Division of Public Health
Agreement Addendum
FY 25-26

Durham County Department of Public Health **Local Health Department Legal Name**	Chronic Disease and Injury Section/ Cancer Prevention and Control Branch **DPH Section / Branch Name**
452 Breast and Cervical Cancer **Activity Number and Description**	Lisa Brown, 919-707-5326 Lisa.M.Brown@dhhs.nc.gov **DPH Program Contact** (name, phone number, and email)
06/01/2025 – 05/31/2026 **Service Period**	**DPH Program Signature** **Date** (only required for a negotiable Agreement Addendum)
07/01/2025 – 06/30/2026 **Payment Period**	

☒ Original Agreement Addendum
☐ Agreement Addendum Revision # ___

I. Background:

In the United States, breast cancer is the most commonly diagnosed cancer in women. It is the leading cause of cancer death in Hispanic women and the second most common cause of cancer death among white, black, Asian/Pacific Island, and American Indian/Alaska Native women.[1] In 2021, the U.S. incidence of breast cancer was 129.4 per 100,000 women and the mortality was 19.3 per 100,000 women.[2] In 2024, an estimated 310,720 new cases of invasive breast cancer are expected to be diagnosed among U.S. women, as well as an estimated 56,500 additional cases of in situ breast cancer. In 2024, approximately 42,250 U.S. women are expected to die from breast cancer. Only lung cancer accounts for more cancer deaths.[3] In North Carolina, an estimated 12,724 new female breast cancer cases (in-situ cases included) will be diagnosed in 2024, resulting in 1,544 deaths.[4]

Cervical cancer, once the leading cause of death for women in the U.S., has significantly decreased in incidence and mortality since the mid-1970s due to an increase in Pap tests being conducted. Between 2016 and 2020, the incidence of cervical cancer was 7.7 per 100,000 women[5] While cervical cancer incidence and mortality continue to decrease, both are considerably higher among Hispanic and non-Hispanic Black women. In 2024, an estimated 13,820 new cases are expected to be diagnosed, with an

[1] U.S. Cancer Statistics Working Group, U.S. Cancer Statistics Data Visualization Tools, 2024
[2] National Cancer Institute SEER Stat Fact Sheets, Female Breast Cancer, 2024, https://seer.cancer.gov/statistics
[3] American Cancer Society Cancer Facts and Figures, 2024
[4] N.C. State Center for Health Statistics, 2024
[5] American Cancer Society Cancer Facts and Figures, 2024

DocuSigned by:
Rodney Jenkins
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Health Director Signature (use blue ink or verifiable digital signature)

2/27/2025 | 5:30 PM EST
Date

LHD to complete: [For DPH to contact in case follow-up information is needed.]	LHD program contact name:	Malkia Rayner
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Signature on this page signifies you have read and accepted all pages of this document. Template rev. Dec2024

estimated 4,360 women expected to die from cervical cancer.[6] In North Carolina, an estimated 418 cervical cancer cases will be diagnosed in 2024 resulting in 137 deaths.[7]

The most recent available data shows 130,352 uninsured women are eligible for breast cancer screening and diagnostic follow-up and 261,417 uninsured women are eligible for cervical cancer screening and diagnostic follow-up in North Carolina.[8]

The North Carolina Breast and Cervical Cancer Control Program (NC BCCCP) began in North Carolina in 1992 and continues to provide services to underserved North Carolina women. Funding is received through a competitive grant from the Centers for Disease Control and Prevention (CDC). This program was the first chronic disease screening program funded in the United States.

The NC BCCCP is a screening program and does not provide funds for treatment. However, patients enrolled in NC BCCCP and provided with at least one screening and/or diagnostic service prior to diagnosis may be eligible to receive Breast and Cervical Cancer Medicaid (BCCM) to cover acute treatment services for breast and cervical cancers and eligible precancerous breast and cervical findings and for reconstruction surgeries. Additionally, patients who are diagnosed outside of NC BCCCP with breast and/or cervical cancer and/or precancerous lesions and who meet NC BCCCP and NCDHHS Department of Health Benefits eligibility may receive assistance to apply for BCCM by a local NC BCCCP provider.

II. Purpose:

The goal of NC BCCCP is to reduce the morbidity and mortality due to breast and cervical cancers in individuals by providing breast and cervical cancer screening services, diagnostic services, and patient navigation services for eligible underserved individuals of North Carolina.

III. Scope of Work and Deliverables:

1. **Provided Services**. The Local Health Department (LHD) shall provide breast and cervical cancer screening services and/or diagnostic services, and patient navigation-only (PN only) services to NC BCCCP-enrolled patients according to the following two tables:

Breast and Cervical Cancer Screening and/or Diagnostic Services Provided	Number of NC BCCCP-Enrolled Patients		
Service Period	State-Funded	Federally Funded	Total
June 1, 2025–May 31, 2026	30	0	30
July 1, 2025–May 31, 2026	0	25	25
Total	30	25	55

Patient Navigation Only Services-Medicaid Application Completion	Number of NC BCCCP-Enrolled Patients		
Service Period	State-Funded	Federally Funded	Total
June 1, 2025–May 31, 2026	2	—	2
Total	2	—	2

[6] American Cancer Society Cancer Facts and Figures, 2024
[7] N.C. State Center for Health Statistics, 2024
[8] SAHIIE 2021

2. Priority Populations

a. The priority population for **NC BCCCP mammography services** is individuals who are low-income (<250% of federal poverty level), who have not been screened in the past year and are between the ages of 40 and 64.

b. The priority population for **NC BCCCP cervical cancer screening services** is individuals who are low-income (<250% of federal poverty level), who have never or rarely ever (>10 years) been screened and are between the ages of 21 and 64.

c. The priority population for **NC BCCCP services** is individuals who are defined as disproportionately burdened populations. While all segments of society are affected by cancer, there are certain populations that are disproportionately burdened by the increased risk of cancer or by a lack of adequate healthcare options for prevention and/or treatment. Special emphasis is placed on outreach efforts to achieve health equity by recruiting individuals disproportionately affected by cancer, including individuals of ethnic minorities.

