

**NATIONAL COLORECTAL CANCER ROUNDTABLE**  
**Policy Action Task Group**  
**Monday, June 22<sup>nd</sup>, 2015**  
***Increasing Access and Removing Barriers to Achieve***  
***80% Colorectal Cancer Screening rate by 2018***

**MEETING OBJECTIVES:**

- Emerge with a better understand of the policy priorities and work of those around the table;
- Review and prioritize the policy needs that have emerged from the 80 percent by 2018 strategic planning process thus far;
- Ensure we have captured common problems in the delivery of colorectal cancer (CRC) screening at the state and local levels that require a policy solution;
- Identify pressing policy questions that continue to arise in this area; and
- Determine how the National Colorectal Cancer Roundtable (NCCRT) can best support progress on these priorities.

**WELCOME AND INTRODUCTORY REMARKS**

**Dr. Holly Wolf, Director, Colorado Colorectal Screening Program, NCCRT Policy Action Task Group Co-Chair**

Dr. Wolf began by thanking everyone for attending the strategy planning session to help inform the development of a policy agenda to achieve 80% colorectal cancer screening rate by 2018. She outlined the five key objectives for the day.

She acknowledged that today's meeting is just one piece of the solution. The Roundtable Steering Committee and its many other Task Groups have all been working hard to develop the products, tools, resources and momentum needed to get to 80%, and 80% by 2018 will take all hands on deck. She concluded that working together in a more unified and systematic way to set goals, track progress and create a common pathway has incredible potential. She then thanked everyone for being there on behalf of their organizations.

**Lynda Flowers, Senior Strategic Policy Advisor, AARP Public Policy Institute, NCCRT Policy Action Task Group Co-Chair**

Ms. Flowers outlined the agenda for the day and noted that for each discussion, the group needs to be thinking about what the priorities need to be and how the NCCRT can help, keeping in mind that because the NCCRT receives CDC dollars, lobbying cannot be a part of the process. She stressed that what the NCCRT can do is provide information and answer key policy questions that can help clarify the work that needs to be done.

## **ACHIEVING 80% BY 2018: IDENTIFYING AND OVERCOMING POLICY BARRIERS**

**Dr. Richard Wender, NCCRT Chair and Chief Cancer Control Officer for the American Cancer Society**

Dr. Wender began his presentation by noting that in 2012, 65% of U.S. adults reported being up to date with screening, which was no different between individuals of European and African descent and that there has been an increasing decline in colorectal cancer deaths since the 1970s. He spent the remainder of the presentation outlining the ten events, accomplishments and decisions that have converged to create this truly extraordinary opportunity to achieve a public health goal of 80% by 2018. Dr. Wender elaborated on steps that had a pronounced policy connection:

### **1. Convene and educate clinicians, insurers, employers, and the general public.**

There is federal support through the CDC's CRC grants to support organized approaches to CRC screening and comprehensive cancer control with a renewed emphasis on systems change. The challenges are to ensure that lawmakers understand these programs, to decide if the "business case" needs to be made from the local perspective and to determine if Meaningful Use requirements can be used to support clinicians in population outreach.

### **2. Find strategies to reach newly insured Americans.**

Looking from state to state, there is a very strong correlation between percent insured and the percent screened. While newly insured Americans are the low hanging fruit when it comes to screening, the issue remains of how to effectively reach this demographic. Dr. Wender discussed several options such as partnering with Medicaid programs, working through the exchanges during enrollment and getting assistance from "insurance navigators".

### **3. More effectively engage employers and payors.**

### **4. Find new ways to communicate with the insured, unworried well.**

### **5. Make sure colonoscopy is available to everyone.**

Unscreened Americans cite affordability as the number one reason for not getting a colonoscopy. Colonoscopy copay issues continue to plague consumers, particularly Medicare beneficiaries, despite promise of free preventive care benefit through the ACA. Additionally, our ability to secure no cost screening is changing, as the CDC grant programs have reduced the provision of direct coverage for CRC screening. This was a change made in anticipation of the expansion of health care coverage, but screening access issues will continue to be a problem in states that don't expand Medicaid.

### **6. Ensure everyone can be offered a stool blood test option.**

There is a sector of the population that either cannot or will not have a colonoscopy, and Fecal Immunochemical Tests (FIT) need to be offered to these individuals. In some settings, FITs may be the most appropriate primary screening strategy. In addition, there needs to be provisions to ensure the quality delivery of FOBT. The copay issues mentioned above, plague stool testing as well. Colonoscopies following positive stool test face cost-sharing in both the Medicare program and in commercial plans. Additionally, there are issues with FDA approval process of new stool tests.

### **7. Create powerful, reliable, committed medical neighborhoods around Federally Qualified Health Centers (FQHCs).**

Fortunately, the “fiscal cliff” issue that was looming over FQHCs has passed for the time being. We know that good medical neighborhoods rely on good care coordination. With respect to screening, screening navigators are key to building good transitions between the FQHC setting and the rest of the care continuum. The key question is how to pay for screening navigation. Additionally, more intensive strategies to secure low cost/no cost care are going to be necessary in states that did not expand their Medicaid programs.

