof, agrees to pay providers for clinical services accepted and approved on the CSP data system in accordance with the approved reimbursement schedule.

10. Maintain adequate medical, business, financial, personnel, and other records, which may be applicable to the CSP (STATE). Providers agree to provide the (STATE) CSP access to medical, including original mammograms, consents, business and personnel, financial and other records, which may be relevant to the Cancer Services Program for purposes of inspection, auditing and copying.

11. Ensure that all licensed health care professionals are appropriately licensed to practice their profession in the State of New York, and maintain the appropriate credentials for the services that they are providing. Maintain all applicable provider, office-based surgery and/or facility credentials, certifications, licenses, operating certificates, and/ or approvals required by law and necessary to perform and bill for CSP services and facility fees, including, but not limited to, approvals for laboratory, mammography, office-based surgery and diagnostic and treatment center services.

12. Immediately notify the CSP (i) if Provider's or Practitioner's license to practice or certification to operate in any state, certification(s) to prescribe medication if applicable, or staff privileges at any hospital, if applicable, are voluntarily surrendered, restricted temporarily or permanently reclassified, suspended or revoked for any reason; and (ii) if Provider or Practitioner is indicted or convicted of a criminal offense, regardless of the nature of the offense, or if the Provider or Practitioner becomes subject to any disciplinary action taken by a government program, hospital, managed care organization, or licensing authority, including, but not limited to, an active or stayed suspension or restriction of Provider's or Practitioner's license or certification.

13. Provide all information necessary to comply with the credentialing and recredentialing activities, and further, to provide such information within a reasonable time period.

14. Cooperate fully with CSP quality assurance efforts, including participating in discussions to explore reasons for unusual data patterns, and agree to undertake any proposed remediation plans to any clinical and/or data reporting deficiencies in a timely manner.

15. The CSP (STATE) reserves the right to discontinue any service Providers from participation in the CSP for any reason.

16. Paragraphs ten and fourteen of these Participating Provider agreements shall survive termination of the AGREEMENT.

Revised May 2013

E. Confidentiality

1. Health Insurance Portability and Accountability Act (HIPAA)

The first federal privacy standards to protect patients' medical records and individually identifiable health information provided to health plans, doctors, hospitals, and other health care providers, which were issued as part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 took effect on April 14, 2003. These standards, developed by the US Department of Health and Human Services, provide patients with access to their medical records and more control over how their personal health information is used and disclosed. Additionally, HIPAA includes provisions designed to encourage electronic transactions and requires safeguards to protect the security and confidentiality of health information. For medical information to be released, patients need to sign a specific authorization, unless a specific exception in the law applies.

The New York State Department of Health's Cancer Services Program (CSP) contractors and subcontractors have access to personal and health-related information only as necessary to fulfill direct responsibilities associated with the CSP. Contractor and subcontractor staff are to disclose this information only in the appropriate context of their direct responsibilities as CSP contractors or subcontractors, and only to appropriate health care providers, contractor staff, or New York State Department of Health CSP staff, and are not to further disclose copies of medical information to other parties, including but not limited to the patients, family, or other representatives. Contractor and subcontractor staff are also responsible to ensure such information is secure from theft, accidental loss, or exposure. Failure to maintain confidentiality by any contractor or subcontractor will result in inactivation of the staff member's CSP data system account, if applicable, and may lead to contract termination pursuant to the Standard Terms and Conditions of the Master Contract.

CSP contractors and subcontractors receive and process confidential personal and health-related information in the course of recruiting clients, collecting medical records from providers, completing data collection forms, entering data on the CSP data system, conducting case management and completing Medicaid Cancer Treatment Program applications for CSP clients. Confidentiality must be maintained for all the information collected and processed through these activities.

It is the responsibility of the contractor to ensure all program and subcontracted staff sign written Confidentiality Agreements (Attachment 2-VIII) to maintain the confidentiality of all CSP clients' information. Confidentiality agreements should be submitted electronically to the New York State Department of Health at CanServ@health.ny.gov. Additionally, all contractor and subcontractor staff requesting access to the CSP data system must have a signed confidentiality agreement on file prior to receiving access to the data system. Staff permitted by the contractor to work from home must be able to demonstrate appropriate safeguards to prevent inadvertent sharing or loss of patient information including, but not limited to, firewalls that do not

allow outside access to a wireless network and a level of encryption that ensures security.

Any proposed research regarding any CSP client(s) or the CSP must first be approved by the NYSDOH Institutional Review Board. Please forward all such requests to your assigned Regional Manager.

F. Data System Access

The Contact Update Form, submitted to CanServ@health.ny.gov for new CSP contractor staff, is also used to request data system access for new staff. If the Coordinator indicates on the form that the new staff should have Data System access, the Data Unit receives notification and follows up as needed, based on the new employee's roles and responsibilities. Coordinators should be sure to complete all applicable sections on the form.

G. Data Submission and Form Retention

The NYSDOH CSP maintains a secure on-line, real-time, internet-based data entry system (commonly referred to as "the data system"). Contractors are responsible for entering screening, diagnostic, treatment, and demographic information into this data system for CSP clients. The use of data available through the data system facilitates timely provider reimbursement, patient tracking and follow up, improves the quality of data collected, and helps reinforce CSP procedures. On-line data queries and reports are available for contractors and NYSDOH CSP staff to monitor performance.

Contractors should establish efficient notification systems with CSP providers to receive information from them, to ensure timely reporting of services. These systems are needed to ensure:

- prompt and appropriate follow up of positive screening findings
- provision of timely case management services
- clients eligible for the NYS MCTP can receive coverage for treatment
- provision of quality clinical care for all CSP clients
- rescreening can occur at the appropriate interval(s); and
- CSP providers are reimbursed as soon as possible

Detailed instructions regarding form completion and on-line data entry are in the CSP Data Dictionary. Current versions of data entry forms and the CSP Data Dictionary are located on the CSP data system resource document page and available by contacting the NYSDOH CSP Data Unit at CSPData@health.ny.gov

1. Timely submission of Screening Intake Forms (SIFs) and Follow-up Forms (FFs) on the CSP data system

The CSP data system allows for the reimbursement of CSP funds only for services that are submitted and accepted on the data system within 90 days from the date of service.

Exceptions to this 90-day rule can be made for services processed with Insurance Denial Conversion Forms, for contractor errors corrected through Revision Forms, and for other special circumstances that justify a longer period for data submission. CSP Data Unit administrators have the capability to override the 90-day rule on the data system. Requests for overrides should be submitted by email to CSPData@health.ny.gov

The 90-day rule for data submission on the SIF and FF is outlined below.

SIF: The data system assesses the submission date for each individual service on the SIF and determines whether the service was submitted and accepted in the system within 90 days of the service date.

> *For example, if a mammogram is provided on May 15, 2016 and submitted and accepted into the data system on August 20, 2016, the system will NOT allow program funds for this service.*

It is not prudent to delay entry of SIFs until all screenings are complete. The data system allows contractors to submit services on the SIF, have the form accepted, and then add additional services as they are provided.

FF: The data system starts counting the 90 days with the LAST service date on the FF.

> *For example, if an FF with a surgical consult on May 15, 2016 and a colonoscopy on July 15, 2016 is submitted and accepted in the system on September 20, 2016, the data system will allow reimbursement for both services on this FF, even though the submission is more than 90 days after the surgical consult in May. The data system begins counting the 90 days with the LAST service date on the form (in this case: July 15, 2016).*

Given these rules, situations such as cancellation of appointments, delays in scheduling colonoscopies, and extended periods of time between follow-up services should not affect whether services can be reimbursed. FFs should not be submitted onto the data system until they are complete.

Contractors are expected to ensure data are submitted in accordance with the 90-day rule so services can be reimbursed.

Revisions to SIFs and FFs on the data system

Once SIFs and FFs have been submitted and accepted on the data system, there are several types of revisions that CSP contractor staff can make.

CSP contractor staff can directly modify the following fields on an accepted form:

Profile Section

- All fields

Demographic Section

- All fields

Assessment Section

- All fields

Screening Intake Form

- Encounter Date
- Encounter Label (Medical Record Number)
- Q40. Recommended Dates of Next Exam
- Q41. Immediate Breast Cancer Screening Follow-up
- Q54. Recommended Date of Next Exam
- Q55. Immediate Cervical Cancer Screening Follow-up
- Q71. Immediate Colorectal Cancer Screening Follow-up
- BCC Notes
- CRC Notes

Breast, Cervical and Colorectal Follow-up Forms

- Encounter Date
- Provider (follow-up completion site)
- Encounter Label (Medical Record Number)

Contractor staff can make the following types of revisions to an accepted SIF:

- if SIF was entered and accepted on the data system with the cervical portion of the form completed (and the breast portion blank), the contractor staff can directly edit the form to add breast cancer screening services that occur within 90 days of the cervical screening services
- if SIF was entered and accepted on the data system with the breast portion of the form completed (and the cervical portion blank), the contractor staff can directly edit the form to add cervical cancer screening services that occur within 90 days of the breast screening services
- if SIF was entered and accepted on the data system with a CBE and no mammogram, the contractor staff can directly edit the form to add a screening mammogram that occurred within 90 days of the CBE. this also

applies if the form was accepted with a mammogram and no CBE – the contractor staff can directly edit the form to add a CBE that occurred within 90 days of the mammogram

- if SIF was entered and accepted on the data system with breast and/or cervical cancer screening services, the contractor staff can directly edit the form to add colorectal cancer services that occur within 6 months of the breast and/or cervical screenings

For all other changes, corrections, or additions of data to SIFs or FFs that have already been submitted and accepted in the data system, CSP Contractor staff must submit either a **Screening Intake Revision Form** or a **Follow-up Revision Form**. These forms, and detailed instructions on their completion, are available under the "Resource Document" icon of the data system or by contacting the NYSDOH CSP Data Unit at CSPData@health.ny.gov.

Submitting SIFs and FFs on the data system for NYS MCTP clients

When submitting SIFs and FFs for potential NYS MCTP clients, it is important to consider the Medicaid enrollment to avoid duplicate payment of services by both CSP and Medicaid. Enrollment in the MCTP starts on the first day of the month of diagnosis (e.g.: for a biopsy done on 1/18/16 with a positive finding, enrollment would start 1/1/16) **OR** 90 days prior to the application date, whichever is later. The CSP should be the payor of last resort.

NYS MCTP clients can enter the CSP at several points during the process of diagnosis and treatment. The guidance for submission of SIFs and FFs on the data system depends on when the client enters the program. The following scenarios represent different types of clients and the appropriate way to submit the SIFs and FFs for these clients.

- **CSP-enrolled clients:** If a client enrolled in the CSP who received screening and/or follow up procedures through the program is believed to be eligible for the MCTP, contractor staff should submit SIFs and FFs into the data system as if Medicaid will be paying for some services. Any procedures that occurred within the month of diagnosis should be entered on the SIF and FF as paid with "other" funds, because Medicaid will enroll the client and pay for services rendered back to the first day of the month in which the client was diagnosed. Remember, the client will be covered by Medicaid for all Medicaid-approved procedures that occurred during that month, as long as they were performed by a provider who accepts Medicaid reimbursement. Services that are not Medicaid approved, or are rendered by providers who do NOT accept Medicaid reimbursement should be entered on the SIF and FF as being paid with "program" funds.
    - if the client is approved for the MCTP, the acceptance letter will include an enrollment date. The contractor staff should compare this enrollment date to the already-accepted SIF/FF and confirm that any services that

occurred prior to the client's MCTP enrollment date are paid for with "program funds", and services that occurred on or after the enrollment date, and were rendered by a provider who accepts Medicaid reimbursement, are entered as "other funds". Revision forms should be submitted to the CSP data unit to change funds as needed. Please list "MCTP" on the form as the reason for the revision.

- if the client is NOT approved for MCTP, submit a revision form to the CSP Data Unit to change procedures listed as "paid with other funds" to show "paid with program funds". Please list "denied MCTP" as the reason for the revision on the form.

- **Clients NOT enrolled in the CSP:** For all applicants to the MCTP who were not enrolled in the CSP at the time they received screening and follow-up procedures, the SIFs and FFs should NOT be entered on the data system. Hard copies of SIFs and FFs should be submitted with the MCTP applications.

Please see CSP Operations Manual Chapter 7 and the Medicaid Cancer Treatment Program Application manual for more information about eligibility criteria and the application process for the MCTP.

Form retention recommendations

The NYSDOH CSP does not have formal requirements for retention of SIFs, FFs, or monthly billing reports. Accepted forms and monthly billing reports are available electronically in the data system. Contractors are required to follow their agency's policies on retention of SIFs, FFs and monthly billing reports, as well as consent forms, clinical or medical records, and case management notes. If a contractor disposes of forms with confidential client information, these forms must be shredded.

The NYSDOH CSP does recommend contractors retain SIFs and FFs until the services on these forms appear on the monthly billing report to verify the information was accurately entered on the data system, and that it appears correctly on the monthly billing report. The NYSDOH CSP also recommends retaining monthly billing reports until the voucher is submitted and processed.

Clients who receive case management services should have all case management notes, documentation, forms, etc. retained within their individual charts. Clinical documentation related to case management needs should be retained for a minimum of two (2) years following the conclusion of that client's diagnostic follow-up. For questions or guidance about case management issues, please contact the CSP Case Management Coordinator at (518) 474-1222.

H. CSP Performance Measures Reports

The CSP Data Unit prepares performance measure (PM) reports for contractors and NYSDOH CSP staff to monitor program services and other issues relevant to quality

assurance, as well as to identify contractors in need of assistance or intervention. The CSP distributes PM reports to all contractors, summarizing key indicators of performance, such as the ability to reach the priority populations, timeliness and appropriateness of follow-up, and timely submission of data forms. Contractors are expected to meet or exceed PM goals. The PMs are included in contractor work plans and are used to measure effectiveness related to required activities. The NYSDOH CSP PMs are primarily modeled after those used by the CDC to measure statewide performance. Contractors who meet or exceed the PM goals, as well as other contract requirements, are best positioned to receive the maximum available funding for subsequent contract years. Below is a table showing the CSP Performance Measures.

NYSDOH Cancer Services Program
Program Performance Measures
Program Year 2016-2017

No.	Performance Measure Description	Goal
1	Percent of screening mammogram clients age 50 and older	≥75%
2	Percent of initial program-funded Pap tests for women rarely or never screened for cervical cancer	≥20%
3	Percent of women rescreened by mammogram within 24 months	≥60%
4	Percent of clients who are male	≥20%
5	Percent of clients rescreened by fecal test within 10-14 months	≥60%
6	Percent of clients age 50 to 64	≥75%
7	Percent of women age 50 and older with comprehensive cancer screening	≥50%
8	*PM Removed*	---
9	Percent of eligible population screened in each county	≥20%
10	Percent of abnormal cervical screenings with timely follow-up	≥75%
11	Percent of abnormal breast screenings with timely follow-up	≥75%
12	Percent of abnormal colorectal screenings with timely follow-up	≥75%
13	Percent of eligible clients enrolled in the Medicaid Cancer Treatment Program	≥90%
14	Percent of Screening Intake Forms with timely submission	≥85%
15	Percent of Follow-up Forms with timely submission	≥85%

See Attachment 2-IX of this chapter for Performance Measure Definitions.

I. Reporting Requirements and Contract Monitoring

Annual work plan and budget development

CSP contractors complete a detailed work plan and budget, which is updated and submitted on an annual basis. The NYSDOH CSP provides required goals and objectives that focus on implementation and evaluation of CSP activities consistent with the required scope of work and PMs. Work plans should include detailed activities that will be implemented to fulfill each of the required objectives. A detailed budget and budget justification is required to justify proposed expenditure of infrastructure funding. The work plan and budget templates are provided by NYSDOH CSP to contractors. Please contact your Regional Manager to obtain the most current work plan and budget forms.

Quarterly Progress Reports

On a quarterly basis, NYSDOH CSP requires contractors to report progress toward work plan activities using the Catalyst Planning and Evaluation Module. See the New York State Department of Health Catalyst Planning and Evaluation Module Technical Guide for additional information on required performance reports.

Monthly Contract Monitoring

On a monthly basis, Regional Managers will:

- review contractor vouchers to ensure all clinical services and infrastructure budget lines are expended and that expenditures are related and appropriate to activities detailed in approved work plans. In addition, Regional Managers will review contractors' clinical services allocations in comparison with key PMs to determine success reaching eligible priority populations
- review contractor PMs to identify challenges and barriers, and provide contractors with assistance to meet or exceed measures
- review the contractor Incentive Tracking Tool, which is used to track each incentive distributed to CSP clients (e.g.: a $5 gas card for returning a FIT kit). Regional Managers will require use of this tool to ensure contractor accountability for program incentives. See Attachment 2-IV for the Incentive Tracking Form
- track and monitor whether contractors have responded to requests from NYSDOH CSP in a timely and accurate manner (e.g. status of outstanding FFs and medical records requests)

Equipment Inventory

Per contract requirements, contractors are required to maintain inventory of all equipment purchases made with grant funds. Equipment is defined as items such as computers, printers,

phones, apparatus or fixed asset (other land or a building) that are tangible personal property having a useful life of more than one year and a purchase price equal or exceeding $5,000. This also includes a grouping of like items which equals or exceeds $5,000.

Equipment items purchased with NYSDOH funds by the contracting agency must be listed in the inventory with identifying information such as tag number (number assigned by contracting agency), serial number (manufacturer's serial number), location, and any relevant remarks. See Attachment 2-III for a sample of an Equipment Inventory Form.

Contractors are required to submit equipment inventory forms as part of the contract term close out. Regional Managers may, at their discretion, also request and review these forms at any time throughout the funding period.

J. Communications

The NYSDOH CSP provides information, support, training, and technical assistance to contractors in a variety of ways. As appropriate, contractor staff should ensure they refer to, and participate in, the following.

1. Contact Information Form

Contractors must provide updates via the Contact Update form whenever they add new staff, when staff leaves, and/or when there are any other changes to staff function or contact information (e.g. email, address, phone number). *Any changes to the Contracting Agency's Administrative or Board of Directors staff must also be provided on this form*. Submit the completed form to CanServ@health.ny.gov (with cc to the Regional Manager) as soon as staff changes occur. Attachment 2-V shows an example of the CSP Contact Update Form. The most recent version of this form is housed in the Resource Documents area of the Data System. Contractors *should not* save these forms locally, but should download the form as needed directly from the Data System.

2. Program updates and communication databases

The CSP uses contact information received via the Contact Update form to distribute general information, periodic updates, programmatic changes, and training announcements and opportunities via the CSP mailbox (CanServ@health.ny.gov). Contractors should forward information provided by the CSP to their participating clinical services providers as appropriate. The communication target audience should share information with other staff as deemed appropriate based on the content.

3. Naming conventions and use of logo

The CSP has developed guidelines for contractors specifying the program name, use of the CSP logo and the development and review of educational and promotional

materials. The CSP requires contractors to use the name *Cancer Services Program of X County/Counties* to build name awareness and consistency for clients, partners, and health care providers across the state. The name reflects the integration of the three screening services and acknowledges that the programs serve both women and men. The CSP developed a logo with the tagline "*Your partner for cancer screening, support, and information"* to offer contractors a common symbol and tagline with the potential to become universally recognized and understood. See CSP Operations Manual Chapter 9 for more information.

4. Data Unit inquiries

For questions about data inquiries, access to the data system, SIFs, data dictionary copies, data corrections, and insurance denial conversions, please contact the CSP Data Unit via email at CSPData@health.ny.gov

5. Case Management conference calls

Case management conference calls are held bi-monthly to discuss common case management challenges, to identify and share solutions and strategies, to discuss the implementation of new policies, and to review case management protocol. Contractors are expected to share this information with their providers who offer case management services to CSP clients. For questions or guidance about case management conference calls, please contact the CSP Case Management Coordinator at (518) 474-1222.

6. Public Education and Targeted Outreach (PETO) conference calls and webinars

The PETO team holds bi-monthly conference calls and/or webinars to discuss common public education, targeted outreach, and recruitment challenges, as well as partner relations, communications, and evidence- and population-based strategies to increase cancer screening. The calls provide an opportunity to network with, and learn from, others across the state. Contractors are expected to actively participate and implement shared strategies as appropriate. The calls and webinars are open to CSP Program Coordinators, staff fulfilling the PETO functions, and community partners. For questions about PETO conference calls, please contact the Communications and Education Unit at (518) 474-1222.

7. Data Unit conference calls

Data conference calls are held monthly to provide a forum for the Data Unit and all contractors to discuss pertinent topics related to data collection, completion of CSP forms or the use of the data system, and to provide clarification for any data-related questions. This call is also a way for contractors to share best practices or successes. The calls are open to Program Coordinators, Data Managers, or any other CSP staff member who uses the data system on a regular basis. For questions or guidance about the Data conference calls, please contact the CSP data Unit at CSPData@health.ny.gov or at (518) 474-1222.

8. New staff orientation

All new contractor staff must participate in training offered by the NYSDOH CSP. These training sessions provide new staff with an overview of all aspects of the CSP. Some sessions are available 24/7 via webinar and/or the Learning Management System (LMS); others are offered in-person periodically throughout the year. All are announced via email from the CanServ (CanServ@health.ny.gov)

Attachment 2-I – Credentialing Packet Instructions & Form– Component A

NEW YORK STATE DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM

INSTRUCTIONS FOR CREDENTIALING PACKET
(COMPONENT A)

Application Submission and Review Process
Please complete each field and submit all required documentation when requesting a new site or reactivating a site. The NYSDOH CSP reviews each of the fields in the application for accuracy and validity. This information is necessary to ensure the quality and credibility of CSP providers. For all other requests please complete the information as requested on page 1 of the credentialing packet.

Type of Request	Select the type of request you need and complete the corresponding pages as indicated in parentheses.
Obtained Provider Agreement through September 30, 2018	In accordance with contract Attachment A-1 Part B, provision F. contractors are responsible for establishing provider agreements. Please indicate if an agreement has been obtained through September 30, 2018. If it has not, contractors are given up to 30 days to obtain the agreement before the site is closed.
Practice/ Facility Name	Please provide the legal name of the practice or the corporation. The NYSDOH CSP will verify legal names of incorporated practices with the Department of State. For practices that are not incorporated (sole proprietorships or general partnerships) the contractor must supply the NYSDOH CSP with a copy of a W-9 or Assumed Name Certificate for legal name verification.
Doing Business As (DBA) Name	Provide if applicable.
CSP Name & Contact Information	Enter the name of the CSP this application is being submitted for. Also include the name of the CSP contractor staff submitting the credentialing packet and the associated phone, fax and e-mail address information. Application are not accepted directly from providers.
Correspondence Address	Enter the address where all correspondence will be sent. Please include the contact person (first and last name), e-mail address and phone and fax for the contact person.
Pay to Address	Enter the address where the payments will be sent. Please include the contact person (first and last name), e-mail address and phone and fax for the contact person. If payments are sent to the Correspondence Address check the Same as Correspondence Address box.
Service Address	Enter the service site address. Please include the contact person (first and last name), e-mail address and phone and fax for the contact person. If the service address is the same as the correspondence check the Same as Correspondence Address box. If services are provided at more than one location, complete a new credentialing packet for each service address.
Place of Service	Check the box from the list which describes the service site.
	Hospital- Services are provided within a hospital setting, this may include clinics located within the hospital or hospital departments.
	Hospital Extension Clinic- Off site or satellite extension clinic of the hospital, that appear on the hospital Article 28 Operating Certificate.
	Private Office- Services are provided in a physician's office or in an office owned by a group that is not licensed by the NYS DOH.

NEW YORK STATE DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM

INSTRUCTIONS FOR CREDENTIALING PACKET
(COMPONENT A)

	Diagnosis & Treatment Center/ Free Standing Clinic- Services are provided in a clinic setting that is not connected to a hospital. The clinic is licensed under Article 28 of public health law.
	Mobile Van- Services are provided on a mobile van and services appear on the Operating Certificate.
	Free Standing Imaging Center- Services are provided in a free standing imaging center that is not connected to another facility.
	Laboratory- Facility that examines specimens for the purpose of providing information on diagnosis, prognosis, or treatment of disease.
	Other- Services are provided in a setting not described in this list. Please provide the type of service setting.
Family Planning Provider &/or Federally Qualified Health Center	Please indicate if the practice is a NYS DOH supported Family Planning Provider, Title X Provider or a Federally Qualified Health Center (FQHC). A FQHC is a non-for profit organization that receives grant funds under Section 330 of the Public Health Services Act.
Organizational Structure	Check the box from the list that indicates how the practice or facility is organized. A copy of a W-9 or Assumed Name Certificate must be included for sole proprietorships or general partnerships.
Licensed Under Article 28	Article 28 refers to all facilities licensed under Article 28 of the Public Health Law. For example: hospitals, extension clinics, diagnostic and treatment centers, or health clinics, such as Planned Parenthood are licensed as an Article 28 facility. They have a facility license that lists the services they can provide. Laboratories would only be considered Article 28 facilities if they are the hospital's lab. Non-Article 28 refers to provider practices which include individual professional corporations (PCs), limited liability partnerships (LLPs), sole proprietors and non-hospital laboratories among others. The NYSDOH CSP requires license information for health care providers practicing at non-article 28 facilities with the exception of laboratories, RNs and LPNs. See Provider List section for additional details.
Facility National Provider Identifier (NPI)	Please list the facility or practice NPI. The NPI is a unique identification number for health care providers; it is an intelligence-free numeric identifier (10-digit number). Contractor staff can search the NPI registry for organizational and individual NPI numbers. Searches can be done by provider/facility name, city, state or zip.
Federal Employer Id No	Please list the facility tax identification number.
Services	Providers can submit for the services for which they are authorized to perform and have indicated so on the application.
Breast Services	Please check all breast services that will be provided to CSP clients.

For facilities that are FDA approved for mammography please indicate if the facility is approved for analog, digital and/or 3D Tomosynthesis mammography units. Please submit a copy of the FDA certificate.

For facilities that are ACR approved for Breast MRI please submit a copy of the ACR accreditation.

For facilities that provide CBE, please indicate if they use the NYSDOH CSP CBE form. If they use an alternative form, please submit a copy of their CBE form for review.

Cervical Services Please check all cervical services that will be provided to CSP clients.

Colorectal Services Please check all colorectal services that will be provided to CSP clients.

Prostate Services Clients must access the Medicaid Cancer Treatment Program (MCTP) for prostate cancer treatment through a CSP credentialed provider. You will not need to obtain a provider agreement since there is no reimbursement for screening or diagnostic procedures at this time.

Laboratory Services Please check the box for the corresponding level of laboratory services. Please provide a copy of the facility's most recent Clinical Laboratories Improvement Amendment (CLIA) certificate.

- **CLIA Approved/ Compliance** means that the provider is certified to provide specific, more complex testing, such as cytology, pathology, blood bank, clinical testing, etc.
- **CLIA Waived** means that a provider received a waiver from CLIA to perform low-level complexity testing. For the purposes of CSP reimbursement the only tests would be the FOBT kits and limited FIT kits.
- **No CSP Laboratory Services Provided**- Please choose this option if the facility or practice does not perform any CSP reimbursable laboratory services.

Pre-Op Testing Services Only Please check all pre-op testing services that will be provided to CSP clients.

- CBC can only be checked if the provider is CLIA Approved.

Other

Office Based Surgery

- Please identify practices performing Office Based Procedures (OBS) and their accrediting organization. Non-article 28 practices that perform OBS are required by NYS Public Health Law to be accredited. Any surgical or other invasive procedure requiring general anesthesia, moderate sedation, or deep sedation performed in a private office setting requires accreditation. Practices must be accredited by one of the following three organizations: Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), or The Joint Commission.

Intake Site Only

- Please indicate if the provider site is an intake site only.

Anesthesia

- Please indicate if practice provides anesthesia.

Facility Fees

- Please indicate if site is reimbursed for facility fees. Site must be an article 28 that provides services the CSP reimbursed facility fees for (See Reimbursement Schedule).

Service Notes Please add any notes regarding the provision of services that may assist the CSP in understanding the set-up of this practice or facility.

Provider List List all provider names, medical license numbers, NPIs, and profession information for providers that will see CSP clients at non-Article 28 facilities excluding laboratories. The NYSDOH CSP only requires information on physicians, physicians' assistants, nurse practitioners, and nurse midwives. Provider license information is not required for Article 28 facilities.

Websites: Below is a list of websites that may assist contractor staff with completing their enrollment packets.

New York State Department of State
http://www.dos.ny.gov/

National Provider Identifier
https://npiregistry.cms.hhs.gov/

Food and Drug Administration – Mammography Database
http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMQSA/mqsa.cfm

New York State- Office Based Surgery
http://www.health.ny.gov/professionals/office-based_surgery/practices/

New York State- Office of the Professions
http://www.op.nysed.gov/opsearches.htm

Please make sure you have included the following documents with your completed application (if applicable):

- W9 Tax Form or Assumed Name Certificate
- Mammography Certificate
- CLIA Certificate

NEW YORK STATE DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM CREDENTIALING PACKET (COMPONENT A)

TYPE OF REQUEST:

- ☐ REQUEST NEW SITE CODE (complete entire packet)
- ☐ RE-ACTIVATE SITE CODE (complete entire packet)

OBTAINED NEW PROVIDER AGREEMENT THROUGH SEPTEMBER 30, 2018: YES ☐ NO ☐ PENDING ☐

Make changes to site code: _____ (Please check appropriate box below).

- ☐ ADD ADDITIONAL PROVIDERS TO ACTIVE SITE CODE (complete page 1 and 5)
- ☐ ADD SERVICES PROVIDED TO ACTIVE SITE CODE (complete page 1,3 and 4)
- ☐ CHANGE ADDRESS OR CONTACT INFORMATION TO ACTIVE SITE CODE (complete page 1 and 2)
- ☐ INACTIVATE PROVIDER(S) (complete page 1 and 5)
- ☐ INACTIVATE SITE CODE (complete page 1 only- Indicate reason(s) why you are closing this code:
  - ☐ Provider does not see the priority population
  - ☐ Delay in receiving payment
  - ☐ Reduction in reimbursement rates
  - ☐ Not willing to sign provider agreement
  - ☐ Screening cap
  - ☐ Other _____

PRACTICE/FACILITY NAME: _____
DBA (IF APPILCABLE): _____
PARTNERSHIP NAME: _____
SUBMITTED BY: _____
PHONE NO: _____
FAX NO: _____
E-MAIL ADDRESS: _____

DOH ADMINISTRATIVE USE ONLY

SITE CODE: _____
APPROVED ☐ DENIED ☐ PROVIDER AGREEMENT DUE DATE IF 'NO' OR' PENDING' _____
REASON DENIED: _____
DATE: _____ REVIEWED BY: _____

Please e-mail Enrollment Packet and required documents to:
cspcredentialing@health.ny.gov

ENROLLMENT PACKET MUST BE COMPLETED BY CSP CONTRACTOR STAFF
ALL FILEDS MUST BE COMPLETELY FILLED OUT AND REQURIED DOCUMENTS INCLUDED FOR PACKET TO BE PROCESSED
DETAILED INSTRUCTIONS FOR COMPLETNG CREDENTIALING PACKET ARE AVAILABLE
PLEASE ALLOW UP TO 2 WEEKS FOR NEW SITE CODE REQUESTS TO BE PROCESSED

CREDENTIALING PACKET Rev. Jan. 2017
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NEW YORK STATE DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM CREDENTIALING PACKET (COMPONENT A)

CORRESPONDENCE ADDRESS (Primary Contact)

ATTENTION (FIRST AND LAST NAME): _____
STREET: _____
_____
CITY: _____ STATE: _____ ZIP CODE: _____
COUNTY: _____
TELEPHONE (INCLUDING AREA CODE): _____ FAX: _____
E-MAIL: _____

PAY TO ADDRESS (Used by Contractor for contact on billing and payment issues and is used by HRI for payments and client summary documents)

☐ **Same as Correspondence Address**
ATTENTION (FIRST AND LAST NAME): _____
STREET: _____
_____
CITY: _____ STATE: _____ ZIP CODE: _____
TELEPHONE (INCLUDING AREA CODE): _____ FAX: _____
E-MAIL: _____

SERVICE SITE ADDRESS

☐ **Same as Correspondence Address**
ATTENTION (FIRST AND LAST NAME): _____
STREET: _____
_____
CITY: _____ STATE: _____ ZIP CODE: _____
COUNTY: _____
TELEPHONE (INCLUDING AREA CODE): _____ FAX: _____
EMAIL: _____

ADDITIONAL SERVICE SITE ADDRESSES

If services are provided at multiple locations, please complete an enrollment packet for each service site that sees CSP clients.

CREDENTIALING PACKET Rev. Jan. 2017
PAGE 2 OF 5

NEW YORK STATE DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM CREDENTIALING PACKET (COMPONENT A)

PLACE OF SERVICE (CHECK ONE)

☐ HOSPITAL ☐ HOSPITAL EXTENSION CLINIC ☐ PRIVATE OFFICE ☐ DTC/FREE STANDING CLINIC
☐ MOBILE VAN ☐ FREE STANDING IMAGING CENTER ☐ LABORATORY ☐ OTHER

Please indicate if this site is a Family Planning Provider, Title X Provider and/or a Federally Qualified Health Center
☐ Family Planning Provider ☐ Title X Provider ☐ Federally Qualified Health Center

ORGANIZATIONAL STRUCTURE

Please check the box that described the organizational structure of the business.
☐ CORPORATION (e.g. PC, PLLC, LLC, LLP, INC) ☐ GOVERNMENTAL (local, state, federal)
☐ SOLE PROPRIETORSHIP* ☐ GENERAL PARTNERSHIP*
**Please submit a copy of a W9 or Assumed Name Certificate for Sole Proprietors or General Partnerships*
LICENSED UNDER ARTICLE 28: ☐ YES ☐ NO
FACILITY/PRACTICE NPI: FEDERAL EMPLOYER ID NO:

SERVICES PROVIDED

BREAST SERVICES

☐ CBE ☐ Uses CSP CBE Form ☐ Uses Alt Form (include in packet)
☐ Diagnostic Breast Ultrasound ☐ Surgical Consult
☐ MAMMOGRAPHY (Must be a FDA certified breast imaging center).
Please submit a copy of certificate. Check type(s) of approved unit(s).
☐ Digital ☐ Analog* ☐ 3D Tomo**
*If not digital, then CSP reimbursement will need to be requested as partial payment for Analog film mammogram.
**NYS provides reimbursement for full field digital mammography or Tomosynthesis mammography at the same rate

BIOPSY – SELECT APPLICABLE SERVICES

☐ FNA BX W/ IMAGE GUIDANCE
☐ INCISIONAL BX
☐ CORE BX
☐ PRE-OP MAMMOGRAPHIC NEEDLE LOC & WIRE PLACEMENT
☐ STEREOTACTIC BX* *STEREO LOCATION IF NOT FDA APPROVED SITE:
Stereotactic Bx must be done at FDA Mammography approved sites.
☐ FNA BX W/O IMAGE GUIDANCE
☐ EXCISIONAL BX
☐ U/S GUIDED CORE VACUUM ASSISTED BX
☐ PRE-OP U/S NEEDLE LOC & WIRE PLACEMENT

Other Diagnostic Breast Services

☐ DUCTOGRAM/GALACTOGRAM
☐ BREAST MRI (Must be ACR accredited for Breast MRI).
☐ OTHER BREAST SERVICES:

CREDENTIALING PACKET Rev. Jan. 2017
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NEW YORK STATE DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM CREDENTIALING PACKET (COMPONENT A)

CERVICAL SERVICES

☐ PELVIC EXAM
☐ CONSULT
☐ COLPOSCOPY AND BX
☐ LEEP/LEETZ
☐ CERVICAL CONE BX
☐ OTHER CERVICAL SERVICES:

COLORECTAL SERVICES

FIT TESTING SERVICES	gFOBT TESTING SERVICES
☐ FIT DISTRIBUTION FIT BRAND	☐ gFOBT DISTRIBUTION gFOBT BRAND
☐ FIT PROCESSING AT THIS SITE	☐ gFOBT PROCESSING AT THIS SITE
☐ FIT PROCESSED IN LAB*	☐ gFOBT PROCESSED IN LAB*
FIT LAB NAME*	gFOBT LAB NAME*
☐ FIT CLIA CERTIFICATE OF WAIVER*	☐ gFOBT CLIA CERTIFICATE OF WAIVER
*If FIT Test processed in lab, indicate lab name. If processed in office, must have a CLIA Certificate of Waiver on file	*If gFOBT Test processed in lab, indicate lab name. I processed in office, must have a CLIA Certificate of Waiver on file

☐ CONSULT
☐ SIGMOIDOSCOPY
☐ DCBE
☐ COLONOSCOPY* Colonoscopies at non-Article 28 facilities must be done at OBS accredited facilities. Facility fee does not apply unless performed at Article 28 facility.
☐ OTHER COLORECTAL SERVICES:

PROSTATE

☐ DIAGNOSTIC SERVICES*
*No reimbursement for screening and diagnostic services

LABORATORY SERVICES

☐ APPROVED/COMPLIANCE* Please submit a copy of the most recent CLIA certificate. (INCLUDES: HR HPV DNA, CYTOLOGY, PATHOLOGY, HISTOPATHOLOGY)
☐ NO CSP LABORATORY SERVICES PROVIDED

PRE-OP TESTING SERVICES ONLY	OTHER
☐ CBC (Must be CLIA Approved)	☐ OBS PROVIDER- Check OBS Accreditation Org.
☐ EKG/ECG	☐ AAAASF ☐ AAAHC ☐ JOINT COMMISSION
☐ CHEST X-RAY	☐ INTAKE SITE ONLY ☐ ANESTHESIA
	☐ FACILITY FEE

Service Notes:

CREDENTIALING PACKET Rev. Jan. 2017
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NEW YORK STATE DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM CREDENTIALING PACKET (COMPONENT A)

PROVIDER LIST

This form must be completed for non-article 28 facilities with the exception of laboratories. Please list the name, license number, National Provider Identifier (NPI), and profession of each provider that will see CSP clients.

PROVIDER NAME	LICENSE NUMBER	NPI	PROFESSION (MD, DO, PA, NP, MIDWIFE)

CREDENTIALING PACKET Rev. Jan. 2017
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Attachment 2-II – Credentialing Packet Instructions & Form– Component B

Application Submission and Review Process
Please complete each field and submit all required documentation when requesting a new site or reactivating a site. The NYSDOH CSP reviews each of the fields in the application for accuracy and validity. This information is necessary to ensure the quality and credibility of CSP providers. For all other requests please complete the information as requested on page 1 of the credentialing packet.

Type of Request	Select the type of request you need and complete the corresponding pages as indicated in parentheses.
Obtained New Provider Agreement for April 1, 2016 – September 30, 2018	In accordance with contract Attachment A-1 Part B, provision F. contractors are responsible for establishing provider agreements. Please indicate if an agreement has been obtained for the new extended program year end date, September 30, 2018. If it has not, contractors are given up to 30 days to obtain the agreement before the site is closed.
Practice/ Facility Name	Please provide the legal name of the practice or the corporation. The NYSDOH CSP will verify legal names of incorporated practices with the Department of State. For practices that are not incorporated (sole proprietorships or general partnerships) the contractor must supply the NYSDOH CSP with a copy of a W-9 or Assumed Name Certificate for legal name verification.
Doing Business As (DBA) Name	Provide if applicable.
SFS Payee Name	Please provide the payee name (if different from Practice/Facility Name) that corresponds with the SFS Vendor ID Number
CSP Name & Contact Information	Enter the name of the CSP this application is being submitted for. Also include the name of the CSP contractor staff submitting the credentialing packet and the associated phone, fax and e-mail address information. Application are not accepted directly from providers.
Correspondence Address	Enter the address where all correspondence will be sent. Please include the contact person (first and last name), e-mail address and phone and fax for the contact person.
Pay to Address	Enter the address where the payments will be sent. Please include the contact person (first and last name), e-mail address and phone and fax for the contact person. If payments are sent to the Correspondence Address check the Same as Correspondence Address box.
SFS Pay to Address	Enter the address (if different from Pay to Address) that corresponds with the SFS Vendor ID Number. Please include the contact person (first and last name), e-mail address and phone and fax for the contact person.
Service Address	Enter the service site address. Please include the contact person (first and last name), e-mail address and phone and fax for the contact person. If the service address is the same as the correspondence check the Same as Correspondence Address box. If services are provided at more than one location, complete a new credentialing packet for each service address.
Place of Service	Check the box from the list which describes the service site.

Hospital- Services are provided within a hospital setting, this may include clinics located within the hospital or hospital departments.

Hospital Extension Clinic- Off site or satellite extension clinic of the hospital, that appear on the hospital Article 28 Operating Certificate.

Private Office- Services are provided in a physician's office or in an office owned by a group that is not licensed by the NYS DOH.

Diagnosis & Treatment Center/ Free Standing Clinic- Services are provided in a clinic setting that is not connected to a hospital. The clinic is licensed under Article 28 of public health law.

Mobile Van- Services are provided on a mobile van and services appear on the Operating Certificate.

Free Standing Imaging Center- Services are provided in a free standing imaging center that is not connected to another facility.

Laboratory- Facility that examines specimens for the purpose of providing information on diagnosis, prognosis, or treatment of disease.

Other- Services are provided in a setting not described in this list. Please provide the type of service setting.

Family Planning Provider &/or Federally Qualified Health Center	Please indicate if the practice is a NYS DOH supported Family Planning Provider, Title X Provider or a Federally Qualified Health Center (FQHC). A FQHC is a non-for profit organization that receives grant funds under Section 330 of the Public Health Services Act.
Organizational Structure	Check the box from the list that indicates how the practice or facility is organized. A copy of a W-9 or Assumed Name Certificate must be included for sole proprietorships or general partnerships.
Licensed Under Article 28	Article 28 refers to all facilities licensed under Article 28 of the Public Health Law. For example: hospitals, extension clinics, diagnostic and treatment centers, or health clinics, such as Planned Parenthood are licensed as an Article 28. They have a facility license that lists the services they can provide. Laboratories would only be considered Article 28 facilities if they are the hospital's lab. Non-Article 28 refers to provider practices which include individual professional corporations (PCs), limited liability partnerships (LLPs), sole proprietors and non-hospital laboratories among others. The NYSDOH CSP requires license information for health care providers practicing at non-article 28 facilities with the exception of laboratories, RNs and LPNs. See Provider List section for additional details.
Facility National Provider Identifier (NPI)	Please list the facility or practice NPI. The NPI is a unique identification number for health care providers; it is an intelligence-free numeric identifier (10-digit number). Contractor staff can search the NPI registry for organizational and individual NPI numbers. Searches can be done by provider/facility name, city, state or zip.

Federal Employer Id No Please list the facility tax identification number.

SFS Vender ID No Please list the SFS Vendor ID number that is associated with the Federal Employer ID Number. This number should also correspond with the SFS Vendor Payee Name.

Services Providers can submit for the services for which they are authorized to perform and have indicated so on the application.

Breast Services Please check all breast services that will be provided to CSP clients.

For facilities that are FDA approved for mammography please indicate if the facility is approved for analog, digital and/or 3D Tomosynethisis mammography units. Please submit a copy of the FDA certificate.

For facilities that are ACR approved for Breast MRI please submit a copy of the ACR accreditation.

For facilities that provide CBE, please indicate if they use the CSP CBE form. If they use an alternative form, please submit a copy of their CBE form for review.

Cervical Services Please check all cervical services that will be provided to CSP clients.

Colorectal Services Please check all colorectal services that will be provided to CSP clients.

Prostate Services Clients must access the Medicaid Cancer Treatment Program (MCTP) for prostate cancer treatment through a CSP credentialed provider. You will not need to obtain a provider agreement since there is no reimbursement for screening or diagnostic procedures at this time.

Laboratory Services Please check the box for the corresponding level of laboratory services. Please provide a copy of the facility's most recent Clinical Laboratories Improvement Amendment (CLIA) certificate.

- **CLIA Approved/ Compliance** means that the provider is certified to provide specific, more complex testing, such as cytology, pathology, blood bank, clinical testing, etc.
- **CLIA Waived** means that a provider received a waiver from CLIA to perform low-level complexity testing. For the purposes of CSP reimbursement the only tests would be the FOBT kits and limited FIT kits.
- **No CSP Laboratory Services Provided**- Please choose this option if the facility or practice does not perform any CSP reimbursable laboratory services.

Pre-Op Testing Services Only Please check all pre-op testing services that will be provided to CSP clients.
- CBC can only be checked if the provider is CLIA Approved.

Other **Office Based Surgery**

- Please identify practices performing Office Based Procedures (OBS) and their accrediting organization. Non-article 28 practices that perform OBS are required by NYS Public Health Law to be accredited. Any surgical or other invasive procedure requiring general anesthesia, moderate sedation, or deep sedation performed in a private office setting requires accreditation. Practices must be accredited by one of the following three organizations: Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), or The Joint Commission.

Intake Site Only
- Please indicate if the provider site is an intake site only.

Anesthesia
- Please indicate if practice provides anesthesia.

Facility Fees
- Please indicate if site is reimbursed for facility fees. Site must be an article 28 that provides services the CSP reimbursed facility fees for (See Reimbursement Schedule).

Service Notes Please add any notes regarding the provision of services that may assist the CSP in understanding the set-up of this practice or facility.

Provider List List all provider names, medical license numbers, NPIs, and profession information for providers that will see CSP clients at non-Article 28 facilities excluding laboratories. The NYSDOH CSP only requires information on physicians, physicians' assistants, nurse practitioners, and nurse midwives. Provider license information is not required for Article 28 facilities.

Websites: Below is a list of websites that may assist contractor staff with completing their enrollment packets.

New York State Department of State
http://www.dos.ny.gov/

National Provider Identifier
https://npiregistry.cms.hhs.gov/

Food and Drug Administration – Mammography Database
http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMQSA/mqsa.cfm

New York State- Office Based Surgery
http://www.health.ny.gov/professionals/office-based_surgery/practices/

New York State- Office of the Professions
http://www.op.nysed.gov/opsearches.htm

Please make sure you have included the following documents with your completed application (if applicable): ☐
- W9 Tax Form or Assumed Name Certificate
- Mammography Certificate
- CLIA Certificate

NEW YORK STATE DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM
CREDENTIALING PACKET (COMPONENT B)

TYPE OF REQUEST:

- ☐ REQUEST NEW SITE CODE (complete entire packet)
- ☐ RE-ACTIVATE SITE CODE (complete entire packet)

OBTAINED NEW PROVIDER AGREEMENT THROUGH - SEPTEMBER 30, 2018: YES ☐ NO ☐ PENDING ☐

Make changes to site code: ____ (Please check appropriate box below).

- ☐ ADD ADDITIONAL PROVIDERS TO ACTIVE SITE CODE (complete page 1 and 4)
- ☐ ADD SERVICES PROVIDED TO ACTIVE SITE CODE (complete page 1 and 3)
- ☐ CHANGE ADDRESS OR CONTACT INFORMATION TO ACTIVE SITE CODE (complete page 1 and 2)
- ☐ INACTIVATE PROVIDER(S) (complete page 1 and 4)
- ☐ INACTIVATE SITE CODE (complete page 1 only- Indicate reason(s) why you are closing this code:
  - ☐ Provider does not see the priority population
  - ☐ Delay in receiving payment
  - ☐ Reduction in reimbursement rates
  - ☐ Not willing to sign provider agreement
  - ☐ Screening cap
  - ☐ Other ____

PRACTICE/FACILITY NAME: ____
DBA (IF APPILCABLE): ____
SFS PAYEE NAME: ____
PARTNERSHIP NAME: ____
SUBMITTED BY: ____
PHONE NO: ____
FAX NO: ____
E-MAIL ADDRESS: ____

DOH ADMINISTRATIVE USE ONLY

SITE CODE: ____
APPROVED ☐ DENIED ☐ PROVIDER AGREEMENT DUE DATE IF 'NO' OR' PENDING' ____
REASON DENIED: ____
DATE: ____ REVIEWED BY: ____

Please e-mail Enrollment Packet and required documents to:
cspcredentialing@health.ny.gov

ENROLLMENT PACKET MUST BE COMPLETED BY CSP CONTRACTOR STAFF
ALL FILEDS MUST BE COMPLETELY FILLED OUT AND REQURIED DOCUMENTS INCLUDED FOR PACKET TO BE PROCESSED
DETAILED INSTRUCTIONS FOR COMPLETNG CREDENTIALING PACKET ARE AVAILABLE
PLEASE ALLOW UP TO 2 WEEKS FOR NEW SITE CODE REQUESTS TO BE PROCESSED
***COMPONENT B CONTRACTORS MUST MAIL ORIGINAL PROVIDER AGREEMENT ***
***CSP, Attention Credentialing, Riverview Center, 150 Broadway, Room 350, Albany NY, 12204 ***

CREDENTIALING PACKET
Rev. Jan. 2017
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NEW YORK STATE DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM
CREDENTIALING PACKET (COMPONENT B)

CORRESPONDENCE ADDRESS (Primary Contact)
ATTENTION (FIRST AND LAST NAME): ____
STREET: ____
CITY: ____ STATE: ____ ZIP CODE: ____
COUNTY: ____
TELEPHONE (INCLUDING AREA CODE): ____ FAX: ____
E-MAIL: ____

PAY TO ADDRESS (Used by Contractor for contact on billing and payment issues and is used by HRI for payments and client summary documents)
☐ **Same as Correspondence Address**
ATTENTION (FIRST AND LAST NAME): ____
STREET: ____
CITY: ____ STATE: ____ ZIP CODE: ____
TELEPHONE (INCLUDING AREA CODE): ____ FAX: ____
E-MAIL: ____

SFS PAY TO ADDRESS (If contact/address in SFS is different than the above Pay to Contact)
☐ **Same as Pay to Address**
ATTENTION (FIRST AND LAST NAME): ____
STREET: ____
CITY: ____ STATE: ____ ZIP CODE: ____
TELEPHONE (INCLUDING AREA CODE): ____ FAX: ____
E-MAIL: ____

SERVICE SITE ADDRESS
☐ **Same as Correspondence Address**
ATTENTION (FIRST AND LAST NAME): ____
STREET: ____
CITY: ____ STATE: ____ ZIP CODE: ____
COUNTY: ____
TELEPHONE (INCLUDING AREA CODE): ____ FAX: ____
EMAIL: ____

ADDITIONAL SERVICE SITE ADDRESSES
If services are provided at multiple locations please complete an enrollment packet for each service site that sees CSP clients.