Disproportionately burdened populations may be defined by sex, race, ethnicity, disability, sexual orientation, gender identity, geographic location, or socioeconomic status. Among the populations that will benefit from this program are those living in rural and frontier geographic areas; culturally isolated individuals; incarcerated or institutionalized individuals; medically underserved individuals; individuals from minorities defined by race, religion, ethnicity, or culture, including African American, Alaska Native, American Indian, Asian American, Pacific Island, and Hispanic; lesbian, gay, bisexual, or transgender individuals; individuals with low literacy, non-English speaking language barriers; and individuals with disabilities.

3. Eligible Populations

a. Individuals who have income below 250% of the federal poverty level, according to the Federal Poverty Guidelines, and who are uninsured or underinsured, may be eligible for breast and cervical services, subject to limitations and exceptions listed below.
    1. Patients enrolled in Medicare (Part B) and/or Medicaid programs <u>are not eligible</u> for NC BCCCP-funded services.
    2. Patients receiving Family Planning (Title X of the Public Health Service Act) services <u>are not eligible</u> for NC BCCCP-funded services that are available through Title X funding.

b. Documented citizenship is not required for screening and/or diagnostic services through NC BCCCP.

c. Breast Services
    1. Symptomatic patients under the age of 40.
    NC BCCCP funds can be used to reimburse for diagnostic services for symptomatic patients under the age of 40. For abnormal findings (including a discrete palpable mass, nipple discharge, and skin or nipple changes), a patient can be provided a diagnostic work-up including a referral for a surgical consultation.
    2. Asymptomatic patients ages 40 to 64

    NC BCCCP funds may be used to reimburse for screening mammograms for patients ages 40 to 64.
    3. Asymptomatic patients under the age of 40
    NC BCCCP funds can be used to screen asymptomatic patients under the age of 40 if they are at high risk for developing breast cancer (as defined under this Section III: Scope of Work and Deliverables, Paragraph 4: Clinical Protocols, Subparagraph C.4).

4. Asymptomatic or symptomatic patients above age 64

   NC BCCCP funds may be used to reimburse for screening mammograms for patients greater than 64 years of age if no other source of funding is available. NC BCCCP funds may be used for symptomatic patients in this population.

5. All patients should undergo a risk assessment to determine if they are at high risk for developing breast cancer.

d. Cervical Services. At least 35% of all enrolled patients screened for cervical cancer shall meet the definition of never or rarely ever (>10 years) screened. The priority age for cervical cancer screening is patients between the ages of 21 and 64. All patients should undergo a risk assessment to determine if they are at high risk for developing cervical cancer.

e. Patients may receive Patient Navigation-only services (to apply for BCCM) by a NC BCCCP provider if **both** of the following conditions are met:
   1. Have been diagnosed outside of NC BCCCP with one or more of the following:
      a. Breast cancer
      b. Cervical cancer
      c. Breast precancerous lesions
      d. Cervical precancerous lesions
   2. Meets the NC BCCCP eligibility criteria.

4. Clinical Protocols

a. Standing Orders. All standing orders or protocols developed for nurses in support of this program must be written in the North Carolina Division of Public Health (NC DPH) Public Health Nursing Professional Development Unit (PHNPDU) format. The LHD shall have a policy in place that supports nurses working under standing orders.

b. Breast Screening
   1. Protocols for breast screening and follow-up shall be in accordance with the *Breast Screening Manual: A Guide for Health Departments and Providers* (DHHS, 2022).[9].
   2. Protocols for mammography facilities and follow-up shall be in accordance with the Federal Food and Drug Administration (FDA) regulations. When contracting with any mammography facility, the LHD shall assure that the facility is accredited under the Mammography Quality Standards Act (MQSA) regulations. (*See Breast Screening Manual: A Guide for Health Departments and Providers*, DHHS, 2022.)
   3. All eligible patients shall receive breast cancer screening services based on the guidelines under this Section III: Scope of Work and Deliverables, Paragraph 3: Eligible Populations. The vertical strip method for CBE services is endorsed.
   4. All patients enrolled in NC BCCCP should undergo a risk assessment to determine if they are at high risk for developing breast cancer. NC BCCCP funds can be used for annual breast cancer screening among patients who are considered high risk for developing breast cancer. Patients at high risk includes those who have a known genetic mutation such as BRCA 1 or 2, first-degree relatives with premenopausal breast cancer or known genetic mutations, a history of radiation treatment to the chest area before age 30 (typically for Hodgkin's lymphoma), or a lifetime risk of 20% or more for development of breast cancer based on risk assessment models that are largely dependent on family history. These patients should be screened with both an annual mammogram and an annual breast MRI.

c. Cervical Screening

[9] https://bcccp.dph.ncdhhs.gov/providers.htm

1. Protocols for cervical cancer screening and follow-up shall be in accordance with *The Cervical Screening Manual: A Guide for Health Departments and Providers* (DHHS, December 2020).[10]
2. Laboratories processing cervical cytology and HPV testing samples must be certified under the most recent version of Clinical Laboratory Improvement Amendments. The latest version of the Bethesda System is required for reporting the results of cervical cytology. (See the *Cervical Screening Manual: A Guide for Health Departments and Providers*. DHHS, 2020).
3. For patients under age 30 with no abnormal findings, the screening interval for cervical cytology is every three years. For patients ages 30 to 65, the patient may opt for testing with cervical cytology alone every three years, co-testing with cervical cytology and hrHPV testing every five years, or primary hrHPV testing alone every five years.
4. All patients enrolled in NC BCCCP should undergo a risk assessment to determine if they are at high risk for developing cervical cancer. Patients who are at high risk for cervical cancer need to be screened more frequently than average-risk patients. NC BCCCP funds can be used for annual screening among patients who are considered high risk for cervical cancer. This includes patients with HIV infection, who have had an organ transplantation, who may be immunocompromised from another health condition, or who had diethylstilbestrol (DES) exposure in utero.
5. NC BCCCP funds <u>cannot</u> be used for cervical cancer screening in patients with total hysterectomies (i.e., those without a cervix), unless the hysterectomy was performed because of cervical neoplasia or invasive cervical cancer, or if it was not possible to document the absence of neoplasia or reason for the hysterectomy. (A one-time pelvic exam is permitted to determine if a patient has a cervix.)
6. Patients who have had a total hysterectomy for cervical intraepithelial neoplasia (CIN) disease should undergo cervical cancer screening for 20 years post hysterectomy, even if it goes past the age of 65.
7. Patients who have had cervical cancer should continue screening indefinitely as long as they are in reasonable health.
8. Patients who have had a supracervical hysterectomy remain eligible for cervical cancer screening.
9. A pelvic exam should not be performed using NC BCCCP funds in the absence of a cervical cancer screening, with the exception of determining if a patient has a cervix (as outlined above in Subparagraph 5).

