



Improving Colorectal Cancer Screening Rates

A Promising Practices Guide for
State-Medicaid Agencies



CONTENTS

- Acknowledgments 3
- National Colorectal Cancer Roundtable & 80% in Every Community 4
- Background 5
- Promising Practices 6
 - Define a Colorectal Cancer Screening Metric for State Medicaid Plans..... 8
 - Support or Mandate Public Reporting of CRC Screening Rates 13
 - Develop an Incentive Program/Value-Based Purchasing Measure for CRC 17
 - Provide Education and Technical Support
to Managed Care Organizations and Providers..... 20
 - Collaborate with State Public Health Staff..... 24
 - Work Closely with FQHCs that Serve Large Medicaid Populations..... 27
 - Promote Evidence-Based Strategies and Interventions 29
 - Facilitate Access by Covering Multiple Types of Tests Without Cost Sharing.... 36
 - Promote Test Options to Overcome Compliance Barriers,
Provider Shortages, Geographic Issues, and Logistical Constraints 38
- Appendix: Links and Examples 40
- References 59

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NATIONAL COLORECTAL CANCER ROUNDTABLE & 80% IN EVERY COMMUNITY

The NCCRT is a national coalition of public organizations, private organizations, voluntary organizations, and invited individuals. It was established in 1997 by the American Cancer Society (ACS) and the Centers for Disease Control and Prevention (CDC).

- **Mission:** Reduce the incidence of and mortality from colorectal cancer in the U.S., through coordinated leadership, strategic planning, and advocacy.
- **Goal:** Increase the use of proven colorectal cancer screening tests among the entire population for whom screening is appropriate
- **Core Principles:** Collective action among the member organizations will be more successful in reducing the burden of disease, and reducing that burden faster, than if we worked alone. The NCCRT will not duplicate or take on roles of member organizations, but rather fulfill those roles that would otherwise go undone.
- Learn more: www.nccrt.org

80% IN EVERY COMMUNITY

80% in Every Community is an NCCRT initiative that aims to substantially reduce colorectal cancer as a major public health problem. Nearly 1800 organizations have committed to working toward the shared goal of 80% of adults aged 50 and older being regularly screened for colorectal cancer. Through dedication, determination, and collective action, we are seeing that 80% and higher screening rates are possible as community health clinics, health plans, employers, counties, and many others are achieving their goals.

But not everyone is benefiting equally. There are still too many communities with lower colorectal cancer screening rates –certain racial and ethnic communities, low income communities, rural communities, among others. We will continue working to bring down barriers to screening because everyone deserves to live a life free from colorectal cancer. Our mission isn't achieved until we see 80% screening rates in every community.



BACKGROUND

With the passage of the Affordable Care Act and the associated expansion of Medicaid in many states, a large number of adults over age 50 have entered the Medicaid population for the first time. Research shows that Medicaid members are significantly less likely to be up to date with colorectal cancer (CRC) screening, compared to individuals with other types of insurance. Therefore, this cohort’s newly-insured status represents an important opportunity for state Medicaid agencies and public health divisions that seek to improve the overall health status of their state populations.

This report follows up on a 2015 report commissioned by the National Colorectal Cancer Roundtable (NCCRT), *Colorectal Cancer Initiatives in Medicaid Agencies—A National Review*. That report broadly described the activities being undertaken by Medicaid programs in all 50 states, identifying ten states that had adopted more robust approaches to colorectal cancer screening.

To develop a deeper understanding of how these higher-performing states are approaching the challenges of colorectal cancer screening, the NCCRT engaged QNA Group to conduct follow-up research with several of the states that had progressed further on their efforts. This report documents the results of that process, focusing on the following states that had made significant progress and were willing to share detailed information about their programs:

- Arizona
- Minnesota
- New York
- Maryland
- Montana
- Oregon

To gather insights, QNA conducted lengthy telephone interviews with staff members from Medicaid agencies and public health departments from each state. States also provided data, reports, and samples of materials they are using to support their colorectal cancer screening programs.

Individual participants include staff members who are responsible for many different aspects of cancer prevention and control, including evaluation and data analytics, administration of CRC-related grants and demonstration projects, quality improvement initiatives, value-based purchasing, public health promotion, and oversight of Medicaid managed care organizations.

After analyzing the information provided by these states, the following promising practices were identified (see page 7). Given that Medicaid expansion and associated screening efforts are still relatively new, most states do not yet have long-term data to support a robust evaluation of their work. In some cases, smaller demonstration projects have delivered positive results, while in other cases, screening data is not yet available to evaluate impact.

Despite these limitations, we believe that the practices described here have shown sufficient promise to merit consideration by other state Medicaid agencies who wish to enhance their screening efforts for this important population.

PROMISING PRACTICES

This report highlights the following practices that each state described as part of their quality improvement programs. As shown, some states have employed multiple strategies, while others have only tried a few thus far. We believe their varied work indicates that every strategy does not need to be pursued in order to make progress. (Note that states may also be pursuing selected practices through other programs and interventions that may not have been specifically identified through this research.)

| PRACTICE | AZ | MD | MN | MT | NY | OR |
|---|----|----|----|----|----|----|
| Define a CRC Metric for State Medicaid Plans | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Support or Mandate Public Reporting of CRC Screening Rates | | | ✓ | | ✓ | ✓ |
| Develop an Incentive Program/Value-Based Purchasing Measure for CRC | | | | ✓ | ✓ | ✓ |
| Provide Education and Technical Support to Managed Care Organizations and Providers | ✓ | ✓ | | ✓ | ✓ | ✓ |
| Collaborate with State Public Health Staff | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Work Closely with FQHCs that Serve Large Medicaid Populations | ✓ | | | ✓ | ✓ | ✓ |
| Promote Evidence-Based Strategies and Interventions | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Facilitate Access by Covering Multiple Tests Without Cost-Sharing | ✓ | ✓* | ✓* | ✓* | ✓* | ✓ |
| Promote Test Options to Overcome Compliance Barriers, Provider Shortages, Geographic Issues, and Logistical Constraints | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

*Includes coverage of computerized tomography (CT) colonography and/or stool DNA testing

DESCRIPTION OF PROMISING PRACTICES

| | | |
|---|--|---|
| 1 | Define a Colorectal Cancer Screening Metric for State Medicaid Plans | In the absence of a mandatory CRC measurement for Medicaid programs, some states have either chosen to adopt the Healthcare Effectiveness Data and Information Set (HEDIS) approach for their Medicaid populations or developed measures of their own using data from claims, medical records, or both. |
| 2 | Support or Mandate Public Reporting of Colorectal Cancer Screening Rates | Public reporting of screening rates for Medicaid beneficiaries (either by plan or clinic) leads plans and providers to greater accountability and pursuit of quality improvement. |
| 3 | Develop an Incentive Program/ Value-Based Purchasing Measure for Colorectal Cancer Screening | Though CRC is inherently a challenging measure, some states are incentivizing screening through bonus payments or negative payment adjustments, pairing the effort with tools and technical support to help plans and providers reach quality goals. |
| 4 | Provide Education and Technical Support to Managed Care Organizations and Providers | Support programs address data resources, outreach strategies, workflow guidance, client reminder programs, and others which are delivered in person, by webinar, or through regular meetings and calls. |
| 5 | Collaborate with State Public Health Staff | Close working relationships between public health and Medicaid staff enable both to share program resources, provider relationships, knowledge, and data to efficiently reach high need populations. |
| 6 | Work Closely with FQHCs that Serve Large Medicaid Populations | Efforts include FQHC quality improvement training programs on topics such as data collection, client reminders, and workflow, as well as pilot efforts to test the efficacy of new programs. |
| 7 | Promote Evidence-Based Strategies and Interventions | Most states are using proven strategies recommended by the NCCRT and The Community Guide, as well as making use of already developed materials and templates for client reminders, mailers, etc. |
| 8 | Facilitate Access by Covering Multiple Tests Without Cost-Sharing | Some states have passed legislation to ensure that Medicaid clients incur no costs for diagnostic colonoscopies following a positive stool test. Others have extended Medicaid benefits to cover newer tests such as stool DNA or CT colonography. |
| 9 | Promote Test Options to Overcome Compliance Barriers, Provider Shortages, Geographic Issues, and Logistical Constraints | Agencies are promoting the use of high-quality stool tests as an effective way of encouraging compliance among those who cannot take time off work for colonoscopy or who face logistical challenges or long wait times in their region. |

1

DEFINE A COLORECTAL CANCER SCREENING METRIC FOR STATE MEDICAID PLANS

The impetus for a state to pursue a more robust screening program for their Medicaid population sometimes comes from measurement and the availability of data that clearly demonstrates the heightened needs of this cohort.

Examples of data that most states would have access to include colorectal cancer incidence rates and stage at diagnosis data from state cancer registries, Uniform Data System (UDS) screening rates for federally-funded community health centers that serve large Medicaid populations, or self-reported Behavioral Risk Factor Surveillance System (BRFSS) screening data. Although these sources may not be exclusive to the Medicaid population, they can offer a strong indication of the need for more focused data collection within the state.

Adjustments can also be made to existing measurements such as the BRFSS to include health coverage questions that enable states to isolate statistics for their Medicaid population. In 2014, Oregon conducted a Medicaid-specific BRFSS survey which measured screening at 48.9%, compared to 66% for the overall adult population in the state.

States can also estimate screening rates if data is not readily available for the Medicaid population. For example, although the type of health insurance is not a core question¹ on the BRFSS, New York includes a state-added question on health care access.

Even without a Medicaid-specific question, states can use the BRFSS survey to roughly estimate screening rates for adults with incomes below \$25,000 as a proxy for the Medicaid population.

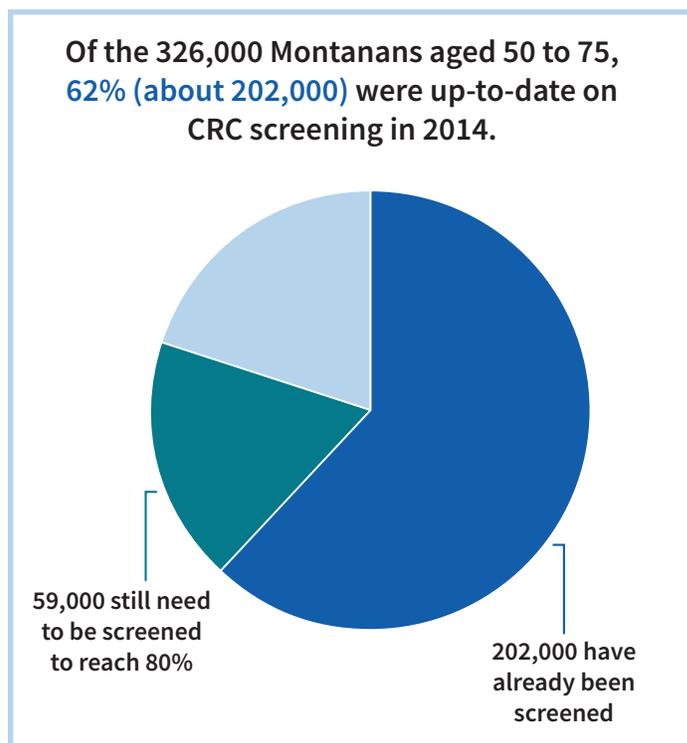


Figure 1: Excerpt from Montana Report on Colorectal Cancer Screening Capacity - Montana Behavioral Risk Factor Surveillance System 2014 Data

In this research, both Montana and Arizona were prompted to focus on colorectal cancer screening after reviewing these types of data sources. Montana (see Figure 1) identified a need for a focused screening effort based on low colorectal cancer screening rates in their BRFSS data.² Similarly, Arizona (see Figure 2) examined its state cancer registry and observed an alarmingly high rate of late-stage diagnoses for colorectal cancer in their state; between 2008 and 2012, a majority of cases were diagnosed as late stage, prompting them to take action statewide.

