



## **Webinar: Colorectal Cancer Screening Best Practices Handbook for Health Plans Additional Questions & Answers March 28th, 2017**

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Webinar replay: <http://nccrt.org/webinars/>

- 1. Q: Any recommendations to measure 80% by 2018 success among health plans? HEDIS or other data?**

**A:** Overall screening rate improvements (HEDIS or electronic medical record reports) appear to be the primary method health plans are using to measure success. Large health plans often assess their performance both on the state/market population and as an aggregate of their performance nationwide. Other measures of success include narrowing of disparity gaps, provider and member satisfaction, and in the long-term, decreased colorectal cancer incidence and death. (For more information, reference the impact sections for the case studies: <http://nccrt.org/Health-Plan-Handbook.>)
- 2. Q: What has been the policy for charging patients when polyps are found and removed in a screening colonoscopy?**

**A:** Federal guidelines state that non-grandfathered commercial plans cannot impose cost-sharing for colonoscopies done as an initial screening test, even if lesions or polyps are found and removed during the procedure. Recent rulings also require commercial plans to cover additional screening colonoscopy procedure-related costs including pre-exam consultation, pathology, bowel prep, and anesthesia. However, Medicare members can be subject to 20% in coinsurance if polyps are found and removed during a routine colonoscopy. Several high-performing health plans, including Blue Cross Blue Shield of Massachusetts, Cigna and Gateway Health, waive cost sharing for all screening procedures to include colonoscopy that include polyp removal and those that follow positive stool tests. Other profiled plans did not specify their policies for charges to Medicare patients for polyp removal. (For more information, reference best practice 5 on page 13 as well as the relevant case studies: <http://nccrt.org/Health-Plan-Handbook.>)
- 3. Q: For MAPD plans (Medicare Advantage plans that provides drug coverage) or Medicare FFS (fee for service) plans, would CMS allow plans to "waive" coinsurance for polyp removal (as Cigna did)?**

**A:** This would be a CMS payment decision to which ACS and the NCCRT are not authorized to advise.

**4. Q: In one of the best practices cited from the larger plans (Cigna) are the increases seen nationwide or specific to certain markets?**

**A:** Cigna shared that they have seen consistent, statistically significant improvement in screening rates year over year. Depending on the market, their screening rates range from 60% to over 70%. Nationwide, they saw a 23.7% increase in rates from 2012 to 2013 alone. (For more information, reference the case study: <http://ncprt.org/Health-Plan-Handbook>.)

**5. Q: Could you provide more detail related to the attribution model used to identify members/providers to set up your [Wellmark's] outreach?**

**From Cigna:** Members are attributed to an ACO based on the steps below:

- a. Members designating a primary care physician (PCP) through insurance product design will be attributed to that PCP.
- b. Members who do not designate a PCP will be assigned to the provider they have the most office visits with in a 12-month period. There are tie breakers such as the most non-E&M services, most recent visit, etc. when a member has the same number of office visits with more than one PCP.
- c. If a member remains unattributed after the above, the steps are repeated using 24 months of historic claims data.

The PCPs are able to see their attributed members and relevant data through a secure dashboard.

**6. Q: Does the handbook elaborate on how Care N' Care provided transportation to their patients when they are in need of care for the 24 hours following the colonoscopy procedure?**

**A:** The case study for Care N' Care describes how their Healthcare Concierge service assists members with finding a physician, scheduling appointments, answering plan and benefit questions, helping with claims and billing resolutions and prescription drug assistance. Care N' Care did not describe this service as including transportation assistance.

Gateway Health care management staff help members overcome a variety of barriers that may prevent them from following through with needed screenings, including help with community referrals for those who need help with non-medical needs such as transportation, food, child care, or financial counseling. Transportation service availability in the 24 hours following a colonoscopy procedure likely varies depending on the services available in each community.