d. Clinical Records
   1. The LHD shall maintain clinical records for each patient receiving NC BCCCP services as a part of the patient's individual medical record.
   2. The LHD shall audit a random sample of at least five NC BCCCP patient records at least once annually to check for compliance with program requirements.

e. Tobacco Screening and Cessation. The LHD is required to assess the tobacco use status of every patient screened by NC BCCCP and refer those who use tobacco to a tobacco cessation program such as QuitlineNC or document the patient's declination of referral. (See *NC BCCCP Tobacco Use Assessment Policy*, effective July 1, 2024).

f. Colorectal Cancer Screening Status. The LHD shall assess each patient aged 45 and above for colorectal cancer screening status. (See *NC BCCCP Colorectal Cancer Screening Information and Assessment Policy*, effective May 29, 2015, revised January 12, 2024.)

[10] https://bcccp.dph.ncdhhs.gov/providers.htm

g. Insurance Status. The LHD shall assess all patients seeking to be enrolled in NC BCCCP for insurance status at each visit. Uninsured patients must be referred to available insurance options, such as the Health Insurance Marketplace (i.e., HealthCare.gov). If the patient's visit does not coincide with open enrollment, the patient must be provided information about how to enroll at the next opportunity. (See *NC BCCCP ACA Referral Policy*, effective June 29, 2015, revised January 12, 2024.)

h. Follow-up Services

1. When follow-up services are required, NC BCCCP funds are to be used to pay for or provide the diagnostic services listed on the most current NC BCCCP Services Fee Schedule up to a maximum of $2,000 per patient. (All fee schedules[11] were sent by the DPH Program Contact via email in January 2025 to the LHD NC BCCCP navigators. The NC BCCCP Services Fee Schedule is updated annually each January.) The LHD must hold sufficient NC BCCCP funds to complete the screening, follow-up, and/or diagnostic services for each patient served. (See *NC BCCCP Diagnostic Cap Policy*, effective February 1, 2016, revised January 12, 2024.)
2. The LHD shall assure that a referral system for the diagnosis and treatment of all abnormal findings is in place. The LHD shall designate a primary person who shall be responsible for implementing a protocol that ensures all patients receive follow-up services or medical treatment when required. Cross-training is strongly encouraged. Follow-up of abnormal screening results must be completed within 60 days of the patient's screening visit for breast cancer screening and/or cervical cancer screening.
3. Patients having an abnormal breast or cervical cancer screening result shall be referred for assessment of the following findings:
    a. Clinical breast exam results of discrete palpable mass, serous or bloody nipple discharge, nipple or areolar scaliness, or skin dimpling or retraction.
    b. Mammogram result of Category IV (suspicious abnormality, biopsy should be considered) or Category V (highly suggestive of malignancy).
    c. Cervical cytology result of low-grade squamous intraepithelial lesion (LSIL), atypical squamous cells of undetermined significance (ASC-US) with positive Human Papillomavirus (HPV), atypical squamous cells - cannot exclude high-grade lesions (ASC-H), high-grade squamous intraepithelial lesion (HSIL), squamous cell carcinoma (SCC), abnormal glandular cells (AGC) including atypical glandular cells of undetermined significance (AGUS) or adenocarcinoma.
4. At least three attempts must be made to locate and inform the patient of **abnormal screening results**. The last attempt must be made by certified letter. Written documentation of all attempts to inform the patient must be included in the patient's medical record.
5. For all abnormal mammograms, clinical breast examinations, and cervical cancer screening results, the following information shall be documented in the patient's medical record:
    a. Patient contact information (number and date of attempts made to follow up).
    b. Follow-up appointment information (date, follow-up provider, and follow-up location).
    c. Date the referral was made.
    d. Results of all referrals, including the report from the follow-up provider.

[11] Fee schedules can be found at https://bcccp.dph.ncdhhs.gov/providers.htm.

i. Patient Navigation. Patient Navigation (PN) is defined as "individualized assistance provided to patients to help overcome barriers and facilitate timely access to quality screening and diagnostic services, as well as initiation of timely treatment for those diagnosed with cancer."[12]

1. The LHD shall establish services to assist patients eligible for NC BCCCP-paid clinical services in overcoming barriers to complete screening services, diagnostic services, and/or the initiation of cancer treatment.
2. Patient Navigation shall be provided for each patient enrolled and served by NC BCCCP and must include the following activities:
    a. Assessment of individual patient barriers to cancer screening, diagnostic services, and/or initiation of cancer treatment.
    b. Patient education and support.
    c. Resolution (to the extent possible) of identified patient barriers (e.g., transportation, translation services).
    d. Patient tracking and follow-up to monitor the patient's progress in completing screening, diagnostic testing, and/or the initiation of cancer treatment.
    e. A minimum of two (but preferably more) contacts with the patient due to the centrality of the patient-navigator relationship.
    f. Collection of data and reporting to NC BCCCP to evaluate the primary outcomes of cancer screening and/or diagnostic testing, final diagnosis, and treatment initiation (as required).
3. The LHD shall establish services to support low-income patients (the priority population) but who have other payment sources (e.g., Medicaid) for screening in overcoming barriers to complete screening services, diagnostic services, and/or the initiation of cancer treatment.
    a. Assessment of individual patient barriers to cancer screening, diagnostic services, and/or the initiation of cancer treatment.
    b. Patient education and support.
    c. Resolution (to the extent possible) of identified patient barriers (e.g., transportation, translation services).
4. The LHD may assist eligible patients with a breast cancer or cervical cancer diagnosis with applying for BCCM. Providers are not required to provide a screening or diagnostic work-up for patients to be eligible to apply for BCCM. (See *NC BCCCP Patient Navigation Policy*, effective May 4, 2015, revised July 26, 2024.)