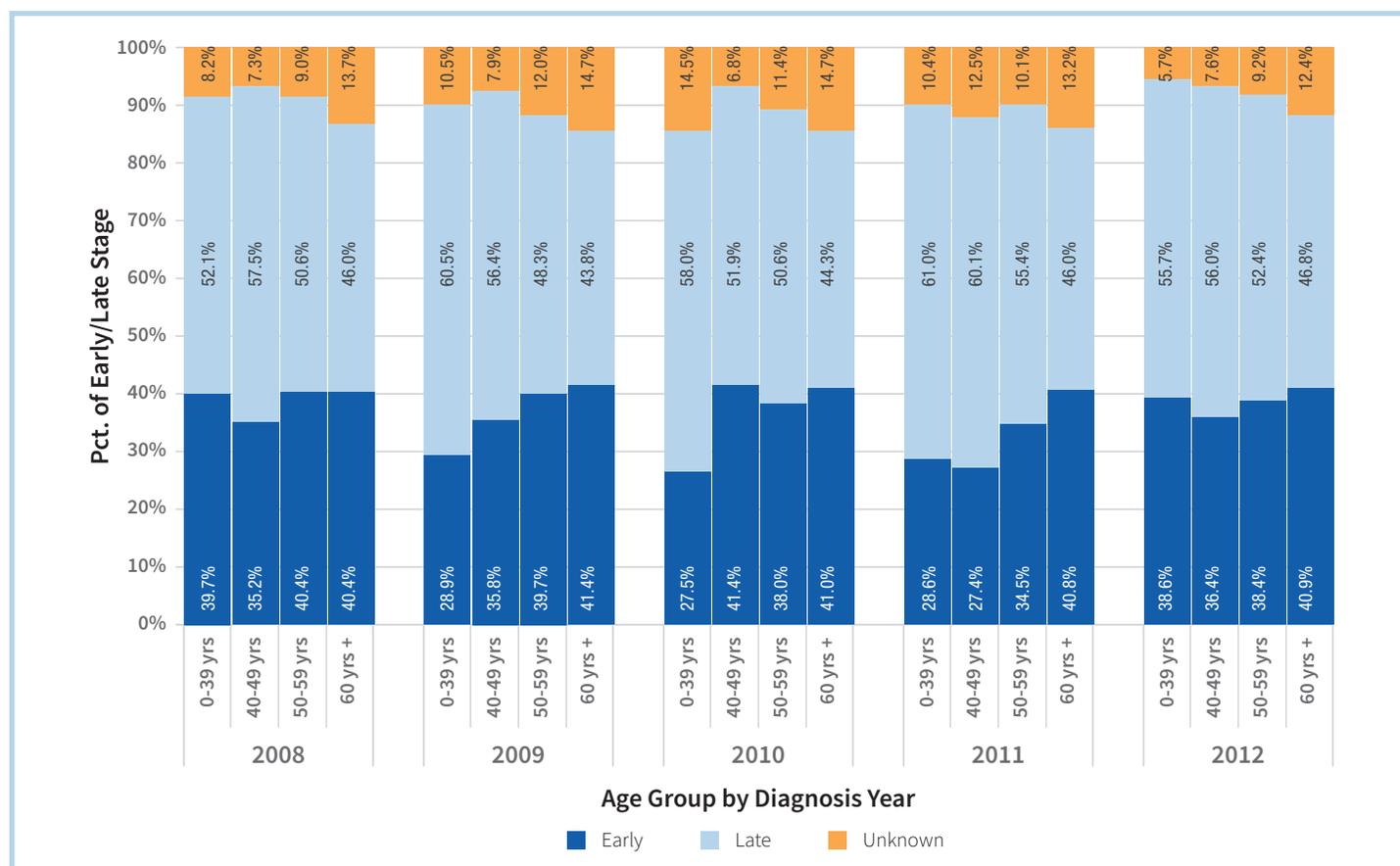


Figure 2: Late Stage Colorectal Cancer Diagnosis by Age (Arizona, 2008–2012)

While these readily-available data sources can be important in promoting awareness of screening deficits, high-performing states have recognized the need to more accurately measure the screening rate for their Medicaid populations. The states profiled in this report have taken varied steps to determine exactly how measurement should be done and have mandated a measurement standard that they can consistently monitor over time.

Define a Colorectal Cancer Screening Metric for State Medicaid Plans

For example, although there is no Medicaid HEDIS measure for colorectal cancer screening,³ New York has required Medicaid health plans to report on it using the National Committee for Quality Association (NCQA) HEDIS methodology under its Quality Assurance Reporting Requirements (QARR) since 2012.⁴ New York also uses state BRFSS data from a state-added health care access module to inform cancer control decision making and to examine differences in screening rates between Medicaid managed care populations and privately insured or uninsured residents.

| PERCENT UP-TO-DATE WITH COLORECTAL CANCER SCREENING AMONG NEW YORK STATE (NYS) ADULTS AGES 50 TO 75 YEARS, BY SELECTED CHARACTERISTICS, 2016 BRFSS | | | | | | | |
|--|---------------------------|---------------------------|-----------|------------------------------|-----------|-----------------------|----------|
| | ESTIMATED POPULATION SIZE | UP-TO-DATE WITH SCREENING | | COLONOSCOPY IN PAST 10 YEARS | | FOBT/FIT IN PAST YEAR | |
| | | N | % | 95% CI | % | 95% CI | % |
| Total NYS [N=17,871] | 5,926 | 68.5 | 66.8-70.1 | 66.2 | 64.6-67.9 | 7.3 | 6.5-8.2 |
| HEALTH CARE COVERAGE | | | | | | | |
| Private Insurance | 2,659 | 69.8 | 67.5-72.0 | 68.2 | 66.0-70.5 | 6.0 | 4.9-7.1 |
| Medicare | 1,296 | 76.1 | 73.1-79.2 | 73.9 | 70.8-77.0 | 8.8 | 7.2-10.4 |
| Medicaid | 494 | 57.9 | 52.5-63.3 | 54.2 | 48.7-59.6 | 9.0 | 6.0-12.0 |
| Other Insurance | 216 | 68.8 | 60.1-77.5 | 64.7 | 56.1-73.3 | 12.2 | 7.5-16.9 |
| No Insurance | 343 | 41.5 | 33.3-49.7 | 38.5 | 30.3-46.7 | 5.4 | 2.4-8.3 |

Figure 3: New York 2016 BRFSS Data

States recognize that documenting colorectal cancer screening is complicated, given that patients can qualify as up-to-date with their screening via many different tests, each with varying screening intervals that can further vary based on family history and other risk factors. Because of this, developing a metric that applies to a state’s entire Medicaid population is a process that may take some time and careful study. For example, Arizona needed around two years after the state expanded Medicaid to set up their colorectal cancer screening measure, doing so with significant input from health plans and providers that would be affected.

“If you’re just relying on claims, and you’re not using a hybrid methodology to look at all sources of the data, you’re going to have an imperfect view of it. That is a challenge against this measure.” (New York)



In establishing a standard measurement methodology for colorectal cancer screening, states have options such as exclusively examining claims/billing records, sampling patient medical records, or a hybrid approach that makes use of both sources. Whichever approach is chosen, high performing states have acknowledged their limitations, recognizing that challenging population, no measurement approach is likely to be entirely accurate. Importantly, they have explained these limitations to participating plans and providers and indicated that the objective of their chosen approach to measurement is essentially one of tracking progress and improvement, not necessarily arriving at a 100% accurate figure.

| LIMITATIONS OF MEASURING SCREENING WITH CLAIMS/BILLING RECORDS | LIMITATIONS OF MEASURING SCREENING WITH PATIENT MEDICAL RECORDS/EMRs |
|--|---|
| <ul style="list-style-type: none"> • Timing: the lookback period for CRC screening is up to ten years for colonoscopy. • Continuous enrollment issues: there is often a great deal of “churn” with Medicaid patients; they may be enrolled in Medicaid on and off even within a single year as their situations change, resulting in gaps that providers or health plans cannot account for. Hence claims records may not reflect screenings they had while not enrolled in the program. | <ul style="list-style-type: none"> • Medicaid patients are less likely to consistently see the same health care providers year after year. Their electronic medical records are more likely to be incomplete. • Providers must be consistent in how they record past screening activities (e.g., requiring a copy of a colonoscopy report vs. taking the patient’s word for it that they were screened.) • Chart reviews to gather accurate screening data may be prohibitively labor-intensive without access to audit resources that are available for other HEDIS measures. |

In Oregon, the HEDIS hybrid approach to colorectal cancer screening measurement is being employed, based on a combination of chart review and administrative/billing data. Specifically, the Oregon Health Authority, which administers the Medicaid program, requires two years of continuous enrollment for anyone in the sampling frame, and lab results are required to validate a test result only if it is not clearly part of the medical history section of the record. (See the Appendix for Oregon’s CRC measure specifications, which detail screening guidelines for each type of test, member enrollment criteria, data elements, exclusions, and definitions for numerator and denominator.)

In contrast, the Maryland Department of Health created a “homegrown” metric based on the technical specifications of the National Committee for Quality Assurance (NCQA) HEDIS measure for the 50–64 age group—those newly covered under Medicaid. The new measure was developed through a collaborative effort amongst many Medicaid stakeholder groups, including providers, the American Cancer Society, and medical directors from participating managed care organizations. Collaborating with these stakeholders was an important part of introducing this measure. At the present time, they are only using claims data to measure screening rates. As a result, the measurement is acknowledged to be artificially low and therefore more of a snapshot in time that may only serve as a year-over-year comparison.

“Clinicians and leaders, they want to be data-driven. If they know that their screening rates are pretty abysmal, they might be motivated to do something about that, even if it’s not in a value-based purchasing program.” (Maryland)

Define a Colorectal Cancer Screening Metric for State Medicaid Plans

In Minnesota, medical groups and clinics report their rates directly to Minnesota Community Measurement, based on either electronic health records or paper charts. (See the Appendix for a description of their methods for determining the eligible population, numerator, and denominator for their measurement.)

| UDS CRC SPECIFICATION ⁵ | HEDIS CRC SPECIFICATION |
|---|--|
| <p>Definition: Percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer</p> <p>Denominator: Patients 50–75 who had a medical visit during the measurement period. Exclude: patients with a diagnosis of colorectal cancer or total colectomy; patients in hospice care during the measurement period.</p> <p>Numerator: Patients with one or more screenings for CRC, defined by one of the following:</p> <ul style="list-style-type: none"> • Fecal Occult Blood Test FOBT (gFOBT or iFOBT) during the measurement period • Fecal Immunochemical Test (FIT) DNA during the measurement period or the 2 years prior to the measurement period • Flexible sigmoidoscopy during the measurement period or 4 years prior • CT colonography during the measurement period or 4 years prior • Colonoscopy during the measurement period or 9 years prior <p>Specification Guidance:</p> <ul style="list-style-type: none"> • Do not use patient self-report for laboratory tests. • Tests performed elsewhere must be confirmed by documentation in the chart (copy of test results or correspondence with performing lab/clinician). | <p>Definition: Percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer</p> <p>Denominator: Patients aged 50 – 75 as of the end of the measurement year. Exclude: patients with a diagnosis of colorectal cancer or total colectomy; patients in hospice care during the measurement period; patients age 65 and older as of January 1 of the measurement year who are either enrolled in an Institutional SNP (I-SNP) any time during the measurement year, or living long-term in an institution any time during the measurement year as identified by the LTI flag in the Medicare Part C monthly membership file.</p> <p>Numerator: Eligible patients with appropriate screening for colorectal cancer as defined by the screenings below::</p> <ul style="list-style-type: none"> • Fecal Occult Blood Test FOBT (gFOBT or iFOBT) during the measurement period • Fecal Immunochemical Test (FIT) DNA during the measurement period or the 2 years prior to the measurement period • Flexible sigmoidoscopy during the measurement period or 4 years prior • CT colonography during the measurement period or 4 years prior • Colonoscopy during the measurement period or 9 years prior |



2

SUPPORT OR MANDATE PUBLIC REPORTING OF CRC SCREENING RATES

Several states profiled in this report mandate public reporting of colorectal cancer screening rates for Medicaid managed care plans or providers. Some do so in the context of an incentive system or value-based purchasing program (see Promising Practice #3). However, even without such incentive programs, the states interviewed for this report indicate that public reporting of screening rates for Medicaid beneficiaries is likely to lead to improvements because health plans and providers will respond to seeing comparative data about their performance.

“Just making it a measure that’s recorded and publicly available is a really big step forward.” (Maryland)

When establishing public reporting, states indicate that there will be questions and concerns from managed care organizations (MCOs) and providers; the long look-back period for colorectal cancer screening and nature of the audience mean that reported rates are likely to be low—especially early in the process before procedures are well established.

Higher performing states have listened and responded to these concerns with strong training and education programs. A task force comprised of stakeholders that includes plans, providers, and public health specialists can be an important opportunity to collaboratively define and support new measurements.

