Colorectal Cancer Initiatives in Medicaid Agencies – A National Review

Sara Wilensky, JD, PhD
The Milken Institute of Public Health at The George Washington University

Prepared for the American Cancer Society

September, 2016

ACKNOWLEDGMENTS

We acknowledge the contributions of the following individuals in the preparation of the report: Holly Wolf, PhD, MSPH; Citseko Staples; Mary Doroshenk, MA, Lynda Flowers, JD, MSN, RN, Caroline Powers, Durado Brooks, MD, MPH, Katie McMahon, MPH, Kathleen Teixeira and Djenaba Joseph, MD, MPH.

The research for this publication was made possible by funding from the Centers for Disease Control and Prevention Cooperative Agreement Number 1U38DP004969-02The views expressed in the materials do not necessarily reflect the official policies of the Dept. of Health and Human Services.

EXECUTIVE SUMMARY

Colorectal cancer (CRC) is the second leading cancer killer in the United States when men and women are combined and the third most diagnosed cancer among men and women.[1] The United States Preventive Services Task Force (USPSTF) recommends screening for all men and women between the ages of 50 and 75. Approximately 60% of deaths from CRC could be avoided if everyone age 50 and older were screened regularly. Yet, only 65% of the US population receives the recommended screening.[2] According to 2013 NHIS data, only 36% of Medicaid-insured adults were up to-date with USPSTF CRC screening recommendations compared with at least 60% of privately or Medicare-insured adults.[3]

The expansion of many state Medicaid programs under the Patient Protection and Affordable Care Act (ACA) to include childless adults means that more adults within recommended screening ages will now have access to insurance coverage through state Medicaid programs and subsequently, increased access to colorectal cancer screening.[4] While this change offers great promise, little is known

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[1] American Cancer Society. Cancer Prevention and Early Detection Facts & Figures 2015-2016. Atlanta, GA: American Cancer Society; 2015. Available at http://www.cancer.org/acs/groups/content/@research/documents/document/acspc-047079.pdf. Accessed April 5, 2016.

[2] Centers for Disease Control and Prevention. "Screening for Colorectal Cancer: it's the right choice" infographic. Available at http://www.cdc.gov/cancer/colorectal/basic_info/screening/infographic.htm. Accessed April 19, 2016.

[3] Fedewa SA, et al. How many people will need to be screened to increase Colorectal Cancer Screening Prevalence to 80% by 2018? *Cancer* 2015 Dec 1;121(23):4258-65.

[4] Wilensky S. & Gray E. (2013); Existing Medicaid beneficiaries left of the Affordable Care Act's prevention bandwagon. *Health Affairs* 32(7): 1188-1195.

about the efforts state Medicaid agencies are taking to increase colorectal cancer screening rates among their beneficiaries. This study investigates what activities, if any, state Medicaid agencies are taking to increase colorectal cancer screening rates, what barriers exist to focusing on colorectal cancer screening, and any assistance that state Medicaid agencies would find useful in addressing this health issue. We conducted a nationwide survey to begin to establish the degree to which state Medicaid agencies were focusing on CRC screening. Our main findings are:

Most Medicaid agencies are not focused on increasing colorectal cancer screening rates among beneficiaries, but 10 states are leading the way by adopting strategies to address this health issue. Out of the 47 states and District of Columbia that responded to our survey, 21 states are not taking any action to increase colorectal cancer screening rates and another 16 states are engaged in limited activities. Limited activity states generally pursue only one strategy and/or are at the beginning of a collaborative relationship with their state's public health program. In contrast, 10 states (AZ, KY, MD, MA, MN, MT, NY, OR, WA, WY) engage in extensive activities in this area. These states often pursue multiple strategies to increase screening rates and usually partner with their state public health department/cancer control program.

Very few states (10) track the colorectal cancer screening rates among Medicaid beneficiaries. While many state Medicaid agencies indicate they could calculate their colorectal cancer screening rates through review of utilization codes,

only 10 states track colorectal cancer screening rates as a regular activity. Even two of the extensive activity states (AZ, MT) do not track screening rates. One of the reasons is a lack of a national measure. While HEDIS includes a colorectal cancer screening measure for Medicare and commercial plans, this requirement does not extend to Medicaid managed care plans. In addition, CMS has not included this measure in its Adult Core Set.

Respondents identify multiple barriers to focusing on colorectal cancer screening among their Medicaid beneficiaries. The barriers fall into four main categories:

- *Measurement issues*. In addition to a lack of a national measurement, there are difficulties measuring progress and evaluating programs because of the 10-year gap between recommended screening colonoscopies, the most common colorectal cancer screening exam. Many Medicaid beneficiaries change plans, move locations, and are hard to find for follow-up. The lag time between recommended screening exams combined with the tendency of Medicaid beneficiaries to cycle in and out of Medicaid make it difficult to assess initiatives aimed at improving colorectal cancer screening rates.[5]

  Mixed views about screening options. Colonoscopies are considered by many policy leaders and providers to be the "gold standard" in screening, but difficulties associated with the procedure (time needed off work, travel and

[5] Sommers BD, Graves JA, Swartz K, Rosenbaum S. Medicaid and marketplace eligibility changes will occur often in all states; options can ease impact. 2014; *Health Affairs* 33(4): 700-707.

other logistics, discomfort, etc.) contribute to low screening rates in general. These difficulties are exacerbated when dealing with a low-income population that is more likely to have transportation issues, job-related restrictions, lack of other supports to assist them, etc. Providers and policymakers appear unaware of or unconvinced by modeling studies that have shown newer generations of Fecal Immunochemical Tests to be nearly as effectives in reducing CRC incidence and mortality as screening colonoscopies every 10 years.[6] In addition, recent studies have shown that when provided with options many patients choose stool-based testing over colonoscopy for CRC screening, and are more likely to adhere to regular screening when they have a choice of tests.[7]

- *Agency Culture*. Some Medicaid agency cultures create a barrier to addressing colorectal cancer issues because they view screening, outreach, education etc. a public health responsibility, not a responsibility of a Medicaid agency, and/or they are not interested in collaborating with public health on these strategies.
- *Other Priorities/Limited Resources.* Many state agencies did not reject the notion of working on colorectal cancer screening rates as much as they prioritized other issues. Given limited resources for quality improvement

[6] Screening for Colorectal Cancer: U.S. Preventive Services Task Force Draft Recommendation Statement. Figure B. Released October 5th, 2015.
[7] Inadomi JM, Vijan S, Janz NK et al Adherence to colorectal cancer screening: a randomized clinical trial of competing strategies Arch Intern Med. 2012 Apr 9;172(7):575-82.

initiatives, states often focus on the largest segments of the Medicaid population, moms and children, for targeted initiatives.

While the 10 states that engage in extensive activities to increase colorectal cancer screening rates often partner with their state public health agency, other respondents identify several reasons such partnerships do not exist in their state. Barriers to creating partnerships identified by Medicaid agencies include competing priorities such as implementing ACA requirements and Medicaid managed care requirements; resisting sharing resources outside of the agency; and focusing on payment and coverage, not outreach and education. Perhaps most importantly, most states have not required their Medicaid managed care plans to focus on colorectal cancer screening activities. Such requirements would likely be initiated by the state Medicaid agency or the state agency that oversees the Medicaid program. States have not made colorectal cancer screening rates a focus of, or even an option for, managed care plans to address in their annual Performance Improvement Projects, which are required of all Medicaid managed care programs. Many public health agency officials indicate that partnering with the Medicaid agency in their state is a low priority given the limited resources of the public health agency and poor relationships with the state Medicaid office.

Respondents identify several areas that they would welcome assistance in addressing colorectal cancer screening. Respondents would like to receive assistance from the federal government relating to the creation of a national

screening measure, the development and distribution of resources, and increased public awareness of the issue.

INTRODUCTION

Colorectal cancer is the second leading cancer killer in the United States when men and women are combined and the third most diagnosed cancer among men and women, with an estimated 132,700 new cases expected in 2015.[8,9] It is most common among men or women 50 or older, and risk increases with age. Many people with colorectal cancer are asymptomatic. Those with symptoms may experience blood in their stool, persistent stomachaches and cramps, or unexplained weight loss.[10]

The United States Preventive Services Task Force (USPSTF) recommends screening for all men and women between the ages of 50 and 75.[11] Approximately 60% of deaths from colorectal cancer could be avoided if everyone age 50 and older were screened regularly.[12] Unfortunately, only 65% of the US population receives the recommended screening.[13]

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[8] American Cancer Society. What are the key statistics about colorectal cancer? Available at http://www.cancer.org/cancer/colonandrectumcancer/detailedguide/colorectal-cancer-key-statistics. Accessed October 2, 2015.
[9] Centers for Disease Control and Prevention. Colorectal Cancer Screening – Basic Fact Sheet. Available at http://www.cdc.gov/cancer/colorectal/pdf/basic_fs_eng_color.pdf. Accessed October 2, 2015.
[10] Id.
[11] Id.
[12] Id.
[13] Centers for Disease Control and Prevention, supra note 2.

Colorectal cancer usually starts as pre-cancerous polyps that form in the colon or rectum. Screening is effective because if detected early, physicians can remove polyps before they turn into cancer or at a very early stage after becoming cancerous.[14] The two most common screening methods recommended by the USPSTF, the American Cancer Society and other guideline making bodies are:

1. *Fecal Occult Blood Testing (FOBT).* FOBT tests determine if blood is present in a person's stool. There are two types of FOBT tests, one that uses the chemical guaiac to detect blood and the other that uses antibodies to detect blood. The antibody FOBT test is referred to as a FIT test, which stands for Fecal Immunochemical Test. Both tests are performed at home. The individual retrieves a small stool sample and returns the sample with the test kit to the lab which checks the samples for blood. USPSTF recommends this test annually.

2. *Colonoscopy*. This test also occurs at the doctor's office or outpatient clinic. The physician inserts a longer flexible, lighted tube into an individual's rectum to check the rectum and entire colon for polyps. A full bowel preparation is needed and the patient is sedated prior to the procedure. USPSTF recommends this test every 10 years.

[14] Centers for Disease Control. Screen for Life: National Colorectal Cancer Action Campaign. Available at http://www.cdc.gov/cancer/colorectal/sfl/index.htm. Accessed October 2, 2015.