CREDENTIALING PACKET
Rev. Jan. 2017
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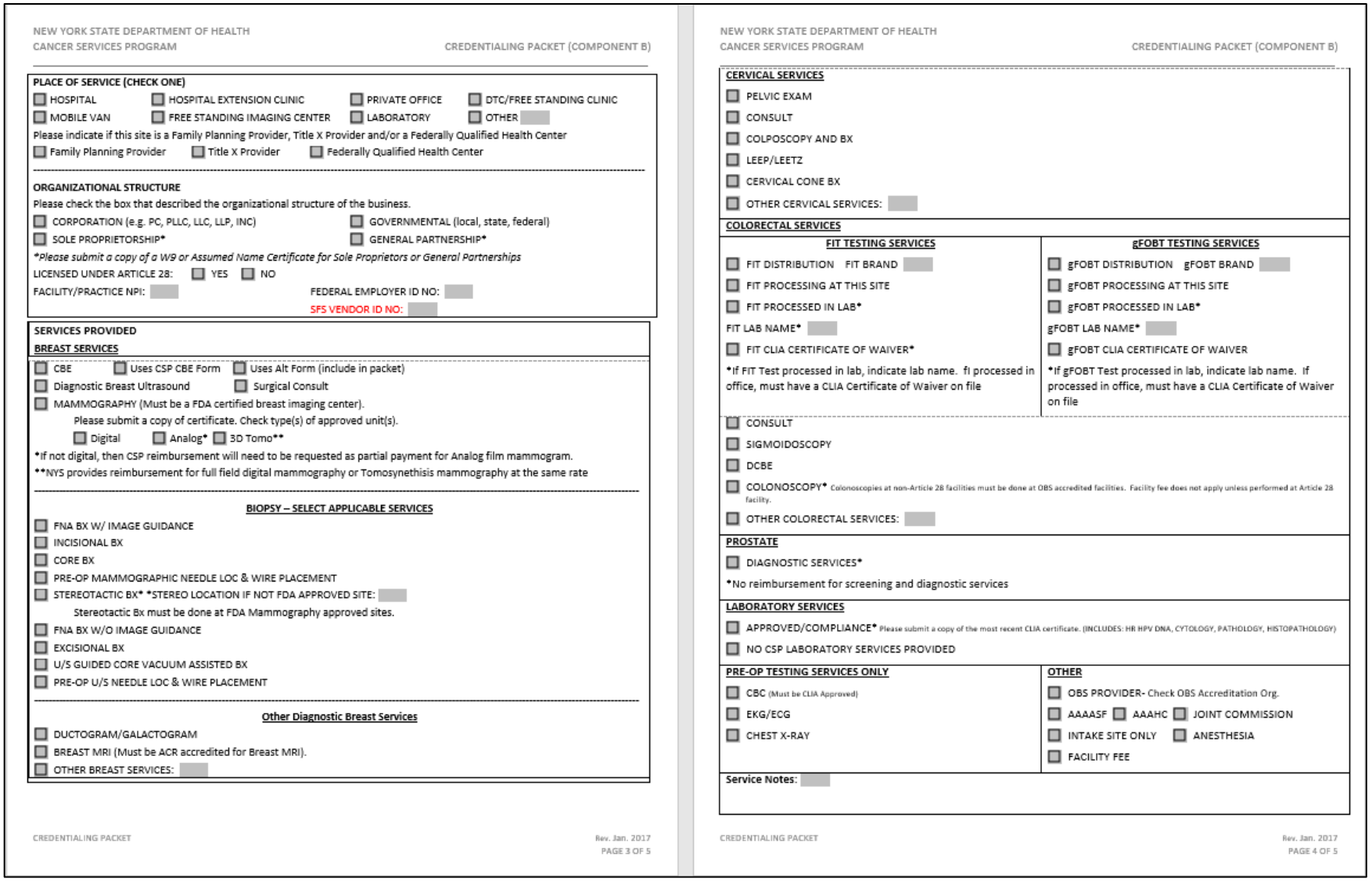

NEW YORK STATE DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM CREDENTIALING PACKET (COMPONENT B)

PLACE OF SERVICE (CHECK ONE)

☐ HOSPITAL ☐ HOSPITAL EXTENSION CLINIC ☐ PRIVATE OFFICE ☐ DTC/FREE STANDING CLINIC
☐ MOBILE VAN ☐ FREE STANDING IMAGING CENTER ☐ LABORATORY ☐ OTHER

Please indicate if this site is a Family Planning Provider, Title X Provider and/or a Federally Qualified Health Center
☐ Family Planning Provider ☐ Title X Provider ☐ Federally Qualified Health Center

ORGANIZATIONAL STRUCTURE

Please check the box that described the organizational structure of the business.
☐ CORPORATION (e.g. PC, PLLC, LLC, LLP, INC) ☐ GOVERNMENTAL (local, state, federal)
☐ SOLE PROPRIETORSHIP* ☐ GENERAL PARTNERSHIP*
**Please submit a copy of a W9 or Assumed Name Certificate for Sole Proprietors or General Partnerships*
LICENSED UNDER ARTICLE 28: ☐ YES ☐ NO
FACILITY/PRACTICE NPI: FEDERAL EMPLOYER ID NO:
SFS VENDOR ID NO:

SERVICES PROVIDED

BREAST SERVICES

☐ CBE ☐ Uses CSP CBE Form ☐ Uses Alt Form (include in packet)
☐ Diagnostic Breast Ultrasound ☐ Surgical Consult
☐ MAMMOGRAPHY (Must be a FDA certified breast imaging center).
Please submit a copy of certificate. Check type(s) of approved unit(s).
☐ Digital ☐ Analog* ☐ 3D Tomo**
*If not digital, then CSP reimbursement will need to be requested as partial payment for Analog film mammogram.
**NYS provides reimbursement for full field digital mammography or Tomosynethisis mammography at the same rate

BIOPSY – SELECT APPLICABLE SERVICES

☐ FNA BX W/ IMAGE GUIDANCE
☐ INCISIONAL BX
☐ CORE BX
☐ PRE-OP MAMMOGRAPHIC NEEDLE LOC & WIRE PLACEMENT
☐ STEREOTACTIC BX* *STEREO LOCATION IF NOT FDA APPROVED SITE:
Stereotactic Bx must be done at FDA Mammography approved sites.
☐ FNA BX W/O IMAGE GUIDANCE
☐ EXCISIONAL BX
☐ U/S GUIDED CORE VACUUM ASSISTED BX
☐ PRE-OP U/S NEEDLE LOC & WIRE PLACEMENT

Other Diagnostic Breast Services

☐ DUCTOGRAM/GALACTOGRAM
☐ BREAST MRI (Must be ACR accredited for Breast MRI).
☐ OTHER BREAST SERVICES:

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PAGE 3 OF 5

NEW YORK STATE DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM CREDENTIALING PACKET (COMPONENT B)

CERVICAL SERVICES

☐ PELVIC EXAM
☐ CONSULT
☐ COLPOSCOPY AND BX
☐ LEEP/LEETZ
☐ CERVICAL CONE BX
☐ OTHER CERVICAL SERVICES:

COLORECTAL SERVICES

FIT TESTING SERVICES	gFOBT TESTING SERVICES
☐ FIT DISTRIBUTION FIT BRAND	☐ gFOBT DISTRIBUTION gFOBT BRAND
☐ FIT PROCESSING AT THIS SITE	☐ gFOBT PROCESSING AT THIS SITE
☐ FIT PROCESSED IN LAB*	☐ gFOBT PROCESSED IN LAB*
FIT LAB NAME*	gFOBT LAB NAME*
☐ FIT CLIA CERTIFICATE OF WAIVER*	☐ gFOBT CLIA CERTIFICATE OF WAIVER
*If FIT Test processed in lab, indicate lab name. fI processed in office, must have a CLIA Certificate of Waiver on file	*If gFOBT Test processed in lab, indicate lab name. If processed in office, must have a CLIA Certificate of Waiver on file

☐ CONSULT
☐ SIGMOIDOSCOPY
☐ DCBE
☐ COLONOSCOPY* Colonoscopies at non-Article 28 facilities must be done at OBS accredited facilities. Facility fee does not apply unless performed at Article 28 facility.
☐ OTHER COLORECTAL SERVICES:

PROSTATE

☐ DIAGNOSTIC SERVICES*
*No reimbursement for screening and diagnostic services

LABORATORY SERVICES

☐ APPROVED/COMPLIANCE* Please submit a copy of the most recent CLIA certificate. (INCLUDES: HR HPV DNA, CYTOLOGY, PATHOLOGY, HISTOPATHOLOGY)
☐ NO CSP LABORATORY SERVICES PROVIDED

PRE-OP TESTING SERVICES ONLY	OTHER
☐ CBC (Must be CLIA Approved)	☐ OBS PROVIDER- Check OBS Accreditation Org.
☐ EKG/ECG	☐ AAAASF ☐ AAAHC ☐ JOINT COMMISSION
☐ CHEST X-RAY	☐ INTAKE SITE ONLY ☐ ANESTHESIA
	☐ FACILITY FEE

Service Notes:

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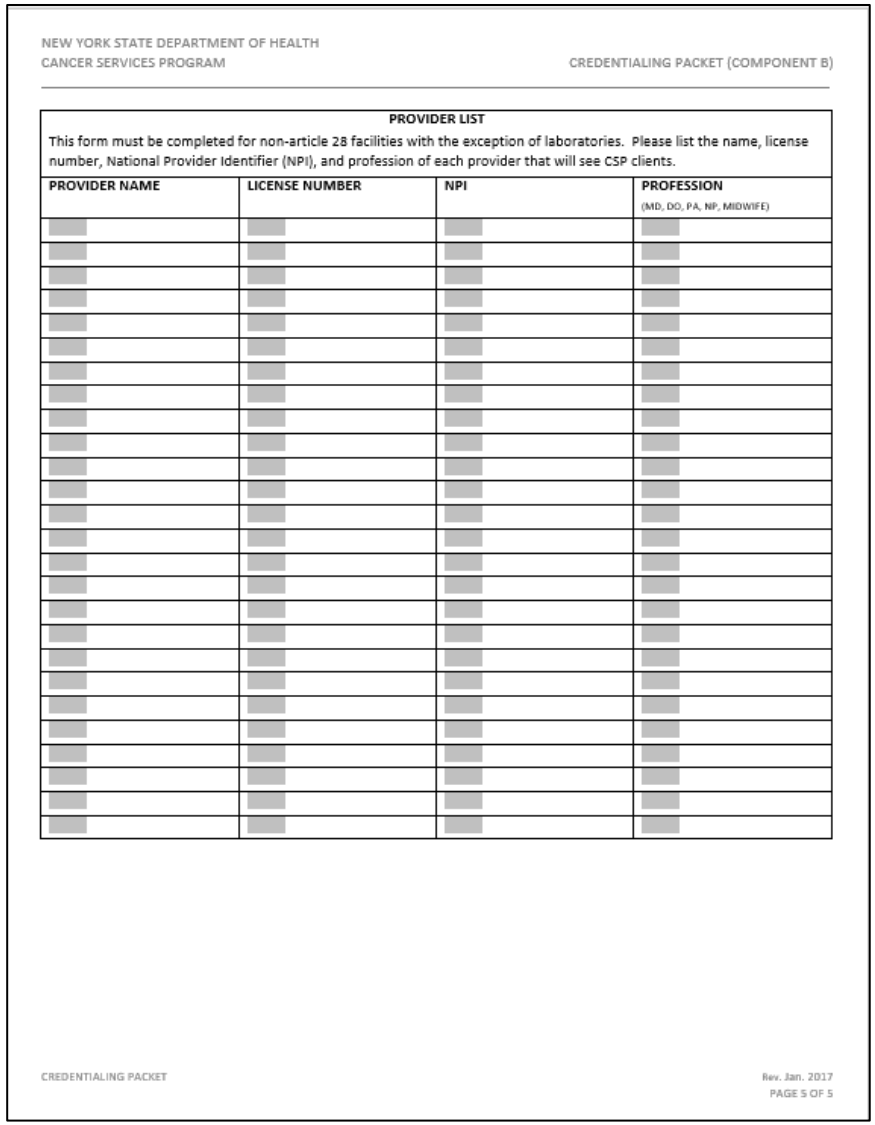

NEW YORK STATE DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM

CREDENTIALING PACKET (COMPONENT B)

PROVIDER LIST

This form must be completed for non-article 28 facilities with the exception of laboratories. Please list the name, license number, National Provider Identifier (NPI), and profession of each provider that will see CSP clients.

PROVIDER NAME	LICENSE NUMBER	NPI	PROFESSION (MD, DO, PA, NP, MIDWIFE)

CREDENTIALING PACKET

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Attachment 2-III – Inventory Report

Annual Office Technology and Equipment Inventory

Per contract requirements, contractors are required to maintain inventory of all equipment purchases made with grant funds. Equipment is defined as items such as computers, printers, phones, apparatus or fixed asset (other land or a building) that are tangible personal property having a useful life of more than one year and a purchase price equal or exceeding $5,000. This also includes a grouping of like items which equals or exceeds $5,000.

Equipment items purchased by the contracting agency using State Health Department funds are to be listed in the inventory with identifying information such as tag number (number assigned by contracting agency), serial (manufacturer's serial number), location, and any relevant remarks.

Disposition of the inventoried property will be made in accordance with applicable provisions of the law at the end of the contract.

ANNUAL OFFICE TECHNOLOGY AND EQUIPMENT INVENTORY

Contractor Name: _____

Contract Number: _____

Contract Period: MM/DD/YYYY - MM/DD/YYYY

Item Description	Tag #	Serial #	Location

Date: _____ Signature: _____

Inventory 2017

Attachment 2-IV – Incentive Tracking Form

Incentive Tracking Form

Contract Period: _____ CSP of _____

	Vendor	Card #	Amount	Given to (Client ID#)	Authorizing Program Staff (print name)	Authorizing Program Staff signature
1			$			
2			$			
3			$			
4			$			
5			$			
6			$			
7			$			
8			$			
9			$			
10			$			
11			$			
12			$			
13			$			
14			$			
15			$			
16			$			
17			$			
18			$			
19			$			
20			$			

Use this form to track each incentive distributed to CSP clients (e.g. $5 store card for returning FIT, $10 gas card to assist with transportation barrier). Regional Managers will require use of this tool to ensure accountability for program incentives.

Incentive 2017

Attachment 2-V – CSP Contact Update Form

CSP Contact Update Form

This information is required with contract renewal and **immediately upon any changes to staff, administration, or contact information for either group.**
Email completed form to CanServ@health.ny.gov

Completed by: , Coordinator County(ies) (list all):		Date:
Contracting Agency Administrative & Board of Director Contacts *NOTE: all contract communications are sent electronically; accurate and up-to-date information will reduce delays in processing contracts.*		**Eff Date** (if new/update)
Contract Signatory (person authorized to sign contract)	Name: Title: Address: City: State: NY ZIP: Phone#: Ext: Email:	
Board Chair: (if applicable)	Name: Title: Address: City: State: NY ZIP: Phone#: Ext: Email:	
Primary Administrative Contact: (has administrative responsibility for program; may also fill Coordinator role)	Name: Title: Address: City: State: NY ZIP: Phone#: Ext: Email:	
Primary Program Contact: (works directly with the program, may also fill Coordinator role)	Name: Title: Address: City: State: NY ZIP: Phone#: Ext: Email:	
Primary Fiscal Contact: (works with and/or holds responsibility for budgetary issues; may also fill Fiscal Manager role)	Name: Title: Address: City: State: NY ZIP: Phone#: Ext: Email:	
SFS Vendor Name:		
SFS Vendor ID#:		
State Contract # (infrastructure)		**State Contract #** (clinical services)

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CSP Staff/Contact Update Form

Use this form to notify CSP and Regional Manager of all new/departing staff or changes in function or contact information.
Email completed form to CanServ@health.ny.gov.
If staff member is no longer with CSP, provide information for interim staff.

Public Contact Ph #	This number is the contact number the toll-free referral line provides to callers for information about the program and screening services and will be listed on the NYSDOH website.

CSP of (County/ies) Completed by: , Coordinator Date:

Staff Member/Contact Information	**Function(s) Performed**	
*Check **all** that apply in each section. **For updates, include only new/updated information or staff member.***		
☐ New Staff ☐ New Contact Info ☐ New/added function ☐ No longer with CSP (indicate interim staff & contact information if new) Name: Address: City: State: NY ZIP: *Phone#: Ext: *Fax#: *Enter digits only, will format as (###) ###-#### when you click out of the field* Email: Started w/CSP: Left CSP:	☐ Coordinator ☐ Case Manager ☐ Data Manager ☐ Designated Qualified Entity (DQE) SELECT ONE ☐ Fiscal Manager ☐ Intake/Eligibility ☐ Public Education & Targeted Outreach (PETO) ☐ Other (specify)	**Required for Component B (optional for Comp A)** ☐ Clinical Care Coordinator ☐ Patient Navigator **Data System access:** ***Select all that apply*** ☐ Database module SELECT ONE ☐ Planning/Eval module ☐ None
☐ New Staff ☐ New Contact Info ☐ New/added function ☐ No longer with CSP (indicate interim staff & contact information if new) Name: Address: City: State: NY ZIP: *Phone#: Ext: *Fax#: *Enter digits only, will format as (###) ###-#### when you click out of the field* Email: Started w/CSP: Left CSP:	☐ Coordinator ☐ Case Manager ☐ Data Manager ☐ Designated Qualified Entity (DQE) SELECT ONE ☐ Fiscal Manager ☐ Intake/Eligibility ☐ Public Education & Targeted Outreach (PETO) ☐ Other (specify)	**Required for Component B (optional for Comp A)** ☐ Clinical Care Coordinator ☐ Patient Navigator **Data System access:** ***Select all that apply*** ☐ Database module SELECT ONE ☐ Planning/Eval module ☐ None
☐ New Staff ☐ New Contact Info ☐ New/added function ☐ No longer with CSP (indicate interim staff & contact information if new) Name: Address: City: State: NY ZIP: *Phone#: Ext: *Fax#: *Enter digits only, will format as (###) ###-#### when you click out of the field* Email: Started w/CSP: Left CSP:	☐ Coordinator ☐ Case Manager ☐ Data Manager ☐ Designated Qualified Entity (DQE) SELECT ONE ☐ Fiscal Manager ☐ Intake/Eligibility ☐ Public Education & Targeted Outreach (PETO) ☐ Other (specify)	**Required for Component B (optional for Comp A)** ☐ Clinical Care Coordinator ☐ Patient Navigator **Data System access:** ***Select all that apply*** ☐ Database module SELECT ONE ☐ Planning/Eval module ☐ None

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Attachment 2-VI – Required Provider Agreement for Contractors and Providers with Direct Reimbursement (Component B)

New York State Department of Health Cancer Services Program
PROVIDER AGREEMENT with STATE CSP CONTRACTOR

I/We agree to participate as a provider in the Cancer Services Program of _____ (name of CSP) and agree to provide cancer screening and/or diagnostic services as outlined in the New York State Department of Health Cancer Services Program (CSP) Operations manual to CSP-eligible clients and will abide by the provisions as defined in the attached Participating Provider Requirements. This agreement shall be in effect for the period of ___/___/___.

Additionally, as a participating provider of the CSP:

- I agree to treat all information regarding patients and the business of the other partners in the strictest confidence and, consequently, to abide by all local, state, and federal laws and regulations, as well as the policies of other partners regarding such confidentiality.
- I acknowledge receipt of, and agreement with, the CSP Operations Manual, the CSP Reimbursement Schedule, and Participating Provider Requirements, which are integral to this agreement and are hereby incorporated into, and made part of, this Agreement.

_____
Print Name of Provider/Facility

_____
Print Name/Title of CSP Contractor

_____
Provider/Facility Address

_____/_____
Provider Authorized Signature/Date

_____/_____
CSP Contractor Authorized Signature/Date

_____/_____
NYS Authorized Signature/Date

Attachment 2-VII – Sample NYSDOH CSP Provider Agreement (Component A)

Attachment 2-VII Sample NYSDOH CSP Provider Agreement (Component A)

New York State Department of Health Cancer Services Program
PROVIDER AGREEMENT with STATE CSP CONTRACTOR

I/We agree to participate as a provider in the Cancer Services Program of _____ (name of CSP) and agree to provide cancer screening and/or diagnostic services as outlined in the New York State Department of Health Cancer Services Program (CSP) Operations manual to CSP-eligible clients and will abide by the provisions as defined in the Participating Provider Requirements. This agreement shall be in effect for the period of ___/___/___.

Additionally, as a participating provider of the CSP:

- I agree to treat all information regarding patients and the business of the other partners in the strictest confidence and, consequently, to abide by all local, state, and federal laws and regulations, as well as the policies of other partners regarding such confidentiality.
- I acknowledge receipt of, and agreement with, the CSP Operations Manual, the CSP Reimbursement Schedule, and Participating Provider Requirements, which are integral to this agreement and are hereby incorporated into, and made part of, this Agreement.

_____ _____
Print Name of Provider/Facility Print Name/Title of CSP Contractor

_____
Provider/Facility Address

_____/_____ _____/_____
Provider Authorized Signature/Date CSP Contractor Authorized Signature/Date

Attachment 2-VIII Contractor Confidentiality Policy and Pledge to Maintain Confidentiality

New York State Department of Health
Cancer Services Program
Confidentiality Policy for Integrated Breast, Cervical and Colorectal Cancer Screening Program Contractors

The New York State Department of Health's Cancer Services Program (CSP) contractors and subcontractors have access to personal and health-related information only as necessary to fulfill direct responsibilities associated with the CSP. Contractor and subcontractor staff are to disclose this information only in the appropriate context of their direct responsibilities as CSP contractors or subcontractors, and only to appropriate health care providers, contractor staff or New York State Department of Health CSP staff, and are not to further disclose copies of medical information to other parties, including but not limited to the patients, family or other representatives. Contractor and subcontractor staff are also responsible for ensuring that such information is secure from theft, accidental loss, or exposure. Failure to maintain confidentiality by any contractor or subcontractor will result in inactivation of the staff member's CSP data system account, if applicable, and may lead to contract termination pursuant to the Standard Terms and Conditions of the Master Contract.

CSP contractors and subcontractors receive and process confidential personal and health-related information in the course of recruiting clients, collecting medical records from providers, completing data collection forms, entering data on the CSP data system, conducting case management and completing Medicaid Cancer Treatment Program applications for CSP clients. Confidentiality must be maintained for all the information collected and processed through these activities.

The following practices with respect to confidentiality must be observed:

1. All material which contains personal and health-related information should be kept in secure areas and/or locked file cabinets.
2. No material which contains personal or health-related information should be left on desk tops or in other locations where confidentiality could be compromised inadvertently. Personal and health-related information should be properly secured from casual observation or loss, and returned to secure storage during and after working hours.
3. Copying of materials containing personal or health-related information should be minimized; when possible, circulate one copy rather than making numerous copies. Avoid sending confidential materials to individuals who do not need to see them.
4. Personal and health-related information stored electronically should be accessible only by authorized personnel.
5. Documents containing personal or health-related information that are drafts, obsolete or no longer needed should be promptly disposed of in a manner that protects the confidentiality of the information. Regular trash disposal is unacceptable; these documents should not be recycled. These materials should be placed in the appropriate boxes for shredding or should be shredded in the office.
6. CSP contractor or subcontractor staff IDs and passwords for the CSP data system should not be shared with ANYONE (even colleagues within the same contractor). The confidentiality practices and protection described above apply to all personal and health-related information viewed or obtained on the CSP data system.

Confidentiality Agreement

All Integrated Breast, Cervical and Colorectal Cancer Screening Program contractor and subcontractor staff must complete, sign and date the following confidentiality agreement. Confidentiality agreements should be submitted electronically to the New York State Department of Health at canserv@health.ny.gov. All contractor and subcontractor staff requesting access to the CSP data system must have a signed confidentiality agreement on file prior to receiving access to the data system. See the CSP Operations Manual for full instructions on how to submit the confidentiality agreement and obtain data system access.

I, _____ (please print your name) understand that the nature of my work as a contractor or subcontractor with the New York State Department of Health Cancer Services Program (CSP) provides me with access to confidential information collected by the program including information obtained from CSP clients, family members, medical providers, hospitals, insurance companies and other confidential sources.

I hereby agree to guard the confidentiality of all information entrusted to me in the performance of my duties as a CSP contractor or subcontractor. I will not verbally or otherwise divulge the names of CSP clients or any information regarding CSP clients unless the sharing of information is directly related to the performance of my duties as a CSP contractor or subcontractor. I will never leave data unattended except in designated secure areas or in locked files.

I understand that a breach of confidentiality is a serious act of misconduct. I understand that a breach of confidentiality at any time, whether or not I continue as a contractor or subcontractor with the CSP, will result in loss of access to the CSP data system, if applicable, and may lead to contract termination pursuant to the Standard Terms and Conditions of the Master Contract.

_____ _____
Signature Date

_____ _____
Witness Signature Date

Attachment 2-IX – NYSDOH CSP 2016-2017 PY Performance Measure Definitions

Performance Measure Definitions: 2016-2017 Program Year
NYSDOH Cancer Services Program

Performance Measure (PM) Description	Goal
PM #1: Percent of Screening Mammogram Clients Age 50 and Older This measure is based on the proportion of women who received a program-funded screening mammogram during the most recent 12-month period (denominator) and were age 50 and older (numerator). **Numerator** = Number of women who were age 50 and older at the time of their program-funded screening mammogram provided during the most recent 12-month period --- **Denominator** = Number of women who received a program-funded screening mammogram during the most recent 12-month period • **Purpose** = This indicator is intended to represent a contractor's ability to reach the priority age group when mammography is most effective **Notes/Definitions:** • Age is calculated using Birth Date (from Participant Information section on SIF) and Mammogram Date (Q34 on SIF). • Female is indicated by a response of "Female" (2) for Gender (from Participant Information section on SIF). • Program-funded is indicated by a response of "Program" (1) or "Partial" (3) for Mammogram Funds (Q37 on SIF) for all types of mammograms included under Type of Mammogram (Q38 on SIF). • Mammogram Date (Q34 on SIF) is used to determine if the service occurred during the 12-month period.	>=75%
PM #2: Percent of Initial Program-Funded Pap Tests for Women Rarely or Never Screened for Cervical Cancer This measure is based on the proportion of women who had their first program-funded Pap test during the most recent 12-month period (denominator) and were considered rarely or never screened for cervical cancer (numerator). **Numerator** = Number of women who had their first program-funded Pap test during the most recent 12-month period and were considered rarely or never screened for cervical cancer --- **Denominator** = Number of women who had their first program-funded Pap test during the most recent 12-month period. • **Purpose** = This indicator measures the effectiveness of the contractor's outreach strategies to reach this underserved population. **Notes/Definitions** • Rarely or never screened refers to a woman who has never had a Pap test or her previous Pap test was more than 5 years ago.	>=20%

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• First program-funded Pap test is determined by the absence of a previous SIF with a program-funded Pap test for this client. • Female is indicated by a response of "Female" (2) for Gender (from Participant Information section on SIF). • Never Screened is indicated by a response of "No" (2) for Previous Pap Test (Q20 on SIF). • Rarely Screened is indicated by a response of "Yes" (1) for Previous Pap Test (Q20 on SIF) **AND** a date more than 5 years ago from the Date of Pelvic with Pap Test (Q43 on SIF). • "Unknown" (3) responses for Previous Pap Test (Q20 on SIF) are included in the denominator, but not counted in the numerator. • Program-funded is indicated by a response of "Program" (1) or "Partial" (3) for Pap Funds (Q48 on SIF). • Women with hysterectomies indicated by a response of "Not indicated – hysterectomy with cervix removed" (5) for Referral for Cervical Screening (Q42a on SIF) are removed from the calculation. • Date of Pelvic with Pap Test (Q43 on SIF) is used to determine if the service occurred during the 12-month period.	
PM #3: Percent of Women Rescreened by Mammogram within 24 Months This measure is based on the proportion of women age 50 to 63 who received a program-funded mammogram with normal results during a 12-month period (denominator) and were rescreened by a mammogram within 24 months (numerator). **Numerator** = Number of women age 50 to 63 who received a program-funded screening mammogram with normal results during a 12-month period and were rescreened within 24 months --- **Denominator** = Number of women age 50 to 63 who received a program-funded screening mammogram with normal results during a 12-month period • **Purpose** = This indicator measures the contractor's ability to promote mammography rescreening. **Notes/Definitions** • Age is calculated using Birth Date (from Participant Information section on SIF) and Mammogram Date (Q34 on SIF). • Female is indicated by a response of "Female" (2) for Gender (from Participant Information section on SIF). • Program-funded is indicated by a response of "Program" (1) or "Partial" (3) for mammogram funds (Q37 on SIF) for all types of mammograms included under Type of Mammogram (Q38 on SIF). • Normal results on a mammogram are indicated by responses of "BIRADS 1 - Negative" (1) or "BIRADS 2 - Benign Finding" (2) for Mammogram Results (Q39 on SIF). • Women with an abnormal finding on a CBE, indicated by a response of "Mass or other findings - immediate testing - submit follow-up form" (3) for Breast Findings (Q33b on SIF) are removed from the calculation. • Mammogram Date (Q34 on SIF) is used to determine if the service occurred during the 12-month period. • The 12-month period used for this indicator ends 24 months prior to the current data submission. • Women with a participant status set to: deceased, moved out of county, moved out of state or country, no longer eligible for program, or rescreened outside of partnership are removed from the calculation.	**>=60%**

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PM #4: Percent of Clients Who Are Male This measure is based on the proportion of clients age 50 and older who received at least one program-funded cancer screening during the most recent 12-month period (denominator) and were men (numerator). **Numerator** = Number of clients age 50 and older who received at least one program-funded screening during the most recent 12-month period and were men --- **Denominator** = Number of clients age 50 and older who received at least one program-funded screening during the most recent 12-month period • **Purpose** = This indicator measures the effectiveness of the contractor's outreach strategies to reach men. **Notes/Definitions:** • Male is indicated by a response of "Male" (1) for Gender (from Participant Information section on SIF). • Age is calculated using Birth Date (from Participant Information section on SIF) and the date of the earliest breast (CBE or mammogram), cervical or colorectal cancer screening, as indicated by the CBE Date (Q29 on SIF), Mammogram Date (Q34 on SIF), Date of Pelvic with Pap Test (Q43 on SIF), Date Kit Developed (Q69 on SIF) or Date of Last Procedure (Q14 on Colorectal FF) when "Work-up Complete" (1) for Status of Diagnostic Work-up (Q13 on Colorectal FF) AND the client is at increased or high risk for colorectal cancer indicated by a response to Q26 or Q27a or HHC average risk colonoscopy (Q72) on SIF. • Program-funded is indicated by a response of "Program" (1) or "Partial" (3) for CBE Funds (Q32 on SIF), Mammogram Funds (Q37 on SIF), Pelvic Funds (Q47 on SIF), Pap Funds (Q48 on SIF), Kit Funds (Q68 on SIF) or Diagnostic Work-Up Funds (Q12 on Colorectal FF for procedure codes 32-39 or 80) when "Work-Up Complete" (1) for Status of Diagnostic Work-Up (Q13 on Colorectal FF) AND the client is at increased or high risk for colorectal cancer as indicated by the response to Q26 or Q27a on the SIF or HHC average risk colonoscopy (Q72 on SIF). • CBE Date (Q29 on SIF), Mammogram Date (Q34 on SIF), Date of Pelvic with Pap Test (Q43 on SIF), Date Kit Developed (Q69 on SIF) and Date of Last Procedure (Q14 on Colorectal FF) when "Work-up Complete" (1) for Status of Diagnostic Work-up (Q13 on Colorectal FF) AND the client is at increased or high risk for colorectal cancer as indicated by the response to Q26 or Q27a on the SIF or HHC average risk colonoscopy (Q72 on SIF) are used to determine if the service occurred during the 12-month period.	**>=20%**
PM #5: Percent of Clients Rescreened by Fecal Test within 10-14 Months This measure is based on the proportion of clients who completed a program-funded fecal test with negative results during a 12-month period (denominator) and were rescreened by a fecal test within 10 to 14 months of the baseline fecal test development date (numerator). **Numerator** = Number of clients who completed a program-funded fecal test with negative results during a 12-month period and were rescreened by a fecal test within 10 to 14 months of the baseline fecal test development date --- **Denominator** = Number of clients who completed a program-funded fecal test with negative results during a 12-month period	**>=60%**

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• **Purpose** = This indicator measures the contractor's ability to promote annual fecal test screening. **Notes/Definitions:** • A fecal test with negative results is indicated by a response of "Negative" (2) for Kit Results (Q70 on SIF). • Program-funded is indicated by a response of "Program" (1) or "Partial" (3) for Kit Funds (Q68 on SIF). • Date Kit Developed (Q69 on SIF) is used to determine if the service occurred during the 12-month period. • The 12-month period used for this indicator ends 14 months prior to the current data submission. • Clients with a participant status set to: deceased, moved out of county, moved out of state or country, no longer eligible for program, or rescreened outside of partnership are removed from the calculation.	
PM #6: Percent of Clients Age 50 to 64 This measure is based on the proportion of clients who received at least one program-funded breast, cervical or colorectal cancer screening in the program during the most recent 12-month period (denominator) and were age 50 to 64 (numerator). **Numerator** = Number of clients who received at least one program-funded breast, cervical or colorectal cancer screening during the most recent 12-month period and were age 50 to 64 --- **Denominator** = Number of clients who received at least one program-funded breast, cervical or colorectal cancer screening during the most recent 12-month period • **Purpose** = This indicator measures the effectiveness of the contractor's outreach strategies to reach this priority population. **Notes/Definitions:** • Age is calculated using Birth Date (from Participant Information section on SIF) and the date of the earliest breast (CBE or mammogram), cervical or colorectal cancer screening, as indicated by the CBE Date (Q29 on SIF), Mammogram Date (Q34 on SIF), Date of Pelvic with Pap Test (Q43 on SIF), Date Kit Developed (Q69 on SIF) or Date of Last Procedure (Q14 on Colorectal FF) when "Work-up Complete" (1) for Status of Diagnostic Work-up (Q13 on Colorectal FF) AND the client is at increased or high risk for colorectal cancer as indicated by the response to Q26 or Q27a on the SIF or HHC average risk colonoscopy (Q72 on SIF). • Program-funded is indicated by a response of "Program" (1) or "Partial" (3) for CBE Funds (Q32 on SIF), Mammogram Funds (Q37 on SIF), Pelvic Funds (Q47 on SIF), Pap Funds (Q48 on SIF), Kit Funds (Q68 on SIF) or Diagnostic Work-Up Funds (Q12 on Colorectal FF for procedure codes 32-39 or 80) when "Work-Up Complete" (1) for Status of Diagnostic Work-Up (Q13 on Colorectal FF) AND the client is at increased or high risk for colorectal cancer as indicated by the response to Q26 or Q27a on the SIF or HHC average risk colonoscopy (Q72 on SIF). • CBE Date (Q29 on SIF), Mammogram Date (Q34 on SIF), Date of Pelvic with Pap Test (Q43 on SIF), Date Kit Developed (Q69 on SIF) and Date of Last Procedure (Q14 on Colorectal FF) when "Work-up Complete" (1) for Status of Diagnostic Work-up (Q13 on Colorectal FF) AND the client is at increased or high risk for colorectal cancer as indicated by a response to Q26 or Q27a on the SIF or HHC average risk colonoscopy (Q72 on SIF) are used to determine if the service occurred during the 12-month period.	>=75%

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PM #7: Percent of Women Age 50 and Older with Comprehensive Cancer Screening This measure is based on the proportion of women age 50 and older who received at least one program-funded breast, cervical or colorectal cancer screening during a 6-month period (denominator) and received comprehensive cancer screening (numerator) **Numerator** = Number of women age 50 and older with at least one program-funded breast, cervical or colorectal cancer screening during a 6-month period who received comprehensive cancer screening --- **Denominator** = Number of women age 50 and older with at least one program-funded breast, cervical or colorectal cancer screening during a 6-month period • **Purpose** = This indicator assesses contractor systems for providing comprehensive cancer screening for eligible clients. **Notes/Definitions:** • Age is calculated using Birth Date (from Participant Information section on SIF) and the date of the earliest breast, cervical or colorectal cancer screening, as indicated by the Mammogram Date (Q34 on SIF), Date of Pelvic with Pap Test (Q43 on SIF), Date Kit Developed (Q69 on SIF) or Date of Last Procedure (Q14 on Colorectal FF) when "Work-up Complete" (1) for Status of Diagnostic Work-up (Q13 on Colorectal FF) AND the client is at increased or high risk for colorectal cancer as indicated by the response to Q26 or Q27a on the SIF or HHC average risk colonoscopy (Q72 on SIF). • Female is indicated by a response of "Female" (2) for Gender (from Participant Information section on SIF). • Program-funded is indicated by a response of "Program" (1) or "Partial" (3) for Mammogram Funds (Q37 on SIF), Pelvic Funds (Q47 on SIF), Pap Funds (Q48 on SIF), Kit Funds (Q68 on SIF) or Diagnostic Work-Up Funds (Q12 on Colorectal FF for procedure codes 32-39 or 80) when "Work-Up Complete" (1) for Status of Diagnostic Work-Up (Q13 on Colorectal FF) AND the client is at increased or high risk for colorectal cancer as indicated by the response to Q26 or Q27a on the SIF or HHC average risk colonoscopy (Q72 on SIF). • A client with at least one screening service provided within the 6-month period is indicated by the Mammogram Date (Q34 on SIF), Date of Pelvic with Pap Test (Q43 on SIF), Date Kit Developed (Q69 on SIF) or Date of Last Procedure (Q14 on Colorectal FF) when "Work-up Complete" (1) for Status of Diagnostic Work-up (Q13 on Colorectal FF) AND the client is at increased or high risk for colorectal cancer as indicated by the response to Q26 or Q27a on the SIF or HHC average risk colonoscopy (Q72 on SIF). • All cancer screenings (i.e., breast, cervical and colorectal) **DUE** for the 6-month period will be determined for each female age 50 and older included in the denominator using responses from the Cancer Screening History section of the SIF: Previous Mammogram (Q19a), Previous Pap Test (Q20), Previous guaiac Fecal Occult Blood Test (gFOBT) (Q21), Previous Fecal Immunochemical Test (FIT) (Q22), Previous Sigmoidoscopy, DCBE or other CRC screening (Q23) and Previous Colonoscopy (Q24) **AND** the dates of last screenings from previous SIFs and FFs. • Clients who receive all cancer screenings for which they are due in the 6-month period will be considered comprehensively screened. A "window" of three months will be provided around the due date for the cancer screening. This window may extend beyond the 6-month period. • A comprehensive breast cancer screening includes a mammogram (CBE not required).	**>=50%**

• A comprehensive colorectal cancer screening includes either a fecal test (average risk) or a completed screening colonoscopy (increased or high risk or HHC average risk colonoscopy). • The 6-month period used for this indicator ends 3 months prior to the current data submission.	
PM #9: Percent of Eligible Population Screened in Each County • This measure is based on the proportion of the eligible population in each county (denominator) screened with at least one program-funded breast, cervical or colorectal cancer screening during the current program year (numerator). **Numerator** = Number of men and women age 40 to 64 who were screened in each county with at least one program-funded breast, cervical or colorectal cancer screening during the current program year --- **Denominator** = The estimated number of uninsured men and women age 40 to 64 who are at or below 250% of the income-to-poverty ratio in each county • **Purpose** = This indicator measures the effectiveness of the contractor's outreach strategies to reach the priority population. **Notes/Definitions:** • Age is calculated using Birth Date (from Participant Information section on SIF) and the date of the earliest breast (CBE or mammogram), cervical or colorectal cancer screening, as indicated by the Clinical Breast Exam Date (Q29 on SIF), Mammogram Date (Q34 on SIF), Date of Pelvic with Pap Test (Q43 on SIF), Date Kit Developed (Q69 on SIF) or Date of Last Procedure (Q14 on Colorectal FF) when "Work-up Complete" (1) for Status of Diagnostic Work-up (Q13 on Colorectal FF) AND the client is at increased or high risk for colorectal cancer indicated by a response to Q26 or Q27a on the SIF or HHC average risk colonoscopy (Q72) on the SIF. • Program-funded is indicated by a response of "Program" (1) or "Partial" (3) for CBE Funds (Q32 on SIF), Mammogram Funds (Q37 on SIF), Pelvic Funds (Q47 on SIF), Pap Funds (Q48 on SIF), Kit Funds (Q68 on SIF) or Diagnostic Work-Up Funds (Q12 on Colorectal FF for procedure codes 32-39 or 80) when "Work-Up Complete" (1) for Status of Diagnostic Work-Up (Q13 on Colorectal FF) AND the client is at increased or high risk for colorectal cancer indicated by a response to Q26 or Q27a on the SIF or HHC average risk colonoscopy (Q72) on the SIF. • Clinical Breast Exam Date (Q29 on SIF), Mammogram Date (Q34 on SIF), Date of Pelvic with Pap Test (Q43 on SIF), Date Kit Developed (Q69 on SIF) and Date of Last Procedure (Q14 on Colorectal FF) when "Work-up Complete" (1) for Status of Diagnostic Work-up (Q13 on Colorectal FF) AND the client is at increased or high risk for colorectal cancer indicated by a response to Q26 or Q27a on the SIF or HHC average risk colonoscopy (Q72) on the SIF are used to determine if the service occurred during the 12-month period. • County is indicated by the response to County (from Contact Information section on SIF) and a client is counted in the numerator when the county of residence matches the contractor's county. • For contractors that cover multiple counties, this measure will be provided for each county separately.	**>=20%**

• Estimates for the eligible population in the denominator are from the Small Area Health Insurance Estimates (SAHIE) 2014 Health Insurance Status (Uninsured Only) in New York for Age (40 to 64) and Income (at or below 250% of income-to-poverty ratio) by County, sponsored by the U.S. Census Bureau and the Centers for Disease Control and Prevention (http://www.census.gov/did/www/sahie/data/index.html). The estimates combine survey data from the American Community Survey (ACS) with administrative records and Census 2010 data.	
PM #10: Percent of Abnormal Cervical Screenings with Timely Follow-up This measure is based on the proportion of program-funded cervical screenings with abnormal results provided during a 12-month period (denominator) with completed follow-up care within 90 days (numerator). **Numerator** = Number of program-funded cervical screenings provided during a 12-month period with abnormal results with completed diagnostic follow-up within 90 days --- **Denominator** = Number of program-funded cervical screenings provided during a 12-month period with abnormal results • **Purpose** = This indicator is intended to represent a contractor's ability to provide timely follow-up care for women with abnormal cervical screenings. **Notes/Definitions:** • An abnormal cervical screening is indicated by any of the following: 1) A response of "Suspicious for cervical cancer" (1) for Pelvic Exam Findings (Q49 on SIF) 2) A response of "Low grade SIL" (4), "High grade SIL" (5), "Squamous cell cancer" (6), "A.S.C.-H." (8) or "A.G.C. – all subcategories" (12) for Pap Test Results (Q51 on SIF) 3) A response of "A.S.C.-U.S." (3) or "Other" (7) for Pap Test Results (Q51 on SIF) **AND** a date indicated for Immediate Cervical Screening Follow Up (Q55 on SIF) • Program-funded is indicated by a response of "Program" (1) or "Partial" (3) for Pelvic Funds (Q47 on SIF) or Pap Funds (Q48 on SIF). • The number of days from abnormal screening to follow-up is calculated for clients with Status of Diagnostic Work-up (Q13 on the Cervical FF) of "Work-up Complete" (1) using the Date of Pelvic with Pap Test (Q43 on SIF) and the Date of Last Procedure or Last Contact if Refused or Lost to Follow Up (Q14 on Cervical FF). • Clients who are lost to follow-up or have refused work up as indicated by responses of "Lost to Follow-up" (2) or "Work-up Refused" (3) for Status of Diagnostic Work Up (Q13 on Cervical FF) respectively are included in the denominator. • Clients with a response of "Deceased" or "Irreconcilable" for Status of Diagnostic Work Up (Q13 on Cervical FF) are removed from the calculation. • Date of Pelvic with Pap Test (Q43 on SIF) is used to determine if the service occurred during the 12-month period. • The 12-month period used for this indicator ends 6 months prior to the current data submission.	>=75%

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PM #11: Percent of Abnormal Breast Screenings with Timely Follow-up This measure is based on the proportion of program-funded breast screenings with abnormal results provided during a 12-month period (denominator) with completed follow-up care within 60 days (numerator). **Numerator** = Number of program-funded breast screenings provided during a 12-month period with abnormal results with completed diagnostic follow-up within 60 days --- **Denominator** = Number of program-funded breast screenings provided during a 12-month period with abnormal results • **Purpose** = This indicator is intended to represent a contractor's ability to provide timely follow-up care for women with abnormal breast screenings. **Notes/Definitions:** • An abnormal breast screening is indicated by a response of "Mass or other findings-immediate testing-submit follow-up form" (3) for Breast Findings (Q33b on SIF) **OR** a response of "BIRADS 4 - Suspicious abnormality, biopsy should be considered" (4), "BIRADS 5 - Highly suggestive of malignancy" (5), "BIRADS 0 – Need additional imaging" (6) or "BIRADS 0 – Need prior mammogram for comparison" (7) for Mammogram Results (Q39 on SIF) **OR** a response of "BIRADS 4 – Suspicious, biopsy recommended" (4), "BIRADS 5 – Highly suggestive of malignancy" (5) or "BIRADS 0 – Incomplete, need additional imaging" (6) for Breast MRI Results (Q39e on SIF). • Program-funded is indicated by a response of "Program" (1) or "Partial" (3) for CBE Funds (Q32 on SIF), Mammogram Funds (Q37 on SIF) or Breast MRI Funds (Q39d on SIF). • The number of days from abnormal screening to follow-up is calculated for clients with Status of Diagnostic Work-up (Q13 on the Breast FF) of "Work-up Complete" (1) using the date of the earliest abnormal breast screening from the CBE Date (Q29 on SIF), Mammogram Date (Q34 on SIF) or Breast MRI Date (Q39a on SIF) and Date of Last Procedure or Last Contact if Refused or Lost to Follow-up (Q14 on Breast FF) • Clients who are lost to follow-up or have refused work up indicated by responses of "Lost to Follow-up" (2) or "Work-up Refused" (3) for Status of Diagnostic Work Up (Q13 on Breast FF) respectively are included in the denominator. • Clients with a response of "Deceased" or "Irreconcilable" for Status of Diagnostic Work Up (Q13 on Breast FF) are removed from the calculation. • The earliest abnormal CBE Date (Q29 on SIF), Mammogram Date (Q34 on SIF) or Breast MRI Date (Q39a on SIF) is used to determine if the service occurred during the 12-month period. • The 12-month period used for this indicator ends 6 months prior to the current data submission.	**>=75%**
PM #12: Percent of Abnormal Colorectal Screenings with Timely Follow-up This measure is based on the proportion of clients with program-funded positive fecal tests developed during a 12-month period (denominator) who had a completed colonoscopy (unless medically contraindicated) within 90 days (numerator).	**>=75%**

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Numerator = Number of clients with program-funded fecal tests provided during a 12-month period with positive results that completed a colonoscopy (unless medically contraindicated) within 90 days --- **Denominator** = Number of clients with program-funded fecal tests provided during a 12-month period with positive results • **Purpose** = This indicator is intended to represent a contractor's ability to provide timely follow-up care for clients with positive fecal tests. **Notes/Definitions:** • An abnormal colorectal screening is indicated by a response of "Positive" (1) for Kit Results (Q70 on SIF). • Program-funded is indicated by a response of "Program" (1) or "Partial" (3) for Kit Funds (Q68 on SIF). • The number of days from abnormal screening to follow-up is calculated for clients with Status of Diagnostic Work-up (Q13 on the Colorectal FF) of "Work-up Complete" (1) using the Date Kit Developed (Q69 on SIF) and Date of Last Procedure, or Last Contact if Refused or Lost to Follow-up (Q14 on Colorectal FF). • Clients who are lost to follow-up or have refused work up indicated by responses of "Lost to Follow-up" (2) or "Work-up Refused" (3) for Status of Diagnostic Work Up (Q13 on Colorectal FF) respectively are included in the denominator. • Clients with a response of "Deceased" or "Irreconcilable" for Status of Diagnostic Work Up (Q13 on Colorectal FF) are removed from the calculation. • Q69 (Date Kit Developed) on the SIF is used to determine if the service occurred during the 12-month period. • If a colonoscopy is medically contraindicated, then a sigmoidoscopy and/or double contrast barium enema must be completed. • The 12-month period used for this indicator ends 6 months prior to the current data submission.	
PM #13: Percent of Eligible Clients Enrolled in the Medicaid Cancer Treatment Program (MCTP) This measure is based on the proportion of clients eligible for the Medicaid Cancer Treatment Program (MCTP) (denominator) who were enrolled in the MCTP (numerator). **Numerator** = Number of eligible clients enrolled in the MCTP during a 12-month period --- **Denominator** = Number of clients eligible for the MCTP during a 12-month period • **Purpose** = This indicator is intended to represent a contractor's ability to enroll eligible clients in the MCTP in order to ensure they receive full Medicaid coverage for the duration of their treatment. **Notes/Definitions:** • Clients eligible for the MCTP are defined as those with:	**>=90%**

1. Responses of "Not insured" (2) for Insurance Status (in Insurance section of SIF), or responses of "Medicaid Monthly Spend Down" (2) or "Title X Family Planning/FPBP" (6) for Insurance Coverage (in Insurance section of SIF) **AND**; 2. Diagnosed during the 12-month period based on the Date of Last Procedure (Q14 on FF) **AND**; 3. The Final Diagnoses (Q15 on FF) is any of the following: • Lobular Carcinoma in Situ • Other Carcinoma in Situ, including Ductal • Invasive Breast Cancer • Colorectal Cancer • CIN I, Mild Dysplasia AND treatment started as indicated by a response of "Treatment Started" (1) for Status of Treatment (Q18 on Cervical FF) • CIN II, Moderate Dysplasia • CIN III, Severe Dysplasia/Carcinoma in Situ • Invasive Cervical Cancer • The denominator will include clients enrolled in the MCTP and eligible clients for whom the contractor indicated that the application is pending, the client refused to complete an application, the client refused treatment, it was too late to apply or they were unable to locate the client. All other reasons provided by a contractor for not enrolling an eligible client will remove the client from the calculation. • Enrollment in the MCTP is indicated by an approved application. • The 12-month period used for this indicator ends 3 months prior to the current data submission.	
PM #14: Percent of Screening Intake Forms (SIFs) With Timely Submission This measure is based on the proportion of all SIFs submitted on the CSP data system data system during a 12-month period (denominator) that were submitted on time (numerator). **Numerator** = Number of all SIFs submitted on CSP data system data system during a 12-month period that were submitted on time --- **Denominator** = Number of all SIFs submitted on CSP data system data system during a 12-month period • **Purpose** = This indicator is intended to assess whether screening services are reported on a timely basis so that: timely case management services can be provided; clients eligible for the MCTP can receive coverage for treatment; positive screening results are followed up quickly and appropriately; quality clinical care is provided to our clients; rescreening can occur at the appropriate interval; and providers are reimbursed as soon as possible. **Notes/Definitions:** • Timely submission is defined as within 60 days from the date of an abnormal screening (***although 30 days is considered optimal***) and within 90 days from the date of a normal screening. • An abnormal cervical screening is indicated by any of the following: 1) A response of "Suspicious for cervical cancer" (1) for Pelvic Exam Findings (Q49 on SIF)	**>=85%**

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2) A response of "Low grade SIL" (4), "High grade SIL" (5), "Squamous cell cancer" (6), "A.S.C.-H." (8) or "A.G.C. – all subcategories" (12) for Pap Test Results (Q51 on SIF) 3) A response of "A.S.C.-U.S." (3) or "Other" (7) for Pap Test Results (Q51 on SIF) **AND** a date indicated for Immediate Cervical Cancer Screening Follow Up (Q55 on SIF) • An abnormal breast screening is indicated by a response of "Mass or other findings-immediate testing-submit follow-up form" (3) for Breast Findings (Q33 on SIF) **OR** a response of "BIRADS 4 - Suspicious abnormality, biopsy should be considered" (4), "BIRADS 5 - Highly suggestive of malignancy" (5), "BIRADS 0 – Need additional imaging" (6) or "BIRADS 0 – Need prior mammogram for comparison" (7) for Mammogram Results (Q39 on SIF) **OR** a response of "BIRADS 4 – Suspicious, biopsy recommended" (4), "BIRADS 5 – Highly suggestive of malignancy" (5) or "BIRADS 0 – Incomplete, need additional imaging" (6) for Breast MRI Results (Q39e on SIF). • An abnormal colorectal screening is indicated by a response of "Positive" (1) for Kit Results (Q70 on SIF). • The number of days from the date of screening to acceptance of the form on the CSP data system data system is calculated using the latest date of an abnormal screening result, indicated by the CBE Date (Q29 on SIF), Mammogram Date (Q34 on SIF), Breast MRI Date (Q39a on SIF), Date of Pelvic with Pap Test (Q43 on SIF) or Date Kit Developed (Q69 on SIF). • Date of acceptance of the form on the CSP data system data system is used to determine if included in the 12-month period.	
PM #15: Percent of Follow-Up Forms (FFs) With Timely Submission This measure is based on the proportion of all Follow Up Forms (FFs) submitted on the CSP data system data system during a 12-month period (denominator) that were submitted on time (numerator). **Numerator** = Number of all FFs resulting from an abnormal breast, cervical or colorectal cancer screening that had a complete work-up and were submitted on time on the CSP data system data system during a 12-month period --- **Denominator** = Number of all FFs resulting from an abnormal breast, cervical or colorectal cancer screening that had a complete work-up and were submitted on the CSP data system data system during a 12-month period • **Purpose** = This indicator is intended to assess whether diagnostic follow up services are reported on a timely basis so that: clients eligible for the MCTP can receive coverage for treatment; quality clinical care is provided to our clients; and providers are reimbursed as soon as possible. **Notes/Definitions:** • Timely submission is defined as within 90 days from the Date of Last Procedure (Q14 on FF) to the date when the form is accepted on the CSP data system data system. • A complete work-up is indicated by a response of "Work-up Complete" (1) for Status of Diagnostic Work-up (Q13 on FF). • Date of acceptance of the form on the CSP data system data system is used to determine if included in the 12-month period.	**>=85%**

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NOTES:
a) Program Funds refer to reimbursement with either state or federal funds.
b) SIF=Screening Intake Form
c) FF= Follow-Up Form

Chapter 3 – Eligibility

CSP Operations Manual 2017

Chapter 3: Eligibility

This section provides guidance for determining which screening and diagnostic services individuals are eligible to receive through the CSP. The section includes definitions to determine individual eligibility based on gender, age, income, health insurance status, and other clinical assessment, as well as an algorithm and script for use with clients at initial contact. Clients determined to be eligible for one or more CSP screening services are then enrolled in the program. Clients can be enrolled by CSP contractor staff or by provider staff, depending on where they access services.

