80% by 2018
Strategic Planning Meeting on Policy
Pre-Meeting Survey Results

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80% by 2018
Strategic Planning Meeting on Policy
Pre-Meeting Survey Results

What:

- Participants took a 12 question on-line survey

Participants:

- 21 individuals took the survey, representing 16 organizations
- 20 organizations represented at the meeting

Purpose:

- To understand current legislative/policy efforts around colorectal cancer control and access, pressing policy questions that continue to arise and how the NCCRT can best support work in these areas.

Active legislative efforts -- Federal

- Colonoscopy copay issue – Medicare (HR 1220)
- Copay for colonoscopy after positive stool test
- Increase CDC CRC screening program funding
- FDA approval process of stool tests
- Include CRC in DoD Research program

Active legislative efforts -- Federal

- 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

Active legislative efforts -- State

- Securing state dollars for screening/treatment for uninsured
- Colonoscopy copay issue – Private payers
- Paid time off work for screening colonoscopy for employers/govt.
- Adding CRC screening to Medicaid Managed Care Incentive package

Active legislative efforts -- State

- Engage key policy stakeholders through 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

Relevant data, studies and reports

Commentary

Eliminating Cost-Sharing Requirements for Colon Cancer Screening in Medicare

David H. Howard, PhD[1]; Gery P. Guy, Jr, PhD[2]; and Donatus U. Ekwueme, PhD[2]

Uniform Data System (UDS)

Optimal Colorectal Cancer Screening in States' Low-Income, Uninsured Populations—The Case of South Carolina

Alex van der Steen, Amy B. Knudsen, Frank van Hees, Gailya P. Walter, Franklin G. Berger, Virginie G. Daguise, Karen M. Kuntz, Ann G. Zauber, Marjolein van Ballegooijen, and Iris Lansdorp-Vogelaar

SCREENING

No One Left Behind:

THE ROAD TO 80% BY 2018

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Despite widespread availability of colorectal cancer screening techniques that are proven to reduce both incidence and mortality of CRC, colon cancer remains the second leading cause of cancer deaths in the U.S. As reported by the CDC in November 2013, only 65 percent of Americans are up-to-date on CRC screening, although rates of CRC screening among uninsured or underinsured people are significantly lower.[1]

The CDC has announced a goal of "80% by 2018" — an ambitious plan to which AGA has signed on, because a majority of patients not screened are minority, low-income and historically uninsured. With the arrival of the Affordable Care Act containing provisions for universal coverage of preventive screenings, some current barriers may be reduced,[1] but numerous studies have underscored nonfinancial barriers to screening, including factors such as lack of trust, language barriers and health illiteracy, that continue to play important roles in keeping screening rates at unacceptably low levels.

A growing body of published data supports the role of patient navigation in improving CRC screening rates.[1] What has not been widely reported is what constitutes best practice in the field of CRC patient navigation.

Lessons Learned: Building a Patient Navigation Program

were (often mistakenly) interpreted by participating gastroenterologists to be indicative of "failure" of the open-access, heavily navigated program. When systems were carefully scrutinized to identify factors that contributed to a no-show, it became clear that three factors were the most impactful contributors to the no-show rate:

1. Length of time between initial face-to-face visit with navigator and date of scheduled colonoscopy.
2. The number of contacts, either face-to-face visits or phone calls, between navigator and patient.
3. Lack of contact in the week preceding the scheduled colonoscopy.

Best Practices

On the basis of our experiences with the no-cost colonoscopy program for screening of uninsured Connecticut patients, we would offer the following recommendations for sites considering the adoption of a similar program. The recommendations run across three broad categories: provider engagement, guidelines and navigator training.

1. **Engagement of providers.** To engage providers, one must demonstrate that the financial impact on their individual practices is minimal and the gain in CRC

REFERENCES

1. What signs: colorectal cancer screening test use—United States, 2012. Morbidity & Mortality Weekly Report. November 2013;62:881–888.
2. Coverage of colonoscopies under the Affordable Care Act's prevention benefit. September 2012. Kaiser Family Foundation, American Cancer Society, National Colorectal Cancer Roundtable.
3. DeGroff A, Cole K, Shapiro RS, et al. Key considerations in designing a patient navigation

prevent cancer FOUNDATION

Communication

Public Health Impact of Achieving 80% Colorectal Cancer Screening Rates in the United States by 2018

Reinier G. S. Meester, MS[1]; Chyke A. Doubeni, MD, MPH[2,3]; Ann G. Zauber, PhD[4]; S. Luuk Goede, MPH[1]; Theodore R. Levin, MD[5]; Douglas A. Corley, MD, PhD[5]; Ahmedin Jemal, DVM, PhD[6]; and Iris Lansdorp-Vogelaar, PhD[1]

Relevant data, studies and reports

- 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)

Recommended 80% by 2018 Policy Priorities -- Federal

- Addressing colonoscopy copay issue
- Fix screening definition to include follow up colo to + stool test
- Removal of financial barriers for screening navigation 'Care &'Caid
- Providing CRC treatment for the uninsured, including undocumented
- Fully fund CDC CRCCP program in every state

Recommended 80% by 2018 Policy Priorities -- Federal

- Improve Medicare reimbursement for PCPs to address PCP shortage created by ACA
- Incentive 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

Recommended 80% by 2018 Policy Priorities -- State

- **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 colonoscopy for employers/govt.**

Recommended 80% by 2018 Policy Priorities -- State

- **Fix screening care continuum definition to include follow up colo to positive stool test**
- **Require providers to donate care by building it in to the Certificate of Need**
- **Support outpatient Gis**
- **Support for state level roundtables**

Health care expansion issues

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

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

What should the role of government be in the 80% by 2018 effort?

- Address issue of CHC access to specialists
- Promote CRC screening to docs in ‘Care and ‘Caid
- Clarify definition of screening
- Provide visible spokesperson like the Surgeon General

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 Payers to incent providers to increase screening.
- Grasstops advocates

What do you need to advance your policy work?

- What do we know about Medicare patients who aren't getting screened?
- Strategies to pay for patient navigation
- Policy makers to better understand existing safety net programs
- Highlighting areas where there is a GI shortage
- Edgy awareness campaigns to drive demand; start message earlier

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 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

What studies/assessments could help you?

- ROI 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
- ROI for polyp removal for Medicare beneficiaries
- State specific data on cost of screening, treatment and savings if we were at 80%

What studies/assessments could help you?

- **Would more specialists donate care if cancer treatment was assured?**
- **Would delivering CRC screening messages earlier help with “on time” screening?**
- **Study on sedation safety**
- **Unmet need by geographic areas**

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
- What does the future of reimbursement look like?
- Best health plan practices around screening

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 enrolled in govt sponsored programs to get a wellness visit
- Access to docs in rural communities with full compensation to ambulatory surgical centers
- Higher reimbursement for GIs where there is a shortage

Final takeaways