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Report to the Chairman, Committee on Finance, U.S. Senate

October 2020

PUBLIC HEALTH

Federal Programs Provide Screening and Treatment for Breast and Cervical Cancer

GAO-21-35

GAO Highlights

Highlights of GAO-21-35, a report to the Chairman of the Committee on Finance, U.S. Senate

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Federal Programs Provide Screening and Treatment for Breast and Cervical Cancer

Why GAO Did This Study

According to the CDC, tens of thousands of people die each year from breast or cervical cancer. Early screening and detection, followed by prompt treatment, can improve outcomes and, ultimately, save lives. Federal programs, like CDC's Early Detection Program, are intended to improve access to these services.

GAO was asked to examine the implementation of the Early Detection Program and the states' use of Medicaid under the Treatment Act. This report provides information on the number of people who were 1) screened through the Early Detection Program and 2) enrolled in Medicaid under the Treatment Act.

GAO analyzed CDC data on the number of people screened by the Early Detection Program from calendar years 2011 through 2018—the most recent available. GAO also analyzed CMS Medicaid enrollment data from 2016 through 2019—the most recent available. Additionally, GAO reviewed a 2020 study funded by CDC that examines the number of people eligible for the Early Detection Program from 2011 through 2017. Finally, GAO interviewed CDC and CMS officials and reviewed relevant CDC and CMS documents.

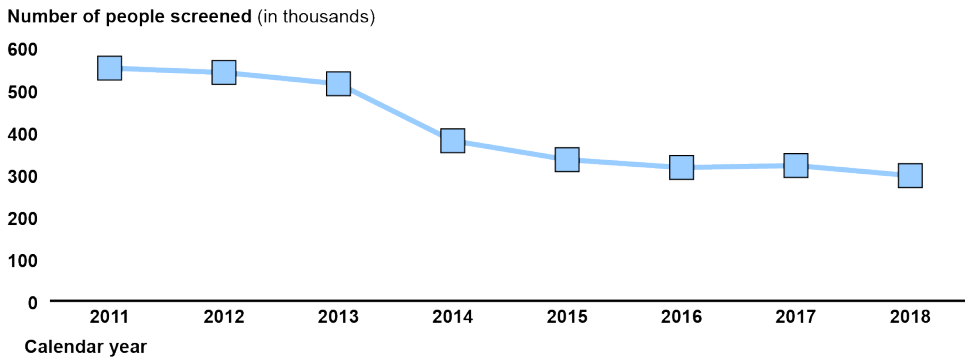
View GAO-21-35. For more information, contact John E. Dicken, (202) 512-7114, dickenj@gao.gov.

What GAO Found

The Centers for Disease Control and Prevention (CDC) operates the National Breast and Cervical Cancer Early Detection Program (the Early Detection Program) to provide cancer screening and diagnostic services to people who are low-income and uninsured or underinsured. For those screened under the program who require treatment, the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (the Treatment Act) allows states to extend Medicaid eligibility to individuals not otherwise eligible for Medicaid.

GAO analysis of CDC data show that the Early Detection Program screened 296,225 people in 2018, a decrease from 550,390 in 2011 (about 46 percent). The largest decrease occurred from 2013 to 2014 (see figure). According to a CDC-funded study, the number of people eligible for the Early Detection Program decreased from 2011 through 2017, by about 48 percent for breast cancer and about 49 percent for cervical cancer. CDC officials attributed these declines in screening and eligibility, in part, to improved access to screening under the Patient Protection and Affordable Care Act (PPACA). For example, PPACA required health plans to cover certain women's preventive health care with no cost sharing.

Number of People Screened by CDC's Early Detection Program, 2011-2018



Source: GAO analysis of data from the Centers for Disease Control and Prevention (CDC). | GAO-21-35

GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data found that, in 2019, 43,549 people were enrolled in Medicaid under the Treatment Act to receive treatment for breast or cervical cancer, a decrease from 50,219 in 2016 (13.3 percent). Thirty-seven states experienced a decrease in Medicaid enrollment under the Treatment Act during this time period, 13 states experienced an increase, and one state had no change. CMS officials noted that Medicaid expansion to adults with incomes at or below 133 percent of the federal poverty level under PPACA (the new adult group) is a key factor that contributed to these enrollment trends. CMS officials said that, in Medicaid expansion states, there were some people who previously would have enrolled in Medicaid based on eligibility under the Treatment Act who instead became eligible for Medicaid in the new adult group. The CMS data show that total enrollment under the Treatment Act in Medicaid expansion states decreased by 25.6 percent from 2016 to 2019. In contrast, total enrollment under the Treatment Act in non-expansion states increased by about 1 percent during this time period.

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Abbreviations

CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
PPACA	Patient Protection and Affordable Care Act

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

October 28, 2020

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate

Dear Chairman Grassley:

According to the Centers for Disease Control and Prevention (CDC), tens of thousands of people die each year from breast or cervical cancer.[1] In 2017, the most recent year of data available from the CDC, about 251,000 women in the United States were diagnosed with breast cancer and about 42,000 died of the disease. While cervical cancer is less common than breast cancer, CDC data show that nearly 13,000 women were diagnosed with cervical cancer in the United States in 2017 and about 4,200 died. Early screening and detection, followed by prompt treatment, can improve outcomes and, ultimately, save lives. Yet, research has shown that low-income, uninsured, and underinsured people face challenges accessing timely screening and treatment for breast and cervical cancer.[2]

To improve access to screening and diagnostic services for these underserved and high-risk populations, since 1991, CDC has administered the National Breast and Cervical Cancer Early Detection Program (which we refer to as the Early Detection Program) to provide cancer screening and diagnostic services to low-income and uninsured and underinsured individuals.[3] In addition, under the Breast and Cervical

[1]Centers for Disease Control and Prevention, *United States Cancer Statistics: Data Visualizations*, accessed June 22, 2020, www.cdc.gov/cancer/dataviz.

[2]See, for example, CDC, "Cancer Screening Test Use – United States, 2015," *Morbidity and Mortality Weekly Report*, vol. 66, no. 8 (2017); and G. Zhao et al. "Health Insurance Status and Clinical Cancer Screenings Among U.S. Adults," *American Journal of Preventive Medicine*, vol. 54, no. 1 (2018).

[3]The Early Detection Program was authorized by the Breast and Cervical Cancer Mortality Prevention Act of 1990, Pub. L. No. 101-354, 104 Stat. 409 (1990) (codified, as amended, at 42 U.S.C. §§ 300k, et seq.).

CDC defines eligibility for the Early Detection Program as those who are low-income and uninsured or underinsured, such as those who cannot afford large out-of-pocket cost sharing required by their health insurance plan.

Cancer Prevention and Treatment Act of 2000 (which we refer to as the Treatment Act), states have the option to extend coverage for breast and cervical cancer treatment under Medicaid, the joint federal-state health financing program for low-income and medically needy individuals.[4] Medicaid programs are administered at the state level and overseen at the federal level by the Centers for Medicare & Medicaid Services (CMS). Since we last reported on these programs in 2009, the Patient Protection and Affordable Care Act (PPACA) was enacted, which included provisions that increased insurance coverage and affected cancer screening.[5] For example, PPACA gave states the authority to expand their Medicaid programs to low-income adults and required health plans to cover certain women's preventive health care with no cost sharing.

To help inform Congress on the implementation and effectiveness of these programs, you asked us to examine how many people have been screened through the Early Detection Program and treated by Medicaid under the Treatment Act. This report provides information on

1. the number of people screened by CDC's Early Detection Program and
2. the number of people enrolled in Medicaid under the Treatment Act.

To determine the number of people screened through the Early Detection Program, we analyzed CDC data on the number of people screened and diagnosed for breast and cervical cancer by the Early Detection Program

[4]Pub. L. No. 106-354, 114 Stat. 1381 (2000) (codified, as amended, at 42 U.S.C. §§ 1396a, 1396b, 1396d, 1396r-1b). In addition, states may extend this Medicaid coverage to American Indians and Alaska Natives who are eligible for health services provided by the Indian Health Service or by a tribal organization. Pub. L. No. 107-121, 115 Stat. 2384 (2002) (codified, as amended, at 42 U.S.C. § 1396a(aa)). U.S. territories may also extend this optional Medicaid coverage to eligible individuals.

[5]GAO, *Medicaid: Source of Screening Affects Women's Eligibility for Coverage of Breast and Cervical Cancer Treatment in Some States*, GAO-09-384, (Washington, D.C.: May 22, 2009).

Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). For purposes of this report, references to PPACA include the amendments made by the Health Care and Education Reconciliation Act of 2010.

from calendar years 2011 through 2018, both nationally and by grantee.[6] We examined this time period in order to capture data before and after the implementation of PPACA. In addition, 2018 was the most recent full calendar year of data available.[7] We present data on 67 of the 70 current grantees because data were unavailable for three grantees that were new to the Early Detection Program in 2017.[8] We also reviewed the results of a 2020 study funded by CDC that estimated the number of women eligible for the Early Detection Program in the 50 states and Washington, D.C., each year from 2011 through 2017.[9] These estimates are likely an underestimate due to the exclusion of underinsured women, among other reasons noted in the study.[10] We also spoke to CDC officials and representatives from two national cancer advocacy groups—Susan G. Komen and the American Cancer Society—to learn more about the program. We assessed the reliability of the CDC dataset by checking for

[6]There are currently 70 Early Detection Program grantees, which include state, territorial, and tribal health departments and other tribal organizations. Breast cancer screening includes clinical breast exams and mammograms. Cervical cancer screening includes Pap tests and human papilloma virus tests.

We did not analyze screening data by sex or gender because CDC does not track this information; however, cisgender women, transgender women, and transgender men may all be eligible for screening under the Early Detection Program if they meet eligibility and screening criteria. Cisgender men are not eligible—according to the CDC, less than one percent of all breast cancer cases occur in men. The term "cisgender" refers to a person whose gender identity corresponds with the sex that person was identified as having at birth, while the term "transgender" refers to a person whose gender identity differs from the sex that person was identified as having at birth. We use the gender-neutral term "people" throughout this report, except where gendered language is necessary to be consistent with agency reporting.

[7]The last complete year of final diagnosis data available was 2017 because, according to CDC officials, there is a time lag between when people are screened and when their final diagnosis data are received.

[8]These grantees are Great Plains Tribal Chairmen's Health Board, American Indian Cancer Foundation, and the Republic of the Marshall Islands. In addition to the 70 current grantees, the Poarch Band of Creek Indians was a grantee until 2012 and then discontinued participation in the program. We present data for the years this grantee participated.

[9]The CDC awards Early Detection Program funding to the U.S. territories and tribes via cooperative agreements, but the study does not report separately for these groups. Florence Tangka et al., "The Eligibility and Reach of the National Breast and Cervical Cancer Early Detection Program after Implementation of the Affordable Care Act," *Cancer Causes & Control*, vol. 31 (2020): pp. 473-489.

[10]CDC officials told us that they do not have a source of data that would enable them to estimate the size of the underinsured population.

missing values and obvious errors, reviewing relevant CDC documents, and speaking to CDC officials. We determined the CDC data were sufficiently reliable for the purposes of our reporting objective.

