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INTRODUCTION

The purpose of the Iowa Care for Yourself (IA CFY) Program Policy Manual is to furnish local programs with the policies and guidelines of the IA CFY Program.

To provide services for the IA CFY Program, the local Boards of Health must have a signed cooperative agreement with the Iowa Department of Public Health’s IA CFY Program and designate an agency to provide the recruitment, enrollment, tracking, follow-up and case management components of the IA CFY Program. The agency is expected to follow program policies and protocols.

Changes in the IA CFY Program policies may be made without advance notice, based on guidance from the Centers for Disease Control and Prevention (CDC). Health care providers, facilities, staff and/or billing agencies will receive notification of program updates when indicated.

POLICIES AND PROCEDURES

Written policies and procedures are standard for most agencies and special programs. The purpose is to:

1. Establish and maintain written documents to provide consistency and accuracy of services being offered to eligible and enrolled women.
2. In case an unplanned event occurs, in which a ‘local program coordinator’ or other IA CFY Program representatives are unable to perform their duties, the written policies and procedures are an added safeguard to maintain the program services.

Each local program is to maintain and follow written policies and procedures addressing the following participant elements:

- Eligibility and Enrollment
- Patient Navigation of participants who have resources to pay for screening, diagnostics and treatment services
- Tracking, Follow-up and Case Management of participants with abnormal screening results
- Recall of participants for screening at appropriate intervals
- Health care provider recruitment, enrollment and orientation
- Process for obtaining and reporting data
- Process for submitting claims for reimbursement of services

The local program must have policies and procedures written, revised as needed and accessible to appropriate staff. The ‘Local Program Coordinator’ is responsible to see that this is done.
CONFIDENTIALITY STATEMENT

Confidentiality is both an ethical and legal responsibility. State and federal courts uphold the common patient confidentiality standards such as the American Medical Association (AMA) ‘Code of Ethics.’ Divulging medical information to a third party without appropriate permission from a participant is considered a breach of confidentiality. Revealing such information may include any or all types of communication (verbal, written, phone, fax, electronic, etc.) and is considered a breach of confidentiality whether intentional or unintentional.

To accomplish this, procedures and systems must be in place and maintained at all IA CFY Program sites and by all program representatives. Participant records and information must be secured in a manner accessible only by IA CFY Program representatives. This includes but is not limited to locking files, private areas for verbally communicating with participants (face to face or by telephone) and a method for securing participant information at an agency’s or representative’s workstation (desktop, computer, mail, etc.).

QUALITY ASSURANCE AND QUALITY IMPROVEMENT

Quality assurance and improvement are integral components of the IA CFY Program and contribute to program success. The purpose of quality assurance and improvement is to:

- Ensure the quality of services delivered through the program
- Monitor performance and identify opportunities for improvement
- Plan effective strategies for improving services

Program requirements and monitoring activities include:

- Professional Licensure and Accreditation – health facilities and professionals must be currently licensed or accredited to practice
- Reporting standards for radiological, laboratory and pathology – reports must be reported according to national standards
- Standards for adequacy of follow-up – data reports track appropriate and timely diagnostic, short-term and rescreening services
- Patient Navigation – local program staff evaluate needs, implement plans and refer participants who need screening, diagnostic or treatment services
- Case Management services – local program staff evaluate needs, implement plans and refer participants who need diagnostic services and/or are diagnosed with cancer
- Accurate data and documentation – Minimum Data Elements (MDE) are reported to CDC semi-annually
- Evaluations – reports are completed routinely and as needed to assess how well IA CFY Program is meeting CDC-set goals
- Adherence to CDC policies and guidelines
POLICIES

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ELIGIBILITY

To qualify for the Iowa Care for Yourself (IA CFY) Program each woman must meet age and income eligibility criteria.

Priority Population

Direct efforts should be made to identify and screen uninsured, underinsured and underserved women between the ages of 40 and 64 years.

Eligibility for Services

Age criteria:
- Women age 40 and over
- A woman of any age who is symptomatic for breast cancer

Income criteria:
- **Net** household income\(^1\) at or below 250% of the federal poverty level based on household size (Refer to current year IA CFY Program income guidelines found at [www.idph.iowa.gov/CFY](http://www.idph.iowa.gov/CFY) on the Information for the Public page.)
- No proof of income is required
- Assets do not affect income status

Insurance criteria:
- No health insurance
- Women with health insurance may receive services if:
  - Insurance does not cover these services
    - EXCEPTION: A participant can be fully insured and receive Patient Navigation services if barriers to receiving services exist (must meet income and age program requirements)
  - No Medicaid or Medicare Part B coverage
    - EXCEPTIONS: Medicaid Marketplace with large deductible for diagnostics, Iowa family planning network

Residency criteria:
- No residency requirement
- Women residing in states other than Iowa may receive services if:
  - State of residence’s Medicaid Breast and Cervical Cancer Treatment (BCCT) accepts women screened/diagnosed with National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funds. (Refer to Table I on page 10)

Ineligible for Services
- Men
- Women with Medicaid and Medicare B
- Women ages 39 and younger unless they have symptoms of breast cancer

---

\(^1\) Net household income refers to take home pay or the amount of money earned after payroll withholding such as state and federal income taxes, social security taxes, and pretax benefits like health insurance premiums. If enrolled in a flexible spending account to pay for medical costs, the amount withheld from each check is also on a pre-tax basis. Net Household Income is gross income (minus deductions) of each person living in that household whether or not they are related.
Table I: State Eligibility for Breast and Cervical Cancer Treatment (BCCT) Medicaid

<table>
<thead>
<tr>
<th>State</th>
<th>Eligibility for BCCT Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td>Accepts women screened and diagnosed by any health care provider</td>
</tr>
<tr>
<td>Iowa</td>
<td>Accepts women screened and diagnosed by any National BCCEDP or breast services paid by family-planning agency, federally qualified health center or non-profit organization</td>
</tr>
<tr>
<td>Minnesota</td>
<td>All screening and diagnostic services must be paid for by the MN BCCEDP</td>
</tr>
<tr>
<td>Missouri</td>
<td>At least one screening/diagnostic service must be paid by the MO BCCEDP</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Accepts women screened and diagnosed by any National BCCEDP</td>
</tr>
<tr>
<td>South Dakota</td>
<td>All screening and diagnostic services must be paid for by the SD BCCEDP</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>All screening and diagnostic services must be paid for by the WI BCCEDP</td>
</tr>
</tbody>
</table>

**NOTE:** Women residing in a state whose BCCT does not accept women screened with another state’s NBCCEDP funds should be referred to the BCCEDP in their state of residence (Refer to Table II below). A woman enrolled in the IA CFY Program and choosing to continue receiving IA CFY Program services must be informed that she may not be eligible for the BCCT Medicaid option in her state of residence should she need financial assistance for treatment.

Table II: Enrollment telephone numbers for surrounding states’ BCCEDP

<table>
<thead>
<tr>
<th>State</th>
<th>Program Name</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td>Illinois Breast &amp; Cervical Cancer Program</td>
<td>(888) 522-1282</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Sage Screening Program</td>
<td>(888) 643-2584</td>
</tr>
<tr>
<td>Missouri</td>
<td>Show Me Healthy Women Program</td>
<td>(573) 522-2845</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Every Woman Matters Program</td>
<td>(402) 471-0314</td>
</tr>
<tr>
<td>South Dakota</td>
<td>All Women Count! Program</td>
<td>(800) 738-2301</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Wisconsin Well Woman Program</td>
<td>(608) 266-8311</td>
</tr>
</tbody>
</table>

For information about other states, contact the IA Care for Yourself Program Health Services Coordinator at (515) 242-6200.
SCREENING POLICIES

The Centers for Disease Control and Prevention (CDC) screening policies for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) result from careful review of scientific research, analysis of many complex program issues and input from partners in the health care field. The Iowa Care for Yourself (IA CFY) Program has implemented CDC’s recommendations.

Priority Population

Direct efforts should be made to identify and screen for breast and cervical cancer women who are uninsured, underinsured and underserved between the ages of 40 and 64.

Eligibility for Screening Services

Program-eligible women may be enrolled to receive screening services dependent on funding availability for breast and cervical cancer screening.

If a participant was screened by a local program in a prior year and enrolls for services in a different program in a subsequent year, a transfer of the participant’s screening and/or diagnostic information will need to be made. A transfer of the participant’s information from one program to another must be initiated through the data reporting system and also third-party billing agency. The transfer of information must be requested by the 25th day of each month to allow adequate processing time.

<table>
<thead>
<tr>
<th>Age</th>
<th>B/P, Height, Weight</th>
<th>Clinical Breast Exam (CBE)</th>
<th>Mammogram</th>
<th>Pelvic/Pap¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 40</td>
<td>ONLY if reporting symptoms of breast cancer²</td>
<td>ONLY if reporting symptoms of breast cancer</td>
<td>If CBE is abnormal</td>
<td>ONLY if reporting symptoms of breast cancer</td>
</tr>
<tr>
<td>40 – 49³</td>
<td>Annually</td>
<td>Asymptomatic</td>
<td>Asymptomatic</td>
<td>Asymptomatic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annually</td>
<td>See Note</td>
<td>Per CFY protocol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symptomatic</td>
<td>Symptomatic</td>
<td>Symptomatic As indicated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>As needed</td>
<td>As indicated</td>
<td>As indicated</td>
</tr>
<tr>
<td>50 – 64</td>
<td>Annually</td>
<td>Asymptomatic</td>
<td>Asymptomatic</td>
<td>Asymptomatic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annually</td>
<td>Annually</td>
<td>Per CFY protocol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symptomatic</td>
<td>Symptomatic</td>
<td>Symptomatic As indicated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>As needed</td>
<td>As indicated</td>
<td>As indicated</td>
</tr>
<tr>
<td>Over 64</td>
<td>Women over age 64, who do not have Medicare Part B and meet income guidelines, are to receive services as above for 50 – 64 year old.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1 - IA CFY Program Screening Services Guideline

¹ IA CFY Program services are not available for cervical cancer screening in women with hysterectomies, unless the hysterectomy was done due to cervical cancer or neoplasia. If a woman does not know if she has a cervix, a pelvic will be provided for initial physical examination to determine if a woman has a cervix. If the cervix is intact, services may be reimbursed for cervical cancer screening according to IA CFY Program protocol.

² Examples of breast cancer symptoms are breast skin dimpling or retraction, palpable mass or nipple discharge, inversion or scaliness or an abnormal CBE.

³ An alternate resource, such as Susan G Komen for the Cure® funds, should pay for mammograms for women under 50 years of age.
All IA CFY Program participants

The following must be assessed at the baseline screening for all participants:

- Smoking behavior
  - All participants who currently smoke are to be provided information related to smoking cessation and referred to the Quitline Iowa
  - For more about Quitline Iowa, go to https://www.quitnow.net/iowa
- Environmental second hand tobacco smoke exposure
- Blood Pressure measurements
  - Two systolic and two diastolic measurements must be recorded
  - The two blood pressures must be taken separated by a minimum of two minutes
- Height (inches) and weight (pounds)
- Personal Medical History
  - Breast cancer
  - Hysterectomy and reason for having the hysterectomy
- Brief Family History
  - Breast cancer

Breast Services

Breast Cancer Screening Protocol

Program eligible women ages 40 and over may receive breast cancer screening services reimbursed by the IA CFY Program. Refer to Table 1 - IA CFY Program Screening Services Guideline (found on page 11) for clinical breast exam and mammogram recommendations.

Cervical Services

These guidelines are developed to address cervical cancer screenings in the CFY Program general population. Every effort should be made to ensure that women are screened at the recommended intervals. There is little scientific evidence to support annual cervical cancer screening. Education, systems changes and surveillance are methods that should be used to increase the understanding of these Cervical Cancer Screening Protocol criteria.

Priority Population

For cervical cancer screening, efforts should be made to identify and screen women who have not had a Papanicolaou (Pap) screening test in the last five years (rarely screened) or have never had a Pap test.

Payment for Pap test Following Hysterectomy:

- IA CFY Program funds may pay an initial program pelvic examination to determine whether the woman has a cervix after a hysterectomy has been done; it is reimbursed as part of the office visit.
  - If a cervix is present (or cervical cuff), IA CFY Program funds may pay for a cervical cancer screening following the Cervical Cancer Screening Protocol.
  - If a cervix is not present, IA CFY Program funds may not pay for cervical cancer screening. (See Exceptions to Cervical Cancer Screening Protocol)
- IA CFY Program funds may pay for a cervical cancer screening in a woman with complete hysterectomy (no cervix remains), if the participant does not know if the reason for the hysterectomy was cervical cancer (refer to Cervical Cancer Screening Protocol).