5. Recruitment Outreach, and Professional Development

a. Recruitment and Outreach

1. To enhance internal LHD referrals to NC BCCCP, the LHD shall provide in-reach activities. These activities are to ensure that staff in all LHD clinics are aware of NC BCCCP eligibility guidelines and know how to refer a potentially eligible patient to the appropriate contact person.
2. The LHD shall conduct appropriate evidence-based interventions, recruitment, and outreach strategies to reach patients who have never been screened for breast and/or cervical cancer as well as populations who are most at risk.
3. The LHD shall return all recruitment data and surveys by the required deadline as requested by the NC BCCCP Program Staff.

b. Professional Development

[12] CDC, NBCCEDP, DP22-2202 Program Manual: Part I, 2022

1. The LHD shall participate in educational opportunities provided by or recommended by NC BCCCP, as appropriate. All newly hired LHD NC BCCCP staff must contact their nurse consultant within two months of their hire date to arrange necessary trainings based on their NC BCCCP role.
2. The LHD's NC BCCCP staff must attend:
    a. Scheduled statewide conference calls, as indicated.
    b. At least one of the NC BCCCP training sessions (in person or virtual) offered twice a year. Newly hired staff must attend the first biannual NC BCCCP training following the date of hire.
3. All LHD staff who need access to the data system are required to attend a data training session prior to receiving access to the data system. The LHD will contact the NC BCCCP Data Manager to schedule the required data training.
4. All registered nurses without advanced practice certification who perform clinical examinations for the NC BCCCP must enroll in and complete the Physical Assessment of Adults Course. This course is conducted by the University of North Carolina Gillings School of Global Public Health and is co-sponsored by the NC DPH. Evidence of the satisfactory completion of a comparable course of study may be substituted for this requirement with the approval of the PHNPDU. Proof of this certification must be on file with the LHD. [See NC BCCCP Enhanced Role Registered Nurse (ERRN) Policy, effective July 17, 2020, revised July 18, 2024.] Policies and procedures must be in place for assuring the competency of nurses and the documentation of competency for each nurse performing the clinical examinations. (See *North Carolina Nurse Practice Act.*[13])
5. All staff performing clinical breast examinations (CBEs) are encouraged to use the vertical strip method. Training is available through Mammacare.com.

6. Performance Standards

a. The LHD shall maintain clinical records for each patient receiving NC BCCCP services as part of the patient's individual medical record.
b. The LHD shall conduct internal monitoring by auditing a random sample of at least five NC BCCCP patient records at least once annually to check for compliance with program requirements.
c. The LHD shall notify NC BCCCP staff of any LHD NC BCCCP staff changes (including the Health Director, Nursing Director/Supervisor, NC BCCCP Navigator, Health Educator, or Financial Contact). NC BCCCP is to be advised of the name and contact information of that person within one month of hire using the *Staff Change Notification Form*.[14]

IV. <u>Performance Measures / Reporting Requirements</u>:

1. Performance Measures - Indicators and Benchmarks

Indicator Type	Program Performance Indicator	CDC Minimum Standard
Screening Goal	Total number of patients served	100%
Budget Expenditures	Reimbursement requested for each patient served and equals amount of allocated funds awarded	100%

[13] https://www.ncleg.net/enactedlegislation/statutes/ html/byarticle/chapter_90/article_9a.html
[14] https://bcccp.dph.ncdhhs.gov/linksandresources/Manuals/Section10-Forms/1001-Staff-Change-Notification-Form.pdf

Indicator Type	Program Performance Indicator	CDC Minimum Standard
Breast Cancer Screening Performance Indicators	Abnormal screening results with complete follow-up.	≥90%
	Abnormal screening results: Time from screening to diagnosis ≥60 days.	≤25%
	Treatment started for breast cancer.	≥90%
	Breast cancer: Time from diagnosis to treatment ≥60 days.	≤20%
Cervical Cancer Screening Performance Indicators	Initial screening: Patients ages 30 years and older who have never or rarely ever (greater than 10 years) been screened.	≥35%
	Abnormal screening results with complete diagnostic work-up.	≥90%
	Time from abnormal screening results to diagnosis ≥60 days.	≤25%
	Treatment started - HSIL, CIN2, CIN3/CIS, invasive carcinoma.	≥90%
	Time from diagnosis to treatment ≥60 days.	≤20%

2. **Reporting Requirements - Screening Data**
   All NC BCCCP data, including initial screening or diagnostic service, follow-up of abnormal results, and treatment disposition shall be recorded by the LHD in a data system and that NC BCCCP data shall be transferred to the State data system as follows:
   a. All screening data for each month shall be entered and transferred by the 10th of the following month.
   b. All test results, including follow-up, diagnosis, and treatment, shall be updated as soon as received according to these NC BCCCP timelines:
      1. Diagnostic disposition must be entered within 60 days of the breast and/or cervical screening date.
      2. Treatment disposition must be entered within 60 days of the diagnostic disposition date for breast cancer, cervical cancer, HSIL, CIN2,3, or CIS of the cervix.
   c. The LHD shall never withhold inputting data on any patient. The LHD shall not wait for the completion of follow-up to enter data, even if there are abnormal findings that require follow-up.
   d. The LHD shall provide the required screening and patient navigation data for Patient Navigation-only services for BCCM by completing the PN-only Data Reporting form for each patient who receives PN-only services to apply for BCCM and by submitting the completed form via fax to the NC BCCCP office at 919-870-4812. This form must be submitted to NC BCCCP before the LHD requests reimbursement for providing PN-only services to assist with BCCM application based on the Aid-to-Counties schedule for calendar year 2025.
   e. The LHD shall let NC BCCCP know when staff members no longer need access to the data system within 48 hours of the staff members leaving their position. This will ensure NC BCCCP can remove their access from the data system in a timely manner.
3. **Reporting Requirements – Smartsheet: Performance and Financial Data**
   The LHD shall complete the following reports via the Smartsheet dashboard.[15] All of the due dates for these reports are posted on the Smartsheet dashboard.
   a. **Monthly Financial Reports:** These monthly financial reports will report on activity from the prior month using the FY 25-26 LHD Monthly Expenditure Report (MER) form. The first financial report is for June 2025 and is due July 10, 2025.