When Maryland made the decision to publicly report colorectal cancer rates by adding the metric to their annual managed care evaluation, they worked closely with the plans (including corporate leadership, medical directors, and quality assurance liaisons) to reassure them that they were not trying to “throw them under the bus” by publishing these rates. A compromise emerged such that—at least initially—screening rates would only be reported in aggregate across the entire Medicaid population, not by individual MCO.

Additionally, public reporting clearly explains the potential negative interpretations of data. For example, Figure 4 below shows that screening rates declined significantly from 2013 to 2014, before rebounding in subsequent years. Reports clearly explain that such a decline is attributable to the state’s expansion of Medicaid and the influx of more than 300,000 previously uninsured adults into the Medicaid population.

Analysis of the plans’ performance data is largely focused on year-over-year comparisons and improvement, rather than absolute measures of performance.

PERCENTAGE OF HEALTHCHOICE PARTICIPANTS AGED 50-64 YEARS WHO RECEIVED A COLORECTAL CANCER SCREENING, CY 2012-CY 2016

| | CY 2012 | CY 2013 | CY 2014 | CY 2015 | CY 2016 |
|-------------------|---------|---------|---------|---------|---------|
| Screened Patients | 38.8% | 38.7% | 32.1% | 35.0% | 37.2% |

Figure 4: Excerpt from Maryland HealthChoice Evaluation Report

The Oregon Health Authority also publishes annual Performance Metrics Reports⁶ that detail the performance of its Medicaid Coordinated Care Organizations (CCOs) on 16 different quality measures. This data is reported cumulatively for all CCOs, but also details the performance of individual CCOs, so that the public can easily compare how each provider organization fares on colorectal cancer screening as well as childhood immunizations, tobacco use, and a variety of other measures. As shown in Figure 5, Oregon saw a 10 percentage-point increase in colorectal cancer screening among its CCOs from 2014 to 2017.

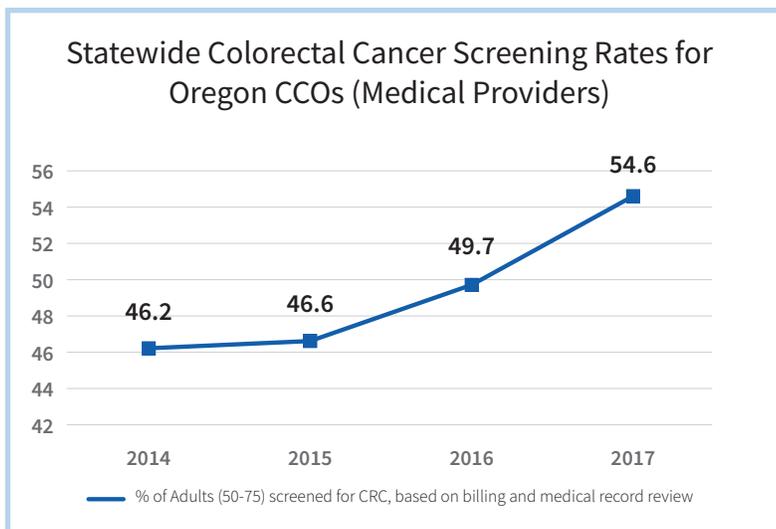


Figure 5: Excerpt from an Oregon Performance Metrics Report

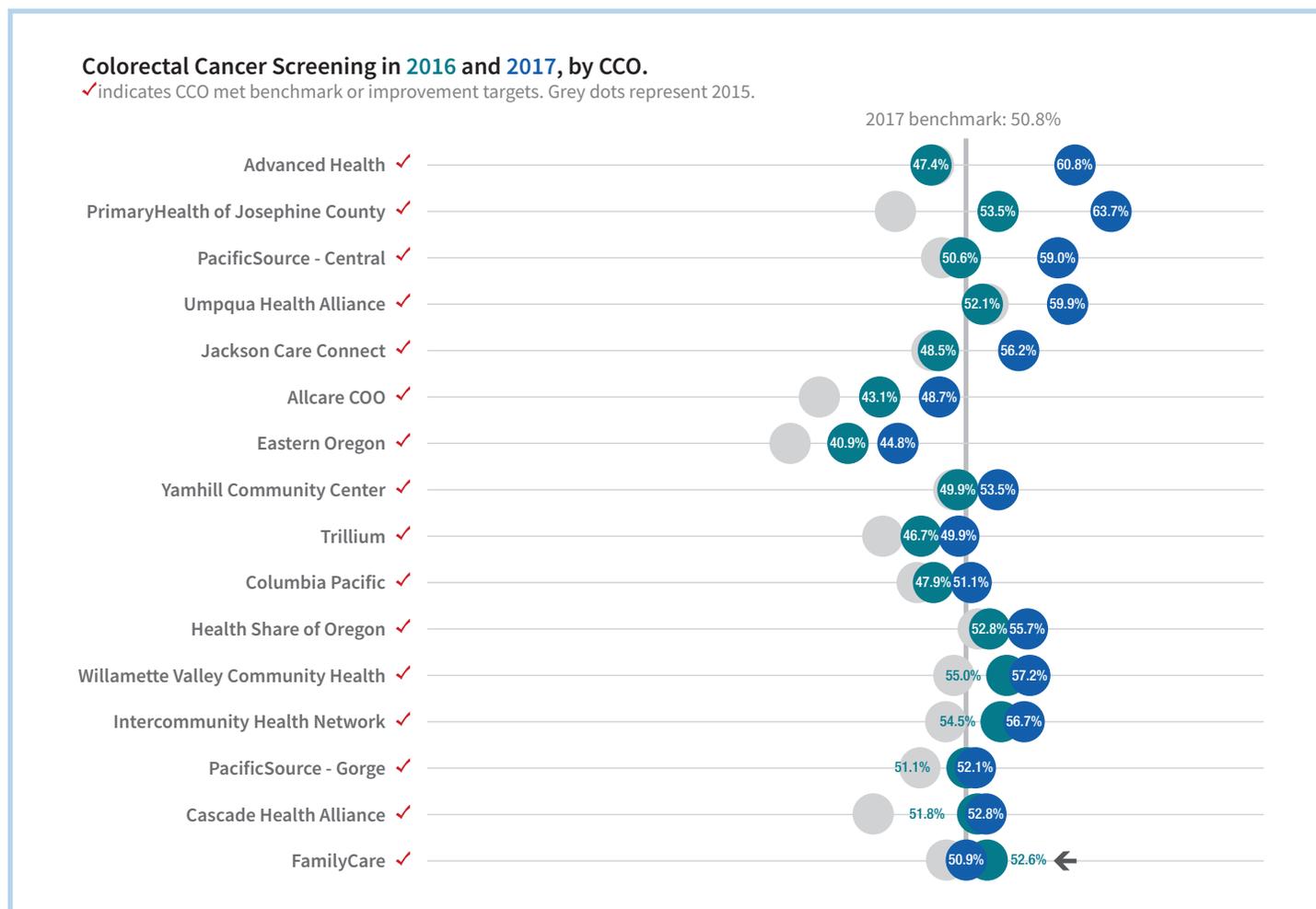


Figure 6: CRC Screening Performance Reporting for Individual CCOs (Oregon)

Figure 7 below is another example of public accountability reporting, in this instance, for individual medical groups. For the past ten years, Minnesota Community Measurement has collaborated with the Minnesota Department of Human Services to produce annual quality reports on 11 performance measures that are tracked by Minnesota Health Care Programs (MHCP). These programs cover residents enrolled in managed care plans who receive Medical Assistance as well as dual-eligible Medicare-Medicaid beneficiaries. Quality measures tracked by the program include colorectal cancer screening along with high blood pressure, childhood immunization, diabetes care, and others.⁷

As shown below, colorectal cancer screening rates are reported for medical groups and clinics throughout the state. To qualify for inclusion in this analysis, clinics must have at least 30 patients that meet the measurement specifications. Reports also compare the performance rates for Minnesota Health Care Programs and other purchasers, with a focus on narrowing the gap over time. In addition to reporting raw screening rates, positive public recognition of high performing providers plays a role in these reports. Specifically, the reports draw readers' attention to medical groups that have an above-average performance on quality measures or have made the largest improvements over the previous year. For example, one clinic was called out by name for achieving a 33 percentage point increase for CRC screening among MHCP patients from 2016 to 2017.

| COLORECTAL CANCER SCREENING – RATE CHANGES FOR REPORTING YEARS 2015 TO 2017 | | | | | | | |
|---|----------------|----------------|----------------|--------------------|--------------------|--------------------|-----------------------------|
| MEDICAL GROUP NAME | 2015 MHCP RATE | 2016 MHCP RATE | 2017 MHCP RATE | CHANGE (2016-2015) | CHANGE (2017-2016) | CHANGE (2017-2015) | CHANGE PATTERN (2015-2017) |
| Obstetrics and Gynecology Associates | 79.3% | 81.3% | 76.4% | 2.0% | -4.9% | -2.9% | Consistent High Performance |
| Southdale Ob/Gyn Consultants | 95.0% | 85.2% | 74.1% | -9.8% | -11.1% | -20.9% | Consistent High Performance |
| Fairview Health Services | 64.3% | 66.7% | 66.4% | 2.5% | -0.3% | 2.2% | Consistent High Performance |
| Mayo Clinic | 60.9% | 63.9% | 64.9% | 3.0% | 1.0% | 4.0% | Consistent High Performance |
| Alexandria Clinic | 65.6% | 61.7% | 64.9% | -3.9% | 3.2% | -0.7% | Consistent High Performance |
| Allina Health Clinics | 65.0% | 66.1% | 63.2% | 1.1% | -3.0% | -1.9% | Consistent High Performance |
| Sanford Health - Fargo Region | 56.2% | 58.1% | 62.1% | 1.9% | 4.0% | 5.9% | Consistent High Performance |
| HealthPartners Clinics | 63.2% | 62.9% | 61.7% | -0.3% | -1.2% | -1.5% | Consistent High Performance |
| Allina Health Specialties | 60.2% | 60.0% | 61.5% | -0.1% | 1.5% | 1.3% | Consistent High Performance |
| Mankato Clinic, Ltd. | 59.2% | 61.6% | 61.5% | 2.4% | -0.1% | 2.3% | Consistent High Performance |
| Mayo Clinic Health System | 63.9% | 63.7% | 61.1% | -0.2% | -2.6% | -2.8% | Consistent High Performance |
| CentraCare Health | 63.7% | 60.3% | 60.7% | -3.4% | 0.4% | -3.0% | Consistent High Performance |
| Valley Family Practice - MHN | 45.7% | 56.1% | 58.5% | 10.4% | 2.4% | 12.8% | Consistently Improved |
| Northfield Hospital + Clinics | 44.4% | 52.3% | 58.1% | 8.0% | 5.7% | 13.7% | Consistently Improved |
| Riverwood Healthcare Center | 52.9% | 55.3% | 57.4% | 2.3% | 2.2% | 4.5% | Consistently Improved |
| HealthPartners Central Minnesota Clinics | 49.7% | 52.0% | 56.2% | 2.2% | 4.2% | 6.4% | Consistently Improved |
| Renville County Hospital and Clinics | 43.5% | 50.9% | 53.4% | 7.4% | 2.5% | 9.9% | Consistently Improved |
| NorthPoint Health & Wellness Center | 47.4% | 50.7% | 53.3% | 3.3% | 2.6% | 5.9% | Consistently Improved |

Figure 7: Excerpt from 2017 Minnesota Health Care Disparities Report for Minnesota Health Care Programs (Ages 51–75, Enrolled in Medical Assistance/Medicaid and MinnesotaCare)⁸

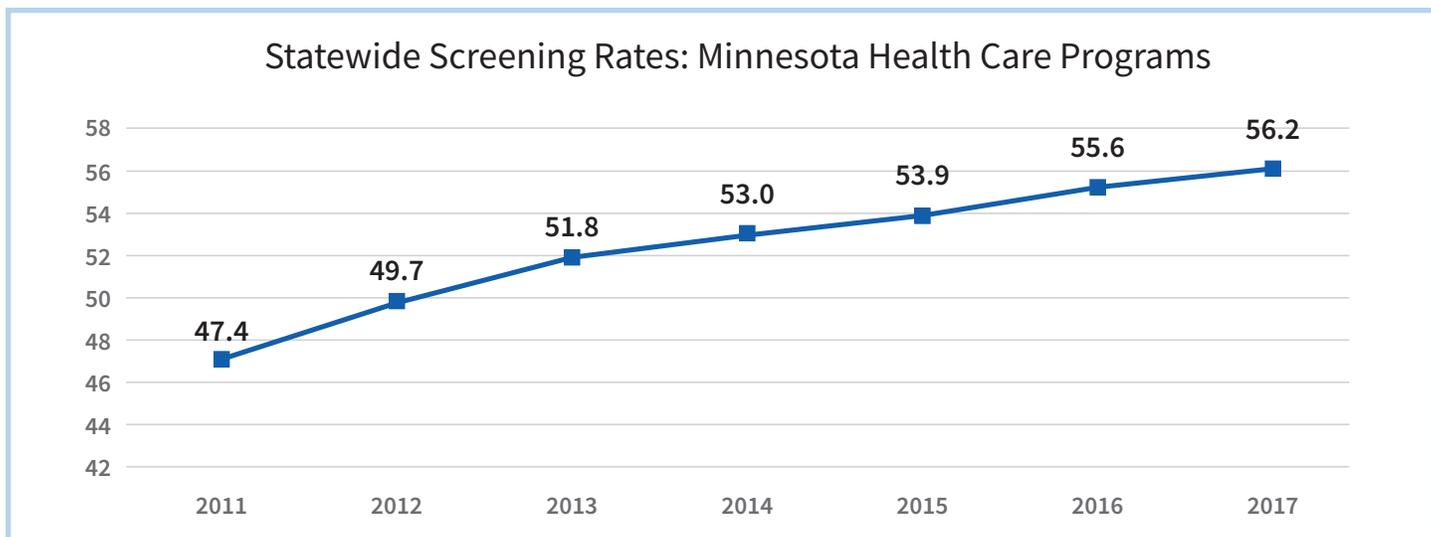


Figure 8: Source – 2017 Health Care Disparities Report for Minnesota Health Care Programs. Patients Sampled in 2017: 116,426.