To determine the number of people enrolled in Medicaid under the Treatment Act, we analyzed CMS Medicaid enrollment data from 2016 through 2019 for the 50 states and the District of Columbia.[11] We examined this time period because, according to CMS officials, 2016 was the first year in which a complete calendar year of data became available for all states.[12] In addition, 2019 was the most recent full calendar year of data available. Specifically, in the data, we analyzed the eligibility group variable to identify individuals whose basis for Medicaid eligibility was the "Certain Individuals Needing Treatment for Breast or Cervical Cancer" group code during at least one month of the year.[13] We also spoke to CMS officials and representatives from the two national cancer advocacy groups to learn more about the program. We assessed the reliability of the dataset used in our analysis by checking for missing values and obvious errors, reviewing relevant CMS documents, and speaking to CMS officials. We analyzed the Medicaid enrollment data as they were reported by states to CMS and we did not independently verify the accuracy or completeness of the Medicaid enrollment information with the

[11]We analyzed Medicaid enrollment by sex (according to a binary male/female classification) because both women and men may be eligible. We did not analyze Medicaid enrollment by gender because CMS's data do not track this information. As a result, we could not determine how many enrollees were cisgender and how many were transgender.

Because, according to CMS officials, only the U.S. Virgin Islands has elected to provide coverage under the Treatment Act, we did not examine Medicaid data from U.S. territories. While territories have the option of extending this Medicaid coverage to eligible people, Puerto Rico and Guam have not elected to provide this coverage and American Samoa and the Commonwealth of the Northern Mariana Islands operate their Medicaid programs under different guidelines and a different state plan format than other jurisdictions, according to CMS.

[12]We analyzed enrollment data accessed on September 2, 2020, from the Transformed Medicaid Statistical Information System Analytic File, a national Medicaid dataset administered by CMS. This dataset replaced CMS's prior Medicaid dataset, the Medicaid Statistical Information System, which we used in our prior report; see GAO-09-384. We have previously reported on data challenges associated with the ongoing development and implementation of the Transformed Medicaid Statistical Information System. GAO, *Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight*, GAO-18-70 (Washington, D.C.: Dec. 8, 2017). See also GAO, *Medicaid Eligibility: Accurate Beneficiary Enrollment Requires Improvements in Oversight, Data, and Collaboration*, GAO-20-147T (Washington, D.C.: Oct. 30, 2019).

[13]For Tennessee in 2016, we derived data from the "Medicaid Basis of Eligibility" variable due to data reliability concerns with the eligibility group variable for that state in that year.

states. We determined the CMS data were sufficiently reliable for the purposes of our reporting objective.

We conducted this performance audit from December 2019 to October 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Early Detection Program Structure and Eligibility Requirements

The Early Detection Program is implemented through cooperative agreements between the CDC and 70 grantees—health departments in the 50 states, the District of Columbia, and six U.S. territories, as well as 13 tribes and tribal organizations. In addition to CDC funding, all grantees are required to provide non-federal matching funds. According to self-reported data from the grantees for the 2018 to 2019 program year, about 63 percent of grantees have acquired state-appropriated funds to support their programs, 10 percent of grantees have acquired additional federal resources, and about 21 percent of grantees have acquired funds from non-profits.[14] Grantees typically provide the screenings through a network of local providers, such as community health centers and private providers. To ensure that people receive complete screening, the Early Detection Program provides diagnostic testing and follow-up services for those whose screening results are abnormal, although treatment is not provided with Early Detection Program funds.[15]

The Early Detection Program funds breast and cervical cancer screening services for people who are uninsured or underinsured, have an income

[14]CDC officials explained that "state-appropriated funds" are funds appropriated by the state legislature specifically for breast or cervical cancer screening. Although grantees are required to provide non-federal matching funds, CDC officials said that these can also take the form of cash (non-appropriated funds) or in-kind services.

[15]Additionally, in a small number of cases each year, the Early Detection Program also provides diagnostic services to people who did not receive CDC-funded screening services through the program, according to CDC. This may occur when people are referred into the program after receiving screening services elsewhere or if a person is underinsured and their health insurance does not fully cover diagnostic services or covers them, but with substantial cost sharing.

equal to or less than 250 percent of the federal poverty level, are aged 40 through 64 for breast cancer screenings or aged 21 through 64 for cervical cancer screenings, and meet clinical cancer screening guidelines.[16] Within this population, CDC prioritizes and sets screening targets for certain groups; specifically, CDC expects that 75 percent or more of the people grantees screen for breast cancer will be women aged 50 to 64 and that 20 percent or more of the people grantees screen for cervical cancer will be women who have never been screened. Individual grantees also have some flexibility to set their own eligibility requirements, which may be broader or narrower than these CDC targets.[17]

CDC also prioritizes other groups for screening without setting screening targets, based on a group's disproportionate risk of developing cancer or a lack of adequate health care options for prevention or treatment. For example, according to CDC, Black women have a similar incidence rate for breast cancer compared with White women but are approximately 40 percent more likely to die from the disease, and CDC specifically highlights Black women as a population that would benefit from the Early Detection Program.[18] Although health disparities are often considered in the context of race or ethnicity, other population groups may experience health disparities. According to CDC, these include groups that may be

[16]For example, women who have had total hysterectomies for benign disease are not eligible for cervical cancer screening through the Early Detection Program in accordance with recommendations from the U.S. Preventive Services Task Force and other organizations. Further, in accordance with recommendations from the Center of Excellence for Transgender Health, the Early Detection Program may cover breast cancer screening for transgender women if they have taken or are taking hormones, and transgender men may be eligible for breast and cervical cancer screening if they have not undergone a bilateral mastectomy or a total hysterectomy, respectively.

People outside of the standard age ranges may also be eligible for screening under certain circumstances. For example, people who are symptomatic or at high-risk for breast cancer (due to conditions such as the BRCA 1 or 2 genetic mutations) are eligible for breast cancer screening under age 40.

[17]According to CDC's most recent annual grantee survey, while the majority of grantees use the same minimum screening ages and income threshold targeted by CDC, two grantees use a lower minimum age for breast cancer screening; 21 grantees use a higher minimum age for breast cancer screening; 18 grantees use a higher minimum age for cervical cancer screening; and 15 grantees use a lower income threshold. Additionally, 63 grantees extend eligibility to underinsured people, while 7 do not.

[18]Lisa C. Richardson et al., *Patterns and Trends in Age-Specific Black-White Differences in Breast Cancer Incidence and Mortality – United States, 1999-2014*, Morbidity and Mortality Weekly Report, vol. 65, no. 40 (2016).

defined by disability, sexual orientation, gender identity, geographic location, or socioeconomic status. Early Detection Program grantees are required to identify these types of target populations and are then responsible for educating and motivating them to seek screening and ensuring that services are accessible and provided in a culturally competent manner.

Treatment Act Option and Eligibility Requirements

To address concerns that the Early Detection Program did not include a treatment component for people who received a cancer diagnosis, the Treatment Act was enacted in 2000 to allow states to extend Medicaid eligibility to those in need. Under the law, states can opt to extend Medicaid eligibility to those who are under age 65, do not have other creditable coverage for cancer treatment,[19] are otherwise not eligible for Medicaid, and have been (1) screened under CDC's Early Detection Program and (2) found to be in need of treatment for breast or cervical cancer, including for precancerous conditions.[20]

We previously reported that, as of 2008, all states and the District of Columbia had opted to extend this Medicaid eligibility to those determined to be in need of treatment through the Early Detection Program.[21] We also noted that states have flexibility regarding beneficiary eligibility. Specifically, CMS defines "screened under the Early Detection Program" as including people under any of three categories: (1) those whose clinical services under the Early Detection Program were provided all or in part with CDC funds; (2) those screened by a CDC-funded provider within the scope of the state's Early Detection Program, even if CDC funds did not pay for the particular service; or (3) those screened by a non-CDC-funded provider whom the state has elected to include as part of its Early

[19]For purposes of this group, CMS defines "creditable coverage" as coverage under a group health plan; comprehensive health insurance; Medicare Part A or Part B; full-benefit Medicaid; health coverage of the military and uniformed services; health coverage of employees of Congress and the District of Columbia; and a state health benefits risk pool. The term expressly excludes medical care programs of the Indian Health Service or of a tribal organization.

[20]States must provide full Medicaid coverage for the period when the enrollee needs treatment for breast or cervical cancer. After the initial period of eligibility based on screening through the Early Detection Program and determination of the need for breast or cervical cancer treatment, eligibility may be continued based on the determination of an individual's treating health professional.

[21]GAO-09-384.

Detection Program.[22] Early Detection Program grantees determine who is considered to have been screened under their program. When we previously reported, 16 states and the District of Columbia extended eligibility only to those screened or diagnosed with CDC funds, while the remaining 34 states used a broader definition of "screened under the Early Detection Program."

Changes Made by the Patient Protection and Affordable Care Act

PPACA gave states the authority to expand their Medicaid programs (which we refer to as Medicaid expansion) to cover adults ages 19 through 64 who are not pregnant, not entitled to Medicare, and with household incomes at or below 133 percent of the federal poverty level beginning January 1, 2014 (which we refer to as the new adult group).[23] Historically, eligibility for Medicaid had been limited to certain categories of low-income individuals, including children, parents, pregnant women, and individuals who have disabilities or who are aged 65 and older. As of July 2020, 35 states and the District of Columbia had opted to expand their Medicaid programs and, according to CMS, three states planned to expand Medicaid later in 2020 or in 2021.[24] In addition, PPACA required the creation of health insurance exchanges—marketplaces where individuals and small employers can compare and select among insurance plans offered by participating private health plans.[25] PPACA also improved coverage of breast and cervical cancer screening by

[22]Although cisgender men are not eligible for CDC-funded screening through the Early Detection Program, a cisgender man may still be eligible for Medicaid enrollment under the Treatment Act through one of these broader definitions of "screened under the Early Detection Program", according to CMS guidance, such as when a CDC-funded Early Detection Program provider screens a man without using CDC funds. See Centers for Medicare and Medicaid Services, *Implementation Guide: Medicaid State Plan Eligibility, Individuals Needing Treatment for Breast or Cervical Cancer* (2020).

[23]PPACA also permitted an early expansion option, whereby states could expand eligibility for this population, or a subset of this population, starting on April 1, 2010. Additionally, PPACA provides for a disregard equivalent to 5 percent of the federal poverty level when calculating income for determining Medicaid eligibility for most individuals, which effectively increases income eligibility from 133 percent of the federal poverty level to 138 percent of the federal poverty level for the new adult group.

[24]According to CMS, Nebraska plans to expand Medicaid on October 1, 2020; Oklahoma and Missouri are planning to expand Medicaid by July 1, 2021.