[15] https://app.smartsheet.com/b/publish?EQBCT=82018408e7b44ef9b44e113b6e536ffb

LHDs must complete and submit the MER via Smartsheet before funds can be drawn down from ATC. Electronic attestation will be used in Smartsheet. The current iteration of the LHD MER form, available on the Smartsheet dashboard for Activity 452 Breast and Cervical Cancer, must be used by the LHD for its monthly submissions.

b. **Quarterly Performance Reports:** These quarterly performance reports will detail the prior quarter's progress. The first quarterly report will report the LHD's NC BCCCP activity in June, July, and August 2025 and is due by September 15, 2025. The quarterly periods and due dates for these reports are as follows:

Quarterly Periods	Due Dates
June – August 2025	September 15, 2025
September – November 2025	December 15, 2025
December 2025 – February 2026	March 15, 2026
March – May 2026	June 15, 2026

4. **Reporting Requirements – Process and Outcome Evaluation**
The NC BCCCP Evaluator will send NC BCCCP evaluation requests to the LHD during the service period of this Agreement Addendum. Each evaluation request will include a written due date which will provide at least two weeks' notice. The LHD will provide each required report to the DPH Program Contact by the due date given. These reports are to include completing evaluations, surveys, focus groups, interviews, and utilize other data collection methods as outlined in the CDC and NC BCCCP Evaluation Plans.

5. **Reporting Required Subcontract Information**
In accordance with revised NCDHHS guidelines effective October 1, 2024, the LHD must provide the information listed below for every subcontract receiving funding from the LHD to carry out any or all of this Agreement Addendum's work.

This information is not to be returned with the signed Agreement Addendum (AA) but is to be provided to DPH when the entities are known by the LHD.

a. Subcontracts are contracts or agreements issued by the LHD to a vendor ("Subcontractor") or a pass-through entity ("Subrecipient").
    1. Subcontractors are vendors hired by the LHD via a contract to provide a good or service required by the LHD to perform or accomplish specific work outlined in the executed AA. For example, if the LHD needed to build a data system to satisfy an AA's reporting requirements, the vendor hired by the LHD to build the data system would be a Subcontractor. (However, not all Vendors are considered Subcontractors. Entities performing general administrative services for the LHD (e.g., certified professional accountants) are not considered Subcontractors.)
    2. Subrecipients of the LHD are those that receive DPH pass-through funding from the LHD via a contract or agreement for them to carry out all or a portion of the programmatic responsibilities outlined in the executed AA. (Subrecipients are also referred to as Subgrantees in NCAC.)

The following information must be provided to the DPH Program Contact listed on Page 1 of this AA for review prior to the entity being awarded a contract or agreement from the LHD:

The following information must be submitted via Smartsheet for review prior to the entity being awarded a contract or agreement from the LHD:

- Organization or Individual's Name (if an individual, include the person's title)
- EIN or Tax ID
- Street Address or PO Box
- City, State and ZIP Code

- Contact Name
- Contact Email
- Contact Telephone
- Fiscal Year End Date (of the entity)
- State whether the entity is functioning as a pass-through entity Subcontractor or Subrecipient of the LHD.

V. Performance Monitoring and Quality Assurance:

1. NC BCCCP staff shall monitor the LHD's performance by:
   a. Reviewing the LHD-HSA data monthly to determine whether the LHD is on track to provide services in accordance with the number of NC BCCCP-enrolled patients specified in Section III, Paragraph 1.
   b. Reviewing the LHD's Program Performance Indicators in the program data system monthly.
      1. Technical assistance is provided, as needed.
      2. If the LHD is not meeting monthly performance indicators at the time of the mid-year performance evaluation, NC BCCCP staff will notify the LHD that it has been placed on "high-risk status." (See Paragraph 2: LHD Risk Assessment [below] for information about high-risk status.)
   c. Providing progress reports to the LHD to report performance and identify individual cases requiring follow-up or correction by the LHD. All patients with abnormal findings or data errors are to remain listed on the monthly provider progress reports for two program years, or until follow-ups are completed or errors are corrected, whichever is earlier.
   d. Providing the LHD with more frequent technical assistance if there are indications of problems meeting performance requirements or if requested by the LHD.
   e. Conducting a site visit to verify and document timeliness and adequacy of follow-up, quality of services, efficiency of operations, and compliance with program requirements. The monitoring visit will be conducted on-site at the LHD, if possible. If travel to the LHD site is not possible, a remote monitoring visit would then be conducted. NC BCCCP staff will provide the LHD with advance notice of the date and time of the monitoring visit.

2. LHD Risk Assessment
   a. NC BCCCP will have conducted a risk assessment of the LHD prior to the release of this Agreement Addendum and will have determined the LHD's risk category as either low risk or high risk. An LHD categorized as high risk will be notified of such via letter that includes a specific date for the LHD's Corrective Action Plan (CAP) to be completed and details about NC BCCCP's monitoring plan.
   b. NC BCCCP will reassess the LHD's risk category at least annually, and more often if irregularities are noted. The frequency and intensity of monitoring techniques applied are directly proportional to the level of risk assigned.
      1. An LHD categorized as low risk will receive a detailed monitoring visit at least once every three years.
      2. An LHD categorized as high risk will receive a detailed monitoring site visit at least annually.