## Questions about FIT distribution programs:

7. **Q: Is the FIT test that is referenced in these best practice slides the FIT immunoassay or the DNA-FIT (Cologuard) test?**

**A:** FIT refers to fecal immunochemical tests.

8. **Q: What is the rate of return on the FIT kits for the plan who sends them out automatically?**

**A:** Care N' Care shared that initial data for their FIT distribution program in 2016 indicates a 20% return rate. (This rate does not include the FIT kits that are managed by the PCPs.) Gateway achieved a 22% return rate for their FIT mailings. (For more information, reference the relevant case studies: <http://ncrt.org/Health-Plan-Handbook>.)

**From Cigna:** There is a lot of variability, depending on how the person was identified for an auto deploy FIT kit. It is higher for customers who have completed the test before, and lower for those who are sent a kit because they just turned 50 years. Overall, our return rate is between 40% to 50%. One year, we sent kits to all Cigna employees and dependents who had not had screening. While we saw a good response in returned kits, we saw a higher volume of employees who obtained their colonoscopy within 6 months of the mailing. The real value of auto deploy is that it conveys a stronger message of the importance of colon cancer screening than an educational brochure.

**From Kaiser Permanente:** Between 65% and 70% of patients who receive FIT kit mailings end up completing screening by the end of the year.

9. **Q: If FIT tests are sent to the patient, who will receive the results if they do not have a PCP? How are positive FIT tests followed up?**

**From Cigna:** Each patient with positive results is contacted by phone by a physician licensed to practice in the customer's state. The physician will explain the results and next steps, answer questions and send the results to both the customer and his/her PCP, if desired. Customers who do not have a PCP are instructed to call Customer Service for assistance with locating a PCP. The physicians make three attempts by phone. If unsuccessful, a certified letter is sent with the same information. We monitor customers who test positive for follow up care, and reach out to each customer we identify who may not have followed through to provide assistance to obtain follow up care.

**From Care N' Care:** We do not send a FIT test to members without a declared PCP. All PCPs that participate in the program have given me signed permission to order/process a FIT FOBT using their name. I have access directly into QUEST 360. I have my own mailbox. I place the order for the physician, both of us receive the results, I fax all results

to the PCP office. Positive results warrant a fax, phone call, and email.

**From Gateway:** All of our members choose a PCP as they join the plan, so we don't run into the issue of a member not having a PCP to receive results. With that being said, a request for this information from the members could be made via Interactive Voice Response calls ahead of the campaign or a field to fill out and send in with the kit. The process for positive results follow-up is typically worked out with whatever vendor is being used, but typically includes a phone call and letter to the member and results sent to the provider. We have several other steps that we might take internally if the member has any issues or concerns after the test.

**From Kaiser Permanente:** All patients either have a PCP or a primary care department in their neighborhood. If there is no PCP, there is a physician leader who takes responsibility for getting results.

We have a tightly run follow up system with regular tracking of positive results and follow through to colonoscopy. Depending on the location, positive tests are either referred for colonoscopy by their PCP, or there is a designated mid-level provider in the gastroenterology department reviewing lists of patients with a positive FIT, ensuring that they get a colonoscopy.

Patients who refuse to schedule a colonoscopy, receive a letter outlining the risk of cancer associated with a positive FIT, and many will end up getting a colonoscopy. (Watch for an upcoming publication in JAMA on this topic from Douglas Corley, MD, PhD, MPH of Kaiser Permanente.)

*The case studies for Community Health Plan of Washington and HealthPartners also address outreach to unattributed members: <http://nccrt.org/Health-Plan-Handbook>.*

**10. Q: How are charges handled for an individual with positive FIT results that then go for diagnostic colonoscopy as a result? If the charges are not covered, are members informed that they may face a cost share if the FIT is positive?**

*and*

**Q: If a patient selects Cologuard as their form of screening, will the insurance companies also pay for a colonoscopy if the Cologuard is positive? Or does the patient have to cover the cost of follow up colonoscopy?**

**A:** It is important to remember that in most cases, the patient receiving the intervention from the health plan is a member of that health plan. Thus, the member has available to him or her, the full range of benefits and access that is outlined in their Evidence of Benefits. Several high-performing health plans, including Blue Cross Blue Shield of Massachusetts, Cigna and Gateway Health, have made the decision to waive cost sharing for colonoscopies that follow a positive first-line screening test, even though it is not currently mandated by the Affordable Care Act, although use of Cologuard as a first line screening was not mentioned specifically. (For more information, reference best

practice 5 on page 13 as well as the relevant case studies: <http://nccrt.org/Health-Plan-Handbook>.)