New York’s Medicaid Managed Care Plans quality performance is also publicly reported via its Quality Assurance Reporting Requirements (QARR) program.⁹

The chart at right is excerpted from the 2016 Health Plan Comparison in New York State report, which provides ratings on both quality indicators and customer satisfaction among Medicaid and commercial plan populations.

Also, in development for the state is a Medicaid Value-Based Purchasing dashboard that will allow performance measures to be assessed for individual provider organizations.

| PLAN | COLON CANCER SCREENING |
|--|------------------------|
| Affinity Health Plan | 63 |
| CDPHP | 56 ▼ |
| Empire BlueCross BlueShield HealthPlus | 57 |
| Excellus BlueCross BlueShield | 49 ▼ |
| Fidelis Care New York, Inc. | 61 |
| HIP (EmblemHealth) | 52 ▼ |
| HealthNow New York Inc. | 45 ▼ |
| Healthfirst PHSP, Inc. | 67 ▲ |
| Hudson Health Plan | 50 ▼ |
| Independent Health’s MediSource | 53 ▼ |
| MVP Health Care | 46 ▼ |
| MetroPlus Health Plan | 56 ▼ |
| Total Care, a Today’s Option of New York Health Plan | 43 ▼ |
| UnitedHealthcare Community Plan | 71 ▲ |
| WellCare of New York | 60 |
| YourCare Health Plan | 45 ▼ |
| MMC Statewide Average | 61 |
| National Average | * |

Figure 9: Excerpt from New York Medicaid Health Plan Performance Report (2016) – Percentage of adults enrolled in Medicaid Managed Care Plans, age 50–75 years old, who had appropriate screening for colorectal cancer.

▲ Significantly better than the statewide average. ▼ Significantly worse than the statewide average

3

DEVELOP AN INCENTIVE PROGRAM/VALUE-BASED PURCHASING MEASURE FOR CRC

After defining and mandating regular measurement of screening rates, the next step that some states have taken is to incentivize colorectal cancer screening through the use of bonus payments, negative payment adjustments, or other value-based purchasing programs (VBP). Because most Medicaid programs have only included CRC in their value-based purchasing programs since the expansion of Medicaid under the Affordable Care Act (ACA), most do not yet have robust data to document the impact of these efforts. However, while it is beyond the scope of this report to fully describe VBP programs, some studies have shown that when they are carefully designed, such programs can have a measurable positive impact on clinical quality indicators.¹⁰

Adding colorectal cancer screening to a VBP program is acknowledged to be a challenge due to this measure's many screening options and varying intervals. As a result, some states are "easing into" including colorectal cancer screening in their value-based purchasing programs by allowing providers to choose from a broader set of measures, of which colorectal cancer is one. For example, Medicaid Managed Care Organizations in VBP arrangements are required to report on a core set of measures for each arrangement type but can select which ones impact their actual payments. Colorectal cancer screening was added as a Category 1 measure for Measurement Year 2018, and most arrangement types will be required to report on it.

Establishing reasonable goals and benchmarks for plans and providers when the quality measure is brand new can be a challenge. When Montana established new CRC screening goals as part of a Centers for Medicare & Medicaid Services (CMS) demonstration program, they did not have the luxury of having several years of data to consult. If this is the case, states can make use of data that is available, even if it is acknowledged to be imperfect or incomplete (e.g., BRFSS survey data, Medicaid claims data) and expect that adjustments will need to be made after the first year or two. As part of its Medicaid Innovation Accelerator Program, CMS has provided guidance on establishing benchmarks for Medicaid value-based payment programs.¹¹

"When you do one of these value-based medical models, you should be looking at data for a couple of years ahead of time and then set a benchmark...we set them a little bit higher this year, and we will see where we are, and then next year we'll adjust those benchmarks to be more realistic." (Montana)

When setting benchmarks for colorectal cancer measures, participating states also note that statewide cancer prevention goals (for example commitments to NCCRT’s 80% national screening campaign) are likely to differ from goals set for the Medicaid population or for performance incentives. For example, New York’s state Prevention Agenda has the stated goal of achieving 80% screening for adults aged 50–75. However, for adults making less than \$25,000, the goal is 65.4%. Incentives for the state’s managed care organizations are based on yet another type of calculation.

New York’s Medicaid Managed Care plans receive quality incentive awards¹² based on a cumulative quality score, derived from a combination of quality of care, patient satisfaction, regulatory compliance, and prevention quality indicators (other bonus points are also possible). Scores are compiled based on a composite measure of quality, with colorectal cancer screening being one of many measures that comprise the ratings. Plans receive points in each category if they score at or above the 50th percentile in a given year. Scoring above the 90th percentile yields the maximum number of points. As shown below, managed care organizations in 2017 that achieved 64% or above with their Medicaid members were eligible for the highest incentives.

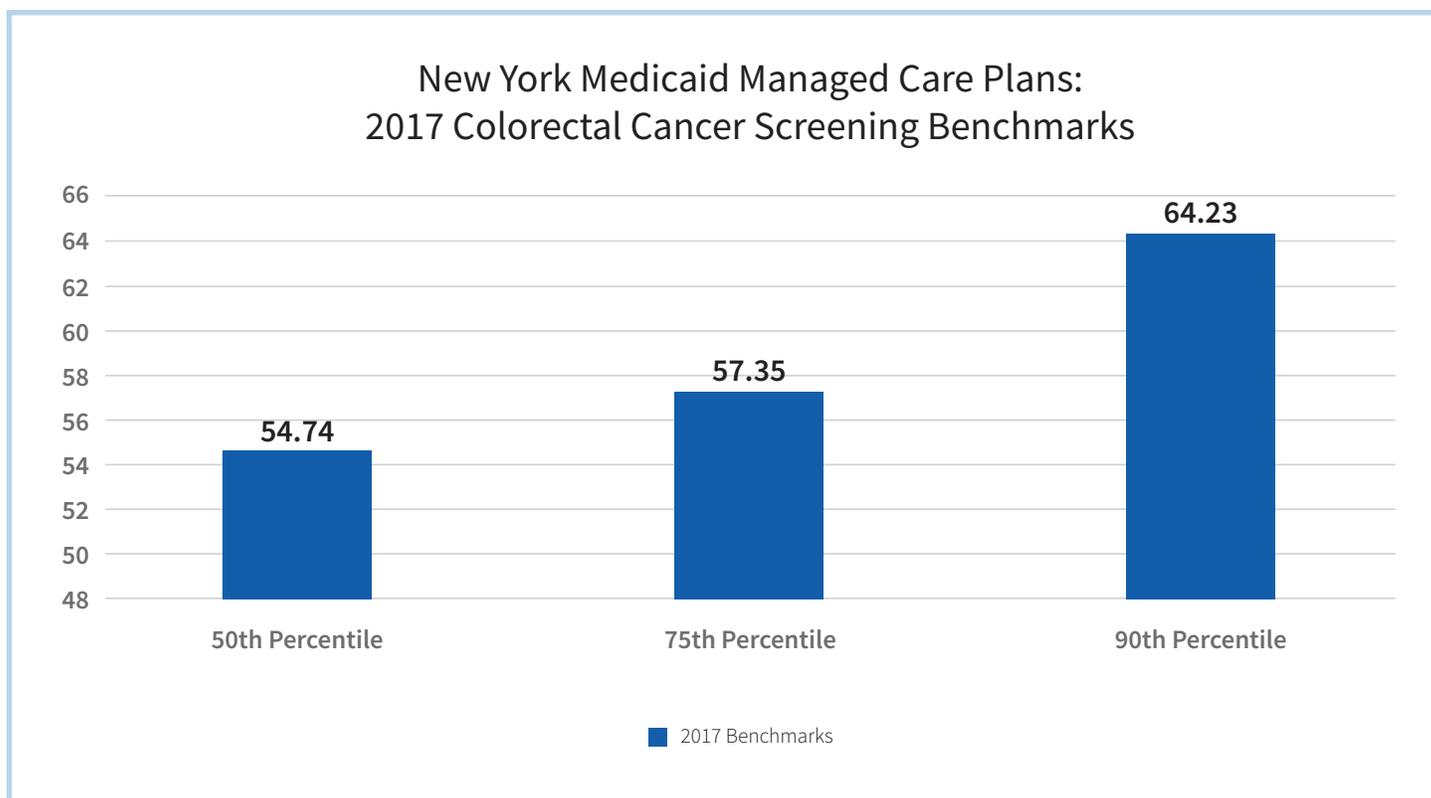


Figure 10: Example of cumulative quality scores from New York Medicaid program



Montana's Medicaid program participates in the Comprehensive Primary Care Plus model, a CMS demonstration project which uses incentive payments to encourage quality improvement. Under this program, providers in 50 different Montana clinics are eligible for incentive payments if they exceed benchmarks for a variety of quality measures, of which CRC screening is one. In 2017, providers who exceeded 56% screening (based on claims data) were eligible for an incentive payment.

For the past five years, Medicaid health plans in Oregon (Coordinated Care Organizations CCOs) have received bonus dollars for reaching quality goals. For 2018, the Health Policy and Analytics Division has defined 18 measures¹³ that health plans must report on as part of the incentive program, ranging from depression screening to cigarette smoking to colorectal cancer screening. Each measure has a yearly benchmark, with bonus payments tied to achievement levels for each metric. (The 2018 CRC benchmark was set at 54%.)

However, health plans do not necessarily have to meet the benchmark in order to receive an incentive; if they do not meet the benchmark, they can still earn quality payments by meeting their individual improvement target (at least a 10 percentage point reduction in the gap between their baseline and the benchmark screening level). In this way, even CCOs that serve very challenging populations are incentivized for making quality improvements. CCOs that receive bonus payments are then able to distribute incentives to their providers as they see fit. CCOs can earn a full incentive payment for meeting benchmarks or improvement targets for a minimum number of measures. (See the Appendix for an example of the method for calculating incentives, using the method developed by the Minnesota Department of Health.)

In addition, the Oregon Health Authority is collaborating with the Oregon Primary Care Association on the Alternative Payment and Advanced Care Model.¹⁴ This model was approved by CMS on a State Plan Amendment in 2012 and is engaging federally qualified health centers in Oregon's health system transformation, including payment reform.

4

PROVIDE EDUCATION AND TECHNICAL SUPPORT TO MANAGED CARE ORGANIZATIONS AND PROVIDERS

Beyond mandating measurement and incentivizing quality improvement, the Medicaid programs and state health departments profiled in this report have developed robust systems for educating participating providers and health plans on colorectal cancer screening.