### **8. Recruit as many partner organizations as possible.**

Dr. Wender stressed that signing this pledge to join the 80% by 2018 means that your organization specifically will dedicate additional resources to achieve the goal. The role of state and federal government and governmental leaders in the 80% by 2018 campaign needs to be clearly defined.

### **9. Implement intensive efforts to reach low socioeconomic populations.**

### **10. Believe we will achieve this goal!**

#### **General Discussion Points:**

- We need to do more to track the efforts of partner organizations and how to keep them engaged. There is a need to ramp up efforts. NCCRT and ACS networks can be helpful to prioritize issues and replicate successes that are occurring in individual states. Plans to conduct a survey to gather information on ongoing interventions is underway.
- Non-expansion states are going to have much more significant access issues and may need more intensive interventions. Providing policy guidance to non-expansion states to organize them and motivate them around the 80% by 2018 goal is a big opportunity.
- We should be closely looking into the role that community health centers play in meeting targets, and then determine how to effectively engage them in our efforts.
- Clinical registries can provide meaningful data that can be used to track screening. Some NCCRT members are urging Congress and CMS to support mechanisms that give credit to physicians who use such registries.

- Engagement with large corporations is a new area for us. We need to match our agenda to theirs and determine where there is synergy with our goals. Identifying CEO champions within this sector will be important for meaningful partnerships to develop.
- With regards to partners it will be important for us to sort out what we want them to do around policy. We should figure out the many different routes of access to screening in states. We may want to provide a menu of policy options for state roundtables to pursue, such as securing dollars for screening programs, supporting screening navigation, activities to screen their Medicaid patients screened or utilizing the state as a major employer.
- We need specific plans, strategies, and associated actions to reach the underserved. We have to work with state Medicaid to get them interested and engaged, and determine what we can do from a policy perspective. Can we create a menu of ideal Medicaid activities and try and replicate those activities in three to five states?
- Look into replicating strategies and efforts from other successful public health interventions.

## **80% BY 2018: STRATEGIC PLANNING MEETING ON POLICY — PRE-MEETING SURVEY RESULTS**

**Mary Doroshenk, NCCRT Director**

The purpose behind the survey was to understand the current legislative/policy efforts around colorectal cancer control and access in order to identify pressing policy questions that continue to arise and determine how the NCCRT can best support work in these areas. Twenty-one individuals representing 16 of the 20 organizations that were represented at the meeting completed the survey. The key findings from the survey are presented in this section.

### **1. Active legislative efforts at the federal level:**

- Colonoscopy copay issue to fix the Medicare loophole (HR 1220)
- Copay for colonoscopy after positive stool test — address this through the regulatory process
- Increase funding for CDC CRC screening program
- FDA approval process of stool tests
- Include CRC in DoD research program
- Quality of life issues
- Accreditation
- Bundled payments/GI reimbursement for colonoscopy
- SCREEN Act/Pre-colonoscopy visit
- Giving noncompliant patients access to Cologuard in VA/Tricare

### **2. Active legislative efforts at the state level:**

- Securing state dollars for screening/treatment for uninsured — major issue

- Colonoscopy copay issue — private payors
- Paid time off work for screening colonoscopy for employers/government
- Adding CRC screening to the Medicaid Managed Care Incentive package
- Engage key policy stakeholders through the CCC
- Educating a “red” state on the benefits of ACA
- State Quality of Life forums to educate legislators and others on policy issues
- New “Healthy Connections” program in SC

### **3. Relevant data, studies and reports:**

- Cost ramifications of eliminating the cost-sharing requirement for colonoscopy screening (CDC)
- Estimated uninsured aged 50 to 64 with/without expansion by state (Coming soon – ACS CAN)
- State-by-state Medicaid/Exchanges reimbursement rate for CRC screening (Coming soon – AGA)
- State-by-state assessment of Medicaid CRC screening outreach efforts (NCCRT)
- How to Pay for Screening Navigation Tool (NCCRT)
- How to evaluate policy efforts guidance (NCCRT)
- Case studies of health plan practices around CRC (NCCRT)

### **4. Recommended 80% by 2018 policy priorities at the federal level:**

- Addressing the colonoscopy copay issue
- Fix screening definition to include a follow-up colonoscopy after a positive stool blood test
- Remove financial barriers for screening navigation ‘-Care & -Caid’
- Providing CRC treatment for the uninsured, including the undocumented
- Fully fund CDC CRCCP program in every state
- Improve Medicare/Medicaid reimbursement for PCPs to address PCP shortage created by ACA
- Incentives for Medicare providers to improve CRC screening rates
- Reform approval for stool tests at FDA
- Need for EMR/workflow improvements
- Continued investment in evidence-based interventions
- Establish accreditation policy at CMS