3. Consequences of Inadequate Performance

a. Failure to meet allocated number of patients served, expend funds, submit data, and other required reporting may result in reduced current and/or future allocations.

b. Failure to submit data monthly with corrections to the previous error report could result in the LHD being deemed as out of compliance. If the LHD is deemed out of compliance, NC BCCCP will provide technical assistance and the LHD shall be requested to cease drawing down funds in ATC until the LHD is back in compliance with deliverables. If technical assistance does not prove beneficial, the agreement may be terminated.

c. If monthly or triennial monitoring uncovers deficits, NC BCCCP staff will work with the LHD to correct those deficits.
    1. Ongoing deficits will require development and implementation of a CAP.
    2. Persistent failure to meet program requirements will result in termination of the Agreement Addendum.

d. If the LHD terminates or is terminated from the NC BCCCP, the following procedures shall be followed:
    1. If the LHD chooses to terminate, it shall notify the NC BCCCP Program Director of the reason and intent to terminate in a letter written on the LHD's letterhead and signed by the health director, which includes the effective date of the termination.
    2. Identify resources in the community and refer patients who have abnormal findings found prior to termination of the LHD's NC BCCCP activity.
    3. Notify all current NC BCCCP participants of closure of the program and offer assistance to find alternative providers of screening services.
    4. Maintain all NC BCCCP records and program manuals according to the local record retention schedule.

e. With termination, all remaining NC BCCCP funds will revert to DPH.

VI. Funding Guidelines or Restrictions:

1. **Federal Funding Requirements**: where federal grant dollars received by the Division of Public Health (DPH) are passed through to the Local Health Department (LHD) for all or any part of this Agreement Addendum (AA).

    a. Requirements for Pass-through Entities: In compliance with 2 CFR §200.331 – Requirements for pass-through entities, DPH provides Federal Award Reporting Supplements (FASs) to the LHD receiving federally funded AAs.
        1. Definition: An FAS discloses the required elements of a single federal award. FASs address elements of federal funding sources only; state funding elements will not be included in the FAS. An AA funded by more than one federal award will receive a disclosure FAS for each federal award.
        2. Frequency: An FAS will be generated as DPH receives information for federal grants. FASs will be issued to the LHD throughout the state fiscal year. For a federally funded AA, an FAS will accompany the original AA. If an AA is revised and if the revision affects federal funds, the AA Revision will include an FAS. FASs can also be sent to the LHD even if no change is needed to an AA. In those instances, the FAS will be sent to provide newly received federal grant information for funds already allocated in the existing AA.

    b. Required Reporting Certifications: Per the revised Uniform Guidance, 2 CFR 200, if awarded federal pass-through funds, the LHD as well as all subrecipients of the LHD must certify the

following whenever 1) applying for funds, 2) requesting payment, and 3) submitting financial reports:

> "I certify to the best of my knowledge and belief that the information provided herein is true, complete, and accurate. I am aware that the provision of false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil, or administrative consequences including, but not limited to violations of U.S. Code Title 18, Sections 2, 1001, 1343 and Title 31, Sections 3729-3730 and 3801-3812."

2. Financial
   a. **Breast and Cervical Cancer Screening Services and/or Diagnostic Services for NC BCCCP-Enrolled Patients** — The $325 per capita reimbursement for each patient enrolled and receives at least one NC BCCCP-funded clinical service (mammogram, clinical breast exam, Pap test, Pap test with HPV co-test, primary hrHPV test, or diagnostic service) will be funded with either state or federal appropriations:
      1. State appropriations for services rendered between June 1, 2025 and May 31, 2026.
      2. Federal appropriations for services rendered between July 1, 2025 and May 31,2026.
         a. Federal funds are allocated based on the federal grant schedule and must be requested by June 2026.
   b. **Patient Navigation-Only Services** (Assistance with the Breast and Cervical Cancer Medicaid Application) — The LHD will be reimbursed at a capitated rate of $50 for each unduplicated patient who receives PN-only services as listed under Section III, Paragraph 1. **LHDs cannot request reimbursement for providing Patient Navigation-only services ($50) in addition to screening/diagnostic service funding ($325) for the same patient.** LHDs are not allowed to drawdown the $50 per capita reimbursement funding for patients diagnosed while enrolled in NC BCCCP who receive assistance applying for BCCM.
   c. Refer to the Aid-to-Counties Schedule for Calendar Year 2026 (ATC Schedule) for the LHD's expenditure reporting period deadline for June 2026. The LHD shall adhere to the ATC Schedule for each monthly deadline when requesting reimbursement for services rendered in the preceding month. The LHD shall submit its monthly report on the total number screened in the preceding month before requesting funds in ATC.
   d. The total funds awarded from NC BCCCP shall be maintained by the LHD in a separate budget cost center to assure proper auditing of expenditures. Funding allocations are based on performance measures as stated in Section IV - Performance Measures / Reporting Requirements.
   e. At the end of this Agreement Addendum's service period (May 31, 20254), NC BCCCP funds held by the LHD in excess of the provider's actual costs of providing the initial screening and any necessary follow-up/diagnostic procedures may be used to cover staff providing indirect services or expenses such as salaries and fringes (e.g., data entry clerk or indirect personnel involved with screening services), travel, office supplies, medical supplies, postage, mailings, and flyers.
   f. NC BCCCP funds **shall not be used** to reimburse for treatment services. Payment to a subcontractor using NC BCCCP funds is limited to those screening and diagnostic follow-up services listed in the current NC BCCCP Services Fee Schedule and those that have been preauthorized by NC BCCCP Nurse Consultants.