Colonoscopies are also used as follow up tests if any abnormalities are found with using an FOBT or flexible sigmoidoscopy test.

This research study evaluates the level of activity, if any, by state Medicaid agencies to increase colorectal cancer screening for Medicaid beneficiaries, as well as barriers faced by Medicaid agencies in implementing colorectal cancer control efforts. The study builds on prior research that showed Medicaid coverage was generally not an obstacle for beneficiaries who need to be screened for colorectal cancer. Most Medicaid programs covered all USPSTF-recommended preventive screens for colorectal cancer, and only five states explicitly did not cover these tests preventively (AR, NE, OK, SD, UT).[15] Despite coverage of colorectal cancer screening tests, according to 2013 NHIS data, only 36% of Medicaid-insured adults were up to-date with USPSTF CRC screening recommendations compared with at least 60% of privately or Medicare-insured adults.[16] Access to screening may be difficult, given additional barriers that are associated with access to care for an indigent population (frequent moving, churning on/off Medicaid, finding providers who accept Medicaid, logistical hurdles etc.).[17] These are important issues to consider, given Medicaid expansion under the Patient Protection and Affordable Care Act (ACA),

[15] Wilensky & Gray. Coverage of Preventive Services for Adults – A National Review. The Milken Institute School of Public Health at the George Washington University. November, 2012 or Wilensky, supra note 4.
[16] Fedawa, supra note 3.
[17] Sommers, supra note 5.

which will increase the number of individuals eligible for Medicaid who fall within the recommended guidelines for colorectal cancer screening.[18]

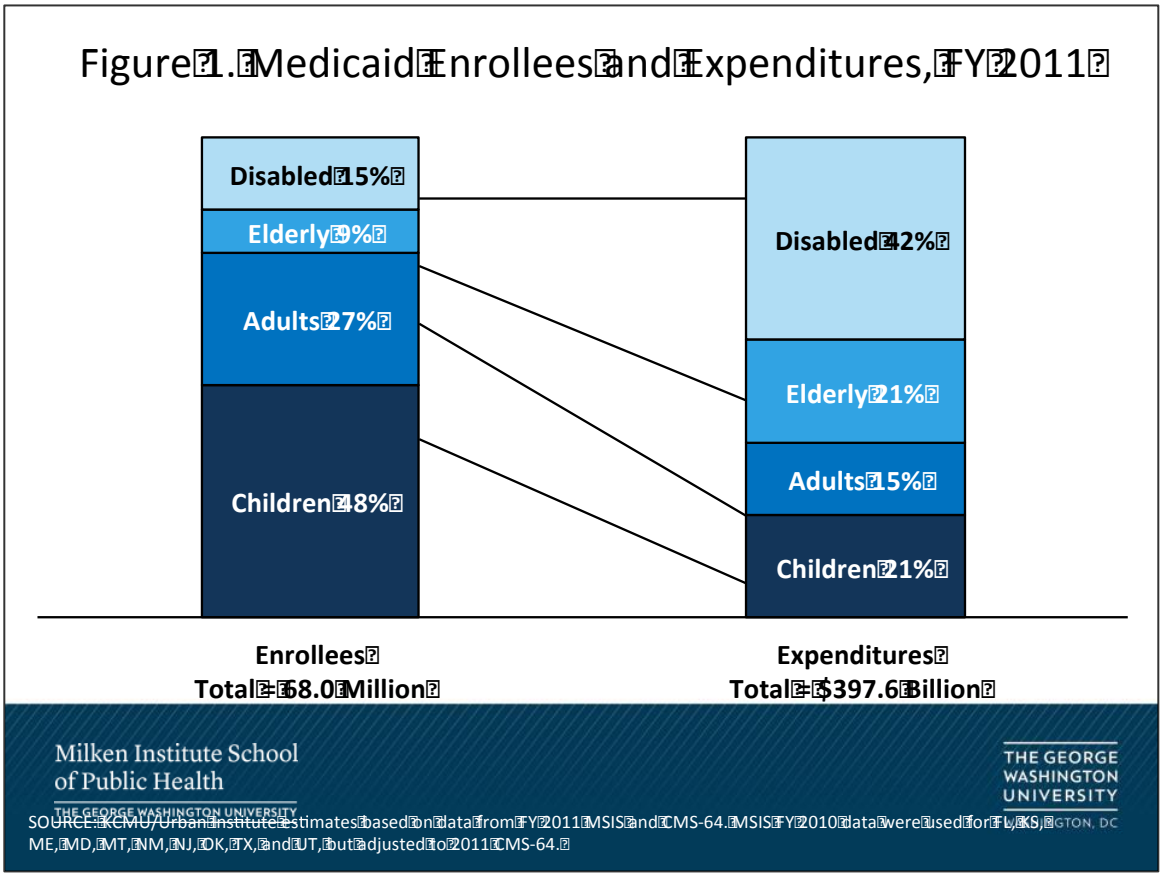
MEDICAID

Medicaid is the nation's federal-state public health program for the indigent. It is the single largest public source of health insurance coverage, insuring approximately 70 million individuals.[19] Traditionally, to be eligible for Medicaid an individual had to meet five requirements: 1) fit into a designated category (e.g., pregnant women, child under one year of age), 2) earn an income no higher than is allowed for that category, 3) have non-wage resources that do not exceed a state mandated threshold, 4) be a resident of the United States and the state where benefits are received, and 5) meet immigration requirements if applicable.

As a result of these eligibility rules, traditional Medicaid (as opposed to Medicaid expansion under the ACA) generally covers children, pregnant women, disabled adults and the elderly, and excludes many non-disabled adults. As shown in Figure 1, children, who do not need colorectal cancer screening on a preventive basis, make up almost half of all Medicaid beneficiaries. Under traditional Medicaid, non-elderly adults without children are ineligible for Medicaid in most states, and eligibility for working parents, disabled, and the elderly is limited.[20] As a result, men

[18] Pub. Law. 111-148.
[19] Kaiser Family Foundation. Medicaid Moving Forward. March 2015. Available at http://kff.org/health-reform/issue-brief/medicaid-moving-forward/. Accessed October 2, 2015.
[20] Id.

and women between50-75 comprise a relatively small proportion (approximately 14%) of the traditional Medicaid population.[21]



The ACA permits states to expand their Medicaid program to all individuals under age 65 who are under 138% of the federal poverty level. Under expansion Medicaid individuals do not need to fit into a specific category, such as a pregnant

[21] U.S. Department of Commerce, Bureau of the Census (2013). American Community Survey 3-Year Estimates - Public Use Microdata Sample, 2011-2013. Universe: ((AGEP in (50,75)) AND (HINS4 in (1,2)); Weight used: PWGTP. Generated by the author via DataFerrett. Available at: http://dataferrett.census.gov/TheDataWeb/index.html Files generated October 6, 2014.

woman or a child. As of September 1, 2015, 29 states and DC have chosen to expand Medicaid.[22] In states that have expanded Medicaid, coverage for low-income adults is significantly greater than in non-expansion states. As a result, a higher proportion of expansion Medicaid beneficiaries are likely to meet the recommended guidelines for colorectal cancer screening.

Quality Improvement in Medicaid

The Centers for Medicaid and Medicare Services (CMS) require all state Medicaid agencies to develop a written strategy to assess and improve the quality of care provided by Medicaid Managed Care Organizations (MCO).[23] This strategy must include how states will measure the quality performance of their plans.[24] Most states rely on national performance measures such as HEDIS (Healthcare Effectiveness Data and Information Set), though some states require their own state-specific performance measures as well.[25]

HEDIS was developed by the National Committee for Quality Assurance (NCQA) and includes 81 measures over 5 domain areas: effectiveness of care, access/availability of care, experience of care, utilization and relative resource use,

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[22] The Advisory Board. Where the states stand on Medicaid expansion. Available at https://www.advisory.com/daily-briefing/resources/primers/medicaidmap. Accessed October 2, 2015.
[23] 42 CFR 438.202(a).
[24] 42 CFR 438.204
[25] Association for Community Affiliated Health Plans. How can states leverage Medicaid Managed Care to improve health care quality - Fact Sheet. Available at http://communityplans.net/Portals/0/Fact%20Sheets/2012_0621%20How%20states%20leverage%20Medicaid%20Managed%20Care%20to%20improve%20quality.pdf. Accessed October 1, 2015.

and MCO descriptive information. More than 90% of America's health plans use HEDIS, allowing for an "apples-to-apples" comparison on plan performance.[26]

NCQA uses a multi-step process to develop or update HEDIS measures. This process includes identifying a clinical area for evaluation, conducting a literature review relating to that area, developing the measure through Measurement Advisory Panels, and working with stakeholders such as purchasers, consumers, health plans, providers, and policy makers to assess the measure design, and conducting a field test focused on validity, reliability, and feasibility.[27,28]

The HEDIS measure for colorectal cancer screening provides a description of individuals age 50-75 who are up to date with colorectal cancer screening. The HEDIS screening measure is only required for Medicare and commercial managed care plans; the requirement does not apply to Medicaid managed care plans. States, of course, may choose to require their Medicaid managed care plans to track measures in addition to the HEDIS requirements. According to the technical specifications for the HEDIS measure, the individual being tested must be enrolled in the plan during both the measurement year and the prior year, and the individual being tested must not have more than one gap longer than 45 days to be counted as a continuous enrollment year.[29,30] Due to the frequent churning of Medicaid

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[26] NCQA. HEDIS & Performance Measurement. Available at http://www.ncqa.org/tabid/59/Default.aspx. Accessed October 1, 2015.
[27] NCQA. HEDIS measure development process. Available at http://www.ncqa.org/tabid/414/Default.aspx. Accessed October 1, 2015.
[28] NCQA. Quality Rating System Measure Technical Specifications. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2016-QRS-Measure-Technical-Specifications.pdf. Accessed October 1, 2015.
[29] Id. at 116.

enrollees on and off programs because of eligibility changes, administrative problems, geographic changes, or other reasons, the continuous enrollment criteria makes it difficult to apply the colorectal cancer screening HEDIS measures to Medicaid plans.