The support delivered to providers and health plans addresses a broad range of quality improvement topics and resources:

- Data resources & state/local screening or cancer incidence rates
- Patient education/instructions
- Guidance on systems/operational changes
- Client reminders
- Improvement in patient compliance with screening recommendations
- FluFit program or mailed FIT guidance
- Marketing and mass media strategies or messages
- Optimizing use of electronic medical records
- Practice workflow and efficiency advice
- Measurement and reporting
- Provider lists or local screening resources

States describe their approach to the delivery of this information in many ways, including webinars, academic detailing training, electronic toolkits, one-on-one support from subject matter experts, and monthly in-person meetings or calls. Sometimes through trial and error, agencies have determined that delivering easy-to-implement strategies and materials significantly enhances the likelihood that they will be implemented by providers. As a result, agencies often provide customizable materials, such as letter templates, that can be used by their outreach or provider relations staff in a turnkey manner.

“We give them canned tweets, social media messaging, samples of press releases, and articles that they can tailor to their specific community...the idea is to engage these practices and contractors in engaging their patients.” (New York)



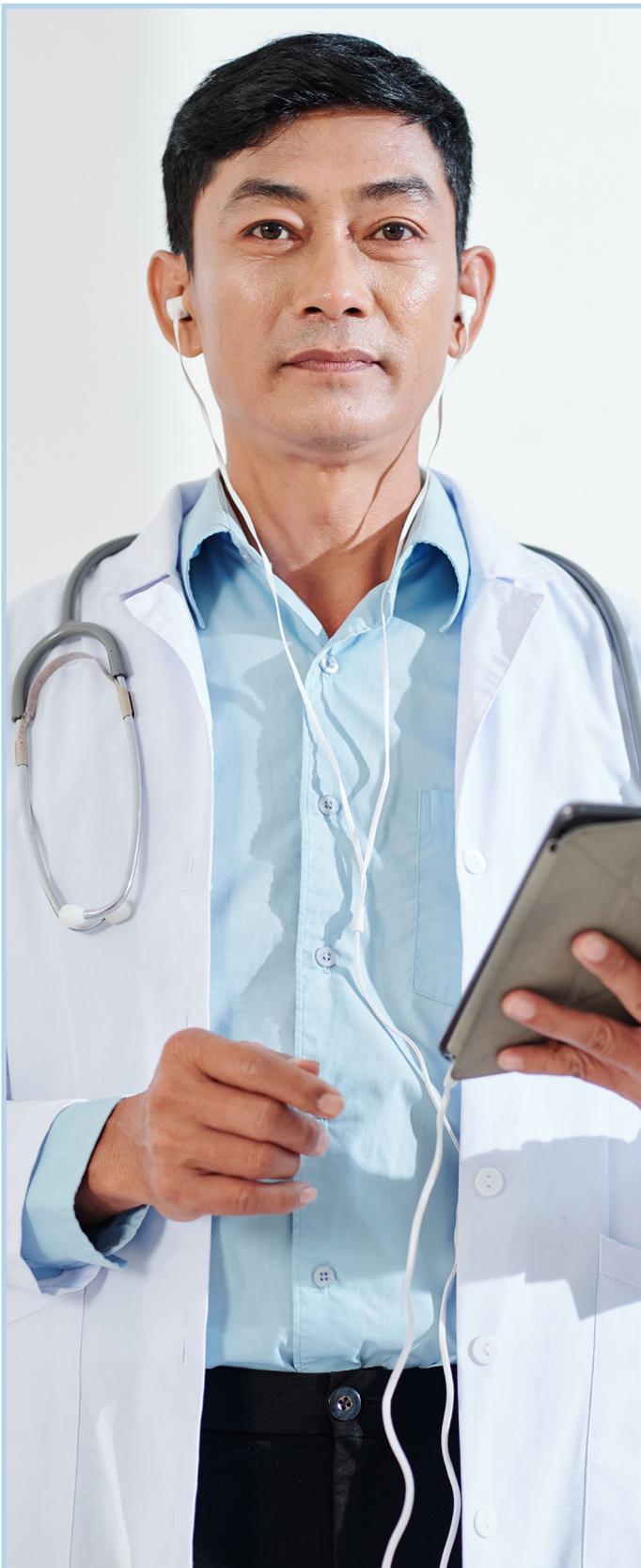
One robust example of this type of support is the Oregon Health Authority’s Transformation Center¹⁵, which provides technical support and resources to their coordinated care organizations (CCOs). The Transformation Center highlights best practices and innovative work that Oregon CCOs have undertaken to address a broad range of quality improvement goals, including colorectal cancer screening. CCOs can apply to receive individual guidance from subject matter experts, either in person or by phone or consult best practice sheets on each metric for which incentive payments are being offered. The Transformation Center also offers an extensive library of recorded webinars¹⁶ on a range of colorectal cancer screening topics. A key outcome of this technical assistance has been the engagement of CCOs and clinics working together to improve screening processes, such as coordinating the implementation of a CCO direct mail initiative with one or more clinics.

OREGON HEALTH AUTHORITY TRANSFORMATION CENTER: WEBINAR SERIES

- Screening Options for Colorectal Cancer—A Summary of the Evidence Behind Colonoscopy and Fecal Testing (FIT/FOBT)
- An Overview and Discussion of Evidence-based CRC Screening Interventions – Translating Research into YOUR Clinic and Community Setting
- Finding the Right Interventions for the Right Setting at the Right Time: A Focus on STOP CRC
- Partnerships with Health Plans: Design of BENEFIT, a Direct-mail Program Supported by a Medicaid Health Plan
- Operationalizing Direct-Mail Interventions in Practice: EMR Tools and Practice Readiness Assessment
- Improving Colorectal Cancer Screening – Best Practices from Oregon CCOs.
- Partnering with Small Clinics in Your Network to Take Action on the Colorectal Cancer Screening Metric
- Addressing Disparities: Tailoring Colon Cancer Screening Approaches for Latinos
- Implementing Interventions to Increase Colorectal Cancer Screening in Primary Care: Operationalizing In-Reach and Outreach Strategies

Several of the Medicaid programs profiled in this report conduct regular calls or meetings with the health plans in their state, where staff share quality improvement information on a rotating series of topics. In Arizona, cancer prevention and control staff participate in quarterly group meetings with the medical directors of the state’s Medicaid health plans to share advice and recommended practices.

“We have met with health plans on a regular basis to teach them about systems change and evidence-based initiatives like client reminders, provider reminders. Some of the health plans are tracking the responses and change in their screening rates based on that.” (Arizona)



Similarly, Maryland's Medicaid and Public Health teams worked collaboratively to develop and distribute a colorectal cancer screening toolkit for managed care organizations, which incorporates screening guidelines, templates, and other turnkey materials that can be used by health plans and/or providers. The toolkit and other quality improvement guidance have been presented to managed care organization (MCO) medical directors, corporate staff, and quality assurance data teams. Staff credit the involvement of Maryland Medicaid's chief medical officer (who introduced the toolkit in a webinar) with signaling the importance of the initiative and encouraging participation from MCO leadership.

MARYLAND MCO TOOLKIT: SUMMARY OF CONTENT

- CRC At-a-Glance for providers and Administrators
- CRC Screening Minimal Clinical Elements Summary
- 80% by 2018 Fact Sheet (NCCRT)
- 80% by 2018 Pledge (NCCRT)
- Increasing CRC Screening Resource List
- Provider Relations CRC Slides
- Cancer Screening Patient Questionnaire
- Cancer Screening Patient Questionnaire: Provider Letter Template
- CRC Screening Patient Reminder Template
- Local CRC Screening and PN Resource List
- CRC Articles for Newsletters
- CRC Screening Messaging for Targeted Populations (NCCRT)
- CRC Screening Promotion Toolkit Feedback Form

Gaining Ground Among Your Clients

Office-wide shared responsibility and accountability for CRC screening rates. Spread the responsibilities and successes among the staff that you have available within your organization. For example:

- **Front desk staff:** Distribute cancer screening questionnaire to all age-eligible clients
- **Medical assistants and nurses:** Flag records of patients who are not up-to-date to trigger screening conversations
- **Providers:** Verbally recommend appropriate screening and use support staff to help ensure patient follow-through
- **Referral specialists and financial aid clerks:** Help patients make recommended appointments, keep referral sources up-to-date
- **Patient navigators and health educators:** Identify and overcome barriers for patients who are unable to complete screening on their own, educate every client regarding the screening recommended to them

Figure 11: Excerpt from Maryland Provider Relations Presentation

In establishing these educational or training efforts, state agency staff indicate that it is important to communicate with both the health plan leadership and supporting staff who might be involved in implementing quality improvement activities—such as medical directors, provider relations staff, and quality management staff. The educational content should also be tailored and targeted toward the needs of different audiences: MCO medical directors, providers, communications team, office staff, or patients. Similarly, written materials or toolkits should include separate materials intended for each audience.

After delivering training programs or materials, states recommend maintaining contact and obtaining feedback on how they are using the materials, so that adjustments can be made in the future.

5

COLLABORATE WITH STATE PUBLIC HEALTH STAFF

States that are effectively working on colorectal cancer screening typically report a close working relationship between their state’s Medicaid and public health team members. Participants describe close collaboration on strategies, sharing of funds, and special projects that may be outside the typical role of either agency. This collaboration is said to work well because the kind of messaging and outreach that is effective with Medicaid audiences often overlaps with public health efforts to promote cancer screening among a state’s general population.

“Collaboration is really key if you can achieve it because what they’re saying through the public health pathways, through local health departments—it’s helpful when it aligns with what is going on through Medicaid MCOs.”
(Maryland)

In several states, the public health team is credited with having initiated or taken the lead on the colorectal cancer screening efforts described in this report. These public health departments may work side-by-side with Medicaid staff, or perhaps just consult with them periodically while making use of Medicaid data to track the impact of their programs or to identify unscreened populations to target.

Public health agencies are an essential partner for Medicaid programs because they often have infrastructure, staff, or funding available for special demonstration projects or outreach campaigns like the ones described in this report. They play critical roles in Comprehensive Cancer Control Coalitions, setting state agendas, and educating the general public about cancer prevention. They are also likely to already have strong relationships with health care providers who serve large Medicaid populations, such as FQHCs, as well as with primary care associations, state coalitions, advocacy groups, and other partners who can contribute knowledge and resources. These connections can significantly expand the reach of Medicaid agencies’ efforts.

The development of Maryland’s colorectal cancer screening metric is one example of the benefits of a close working relationship between Medicaid and public health agencies. In this case, Maryland’s public health team had extra funds available at the end of the fiscal year, which spurred conversation with the Medicaid team. After brainstorming options together, the conversation focused on the inclusion of the new screening metric in the annual managed care evaluation, which ultimately did not involve any new costs. In other states, public health staff collaborate with Medicaid to mine member data and develop member education mailings promoting cancer screening.



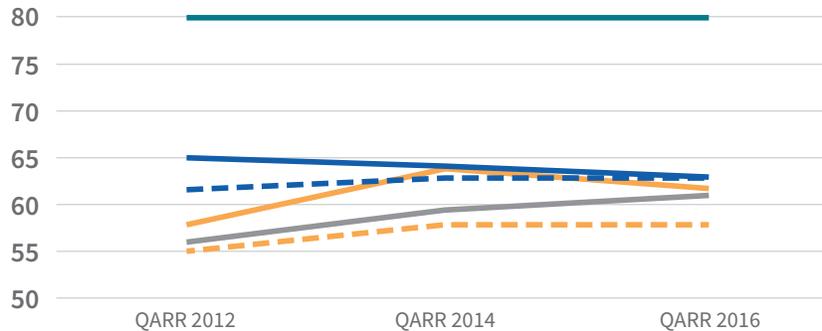
“We’re different from a lot of states in that our public health and Medicaid are in the same group. That’s very different from other states. But working with public health, using their resources and working together is huge. Getting the best you can from both places is the best way to make sure everybody is getting the care they need.” (Montana)

Additionally, state public health departments may have patient navigation resources, which often have a significant impact on patient compliance with colonoscopy recommendations. In New York, the Office of Public Health funds patient navigation projects to increase breast, cervical, and colorectal cancer screening rates in several FQHCs.

Quality reporting and expanded coverage of newer screening methods have also been implemented in the state as a result of a collaborative effort between the New York State Department of Health’s Office of Health Insurance Programs, the Office of Public Health, and the Office of Quality and Patient Safety.

Public health departments are also able to bring together data and participants from multiple state agencies, public health associations, and provider groups to share information and generate new insights about the impact that different programs are having on their common goals. For example, New York’s Department of Health recently partnered with NYS Medicaid, the American Cancer Society, and the New York City Department of Health and Mental Hygiene to host a webinar on CRC screening progress in the state. The webinar addressed screening progress toward the 80% goal and reported findings from multiple data sources, including BRFSS, UDS, an NYC community health survey, and state quality-incentive measurements.