3. Payment of Services
   a. Subcontractors

1. The payment to subcontractors for any service described in Section III may not exceed the prevailing Medicare-allowable rate for the service. The most current fee schedules shall be provided to the participating subcontractor by the LHD.
2. The payment to subcontractors can be a bundled rate or a flat fee if the subcontracted rate is less than the Medicare-allowable rate for the individual services.
3. NC BCCCP funds shall be used only for payment after all other third-party payment sources (private insurance but not Medicare [Part B] and Medicaid) provide evidence of partial or non-payment of eligible services. NC BCCCP funds may be used to reimburse for a deductible and/or co-payment required of the patient, provided that the total payment (including the deductible and co-payment) to the subcontractor or subcontractors does not exceed the prevailing Medicare-allowable rate.

b. Patients

1. Patients whose gross incomes are less than or equal to 100% of the federal poverty level shall not be charged for any services covered through NC BCCCP. However, ancillary costs and non-NC BCCCP covered fees may be charged to the NC BCCCP participant. Participants shall be notified of any possible charges prior to committing to the procedure.
2. A flat fee may not be charged for NC BCCCP services to any patient enrolled in NC BCCCP.
3. Sliding fee scales may be used for patients whose gross incomes are between 101% and 250% of the federal poverty level per reasonable and customary fees

4. Agreement Addendum Funding Allocation Adjustments

a. As of June 1, 2025, the number of patients served in compliance with performance indicators is determined by the number of patients who have a screening and/or diagnostic service paid partially or in full of NC BCCCP funds.

b. To retain the baseline budget for the following fiscal year, the LHD must screen a minimum of 100% of their allocated number of patients and expend a minimum of 100% of the funds awarded each year based on the availability of funding.

c. Funding adjustments may be made to the baseline budget of the LHD. State accessible data shall be reviewed in November 2025 to determine if budget adjustments are indicated based on compliance with performance indicators and number of patients served based on the availability of funding.

Technical assistance will be provided to the LHD if it is unable to meet allocated number of patients served.

DPH-Aid-To-Counties **For Fiscal Year: 25/26** **Budgetary Estimate Number : 0**

Activity 452 Service Period Payment Period		AA	133300 2B03100 20G0167001 07/01-05/31 08/01-06/30	Total Allocated	133300 2B05599 2000000000 06/01-05/31 07/01-06/30	Total Allocated	133300 2B05599 2000000000 06/02-05/31 07/02-06/30	Total Allocated	Proposed Total	New Total
01 Alamance			0	$0.00	0	$0.00	0	$0.00	0	0
D1 Albemarle	*	0	48,750	$0.00	29,250	$0.00	100	$0.00	78,100	78,100
02 Alexander			0	$0.00	0	$0.00	0	$0.00	0	0
04 Anson			0	$0.00	0	$0.00	0	$0.00	0	0
D2 Appalachian	*	0	8,125	$0.00	3,250	$0.00	100	$0.00	11,475	11,475
07 Beaufort	*	0	17,875	$0.00	13,000	$0.00	100	$0.00	30,975	30,975
09 Bladen			0	$0.00	0	$0.00	0	$0.00	0	0
10 Brunswick	*	0	26,000	$0.00	26,000	$0.00	100	$0.00	52,100	52,100
11 Buncombe	*	0	130,000	$0.00	102,375	$0.00	100	$0.00	232,475	232,475
12 Burke			0	$0.00	0	$0.00	0	$0.00	0	0
13 Cabarrus	*	0	27,625	$0.00	16,250	$0.00	100	$0.00	43,975	43,975
14 Caldwell	*	0	21,125	$0.00	11,375	$0.00	100	$0.00	32,600	32,600
16 Carteret	*	0	8,125	$0.00	8,125	$0.00	100	$0.00	16,350	16,350
17 Caswell			0	$0.00	0	$0.00	0	$0.00	0	0
18 Catawba	*	0	21,125	$0.00	16,250	$0.00	100	$0.00	37,475	37,475
19 Chatham	*	0	8,125	$0.00	4,875	$0.00	100	$0.00	13,100	13,100
20 Cherokee			0	$0.00	0	$0.00	0	$0.00	0	0
22 Clay			0	$0.00	0	$0.00	0	$0.00	0	0
23 Cleveland	*	0	19,500	$0.00	13,000	$0.00	100	$0.00	32,600	32,600
24 Columbus	*	0	3,250	$0.00	4,875	$0.00	100	$0.00	8,225	8,225
25 Craven	*	0	11,375	$0.00	11,375	$0.00	100	$0.00	22,850	22,850
26 Cumberland	*	0	19,500	$0.00	16,250	$0.00	100	$0.00	35,850	35,850
28 Dare	*	0	14,625	$0.00	11,375	$0.00	100	$0.00	26,100	26,100
29 Davidson	*	0	26,000	$0.00	17,875	$0.00	100	$0.00	43,975	43,975
30 Davie	*	0	11,375	$0.00	8,125	$0.00	100	$0.00	19,600	19,600
31 Duplin	*	0	13,000	$0.00	13,000	$0.00	100	$0.00	26,100	26,100
32 Durham	*	0	8,125	$0.00	9,750	$0.00	100	$0.00	17,975	17,975
33 Edgecombe	*	0	650	$0.00	975	$0.00	100	$0.00	1,725	1,725
D7 Foothills	*	0	14,625	$0.00	26,000	$0.00	100	$0.00	40,725	40,725
34 Forsyth	*	0	21,125	$0.00	14,625	$0.00	100	$0.00	35,850	35,850
35 Franklin			0	$0.00	0	$0.00	0	$0.00	0	0
36 Gaston	*	0	22,750	$0.00	14,625	$0.00	100	$0.00	37,475	37,475
38 Graham	*	0	4,875	$0.00	3,250	$0.00	100	$0.00	8,225	8,225
D3 Gran-Vance			0	$0.00	0	$0.00	0	$0.00	0	0
40 Greene	*	0	6,500	$0.00	3,250	$0.00	100	$0.00	9,850	9,850
41 Guilford			0	$0.00	0	$0.00	0	$0.00	0	0
42 Halifax			0	$0.00	0	$0.00	0	$0.00	0	0
43 Harnett			0	$0.00	0	$0.00	0	$0.00	0	0
44 Haywood	*	0	3,250	$0.00	3,250	$0.00	100	$0.00	6,600	6,600
45 Henderson	*	0	9,750	$0.00	8,125	$0.00	100	$0.00	17,975	17,975
47 Hoke	*	0	6,500	$0.00	4,875	$0.00	100	$0.00	11,475	11,475
48 Hyde	*	0	3,250	$0.00	3,250	$0.00	100	$0.00	6,600	6,600
49 Iredell			0	$0.00	0	$0.00	0	$0.00	0	0
50 Jackson	*	0	11,375	$0.00	8,125	$0.00	100	$0.00	19,600	19,600
51 Johnston	*	0	30,875	$0.00	17,875	$0.00	100	$0.00	48,850	48,850
52 Jones	*	0	3,250	$0.00	1,625	$0.00	100	$0.00	4,975	4,975
53 Lee	*	0	4,875	$0.00	3,250	$0.00	100	$0.00	8,225	8,225
54 Lenoir	*	0	9,750	$0.00	4,875	$0.00	100	$0.00	14,725	14,725
55 Lincoln	*	0	14,950	$0.00	17,550	$0.00	100	$0.00	32,600	32,600
56 Macon	*	0	8,125	$0.00	8,125	$0.00	100	$0.00	16,350	16,350
57 Madison	*	0	8,125	$0.00	8,125	$0.00	100	$0.00	16,350	16,350
D4 M-T-W	*	0	3,250	$0.00	6,500	$0.00	100	$0.00	9,850	9,850
60 Mecklenburg	*	0	97,500	$0.00	65,000	$0.00	100	$0.00	162,600	162,600
62 Montgomery			0	$0.00	0	$0.00	0	$0.00	0	0
63 Moore			0	$0.00	0	$0.00	0	$0.00	0	0
64 Nash	*	0	26,650	$0.00	18,850	$0.00	100	$0.00	45,600	45,600