Acceptable screening exams include an FOBT with required number of samples returned, a flexible sigmoidoscopy during the measurement year or 4 years prior, or a colonoscopy during the measurement year or nine years prior. The explanation of the measure changed slightly in the 2016 update by clarifying that FOBT tests performed in the office setting or a sample collected through a digital rectal exam does not qualify as meeting the performance measure.[31]

Medicaid managed care plans must have an External Quality Review Organization (EQRO) conduct an annual review of the quality, timeliness, and access to services provided by the plans.[32,33] EQROs validate MCO performance measures and assess the Performance Improvement Plans (PIP) conducted by the organizations on an annual basis. In addition, every three years EQROs review MCOs to ensure compliance with state and federal requirements.[34]

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[30] NCQA. HEDIS 2015 measures. Available at. http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2016. Accessed March 31, 2016.
[31] NCQA. HEDIS 2016 measures. Available at http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2016. Accessed March 31, 2016.
[32] 42 CFR 438.
[33] Medicaid.gov. Medicaid Managed Care Quality. Available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/medicaid-managed-care-quality.html . Accessed October 1, 2015.
[34] 42 CFR 438.358(b).

CMS requires that states compel their Medicaid MCOs to conduct PIPs on a regular basis.[35] PIPS allow states and plans to focus on improving quality performance in specific areas. It is up to the state to determine how many PIPs its plans should conduct each year and whether the state or the plan determines the focus areas for the PIPs.[36] Some states give MCOs a choice among selected topics or within broad health areas such as pediatric care or maternal care.

As part of the national effort to develop standardized quality measurement, reporting, and improvement activities, the Children's Health Insurance Program Reauthorization Act of 2009 required the Department of Health and Human Services to develop a set of core measures for children's health care.[37] States may voluntarily track and report these measures and there has been significant variation among the states regarding the extent that they do so.[38]

Building on that strategy, the ACA required CMS to develop and publish a core set of quality measures for all adult Medicaid beneficiaries that states may voluntarily report.[39,40] CMS published an initial Adult Core Set in 2012 and is currently using the 2015 Update.[41] Colorectal cancer screening has never been included in the Adult Core Set. Furthermore, the Measures Applications Partnership,

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[35] 42 CFR 438.240(d).
[36] Association for Community Affiliated Health Plans, supra note 25.
[37] Pub. L. 111-3.
[38] Association for Community Affiliated Health Plans, supra note 25.
[39] ACA Section 1139B.
[40] Medicaid.gov. Adult Health Care Quality Measures. Available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html . Accessed October 1, 2015.
[41] Medicaid.gov. Adult Healthcare Quality Measures. Available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html. Accessed October 1, 2015.

the public-private multi-stakeholder entity making recommendations to HHS for future changes to the core set, does not list colorectal cancer screening as one of its priority measures for inclusion in future sets.[42]

RESEARCH QUESTIONS AND METHODOLOGY

This research evaluates the extent that Medicaid agencies undertake activities related to colorectal cancer screening and prevention. Specifically, the following three research questions are addressed.

1. **What activities, if any, are state Medicaid agencies undertaking to increase colorectal cancer screening rates among beneficiaries?** While prior research indicated that preventive screening tests for colorectal cancer are generally covered by Medicaid agencies, little information is known about any actions state Medicaid agencies are taking to increase the use of colorectal cancer screening options. Efforts to increase screening rates are essential since CRC screening rates for recommended adults is significantly lower among Medicaid beneficiaries than for individuals on Medicare or who are privately insured. This question investigates whether state Medicaid agencies are taking steps to increase screening rates by conducting patient

[42] National Quality Forum. Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2015. Available at http://www.qualityforum.org/Publications/2015/08/Strengthening_the_Core_Set_of_Healthcare_Quality_Measures_for_Adults_Enrolled_in_Medicaid,_2015.aspx Accessed October 1, 2015. See generally, http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx. Accessed March 31, 2016.

outreach, emphasizing provider education, partnering with public health agencies, establishing tracking measures, or employing other strategies.

2. **What barriers exist that inhibit Medicaid agencies from undertaking activities to increase colorectal cancer screening rates among beneficiaries?** If Medicaid agencies are not focused on improving colorectal cancer screening rates, this questions addresses whether barriers exist that could be reduced or eliminated that might increase attention to this issue. If there are barriers, are these barriers common across Medicaid agencies or are they specific to particular states or programs?

3. **What actions would assist states in undertaking activities to increase colorectal screening rates among beneficiaries?** If state Medicaid programs are not focused on decreasing colorectal cancer screening and common barriers are identified, are there any actions that could reduce or eliminate any of the barriers? Is there agreement among state Medicaid agencies about the type of action that could be helpful?

This study was completed by reviewing publically available information and surveying state Medicaid officials across the country. In addition, public health officials from 27 states were contacted, including 13 cancer control program directors and 14 cancer control program managers. These individuals were contacted to confirm and/or elaborate on partnership activity their state's Medicaid

agency. The review of publically available information included an examination of state Medicaid agency websites, associated materials relating to colorectal cancer (e.g., research report cited by Medicaid agency, different state programs referred to by Medicaid agency), a general internet search of colorectal cancer activities in each state, and a review of public health/cancer control program activity in each state. If a state did not respond to the survey, publically available information is not included in the findings. In addition, every Medicaid agency was contacted for a telephone survey relating to the three research questions identified earlier. (Appendix A). Some Medicaid officials preferred to complete the survey via email, but were then available for follow-up questions via telephone or email correspondence. Upon completion of the survey, Medicaid Directors in every state were sent a letter including the information relevant to that state and given the opportunity to correct any erroneous information or add new information.

FINDINGS

The findings focus on four main areas: level of colorectal cancer screening related activity by Medicaid agencies, overall barriers to Medicaid agencies preventing them from focusing on colorectal cancer screening activity, actions that would be helpful to Medicaid agencies to increase their efforts toward colorectal cancer screening activity, and partnerships between Medicaid and other interested parties to address colorectal cancer screening rates. Four states did not respond to/declined to participate in the survey (IL, NJ, OH, TX).

Activity Level

As shown in Figure 2 and Table 1, 10 states engage in extensive activities to increase colorectal cancer screening, 16 states have limited activities in this area, and 21 have no activities focused on colorectal cancer. As compared to states with limited activities, those with extensive activities are more likely to address colorectal cancer through multiple initiatives and develop partnerships with other agencies (i.e., Department of Health) or interested parties (i.e., providers, insurers). A detailed description of each state with extensive activities is provided below, but overall Medicaid agencies with extensive activities are likely to engage in one or more of the following endeavors:

- Significant quality measurement, tracking, and/or incentive activities;
- Partnerships with public health and/or cancer control programs;
- Participation in advisory committees and data sharing;
- Significant outreach activities to patients and/or providers;
- Participation in a larger public health strategy that specifically incorporates colorectal cancer screening;
- Research activities focused on increasing colorectal cancer screening rates; or
- Identifying effective strategies to improve colorectal cancer screening rates with the use of expert assistance.

Figure 2. Medicaid Colorectal Cancer Activity Level, 2016

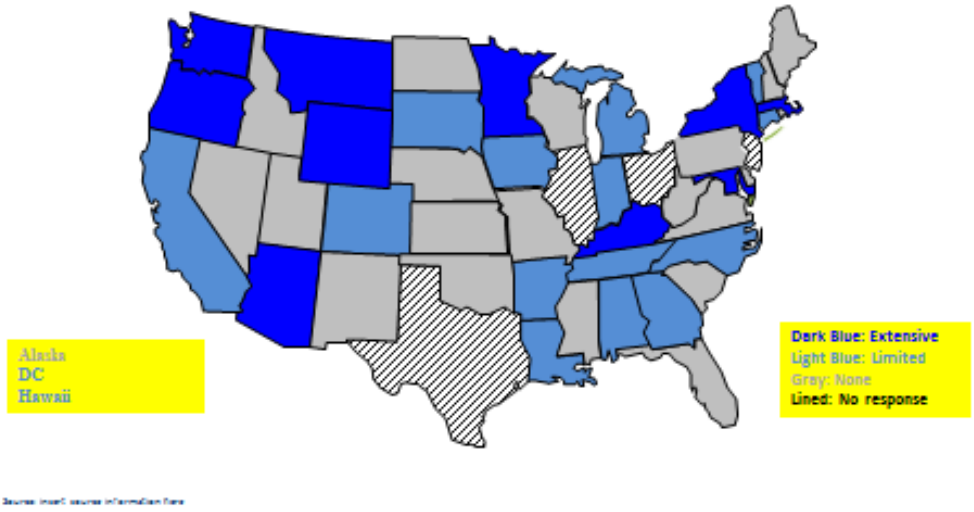


Table 1. Medicaid Agency Colorectal Cancer Activity Level, by State, 2016

State	Activity Level	Colorectal Cancer Activity Description
AL	Limited	Medicaid/Public Health data sharing.
AK	None	
AZ	Extensive	Health Dept. all population initiative includes CRC outreach through Medicaid MCOs; Medicaid collaborates with Health Dept. on CRC messaging to providers and members.
AR	Limited	CDC grant to increase CRC screening that focuses on private practice providers, but could include Medicaid providers.
CA	Limited	Some collaboration with public health to increase CRC screening rates; in discussions for more extensive collaboration.

