# 2021 USPSTF Colorectal Cancer Screening Recommendation Lowers Screening Age From 50 To 45: Implications for NCCRT Partners

*June 7, 2021*
*12:00-1:00 PM ET*

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# Purpose of Today's Webinar

- Understand what changed in the new recommendation and how recent data informed the decision to lower the screening age to 45.
- Learn what we know about screening in 45-49-year-olds and general demographics in this age group.
- Examine how the recommendation impacts insurance coverage.
- Understand when the new guideline will be reflected in CRC screening quality measures and national screening rate indicators.
- Hear about the experiences of one state (Indiana) that began implementing screening at age 45 following legislation in 2019.
- Q&A

Clinical Review & Education

JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

Screening for Colorectal Cancer
US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force

**IMPORTANCE** Colorectal cancer is the third leading cause of cancer death for both men and women, with an estimated 52 980 persons in the US projected to die of colorectal cancer in 2021. Colorectal cancer is most frequently diagnosed among persons aged 65 to 74 years. It is estimated that 10.5% of new colorectal cancer cases occur in persons younger than 50 years. Incidence of colorectal cancer (specifically adenocarcinoma) in adults aged 40 to 49 years has increased by almost 15% from 2000-2002 to 2014-2016. In 2016, 26% of eligible adults in the US had never been screened for colorectal cancer and in 2018, 31% were not up to date with screening.

**OBJECTIVE** To update its 2016 recommendation, the US Preventive Services Task Force (USPSTF) commissioned a systematic review to evaluate the benefits and harms of screening for colorectal cancer in adults 40 years or older. The review also examined whether these findings varied by age, sex, or race/ethnicity. In addition, as in 2016, the USPSTF commissioned a report from the Cancer Intervention and Surveillance Modeling Network Colorectal Cancer Working Group to provide information from comparative modeling on how estimated life-years gained, colorectal cancer cases averted, and colorectal cancer deaths averted vary by different starting and stopping ages for various screening strategies.

**POPULATION** Asymptomatic adults 45 years or older at average risk of colorectal cancer (ie, no prior diagnosis of colorectal cancer, adenomatous polyps, or inflammatory bowel disease; no personal diagnosis or family history of known genetic disorders that predispose them to a high lifetime risk of colorectal cancer [such as Lynch syndrome or familial adenomatous polyposis]).

**EVIDENCE ASSESSMENT** The USPSTF concludes with high certainty that screening for colorectal cancer in adults aged 50 to 75 years has substantial net benefit. The USPSTF concludes with moderate certainty that screening for colorectal cancer in adults aged 45 to 49 years has moderate net benefit. The USPSTF concludes with moderate certainty that screening for colorectal cancer in adults aged 76 to 85 years who have been previously screened has small net benefit. Adults who have never been screened for colorectal cancer are more likely to benefit.

**RECOMMENDATION** The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years. (A recommendation) The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years. (B recommendation) The USPSTF recommends that clinicians selectively offer screening for colorectal cancer in adults aged 76 to 85 years. Evidence indicates that the net benefit of screening all persons in this age group is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the patient's overall health, prior screening history, and preferences. (C recommendation)

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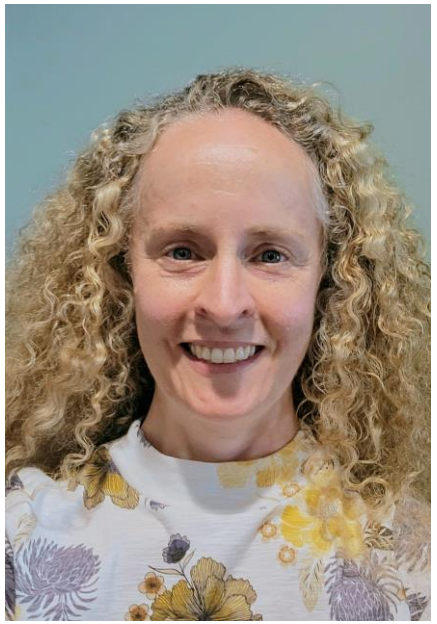
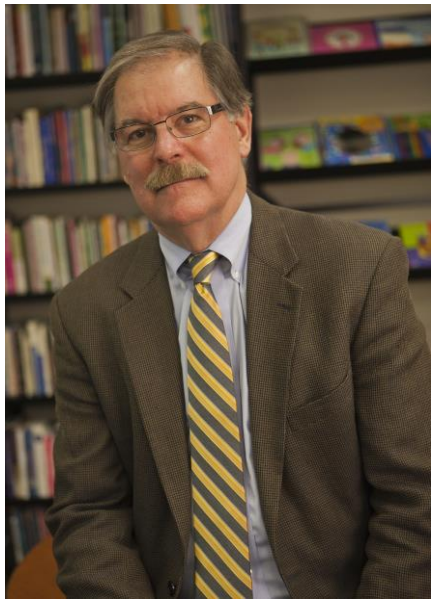
# Today's Panelists