### **5. Recommended 80% by 2018 policy priorities at the state level:**

- Focus on policy efforts in states where there is no Medicaid expansion
- Medicaid reforms: Treatment dollars, PCP reimbursement, screening navigation, access and coverage for CRC screening
- Provide state dollars for screening

- Paid time off work for screening colonoscopies for employers/government
- Fix screening-care definition to include a follow-up colonoscopy after a positive stool test
- Require providers to donate care by building it into the Certificate of Need
- Support outpatient GIs
- Support for state-level roundtables

**6. Health care expansion issues:**

- Medicaid expansion
- Fix copays (during polyp removal and follow up after a stool test)
- Pay for screening navigation
- Access to doctors in rural communities
- More transparency for payors
- More regulation around screening for high-risk individuals
- Support ACA Prevention Fund
- Assistance with transportation for low-income individuals
- Need for quick fix if the Supreme Court rolls back subsidies

**7. What should the role of government be in the 80% by 2018 effort:**

- Convene strategic partners; ensure it's a goal for CCC partners and support with funding
- Assist in CRC promotion; provide "edgy" messaging; provide funding for evidenced-based interventions
- Fund research to determine best practices at the point of care, including social determinant issues
- Assist in national goal setting
- Legislative: Find ways to pay for screening navigation, treatment; fix copays
- Address issue of CHC access to specialists
- Promote CRC screening to doctors in Medicare and Medicaid
- Clarify the definition of screening so a colonoscopy is covered when it follows a positive stool test
- Provide visible spokesperson such as the Surgeon General

**8. What do you need to advance your policy work:**

- Policy guidance for state-level roundtables; concrete examples of successful policy activity
- Accurate data on CRC treatment costs
- Fact sheets on cost effectiveness and lives saved based on Ann Zauber's work
- Strategies for approaching payors to incentivize providers to increase screening
- Grasstops advocates

- Increase the understanding of Medicare patients who aren't getting screened; what is needed to push those people to screening completion
- Strategies to pay for patient navigation
- Policymakers to better understand existing safety net programs
- Highlighting areas where there is a GI shortage
- Edgy awareness campaigns to drive demand; start message earlier

**9. What pushback/questions do you get that you can't answer:**

- What are the long-term cost implications of expanding Medicaid?
- Where should the funding come from to pay for the HR 1220/CBO score?
- Why do you need funding if ACA fixed everything?
- Isn't CDC already doing this?
- Why should we prioritize one public health campaign over others?
- General resistance to mandates/spending

**10. What studies/assessments could help you:**

- Return on investment for screening and interventions, such as navigation
- Cost of state-level population-based CRC program
- Clear evidence-based estimates of treatment costs and potential for savings
- Return on investment for polyp removal for Medicare beneficiaries
- State-specific data on cost of screening, treatment and savings if we were at 80%
- Would more specialists donate care if cancer treatment was assured? Request for a study
- Would more timely CRC screening messages help with "on-time" screening?
- Study on sedation safety
- Unmet need plotted by geographic areas

**11. What policy issues do you want to learn more about:**

- Clearer guidance for states on needed policy activities
- Stay abreast of colonoscopy copay issue
- EMRs and Meaningful Use
- Shortage of specialty care and what to do about it
- Understanding what the future of reimbursement looks like
- Best health plan practices around screening

**12. New ideas:**

- Pay for screening navigation in Medicaid and Medicare
- Paid time off work at the federal level
- Tax incentives/requirements for pro bono care
- Increased Medicaid reimbursement for specialty care

- Consistent measures (UDS, meaningful use, PCMH)
- Requiring individuals who are enrolled in government-sponsored programs to get a wellness visit
- Access to doctors in rural communities with full compensation to ambulatory surgical centers
- Higher reimbursement for GIs where there is a shortage

### **13. Final takeaways:**

- In many ways the federal agenda is set, but the vision needs to be sharpened at the state level
- Securing state dollars for screening and treatment
- Figuring out the mechanism to pay for screening navigation
- Backing up some of these directions with cost studies

### **General Discussion**

- If we increase the number of people who need colonoscopy, is there capacity to meet the colonoscopy needs? This is something to look into, particularly in rural areas.
- With rates of CRC going up in people under the age of 50, there is need to address this population. Is there a policy solution for engaging the unscreened to include younger populations with early onset symptoms, no family history, or no signs of concern? Can we fund research to look into this?
- Frame the issue of young colon cancer not in terms of barriers, but in terms of opportunities that exist with new testing, new technology and innovations.

## **HEALTH CARE COVERAGE LANDSCAPE: OPPORTUNITIES, CHALLENGES AND TRENDS IN COVERAGE**

### **Citseko Staples-Miller, Senior Specialist, American Cancer Society Cancer Action Network**

Health care coverage in the United States consists both of private insurance and government-sponsored programs, including Medicare and Medicaid, and serves as the primary source of care for millions of Americans. Despite this, there are nearly three million low-income adults under the age of 50 who remain uninsured, and the majority of them reside in non-Medicaid expansion states. These individuals still need a safety net program in order to gain access to some type of screening service.