[25]Certain consumers purchasing health insurance through the exchanges are eligible for premium tax credits and cost-sharing reductions that reduce their out-of-pocket costs for health insurance. Individuals with incomes between 100 and 400 percent of the federal poverty level may qualify for premium tax credits, and those with incomes between 100 and 250 percent may qualify for cost-sharing reductions.

requiring health plans to cover certain women's preventive health care with no cost sharing.[26]

CDC's Early Detection Program Screened nearly 300,000 People in 2018, Reflecting an Overall Decline in Screening and Eligibility

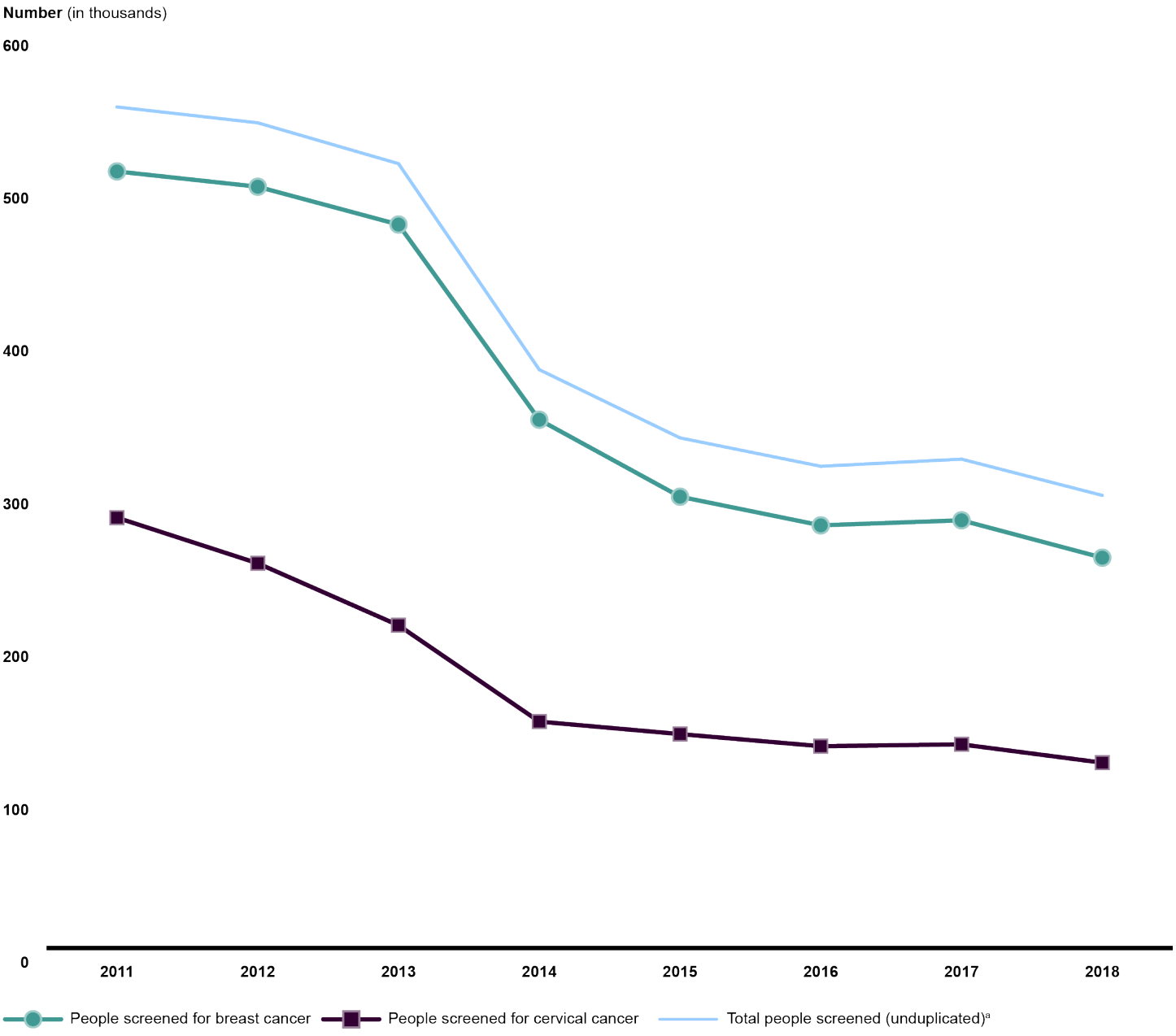
According to data from CDC, 296,225 people were screened for breast or cervical cancer by the Early Detection Program in 2018, a decrease from 550,390 in 2011 (about 46 percent).[27] (See fig. 1.) The largest decrease occurred from 2013 to 2014—the first year that several key PPACA provisions went into effect, including Medicaid expansion and the implementation of health insurance exchanges and subsidies, such as premium tax credits and cost-sharing reductions, to help people purchase health plans. According to CDC officials, health insurance coverage expansions and improved access to screening under PPACA were significant factors, among others, contributing to a decrease in the number of people who were eligible and, subsequently, a decrease in those screened. Other factors that can influence the number of people a grantee is able to screen include the amount of CDC funding awarded, the availability of other resources, changes in screening guidelines, and changes in clinical costs, such as more costly screening technologies.[28] (See app. I, tables 1-3 for screening data at the grantee level.)

[26]Diagnostic and treatment services may be subject to cost-sharing.

[27]This number is unduplicated, meaning that people who received multiple screenings—such as both a breast cancer screening and a cervical cancer screening—in the same year are counted only once. It does not include the small number of people who received diagnostic services through the program without receiving CDC-funded screening services, although that number also decreased through 2017. In 2017 (the most recent full calendar year for which diagnostic data were available), 11,894 people received breast cancer diagnostic services and 5,810 people received cervical cancer diagnostic services without first receiving CDC-funded screening services, decreases of 14.8 and 54.1 percent, respectively, from 2011.

[28]For example, in March 2012, the U.S. Preventive Services Task Force changed the minimum recommended age for cervical cancer screening, increasing it from 18 years old to 21 years old, and cervical cancer screening intervals increased from 3 years to 5 years for some women.

Figure 1: People Screened by CDC's National Breast and Cervical Cancer Early Detection Program, 2011 through 2018



Source: GAO analysis of data from the Centers for Disease Control and Prevention (CDC). | GAO-21-35

[a]The total number of unduplicated people screened means that individuals who received multiple screenings in the same year, such as both a breast cancer screening and a cervical cancer screening are counted only once.

The number of people eligible for screening through the Early Detection Program also decreased by about half from 2011 through 2017, according to a CDC-funded study. Specifically, the authors estimated that the number of women eligible for screening through the Early Detection program decreased from approximately 5.4 million in 2011 to approximately 2.8 million in 2017 for breast cancer (a decrease of 48 percent), and from approximately 10.3 million in 2011 to approximately 5.3 million in 2017 for cervical cancer (a decrease of about 49 percent).[29] (See fig. 2.) The authors attributed this decrease to insurance coverage expansions under PPACA, such as Medicaid expansion, and the introduction of premium tax credits to purchase private insurance through the new health insurance exchanges, as well as to a decreasing unemployment rate during the study time period.[30] The study estimated that the Early Detection Program served 15 percent of all women eligible for breast cancer screening through the program in 2016-2017, an increase from 10.6 percent in 2011-2012, and 6.8 percent of all women eligible for cervical cancer screening through the program in 2015-2017, an increase from 6.5 percent in 2010-2012.[31] According to CDC officials,

[29]The study estimated eligibility of women for the program using U.S. Census data, which uses a male/female sex binary; while cisgender women would be included in these estimates, the extent to which transgender men and women would be included is unclear due to the lack of corresponding information about gender identity. These numbers are statistical estimates. The 90 percent confidence intervals for breast cancer are 5.2 – 5.6 million (2011) and 2.6 – 3.0 million (2017). The 90 percent confidence intervals for cervical cancer are 10.0 – 10.6 million (2011) and 5.1 – 5.6 million (2017). Tangka et al., "Eligibility and Reach after the Affordable Care Act."

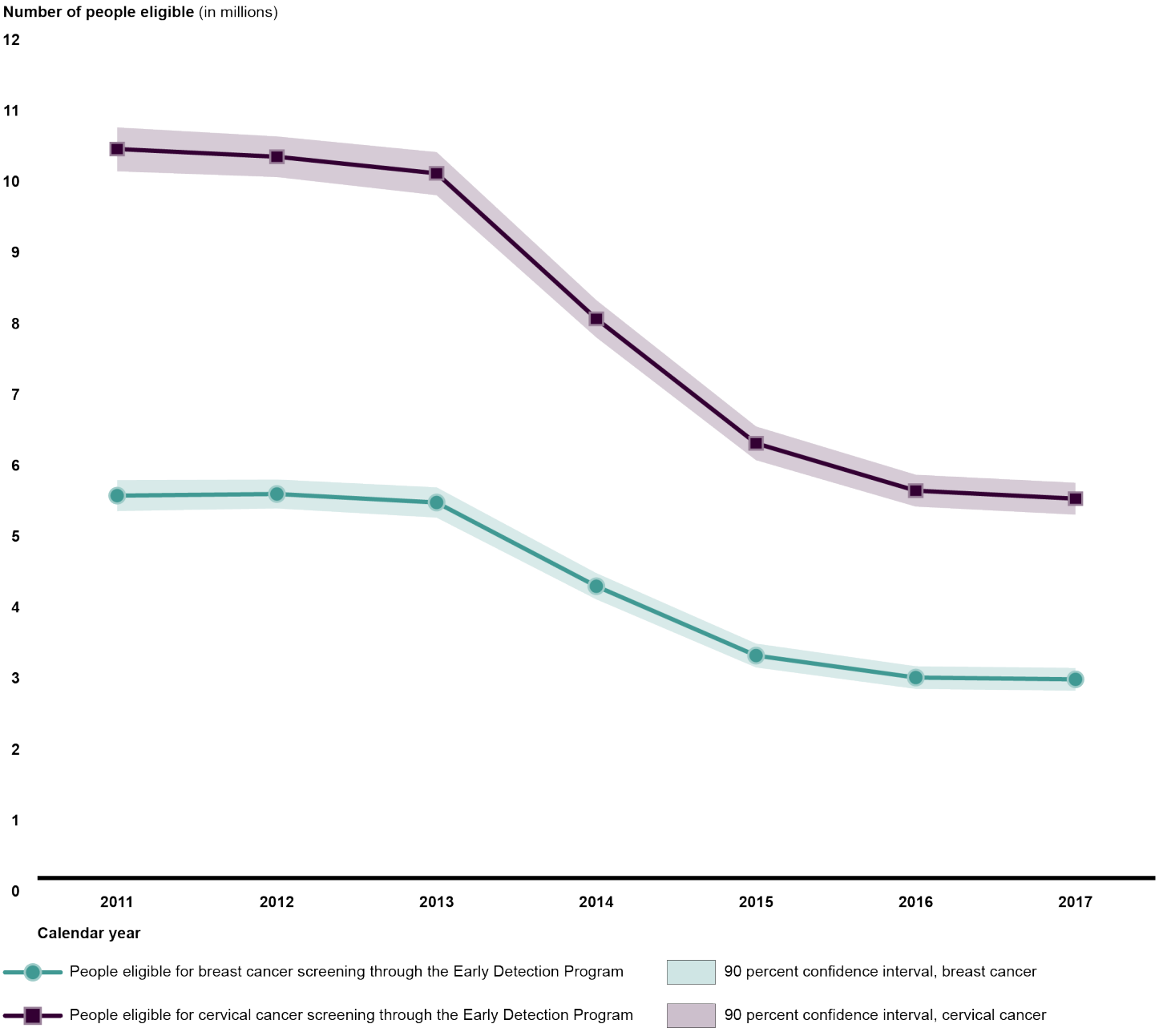
[30]Conversely, an increase in the unemployment rate might increase eligibility for the Early Detection Program. Studies have estimated that job losses associated with the Coronavirus Disease 2019 pandemic are leading to a loss of employer-sponsored health insurance and an increase in the number of uninsured people. While some newly uninsured people may qualify for coverage through Medicaid or coverage assistance in the form of marketplace tax credits, others may remain uninsured, potentially increasing the number of people eligible for the Early Detection Program. See Jessica Banthin et al., *Changes in Health Insurance Coverage Due to the COVID-19 Recession: Preliminary Estimates Using Microsimulation* (Washington, D.C.: Urban Institute and Robert Wood Johnson Foundation, July 2020); The National Center for Coverage Innovation, *The COVID-19 Pandemic and Resulting Economic Crash Have Caused the Greatest Health Insurance Losses in American History* (Washington, D.C.: Families USA, July 17, 2020); and Rachel Garfield et al., *Eligibility for ACA Health Coverage Following Job Loss* (San Francisco, Calif: Kaiser Family Foundation, May 13, 2020).