**Heather Dacus, DO, MPH**; Director, Bureau of Cancer Prevention and Control, NYS Dept. of Health; NCCRT Policy Action SPT Co-chair (Moderator)



**Robert Smith, PHD**; Senior Vice President, Cancer Screening; American Cancer Society; NCCRT Co-chair

**Stacey Fedewa, PhD**; Scientific Director, Screening and Risk Factors Surveillance; American Cancer Society

# Today's Panelists

**Anna Schwamlein Howard**; Principal, Policy Development, Access to and Quality of Care; American Cancer Society Cancer Action Network

**Sepheen Byron**; Assistant Vice President of Performance Measurement, the National Committee for Quality Assurance

**Bryan Hannon**; Regional Government Relations Director; American Cancer Society Cancer Action Network

# Virtual Housekeeping

- **The event is being recorded.** The replay and slides will be made available on www.nccrt.org within a few days.
- **All participants are muted.**
- **Submit questions through the Q&A box at any time.** Use the chat box for general comments and technical questions only.
- **Please complete our evaluation.**

Funding for this webinar was made possible (in part) by the Centers for Disease Control and Prevention. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

| Comparison of ACS Colorectal Cancer Screening Guidelines (2018) and the USPSTF Updated CRC Recommendations (2021) | | |
|---|---|---|
| **Guideline/ Recommendation** | ACS (2018) | USPSTF (2021) |
| **Age to begin screening (recommendation grade)[1]** | 45 (qualified)<br>50-75 (strong) | 45 (B rating)<br>50-75 (A rating) |
| **Age to stop screening** | Continue to 75y as long as health is good and life expectancy 10+y;<br>76-85y individual decision making;<br>>85y discouraged from screening | 76-85y individual decision making (C rating) |
| **Acceptable test options[2]** | FIT annually,<br>HSgFOBT annually<br>mt-sDNA every 3y<br>Colonoscopy every 10y<br>CTC every 5y<br>FS every 5y<br>All positive non-colonoscopy tests should be followed up with colonoscopy. | FIT annually,<br>HSgFOBT annually<br>mt-sDNA every 3y<br>Colonoscopy every 10y<br>CTC every 5y<br>FS every 5y<br>FS every 10y, plus FIT every year<br>All positive non-colonoscopy tests should be followed up with colonoscopy. |