65 New Hanover	*	**0**	11,375	**$0.00**	11,375	**$0.00**	100	**$0.00**	22,850	22,850
66 Northampton			0	**$0.00**	0	**$0.00**	0	**$0.00**	0	0
67 Onslow	*	**0**	13,000	**$0.00**	13,000	**$0.00**	100	**$0.00**	26,100	26,100
68 Orange	*	**0**	4,875	**$0.00**	6,500	**$0.00**	100	**$0.00**	11,475	11,475
69 Pamlico	*	**0**	6,825	**$0.00**	4,875	**$0.00**	100	**$0.00**	11,800	11,800
71 Pender	*	**0**	6,500	**$0.00**	4,875	**$0.00**	100	**$0.00**	11,475	11,475
73 Person			0	**$0.00**	0	**$0.00**	0	**$0.00**	0	0
74 Pitt	*	**0**	20,800	**$0.00**	18,200	**$0.00**	100	**$0.00**	39,100	39,100
75 Polk			0	**$0.00**	0	**$0.00**	0	**$0.00**	0	0
76 Randolph			0	**$0.00**	0	**$0.00**	0	**$0.00**	0	0
77 Richmond	*	**0**	11,375	**$0.00**	6,500	**$0.00**	100	**$0.00**	17,975	17,975
78 Robeson			0	**$0.00**	0	**$0.00**	0	**$0.00**	0	0
79 Rockingham			0	**$0.00**	0	**$0.00**	0	**$0.00**	0	0
80 Rowan	*	**0**	9,425	**$0.00**	6,825	**$0.00**	100	**$0.00**	16,350	16,350
82 Sampson	*	**0**	7,475	**$0.00**	8,775	**$0.00**	100	**$0.00**	16,350	16,350
83 Scotland			0	**$0.00**	0	**$0.00**	0	**$0.00**	0	0
84 Stanly	*	**0**	3,250	**$0.00**	3,250	**$0.00**	100	**$0.00**	6,600	6,600
85 Stokes	*	**0**	6,500	**$0.00**	4,875	**$0.00**	100	**$0.00**	11,475	11,475
86 Surry	*	**0**	26,000	**$0.00**	17,875	**$0.00**	100	**$0.00**	43,975	43,975
87 Swain			0	**$0.00**	0	**$0.00**	0	**$0.00**	0	0
D6 Toe River	*	**0**	8,125	**$0.00**	4,875	**$0.00**	100	**$0.00**	13,100	13,100
88 Transylvania	*	**0**	3,250	**$0.00**	3,250	**$0.00**	100	**$0.00**	6,600	6,600
90 Union	*	**0**	9,750	**$0.00**	9,750	**$0.00**	100	**$0.00**	19,600	19,600
92 Wake	*	**0**	71,500	**$0.00**	58,500	**$0.00**	100	**$0.00**	130,100	130,100
93 Warren	*	**0**	3,250	**$0.00**	3,250	**$0.00**	100	**$0.00**	6,600	6,600
96 Wayne	*	**0**	34,125	**$0.00**	22,750	**$0.00**	100	**$0.00**	56,975	56,975
97 Wilkes	*	**0**	11,375	**$0.00**	8,125	**$0.00**	100	**$0.00**	19,600	19,600
98 Wilson	*	**0**	16,250	**$0.00**	6,500	**$0.00**	100	**$0.00**	22,850	22,850
99 Yadkin			0	**$0.00**	0	**$0.00**	0	**$0.00**	0	0
00 Yancey	*	**0**	975	**$0.00**	650	**$0.00**	100	**$0.00**	1,725	1,725
Totals			1,041,625	0	803,075	0	6,100	0	1,850,800	1,850,800

Sign and Date - DPH Program Administrator Ciara Rukse 12/6/24	Sign and Date - DPH Section Chief Davonyia K. Thompson 12/6/2024
Sign and Date - DPH Budget Office – ATC Coordinator Sarah Griffin 12/6/2024	Sign and Date - DPH Budget Officer Apryl Johnson 12/6/2024

S L 12/06/24