A woman with an abnormal cervical screening result should receive timely and appropriate diagnostic testing and treatment (as defined by the American Society for Colposcopy and Cervical Pathology algorithms [http://www.asccp.org/Portals/9/docs/Algorithms%207.30.13.pdf]). When
recommended follow-up and treatment are completed, the participant may receive Pap tests paid for by the CFY Program following the Cervical Cancer Screening Protocol.

Exceptions to Cervical Cancer Screening Protocol

- These guidelines do not address special high-risk populations who may need more intensive or alternative screening. These special populations include women:
  - With a history of cervical cancer;
  - Who were exposed while in their mother’s uterus to diethylstilbestrol (DES); and
  - Who are immuno-compromised, such as HIV infection or organ transplantation.

- Women who express concern about their cervical health, or indicate changes in gynecological health status to the health care provider, will be reviewed for reimbursement of Pap test services sooner than three (or five) years on a case-by-case basis.
  - Documentation from the IA CFY Program provider of the need for a Pap test earlier than three (or five) years for approval and authorization of reimbursement will need to be provided for this review.
  - The Health Services Coordinator will be responsible for the review of the request.

Abbreviations

- **ASC-US** Atypical squamous cells of undetermined significance
- **ASCCP** American Society for Colposcopy and Cervical Pathology
- **HPV** Human papillomavirus
- **LSIL** Low-grade squamous intraepithelial lesion
- **CIN2** Cervical intraepithelial neoplasia grade 2
- **HSIL** High-grade squamous intraepithelial lesion
# Recommendations and Rationale for Cervical Cancer Screening Protocol

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommended Screening Method</th>
<th>Management of Screening Results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages &lt; 21 Years</td>
<td>No cervical screening</td>
<td></td>
<td>HPV testing should not be used for screening or management of ASC-US in this age group.</td>
</tr>
<tr>
<td>Ages 21-29 Years</td>
<td>Pap cytology alone every 3 years</td>
<td>HPV-positive ASC-US or Pap cytology of LSIL+: Refer to ASCCP guidelines</td>
<td>HPV testing should not be used for screening in this age group.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pap cytology negative or HPV-negative ASC-US: Rescreen with Pap cytology in 3 years</td>
<td></td>
</tr>
<tr>
<td>Ages 30-65 Years</td>
<td>Cotest(^6) Screening every 5 years <strong>Preferred</strong></td>
<td>HPV-positive ASC-US or Pap cytology of LSIL+: Refer to ASCCP guidelines</td>
<td>Screening by HPV testing alone is not recommended for most clinical settings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HPV-positive, Pap cytology negative: \n<strong>Option 1:</strong> 12-mo follow-up with cotesting \n<strong>Option 2:</strong> Test for HPV16 or HPV16/18 genotypes \n• If HPV16 or HPV16/18 positive: refer for colposcopy \n• If HPV16 or HPV16/18 negative: 12-mo follow-up with cotesting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HPV-negative ASC-US: Rescreen with cotesting in 3 years.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cotest negative: Rescreen in 5 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Screening with Pap cytology alone every 3 years <strong>Acceptable</strong></td>
<td>HPV-positive ASC-US or Pap cytology of LSIL+: Refer to ASCCP guidelines</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pap cytology negative or HPV-negative ASC-US: Rescreen with Pap cytology in 3 years</td>
<td></td>
</tr>
<tr>
<td>Ages &gt; 65 Years</td>
<td>No screening if the woman has had an adequate prior negative screening history</td>
<td>Consult with health care provider for individualized case-by-case follow-up care (reimbursement of Pap cytology may not be covered by the CFY program)</td>
<td>Women with a history of CIN2/HSIL+ should continue screening every three years for at least 20 years after a period of frequent screening</td>
</tr>
<tr>
<td>After hysterectomy</td>
<td>No screening</td>
<td>Consult with health care provider for individualized case-by-case follow-up care (reimbursement of Pap cytology may not be covered by the CFY Program)</td>
<td>Applies to women who no longer have a cervix and do not have a history of CIN2+ in the past 20 years or cervical cancer ever</td>
</tr>
</tbody>
</table>

---

4 Refer to Services Policy: Cervical Services *Abbreviations* section for definition of abbreviations.
5 + means Pap test results equal to or more severe than the original pathology of Pap test result listed.
6 Pap Test + HPV test = “cotest”
PATIENT NAVIGATION SERVICES

The Centers for Disease Control and Prevention defines “patient navigation” as “Individualized assistance offered to clients to help overcome healthcare system barriers and facilitate timely access to quality screening and diagnostics as well as initiation of treatment services for persons diagnosed with cancer.”

Policy

Effective November 1, 2015, patient navigation services are to be provided to clients who have other resources to pay for screening and diagnostic services. Women must meet IA CFY Program income guidelines and be of appropriate age per USPSTF screening guidelines to receive navigation services through the IA CFY Program.

Clients often face significant barriers to accessing and completing cancer screening and diagnostics. Patient navigation is a process that the CFY local program coordinator uses to guide clients through barriers in the healthcare system. Barriers to screening, diagnostics and treatment may include but are not limited to:

- Financial and economic
- Language and cultural
- Communication
- Health care system
- Transportation
- Fear
- Bias based on culture/race/age
- Need for child/elderly/family care
- Comfort level with provider/facility
- Disability

Priority Populations

Clients who are fully insured, for example, Medicare A & B, Medicaid, private insurance, are eligible for patient navigations services if a barrier to receiving services is identified. Clients that start receiving screening services reimbursed by the CFY Program but then receive insurance may continue to receive services. In such instances, coordinators are encouraged to continue navigating clients to ensure diagnostic procedures are completed, and if cancer is diagnosed, that treatment is initiated. In both instances, coordinators must obtain complete MDE data for the CFY Program database.

Required Patient Navigation Activities

Patient navigation services will vary based on the client’s needs. At a minimum, patient navigation services must include the following activities as well as a minimum of two, but preferably more, contacts with the client:

- Written assessment of individual client barriers to cancer screening, diagnostic testing and initiation of cancer treatment
  - A needs assessment will be completed by the local program case manager and the participant to obtain specific information to identify barriers and concerns.
  - Local program case managers will actively ensure that each participant receives the services identified
- Resolution of client barriers (e.g., transportation, translation services)
  - A plan of care will be developed, reviewed and revised as needed by the local program case manager and participant. This plan of care is to be kept in the participant’s file. The plan of care is to:
    - Meet immediate, short-term and long-term needs identified by the assessment
    - Set goals and actions with timelines
    - Delineate each individual’s responsibility for reaching the identified goals
If local program case managers are unable to resolve problems for meeting identified needs, the IA CFY Program Health Services Coordinator should be notified for assistance.

- Client education and support
- Client tracking and follow-up to monitor client progress in completing screening, diagnostic testing and initiating cancer treatment
- Collection of data to evaluate the primary outcomes of patient navigation—client adherence to cancer screening, diagnostic testing and treatment initiation for all clients receiving navigation services

**Duration of Patient Navigation Services**

Patient navigation begins with a woman contacting the program and it is determined that she has insurance that pays for all services without co-pays or deductibles. The woman must have at least one barrier to receiving the services needed.

Dependent on screening and diagnostic outcomes, patient navigation services end when a participant:

- Completes screening and has a normal result
- Completes diagnostic testing and has normal results
- Initiates cancer treatment
- Refuses treatment

<table>
<thead>
<tr>
<th>Criteria/Service</th>
<th>Participant IA CFY Program</th>
<th>Participant Patient Navigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Age</td>
<td>Per Eligibility guidelines</td>
<td>Must meet IA CFY Program age guidelines and USPSTF screening guidelines</td>
</tr>
<tr>
<td>Income</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Insurance</td>
<td>• Uninsured</td>
<td>Insurance will cover payment of services</td>
</tr>
<tr>
<td></td>
<td>• Insured but high deductible or high copay</td>
<td></td>
</tr>
<tr>
<td>Barriers to Obtaining Services/ Needs Assistance</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CFY Pays for Services</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
CASE MANAGEMENT SERVICES

The Centers for Disease Control and Prevention defines “case management” as establishing, brokering and sustaining a system of essential support services for enrolled women to identify and overcome barriers to definitive diagnosis and treatment.

Iowa Care for Yourself (IA CFY) Program participants with an abnormal breast or cervical screening result must be assessed to determine need for case management services. If any needs are identified, services to address the need are to be provided.

Policy

All IA CFY Program participants with abnormal breast or cervical results (Refer to Table 2 for descriptions) and/or a diagnosis of precancer or cancer will have a Needs Assessment completed by the local program case manager:

- Within 14 days of an abnormal breast screening
- Within 30 days after an abnormal Pap test was conducted (not the date results were received)
- Within 14 days of the diagnoses of breast or cervical precancer or cancer.

If the program does not meet the specified number of days of follow-up, the local program case manager must document why the policy was not met.

Table 2: Definition of Abnormal Screening Results Requiring Case Management

<table>
<thead>
<tr>
<th>Clinical Breast Exam (CBE)</th>
<th>Abnormal results (suspicious for cancer) include but not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Discrete Mass (Cystic or Solid)</td>
<td></td>
</tr>
<tr>
<td>- Bloody or Serous Nipple Discharge</td>
<td></td>
</tr>
<tr>
<td>- Skin Dimpling or Retraction</td>
<td></td>
</tr>
<tr>
<td>- Nipple/Areolar Scaliness</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mammography</th>
<th>Abnormal results of the following American College of Radiology (ACR) categories:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- BIRADS III – Probably benign (short-term follow-up indicated)</td>
<td></td>
</tr>
<tr>
<td>- BIRADS IV – Suspicious Abnormality, (consider Biopsy)</td>
<td></td>
</tr>
<tr>
<td>- BIRADS V – Highly Suggestive of Malignancy</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pap Test</th>
<th>Abnormal results include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Atypical squamous cells – undetermined significance (ASC-US)</td>
<td></td>
</tr>
<tr>
<td>- Atypical squamous cells – Cannot exclude High Grade SIL (ASC-H)</td>
<td></td>
</tr>
<tr>
<td>- Low Grade squamous cells intraepithelial lesion encompassing: HPV, Mild dysplasia/CIN 1</td>
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<tr>
<td>- High Grade squamous cells intraepithelial lesion encompassing: moderate and severe dysplasia, CIS/CIN 2 and CIN 3</td>
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<tr>
<td>- Squamous cell carcinoma</td>
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<tr>
<td>- Abnormal glandular cells including: atypical glandular cells of undetermined significance (AGUS), endocervical adenocarcinoma, endocervical adenocarcinoma in situ, endometrial adenocarcinoma, extrauterine adenocarcinoma, adenocarcinoma, NOS</td>
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</table>
Priority Population
Case Management services are to be provided to women to assure that participants of the IA CFY Program receive timely and appropriate diagnostic, treatment and rescreening services.

Eligibility for Services
Women enrolled in the IA CFY Program are eligible for case management (CM) services dependent on screening/diagnostic testing results and needs assessment findings.

Duration of Case Management Services
Case management begins with:
- An abnormal breast or cervical screening result (Refer to Table 2 on page 15 for descriptions)
- A diagnosis of precancer or cancer

Case management ends with:
- A completed diagnostic process with breast or cervical disease not diagnosed
- Initiation of treatment
- Refusal of treatment or
- When the participant is no longer eligible for the IA CFY Program

A participant may re-enter the CM process with a new abnormal breast or cervical screening/diagnostic result or with the participant’s request for assistance.

Case Management Services
- A needs assessment will be completed by the local program case manager and the participant to obtain specific information to identify barriers and concerns.
- A plan of care will be developed, reviewed and revised as needed by the local program case manager and participant. This plan of care is to:
  1. Meet immediate, short-term and long-term needs identified by the assessment
  2. Set goals and actions with timelines
  3. Delineate each individual’s responsibility for reaching the identified goals
- Local program case managers will actively ensure that each participant receives the services identified.
- If local program case managers are unable to resolve problems for meeting identified needs, the IA CFY Program Health Services Coordinator will be immediately notified for assistance.