With the expansion of Medicaid in 29 states, there has been a significant increase in the number of previously uninsured individuals who are at the age where they require access to the three cancer screenings that are being offered, colorectal cancer being one of them. There is also great opportunity through the Affordable Care Act to address the more than 40 million uninsured individuals in this country.

Ms. Staples-Miller identified several key barriers to colorectal cancer screening, including access to care, cost and a lack of patient education and awareness. This lack of public awareness stems from a lack of information provided by government-sponsored insurers about preventative services coverage and utilization. She ended her presentation by talking about the ACS CAN's efforts to address these barriers including Medicaid expansion, increased federal and state funding for CRCCP, federal engagement concerning the known barriers, and encouraging stakeholder to sign the 80% by 2018 pledge and take action.

### **ROUND ROBIN #1- FEDERAL: CURRENT ACTIVITIES AND PERCEIVED GAPS**

The purpose of this panel was to get the most recent information on policy issues that are priorities for many of the attending organizations. The presentations are intended to ensure that all attendees are aware of the variety of ongoing policy work, to encourage thinking about the role of the Roundtable in advancing these efforts, to put key policy questions on the table, and to hear the views from various experts on needed next steps.

### **REMAINING BARRIERS TO CRC SCREENING: MEDICARE AND QHPS**

**Caroline Powers, Director, Federal Relations, American Cancer Society Cancer Action Network**

The Affordable Care Act was supposed to take care of all the cost-sharing issues with colorectal cancer screening, but surprisingly, it has not. The Administration does have the power to clarify cost-sharing issues and has demonstrated this power with regard to polyp removal during a screening colonoscopy for private insurance. However, outstanding issues remain in both Medicare and private insurance.

Ms. Powers identified inappropriate cost sharing as one of the major barriers to CRC screening promotion, noting that appropriate cost sharing for Medicare beneficiaries is an issue with both polyp removal during colonoscopy, and also the cost sharing for a follow-up colonoscopy. Confusion about cost sharing for follow-up colonoscopies also occurs in the private insurance sector.

The American Cancer Society Cancer Action Network is currently working to increase CRC screening rates through legislative means including the Removing Barriers to Colorectal Cancer Act of 2015 (H.R. 1220 / S. 624), which specifically looks at the polyp removal loophole in Medicare. She explained in greater detail the nature of the cost-sharing problem with CRC screening in Medicare where, depending on the circumstances, the beneficiary can be required to pay both the deductible and the copay. HR 1220 Senate 624 fixes this problem in Medicare and is bipartisan in both the House and the Senate, although the presence of a new Congress has led to the need to get new cosponsors and support, particularly within the Republican Party. ACS CAN has been working with their volunteers to do member outreach, both back in the districts and here in Washington, with calls and letters and emails, including their "Pain in

the Butt” literature. They have also identified several administrative means to help deal with cost-sharing issues with follow-up colonoscopies, both in Medicare and with private insurance.

## **FDA APPROVAL PROCESS FOR STOOL TESTS**

**Dr. Durado Brooks, Director, Prostate and Colorectal Cancers, American Cancer Society**

Dr. Brooks began by noting that stool testing is an important component of getting to 80%, as many people will actually choose stool tests over a colonoscopy, and that there are data demonstrating that high-quality stool testing has very good long-term outcomes in colorectal cancer screening. He identified the primary issue as the quality of the Fecal Immunochemical Tests (FIT) since they are treated as a homogeneous “class” by ACS and USPSTF guidelines, and a steadily increasing number of FITs have been entering the U.S. market (> 15 now available). While many claim very high sensitivity and specificity, independent studies have raised doubts regarding the accuracy of some reported performance characteristics.

They investigated the FDA process for getting approved and discovered that the FDA does not assess these tests based on the effectiveness of the colorectal cancer screening test, but instead approves them to be marketed simply to detect blood in the stool. There is also the fact that the FDA approval only requires “substantial equivalence”, whereby manufacturers only need to demonstrate that the sensitivity and specificity of the new test are roughly equivalent to a reference test, which can be any stool test that is already approved for marketing in the United States, including old versions of tests that are no longer recommended for screening by the ACS or USPSTF.

A joint meeting was held between the ACS, Fight CRC and FDA leadership and staff, with the goal of expressing the issues of concern related to the approvals process for FIT as well as potential misuse in clinical practice. The main issues of concern included:

- The inconsistency between the FDA clearance process of FIT – which clears tests based on the ability to detect blood – and the clinical use of FIT to detect cancer and adenomatous polyps in an asymptomatic population
- The difference between manufacturers’ claims of FIT sensitivity/specificity and the actual results; a lack of standardization between FITs on issues such as cut-off values
- Inadequate information on the number of stool specimens required to achieve optimal performance, and anecdotal reports of companies marketing FIT as single-sample tests when the tests were cleared based on multi-sample data
- The testing of specimens from a digital rectal exam (DRE)
- The need for consumer-friendly labeling

A number of recommendations were made to the FDA, starting with the need to establish a new approval process for FIT that assesses their ability to detect colorectal cancer and adenomatous polyps, not solely the ability to detect blood in a stool specimen. They will also

need to consider whether currently approved tests should be required to go through another approval process, and if they're going to continue to use the substantial equivalents approach, ensuring sure that they are not allowing companies to use old versions of tests that are no longer recommended for screening. They also went through the FDA guidance document and made suggestions for improvement, encouraging the FDA to do more to try to educate clinicians about the appropriate use of these tests.