Trending in Measure Performance by Product Colorectal Cancer Screening



| | QARR 2012 | QARR 2014 | QARR 2016 |
|-------------------------|-----------|-----------|-----------|
| NYS Commercial HMO | 65 | 64 | 63 |
| NYS Commercial PPO | 57 | 64 | 62 |
| NYS Medicaid | 56 | 59 | 61 |
| National Commercial HMO | 62 | 63 | 63 |
| National Commercial PPO | 55 | 57 | 57 |
| Target | 80 | 80 | 80 |



NYS UDS Colorectal Cancer Screening Rate Trends, 2012-2016

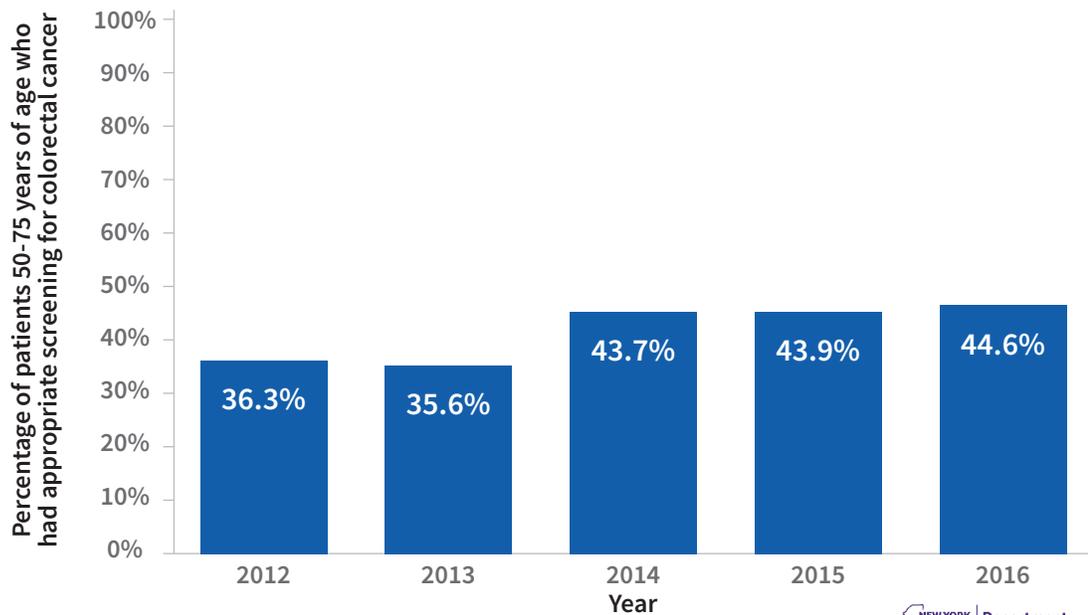


Figure 12: Excerpts from the New York State Department of Health Partner Webinar on CRC Screening Progress

6

WORK CLOSELY WITH FQHCs THAT SERVE LARGE MEDICAID POPULATIONS

Federally Qualified Health Centers (FQHCs) often serve a high proportion of Medicaid patients; therefore, they represent an important avenue for Medicaid and public health departments seeking to increase screening rates with this population. States report using Centers for Disease Control and Prevention (CDC) Colorectal Cancer Control Program (CRCCP) grant funding to support their work with FQHCs, providing support for quality improvement training on topics such as data quality, patient navigation, client reminders, and workflow.

Oregon's public health staff work with their Primary Care Association to directly engage with a number of FQHCs on quality improvement, hosting monthly calls that address topics such as systems change, clinic flows, mailed FIT, and FluFIT programs.

States report that strong relationships with individual FQHCs also provide good opportunities to conduct pilot tests for new screening programs. Some of the states in this report have tested programs that combine colorectal cancer screening with other preventive health efforts or make use of medical assistants and volunteers to conduct patient navigation activities, like following up on positive FIT tests. Such collaborations have been beneficial not just to FQHCs but also to Medicaid MCOs, such as in Oregon where CCOs and FQHCs have come together to work on quality improvement efforts, including a joint FIT direct-mail initiative, administered by the health plans and tracked at the clinic level.

“We’ve got a pilot that we’re doing with one clinic that has a high proportion of Medicaid patients. We’re working with them to look at broader cancer screening, and how do you work your system, your data, and tracking to seize that clinic opportunity for multiple services.” (Oregon)

In Arizona, Medicaid program staff regularly attend monthly committee meetings held by 22 FQHC systems in the state, providing technical assistance to FQHCs on a variety of quality improvement topics. This represents an important, regular dialogue and training opportunity. They report that the training provided has included evidence-based approaches to cancer screening from The Community Guide.

“We’ve been working with our primary care association, which represents about 17 FQHCs in the state. The FQHCs push FIT testing a lot, so we’ve seen a lot of progress in that area.” (Montana)

Similarly, Montana uses a CDC grant to fund staff to help state FQHCs enhance colorectal cancer screening activities. The grant supports staff time to clean electronic health record (EHR) data, train staff on proper data collection and reporting, improve office policies and workflow, and develop consistent policies for delivering screening recommendations.

In 2017, Montana also partnered with their state Primary Care Association and the American Cancer Society to bring a training program to nine rural FQHCs across the state. The two-week training roadshow featured expert speakers and primary care staff who shared the latest research and best practices in colorectal cancer screening with over 150 staff and clinicians.

Montana's next step will be to address patient navigation activities to make sure patients return FIT tests, complete colonoscopies, or otherwise follow through with provider recommendations.



Figure 13: Participants at an ACS Colorectal Cancer Training Event for Rural FQHCs in Montana

The New York State Department of Health used a CDC grant to advance cancer screening efforts with FQHC patients, including colorectal, breast, and cervical cancer screening.¹⁷ Although this effort did not exclusively target Medicaid recipients, 57% of the state’s FQHC patients have Medicaid coverage, so the effort overlaps considerably with this population. The project focused on improving clinical information systems in FQHCs throughout the state, covering more than 150 practice sites. Quality improvement training has included webinars, emails, coaching calls, and in-person meetings, addressing topics such as data quality, workflow, provider recommendations, tracking, and monitoring. The effort resulted in significant improvements in screening rates for colorectal cancer in targeted practice sites, as shown in the following chart.

Cohort 1 TY Monthly Colorectal Cancer Screening Rates, (N=14*)



* 14 Health care settings (5 practices and 9 practice sites) participated in Cohort 1; data from 1 practice excluded; As of TY June 2016 missing data from 1 practice site due to site closure.

Figure 14: CRC Screening Rate Increases in 14 FQHC Demonstration Project Sites (New York)

7

PROMOTE EVIDENCE-BASED STRATEGIES AND INTERVENTIONS

Many of the states interviewed for this report are using the Community Guide and NCCRT 80% screening campaign materials¹⁸ as resources for recommending strategies and providing templates and materials for Medicaid MCOs and providers. States like Arizona have provided technical assistance focused on topics such as client reminders, tracking, and reporting. These are also important sources for recommending specific screening strategies for specific target groups such as Hispanics/Latinos or Asian-Americans.¹⁹

CPSTF FINDINGS ON CANCER SCREENING

The Community Preventive Services Task Force (CPSTF) has released the following findings on what works in public health to increase cancer screenings. These findings are compiled in *The Guide to Community Preventive Services* (The Community Guide) and are listed in the table below. Use the findings to identify intervention strategies you could use for your community.

LEGEND: ● RECOMMENDED ◆ INSUFFICIENT EVIDENCE ▲ RECOMMENDED AGAINST

| INTERVENTION STRATEGY | CPSTF FINDING | | |
|---|---------------|-----------------|-------------------|
| INCREASING BREAST, CERVICAL, AND COLORECTAL CANCER SCREENING | | | |
| CLIENT-ORIENTED SCREENING INTERVENTION STRATEGIES | | | |
| Interventions | Breast Cancer | Cervical Cancer | Colorectal Cancer |
| Client Reminders | ● | ● | ● |
| Client Incentives | ◆ | ◆ | ◆ |
| Small Media | ● | ● | ● |
| Mass Media | ◆ | ◆ | ◆ |
| Group Education | ● | ◆ | ◆ |
| One-on-One Education | ● | ● | ● |
| Reducing Structural Barriers | ● | ◆ | ● |
| Reducing Client Out-of-Pocket Costs | ● | ◆ | ◆ |
| MULTICOMPONENT INTERVENTION STRATEGIES | | | |
| Increase Screening and Provider Delivery of Services | ● | ● | ● |
| PROVIDER-ORIENTED SCREENING INTERVENTION STRATEGIES | | | |
| Provider Assessment and Feedback | | ● | |
| Provider Incentives | | ◆ | |
| Provider Reminder and Recall Systems | | ● | |

Figure 15: Source – <https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-CancerScreening.pdf>

The interventions and strategies recommended in the Community Guide are those that have been shown to be effective based on a systematic review of existing scientific studies. However, some interventions have not been sufficiently tested or lack sufficient evidence to be recommended in the Community Guide. As such, states may find success with other interventions that may be customized based on local conditions or targeted at unique populations.

Before rolling out new interventions—even those that are evidence-based—several states have first conducted smaller-scale tests or demonstration projects to evaluate how well these efforts will work with Medicaid populations in particular. In some cases, these projects are limited to one or more MCOs or specific geographic areas.

For example, New York has conducted a CDC CRCCP-funded demonstration project with three Medicaid Managed Care Plans to examine the efficacy of patient reminder letters as well as the impact of phone calls and patient incentive payments (\$25 cash card) on screening behaviors. The results of this effort were not yet available as of the date of this report, but Medicaid claims data will be monitored to evaluate the initial impact of the program. Additional enhancements to patient letters, phone calls, and more direct outreach to providers are program enhancements that are planned for the future.

Direct-to-member marketing, health promotion, and education are not traditional strategies that many Medicaid agencies have pursued, often leaving them up to managed care organizations, clinics, or other health care providers. However, some states interviewed for this report are increasing their efforts to encourage preventive screenings and directly educate members about their benefits.

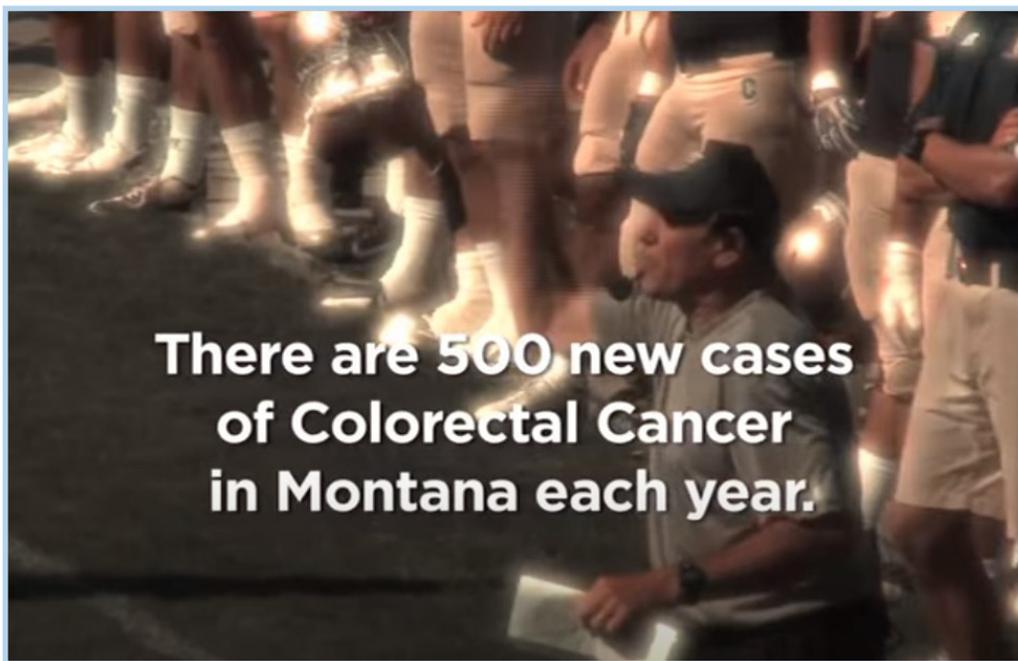


Figure 16: Montana DPHHS TV Ad (<https://www.youtube.com/watch?v=yoRZtZJetvA>)



June 26, 2014

FirstName LastName
Address 1
Address 2
City, State zip

**Baltimore Medical System
at Annapolis Road**
4000 Annapolis Rd.
Suite 105
Baltimore, MD 21227
410-789-8399

**Baltimore Medical System
at Middlesex**
1245 Eastern Blvd.
Baltimore, MD 21221
410-558-4700

**Baltimore Medical System
at Orleans Square**
2323 Orleans St.
Baltimore, MD 21224
410-558-4747

**Baltimore Medical System
at St. Agnes**
900 Caton Ave.
Mailbox #081
Baltimore, MD 21229
443-703-3200

**Belair-Edison Family
Health Center**
3120 Erdman Avenue
Baltimore, MD 21213
410-558-4800

**Highlandtown Healthy
Living Center**
3700 Fleet St., Suite 200
Baltimore, MD 21224
410-558-4900

Dear FirstName LastName;

In reviewing your medical record, it seems that you are due to be screened for colorectal cancer. Colorectal cancer (CRC) is cancer of the colon and rectum, and is the second leading cause of cancer deaths in Maryland. As you may know, it is recommended that women and men over 50 years of age be screened for CRC. It's important to detect cancer early, when treatment works best, by having screenings at the right times during your life.