A. Eligibility Assessment and Triage

Contractors should use the intake script and algorithm (Attachments 3-I and 3-II) when first speaking with potential clients. Use of these tools ensures that all clients receive the same information about CSP eligibility. Please note that these are scripts for use at initial client contact and are not meant for use to determine final client eligibility and subsequent enrollment in the CSP. Any staff conducting initial client intake should refer clients to those people in the program who have the ultimate responsibility for determining client eligibility. Upon intake, staff should inform and educate clients who are uninsured about the fact that they might be eligible for comprehensive, low cost health insurance through the New York State of Health (NYSoH). See Attachment 3-III – NYSoH and the CSP – Contractor Guidance for additional information. See also Attachment 3-IV (Underinsured FAQ Guidance).

B. Eligibility Criteria

The following section describes eligibility for screening and diagnostic services in the CSP. CSP contractor staff should be familiar with eligibility and communicate eligibility guidance and intake processes to all providers and partners engaging in client intake, eligibility assessment, program enrollment, and provision of clinical services to CSP clients. The CSP will only provide reimbursement for services provided to eligible CSP clients. (Please see CSP Operations Manual, Chapter 6: Reimbursement for a description of all screening and diagnostic services that are reimbursed by the CSP.) Staff responsible for enrolling clients will review eligibility criteria with all clients prior to obtaining client consent. The consent form includes an attestation by the client that he or she meets CSP eligibility guidelines for income and insurance status (see CSP Operations Manual, Chapter 4: Cancer Screening Guidance, Attachment 4-I). Staff responsible for enrolling clients must review eligibility, acquire the attestation from the client, and maintain documentation of the client consent. While eligibility should be assessed at each service, a new consent form should be obtained with each new screening cycle, at least annually.

Eligibility Criteria

Eligibility Categories ⇒	Residency	Gender		Age			Income (See C-4 for income definitions)		Health Insurance			Other		
Screening and Prevention Services ⇓	**New York State Resident**	**Female**	**Male**	**18-39***	**40-49**	**50-64****	**<250 % FPG**	**>250% FPG (See C.5 for expanded income eligibility**	**Uninsured**	**Underinsured (See C.7 for definitions)**	**Insured**	**Post Hysterectomy**	**No FOBT or FIT kit in 10**	**Not Undergoing Treatment**
Clinical Breast Exam	√	√	See C.2	See C.3	√	√	√	See C.7	√	√	Not Eligible	N/A	N/A	√
Pap Test & Pelvic Exam	√	√	Not Eligible	Not Eligible	√	√	√	See C.7	√	√	Not Eligible	√	N/A	√
Screening Mammogram	√	√	Not Eligible	See C.3	√	√	√	See C.7	√	√	Not Eligible	N/A	N/A	√
FOBT/FIT Kit	√	√	√	Not Eligible	Not Eligible	√	√	See C.7	√	√	Not Eligible	N/A	√	√
Colonoscopy Screening/Diagnostic	√	**ALL CLIENTS MUST MEET Prior Approval SEE SECTION C.9**									Not Eligible	N/A	N/A	√
Medical Consultation for Symptoms of CRC only	√	See C.10	See C.10	Not Eligible	Not Eligible	√	See C.10	See C.10	See C.9	See C.9	Not Eligible	N/A	N/A	N/A

* Persons under age 40 are generally not eligible for the CSP

** Age >64 are not eligible unless uninsured or underinsured for screening service. Cancer Services Program sets the upper limit for cervical cancer screening at 65 (unless history warrants to continue past 65) and at age 75 for breast and colorectal cancer screening, in accordance with USPSTF guidelines.

√= Eligible for program reimbursement N/A = Not Applicable

C. Eligibility Criteria Definitions

Residency

Women and men whose permanent or principal home is in New York State are eligible for the program. A person who is visiting New York is not considered a New York resident. There is no length of residency requirement.

Male Clinical Breast Examination (CBE) Criteria

Men who are at higher risk for breast cancer based on a personal or family history of breast cancer, or men who are currently experiencing symptoms of breast cancer and who also meet all other eligibility criteria, may be enrolled in the CSP for associated diagnostic testing. A licensed health care provider should provide documentation that attests to the need for diagnostic services for breast cancer evaluation.

Breast Cancer Screening/Diagnostics for Women Ages 18-39

Women ages 18-39 who are found to be at high risk for or who have clinically significant findings for breast cancer may be eligible for CSP services. These findings must be assessed by a NYS-licensed health care provider and documented on the *CSP Provider Attestation of Client Eligibility for Women less than 40 Years of Age form* (CSP Operations Manual, Chapter 4 (Attachment 4-IX). Women who are ages 18-39 who present with self-reported symptoms are not eligible for clinical breast exams (CBEs) through the CSP; they must first be assessed by a NYS-licensed health care provider as described above. Please refer to CSP Operations Manual, Chapter 4 for more information.

Income

Persons living at or below 250% of the current Federal Poverty Guidelines (FPG) meet the income criteria for CSP enrollment (see Table 1). Base calculations on self-reported, gross household income from all non-public sources. Child support and sources of public support (i.e. food stamps and housing subsidy) should not be included.

The CSP client consent form (see CSP Operations Manual, Chapter 4: Cancer Screening Guidance, Attachment 4-I: *Informed Consent/Release of Medical Information/Provision of Case Management*) includes an attestation of income eligibility by the client. Staff responsible for enrolling clients must confirm the attestation by signing and dating the form. The form must be maintained in appropriate program files.

Household income is the sum of income received in the previous calendar year by all household members, including household members not related to the client, people living alone, and others in non-family households.

Table 1: 2017 Federal Poverty Guidelines			
Size of Family Unit	**Poverty Guideline**	**250 % of Guideline**	**Total Monthly Household Income**
1	$12,060	$30,150	$2,513
2	$16,240	$40,600	$3,383
3	$20,420	$51,050	$4,254
4	$24,600	$61,500	$5,125
5	$28,780	$71,950	$5,996
6	$32,960	$82,400	$6,867
7	$37,140	$92,850	$7,738
8	$41,320	$103,300	$8,511
For families with more than 8 persons, add the following amount for each additional person		$4,180	

Source: Department of Health and Human Services 2017 Federal Poverty Guidelines

For more information on poverty guidelines, access the U.S. Department of Health and Human Services website at aspe.hhs.gov/poverty/

Expanded Income Eligibility

A client living above 250% of the FPG who meets all other eligibility criteria may be enrolled in the CSP if s/he meets the criteria for uninsured or underinsured outlined below.

Uninsured Criteria

A client is "uninsured" if s/he has no health insurance of *any type.*

Underinsured Criteria

A client is underinsured if s/he has:

- health insurance that does not cover clinically appropriate cancer screening or diagnostic services
- health insurance with an annual deductible, monthly spend down, or copayment high enough to prevent him/her from obtaining cancer screening services

Staff responsible for enrolling clients will review eligibility with all clients prior to obtaining client consent. The consent form includes an attestation by the client that s/he meets CSP eligibility guidelines for income and insurance status as noted above. The client's insurance will be billed first and the CSP will reimburse for services based on the CSP maximum allowable reimbursement rates after the insurance has either denied the claim or made partial payment. Both client and CSP provider must be aware that there is no CSP reimbursement if the insurance payment is equal to, or greater than, the CSP maximum allowed reimbursement.

Clients with high deductibles must be enrolled in the CSP before receiving services, and only after the client has identified the deductible as a barrier to obtaining screening services. Data submission for services does not occur until after information is obtained from billing insurance. It is not appropriate to enroll clients after the service has occurred as a means to pay a bill.

Clients who meet these eligibility criteria must attest that they are "underinsured" on the CSP client consent form (See CSP Operations Manual Attachment 4-I: *Consent for Cancer Services Program Participation).* Staff responsible for enrolling clients must confirm the attestation by signing and dating the form, and all insurance billing information, all of which must be maintained in appropriate program files. For detailed information regarding the CSP Policy and Procedure for Requesting Reimbursement for Screening or Diagnostic Services for Underinsured Clients see Attachment 6-VII

Contractors should focus client recruitment activities on the uninsured populations in their communities.

Post Hysterectomy

Clients who have had a hysterectomy (surgical removal of a woman's uterus) must meet one of the following criteria to be eligible for a Pap test and pelvic exam:

- Must have had a "supracervical or partial hysterectomy" and, therefore, have an intact cervix

- NOTE: the presence of a cervix can be determined by physical exam if the client is not sure whether they have a cervix and medical records to assess the presence of a cervix are unavailable. Clients are eligible for an initial pelvic exam for this determination.

Colonoscopy, screening or diagnostic

Uninsured and underinsured clients of any age who are found to be at increased or high risk for colorectal cancer (CRC) may be eligible for colonoscopy through the CSP after undergoing prior approval for colonoscopy. Refer to CSP Operations Manual Chapter 4 Section E for additional information. Contact staff at the NYSDOH Health Systems Improvement Unit at (518) 474-1222 for questions about age eligibility for those at increased or high risk. Clients ages 50-64 who are symptomatic for colorectal cancer may be eligible for a diagnostic colonoscopy. For more information, see section C-10 below.

Please note that clients who are at increased risk, high risk, or who have clinically significant findings and symptoms of CRC should NOT receive a fecal test (FOBT or FIT kit).

Medical Consultation

Clients ages 50-64 who present with one or more of the signs and symptoms of CRC listed below may be eligible for the CSP. These signs and symptoms must be assessed by a NYS licensed health care provider to aid in the determination of CSP eligibility. A client may be referred directly for medical consultation for this evaluation.

Signs and symptoms of CRC:

- definite, palpable, right-sided abdominal mass
- definite, palpable rectal (not pelvic) mass
- prolonged rectal bleeding with change in bowel habit to more frequent defecation or looser stools
- persistent rectal bleeding without anal symptoms (soreness, discomfort, itching, lumps, prolapse, pain)
- nonspecific signs or symptoms strongly suggestive of colorectal cancer: melena (black, tarry stools), penciling of stools (thin stools difficult to pass) or iron deficiency anemia of undefined origin

Not undergoing treatment

To be eligible for screening services through the CSP, clients with a personal history of breast, cervical, or colorectal cancer or cervical dysplasia must complete treatment and have no evidence of residual or recurrent disease, must not currently be receiving

coverage through the NYS Medicaid Cancer Treatment Program (See CSP Operations Manual Chapter 7), and must be released to routine screening. Women receiving long-term hormone therapy (e.g.: Tamoxifen) are considered to have completed treatment for the purposes of this definition.

Attachment 3-I: Client Intake Script

Instructions for Use: This phone script is to be used to triage potentially eligible clients and will provide a consistent message to clients across all contractors. This is **not** the final eligibility determination and as such, contractors should train staff to refer clients to those people in your program who have the ultimate responsibility for determining client eligibility.

1) *Do you have any insurance (or have you or your spouse served in the military (and could be eligible for Veterans' Benefits?*

- **Yes** → go to Q 1a
- **No** → "*Have you applied for some type of public or commercial health insurance (including NYSOH)?"*
    - ♦ Yes, did not qualify →Go to Question 2
    - ♦ Yes, it is pending → *"In that case, we recommend you call the carrier/insurance company so you can get the names and phone numbers of providers in your area who accept that coverage. However, if you find out that you did not qualify, please call us back and we'll ask a few additional questions to determine eligibility for our program."* <Collect contact information for follow up>
    - ♦ No → *"You and your family may now be eligible for health insurance that covers more than just your cancer screening tests. The New York State of Health, New York's health benefit exchange, is a place where individuals and families can shop for insurance that provides a comprehensive set of benefits and coverage. Insurance plans included in NYSOH cover breast, cervical, and colorectal cancer screenings without a cost share. At NYSOH, you can also find out if you qualify for tax credits to help you pay for your health insurance plan."* <Give caller toll free number for NYSOH (1-855-355-5777) and web address (www.nystateofhealth.ny.gov) and contact information for the NYS Navigator or Certified Application Counselor. *"In case you're not eligible for public or commercial health insurance, I'd like to ask you a few additional questions to determine if you're eligible for our program."*, then proceed to question #2.

1a) *Does your plan cover cancer screenings?*

- **Yes** but caller indicates they cannot have screening because of co-pay, deductible, or spend-down amount → Go to Question 2
- **Yes** and caller does *not* indicate they cannot have screening because of co-pay, deductible or spend-down amount → "*I'm sorry but you don't meet the eligibility criteria for the Cancer Services Program. You should contact your insurance company (or nearest Office of Veterans' Affairs) so*

you can get the names and phone #s of providers in your area who accept your type of insurance."

- **No** → Go to Question 2

2) How old are you?

- Under age 40
  - ♦ seeking breast cancer screening → proceed to response **A** (below)
  - ♦ seeking cervical cancer screening → "*The CSP does not offer cervical cancer screening to those under age 40. Let me give you the names and phone #s of some providers in the community** who offer this service at low cost or on a sliding fee scale."*

  ** Use individual providers, FQHCs, or family planning clinics/Title X providers

  - ♦ seeking colorectal cancer screening → "*The CSP does not offer colorectal cancer screening to those at average risk under age 40 because there is no recommended screening age under 40."* If caller thinks they are high risk or symptomatic, → proceed to response **A** below.
- ages 40 – 49 → proceed to response **B** below
- ages 50 and older → proceed to response **C** below

RESPONSES:

A: The client meets insurance eligibility but is under age 40 and is seeking breast or colorectal cancer screening: *"You may be eligible for a cancer screening. I'm going to give your information to our program Coordinator who will (talk to you now* OR *call you back within 24 hrs. Her/his name is _____."*

B: The client meets insurance eligibility and is 40-49 years old: *"You may be eligible for breast and cervical cancer screening."* Proceed to refer for income eligibility and completion of INTAKE or, if INTAKE done by provider → *"Let me give you the names and phone #s of participating providers in your area who offer breast and cervical cancer screenings."*

C: The client meets insurance eligibility and is 50 or older: *"You may be eligible for breast, cervical and colorectal cancer screening."* Proceed to refer for income eligibility and completion of INTAKE or, if INTAKE done by provider → *"Let me give you the names and phone #s of providers in your area who offer breast, cervical and colorectal cancer screening."*

Attachment 3-II: Client Intake Algorithm

Instructions for use: Use this phone script to triage potentially eligible clients and provide a consistent message to clients across all contractors. This is **not** the final eligibility determination and, as such, contractors should train staff to refer clients to staff in your group who have ultimate responsibility for determining client eligibility.

Q1: Do you have any insurance (or have you or your spouse served in the military (and could be eligible for Veterans' Benefits?

YES → **Q1a: Does it cover cancer screenings?**

YES with ***no*** barriers → **Yes** and caller does not indicate they cannot have screening because of co-pay, deductible or spend-down amount→ *"I'm sorry but you don't meet the eligibility criteria for the Cancer Services Program. You should contact your insurance company (or nearest Office of Veterans' Affairs) so you can get the names and phone #s of providers in your area who accept your type of insurance."*

YES but ***with*** barriers → **Yes** but caller indicates they cannot have screening because of co-pay, deductible, or spend-down amount

NO → *"Have you applied for some type of public or commercial health insurance (e.g.: NYSOH)?"*

NO → *"You and your family may now be eligible for health insurance that covers more than just your cancer screening tests. The New York State of Health, New York's health benefit exchange, is a place where individuals and families can shop for insurance that provides a comprehensive set of benefits and coverage. Insurance plans included in NYSOH cover breast, cervical, and colorectal cancer screenings without a cost share. At NYSOH, you can also find out if you qualify for tax credits to help you pay for your health insurance plan." <Give caller toll free number for NYSOH (1-855-355-5777) and web address (www.nystateofhealth.ny.gov) and contact information for the NYS Navigator or Certified Application Counselor. Add "In case you're not eligible for public or commercial health insurance, I'd like to ask you a few additional questions to determine if you're eligible for our program.", then proceed to Q2*

YES → **Yes, it is pending** → *"In that case, we recommend you call the carrier/insurance company so you can get the names and phone numbers of providers in your area who accept that coverage. However, if you find out that you did not qualify, please call us back and we'll ask a few additional questions to determine eligibility for our program."* <Collect contact information for follow up>

OR → **Yes, but did not qualify:** Go to Q2

Q2: How old are you?

Under age 40 and:

seeking breast cancer screening→ proceed to **response A**

seeking cervical cancer screening→ *"The CSP does not offer cervical cancer screening to those under age 40. Let me give you the names and phone #s of some providers in the community* who offer this service at low cost or on a sliding fee scale."*

* Use individual providers, FQHCs, or family planning clinics/Title X providers

seeking colorectal cancer→ *"The CSP does not offer colorectal cancer screening to those at average risk under age 40 because there is no recommended screening age under 40."* If caller thinks they are high risk, → proceed to **response A**

RESPONSES

A: The client meets insurance eligibility but is under age 40 and is seeking breast or colorectal cancer screening: "*You may be eligible for a cancer screening. I'm going to give your information to our program Coordinator who will (talk to you now OR call you back within 24 hrs. Her/his name is _____."*

B: The client meets insurance eligibility and is 40-49 years old: "*You may be eligible for breast and cervical cancer screening." Proceed to refer for income eligibility and completion of INTAKE or, if INTAKE done by provider* **->** *"Let me give you the names and phone #s of participating providers in your area who offer breast and cervical cancer screenings."*

Attachment 3-III – NYSoH and the CSP – Contractor Guidance

New York State of Health (NYSOH) and the
New York State Department of Health Cancer Services Program (CSP)
Guidance for Contractors

On October 1, 2013, New York's health benefit exchange — the New York State of Health — opened for enrollment. The New York State of Health (NYSOH) is the online resource to enroll in health insurance plans, as required by the Patient Protection and Affordable Care Act (PPACA). The New York State of Health (NYSOH), New York's health benefit exchange, is a place where individuals and families can shop for affordable health insurance, which includes a full set of benefits. Individuals, families, sole proprietors and small employers can use the NYSOH to shop, compare, and enroll in comprehensive, low-cost health insurance through either Medicaid, Child Health Plus or Qualified Health Plans (QHPs).

The NYSOH is open for enrollment during certain months each year, typically from November through January 31, however, the NYSOH remains open all year to enroll eligible individuals into Medicaid, Child Health Plus, the Essential Plan and to enroll individuals that have had qualifying life events into a QHP. A few key points to remember about enrollment eligibility in the NYSOH are:

- An individual can apply for **Medicaid and the Essential Plan** through the NYSOH at any time and does not need to wait for an open enrollment period.
- New York's Medicaid program has expanded to provide health care coverage to childless adults with incomes at or below 138% of the federal poverty level and changed budgeting rules and enrollment processes for Medicaid and Child Health Plus (CHP) to conform to the provisions set forth in the PPACA.
- The Essential Plan is a health plan offering the same essential benefits, for lower-income people who don't qualify for Medicaid or CHP.
- Pregnant women and infants under one year of age are eligible for full Medicaid coverage up to 233% of the federal poverty level.
- Outside of the open enrollment periods, residents must experience a "qualifying life event" in order to enroll into a QHP. There is a special enrollment period of 60 days following these life events. Examples of qualifying life events are moving to a new state, certain changes in income, and changes in family size (for example, marriage, divorce, or having a baby). Information and new resources regarding qualifying life events can now be found on the NYSOH website, info.nystateofhealth.ny.gov/SpecialEnrollmentPeriods.

The Role of CSP Contractors

1. *Enroll Eligible Clients into the CSP*

Eligibility requirements for the CSP have not changed. The CSP can continue to enroll and provide cancer screening services to eligible clients (See Attachment 3-I, Client Intake Script). Many of your current and potential clients will qualify and enroll in expanded Medicaid comprehensive coverage or the Essential Plan or may enroll in a QHP through the NYSOH (see items 2-4 below). However, there are, and will be, individuals who will not be eligible for coverage and not everyone who is eligible for NYSOH will enroll. CSP contractors should:

- Continue to plan outreach and recruitment activities to increase community demand for cancer screening and to reach the program priority population (uninsured men and women aged 50 – 64 years).
- Identify organizations with access to hard to reach, marginalized populations and develop strategic partnerships which result in reciprocal referrals.
- Work with existing providers to increase referrals and/or recruit providers who have access to priority populations to participate in the CSP.
- Continue to enroll eligible clients diagnosed with breast, cervical, colorectal, or prostate cancer, through trained designated qualified entities (DQEs), in the Medicaid Cancer Treatment Program.
- Assist clients aging into Medicare with the transition to ensure they maintain their screening schedules. Clients eligible for Medicare should begin their application process two months prior to their 65th birthday. Helpful resources include:
    - Medicare & You (current year): www.medicare.gov/Pubs/pdf/10050.pdf
    - Medicare website: www.medicare.gov

2. *Educate the Public and Former Clients about the NYSOH*

With the implementation of the NYSOH over the past several years, there continues to be a need for public education about the NYSOH and the coverage options available. CSP contractors can help meet this ongoing need by learning about the NYSOH and how to communicate about it. The following are general resources and/or guidance related to the NYSOH that will inform your education efforts and provide good resources for those you educate about the NYSOH.

- NYSOH web portal: www.nystateofhealth.ny.gov

- NYSOH Customer Service Call Center free help line: 1-855-355-5777. Hours of operation: 8 am to 8 pm (M-F) and 9 am- 1pm on Saturday.
- Former clients who are now insured through NYSOH may come to you with questions about utilizing their policy. You should:
    - Reassure your former clients that screening for breast, cervical and colorectal cancer is a covered benefit in all plans in NYSOH.
    - Encourage clients to use their new coverage for their preventive screenings as well as for sick care. Explain that they can use their health coverage when they are sick and when they are well. Getting recommended preventive services with their new health coverage is a key step to good health and well-being. Refer clients to the ***Using Your Insurance*** resource on the NYSOH website at info.nystateofhealth.ny.gov/UsingYourInsurance , which explains preventive care and acute (sick) care in further detail.
    - Encourage them to contact their new plan's Member Services department or an NYSOH In-Person Assistor (Navigator or Certified Application Counselor), to answer specific questions about their cost sharing responsibilities before they move forward with obtaining any screening or diagnostic services. If after they have determined their cost sharing responsibility they state they will not get the recommended diagnostic service due to the cost, they may be enrolled in the CSP. Please see the CSP Operations Manual, Chapter 3, for detailed instructions regarding the CSP client Insurance Denial Conversion process.

3. *Establish Relationships with NYSOH In-Person Assistance (IPA) Counselors (Navigators or Certified Application Counselors)*

- Connect with the NYSOH IPA counselors who help support enrollment into health insurance plans via the NYSOH in your area. Discuss and establish a formal referral process to facilitate client enrollment in either Medicaid or a QHP. Provide the NYSOH IPA counselors with your CSP Palm Card and /or program information that includes the CSP toll free number (1-866-442-2262) to encourage referrals back to the CSP for those who are ineligible for the NYSOH. This link brings you to the website where you can see a full list, by county, of the Navigator enrollment sites and contact information: info.nystateofhealth.ny.gov/IPANavigatorSiteLocations

- As a part of regular outreach and recruitment strategies, incorporate the NYSOH IPA counselors in joint outreach and recruitment activities to actively promote the NYSOH to communities and especially to low income, uninsured populations.
    - Visit the NYSOH resources section for promotional material: info.nystateofhealth.ny.gov/resources
    - Other useful resources include:
        - Online calendar of events where New Yorkers can see when a Navigator will be at an event in their community: info.nystateofhealth.ny.gov/events
        - You can order a free supply of NYSOH materials using the online order form found here: info.nystateofhealth.ny.gov/resource/materials-and-publications-order-form

4. *Develop and initiate procedures that encourage and facilitate enrollment into the NYSOH. Communicate and train providers about these procedures as applicable. Activities include:*

- Upon intake, inform and educate clients who are due for cancer screening(s) about the fact that they might be eligible for comprehensive, low cost health insurance through the NYSOH (See Attachment 3-I Client Intake Script). Provide resources and information about IPA counselors in their area and refer clients for enrollment in health insurance coverage. You do not have to wait for clients to demonstrate ineligibility for Medicaid or a subsidized health plan to enroll them in the CSP if they are otherwise eligible.
- Insurance status should be assessed before any clinical service is provided. Assessment should also occur at time of recall, and at the time of follow-up or for diagnostic services occurring within the same screening cycle. Assessment of insurance status may involve both intake and case management staff.
- Revise your existing client rescreening letter to include information about the NYSOH (see rescreening letter template below).

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CSP Rescreening Letter Template

Dear :

Your health is important to us. It is time to schedule your breast exam/mammogram/Pap test/FIT test. We are happy to help schedule that test for you.

We also want to be sure you know that you and your family may now be eligible for health insurance that covers more than your cancer screening tests. The New York State of Health (NYSOH), New York's health benefit exchange, is a place where individuals and families can shop for affordable health insurance, which includes a full set of benefits. All of the insurance plans included in the NYSOH cover breast, cervical and colorectal cancer screenings without charging you a copayment or coinsurance, even if you haven't met your yearly deductible. The NYSOH is also where you can find out if you qualify for tax credits to help pay for your health insurance plan.

We encourage you to contact the NYSOH at 1-855-355-5777 or www.nystateofhealth.ny.gov to learn about full insurance coverage for your health needs or to find a local Navigator who can assist you with selecting a plan that best suits your health care needs.

If you have any questions, or want to continue to receive your cancer screenings through the Cancer Services Program while you consider the New York State of Health, please call us at ### ### ####. We look forward to hearing from you.

Sincerely,

Attachment 3-IV – Underinsured FAQ Guidance

New York State Department of Health Cancer Services Program (CSP) Implementation and Eligibility since the Launch of the New York State of Health (NY State of Health) Frequently Asked Questions

This document is being provided to CSP contractors to answer commonly asked questions about program implementation and eligibility since the launch of the New York State of Health (NY State of Health) on October 1, 2013. Many current CSP clients now qualify for expanded Medicaid, a Qualified Health Plan or the Essential Plan through the NY State of Health, and have or will enroll in these plans. However, some individuals eligible for the CSP will not qualify for insurance through NY State of Health and not everyone who is eligible will enroll.

The eligible populations screened through the CSP, and for whom clinical services are reimbursed by the CSP, include women ages 40 and over and men ages 50 and over who are uninsured or underinsured*. See the CSP Operations Manual for a more detailed description of the eligible and priority populations.

*underinsured is defined as:

- Health insurance that does not cover clinically appropriate screening or diagnostic services or
- Health insurance with a "cost share" that may include an annual deductible, monthly spend down, or co-payment that is high enough to be a barrier and prevent him/her from obtaining screening services

Frequently Asked Questions

1. What is the role of contractor staff in working with individuals who need to enroll in insurance plans?

CSP contractor staff should:

- Inform all uninsured individuals that they may be eligible for full insurance coverage through the NY State of Health. If you would like to order a supply of NY State of Health promotional materials free of charge, you may do so here.
- Refer uninsured individuals to NY State of Health In-Person Assistors (IPAs)/Navigators, the NYSOH Customer Service Center at 1-855-355-5777, or to the website (www.nystateofhealth.ny.gov) or enrollment assistance.

NY State of Health has a large network of trained and certified in-person assistors (Navigators) who are available to assist individuals in every county of the state with the application process. They have access to up-to-date information and are the appropriate staff to answer questions about NY State of Health and provide enrollment assistance. A link to the IPA/Navigator Site Locations document can be found here. You can use this to locate the enrollment sites in your county and provide an individual with the local IPA/Navigator information.

2. What is the role of contractor staff between open enrollment periods?

Contractor staff should continue to educate clients about NY State of Health and refer them to an assistor, the website, or Customer Service Center for enrollment assistance. The open enrollment period for private health coverage through NY State of Health is typically between November 1 and January 31, however, *enrollment continues* for those applying for Medicaid, Child Health Plus**,** the Essential Plan and people who experience a "Qualifying Life Event", as well as small businesses with 50 or fewer employees.

People who are uninsured and experience a "Qualifying Life Event" may be eligible for a Special Enrollment period, which ends 60 days after the Qualifying Life Event occurs. Examples of qualifying life events include moving to a new state (or, in some cases, in-state), certain changes in income, involuntary loss of coverage and changes in family size (for example, marriage, divorce, or having a baby). You can access additional information about special enrollment periods here.

3. **What is the role/responsibility of the CSP contractor staff to someone previously enrolled in the CSP who is now insured?**

When clients on CSP rescreening lists indicate that they now have insurance, contractor staff should update their disposition on the data system to indicate “no longer eligible for program.” If contractor staff are on the phone with the person, staff should encourage the individual to continue to obtain cancer screening services through their new health plan. Contractor staff should encourage the individuals to carefully review their policies so that they understand what services are included in their coverage, what their cost share is, and which providers are in their plan’s network. Individuals can be encouraged to visit the NY State of Health website for answers to some frequently asked questions about using their coverage.

4. **Should CSP contractor staff verify whether or not an individual calling for cancer screening services has insurance?**

Contractor staff should ascertain whether or not an individual has insurance per the “Client Intake Script” in the CSP Operations Manual. Contractor staff are not responsible for verifying insurance status beyond this initial assessment.

5. **If someone isn’t sure if they have insurance through NY State of Health, how can CSP contractor staff assist them?**

While it is not the role of CSP contractor staff to verify insurance status, CSP contractor staff should encourage individuals who aren’t sure if they are successfully enrolled in coverage through NY State of Health to contact NY State of Health Customer Service Center (1-855-355-5777) or their insurance plan’s customer service phone number to confirm coverage. Contractor staff should wait to enroll the person until he or she confirms whether or not they have insurance.

6. **What should CSP contractor staff tell providers about accessing the CSP now that NY State of Health is operational?**

Contractor staff should inform providers that the CSP continues to provide reimbursement to eligible clients as outlined in the CSP Operations Manual. The required annual review of the CSP Operations Manual and establishment/renewal of provider agreements may be an ideal time to engage providers in this conversation.

7. **Is it the responsibility of CSP contractor staff to track and make follow up calls to clients referred to NY State of Health to determine if they have obtained insurance?**

No. It is not the responsibility of CSP contractor staff to make follow up calls to determine if someone has obtained insurance. CSP contractor staff should provide individuals with resources (palm cards, brochures, etc.) containing CSP contact information and encourage individuals to contact the CSP if they do not obtain insurance coverage.

8. **What if an individual has enrolled in a health insurance plan but the coverage has yet to take effect, can this person be enrolled for CSP screening services as an uninsured individual?**

No, the individual should not be enrolled in the CSP. If the individual is experiencing symptoms that may be indicative of risk for breast, cervical or colorectal cancer, contractor staff should

contact their New York State Department of Health Cancer Services Program Regional Managers (RM) to discuss possible enrollment on a case-by-case basis.

9. If a person states they cannot afford insurance because the plans are too costly, can they be enrolled in the CSP?

Yes, this person remains uninsured, and, assuming they meet all other eligibility requirements, may be enrolled in the CSP.

10. Does the CSP priority population now include clients with high deductibles, spend-downs or co-payments?

No. Individuals may be eligible for the CSP if they have insurance coverage that requires annual deductibles, monthly spend-downs, or co-payments (collectively referred to as cost share throughout the remainder of this document) that are high enough to pose a barrier and prevent them from obtaining cancer screening or diagnostic services. However, this is not the CSP priority population and outreach efforts should not be directed to recruiting and enrolling individuals with cost shares. CSP contractors should focus outreach and enrollment efforts to people who remain uninsured.

11. Can the CSP enroll individuals in need of diagnostic services if they have a cost share that is a barrier to their care?

Yes, insured individuals may be enrolled in the CSP if they specifically state that they will not obtain the recommended diagnostic services due to the cost. As per the CSP Operations Manual, a consent form must be signed and dated prior to obtaining any services through the CSP, including diagnostic services. The client's insurance will be billed first and the CSP will reimburse for services based on the Maximum Allowable Reimbursement Rates after the insurance has either denied the claim or made a partial payment. Both the client and the CSP provider must be aware that there may be no additional CSP reimbursement if the insurance payment is equal to the allowable insurance amount.

As always, CSP contractors should focus outreach and enrollment efforts to people who remain uninsured.

12. Is it appropriate to have insured individuals sign a consent form prior to obtaining screening services "just in case" they have a cost share for anticipated diagnostic services?

No, consent forms should not be routinely completed for insured individuals prior to screening services "just in case" there may be diagnostic services requiring a cost share. This applies to insured individuals whether or not they are former CSP clients. The CSP may enroll this person **only** if the individual contacts the CSP **prior** to receiving diagnostic services and specifically states that he/she will not obtain the recommended diagnostic services due to the cost. As per the CSP Operations Manual, a consent form must be signed and dated prior to obtaining any services through the CSP, including diagnostic services. It is not appropriate to enroll clients after the service has already occurred as a means to pay a bill.

13. Can the CSP reimburse for diagnostic services that have been completed if the individual realizes that he/she cannot afford to pay the bill?

No. The CSP is not able to provide retroactive reimbursement. As per the CSP Operations Manual, a consent form must be signed and dated prior to obtaining any services through the CSP. Unfortunately, there will be individuals who do not understand their health insurance and who will be unprepared to pay for deductibles and copays. These individuals can be

encouraged to contact the provider to negotiate a reduced rate or payment plan. Individuals can also be encouraged to carefully review their health insurance policies so that they understand covered benefits and cost sharing responsibilities.

14. Should screening and/or diagnostic services be entered onto the CSP Data System for an insured person who has a cost share prior to obtaining the Explanation of Benefits (EOB)?

No. Screening intake forms and follow-up forms should not be entered onto the data system until after the CSP contractor has received the EOB from the medical provider to determine the reason the medical claim was denied. Once the EOB is received, screening intake forms and/or follow-up forms should be submitted onto the data system and an Insurance Denial Conversion Form should be completed and submitted to the CSP fax (518-486-6860). See the Insurance Denial Conversion Policy and Instructions document posted in the "resources" section on the data system web site for further information.

15. What happens if someone loses insurance (i.e. job loss, divorce, failure to pay a premium)? Can the CSP enroll these individuals?

As always, the CSP may enroll clients who are uninsured or underinsured for cancer screening. As per the CSP Operations Manual, all clients must sign a consent form prior to receiving services. The consent form requires clients to attest to their eligibility for services based on insurance status (e.g. I do not have health insurance of any type, this includes Medicare, Medicaid, Family Health Plus, or other public or private insurance). Clients can also be referred to NY State of Health IPAs/Navigators, the Customer Service Center at 1-855-355-5777, and/or a certified application counselor to determine if they are eligible to enroll in coverage.

16. Who covers services if a person has enrolled in a health plan, has services during the grace period, but never makes a payment and has their insurance cancelled?

The CSP does not provide retroactive reimbursement for services. In this case, the person is responsible for payment of services rendered. Since no consent form would have been signed prior to services being provided, this person could not be reimbursed through the CSP as per the CSP Operations Manual. This applies to former CSP clients as well. CSP contractor staff can encourage individuals to contact the provider to negotiate a reduced fee or payment plan. Additional information about rules governing grace periods on individual policies (inside and outside the marketplace) issued by the Department of Financial Services can be found here.

17. Can the CSP reimburse for services if a provider does not accept an individual's new health insurance?

No. The CSP will not reimburse services for insured individuals who go out of network or because they prefer a CSP provider who does not participate with their insurance. CSP contractor staff should refer these individuals to their health plan customer service phone number to confirm that a particular provider accepts their insurance.

18. Can the CSP reimburse for services if someone gets billed for a service because they didn't know that the provider does not accept their insurance or did not understand that they have to meet a cost share for services?

No, the CSP cannot reimburse the service(s). See questions 13 and 17.

Chapter 4 – Cancer Screening Guidance

CSP Operations Manual 2017

Chapter 4: Cancer Screening Guidance

This chapter provides Cancer Services Program (CSP) contractors with clinical background information about the screening tests reimbursed* by the CSP. It also describes the use of the client informed consent document, a description of tests for each of the three cancers for which the CSP screens, and a review of screening intervals for each of these cancers as they relate to CSP data reporting on the CSP Screening Intake Form (SIF) and Follow-up Form (FF). The chapter includes important information about diagnostic evaluation of abnormal screening results and reporting. Additionally, this section addresses the definitions of "high risk" and "clinically significant findings" related to breast and colorectal cancer. This section reviews only those clinical services for which the CSP provides reimbursement.

*Please see Chapter 6 for information about reimbursement guidelines and the Maximum Allowable Reimbursement schedule for all services.

The CSP is a population-based, average-risk screening program, which bases its recommendations and reimbursement policies on evidence-based guidelines published by reputable organizations. Some of these organizations include the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality, the US Preventive Services Task Force (USPSTF), the National Comprehensive Cancer Network (NCCN), the National Cancer Institute (NCI), the American College of Obstetricians and Gynecologists (ACOG) and the American Society for Colposcopy and Cervical Pathology (ASCCP). When evidence-based guidelines are not available, the NYSDOH CSP relies on developing consensus through internal and external clinician review.

A. Client Consent for Participation in the CSP

Staff responsible for enrolling clients must obtain a signed CSP consent from each client at the time of his or her enrollment, prior to provision of services by a CSP provider. The consent informs the client about CSP reimbursed services and income and insurance eligibility guidelines, and requires clients to attest to their eligibility for CSP services. The consent also serves as permission to release information regarding services provided, and gives permission for a case manager to contact the client in the event of an abnormal screening result. The consent, which all contractors and their participating providers are required to use, is included as Attachment 4-I. The consent is available in English, Spanish, Russian, Chinese, French, Korean, and Haitian Creole. All languages are also available on the CSP data system in the Resource Document area; you can also contact your CSP Regional Manager to obtain copies of the consent.

B. Cancer Screening

Breast Cancer Screening

Breast cancer screening tests reimbursed by the CSP include:

- mammography (either screen film or digital) and
- clinical breast examination (CBE)

According to program guidance from the National Breast and Cervical Early Detection Program (NBCCEDP), a combination of CBE and mammography can generally detect an abnormality at an early stage of disease. Mammography is recommended to detect breast cancer in its earliest, most treatable stage. Research from clinical trials demonstrates that mammography can reduce breast cancer mortality by more than 30%. Additionally, several studies have evaluated the proportion of cancers (4.6%-5.9%) identified by CBE that were not detected by mammography. While the USPSTF indicates there is insufficient evidence to recommend CBE as a screening for breast cancer, the CSP supports women having access to primary health care and will reimburse for a clinical breast exam as the related primary care visit.

Breast self-examination (BSE) is the regular practice of observation and palpation of one's own breasts for identifying changes. Although BSE is frequently advocated, evidence for its effectiveness has not been shown to date to decrease breast cancer mortality. BSE is not reimbursed by the CSP. Many organizations indicate that it is important for women to know how their breasts usually look and feel, and talk to a health care provider if they notice any lumps or other changes in the breast. The CSP recommends BSE be taught only in the context of a CBE by an examining clinician.

Mammography

A mammogram is an x-ray examination of the breast. A screening mammogram is performed in women who do not have symptoms of breast cancer (i.e. the woman is asymptomatic). A diagnostic mammogram is performed in women presenting with symptoms for follow up of a previous probably benign radiographic finding, or in some cases, a history of breast cancer. A standard screening mammogram takes four views of the breasts, and may locate abnormalities before they can be felt on physical examination. In NY, a screening mammography almost exclusively utilizes digital technology, while few continue to use screen-film technology. The ability of a mammogram to find breast cancer may depend on the size of the tumor, the density of the breast tissue, and the skill of the radiologist. Tomosynthesis (DBT, sometimes referred to as 3D mammography), while growing in use, is not yet the recommended standard for breast cancer screening, and is not covered by all insurance plans. The CSP reimburses for exams utilizing tomosynthesis technology at the same rate as full field digital.

The results of screening mammograms provided to CSP clients must be reported using the Breast Imaging Reporting and Data System (BIRADS) categories developed by the American College of Radiology (ACR). Mammography providers are also required by the Mammography Quality Standards Act (MQSA) to include a BIRADS result on each mammogram report. The mammography result reported to the CSP on the SIF should be the same as the result indicated by the radiologist on the mammography report.

While it is important for clinicians to correlate the results of both a mammogram and a CBE (described below), the results of each test should be determined and reported independently (i.e. the mammography result should NOT be changed because of a CBE finding). For additional questions about BIRADS categories, please visit www.acr.org

Under the MQSA enacted by Congress in 1992, only facilities that are fully certified by the US Food and Drug Administration (FDA) may provide mammography. Only those facilities that meet this standard are, therefore, eligible to participate in the CSP. You can find additional information about the MQSA on line at the FDA website, which also includes information on locating FDA-certified mammography facilities. Please note that new mammography equipment used by a provider with full certification for other equipment is allowed during the provisional phase of the certification process for the new equipment. For questions about mammography certification in NYS, contact the Bureau of Environmental Radiation Protection at (518) 402-7550.

In NYS, a written order is required for the performance of a mammogram. However, there are two exceptions:

- FDA certified mammography facilities that have provider agreements with CSP contractors may accept CSP enrolled clients for breast cancer screening and diagnostic services without a written order, as the CSP contractor has an established system in place for follow up and client management.
- FDA certified mammography facilities may apply to the Department (BERP) to become a screening program and provide documentation of the required information as described in 10 NYCRR 16.22(a) to comply.

- *Dense Breasts:* Under the Federal MQSA, a provider of mammography services is required to give each patient a lay summary report of her mammography findings. A recent NYS law requires mammographers to notify women if they have dense breast tissue. Dense breast tissue may make it more difficult to spot cancers, and may also be associated with an increased risk of breast cancer. The law recommends that women discuss this issue with their physicians. This legislation was signed in July 2012 and went into effect in January 2013. The new law expands that report to now include the following notification in the summary of mammography reports provided to patients found to have dense breast tissue:

"Your mammogram shows that your breast tissue is dense. Dense breast tissue is very common and is not abnormal. However, dense breast tissue can make it harder to find cancer on a mammogram and may also be associated with an increased risk of breast cancer. This information about the result of your mammogram is given to you to raise your awareness. Use this information to talk to your doctor about your own risks for breast cancer. At that time, ask your doctor if more screening tests might be useful, based on your risk. A report of your results was also sent to your physician."

This legislation was meant to inform and educate and is not a mandate for additional diagnostic testing. There is no current guideline that recommends screening breast ultrasound and there is no current reimbursement code for a screening breast ultrasound. NBCCEDP supports only guideline-recommended screening, noting that the use of ultrasound as a tool for breast cancer screening is investigational.

Mobile Mammography Van Providers: Mobile mammography units provide access to breast cancer screening mammograms for age-eligible, asymptomatic women. Mobile units do not provide diagnostic mammograms. See Attachment 4-II for important guidance for mobile mammography providers.

Clinical Breast Examination (CBE)

A CBE is a thorough examination, by a trained health care professional, of the breast and related structures. The exam includes inspection and palpation of the breast and surrounding tissue, including the axilla (under the arms), above and below the clavicle, and the nipple.

The CSP will reimburse for the provision of a comprehensive CBE and documentation as described in the National Comprehensive Cancer Network®, *NCCN Clinical Practice Guidelines Version 2.2016 Breast Cancer Screening and Diagnosis, Breast Cancer Screening considerations, page 27.*

When performed, it is optimal for the CBE to precede a screening mammogram so the doctor reading the x-ray (radiologist) has knowledge of any CBE findings when interpreting the mammogram. A CBE should be scheduled 7 – 10 days after the onset of the menstrual cycle, when the breasts are often less tender. For lactating women, the breasts should be empty.

When performed, CBE results, whether normal or abnormal, must be documented on the CSP CBE Documentation form (Attachment 4-III) by the clinician who performed the examination. The recommended care plan (immediate follow-up, short-term rescreening, or annual screening) should also be indicated on the documentation form. With prior approval by the NYSDOH CSP, CSP providers may use an alternate form or Electronic Medical Record (EMR) screenshot. The alternate form must contain, at minimum, the same information required on the CSP CBE documentation form. Alternate forms must be sent to the CSP for approval prior to use; providers will be notified in writing within 30 days if the alternate form is acceptable. Send proposed alternate CBE forms to the CSP Health Systems Improvement Unit by email (CanServ@health.ny.gov), by fax (518-473-0642) or by US Mail to:

NYS Department of Health Cancer Services Program
CSP Health Systems Improvement Unit
150 Broadway, Rm 350
Menands, NY 12204

Minimum qualifications for CBE Providers

In accordance with NYS Education Law (Title VIII, Article 130, 131, 131-B, 139, 140), CBEs must be performed by a practitioner who is licensed by the State of New York (or another state) as a Registered Nurse (RN), Nurse Practitioner (NP), Physicians' Assistant (PA), Doctor of Medicine (MD), or Doctor of Osteopathy (DO). A licensed radiologic technologist (RT) may perform CBEs in the CSP under the supervision of a licensed physician, provided that:

- the licensed RT meets the personnel requirements for performing mammography as defined by the MQSA administered by the FDA. The licensee must maintain MQSA status through continuing medical education as required under MQSA,
- the licensed RT is certified in mammography and maintains registration in this specialty through the American Registry of Radiologic Technologists; and
- the licensed RT successfully completes a training course in the performance of CBEs.

It is recommended that providers who perform CBEs attend a skills update as needed.

Magnetic Resonance Imaging (MRI)

The CSP reimburses for MRI as an adjunct screening tool in women at high risk for breast cancer. Magnetic resonance imaging (MRI) of the breast is a computerized imaging tool that can generate detailed, multidimensional images of the breast(s) to detect and characterize disease. Breast MRIs may be used in addition to mammography to screen high-risk patients for breast cancer. The NYSDOH CSP has developed guidance for the use of MRI, in addition to mammography, that will require strict adherence to the guidelines to determine medical necessity and the procedures for prior approval before any CSP eligible client will be authorized to schedule or have a MRI for breast cancer screening provided. For detailed instruction, please review Attachment 4-IV, Cancer Services Program Guidelines for Determination of Medical Necessity for Breast MRI, Attachment 6-IX, Process for Submitting Prior Approval and Data Submission to the CSP for Reimbursement of MRI, and Attachment 6-VIII, Prior Approval for Breast MRI Form.

5. Cervical Cancer Screening

Cervical cancer screening tests reimbursed by the CSP include:

- Papanicolaou (Pap) test, either conventional or liquid-based and pelvic examination
- high-risk HPV DNA test, Hybrid Capture II, Cervista HR or cobas® HPV

6. Pap test (Pap smear) and pelvic examination

A Pap test is a procedure performed to collect cells from the surface of the cervix (ectocervix) and from the endocervical canal to check for abnormalities. Cells are gently scraped from the cervix and endocervix using a spatula, broom, or endocervical brush. Conventional Pap tests are done by placing the scraped cells onto a glass microscope slide and then applying a fixative. Liquid-based Pap tests are done by vigorously dispersing the scraped cells into a liquid solution. In either test type, the cells are later examined for the presence or absence of abnormalities.

A Pap test is completed during the visual part of a pelvic examination. A bi-manual examination occurs when a clinician uses both hands to feel inside the vagina, the uterus, and the ovaries for any problems. Bi-manual exams are not specific tests for cervical cancer and may be done without also performing a Pap test. Bi-manual pelvic exams performed in conjunction with a Pap test at appropriate intervals are reimbursable through the CSP.

Contractors must utilize cytology laboratories certified under the Clinical Laboratory Improvement Amendments (CLIA) of 1998 to evaluate Pap tests.

7. High-risk HPV DNA test

The high-risk HPV DNA test tests for high-risk types of the human papillomavirus (HPV) that cause abnormal cervical cell changes. HPV infection is the main risk factor for the development of cervical cancer. An HPV DNA test can be done after abnormalities are seen on a Pap test to determine if the cell changes are being caused by any of the types of HPV known to cause cervical cancer. The results of this test can help health care providers determine the best course of treatment for a patient. The high-risk HPV test can be performed from the same sample obtained in a liquid-based Pap test. An HPV DNA test may also be done in women over the age of 30 at the same time as a Pap test to screen for HPV infection. There is also an HPV test that will provide information regarding the specific genotyping of the high-risk types when stratification is necessary, however, this test is reimbursed at the same rate as the HR HPV DNA test.

8. Colorectal cancer (CRC) screening

CRC screening tests reimbursed by the CSP include

- *fecal tests*: high-sensitivity immunochemical FOBT (iFOBT, also known as fecal immunochemical tests, or "FIT") OR high-sensitivity guaiac fecal occult blood test (gFOBT)
- *colonoscopy* (under special circumstances as described below)
- *double contrast barium enema* when a colonoscopy is medically contraindicated (see below)

- *flexible sigmoidoscopy* when a colonoscopy is medically contraindicated (see below)

9. Fecal tests

Guidelines from the American Cancer Society, the US Preventive Services Taskforce, and others recommend FIT or high-sensitivity gFOBT as one option for colorectal cancer screening.

- Colorectal cancer screening with FOBT has been shown to decrease both incidence and mortality in randomized controlled trials.
- High-sensitivity FOBT detects colorectal cancer at relatively high rates.
- Modeling studies suggest that the years of life saved through a high-quality FOBT screening program are essentially the same as with a high-quality colonoscopy-based screening program.
- Access to colonoscopy and other invasive tests may be limited or non-existent for many patients.

In addition, some adults prefer less invasive tests. All of these elements make FIT and high sensitivity gFOBT a reasonable choice for patients.

Fecal tests check for blood in the stool. Individuals perform these tests at home by using small stool samples placed on special cards or specimen containers, which are then returned to the doctor or laboratory for testing. Both gFOBT and FIT require annual screening and a complete diagnostic evaluation when positive results are found. Microscopic blood in the stool may be a sign of polyps (abnormal growths) within the colon, which may mean an increased risk of CRC or cancer. See Attachment 4-V and 4-VI for more information on laboratory and physician ordering requirements. Individual manufacturer instructions must be used for the completion of kits. Test kits are returned to a physician or lab for development.