State	Activity Level	Colorectal Cancer Activity Description
CO	Limited	Public Health and Univ. Colorado Medical School had all population CRC screening program that ended 7/1/2015; Medicaid currently considering requesting budget authority to increase reimbursement for screening colonoscopies.
CT	Limited	No CRC-specific program, but CRC screening part of overall preventive care analytics/provider reporting.
DE	None	
DC	Limited	Rely on MCOs to provide required preventive health screening and outreach; one MCO has CRC screening as a care gap intervention on an individual assessment by Care Managers.
FL	None	
GA	Limited	Track screening rates only. Now covers USPSTF A&B preventive services, but no CRC specific activity.
HI	Limited	Tracks CRC screening rates. Includes CRC question in adult health assessment.
ID	None	
IL	No response/not participate	
IN	Limited	Work with Public Health on CDC planning grant.
IA	Limited	Medicaid CRC screening targeted outreach to Disease Management patients only.
KS	None	
KY	Extensive	Work with Public Health on CRC Medicaid data sharing to assist Public Health CDC grant; have KY CRC advisory committee with Medicaid and Public Health.
LA	Limited	Beginning to work on quality measures that include CRC, but not implemented yet.
ME	None	

State	Activity Level	Colorectal Cancer Activity Description
MD	Extensive	Created state-specific CRC tracking measure; Medicaid working closely with Public Health and FQHCs to do targeted outreach; outreach to MCOs to promote CRC screening and patient.
MA	Extensive	MassHealth included in larger Public Health chronic disease strategy that focuses on improving CRC screening rates as one of its strategies; health plans include preventive care as a major focus for measurement and improvement.
MI	Limited	Recently began tracking CRC screening rates. Starting to work on ideas for partnership with public health. Need to assess data results before making strategic decisions.
MN	Extensive	Medicaid assists with 5-year CDC research project that focuses on increasing screening for CRC and breast cancer among Medicaid beneficiaries.
MS	None	
MO	None	
MT	Extensive	Medicaid and Public Health have very close working relationship; until this summer had CDC CRC grant that included outreach to Medicaid patients and direct screening services; current CDC funding does not include direct service pilot project with provider reminders and mass media campaign; held CRC roundtable with providers and insurers.
NE	None	
NV	None	
NH	None	
NJ	No response/not participate	
NM	None	

State	Activity Level	Colorectal Cancer Activity Description
NY	Extensive	CRCCP funding to improve CRC screening among Medicaid managed care members, CRC screening reporting required by state and in Medicaid Managed Care contracts, other contract provisions encourage screening; Medicaid working closely with health plans on outreach and messaging to providers; State has quality incentives for Medicaid MCOs; 2008 two health plans had quality improvement projects relating to CRC; Medicaid and Public Health work closely together.
NC	Limited	Medicaid is participating in early stages of state CRC roundtable discussions; tracking CRC screening rates.
ND	None	
OH	No response/not participate	
OK	None	
OR	Extensive	CRC screening is one of 16 P4P measures for Coordinated Care Organizations; track CRC screening rates; Public Health has CRC community education materials available to CCOs that likely reach Medicaid beneficiaries; worked with experts to identify effective strategies to improve CRC screening rates.
PA	None	
RI	None	
SC	None	
SD	Limited	Focus on CRC screening for Medicaid Health Home population; early stages of discussion with Public Health to assist with their CRC grant.
TN	Limited	Creating episodes-of-care tied to overall health reform payment strategy in state. An episode of care has been created for screening and diagnostic CRC. Reform effort in initial stages, but will tie reimbursement to quality measures on episodes-of-care.

State	Activity Level	Colorectal Cancer Activity Description
TX[a]	No response	
UT	None	
VT	Limited	Track screening rates only.
VA	None	
WA	Extensive	Track CRC screening rates; CRC rate will be part of statewide performance measure for all payers in 2016; Medicaid targeted outreach.
WV	None	
WI	None	
WY	Extensive	Track screening rates for PCMH only; Medicaid uses CRC as one of 9 clinical quality measures for PCHM. In first year of project, but will base reimbursement level on screening rates.

[a] Texas did not respond to this survey, but we note that the University of Texas MD Anderson Cancer Center received funding, partially through a Medicaid waiver, to provide CRC screening to Medicaid beneficiaries, dual eligible and uninsured individuals.

States with limited activities are more likely to use a single strategy focused on colorectal cancer or be at the beginning of a process to address colorectal cancer rates, and are less likely to have engaged in partnerships with other entities. Examples of limited activities include:

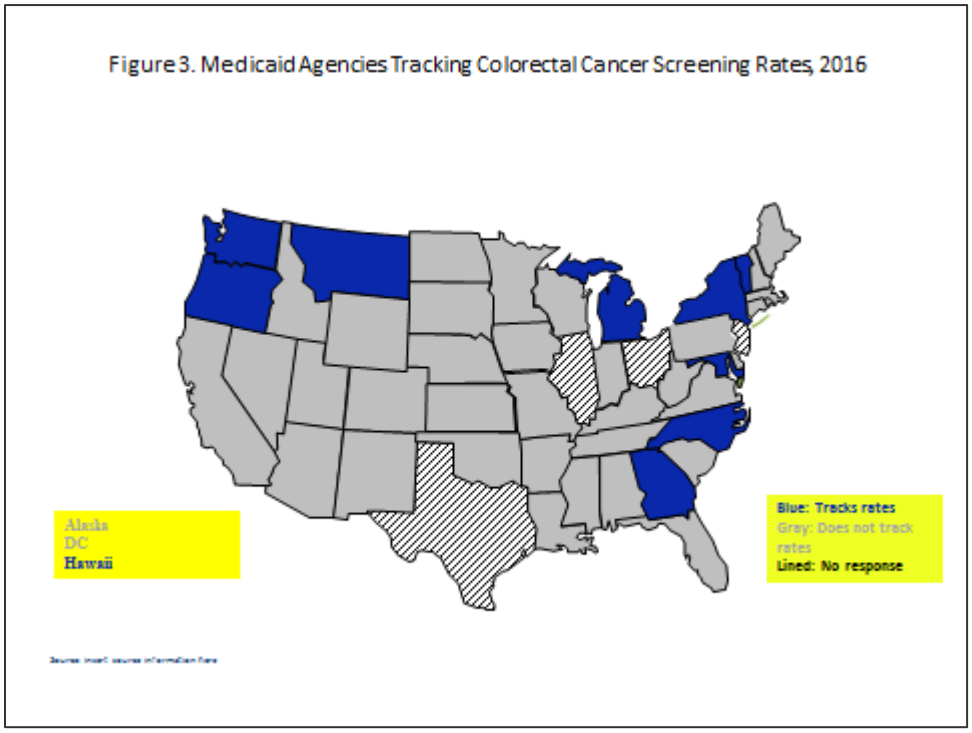
- Being in the early stages of a collaboration or planning process;
- Data sharing only;
- Screening rate tracking only;
- Colorectal cancer specific activity only required for a limited Medicaid population (i.e., Patient Centered Medical Home, Disease Management);
- Using an overall preventive care strategy that includes colorectal cancer screening, but it is not a colorectal cancer specific program; and

- Providing assistance with grant writing or a planning grant related to colorectal cancer control efforts.

Twenty-one states reported no activity focused on colorectal cancer screening. Nine of these states (DE, FL, KS, LA, MI, NV, NH, RI, WI) as well as DC (a limited activity area) indicated they leave the decision whether to have a colorectal cancer screening initiative up to their Medicaid managed care plans as part of the plans' overall responsibility to provide preventive care and adhere to clinical practice guidelines. While it was beyond the scope of this research project to investigate whether every Medicaid managed care plan has a colorectal cancer screening initiative, conversations with Medicaid personnel in three "no activity" states (NV, NH, NM) and DC revealed that one or more of their managed care plans engage in colorectal cancer screening outreach to patients and/or providers. These states were not considered limited activity states because the Medicaid agency does not require colorectal cancer screening related initiatives and the plans could discontinue the initiatives at any time. (DC is considered a limited activity "state" because it has other colorectal cancer specific activities as well).

As shown in Figure 3, out of the 47 states and DC that responded to this survey, only 10 states track colorectal cancer screening rates in their Medicaid population. While Washington's health authority collects CRC screening rates for its Medicaid beneficiaries, it does not review these figures on a regular basis. Several other states indicated they could discover their colorectal cancer screening rates

through claims data or code utilization, but that they did not do so unless a special request was made for that information.



Profiles of States with Extensive Activity Levels

ARIZONA

The respondent from Arizona Medicaid, indicated that the state Medicaid agency partners with the Arizona Department of Health on their initiatives focused on colorectal, breast, and cervical cancer screening and treatment. The initiatives focus on all populations, including Medicaid recipients. Arizona Medicaid also collaborates with the Department of Health regarding colorectal cancer screening messaging to providers and members. In addition, the respondent indicated that Arizona Medicaid conducts outreach relating to colorectal cancer screening through its Medicaid managed care plans. While the respondent indicated that Public Health

is most ideally suited to take the lead on population health screening programs, strong participation by Medicaid, Medicaid managed care plans, and advocacy groups is essential. In addition, the respondent felt that hat the most effective activities to increase screening rates include: requirements in managed care contracts, including health risk assessments for new enrollees, provider reminders and education, and patient reminders.

KENTUCKY

The respondent from Kentucky Medicaid indicated that the agency shares its data with the state's public health officials to assist with their CDC colorectal cancer grant. In addition, officials from both Kentucky Medicaid and the state's Department of Public Health participate in a colorectal cancer advisory committee.

MARYLAND

The respondents from Maryland Medicaid indicated that state has worked closely with the Colorectal Cancer Control Program (CRCCP) in the state over the last several years. The state developed its own colorectal cancer screening measurement because there is not a corresponding HEDIS measure for Medicaid. Because the commercial HEDIS measure utilizes chart reviews--which the State of Maryland is not able to conduct--in addition to administrative data, Maryland Medicaid and the CRCCP program created a homegrown colorectal cancer screening measure using administrative (claims) data. Apart from the data source, Maryland's homegrown measure uses the same clinical specifications as the commercial HEDIS

measure. The Medicaid agency works with the Hilltop Institute at the University of Maryland, Baltimore County--which warehouses Maryland Medicaid claims data--to run the measure for its Medicaid managed care population.

Prior to participating in CRCCP, Maryland Medicaid and cancer control officials worked together on colorectal cancer demonstration projects and developed a Memorandum of Understanding to formalize their partnership. These projects included a postcard mailing using the CDC's Screen for Life templates to all non-institutionalized Medicaid recipients 50-64, a different post card mailing to non-institutionalized Medicaid recipients 51-56 combined with a mass media transit campaign and call center, and a letter from FQHC providers to patients combined with a call center. Current plans include promoting their state tracking measure with the Medicaid managed care plan CEOs and Medical directors, through their Medical Advisory Committee, and with the managed care plan quality assurance liaisons.