**CDC'S COLORECTAL CANCER PREVENTION PRIORITIES: COLLABORATION IS THE KEY**  
**Nikki Hayes, Comprehensive Cancer Control Branch, Division of Cancer Prevention and Control, CDC**

Ms. Hayes began her presentation by depicting what the CDC considers its role to be in cancer prevention and control. Her division provides leadership in comprehensive public health approaches to cancer issues. They do so by providing:

- An established infrastructure to collect surveillance data to track and monitor incidence and mortality
- Technical assistance and guidance to public health programs for planning and implementing policy, systems and environmental change strategies to prevent and control cancer
- Researching and addressing the issues related to disparate cancer outcomes in underserved and disadvantaged populations
- Public education and outreach; providing access to quality clinical preventive services
- Improving cancer prevention and control infrastructure
- Improving the quality of life for cancer survivors

In addition, their division funds a number of cancer programs, initiatives and campaigns including the Comprehensive Cancer Control (CCC) Program. The CCC Program provides the infrastructure to support a coalition approach to cancer prevention and control in all 50 U.S. states, Washington D.C., seven tribal organizations and seven territories. They have helped these coalitions bring together diverse leaders, stakeholders and decision-makers to plan and prioritize strategies to address cancer control issues in their communities. One of their six program priorities is secondary prevention, and this is where their work on 80% by 2018 occurs, a cause to which the Agency is very committed. In September, working in collaboration with the ACS and NCI, they are convening an 80% by 2018 forum for the Comprehensive Cancer Control Coalition to come together with a team to do action planning around how to increase colorectal cancer screening by increasing or enhancing relationships with federally qualified health ventures. The CDC is committed not only to working together in this setting, but also to providing resources to get plans implemented at the various state levels.

She also spoke about the Colorectal Cancer Control Program. The CCC Program was launched five years ago and provides funding to determine how to increase screening rates and decrease barriers, using a two-pronged approach. The first component is health systems change to increase and improve colorectal cancer screening, including improving the clinical environment to more effectively deliver quality preventive services and help Americans more effectively use and benefit from those services. The second component is CRC screening delivery, and includes aspects such as program management, CRC screening services, diagnostic follow-up and patient navigation services.

The last major initiative Ms. Hayes spoke of was their National Action Campaign, Screen for Life, which began in 1999. It informs men and women aged 50 years and older about the importance of having regular colorectal cancer screening tests, and provides a variety of resources for health care providers and organizations to share with their patients and communities to help increase awareness of colorectal cancer screening.

### **CRC COST SHARING: HIGH-RISK PATIENTS**

#### **Dr. Joel V. Brill, Chair, Payor Policy Workgroup, American Gastroenterological Association**

Dr. Brill opened with an executive summary stating that one of the key issues is that clarification is lacking as to whether or not high-risk patients are covered as a preventive service. Some plans suggest that patients contact their physician to determine whether they are considered high risk, without providing guidance as to what criteria are used to determine high risk. In addition, payor policies are inconsistent in terms of whether the plans deem the procedure for high-risk patients to be preventive and thus will waive cost sharing.

Dr. Brill explained that in terms of CRC and family history, the Center for Consumer Information and Insurance Oversight (CCIIO) states that identifying high-risk individuals is determined by clinical expertise. If the attending provider determines that a patient belongs to a high-risk population and a U.S. Preventive Services Task Force (USPSTF) recommendation applies to that population, that service is required to be without cost sharing, subject to reasonable medical management. He also pointed out that some payor policies are very silent with respect to high-risk patients.

In terms of where this information originates, Dr. Brill determined that it is coming from the National Comprehensive Cancer Network (NCCN). He presented several slides summarizing the NCCN's 2015 statements concerning increased/high-risk screening based on positive family history. The 2015 version has recommendations for those with a positive family history of CRC, including inherited risk, personal or inherited risk of polyposis syndromes or FAP, MYH associated polyposis, and Lynch Syndrome.

In his opinion, the NCCN has done a good job of outlining who is at risk, and when screening should begin for the people who would be considered to be high risk. One of the takeaways he would like from this group is to determine if the NCCN guidelines make sense, and if so, how people can be encouraged to incorporate these guidelines.

**General Discussion Points:**

- We need contacts and talking points for reaching out to folks in CMS regarding policy change around stool testing.
- NCCN guidelines for colorectal cancer are complex. We need good tactics and logistical support to bring it to the patients.
- Use roundtables with their support from CDC, ACP, and GI associations as an integrating platform across states to bring key people engaged in the issue, and to help with implementation on the ground. Use examples of HPV roundtables, lung cancer roundtables.
- To get the entire population screened, we might need to reconsider the framework from a one-step test to a multi-step screening protocol similar to breast cancer screening.