Documentation of Case Management Services
Documentation of CM services must be maintained in the participant’s record. Documentation should include:
- Consent for CM services
- Assurance of confidentiality
- Needs assessment
- Plan of care.
CASE MANAGEMENT = Ensure timely and complete clinical follow-up of abnormal screening results for the participant.
DIAGNOSTICS SERVICES

Timeliness of Follow-up
The NBCCEDP has established quality standards for timeliness of follow-up for clinical breast exams (CBEs) and mammograms:
- When diagnostic work-up is indicated – the time from screening (earliest of a CBE or mammogram) to a final diagnosis must be no more than 60 days
- If cancer is diagnosed – the time from the diagnosis to start of treatment must be no more than 60 days

The NBCCEDP has established quality standards for timeliness of follow-up for cervical cancer screening:
- When diagnostic work-up is indicated – the time from screening to a final diagnosis must be no more than 90 days
- If cancer is diagnosed – the time from the diagnosis to start of treatment must be no more than 90 days

Adequacy of Follow-up
The NBCCEDP has established quality standards for adequacy of follow-up for CBEs and mammograms: (Refer to Table 3 on page 19)
- A diagnostic work-up must be planned whenever there is an abnormal (suspicous for cancer) CBE and/or when the screening mammogram result is ‘Suspicious Abnormality’, ‘Highly Suggestive of Malignancy’ or ‘Assessment Incomplete’
- Appropriate diagnostic follow-up for abnormal CBE and/or mammography results (refer to Table 3: Algorithm for Breast Cancer Screening Follow-up Adequacy)
- When a diagnostic work-up is complete, a final diagnosis must be recorded
- A ‘Lost to follow-up’ or ‘Refused’ diagnostic work-up is considered inadequate

The NBCCEDP has established quality standards for adequacy of follow-up for cervical cancer screening: (Refer to Table 4 on page 20)
- A diagnostic work-up must be planned whenever there is an abnormal Pap finding (ASC-US, LSIL, ASC-H, HSIL, squamous cell carcinoma, Abnormal Glandular Cells)
- Appropriate diagnostic follow-up for abnormal Pap results (refer to Table 4: Algorithm for Cervical Cancer Screening Follow-up Adequacy, page 20)
- When a diagnostic work-up is complete, a final diagnosis must be recorded
- A ‘Lost to follow-up’ or ‘Refused’ diagnostic work-up is considered inadequate

Enrolling for Diagnostic Services
- Women aged 40 and over, with a recent abnormal CBE, mammogram or Pap test, may be enrolled in the IA CFY Program for diagnostic breast and cervical cancer screening services. A woman must meet eligibility criteria and the abnormal results must be documented in the Program’s MDEs.
- A woman under age 40 is not eligible for IA CFY Program diagnostic services unless she has breast cancer symptoms and has received screening services provided by the IA CFY Program.
### Table 3: Algorithm for Breast Cancer Screening Follow-up Adequacy

<table>
<thead>
<tr>
<th>CBE RESULT</th>
<th>MAMMOGRAM RESULT</th>
<th>DIAGNOSTIC PROCEDURES REQUIRED FOR ADEQUACY</th>
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</thead>
</table>
| **Normal/Benign** (including fibrocystic, lumpiness or nodularity) | • Negative  
• Benign  
• Probably Benign (Short term follow-up indicated) | • No work-up required  
• If work-up is planned at least one diagnostic procedure must be done, and a final diagnosis recorded |
| **Abnormal** (suspicous for cancer) | • Negative  
• Benign  
• Probably Benign – (Short term follow-up indicated)  
• Assessment Incomplete | One or more of the following:  
• Surgical Consult for repeat breast exam  
• Ultrasound  
• Biopsy/Lumpectomy  
• Fine Needle/Cyst Aspiration  
*Note: A mammogram or additional mammogram views only are not considered adequate* |
| **Abnormal** (suspicous for cancer) | • Suspicious Abnormality  
• Highly Suggestive of Malignancy | One or more of the following:  
• Biopsy/Lumpectomy  
• Fine Needle/Cyst Aspiration |
| **Normal/Benign** (including fibrocystic, lumpiness or nodularity) | • Suspicious Abnormality | One or more of the following:  
• Surgical Consult for repeat breast exam  
• Ultrasound  
• Biopsy/Lumpectomy  
• Fine Needle/Cyst Aspiration |
| **Normal** (including fibrocystic, lumpiness or nodularity)  
**Abnormal** (suspicous for cancer) | • Highly Suggestive of malignancy | One or more of the following:  
• Biopsy/Lumpectomy  
• Fine Needle/Cyst Aspiration |
| **Normal/Benign** (including fibrocystic, lumpiness or nodularity) | • Assessment Incomplete | One or more of the following:  
• Additional mammography views  
• Ultrasound |

---

7 This algorithm is inappropriate as a tool for clinical decision-making for individual women or to determine whether individual providers are performing according to accepted national practices.

8 Clinical interventions based on clinical guidelines endorsed by the Commission on Cancer of the American College of Surgeons, the American College of Obstetrics and Gynecology, and the National Cancer Institute.
### Table 4: Algorithm for Cervical Cancer Screening Follow-up Adequacy\(^9\)

**NOTE:** Pap Specimen Adequacy must be “Satisfactory” for Pap Test results to be recorded.

<table>
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<tr>
<th>PAPANICOLAOU (PAP) TEST RESULT</th>
<th>DIAGNOSTIC PROCEDURES REQUIRED FOR ADEQUACY(^{10})</th>
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<tr>
<td>1. Negative for Intraepithelial Lesion or Malignancy</td>
<td>• No work-up required</td>
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</table>
| 2. ASC-US (Atypical Squamous Cells – Undetermined Significance) | • No work-up required but follow-up @ one year required  
  • If HPV test negative, co-testing follow-up @ 3 years  
  • If HPV test positive, colposcopy required  
  • If work-up is planned, colposcopy must be done |
| 3. Low Grade SIL encompassing: | One or more of the following:  
  • HPV  
  • Mild Dysplasia/CIN 1 |
|   • HPV  
|   • Mild Dysplasia/CIN 1 | • Negative HPV, repeat co-testing @ 1 year  
  • Negative HPV, colposcopy (with or without biopsy)  
  • No or Positive HPV, colposcopy (with or without biopsy) |
| 4. ASC-H (Atypical Squamous Cells – Cannot exclude High Grade Squamous Intraepithelial Lesion [SIL]) | One or more of the following:  
  • Colposcopy  
  • Colposcopy with biopsy |
| 5. High Grade SIL encompassing (with features suspicious for invasion): | One or more of the following:  
  • Moderate & Severe Dysplasia  
  • CIS/CIN 2 & CIN 3 |
|   • Moderate & Severe Dysplasia  
|   • CIS/CIN 2 & CIN 3 | • Colposcopy  
| 6. Squamous Cell Carcinoma | One or more of the following:  
  • Colposcopy  
  • Colposcopy with biopsy |
| 7. Abnormal Glandular Cells including: | One or more of the following:  
  • AGUS (Atypical Glandular cells of Undetermined Significance)  
  • Endocervical adenocarcinoma  
  • Endocervical adenocarcinoma in situ  
  • Endometrial adenocarcinoma  
  • Extraterine adenocarcinoma  
  • Adenocarcinoma, NOS |
|   • AGUS (Atypical Glandular cells of Undetermined Significance)  
|   • Endocervical adenocarcinoma  
|   • Endocervical adenocarcinoma in situ  
|   • Endometrial adenocarcinoma  
|   • Extraterine adenocarcinoma  
|   • Adenocarcinoma, NOS | • Colposcopy  
  • Colposcopy with biopsy  
  • Cold knife Conization \(^{\#}\)  
  • Endometrial Biopsy \(^{\#}\)  
  \(^{\#}\) (Must be preauthorized with IA BCCEDP state staff) |

---

\(^9\) This algorithm is inappropriate as a tool for clinical decision making for individual women or to determine if individual providers are performing according to accepted national practices.

\(^{10}\) Clinical interventions based on the American Society for Colposcopy and Cervical Pathology’s 2012 Algorithms from the Consensus Guidelines for the Management of Women with Cervical Cytological Abnormalities.
DIAGNOSTICS SERVICES (cont’d)

Preauthorization

Breast Services
Preauthorization for reimbursement of a magnetic resonance imaging (MRI) of the breast as a diagnostic procedure must be obtained before performing the procedure. IA CFY Program state staff are responsible for granting preauthorization to health care providers. Reimbursement of a MRI may be possible if the woman:

- Or close relative has tested positive for the Breast Cancer 1 or 2 gene mutation (BRCA1 or BRCA2 mutation)
- Has a first degree relative with breast cancer (parent, brother, sister or child)
- Has a lifetime risk score of 20% or greater on the International Breast Cancer Intervention Study (IBIS) Breast Cancer Risk Evaluation Tool. This tool looks at family history, use of female hormone, benign disease, risk factors such as age and how many children the woman had and at what age…
- Has a past history of breast cancer
- Has an area of the mammogram that the radiologist is recommending MRI

The MRI can not be reimbursed by the IA CFY Program if it is being used as a screening tool or to assess the extent of disease of a woman that is already diagnosed with breast cancer.

Cervical Services
Preauthorization for reimbursement of a LEEP, cervical conization, or endometrial biopsy as a diagnostic procedure must be obtained before performing the procedure. IA CFY Program state staff are responsible for granting preauthorization to health care providers.

The American Society of Colposcopy and Cytopathology (ASCCP) Consensus Conference on Management of Abnormal Cervical Cytology Reports held in 2012 recommended that, in certain circumstances, invasive procedures for diagnosis of cervical disease are indicated. The IA CFY Program policy is consistent with ASCCP recommendations and NBCCEDP policy.

- High Grade Squamous Intraepithelial Lesions (HSIL)
  Reimbursement of loop electrosurgical excision (LEEP) or conization of the cervix for diagnosis is based on the ASCCP algorithm for Management of Women with High-grade Squamous Intraepithelial Lesions (HSIL).

- Atypical Glandular Cells (AGC)
  Reimbursement of cold conization of the cervix for diagnosis is based on the ASCCP algorithm for Management of Women with Atypical Glandular Cells (AGC).
  Subcategories of AGC are:
  - atypical glandular cells of undetermined significance (AGUS)
  - atypical endometrial cells
  - AGC “not otherwise specified” (NOS)
  - AGC “favor neoplasia”
  - adenocarcinoma in situ (AIS)

- Endometrial Biopsy
  Reimbursement of endometrial biopsy for diagnosis is based on the ASCCP algorithm for Management of Women with Atypical Glandular Cells (AGC).
TREATMENT SERVICES

Eligibility for Referral to the IA Breast and Cervical Cancer Treatment (BCCT) Option of Medicaid

1. An individual (male or female) is eligible for the Breast and Cervical Cancer Prevention and Treatment Act option of Medicaid if the individual:
   a. Is not covered by a mandatory category of Medicaid;
   b. Has not reached age 65;
   c. Was eligible, enrolled and received services under the National Breast and Cervical Cancer Early Detection Program (BCCEDP); OR
      Had breast or cervical cancer screenings or related diagnostic services provided or funded by:
      i. family planning centers
      ii. community health centers
      iii. non-profit organizations;
   d. Does not have creditable insurance coverage for breast or cervical cancer treatment.

2. The individual must meet the income eligibility requirements established by the Iowa Care for Yourself Program.

3. The individual must be diagnosed with a precancerous/cancerous breast or cervical condition and require treatment for the diagnosis.

Presumptive Eligibility (PE)

Presumptive Eligibility refers to a federal government program available for states to use that offers immediate health services access by providing temporary health insurance through Medicaid.

A local organization, for example a local public health agency, authorized by the Department of Human Services (DHS) has employees with the authority to make BCCT PE determinations. This employee is designated a Qualified Entity (QE). This QE can help the individual fill out the necessary information on the DHS’s Health Services Application (HSA) form and then completes the PE application online on the Iowa Medicaid Presumptive Eligibility Portal (MPEP). A state identification number will be assigned to the individual by the system and available when the Notice of Action (NOA) is printed.

PE Rules

1. Must be an Iowa resident
2. Must be a US citizen or qualified alien
   a. Exceptions: Pregnant Women and BCCT applicants
3. Must not have received PE in the last twelve months
   Exceptions: Pregnant Women and BCCT applicants

Notes:

* PE is granted on a day-by-day basis.
* An individual may have PE once during a 12-month period.
  EXCEPTIONS:
   - An individual is diagnosed with breast or cervical cancer/precancer, has treatment, and then has a new diagnosis.
   - A woman is pregnant, delivers and is pregnant within the same 12-month period.
* If the individual’s treatment is expected to exceed 45–60 days, the woman will need to complete a full DHS HSA.
If the local organization does not have the authorization from the DHS to make BCCT PE determinations, the local entity needs to:

1. Assist the individual to complete a DHS HAS,
2. Complete a Medicaid Treatment Option Eligibility Verification form, and
3. Refer the woman to the DHS office for her county of residence with the DHS HSA and Verification forms to apply for ongoing Medicaid.

**Note:** On-going Medicaid should start the first day of the month that she is approved for Medicaid by DHS.

**ASSISTANCE:**

Once an individual is enrolled for BCCT Medicaid services, the person has access to full Medicaid benefits for the duration of treatment for a precancerous or cancer breast or cervical diagnosis.