# CRC Screening Utilization Among People Aged 45 years: Where are we now?

Stacey A Fedewa, PhD

NCCRT Meeting

June 2021

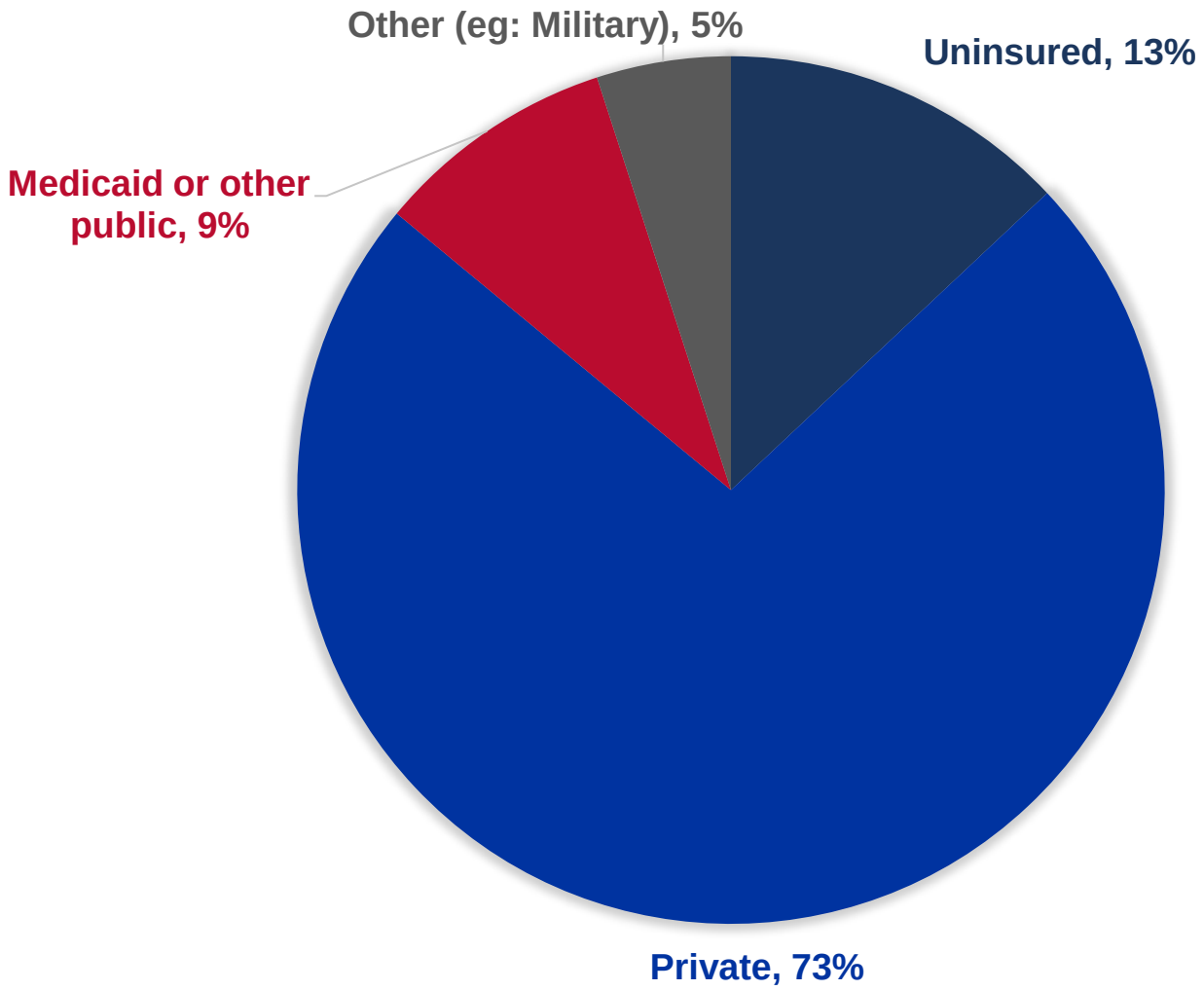
American Cancer Society®

# Characteristics of people 45-49 years

- 20.4 million people
- 52% female
- 38% are non-White (17% Hispanic, 12% Black, 7% Asian)
- 24% not born in the US
- 68% have seen a physician in the past year
- 14% currently smoke
- 72% are classified as overweight or obese