MASSACHUSETTS

The respondents from Massachusetts Medicaid and Department of Public Health indicated that the Medicaid agency is involved in a Public Health Chronic Disease Strategy that includes colorectal cancer screening rates as one of its measures. However, the screening rates are collected on a statewide basis and cannot be separated out by payer source at this time. They are also working with FQHCs to track screening rates of their patients, many of whom are on Medicaid, but cannot separate also that data by payer source. The strategy includes Medicaid as

well as other providers, so there is not a Medicaid-specific initiative, but Medicaid is involved in all relevant aspects of the strategy. The Massachusetts Department of Public Health is promoting FOBT and FIT testing to all providers, especially those serving vulnerable populations. While the Medicaid agency does not have a colorectal cancer specific initiative, preventive care in general is a major focus of measurement and improvement for Medicaid managed care plans. The respondent from Massachusetts Medicaid believes managed care health risk assessments, patient reminders, provider reimbursement incentives, provider assessments and feedback, data collection, and screening navigation programs are effective strategies to address colorectal cancer screening rates.

MINNESOTA

Respondents from Minnesota Medicaid and the Minnesota Department of Health indicated that the Medicaid agency assists the Minnesota Department of Health as needed while they conduct a 5-year CDC-funded research study on improving colorectal, breast and cervical cancer screening rates among Medicaid beneficiaries. The study design is a Randomized Control Trial targeting Medicaid beneficiaries that are overdue for screenings. The interventions include: direct mail reminders, monetary incentives, a call center, and patient navigation services. Based on evidence from prior research, the mailings were designed to be persuasive by evoking fear of not getting screened, with the goal of spurring people to take action. For example, one mailing had an individual on first side with the words "Maybe tomorrow" and then on the flip side the tag line was "They thought they had

tomorrow too" over small pictures of many faces. Providers were made aware of the intervention as well. The intervention ended in early 2015, the research team is still assessing the findings, but initial results appear promising.

MONTANA

According to the respondents, Montana Medicaid and Montana Department of Public Health and Human Services have a close working relationship regarding cancer related issues. They work in the same building and their physical proximity to each other encourages collaboration. Public health officials have direct access to Medicaid's data, including colorectal cancer screening rates, and public health staff has been trained how to use Medicaid's database. Until June 2015, Montana had a CDC funded colorectal cancer control program which covered providing screening services. The state continues to be funded by the CDC, but not for screening services. In 2013 and 2014, public health and Medicaid staff focused on increasing colorectal cancer screening rates for Medicaid patients, among other patient populations. They sent two postcard reminders to individuals over 50 who were not up to date on their colorectal cancer screening and they plan to do a third reminder this fall. They have not assessed the effectiveness of the reminders yet, but in other patient populations they found that multiple reminders were needed to be effective. As part of their program, they assisted eligible applicants in applying for Medicaid. In addition, public health and Medicaid personnel have started a pilot program in two sites that includes provider reminders for breast and colorectal cancer screening and a multifaceted colorectal cancer screening mass media

campaign featuring a local college football coach. The agencies also held a colorectal cancer roundtable last year and will do so again this year. The roundtable includes provider education, webinars with the American Cancer Society, and works with FQHCs and insurers. Given the change in CDC funding, the public health department will not be able to provide screening directly next year, but will focus on continuing partnership activities, provider education and outreach.

NEW YORK

In June 2015, the New York State Department of Health (the Department) received funding from the Centers for Disease Control and Prevention's Colorectal Cancer Control Program (CRCCP) to increase CRC screening rates in New York State. A main project of the grant is to improve CRC screening rates in the Medicaid managed care population. Led by the Department's Office of Public Health and Office of Quality and Patient Safety, grant activities have thus far included identification of target areas in the state, recruitment of three health plan partners with substantial Medicaid managed care membership in the target areas, and implementation of patient and provider level evidence-based interventions, including mailed patient reminders, provider outreach and, for one target area, a 2-month mass media campaign. Evaluation of work thus far is underway, with continued efforts planned for the remainder of the 5-year grant period.

From a broader standpoint, the Department is working to improve cancer screening in the Medicaid managed care population though quality measurement and requirements in the managed care contracts. The NYS QARR (Quality Assurance

Reporting Requirements) includes a colorectal cancer screening measure, which is calculated using the National Committee for Quality Assurance's HEDIS® technical specifications. This screening measure is also part of the NYS Medicaid Managed Care Quality Incentive program. In addition, New York's Medicaid managed care contracts include requirements to educate enrollees about cancer screening, follow practice guidelines consistent with the standard of care, and attempt to conduct a brief health screening within sixty (60) days of the enrollee's effective date of enrollment to assess the enrollee's need for any special health care.

Medicaid staff in the Department's Office of Health Insurance Programs engages in provider and plan staff education by creating Medicaid policy updates to increase provider awareness of various issues. A March 2014 Medicaid Update article focused on increasing colorectal cancer screening by identifying appropriate screening parameters and testing options, discussing the prevalence of colorectal cancer, and providing tips for providers to increase screening rates. Medicaid managed care plans also receive policy changes and other updates through monthly meetings with the Office of Health Insurance Programs, policy email blasts, and quarterly meetings of Medical Directors for all plans in the state. New York Medicaid officials believe that an ideal program would include: quality measures tied to CRC screening rates, requirements in managed care contracts, mass media campaigns, and partnerships with public health and community resources.

In 2008, two New York Medicaid managed care plans focused on colorectal cancer as part of their obligation to conduct Performance Improvement Projects.[43] HealthPlus conducted a randomized clinical trial to promote colorectal cancer screening in the context of other recommended screens for breast and cervical cancer. The trial focused on women aged 50-64 years who received care at one of 11 community health centers and were overdue for a colorectal cancer screen. Patients were randomized to either the Prevention Care Manager arm of the study or to usual care. The intervention arm included a screening recommendation letter from the patient's primary care site, telephone reminder, mailed patient reminders and patient education, and follow up phone calls and assistance in scheduling appointments from care managers. Interim analysis revealed higher up-to-date colorectal cancer screening rates in the intervention arm compared to usual care. MetroPlus also focused on the same patient population and tested whether different care models were more or less effective in increasing colorectal cancer screening rates. They assessed telephone-based case management, patient navigation, and the combination of the two models. Results show that both case management and patient navigation on their own were more effective than either a combined approach or the usual follow up process used by primary care providers.

[43] New York State Office of Health Insurance Programs. Medicaid managed care plans 2008 Performance Improvement Projects. October 2009. Available at http://www.health.ny.gov/health_care/managed_care/reports/docs/performance_improvement_projects.pdf. Accessed September 29, 2015.

OREGON

According to respondents, Oregon Medicaid tracks colorectal cancer screening rates, and this metric is part of Oregon's pay-for-performance incentive program for its Coordinated Care Organizations (CCO). CCO's are networks of all types of providers who work together in communities to serve Medicaid patients. The state includes 16 metrics in this program, and colorectal cancer screening was added in 2013. As a result, CCOs have developed efforts to target colorectal cancer in their communities. The Oregon Health Authority's Public Health Division conducts colorectal cancer screening outreach activities that are not Medicaid specific, but are available to CCOs serving Medicaid beneficiaries. In addition, Oregon Medicaid staff has worked with local experts to identify recommended strategies for CCOs to improve colorectal cancer screening rates. This report highlighted effective activities to increase screening rates, such as: quality measurements, health plan reimbursement, outreach strategies that are not provider-office based (e.g., mail home FOBT kits), offering take-home FIT tests when flu shots are given, better use of HIT, improved communication among patients, providers, and health plans, and offering patients screening choices.[44]

[44] Oregon Health Authority. Colorectal cancer screening – overview. Revised January 2, 2015. Available at http://www.oregon.gov/oha/analytics/CCOData/Colorectal%20Cancer%20Screening%20Overview%20--%20revised%20Jan%202015.pdf. Accessed September 29, 2015.)

WASHINGTON

In 2014, Washington included colorectal cancer screening as a statewide measure for most insurers, including Medicaid (medical groups will be added in 2016).[45] Although the state collects CRC screening rates for Medicaid patients, survey respondents indicated that while they can pull those data for review, they do not evaluation CRC screening rates on a routine basis. In addition, Medicaid staff mailed postcard reminders to all Medicaid beneficiaries over 50. Washington State Department of Health also issued reminders to all relevant individuals, including Medicaid beneficiaries. Medicaid respondents believe the Medicaid agency is the logical leader of colorectal cancer screening initiatives and that the most effective activities are provider reimbursement incentives, managed care contract requirements, patient reminders, mass media campaigns, and data collection.

WYOMING

According to respondents, starting in January 2015, Wyoming Medicaid included colorectal cancer screening as a quality measure through its Patient Centered Medical Home program that includes 60% of Medicaid beneficiaries in the state. The Medicaid agency staff reviews medical records to determine screening rates. Once this program gets established, provider reimbursement will be tied to quality measurement performance so low performing providers will receive lower reimbursement for conducting colorectal cancer screening procedures or exams. If

[45] Washington State Common Measure Set for Health Care Quality and Cost. December 2014. Available at http://www.hca.wa.gov/hw/Documents/pmcc_final_core_measure_set_approved_121714.pdf. Accessed September 29, 2015.

providers fail to report screening rates, they will not receive reimbursement for colorectal cancer screening procedures or exams. In addition, Wyoming Medicaid works closely with the Wyoming Department of Health's Public Health Division. In fact, a portion of the Medicaid Medical Director's salary is paid for with public heath funds.

Barriers to Engaging in More Colorectal Cancer Activities

Most Medicaid agencies have limited or no colorectal cancer control activities. The agencies identified numerous barriers to increased engagement with this health issue. Even agencies with extensive activity on colorectal cancer screening noted that many of these hurdles exist for them as well.

- **Measurement/Data Issues.** Medicaid officials identified a number of measurement and data issues that make it difficult to address colorectal cancer screening rates. While there is a HEDIS measure for colorectal cancer screening, it is only required for Medicare and commercial managed care plans. Thus, in states that only require their Medicaid managed care plans to report HEDIS measures, the plans will not be required to track CRC screening rates. Managed care plans are comfortable with using standardized measures, and most states do not require Medicaid programs to incorporate colorectal cancer screening as a measurement. If states require additional performance measures, it is likely to be those items that are part of the CMS Adult Core Set, which does not include colorectal cancer screens. Furthermore, measurement difficulties that are common with the Medicaid

population (frequent moving, churning on/off Medicaid, being unreachable, etc.) are exacerbated by the 10-year gap between recommended colonoscopies and the logistics of performing the screening exam (time off needed, assistance of a friend, for a colonoscopy; returning stool samples for stool blood tests, etc.). The 10-year gap between colonoscopies also makes it difficult to evaluate program effectiveness on a short-term basis, so other measures must be used for that purpose.