**STATE CONTACTS:**

Department of Public Health
IA Care for Yourself Program:
Jolene Carver
(515) 242-6200
jolene.carver@idph.iowa.gov

Department of Human Services:
Amela Alibasic
(515) 281-4521
AAlibas@dhs.state.ia.us
REFUSAL OF SERVICES OR LOST TO FOLLOW-UP

In some cases, participants do not follow through with the recommended screening, diagnostic and/or treatment services. Every attempt should be made to ensure participants have appropriate diagnostic and/or treatment follow-up required by the CFY Program. *These processes are only required to follow-up after an abnormal finding occurs.*

**Refusal Of Services**

A participant should be documented as “Refused” when:

1. The participant verbally refuses any recommended follow-up care.
2. The participant refuses in writing any recommended follow-up care.

It is recommended that participants be notified verbally, if possible, and in writing of what type of follow-up is needed, when it is needed and what may happen if the follow-up does not occur. Documentation of the informed refusal should be kept in the participant’s file. This can be done either by documentation quoting the verbal conversation that occurred with the participant or by having the participant sign a form that states specifically what she is refusing and that she understands the risks involved if she does not complete the recommended follow-up.

**Lost To Follow-Up**

A participant should be documented as “Lost to Follow-Up” when:

1. At least three contact attempts have been completed and documented in the participant’s file.
   a. This documentation should include the type of contact attempted, date and the outcome.
2. The last contact attempt is by certified mail with a return receipt. A copy of the certified letter sent and the return receipt should be kept in the participant’s file.

**Methods for Contact Attempts**

It is recommended different methods be used to contact a woman for completion of any follow-up services. This includes:

- Telephone,
- Written communication,
- Telephone the contact person listed on the woman’s last enrollment but maintain the woman’s confidentiality,
- Contact the woman’s health care provider for additional contact information, or
- Other options identified and documented.

Local program staff may continue to follow or track a participant’s progress for quality of care issues, but a determination of the participant’s status needs to be made before the performance measure timeframe is exceeded.
RESCREENING SERVICES
Rescreening is the process of returning for a screening test at a predetermined interval. The Centers for Disease Control and Prevention (CDC) defines that interval for the BCCEDP at ten months or greater.

Priority Population
Direct efforts should be made to provide regular screening services for breast and cervical cancer to eligible women between the ages of 40 and 64 that were previously screened in the IA Care for Yourself (IA CFY) Program.

Eligibility for Services
When it is time for a woman to receive rescreening services, she needs to be evaluated to verify that she continues to meet IA CFY eligibility criteria. If the woman meets the eligibility criteria, she can re-enroll in the program.

Services Offered
- Education about the importance of clinical breast examinations (CBE) and mammography for breast cancer screening and of the Pap test for cervical cancer screening;
- A reminder system to facilitate the return of women who were previously screened by IA CFY Program.

Program Goal
Screening at regular intervals leads to women having a decreased risk of dying from breast cancer or developing cervical cancer. The IA CFY Program goal is to maintain a 60% mammography rescreening rate at a 30-month interval for program-eligible women who are 50 years of age and older.

Recall Reminder System
Responsibilities
- The IA CFY Program epidemiologist is responsible for:
  - Generating the rescreening reminder lists from the database.
  - Calculating the rescreening rates for state and local programs at 6-month intervals.
- IA CFY Program state and local program staff are responsible to:
  - Review information yearly that is sent to women as a reminder that it is time for screening.
    - Information to include counseling of the importance of regular screening leading to early detection and a better outcome if diagnosed with breast or cervical cancer.
  - Implement the reminder system. The system is comprehensive, utilizing the woman’s last dates of CBE, mammography and Pap test, to determine when a woman is due for screening services.
- Local program staff are responsible to:
  - Indicate yearly whether their program or the state program will be responsible for the initial reminder sent to the woman.
  - Determine if the woman is still eligible for IA CFY Program services.
    - If woman is not eligible, document the reason on the Client Ineligibility Form in the live web-based data system. A printout of this form is to be kept in the woman’s file.

  Note: A woman is determined to be not eligible if:
  - Obtained insurance that pays for these services (Exception: needs patient navigation)
  - Moved without forwarding address
  - Age (< 40 years without breast issues)
  - Household income ineligible (net household income > 250% federal poverty guidelines)
- Lost to follow-up
- Deceased
- Declined re-enrollment

If at a later date the woman becomes eligible to receive services, the Reactivation portion of the Client Ineligibility Form in the live web-based data system is to be completed. A printout of the form is kept in the woman’s file.

- Document the date of the reminder contact(s) in each woman’s file.
- IA CFY Program Health Services Coordinator is responsible for administration of the rescreening process. This includes: training, verifying local program compliance, review and update of the policy, monitoring rescreening rates and evaluation of barriers.

Reminder Process
- The woman’s initial contact is made approximately eleven months following a screening procedure date. The woman is encouraged to contact the local program to re-enroll for services.
- If the woman has not contacted the local program approximately one month following the first contact, the local program staff will attempt a second contact.
- If these contacts fail to produce re-enrollment, a letter must be sent to the participant’s last known mailing address approximately two weeks following the second reminder. The letter will inform the woman that she is due for rescreening, explain the importance of regular screening and ask her to contact the local program.
- It is recommended various methods be used to contact a woman for rescreening. This includes:
  - Telephone
  - Written communication (letter or reminder card)
  - Contact the woman’s health care provider for additional information
  - Telephone the contact person listed on the woman’s last enrollment but maintain the woman’s confidentiality or
  - Other options identified and documented

Re-screening Process Option
Not applicable to women with diagnostics or short term follow-up\(^\text{11}\).

1. The woman’s initial contact is made approximately eleven months following a screening procedure date. The woman is encouraged to contact the local program to re-enroll for services.

2. If the woman has not contacted the local program within one month after the initial reminder, the local program staff will attempt a second contact to women 50 years or older. The target population of the IA CFY Program breast and cervical cancer screening portion is 50 – 64 years of age. Participants aged 49 years and younger do not need to be notified again.

3. If the woman aged 50 years or older does not contact the local program within two weeks after the second reminder, the local program will attempt a final contact.

   If the participant does not respond to the final reminder within approximately 30 days, local program staff should document the woman as “not interested.” per the ‘Determine if the woman is still eligible for IA CFY Program services’ section above.

Each program may choose to:
- Continue to notify women aged 40 – 49 after the initial reminder; and/or

\(^{11}\) Short term follow-up is defined by CDC as a health care provider recommended visit that is less than 10 months from prior screening.
• Enroll a woman aged 40 – 49 years if she contacts the program after the above process is completed.

Attempts to contact the woman should be documented in the woman’s IA CFY Program file. It is not necessary to document a reason for not contacting a woman age 40 – 49 more than once for re-screening.
Guidelines

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### FY16 CALENDAR OF SCHEDULED EVENTS
**FOR LIMITED SERVICES**

#### JULY 2015
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- 3 – State Holiday (office closed)
- 17 – Final Program Report for FY15
- 28-29 – Limited Annual Meeting

#### AUGUST 2015
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- 3 – Tracking Log due

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- 1 – Tracking Log due
- 7 – State Holiday (office closed)

#### OCTOBER 2015
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- Outreach Informational Training (TBD)
- Contract Performance Review (TBD)
- 1 – Tracking Log due
- 21 – PRAB conference call @ 11:00

#### NOVEMBER 2015
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</table>

- 2 – Tracking Log due
- 4 – West Regional Meeting
- 11 – State Holiday (office closed)
- 12 – South Regional Meeting
- 17 – East Regional Meeting
- 18 – North Regional Meeting
- 26-27 – State Holiday (office closed)

#### DECEMBER 2015
<table>
<thead>
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</table>

- 1 – Tracking Log due
- 25 – State Holiday (office closed)
- 31 – Screening Services Performance Measure deadline

#### JANUARY 2016
<table>
<thead>
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</table>

- Limited Service Training (TBD)
- 1 – State Holiday (office closed)
- 4 – Tracking Log due
- 15 – Semi-Annual Report due
- 18 – State Holiday (office closed)

#### FEBRUARY 2016
<table>
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</table>

- 1 – Tracking Log due
- 17 – PRAB conference call @ 11:00

#### MARCH 2016
<table>
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</tbody>
</table>

- 1 – Tracking Log due
- 2 – West Regional Meeting
- 3 – South Regional Meeting
- 8 – East Regional Meeting
- 9 – North Regional Meeting
- 30 – Examples of Outreach Activities due

#### APRIL 2016
<table>
<thead>
<tr>
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- 1 – Tracking Log due
- 15 – Outreach Implementation Report due
- 20 – PRAB conference call @ 11:00

#### MAY 2016
<table>
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</tbody>
</table>

- 2 – Tracking Log due
- 30 – State Holiday (office closed)

#### JUNE 2016
<table>
<thead>
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</tr>
</tbody>
</table>

- 1 – Tracking Log due
- 3 – Screenings completed
- 24 – Diagnostics completed
- 29 – All FY16 data documentation entered

---

**IA Care for Yourself Program – FY16**

**CALENDAR OF SCHEDULED EVENTS**

**For Limited Services**
2016 Income Guidelines

<table>
<thead>
<tr>
<th>Persons in family/household</th>
<th>Percentage of Federal Poverty Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of Yearly Income</td>
</tr>
<tr>
<td>1</td>
<td>$11,770</td>
</tr>
<tr>
<td>2</td>
<td>15,930</td>
</tr>
<tr>
<td>3</td>
<td>20,090</td>
</tr>
<tr>
<td>4</td>
<td>24,250</td>
</tr>
<tr>
<td>5</td>
<td>28,410</td>
</tr>
<tr>
<td>6</td>
<td>32,570</td>
</tr>
<tr>
<td>7</td>
<td>36,730</td>
</tr>
<tr>
<td>8</td>
<td>40,890</td>
</tr>
</tbody>
</table>

For families/households with more than 8 persons add for each additional person:

<table>
<thead>
<tr>
<th></th>
<th>100% of Yearly Income</th>
<th>138% of Yearly Income</th>
<th>250% of Monthly Income</th>
<th>250% of Yearly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$4,160</td>
<td>$5,741</td>
<td>$867</td>
<td>$10,400</td>
</tr>
</tbody>
</table>

Net household income refers to take home pay or the amount of money earned after payroll withholding such as state and federal income taxes, social security taxes, and pretax benefits like health insurance premiums. If enrolled in a flexible spending account to pay for medical costs, the amount withheld from each check is also on a pre-tax basis. **Net Household Income is gross income (minus deductions) of each person living in that household whether or not they are related.**

Iowa *Care for Yourself* Program Income Guidelines are updated annually. For updates, contact:

Iowa *Care for Yourself* Program  
Iowa Department of Public Health  
Lucas State Office Building  
321 E. 12th Street  
Des Moines, IA 50319-0075

Phone: (515) 281-5616

Source: Iowa Department of Public Health, 01/2016

---

1 Iowa *Care for Yourself* Program Income Guidelines are set at 250% of Poverty Guidelines issued by the U.S. Department of Health and Human Services for 2016.
### IOWA CARE FOR YOURSELF (CFY) SCREENING SERVICES AVAILABLE

<table>
<thead>
<tr>
<th>Age</th>
<th>BLOOD PRESSURE, HEIGHT, WEIGHT</th>
<th>CLINICAL BREAST EXAM (CBE)</th>
<th>MAMMOGRAM&lt;sup&gt;3&lt;/sup&gt;</th>
<th>PELVIC/PAP&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 40</td>
<td>ONLY if reporting symptoms of breast cancer&lt;sup&gt;1&lt;/sup&gt;</td>
<td>ONLY if reporting symptoms of breast cancer</td>
<td>If CBE is abnormal</td>
<td>ONLY if reporting symptoms of breast cancer</td>
</tr>
<tr>
<td>40 – 49</td>
<td>Annually</td>
<td>Asymptomatic</td>
<td>Asymptomatic</td>
<td>Asymptomatic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annually</td>
<td>See Note</td>
<td>Per CFY protocol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symptomatic</td>
<td>Symptomatic</td>
<td>Symptomatic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>As needed</td>
<td>As indicated</td>
<td>As indicated</td>
</tr>
<tr>
<td>50 – 64</td>
<td>Annually</td>
<td>Asymptomatic</td>
<td>Asymptomatic</td>
<td>Asymptomatic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annually</td>
<td>Annually</td>
<td>Per CFY protocol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symptomatic</td>
<td>Symptomatic</td>
<td>Symptomatic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>As needed</td>
<td>As indicated</td>
<td>As indicated</td>
</tr>
<tr>
<td>Over 64</td>
<td>Annually</td>
<td>IA Care for Yourself Program services are not available if a woman has Medicare Part B. Women over age 64, who do not have Medicare Part B and meet income guidelines, are eligible to receive services as above for 50 – 64 year old.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup>Examples of breast cancer symptoms are breast skin dimpling or retraction, palpable mass or nipple discharge, inversion or scaliness or an abnormal CBE.