Source: US Census Data and National Health Interview Survey, 2018

# Health Insurance among People Aged 45-49 years*




*As of 2018

# What do we know about screening among people 45-49 years?

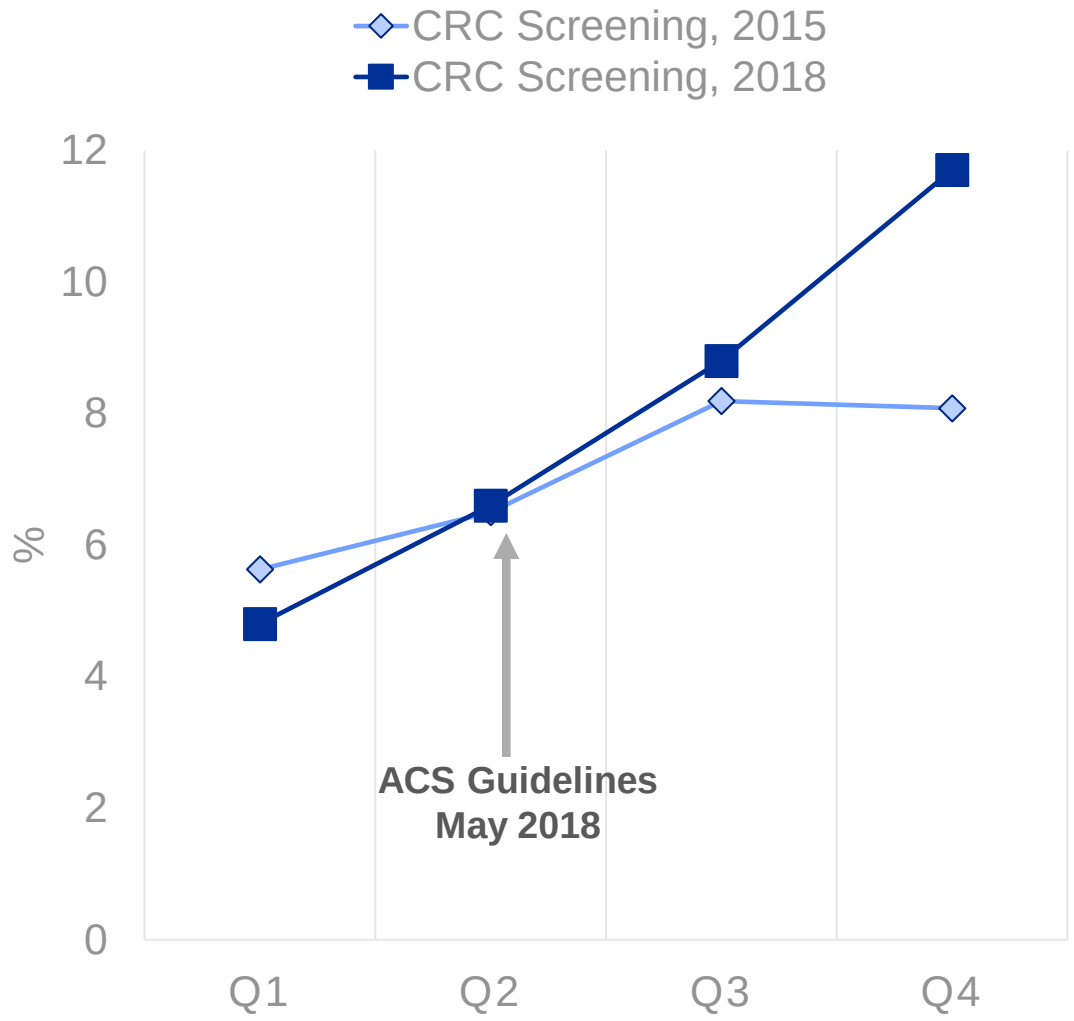
- In 2018 NHIS, 21% of people 45-49 years reported “being up to date”


- Asian (17%) and Hispanic (12%) individuals
- Uninsured (10%)
- No PCP visit in the past year (9%)


- Black individuals (28%)
- PCP visit in the past year (26%)

Source: National Health Interview Survey, 2018

# Recent Colorectal Screening (Past Year) among Adults 45-49 years, NHIS 2015 and 2018




Source Fedewa et al, 2020: https://pubmed.ncbi.nlm.nih.gov/31850529/

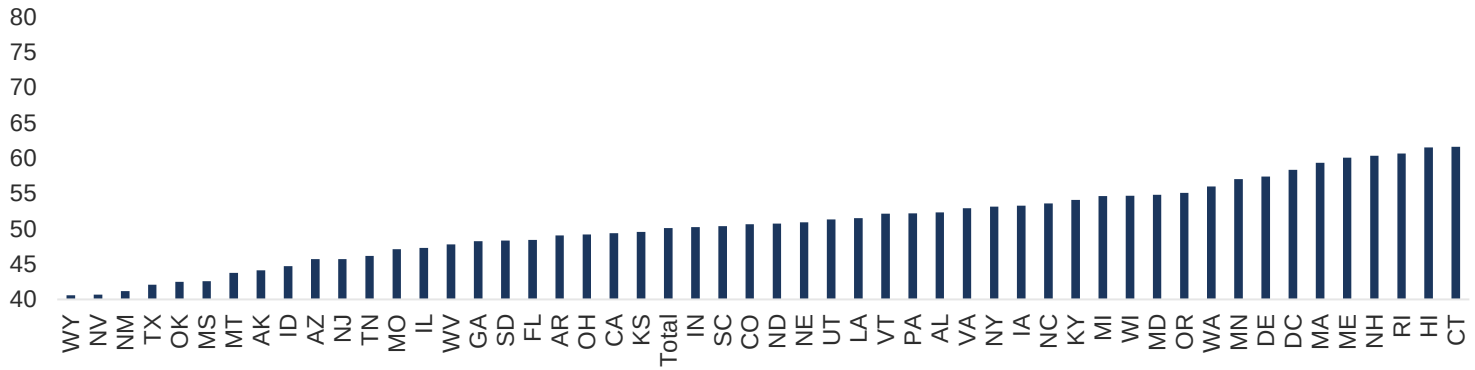
# What do we know about CRC screening initiation among People 50 years?