Please read the enclosed brochure to learn more about CRC screening options. One option, the colonoscopy, usually only needs to be completed once every 10 years. People at higher risk for CRC may need to get screened more often.

Many health insurance companies pay for screening, including Medical Assistance. Call my office today to see if you need to schedule your CRC screening. If you have already been screened, please share the brochure included with this letter with a friend or family member.

Now is the perfect time to take charge of your health. This first step will help ensure you can enjoy life for many years to come. I look forward to hearing from you.

Sincerely,

Erica Isles, M.D.



Accredited by the Joint
Commission on Accreditation
of Healthcare Organizations

The Ian J. Gray Building
3501 Sinclair Lane
Baltimore, MD 21213

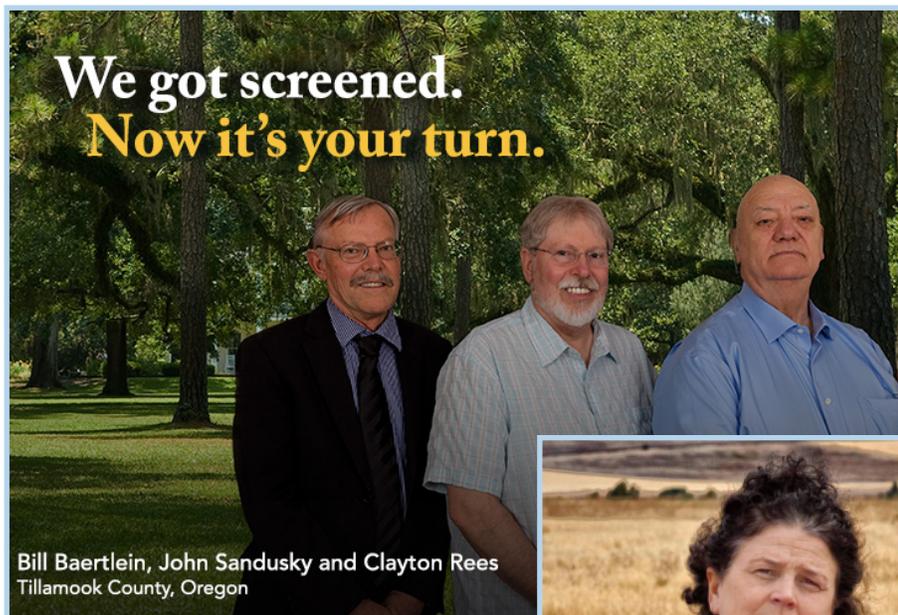
PHONE 410.732.8800
FAX 410.327-1693
WEB www.bmsi.org

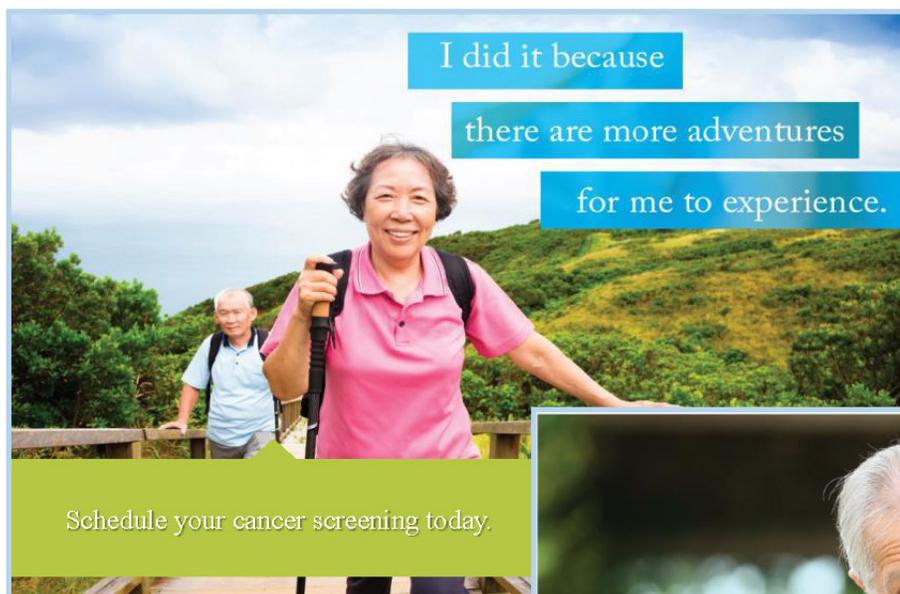


The Montana Department of Health and Human Services has pursued a variety of direct-to-member mail and media efforts, including featuring colorectal cancer screening in their quarterly member e-newsletter and developing an advertising campaign (TV and outdoor) which was funded by a tobacco settlement fund. Their advertising featured a popular local college football coach, as well as a man who died from colorectal cancer.

Although not exclusively targeted toward the Medicaid population, a research study revealed that the campaign was successful at raising awareness of the importance of screening. The agency now has plans to expand its efforts, develop a mobile app, and implement text reminders for Medicaid members who wish to receive them.

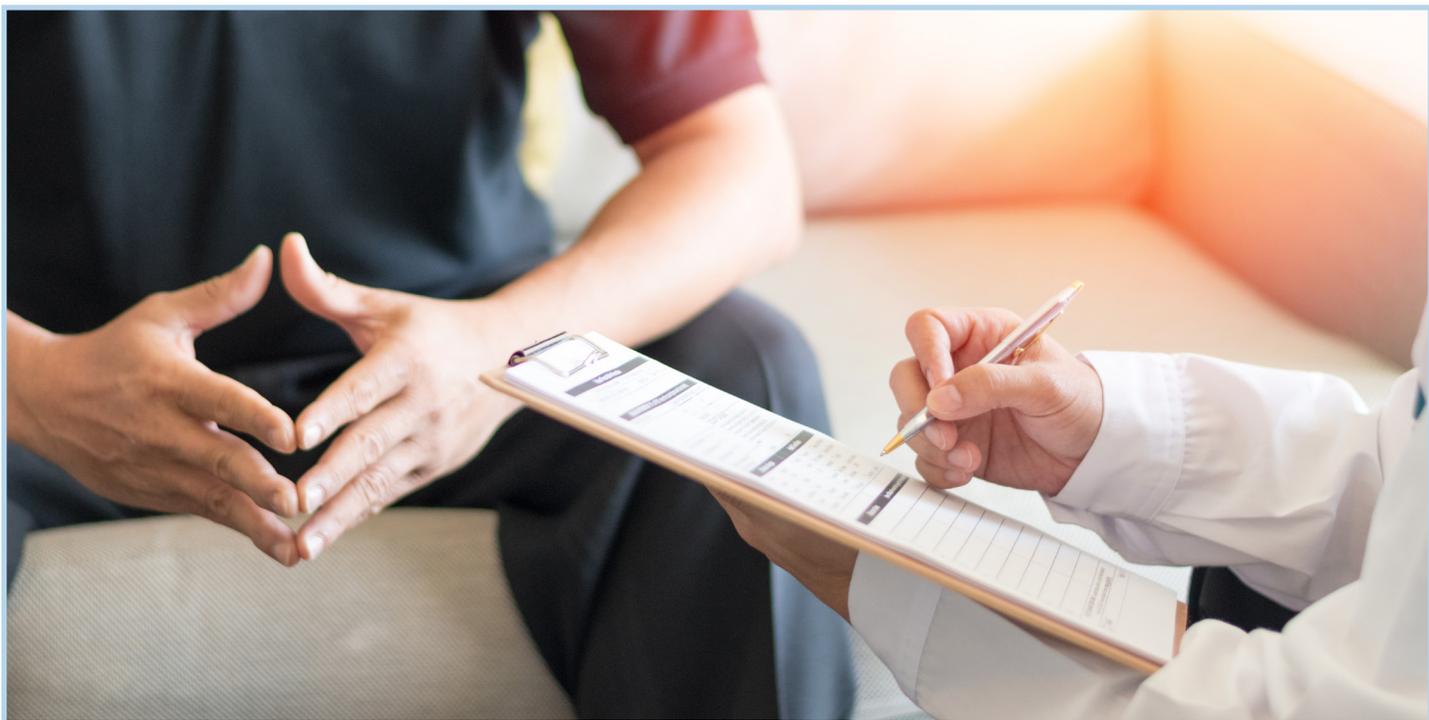
Small media materials can provide communication and awareness tools to reduce barriers to screening for the public, providers, and patients. The Oregon Health Authority's *The Cancer You Can Prevent* campaign provides an opportunity for collaboration between state and local public health, community partners, businesses, health systems, and clinics. The campaign features local spokespersons who have been screened and encourages others to get screened. Since 2015, the promotional materials have been used by coordinated care organizations (CCOs) and clinics to support their screening initiatives. Local spokespersons, quotes, and logos are available for use via online templates. (www.thecanceryoucanprevent.org)





Direct mail efforts are an evidence-based tactic²⁰ that several states have employed to reach their Medicaid members. They may include letters that alert patients of their screening status and encourage them to see their primary care provider to discuss screening options. Other campaigns may mail FIT kits directly to members, eliminating the extra step of seeing a provider first. These approaches can be valuable in reaching any patient population, but Medicaid managed care plans can further customize direct mail programs based on known information about members, such as age, gender, primary care provider, or geography. Calls to action in direct mail communications may be more effective if members are explicitly reminded that screening is covered by Medicaid and if customized with the name the individual's primary care physician.

In planning these types of direct-to-member interventions, some states interviewed for this report advise about the importance of developing a strategy for evaluating their impact before putting them into action. For direct mail campaigns, a call to action with a unique, dedicated phone number or website address can accomplish this goal. Measuring increases in screening claims during and immediately after a campaign is another way of attributing impact.



Additionally, expect that some tactics such as direct mail are likely to suffer from some inefficiency due to the fact that Medicaid members move more frequently, resulting in many returned mail pieces. Though states do not necessarily say this should deter direct mail outreach, it is an important limitation to consider when estimating the potential impact of such a program. Some states have been able to minimize these issues by collaborating with clinics to scrub patient lists prior to mailing.

One-on-one patient reminders and education, another evidence-based tactic, was successfully used by Medicaid managed care organizations (MCOs) in a randomized clinical trial conducted in New York City.²¹ In this program, MCO outreach staff contacted unscreened Medicaid members by mail and telephone in order to deliver screening recommendations and address barriers, concerns, and misconceptions about colorectal cancer screening, making up to 12 call attempts per person. Calls and reminders continued for up to 18 months, or until evidence of screening was received. Program outcomes were evaluated using claims data, which found that those who received the intervention were significantly more likely to be screened (15 percentage points higher than the usual care group).

Although the efficacy of **direct-to-member incentive payments** has shown mixed results in past research, at least two states profiled in this report have pursued this strategy with their Medicaid members. At least four Medicaid MCOs in New York offer their members incentives in return for completing colorectal cancer screening. Analysis of this effort, as well as one in Minnesota, suggested that many factors can impact the efficacy of patient incentives—particularly the amount of time that elapsed between screening and promised receipt of the incentive payment. If members are told that it may take months or weeks for the incentive to be delivered, the impact of the offer is likely to be much lower.

The Minnesota Department of Health (MDH) reports measurable success at increasing colorectal cancer screening among Medicaid members by using direct mail coupled with incentive payments. In the study, which was recently published in *Cancer Epidemiology, Biomarkers & Prevention*, the MDH team collaborated with the Minnesota Medicaid Program on a \$6 million CDC-funded, randomized controlled trial.