[31]The authors used these time periods to reflect the frequency at which many women undergo screening, which is every 2 years for breast cancer and every 3 years for cervical cancer. The 90 percent confidence intervals for 2017 are 14.8 – 15.1 percent for breast cancer and 6.7 – 6.8 percent for cervical cancer. The 90 percent confidence intervals for 2012 are 10.4 – 10.9 percent for breast cancer and 6.4 – 6.6 percent for cervical cancer.

people may not receive breast or cervical cancer screenings through the Early Detection Program for a variety of reasons, including lack of knowledge about the need for screening, fear of a cancer diagnosis, lack of trust in health care providers, inconvenient clinic hours, language and cultural barriers, lack of transportation, and lack of clinical providers and services in rural or isolated areas. As we previously reported, some people eligible for the Early Detection Program who are not screened by the program may receive screening from other sources in the community, such as non-profit organizations.[32]

[32]GAO-09-384.

Figure 2: Estimated Number of People Eligible for the National Breast and Cervical Cancer Early Detection Program, 2011 through 2017



Source: GAO presentation of data from Tangka et al., "Eligibility and Reach after the Affordable Care Act." | GAO-21-35

According to CDC officials, in order to address these types of barriers and in response to declining trends in the number of people eligible for and screened by the Early Detection Program, CDC expanded the scope of the program beginning in 2017. In addition to screening people for breast or cervical cancer, the program also focuses more broadly on efforts that increase screening among all low-income women—a strategy known as a population-based approach.[33] As part of this program expansion, grantees must implement patient navigation as well as evidence-based strategies to overcome screening barriers and community strategies to link people to clinical services, as recommended in *The Guide to Community Preventive Services*.[34] These strategies include community health worker engagement, patient and provider reminders, provider assessment and feedback, one-on-one and group education, small media, reduction of structural barriers, and reduction of out-of-pocket costs.[35] CDC officials said they are collecting data from the grantees that will allow them to assess how well they are implementing this new

[33]According to CDC, a population-based approach includes strategies that increase screening to all individuals in a target group.

[34]Community Preventive Services Task Force, *The Guide to Community Preventive Services* (Department of Health and Human Services), accessed August 28, 2020, www.thecommunityguide.org.

Patient navigation is individualized assistance to help overcome barriers and facilitate access; for example, this could include activities such as providing transportation or translation services.

[35]Community health workers are frontline, culturally competent, public health workers who serve as a bridge between underserved communities and healthcare systems. Patient reminders are written or telephone messages advising people that they are due for screening, and provider reminders inform health care providers that it is time for a client's cancer screening or that a client is overdue for screening. Provider assessment and feedback interventions evaluate provider performance in delivering or offering screening to clients and then provide feedback on that performance. One-on-one and group education consists of conveying information on indications for, benefits of, and ways to overcome barriers to screening with the goal of informing, encouraging, and motivating participants to seek recommended screening. Small media include videos and printed materials, such as letters, brochures, and newsletters, which can be used to inform and motivate people to be screened for cancer. Structural barriers are non-economic burdens or obstacles that make it difficult for people to access cancer screening. Interventions to reduce out-of-pocket costs attempt to minimize or remove economic barriers that make it difficult for people to access cancer screening services.

population-based approach, but because this database was just recently implemented, data are not yet available.[36]

During the time period examined, while the overall number of people screened decreased, CDC's data show that the share of people screened who were racial or ethnic minorities increased from 53.4 percent in 2011 to 73.2 percent in 2018 for breast cancer and from 54.1 percent in 2011 to 74.8 percent in 2018 for cervical cancer.[37] Hispanic people were the largest minority group served by the Early Detection Program in the time period examined, and they made up a larger share of racial and ethnic minorities screened by the program over time, increasing from 49.0 percent of minorities screened for breast cancer in 2011 to 68.9 percent in 2018, and from 50.9 percent of minorities screened for cervical cancer in 2011 to 73.1 percent in 2018. As the CDC data show, although the number of Hispanic people screened by the Early Detection Program decreased, this decrease was much smaller than the decreases for other racial and ethnic groups.[38] (See fig. 3.) Similarly, the 2020 study funded by CDC found that the number of Hispanic women eligible for screening through the Early Detection Program decreased by a smaller percentage when compared to other racial and ethnic groups.[39] For additional race

[36]At the time of our review, grantees had not yet submitted their first data submission to CDC.

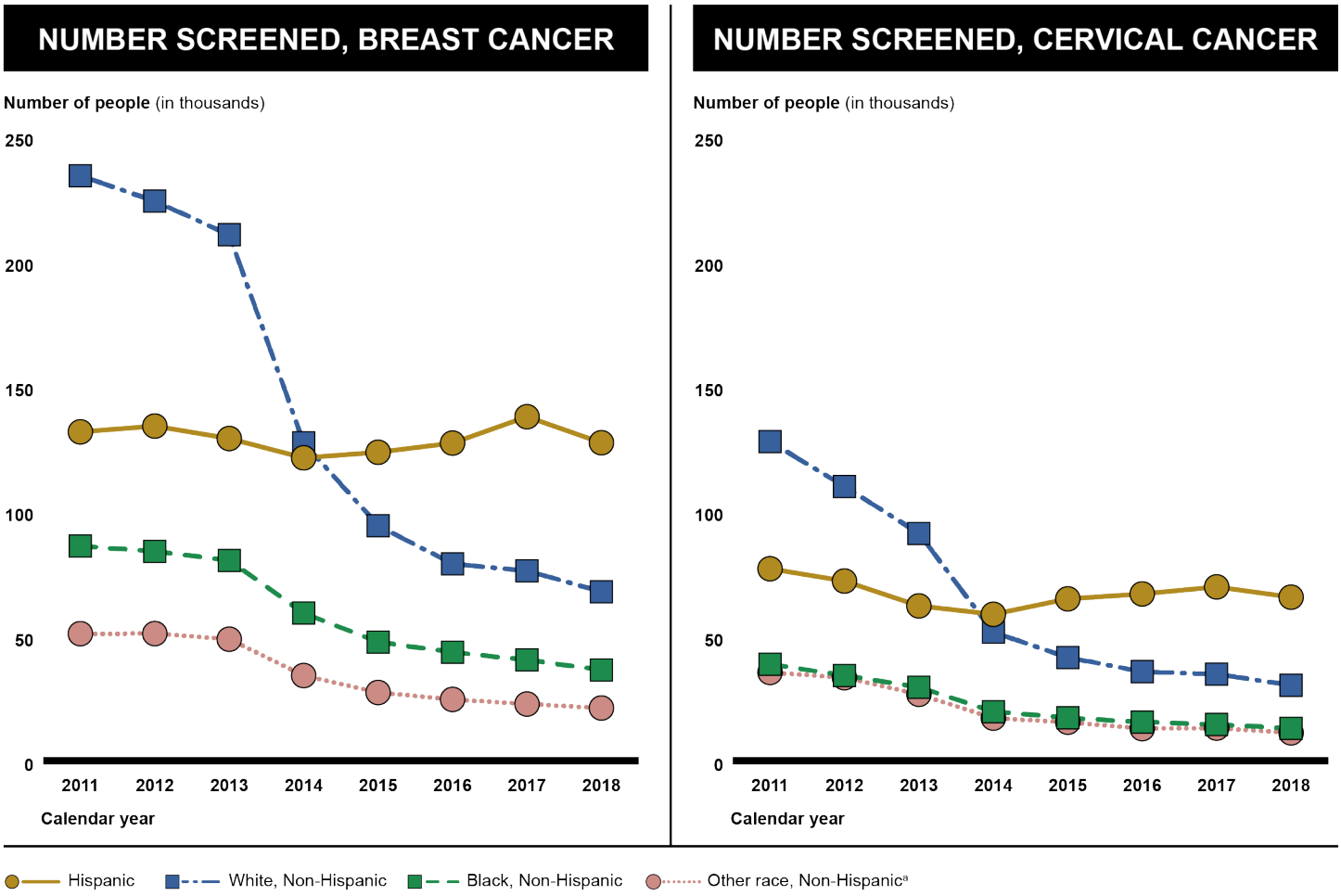
[37]For our analysis of CDC's data by race and ethnicity, we excluded people screened whose race and ethnicity were identified as "unknown." Race and ethnicity are self-reported by program participants.

[38]The number of non-Hispanic people screened each year decreased by 66.3 percent and 73.1 percent from 2011 to 2018, for breast and cervical cancer, respectively, whereas the number of Hispanic people screened each year only decreased by 3.3 percent for breast cancer and 14.8 percent for cervical cancer.

[39]According to the study, the number of Hispanic women eligible for services decreased by 30.4 percent for breast cancer and 37.7 percent for cervical cancer from 2011 to 2017. By contrast, the number of Black, non-Hispanic women eligible for services decreased by 51.5 percent for breast cancer and 48.9 percent for cervical cancer, and the number of White, non-Hispanic women eligible for services decreased by 55.9 percent for breast cancer and 54.9 percent for cervical cancer. Additionally, the percentage of Hispanic women eligible for the program was always higher than the percentage of Black, non-Hispanic women and White, non-Hispanic women eligible. In 2017, the percentage of Hispanic women that were eligible for screening services was about twice as high as the percentage of Black, non-Hispanic women eligible and about four times as high as the percentage of White, non-Hispanic women eligible. While the percentage of women eligible was also higher for Hispanic women than for White, non-Hispanic and Black, non-Hispanic women for 2011 through 2016, the relative difference between these groups was slightly smaller in earlier years.

and ethnicity screening data at the grantee level, see appendix I, tables 4 and 5.

Figure 3: People Screened by CDC's National Breast and Cervical Cancer Early Detection Program, by Race and Ethnicity, 2011 through 2018



Source: GAO analysis of data from the Centers for Disease Control and Prevention (CDC). | GAO-21-35

Note: People screened whose race and ethnicity were identified as "unknown" are excluded from this figure.

[a]Includes non-Hispanic people from the following racial groups: Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, and Multiracial. Also includes Asian/Pacific Islander, a legacy category from an earlier version of CDC's data collection.

The number of people screened under and eligible for the Early Detection Program also varied according to the states' Medicaid expansion status.