Differences between gFOBT and FIT include the following:

- FOBT tests for peroxidase, which is non-specific for human blood (certain foods in a person's diet can make FOBTs appear abnormal), while FIT tests for human globin, which is specific for human blood
- FOBT requires patients to adhere to certain dietary and medicinal restrictions, while most FIT do not have dietary or medicinal restrictions.
- the sampling method for FOBTs and some FITs are different
- FOBT costs less than FIT

Scientific studies have found the FIT provides improved specificity and slightly better sensitivity than gFOBT. Studies have also found that the elimination of dietary and medicinal restrictions, and the simplified stool sampling of some FIT brands, may

significantly improve patient participation rates in CRC screening and annual re-screening. For these reasons, the CSP highly recommends the use of an approved FIT over gFOBT.

Brands of Fecal Tests: Fecal tests have been proven to reduce the risk of mortality due to CRC. The NYSDOH CSP prefers the use of the high sensitivity fecal immunochemical test (FIT), because FITs are easier to use and more likely to be completed by patients than gFOBT. However, the CSP will reimburse for the use of either high-sensitivity gFOBT (e.g. Hemoccult II SENSA®) or FIT, as long as it is a brand available in the US that has published data for the highest sensitivity and specificity for individuals at average risk (no known risk factors) for CRC (See Table 1). The CSP will reimburse for multi-sample and single sample FIT, depending on manufacturer instructions. All FIT tests reimbursed by the CSP must comply with guidelines for specificity and sensitivity as recommended per the USPSTF or tests that have significant published data. See Table 1 below.

Table 1: Fecal Tests (gFOBT and FIT) with Published Data*	
Hemoccult-ICT/Flexsure OBT	Beckman-Coulter
Hemosure One Step	WHPM, Inc.
InSure / ColoVantage	Clinical Genomics
OC-Sensor / OC FIT-CHEK	Polymedco
OC-Auto Micro	Polymedco
OC-Light	Polymedco

*List may not be comprehensive. If you or your provider wish to utilize a test not listed here, please submit test information and published data to the CSP Health Systems Unit for approval for CSP reimbursement.

In-Office, Single Sample Testing: An in-office, single sample fecal test done in conjunction with a digital rectal exam during an office visit is *not* recommended for CRC screening and is *not* reimbursed by the CSP. Additionally, any client who receives an in-office, single sample fecal test, collected during a digital rectal exam and who had a positive or abnormal result cannot be enrolled in the CSP for a screening or diagnostic colonoscopy. While these clients should be referred for gastrointestinal (GI) evaluation, they are not eligible for CSP-funded services.

Stool DNA Fecal Testing: The CSP does not reimburse for stool DNA testing. Multi-targeted stool DNA testing (FIT-DNA) is another screening strategy that combines a FIT with testing for altered DNA biomarkers in cells shed into the stool. The harms of stool-based testing result primarily from adverse events associated with follow-up colonoscopy of positive findings. The specificity of FIT-DNA is lower than that of FIT

alone, which means it has a higher number of false-positive results and higher likelihood of follow-up colonoscopy and experiencing an associated adverse event per screening test. There are no recommendations for the appropriate longitudinal follow-up for an abnormal FIT-DNA test result followed by a negative colonoscopy (i.e., there is potential for overly intensive surveillance due to clinician and patient concerns about the implications of a positive finding in the genetic component of the test).

10. Screening colonoscopy

A colonoscopy involves the examination of the entire colon and rectum using a long, flexible, tubular instrument called a colonoscope. The colonoscope contains a light source and a camera lens. If polyps or suspicious areas are seen, these areas can be removed during the procedure. Most colonoscopies are performed in a hospital or diagnostic and treatment center by a gastroenterologist. Because the procedure is uncomfortable, conscious sedation or anesthesia is typically provided during the exam. Section F below provides information about CSP reimbursement for anesthesia with colonoscopy.

The colon must be flushed before a colonoscopy so the doctor can clearly see the lining. This preparation includes dietary restrictions for one week before the colonoscopy. The day before the procedure, the patient may consume only clear liquids, and must take a prescribed laxative, which can cause loose and frequent bowel movements.

The CSP provides reimbursement for the use of colonoscopy as a first-line CRC screening test *only* for those individuals determined to be at high or increased risk for CRC. Section E below describes the prior approval process for colonoscopy for individuals symptomatic for, at increased risk, or at high risk for CRC below. The use of colonoscopy in average-risk clients is limited to diagnostic colonoscopy if an abnormality is found during a fecal test. Approximately 15% to 20% of CRC cases occur among people who are at increased risk, and approximately 5% to 10% of CRC cases occur among people who are at high risk. If a colonoscopy is determined to be medically contraindicated by a physician, individuals at increased or high risk should be screened with a double contrast barium enema alone, or in combination with a flexible sigmoidoscopy (see below).

Complications resulting from a CSP-funded colonoscopy must be reported to the CSP. Please see section G below for guidance on the identification and reporting of colorectal cancer screening complications.

11. Double contrast barium enema (DCBE) and flexible sigmoidoscopy

The CSP provides reimbursement for DCBE and flexible sigmoidoscopy only for individuals at increased or high risk for CRC when colonoscopy is medically contraindicated.

During a DCBE, the colon is first filled with a chalky white solution containing barium, and is then drained, leaving behind a thin layer of barium along the colon's surface. The colon is filled with air to provide a detailed view of the inner surface of the colon, and an x-ray is taken. If any polyps or suspicious areas are seen during the DCBE, a diagnostic colonoscopy should be performed.

A flexible sigmoidoscopy involves the examination of the first third of the colon by a flexible, tubular, instrument that is shorter than a colonoscope. The tubular instrument contains a light source and camera to view this portion of the colon. Cleansing of the bowel, similar to colonoscopy preparation, is required. Sedation may be used; however, many sigmoidoscopies are performed without sedation in an office by general internists and family practice doctors. A diagnostic colonoscopy should be performed if any polyps or suspicious areas are detected during the sigmoidoscopy.

C. Cancer Screening Intervals

Breast cancer

The most current guidelines suggest women ages 50 to 74 years old should have a screening mammogram every two years. Women ages 40–49 years old are encouraged to talk to their health care providers about when and how often they should have screening mammograms. The CSP reimburses for breast cancer screening tests for average risk individuals at the following intervals:

- mammogram – every one to two years, beginning at age 40 and continuing for as long as a woman is in good health
- CBE – annually for women ages 40 and over, in conjunction with a gynecological health assessment, or just prior to the screening mammogram

Section H below provides guidance on the CSP policy for breast cancer screening in women under the age of 40 years.

Women at increased risk for breast cancer should discuss screening options with their medical providers. While the CSP does not provide reimbursement for all advanced testing for women at high risk for breast cancer, the CSP does assist women who are deemed high risk in obtaining clinically recommended MRI breast screening. See B.4. above and Attachment 4-IV below.

Cervical cancer

The NBCCEDP has adopted USPSTF updated screening recommendations effective July 1, 2012. The CSP's screening policies are intended to reach the population of women aged 40 – 65 years, with a continued emphasis on reaching the priority population for cervical cancer screening of women who have never or rarely been screened (screening in the last 5 years). The CSP recommends, and reimburses for, cervical cancer screening tests at the following intervals:

- in women 40 – 65 years of age, with cytology (Pap test) every three (3) years, or screening with a combination of cytology and high-risk HPV testing every five (5) years for women aged 40 – 65;
- annually among women who are considered "high risk" (e.g. HIV positive, immunocompromised, and those exposed in utero to diethylstilbestrol (DES));
- among women who have had hysterectomy for CIN disease (CIN 2 or 3) with routine cervical cancer screening for 20 years (even if it goes past age 65); and,
- Among women who have had cervical cancer, with routine screening for as long as they are in reasonable health. Routine screening is recommended every three (3) years, with cytology after initial post-surgery surveillance.

The CSP does not recommend, or reimburse for, cervical cancer screening in the following situations:

- among women older than 65 years who have had adequate screening (three (3) negative cytology alone, or two (2) negative HR HPV DNA tests) in the 10 years preceding their 65th birthday, regardless of sexual history, and if they are not at high risk; or,
- among women who have had a hysterectomy with the removal of the cervix and who do not have a history of a high-grade pre-cancerous lesion (cervical intraepithelial neoplasia (CIN) grade 2 or 3) or cervical cancer lesion.

Additional information about cervical cancer screening in women who have had a hysterectomy (removal of the uterus) is addressed in CSP Operations Manual Chapter 3, Section C-8.

Colorectal cancer

The CSP recommends, and reimburses for, CRC screening tests at the following intervals:

- approved single or multi-sample fecal tests (either high sensitivity gFOBT or FIT; see Table 1) annually in average-risk women and men aged 50 and older
- colonoscopy in women and men at increased risk for CRC – to begin at varying ages, depending on the individual's risk criteria (see section E, Prior approval process for colonoscopy for individuals symptomatic for, at increased risk, or at high risk for CRC below)

D. Diagnostic follow-up of abnormal screening test results

Breast cancer

Diagnostic follow-up is performed when a breast cancer screening test (mammogram and/or CBE) indicates that additional evaluation is required to assess an abnormal

finding. A self-reported finding (i.e., a finding reported by a client) is not considered an abnormal finding. CSP contractors and providers must follow the required timeframes for diagnostic follow-up per program guidance from the NBCCEDP.

Diagnostic follow-up for an abnormal finding on a breast cancer screening must be completed as soon as possible, but no later than 60 days from the initial screening date. The CSP will reimburse for breast cancer diagnostic services only under the following circumstances:

- a mass or other suspicious finding is noted on a CBE. For the purposes of a follow-up, a repeat CBE, surgical consultation and/or ultrasound must be performed. A mammogram alone cannot rule out breast cancer after an abnormal CBE
- a screening mammogram is interpreted with BIRADS result of "suspicious abnormality", "highly suggestive of malignancy", or "assessment incomplete". In the CSP, a BIRADS 0 or "assessment incomplete" mammogram that requires additional mammographic or special views is reported as "diagnostic mammogram" on the follow-up form, not on the screening intake form. For further information related to the reporting of information on CSP data forms, please refer to the CSP Data Dictionary, located on the CSP data system.

The CSP provides reimbursement for diagnostic follow up for abnormal breast findings that are related to breast cancer. The CSP does not reimburse for surveillance of benign breast conditions. The CSP does not reimburse for screening breast ultrasound for a finding of "dense breast tissue" alone. If there is a clinically significant change to a previously confirmed benign breast finding, a new diagnostic evaluation may be initiated.

Clients of any age diagnosed with breast cancer or pre-cancerous breast conditions should be appropriately referred for treatment, and may be eligible for Medicaid coverage for this treatment. See CSP Operations Manual Chapter 7 (NYS Medicaid Cancer Treatment Program) for information about Medicaid coverage for breast cancer treatment.

Cervical cancer

Diagnostic follow-up is performed when a cervical cancer screening test indicates that additional evaluation is required to assess an abnormality. CSP contractors and providers must follow the required timeframes for diagnostic follow-up per program guidance from the NBCCEDP.

Diagnostic follow-up for an abnormal finding on a cervical cancer screening test should be completed as soon as possible, but no later than 90 days after the date of the initial screening.

The CSP provides reimbursement only for diagnostic follow-up for abnormal Pap test results, and pelvic exam findings that are potentially related to cervical cancer or pre-cancerous cervical changes. For women who have Pap tests and pelvic exam results indicative of another type of gynecologic cancer (vaginal, vulvar, endometrial, or ovarian), the local CSP should help them obtain alternate funds through referral to public health insurance programs (for eligible women) or through other sources. Clients with non-cancerous conditions, such as infections or sexually transmitted diseases (STDs) may be referred to Title X Family Planning Clinics, Federally Qualified Health Centers, or STD clinics, for diagnosis and treatment of those conditions.

Clients of any age diagnosed with cervical cancer or pre-cancerous cervical conditions should be appropriately referred for treatment, and may be eligible for Medicaid coverage for this treatment. Refer to CSP Operations Manual Chapter 7 (NYS Medicaid Cancer Treatment Program) for information about Medicaid coverage for cervical cancer treatment.

Colorectal cancer

Diagnostic follow-up is performed when a CRC screening test indicates additional evaluation is required to assess an abnormality that is present. CSP contractors and providers must follow required timeframes for diagnostic follow-up per program guidance.

Diagnostic follow-up for all positive fecal tests must be completed as soon as possible, but no later than 90 days from the fecal test development date. Providers should conduct proper follow-up for all positive fecal tests with a complete examination of the colon.

Abnormal results on a colonoscopy may be indicative of different conditions, including some not related to CRC or polyps. Clients found to have a condition other than polyps or CRC, such as hemorrhoids, upper gastrointestinal bleeding, or inflammatory bowel disease, should be appropriately managed by a health care provider. Clients with colonoscopy findings concerning for a genetic predisposition should receive appropriate follow-up per clinical guidelines. The CSP does not reimburse for genetic services or for treatment services for diagnoses other than those related to CRC. The local CSP may help such women and men obtain alternate funds, through referral to public health insurance programs or other sources. Clients diagnosed with CRC should be appropriately referred for treatment, and may be eligible for Medicaid coverage for this treatment. See CSP Operations Manual Chapter 7 (NYS Medicaid Cancer Treatment Program) for information on Medicaid coverage for CRC.

E. Prior approval process for colonoscopy for individuals symptomatic for, at increased risk, or at high risk for CRC

The CSP supports screening for asymptomatic, average-risk people age 50 and older by high sensitivity, take-home fecal tests. CSP clients with abnormalities found on these tests should be scheduled for a colonoscopy.

Individuals aged 50-64 who have specific symptoms of CRC, and those individuals 18 and older determined to be at elevated risk due to a personal or family medical history or current medical or genetic condition (e.g., Lynch syndrome, familial adenomatous polyposis) may be screened directly by colonoscopy. To be screened directly by colonoscopy, clients must receive prior approval through the CSP contractor. CSP contractors are responsible for communicating this policy to their providers and clients.

CSP providers must submit clear documentation of the individual's risk status to the CSP contractor in accordance with eligibility criteria. See CSP Operations Manual Chapter 3 for more information. The designated CSP contractor staff will review the medical record documentation and complete a *CSP Colonoscopy Prior Approval Request* (Attachment 4-VII). A signed copy of this form shall be maintained in the CSP client's record, and a copy returned to the provider for inclusion in the client's medical record.

F. CSP reimbursement for anesthesia with colonoscopy

The CSP reimburses for monitored anesthesia care only when medically indicated and administered by an anesthesiologist or certified registered nurse anesthetist (CRNA). If a medical provider or hospital chooses to use monitored anesthesia care when it is not medically necessary, the CSP will not reimburse for this service, and the provider must find an alternate means of payment. The CSP does not reimburse for conscious sedation as a separate reimbursement fee. Conscious sedation is included in the fee for colonoscopy, regardless of who administers the sedation.

The routine assistance of an anesthesiologist or CRNA for average-risk adult patients undergoing lower GI endoscopic procedures is not considered medically necessary. Thus, the CSP will not reimburse for anesthesia services unless there is a determined medical necessity, with accompanying documentation provided. This position is supported by the March 2004 consensus statement issued by the American College of Gastroenterology, American Gastroenterological Association, and American Society for Gastrointestinal Endoscopy. This guidance is not intended to dictate to providers how to practice medicine: providers are expected to exercise their medical judgment in providing the care most appropriate for the patient. However, reimbursement by the CSP will require provider documentation of the medical necessity to include supporting clinical documentation (i.e., documentation as written in a colonoscopy consultation or procedure report). The contractor will review supporting clinical documentation. If evidence of medical necessity is sufficient, the contractor will complete the *Request for Program-funded Anesthesia with Colonoscopy* (Attachment 4-VIII) form, enter the services into the CSP data system and forward the form to the CSP data unit. The NYSDOH CSP staff will, in turn, perform an override to allow reimbursement. CSP contractors are required to communicate this policy and procedure to their credentialed

providers. Please note that documenting the reason for the request on the CSP reporting form alone is not appropriate documentation of medical necessity.

Clients who are scheduled for an upper endoscopy evaluation at the same time as a CSP-reimbursed colonoscopy do not qualify for CSP-funded monitored anesthesia care under the "medically necessary criteria" category of "prolonged procedure".

G. Identification and reporting of colorectal cancer screening complications

Any complications resulting from a CSP-funded colonoscopy MUST be identified and reported. This includes colonoscopy performed in an outpatient setting, such as a diagnostic and treatment center credentialed under PHL Article 28, an ambulatory surgical center, or an accredited office-based surgery practice. The CSP case manager is responsible for identifying clients who have experienced complications and reporting these to the CSP on the data system. See CSP Operations Manual Chapter 5 (Case Management) for more information.

H. CSP policy for breast cancer screening for women under the age of 40

Beginning April 1, 2009, women under the age of 40 were no longer considered eligible for breast cancer screening through the CSP, except for women in that age group who are at high risk for breast cancer, or who have clinically significant findings for breast cancer. The CSP established criteria and the implementation of an evaluation of women under 40 who may be at high risk for breast cancer; this evaluation is consistent with the National Cancer Institute recommendation that women at higher than average risk for breast cancer talk with a health care provider about whether to have breast cancer screening before age 40. The decision to screen for breast cancer should be based on an informed decision-making process between a woman and her health care provider.

Please note that mammography may not be indicated for women younger than age 35 who meet one or more of the high-risk criteria on a risk assessment. Clinically accepted guidelines from the National Comprehensive Cancer Network (www.nccn.org) should be used when determining whether breast cancer screening is necessary in younger women.

Evaluation

There are multiple factors that determine a woman's risk for breast cancer including, but not limited to, a personal and/or family history of breast, ovarian, and other cancers, the age of the person(s) diagnosis with a particular cancer, or a history of chest irradiation for treatment of lymphoma during adolescence or young adulthood. these individuals are considered to have "undetermined" risk for breast cancer and should be referred to an appropriate health care provider for a full clinical assessment,

which can include an evaluation of lifetime risk of breast cancer, using clinically recognized risk assessment tools. Where appropriate, individuals can be referred for zero-based sliding fee scale genetic counseling for assessment of risk. The CSP's toll-free referral line (**1-866-442-2262**) can link individuals with genetic counseling services in their area. It is not the role of local CSP staff to provide clinical risk assessments.

Women under the age of 40 who meet CSP financial eligibility and present to the local CSP with a concern they are at high risk for breast cancer should undergo risk evaluation by an appropriate health care provider before being referred for breast cancer screening services in the CSP. The CSP will reimburse for breast cancer screening services (CBE and screening mammography), and for any necessary CSP-reimbursable diagnostic services for individuals under age 40 when one of the following criteria are met. Screening must be recommended and documented by a NYS-licensed health care provider on the *Provider Attestation of Client Eligibility for Women Less than 40 Years of Age* (Attachment 4-IX).

High risk for breast cancer criteria

- a woman is determined to have a 5-year risk of invasive breast cancer greater than, or equal to, 1.7%, or a lifetime risk greater than, or equal to, 20%
- a woman is determined to have a known genetic predisposition for breast cancer by genetic testing (i.e. a BRCA 1 or 2 mutation)
- a woman has a personal history of breast cancer and is not in active treatment
- a woman has a personal history of receiving thoracic (chest) irradiation in her teens or 20s

These high-risk criteria have been adapted from those identified by the NCCN.

Clinically significant findings criteria

Women under age 40 presenting with a self-reported symptom or concern of breast cancer should undergo an evaluation with a NYS-licensed health care provider. The CSP will not reimburse for CBE in 18-39-year-old individuals with self-reported symptoms. The CSP will reimburse for genetic evaluation of one or more of the following clinically significant findings, after such a finding has been evaluated by a NYS-licensed health care provider who determines whether diagnostic evaluation is necessary AND that provider documents the request on a *Provider Attestation of Client Eligibility for Women Less than 40 Years of Age* (Attachment 4-IX). The following clinically significant findings have been identified by the NBCCEDP and NCCN, and are endorsed by the CSP:

- discrete, dominant mass in breast

- spontaneous nipple discharge without a discrete, dominant mass in breast
- asymmetric thickening or nodularity
- skin or nipple changes

The following diagnostic services, where appropriate, are reimbursable through the CSP:

- diagnostic ultrasound
- breast fluid cytology
- diagnostic mammography and/or
- referral for surgical consultation and biopsy if necessary

Attachment 4-I – Consent for CSP Participation

New York State Department of Health
Cancer Services Program
Your partner for cancer screening, support and information

Participant ID: _____
Contractor ID: _____
Fax Number: _____

CONSENT FOR CANCER SERVICES PROGRAM PARTICIPATION

About the Cancer Services Program (CSP)

The CSP is a New York State Department of Health (NYSDOH) program that works with contract administrators, and with doctors, nurses and other health care providers to offer free, age-appropriate, risk-based screening for breast cancer, cervical (opening of the womb) cancer, and colorectal (the colon and rectum) cancer. Screening tests can help find these cancers in early stages when they may be easier to treat. Sometimes, when these cancers are found and treated early, they can be cured. Contract administrators work with you, health care providers and the NYSDOH to provide the services described in this consent.

The Age-Appropriate, Risk-Based Screenings Offered by the CSP are:

- Mammograms and clinical breast exams for breast cancer
- Pap tests and pelvic exams for cervical cancer
- Take home fecal tests (FIT or FOBT) for colorectal cancer
- Screening colonoscopy for men and women at increased risk for colorectal cancer (this means they have a greater chance of getting colorectal cancer)

People Who Have Abnormal Screening Tests (the screening tests show they may have one of these cancers) May Also Have the Following Services from the CSP:

- Diagnostic tests: These are tests and exams that check to see if cancer is there.
- Case management: People help you get to the diagnostic tests by helping make appointments, finding a way to appointments, finding child care, and many other ways to make it easier to get to the important diagnostic test appointments.
- Help finding treatment if cancer is found.
- Help getting in the Medicaid Cancer Treatment Program if you meet the program eligibility (rules). The Medicaid Cancer Treatment Program offers full Medicaid insurance for people with breast, cervical, colorectal or prostate cancer who meet the program eligibility (rules).

Income and Insurance Eligibility

Free cancer screening by the CSP is only offered to women and men who meet income and health insurance eligibility (rules). Income eligibility means that the total amount of money earned by people living in your house must be below a certain amount for you to get free CSP services. CSP services are also offered to women and men who do not have health insurance (including Medicaid or other public insurance) or whose health insurance does not pay for cancer screenings. CSP services may also be offered to women and men who have health insurance, but cannot afford to pay the insurance co-pay, deductible, or spend down. The CSP contractor staff or health care provider will give you information about income and health insurance and talk to you about whether or not you meet these program rules.

Client Initials _____ Page 1 of 2 01/16

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New York State Department of Health
Cancer Services Program
Your partner for cancer screening, support and information

Participant ID: _____
Contractor ID: _____
Fax Number: _____

Signing this consent means that:

- I have read the program information on page 1 and have talked to a CSP contractor staff or provider and understand the services being offered to me by the CSP.
- I agree to be in this program and understand that by agreeing to be in this program, I give permission to the New York State Department of Health, contract administrators and health care providers, including doctors, clinics, and/or hospitals to release (share) information about me. I understand this information includes financial and insurance information and medical information about me and related to my breast, cervical and/or colorectal cancer screening, and any related diagnostic and treatment care I receive. I understand this information will be released (shared) to other health care providers, contract administrators, other staff, health care providers or agencies participating in the CSP and the New York State Department of Health for my health care, treatment and follow-up, and for case management, tracking and payment purposes.
- I understand that information about me and my medical information will be released only as allowed by this consent or as allowed or required by law.
- I understand that this consent is for CSP cancer screening and related diagnostic and treatment services and case management, as needed and as provided under the Cancer Services Program.
- I understand that I may choose not to have the services that are offered to me at any time.
- I understand that someone will contact me if I am found to have an abnormal screening test (my screening test shows that I may have cancer). Case management services are provided to help me to get the recommended diagnostic follow-up testing and treatment, if needed. I understand that case management services are provided at no cost to me and that I can choose not to have the service at any time.
- I understand that my healthcare provider may recommend tests or procedures that may not be paid for under this program.

Attestation of Eligibility

A CSP staff person or provider told me about the program services and eligibility requirements and answered any questions I had. By signing this consent, I attest that to the best of my knowledge, I understand this information and by checking the boxes below, the following is true. I understand that the CSP and the New York State Department of Health may verify (check) the information I have provided herein.

I meet the following income eligibility requirements (choose one):

☐ My household income is at or below 250% of the Federal Poverty Guideline (FPG).
☐ My household income is above 250% of the FPG, but I cannot afford cancer screening/s.

I meet the following insurance eligibility requirements (choose one):

☐ I do not have health insurance of any type (this includes Medicare, Medicaid, Family Health Plus, or other public or private insurance).
☐ My health insurance deductible, monthly spend down, or co-payment is too high and prevents me from getting cancer screening services or my health insurance does not provide coverage for cancer screening and/or diagnostics.

☐ I authorize information about my services to be left on my answering machine.

Client Information and Signature

Client Name (Print)_____ DOB _____

Client Signature_____ Date _____

Contractor Witness (Signature)_____ Date _____

Client Initials _____ Page 2 of 2 1/16

Attachment 4-II Cancer Services Program (CSP) Guidance for Screening Mammography provided via Mobile Screening Vans Participating in the CSP

In accordance with American College Radiology, *ACR Practice Parameters for the performance of Screening and Diagnostic Mammography, 2014.,* clients scheduled to receive breast cancer screening services performed on mobile mammography van(s), must be asymptomatic. Clients must be assessed for symptoms before scheduling them for a van event. Walk-in clients at van events should also be assessed for symptoms before undertaking services on the van.

Asymptomatic clients are those not complaining of a lump or a change in their breast since last examination.

Additional assessment of clients who are not appropriate for a "screening" mammography (i.e., these clients should not be scheduled for screening on a mobile van) includes, but is not limited to the following situations:

- clients who have a recent breast cancer diagnosis and have been told they need a diagnostic examination or who are still in treatment;
- clients requiring a six-month short term follow up examination of a "BIRADs 3, probable benign" mammography in the last 6 to 12 months;
- clients with breast implants; and
- clients who are post-mastectomy.

Attachment 4-III – CBE Form

CANCER SERVICES PROGRAM CLINICAL BREAST EXAM FORM

Name: _____ DOB: _____ Date: _____
Last First MI MM/DD/YR MM/DD/YR

Review of Patient History
Patient noticed changes in breasts since last visit? Site code ☐☐☐☐☐☐
No ___ Yes ___ Describe _____
Patient has a personal or family history of breast cancer?
No ___ Yes ___ Who? _____ What age? _____
Patient noted spontaneous nipple discharge?
No ___ Yes ___ Describe _____

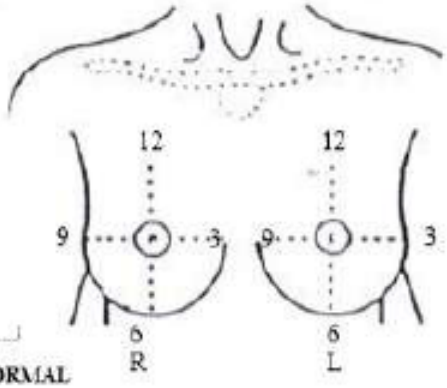
Visual Exam:
Skin: ☐ Normal/Benign ☐ Scar(s) ☐ Dimpling ☐ Other: _____
Nipples: ☐ Everted ☐ Inverted ☐ Retraction

Physical Exam:

	Right		Left	
Lymph Nodes (Axillary/Clavicular)	☐ +	☐ -	☐ +	☐ -

Diagram Documentation Codes

Scar +++	Nodularity ≡	Mole *
Fibrocystic Area ///	Node ○	Dimpling ◿
Mass ●		



Describe all clinical exam findings, including NORMAL and ABNORMAL (indicate size, shape, mobility, location of palpable findings).
Findings: _____

Plan: _____

Referral: No _____ Yes _____ (explain) _____

Breast Findings: Check one box only
☐ 1. Normal, Benign, Fibrocystic – Rescreen in 1-2 Years
☐ 2. Probably Benign – Repeat Exam in 3-6 months
☐ **3. Mass or Other Findings – Immediate Testing**

_____
Name of Examiner (please print)

_____
Signature of Examiner Date

This report should be maintained as part of the patient medical record.

(04/2011)

Attachment 4-IV – CSP Guidelines for Determination of Breast MRI Medical Necessity

These guidelines identify the clinical information that is required by the NYS DOH Cancer Services Program (CSP) to determine medical necessity for breast magnetic resonance imaging (MRI). These guidelines are based on generally accepted standards of practice, review of the medical literature, clinical practice guidelines published by NCCN (National Comprehensive Cancer Network) and the American Cancer Society, as well as National Breast and Cervical Cancer Early Detection Program policies from the Centers for Disease Control and Prevention and guidance from the NYS Cancer Detection and Education Program Advisory Council.

CSP reimbursement for screening or diagnostic breast MRI remains subject to CSP general eligibility coverage, limitations, service conditions, and other prior-authorization requirements (e.g. CSP Attestation for clients under age 40). CSP contractors should refer to the CSP Operations Manual, Chapter 3.

The NYS DOH CSP reviews requests for prior authorization based on medical necessity. If the CSP approves the request, payment is still subject to all general conditions of the CSP, including client eligibility, other insurance and other program requirements.

To be most effective, it is critical that breast MRI is done at facilities with dedicated breast MRI equipment and by experienced providers who can perform MRI-guided breast biopsies. Therefore, only facilities that have achieved the American College of Radiology's Breast Magnetic Resonance Imaging (MRI) Accreditation will be credentialed by the CSP for reimbursement of MRI or MRI-related procedures.

Section I. General Information

Magnetic resonance imaging (MRI) of the breast is a computerized imaging tool that can generate detailed, multi-dimensional images of the breast(s) to detect and characterize disease. Breast MRIs may be used **in addition** to mammography to screen high-risk patients for breast cancer. While this modality may also be used to evaluate the extent of disease in patients newly diagnosed with breast cancer, to monitor treatment response, to detect silicone implant ruptures, and/or as guidance for biopsy, the CSP **does not** reimburse breast MRI for those purposes. The CSP will consider reimbursement requests for the use of breast MRI as a diagnostic tool in women with a personal history of breast cancer who have completed treatment, as described below.

Breast MRI is not a replacement for mammogram, ultrasound, or biopsy. The CSP considers approval for coverage of breast MRIs on an individual, case-by-case basis, only prior to the provision of services. The CSP will only reimburse prior approved breast MRIs, performed at designated eligible CSP credentialed facilities.

Section II. Clinical Guidelines

A. Clinical Coverage

Screening

The CSP bases its determination of medical necessity for screening breast MRI on a combination of clinical data and the presence of indicators that would affect the relative risks and benefits of the procedure. Coverage for screening breast MRI for women requires that one or more of the following criteria are met:

a. The patient is a known carrier of a BRCA 1 or BRCA 2 gene mutation.

b. The patient hasn't been tested but has a first-degree relative(s) (parent, brother, sister or child) with a known BRCA 1 or BRCA 2 gene mutation.

c. The patient has a lifetime breast cancer risk of 20% or greater as estimated and documented with a validated risk assessment model (such as the BRCAPRO, Gail, Tyrer-Cuzick or similar models).

d. The patient was treated with radiation to the chest wall between age 10 and 30 years (e.g., for the treatment of Hodgkin's disease).

e. The patient has a personal history of or a first-degree relative with Li-Fraumeni syndrome or Cowden and Bannayan-Riley-Ruvalcaba syndromes.

Diagnostic

Diagnostic breast MRI may also be used to assess areas of concern on a mammogram for further evaluation of women with personal histories of breast cancer after completion of treatment if the client is no longer eligible for the Medicaid Cancer Treatment Program. Documentation of breast MRI necessity must be submitted for prior approval of a breast MRI for these clients.

B. Noncoverage

1. The CSP does not reimburse for screening or diagnostic breast MRIs under circumstances that include, but are not limited to, the following:

a. breast MRI as a screening tool to detect breast cancer in average risk, asymptomatic patients;

b. breast MRI as a replacement for mammogram, ultrasound, or biopsy or biopsy guidance;

c. to further evaluate an average risk patient for disease when clinical and standard imaging results (i.e. mammographic and sonographic evaluations) are inconclusive;

d. to confirm rupture of a silicone breast implant in a symptomatic patient;

e. to detect occult cancer in the contralateral breast in a patient with a new breast malignancy;

f. to determine the extent of disease and the presence of multifocality and multicentricity in a patient with a new breast malignancy;

g. to monitor a patient's response to neoadjuvant chemotherapy; or

h. to detect residual disease in patients who have undergone lumpectomy with positive margins.

i. to screen men for breast cancer; there are no clinical guidelines that recommend breast cancer screening for men who may be at higher risk for breast cancer.

Post-diagnosis reimbursement of MRI may be available through the Medicaid Cancer Treatment Program if the client is successfully enrolled.

Section III. Submitting Clinical Documentation

Requests for **prior** authorization for breast MRIs must be submitted by a CSP contractor before scheduling breast MRI at a CSP credentialed imaging provider and accompanied by clinical documentation supplied by the oncologist or primary care provider that supports the medical necessity for this procedure.

A. Documentation of medical necessity for breast MRIs for **screening** purposes must include one or more of the following:

a. Results of genetic test in either the affected individual or the patient's first-degree relative (parent, brother, sister or child);

b. Documentation describing the model (such as Gail, Tyrer-Cuzick, or BRCAPRO) used to predict the lifetime risk for breast cancer and resulting calculated lifetime risk. Documentation must explain all known risk factors used to calculate lifetime risk (such as personal and/or family history);

c. Documentation describing history of radiation to chest wall. Documentation must describe patient's medical condition and the patient's age when radiation was received (age at first exposure and dates/length of exposure); or

d. Documentation describing personal and/or first-degree family history of Li-Fraumeni syndrome or Cowden and Bannayan-Riley-Ruvalcaba syndromes.

B. Documentation of medical necessity for breast MRIs for **diagnostic** purposes must include one or more of the following:

   a. Documentation of the mammographic finding that requires MRI evaluation in a woman with a personal history of breast cancer and for whom treatment is completed and no longer qualifies for the MCTP.

Documentation will be reviewed by NYSDOH CSP designated clinical staff and a determination rendered to the CSP contractor. Upon approval of the breast MRI by the DOH staff, the CSP contractor will inform the clinical provider and patient and will facilitate scheduling a patient at a CSP credentialed provider for breast MRI. Please see CSP process for submitting prior approval and data submission to the CSP for reimbursement of breast MRI.

Select References

NCCN Clinical Practice Guidelines, Breast Cancer Screening and Diagnosis, Version 1.2014

Saslow D, Boetes C, Burke W, et al. American Cancer Society Guidelines for breast screening with MRI as an adjunct to mammography. CA Cancer J Clin. 2007; 57(2):75-89.

American College of Radiology. ACR practice guideline for the performance of contrast-enhanced magnetic resonance imaging (MRI) of the breast. Revised 2008. Accessed February 2010.

2014 CDC NBCCEDP guidelines for reimbursement of screening MRI for women high risk for breast cancer.

ACR Breast MRI Accreditation
http://www.acr.org/~/media/ACR/Documents/Accreditation/BreastMRI/Requirements.pdf

Harris JR, Lippman, ME, Morrow M, Osborne, CK. Diseases of the Breast. 4th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2010.

Weinstein SP, Localio R, Conant EF, Rosen M, Thomas KM, Schnall MD. Multimodality screening of high risk women: a prospective cohort study. J Clin Oncol. 2009; 27(36): 6124-8.

Taylor AJ, Taylor RE. Surveillance for breast cancer after childhood cancer. JAMA. 2009; 301(4): 435-6.

Attachment 4-V: Regulations regarding fecal tests

New York State Department of Health Regulations Regarding Laboratory Testing

Fecal Tests

In accordance with 10 NYCRR Section 58, all fecal tests (FOBT and FIT) must be ordered by a licensed physician or other health care provider authorized by law (nurse practitioner, physician assistant or certified nurse midwife), and developed by a clinical laboratory holding a permit, as designated in Section 58-1.1. The laboratory must provide a report to the ordering provider who, in turn, is responsible for ensuring that the patient is notified of the test results and that those patients with abnormal/at-risk results are counseled appropriately and/or referred to appropriate follow-up care.

In order for CSPs to distribute fecal test kits outside of a clinical setting such as at screening events, health fairs, educational sessions, or during enrollment for breast and cervical cancer screening services, a "standing order" from ordering licensed provider, which is kept on file with the contractor and the laboratory used to process the fecal test kit, is necessary. A standing order outlines the ordering provider's responsibility as well as the policies and procedures for ordering the test, release of test results and the follow-up of abnormal results. Attachment 4-VI is a template for a standing order, but providers usually work with the laboratory to create one that is satisfactory to both parties. This is a typical agreement between laboratories and ordering providers when testing occurs in what is collectively known as "health fair settings".

When kits are distributed outside a clinical setting, the program falls within the "health fair" category. In this case, the laboratory that processes the FIT/FOBT kit distributed by a CSP contractor, must also apply for a Health Fair Permit. The laboratory is probably already familiar with the process and may have this permit or may only need to add health fairs to an existing permit. This is a simple process, is offered at no cost and approval is usually swift. For more information, or to get an application form, go to www.wadsworth.org/labcert/regaffairs/RAindex.htm.

In summary, NYSDOH CSP contractors who are distributing fecal tests must have an up to date standing order identifying the process for ordering and for follow up by a licensed health care provider. Also, participating laboratories must obtain a Health Fair Permit. These requirements can be found in the NYSDOH Clinical Laboratory Statute and Regulations, located at the web address above. For additional information, contact your CSP Regional Manager.

Attachment 4-VI: Sample Standing Order for Distribution of FIT Kits

Sample standing order for the distribution of Fecal Immunochemical Test (FIT) Kit to adults over 50 years old

Purpose: To provide standing order for distribution, development and follow up of FIT to screen uninsured adults, age 50 and older, who are asymptomatic, for colorectal cancer.

Policy: Under these standing orders, staff of the Cancer Services Program (CSP) of _____will distribute FIT Kits to adults aged 50 and older who meet the following criteria:

- Staff will identify adults eligible for colorectal cancer screening in accordance with CSP eligibility guidelines; Uninsured, aged 50-64* years old. (*Age 65-74 are not eligible unless uninsured (No Medicare Part B))
- Have determined that client is average risk and has not had a fecal test in last 12 months or a negative screening colonoscopy in last 5 years.
- Provide all average risk eligible clients education on completion of the test and a copy of the FIT kit instructions and FIT kit, which includes a self-addressed stamped envelope to return the FIT kit to the CSP credentialed laboratory (i.e., InSure FIT to Quest Diagnostics.) with the requisition indicating the Standing Ordering physician designated as the ordering provider.
- Provide all clients receiving a FIT kit with the CSP contact information for questions and or concerns.
- CSP staff will log and track all FIT kits dispensed, and will follow-up with client within two weeks, for return of the kit, and/or need for education to complete the FIT kit.
- CSP staff will receive FIT kit results (i.e., InSure FIT, via Quest Diagnostic's Care 360 system.) CSP staff will review all FIT kit results. CSP designated staff will inform clients of both normal and abnormal results via phone call and/or letter. All clients with an abnormal result are case managed and referred to appropriate CSP credentialed specialist for follow up with a colonoscopy.
- The CSP staff will notify standing order physician of any clients who are non-compliant in need of follow-up.
- All FIT kit results, normal and abnormal, will be mailed to the clients designated primary care physician by CSP staff.

This standing order shall remain in effect for CSP clients for the period of _____ to _____, unless otherwise revised.

Standing order provider _____
(Print Name and license #)

Title/Address:_____

Signature: _____

Date: _____

Attachment 4-VII – CSP Colonoscopy Prior Approval Request Form

Cancer Service Program Colonoscopy Prior Approval Request Form

Participant ID #_____Initials _____ Contractor ID # ___ Site Code_____

Colonoscopy Screening for Individuals at Increased Risk for CRC

Documentation has been provided and this client is eligible for a colonoscopy:

- ☐ Un/underinsured individuals with a single, small (<1 cm) adenoma, eligible 3-6 years after original polypectomy
- ☐ Un/underinsured individuals with a large (1 cm+) adenoma, multiple adenomas, or adenomas with high-grade dysplasia or villous change, eligible within 3 years after the initial polypectomy
- ☐ Un/underinsured individuals with a history of curative-intent resection for colorectal cancer, eligible 1 year after cancer resection
- ☐ Un/underinsured individuals with either colorectal cancer or adenomatous polyps, in any first-degree relative before age 60, or in two or more first-degree relatives at any age, eligible at age 40, or 10 years before youngest case in the family, whichever comes first

Colonoscopy Screening for Individuals at High-Risk for CRC

Documentation has been provided and this client is eligible for a colonoscopy:

- ☐ Un/underinsured individuals with a family history of familial adenomatous polyposis (FAP), eligible at puberty
- ☐ Un/underinsured individuals with a family history of hereditary non-polyposis colon cancer (HNPCC), eligible at age 21
- ☐ Un/underinsured individuals diagnosed with inflammatory bowel disease, chronic ulcerative colitis or Crohn's disease, 8 years after onset of symptoms.

Diagnostic Colonoscopy for Symptomatic Clients (Age 50-64 only)

Documentation has been provided and the client is eligible for a diagnostic colonoscopy:

- ☐ Un/underinsured individuals age 50 to 64 with a definite, palpable, right sided, abdominal mass
- ☐ Un/underinsured individuals age 50 to 64 with a definite, palpable, rectal (not pelvic or anal) mass
- ☐ Un/underinsured individuals age 50 to 64 with **prolonged** rectal bleeding with change in bowel habit
- ☐ Un/underinsured individuals age 50 to 64 with rectal bleeding **persistently without anal symptoms** (soreness, discomfort, itching, lumps, prolapse, pain)
- ☐ Un/underinsured individuals age 50 to 64 with nonspecific signs or symptoms strongly suggestive of colorectal cancer: melena (black, tarry stools), penciling of stools (thin stools difficult to pass) or iron deficiency anemia of undefined origin

☐***Documentation provided does not meet criteria for a CSP funded colonoscopy***

☐ **I have reviewed the documentation provided and confirm eligibility of a CSP reimbursed colonoscopy.**

Date_____ Print Name _____

Signature of CSP Contractor Designee _____

January 2016

Attachment 4-VIII – Request for Program-funded Anesthesia with Colonoscopy

Cancer Services Program

Request for Program Funded Anesthesia with Colonoscopy

Contractor: _____
Provider Name: _____
CSP Site Code: _____

Client Name: _____
CSP participant #: _____
Client Date of Birth: _____

Client requires program-funded anesthesia and **documentation of medical necessity is included in the clinical records reviewed by the CSP partnership staff.** (Please check at least one):

☐ Client has an unstable medical condition: Please state condition:

_____

☐ Client has respiratory complications such as emphysema, shortness of breath, or asthma

☐ Client has a psychiatric or developmental diagnosis that prevents him/her from cooperating during the procedure (acute confusion state, senile dementia, anxiety, panic attacks)

☐ Client is or becomes uncooperative or combative during procedure (Requiring Anesthesia to be called in)

Client's airway is in danger of compromise

- ☐ Client has dysmorphic facial features
- ☐ Client has oral, neck or jaw abnormalities
- ☐ Client is morbidly obese (BMI > 41 or BMI > 35 with comorbid medical conditions)
- ☐ Client has a diagnosis of clinically significant sleep apnea, stridor, or tracheal stenosis

Clients with intolerance to standard sedatives

- ☐ Client has had previous problems with or allergies to anesthesia or sedation
- ☐ Client is anticipated to be poorly responsive to sedation. This includes patients who have long term use of narcotics, benzodiazepines, alcohol, or neuropsychiatric medications or prior history of poor response to standard sedatives
- ☐ Drug or alcohol withdrawal or intoxication

Other

- ☐ Complicated or prolonged procedures (standard colonoscopies do not fit into this category) requiring Anesthesia to be called in.

_____

Print name of Contractor Staff requesting and then provide Signature and Date
FAX to CSP Data Unit @ 518-486-6860
*Date received in CSP*_____ *Date entered in Data system*_____
CSP staff signature _____

Form revised January 2016

Attachment 4-IX – Provider Attestation of Eligibility for Women Under 40

New York State Department of Health
Cancer Services Program

Provider Attestation of Client Eligibility for Women less than 40 Years of Age

_____ _____
Print name of provider

_____ _____
CSP designated site code

_____ _____ _____
Print name of CSP Partnership

Print Client Name: _____ _____
CSP client #: _____ _____
Client Date of Birth: _____ _____

☐ High Risk for Breast Cancer

I have performed a clinically recognized risk assessment for the above named client and it is my clinical judgment that this client meets the criteria outlined in the New York State Department of Health Cancer Services Program (CSP) Operations Manual for breast cancer screening for high risk women less than 40 years of age.

High Risk for Breast Cancer Criteria (Choose all that apply)

☐ Client 5-year risk =_____. (A woman of any age is determined to have a 5-year risk of invasive breast cancer greater than or equal to 1.7 %, as determined by a clinically recognized risk assessment tool.)
☐ Client lifetime risk =_____. (A woman age 35 or older with a lifetime risk greater than or equal to 20%, as determined by a clinically recognized risk assessment tool.)
☐ A known genetic predisposition for breast cancer by genetic testing (e.g. *BRCA* 1 or 2 mutation)
☐ A personal history of breast cancer (and is not in active treatment)
☐ A personal history of receiving thoracic (chest) irradiation in teens or 20s.

OR

☐ Clinically Significant Finding(s) for Breast Cancer

I have performed a clinical breast exam on the above named client and have determined that she meets the criteria outlined in the New York State Department of Health Cancer Services Program (CSP) Operations Manual for clinically significant finding(s) of breast cancer in women less than 40 years of age.

Clinically Significant Findings Criteria (Choose all that apply)

☐ Discrete, dominant mass in breast
☐ Spontaneous nipple discharge without a discrete, dominant mass in breast
☐ Asymmetric thickening or nodularity
☐ Skin or nipple changes

_____ _____
Provider Signature Date

Cancer Services Program Provider Attestation of Eligibility for Women <40 Y/O Rev 01/2011

Chapter 5 – Case Management

CSP Operations Manual 2017

Chapter 5: Case Management

A. Case Management Definitions and Implementation Guidance

Case management begins at the point of an abnormal screening finding, and is defined as "activities that increase client adherence to diagnostic and treatment recommendations". Case management services must be available to clients to address any barriers that could prevent or delay their seeking care. The key components of case management are assessment, planning, coordination, resource development, monitoring, and evaluation.

1. **Assessment** is the process of gathering critical information from the client and examining the client's need for re-screening, diagnostic, treatment, and support services. Some CSPs may choose to use the *Barrier Assessment Checklist* (Attachment 5-I) to expedite the assessment process. During the initial assessment, it is important to ascertain whether the client has signed an Informed Consent/Release of Medical Information/Case Management form. If not, the program must obtain one (see Section B-2 of this chapter for more information).

2. **Planning** involves addressing barriers found during the client's assessment and documenting them in an individual written Client Care Plan. The *Client Care Plan* (Attachment 5-II) outlines identified issues and the steps being taken to overcome barriers. The plan to address the barriers to care requires contact with the client to ensure his/her needs are being met. See Section B-10 of this chapter for more information about documentation requirements.

3. **Coordination** is the provision of active assistance by the case manager to ensure the client receives the services identified on the Client Care Plan. This is a collaborative process: the case manager works to encourage self-sufficiency and supports client/family autonomy through provision of information, resources, skills, and other tools. Any steps taken to coordinate services should be documented in the client's CSP record. Development of, and consistent updates to, the local Community Resource Guide are imperative for this phase of case management to be successful in helping a client to overcome identified barriers. See Section B-6 of this chapter for information about the Community Resource Guide.

4. **Monitoring** refers to the ongoing reassessment of the client's needs, throughout the duration of care, to ensure that the quality of care and the services provided meet the client's current needs, and that new needs are identified and met. Any newly identified barriers should be documented in the client's CSP record, noting the steps necessary to address these barriers (the Client Care Plan). A client who decides s/he no longer needs

case management services should be informed that this service is available at any time during the diagnostic follow up process, and that s/he can call the local CSP should s/he decide to resume case management services. As with other elements of case management, this should be documented in the client's record.

5. **Resource Development** involves establishment of formal and informal agreements to maximize availability and access to essential diagnostic, treatment, and support services. This step is accomplished through contracts and agreements with providers and community organizations. These resources should be included in the Community Resource Guide developed by the local CSP (see Section B of this chapter).

6. **Evaluation** refers to the process of assessing client satisfaction, access, and timeliness of referral services, and the quality of individual case management plans. Once case management ends, the *Case Management Satisfaction Survey* (Attachment 5-III) must be sent to the client with a self-addressed, stamped envelope for its return at no cost to her/him (see Section B-7 of this chapter for more information).

B. Expectations of Case Managers

Case managers should develop a Community Resource Guide. This guide should be routinely reviewed and updated to ensure clients receive accurate information about current resources available to address barriers to diagnostic follow-up. The Guide should include the names and contact information for community-based organizations, transportation, translation, and financial services, as well as other state, local, and national resources. Any staff member working for the local CSP can update this guide. Additionally, Case Managers are expected to:

1. meet with providers to discuss the case management services available to CSP clients. If the provider is performing case management activities, inform him/her that the contractor's case manager is available to assist with locating clients who cancel or miss appointments. Explain the importance of receiving results of abnormal findings within three business days of the provider's review of those results, and discuss how the results will be communicated to the contractor's case manager (e.g. fax, email, telephone call and/or select a specific day of the week that providers can communicate the results to the CSP case manager).

2. obtain an Informed Consent/Release of Medical Information/Consent for Case Management Services from the provider or client; keep a copy in the client's CSP record (Operations Manual Chapter 4, Attachment 4-I). Verbal consent from the client is acceptable, however, it must be followed by an attempt to obtain a signed consent. Send the consent to

the client with a cover letter requesting their signature, and include a self-addressed, stamped envelope. Before calling the client, refer to the CSP Consent to Participate and note whether you may leave a message; always adhere strictly to the client's request.

3. ensure every client with an abnormal finding has a CSP client record. This record should contain all clinical documentation related to the abnormal screening and diagnostic procedures, case management notes (including the Barrier Assessment and Client Care Plan), case management notes from the provider, and the signed Informed Consent.

4. after verifying with the provider that the client is aware of her/his abnormal finding, contact the client to offer case management services; explain the role of the case manager and that the case management services are free. If the client states they do not need case management services at this time, provide the local CSP phone number, and assure the client the service will be available as needed in the future.

5. if the client consents to case management, conduct a *Barrier Assessment* (Attachment 5-I). Document identified barriers and the steps that will be taken to resolve them as part of the written *Client Care Plan* (Attachment 5-II). The *Barrier Assessment* and accompanying *Client Care Plan* should be dated and signed by the CM. If no barriers are identified, this should be documented as well.

6. contact the client 1-2 days before an appointment as a reminder; perform a barrier assessment at that time. The call provides the client an opportunity to verify whether s/he will be able to keep the scheduled appointment. If the client cannot make the appointment because of an identified barrier, implement a care plan to address and resolve that barrier. Use of a tickler/reminder system may be helpful to trigger client contact. Although providers may make reminder calls to clients, the expectation remains that the contractor's case manager will also make reminder calls, as this is an effective way to ensure compliance with scheduled appointments.

7. document all client contact, or contact pertaining to the client completely and comprehensively. Document date and time, a summary of the discussion, newly identified barriers, newly identified care plan activity, and any follow-up activities to be carried out by CSP staff or the client. Each entry should include the CSP staff member's signature (first entry) or initials (acceptable for subsequent entries). Documentation can be completed by anyone who assists the client with his/her needs; it is not necessary to have case management activities documented solely by the case manager. If case management is initiated at the provider's office

and transferred to the local CSP, include documentation of all case management activities conducted by the provider's office in the CSP notes as well. This ensures continuity of care for the client.