**11. Q: Did the plans that mailed the FIT kits to members wait for HEDIS results? What time of year were they sent out?**

**A:** Typically, health plans will execute interventions throughout the calendar year. The period between January and May is often when data analysis and reporting to NCQA for HEDIS takes place. Other than Kaiser Permanente (described below in the answer to question 13), the plans that mailed FIT to members did not mention conducting mailings at a specific time of year or waiting for HEDIS data to assess results. (For more information, see the question below about FIT return rates.)

**12. Q: How do the plans that distribute FIT incorporate primary care risk stratification (i.e. identify increased or high risk patients for whom FIT is not appropriate) and results follow-up into their FIT distribution process?**

**From Cigna:** Our communication materials provide an overview of all tests available. We do indicate that the FIT is appropriate for individuals with average risk. We also encourage customers to discuss with their physician which test is best for them, given their personal history and situation.

**From Care N' Care:** I send the PCP a gap list, which shows all of his/her patients that need a COL cancer screen. They review it, if there are any issues/problems, he/she will send me a fax with instructions/omissions prior to the kit mail out process. The PCP directs the process for his/her patients

**From Gateway:** The risk stratification piece is a little bit complicated because plans will have varying levels of historical data on members to build out from. We have our data mapped appropriately for our eligibility files according to specific parameters that we set based off of the amount of data that we have and it is as easy as hitting the "run" button at this point to generate a list of members. Many of the factors that make someone increased or high risk are things that we would automatically remove from this list, such as a history of colorectal cancer. Other risk factors, like family history, may or may not be present in a plan's data and need to be addressed as they see fit. We sat down as a team and had a conversation about what should be included and I would urge anyone thinking of starting a program like this to do the same. There are many things to consider in the early part of this intervention.

New members are a little bit more challenging to fit into our model because we may not have enough data to evaluate their risk. We do attempt to educate through telephonic outreach and letters about different screening methods, which is meant to urge all members to speak with their physician about the appropriate testing for them. Ideally the member is making the decision to screen with their physician and we are just helping to facilitate.

**From Kaiser Permanente:** With the FIT mailing, people with a family history of colorectal cancer are advised to contact their physician to get a personalized screening recommendation. The outreach population starts with people who have not had a colonoscopy in the last 10 years or a FIT in the last year. Patients who are at known high risk are likely to have already had their colonoscopy and will not be in the outreach population.

**13. Q: Do they [Kaiser Permanente] do a blanket physician order for all patients with an outstanding colorectal measure annually?**

**A:** The case study describes how Kaiser Permanente sends letters to patients to inform them that they are due for screening and will soon receive a FIT kit either on the anniversary of their last screening or their birthday (for those who are unscreened). (For more information, reference the case study: <http://nccrt.org/Health-Plan-Handbook>.)

**Questions about the [Colorectal Cancer Screening Best Practices Handbook for Health Plans](#):**

**14. Q: Would we be able to utilize some of the templates?**

**A:** The sample content included in the appendix of the handbook was generously shared by health plans with the intention that it be used as inspiration in the development of similar materials.

**15. Q: Will there be an opportunity to ask questions to those with the profiled best practices?**

**A:** There are no plans to provide an opportunity for Q&A with the case study contributors at this time. We encourage you to review the case study and email [nccrt@cancer.org](mailto:nccrt@cancer.org) with any unanswered questions. Plans profiled in the handbook may be willing to share additional information about their work on a case-by-case basis. We appreciate your understanding since the contributors have already been very generous in volunteering their time.

**16. Q: CD or VIDEO for teaching?**

**A:** We have not developed a CD or video version of the handbook, but the replay of this webinar is available at <http://nccrt.org/webinars/>.