In general, the number of people screened for breast and cervical cancer decreased more, and the percentage of people eligible for the Early Detection Program was smaller, in states that expanded Medicaid eligibility. CDC's data show that the number of people screened each year by the Early Detection Program decreased more in Medicaid expansion states (54.6 percent from 2011 through 2018) than in states that have not expanded Medicaid (29.2 percent from 2011 through 2018).[40] Similarly, the 2020 study funded by CDC found that the percentage of women eligible for screening through the Early Detection Program was always higher for states that did not expand Medicaid than for expansion states.[41] However, as noted previously, the 2020 study funded by CDC did not estimate the eligibility of underinsured people. Advocacy groups we spoke with noted that, while the number of uninsured people has decreased since the implementation of PPACA, there may still be many underinsured people who need assistance through the Early Detection Program.

[40]We used Medicaid expansion status information available on the Kaiser Family Foundation's website, which tracks the date when each state's expansion went into effect. These data are current as of February 19, 2020. Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision, July 1, 2020," accessed July 22, 2020, https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. For purposes of this analysis, states were only counted as expansion states if expansion occurred during or before 2018. Although Maine implemented Medicaid expansion on January 10, 2019, retroactive to July 2018, we did not include it as an expansion state in this analysis because the retroactive expansion was only for part of the year.

[41]The study estimated that eligibility in states that did not expand Medicaid in 2017 was about double what it was in states that did expand Medicaid. The percentage of women eligible for breast cancer screening in 2017 was estimated to be 3.6 percent in states that did expand Medicaid (90 percent confidence interval: 3.4-3.9 percent) and 7.5 percent (90 percent confidence interval: 7.1-7.9 percent) in states that did not. The percentage of women eligible for cervical cancer screening in 2017 was estimated to be 3.9 percent in states that did expand Medicaid (90 percent confidence interval: 3.7-4.1 percent) and 8.1 percent in states that did not (90 percent confidence interval: 7.8-8.4 percent). While estimated eligibility was also higher for states that did not expand Medicaid for 2011 through 2016, the relative difference was smaller in earlier years, with eligibility in non-expansion states being about one-and-a-half times as high as expansion states in 2011.

About 43,500 People Were Enrolled in Medicaid under the Treatment Act in 2019, and Enrollment Varied by State in Recent Years

According to data from CMS, 43,549 people were enrolled in Medicaid under the Treatment Act to receive treatment for breast or cervical cancer in 2019, a decrease from 50,219 in 2016 (13.3 percent).[42] CMS data also show that enrollment trends varied by state from 2016 through 2019. Specifically, 37 states experienced a decrease in Medicaid enrollment under the Treatment Act during this time period, 13 states experienced an increase, and one state had no change. (See app. II.)

According to CMS officials, Medicaid expansion is a key factor that contributed to these trends. Specifically, the officials said that, in the states that expanded their Medicaid programs, there were some people who previously would have enrolled in Medicaid based on eligibility under the Treatment Act who instead became eligible for Medicaid through the new adult group created through PPACA.[43] The CMS data show that total enrollment under the Treatment Act in Medicaid expansion states decreased by 25.6 percent from 2016 to 2019. In contrast, total enrollment under the Treatment Act in non-expansion states increased by about 1 percent during this time period. Further, 29 of the 34 states that expanded Medicaid had a decrease in enrollment under the Treatment Act from 2016 through 2019.[44] For some of these Medicaid expansion states, the decrease was larger than others. For example, enrollment in Illinois decreased from 1,441 people in 2016 to 104 people in 2019 (92.8

[42]We were unable to examine this trend prior to the implementation of PPACA because, according to CMS officials, 2016 was the first year in which a complete calendar year of data became available for all states. CMS data we analyzed for 2016 in Tennessee are based on a different data field than the other states and years due to data reliability concerns with the reported number of individuals enrolled in Medicaid under the Treatment Act.

[43]According to CMS officials, in Medicaid expansion states, people would only be eligible for Medicaid enrollment under the Treatment Act if they were not already eligible for Medicaid under this new adult group or any of the other Medicaid eligibility groups. However, people who were eligible for and enrolled under the Treatment Act when the state implemented Medicaid expansion may remain in that eligibility group without having their eligibility determined for the new adult group.

[44]For purposes of this analysis, states were only counted as Medicaid expansion states if expansion occurred during or before 2019.

percent), whereas enrollment in Iowa decreased from 197 people in 2016 to 192 in 2019 (2.5 percent).[45]

Additionally, according to CMS, two states that expanded Medicaid—Arkansas and Maryland—opted to discontinue offering Medicaid coverage to the breast and cervical cancer eligibility group under the Treatment Act beginning in 2014, and CMS data show their enrollment under the act subsequently decreased or remained at zero over the time period examined.[46] This is a change from our 2009 report, where we found that all 50 states and the District of Columbia opted to extend Medicaid coverage to the breast and cervical cancer eligibility group.[47] Officials from Arkansas and Maryland said the decision to discontinue coverage under the Treatment Act was made because their states expanded Medicaid. In addition, those state officials noted that people screened and diagnosed by the Early Detection Program who did not qualify for Medicaid could obtain insurance under PPACA through their states' health insurance marketplaces.

In addition, CMS officials said that enrollment trends may be affected by changes in state policies for Medicaid eligibility under the Treatment Act, which vary depending upon how the state Early Detection Program grantee defines what it means to be "screened under the Early Detection Program."[48] Representatives from one of the advocacy groups we spoke with indicated that, since our 2009 report, some of these states have changed their definition of what it means to be screened under the Early Detection Program. For example, Oregon and Colorado previously limited eligibility to those screened with CDC funds, but, in 2012 and 2014, respectively, the states expanded this eligibility to include people screened by providers not participating in the states' Early Detection

[45]Enrollment changes during the time period examined were small for the four states that expanded Medicaid and had an increase in enrollment under the Treatment Act, with increases ranging from 2.7 to 12.6 percent. The remaining Medicaid expansion state—Arkansas—had no change in enrollment under the Treatment Act during the time period examined.

[46]CMS data show no enrollment under the Treatment Act in Arkansas from 2016 to 2019, while Maryland's enrollment decreased over time. Although Maryland discontinued new enrollment, Maryland officials explained that people enrolled prior to December 31, 2013, and actively in treatment are allowed to continue treatment to completion.

[47]GAO-09-384.

[48]We also previously reported that these differences in state policies for Medicaid eligibility under the Treatment Act could affect enrollment trends. GAO-09-384.

Programs. This expansion of eligibility would likely have increased enrollment under the Treatment Act. However, both states expanded Medicaid in 2014, which would likely have decreased Medicaid enrollment under the Treatment Act due to the new adult group created through PPACA. CMS data show that Medicaid enrollment under the Treatment Act decreased in both Oregon and Colorado from 2016 through 2019.[49]

Finally, in 2016, CMS issued a regulation that may affect states' Medicaid enrollment under the Treatment Act. In 2016, CMS codified eligibility requirements under the Treatment Act based on its January 4, 2001, guidance.[50] In the preamble to its proposed rule, CMS noted the rule would explicitly provide for coverage of men where the state's Early Detection Program considers men to have been screened under its program.[51] CMS data show that 14 states had at least one man enrolled in Medicaid under the Treatment Act in 2019, for a total of 331 male enrollees.[52] Further, the 2016 regulation specified that ongoing eligibility for Medicaid under the Treatment Act must be determined by the individual's treating health care professional. Based on that determination, states must dis-enroll people from Medicaid under the Treatment Act if they no longer need treatment for breast or cervical cancer, which could affect enrollment trends.

Agency Comments

We provided a draft of this report to the Department of Health and Human Services for review and comment. The department provided technical comments, which we incorporated as appropriate.

[49]In Oregon, Medicaid enrollment under the Treatment Act decreased from 439 to 250 (43.1 percent) over the time period examined, and, in Colorado, Medicaid enrollment decreased from 252 to 237 (6.0 percent).

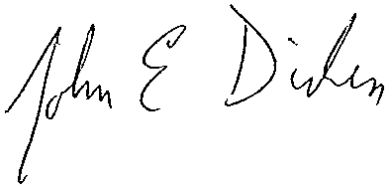
[50]81 Fed. Reg. 86,382, 86,452 (Nov. 30, 2016) (codified at 42 C.F.R. § 435.213).

[51]78 Fed. Reg. 4594, 4609 (proposed Jan. 22, 2013)

[52]According to CMS data, 10 additional states that had no male enrollees under the Treatment Act in 2019 had at least one male enrollee in 2016, 2017, or 2018. The vast majority of male enrollees each year were in Massachusetts, which had 303 men enrolled in Medicaid under the Treatment Act in 2019. Massachusetts covers all individuals with breast and cervical cancer under a section 1115 demonstration project. Section 1115 demonstrations allow states, with CMS approval, to test and evaluate new approaches for delivering services under Medicaid.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the appropriate congressional committees, the Secretary of the Department of Health and Human Services, and other interested parties. In addition, the report will be available at no charge on the GAO website at https://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in Appendix III.



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Director, Health Care

Appendix I: Screening through the Early Detection Program

Table 1: Total Number of People Screened by National Breast and Cervical Cancer Early Detection Program Grantees, 2011 and 2018

Grantee category/grantee	Total screened, 2011[a]	Total screened, 2018[a]	Percentage change in people screened, 2011 through 2018
All grantees combined	550,390	296,225	-46.2
States and D.C.	530,600	283,059	-46.7
Alabama	8,905	6,899	-22.5
Alaska	7,237	3,664	-49.4
Arizona	7,742	4,924	-36.4
Arkansas	4,570	5,143	12.5
California	43,672	29,741	-31.9
Colorado	15,435	5,260	-65.9
Connecticut	8,420	3,135	-62.8
Delaware	2,927	938	-68.0
District of Columbia	686	543	-20.8
Florida	13,871	15,047	8.5
Georgia	11,381	9,306	-18.2
Hawaii	1,130	172	-84.8
Idaho	4,387	2,010	-54.2
Illinois	32,667	11,500	-64.8
Indiana	6,122	2,469	-59.7
Iowa	5,562	2,215	-60.2
Kansas	6,908	3,723	-46.1
Kentucky	15,928	4,135	-74.0
Louisiana	13,119	3,749	-71.4
Maine	4,799	2,438	-49.2
Maryland	9,524	4,069	-57.3
Massachusetts[b]	144	-	-100.0
Michigan	26,386	4,823	-81.7
Minnesota	13,137	6,291	-52.1
Mississippi	6,564	3,391	-48.3
Missouri	10,947	5,900	-46.1
Montana	5,802	1,753	-69.8
Nebraska	10,015	1,564	-84.4
Nevada	7,094	6,705	-5.5
New Hampshire	4,652	1,531	-67.1
New Jersey	13,087	8,371	-36.0

Grantee category/grantee	Total screened, 2011[a]	Total screened, 2018[a]	Percentage change in people screened, 2011 through 2018
New Mexico	13,856	5,141	-62.9
New York	34,572	18,392	-46.8
North Carolina	14,656	8,710	-40.6
North Dakota	3,138	1,127	-64.1
Ohio	15,914	3,730	-76.6
Oklahoma	3,556	1,023	-71.2
Oregon	8,547	3,916	-54.2
Pennsylvania	5,647	10,093	78.7
Rhode Island	5,629	2,083	-63.0
South Carolina	8,865	13,758	55.2
South Dakota	4,041	2,038	-49.6
Tennessee	8,909	6,065	-31.9
Texas	24,655	21,795	-11.6
Utah	5,694	4,529	-20.5
Vermont	852	201	-76.4
Virginia	7,254	5,760	-20.6
Washington	15,796	7,301	-53.8
West Virginia	15,251	2,161	-85.8
Wisconsin	9,998	3,495	-65.0
Wyoming	950	332	-65.1
Territories	2,845	2,237	-21.4
American Samoa	860	390	-54.7
Commonwealth of Northern Mariana Islands	644	364	-43.5
Guam	502	414	-17.5
Puerto Rico	212	297	40.1
Republic of Palau	627	772	23.1
Tribes and tribal organizations	16,945	10,929	-35.5
Arctic Slope Native Association Limited	477	454	-4.8
Cherokee Nation	2,838	2,081	-26.7
Cheyenne River Sioux	872	990	13.5
Hopi Tribe	839	234	-72.1
Kaw Nation	557	446	-19.9
Native American Rehabilitation Association of the Northwest	421	411	-2.4
Navajo Nation	1,384	1,377	-0.5

Grantee category/grantee	Total screened, 2011[a]	Total screened, 2018[a]	Percentage change in people screened, 2011 through 2018
Poarch Band of Creek Indians[c]	53	-	-100.0
South Puget Intertribal Planning Agency	789	484	-38.7
Southcentral Foundation	4,660	2,385	-48.8
Southeast Alaska Regional Health Consortium	2,510	1,756	-30.0
Yukon-Kuskokwim Health Corporation	1,545	311	-79.9

Source: GAO analysis of Centers for Disease Control and Prevention (CDC) data | GAO-21-35

Note: Data were not available for three grantees (two tribal organizations and one territory) that were new to the Early Detection Program in 2017: Great Plains Tribal Chairmen's Health Board, American Indian Cancer Foundation, and the Republic of the Marshall Islands.