8. ensure the client is aware of the provider's rescreening recommendation. Both the recommendation and the client's notification of such must be documented in the chart.

9. send the *Case Management Satisfaction Survey* (Attachment 5-III) with a self-addressed, stamped envelope within 30 days of the end of case management services. Review survey results upon receipt to identify any issues that should be addressed immediately. Complete a quarterly review of surveys to identify possible trends (e.g. a provider billing CSP clients, lengthy wait times at a particular clinic, etc.). Although the survey does not need to be kept in clients' records, the case management notes must include documentation that the survey was sent. All returned surveys should be kept in a central, easily accessed location to facilitate the quarterly review process.

10. review and assess the quality of case management services offered to clients within the local CSP using the *CSP Case Management Evaluation Tool* (Attachment 5-IV).

11. each contractor case manager is required to be trained as a Designated Qualified Entity (DQE) to ensure clients with a pre-cancerous or cancer diagnosis can immediately begin the application process for the NYS Medicaid Cancer Treatment Program (MCTP). In some instances, there may be other CSP providers trained as DQEs who can also help the client complete the MCTP application. Those DQEs may request assistance from the case manager to obtain required documentation or to help the client with transportation for the face-to-face interview with the DQE. Although case management through the CSP ends once a client begins treatment, the CSP recommends that case managers maintain occasional contact (every 4-6 months) with the cancer treatment center case manager and the client to ensure the client is following through on treatment recommendations. Please see CSP Operations Manual Chapter 7 for more information about the MCTP.

12. identify clients who have experienced complications following a CSP-funded colonoscopy. See Attachments 5-VI, 5-VII, and 5-VIII for more information.

13. use the CSP Client Contact Protocol to reach clients where case management has been initiated, but who then become difficult to reach

or non-compliant with appointments. See Attachment 5-V for more information.

14. monitor the status of outstanding follow-up forms by running the "Outstanding Follow-up Forms" query in the data system. This should be performed on a bi-weekly basis to identify any forms that still need to be completed. The case manager should address each new follow-up form that has not yet been touched and any pending follow-up form that is within 30 days of becoming outstanding. Appropriate comments should be noted in the case management file detailing the client's current status.

Attachment 5-I Barrier Assessment

Barrier Assessment

Client Name: *Client Phone #:* *Client DOB:*

1	Do you understand what follow-up appointments the doctor has recommended?	☐ Yes	☐ No
2	Do you need help in scheduling these appointments?	☐ Yes	☐ No
	If yes, what type of help? e.g. is there a language barrier? difficulty navigating a provider's phone system? no phone access?		
3	Do you work outside the home?	☐ Yes	☐ No
	If yes, what type of work?		
	Are appointments scheduled during work hours a problem?	☐ Yes	☐ No
	Do you receive paid time off at work? (Clients may not want to take time off work for appointments if they won't be paid for that time.)	☐ Yes	☐ No
4	Is transportation (or distance to appointment(s)) a problem? If so, why? (e.g. gas money, lack of transportation, too far away, etc.).	☐ Yes	☐ No
5	Do you need someone to go with you to your appointment(s), either for physical assistance (wheelchair, poor eyesight, etc.) or to provide emotional support?	☐ Yes	☐ No
	If yes, do you have someone to go with you?	☐ Yes	☐ No
	If for physical assistance, what type of assistance is needed?		
6	Do you need child or elder care in order to make it to appointment(s)?	☐ Yes	☐ No
7	There may be some services that will not be paid for by the CSP. Will this cause a problem or keep you from following up?	☐ Yes	☐ No
8	Do you need help filling out paperwork or forms (i.e.: due to literacy, language, education, etc.)?	☐ Yes	☐ No
9	Do you have questions for your doctor?	☐ Yes	☐ No
	If yes, what questions do you have? (e.g. about the test(s) and what the results might mean, what's involved in a test or procedure, etc.)?		
10	Did the doctor's office say that you need someone to drive you to/from the appointment(s) (e.g. due to medication the client might have to take or the procedure the client will undergo)?	☐ Yes	☐ No
	If yes, do you have someone to drive you?	☐ Yes	☐ No
11	**For colonoscopy only** – was the preparation for this test explained to you?	☐ Yes	☐ No
12	During the course of your conversation you will need to determine if there are any cultural or religious beliefs that might prevent her/him from following up or going to appointment(s). Please document any such barriers below.		

Case Manager Signature: *Date:*

(04/2011)

Attachment 5-II Client Care Plan

Client Care Plan

Client Name: _____ Phone Number: _____
DOB: _____

Identified Barrier(s)		Plan
1	Provider recommended follow-up appointments	
2	Needs help to schedule appointment(s)	
3	Works outside the home Does not get paid time off Unable to schedule appointments during work hours	
4	Transportation issues	
5	Needs someone to go with her/him to appointment Physical/emotional support To drive	
6	Needs child/elder care	
7	Money issues	
8	Needs help completing paperwork	
9	Needs referral for MCTP	
10	Client questions for provider/MD	
11	Needs further instruction regarding preparation for colonoscopy	
12	Cultural/religious barriers	
13	Other	
Case Manager Signature		Date:

(04/2011)

Attachment 5-III Case Management Satisfaction Survey

Case Management Satisfaction Survey

	Very Satisfied	Satisfied	No Opinion	Dissatisfied	Very Dissatisfied	N/A
Case management services were explained to me						
The case manager listened to my concerns and answered my questions						
The case manager returned my calls within 1-2 business days						
I received information in a language I understood						
I received help from the case manager to get the services I needed						
I feel I was referred to specialists/others in a timely manner						
I was treated with respect						
The case manager asked about any problems I might have in being able to make my appointments						
Overall rating of case manager						
Overall rating of medical providers						
If treatment was required, please answer the following questions:						
The case manager called me occasionally to see how I was doing						
The case manager helped me, or referred me to someone, to complete a Medicaid application that would pay for my treatment						

Did you receive a bill for any of the medical services you received? ____ Yes ____ No
If so, what bills did you receive, and did the case manager help you resolve them?

Do you think you will need further assistance from the case manager? ___ Yes ___ No
If so, what type of assistance will you need?

Would you recommend our program to other women/men? ___ Yes ___ No
If not, why?

What suggestions do you have that might help us improve our program?

Other comments:

(04/2011)

Attachment 5-IV Contractor Case Management Evaluation Tool

NYS DEPARTMENT OF HEALTH
CANCER SERVICES PROGRAM
CSP Case Management (CM) Evaluation Tool

Client Name: _____ Abnormal Screening: ___ Breast ___ Cervical ___ Colorectal
Client ID#: _____
CSP of: _____ Date of Abnormal Screening _____
Provider Site: _____ Abnormal Result: _____
CM Done By: _____ CSP _____ Provider Date CM Notified of Abnormal Finding _____
Case Manager: _____ Date CM initially contacted client _____
Date of Review: _____

CSP Case Management Questions	Yes	No	N/A	Comments
Did the client receive all diagnostic services within 60 days (for breast) or 90 days (for cervical/colorectal) from the date of the initial screening? ****If no, explain reason for delay. If reason for delay is unknown, state this as well.**				
Is there a signed CSP informed consent in the client record? Eligibility questions checked? Witness signature present? Adherence to leaving a message?				Date consent signed:
Is the client under 40 years old? If yes, is there a breast attestation present?				
Is clinical documentation of the abnormal screening in the chart?				
Is clinical documentation of the diagnostic follow-up procedures and/or testing in the chart?				
If applicable, were attempts made to contact the client during non-working hours/days?				
Was a barrier assessment completed?				
Is there a plan to address each barrier documented?				
Is there documentation/evidence of ongoing monitoring for other barriers/				
Was the client contacted 1-2 days prior to her/his appointment?				
Was the client contacted after appointment?				
If applicable, were the 7 and 30 day calls made after client's colonoscopy?				
Is the client aware of the provider's rescreening recommendation (after the final diagnosis has been made)?				
Did client receive all of the appropriate referrals?				
If applicable, was the protocol for "lost to follow-up" or "workup refused" followed?				
If applicable, was the client referred to a DQE?				
Is there evidence of initial contact with the treatment provider?				
Was a client satisfaction survey sent?				
Is there evidence of adequate communication between client, provider and case manager?				

Comments: _____

_____

_____

(Revised 3/23/12)

Attachment 5-V Client Contact Protocol

New York State Department of Health
Cancer Services Program
Case Management Client Contact Protocol

The following information provides the protocol for contacting clients. This applies to clients who have not yet been contacted (and, therefore, case management has not begun), and to clients contacted after an abnormal finding and case management has been initiated but who then become difficult to reach or non-compliant with appointments.

1. Make three attempts to contact the client by telephone at different times of the day and days of the week (e.g. early morning, late afternoon, evening, weekends, etc.)
2. Call all phone numbers including the "emergency contact" provided on the SIF in an attempt to reach the client. Identify if the client is away or out of the country, or if there is another phone number where the client can be reached.
3. If attempts to contact the client by phone fail, send three letters over a period of three weeks to the client. Detail why you are attempting to contact them and explain the availability of case management services. The last (3rd) letter should be mailed certified with return receipt. If the letter is returned with a new/forwarding address, resend the letter*. If the letters are not returned, or are returned as "unclaimed", this generally means the address was correct. You can then disposition the client as "lost to follow up" or "workup refused" and discontinue further case management attempts.
4. If the phone number is incorrect, or the client has moved, contact directory assistance (dial 4-1-1 or 1+(area code)+555-1212). Provide the client's last name and last known address. If the number is non-published, confirm whether you have the correct address (directory assistance can confirm/deny the information but will not provide any new information).
5. If you reach the client, explain the importance of following through with the diagnostic services and explain that if s/he needs case management services now or in the future, it will be available.
6. If the client refuses follow-up services, explain that a letter of refusal for diagnostic services will be mailed. Once the refusal letter is sent, you may discontinue further case management attempts.

Attachment 5-VI CM Procedure for Identification of Complications Following a CSP-funded Colonoscopy

Case Management Procedure for Identification of Complications Following a CSP-funded Colonoscopy

(See Attachment 5-VII for algorithm and Attachment 5-VIII for definitions of colonoscopy complications)

1. Any client who meets eligibility for a CSP-funded colonoscopy must have follow-up by the CSP case manager to identify potential complications resulting from the colonoscopy. The results of that follow-up must be reported on the CSP data system.

2. The case manager calls the client to offer case management services. At this time, the case manager will complete a barrier assessment and assist the client in scheduling the consult or colonoscopy procedure, if needed.

    a. if the client is able to schedule his/her own appointment, the case manager will remind him/her to call back with the date and time

    b. the case manager will follow up with the client within three (3) days to ensure s/he has been able to make the appointment. If not, the case manager will offer to schedule the appointment. If the case manager is unable to reach the client by phone, s/he will contact the provider's office to determine if the client has made an appointment.

3. If the client has a consult prior to the colonoscopy, the case manager will call her/him 1-2 days following the consult to see if there are any tests that need to be completed before the colonoscopy can be scheduled. Any required pre-testing should be confirmed with the consulting provider. If needed, the case manager will assist the client in completing these tests.

4. The case manager will call the client 1-2 days prior to the appointment as a reminder and to confirm that the client understands the prep instructions. The case manager will also complete another barrier assessment to ensure the client will be able to make the appointment.

5. The case manager will call the client 7 days after the colonoscopy to ask about the procedure and about any complications s/he experienced.*

    a. if no complications are reported, the case manager will inform the client to expect a call in a few weeks to "check up" and make sure everything is still going well.

b. if a complication is reported, the case manager will ask the client what it was. The case manager will then ascertain where care was provided and will contact the hospital/provider to request the report and clinical documentation to verify the complication. If the document does not support evidence of a complication, the case manager will indicate this when reporting on the data system. If the documentation does indicate that a complication occurred, the case manager will indicate the complication on the data system.

6. If no complications are reported, the case manager will call the patient again 30 days after the procedure to inquire about any complications up to this point.

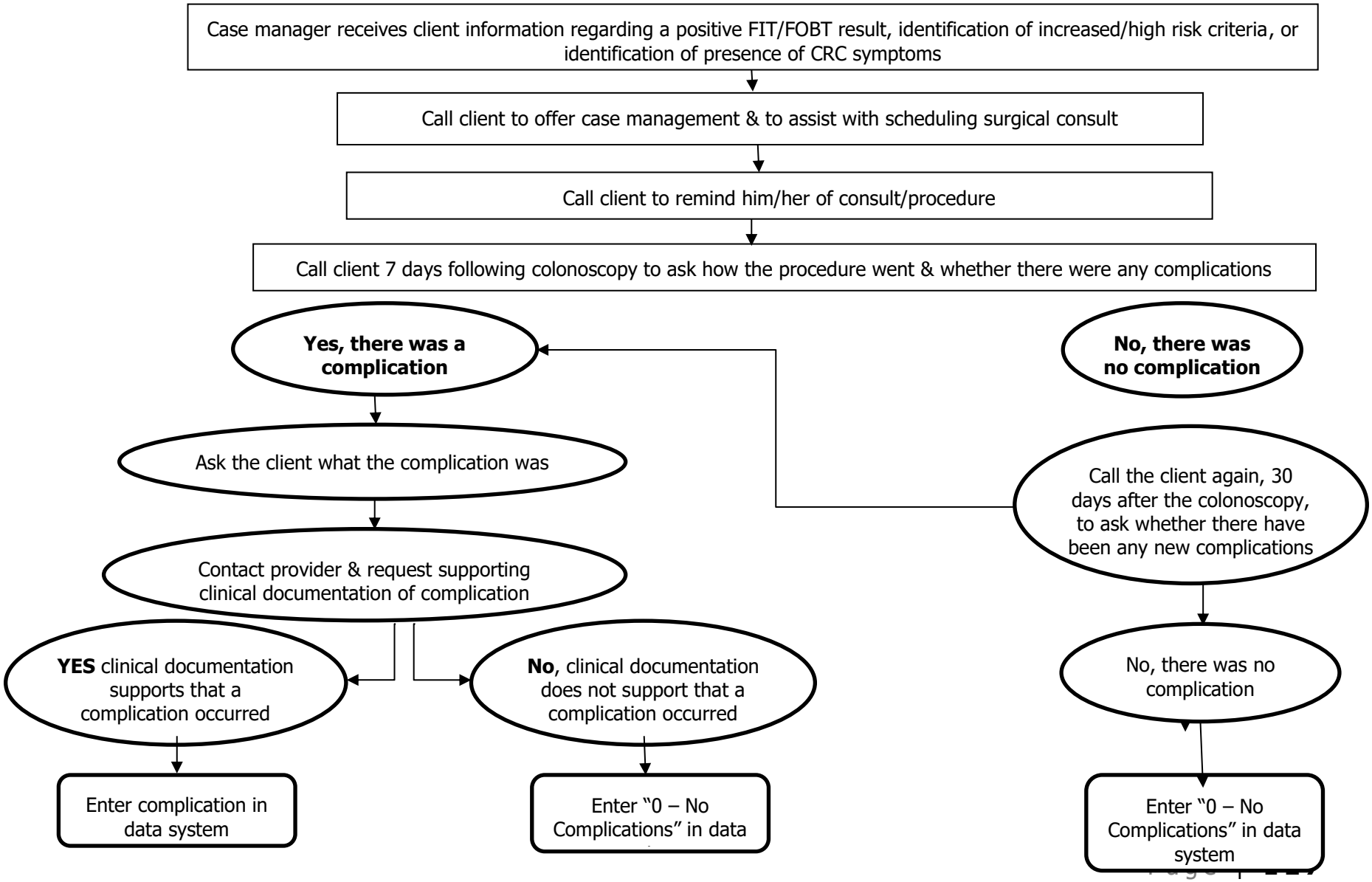
    a. If no complications are reported, the case manager will indicate this on the data system.

    b. If a complication is reported, the case manager will ask the client what it was. The case manager will then ascertain where care was provided and will contact the hospital/provider to request the report and clinical documentation to verify the complication. If the document does not support evidence of a complication, the case manager will indicate this when reporting on the data system. If the documentation does indicate that a complication occurred, the case manager will indicate the complication on the data system.

*See attachment 5-VIII for definitions of these complications.

Attachment 5-VII Case Management CRC Complications Algorithm

Case Management Colorectal Cancer Complications Algorithm



Attachment 5-VIII Definitions of Colonoscopy Complications

Definitions of Colonoscopy Complications

0 = *No complication reported*: self-explanatory

1 = *Bleeding requiring transfusion*: if a transfusion has occurred, clinical documentation will state one of the following examples: "transfused with packed red blood cells", "transfused with packed cells", "transfused with red cells", or "transfused with RBCs"

2 = *Bleeding not requiring transfusion*: clinical documentation will have a description of the bleeding, including the amount ("scant", "small", or a measured amount), with a description of what steps were taken to stop the bleeding. The documentation samples in #1 will NOT appear on the report.

3 = *Cardiopulmonary events (e.g. hypotension, hypoxia, arrhythmia, etc.)*: hypotension (low blood pressure), hypoxia (lack of oxygen), arrhythmia (irregular heartbeat accompanied by palpitations, dizziness, fainting, shortness of breath and/or chest pains). These symptoms will typically occur during, or immediately after, the colonoscopy procedure.

4 = *Complications related to anesthesia*: these include allergic reactions (the medical term is anaphylaxis), which are usually described as difficulty breathing, swelling of the face/mouth, appearance of a red rash, increased heart rate, and/or low blood pressure (the medical term is hypotension). Non-allergic reactions that might occur are nausea, vomiting, hypotension, and respiratory depression (poor breathing).

5 = *Bowel perforation**: clinical documentation may state that the client complained of persistent abdominal pain and distention, or that the client presented with peritonitis, fever, and an elevated white blood cell count (the medical term is leukocytosis). Documentation will state that a perforation occurred, and where it is located; how the perforation was treated will also be included.

6 = *Post-polypectomy syndrome/excessive abdominal pain**: clinical documentation will reveal client complains of abdominal pain, fever, and an elevated white blood cell count (the medical term is leukocytosis). This complication may occur if a polyp has been removed.

7 = *Death*: self-explanatory

8 = *Other*: other possible complications include rupture of the spleen, appendicitis, excessive bleeding related to reasons other than polyp removal or bowel perforation, and problems related to improper disinfection of the colonoscope (the lighted tube used to view the colon).

***** Although numbers 5 & 6 have similar symptoms, the complications are a result of different issues. Symptoms for #5 occur from a bowel perforation, and symptoms from #6 occur from the removal of a polyp.

Chapter 6 – Reimbursement

CSP Operations Manual 2017

Chapter 6: Reimbursement

A. Guidelines

Clinical services are paid for by the CSP Contractor (Component A grantees) or by the State and/or Health Research, Inc. (HRI) (Component B grantees). Payment is made to the CSP-credentialed provider after the contractor has submitted all required data to the NYSDOH CSP. Monthly billing reports generated from the data system are used to create vouchers, which are then used to bill the State and HRI for reimbursable clinical services provided to eligible clients.

Component A contractors receive payment from the State and HRI and subsequently reimburse the providers with whom they have agreements for provision of services to eligible CSP clients. These contractors then invoice for the services in accordance with the CSP maximum allowable reimbursement rates.

All contractors must have written agreements with participating providers that include consent to provide services, as outlined in the CSP Operations Manual and provisions of the contract described in Participating Provider Requirements (see Operations Manual Chapter 2, Section D). For reimbursement of clinical services, contractors and providers must:

1: request reimbursement for clinical services only for clients who meet the eligibility criteria as defined in CSP Operations Manual Chapter 3 *(Eligibility)*

2: treat the CSP as the payor of last resort. All providers agree to first bill clients' other insurance and/or third party payor(s) for services provided through the CSP. Providers further agree that they may not submit claims for reimbursement directly to New York State (NYS) but will provide information to CSP contractors for submission on the CSP data system for reimbursement

3: accept reimbursement rates as established by the CSP as payment in full for all services that are covered by the CSP. Maximum Allowable Reimbursement Schedule (MARS) rates are issued annually by the CSP, and are included in the *New York State Department of Health Cancer Services Program Reimbursement Schedule* (Attachment 6-I). That schedule represents reimbursement in full for specific services, including a visit required to receive results.

   The CSP does not reimburse for services billed by Current Procedural Terminology (CPT) code, or on Health Care Financing Administration (HCFA) billing forms. Providers agree not to charge clients for the difference between the CSP reimbursement rate and provider's usual fees or the amount allowed by the client's insurance plan. The CSP reimbursement rate is based on Medicare regional global rates, which include the technical and professional components of the service to be reimbursed. Under no circumstance shall providers bill CSP clients for the services that are reimbursed by the CSP.

4: submit reimbursable services in a timely manner, on a completed Screening Intake Form (SIF) or, where applicable, a Follow-up Form (FF)

5: submit accurate demographic, screening, diagnostic, treatment, and any other data required by NYS in a timely manner and in the format required by NYS

6: agree that the reimbursement for clinical services will not be provided by NYS for reimbursement to the provider until appropriate data have been submitted and accepted in the CSP data system

B. Maximum Allowable Reimbursement for Clinical Services

The CSP is the payor of last resort. The CSP will pay for services according to the *New York State Department of Health Cancer Services Program Reimbursement Schedule* (Attachment 6-I) ONLY if the client meets all eligibility criteria, and no other sources of payment are available for the services. Other sources include private insurance, managed care plans, Medicare, Medicaid, and Title X Family Planning Services.

> Payor of last resort as it applies to Indian Health Services (IHS) clinics and tribally-operated clinics is described as follows: IHS is designated as the payor of last resort meaning that all other available alternative resources, including IHS facilities, must first be used before payment is expected. According to 42 CFR 136.61 (2002), IHS is the payor of last resort for persons who have an alternate resource, notwithstanding any State or local law or regulation to the contrary. Accordingly, IHS will not be responsible for, or authorize payment for, medical services to the extent that an alternate resource is available[1]. Therefore, the CSP may be billed for eligible services rendered outside of the IHS provider or facility to persons qualifying under the IHS who have no additional health insurance coverage or source of payment.

The reimbursement criteria are not clinical guidelines. These criteria address reimbursement of services through the CSP only. Alternate funds must be identified to reimburse for services that are recommended by providers but which are not reimbursed by the CSP.

NOTE: for reimbursement policies related to Family Planning Programs, refer to Attachment 6-II: *Guidance for Cancer Services Program Contractors and Title X Family Planning Providers, July 2009*.

Breast cancer screening services

[1] Ref: CDC, NBCCEDP Program Guidance Manual, Policies and Procedures, Attachment C1, April 2007

clinical breast exam (CBE)

The CSP will reimburse for:

- a screening CBE annually for women 40 years of age and older
    - a screening CBE for a woman under age 40 who has been determined to be high-risk for breast cancer in accordance with CSP high-risk criteria, and for whom there is a signed attestation. See Operations Manual Chapter 4, Section H
- a short-term CBE (i.e. performed sooner than one year) for women aged 40 and older, if ordered by a clinician at least 30 days after an initial CBE to assess a "probably benign" finding. This should be submitted on a new SIF
- more than one CBE in a year if a woman aged 40 or older presents with an interval finding within the year (e.g. a woman finds a lump in her breast after having a negative CBE within the past year)

The CSP does not reimburse for a screening CBE in women under age 40 who have clinical significant findings for breast cancer, or for men at any age. The CSP will, however, reimburse for a repeat CBE reported on the FF as part of a diagnostic evaluation for a woman under age 40, and for men 18 years of age and older for clinical correlation of diagnostic testing, and when it is performed within 30 days of the diagnostic testing.

screening mammogram

The CSP will reimburse for

- a screening mammogram annually for women 40 years of age and older
- a short-term (i.e. a mammogram performed sooner than one year) repeat mammogram following a reported BI-RAD 3 ("probably benign, short-term mammogram recommended). This should be submitted on a new FF

The CSP does not reimburse for screening mammography in average-risk women under age 40. Women ages 18 – 39 who are determined to be at high risk for breast cancer, or who have clinically significant findings for breast cancer may be eligible for some CSP-reimbursed services. See Operations Manual Chapter 3, Section C-3.

The CSP reimburses for digital mammography, with or without tomosynthesis, at the same rate. Providers who are credentialed to provide film screen mammography will be reimbursed a partial amount of the CSP "program" reimbursement for screening and diagnostic mammography. This "partial" amount is equal to the Medicare regional reimbursement for film screen mammography and is noted at the bottom of the CSP Maximum Allowable Schedule. (Attachment 6-I). The process for requesting this payment is in Attachment 6-X. The CSP will *not* reimburse for computer-assisted detection (CAD). *The CSP does not reimburse for a screening mammogram for men*.

The CSP will reimburse for a breast MRI screening for women who are high risk for breast cancer ONLY under the specific conditions set forth in the *CSP Guidelines for Determination of Medical Necessity for Breast MRI* (see Attachment 4-IV).

Cervical screening services

pelvic exam

The CSP will reimburse for:

- a pelvic exam for women 40 years of age and older, when performed at the same time as an appropriate cervical cancer screening test
- a short-term (i.e. performed sooner than one year) repeat pelvic exam in women ages 40 and older, and based on abnormal findings of a previous cervical cancer screening, or a cervical cancer screening performed for surveillance purposes after recommended treatment, when performed at the same time as an appropriate cervical cancer screening test. This should be submitted on a new SIF.
- a short term (i.e. performed sooner than one year) pelvic exam in women ages 40 and older who present with an interval finding that may be suspicious for cervical cancer. This should be documented in the medical record, and submitted on a new SIF.
- an initial pelvic exam to determining if the client has an intact cervix for women ages 40 and older who have had a hysterectomy, but who are not sure if they have an intact cervix. For further explanation, see Operations Manual Chapter 3, Section C-8.

The CSP will not reimburse for pelvic exams performed during the years in between cervical cancer screenings for women who are receiving cervical cancer screening according to an appropriately lengthened interval.

cervical cytology (Pap test)

The CSP will reimburse for:

- a liquid-based Pap test every three (3) years for women 40 years of age and older who have an intact cervix and a prior negative test. An exception applies for those with a medical exemption from the three-year screening interval (see below)

- a conventional Pap test every three (3) years for women 40 years of age and older who have an intact cervix and a prior negative test

- a liquid-based Pap test every five (5) years when performed in combination with a high-risk HPV test, and when both tests are negative

- a short term (i.e. performed no sooner than 30 days, but usually 2-4 months after the initial unsatisfactory Pap) repeat Pap test in women ages 40 and older when the prior Pap test was deemed unsatisfactory. This should be submitted on a new SIF.

- a conventional or liquid-based Pap test every three (3) years (after initial surveillance at the appropriate prescribed intervals with negative results) for women 40 and older, who have had a hysterectomy due to cervical cancer or pre-cancerous cervical dysplasia. See Operations Manual Chapter 3, Section C-8 for more information.

- a conventional or liquid-based Pap test annually for women 40 years and older who have a documented medical exception due to being immunocompromised, infected with HIV, or who were exposed to diethylstilbestrol (DES) while in utero (as a fetus).

The CSP provides reimbursement for conventional and liquid-based cytology at different reimbursement rates. The CSP applies one rate to conventional cytology, and another rate for liquid-based cytology, regardless of the methodology, level of interpretation, or the CPT code billed for reimbursement.

The CSP will reimburse for cervical cancer screening at intervals prescribed by the updated Cervical Cancer Screening CSP Reimbursement Guidelines (Attachment 6-IV).

The CSP does not reimburse for a Pap test in a client who has had a total hysterectomy, and whose cervix was removed, for reasons other than cervical cancer or pre-cancerous cervical dysplasia. See Operations Manual Chapter 3, Section C-8.

human papillomavirus (HPV) DNA testing (high-risk only)

The CSP will reimburse for high-risk (HR) HPV DNA (Hybrid Capture II), Cervista HR HPV, or cobas® HPV test for women ages 40 and older for screening:

- in conjunction with cytology for cervical cancer screening, performed at the appropriate intervals
- when performed as surveillance 12 months after biopsy has confirmed CIN 1 or less, with index Pap test for colposcopy of ASC-US, ASC-H, or LGSIL
- when performed in 12 months as follow-up to a prior negative Pap test and a positive HR HPV DNA test
- when performed as surveillance co-testing 12 months and 24 months after treatment of CIN 2 or greater

The CSP will reimburse for HR HPV testing, but will not reimburse for additional genotyping of 16/18. If genotyping is subsequently performed, only **one** HR HPV testing rate will be reimbursed.

colorectal cancer screening services

- fecal tests
- high sensitivity fecal occult blood test (gFOBT).

The CSP will reimburse for an annual, take-home high sensitivity approved FOBT kit:

- only for women and men 50 years of age and older who are at average risk for colorectal cancer and who have not completed an FOBT or FIT kit in the past ten (10) months

The CSP will not reimburse for an in-office, single-slide fecal test. *Please note: diagnostic services based on a positive in-office, single-slide fecal test will not be reimbursed.*

fecal immunochemical test (FIT) kit

The CSP will reimburse for an annual, take-home FIT kit from the approved list:

- only for women and men 50 years of age and older who are at average risk for colorectal cancer and who have not completed a FIT or FOBT kit in the past ten (10) months

screening colonoscopy

The CSP will reimburse for:

- screening colonoscopy for clients who are at increased or high risk for colorectal cancer. See Operations Manual Chapter 3, Section C-9

The CSP will not reimburse for screening colonoscopy in clients who are at average risk for colorectal cancer. An exception is those clients who have undergone screening in the selected CSP pilot programs.

Breast cancer diagnostic services

The reimbursement policies below apply to women 40 years of age and older, women under age 40 who are deemed high-risk for, or with clinically significant findings for, breast cancer and who are otherwise eligible for the CSP. The following diagnostic procedures can be reimbursed only following an abnormal CBE or a screening mammogram with a finding of BI-RAD 4, 5, or 6/0. The CSP will reimburse for the following services only until a definitive diagnosis is obtained. Coverage for post-diagnostic services may be available to eligible clients who enroll in the New York State Medicaid Cancer Treatment Program. See Operations Manual Chapter 7 for more information.

The numbers in parentheses below represent the codes on the follow-up form and CSP data system for each procedure.

(01) unilateral diagnostic mammogram, (90) bilateral diagnostic mammogram (special views ONLY)

The CSP will reimburse for:

- a diagnostic mammogram, either bilateral or unilateral. In the CSP, a diagnostic mammogram is defined as "one or more special views, such as a cone view, magnification view, or compressed view, which is performed in addition to the four standard views – medial, lateral and oblique [MLO] and craniocaudal [CC] view of the left and right breasts"
- a specimen radiograph (post-operative mammogram of the removed area of concern), if not included in an all-inclusive procedure fee
- a post-procedure mammogram to examine the site of biopsy, if not included in an all-inclusive procedure fee
- a six (6)-month short term follow-up after the biopsy for a **mammographic** finding to ascertain stability (report on new SIF)

NOTE: procedures (16) and (84) stereotactic breast biopsy, and procedure (25) and (86) are all-inclusive codes, and already include specimen radiograph and post-procedure film. The CSP does not reimburse for additional implant-displaced views as a diagnostic mammogram. The CSP does not reimburse for tomography as a special view.

Note: reimbursement for film screen mammography is a partial amount of the CSP "program" reimbursement for diagnostic mammography. This "partial" amount is equal to the Medicare regional reimbursement for film screen mammography and found at the bottom of the CSP Maximum Allowable Schedule (Attachment 6-1). See Attachment 6-X for the process to request this payment.

(02) repeat clinical breast exam (RCBE)

The CSP will reimburse for:

- a repeat CBE following a finding on a screening CBE
- a repeat CBE if done at the time of a surgical consult or a second opinion for a clinically palpable finding
- a repeat CBE for clinical correlation of imaging findings within 30 days of the original abnormal screening CBE (after 30 days can be reported on a new SIF, if appropriate.)

(03) surgical consult/second opinion

The CSP will reimburse for:

- a surgical consult prior to a biopsy OR on the same day as the biopsy
- a second opinion when performed prior to a biopsy
- a second opinion/surgical consult when 1: performed by a different provider and 2: following a biopsy that is discordant with physical examination or imaging or pathology findings and 3: that requires a second biopsy for a definitive diagnosis to rule out breast cancer. Example: A client has a stereotactic breast biopsy in which atypical micropapillomas are present in pathology specimen, and the recommendation is a surgical consult for excisional biopsy. The second surgical consult, if performed by a different provider after the initial biopsy, would be reimbursed.

The CSP does not reimburse for a surgical consult or a second opinion once a diagnosis has been determined (i.e. post-diagnosis).

(04) diagnostic breast ultrasound (sonogram)

The CSP will reimburse for:

- a breast ultrasound, only after a clinically significant finding has been determined by a NYS-licensed health care provider on a CBE or mammogram
- bilateral ultrasounds (ultrasounds performed on both breasts), reimbursed at the same rate as a unilateral ultrasound. Bilateral ultrasound should be performed only if there are bilateral findings that require diagnostic ultrasound.
- one short-term, repeat ultrasound, when clinically indicated based on the findings from a previous "probable benign" short-term study. To receive reimbursement for this procedure, the contractor must submit the procedure on a Revision Form for inclusion on the follow-up form that contains the initial "probable benign" short-term ultrasound.
- a diagnostic ultrasound when performed as image guidance for a biopsy
- a diagnostic ultrasound when performed as image guidance for a biopsy procedure that does not result in biopsy because the lesion/area to be biopsied is not located.

The CSP reimbursement for a diagnostic breast ultrasound is for a unilateral OR bilateral ultrasound. The CSP will not reimburse for screening breast ultrasounds or survey ultrasounds for dense breast tissue alone. The CSP will not reimburse for ultrasounds when performed as follow-up to mammography findings of benign dense breast tissue alone, or to follow benign breast conditions post-diagnosis. This includes routine 6-month ultrasound following a breast biopsy with a benign finding. The CSP will reimburse for only one ultrasound on the same day performed by the same provider.

(07) fine needle aspiration biopsy (FNAB) with ultrasound guidance

The CSP will reimburse for:

- FNAB with image guidance only when performed to rule out breast cancer, not when performed to drain a cyst or to reduce pain from simple cysts
- one FNAB with image guidance per lesion if there are multiple lesions
- only one FNAB with image guidance if there are multiple samples taken from a single lesion

Please note that the reimbursement rate includes reimbursement for ultrasound guidance used during the FNAB. If the ultrasound does not locate the lesion at the time of FNAB, and the biopsy is not performed, then the ultrasound can be reimbursed as (04) diagnostic ultrasound, and the FNAB is not reported. The CSP will not reimburse for a post-biopsy FNAB. The CSP will not reimburse for FNAB for cyst draining or when performed to relieve symptoms of mastalgia.

(08) core breast biopsy

The CSP will reimburse for:

- core biopsy taken from a lesion to rule out breast cancer

(09) incisional breast biopsy

The CSP will reimburse for:

- an incisional biopsy taken from a lesion to rule out breast cancer

(10) excisional breast biopsy

The CSP will reimburse for:

- an excisional breast biopsy that removes the entire lesion to rule out breast cancer
- one excisional biopsy per lesion, if there are multiple lesions
- only one excisional biopsy if there are multiple samples taken from a single lesion

The CSP does not reimburse for an excisional breast biopsy (lumpectomy) if performed after a diagnosis of cancer has already been determined.

(11) cytology, breast fluids

The CSP will reimburse for:

- cytology of breast fluids only when submitted to a lab for diagnosis following FNAB

- one cytology per lesion, if there are multiple lesions

(12) histology, breast tissue

The CSP will reimburse for:

- breast tissue histology following a core, incisional, excisional, or stereotactic biopsy
- only one histology per lesion for all biopsies. Multiple samples from the same lesion will be reimbursed as one histology

(82) surgical pathology, gross and microscopic, needing examination of surgical margins

This code is used only in the special circumstance of a pathology specimen that requires examination of the margins to determine the extent of disease. It is not used for examination of benign specimens.

(14) cytology, nipple smear

The CSP will reimburse for:

- nipple smear cytology when done to rule out breast cancer

The reimbursement fee includes both the collection and reading of the sample.

(15) pre-operative mammographic needle localization and wire placement (all-inclusive procedure reimbursement)

The CSP will reimburse for:

- mammographic needle localization, when performed pre-operatively to a biopsy to locate a lesion and place a wire to localize the lesion prior to biopsy

When a mammographic needle localization is attempted and the area of concern is not found and, therefore, no needle/wire is advanced and the biopsy is cancelled, the (01) diagnostic mammogram and (03) surgical consult can be reimbursed, and the (15) pre-operative mammographic needle localization and wire placement should not be reported on the FF.

(83) additional pre-operative mammographic needle localization and wire placement, second lesion

- reimbursed as noted above in (15), when a second lesion requires mammographic needle localization and wire placement on the same day

(16) stereotactic biopsy procedures (regardless of biopsy apparatus employed) – all-inclusive procedure; placement of breast localization device(s) (e.g. clip, metallic pellet), **imaging of the biopsy specimen, percutaneous biopsy first lesion, including stereotactic guidance**

The CSP will reimburse for:

- a stereotactic biopsy when performed to rule out breast cancer

When a stereotactic procedure is performed using core biopsy(ies), the all-inclusive rate for stereotactic procedures includes payment for mammographic localization, core biopsy(ies), image-guided clip placement and post-procedure imaging of placement, and the post-procedure specimen radiograph. Procedure (16) stereotactic biopsy procedures with core(s) must be reported.

(84) stereotactic procedure, all-inclusive – second lesion (as above)

When a second stereotactic procedure is performed on a second lesion (same or opposite breast) on the same day, procedure code (84) is reported for the second lesion, and for any additional lesions where stereotactic biopsy procedure is employed.

For pathology reimbursement associated with the stereotactic biopsy procedure, see (12) breast tissue histology (above).

If stereotactic breast biopsy is attempted and the lesion cannot be identified and, therefore, the biopsy cannot be performed, (01) diagnostic mammogram view(s) to locate the lesion, and (03) surgical consult can be reimbursed; the all-inclusive stereotactic procedure should not be reported on the FF.

(17) Mammary ductogram/galactogram

The CSP will reimburse for:

- a ductogram/galactogram to evaluate abnormal nipple discharge (bloody, colorless, or clear in color are categorized as more suspicious) from a single duct.

(18) anesthesiologist services

The CSP will reimburse for:

- anesthesiologist services only when an anesthesiologist or nurse anesthetist administers IV monitored anesthesia care

An anesthesiologist's fee will not be reimbursed for a surgeon or other physician (non-anesthesiologist) administering local anesthesia or conscious sedation.

(19) chest x-ray

The CSP will reimburse for:

- a pre-operative chest x-ray only prior to an incisional or excisional breast biopsy

(20) electrocardiogram (ECG/EKG)

The CSP will reimburse for:

- a pre-operative ECG/EKG only prior to an incisional or excisional breast biopsy

(21) complete blood count (CBC)

The CSP will reimburse for:

- a preoperative CBC only prior to an incisional or excisional breast biopsy

(22) pre-operative ultrasonic needle localization and wire placement – all-inclusive procedure reimbursement

The CSP will reimburse for:

- ultrasonic needle localization when performed pre-operatively to locate a lesion and place a wire to localize the lesion prior to excisional biopsy

When ultrasonic needle localization is attempted but the area of concern is not found and, therefore, the needle/wire is not advanced and the biopsy is cancelled, (04) diagnostic ultrasound, and (03) surgical consult can be reimbursed, and the (22) is not reported.

(85) additional pre-operative ultrasonic needle localization and wire placement, second lesion

- as above, when a second lesion requires US needle localization and wire placement on the same day

(23) facility fee – core biopsy

The CSP will reimburse for:

- facility fee for a core biopsy when performed at an Article 28 facility

A facility fee is intended to cover the use of operating and recovery rooms, and medical-surgical supplies. Reimbursement is provided for only one facility fee per day, regardless of the number of biopsies performed.

(24) facility fee – excisional/incisional biopsy

The CSP will reimburse for:

- facility fee for an excisional or incisional biopsy when performed at an Article 28 facility

A facility fee is intended to cover the use of operating and recovery rooms, and medical-surgical supplies. Reimbursement is provided for only one facility fee per day, regardless of the number of biopsies performed.

(25) ultrasound-guided core needle biopsy with vacuum-assisted device – all-inclusive procedure; placement of breast localization device(s) (e.g. clip, metallic pellet), imaging of the biopsy specimen, percutaneous biopsy(ies); first lesion, including US guidance

The CSP will reimburse for:

- ultrasound-guided core needle biopsy using a vacuum-assisted rotating biopsy device, only when performed to rule out breast cancer

Please note that the reporting of this procedure code is all-inclusive

(86) second lesion – US-guided vacuum-assisted breast biopsy procedure – all-inclusive (as above)

When a second US-guided, vacuum-assisted breast biopsy procedure is performed on a second lesion (same or opposite breast) on the same day, procedure code (86) is reported for the second, and any additional lesions, where stereotactic biopsy procedure is employed.

(29) fine needle aspiration breast biopsy (FNAB) without image guidance

The CSP will reimburse for:

- FNAB without image guidance, only when performed to rule out breast cancer and not when performed to drain a cyst or reduce pain from simple cysts
- one FNAB without image guidance per lesion if there are multiple lesions
- only one FNAB without image guidance if there are multiple samples taken from a single lesion

Please note that, if the lesion is not palpable at the time of the biopsy, and the biopsy is not performed, then FNAB is not reported. The CSP will not reimburse for a post-biopsy FNAB. The CSP will not reimburse for FNAB for cyst draining, or when performed to relieve mastalgia.

(26) bilateral breast MRI-

(89) unilateral breast MRI

The CSP will reimburse for breast MRI screening for women who are high risk for breast cancer ONLY under the specific conditions set forth in the CSP Guidelines for Determination of Medical Necessity for Breast MRI. See Clinical Guidance, Chapter 4 (Attachment 4-IV).

Cervical cancer diagnostic services

The reimbursement policies below apply to women aged 40 years and older, who are otherwise eligible for the CSP.

The following procedures can be reimbursed only after one or more of the following conditions have been met:

- the client has had a screening pelvic exam with an exam finding that is reported as suspicious for cervical cancer
- the client has had a Pap test finding of:
- 2nd atypical squamous cells of undetermined significance (ASC-US) at 12 months (03)
- low-grade squamous intraepithelial lesion (LSIL) (04), no HPV performed, or positive HR HPV co-test
- high-grade squamous intraepithelial lesion (HSIL) (05)
- squamous cell cancer (06)
- atypical squamous cells; cannot exclude HSIL (ASC-H) (08)
- atypical glandular cells (AGC); all sub-types including adenocarcinoma in situ, but excluding atypical endometrial cells only (12)
- 2nd negative Pap cytology with a positive HR HPV at 12 months

The CSP will reimburse for services only until a definitive diagnosis is obtained. Coverage for post-diagnostic services may be available to clients who enroll in the NYS MCTP. See Operations Manual Chapter 7 for more information.

The numbers in parentheses below are the codes that should be reported for each procedure on the CSP follow-up form and in the data system.

(52) colposcopy without biopsy

The CSP will reimburse for:

- a colposcopy without biopsy when a colposcopy is performed and no lesion is visualized or biopsied

According to the American Society for Colposcopy and Cervical Pathology (ASCCP), colposcopy with endocervical sampling is preferred in women with no lesions observed and/or with unsatisfactory colposcopy (incomplete visualization of entire squamocolumnar junction and margin of any visible lesion).

The CSP will not reimburse for the colposcopy if a Pap test and a colposcopy are performed on the same day.

The CSP will reimburse for a short-term repeat colposcopy without biopsy only as active surveillance at 6-month intervals to a biopsy-confirmed grade 2 or 2,3 cervical intraepithelial neoplasia (CIN 2 or CIN 2,3) that is not being actively treated when the client is not eligible for MCTP active surveillance.

The CSP will not pay for surveillance or repeat colposcopy when a diagnosis of CIN1 is obtained, unless the client has a new abnormal Pap test that initiates colposcopy follow-up.

(53) colposcopy-directed biopsy

The CSP will reimburse for:

- a colposcopy-directed biopsy when a colposcopy is performed, lesions are visualized, and a biopsy is taken from one or more lesions

Only one colposcopy fee will be reimbursed regardless of the number of tissue samples taken during biopsy.

(54) gynecologic consultation (cervical)

The CSP will reimburse for:

- a gynecologic consultation prior to a colposcopy to discuss with the client the risks & benefits and/or the procedure to be performed
- a gynecologic consultation after a colposcopy but prior to a diagnostic excisional procedure to discuss with the client the options available and/or the procedure to be performed

Only one gynecologic consult will be reimbursed, unless it is a second opinion by a participating provider prior to the colposcopy. The CSP will not reimburse for a surgical consult or a second opinion completed post-diagnosis. The gynecologic consultation is not intended to be the appointment to discuss the results of a Pap test.

(56) diagnostic loop electrosurgical excision procedure (LEEP) or loop electrical excision of the transformation zone (LEETZ) biopsy (the process of obtaining a specimen from the transformation zone and endocervical canal for histological evaluation

The CSP will reimburse for:

- a LEEP or LEETZ biopsy that is performed as a diagnostic procedure and meets these criteria:
- the initial Pap test finding was: AGC (favor neoplasia), adenocarcinoma in situ (AIS), or squamous cell cancer
- the initial Pap test finding was HSIL or ASC-H, and the colposcopy was unsatisfactory; or if HSIL is found on surveillance co-testing at 12 and 24 months

(57) diagnostic cold knife cone biopsy

The CSP will reimburse for:

- a diagnostic cold knife cone biopsy that is performed as a diagnostic procedure, and meets the following criteria:
- the initial Pap test finding was: AGC (favor neoplasia), adenocarcinoma in situ (AIS), or squamous cell cancer
- the initial Pap test finding was HSIL or ASC-H, and the colposcopy was unsatisfactory; or if HSIL is found on surveillance co-testing at 12 and 24 months

(59) cervical pathology tissue

The CSP will reimburse for:

- one pathology charge when the tissue samples are submitted as one specimen in one container (in toto)
- multiple pathology charges, if the separate tissue samples are submitted in separate containers
- ECC pathology when the procedure is performed on the same day as the colposcopy

(88) surgical pathology, gross and microscopic, needing examination of surgical margins

This code is used only in the special circumstance where a pathology specimen requires examination of the margins to determine the extent of disease (e.g. +LEEP, +cone). It is not used for examination of benign specimens.

(61) conventional cytology

The CSP will reimburse for:

- conventional cytology when required to be performed at the time of a surveillance colposcopy, or when the colposcopy for an HSIL or AGC Pap test

occurs more than five (5) months after the initial (index) cytology. These are the only instances in which a Pap test is submitted on the follow-up form.

(62) chest x-ray

The CSP will reimburse for a pre-operative chest x-ray:

- only prior to a colposcopy or diagnostic excisional procedures (LEEP, LEETZ, cold knife, or laser cone biopsy)

(64) complete blood count (CBC)

The CSP will reimburse for a pre-operative CBC:

- only prior to a colposcopy or diagnostic excisional procedures (LEEP, LEETZ, cold knife, or laser cone biopsy)

(65) high-risk human papillomavirus DNA test (HR HPV)

The CSP will reimburse for:

- HR HPV DNA hybrid capture 2 high-risk types only or Cervista HR HPV test immediately following a finding of ASCUS (03) on a screening Pap test (reflex testing)
- when performed at the time as a colposcopy for evaluation of an AGC pap, when HPV testing was not done as part of screening with a Pap test

The CSP will not reimburse for HR HPV testing performed on a Pap test finding greater than ASC, as those clients will be referred for diagnostic evaluation with colposcopy/ECC.

The CSP will not reimburse for a HR HPV DNA test performed on the same day as a colposcopy, except in the case of a woman aged 40 or older with a diagnosis of AGC as indicated above.

(66) colposcopy with cervical biopsy and endocervical curettage (ECC)

The CSP will reimburse for a colposcopy with cervical biopsy and ECC:

- when a colposcopy is performed, lesions are visualized, a biopsy is taken from one or more lesions, and an ECC is performed

(67) colposcopy with ECC

The CSP will reimburse for:

- a colposcopy without cervical biopsy and an ECC is performed

(68) endometrial biopsy

The CSP will reimburse for:

- endometrial biopsy after a Pap test result of AGC (all subcategories except endometrial only) AND when the client is either aged 40 or older with a clinical history of abnormal bleeding OR a condition consistent with anovulation (a condition wherein an egg is not released from the woman's ovary)

(69) Article 28 facility fee for diagnostic LEEP, LEETZ, cold knife, or laser cone biopsy

The CSP will reimburse for:

- a facility fee for diagnostic LEEP, LEETZ, cold knife, or laser cone biopsy when performed at an Article 28 facility

A facility fee is intended to cover the use of operating and recovery rooms, personnel, and medical/surgical supplies.

(70) anesthesiologist services

The CSP will reimburse for:

- anesthesiologist services during diagnostic LEEP, LEETZ, cold knife, or laser cone biopsy ONLY when an anesthesiologist or nurse anesthetist administers IV monitored anesthesia care

An anesthesiologist fee will not be reimbursed for a surgeon or other physician (non-anesthesiologist) administering local anesthesia or conscious sedation.

(71) liquid-based cytology

The CSP will reimburse for:

- liquid-based cytology when required to be performed at the time of surveillance colposcopy, or when the colposcopy for an HSIL or AGC Pap test occurs more than five (5) months after the index cytology. These are the only instances in which a Pap test is submitted on a follow-up form

Colorectal cancer diagnostic services

The following diagnostic procedures will be reimbursed only after a positive, take-home fecal test result, OR if the client is assessed to be at increased or high risk for colorectal cancer or is symptomatic for colorectal cancer. See Operations Manual Chapter 3 Section C-9. The CSP will reimburse for services only until a definitive diagnosis is

obtained. Coverage for post-diagnostic services may be available to clients who enroll in the NYS MCTP (see Operations Manual Chapter 7).

The numbers in parentheses below are the codes for each procedure that should be indicated on the CSP follow-up form and in the data system.