- **Mixed views of screening options.** Colonoscopies are still considered the gold standard screening exam by many policy makers and providers, who may not be aware of recent research regarding the higher quality of newer generation FIT tests. Thus, even though many consumers prefer stool testing when given an option, and many aspects of colonoscopy screening create barriers that are appreciated by Medicaid officials (time, logistics, stigma, discomfort with the procedure), they may be reluctant to promote stool testing as an option as they may consider it a "second class test." Regardless of the testing option used, follow up to positive tests can be difficult to conduct as Medicaid beneficiaries often move, churn on and off Medicaid, or can be hard to reach. At least one state Medicaid agency (KY) does not accept a code for the FIT test, limiting screening options in that state.
- **Medicaid Culture.** The culture of any agency is often specific to the state, leadership, and other personnel in that agency. Discussions with Medicaid officials across the country revealed a variety of agency cultures. Some cultures provided a barrier to addressing colorectal cancer issues because

they viewed screening, outreach, education etc. a public health issue, not a Medicaid issue, and/or they were not interested in collaborating with public health on these strategies. Several respondents indicated, both positively and negatively, that the leadership of their agency drove the agency culture. On the positive side, when a Medicaid or state health agency head either came from a public health background or had worked in both public health and Medicaid, collaboration and focusing on issues such as outreach and education were more likely to be seen as part of Medicaid's mission. On the other hand, it is difficult for Medicaid personnel to pursue colorectal cancer control efforts once the leadership determined that partnering with public health or working on colorectal cancer screening-related issues were not a priority.

- **Other Priorities/Limited Resources.** In many cases, Medicaid officials were not resistant to focusing on colorectal cancer screening specifically, as much as they were inclined to prioritize other health concerns due to the characteristics of their Medicaid population and needs of their state. Some Medicaid agencies have very limited quality assurance resources, so they can only focus on one or two issues at a time. Given the high proportion of mothers and children in the Medicaid population, many states chose to focus on health issues specific to those subgroups. In addition, there might be other health issues of high importance in the state. As noted above, demands due to the ACA and managed care requirements also limit Medicaid resources to focus on other areas. Finally, a number of states indicated they would have

preferred to focus on colorectal cancer but did not receive CDC CRCCP grant funding that would have allowed for new or further collaboration with public health on this issue.

Suggestions to Reduce Barriers to Facilitate state Medicaid Focus on Colorectal Cancer Control

Given the numerous barriers faced by Medicaid agencies in focusing on colorectal cancer activities, agencies were asked if there were any actions that could be taken to reduce those barriers. The most common requests included:

- Developing a federal measure for colorectal cancer screening in Medicaid programs;
- Requiring tracking of colorectal cancer screening rates in Medicaid programs;
- Providing a federally funded initiative to improve screening rates and/or partner with public health/cancer control programs;
- Engaging in a federal public awareness campaign to promote colorectal cancer screening, including a bigger push for the 80% by 2018 campaign;
- Developing culturally competent templates and tools for states to use to address fears and stigma associated with colorectal cancer screens;
- Publishing national screening reports so states can compare own rates with peers; and
- Disseminating knowledge across states regarding screening options and existing research of evidence-based approaches to increase screening.

Many Medicaid officials were interested in learning from their peers about what worked, what did not work, and why they experienced success or struggled with an initiative. Having tools, templates, easily digestible research findings, evidence-based activities to increasing screening rates, etc. being made in an easily available package would help many Medicaid agencies initiative activities in this area. Given the limited resources and competing priorities faced by most agencies, a federally funded initiative focused on colorectal cancer was suggested frequently. Finally, having the federal government do even more to promote the current 80% by 2018 campaign and other public awareness campaigns was considered essential by many respondents.

Partnerships

As is shown in the state profiles above, most of the Medicaid agencies that are engaged in extensive activities to reduce colorectal cancer screening rates have an on-going relationship with their state public health officials. These partnerships permeate the actions states are undertaking to improve colorectal cancer screening rates, and Medicaid and public health personnel work closely on developing and implementing their strategies.

As shown in Table 2, outside of the 10 extensive activity states, Medicaid/Public Health partnerships related to colorectal cancer are fairly rare. Nine Medicaid agencies indicated they have limited partnership activity with public health personnel. For example, Alabama and Nevada share data with public health

staff, Indiana and Vermont worked with public health personnel on a grant submission, California has some collaboration with public health officials, and South Dakota and North Carolina have had initial discussions about working their public health agency. It is worth noting that 8 Medicaid respondents indicated that they work with public health staff on other health issues, such as breast and cervical cancer or diabetes prevention.

Table 2. Medicaid and Public Health Partnerships, by State, 2016

State	Activity Level	Public Health Partnership Activity
AL	Limited	Data share with Public Health.
AK	None	None
AZ	Extensive	Extensive partnership with Public Health.
AR	Limited	A non-profit QI org works with Medicaid and Public Health on a Public Health CDC grant that might affect Medicaid patients.
CA	Limited	Some collaboration with public health to increase CRC screening rates; in discussions for more extensive collaboration.
CO	Limited	None, though prior program addressed Medicaid beneficiaries.
CT	Limited	Work with Public Health on other issues, such as diabetes.
DE	None	Work with Public Health on other issues, such as breast and cervical cancer.
DC	Limited	None
FL	None	

State	Activity Level	Public Health Partnership Activity
GA	Limited	Work with Public Health on other issues, such as diabetes.
HI	Limited	
ID	None	Work with Public Health on other issues.
IL	No response	
IN	Limited	Worked with Public Health on grant submission.
IA	Limited	Work with Public Health on other issues, such as breast and cervical cancer.
KS	None	None
KY	Extensive	Extensive partnership with Public Health.
LA	Limited	Work with Public Health on other issues, such as breast and cervical cancer.
ME	None	None
MD	Extensive	Extensive partnership with Public Health.
MA	Extensive	Extensive partnership with Public Health.
MI	Limited	Limited role in postcard reminders to Medicaid beneficiaries. Recently began tracking CRC rates. Beginning to think about working with Public Health on CRC issues. Need to assess recent data collection.
MN	Extensive	Extensive partnership with Public Health.
MS	None	None
MO	None	Initial discussions with Public Health about data sharing.
MT	Extensive	Extensive partnership with Public Health.

State	Activity Level	Public Health Partnership Activity
NE	None	Work with Public Health on other issues.
NV	None	Data share with Public Health.
NH	None	None
NJ	Declined to respond	
NM	None	None
NY	Extensive	Extensive partnership with Public Health.
NC	Limited	Initial discussions with Public Health.
ND	None	None
OH	No response	
OK	None	None
OR	Extensive	Activities directed at the state level through the Oregon Health Authority, which includes both Medicaid and Public Health.
PA	None	Work with Public Health on other issues.
RI	None	None
SC	None	None
SD	Limited	Initial discussions with Public Health.
TN	Limited	None
TX	No response	
UT	None	None
VT	Limited	Worked with Public Health on CRCCP grant submission; work with Public Health on other issues, such as breast and cervical cancer.
VA	None	None
WA	Extensive	Limited, activities usually originate in Medicaid.
WV	None	

State	Activity Level	Public Health Partnership Activity
WI	None	Work with Public Health on other issues, may data share.
WY	Extensive	Works closely with Public Health on all issues; Medicaid medical director salary paid in part by public health.

Both Medicaid and Public Health officials identified several reasons that partnerships may not occur between the agencies. Currently, Medicaid agencies have many demands on them with ACA-required changes, so their focus is on those tasks. As noted above, given limited resources many Medicaid agencies target health concerns specific to the populations that dominate their programs. While population demographics will shift for Medicaid expansion states, many of those states are just beginning to think about how their priorities might change given the make-up of the newly insured individuals. Some Medicaid agencies indicated that it was more appropriate for public health departments to tackle outreach and screening, while Medicaid agencies focused on coverage and payment. Finally, some Medicaid agencies were not interested in sharing their resources, data, or relationships with other organizations. From the public health perspective, these respondents often considered developing a partnership with Medicaid a low-priority task given their limited resources, other obligations, and in some states, poor relationships with Medicaid officials. As one public health official said, partnering with Medicaid is not the "low-hanging fruit" so they focused on other

strategies. In some states, however, CDC's CRCCP provided a means for Medicaid agencies and public health departments to work together.

Medicaid agencies described three types of relationships with their managed care organizations: one where the Medicaid agency requires managed care plans to address colorectal cancer screening specifically, one where the Medicaid agency requires managed care plans to emphasize prevention generally and/or performance measurement, but does not have a colorectal cancer screening specific requirement, and one where the Medicaid agency explicitly leaves it up to managed care plans whether to have a colorectal cancer screening initiative. Other than in states that mandate Medicaid managed care plans track colorectal cancer screening rates, there is little evidence that agencies require states to focus on colorectal cancer. Instead, conversations with Medicaid personnel emphasized outreach to plans or relied on plan responsibility to provide all required services. In addition, states could require their MCOs to conduct PIPs related to colorectal cancer screening. While two New York MCOs focused on colorectal cancer screening for their 2008 PIPs, it does not appear that any states currently require or even offer colorectal cancer as a topic area for states to select as a PIP project. PIP topic areas were more likely to cover pediatric and women's issues such as pediatric asthma or breast cancer screening or other health problems such as diabetes or cardiovascular disease.

DISCUSSION

This research study provides insight into both the limits of Medicaid activities related to colorectal cancer control efforts and barriers to improving screening rates among Medicaid beneficiaries. Prior research showed that coverage is generally not a barrier as most Medicaid agencies cover the two most commonly recommended screening tests for colorectal cancer (FOBT and colonoscopy). As a result, efforts to improve screening rates must focus on removing barriers to this covered service for Medicaid beneficiaries. As is usually the case with Medicaid, states agencies have significant discretion in the amount of and type of efforts they put into addressing any particular health issue, and for a variety of reasons, addressing colorectal cancer is not a frequent priority among Medicaid agencies.

10 states have extensive activities addressing colorectal cancer.