[a]Total screened is an unduplicated count of all people (all ages) who received screening services funded by CDC's Early Detection Program. Individuals who received more than one screening service (e.g., both a breast cancer screening and a cervical cancer screening) are only counted once.

[b]Massachusetts was given CDC approval to suspend screening for 2016-2018 in order to redesign service delivery. In 2015, the state screened 89 people.

[c]Funding for the Poarch Band of Creek Indians ended in 2012.

Table 2: Number of People Screened and Diagnosed with Breast Cancer by National Breast and Cervical Cancer Early Detection Program Grantees, 2011 through 2018

Grantee category/grantee	Screened for breast cancer, 2011[a]	Screened for breast cancer, 2018[a]	Percentage change in people screened for breast cancer, 2011 through 2018	Total diagnosed with breast cancer, 2011 through 2017[b]
All grantees combined	508,192	255,466	-49.7	33,161
States and D.C.	494,962	245,821	-50.3	32,556[c]
Alabama	8,795	6,055	-31.2	816
Alaska	6,416	3,033	-52.7	213
Arizona	7,621	4,757	-37.6	440
Arkansas	4,462	1,736	-61.1	368
California	32,919	19,882	-39.6	1,170
Colorado	14,971	3,410	-77.2	767
Connecticut	8,274	3,024	-63.5	307
Delaware	2,544	667	-73.8	59[c]
District of Columbia	629	534	-15.1	51[c]
Florida	13,726	14,847	8.2	1,957
Georgia	11,053	9,145	-17.3	924
Hawaii	1,107	166	-85.0	71[c]
Idaho	3,514	1,174	-66.6	399
Illinois	31,492	11,110	-64.7	1,417
Indiana	6,018	2,347	-61.0	377
Iowa	5,493	2,189	-60.1	350
Kansas	6,766	3,517	-48.0	358
Kentucky	15,635	3,911	-75.0	436
Louisiana	12,702	2,919	-77.0	756
Maine	4,661	2,312	-50.4	239
Maryland	7,875	3,428	-56.5	291
Massachusetts[d]	117	0	-100.0	-[c]
Michigan	25,946	4,726	-81.8	1,541
Minnesota	12,757	5,638	-55.8	552
Mississippi	6,497	3,365	-48.2	690
Missouri	10,483	5,567	-46.9	1,299
Montana	5,431	1,468	-73.0	360
Nebraska	9,422	1,522	-83.8	354
Nevada	6,995	5,538	-20.8	493
New Hampshire	4,436	1,376	-69.0	249
New Jersey	9,131	5,501	-39.8	660

Grantee category/grantee	Screened for breast cancer, 2011[a]	Screened for breast cancer, 2018[a]	Percentage change in people screened for breast cancer, 2011 through 2018	Total diagnosed with breast cancer, 2011 through 2017[b]
New Mexico	13,249	4,348	-67.2	578
New York	32,173	17,723	-44.9	1,505
North Carolina	13,778	8,107	-41.2	1,533
North Dakota	3,086	1,083	-64.9	89[c]
Ohio	15,671	3,562	-77.3	1,233
Oklahoma	3,450	980	-71.6	190
Oregon	7,949	3,505	-55.9	512
Pennsylvania	5,476	9,338	70.5	611
Rhode Island	5,380	1,867	-65.3	209
South Carolina	8,821	13,097	48.5	722
South Dakota	3,434	1,708	-50.3	169
Tennessee	7,367	4,722	-35.9	1,409
Texas	23,110	18,104	-21.7	2,482
Utah	5,600	4,472	-20.1	361
Vermont	746	183	-75.5	20[c]
Virginia	7,214	5,737	-20.5	883
Washington	15,473	6,653	-57.0	905
West Virginia	14,701	2,099	-85.7	409
Wisconsin	9,593	3,413	-64.4	673
Wyoming	803	256	-68.1	99[c]
Territories	2,572	1,965	-23.6	11[c]
American Samoa	846	382	-54.8	-[c]
Commonwealth of Northern Mariana Islands	559	301	-46.2	-[c]
Guam	497	362	-27.2	-[c]
Puerto Rico	159	262	64.8	11c
Republic of Palau	511	658	28.8	-[c]
Tribes and tribal organizations	10,658	7,680	-27.9	192[c]
Arctic Slope Native Association Limited	293	252	-14.0	-[c]
Cherokee Nation	1,900	1,364	-28.2	43[c]
Cheyenne River Sioux	553	784	41.8	-[c]
Hopi Tribe	794	216	-72.8	-[c]
Kaw Nation	542	360	-33.6	-[c]
Native American Rehabilitation Association of the Northwest	401	391	-2.5	-[c]

Grantee category/grantee	Screened for breast cancer, 2011[a]	Screened for breast cancer, 2018[a]	Percentage change in people screened for breast cancer, 2011 through 2018	Total diagnosed with breast cancer, 2011 through 2017[b]
Navajo Nation	1,183	1,126	-4.8	-[c]
Poarch Band of Creek Indians[e]	33	0	-100.0	0
South Puget Intertribal Planning Agency	738	416	-43.6	-[c]
Southcentral Foundation	1,586	1,471	-7.3	112[c]
Southeast Alaska Regional Health Consortium	1,711	1,115	-34.8	37[c]
Yukon-Kuskokwim Health Corporation	924	185	-80.0	-[c]

Source: GAO analysis of Centers for Disease Control and Prevention (CDC) data | GAO-21-35

Note: All numbers are unduplicated, meaning that people who received multiple breast cancer screenings or diagnoses in a single year would be counted once. Because the diagnosis counts sum multiple years of data, individuals could be counted more than once if they received breast cancer diagnoses in multiple years. Numbers include program participants of all ages, including those outside the target breast cancer screening age range of 40 to 64. Data were not available for three grantees (two tribal organizations and one territory) that were new to the Early Detection Program in 2017: Great Plains Tribal Chairmen's Health Board, American Indian Cancer Foundation, and the Republic of the Marshall Islands.

[a]Screenings include all breast cancer screening services (e.g., mammogram, clinical breast exam).

[b]This table excludes 2018 diagnosis data because that data was only available through June 2018. Diagnoses include breast carcinoma in situ (including Lobular Carcinoma in Situ and Ductal Carcinoma in Situ) and invasive cancers. CDC searched for but did not identify any individuals diagnosed with Carcinoma in Situ not otherwise specified.

[c]Individual grantee diagnosis counts do not add to the total due to privacy suppression; to protect patient confidentiality, CDC suppressed individual grantee diagnosis counts in years where the number of diagnoses was between 1 and 9, although those counts were included in "All grantees combined." Flagged counts are undercounts because they include one or more years in which the diagnosis count was suppressed. Grantee counts are noted as "-" when at least one count was suppressed and other counts were zero for all years from 2011 to 2017.

[d]Massachusetts was given CDC approval to suspend screening for 2016-2018 in order to redesign service delivery. In 2015, the state screened 87 people for breast cancer.

[e]Funding for the Poarch Band of Creek Indians ended in 2012.

Table 3: Number of People Screened and Diagnosed with Cervical Cancer by National Breast and Cervical Cancer Early Detection Program Grantees, 2011 through 2018

Grantee category/grantee	Screened for cervical cancer, 2011[a]	Screened for cervical cancer, 2018[a]	Percentage change in people screened for cervical cancer, 2011 through 2018	Total diagnosed with cervical cancer, 2011 through 2017[b]
All grantees combined	281,658	121,315	-56.9	22,960
States and D.C.	269,258	114,980	-57.3	22,178[c]
Alabama	2,998	3,306	10.3	462
Alaska	5,350	2,323	-56.6	415
Arizona	3,392	2,165	-36.2	189
Arkansas	2,051	3,970	93.6	122[c]
California	22,309	13,889	-37.7	416
Colorado	7,854	2,871	-63.4	317
Connecticut	4,716	1,503	-68.1	278
Delaware	2,074	685	-67.0	90[c]
District of Columbia	229	19	-91.7	-[c]
Florida	5,999	2,396	-60.1	182
Georgia	5,232	1,971	-62.3	209
Hawaii	772	90	-88.3	-[c]
Idaho	2,079	1,174	-43.5	391
Illinois	14,972	2,844	-81.0	1,275
Indiana	3,773	1,109	-70.6	141
Iowa	2,787	753	-73.0	87c
Kansas	4,162	2,020	-51.5	228
Kentucky	8,531	2,773	-67.5	340
Louisiana	2,968	1,213	-59.1	61[c]
Maine	2,408	772	-67.9	89
Maryland	5,033	1,588	-68.4	99[c]
Massachusetts[d]	38	0	-100.0	-[c]
Michigan	13,781	1,392	-89.9	1,567
Minnesota	6,483	2,221	-65.7	223
Mississippi	3,677	1,514	-58.8	221
Missouri	3,512	1,823	-48.1	306
Montana	2,761	741	-73.2	325
Nebraska	5,526	355	-93.6	410
Nevada	4,938	4,502	-8.8	169
New Hampshire	2,803	757	-73.0	295
New Jersey	9,355	5,211	-44.3	333