(32) flexible sigmoidoscopy

The CSP will reimburse for a flexible sigmoidoscopy:

- when a colonoscopy is medically contraindicated, as determined by a physician and documented in the client's record
- when a colonoscopy is incomplete and, therefore, no final diagnosis is determined

(33) flexible sigmoidoscopy with polypectomy by hot biopsy forceps or cautery

The CSP will reimburse for a flexible sigmoidoscopy with polypectomy:

- when a colonoscopy is medically contraindicated, as determined by a physician and documented in the client's record
- when a colonoscopy is incomplete and, therefore, no final diagnosis is determined

(34) flexible sigmoidoscopy with biopsy (single or multiple)

The CSP will reimburse for a flexible sigmoidoscopy with biopsy:

- when a colonoscopy is medically contraindicated, as determined by a physician and documented in the client's record
- when a colonoscopy is incomplete and, therefore, no final diagnosis is determined

(35) radiologic exam, colon, barium enema

The CSP will reimburse for a double-contrast barium enema (DCBE):

- when a colonoscopy is medically contraindicated, as determined by a physician and documented in the client's record
- when a colonoscopy is incomplete and, therefore, no final diagnosis is determined

(36) colonoscopy

The CSP will reimburse for:

- a diagnostic colonoscopy following a positive, take-home fecal test kit, or following the identification of symptoms of colorectal cancer
- a screening colonoscopy for any client who has undergone prior approval and is determined to be at increased or high risk for colorectal cancer according to CSP eligibility and guidance for prior approval. See Operations Manual Chapter 3, Section C-9, and Chapter 4, Section E for more information.
- a repeat colonoscopy if the initial colonoscopy could not be completed for reasons such as poor preparation or client's inability to tolerate the first procedure

(37) colonoscopy with biopsy (single or multiple)

The CSP will reimburse for:

- a diagnostic colonoscopy with biopsy, following a positive, take-home fecal test kit, or following the identification of symptoms of colorectal cancer
- a screening colonoscopy with biopsy for any client who has undergone prior approval and is determined to be at increased or high risk for colorectal cancer according to CSP eligibility and guidance for prior approval. See Operations Manual Chapter 3, Section C-9, and Chapter 4, Section E for more information.
- a repeat colonoscopy with biopsy if the initial colonoscopy could not be completed for reasons such as poor preparation or client's inability to tolerate the first procedure

(38) colonoscopy with removal of tumor(s) or polyp(s) by hot biopsy forceps or bipolar cautery

The CSP will reimburse for:

- a diagnostic colonoscopy of this type following a positive, take-home fecal test kit, or following the identification of symptoms of colorectal cancer
- a screening colonoscopy of this type for any client who has undergone prior approval and is determined to be at increased or high risk for colorectal cancer according to CSP eligibility and guidance for prior approval. See Operations Manual Chapter 3, Section C-9, and Chapter 4, Section E for more information.
- a repeat colonoscopy of this type if the initial colonoscopy could not be completed for reasons such as poor preparation or client's inability to tolerate the first procedure

(39) colonoscopy with removal of tumor(s) or polyp(s) by snare technique

The CSP will reimburse for:

- a diagnostic colonoscopy of this type following a positive, take-home fecal test kit, or following the identification of symptoms of colorectal cancer
- a screening colonoscopy of this type for any client who has undergone prior approval and is determined to be at increased or high risk for colorectal cancer according to CSP eligibility and guidance for prior approval. See Operations Manual Chapter 3, Section C-9, and Chapter 4, Section E for more information.
- a repeat colonoscopy of this type if the initial colonoscopy could not be completed for reasons such as poor preparation or client's inability to tolerate the first procedure

(41) anesthesiologist service

The CSP will reimburse for:

- monitored anesthesia care (MAC) ONLY when medically indicated and administered by an anesthesiologist/anesthetist

The CSP will not reimburse for the administration of medication and monitoring of the patient if performed by the endoscopy team. The presence of an anesthesiologist or anesthetist will not be deemed medically necessary except in those rare instances when a client has a pre-existing unstable medical condition. For more information, see Operations Manual Chapter 4, Section F.

Conscious sedation (such as Versed and Demerol) is included in the reimbursement fee for colonoscopy.

(42) surgical pathology, gross and microscopic examination

The CSP will reimburse for:

- surgical pathology of tissue removed during a colonoscopy with biopsy (procedures 37, 38 or 39) or flexible sigmoidoscopy with biopsy (procedures 33 or 34)
- multiple pathologies of tissue samples if removed and analyzed separately during a colonoscopy with biopsy (procedures 37, 38 or 39) or flexible sigmoidoscopy with biopsy (procedures 33 or 34)

(87) surgical pathology, gross and microscopic, needing examination of surgical margins

This code is used only in the special circumstance when a pathology specimen requires examination of the margins to determine the extent of disease. It is not used for examination of benign specimens.

(43) medical or surgical consultation

The CSP will reimburse for:

- a consultation following a positive, take-home fecal test kit result, and prior to a colonoscopy, sigmoidoscopy, or barium enema, or following identification of symptoms of colorectal cancer
- for a client who is determined to be at increased or high risk for colorectal cancer according to CSP guidance: a medical consultation prior to a colonoscopy, sigmoidoscopy, or barium enema. For more information, see Operations Manual Chapters 3 and 4.
- a medical consultation for clients aged 50 – 64 who present with symptoms as outlined in Operations Manual Chapter 3, Sections C-9 and C-10. If the GI consult does not result in a colonoscopy at that time, Contact the CSP Data Unit to perform an override to allow for this service.
- a second opinion by another program provider that occurs prior to a colonoscopy, sigmoidoscopy, or barium enema
- a medical consultation provided for an increased- or high-risk client at an eligible interval determined by prior colonoscopy (see Attachment 6-III), where the GI consult does not result in a colonoscopy at that time. Contact the CSP Data Unit to perform an override to allow for this service.

The CSP will not reimburse for a medical consultation completed post-diagnosis. The CSP will not reimburse for a medical or surgical consultation to determine if a client is at increased or high risk.

(45) chest x-ray

The CSP will reimburse for:

- a pre-operative chest x-ray provided only prior to a colonoscopy

(46) electrocardiogram (EKG/ECG)

The CSP will reimburse for:

- a pre-operative EKG provided only prior to a colonoscopy

(47) complete blood count (CBC)

The CSP will reimburse for:

- a pre-operative CBC provided only prior to a colonoscopy

(48) facility fee – sigmoidoscopy

The CSP will reimburse for:

- a facility fee for a sigmoidoscopy performed at an Article 28 facility

(48) facility fee – colonoscopy

The CSP will reimburse for:

- a facility fee for a colonoscopy performed at an Article 28 facility

These facility fees are intended to cover the use of operating and recovery rooms, and medical/surgical supplies. Reimbursement for the facility fee does not apply to non-Article 28-accredited office-based surgery practices.

(50) second technique – colonoscopy biopsy procedure

The CSP will reimburse for:

- a second biopsy technique performed during a colonoscopy

This reimbursement addresses the additional expense associated with performing a second biopsy technique. For example, one polypectomy may be performed using the snare technique (code 39), while another polypectomy is performed using hot biopsy forceps (code 38) during the same colonoscopy procedure. In this example, the more expensive procedure (snare technique) should be entered on the follow-up form, using procedure code 39. The second technique (hot biopsy forceps) should be entered on the follow-up form using procedure code 50.

Re-screening after a CSP-funded colonoscopy

Refer to Attachment 6-III for detailed reimbursement criteria on which colorectal cancer screening and diagnostic services can be reimbursed, and when those services can be reimbursed after a CSP-funded colonoscopy has been completed.

Note that these reimbursement criteria are not eligibility guidelines for initial screening through the CSP. For eligibility guidelines, refer to Operations Manual Chapter 3, Section C-9.

Attachment 6-I NYSDOH CSP Reimbursement Schedule

New York State Department of Health Cancer Services Program Reimbursement Schedule 4/1/2017- 3/31/2018							
			< ---------- Medicare Regions---------- >				
	Data system Procedure Codes	Guiding CPT Code(s)***	Upstate 13282-99	Manhattan 13202-01	Rest of Metro 13202-02	Hudson Valley 13202-03	Queens 13292-04
Breast/Cervical Procedures							
Screening mammogram - bilateral (Full Field digital or Tomosynthesis) **	SIF	G0202, or G0202 + 77063	$131.92	$159.81	$164.08	$147.10	$163.48
Screening mammogram - bilateral diagnostic (film or digital) **	SIF	G0204,G-0279, or + 77062	$163.48	$197.89	$203.22	$182.22	$202.50
Screening mammogram - unilateral diagnostic (film or digital) **	SIF	G0206, 77061	$128.85	$155.99	$160.24	$143.65	$159.68
Assessment, education and CBE	SIF	99201	$42.60	$51.07	$52.66	$47.28	$52.56
Assessment, education and pelvic exam with Pap test	SIF	99201	$42.60	$51.07	$52.66	$47.28	$52.56
Repeat CBE	2	Half of 99201	$21.30	$25.54	$26.33	$23.64	$26.28
Diagnostic mammogram - unilateral (special views) (film or digital) **	1	G0206, 77061 (77055*)	$128.85	$155.99	$160.24	$143.65	$159.68
Diagnostic Mammogram bilateral (special views) (film or digital)**	90	G0204, 77062 (77056*)	$163.48	$197.89	$203.22	$182.22	$202.50
Diagnostic Breast US **(unilateral or bilateral)** w/image documentation	4	76641, 76642, 76942	$104.65	$126.24	$129.60	$116.38	$129.18

New York State Department of Health Cancer Services Program Reimbursement Schedule 4/1/2017- 3/31/2018							
	Data system Procedure Codes	**Guiding CPT Code(s)*****	**< ---------- Medicare Regions---------- >**				
			Upstate 13282-99	**Manhattan 13202-01**	**Rest of Metro 13202-02**	**Hudson Valley 13202-03**	**Queens 13292-04**
Fine needle aspiration biopsy without image guidance	29	10021	$118.78	$143.79	$148.83	$132.81	$148.50
Fine needle aspiration biopsy with image guidance (includes image guidance)	7	76942 + 10022	$223.38	$269.08	$276.89	$248.44	$276.15
Core biopsy	8	19100	$145.18	$180.14	$188.12	$165.38	$187.48
Incisional biopsy	9	19101	$328.97	$408.07	$426.83	$374.91	$425.50
Pre-operative ultrasonic needle localization and wire placement	22	19285	$500.64	$613.80	$631.47	$562.79	$628.56
additional US needle loc and wire placement for second lesion	85	19286	$435.86	$536.83	$552.21	$491.73	$549.38
Pre-operative mammographic needle localization and wire placement	15	19281	$234.02	$281.93	$290.03	$260.26	$289.23
additional mammographic needle loc and wire placement second lesion	83	19282	$161.92	$196.58	$202.19	$180.91	$201.46
Excisional biopsy	10	19120	$476.96	$593.48	$624.35	$545.86	$622.80
Stereotactic biopsy procedure - breast-**all inclusive** of placement of breast localization device(s), (e.g., clip, metallic pellet), imaging of the biopsy specimen, percutaneous bx; first lesion, including stereotactic guidance	16	19081	$670.76	$819.95	$844.46	$752.98	$840.98

New York State Department of Health Cancer Services Program Reimbursement Schedule 4/1/2017- 3/31/2018							
	Data system Procedure Codes	**Guiding CPT Code(s)*** **	**< ---------- Medicare Regions---------- >**				
			Upstate 13282-99	**Manhattan 13202-01**	**Rest of Metro 13202-02**	**Hudson Valley 13202-03**	**Queens 13292-04**
each additional lesion, including stereotactic guidance	84	19082	$552.74	$679.28	$699.18	$622.38	$695.83
US guided Vacuum-assisted biopsy breast - **all inclusive** of placement of breast localization device(s) (e.g., clip, metallic pellet) imaging of the biopsy specimen, percutaneous bx; first lesion, including ultrasound guidance	25	19083	$650.62	$795.36	$818.96	$730.33	$815.55
each additional lesion, including US guidance	86	19084	$531.44	$652.61	$671.42	$598.00	$668.20
Mammary ductogram/galactogram	17	77053	$56.86	$68.92	$70.85	$63.45	$70.60
Article 28 Facility Fee - Core Biopsy	23	APC 5071,72,73	$559.64	$559.64	$559.64	$559.64	$559.64
Article 28 Facility Fee - Incisional/Excisional Biopsy	24	APC 5074	$1,438.32	$1,438.32	$1,438.32	$1,438.32	$1,438.32
Cervical Procedures							
Colposcopy without biopsy	52	57452	$106.33	$127.75	$132.51	$118.44	$132.36
Colposcopy with cervical biopsy and ECC	66	57454	$149.29	$177.84	$184.17	$165.32	$184.09
Colposcopy with one or more cervical biopsies	53	57455	$139.08	$166.56	$172.54	$154.53	$172.38
Colposcopy with ECC	67	57456	$131.19	$157.11	$162.70	$145.75	$162.54
Endometrial biopsy	68	58100	$106.48	$127.43	$131.98	$118.26	$131.86

New York State Department of Health Cancer Services Program Reimbursement Schedule 4/1/2017- 3/31/2018							
	Data system Procedure Codes	Guiding CPT Code(s)***	< ---------- Medicare Regions---------- >				
			Upstate 13282-99	Manhattan 13202-01	Rest of Metro 13202-02	Hudson Valley 13202-03	Queens 13292-04
High Risk HPV DNA Hybrid Capture 2 or Cervista HR or types 16/18 only	65	87624, 87625	$48.14	$48.14	$48.14	$48.14	$48.14
Pap smear cytology, conventional	SIF, 61	88164	$14.49	$14.49	$14.49	$14.49	$14.49
Pap smear cytology, liquid based prep	SIF, 71	88142	$27.79	$27.79	$27.79	$27.79	$27.79
Diagnostic LEEP/LEETZ	56	57461	$310.48	$374.67	$387.44	$346.35	$386.64
Diagnostic Cone Biopsy- Cold knife or Laser	CKC 57, LC 58	57520	$299.55	$361.78	$375.98	$334.97	$375.48
Article 28 Facility Fee - Diagnostic LEEP/LEETZ, etc.	69	APC 5414	$1,892.72	$1,892.72	$1,892.72	$1,892.72	$1,892.72
Colorectal Procedures							
FOBT Kit Processing	SIF	82270	$4.46	$4.46	$4.46	$ 4.46	$4.46
FIT	SIF	82274	$17.09	$21.82	$21.82	$21.82	$21.82
Colonoscopy	36	45378 or G0121 or G0105	$307.39	$373.21	$386.80	$344.48	$385.89
Colonoscopy w/biopsy single or multiple	37	45380	$393.25	$477.84	$494.12	$440.53	$492.74
Colonoscopy w/removal of tumor(s), polyp(s) by hot biopsy	38	45384	$435.71	$531.28	$550.62	$489.57	$549.07

New York State Department of Health Cancer Services Program Reimbursement Schedule 4/1/2017- 3/31/2018							
	Data system Procedure Codes	Guiding CPT Code(s)***	< ---------- Medicare Regions---------- >				
			Upstate 13282-99	Manhattan 13202-01	Rest of Metro 13202-02	Hudson Valley 13202-03	Queens 13292-04
Colonoscopy w/removal of tumor(s), polyp(s) by snare technique	39	45385	$413.95	$500.68	$518.32	$462.62	$517.22
Sigmoidoscopy	32	45330	$161.67	$198.26	$204.61	$181.99	$203.77
Sigmoidoscopy with polypectomy	33	45333	$283.97	$348.63	$360.17	$320.01	$358.70
Flexible sigmoidoscopy with biopsy	34	45331	$248.02	$304.10	$313.50	$279.04	$312.16
Radiological exam; colon, barium enema	35	74270	$144.72	$176.13	$180.95	$161.87	$180.21
2nd Technique- Colonoscopy dir bx	50	n/a	$106.91	$129.92	$134.22	$120.43	$133.79
Article 28 Facility Fee - Colonoscopy	49	APC 5312	$765.56	$765.56	$765.56	$765.56	$765.56
Article 28 Facility Fee - Sigmoidoscopy	48	APC 5311	$500.82	$500.82	$500.82	$500.82	$500.82
Other Procedure							
Surgical Consultation	3, 54, 43	99203	$104.97	$125.07	$129.06	$116.10	$128.93
Anesthesiologist fee	18, 70, 41	n/a	$160.00	$160.00	$160.00	$160.00	$160.00
Chest X-ray	19, 62, 45	71020	$27.09	$32.69	$33.63	$30.16	$33.54
CBC - Complete Blood Count pre-operative testing	21, 64, 47	85025	$10.60	$10.66	$10.66	$10.66	$10.66
EKG	20, 63, 46	93000	$16.45	$19.85	$20.50	$18.34	$20.45

New York State Department of Health Cancer Services Program Reimbursement Schedule 4/1/2017- 3/31/2018							
	Data system Procedure Codes	Guiding CPT Code(s)***	< ---------- Medicare Regions---------- >				
			Upstate 13282-99	Manhattan 13202-01	Rest of Metro 13202-02	Hudson Valley 13202-03	Queens 13292-04
Fluid cytology, Breast and nipple, (Not vaginal / cervical)	11,14	88173	$149.77	$177.70	$181.62	$164.62	$181.23
Surgical pathology - Level IV-Gross and microscopic	12, 59, 42	88305	$67.11	$79.01	$80.70	$73.40	$80.59
Surgical pathology - Level IV- needing examination of surgical margins; some excisional, LEEP, Cone, and some polyps	82, 87, 88	88307	$258.23	$310.99	$318.55	$286.65	$317.46
High Risk Women ONLY with Prior Approval (Program funds entered only by NYSDOH CSP Staff)							
Bilateral Screening MRI w or w/o contrast	SIF	77059	$518.68	$635.09	$652.66	$582.36	$649.62
Unilateral Screening MRI w or w/o contrast	SIF	77058	$522.08	$639.30	$656.99	$586.20	$653.92
Bilateral Diagnostic MRI w or w/o contrast	26	77059	$518.68	$635.09	$652.66	$582.36	$649.62
Unilateral Diagnostic MRI w or w/o contrast	89	77058	$522.08	$639.30	$656.99	$586.20	$653.92
NOTES							
*__Film Mammography__ will be reimbursed according to __procedure for partial reimbursement__ of the NYS CSP MARS mammography rate listed above. The maximum allowed partial rate is listed below:							
Screening mammogram- Bilateral FILM	SIF	77067 (77057*)	$81.79	$97.48	$100.08	$89.73	$99.72
Diagnostic mammogram- bilateral FILM	SIF, 90	77066 (77055*)	$115.25	$138.52	$142.25	$127.55	$141.75

New York State Department of Health Cancer Services Program Reimbursement Schedule 4/1/2017- 3/31/2018							
			< ---------- Medicare Regions---------- >				
	Data system Procedure Codes	Guiding CPT Code(s)***	Upstate 13282-99	Manhattan 13202-01	Rest of Metro 13202-02	Hudson Valley 13202-03	Queens 13292-04
Diagnostic mammogram- unilateral FILM	SIF, 01	77065 (77056*)	$90.19	$107.63	$110.56	$99.11	$110.17
** NYS program reimbursement is for full field digital mammography or tomosynthesis mammography at the same rate. No additional reimbursement for CAD *** These CPT codes are for reference only. Reimbursement is not limited to these CPT codes. Other CPT codes that fulfill the service/procedure as listed may also be reimbursed at these rates.							

Attachment 6-II Guidance for CSP Contractors & Title X Family Planning Providers

Guidance for Cancer Services Program Contractors and Title X Family Planning Providers – July 2009

This information is being provided to help CSP contractors and providers understand client eligibility for CSP-reimbursable services when clients are referred to Title X family planning providers. As of April 1, 2009, CSP eligibility for reimbursable services changed to serve women 40 years of age and older. There are a few exceptions to this, which are outlined in the CSP policy. See Operations Manual Chapter 4 – *Cancer Screening Guidance* Section H (CSP Policy for Breast Cancer Screening for Women Under the Age of 40).

However, clients aged 40 and older who are referred to a Title X family planning provider should not automatically be assured that the visit will qualify for submission to the CSP for reimbursement.

The NYS Department of Health recommends that clients receive, as appropriate, the full range of services for which they are eligible. If, therefore, a woman 40 or older presents to a Title X family planning provider for a visit (annual exam), for breast cancer screening (CBE), and/or cervical cancer screening (pelvic exam, Pap test and/or HR HPV DNA), and she is also in need of contraceptive services, the full range of services is to be provided.

Therefore, when a client aged 40 or older requires information and a service to regulate fertility, the visit becomes a Title X family planning visit; the breast and/or cervical cancer screening performed at this family planning visit are not eligible for CSP reimbursement. Clients who receive Title X eligible services will be assessed and assigned to a sliding fee scale for the Title X family planning visit.

A woman aged 40 and older who has breast and/or cervical cancer screening at a family planning provider, and who meets CSP eligibility, will still qualify for a CSP-reimbursable mammogram at the CSP participating provider, whether she is a Title X client or not, as Title X does not cover breast imaging services.

It is recommended that clients referred by CSP contractors to Title X family planning providers be informed at the time of referral that, if at the time of the visit for breast and/or cervical cancer screening, they also need or require any services related to birth control or family planning, the visit will not be eligible for CSP reimbursement, and they will be responsible for the fee-scaled cost of the visit. CSP contractor staff members are not required to triage or ask women questions about their method(s) of contraception. However, CSP contractor staff must communicate to women referred to Title X family planning providers that the cancer screening services provided at the visit may not be reimbursable by the CSP.

Below are some examples of these situations:

CSP contractor staff refers a 40 year old woman to a Title X family planning provider for breast and cervical cancer screening. During the visit, the woman indicates that she needs either a new or renewal prescription for birth control (oral contraceptives, NuvaRing, Evra, Depo-Provera, etc.).

- The visit becomes a Title X family planning visit and is not eligible to be billed to the CSP.

CSP contractor staff refers a 40 year old woman to a Title X family planning provider for breast and cervical cancer screening; she has an IUD.

- If, at the visit, there is a need to discuss a problem with the IUD, or a need to change the method, it is not a CSP-reimbursable visit: this constitutes a Title X family planning visit, which is not eligible for CSP reimbursement. If, however, there is no required method change or counseling for the IUD, and the client only receives her routine breast and cervical cancer screening, the visit is a CSP-eligible visit.

A 40 year old woman had a tubal ligation at age 37 and is not in need of any birth control or fertility regulation services, she requests breast and cervical cancer screening.

- This woman is CSP-eligible. If, however, she requests counseling and information at the visit about reversal of the tubal ligation so she might achieve another pregnancy, the visit would then be a Title X family planning visit and not reimbursable by the CSP.
- A 40 year old woman is relying on her male partner's vasectomy as her method of birth control.
- This woman is eligible for breast and cervical cancer screening. If, however, she indicates during her visit that, while one of her partners has had a vasectomy, she has another partner who has not and now needs to discuss the use of other methods of birth control (including condoms), the visit now becomes a Title X family planning visit and is not reimbursable by the CSP.

A 40 year old woman has a same-sex partner and states she does not need contraception.

- This woman is eligible for a CSP-reimbursed visit for breast and cervical cancer screening. If, however, she indicated at the visit that she wanted information regarding planning a pregnancy using a donor (for either herself or her partner), then the visit is not eligible for CSP reimbursement.

A 40 year old woman is not sexually active and requires no information or services related to birth control or regulation of fertility.

- This woman is eligible for a CSP-reimbursed visit for breast and cervical cancer screening. If, however, she indicated at the visit that she wanted information regarding planning a pregnancy using a donor, then the visit is not eligible for CSP reimbursement.

Attachment 6-III Reimbursement Criteria for Rescreening Following a Program-funded Colonoscopy

New York State Department of Health

This document outlines CSP criteria for reimbursement of re-screening after a CSP-funded colonoscopy. These criteria are based on the updated recommendations of the American College of Gastroenterology[1] and the American Cancer Society[2]. These criteria are not eligibility guidelines for an initial screening through the CSP. Furthermore, they are not clinical guidelines. These criteria pertain only to reimbursement of services through the CSP. Alternate funds must be identified to reimburse for services that are recommended by providers but which are not covered through the CSP.

Information about a client's risk status, and findings from the previously-funded colonoscopy must be taken into account to determine what subsequent services will be reimbursed after a CSP-funded colonoscopy, and when they will be reimbursed. The following are examples of situations that might occur:

1. A client enrolled in the CSP had a positive fecal test and a subsequent diagnostic colonoscopy. The final diagnosis was hemorrhoids. This client would now be eligible for reimbursement for a fecal test no sooner than five (5) years after that funded colonoscopy. **Please note:** an annual fecal test is not recommended for five years after a colonoscopy has been performed. The CSP will not reimburse for annual fecal tests for five years following a program-funded colonoscopy.

2. A client enrolled in the CSP is determined to be at increased risk due to a family history of colorectal cancer in a first-degree relative. During the colonoscopy, the client was found to have 2 small (<10mm) adenomatous polyps. This client would now be eligible for reimbursement for a colonoscopy no sooner than three (3) years after that last colonoscopy. **Please note:** if the physician recommends that the next colonoscopy be scheduled five years later, then the client should be recalled to the next colonoscopy in five years. These reimbursement criteria represent the minimum time interval between reimbursable services.

3. A client enrolled in the CSP (regardless of risk status) was referred for a colonoscopy, which was not able to be completed. Reasons a colonoscopy

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[1] Lieberman D, Rex D, Winawer S, Giardiello F, Johnson D, Levin T, Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer. *Gastroenterology 2012; 143:844-857*

[2] Winawer S, Zauber A, Fletcher R, Stillman J, et al. American Cancer Society Guidelines for Colonoscopy Surveillance after Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer. CA A Cancer Journal for Clinicians. On line at http://onlinelibrary.wiley.com/doi/10.3322/canjclin.56.3.143/abstract

cannot be completed may include, but are not limited to: poor bowel preparation, the client's inability to tolerate the procedure, or incomplete polypectomy or biopsy. In this case, the client would be eligible for another colonoscopy within one year of the incomplete colonoscopy. Ideally, the client should be scheduled for another colonoscopy as soon as possible.

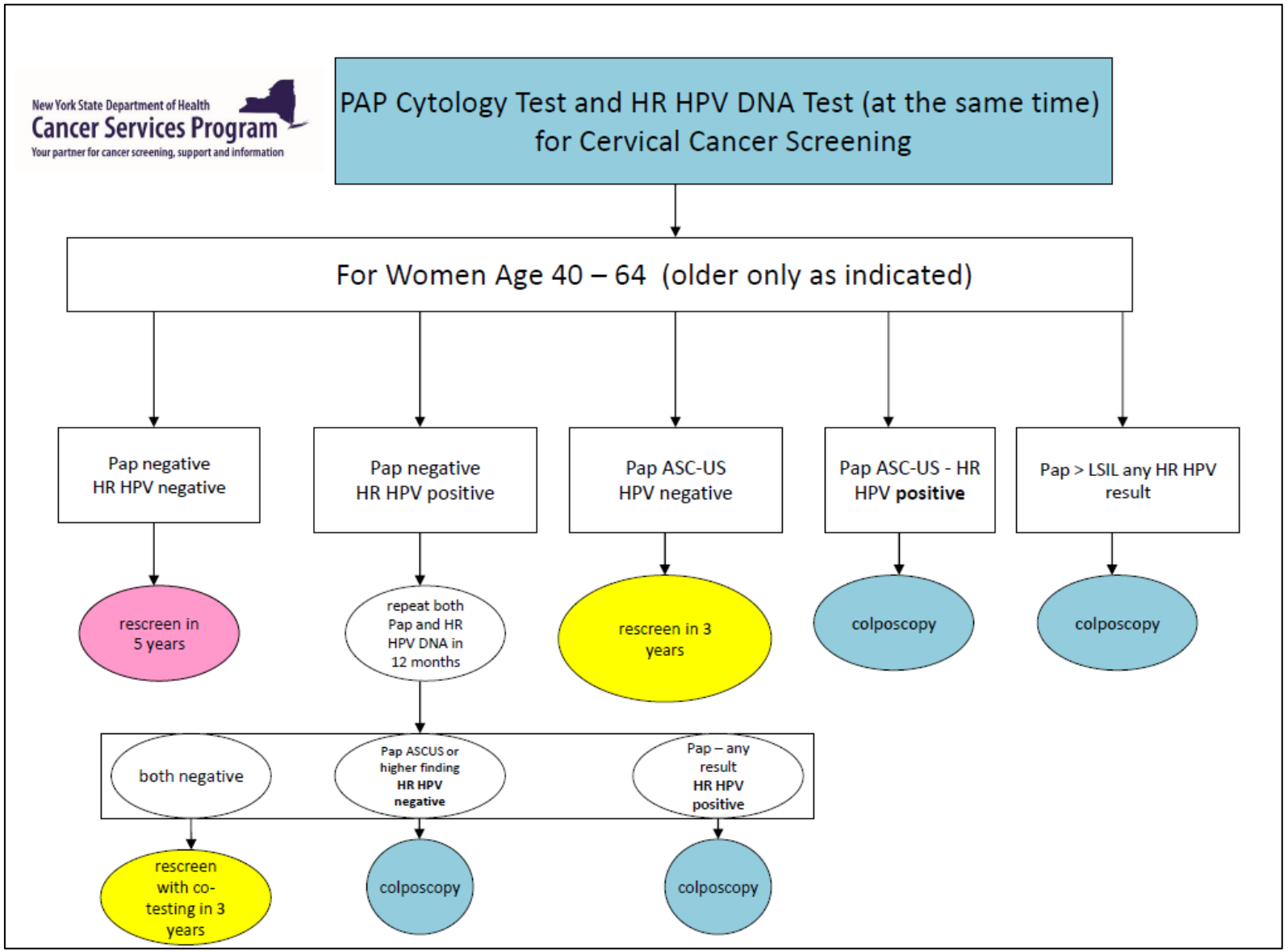
The table below outlines the combination of scenarios showing when an enrolled client would be eligible for reimbursement for a subsequent colonoscopy or fecal test, based on risk status and findings of the previously funded colonoscopy.

While these criteria address the majority of situations that may occur, individual cases may still warrant consultation with NYSDOH CSP staff. Should you have any questions, please feel free to contact your Regional Manager or the NYSDOH CSP Health Systems Improvement Unit at (518) 474-1222.

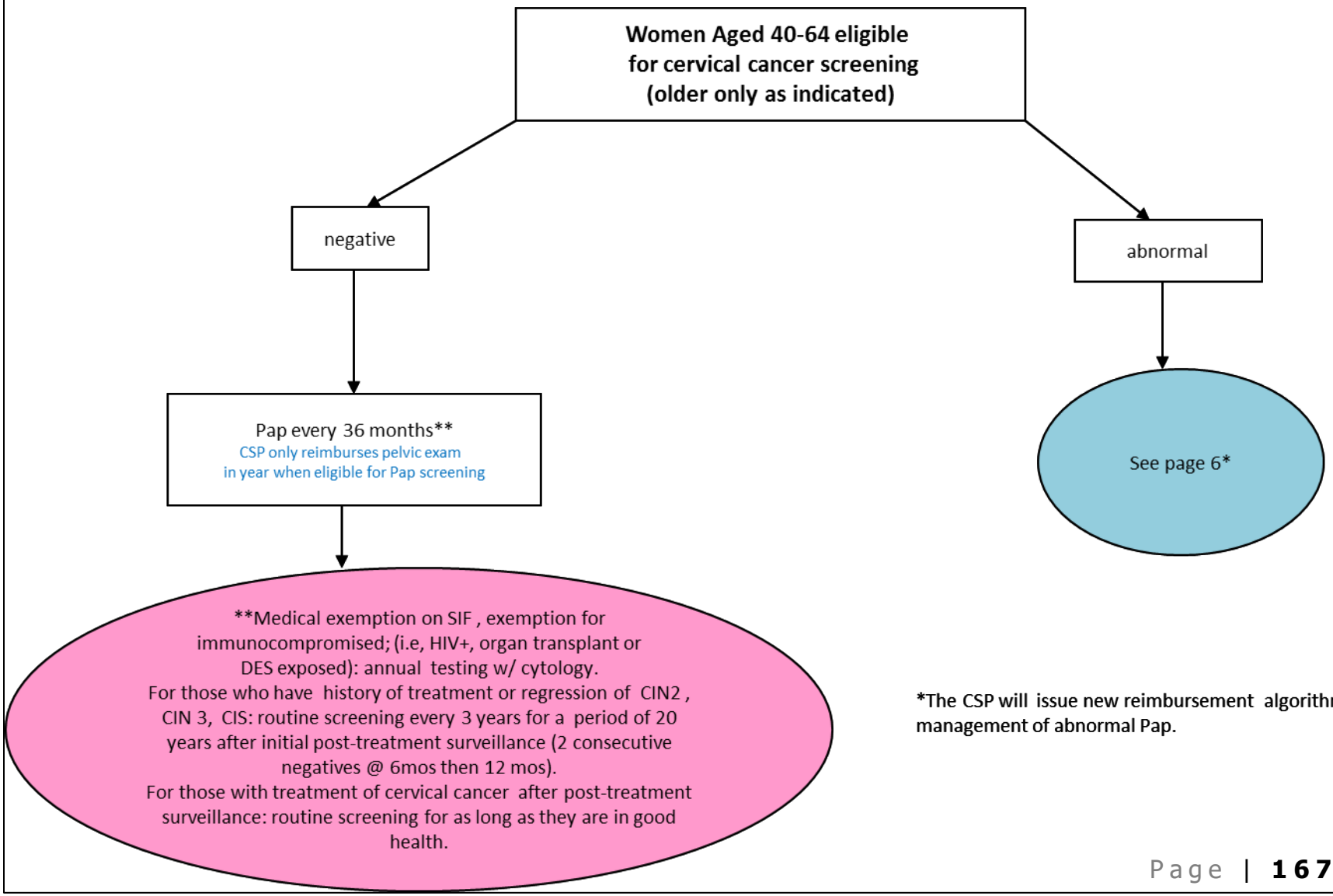
Finding on most recent colonoscopy	**eligible for reimbursement for:**			
	colonoscopy			**fecal test**
	< 1 year	≥ 1 year	≥ 3 years	≥ 5 years
During the previous CSP screening visit, the client completed a program-funded diagnostic colonoscopy because the client was either 1) average-risk, asymptomatic, age 50 or older and had a positive fecal test or 2) average risk, symptomatic, aged 50-64.				
1st colonoscopy could not be completed, with no final diagnosis determined (this is a repeat colonoscopy), or incomplete removal of sessile serrated polyp/removed piecemeal with retention	✓			
colorectal cancer diagnosed *and* cancer treatment completed		✓		
adenomatous polyposis syndrome (>10 adenomas) or serrated polyposis syndrome		✓		
inflammatory bowel disease			✓	
Crohn's disease			✓	
chronic ulcerative colitis			✓	
adenomatous polyp			✓	
other polyps				✓
hemorrhoids				✓
diverticulitis				✓
other diagnosis				✓
no abnormality at this time				✓

During the previous CSP screening visit, the client completed a program-funded screening colonoscopy because the client was at increased or high risk for colorectal cancer, regardless of whether symptoms were present.				
1st colonoscopy could not be completed, with no final diagnosis determined (this is a repeat colonoscopy), or incomplete removal of sessile serrated polyp/removed piecemeal with retention	✓			
colorectal cancer diagnosed *and* cancer treatment completed		✓		
adenomatous polyposis syndrome (>10 adenomas) or serrated polyposis syndrome		✓		
inflammatory bowel disease			✓	
Crohn's disease			✓	
chronic ulcerative colitis			✓	
adenomatous polyp			✓	
other polyps			✓	
hemorrhoids			✓	
diverticulitis			✓	
other diagnosis			✓	
no abnormality at this time			✓	

Attachment 6-IV – Cervical Algorithms

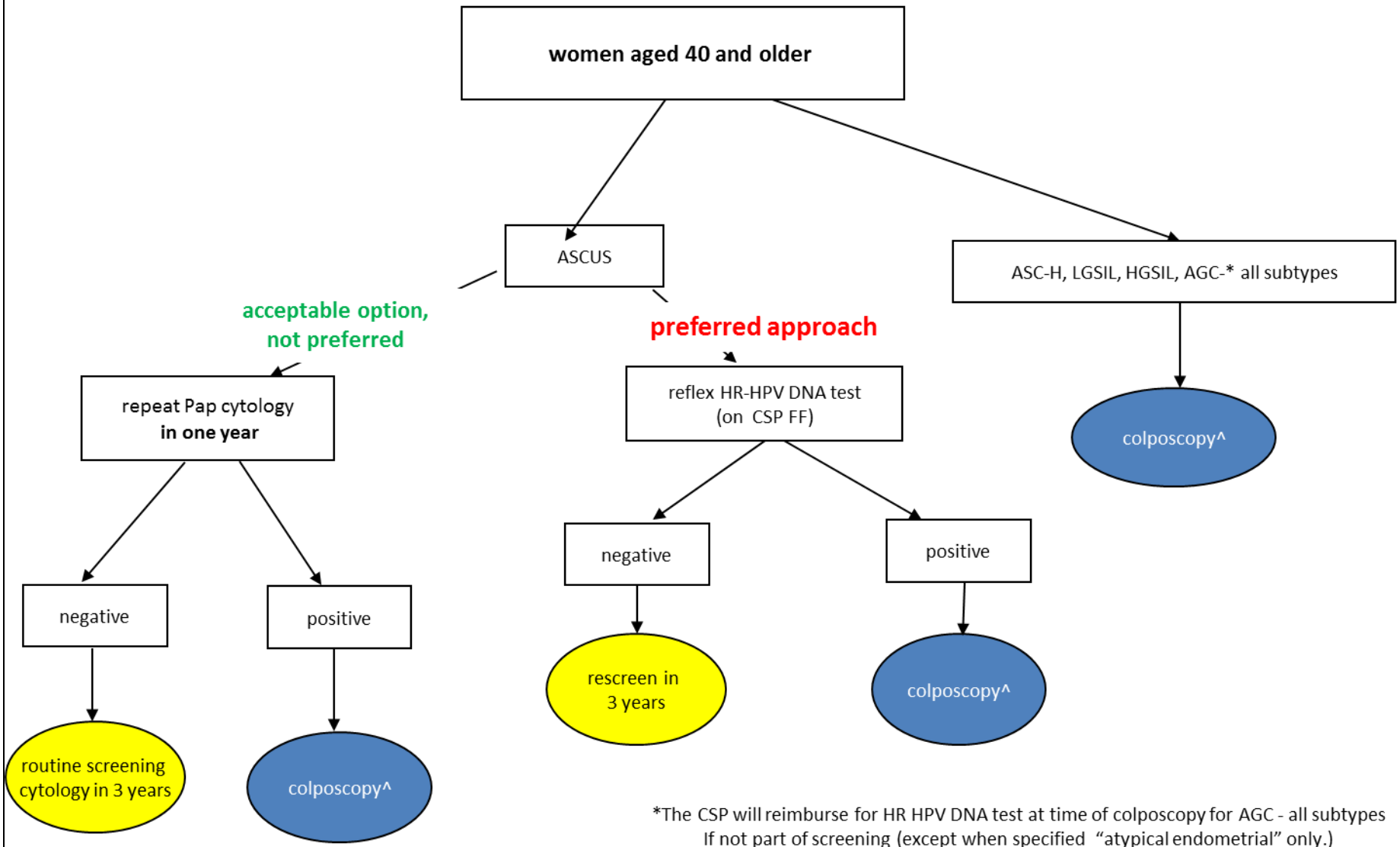


Pap Cytology Testing Only (conventional or liquid-based) for Cervical Cancer Screening



*The CSP will issue new reimbursement algorithms for the management of abnormal Pap.

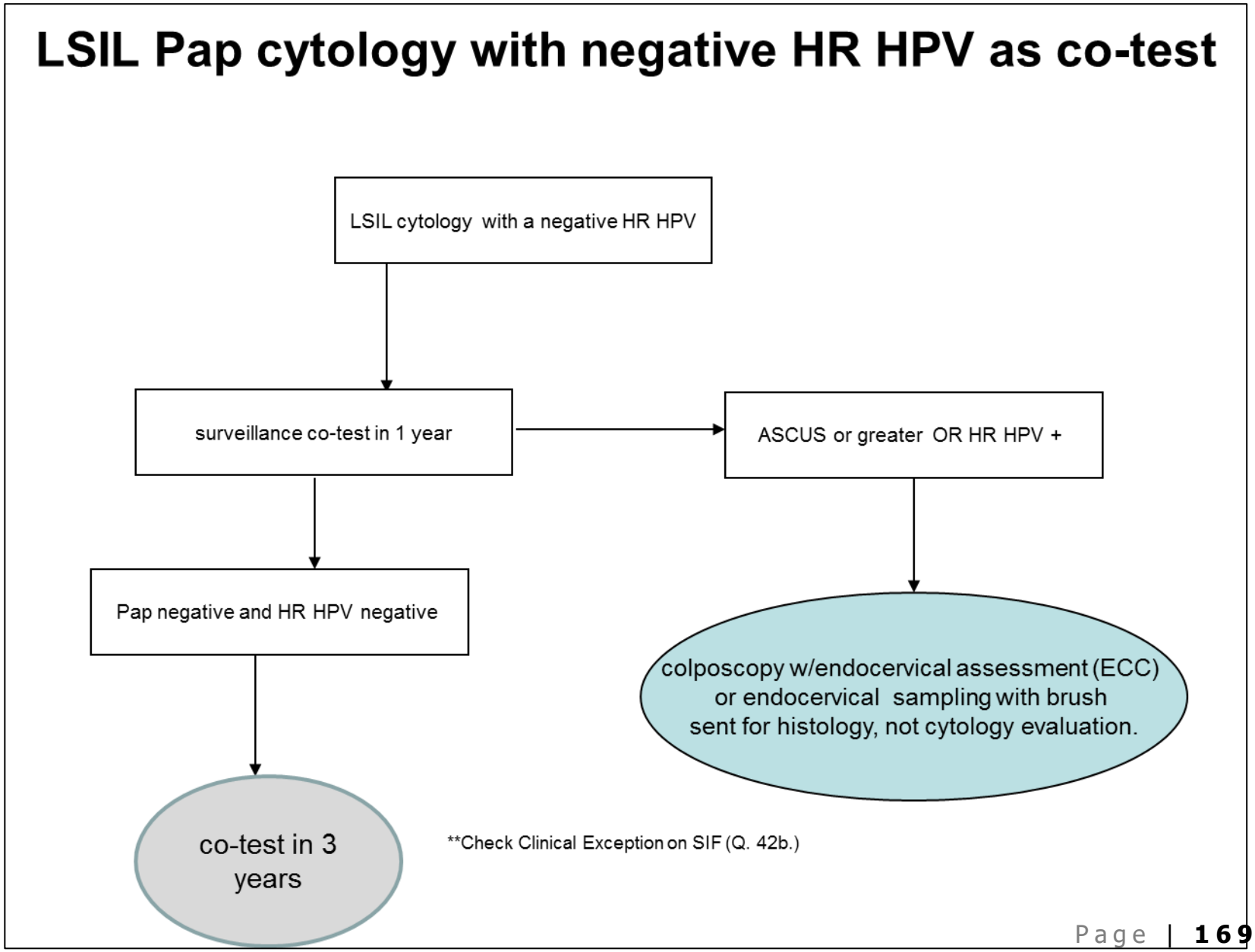
PAP Cytology Testing Only For Cervical Cancer Screening with Abnormal Result

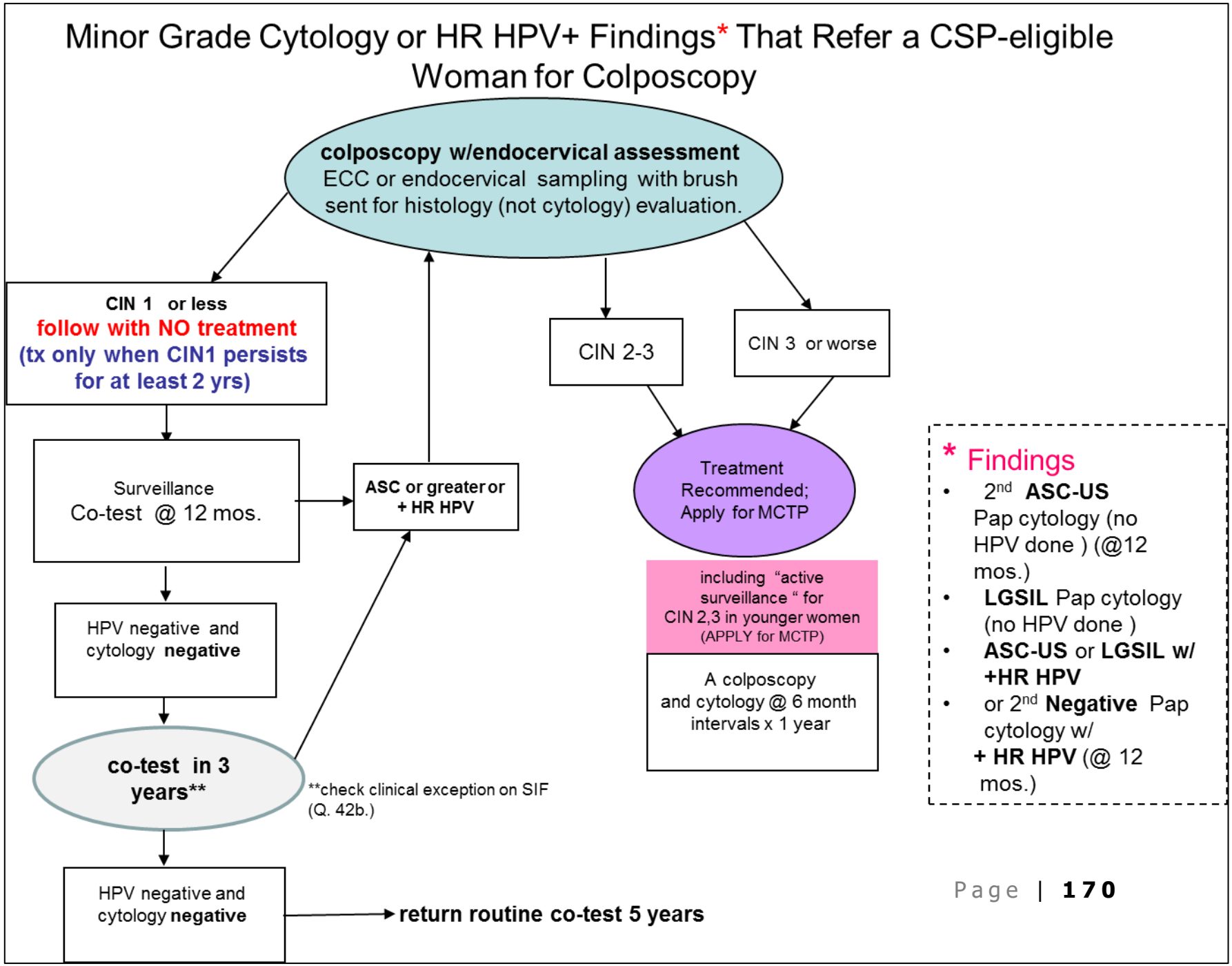


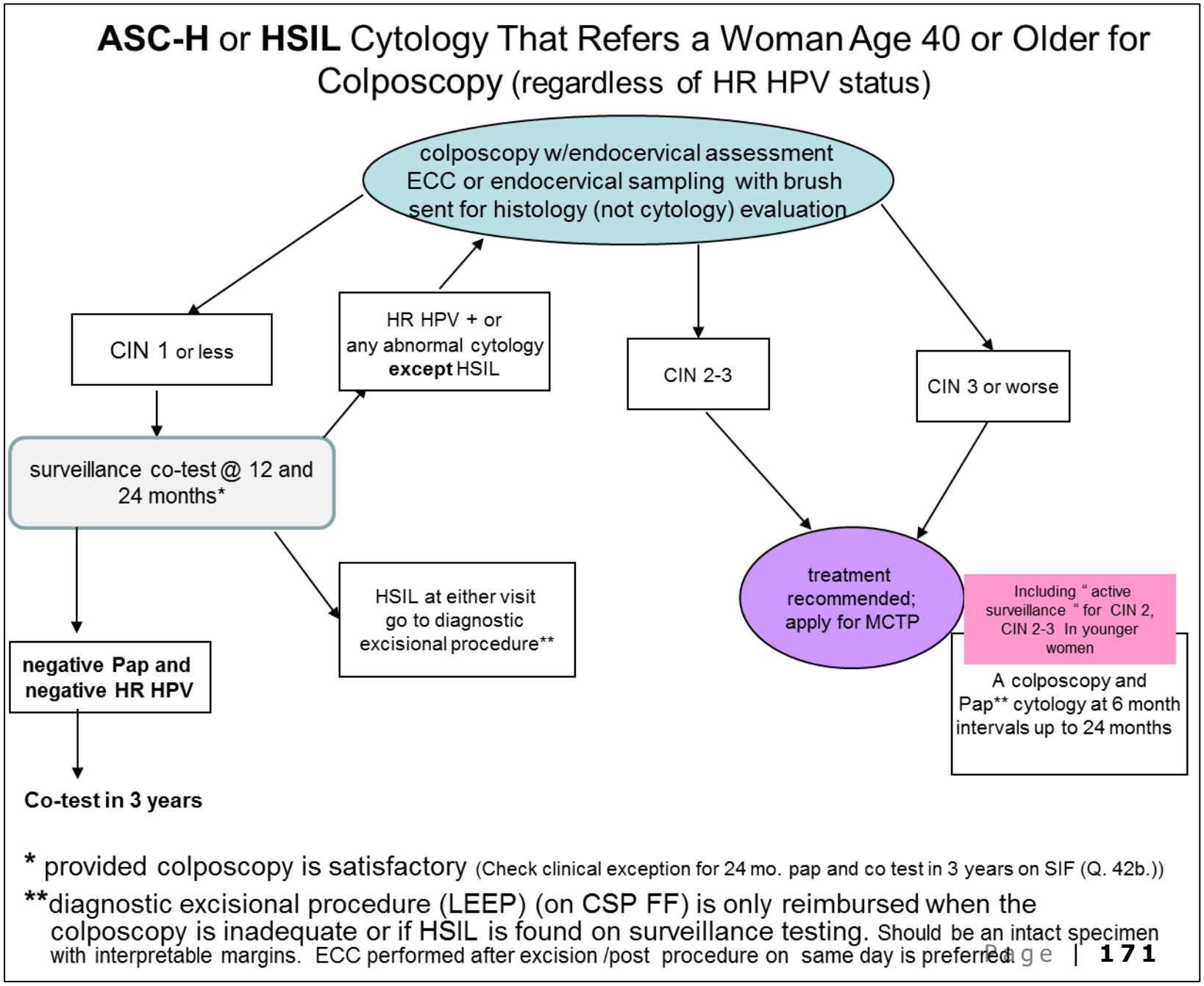
*The CSP will reimburse for HR HPV DNA test at time of colposcopy for AGC - all subtypes If not part of screening (except when specified "atypical endometrial" only.)

^See CSP diagnostic algorithms reimbursement .