- Among Medicaid enrollees within Oregon: 17% of people who were 50 year-initiated CRC screening
- Among Kaiser Northern California's organized program: 51% of people received CRC screening within a year and 72% received CRC screening within 2 years of their 50$^{th}$ birthday
- Nationally, about half of people 50-54 years are up to date

Source: Mojica et al AJPM 2020: https://pubmed.ncbi.nlm.nih.gov/31786031/
Fedewa et al 2017: https://pubmed.ncbi.nlm.nih.gov/28427954/

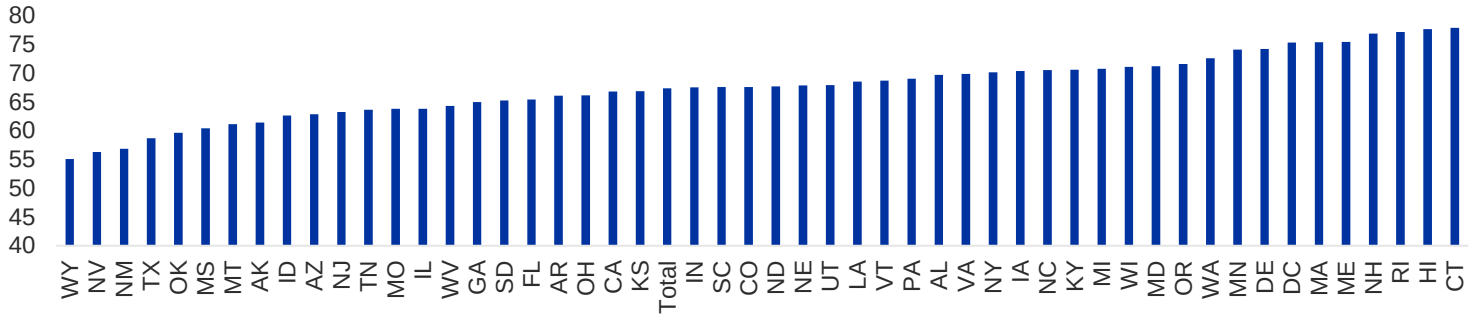
# Up-to-date CRC screening %, 2016 and 2018 BRFSS by State and 5-year Age