**ROUND ROBIN #2- STATE INNOVATIONS**

The purpose of this panel was to understand some of the innovative policy solutions that are happening at the state level. Even though each state is different, the goals are to learn from the different state policies and determine what might be worth replicating on a broader scale, and to evaluate what has been particularly successful and to determine how the NCCRT can assist with this work.

**COLON CANCER SCREENING IN KENTUCKY**

**Dr. Whitney Jones, Colon Cancer Prevention Project**

Dr. Jones provided a timeline of the recent history of colon cancer screening in the state of Kentucky. From 2003 to 2008, the Colon Cancer Prevention Project (CCPP) conducted private and sponsored fundraising directed towards both the provider and general education. During this time, staff members also integrated with the Kentucky Cancer Consortium and other cancer prevention partners at the state level. In 2008 the Project hired a full-time lobbyist, and the Kentucky Colon Cancer Screening Program (KCCSP) was installed by the General Assembly by a near unanimous vote in both houses. From 2008 to 2012, when the program was not funded, CCPP members conducted monthly meetings with KCCSP partners, coordinated their activities, and shared information and teamwork. During this time they also applied for a CDC grant on multiple occasions without success.

In 2010 legislation was passed that implemented a sliding-scale system similar to that of the Breast and Cervical Cancer Screening System. In 2012 the Kentucky Cancer Foundation (KCF) was formed and the CCPP appealed to create a public-private partnership with the KCF; this appeal was passed by the legislature with nearly unanimous support. In 2014 there was a shift to a CHC engagement strategy, and fundraising by the KCF continued. Finally, in 2015 the CCPP lobbied and achieved historic legislation ensuring that no resident of Kentucky would be billed for a screening colonoscopy, even if it is not a colonoscopy conducted after a positive non-invasive fecal test. Another component of the legislation assures that no findings of a screening colonoscopy change the characteristic or billing code of the screening colonoscopy.

## **SCREENING PATIENT NAVIGATION REIMBURSEMENT AND SUSTAINABILITY**

### **Andrea Dwyer, Colorado School of Public Health**

Ms. Dwyer described how her group frames screening navigation in terms of thinking about linking to health care systems, access to screening exams, enrollment in public and private insurance programs and thinking about reducing barriers in access to care. She affirmed that there is sufficient evidence to say that screening navigation in health screening works.

She went on to describe a toolkit co-branded with the NCCRT/ACS and the Colorado School of Public Health. They developed the toolkit with special attention paid to the following domains:

- Current successful screening models
- Models for direct payment
- Quality and accreditation models
- Return on investment on the business case
- Education about policy

Ms. Dwyer emphasized that the issues impacting the toolkit include thinking about longer-term sustainability, quality and evaluation. When the toolkit is implemented they are also thinking about how it is working and what is changing as a result of its implementation. They are interested in hearing from others who have been successful in this area as to sample templates and language that have worked well.

Ms. Dwyer then went into detail about some of the specific activities they are considering in terms of the domains previously mentioned. When thinking about successful screening programs and models, there are a variety of states that have approached this, as well as the CRCCP program and the network of state programs that aren't funded by the CDC. In the domain of direct payment, they are interested in a 'per member, per month' plan, care coordination in the Medicaid population, and examples where the business case has been made institutionally for patient navigators, so that navigators are not on soft funding and fee-for-service is included in bundled payments. She also mentioned the opportunities for quality

improvement and accreditation for patient navigation, patient-centered medical homes and Triple Aim. She noted that the intent with regards to policy is to provide education, not to specifically endorse a discrete legislative agenda. They are interested in determining what else should be engaged in the policy taskforce and long-term vision.

#### **OPTIONS FOR ADDRESSING COPAY ISSUE AT THE STATE LEVEL**

**David Woodmansee, Associate Director, Access to Care, American Cancer Society Cancer Action Network**

Mr. Woodmansee began the presentation with the help of Ms. Staples by describing a process that occurred in 2013 when ACS CAN initiated communications with state regulators and legislators in Oregon in an attempt to get coverage for polyp removal. They were successful in that effort, and the process was simplified because it had minimal impact in terms of a fiscal mandate. They also supported efforts that led to legislature being passed that would cover a follow-up colonoscopy after a positive stool blood test or FIT test without cost sharing. This process emphasized the importance of doing an evaluation or an assessment prior to going into any legislative or regulatory approach to try to remove the barriers related to individuals accessing colorectal cancer screening.