Attachment 6-V: Reimbursement Guidelines Algorithms for Cervical Cancer Diagnostic Follow-up Procedures



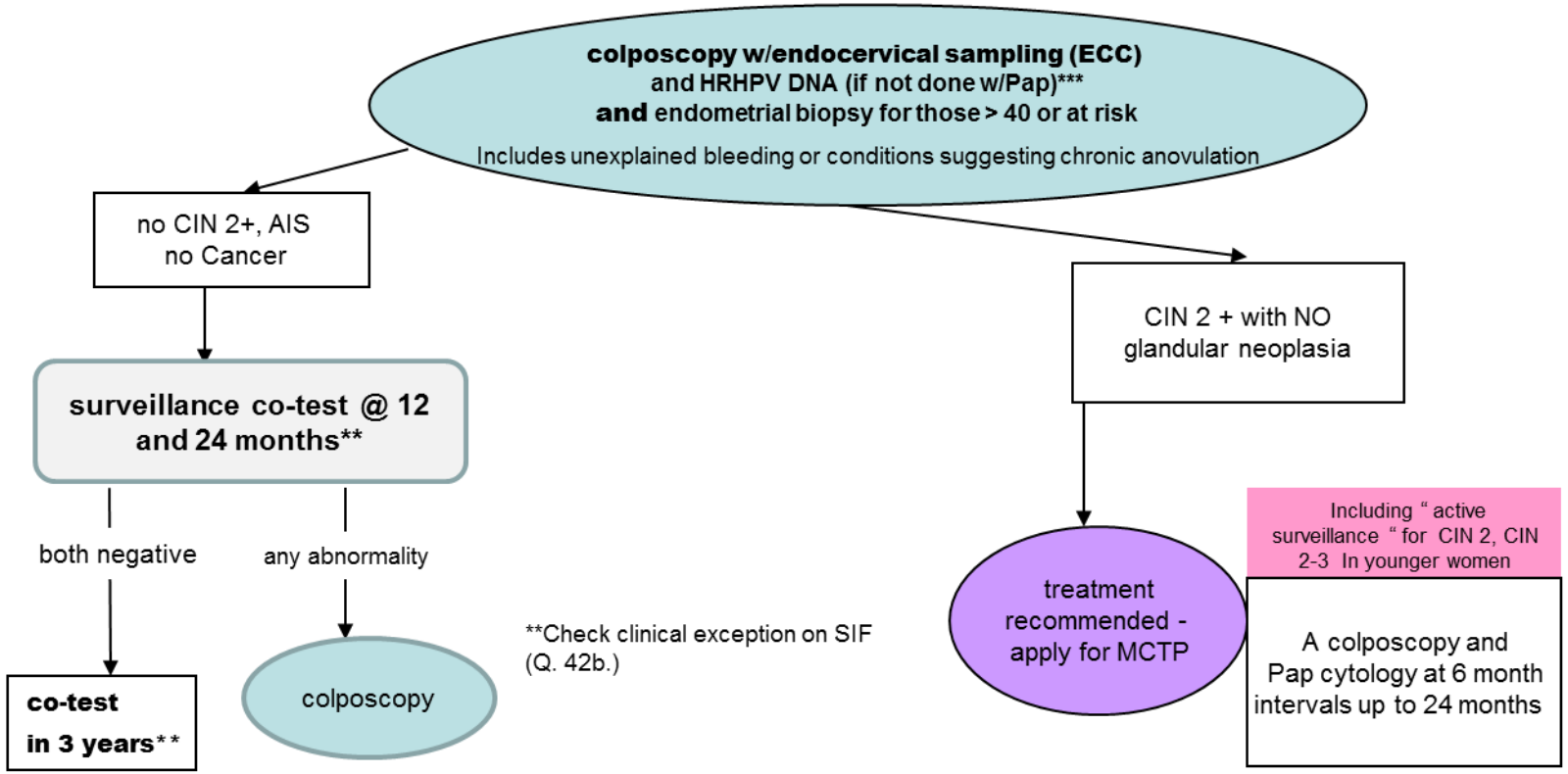

Minor Grade Cytology or HR HPV+ Findings* That Refer a CSP-eligible Woman for Colposcopy
colposcopy w/endocervical assessment
ECC or endocervical sampling with brush sent for histology (not cytology) evaluation.
CIN 1 or less
follow with NO treatment
(tx only when CIN1 persists for at least 2 yrs)
CIN 2-3
CIN 3 or worse
Surveillance
Co-test @ 12 mos.
ASC or greater or + HR HPV
Treatment Recommended; Apply for MCTP
including "active surveillance " for CIN 2,3 in younger women (APPLY for MCTP)
A colposcopy and cytology @ 6 month intervals x 1 year
HPV negative and cytology negative
co-test in 3 years**
**check clinical exception on SIF (Q. 42b.)
HPV negative and cytology negative
return routine co-test 5 years
* Findings
• 2nd ASC-US Pap cytology (no HPV done) (@12 mos.)
• LGSIL Pap cytology (no HPV done)
• ASC-US or LGSIL w/ +HR HPV
• or 2nd Negative Pap cytology w/ + HR HPV (@ 12 mos.)


ASC-H or HSIL Cytology That Refers a Woman Age 40 or Older for Colposcopy (regardless of HR HPV status)
colposcopy w/endocervical assessment ECC or endocervical sampling with brush sent for histology (not cytology) evaluation
CIN 1 or less
HR HPV + or any abnormal cytology except HSIL
CIN 2-3
CIN 3 or worse
surveillance co-test @ 12 and 24 months*
HSIL at either visit go to diagnostic excisional procedure**
treatment recommended; apply for MCTP
Including " active surveillance " for CIN 2, CIN 2-3 In younger women
A colposcopy and Pap** cytology at 6 month intervals up to 24 months
negative Pap and negative HR HPV
Co-test in 3 years
* provided colposcopy is satisfactory (Check clinical exception for 24 mo. pap and co test in 3 years on SIF (Q. 42b.))
**diagnostic excisional procedure (LEEP) (on CSP FF) is only reimbursed when the colposcopy is inadequate or if HSIL is found on surveillance testing. Should be an intact specimen with interpretable margins. ECC performed after excision /post procedure on same day is preferred.

Cytology That Referred a Woman Age 40 or Older for Colposcopy

Atypical Glandular Cells NOS (not otherwise specified)

All sub-types-**except atypical endometrial ∞**

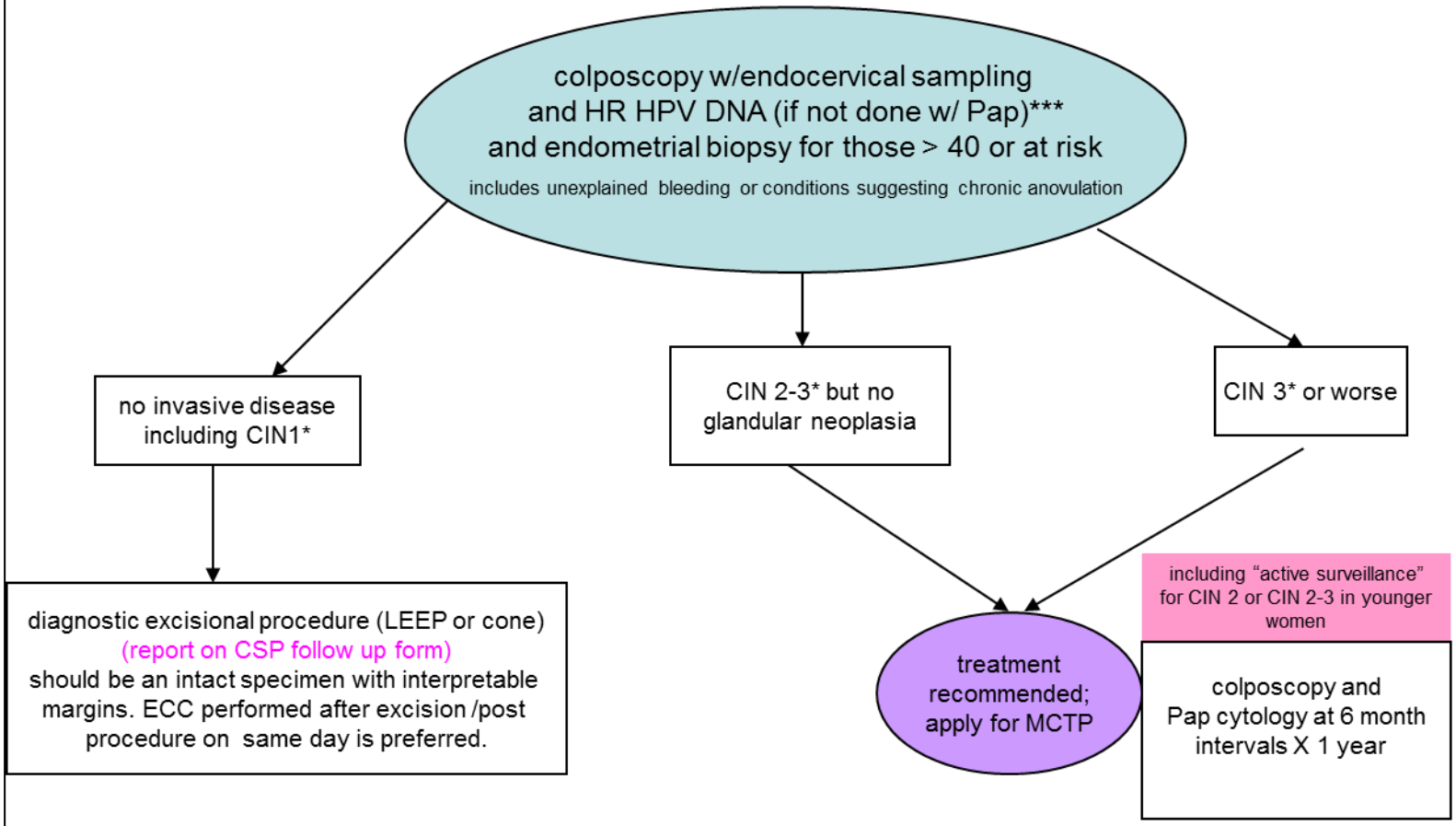


∞The CSP does not reimburse for services to evaluate a finding of atypical endometrial cells (only) in the cervical cancer screening program as the evaluation that is required is for endometrial conditions, not cervical. (i.e., endometrial biopsy/ECC) . However, if there is no endometrial pathology and client continues to colposcopy, the endo biopsy gets reported as "other funds" and the CSP will reimburse for colposcopy evaluation of cervical abnormality.

*** Repeat Pap cytology will be reimbursed when done at time of colposcopy if 5 months or more have elapsed since initial high grade Pap until colposcopy is performed. (Report on CSP Follow up form)

Cytology That Referred a Woman Age 40 or Older to Colposcopy

AGC favors neoplasia or adenocarcinoma in situ



*** A repeat Pap cytology will be reimbursed when done at time of colposcopy if 5 months or more have elapsed since initial high grade Pap, until colposcopy is performed (report on CSP Follow up form)

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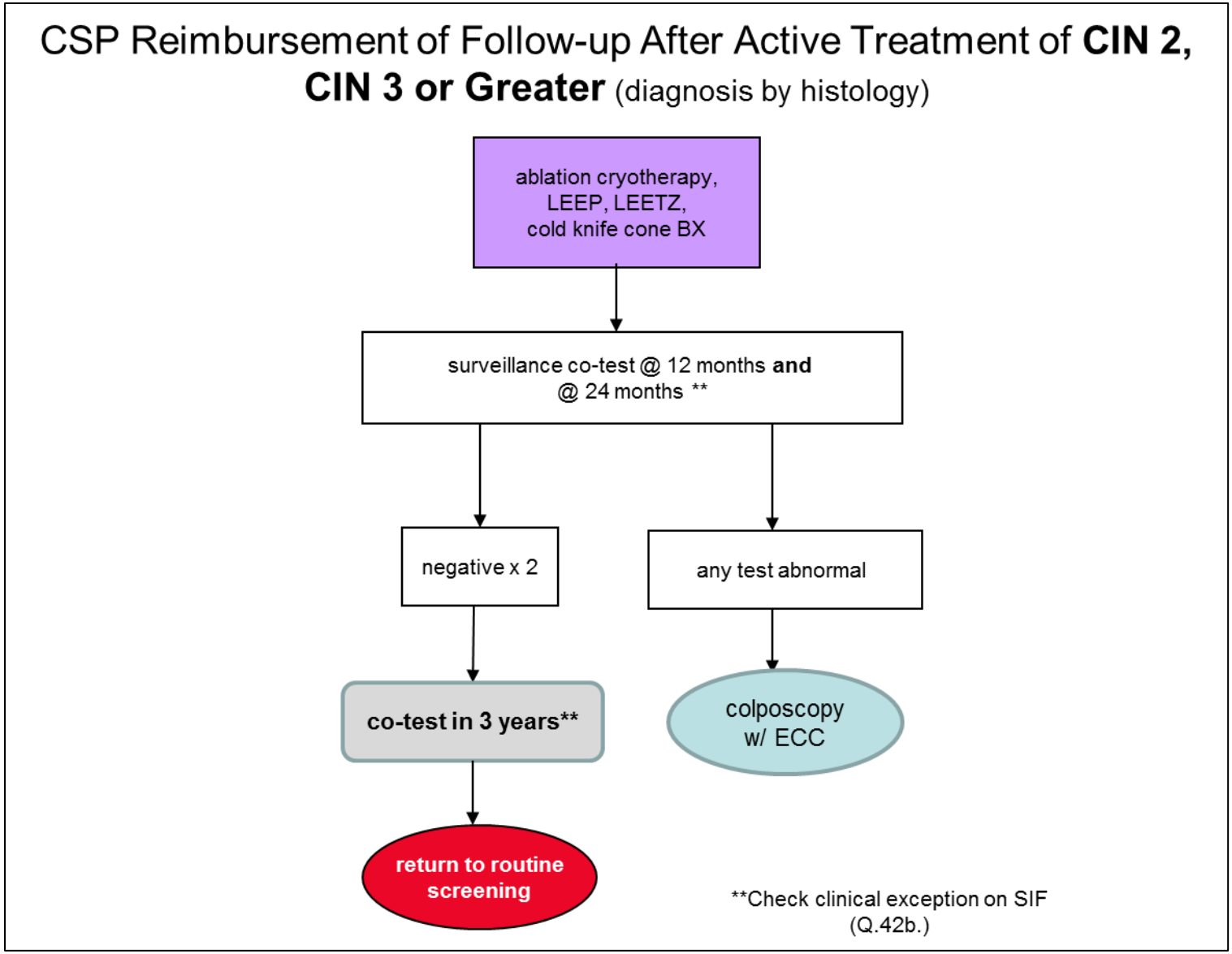
CSP Reimbursement of Follow-up After Active Treatment of CIN 2, CIN 3 or Greater (diagnosis by histology)
ablation cryotherapy, LEEP, LEETZ, cold knife cone BX
surveillance co-test @ 12 months and @ 24 months **
negative x 2
any test abnormal
co-test in 3 years**
colposcopy w/ ECC
return to routine screening
**Check clinical exception on SIF (Q.42b.)

Attachment 6-VI: MCTP Enrollment for Cervical Dysplasia

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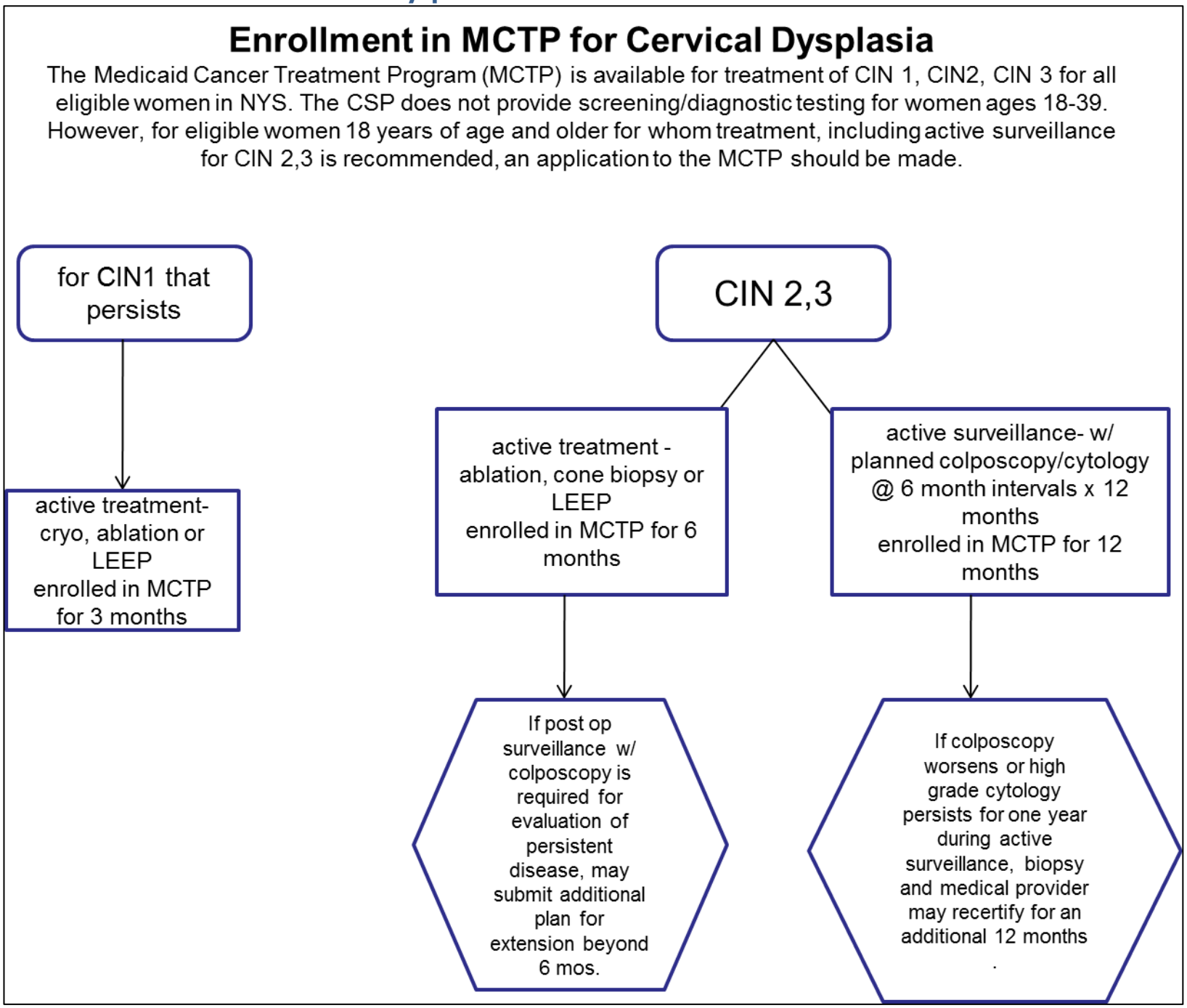

Attachment 6-VII – Insurance Denial Conversion Form Instructions

New York State Department of Health (NYSDOH)
Cancer Services Program (CSP)

Policy and Procedure for Requesting Reimbursement for Screening or Diagnostic Services for Underinsured Clients

Underinsured individuals, those with insurance coverage that require annual deductibles, monthly spend-downs, or co-payments that are high enough to pose a barrier and prevent them from obtaining cancer screening or diagnostic services, may be eligible for the CSP. See the CSP Operations Manual for detailed definitions of eligibility criteria.

Please note the following as it relates to requesting reimbursement for screening or diagnostic services through the CSP for underinsured clients:

- As per the CSP Operations Manual, a *Consent for CSP Participation* (consent form), that includes an attestation of eligibility for the program, must be signed and dated prior to obtaining any services through the CSP, including diagnostic services.
- Per the agreement established between the CSP contractor and the participating credentialed provider:
    - Providers agree to treat the CSP as the payor of last resort, agreeing to first bill a client's insurance and/or third party payor for services.
    - The clinical services for which program funds are being requested must be services that are reimbursed through the CSP. See the Reimbursement Chapter of the CSP Operations Manual for a complete list of CSP reimbursable clinical services.
    - The provider must agree to accept the client as a "CSP client" prior to performing services and therefore agree to accept reimbursement rates established by the CSP as payment in full for all services that are covered by the CSP. Both the client and the CSP provider must be aware that there may be no additional CSP reimbursement if the insurance payment is equal to the allowable insurance amount. See the Reimbursement Chapter of the CSP Operations Manual for the CSP Maximum Allowable Reimbursement Schedule.

Reimbursement requests occur via the use of the Insurance Denial Conversion Form* which must be submitted to the NYSDOH CSP to process reimbursement for full or partial cost of screening and/or diagnostic services for CSP clients determined to be underinsured.

It is the contractor's responsibility to obtain the Explanation of Benefits (EOB) from the medical provider(s) to determine the reason why the medical claim was denied or not paid in full. Please note that an invoice from the provider is not sufficient documentation. Data should not be entered in the data system until the insurance is

billed and the EOB is received, and then only if the CSP is reimbursing for all or part of the services.

The CSP **cannot** reimburse for a clinical service under certain situations, including, but not limited to, the examples below:

- The client chooses to see a medical provider who does not participate in her or his health insurance plan, also known as out-of-network providers (even if it is a CSP credentialed provider).
- The health insurance reimburses for a clinical service at a higher rate than the CSP region-specific maximum allowable rate.

Some reimbursable services are defined by the CSP as a bundled service, such as a stereotactic biopsy (procedure code 16) which includes payment for imaging, core biopsy, needle localization, clip placement, specimen radiograph and post procedure films. Although these services may be reported separately by the medical provider(s) and on the EOB(s), the CSP only reimburses one inclusive fee. The services must be added together before submitting the Insurance Denial Conversion Form to seek reimbursement for CSP services using program funds. Separate EOBs for the multiple providers involved (surgeon, radiology, hospital, lab) must be submitted. For additional CSP-defined bundled services, refer to the Reimbursement Chapter of the CSP Operations Manual.

*Please note that the Insurance Denial Conversion form is also used to request partial payment for an uninsured client in the rare instance when a provider's negotiated rate is lower than the CSP maximum allowable reimbursement rate.

Insurance Denial Conversion Instructions

1. Obtain the Explanation of Benefits (EOB) from the client's insurance and/or third party payor via the medical provider(s) for the client's service or services. Also, contractor must obtain the insurance or third party payor's official definitions for denial codes used on an EOB if they are not provided in a key or legend on the EOB. (Note: The only exception to this step is for choice 6 when the client is uninsured but the clinical provider's reimbursement rate is less than the CSP's, so no EOB is available.)

2. Submit the appropriate clinical services in the data system with other funds. An insurance denial conversion can only be processed for clients with accepted screening intake forms (SIF) and follow-up forms (FF) in the data system. If necessary, a 90-day override will be done at time of processing to allow payment of services that occur after 90 days following the date of service.

3. On the Insurance Denial Conversion Form, complete the CSP Contractor Name, CSP ID Number, Person Completing the Form and Date Submitted at the top of the page. More than one client's information is allowed on each form.

4. Use one line per service per client and provide:

- Client Name
- Nine-Digit Client ID (including leading zeroes)
- Six-Digit Site Code where the procedure occurred (as it is recorded in the data system)
- SIF or FF (to distinguish on which form the service appears)
- Procedure Code for Services on Follow-up Form or Question Number for Service on SIF (do not write the description of the service)
- Procedure Date (as it is recorded on the data system)
- Reason the service was denied (use the appropriate two-digit code)
- Total dollar amount reimbursed by the insurance (for bundled services, add the amount reimbursed for each service; may be on separate EOBs) that is included in the CSP procedure code)
- Dollar amount requested from CSP (the sum of the columns for "Amount Reimbursed by Insurance" and the "Amount Requested from CSP" (Note that the latter amount cannot be more than the maximum allowable rate for the region per the Maximum Allowable Reimbursement Schedule)

5. Include a fax cover sheet with the total number of pages included in the fax to assist the CSP with tracking the forms.

6. Fax the Cover Sheet, Insurance Denial Conversion Form and the EOB(s) (with the official definition for the denial codes used on the EOB) for each client listed on the form to the NYSDOH CSP Health Systems Unit at (518) 486-6860. (Note: The only exception for inclusion of the EOB(s) is for choice 6 when the client is uninsured but the clinical provider's requested reimbursement is less than the CSP's, so no EOB is available.)

7. An email confirming the completion of the process or any denial of request will be sent to the person who is submitting the form to the CSP. Once approved, services and reimbursement amounts will appear on the monthly billing report (MBR).

Note: Please confirm the client's health insurance (SIF question 18) on the data system. Insurance Denial Conversion Forms may be delayed if the health insurance choice on the SIF does not match the reason denied provided. For example, if the client is listed as "uninsured" but the reason the service was denied is "deductible not met", the CSP Data Unit will be unable to process the Insurance Denial Conversion Form until the client's insurance status is updated by faxing a Screening Intake Revision Form to (518) 486-6860. An email will be sent to notify the contractor of the issue, but the confirmation of insurance may delay the reimbursement of a service.

For questions about how to complete an Insurance Denial Conversion Form, email CSPdata@health.ny.gov. For questions about eligibility or reimbursement, refer to the CSP Operations Manual or contact your Regional Manager.

The following is an example of how the process for requesting reimbursement for a cervical cancer-specific screening or diagnostic service typically works for an underinsured client:

- The client has claimed she would not complete a colposcopy and cervical biopsy if she was required to pay for the portion /balance that was not covered by her insurance.
- Client signs a CSP consent form that includes an attestation of eligibility for the program, prior to obtaining any services through the CSP.
- Client goes to CSP participating provider for colposcopy and cervical biopsy.
- The client's insurance is billed $200 first, by the provider, for the colposcopy with cervical biopsy.
- CSP contractor obtains the Explanation of Benefits (EOB) from the client's other insurance and/or third party payor via the medical provider.
- CSP contractor submits the appropriate clinical services on the data system with other funds
- CSP contractor completes and submits the Insurance Denial Conversion Form to the NYSDOH CSP Health Systems Unit at (518) 486-6860.
- The insurance allowable amount for the procedure is $154.00 for the colposcopy with cervical biopsy. The insurance reimburses $54.00 and $100.00 is applied to the client's remaining deductible for the year.
- The CSP reimburses $139.27 for a colposcopy with cervical biopsy (procedure code 53).
- The CSP can reimburse $85.27 ($139.27-$54.00) for the colposcopy with cervical biopsy for this client.

Attachment 6-VIII – CSP Request for Prior Approval for Breast MRI

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Date of submission_____

CSP staff submitting request_____CSP#_____

(Please Print Name)

Contact # and email address_____

CSP client #_____ Date of Birth_____

Screening MRI:

_____The patient is a known carrier of a BRCA 1/2 gene mutation.

_____The patient hasn't been tested but has first-degree relative(s) (parent, brother, sister or child) with a known BRCA 1/2 gene mutation.

Must submit results of genetic test in either the affected individual or the patient's first degree relative (parent, brother, sister or child)

_____The patient has a lifetime breast cancer risk of 20% or greater as estimated and documented with a validated risk assessment model (such as the BRCAPRO, Gail, Tyrer-Cuzick or similar models).

Must submit documentation of the risk assessment tool used to predict the lifetime risk for breast cancer and resulting calculated lifetime risk.

_____The patient was treated with radiation to the chest wall between age 10 and 30 years (e.g., for the treatment of Hodgkin's disease).

Must submit clinical documentation describing history of radiation to chest wall. Clinical documentation must describe patient's medical condition and age at first exposure and dates/length of exposure.

_____The patient has a personal history of or a first-degree relative with Li-Fraumeni syndrome or Cowden and Bannayan-Riley-Ruvalcaba syndromes.

Must submit clinical documentation describing personal and/or first degree family history of Li-Fraumeni syndrome or Cowden and Bannayan-Riley-Ruvalcaba syndromes.

Diagnostic MRI

_____A non-high-risk client with a prior history (not current) of Breast Cancer.

Must submit documentation of the mammographic finding that requires better assessment of an area of concern in a woman with a personal history of breast cancer and for whom treatment is completed and no longer qualifies for the MCTP.

Documentation will be reviewed at the NYSDOH CSP and additional information requested where necessary. An email confirming the completion of the review process with approval (or denial) will be sent. An approval MUST be obtained before scheduling the client for the MRI.

Attachment 6-IX – Process for Submitting Prior Approval & Data for MRI Reimbursement

CSP contractors need to obtain the required clinical documentation from the clinical provider (see Cancer Services Program Guidelines for Determination of Medical Necessity for Breast MRI).

For Breast MRI screening:

1) Contractors either fax or scan/email (only if through a secure email network) the required documentation to the CSP clinical staff with the CSP request for prior approval for MRI form.

2) Requests will be reviewed and additional information requested of contractor where necessary. An email confirming the completion of the process or any denial of request will be sent to contractor staff who submitted the request to the CSP. If the request is approved, the CSP clinical staff also enters it in the Approved MRI log.

3) Once an approval is received, the CSP contractor may arrange for the breast MRI, at a CSP credentialed provider approved for breast MRI.

4) After the MRI is performed and the report obtained by the CSP contractor, the data can be entered on the data system including the date (Q.39a), the site (Q.39b.) and the results (Q.39d). For Q. 39c the funds, must be entered as "Other" funds and a request submitted to the CSP data unit via email, using the MRI template, for the funds to be changed to program funds. Only an MRI that has been logged on the Approved MRI log will be changed to program funds. In addition, the CSP data staff will check Q.25d "DOH determined high risk for breast cancer", which will be carried forward in future SIFs and will signal the client requires MRI for breast cancer screening in future screening cycles. While subsequent documentation of medical necessity will not be required in the next annual screening cycle, the request to the CSP data unit for program funds will be required for each annual screening cycle.

5) Please note: if the client is under age 40, the procedure for obtaining a clinical provider attestation and appropriate data entry in Q. 25b must also be followed.

For Diagnostic Breast MRI:

Diagnostic Breast MRI may be required to assess areas of concern on a diagnostic mammogram for further evaluation of women with personal histories of breast cancer after completion of treatment if the client is not eligible for Medicaid Cancer Treatment Program. CSP contractors need to obtain the documentation of MRI necessity and must be submitted for prior approval of MRI for these clients.

1-3 Same as above.

4) After the MRI is performed and the MRI report obtained by the CSP contractor, the MRI (procedure 26) can be entered on follow up form on the data system. When entering the procedure only "other" funds can be selected and a request must be sent to the CSP data unit via email, using the MRI template, for the funds to be changed to program

funds. Only a diagnostic MRI that has been logged on the Approved MRI log will be changed to program funds.

Please note: the client above who received approval for program funded diagnostic MRI is not automatically authorized to have annual Breast MRI screening unless documentation has also been submitted that meets criteria deeming the client to be high risk for breast cancer.

Attachment 6-X - CSP Process for Submitting for Reimbursement of Analog Film Mammography performed at CSP Credentialed Mammography Providers who utilize Film technology

As part of the annual credentialing process, CSP contractors identify FDA approved mammography facilities that utilize Analog Film technology for mammogram vs. those that utilize Full Field Digital Mammography (FFDM). The CSP data system provides the global regional reimbursement rate for screening and diagnostic mammography for the exams reported by CSP credentialed providers.

Over the course of time, CSP credentialed FDA accredited mammography providers have overwhelmingly changed to FFDM (98.7%) over Analog Film (1.3%). As of April 1, 2016, the CSP reimbursement rate for screening and diagnostic mammography increased to the global Medicare regional rate for Full Field Digital Mammography (FFDM). Please note that the "program" reimbursement rate is also the same for mammography performed utilizing tomosynthesis (3D) technology; there is no additional reimbursement for 3D or computer aided detection (CAD).

The few providers of Analog Film mammography will not be reimbursed the routine "program" rate for mammography when reporting the mammogram on the CSP data system. These few providers will appear as "not credentialed for services" on the data system. Instead, the CSP contractor staff will be required to submit the mammogram as "other funds" and then request the "partial" rate for reported Analog Film mammogram. This rate is identified at the bottom on the CSP Maximum Reimbursement Schedule (MARS). Contractors will submit the request in accordance with the CSP process utilizing the Insurance Denial Conversion Form (IDCF) "06-Uninsured client, provider requests partial amount (no EOB)".

If the client is underinsured, and receives the mammogram at one of the CSP participating providers using Analog Film, the EOB must also be included and the CSP will reimburse the insurance allowed reimbursement up to the CSP MARS rate for Film mammography. Contractors will also be required to submit a copy of the mammogram with the IDCF request for partial payment.

For "Partial" Reimbursement for Film mammography:

1. Contractors submit the appropriate clinical services on the CSP data system with "other" funds. An insurance denial conversion can only be processed for clients with accepted screening intake forms (SIF) and follow-up forms (FF) on the CSP data system.
2. If the client is underinsured, contractors enter the services on the CSP data system only after the insurance has been billed and the explanation of benefits (EOB) from the insurance company is obtained and indicates the appropriate service, allowed reimbursement, and reason for non-payment.
3. Contractors either fax or scan/email (only if through a secure email network) the required IDCF form and copy of the mammogram to CSP staff @ 518-473-0642 or CSPcredentialing@health.ny.gov. If the client is underinsured, then the EOB must also be included.
   Requests will be reviewed and additional information requested from contractors where necessary. An email confirming the completion of the process or any denial of request will be sent to contractor staff who submitted the request.

Chapter 7 –NYS Medicaid Cancer Treatment Program (MCTP)

CSP Operations Manual 2017

Chapter 7: NYS Medicaid Cancer Treatment Program (MCTP)

A. Medicaid Cancer Treatment Program

The Medicaid Cancer Treatment Program (MCTP) is a Medicaid program for eligible persons who are found to be in need of treatment for breast, cervical, colorectal, or prostate cancer (and, in some cases, pre-cancerous conditions of these cancers). See Attachment 7-I for the MCTP Fact Sheet. To be enrolled in the MCTP, an individual must complete an application with a NYS Department of Health Cancer Services Program (CSP) trained designee, referred to as a Designated Qualified Entity (DQE). A DQE is a person designated and trained by the NYS Department of Health as a "qualified" entity for the purpose of assisting individuals in completing the MCTP application.

Once an individual is enrolled in the MCTP, full Medicaid coverage is provided for an initial period of enrollment as determined by the type of cancer being treated. Recertification is required annually, if the individual is still in need of treatment, at which time eligibility is reassessed. Enrollees must receive services from a Medicaid enrolled provider in order to have their services covered. MCTP coverage is limited to the individual enrollee, and cannot be extended to family members or dependents.

When the State Medicaid office processes the application and an applicant appears to be eligible for regular Medicaid in any of the mandatory Medicaid categories, the individual will be authorized for a limited period on the MCTP. They will then be notified by mail to submit an application for regular Medicaid to their local Department of Social Services.

This chapter of the Operations Manual describes eligibility requirements for the MCTP as they relate to each cancer type.

B. Eligibility requirements

This section describes eligibility requirements for each of the four cancer types covered by the MCTP. Differences in eligibility requirements reflect differences in both State and Federal legislation, and subsequent NYS Department of Health policies, (Section C) provides additional clarification regarding the eligibility requirements listed below.

Breast cancer treatment (Legislation enacted 10/1/2002, expanded 11/1/2008)

To be eligible for treatment coverage for breast cancer, or pre-cancerous breast conditions, individuals must be:

- screened for, and diagnosed with, breast cancer or a pre-cancerous breast condition, by a NYS-licensed health care provider, **OR**, if diagnosed with such in another state, were

screened and/or diagnosed by that state's National Breast and Cervical Cancer Early Detection Program

- not covered under any creditable insurance at the time of MCTP application
- in need of treatment for breast cancer or a pre-cancerous breast condition
- a resident of New York State **and**
- a United States (US) citizen, or alien with satisfactory immigration status
- If an individual who meets the requirements above appears to be eligible for Medicaid in any of the mandatory categories, the individual will be given Medicaid coverage under the MCTP for a limited time, pending a Medicaid eligibility determination.

Cervical cancer treatment (legislation enacted 10/1/2002, expanded 11/1/2008)

To be eligible for treatment coverage for cervical cancer, or pre-cancerous cervical conditions, individuals must be:

- screened for, and diagnosed with, cervical cancer or a pre-cancerous cervical condition, by a NYS-licensed health care provider, **OR**, if diagnosed with such in another state, were screened and/or diagnosed by that state's National Breast and Cervical Cancer Early Detection Program
- not covered under any creditable insurance at the time of MCTP application
- in need of treatment for breast cancer or a pre-cancerous breast condition
- a resident of New York State **and**
- a United States (US) citizen, or alien with satisfactory immigration status
- If an individual who meets the requirements above appears to be eligible for Medicaid in any of the mandatory categories, the individual will be given Medicaid coverage under the MCTP for a limited time, pending a Medicaid eligibility determination.

Colorectal cancer treatment (NYS legislation enacted 4/1/2007)

To be eligible for treatment coverage for colorectal cancer, or pre-cancerous colorectal conditions, individuals must be:

- screened and/or diagnosed with colorectal cancer by a CSP-credentialed provider
- under 65 years of age
- income eligible (income at or below 250% of Federal Poverty Guidelines at the time of the MCTP application)
- not covered under any creditable insurance at the time of the MCTP application
- in need of treatment for colorectal cancer or a pre-cancerous colorectal condition
- a resident of NYS **and**
- a United States citizen, or an alien with satisfactory immigration status
- If an individual who meets the requirements above appears to be eligible for Medicaid in any of the mandatory categories, the individual will be given Medicaid coverage under the MCTP for a limited time, pending a Medicaid eligibility determination.

Prostate cancer treatment (NYS legislation enacted 10/1/2007)

To be eligible for treatment coverage for prostate cancer, or pre-cancerous prostate conditions, individuals must be:

- screened and/or diagnosed with prostate cancer by a CSP-credentialed provider*
- under 65 years of age
- income eligible (income at or below 250% of Federal Poverty Guidelines at the time of the MCTP application)
- not covered under any creditable insurance at the time of the MCTP application
- in need of treatment for prostate cancer or a pre-cancerous prostate condition
- a resident of NYS **and**
- a United States citizen, or an alien with satisfactory immigration status

*For the purposes of program implementation, "screened or diagnosed with prostate cancer by a CSP-credentialed provider" is interpreted as a man having received screening or diagnostic testing by a health care provider or facility currently credentialed as a provider in the CSP. Please note that this eligibility criterion reflects the fact that the CSP does not currently provide reimbursement for prostate cancer screening or diagnostic services. Additionally, men or women who are diagnosed with

colorectal cancer by CSP credentialed providers, but did not meet CSP program age or risk status, may also be eligible to apply if they meet the criteria outlined above.

- If an individual who meets the requirements above appears to be eligible for Medicaid in any of the mandatory categories, the individual will be given Medicaid coverage under the MCTP for a limited time, pending a Medicaid eligibility determination.

C. Additional guidance/clarification regarding MCTP eligibility requirements

This section provides additional detail regarding each of the listed eligibility criteria. Direct questions about eligibility criteria to the Cancer Services Program.

Please note that this information, as well as additional detail regarding the MCTP application process, is provided within a separate manual developed for DQEs.

- Income at or below 250% of Federal Poverty Guideline (FPG) at the time of MCTP application (colorectal and prostate cancer treatment only)
- individuals diagnosed with colorectal or prostate cancer who are in need of treatment, and who meet all other eligibility criteria, must have a household income at, or below, 250% of the FPG at the time of MCTP application submission in order to be eligible for the MCTP. The following information should be considered in assessing this eligibility criterion:
- definition of a "household": anyone applying, their spouse, and their eligible children under the age of 21. Medicaid staff will look at legal lines of responsibility in determining who can be included in the Medicaid household, and the programs for which the applicant may be eligible
- definition of "income": any payment received as a result of work activity. This includes wages, salaries, tips, commissions, and income received from self-employment.
- unearned income is income paid because of a legal or moral obligation, rather than for current services performed. It includes pension, government benefits, dividends, interest, insurance compensation, and other types of payments.

If an individual receives Social Security Disability Insurance (SSDI) benefits, (i.e. dependent benefits, disability benefits, survivor benefits), this is counted in the household income. Note: dependent benefits for children under the age of 21 are not counted if the child is not applying for Medicaid.

1. Not covered under any creditable insurance at the time of MCTP application

- individuals with the following types of coverage will be considered to have "creditable coverage", and are not eligible for the MCTP:
- a group health plan, or
- health insurance coverage benefits consisting of medical care (provided directly through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, or
- Medicare, or
- Medicaid, or
- Armed Forces Insurance, or
- a state health risk pool

Note: All plans offered through the New York State of Health are deemed credible coverage for treatment and clients who are on these plans are not eligible for MCTP. Clients on these plans will be subject to deductible and cost share where applicable.

- Insurance (lost coverage or treatment not covered)

all individuals who are in need of treatment for breast, cervical, colorectal, or prostate cancer, or a pre-cancerous condition (and who otherwise meet all other eligibility criteria), and who have either lost their health insurance, or whose insurance does not cover the cost of treatment for breast, cervical, colorectal, or prostate cancer or pre-cancerous conditions, are eligible to apply for the MCTP

2. <u>In need of treatment for cancer</u>

individuals diagnosed with breast, cervical, colorectal, or prostate cancer, or pre-cancerous conditions, must be recommended for treatment in order to meet this eligibility requirement. The following cancer-specific treatment modalities, although not an exhaustive list, reflect treatments that are recognized as meeting the MCTP eligibility criterion for "an individual in need of treatment":

- treatment for breast cancer
- surgery
- chemotherapy
- radiation therapy
- hormone therapy (Tamoxifen, Femara®, etc.)

- treatment for cervical cancer
- LEEP/LEETZ
- cryotherapy
- chemotherapy
- radiation therapy
- hysterectomy
- active surveillance with colposcopy/cytology
- treatment for colorectal cancer
- surgery
- chemotherapy
- radiation therapy
- treatment for prostate cancer
- surgery
- chemotherapy
- radiation therapy
- expectant management/active surveillance
- hormone therapy

3. Out of country residents

Individuals who were diagnosed with breast, cervical, colorectal, or prostate cancer, or a pre-cancerous condition, in another country and later move to NYS are not eligible to apply for the MCTP.

4. Undocumented immigrants

Individuals must be United States citizens, nationals, Native Americans, or aliens with satisfactory immigration status to complete an MCTP application. Individuals who are deemed undocumented may be eligible for Emergency Medicaid and should be referred appropriately. Refer to the Department Fact Sheet regarding Emergency Treatment at: www.health.ny.gov/health_care/medicaid/emergency_medical_condition_faq

5. Underinsured

Clients deemed "underinsured" and who, therefore, may be eligible to apply for MCTP include:

- clients who have Managed Long Term Care with a spend down

- clients who had screening and initial diagnostic test covered under Family Planning Benefit Program
- clients who have exhausted their annual or lifetime cap on treatment benefit on their insurance
- clients who have credible insurance, but are not covered because of a
    - pre-existing condition or have an exclusion/waiting period for coverage
- limited scope coverage, such as those that only cover dental, vision or long term care (must have explicit conformation from insurance of coverage)

Attachment 7-I – Medicaid Cancer Treatment Program Fact Sheet

New York State Department of Health Cancer Services Program

Medicaid Cancer Treatment Program

New York State Department of Health Cancer Services Program
Your partner for cancer screening, support and information

What is the Cancer Services Program?

The New York State Department of Health Cancer Services Program (CSP) oversees the delivery of comprehensive breast, cervical and colorectal cancer screening services to underserved populations in New York State through contractual agreements with local community-based organizations known as *partnerships*.

What is the Medicaid Cancer Treatment Program?

The Medicaid Cancer Treatment Program (MCTP) is a Medicaid program for eligible persons who are found to be in need of treatment for breast, cervical, colorectal or prostate cancer (and in some cases pre-cancerous conditions of these cancers). To be enrolled in the MCTP, an individual must complete an application with a New York State Department of Health Cancer Services Program (CSP) Designated Qualified Entity (DQE). A DQE is a person designated and trained by the New York State Department of Health as a "Qualified" entity for the purpose of assisting individuals to complete the MCTP application.

Once an individual is enrolled in the MCTP, full Medicaid coverage is provided for an initial period of enrollment as determined by the type of cancer or pre-cancerous condition being treated. Recertification is required yearly, if the individual is still in need of treatment, at which time eligibility is reassessed. Enrollees must receive services from a Medicaid enrolled provider in order to have their services covered. MCTP coverage is limited to the individual enrollee and cannot be extended to family members or dependents.

Who is eligible to participate in the MCTP?

BREAST and CERVICAL CANCER TREATMENT

To be eligible for treatment coverage for breast or cervical cancer, or pre-cancerous breast or cervical conditions, individuals must be:

- Screened for and diagnosed with breast or cervical cancer, or a pre-cancerous breast or cervical condition, by a New York State-licensed health care provider, OR, if diagnosed with such in another state, were screened and/or diagnosed by that state's National Breast and Cervical Cancer Early Detection Program;
- Not covered under any creditable insurance at the time of MCTP application;
- In need of treatment for breast or cervical cancer or pre-cancerous breast or cervical conditions;
- A resident of New York State; and
- A United States citizen or an alien with satisfactory immigration status.

COLORECTAL CANCER TREATMENT

To be eligible for treatment coverage for colorectal cancer, or pre-cancerous colorectal conditions, individuals must be:

- Screened and/or diagnosed with colorectal cancer by a current CSP credentialed provider;
- Under 65 years of age;
- Income eligible (income at or below 250% Federal Poverty Guideline [FPG] at the time of MCTP application);
- Not covered under any creditable insurance at the time of MCTP application;
- In need of treatment for colorectal cancer or a pre-cancerous colorectal condition;
- A resident of New York State; and
- A United States citizen or an alien with satisfactory immigration status.

PROSTATE CANCER TREATMENT

To be eligible for treatment coverage for prostate cancer, or pre-cancerous prostate conditions, individuals must be all of the following:

- Screened and/or diagnosed with prostate cancer by a current CSP credentialed provider*;
- Under 65 years of age;
- Income eligible (income at or below 250% Federal Poverty Guideline [FPG] at the time of MCTP application);
- Not covered under any creditable insurance at the time of MCTP application;
- In need of treatment for prostate cancer or a pre-cancerous prostate condition;
- A resident of New York State; and
- A United States citizen or an alien with satisfactory immigration status.

*For the purposes of program implementation, screened or diagnosed with prostate cancer through a current CSP credentialed provider is interpreted as a man having received screening or diagnostic testing by a health care provider or facility currently credentialed as a provider in the CSP. Please note that this eligibility criterion reflects the fact that the CSP does not currently provide reimbursement for prostate cancer screening or diagnostic services.

If an individual who meets the above requirements appears to be eligible for Medicaid in any of the mandatory categories, the individual will be given Medicaid coverage under the MCTP for a limited time pending a Medicaid eligibility determination.

For more information about cancer screening, please call the toll-free CSP referral line at 1-866-442-CANCER (2262). For information about the MCTP, contact John DeFlumer or Sharon Bisner at 518-474-1222.

Updated 10-14

Chapter 8 – Promoting Cancer Prevention and Control

CSP Operations Manual 2017

Chapter 8: Promoting Cancer Prevention and Control

A. Introduction

The goal of this guidance document is to outline Bureau of Cancer Prevention and Control's (Bureau) key messages and provide guidance to Cancer Services Program (CSP) contractors and partners conducting activities that educate stakeholders about the work of the Bureau.

Guided by statewide goals outlined in the New York State Prevention Agenda and the New York State Comprehensive Cancer Control Plan, the Bureau strives to reduce the burden of cancer in New York State (NYS) by implementing multi-pronged approaches including:

1. promoting the importance of cancer screening and access to timely diagnostic exams and referral to treatment for all New Yorkers
2. reducing barriers to screening for both insured and uninsured New Yorkers
3. promoting policy and systems changes that support cancer screening and prevention
4. implementing evidence-based and evidence-informed strategies within healthcare systems to increase cancer screening, and
5. increasing access to quality breast cancer support and survivorship services

As long-standing contractors, the CSP plays an important role in the Bureau's initiatives, particularly working with the uninsured. The need for this work will continue, even as the number of uninsured New Yorkers decline as a result of the successful implementation of the Patient Protection and Affordable Care Act (ACA). For example, data show that insurance status does not guarantee the likelihood of a person being up-to-date with recommended cancer screenings, and those newly insured will benefit from education regarding the importance of screening.

If we are to be successful in our mission of reducing the burden of cancer in NYS, not only do we need to continue our efforts, but we also must continue to educate and engage stakeholders so they become active partners and champions. Working at the local level with knowledge about the communities they serve, CSPs and all bureau contractors are in a unique position to educate local legislators and other stakeholders about the scope of NYS's cancer prevention and control activities and how they affect the health of communities.

This document summarizes cancer prevention and control-related key messages and offers guidance and tools to assist CSP contractors and partners to educate, engage, and mobilize communities and organizational/governmental decision makers to address cancer prevention and control in NYS.

B. Key Messaging

Key messaging is a term to describe how you talk about who you are and *why you exist as an organization*. A key message is the *number one thing* you want your audience to remember. It communicates crucial points *you consistently make* when you reach out to your audience. It connects the dots between *what you do and how it relates to your audience*.

Three important points should be conveyed about cancer prevention and control and the CSP's work: (1) cancer kills a lot of people (burden), (2) some cancers can be prevented or detected early, and (3) NYS programs are effective in reducing the cancer burden in NYS (what we do matters to our audience). Simply put:

Key Message 1 (burden):

Cancer is the second leading killer in NYS.

Key Message 2 (prevention):

Some cancers can be prevented or detected early to improve health outcomes.

Key Message 3 (why our work matters):

New York State cancer prevention and control programs help reduce the cancer burden and promote health in New York State.

These messages underpin the single idea that NYS cancer prevention and control activities are critical to improving the health of New Yorkers. However, effective messaging *must be tailored to the topic you are focusing on and relevant to the specific audience you are addressing.* Consider the messages above as the foundation you build upon to tailor your message for your specific audience (e.g., legislator, community leader, breast screening advocate) and initiative (e.g., early detection, implementation of a cancer prevention policy).

C. Educating Stakeholders

Stakeholders

Stakeholders are individuals or organizations who have an interest in or who are affected by the work of your program –those who have a stake in the results of the program or what will be done with the results. *Key* stakeholders influence or make decisions regarding policies, practices, regulations, and laws at state, regional, or local levels. Key stakeholders who are important to NYS cancer prevention and control include:

- local and state government officials

- elected leaders
- community leaders
- business and non-profit leaders
- media

What Stakeholders Want to Know

Stakeholders want to know how your work affects them, their constituents, and their communities. Referring back to the three key messages above, listed below are additional points to consider researching and including when tailoring your message for the specific stakeholder you are trying to educate or engage.

D. Burden

Cancer is the second leading killer in NYS.

- local breast, cervical and colorectal cancer rates and how these compare to other communities and statewide data
- how the burden of breast, cervical and colorectal cancer affects the stakeholder's community (e.g., racial/ethnic disparities in cancer rates, cancer rates among the low-income populations, costs to the community)

Prevention:

Some cancers can be prevented or detected early to improve health outcomes.

- which cancers are preventable and ways to prevent them (e.g., early detection, promotion of HPV vaccine, avoidance of tanning and excessive UV radiation exposure, and adoption of policies that encourage screening)
- the benefits of cancer screening and early detection and the impact this can have in the stakeholder's community

Why our work matters:

New York State cancer prevention and control programs help reduce the cancer burden and promote health in New York State.

- ways in which NYS cancer prevention and control programs promote cancer prevention and the services offered (e.g., screening provision, population-based policy and environmental change work, community education, support and survivorship initiatives) at the community level
- who in the stakeholder's community benefits most from NYS's programs (e.g., employers, uninsured, low-income populations, those at higher risk for certain cancers, those in need of assistance once diagnosed)

See Attachment 8-I: *Data and Supporting Information* for more material that can be used to craft tailored messaging.

E. Approaches to Educational Activities

While there are many ways to educate stakeholders, the following are the primary activities Bureau contractors should engage in:

- garnering earned media (e.g., letters to the editor, op-eds, press releases, public service announcements, interviews)
- communicating with, and making educational visits to, legislators, other elected officials, or high-ranking community members and decision-makers
- using client stories and testimonials to enhance earned media, educational visits, and other activities as needed.

See Attachment 8-II: *Approaches to Educational Activities* for more about educational activities, as well as a timeline and additional tools.

Attachment 8-I: Data and Supporting Information

Using relevant data and supporting information helps tailor your message to your specific audience. Data also help make messages believable and increase credibility. Data and information presented must be meaningful to the stakeholder and show the impact or potential impact that supporting these initiatives (or not supporting them) could have.

Below are some examples of data and more tailored information, organized by each of the three key messages. While these are mostly state examples, making the information local may be more meaningful to your stakeholder.

Burden: Cancer is the second leading killer in NYS.[1]

- Nearly 1 out of every 5 deaths in NYS is due to cancer.[2]
- Cancer is the leading cause of premature death or death before age 65.[3]
- Each year, about 100,000 New Yorkers are diagnosed with cancer.[4]

Breast Cancer Burden

- Breast cancer is the most common cause of cancer and the second leading cause of cancer deaths among women in NYS.[5]
- About one in eight women will develop breast cancer during her lifetime.[6]
- In NYS, white women are more likely to be diagnosed with breast cancer, but African American/Black women are more likely to die from the disease. The

[1] New York State Cancer Registry and Cancer Statistics, https://www.health.ny.gov/statistics/cancer/registry/. Updated February 2017, accessed October 16, 2017.

[2] New York State Vital Statistics, Accessed October 16, 2017.

[3] New York State Vital Statistics, Table 46a : Leading Causes of Premature Death (<65) and Years of Life Lost New York State – 2015; https://www.health.ny.gov/statistics/vital_statistics/2013/table46a.htm. Updated May 2017, accessed October 16, 2017.

[4] New York State Cancer Registry, 2010-2014., https://www.health.ny.gov/statistics/cancer/registry/. Updated February 2017, accessed October 16, 2017.