50-54



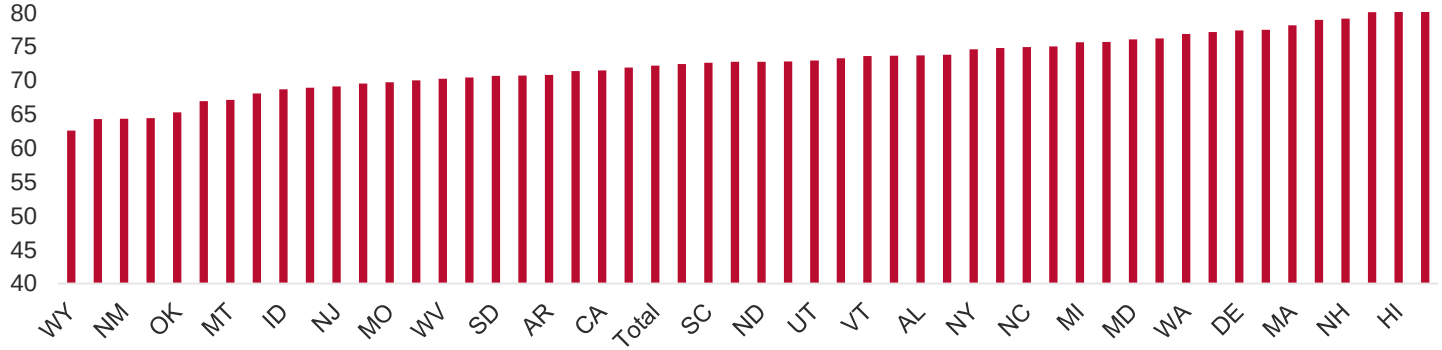

Average=50.1%
Highest CT= 61.6%, lowest WY=40.6%
PR=1.52

55-59




Average=67.6%
Highest CT =77.9%, lowest OK=55.1%
PR=1.41

60-64




Average=72.8%
Highest MA =81.2%, lowest TX=62.6%
PR=1.30

**Prevalence Ratio (PR) comparing the state with the highest v lowest screening**

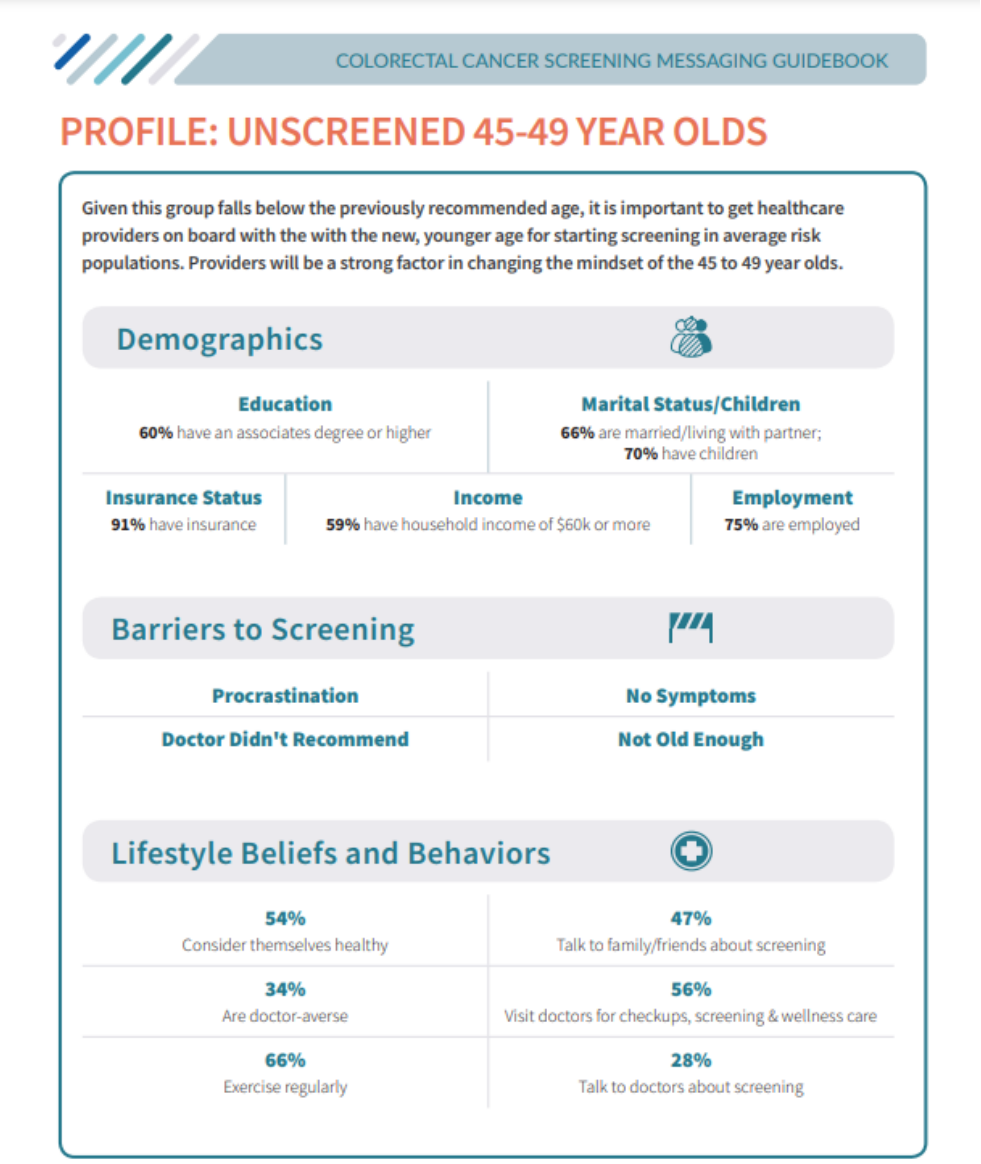
Source: Unpublished data, BRFSS 2016 and 2018