#### **EXPANDING PAID TIME OFF POLICIES FOR CANCER SCREENING**

**Heather Dacus, Comprehensive Cancer Consortium, New York State Department of Health**

The New York State Cancer Consortium received a grant from the CDC in 2010 to demonstrate the ability to implement policy change across comprehensive cancer control programs. In conjunction with a health policy center, they discovered a civil service law from 2002 that allowed civil servants to take time off for breast and prostate cancer screening. They conducted demonstration projects in two counties in New York, implementing activities in the following areas: educating communities to build demand, mobilizing communities by finding a local-level champion, engaging organizational decision makers so they understand the issues, and then educating government decision makers. Using these activities, both counties were successful in getting their county municipalities to adopt an expansion of the civil service law, not only for colorectal cancer, but for cervical cancer as well.

**Dr. Frank Berger, Director, Center for Colon Cancer Research, University of South Carolina**

Dr. Berger spoke about a statewide colon cancer screening program that South Carolina established several years ago. This is an open-access colonoscopy-based program for clients of federally qualified health centers and free medical clinics where all clients are referred by these clinics to our navigators. The program is funded by several sources including the Blue Cross Blue

Shield Foundation, the Duke Endowment, and the South Carolina state budget. The amount of funding has enabled them to expand the program.

Dr. Berger explained that this is a very navigation-centered program. The navigators work with clients to make sure they are eligible for the program, and walk them through the entire process. The navigation is very important in getting patients to engage in colon cancer screening, and the no-show rates are less than 2% due to the success of the navigation process.

He cited legislative funding as the major reason they are able to maintain this program. He also noted that the main determinant of their success is having champions for their cause. In every arena, they have had an individual—or several individuals—who led the way to making contacts and helped get the message across, which has been instrumental.

Finally, Dr. Berger spoke of an awareness initiative, and he hopes to see that turn into policy change. While South Carolina does not accept Medicaid expansion or exchanges, there is a push from a number of organizations within the state to change this.

**General Discussion Points:**

- There is a need to address patient navigation and reimbursement of navigation services; credentialing for navigation. Different models for navigation were noted.
- Identify people who can lobby and get them to the table. They will be critical to changing behavior in the legislature.
- Evaluate the role of GIs in achieving the 80% by 2018 goals, and assess if what is coming out of the policy roundtable is enough to get the GIs involved in this effort.

**Are there other key issues we need to address?**

- Patient education regarding testing options. Need to get message out to general public in a way that takes into account health disparities, i.e., ensuring message gets out to the high-risk communities. Is that something we address from the policy aspect or more from a communication aspect?
- USPSTF will be coming out with new recommendations. Need to consider if message will need to change following the new recommendations.
- To get the voice of the patient and the patient perspective, it is important to engage advocates effectively to help change policy.
- We should think about reworking the white paper to make sure we highlight graphically the business case for screening to justify funding for our programs.
- To make our case against competing priorities such as hypertension, diabetes, and CHF, which are more costly than colorectal cancer, we need to frame our responses using the systems perspective that meets multiple public health needs at once.

**What should be the NCCRT's immediate policy priorities?**

- Reimbursement around screening for the uninsured
- Increasing screening among Medicaid recipients in a few states as demonstration projects
- Implement policy to increase screening of high-risk people in their 50s to meet the target of 80% by 2018
- Addressing disparities in non-expansion states
- Start roundtables in non-expansion states, red states, and southern states using working models from other red states and expansion states to mobilize action
- Encourage formative evaluations before taking a policy action

**What can the Policy Action Task Force do in the non-expansion states in the near term?**

- Help set up roundtable mechanisms
- Establish a learning community or community of practice in red states
- Use roundtables as a venue to establish partnerships with other chronic disease groups

**What can the Policy Action Task Force do in the expansion states in the near term?**

- Propose Medicaid policy legislation initiatives with cancer as a key component
- Use a systematic approach to educate and enter community health centers into the systems change model of intervention
- Develop a policy initiative to earmark care coordinator funds for expansion
- Develop a policy initiative to require doctors to make screening recommendation to Medicaid patients
- Conduct a cost benefit study of mortality
- Engage survivors for advocacy

**NCCRT 80% by 2018 Policy Meeting Roster  
June 22nd**

**Cathy Bauer**

Society of Gastroenterology Nurses and Associates

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Chief Medical Officer, Senior Vice President,  
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**Speaker**

Chair, AGA Payor Policy Work Group  
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**Durado Brooks, MD, MPH**

**Speaker**

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Policy Advisor  
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Roundtable  
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**Speaker**

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**Speaker**

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**Speaker**

Founder  
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**Mike Mizelle**

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Senior Analyst, Policy Analysis and  
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**Citesko Staples (By Phone)**