<sup>2</sup>IA CFY Program services are not available for cervical cancer screening in women with hysterectomies, unless the hysterectomy was performed due to cervical cancer or neoplasia. If a woman does not know if she has a cervix, a pelvic will be provided as initial physical examination to determine if a woman has a cervix. If the cervix is intact, services may be reimbursed for cervical cancer screening according to IA CFY Program protocol.

<sup>3</sup>Susan G. Komen Foundation funding may be available to help pay for non-invasive breast services to underserved women and men who do not meet the eligibility requirements for IA CFY Program services. Refer to “Guide to Program Services and Criteria for Eligibility for Komen and IA CFY Program”.
## DIAGNOSTIC SERVICES AVAILABLE

<table>
<thead>
<tr>
<th>AGE</th>
<th>BREAST</th>
<th>CERVICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 40</td>
<td>Diagnostic services available <strong>if</strong>:</td>
<td>Diagnostic services available <strong>if</strong>:</td>
</tr>
<tr>
<td></td>
<td>1. Symptomatic for breast cancer <strong>and</strong></td>
<td>1. Symptomatic for breast cancer <strong>and</strong></td>
</tr>
<tr>
<td></td>
<td>2. CBE <strong>and/or</strong> mammogram is abnormal <strong>and</strong></td>
<td>2. Pap was abnormal <strong>and</strong></td>
</tr>
<tr>
<td></td>
<td>3. Screening services received through IA CFY Program</td>
<td>3. Screening services received through IA CFY Program</td>
</tr>
<tr>
<td></td>
<td>Services same as 50 – 64 year old</td>
<td>Services same as 50 – 64 year old</td>
</tr>
<tr>
<td>40 – 49 *</td>
<td>Same as 50 – 64 year old</td>
<td>Same as 50 – 64 year old</td>
</tr>
<tr>
<td>50 – 64 *</td>
<td>Diagnostic services available if CBE <strong>and/or</strong> mammogram is abnormal</td>
<td>IA CFY Program funds <strong>will</strong> reimburse ( ^9 ) for:</td>
</tr>
<tr>
<td></td>
<td>IA CFY Program funds <strong>will</strong> reimburse ( ^9 ) for:</td>
<td>1. Surgical consultation</td>
</tr>
<tr>
<td></td>
<td>1. Surgical consultation visit for repeat CBE</td>
<td>2. Colposcopy (with/without biopsy)</td>
</tr>
<tr>
<td></td>
<td>2. Mammogram</td>
<td>3. Pathology fees</td>
</tr>
</tbody>
</table>
|              | 3. Biopsy/Lumpectomy                                                   | If procedure is preauthorized by IA CFY Program funds **will** reimburse for:
|              | 4. Ultrasound                                                           | 1. LEEP or conization                                                    |
|              | 5. Fine needle/cyst aspiration                                          | 2. Endometrial biopsy (for AGC Pap results **only**)                      |
|              | 6. Pathology fees                                                      | IA CFY Program funds **cannot** be used to reimburse for any treatment of cervical cancer or pre-cancer. |
|              | 7. Pathology consult during surgery                                     |                                                                         |
|              | 8. Anesthesia time                                                      |                                                                         |
|              | If procedure is preauthorized, IA CFY Program funds **will** reimburse for: |                                                                         |
|              | IA CFY Program funds **cannot** be used to reimburse for any treatment of breast cancer or pre-cancer. |                                                                         |
| Over 64      | IA CFY Program services are not available if a woman has Medicare Part B; If a woman does not have Medicare Part B, she should receive services as 50 – 64 year old. |                                                                         |

\*For this age group, IA CFY Program funds can be used to reimburse for diagnostic services for program-eligible women referred to the program with abnormal screening results. Diagnostic services must not be performed prior to referral/enrollment.

\*Refer to current ‘Care for Yourself’ Reimbursement Schedule for complete listing.
## CFY Program Services for Eligible Women

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Services Included</th>
</tr>
</thead>
</table>
| **Limited**     | An office visit that includes appropriate/recommended breast and cervical cancer screening:  
                   • Two blood pressure measurements  
                   • Height and weight  
                   • Clinical breast exam  
                   • Pelvic exam  
                   • Pap test as eligible (if provider feels that a Pap test is needed more frequently than every 3-5 years [protocol] the request for that must be made to the state program staff)  
                   • Mammography as recommended by provider  
                   • Breast and/or cervical diagnostic services as recommended by provider (specific services need to be preauthorized by Health Services Coordinator)  
                   • Tobacco cessation referral  
                   • Referral for precancer and cancer treatment as recommended by provider |
Algorithm for Breast Cancer Screening Follow-up Adequacy

<table>
<thead>
<tr>
<th>CBE RESULT</th>
<th>MAMMOGRAM RESULT</th>
<th>DIAGNOSTIC PROCEDURES REQUIRED FOR ADEQUACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal/Benign (including fibrocystic, lumpiness, or nodularity)</td>
<td>Negative</td>
<td>No work-up required</td>
</tr>
<tr>
<td></td>
<td>Benign</td>
<td>If work-up is planned at least one diagnostic procedure must be done, and a final diagnosis recorded</td>
</tr>
<tr>
<td></td>
<td>Probably Benign (Short term follow-up indicated)</td>
<td></td>
</tr>
<tr>
<td>Abnormal (suspicious for cancer)</td>
<td>Negative</td>
<td>One or more of the following:</td>
</tr>
<tr>
<td></td>
<td>Benign</td>
<td>Surgical Consult for repeat breast exam</td>
</tr>
<tr>
<td></td>
<td>Probably Benign – (Short term follow-up indicated)</td>
<td>Ultrasound</td>
</tr>
<tr>
<td></td>
<td>Assessment Incomplete</td>
<td>Biopsy/Lumpectomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fine Needle/Cyst Aspiration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: A mammogram or additional mammogram views only are not considered adequate</td>
</tr>
<tr>
<td>Abnormal (suspicious for cancer)</td>
<td>Suspicious Abnormality</td>
<td>One or more of the following:</td>
</tr>
<tr>
<td></td>
<td>Highly Suggestive of Malignancy</td>
<td>Biopsy/Lumpectomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fine Needle/Cyst Aspiration</td>
</tr>
<tr>
<td>Normal/Benign (including fibrocystic, lumpiness, or nodularity)</td>
<td>Suspicious Abnormality</td>
<td>One or more of the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surgical Consult for repeat breast exam</td>
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<tr>
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<td></td>
<td>Ultrasound</td>
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<tr>
<td></td>
<td></td>
<td>Biopsy/Lumpectomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fine Needle/Cyst Aspiration</td>
</tr>
<tr>
<td>Normal (including fibrocystic, lumpiness, or nodularity)</td>
<td>Highly Suggestive of malignancy</td>
<td>One or more of the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Biopsy/Lumpectomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fine Needle/Cyst Aspiration</td>
</tr>
<tr>
<td>Abnormal (suspicious for cancer)</td>
<td>Assessment Incomplete</td>
<td>One or more of the following:</td>
</tr>
<tr>
<td></td>
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<td>Additional mammography views</td>
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<tr>
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<td></td>
<td>Ultrasound</td>
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</tbody>
</table>

Timeliness of Follow-Up Care:
- From screening (clinical breast exam or mammogram) to diagnosis must be ≤ 60 days
- From diagnosis to start of treatment must be ≤ 60 days

---

1 This algorithm is inappropriate as a tool for clinical decision-making for individual women or to determine whether individual providers are performing according to accepted national practices.
2 Clinical interventions based on clinical guidelines endorsed by the Commission on Cancer of the American College of Surgeons, the American College of Obstetrics and Gynecology, and the National Cancer Institute.
Adequacy of Follow-up
Algorithm for Cervical Cancer Screening Follow-up Adequacy

NOTE: Pap Specimen Adequacy must be “Satisfactory” for Pap Test results to be recorded.

<table>
<thead>
<tr>
<th>PAPANICOLAOU (PAP) TEST RESULT</th>
<th>DIAGNOSTIC PROCEDURES REQUIRED FOR ADEQUACY[^4]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BETHTESDA (TBS) 2001</strong></td>
<td></td>
</tr>
<tr>
<td>1. Negative for Intraepithelial Lesion or Malignancy</td>
<td>• No work-up required</td>
</tr>
</tbody>
</table>
| 2. ASC-US (Atypical Squamous Cells – Undetermined Significance) | • No work-up required but follow-up @ one year required  
  • If HPV test negative, co-testing follow-up @ 3 years  
  • If HPV test positive, colposcopy required  
  • If work-up is planned, colposcopy must be done |
| 3. Low Grade SIL encompassing:  
  • HPV  
  • Mild Dysplasia/CIN 1 | **One or more** of the following:  
  • Negative HPV, repeat co-testing @ 1 year  
  • Negative HPV, colposcopy (with or without biopsy)  
  • No or Positive HPV, colposcopy (with or without biopsy) |
| 4. ASC-H (Atypical Squamous Cells – Cannot exclude High Grade Squamous Intraepithelial Lesion [SIL]) | **One or more** of the following:  
  • Colposcopy  
  • Colposcopy with biopsy |
| 5. High Grade SIL encompassing (with features suspicious for invasion):  
  • Moderate & Severe Dysplasia  
  • CIS/CIN 2 & CIN 3 | **One or more** of the following:  
  • Colposcopy  
  • Colposcopy with biopsy  
  • Loop Electrode Excision Procedure[^6]  
  • Conization[^6]  
  • (Must be preauthorized with IA BCCEDP state staff) |
| 6. Squamous Cell Carcinoma | **One or more** of the following:  
  • Colposcopy  
  • Colposcopy with biopsy |
| 7. Abnormal Glandular Cells including:  
  • AGUS (Atypical Glandular cells of Undetermined Significance)  
  • Endocervical adenocarcinoma  
  • Endocervical adenocarcinoma in situ  
  • Endometrial adenocarcinoma  
  • Extrauterine adenocarcinoma  
  • Adenocarcinoma, NOS | **One or more** of the following:  
  • Colposcopy  
  • Colposcopy with biopsy  
  • Cold knife Conization[^5]  
  • Endometrial Biopsy[^5]  
  • (Must be preauthorized with IA CFY/BCCEDP state staff) |

**Timeliness of Follow-Up Care:**
- From screening (Pap test) to diagnosis must be ≤ 90 days
- From diagnosis to start of treatment must be ≤ 90 days

[^3]: This algorithm is inappropriate as a tool for clinical decision making for individual women or to determine if individual providers are performing according to accepted national practices.
Adequacy of Follow-up
Description of Work and Services

Provide Care for Yourself Program services that include the following:

**Enrollment and Screening**

1. Arrange for screening and diagnostic services as identified in the Screening Service Guideline (Table 1 in Services Policy) for eligible applicants:
   a. Low-income, underinsured or uninsured
   b. Individuals ages 40 or over
   c. Earn less than the set income guidelines (250% Federal Poverty Level)
   d. Not enrolled in Medicare Part B, or
   e. Under age 40 and symptomatic for breast disease.

2. Track the number of participants age 49 and younger who received program-funded mammograms. No more than 25% of the participants who receive mammograms can be of age 49 and younger.

3. Determine eligibility on individuals to enroll as a participant in the CFY-BCC program. Eligibility is based on income, age and insurance status. Once determined eligible and having signed the Consent Form, a participant is eligible for program services for 12 months from the date the consent form is signed. If an individual is eligible for services, the Coordinator shall:
   a. Complete a breast and cervical cancer Consent form
   b. Complete an Annual Enrollment form (pages 1-2)
   c. Assure appointments are scheduled for each participant.

4. Assure all enrollment information is collected, entered and submitted into the live web-based data system prior to entry in the third-party claims processing and payment system
   a. Care for Yourself- Breast and Cervical Cancer Program live web-based data system can be found at [https://careforyourselfiowa.com](https://careforyourselfiowa.com).
   b. Third-party claims processing and payment service system can be found at [https://pcs.nicao-online.org/](https://pcs.nicao-online.org/).

5. Assure participants have one office visit that includes appropriate/recommended breast and cervical cancer screening services as determined by the CFY-BCC Project Coordinator. The visit will include the following breast and cervical screening services:
   a. Two blood pressure measurements collected during the same office visit
   b. Height and weight
   c. Clinical breast exam
   d. Pelvic exam

6. Arrange additional screening services for participants as they are eligible:
   a. Pap test and HPV testing
   b. Mammography

7. Arrange diagnostic follow-up services as determined appropriate by the healthcare provider:
   a. Breast and/or cervical diagnostic services
      • If diagnostic work-up is indicated, the time from screening to a final diagnosis must not exceed 60 days.
   b. Referral for precancer and cancer treatment
Description of Work and Services

- If cancer is diagnosed, the time from the diagnosis to the start of the treatment must be no more than 90 days.