Grantee category/grantee	Screened for cervical cancer, 2011[a]	Screened for cervical cancer, 2018[a]	Percentage change in people screened for cervical cancer, 2011 through 2018	Total diagnosed with cervical cancer, 2011 through 2017[b]
New Mexico	8,161	2,635	-67.7	457
New York	15,444	4,585	-70.3	375
North Carolina	6,494	2,459	-62.1	453
North Dakota	1,473	390	-73.5	50[c]
Ohio	9,830	1,798	-81.7	203
Oklahoma	2,198	400	-81.8	207
Oregon	5,725	1,880	-67.2	230[c]
Pennsylvania	2,506	4,394	75.3	218
Rhode Island	3,206	1,265	-60.5	168
South Carolina	4,273	5,614	31.4	325
South Dakota	2,473	1,124	-54.5	210
Tennessee	3,726	2,713	-27.2	568
Texas	11,863	9,547	-19.5	7,455
Utah	1,981	1,205	-39.2	90[c]
Vermont	469	64	-86.4	22[c]
Virginia	2,884	1,620	-43.8	184
Washington	9,118	3,618	-60.3	290
West Virginia	8,890	890	-90.0	1,054
Wisconsin	5,490	707	-87.1	180
Wyoming	491	122	-75.2	199
Territories	2,166	1,405	-35.1	[c]
American Samoa	733	229	-68.8	[c]
Commonwealth of Northern Mariana Islands	400	260	-35.0	[c]
Guam	260	220	-15.4	[c]
Puerto Rico	166	152	-8.4	[c]
Republic of Palau	607	544	-10.4	[c]
Tribes and tribal organizations	10,234	4,930	-51.8	319[c]
Arctic Slope Native Association Limited	280	256	-8.6	[c]
Cherokee Nation	1,576	1,021	-35.2	68[c]
Cheyenne River Sioux	503	439	-12.7	[c]
Hopi Tribe	213	50	-76.5	[c]
Kaw Nation	271	248	-8.5	[c]
Native American Rehabilitation Association of the Northwest	281	242	-13.9	[c]

Grantee category/grantee	Screened for cervical cancer, 2011[a]	Screened for cervical cancer, 2018[a]	Percentage change in people screened for cervical cancer, 2011 through 2018	Total diagnosed with cervical cancer, 2011 through 2017[b]
Navajo Nation	304	335	10.2	-[c]
Poarch Band of Creek Indians[e]	37	0	-100.0	0
South Puget Intertribal Planning Agency	396	141	-64.4	-[c]
Southcentral Foundation	3,701	1,229	-66.8	193[c]
Southeast Alaska Regional Health Consortium	1,555	794	-48.9	47[c]
Yukon-Kuskokwim Health Corporation	1,117	175	-84.3	11[c]

Source: GAO analysis of Centers for Disease Control and Prevention (CDC) data | GAO-21-35

Note: All numbers are unduplicated, meaning that people who received multiple cervical cancer screenings or diagnoses in a single year would be counted once. Because the diagnosis counts sum multiple years of data, individuals could be counted more than once if they received cervical cancer diagnoses in multiple years. Numbers include program participants of all ages, including those outside the target cervical cancer screening age range of 21 to 64. Data were not available for three grantees (two tribal organizations and one territory) that were new to the Early Detection Program in 2017: Great Plains Tribal Chairmen's Health Board, American Indian Cancer Foundation, and the Republic of the Marshall Islands.

[a]Screenings include all cervical cancer screening services (e.g., Pap test and human papilloma virus test).

[b]This table excludes 2018 diagnosis data because that data was only available through June 2018. Diagnoses include all diagnoses of cervical intraepithelial neoplasia 2 or worse, including cervical intraepithelial neoplasia 2, cervical intraepithelial neoplasia 3, carcinoma in situ, and invasive cancers.

[c]Individual grantee diagnosis counts do not add to the total due to privacy suppression; to protect patient confidentiality, CDC suppressed individual grantee diagnosis counts in years where the number of diagnoses was between 1 and 9, although those counts were included in "All grantees combined." Flagged counts are undercounts because they include one or more years in which the diagnosis count was suppressed. Grantee counts are noted as "-" when at least one count was suppressed and other counts were zero for all years from 2011 to 2017.

[d]Massachusetts was given CDC approval to suspend screening for 2016-2018 in order to redesign service delivery. In 2015, the state screened two people for cervical cancer.

[e]Funding for the Poarch Band of Creek Indians ended in 2012.

Table 4: Race/Ethnicity of People Screened for Breast Cancer by National Breast and Cervical Cancer Early Detection Program Grantees, 2011 and 2018

Grantee category/grantee	People screened for breast cancer[a]							
	White, non-Hispanic		Black, non-Hispanic		Hispanic		Other races, non-Hispanic[b]	
	2011	2018	2011	2018	2011	2018	2011	2018
All grantees combined	234,190	67,668	85,936	36,314	131,653	127,302	50,873	21,110
States and D.C.	233,611	67,073	85,923	36,291	131,418	126,990	38,531	12,434
Alabama	3,915	2,750	4,060	2,256	613	898	204	100
Alaska	4,154	1,881	319	145	715	389	1,026	490
Arizona	2,218	429	139	39	4,995	4,225	230	43
Arkansas	2,665	532	1,199	169	474	971	60	41
California	3,332	489	1,011	216	16,743	17,127	10,743	1,732
Colorado	7,576	1,003	973	194	5,359	1,970	961	202
Connecticut	2,760	468	1,295	399	3,871	2,033	247	69
Delaware	834	29	614	50	996	579	92	9
District of Columbia	20	23	260	96	312	393	31	18
Florida	5,662	5,663	3,299	3,269	4,260	5,411	439	438
Georgia	3,800	2,567	5,382	3,955	1,462	2,490	399	118
Hawaii	377	21	8	6	66	13	656	126
Idaho	2,811	858	10	1	587	258	94	52
Illinois	11,625	1,373	6,356	578	11,321	8,292	2,001	859
Indiana	3,746	501	979	193	1,121	1,597	145	48
Iowa	4,218	807	240	78	792	1,233	132	59
Kansas	3,193	1,164	728	254	2,490	1,956	350	129
Kentucky	12,106	1,690	2,081	207	1,199	1,893	249	105
Louisiana	3,969	1,103	7,520	1,221	808	536	337	39
Maine	4,480	2,170	17	34	60	25	104	83
Maryland	2,832	463	2,662	787	1,636	1,968	633	181
Massachusetts[c]	34	0	28	0	50	0	2	0
Michigan	16,276	1,971	6,952	734	1,730	1,877	925	97
Minnesota	7,430	1,196	1,043	430	2,748	3,370	1,081	554
Mississippi	2,052	980	4,144	2,128	199	198	91	49
Missouri	7,152	3,116	2,274	1,296	735	949	234	183
Montana	4,128	885	11	6	151	100	1,127	467
Nebraska	6,524	909	602	166	1,931	344	350	95
Nevada	1,121	164	224	47	5,402	5,269	225	56
New Hampshire	3,922	886	58	70	255	317	199	102

Grantee category/grantee	People screened for breast cancer[a]							
	White, non-Hispanic		Black, non-Hispanic		Hispanic		Other races, non-Hispanic[b]	
	2011	2018	2011	2018	2011	2018	2011	2018
New Jersey	2,627	863	1,530	545	4,260	3,630	676	444
New Mexico	1,918	207	85	10	8,000	3,771	2,987	305
New York	12,587	2,243	5,372	2,106	9,632	11,132	3,969	1,745
North Carolina	6,900	3,090	4,380	2,368	1,891	2,292	483	210
North Dakota	2,472	768	30	41	138	94	436	174
Ohio	11,272	2,172	3,552	513	440	740	384	123
Oklahoma	1,456	326	462	138	1,133	485	339	27
Oregon	4,872	429	100	26	2,205	2,870	699	110
Pennsylvania	2,858	3,183	1,521	1,869	599	3,190	428	799
Rhode Island	2,297	319	382	145	2,438	1,342	181	36
South Carolina	3,483	3,871	4,739	4,263	484	4,668	110	113
South Dakota	2,499	1,063	71	50	284	246	579	342
Tennessee	4,861	2,942	2,033	997	356	653	33	25
Texas	4,331	2,376	2,483	1,475	15,366	13,469	595	574
Utah	2,652	944	63	34	2,579	3,242	300	230
Vermont	690	163	14	6	8	1	29	10
Virginia	3,761	2,690	2,460	2,158	466	663	412	140
Washington	6,919	574	650	196	5,557	5,403	1,996	353
West Virginia	13,773	1,892	549	119	204	46	120	24
Wisconsin	5,822	688	955	206	2,201	2,332	337	75
Wyoming	629	179	4	2	96	40	71	31
Territories	22	12	1	0	167	264	2,363	1,676
American Samoa	16	3	0	0	1	0	826	378
Commonwealth of Northern Mariana Islands	0	1	0	0	2	1	545	290
Guam	5	7	1	0	4	1	483	351
Puerto Rico	0	1	0	0	159	261	0	0
Republic of Palau	1	0	0	0	1	1	509	657
Tribes and tribal organizations	557	583	12	23	68	48	9,979	7,000
Arctic Slope Native Association Limited	9	25	1	5	7	4	276	216
Cherokee Nation	0	0	0	0	1	1	1,899	1,363
Cheyenne River Sioux	49	83	0	0	0	2	504	697
Hopi Tribe	7	2	0	1	0	1	787	212
Kaw Nation	0	0	0	0	0	3	542	357

Grantee category/grantee	People screened for breast cancer[a]							
	White, non-Hispanic		Black, non-Hispanic		Hispanic		Other races, non-Hispanic[b]	
	2011	2018	2011	2018	2011	2018	2011	2018
Native American Rehabilitation Association of the Northwest	29	63	9	16	14	22	345	286
Navajo Nation	1	1	0	0	0	0	1,166	1,125
Poarch Band of Creek Indians[d]	0	0	0	0	0	0	33	0
South Puget Intertribal Planning Agency	71	61	0	0	14	8	636	330
Southcentral Foundation	56	9	0	0	3	3	1,527	1,458
Southeast Alaska Regional Health Consortium	320	337	1	1	25	4	1,361	773
Yukon-Kuskokwim Health Corporation	15	2	1	0	4	0	903	183

Source: GAO analysis of Centers for Disease Control and Prevention (CDC) data | GAO-21-35

Note: Numbers include program participants of all ages, including those outside the target breast cancer screening age range of 40 to 64. Data were not available for three grantees (two tribal organizations and one territory) that were new to the Early Detection Program in 2017: Great Plains Tribal Chairmen's Health Board, American Indian Cancer Foundation, and the Republic of the Marshall Islands.

[a]All numbers are unduplicated, meaning that people who received multiple breast cancer screenings in a single year would be counted once. Screenings include all breast cancer screening services (e.g., mammogram, clinical breast exam).

[b]Includes non-Hispanic people from the following racial groups: Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, and Multiracial. Also includes Asian/Pacific Islander, a legacy category from an earlier version of CDC's data collection. People whose race/ethnicity was marked unknown are excluded from this table; there were 5,540 people of unknown race/ethnicity screened for breast cancer in 2011 across all grantees, decreasing to 3,072 in 2018.

[c]Massachusetts was given CDC approval to suspend screening for 2016-2018 in order to redesign service delivery. In 2015, the state's screening numbers for breast cancer were eight (white, non-Hispanic), five (black, Non-Hispanic), 71 (Hispanic), and two (other races, non-Hispanic).

[d]Funding for the Poarch Band of Creek Indians ended in 2012.