Forty-seven states and DC responded to our survey. Of all respondents, 10 states engaged in extensive activities to increase colorectal cancer screening rates. These states are: Arizona, Kentucky, Maryland, Massachusetts, Minnesota, Montana, New York, Oregon, Washington, and Wyoming. Not surprisingly, the 10 states with extensive activities in this area also show a general commitment to prevention and coverage of their low-income residents. Of these 10 states, all but one (WY) participates in the CDC's Colorectal Cancer Control Program, all but two (MT, WY) are in states that have expanded Medicaid under the Affordable Care Act, and all but two explicitly cover screening colonoscopies in their Medicaid program (MD likely covers by requiring coverage of all age-appropriate screens, and WY did not

respond to a prior survey on this issue). While the nature of the activities varied by state, overall extensive activity states were likely to tackle colorectal cancer issues on several fronts. Common activities include:

- Developing partnerships with public health and/or cancer control programs often through the CDC's CRCCP program;
- Participating in advisory committees and data sharing;
- Requiring significant quality measurement and/or incentive activities;
- Conducting significant outreach activities to patients and/or providers;
- Participating in a larger public health strategy that specifically incorporates colorectal cancer screening;
- Undertaking research activities focused on colorectal cancer screening; or
- Identifying effective strategies to improve colorectal cancer screening rates with the use of expert assistance.

16 states engage in limited activities addressing colorectal cancer.

State Medicaid agencies with limited activity in this area are more likely to address colorectal cancer with one focused activity instead of through numerous strategies, and are less likely to have developed a partnership with the public health agency in their states. Medicaid agencies that are at the beginning of a collaboration process could be categorized as states with extensive activities in the future depending on the strategies used by the planning group and the extent of engagement by the Medicaid agency. Examples of limited activities include:

- Being in the early stages of a collaboration or planning process;

- Data sharing only;
- Screening rate tracking only;
- Requiring colorectal cancer specific activity only for a limited Medicaid population (i.e., Patient Centered Medical Home, Disease Management);
- Using an overall preventive care strategy that includes colorectal cancer screening, but it is not a colorectal specific program; and
- Providing assistance with grant writing or a planning grant related to colorectal cancer.

21 states do not engage in any activities related to colorectal cancer.

In general, the Medicaid agencies that are not focused on colorectal cancer control did not reject colorectal cancer as a focus area. Instead, they were more unlikely to have considered it as a focus area at all because they had other priorities. For many Medicaid agencies, their priorities reflect the Medicaid population they are serving, meaning a frequent focus on issues related to mothers/young women and children. For instance, it was common to hear about activities related to breast cancer screening or pediatric asthma. In addition, Medicaid agencies also focused on other diseases in their state that impacted many individuals, such as diabetes, obesity, and cardiovascular issues.

10 states track colorectal cancer screening rates.

While many Medicaid agencies indicated they could calculate their colorectal screening rates by assessing claim and utilization data, only 10 states track

screening rates and only 8 of those states routinely measure this rate. Tracking colorectal cancer screening rates is essential to understanding the extent that beneficiaries receive recommended screenings. More than one respondent noted that providers were surprised when confronted with their own low screening rates for their patient population.

Whether on an individual provider basis or a state agency level, if the extent of a problem is unknown, it is much less likely to become a priority area for improvement, especially because there are so many other measures that are required or made a priority by the federal and state governments.[46],[47] As is often stated in public health efforts, "That which gets measured, gets done." Any measure that is required by HEDIS is likely to be collected by Medicaid managed care plans, and a number of states indicated they rely on HEDIS for the required screening tracking in their state. However, colorectal cancer screening is not a required HEDIS measure for Medicaid patients and the specifications of the measure, such as requiring continuous enrollment in a plan, may make it difficult to apply to the Medicaid population. In addition, colorectal cancer screening is not a measure of the CMS Adult Core Set. While reporting on the Adult Core Set is voluntary for states, it is likely that states will start with these measures if they are considering adding requirements to their Medicaid managed care reporting. As one respondent indicated, there are only so many areas Medicaid agencies and plans can focus on at

[46] Joseph DA, DeGroff AS, Hayes NS, Wong FL, Plescia M. The Colorectal Cancer Control Program: partnering to increase population level screening. Gast End. 2011; 73(3): 429-434

[47] Levine, RS, Briggs NC, Gusaini BA, Foster I, Hull PC, Pamies RJ et al. HEDIS preventions performance indicators, prevention quality assessment, and Health People 2010. J Health Care Poor Underserved. 2005; 16.4(Supp A): 64082.

one time, so if colorectal cancer screening is not included in these performance measures it makes it less likely to be a focus area for states. These measurement limitations are evident in the lack of quality improvement projects relating to colorectal cancer undertaken by Medicaid MCOs.

All states identified barriers to engaging in colorectal cancer activities.

Even in states that have extensive activities in this area, respondents indicated that there are numerous barriers they had to overcome. In addition to the lack of a nationally recognized measurement, the nature of the recommended screening exams leads to their own barriers. Colonoscopies are still considered by many policy makers and providers to be the gold standard in screening, but there are several difficulties associated with that procedure. It is time consuming in terms of the preparation and time off of work needed; it is not a pleasant or comfortable procedure; there is a stigma associated with dealing with colorectal issues generally, and differences among cultures as well.[48],[49] It appears that many policy makers and providers are unaware that newer generations of FIT tests can avert nearly as many deaths as colonoscopy with annual adherence. In terms of program evaluations, using a colonoscopy standard raises additional problems because it is recommended every 10 years. Medicaid beneficiaries are likely to move locations or churn on and off Medicaid in a 10-year period, adding a layer of complexity in

[48] Rohan EA, Boehm JE, DeGroff A, Glover0Kudon R, Preissle J. Implementing the CDC's Colorectal Cancer Screening Demonstration Program: wisdom from the field. Cancer 2013;119(S15): 2870-2883.
[49] Denberg TD, Melhado TV, Coombs JM, Beaty BL, Berman K, Byers TE et al. Predictors of non-adherence to screening colonoscopy. J Gen Intern Med. 2005; 20:989-995.

tracking and follow-up for providers. For program staff, the time lag creates an evaluation hurdle because it is difficult to know in the short run if your program is effective in reaching beneficiaries

Given the barriers associated with colonoscopies, some Medicaid agencies are considering promoting FOBT tests because they are less invasive and time consuming. Yet, barriers are also associated with this test. As a result of their views that FIT tests are inferior to colonoscopies, many providers and policymakers are reluctant to promote FOBTs.[50],[51] In addition, any abnormalities or positive indication from FOBTs mean the patient should undergo a colonoscopy anyway, meaning having to get the patient back to the provider and then overcoming all of the colonoscopy related hurdles.

As is commonly the case with Medicaid, limited resources mean agencies must make choices about priorities.[52] Given the difficulties associated with colorectal cancer screening and the fact that the 50-75 population is a limited portion of Medicaid beneficiaries, many Medicaid agencies indicated they addressed problems that would give them more bang for their buck by dealing with the needs of a greater portion of their population or state costs. In addition, many states are focused on ACA and managed care related requirements, further limiting the resources that could be devoted to addressing this particular issue.

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[50] Jones RM, Woolf SH, Cunningham TD, Johnson RE, Krist AH, Rothemich SF et al. The relative importance of patient-reported barriers to colorectal cancer screening. Am J Prev Med. 2010; 38:499-507.
[51] Inadomi JM, Vijan S, Janz NK, Fagerlin A, Thomas JP, Lin YV et al. Adherence to colorectal cancer screening: a randomized clinical trial of competing strategies. Arch Intern Med. 2012; 172: 575-582.
[52] Joseph, supra note 46.

Relatively few Medicaid agencies partner with their state's public health agency to address colorectal cancer

One way that Medicaid agencies could leverage limited resources would be to partner with other stakeholders, such as the public health agency/cancer control program in their state.[53] In most states with extensive activities, Medicaid and public health officials have a developed and productive partnership, sharing staff, data, resources, and collaborating on strategies. In the other states, such partnerships were limited or non-existent. Several reasons were given for not establishing these partnerships. In some Medicaid agencies, the culture of the agency is a barrier to working with public health. Some agency leaders believe Medicaid should focus on payment and coverage while public health should focus on education and outreach. Other Medicaid leaders were not interested in sharing resources with those outside the agency. Of course, Medicaid leadership could simply have other priorities in terms of which health issues they are focusing on at this time. Similarly, some public health agencies found it unproductive to reach out or further engage the Medicaid agency in their state due to their limited resources or poor relationship with the Medicaid agency. As one public health official put it, partnering with their Medicaid agency is not the "low-hanging fruit," so they focused their energy elsewhere.

[53] Id.

Suggestions for assistance to increase focus on colorectal cancer activities

Given the numerous barriers identified by Medicaid agencies, there are a number of suggestions about ways to improve the situation. These suggestions can be grouped into two main areas, measurement concerns and information availability.

In terms of measurement concerns, many Medicaid agencies suggested that the federal government to develop a federal measure for colorectal cancer screening in Medicaid programs and require tracking of colorectal cancer screening rates in Medicaid programs.[54],[55] Once this occurs, the federal government could publish a national screening report so states can compare own rates with peers.[56] Of course, some states are likely to resist another requirement, but even in those states the agency officials recognized that without a federal measurement option, it was very unlikely states would develop or add a colorectal screening measure on their own.

Regarding information on the issue, state Medicaid agencies pushed for both increased public awareness campaigns and information from the federal government that would assist states in developing their own outreach and education plans.[57], [58] Even though there is extensive information available about colorectal cancer screening recommendations, screening options, research, and evidence-based practices, Medicaid officials thought the federal government should

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[54] Patel CG, Tao G. The significant impact of different insurance enrollment criteria on the HEDIS Chlamydia screening measure for young women enrolled in Medicaid and commercial insurance plans. Sex Trans Dis. 2015; 42(10): 575-579.
[55] Felt-List, Barrett A, Nyman R. Public reporting of quality information on Medicaid health plans. Health Care Fin Rev. 2007; 28(3): 5-16.
[56] Id.
[57] Rohan, supra note 48.
[58] Joseph, supra note 46.

conduct a better or more extensive public awareness campaign to promote colorectal cancer screening, including a bigger push for the 80% by 2018 campaign.[59] Furthermore, several state Medicaid agencies asked for templates and tools for states to use to address fears and stigma associated with colorectal cancer screening exams. These tools must be framed in a culturally competent way. To the extent that this information and these tools are already available, it appears better outreach to Medicaid agencies might help to encourage more states to adopt a colorectal cancer control initiative. Of course, federal funding provided to the states to engage in colorectal cancer control efforts was also a common suggestion and likely the most direct way to increase state activity in this area. Indeed, many of the states with extensive activity benefitted from the CDC's Colorectal Cancer Control program.