8. Refer participants to Quitline Iowa for cessation services.

9. Document and maintain a monthly tracking log of enrollments for breast and cervical screening services. Information in the tracking log can be individualized however documentation must be on the Department approved Excel file.

Recall Reminder System

Screening at regular intervals leads to participants having decreased risk of late stage breast cancer and/or developing cervical cancer. The participant’s recall reminder is created approximately eleven months following the screening date for breast or cervical cancer screening services. The Coordinator shall:

1. Indicate yearly whether the Coordinator or the state program will be responsible for rescreening letters sent to persons who have previously enrolled in the CFY-BCC program.

2. Review the rescreening list on a monthly basis. The rescreening list is comprehensive, utilizing the person’s last dates of clinical breast exam, mammogram and Pap test to determine when a person is due for screening services within a 12-month period.

3. Determine if the person is eligible for CFY-BCC program services.
   a. If a person is no longer eligible, enter and submit the information into the live web-based data system on the Client Ineligibility Form.

Refusal of Services or Lost to Follow-Up

In some cases participants do not follow through with recommended screening, diagnostic and/or treatment services. Documentation of attempts to contact and encourage the participant to obtain services is required. If after an abnormal finding is reported, the participant refuses screening services or can no longer be contacted (considered lost to follow-up), the Coordinator shall:

1. Communicate with the participant with abnormal screening results, both verbal and in writing, about follow-up services that are needed, and when they should be performed. Communication will also indicate what may happen if the follow-up services do not occur. The written informed refusal should be done by certified mail with return receipt. A copy of the letter sent and the return receipt should be kept in the participant’s file.

2. A participant must be documented as “lost to follow-up” when a minimum of three contact attempts have been completed and documented in the participant’s file. The Coordinator shall:
   a. Document type of contact attempted, date and outcome.
   b. Complete and distribute a certified letter with return receipt with stating that they were unable to be reached.

Diagnostics

Participants age 40 and over with a recent abnormal clinical breast exam (CBE), mammogram or Pap test may be eligible to receive diagnostic breast and cervical cancer services.
under the age of 40 are not eligible for diagnostic services unless the person has received screening services from the CFY-BCC Program. In addition, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) has established quality standards for timeliness of follow-up for breast and cervical cancer screening services. If an abnormality with a clinical breast exam (CBE) or a mammogram is identified:

1. Follow up with the enrolled participant to assure receipt of diagnostic services as indicated by the healthcare provider. The time from screening (earliest of the CBE or mammogram) to a final diagnosis must not exceed 60 days.

2. Obtain preauthorization from the CFY-BCC Health Services Coordinator at 515-242-6200 prior to scheduling the diagnostic Breast Magnetic Resonance Imaging (MRI).

3. If cancer is diagnosed, the time from the diagnosis to start of treatment must be no more than 60 days.

4. When diagnostic work-up is complete, a final diagnosis must be recorded.

5. Refer participants (who are diagnosed with breast cancer) to ensure that they receive additional resources and support related to the diagnosis through the American Cancer Society (ACS).

6. Refer participants to the Iowa Breast and Cervical Cancer Prevention and Treatment Act Medicaid Option (BCCT), if eligible. The participant must be diagnosed with a precancerous/cancerous breast cancer condition and require treatment to qualify.

If an abnormality with a cervical cancer screening is identified:

1. Follow up on diagnostic services as indicated by the healthcare provider. The time from screening (Pap test) to a final diagnosis must not exceed 90 days. If cancer is diagnosed, the time from diagnosis to start of treatment must be no more than 90 days.

2. Obtain preauthorization from the CFY-BCC Health Services Coordinator at 515-242-6200 prior to scheduling the following diagnostic procedure(s): Loop Electrode Excisional Procedure (LEEP), Cold Knife Cone (CKC) or Endometrial Biopsy.

3. Refer participants (who are diagnosed with cervical cancer) to ensure that they receive additional resources and support related to the diagnosis through the American Cancer Society (ACS).

4. Refer participants to the Iowa Breast and Cervical Cancer Prevention and Treatment Act Medicaid Option (BCCT), if eligible. The participant must be diagnosed with a precancerous/cancerous cervical cancer condition and require treatment to qualify.

**Patient Navigation Services Requirements**

Patient Navigation is defined as “Individualized assistance offered to participants to help overcome healthcare system barriers and facilitate timely access to quality screening and diagnostics as well as initiation of treatment services for persons diagnosed with cancer.” Participants screened by the program in prior years and who are subsequently insured may continue to receive patient navigation services if they need barrier reduction assistance in order to be screened. The Coordinator is encouraged to continue navigating participants to ensure
diagnostic procedures are completed, and if cancer is diagnosed, that treatment is initiated. The Coordinator shall:

1. Provide patient navigation services to eligible individuals. Eligible participants must meet age and income guidelines and be insured.

2. If providing patient navigation services, the Coordinator must complete the:
   a. BCC Consent form
   b. Annual Enrollment form (pages 1-2)
   c. Screening form
   d. Needs Assessment
   e. Plan of Care
   f. Patient Navigation form

3. The Coordinator must:
   a. Resolve barriers that prevent a participant from obtaining screening and/or diagnostic services.
   b. Conduct and document a minimum of two contacts associated with patient navigation services.
   c. Document and maintain a monthly tracking log showing which participants are enrolled for Patient Navigation services. Information in the tracking log can be individualized, however documentation must contain the information on the Department-approved Excel file.
   d. Collect all screening and diagnostic data to enter and submit into the live web-based data system.

<table>
<thead>
<tr>
<th>Service Provision Deadlines</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast and Cervical Cancer Screening Completed</td>
<td>May 19, 2017</td>
</tr>
<tr>
<td>(includes Patient Navigation Services)</td>
<td></td>
</tr>
<tr>
<td>All Diagnostic Follow-Up Completed</td>
<td>June 9, 2017</td>
</tr>
<tr>
<td>Data Entry Deadline</td>
<td>Within six-months from the date the participant received the service, and no later than June 29, 2017 whichever is first.</td>
</tr>
</tbody>
</table>

**Data Collection and Reporting**

The CFY-BCC program uses two different database systems for collection of data and reporting related to screening service, healthcare facility/provider enrollment and submission/payment of claims. The Coordinator shall become familiar with both database systems and understand the capacity of how each system functions.

**Data Reporting System**

The Department contracts with the University of Iowa to maintain and operate a live database system for data collection and reporting by the Coordinator. Data shall be collected and reported for each participant screened and/or provided diagnostic services. A service is not
Description of Work and Services

complete until all data is submitted by the Coordinator and accepted in the CFY-BCC live web-based data system. For collection and reporting of required data, the Coordinator shall:

1. Enter and submit all applicable data into the live web-based data system. Data shall be reported on the following forms or sections of the live database system:
   a. Annual Enrollment
   b. Screening
   c. Patient Navigation (as applicable)
   d. Breast Diagnostic (as applicable)
   e. Cervical Diagnostic (as applicable)
   f. Participant Ineligibility (as applicable)

2. In the event that a participant has been screened by the program in a prior year, yet enrolls for services in a subsequent year, a transfer of the participant’s screening and/or diagnostic information may be made. A transfer of the participant’s information from one program to another must be initiated through the data reporting system and also third-party billing agency. The transfer of information must be requested by the 25th day of each month to allow adequate processing time.

3. Data must be accurately submitted and accepted into the live web-based data system by the last business day of each month at 11:59 p.m. to be included in the monthly data report which documents the number of participants screened, number of patient navigation services provided, number of participants who received a mammogram paid for by Susan G. Komen.

CFY–BCC Provider Billing

The CFY – BCC Provider Billing system is operated by an IDPH third-party claims processing and payment service. The Department contracts with Provider Claims Systems, an entity within the North Iowa Community Action Organization. The CFY-BCC program provides reimbursement for screening/diagnostic services based on approved CPT codes paid at Medicare Part B Participating Provider Rates. In order for claims to be processed and payment to be provided to participating health care facilities, the Coordinator shall:

1. Use the CFY-BCC Provider Billing system [https://pcs.nicao-online.org/](https://pcs.nicao-online.org/)

2. Input program consent dates and identify eligibility for BCC screening services for participants. Program consent dates are valid for a one-year period and submission and payment of claims are valid during that one-year period.

3. Use the participant client ID number generated from the live web-based data system. This number will always serve as a participant identifier.
   a. Obtain a Client ID# from the CFY-BCC live web-based data system. Enrollment and data entry first needs to be completed in the CFY-BCC live web-based data system to obtain a Client ID#.
   b. Assure the enrollment date matches the date of the signed consent.
   c. Provide preauthorization and enter the participant’s data into the third-party database system managed by State Staff prior to the participant receiving diagnostic screening services.
Outreach Activities

Outreach activities shall be conducted by the Coordinator to promote and recruit eligible applicants for the CFY-BCC program. The Coordinator shall conduct outreach in the following manner to identify persons in need. Outreach consists of targeted activities that assist with communication and engagement of eligible participants with the program. The Coordinator shall:

1. Provide outreach services to vulnerable populations, immigrants, refugees, etc. to promote access to the program for breast and cervical cancer screening within the service area. Outreach efforts need to be tailored to reach the specific eligible populations as identified in the Program Screening Services Guideline Table.
   a. Develop, purchase and distribute brochures and other promotional items to direct program eligible persons to the CFY-BCC Program.
   b. Provide the Department with electronic copies of the any developed or purchased outreach materials.
   c. Obtain prior approval on developed or purchased materials from the Department staff. Allow at least two weeks for obtaining Department approval. Assure that outreach materials adhere to the Department’s logo policy. The Department will provide its logo upon the request of the Coordinator.

2. Per the General Conditions of the contract, the Coordinator agrees that the Department shall become the sole and exclusive owners of all materials developed with the use of outreach funds.

Provider Recruitment and Education

The CFY-BCC program provides reimbursement for screening services based on approved CPT codes paid at Medicare Part B provider rates for Iowa. The healthcare Corporation/Lead Facility and sub-facilities must be enrolled to provide appropriate/recommended BCC screening services to eligible participants. The healthcare Corporation/Lead facility agrees to abide by the terms and conditions of the program guidelines listed in the Healthcare Provider Manual. Individual healthcare Providers must be licensed or certified to practice in the state in which they service program participants. For a list of current health care facilities/providers approved as CFY-BCC providers, visit http://pcsview.nicao-online.org/. The CFY-BCC Cooperative Agreement is effective for six (6) years from the date signed. The Coordinator shall work with Department staff to:

1. Identify, recruit and update healthcare facilities and providers to enroll as needed, to serve as official providers of healthcare screening and diagnostic services for the CFY-BCC program.

2. Complete and assist with the following documents:
   a. CFY-BCC Update Form (Only for current Cooperative Agreements in place. To update healthcare facility/healthcare provider information as needed).
   b. CFY-BCC Cooperative Agreement.
   c. Application for Provider Status.
   d. Copy of facility W-9.
Description of Work and Services

e. CLIA certificate if applicable.

3. Provide orientation to the enrolled healthcare facilities/providers on CFY-BCC requirements and program updates as needed.

4. Assure all enrolled healthcare facilities/providers within the designated service area collect and report the required breast and cervical screening data.

5. Reimbursement for the healthcare Corporation/Lead Facility will be provided from the Department through a third party payer according to the current Medicare Part B Participating health care provider rates in Iowa. The Department will serve as a payer of last resort.

6. Reimbursement for screening services will not be provided until a Cooperative Agreement is signed by the healthcare Corporation/Lead facility and the Department.

Required Meetings

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Meeting - Summer 2016</td>
<td>July 14, 2016</td>
</tr>
<tr>
<td>Required CFY Regional Fall 2016 Meeting in East and West Regions</td>
<td>To Be Determined</td>
</tr>
<tr>
<td>Required CFY Regional Spring 2017 Meeting in East and West Regions</td>
<td>To Be Determined</td>
</tr>
<tr>
<td>Outreach Informational Trainings (mode of trainings to be determined)</td>
<td>To Be Determined</td>
</tr>
<tr>
<td>* Fall 2016 Contract Performance Review via telephone</td>
<td>October 2016, Dates and times to be announced</td>
</tr>
</tbody>
</table>
The Centers for Disease Control and Prevention (CDC) National Breast and Cervical Cancer Early Detection Program’s uses 11 Core Indicators to assess a Program’s performance. One of the Core Indicators is that 75% of the CDC funding used to reimburse for mammograms must provide mammograms to women ≥ 50 years of age. This leaves 25% that can provide mammograms for women ≤ 49 years of age.