Table 5: Race/Ethnicity of People Screened for Cervical Cancer by National Breast and Cervical Cancer Early Detection Program Grantees, 2011 and 2018

Grantee category/grantee	People screened for cervical cancer[a]							
	White, non-Hispanic		Black, non-Hispanic		Hispanic		Other races, non-Hispanic[b]	
	2011	2018	2011	2018	2011	2018	2011	2018
All grantees combined	127,763	30,226	38,639	12,960	76,855	65,488	35,351	11,159
States and D.C.	127,376	29,896	38,628	12,949	76,635	65,296	23,612	5,394
Alabama	1,424	1,510	1,233	1,062	264	633	77	67
Alaska	3,383	1,534	307	85	631	247	861	373
Arizona	1,004	194	56	24	2,207	1,916	111	18
Arkansas	1,165	1,156	505	650	312	2,060	30	73
California	2,421	337	479	107	11,103	12,437	7,675	841
Colorado	4,053	1,268	424	139	2,828	1,262	491	163
Connecticut	1,488	218	715	194	2,304	1,025	149	32
Delaware	565	26	399	28	1,050	626	53	4
District of Columbia	13	0	138	9	45	6	32	3
Florida	2,382	888	1,478	527	1,890	894	221	79
Georgia	1,847	548	2,357	868	823	522	198	30
Hawaii	248	14	6	3	48	5	470	68
Idaho	1,562	881	8	6	436	235	59	44
Illinois	5,720	410	2,411	162	5,491	1,895	1,256	374
Indiana	2,269	213	608	72	782	793	95	27
Iowa	2,067	254	104	27	503	443	65	25
Kansas	1,867	633	464	143	1,608	1,152	220	71
Kentucky	6,688	1,307	994	126	708	1,264	141	76
Louisiana	1,433	306	1,423	392	53	459	50	50
Maine	2,314	708	12	25	37	12	45	27
Maryland	1,845	194	1,527	344	1,178	959	435	82
Massachusetts[c]	16	0	7	0	12	0	2	0
Michigan	8,474	643	3,922	221	921	485	438	33
Minnesota	3,723	358	533	184	1,502	1,483	497	145
Mississippi	1,208	440	2,273	951	131	93	59	26
Missouri	2,323	1,069	718	307	340	363	83	75
Montana	2,242	538	7	6	86	70	413	119
Nebraska	3,988	240	367	28	930	61	226	24
Nevada	727	116	134	32	3,919	4,317	143	35
New Hampshire	2,481	458	35	48	160	187	126	63

Grantee category/grantee	People screened for cervical cancer[a]							
	White, non-Hispanic		Black, non-Hispanic		Hispanic		Other races, non-Hispanic[b]	
	2011	2018	2011	2018	2011	2018	2011	2018
New Jersey	2,473	687	1,366	387	4,851	3,762	629	357
New Mexico	1,126	150	44	10	5,044	2,272	1,797	127
New York	6,149	558	2,660	521	4,226	2,887	2,079	466
North Carolina	3,251	982	1,771	667	1,094	715	295	73
North Dakota	1,177	252	14	31	74	35	203	71
Ohio	7,599	1,226	1,703	180	290	345	228	45
Oklahoma	915	143	341	56	658	186	266	14
Oregon	3,409	229	68	22	1,633	1,523	557	66
Pennsylvania	1,770	1,644	415	637	191	1,692	107	274
Rhode Island	1,443	203	216	99	1,393	926	106	20
South Carolina	1,798	1,673	2,126	1,474	289	2,290	56	49
South Dakota	1,829	665	48	37	232	177	364	242
Tennessee	2,454	1,445	912	554	293	623	22	17
Texas	2,259	1,138	1,153	751	8,025	7,369	290	217
Utah	905	310	26	12	945	843	101	38
Vermont	435	56	6	0	7	2	16	3
Virginia	1,572	845	828	499	226	200	213	48
Washington	3,826	198	385	117	3,348	3,049	1,341	190
West Virginia	8,300	781	346	71	138	17	77	10
Wisconsin	3,339	167	556	51	1,309	451	128	15
Wyoming	407	83	0	3	67	28	16	5
Territories	16	7	0	0	170	153	1,969	1,224
American Samoa	11	1	0	0	1	1	718	227
Commonwealth of Northern Mariana Islands	1	0	0	0	1	0	392	244
Guam	2	4	0	0	2	0	255	211
Puerto Rico	0	1	0	0	165	151	0	0
Republic of Palau	2	1	0	0	1	1	604	542
Tribes and tribal organizations	371	323	11	11	50	39	9,770	4,541
Arctic Slope Native Association Limited	13	16	2	2	5	5	259	225
Cherokee Nation	0	0	0	0	0	0	1,576	1,021
Cheyenne River Sioux	1	2	0	0	0	0	502	437
Hopi Tribe	0	1	0	0	1	0	212	49
Kaw Nation	0	0	0	0	0	3	271	245

Grantee category/grantee	People screened for cervical cancer[a]							
	White, non-Hispanic		Black, non-Hispanic		Hispanic		Other races, non-Hispanic[b]	
	2011	2018	2011	2018	2011	2018	2011	2018
Native American Rehabilitation Association of the Northwest	21	40	7	8	10	16	240	176
Navajo Nation	0	0	0	0	0	0	292	335
Poarch Band of Creek Indians[d]	0	0	0	0	0	0	37	0
South Puget Intertribal Planning Agency	36	14	0	0	7	6	347	118
Southcentral Foundation	29	6	1	1	8	4	3,663	1,215
Southeast Alaska Regional Health Consortium	258	244	1	0	18	4	1,271	546
Yukon-Kuskokwim Health Corporation	13	0	0	0	1	1	1,100	174

Source: GAO analysis of Centers for Disease Control and Prevention (CDC) data | GAO-21-35

Note: Numbers include program participants of all ages, including those outside the target cervical cancer screening age range of 21 to 64. Data were not available for three grantees (two tribal organizations and one territory) that were new to the Early Detection Program in 2017: Great Plains Tribal Chairmen's Health Board, American Indian Cancer Foundation, and the Republic of the Marshall Islands.

[a]All numbers are unduplicated, meaning that people who received multiple cervical cancer screenings in a single year would be counted once. Screenings include all cervical cancer screening services (e.g., Pap test and human papilloma virus test).

[b]Includes non-Hispanic people from the following racial groups: Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, and Multiracial. Also includes Asian/Pacific Islander, a legacy category from an earlier version of CDC's data collection. People whose race/ethnicity was marked unknown are excluded from this table; there were 3,050 people of unknown race/ethnicity screened for cervical cancer in 2011 across all grantees, decreasing to 1,482 in 2018.

[c]Massachusetts was given CDC approval to suspend screening for 2016-2018 in order to redesign service delivery. In 2015, the state screened two Hispanic people for cervical cancer and did not screen anyone of other races/ethnicities.

[d]Funding for the Poarch Band of Creek Indians ended in 2012.

Appendix II: Medicaid Breast and Cervical Cancer Prevention and Treatment Act Enrollment

Table 6: Total Number of People Enrolled in Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act, 2016 and 2019

State	Total enrolled, 2016[a]	Total enrolled, 2019[a]	Percentage change in enrollment, 2016 through 2019	Medicaid expansion status, 2019[b]
All states and D.C.	50,219	43,549	-13.3	-
Alabama	1,326	1,504	13.4	Non-expansion
Alaska	88	47	-46.6	Expansion
Arizona	326	240	-26.4	Expansion
Arkansas[c]	0	0	-	Expansion
California	7,903	5,359	-32.2	Expansion
Colorado	252	237	-6.0	Expansion
Connecticut	504	329	-34.7	Expansion
Delaware	43	20	-53.5	Expansion
District of Columbia	10	6	-40.0	Expansion
Florida	1,025	1,047	2.1	Non-expansion
Georgia	3,924	2,880	-26.6	Non-expansion
Hawaii	15	6	-60.0	Expansion
Idaho	342	351	2.6	Non-expansion
Illinois	1,441	104	-92.8	Expansion
Indiana	931	929	-0.2	Expansion
Iowa	197	192	-2.5	Expansion
Kansas	347	351	1.2	Non-expansion
Kentucky	61	44	-27.9	Expansion
Louisiana	1,375	553	-59.8	Expansion
Maine	250	231	-7.6	Expansion
Maryland[c]	201	103	-48.8	Expansion
Massachusetts	3,981	4,088	2.7	Expansion
Michigan	1,124	1,048	-6.8	Expansion
Minnesota	330	292	-11.5	Expansion
Mississippi	224	233	4.0	Non-expansion
Missouri	2,255	2,636	16.9	Non-expansion
Montana	105	72	-31.4	Expansion
Nebraska	166	181	9.0	Non-expansion
Nevada	210	163	-22.4	Expansion
New Hampshire	159	179	12.6	Expansion
New Jersey	637	420	-34.1	Expansion
New Mexico	287	152	-47.0	Expansion

State	Total enrolled, 2016[a]	Total enrolled, 2019[a]	Percentage change in enrollment, 2016 through 2019	Medicaid expansion status, 2019[b]
New York	1,149	979	-14.8	Expansion
North Carolina	10	20	100.0	Non-expansion
North Dakota	18	9	-50.0	Expansion
Ohio	735	388	-47.2	Expansion
Oklahoma	852	778	-8.7	Non-expansion
Oregon	439	250	-43.1	Expansion
Pennsylvania	1,576	1,347	-14.5	Expansion
Rhode Island	156	104	-33.3	Expansion
South Carolina	1,610	1,438	-10.7	Non-expansion
South Dakota	118	96	-18.6	Non-expansion
Tennessee	3,492[d]	4,683	34.1	Non-expansion
Texas	6,475	6,428	-0.7	Non-expansion
Utah	355	263	-25.9	Non-expansion
Vermont	72	52	-27.8	Expansion
Virginia	1,403	1,104	-21.3	Expansion
Washington	452	494	9.3	Expansion
West Virginia	394	407	3.3	Expansion
Wisconsin	769	634	-17.6	Non-expansion
Wyoming	105	78	-25.7	Non-expansion

Source: GAO analysis of Transformed Medicaid Statistical Information System Analytic File from the Centers for Medicare and Medicaid Services (CMS) | GAO-21-35

Note: Data were accessed on September 2, 2020. We analyzed the Medicaid enrollment data as they were reported by states to CMS. We did not otherwise independently verify the accuracy or completeness of the Medicaid enrollment information with the states.

[a]Number of people enrolled in Medicaid through the "Certain Individuals Needing Treatment for Breast or Cervical Cancer" eligibility group during at least one month of the year.

[b]We used Medicaid expansion status information available on the Kaiser Family Foundation's website, which tracks the date when each state's expansion went into effect. These data are current as of February 19, 2020. Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision, July 1, 2020," accessed July 22, 2020, https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. For purposes of this analysis, states were only counted as expansion states if expansion occurred during or before 2019.

[c]Arkansas and Maryland both opted to discontinue offering Medicaid coverage under the Breast and Cervical Cancer Prevention and Treatment Act in 2014. Maryland officials explained that people enrolled prior to December 31, 2013, and actively in treatment are allowed to continue treatment to completion.

[d]CMS data we analyzed for 2016 in Tennessee are based on a different data field than the other states and years due to data reliability concerns with the reported number of individuals enrolled in Medicaid under the Treatment Act.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Karin Wallestad (Assistant Director), Sarah-Lynn McGrath (Analyst-in-Charge), Isabella Guyott, and Julianne Flowers made key contributions to this report. Also contributing to this report were Kristen Anderson, Laurie Pachter, Vikki Porter, and Jennifer Whitworth.