**Speaker**

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## Final Summary

Priorities/Activities Discussed During Meeting	What would the role of the Roundtable be?
	<b>Federal</b>
<b>Address Medicare copay issue of polyp removal during colonoscopy;</b> follow ACS CAN's lead; with all hands on deck approach; identify 1-2 republicans who can take this to the leadership; lobby days; write more letters and make more visits	<ul style="list-style-type: none"> <li>• Continue to share information</li> <li>• Collect and share patient stories to help document the problem</li> </ul>
<b>Address issue of copays for colonoscopies following positive stool test among both Medicare and private insurers;</b> ACS CAN and others contacting CMS and HHS with formal asks	<ul style="list-style-type: none"> <li>• Promote screening definition to include follow-up colonoscopy to a positive stool test</li> <li>• Make the case for coverage; ie. that current policy drives patient to a more expensive test (<i>Underway</i>)</li> </ul>
<b>Figure out how to pay for patient navigation</b>	<ul style="list-style-type: none"> <li>• Document models on paying for screening navigation (<i>Underway</i>)</li> </ul>
<b>Secure dollars for screening and treatment</b>	<ul style="list-style-type: none"> <li>• Make the case for why these programs are needed despite ACA; bust myths about access</li> </ul>
<b>Fully fund CDC CRCCP in every state</b>	<ul style="list-style-type: none"> <li>• Educate about what these programs do</li> </ul>
<b>Improve Medicaid policies/activities around screening</b>	<ul style="list-style-type: none"> <li>• Document current Medicaid CRC activity (<i>underway</i>)</li> </ul>
<b>Promote use of quality FIT tests</b>	<ul style="list-style-type: none"> <li>• Reform approval for stool tests at FDA</li> </ul>
<b>Leverage Medicare to promote screening</b>	<ul style="list-style-type: none"> <li>• Answer the question: What do we know about Medicare patients who aren't getting screened</li> <li>• Continued investment in evidence-based interventions</li> <li>• Establish accreditation policy at CMS</li> </ul>
	<b>State</b>
<b>Support Medicaid expansion</b>	<ul style="list-style-type: none"> <li>• Predict uninsured 50 to 64 population in screening population in expansion/non-expansion states (<i>Complete</i>)</li> </ul>
<b>Improve Medicaid state agency activity around CRC</b>	<ul style="list-style-type: none"> <li>• Document activity to identify promising practices in state (<i>Complete</i>)</li> <li>• Analyze Medicaid program activity to determine what works</li> <li>• Document and promote best practices</li> </ul>

	<ul style="list-style-type: none"> <li>• Demonstration projects in 3 to 5 states</li> </ul>
<b>Secure state dollars for screening</b>	<ul style="list-style-type: none"> <li>• Promote model CRC programs funded with state dollars; could be important solution in non-expansion states</li> <li>• Assess cost of state-level population-based CRC program</li> <li>• Answer question would more specialists donate care if cancer treatment was assured?</li> <li>• Collect and share stories of survivors</li> <li>• Learning collaborative – red states learning from each other about what is possible</li> </ul>
<b>Utilize state role as employer</b>	<ul style="list-style-type: none"> <li>• Explore paid time off work for screening colonoscopy for employers/government</li> </ul>
<b>Address copay issue at the state level</b>	<ul style="list-style-type: none"> <li>• Examine states that have passed such legislation</li> <li>• Promote screening care continuum definition to include follow-up colonoscopy after positive stool test with state leaders</li> <li>• Share state insurance commissioners letter on ACA copay rule to promote uptake of law and enforcement</li> </ul>
<b>Determine how to pay for screening navigation</b>	<ul style="list-style-type: none"> <li>• See above about document models for paying for navigation (Underway)</li> <li>• Make ROI for screening navigation</li> </ul>
<b>Assistance with capacity/transportation for low-income individuals</b>	<ul style="list-style-type: none"> <li>• Determine how states/communities have addressed this locally</li> <li>• Map out areas where there is a GI shortage</li> </ul> <p><b>General needs</b></p>
<b>Utilize state-level roundtables; in concert with local ACS CAN staff</b>	<ul style="list-style-type: none"> <li>• Survey existing CRC state coalitions to determine what's underway</li> <li>• Policy guidance for state-level roundtables; examples of successful policy activity</li> <li>• Demonstration projects in the friendly states</li> </ul>
<b>Develop cost arguments</b>	<ul style="list-style-type: none"> <li>• Provide accurate data on CRC treatment costs</li> <li>• Develop fact sheets on cost effectiveness and lives saved</li> <li>• Develop local cost modeling tool</li> </ul>

	<ul style="list-style-type: none"> <li>• Provide state specific costs estimates on treating and potential savings</li> <li>• Develop local ROI arguments</li> </ul>
<b>Support safety net programs</b>	<ul style="list-style-type: none"> <li>• Help policy makers understand what safety programs do and don't do</li> <li>• Bust myth that we promote one public health goal over another</li> </ul>
<b>Medicaid reimbursement issues</b>	<ul style="list-style-type: none"> <li>• Document state Medicaid reimbursements for screening (AGA underway)</li> </ul>
<b>Improve screening reporting and tracking</b>	<ul style="list-style-type: none"> <li>• Bring some consistency to screening measures to reduce burden and improve reporting (UDS, meaningful use, PCMH)</li> </ul>
	<b>Other</b>
	<ul style="list-style-type: none"> <li>• Provide guidance on how to conduct a formative evaluation before taking on a policy effort (Wilder)</li> </ul>