The IA BCCEDP applies for Susan G. Komen for the Cure Breast Foundation® funding to help meet this Core Indicator by reimbursing for mammograms for women < 50 years of age without federal funds. The program can still provide mammograms for other women < 50 years of age with federal funding increasing the number of women that can be provided services.

**How many total women < 50 years of age is the “Any County” program able to screen and still meet the 75/25 Core Indicator?**

Below is an example of how this would be determined:

“Any County” CFY Program begins the year with 190 participants to enroll. They have 37 Komen slots to use to pay for mammograms. How many women under 50 years of age can have their mammogram paid using federal funds (IA NBCCEDP funds) and still maintain the program’s 75/25 split?

- Individuals to enroll: 190
- Komen funded mammograms: 37
- Total of mammograms to be federally funded by BCC: 153

The 153 is what the 75/25 Core Indicator will be calculated from…

\[
\begin{align*}
190 & \quad \text{Individuals to enroll} \\
- 37 & \quad \text{Komen funded mammograms} \\
153 & \quad \text{Total of mammograms to be federally funded by BCC}
\end{align*}
\]

\[
\begin{align*}
153 & \quad \text{Total of mammograms to be federally funded} \\
\times 0.25 & \quad \text{percent} \\
38.25 & \quad 38 \text{ (rounded [round down if 0.49 or below]) mammograms for women < 50 years of age can be federally funded} \\
153 & \quad \text{Total of mammograms to be federally funded} \\
\times 0.75 & \quad \text{percent} \\
114.75 & \quad 115 \text{ (rounded [round up if 0.5 or above]) mammograms for women ≥ 50 can be federally funded} \\
38 & \quad \text{women < 50 years of age could have federally funded mammograms} \\
37 & \quad \text{women < 50 years of age can have Komen funded mammograms} \\
75 & \quad \text{women < 50 years of age can have mammograms paid in the “Any County” CFY Program}
\end{align*}
\]

“Any County” CFY Program would meet the 75/25 mammogram Core Indicator if 115 of women receiving federally funded mammograms would be ≥ 50 and 75 (38 + 37) women would be < 49 years of age.
Calculating the 75/25 Core Indicator

This Core Indicator is determined by looking at the number of mammograms reimbursed by using BCCEDP funding. **Do not calculate out how many that can be done and do all of the < 50 year of age women without doing the ≥ 50 women.**

What do I mean? If 38 women < 50 years of age and 80 women ≥ 50 years of age were done using federal funding, the Core Indicator would be 52.5/47.5 or Not Met.

**What to do if Core Indicator is not being met:**

If the Program is not meeting the 75/25 Core Indicator, consider starting a waiting list of women < 50 years of age until you meet the Core Indicator again.

In order to meet this Indicator three women ≥ 50 years of age must be screened for every woman < 50 years of age.
Resources

CFY Service Area Map ....................... 57
CancerCare  ........................................ 59
Breast and Cervical Cancer
Prevention and Treatment Act
Guidelines ........................................... 61
Refer to the Iowa Care for Yourself Program website for the most current Service Area map. The map can be found at the web address www.idph.iowa.gov/CFY/public under the section entitled “Contact a Program Near You.”
CancerCare provides limited financial assistance to individuals affected by cancer. As a nonprofit organization, funding depends on the sources of support received at any given time. If funding is not available at the time needed, CancerCare counselors will work to refer to other financial assistance resources. With a gift from the Avon Foundation, CancerCare, Inc. established a special assistance fund for low income, under-, uninsured and underserved individuals (male and female) with a breast cancer diagnosis and their families.

Eligibility
- Individuals with a diagnosis of breast cancer and eligible for the Iowa Care for Yourself Breast and Cervical Cancer Early Detection Program, may qualify for assistance from CancerCare
- Be in active treatment for breast cancer
- Income at or below 250% for federal poverty level [proof of income required]
- Live in the US or Puerto Rico
- No citizenship requirements

Assistance

<table>
<thead>
<tr>
<th>Financial*</th>
<th>Professional:</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Limited assistance to be used for:</strong></td>
<td>- Oncology social workers will provide emotional support, counseling and practical assistance to individuals with cancer, family members and caregivers over the <strong>telephone, online or in person</strong> (limited geographical areas)</td>
<td>- Assists with finding needed resources in their local communities for home care, child care, transportation to and from treatment, pain management or entitlements</td>
</tr>
<tr>
<td>- Transportation to &amp; from treatment services</td>
<td>- Oncology social workers will help people find needed information and provide informative materials about cancer and treatments</td>
<td>- Provides publications online or in print that include cancer-related information</td>
</tr>
<tr>
<td>- Childcare</td>
<td>- Educational seminars and workshops provided by experts designed to provide information about early detection, risk reduction, wellness and coping with cancer</td>
<td>- Offers referrals for obtaining prostheses and wigs to women who have breast cancer or who have lost their hair due to treatment and are unable to afford services on own</td>
</tr>
<tr>
<td>- Home care</td>
<td></td>
<td>- Spanish speaking staff available</td>
</tr>
<tr>
<td>- Pain and anti-nausea medication, oral hormonal medication and durable medical equipment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Services not paid for:**
- Any screening or diagnostic services
- Basic living expenses such as rent, mortgages, utility payments or food

*All requests must be for current services (within 1 month)

Steps for Applying (for complete information go to www.cancercare.org):
1. Call 800-813-HOPE (4673) and speak with a CancerCare social worker to complete a brief interview.
2. If eligible to apply, an individualized bar coded application and a request for documentation to verify income will be sent to the individual.
3. The individual must submit a completed application. An application is not a guarantee of receiving funds.

Compiled by Iowa Care for Yourself Breast & Cervical Cancer Early Detection Program

Reviewed: 5.09, 8.11, 6.13, 4.16
Revised: 8.14

June 2016 Page 59 Policy Manual
Breast and Cervical Cancer Prevention and Treatment Act

On July 1, 2001, Iowa Legislators enacted federal legislation called the BCCPTA of 2000. During the 2013, Iowa Legislative session changes were made. Changes that started January 1, 2014 provided access to Medicaid benefits during their treatment period to males and females diagnosed outside of the NBCCEDP and Komen funding with pre-cancerous or cancerous breast or cervical conditions.

ELIGIBILITY

1. An individual is eligible for the Breast and Cervical Cancer Prevention and Treatment Act option of Medicaid if the individual:
   A. Is not covered by a mandatory category of Medicaid;
   B. Has not reached age 65;
   C. Was eligible, enrolled and received services under the National Breast and Cervical Cancer Early Detection Program (BCCEDP);
   D. Had breast or cervical cancer screenings or related diagnostic services provided or funded by:
      i. family planning centers
      ii. community health centers
      iii. non-profit organizations;
   E. Does not have creditable insurance coverage for breast or cervical cancer treatment.

2. The individual must meet the income eligibility requirements established by the Iowa Care for Yourself/Breast and Cervical Cancer Early Detection Program.

3. The individual must be diagnosed with a precancerous/cancerous breast or cervical condition and require treatment for the cancer.

ENROLLMENT:

1. Presumptive Eligibility (PE)
   Presumptive Eligibility refers to a government program that offers immediate health services access by providing temporary health insurance through Medicaid.
   A local organization authorized by the Department of Human Services (DHS) has employees with the authority to make BCCT PE determinations. The Qualified Entity (QE) can help the individual fill out the necessary information on the DHS’s Health Services Application (HSA) form then complete the PE application online on the Iowa Medicaid Presumptive Eligibility Portal (MPEP). A state identification number will be assigned to the individual by the system and available when the Notice of Action (NOA) is printed.

2. PE Rules
   A. Must be an Iowa resident.
   B. Must be a US citizen or qualified alien
      Exceptions: Pregnant Women and Breast and Cervical Cancer Treatment (BCCT) applicants
   C. Must not have received PE in the last twelve months
      Exceptions: Pregnant Women and Breast and Cervical Cancer Treatment (BCCT) applicants

3. Non-PEP
   The local entity should:
   A. Assist the individual to complete a DHS HSA
   B. Complete a Medicaid Treatment Option Eligibility Verification form
   C. Refer the woman to the DHS office for her county of residence. On-going Medicaid should start the first day of the month that she is approved for Medicaid by DHS.
Notes:
* PE is granted on a day-by-day basis.
* An individual may have PE once during a 12-month period.
  EXCEPTIONS:
    - An individual is diagnosed, has treatment, and then has a new diagnosis of cancer.
    - A woman is pregnant, delivers and is pregnant within the same 12-month period.
* If the individual’s treatment is expected to exceed 45–60 days, the woman will need to complete a full DHS HSA.

ASSISTANCE:
Once an individual is enrolled for BCCT Medicaid services, the person has access to full Medicaid benefits for the duration of treatment for a precancerous or cancer breast or cervical diagnosis.

STATE CONTACTS:
Department of Public Health
IA Care for Yourself Program:
  Jolene Carver
  (515) 242-6200
  jolene.carver@idph.iowa.gov

Department of Human Services:
  Amela Alibasic
  (515) 281-4521
  AAlibas@dhs.state.ia.us
Appendix I

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DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES
[45 CFR 164.512(b)]

Background

The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to protected health information to carry out their public health mission. The Rule also recognizes that public health reports made by covered entities are an important means of identifying threats to the health and safety of the public at large, as well as individuals. Accordingly, the Rule permits covered entities to disclose protected health information without authorization for specified public health purposes.

How the Rule Works

General Public Health Activities. The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This would include, for example, the reporting of a disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions. See 45 CFR 164.512(b)(1)(i). Also, covered entities may, at the direction of a public health authority, disclose protected health information to a foreign government agency that is acting in collaboration with a public health authority. See 45 CFR 164.512(b)(1)(i). Covered entities who are also a public health authority may use, as well as disclose, protected health information for these public health purposes. See 45 CFR 164.512(b)(2).

A “public health authority” is an agency or authority of the United States government, a State, a territory, a political subdivision of a State or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with, a public health agency. See 45 CFR 164.501. Examples of a public health authority include State and local health departments, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, and the Occupational Safety and Health Administration (OSHA).

Generally, covered entities are required reasonably to limit the protected health information disclosed for public health purposes to the minimum amount necessary to accomplish the public health purpose. However, covered entities are not required to make a minimum necessary determination for public health disclosures that are made pursuant to an individual’s authorization, or for disclosures that are required by other law. See 45 CFR 164.502(b). For disclosures to a public health authority, covered entities may reasonably rely on
a minimum necessary determination made by the public health authority in requesting the protected health information. See 45 CFR 164.514(d)(3)(iii)(A). For routine and recurring public health disclosures, covered entities may develop standard protocols, as part of their minimum necessary policies and procedures, that address the types and amount of protected health information that may be disclosed for such purposes. See 45 CFR 164.514(d)(3)(i).

Other Public Health Activities. The Privacy Rule recognizes the important role that persons or entities other than public health authorities play in certain essential public health activities. Accordingly, the Rule permits covered entities to disclose protected health information, without authorization, to such persons or entities for the public health activities discussed below.

• **Child abuse or neglect.** Covered entities may disclose protected health information to report known or suspected child abuse or neglect, if the report is made to a public health authority or other appropriate government authority that is authorized by law to receive such reports. For instance, the social services department of a local government might have legal authority to receive reports of child abuse or neglect, in which case, the Privacy Rule would permit a covered entity to report such cases to that authority without obtaining individual authorization. Likewise, a covered entity could report such cases to the police department when the police department is authorized by law to receive such reports. See 45 CFR 164.512(b)(1)(ii). See also 45 CFR 512(c) for information regarding disclosures about adult victims of abuse, neglect, or domestic violence.

• **Quality, safety or effectiveness of a product or activity regulated by the FDA.** Covered entities may disclose protected health information to a person subject to FDA jurisdiction, for public health purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity for which that person has responsibility. Examples of purposes or activities for which such disclosures may be made include, but are not limited to:

  < Collecting or reporting adverse events (including similar reports regarding food and dietary supplements), product defects or problems (including problems regarding use or labeling), or biological product deviations;
  < Tracking FDA-regulated products;
  < Enabling product recalls, repairs, replacement or lookback (which includes locating and notifying individuals who received recalled or withdrawn products or products that are the subject of lookback); and
  < Conducting post-marketing surveillance.
See 45 CFR 164.512(b)(1)(iii). The “person” subject to the jurisdiction of the FDA does not have to be a specific individual. Rather, it can be an individual or an entity, such as a partnership, corporation, or association. Covered entities may identify the party or parties responsible for an FDA-regulated product from the product label, from written material that accompanies the product (know as labeling), or from sources of labeling, such as the Physician’s Desk Reference.