[5] NYS BRFSS Brief, Number 1714, Breast Cancer Screening, New York State Adult Women 2016, https://www.health.ny.gov/statistics/brfss/reports/. Page updated October 2017, accessed October 17, 2017.

[6] National Cancer Institute, Breast Cancer Risk in American Women, http://www.cancer.gov/types/breast/risk-fact-sheet. Reviewed September 2012, accessed October 16, 2017.

death rate for breast cancer is 30% higher in black women than in white women.[7]

Cervical Cancer/HPV Burden

- In NYS, approximately 840 new cases of cervical cancer are diagnosed each year, and nearly 300 women die from the disease annually.[8]
- Women without health insurance or without a regular health care provider are significantly less likely to have received a Pap test in the past three years.[9]
- Compared to white women, non-Hispanic black and Hispanic women in NYS are more likely to be diagnosed with and die from cervical cancer.[10]
- Nearly all cervical cancer is caused by the human papillomavirus (HPV).[11]
- In NYS, 2,375 residents are diagnosed with an HPV-related cancer each year, nearly two-thirds of which are women.[12]

Colorectal Cancer Burden

- Approximately 9,070 new cases of colorectal cancer diagnosed each year in NYS.[13]
- Colon cancer is the third leading cause of cancer death for men and women in New York State (NYS). More than 3,000 men and women die from colon cancer annually, making it the second leading cause of cancer deaths in NYS for men and women combined.[14]

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[7] NYS BRFSS Brief, Number 1714, Breast Cancer Screening, New York State Adult Women 2016, https://www.health.ny.gov/statistics/brfss/reports/. Page updated October 2017, accessed October 17, 2017.

[8] NYS BRFSS Brief, Number 1509, Cervical Cancer Screening, New York State Adult Women, 2014, https://www.health.ny.gov/statistics/brfss/reports/. Page October 2017, accessed October 16, 2017.

[9] Ibid

[10] Ibid

[11] National Cancer Institute, HPV and Cancer, http://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents/hpv-fact-sheet. Reviewed February 2015, accessed October 17, 2017.

[12] New York State Department of Health, HPV-Related Cancers and HPV Vaccination Rates in New York State, 2015. https://www.health.ny.gov/statistics/cancer/docs/hpv_related_cancers_and_vaccination_rates_2015.pdf.

[13] NYS Cancer Registry, https://www.health.ny.gov/statistics/cancer/registry/. Updated February 2017, accessed October 16, 2017.

[14] Ibid

- Adults without health insurance or without a regular health care provider are significantly less likely to have received a recommended colon cancer screening test.[15]
- Black men and women are most likely to be diagnosed with, and to die from, colon cancer.[16]
- If we achieve the goal of increasing colorectal cancer screening rates to 80% by 2018, nationally we could avert nearly 280,000 new cases of colorectal cancer and 200,000 deaths due to colorectal cancer in less than 20 years.[17]

Prevention: Many cancers can be prevented or detected early to improve health outcomes.

- At least half of all cancer deaths are attributed to preventable causes such as tobacco use, obesity, poor nutrition, and physical inactivity.[18,19]
    - Kick the habit - If you use tobacco, quit. If you don't use tobacco, don't start.
    - Eat healthy - Enjoy a low-fat diet that is high in fruits, vegetables, and whole grains from breads, cereals, nuts, and beans.
    - Skip alcohol - If you drink alcohol, drink only in moderation. The more alcohol a person drinks, the greater his or her chance of getting cancers such as mouth, throat, esophagus, liver, colorectal and breast cancer.
    - Get moving - Maintaining a healthy weight and getting regular exercise, such as walking, gardening, or climbing may help lower your chance of getting colorectal, breast, uterine, prostate, esophagus, kidney, and other cancers.

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[15] Ibid

[16] New York State Cancer Registry. Cancer Incidence and Mortality in New York State, 1976-2013. http://www.health.ny.gov/statistics/cancer/registry/. Accessed October 16, 2017.

[17] Reinier G. S., et al, Cancer, Public Health Impact of Achieving 80% Colorectal Cancer, Screening Rates in the United States by 2018, DOI: 10.1002/cncr.29336, Published online Month 00, 2015 in Wiley Online Library (wileyonlinelibrary.com)

[18] Bureau of Tobacco Control StatShot Vol. 8, No. 3/April 2015, Tobacco is the Leading Cause of Preventable Death, http://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume8/n3_tobacco_leading_cause.pdf. Page updated July 2017, accessed October 17, 2017.

[19] BRFSS Brief, 1701, Overweight and Obesity, New York State Adults, 2015, https://www.health.ny.gov/statistics/brfss/reports/. Page updated October 2017, accessed October 17, 2017.

Breast Cancer Early Detection

- Early detection is the key to survival. Regular check-ups and mammograms can find breast cancer at an earlier stage, when it is easiest to treat.
- More individuals will be alive five years after their breast cancer diagnosis when this cancer is detected in earlier stages.[20]

Cervical Cancer Early Detection and Prevention

- Cervical cancer is preventable. Screening can find abnormal cells that can be removed before becoming cancer.
- Screening has helped lower the U.S. cervical cancer death rate by more than 50%.[21]
- As many as 93% of cervical cancers could be prevented by screening and HPV (human papillomavirus) vaccination.[22]
- More women will be alive five years after cervical cancer diagnosis when this cancer is detected in earlier stages.[23]

Colorectal Cancer Early Detection and Prevention

- Colon cancer is preventable. Screening can find abnormal growths (polyps) and they can be removed before becoming cancer.
- If we achieve the goal of increasing colorectal cancer screening rates to 80% by 2018, nationally we could avert nearly 280,000 new cases of colorectal cancer and 200,000 deaths due to colorectal cancer in less than 20 years.[24]

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[20] American Cancer Society, Breast cancer survival rates, by stage. http://www.cancer.org/cancer/breastcancer/detailedguide/breast-cancer-survival-by-stage. Updated September 2017, accessed October 17, 2017.

[21] American Cancer Society, Key Statistics about Cervical Cancer, http://www.cancer.org/cancer/cervicalcancer/detailedguide/cervical-cancer-key-statistics. Updated January 2017, accessed October 17, 2017.

[22] Centers for Disease Control and Prevention, Vital Signs, Cervical Cancer is Preventable, November 2014. http://www.cdc.gov/vitalsigns/cervical-cancer/index.html. Accessed October 17, 2017.

[23] American Cancer Society, Survival rates for cervical cancer, by stage, http://www.cancer.org/cancer/cervicalcancer/detailedguide/cervical-cancer-survival. Updated December 2016, accessed October 17, 2017.

[24] Reinier G. S., et al, Cancer, Public Health Impact of Achieving 80% Colorectal Cancer, Screening Rates in the United States by 2018, DOI: 10.1002/cncr.29336, Published online Month 00, 2015 in Wiley Online Library (wileyonlinelibrary.com)

- More individuals will be alive five years after their colorectal cancer diagnosis when this cancer is detected in earlier stages.[25]

Why our Work Matters: New York State cancer prevention and control programs help reduce the cancer burden and promote health in New York State.

Examples of Current NYS Programming:

- Provision of free breast, cervical and colorectal cancer screening and diagnostic services to the uninsured.
- Providing case management services to ensure that people with abnormal screening results receive timely follow-up for diagnostic services, and if needed, cancer treatment.
- Facilitation of cancer treatment for eligible individuals via the NYS Medicaid Cancer Treatment Program.
- Engaging community-based organizations to promote and expand early cancer detection services to high need areas.
- Promotion of policy and systems changes that support cancer screening and prevention that remove structural barriers to cancer screening, such as adoption of paid time policies by employers.
- Working with health care settings to implement evidenced-based interventions such as provider and patient reminders and patient navigation to increase cancer screening rates.
- Providing a range of supportive services, such as support groups, massage, wellness classes and more, for women diagnosed with breast cancer.
- Engagement in population based education about the importance of early detection via mass media, publications, and one-on-one/group education.

[25] American Cancer Society, What are the survival rates for colorectal cancer by stage?, http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-survival-rates. Updated March 2017, accessed October 17, 2017.

Attachment 8-II – Approaches to Educational Activities

CSP contractors are expected to educate stakeholders by garnering earned media, regular communication and in-person meetings/visits, and client stories and testimonials. Contractors should work with partners to educate stakeholders. Working with partners allows contractors to improve reach in the community, build relationships with a broad array of stakeholders, gain access to more decision makers, and strengthen credibility. Please note that CSP contractors are required to implement certain activities as outlined in their work plans and according to the timeline in Attachment 8-III-A: CSP Contractor Timeline of Activities for Educating Stakeholders.

A. Garnering Earned Media

Earned media, also known as free media, is publicity or media coverage gained through promotional efforts rather than through paid advertising. Examples of earned media include publicity gained from editorials, interviews, television/radio topic-specific shows, public service announcements, and press releases. Earned media can be in formats that include news coverage (e.g., newspaper articles, letters to the editor, op-eds (opposite the editorial page) television or radio news shows), journal and magazine articles, and social media shares.

1. Key activities to garner earned media:

- Write and submit letters to the editor highlighting your cancer prevention and control work (see Attachment 8-III-B: Letters to the Editors and Samples).
- Write and submit editorials or op-ed pieces to local newspapers for both print and on-line publication.
- Write and issue regular press releases to announce a range of news items, such as scheduled events, cancer awareness month activities, awards, new services, important new data, or program accomplishments.
- Build and maintain relationships with the media to garner newspaper stories, television and radio coverage and interviews, and other forms of earned media.
    - Develop and maintain a list of all local media outlets, relevant reporters, and journalists in your service area. The list should include the names and contact information of reporters for radio, TV, newspapers, penny savers, and shopper guides. Update the list regularly.
    - Ask partners to select one reporter with whom to meet and build a rapport.
    - Meet with editorial boards to highlight local work.
    - Invite media contacts to all events that highlight program accomplishments (e.g., screening events, program recognition events, etc.).

- Provide partners with key messages and sample earned media to engage them in earned media activities.

2. Communicating with and Making Educational Visits to Key Stakeholders

Key stakeholders include legislators (state and local), other elected officials, high-ranking community members, and organizational decision makers.

Activities to educate key stakeholders:

- Foster relationships with key stakeholders to make them strong supporters of your program (and cancer prevention and control activities in general).
- Invite key stakeholders to program events.
- Solicit written entries from partners for a monthly or quarterly newsletter. This communication can be prepared and sent regularly to stakeholders.
- Clip newspaper articles about local area cancer-related services and issues, and send to key stakeholders with a personal note.
- Send copies of published letters to the editor or other garnered earned media (e.g., news stories) with a note thanking the key stakeholder for being a partner.
- Send or "leave behind" educational materials that are brief, focused, and in line with your key messages (see Attachment 8-IV: "Cancer Screening Saves Lives" fact sheet).
- Compile testimonials (see below) and work with statewide partners, such as the American Cancer Society (ACS) and Susan G. Komen for the Cure, to disseminate them to key stakeholders.
- Know your local legislative representatives and keep them informed of your program activities:
    - Create a list of all representatives in the area including those districts that cross into other areas and regions. For the NYS Senate, see www.nysenate.gov/. For the NYS Assembly, see www.assembly.state.ny.us/
    - Collaborate with statewide and local partners to draft submissions to the Legislative Gazette.
    - Meet with legislators at least annually to educate them and make a compelling case for cancer prevention and control activities; emphasize your program's accomplishments and the need for your program in your community.
        - Coordinate the scheduling of educational visits to local legislative representatives with advocacy organizations; advocates can make "asks" about funding, contractor staff/partners cannot.
        - If possible, bring someone from the legislator's constituency with a personal story about the burden of cancer and/or praise for your program.

- Coordinate visits with other cancer prevention and control programs in your legislative district.
- Be aware of ideal times for scheduling legislative visits: Visits in the summer months can often be conducted in a representative's local office; visits scheduled for January through March must often occur in Albany.
- Arrange visits in a way that keeps them manageable; include a small number of people and provide a concise message. Visits should include no more than two program staff or partners, a constituent, and an advocacy organization representative (e.g., ACS).

B. Personal Stories/Testimonials

- Gather testimonials from individuals with a connection to cancer or cancer screening. Individuals may include CSP clients or non-clients, survivors, family members of a person with cancer, CSP providers or health system representative, and/or other community champions (e.g., business leader/owner, faith leader, and government leaders). Testimonials can demonstrate the impact and burden of a cancer on diagnosed individuals and their families, demonstrate the benefits of screening programs such as the CSP, show support for employer-based paid time off policies for cancer screening and systems changes such as patient navigation, and highlight the success of their participation in your program.
- Archive testimonials in various formats (pictures, videos, personal letters, etc.) for different uses. Be sure to obtain releases granting you permission to use the information provided.
- Follow the instructions in the "Cancer Testimonial Collection Project" guidance document to communicate testimonials to Bureau staff for use during statewide media campaigns or special events. Be sure that permission has been obtained for this purpose prior to use.
- Send testimonials to media outlets via letters to the editor or other earned media vehicles, when appropriate.
- Highlight personal stories at visits with legislators, or bring the person who has the story.

Attachment 8-III-A – Timeline of Activities for Educational Activities

CSP contractors should maintain an annual schedule for conducting educational activities. This will help coordination with partners and promotion of events to stakeholders. Contractors within the same region are encouraged to work together to develop regional strategies to educate stakeholders, especially if there is overlap among key stakeholders (e.g., a legislator who represents multiple counties). This can be done via a regional planning meeting.

CSP contractors are required to follow this timeline to plan educational activities.

Calendar of Educational Activities

Monthly

- Submit a letter to the editor or work with a partner who can submit a letter to the editor highlighting your program's accomplishments.
- If published, send a copy of the letter to the legislator, or other relevant key stakeholder, with a note expressing appreciation for support promoting the program from the legislator/key stakeholder.

Conduct the following **additional** activities according to the timeline below:

October - November:

- Begin preparing for upcoming legislative budget cycle (January – March) by coordinating efforts with other regional contractors and community-based partners (i.e. CSP, Peer Education, Patient Navigation contractors)
- Schedule legislative educational visits and, if a CSP contractor, submit schedule to your regional manager.

December - March:

- Conduct legislative educational visits between December and March (earlier if possible).
- If applicable, plan for or participate in a regional press conference.
- Send thank you letters to legislators for completed visits.

June:

- Schedule summer district office legislative educational visits.

July - September:

- Conduct summer district office legislative educational visits.

- Send thank you letters to legislators for completed visits.

On a continuous basis throughout the year:

- Cultivate relationships with media representatives; pitch stories and invite them to events (e.g., Main Streets Go Blue, Colorectal and Breast Cancer Awareness Month activities).
- Gather personal stories and testimonials and engage partners, stakeholders and other community champions who can promote the work of the program (see Attachment 8-III-B).

Attachment 8-III-B –Letters to the Editor and Sample Letters

Purpose

The editorial (opinion and letters to the editor) section is one of the most widely read segments of both print and online newspapers. A letter to the editor (LTE) provides a free and rapid way to respond to news stories. LTEs can be powerful tools for commentary or for adding information or insight to health-related topics. LTEs also offer opportunities to share what you are doing about preventing and detecting cancer and to create calls to action for readers.

Getting started

Before you write an LTE, do your homework:

- Read other LTEs to get an idea of what types of LTEs are published in your target newspaper.
- Review LTE requirements such as formatting, length, and contact information.
- Some papers require that LTE submissions be exclusive to them, so be wary of submitting your letter to multiple papers.
- Be aware of your response time (e.g., The New York Times requires LTEs to refer to articles that have appeared within the last seven days).

Increasing your chances of having an LTE published

Have a clear purpose: Know what you are trying to achieve in your LTE. Are you refuting an issue? Are you clarifying an issue so readers will be more informed or know how to take action? Are you providing facts to correct misinformation? Are you praising an article?

- Be concise: Explain the purpose of your letter early in the text and have a clear main point.
- Support your main point:
    - Back up praise or criticism with facts or evidence *(e.g., In the past year, the CSP of X County diagnosed X cases of early breast cancer, when breast cancer is easier to treat. These are women whose lives may have been saved by getting this important screening at their local CSP.).*
    - Highlight the successes of the program and use personal stories *(e.g., Prior to last month, I had never been screened for colorectal cancer, even though I am 58 years old and my father died of colon cancer at age 55. I was scared and I thought it would be expensive. Then I learned about the CSP of X County and I called them. They discussed the options with me, and now I know that I don't need to worry.)*
    - Use current events *(e.g., The County Legislator is a strong advocate for healthy workers, as evidenced by her recent signing of a law requiring paid time off for all County employees to obtain recommended screening for colorectal, breast, and cervical cancer.)*

- Provide a call to action: State what should be done to address the issue, and point readers to actions, websites, or other resources.
- Know your audience: Write to appeal to your audience; emphasize local activities and interests. Use local data.
- Make sure your LTE is relevant: For example, promote breast cancer screening programs during Breast Cancer Awareness Month in October, or provide information about a successful paid leave policy implemented by a local employer.
- Be aware of these common errors:
    - Making grammatical and spelling errors: give your draft letter to a colleague, friend, or family member to proofread.
    - Being wordy: follow the paper's guidelines; most LTEs are 150-300 words in length (e.g., The New York Times prefers LTEs of 150-175 words).
    - Addressing more than one issue: having multiple issues in one letter can confuse the point you are trying to make.
    - Being rude or sarcastic: it is okay to disagree with an issue, but be respectful not accusatory. Support your position with facts, not opinions.
    - Being overly casual: keep the letter professional and avoid slang or informal phrasing.
    - Repeating what others have said: make your voice original; offer a new perspective on an issue.

<u>Core elements of a successful LTE</u>

- Agency letterhead: if applicable
- Date of letter
- Inside address: Name and address of newspaper (include e-mail/fax)
- Reference line (Re): headline/author of story you are responding to
- Salutation: "Dear Editor" (insert editor's name, if known)
- Body of letter
    - First paragraph: Explain the purpose of your letter. Reference the original newspaper article and clearly state your point of view. If applicable, cite new data. (e.g., *As a public health professional, I applaud your article, Why Our Communities Are Killing Us.*)
    - Second paragraph: Support your argument by sharing statistics or results of studies. Provide background and contextual materials. Convey what your program is doing to address the issue. (e.g., *While the article states that our community is unhealthy and contributing to the poor health of city residents, the article failed to acknowledge recent advances that support healthy choices.*)
    - Third paragraph: Summarize what you want readers to know about the issue. Re-emphasize the main point of your letter and direct readers on what steps you want them to take to address the issue. *(e.g., There are many obstacles to making our communities healthier; the (organization) is taking steps to do just that. Our community members can support this work by….)*

- Simple closing: "Sincerely," with your name, title, organization (include a one sentence description of your program and contact information)

If your letter is published

- Be happy! Most LTEs are not published.
- Be aware that your LTE may be edited and shortened for space.
- Share with your Regional Manager.
- Share with your local legislator or other stakeholders/champions.
- Share it on Facebook, Twitter and other social media platforms, and ask others to share it.

Keep writing and submitting LTEs even if they are not published. The more you write, the greater the likelihood of getting published.

Sample Letter to the Editor #1

April 4, 2011
Daily Freeman
79 Hurley Avenue
Kingston, NY 12401

Re: The NYS Cancer Services Program Saves Lives

Dear Editor:

Cancer is the second leading cause of death in New York State (NYS). Early detection of cancer can save lives by finding cancer early, when treatment is most likely to be successful and before some cancers even start. The New York State Cancer Services Program (CSP) provides breast, cervical and colorectal cancer screenings at NO COST to uninsured women and men. Health outcomes are greatly improved when breast, cervical, and colorectal cancers are found early.

Since its inception in (X year), the CSP of (X County) has provided uninsured and underinsured individuals with (X# of) cancer screenings, resulting in (X# of) diagnoses, and enrolling (X# of) people in the NYS Medicaid Cancer Treatment Program. These are people who otherwise might not have received these critical services. These people could be your family members, friends, neighbors, and co-workers.

Thankfully, many previously uninsured NYS residents have been able to get insurance, and coverage for cancer screenings, through the Affordable Care Act. However, there still remain many uninsured individuals living in our community. The CSP stands ready to serve, but we need the help of our community.

Help spread the word about the CSP in our community by encouraging uninsured men and women to call 1-866-422- CANCER (2262) to promote critical cancer screening services to those who need them.

Sincerely,

John Doe
Director, CSP of X County
1-866-422- CANCER (2262) or jdoe@xcounty.gov

Sample Letter to the Editor #2 *(Adapted from Eileen A.'s letter)*

June 18, 2011

Daily Freeman
79 Hurley Avenue
Kingston, NY 12401

Re: Finding a Guardian Angel at the NYS Cancer Services Program

Dear Editor:

Eighteen months ago, I was diagnosed with cervical and uterine cancer. I had no health insurance. At the time, I was unaware of the New York State Department of Health Cancer Services Program, which provides cancer screenings and other services for free to eligible people.

I had been ill for several months and foolishly put off going to a doctor because I did not know how I was going to pay for it. Finally, I was so sick I didn't have a choice. Rounds of tests were ordered, including cancer screenings. When it was becoming pretty certain that I had cervical and uterine cancer, I received a call from the hospital that my mammogram showed a mass in my breast. I felt like the whole world was falling down on me. I was terrified of having cancer and terrified I would not be able to pay the mounting bills.

Then someone put me in touch with a nurse from the NYS Cancer Services Program, whom I refer to as my "guardian angel," because she was. She immediately took over and got my screenings covered and enrolled me into a program that would cover the cost of my cancer treatments until I was eligible for Medicare. This relieved much of my stress, so that I could focus on my treatment and getting well.

Today, I am in what my doctor says is "perfect remission" and will be considered cured in nine months. Thankfully, the breast mass was benign. The NYS Cancer Services Program helped me during this very difficult period of my life. I don't know what I would have done without this program. I can't begin to express how grateful I am that the Cancer Services Program was there for me. They are there for you, too. If you can't afford to get a cancer screening, call the NYS Cancer Services Program today at 1-866-422- CANCER (2262). Don't put it off like I did.

Sincerely.

Eileen A.

Sample Letter to the Editor #3

November 12, 2013

Daily Freeman
79 Hurley Avenue
Kingston, NY 12401

Re: Paid Time Off for Cancer Screening Saves Lives and Reduces Business Costs

Dear Editor:

Cancer is the second leading cause of death in New York State. However, early detection of cancer can save lives by finding cancer early, when treatment is most likely to be successful and before some cancers even start. Early detection of cancer also makes business sense. It is estimated an employee diagnosed with cancer costs an employer more than $1,600 annually in lost productivity. In addition to saving lives, preventive cancer screenings reduce health care costs, improve workforce health, and reduce related business expenditures.

Studies have found that paid leave benefits in the workplace encourage staff to make regular visits to primary care physicians and obtain routine cancer screenings. Early detection and treatment not only lead to better health outcomes, but also reduce overall health care costs for both the employer and employee. According to researchers, these benefits outweigh the cost of providing leave for preventive screenings. The New York State Cancer Services Program (CSP) of (X County) is currently working with local employers to implement paid time off policies for colorectal, cervical, and breast cancer screening in their workplaces.

If you are employed in X County and interested in this issue, or you are an employer considering implementing paid leave time off for cancer screenings in your organization, contact your local CSP at (518-123-4567) for assistance. Working together, we can support a healthy workforce and lower healthcare costs in our community.

Sincerely,

John Doe
Director, CSP of X County
518-123-4567 or jdoe@xcounty.gov

Attachment 8-IV – "Cancer Screening Saves Lives" fact sheet

Saving lives and lowering health care costs
Learn about the New York State Cancer Services Program

The New York State Department of Health Cancer Services Program (CSP) provides FREE breast, cervical, and colorectal cancer tests to eligible women and men who do not have health insurance. These tests find cancer when it is most treatable - or before it starts.




Cancer is the second leading cause of death in New York State

Nearly 1 out of every 5 deaths in NYS is due to cancer.[1]

Cancer is the leading cause of premature death or death before age 65.[2]

Every day, approximately 300 New Yorkers are diagnosed with cancer.[3]

Early detection saves lives

Early detection finds cancers when they may be easier to treat.

Many cancer deaths could be avoided if people were screened for cancer.

Screening has helped lower the U.S. cervical cancer death rate by more than 50% in the last 40 years.[4]

Mammography may lower the risk of dying from breast cancer by as much as 20%.[5]

Following recommended screening could prevent at least 60% of deaths from colon cancer.[6]

NEW YORK STATE | Department of Health

Early detection is cost effective

Cancer treatment is expensive. Roughly $87.8 billion was spent in 2014 in the U.S. on cancer-related care.[7]

Earlier stage cancers are often easier and less costly to treat for patients and health care payers.[8]

Employers who implement a paid leave policy for cancer screenings can lower costs and help maintain a healthy workforce: every cancer diagnosis is estimated to cost the employer $1,601 in lost productivity each year.[9]

The CSP makes a difference in NY communities

Every year, the CSP provides cancer screening to tens of thousands of New Yorkers.

The CSP provides a range of care that includes timely follow-up and referrals to treatment.

The CSP works with New Yorkers who are least likely to get recommended cancer screening.

The CSP raises awareness about the importance and benefits of early cancer detection by promoting policy changes, such as adoption of employee policies for paid leave for cancer screening

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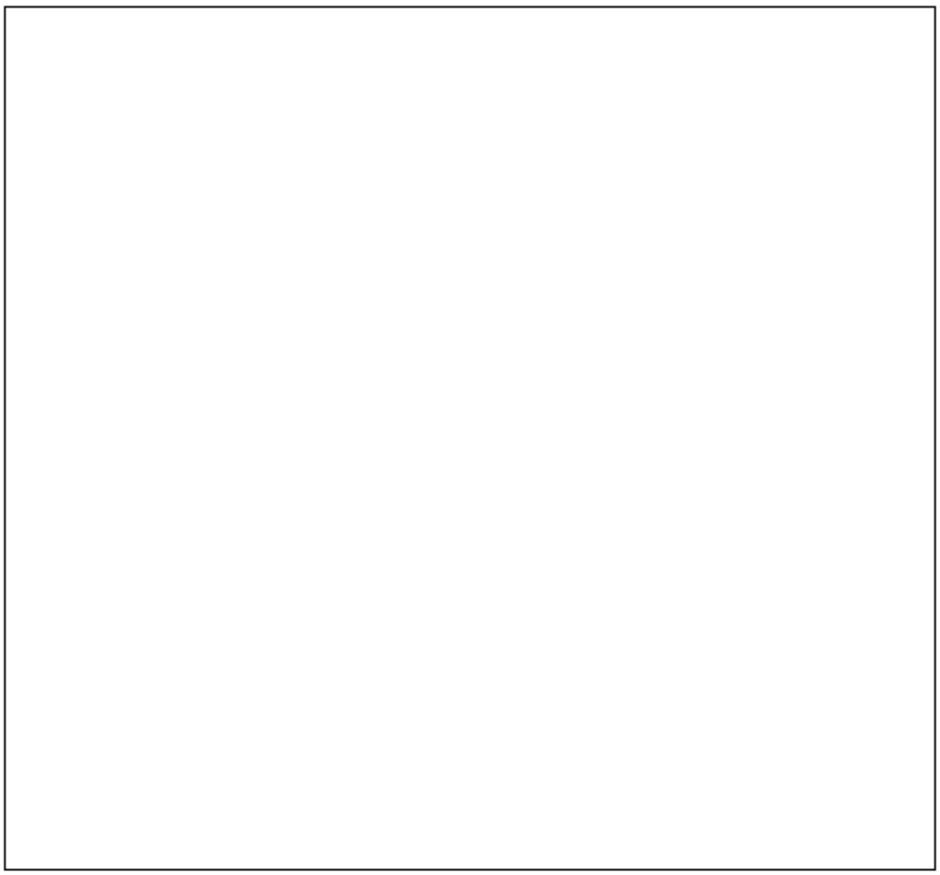

Cancer Screening Saves Lives fact sheet footnotes:

[1]New York State Vital Statistics, 2015
[2]Ibid
[3]New York State Cancer Registry, 2010-2014
[4]Centers for Disease Control and Prevention. https://www.cdc.gov/cancer/cervical/statistics/index.htm. Updated June 2017, accessed October 19, 2017.
[5]American Cancer Society, Breast Cancer Facts & Figures 2017-2018. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/breast-cancer-facts-and-figures/breast-cancer-facts-and-figures-2017-2018.pdf.
[6]CDC, Screening for Colorectal Cancer: It's the right choice." July 2015. https://stacks.cdc.gov/view/cdc/41014)7. American Cancer Society Cancer Action Network, The Costs of Cancer, April 2017. https://www.acscan.org/sites/default/files/Costs%20of%20Cancer%20-%20Final%20Web.pdf.
[8]Ibid
[9]Rebecca J. Mitchell & Paul Bates, Measuring Health-Related Productivity Loss, 14 POPULATION HEALTH MGMT. 93, 96-97 Fig. 1 (2011), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128441/pdf/pop.2010.0014.pdf; cf. Donatus U.Ekwueme et al., Medical Costs and Productivity Losses of Cancer Survivors-United States 2008-2011, 63MORBIDITY AND MORTALITY WEEKLY REPORT 505, 509 Table 2 (June 13, 2014) (of cancer survivors that return to work after treatment, productivity losses average $1459 for men and $1330 for women, compared to those without a history of cancer).

October 2017

Chapter 9 – Guidelines for Review of Contractor Developed Educational and Promotional Material

CSP Operations Manual 2017

Chapter 9: Guidelines for Review of Contractor-Developed Educational and Promotional Material

This chapter describes guidelines for the development of contractor generated educational and promotional material, as well as the process for review and approval. *The guidelines and process are effective November 1, 2015.*

This chapter contains:

A. Material Development Overview

This section provides information on what types of materials need to be reviewed, what content should be included on the material (and when), and guidance on what to consider prior to beginning material development (more specific strategies and resources are provided in Section D).

B. Materials Subject to Review

The following types of materials, newly developed in-house (by the contractor) or by graphic designers or other outside vendors, and paid with NYSDOH CSP funds are subject to the review process outlined in this chapter:

- pamphlet/brochure/booklet
- television or radio public service announcement or paid advertisement
- wallet card/palm card
- poster
- billboard or transit poster
- webpage
- social media post (e.g., Facebook, Twitter)
- fact sheets, pamphlets or other handouts related to developing strategic partnerships
- fact sheets, pamphlets or other handouts related to paid leave work
- fact sheets, pamphlets or other handouts related to sustainability work

***NOTE:** Previously approved contractor developed materials do not have to go through the review process (except in select cases – see Section E, Special Considerations).

General Information

Whenever possible, CSP contractors should use NYSDOH-developed materials.

Any new materials developed in-house or using graphic designers or other outside vendors, and paid with NYSDOH CSP funds *must* be reviewed and approved by the Regional Manager (RM) and the NYSDOH CSP Communications and Education Unit (CEU) *prior* to expenditure of NYSDOH CSP funds or material publication.

C. Acknowledgements

When NYSDOH funds are used during the grant period to develop materials that are subject to review, as noted above, those materials, and products belong to the NYSDOH. These materials must contain the CSP logo (see section G for more information), and the following New York State acknowledgement:

"This (project/publication) is supported with funding from the State of New York. The opinions, results, findings, and/or interpretations of data contained therein are the responsibility of the author and do not necessarily represent the opinions, interpretations, or policy of the State."

If there is limited space, it is sufficient to include an abbreviated version of the Acknowledgement, as follows:

"This project/publication is supported with funds from the State of New York."

D. Material Development

Creating new material takes thought and planning. Consider the following points before embarking on material development, and keep them in mind during your internal review. The RMs and the CEU will also use these items during the review process. This chapter provides detailed material development strategies and resources.

When planning the development of new material, consider these questions:

- Is there a need for the material (i.e. why do you want to develop something new)?
- Does NYSDOH material already exist that addresses the same topic (if so, why do want to develop something new)?
- Is new material development an appropriate use of your budget (if there is a cost associated) at the given phase of the grant?

If you answered "yes" to the above questions and decide to proceed with development, please ensure the draft material contains:

- one main message
- an evidence-based call to action
- clear language, no medical jargon
- appealing design and layout
- accurate information and correct terminology (any data must include a reference so RMs/CEU can confirm accuracy)

The RM and CEU will use CDC's Clear Communication Index ("*the Index*") to guide assessment of the material. It is strongly suggested the CSP contractor also use the Index to assist with development of materials. See more about the Index in Section I.

While the Index is available in paper printout, it is suggested that the electronic version be used as it automatically calculates the scoring. The Full Index Score Sheet is on line at www.cdc.gov/ccindex/pdf/full-index-score-sheet.pdf.

E. Material Approval Process and Timeline

The CEU and RM will work together to review contractor-developed materials. The CEU gives final approval of developed pieces. The RM is responsible for initial review and approval of the budget to cover the cost of material development, production, and placement. The following process aligns with the steps in the Material Approval Request Form ("the form") and the associated checklist – see Attachment 9-I.

Material Review Approval Process

- Contractor submits draft material **in native format** (not PDF), and the Material Approval Request Form with Part I (material justification) and Part II (budget justification) completed, to RM.
- RM reviews the initial draft of the material, along with Parts I and II of the form. RM completes Part III of the form (RM review). If the development of the material seems necessary, and the content and budget are approved, RM submits material and the form (with any minor comments/edits) to CEU. However, if the RM determines the material is not needed, the content needs substantial revision, or the budget is not approved, RM will discuss whether to redo material/budget or reconsider the need for development with the contractor.
- Once CEU receives RM-approved material and the form, CEU will review the material along with any RM comments. CEU will complete Part IV of the form and discuss any content or style edits needed with contractor and, if necessary, return to contractor for revision.

- Once CEU receives the material back from the contractor and is ready to make a final determination, CEU will send the completed review form to the RM and contractor via e-mail.
- It is recommended that the contractor and RM keep a copy of the completed form and the final version of the material, once approved. CEU will also maintain a copy of the approved form and material.

F. Material Review and Approval Timeline

The following timeline provides an estimate of the time that should be allotted for the review process outlined in this chapter. Although contractors should make every effort to allow enough time for review and approval based on the timeframes below, RMs and CEU will attempt to respond to individual needs and unforeseen circumstances that require a shorter turnaround time. In addition, depending on the level of edits needed, final approval may be shorter or longer than indicated.

Contractor submits material and Form to RM	RM reviews and returns to contractor for material edits or budget correction	Contractor revises material / budget and returns to RM	CEU reviews when RM-approved Form and material are received	Contractor revises material, if necessary, and returns to CEU	CEU approves	Total Time
new material	1 week	½ week	2 weeks	½ week	1 week	5 weeks
website / webpage	1 week	½ week	2 weeks	½ week	1 week	5 weeks
social media posts	½ week	½ week	1 week	½ week	½ week	2 ½ weeks
updated material (previously approved)	½ week	½ week	1 week	½ week	½ week	2 ½ weeks

G. Use of CSP Logos[29]

Using a visual symbol consistently over time helps build public awareness and brand recognition. The CSP logo, with the tagline "*Your partner for cancer screening, support, and information*", provides contractors with a statewide brand that is noticeable. This logo is most likely familiar to clients, potential

[29] Please note that guidelines for use of CSP logos are subject to change, as determined by the NYSDOH.

clients, health care providers, and other organizations in the communities served by the CSP.

The CSP requires contractors to use the name "Cancer Services Program of X County/Counties" to build name awareness and consistency for clients, partners, and health care providers. As a reminder, any materials developed by the contractor during grant period, and paid for using grant funds, must contain the New York State acknowledgement (see Section C).

The NYSDOH will provide contractors with electronic versions of local logos for use on contractor materials. Logos are available in .jpg or .eps file formats. Contractors should email CEU staff with CSP name and file format preference to obtain a file of their local logo, if necessary.

H. Logo Options

There are two logos available for contractors' use: a local CSP logo and a New York State Department of Health CSP logo. In most instances, contractors should use their local CSP logo.

Guidance for Use of Local CSP Logos

- The logo should appear on all promotional and educational materials funded in whole or in part by the CSP (including letterhead, business cards, brochures, posters, billboards, etc.). The logo should appear on all materials, whether hard copy or electronic.
- Any material containing the logo must also contain the NYSDOH funding acknowledgement.
- The logo is required on web pages, but it is not required on social media posts or tweets.
- The logo can be used as a stand-alone image on materials or in conjunction with a contractor's organizational logo.
- Contractors may not alter the logo:
    - The size and position of the graphics have been designed to achieve balance with the words and should not be changed.
    - The logo cannot be used with other figures, graphics, photos, or clip art as part of the logo.
    - The logo cannot be printed as a fainter, less opaque version or with shadows.
    - Contractors should not cut and paste the logo from previously printed materials; this can distort the image and will affect its legibility.

  - The logo can be used only in its original color (pantone number 2748), as provided to the contractor, but may also be reproduced/printed in black and white.

- Logo placement:
  - The logo should not be placed in ways that reduce or block its readability.
  - The logo should not be placed on a dark or textured surface.
  - The logo should always be surrounded by sufficient white space.
  - When preparing billboards or posters, it is recommended that the logo be placed in a lower corner, if not used as part of the poster or billboard.
  - The logo cannot be positioned on a diagonal.
- Use of logo on letterhead and business cards:
  - The logo may be used on letterhead alone or in conjunction with the contractor's organizational letterhead, and (in plain text) as part of a signature on a letter (e.g., Coordinator, Cancer Services Program of X County).
  - The logo may be used on business cards. It is recommended that it be placed in the upper left corner.

Guidance for Use of NYSDOH CSP Logo[30]

Contractors may use the NYSDOH CSP logo only with the express, written permission of NYSDOH as provided by the CEU. In most instances, contractors should use their local CSP logo.

The NYSDOH CSP logo may be used primarily on statewide reports and materials or for promoting the program on a statewide or regional level. For example, contractors may want to use the NYSDOH logo in instances where multiple contractors collaborate to develop a regional media campaign or promotion for a regional initiative.

Requests for use of the NYSDOH CSP logo must first go through the RM. If the RM feels the request is appropriate, the RM will discuss the use of the NYSDOH CSP logo with CEU. Contractors may use the NYSDOH CSP logo only on materials that have received approval via the process outlined in this chapter.

[30] Please note that guidelines for use of NYSDOH CSP logo are subject to change, as determined by the NYSDOH.

I. Material Development Strategies and Resources

This section includes strategies (mostly based on CDC's Clear Communication website) and resources to enhance clarity and aid understanding of public messages and materials. To obtain more detailed information about CDC's Clear Communication Index, visit http://www.cdc.gov/ccindex/.

Beginning the Development Process

Before a contractor begins development of new material, they should be able to answer the following questions:

1. **Did you identify your intended audience?**

   Always consider the audience. Why will your message appeal to them? What is their health literacy level? If using pictures, select pictures that reflect your audience or the key message.

2. **Did you conduct audience research?**

   Get to know your audience – don't guess or assume. Review existing data or gather new data/information through research. This is particularly important if material is not being pretested.

3. **Did you identify your behavioral objective(s) and key message?**

   What do you want your target audience to do? Is your key message clear?

4. **Did you determine how your material will be formatted and distributed so it reaches your audience?**

   Consider how your audience will find, receive, and use the material. Choose the best format for your audience and the message (written, visual, audio). Identify dissemination channels, such as social media, community organizations, websites, and activities that match the audience.

5. **Did you build in time and resources to pre-test the material with your intended audience and revise based on feedback?**

   Although budget and timing may not allow for pre-testing, you should complete this step whenever possible. Even the most robust communication guidelines cannot substitute for pre-testing with your intended audience.

Designing and Assessing the Material

CEU strongly suggests using CDC's Clear Communication Index as a guide to developing new material and assessing the completed draft. The Index is a research-based tool containing items representative of the most important characteristics that enhance and aid people's understanding of health information. The Index contains 20 items, each with a numerical score of zero or one. The individual scores are converted to an overall score on a scale of 100. Although 100 is an ideal score, 90 or higher is passing.

To access the Index online, go to www.cdc.gov/ccindex/pdf/full-index-score-sheet.pdf. This document is in fillable PDF format and will automatically calculate the material's score. For complete instructions on how to use the Index, go to www.cdc.gov/ccindex/pdf/clear-communication-user-guide.pdf.

Clear Communication Index Areas

Below is a summary of the seven areas the Index addresses. Reviewing these items can help guide material design and assessment.

1. Main Message and Call to Action

Make sure the material has one main message. The main message statement is the one thing the audience must remember. The statement may be 1-3 short sentences. You can combine the main message statement and the call to action (what you want people to do after receiving and understanding the main message), or they can be separate sentences.

2. Is the main message at the top, beginning, or front of the material?

People look for the most important information at the top, beginning, or front of a material. When you put the main message first, people can find it more easily and quickly. For example, a main message belongs at the top of a web page or poster and on the front page of a folded brochure.

The main message must be in the first paragraph or section. A section is a block of text between headings. For Web material, the first section must be fully visible without scrolling.

3. Is the main message emphasized with visual cues?

Visual cues draw attention to parts of a material. Use visual cues to draw attention to the main message. People perceive differences in size, shape, and color as meaningful. When you draw attention to the main message, people will recognize it quickly and more easily. However, be wary of having too many different font sizes and colors, which is distracting to the reader.

Examples of visual cues are:

- boldface
- color
- shapes
- lines and arrows
- font type, size, alignment, and spacing
- heading, such as "What you need to know"

4. Does the material contain at least one visual that conveys or supports the main message?

Make sure the words and visuals in the material convey the same message and reinforce each other. People expect words and visuals that appear close to each other to be about the same information. When the words and visuals are unrelated, unclear, or contradictory, people can get confused or distracted. Remember: don't overload visuals with too much information.

Photographs, graphs, and infographics are visuals. When they are clearly designed and not overloaded with information, they can help people grasp information easily and quickly. Photographs should be representative of the target audience you are trying to reach, or should support the key message.

5. Does the material include one or more calls to action for the primary audience?

Tell the primary audience what you want them to do with the information you've given them. The action can be a specific behavior (e.g., "get screened"), a prompt to get more information (e.g., "call the toll-free hotline"), or a broad call for program or policy change. Even when your purpose is to inform an audience, think about why they need this information, and use this insight to create a call to action.

6. Do both the main message and the call to action use the active voice?

Use active voice and allow the subject of the sentence to perform the action. Active voice is used most often in conversation.

- Active Voice: Wash fruits and vegetables before you cut or peel them.
- Passive Voice: Fruits and vegetables should be washed before they are cut or peeled.

7. Does the material <u>always</u> use words the primary audience uses?

Choose the most common or frequently used words or terms for the primary audience, that is, words they use every day. When you use the language the audience uses, they will more easily and quickly process information in the material. Be careful, though, not to use slang, colloquial, or offensive language that confuses or upsets the audience or violates their expectations of you as an information source.

When you need to use an unfamiliar term, explain it where you use it – in the same sentence or immediately after.

Some acronyms and abbreviations may be familiar to the primary audience, others may not. The general rule is to use acronyms and abbreviations sparingly,

and when you do use them, spell them out and explain what they mean. If people don't need to know the full word or phrase, use alternative phrasing.

J. Additional Resources

The guidelines above are broad and do not address everything that goes into creating clear and effective educational and promotional material. Below are some additional resources that can help with material development:

CDC Clear Communications Index

www.cdc.gov/ccindex

CDC Gateway to Health Communication and Social Marketing Practice

www.cdc.gov/healthcommunication/

CDC Health Communicator's Social Media Toolkit

www.cdc.gov/healthcommunication/ToolsTemplates/SocialMediaToolkit_BM.pdf

CDC Guide to Writing for Social Media

www.cdc.gov/socialmedia/Tools/guidelines/pdf/GuidetoWritingforSocialMedia.pdf

K. Special Considerations

Material Reprints

Contractor-developed materials that were previously approved do not have to go through the review process except in the following cases:

- substantial changes or revisions have been made
- changes in laws, screening/treatment guidelines, or CSP policies and procedures have occurred since original development
- contractor is reprinting materials developed more than two years ago

In addition, contractors reprinting materials that *have not* gone through this revised review process may want to use the CDC Clear Communications Index attached to the Material Approval Request Form (or at the following link: www.cdc.gov/ccindex/pdf/full-index-score-sheet.pdf) to assess whether it would be beneficial to update the material. If the contractor is unsure about whether to revise a previously approved material, they should discuss it with their RM.

Web Pages and Social Media

All new webpages and social media posts and tweets must be reviewed and approved as per these guidelines prior to posting or going live.

For existing websites, webpages, or social media posts, review and approval is only required in select cases (see "Material Reprints" above). RMs should work with contractors to establish a system for routine review and website maintenance to ensure information remains accurate and up-to-date.

Purchasing of Pre-Developed Educational Materials

If a contractor plans to purchase pre-developed materials that include educational messages (e.g., "cancer screening saves lives"), the contractor will need to submit the request to the RM for both material review and budget approval (the Material Approval Form does *not* need to be used). RMs will make the final decision as to whether the educational message is accurate and aligns with NYSDOH guidelines, policies, and procedures. If so, these materials do *not* need to go through the full review process outlined in this chapter (i.e., CEU does not need to review).

L. Materials That Do Not Require Review

The following materials are not subject to the review process outlined in this chapter:

- material developed and available through the NYSDOH and CDC, including MIYO (Make it Your Own) products
- content that has been reviewed and approved in one format (e.g., brochure) need not be reviewed again for reproduction in another format (e.g., webpage, social media post) if there is no change in content
- material that only promotes CSP name and phone number, and does not contain any educational messages. For example, a pen or palm card promoting a CSP phone number, hours of operation, etc. Please note, however, that the expenditure needs RM approval.
- material developed or purchased using ONLY funds from other sources

CSP promotional material developed and paid for by an outside partner. In this case, NYSDOH does not have the authority to review and comment. However, the CSP contractor should request that acknowledgement of NYSDOH funding of the Cancer Services Program is placed on the material. For example, it is appropriate to request that the material state: "*The Cancer Services Program of X is funded by the New York State Department of Health*." The outside partner may deny this request. If the CSP contractor finds that any information presented is inaccurate, the CSP contractor should bring the error to the attention of their RM immediately.

Attachment 9-I – Materials Review Form

CSP Contractor Material Approval Request Form

For best results/ease of completion, use the TAB key to move forward, Shift+TAB to move backward through fields.
Enter only digits for numbers – form automatically adds ( ) $ %.

CSP of: **Name:** **Position:**
(person responsible for material development & revisions)
Phone: **Email:** **Date to RM:**

PART I – Material Development Justification

Contractor - complete Parts I & II only

***NOTE:** you must provide materials in the "native" format used to create them (e.g. Word, Publisher).*
Do not submit PDF files.

1. Please provide the rationale for development of this material
2. Who is the primary CSP audience (e.g. men >50, women never/rarely screened for cervical cancer, etc.)?
3. List source(s) of any data cited:
4. Did you develop this material using the strategies listed in Section D of this chapter? Select
5. If CDC Clear Communications Index was used, indicate score:

PART II– Material Budget Justification

Contractor completes the following

For each stage of the materials development process, provide the total cost and the amount and percentage paid using CSP funds vs. other funding sources.

Material Type: Select If other, specify type of material:

	Total Cost ($) enter digits only	CSP Cost ($) enter digits only	% CSP Funds enter digits only	% Other Funding enter digits only
Development: (e.g. outside graphic designer)			%	%
Production: (e.g.: printing costs/supplies)			%	%
Placement/Distribution (e.g. mailing, TV/radio ad)			%	%

Materials

CSP Contractor Material Approval Request Form

For best results/ease of completion, use the TAB key to move forward, Shift+TAB to move backward through fields.
Enter only digits for numbers – form automatically adds ( ) $ %.

PART III– Regional Manager Review

RM completes the following

RM score (from CDC Clear Communication Index):

< 90 – requires revision, **return to contractor**
≥ 90 – passing, but may need revision

Is the material necessary (i.e. not already available)? Select

Is the material consistent with objectives identified in workplan? Select

Is the cost supported by the budget? Select

Document revisions below (or in Word via track changes). If score is below 90, return file & revisions to contractor. If 90 or above, submit to CEU with any suggested revisions.

Tab into this field to add revisions.

RM Approval Status:

☐ Rejected

Date Contractor notified

☐ Need budget revision (provide date)

Date returned to Contractor Date revisions received Date to CEU

☐ Need content/style revision (provide date)

Date returned to Contractor Date revisions received Date to CEU

☐ Approved for CEU Review (provide date)

Date sent to CEU

PART IV– CEU Review & Final Determination

CEU completes the following

Date received from RM:

CEU score (from CDC Clear Communication Index):

CEU Approval Status:

☐ Rejected (provide date)

Date Contractor/RM notified

☐ Need content/style revision (provide date)

Date returned to Contractor Date revisions received

☐ Approved by CEU (provide date)

Final Approval Date

Materials

Material Content and Approval Process Checklist ☑
(Chapter 9 Operations Manual Companion)

Content

Accuracy of Messaging

- ☐ Does your material have **one main "take away" message**? The message should be 1-3 sentences and written in active voice. It should always be at the top, beginning, or front of your material.
- ☐ Does your material have a **call to action** (what you want your audience to do)? A call to action should be in active voice.
- ☐ Are you using **plain language**? If you are using data, statistics or figures, are they easily understood? (e.g. 3 out of 10 people may be easier to understand than 30% of people)
- ☐ If your message includes screening ages, does it say age 50 (or 40) and older and **not** over 50 (or 40)? Is it recruiting uninsured and **not** underinsured?
- ☐ Did you remember to include and/or **double-check your phone number**?

Visuals/Graphics

- ☐ If you are using a photograph, is it **reflective of the audience** you are trying to reach? Is it reflective of the priority population for screening?
- ☐ Does the visual used (photographs, infographics, etc.) **reinforce the main message**?

Logos and Acknowledgment

- ☐ Are you using the most **current CSP logo**? Remember, the CSP logo may not be altered in any way.
- ☐ If the material is paid for with any amount of CSP funds, the material **must** include the appropriate NYS acknowledgement.

NOTE: The CEU strongly recommends use of the CDC's Clear Communication Index (CCI) when creating and editing material.

Review Process*

New Material

- New material needs review and approval from the RM (Regional Manager) and the CEU (Communications and Education Unit). The exception is when the material **is not** paid for with CSP funds.
- Plan ahead to allow enough time for review. Review may take anywhere from 1 to 5 weeks.
- RMs will do a first review of material and budget. Send the following to the RM:
  - A draft of the material in its original format (not PDF) for editing
  - The Material Approval Request Form, with Parts I and II completed
  - An email containing information about 1) where the material will be printed, and if an ad, what the final measurements are, and 2) whether COLA or regular budgeted funds are being used
- RM will communicate edits to contractor or forward material to CEU for final approval.
- Once approved (both RM and CEU have signed off) the material may be used.

Previously Approved Material

- Any materials approved more than two years ago must be reviewed again.
- If material was approved within the last two years…
  - and the content is the same, or the content is the same but has been converted to a different format (e.g., from a brochure to a webpage) **review is not required.**
  - and the content has been updated, **review is required**. Updated means *significant* changes have been made, there have been changes in laws, screening/treatment guidelines, or changes in CSP policies and procedures.
- Any previously approved materials that are to be paid from CSP grant funds will require approval by the Regional Manager.

Other or Existing Material

- **Content review/approval** is **NOT** required for:
  - NYSDOH, CDC or MIYO (Make It Your Own) material.
  - Materials developed/purchased with funds from outside sources only.
  - CSP promotional materials (no educational content) developed/funded by an outside partner.
- Any other/existing materials that are to be paid from CSP grant funds will require approval by the Regional Manager.

Regional Manager approval is required for **non-educational materials** (incentives/promotional items) that contain CSP name, phone number, hours of operation, etc. (e.g., palm cards, note pads, etc.) prior to purchase.

** For more in-depth explanations, please refer the Chapter 9 of the Operations Manual, effective November 1, 2015.*