CONCLUSION

Difficulty in increasing colorectal cancer screening rates is a problem across the country and for the entire population. These problems are exacerbated when trying to increase the screening rates in a vulnerable, low-income population such as the patients served by the Medicaid program. While most Medicaid agencies are not focused on addressing colorectal cancer, 10 states are leading the way by focusing on multiple strategies and partnerships. These Medicaid agencies provide examples, guidance, and experience from their successes and failures that other

[59] E.g., National Colorectal Cancer Roundtable in its 80% by 2018 Communication Guidebook. Available at http://nccrt.org/tools/80-percent-by-2018/80-by-2018-communications-guidebook/.

states can draw on if they decide to concentrate on this issue. Furthermore, many of the respondents from Medicaid agencies that are not engaged in colorectal cancer activities offered specific suggestions for ways the federal government could assist in this area. Taken together, a variety of strategies and options exist for improving colorectal cancer screening rates among Medicaid beneficiaries.

Appendix A. Survey Instrument

Medicaid Program Colorectal Cancer Screening Activities

State:_____
Name:_____
Title:_____
Phone:_____ **Email:**_____
Contact Notes:

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1. Does your Medicaid agency keep track of colorectal cancer screening rates for beneficiaries? YES NO DON'T KNOW
    a. If yes, what latest screening rate data (year)?

2. Do you know of any programs or activities in your state that focus on increasing colorectal cancer screening rates for Medicaid beneficiaries? (provide details)

3. What activities do you believe would be most effective and feasible to increase colorectal cancer screening rates in your state Medicaid program? (circle answer)
    (check if state currently does any of these activities)
    (star if responder thinks an activity is a top 2 or 3 best approach)

    a. Quality measures tied to CRC screening rates
    b. Reimbursement incentives tied to CRC screening rates
        i. Provider
        ii. Health plan
        iii. Beneficiary
        iv. FQHC
    c. Requirements in managed care contracts
        i. Health risk assessments for new enrollees?
    d. Provider reminders and/or education
    e. Provider assessment/feedback
    f. Patient reminders
    g. Mass media campaign
    h. Small media campaign (flyers, posters, brochures)
    i. Group/one-on-one education
    j. Data collection/EHR initiatives
    k. Screening navigation programs
    l. Others?_____

    Comments:

4. Who do you think the best individuals/organizations are in your state for the Medicaid agency to partner with to improve colorectal cancer screening?
    a. Managed care organization
    b. Individual providers
    c. Community providers (FQHCs)
    d. Regional Care Coordinators
    e. Advocacy groups
    f. State cancer coalition or CRCCP
    g. Public health agency
    h. All of the above
    i. Others?_____

    Please comment if you think any of those individuals/organizations should take the lead on this issue or the lead on specific activities:

5. Are there any current activities or plans to create partnerships with the individuals or organizations identified in question 4? YES NO DON'T KNOW
    a. If yes, please provide details:

6. What barriers might make it difficult for a state Medicaid program to focus on increasing colorectal cancer screening in the program? How do you suggest we overcome these barriers?

7. Can you provide any documents that you send to providers, beneficiaries or community partners to increase colorectal cancer screening rates? YES NO
    a. If yes, identify documents being sent:

8. Has the state Medicaid program conducted any pilot programs or other activities to improve screening rates for other preventive services? (provide details)

9. Is there anything you would like to be done on the national level to help your state improve colorectal cancer screening rates?

Appendix B

State Activity Level, CRCCP, and Medicaid Activity, 2016

State	Activity Level	Colorectal Cancer Activity Description	CRCCP	Medicaid Expansion	Medicaid CRC Coverage
AL	Limited	Medicaid/Public Health data sharing.	x		Yes
AK	None			x	Yes
AZ	Extensive	Health Dept. all population initiative includes CRC outreach through Medicaid MCOs; Medicaid collaborates with Health Dept. on CRC messaging to providers and members.		x	Yes
AR	Limited	CDC grant to increase CRC screening that focuses on private practice providers, but could include Medicaid providers.	x	x	No
CA	Limited	Some collaboration with public health to increase CRC screening rates; in discussions for more extensive collaboration.	x	x	NR FFS; YES MCO

State	Activity Level	Colorectal Cancer Activity Description	CRCCP	Medicaid Expansion	Medicaid CRC Coverage
CO	Limited	Public Health and Univ. Colorado Medical School had all population CRC screening program that ended 7/1/2015; Medicaid currently considering requesting budget authority to increase reimbursement for screening colonoscopies.	x	x	AAS
CT	Limited	No CRC-specific program, but CRC screening part of overall preventive care analytics/provider reporting.		x	AAS
DE	None		x	x	AAS
DC	Limited	Rely on MCOs to provide required preventive health screening and outreach; one MCO has CRC screening as a care gap intervention on an individual assessment by Care Managers.	x	x	Yes
FL	None		x		Yes

State	Activity Level	Colorectal Cancer Activity Description	CRCCP	Medicaid Expansion	Medicaid CRC Coverage
GA	Limited	Track screening rates only. Now covers USPSTF A&B preventive services, but no CRC specific activity.			Yes
HI	Limited	Tracks CRC screening rates. Includes CRC question in adult health assessment.		x	Yes
ID	None		x		AAS
IL	No response/not participate		x	x	Yes (MCO)
IN	Limited	Work with Public Health on CDC planning grant.		x	Yes
IA	Limited	Medicaid CRC screening targeted outreach to Disease Management patients only.	x	x	AAS
KS	None				NR
KY	Extensive	Work with Public Health on CRC Medicaid data sharing to assist Public Health CDC grant; have KY CRC advisory committee with Medicaid and Public Health.	x	x	Yes (FFS)

State	Activity Level	Colorectal Cancer Activity Description	CRCCP	Medicaid Expansion	Medicaid CRC Coverage
LA	Limited	Beginning to work on quality measures that include CRC, but not implemented yet.	x	x	AAS
ME	None		x		Yes
MD	Extensive	Created state-specific CRC tracking measure; Medicaid working closely with Public Health and FQHCs to do targeted outreach; outreach to MCOs to promote CRC screening and patient.	x	x	AAS
MA	Extensive	MassHealth included in larger Public Health chronic disease strategy that focuses on improving CRC screening rates as one of its strategies; health plans include preventive care as a major focus for measurement and improvement.	x	x	Yes

State	Activity Level	Colorectal Cancer Activity Description	CRCCP	Medicaid Expansion	Medicaid CRC Coverage
MI	Limited	Recently began tracking CRC screening rates. Starting to work on ideas for partnership with public health. Need to assess data results before making strategic decisions.	x	x	AAS
MN	Extensive	Medicaid assists with 5-year CDC research project that focuses on increasing screening for CRC and breast cancer among Medicaid beneficiaries.	x	x	Yes
MS	None				Yes
MO	None				Yes

State	Activity Level	Colorectal Cancer Activity Description	CRCCP	Medicaid Expansion	Medicaid CRC Coverage
MT	Extensive	Medicaid and Public Health have very close working relationship; until this summer had CDC CRC grant that included outreach to Medicaid patients and direct screening services; current CDC funding does not include direct service pilot project with provider reminders and mass media campaign; held CRC roundtable with providers and insurers.	x	x	Yes
NE	None				No
NV	None		x	x	Yes
NH	None		x	x	Yes
NJ	No response/not participate			x	Yes
NM	None			x	Yes

State	Activity Level	Colorectal Cancer Activity Description	CRCCP	Medicaid Expansion	Medicaid CRC Coverage
NY	Extensive	CRCCP funding to improve CRC screening among Medicaid managed care members, CRC screening reporting required by state and in Medicaid Managed Care contracts, other contract provisions encourage screening; Medicaid working closely with health plans on outreach and messaging to providers; State has quality incentives for Medicaid MCOs; 2008 two health plans had quality improvement projects relating to CRC; Medicaid and Public Health work closely together.	x	x	Yes
NC	Limited	Medicaid is participating in early stages of state CRC roundtable discussions; tracking CRC			AAS

State	Activity Level	Colorectal Cancer Activity Description	CRCCP	Medicaid Expansion	Medicaid CRC Coverage
		screening rates.			
ND	None			x	Yes
OH	No response/not participate			x	Yes
OK	None				No
OR	Extensive	CRC screening is one of 16 P4P measures for Coordinated Care Organizations; track CRC screening rates; Public Health has CRC community education materials available to CCOs that likely reach Medicaid beneficiaries; worked with experts to identify effective strategies to improve CRC screening rates.	x	x	Yes
PA	None			x	NR
RI	None		x	x	AAS
SC	None		x		Yes

State	Activity Level	Colorectal Cancer Activity Description	CRCCP	Medicaid Expansion	Medicaid CRC Coverage
SD	Limited	Focus on CRC screening for Medicaid Health Home population; early stages of discussion with Public Health to assist with their CRC grant.	x		No
TN	Limited	Creating episodes-of-care tied to overall health reform payment strategy in state. An episode of care has been created for screening and diagnostic CRC. Reform effort in initial stages, but will tie reimbursement to quality measures on episodes-of-care.			Yes
TX	No response				Yes
UT	None				No
VT	Limited	Track screening rates only.		x	AAS
VA	None		x		Yes
WA	Extensive	Track CRC screening rates; CRC rate will be part of statewide performance measure for all payers in 2016; Medicaid	x	x	Yes

State	Activity Level	Colorectal Cancer Activity Description	CRCCP	Medicaid Expansion	Medicaid CRC Coverage
		targeted outreach.			
WV	None		x	x	Yes
WI	None		x		Yes
WY	Extensive	Track screening rates for PCMH only; Medicaid uses CRC as one of 9 clinical quality measures for PCHM. In first year of project, but will base reimbursement level on screening rates.			NR

AAS - Age Appropriate Screen (prior survey)

NR = Not Reported (prior survey)