C Persons at risk of contracting or spreading a disease. A covered entity may disclose protected health information to a person who is at risk of contracting or spreading a disease or condition if other law authorizes the covered entity to notify such individuals as necessary to carry out public health interventions or investigations. For example, a covered health care provider may disclose protected health information as needed to notify a person that (s)he has been exposed to a communicable disease if the covered entity is legally authorized to do so to prevent or control the spread of the disease. See 45 CFR 164.512(b)(1)(iv).

C Workplace medical surveillance. A covered health care provider who provides a health care service to an individual at the request of the individual’s employer, or provides the service in the capacity of a member of the employer’s workforce, may disclose the individual’s protected health information to the employer for the purposes of workplace medical surveillance or the evaluation of work-related illness and injuries to the extent the employer needs that information to comply with OSHA, the Mine Safety and Health Administration (MSHA), or the requirements of State laws having a similar purpose. The information disclosed must be limited to the provider’s findings regarding such medical surveillance or work-related illness or injury. The covered health care provider must provide the individual with written notice that the information will be disclosed to his or her employer (or the notice may be posted at the worksite if that is where the service is provided). See 45 CFR 164.512(b)(1)(v).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

FAQs on Public Health Uses and Disclosures

FAQs on ALL Privacy Rule Topics
(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)
HIPAA PRIVACY RULES AND THE RELEASE OF INFORMATION TO THE IOWA CARE FOR YOURSELF PROGRAM

The Health Insurance Portability and Accountability Act (HIPAA) regulations contain several major components. The Privacy Rule requires covered entities to obtain consent or authorization from an individual for certain uses and disclosures of identifiable health information. However, the Privacy Rule expressly permits covered entities to release identifiable health information to public health authorities under certain circumstances without obtaining consent or authorization from the patient.

First, although the requirements of HIPAA generally preempt state law, HIPAA provides for certain exceptions to this general preemption rule. One such exception applies when state statute and state administrative rules provide for "the reporting of disease or injury, . . .or for the conduct of public health surveillance, investigation, or intervention." 45 CFR 160.203. Iowa Code chapter 135 and 641 Iowa Administrative Code chapter 8 authorize the Iowa Care For Yourself Program (ICFYP) to have access to information from hospital records, physician records, and clinical charts for the purpose of ensuring service delivery and program and fiscal management. These provisions of law are not preempted by HIPAA and therefore a hospital, clinic, or health care provider is not required to obtain consent or authorization from a patient prior to releasing this information to the ICFYP.

HIPAA also provides for a number of "permitted disclosures," i.e. those disclosures of protected health information for which consent or authorization is not required. HIPAA authorizes such disclosures "to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law." 45 CFR 164.512(a). HIPAA further authorizes disclosures for public health activities to "a public health authority that is authorized by law to collect or receive such information for the purposes of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions.[]" 45 CFR 164.512(b)(1)(i). Hospitals, clinics, and health care providers are authorized by Iowa law to allow the ICFYP to have access to information about patients for purposes of preventing cancer. Hence, HIPAA does not require that covered entities obtain consent or authorization prior to releasing such information to the ICFYP. Additionally, ICFYP participants
execute a release which authorizes health care providers, laboratories, and hospitals to provide the ICFYP with results of the screening and follow-up examinations and treatment.

In short, HIPAA provides no legal basis for hospitals, clinics, or health care providers to prohibit the ICFYP from obtaining information for the purpose of ensuring that women receive appropriate screening tests, confirmatory testing, and treatment.
Appendix II

Definitions......................................................... 73
Definitions:

Patient Navigation - “Individualized assistance offered to clients to help overcome healthcare system barriers and facilitate timely access to quality screening and diagnostics as well as initiation of treatment services for persons diagnosed with cancer.”

“Co-pay” - most plans give a discount on how much is paid for doctor visits and prescriptions if in plan, only having the person pay a small portion or fixed amount

“Deductible” - amount paid before the health insurance helps pay for part of the bill (e.g., $5,000)

“Co-insurance” - after the deductible is met, you pay a percentage of the total bill called co-insurance (e.g., 80/20)

“Out-of-pocket maximum” - Total amount of money paid by the insured in a year per the insurance agreement.

“BCCEDP” - CFY funds being used to pay for the procedure

“Other” – payment has been made out-of-pocket or may have been provided by a free clinic, non-state Komen funding

“Unknown” – source of payment is not known (should rarely be used)

“BCCEDP/Insurance” - combination of insurance and the CFY program helping pay for services, assistance with co-pay or deductable, co-insurance

“Insurance Only” – includes Medicaid, Medicare (A & B…), and other private insurances
Appendix III

Patient Navigation Question and Answers.............................. 77
Questions and Answers - Patient Navigation Webinar – October 27, 2015

1. Are the slides going to be available?
   A. Yes. The recorded webinar and slides will be posted to the website by November 10.

2. What do you mean by “Insurance”?
   “Insurance” includes Medicaid, Medicare (A&B) and insurance.

3. I’m still confused; how does the patient navigation process works?
   Patient navigation will only be provided to clients who are receiving Limited services. If the client has insurance (Medicaid, Medicare A & B, insurance) that will cover the full cost of services and states that she needs assistance with screening/diagnostics/treatment due to a barrier then they would be eligible for patient navigation services.

4. What happens if a client contacts me after she has screening done, and now needs diagnostics?
   She says she has insurance to cover the diagnostic test cost, but needs help to get the diagnostic test done and with going to treatment if she needs it.
   If the client has insurance (Medicaid, Medicare A & B, insurance), however needs assistance with diagnostics/treatment you can enroll them as one of your limited slots for patient navigation. You will need to collect all diagnostic data, screening data, and complete the patient navigation data form.

5. If someone uses IFPN (Family Planning Network) would you mark “Insurance” or would you use “Other”, since “BCCEDP” would pay for mammogram?
   A. On the “Enrollment” form, you would select option 4 – Under-insured since the woman needs help paying for the mammogram.
   B. If a client has IFPN, this is not considered “insurance” as defined by the Marketplace. IFPN is like CFY; helps pay for certain services if the woman qualified. Please reference the definition slide that follows the Screening Form slide for the definition guidance we are giving you. Basically, BCCEDP/Insurance is the choice when a woman is underinsured.
   C. On the “Screening” form, you would select option 1-BCCEDP since CFY is-paying for the mammogram. For instance, if a woman needs BCCEDP to pay for the mammogram and another non-insurance program is to pay for the pap (IFPN), then you would choose “Other”.

6. So we need to fill out the “Plan of Care” form for navigation even if there isn’t a problem like diagnostics, right?
   A. If there are no barriers preventing an insured woman from getting screened or with obtaining diagnostic services on her own, the insured woman should not be assisted.
7. What type of insurance referral should we make when it is outside of the open enrollment period of ACA?
   A. Continue to refer women to the marketplace or other local contacts that are available to talk about insurance eligibility and enrollment even after the enrollment period ends. Women may have a qualifying life event that would allow her to enroll for insurance outside of the regular enrollment period.
   B. Medicaid enrollment is available year round. There is no closed enrollment period.

8. Based on this presentation, is there anyone we would not help?
   A. To be eligible for patient navigation, a woman must meet CFY program eligibility criteria (age and income) and have identified barriers that possibly prevent her from following through with screening or diagnostics on her own. If a woman doesn’t meet the basic criteria of age and income, she is still not eligible for the program or patient navigation services.

9. What constitutes the second contact for patient navigation services?
   A. To be considered eligible for vouching with patient navigation, a woman needs to have two documented contacts showing assistance from the program was provided. Once contact can be for barrier reduction, appointment setting, encouragement. The second contact may be to ensure the woman has gone for services, to review her screening and diagnostic outcomes, etc. Additional contacts may be needed to get the woman through the process of screening, diagnostics and into treatment if needed.
   B. The required two contacts need to be documented on the Patient Navigation form in order for vouching to be paid.

10. What do we do with women that we have already made “ineligible” for the program because when she called to re-enroll earlier she said she had insurance and this had not yet been implemented?
    A. You can call the woman back and check to see if she has done the services. If she hasn’t, explain the program changes and find out if she needs program assistance to follow through.
    B. A reminder that if any women have been marked as “ineligible” in the past, you will need to check eligibility status when re-enrolling them into the program by reviewing and editing the form in the live web database system.

11. Would we be able to get a listing of women to send letters to encourage mammography, well woman exams that we may have discharged from the program in the past 12 months? They have not been getting screened because there are not providers to get them in a timely fashion here.
    A. If you would like a listing of the women, feel free to contact Yumei Sun. Yumei would be happy to pull any requested data. Yumei can be reached at Yumei.Sun@idph.iowa.gov

12. Do we continue to use the 75/25 ration when enrolling patient navigation clients?
    A. The 75/25 does not apply in this instance as the BCCEDP is not paying for the mammogram. In fact, the BCCEDP should not be paying for any of the services for the woman.
13. **How do we find these women?**
   A. We are not asking that you seek out women for patient navigation services. The CFY program remains a screening program. Patient navigation can be offered to those women you contact for rescreening and find that they now have insurance. Patient navigation can be offered to an insured woman who meets age and income guidelines, but has barriers to following through with obtaining screening and/or diagnostics on her own.

14. **Will there be communication from IDPH to private providers on the expanded patient navigation services or should locals provide this info?**
   A. As above, we are not seeking women for patient navigation services. This is a screening program. If a woman needs assistance and contacts you to help in getting her screenings (diagnostic; treatment) then we can assist.

*Is there a template?*
   A. No. IDPH staff will, however, develop a notice that can be sent to the provider for a woman who has been enrolled for patient navigation. That notice will explain that while the woman has insurance coverage now, the program is assisting her through the process, and that data on her screening and diagnostic results will still need to be sent to the local program coordinator.

15. **What happens if the applicant isn’t legally here in the US or a citizen with enrolling them for insurance?**
   A. This would not be a patient navigation client. This would be one of our regular BCCEDP clients. The client can still be referred to local help by finding the nearest contact at [www.healthcare.gov](http://www.healthcare.gov). They may not qualify for any of the insurances or subsidies from the Marketplace, but they may be able to get some private insurance.

16. **What do you do if insurance options are exhausted and the patient does not qualify for anything?**
   A. This would not be a patient navigation participant. The woman would qualify to be served as a regular BCCEDP participant. A woman can be served as a regular BCCEDP participant while she is exploring insurance options.

17. **Will data include the enrollment paperwork and then the clinical reports from the screenings for a patient navigation patient?**
   A. Correct. All data forms are required. Forms include:
   
   i. Consent/Enrollment
   ii. Needs Assessment (required)
   iii. Plan of Care (required)
   iv. Annual Assessment
   v. Screening
   vi. Diagnostics (as needed)
   vii. Patient Navigation (required)
18. Is a consent form still required?
   A. Yes

19. If we enroll a client for patient navigation and find out after the fact that her insurance did not cover the screenings or diagnostics, at that point can the claims be sent to PCS?
   A. Yes
   B. All clients need to be entered into the PCS system regardless if they are receiving patient navigation services. This will ensure that if a woman needs program assistance for claim payment, the payment will proceed without delay.

20. So it is possible that if we enroll a woman in navigation and find she needs a service that is not covered by her insurance we can use BCC funds?
   A. Yes; you will only be able to vouch for that woman once. You would not get two payments.

21. Will there be additional limited vouching slots?
   A. IDPH staff will be monitoring the vouching activity of all programs, and programs may be contacted to reduce their contracts vouching slots or may be given additional slots as program funding and contractual amendments allow.

22. If we have additional questions, who do we contact?
   A. Jolene Carver or Lindsey Jones

23. Where are the new forms located?
   http://idph.iowa.gov/cfy-portal/ScreenAndRefer/Tools
   They can also be ordered from the Clearinghouse.

24. When can we start using the new forms? When will the database system be ready?
   A. This new Patient Navigation activity begins on November 1, 2015.

25. Do we need to use the “Needs Assessment” on the website or may we use one that our program uses?
   A. If it is a form that you have been using for a while, yes, you can continue to use that form.

26. Will contracts have an amendment for patient navigation services?
   A. Yes. Contractual amendments are being produced.
Appendix IV

Pink Ribbon Advisory Board (PRAB) Members ....................... 83
### Pink Ribbon Advisory Board (PRAB) Members

#### Region
#### Representatives

**East**
- Cathy Tieskoetter (Dubuque)
  - Dubuque VNA
  - 1454 Iowa Street
  - Dubuque, IA 52004
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  - Pal Alto PHNS
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  - (F) (641) 842-3442
  - [cboat@marionph.org](mailto:cboat@marionph.org)

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  - Unity Point At Home/Cass Co Public Health
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  - (F) (712) 243-7442
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  - Greenfield, Iowa 50849
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  - (F) (641) 743-6157
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**State Staff**
- As Indicated