# Thank you!

# NCCRT Market Research

- ***2019 Colorectal Cancer Screening Messaging Guidebook*** profile on unscreened 45-49 year olds (research conducted in 2018)
  - Top barriers to screening: procrastination, doctor didn't recommend it, no symptoms, not old enough
- Summer 2021 – new market research deep dive into the young eligible and soon-to-be eligible (ages 30-50)

nccrt.org/resource/2019messagingguidebook/



# Coverage Implications for USPSTF Revised Colorectal Cancer Guidelines

**Anna Schwamlein Howard**
**Policy Principal**
**ACS CAN**

**June 7, 2021**

# Medicare

- Traditional Medicare

| Screening Method | Frequency | Age |
|---|---|---|
| Multi-target stool DNA test | Once every 3 yrs | 50-85 |
| Screening colonoscopy | Once every 10 yrs | No min. age requirement |
| Screening fecal occult blood test | Once every 12 months | 50+ |
| Flexible sigmoidoscopies | Once every 4 yrs | 50+ |

- Medicare Advantage Plans
  - Can provide coverage beyond traditional Medicare

# Medicaid

- Expansion population
  - USPSTF A/B recommended services provided at no cost-sharing
- Non-expansion population
  - Not required
  - Most states choose to cover

# Commercial Market

- ACA-compliant, non-grandfathered health plans must provide coverage for USPSTF A/B recommended services at no cost-sharing
  - Issuers do not have to change coverage mid-year
  - Plans must comply no later than 2023
  - Grandfathered health plans are not required to comply, but may choose to do so

# State Laws

- Some states enacted coverage mandates
  - Variation on plans that must comply
  - Variation on Guideline body

- State mandate defrayal requirement

# Thank you!

anna.howard@cancer.org

# HEDIS Colorectal Cancer Screening Measure

Sepheen C. Byron

*Assistant Vice President, Performance Measurement*
*June 7, 2021*

# HEDIS®

*Healthcare Effectiveness Data and Information Set*

*Tool used by over* **90 percent of America's health plans**

*Allows for* **comparison of health plans** *across* **important dimensions of care**


| | |
|---|---|
| Preventive care | *Colorectal Cancer Screening* |
| Chronic disease | *Comprehensive Diabetes Care* |
| Behavioral health | *Metabolic Monitoring for Children and Adolescents on Antipsychotics* |
| Care coordination | *Transitions of Care* |

# HEDIS Colorectal Cancer Screening

*Current measure description*

Percentage of members **50 - 75 years of age** who had **appropriate screening for colorectal cancer**

- FOBT in the past year
- FIT-DNA in the past three years
- Flexible sigmoidoscopy in the past 5 years
- CT Colonoscopy in the past 5 years
- Colonoscopy in the past 10 years

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| | |
|---|---|
| Product Lines | **Medicare, Commercial** |
| Reporting Methods | **Administrative, Hybrid** or **Electronic Clinical Data Systems** |

Medicare plans report the measure stratified by **socioeconomic status**

***Coming soon*** Plans will report the measure stratified by **race/ethnicity**

# CRC Guideline Updates – Indiana Experience

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# CRC Timeline


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# Indiana CRC Coverage: Before & After

## State Law from 2001-20

- Required coverage at age 50
- Referenced ACS*
- Specified coverage for high-risk individuals
- Did not apply to Medicaid

## 2020 Legislation

- Lowered age to 45
- Removed reference to ACS
- Removed reference to high-risk individuals
- Carved out state's HDHP

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# Since passage of new law

- **Ongoing communications**
  - Leveraged media interest of law's implementation to increase awareness– provided interviews, patient stories (Jul. 2020)
  - Communicated USPSTF revised guidelines to Medicaid and Indiana Dept. of Insurance (May 2021)
  - Continuing to listen to providers and other stakeholders (ongoing)
    - No major hiccups with implementation (that we know of)
    - Some sporadic issues with coding as preventative vs diagnostic
    - Evidence is all anecdotal; lack methods to track payer compliance (state-regulated vs. ERISA-regulated)

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# Still monitoring…

- Unresolved issues
  - Coverage of follow up screenings for positive stool tests
  - Strategies to increase uptake (state-funded screening program?)

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# Thank You!

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## For more information contact:

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