The study targeted over 92,000 Medicaid members who were identified as unscreened in their electronic medical records. Members who received the mailings were encouraged to contact a call center, which was staffed by **patient navigators** who could answer questions and make an appointment directly. Members were also offered a \$20 incentive for completing screening.

The study's authors emphasize the importance of minimizing the lag between screening and gift card delivery by a business reply card rather than relying on claims data, which typically take many weeks to process. The intervention was found to increase screening in the test group by 12%, as measured by claims data.²²

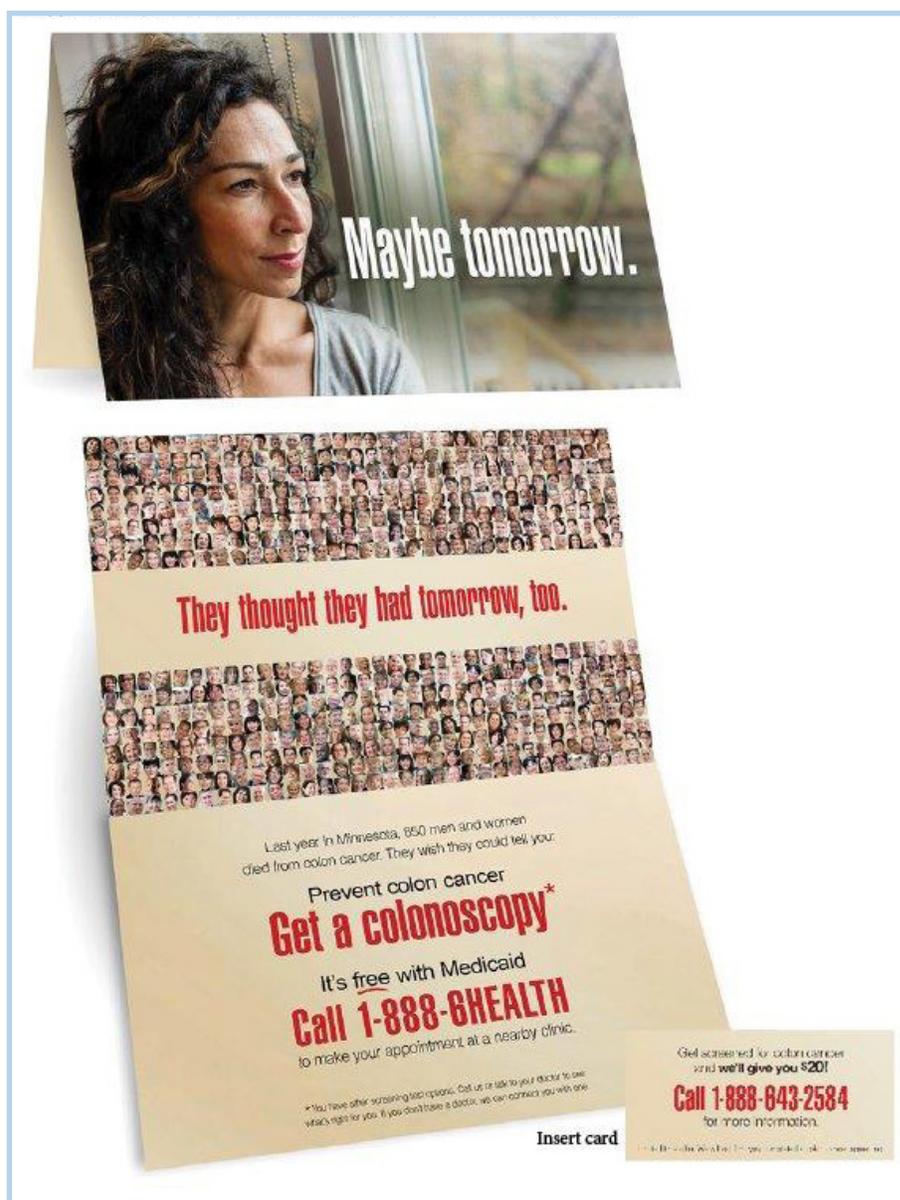


Figure 17: Minnesota Direct Mail Campaign Incentive Payment Insert Card

8

FACILITATE ACCESS BY COVERING MULTIPLE TYPES OF TESTS WITHOUT COST SHARING

Options for colorectal cancer screening are increasing; there are now six different tests that average-risk patients can undergo, with screening intervals that range from once a year to every ten years. Providing patients with a choice of the test has been shown to dramatically increase compliance with screening.²³ Removing disincentives associated with cost-sharing is also extremely important to ensure that positive stool tests are followed up with a colonoscopy. To facilitate easy access to testing, some state Medicaid agencies interviewed for this report have decided to cover newer tests such as stool DNA or CT colonography without imposing any cost-sharing for members. Such changes have been prompted by updates to United States Preventive Services Task Force (USPSTF) recommendations, as well as a desire to address provider shortages that can result in reduced access to testing.

HIGH-SENSITIVITY STOOL-BASED TESTS

| SCREENING TEST | CONSIDERATIONS |
|---|---|
| Fecal Immunochemical Test (FIT) <i>Interval: Every Year</i> | <ul style="list-style-type: none"> Evidence of superior performance in cancer and adenoma detection compared to HSgFOBT High nonadherence (especially in the absence of annual reminder systems) |
| High-sensitivity Guaiac-based Fecal Occult Blood Test (HSgFOBT) <i>Interval: Every Year</i> | <ul style="list-style-type: none"> Higher false-positive rate than FIT (leads to more colonoscopies) High nonadherence (especially in the absence of annual reminder systems) Requires multiple samples, reducing adherence compared with FIT Requires avoidance of nonsteroidal anti-inflammatory drugs for 7 days; and avoidance of vitamin C, red meat, and cruciferous vegetables for 3 days prior |
| Multi-target Stool DNA Test (MT-sDNA) <i>Interval: Every 3 Years</i> | <ul style="list-style-type: none"> Evidence of superior performance in cancer and adenoma detection compared with HSgFOBT and FIT. Improved detection of advanced adenomas and sessile serrated polyps compared to other stool-based tests Higher false-positive rate than FIT (leads to more colonoscopies) Uncertainty in management of positive results followed by a negative colonoscopy New test, needs performance monitoring over time |

STRUCTURAL (VISUAL) EXAMS

| SCREENING TEST | CONSIDERATIONS |
|--|---|
| Colonoscopy <i>Interval: Every 10 Years</i> | <ul style="list-style-type: none"> Offers both early detection and prevention of CRC through polypectomy Risks: bowel perforation – 4 in 10,000; major bleeding – 8 in 10,000; cardiovascular event (due to sedation) – 2-4 in 10,000. These risks increase with age and comorbidity burden. Laxative preparation may not be done properly, leading to suboptimal visualization. |
| CT Colonography (CTC) <i>Interval: Every 5 Years</i> | <ul style="list-style-type: none"> Comparable performance to colonoscopy in identifying cancer and advanced adenomas without procedural risks of colonoscopy Exposure to low-dose radiation Incidental extracolonic findings may require workup. May not be covered by insurance (not covered by Medicare at this time) |
| Flexible Sigmoidoscopy (FS) <i>Interval: Every 5 Years</i> | <ul style="list-style-type: none"> Best evidence among structural exams for reducing CRC mortality and incidence Risks: bowel perforation – 1 in 10,000; major bleeding – 2 in 10,000 Self-administration of enemas may not be done properly, leading to suboptimal visualization. Misses cancers and polyps in the proximal colon |

Figure 18: Source – USPSTF Colorectal Cancer Screening Guideline

Cost-sharing associated with colonoscopies and newer test modalities can be a barrier for low-income Medicaid patients. If newer tests are not fully covered, cost-sharing consequences should be communicated clearly to providers so that they can avoid recommending tests that will result in significant costs to beneficiaries who cannot afford it.

Additionally, some states report that they have worked to educate providers about coding colonoscopies that follow a positive stool test as preventive, rather than diagnostic, in order to avoid cost-sharing barriers. Some states have already addressed this via legislation. For example, Montana eliminated cost-sharing for all USPSTF A and B recommendations when they expanded Medicaid in 2015. Oregon passed legislation in 2014 and 2015 to remove cost-sharing for a colonoscopy where polyps were removed as well as for colonoscopies that follow a positive stool test.

Some states take further steps to reduce the financial burden of being screened, providing Medicaid members with transportation for colonoscopy services.



9

PROMOTE TEST OPTIONS TO OVERCOME COMPLIANCE BARRIERS, PROVIDER SHORTAGES, GEOGRAPHIC ISSUES, AND LOGISTICAL CONSTRAINTS

Despite strong evidence that high-quality stool testing is an effective approach to reducing the burden of colorectal cancer, many providers continue to emphasize colonoscopy to their patients.

The states profiled in this report express concern about this, given that compliance with a colonoscopy referral can be particularly challenging among Medicaid populations. For low-income members, taking one or more days off from work and securing transportation assistance can be sufficiently challenging that they do not follow through with colonoscopy recommendations.

As a result, some states are using technical assistance programs to encourage their Medicaid managed care organizations to promote FIT testing to providers in order to increase adherence.

Others have developed member educational materials and marketing campaigns that deliver the message that there is more than one way to get screened for colorectal cancer and encourage members to discuss options with their health care providers.²⁴

“It might be more difficult for Medicaid enrollees to not only take a day off work to have a colonoscopy done, but you add in transportation needs, and that does present some challenges. Some of the logistics there for the colonoscopy specifically could be challenging.” (Maryland)

Types of Colon Cancer Screening Tests

■ At-Home Stool Tests

- There are 2 types of at-home tests: **Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT)**
- You do these tests at home and send stool samples to a doctor's office or lab.
- These tests show if there is blood in your stool.
- If blood is found, you will need to have a **colonoscopy** to find the cause of the bleeding.
- These tests are safe and easy to complete. No time off from work is needed.
- You do these tests once a year.

■ Colonoscopy

- A colonoscopy is done in a doctor's office or other medical place.
- The doctor looks for growths (polyps) or cancer in the rectum and colon.
- Any polyps found during the test can be removed. This may help prevent cancer.
- You will be given medicine to make you more comfortable or to put you to sleep during the test.
- If the results of your test are normal, a colonoscopy can be done once every 10 years. Otherwise, your doctor will tell you when you should have the next test.

■ Flexible Sigmoidoscopy

- A flexible sigmoidoscopy is done in a doctor's office or other medical place.
- The doctor checks for growths (polyps) or cancer inside the rectum and lower third of the colon.
- This test is done every five years. If this test is done along with an FOBT, the FOBT should be done every three years.

Did You Know...

Colon cancer is the **#2 cause of cancer deaths, but it doesn't have to be.**

Screening tests can find colon cancer early, when treatment works best.

Tests can find growths (polyps) so they can be removed before they turn into cancer.

Colon cancer or polyps may not cause symptoms, especially early on. Don't wait for symptoms before you get tested.

More than half of deaths from colon cancer could be prevented with regular testing.

Talk to your health care provider and choose the test that's right for YOU.

This publication was supported with funding from the Centers for Disease Control and Prevention award U58DP006102. Its contents and views are solely the responsibility of the authors.

Figure 17: New York DOH Get Tested for Colon Cancer Patient Education Brochure

Providing a choice of tests is important for encouraging screening among all audiences. However, states with large rural populations and those with provider shortages particularly benefit from encouraging providers to discuss all types of tests with patients. Patients who are faced with driving long distances for a colonoscopy or waiting long periods of time for the procedure are less apt to follow through with screening.

States like Montana have conducted colonoscopy capacity assessments and found that patients in certain areas—particularly rural communities—face wait times of several months for a screening colonoscopy. To facilitate increased access to screening, Montana’s public health department has collaborated with the state’s primary care association and FQHCs to encourage greater utilization of FIT testing.

“For people that live in rural areas, which is the majority of the state, getting a colonoscopy is logistically challenging... We’re trying to work on increasing use of FIT tests as an excellent alternative and pushing the message that the best test is the one that gets done.” (Montana)

While stool testing options are an important part of many states’ Medicaid population strategies, it is also critical to make sure that follow up on these tests is adequately addressed. This includes following up on tests that were distributed and not returned, as well as ensuring that patients with a positive FIT result receive a colonoscopy to complete their screening. Follow-up on stool testing has been an important issue that Oregon’s Primary Care Association and technical assistance partners are addressing through attention to data management, workflows, and quality improvement processes.

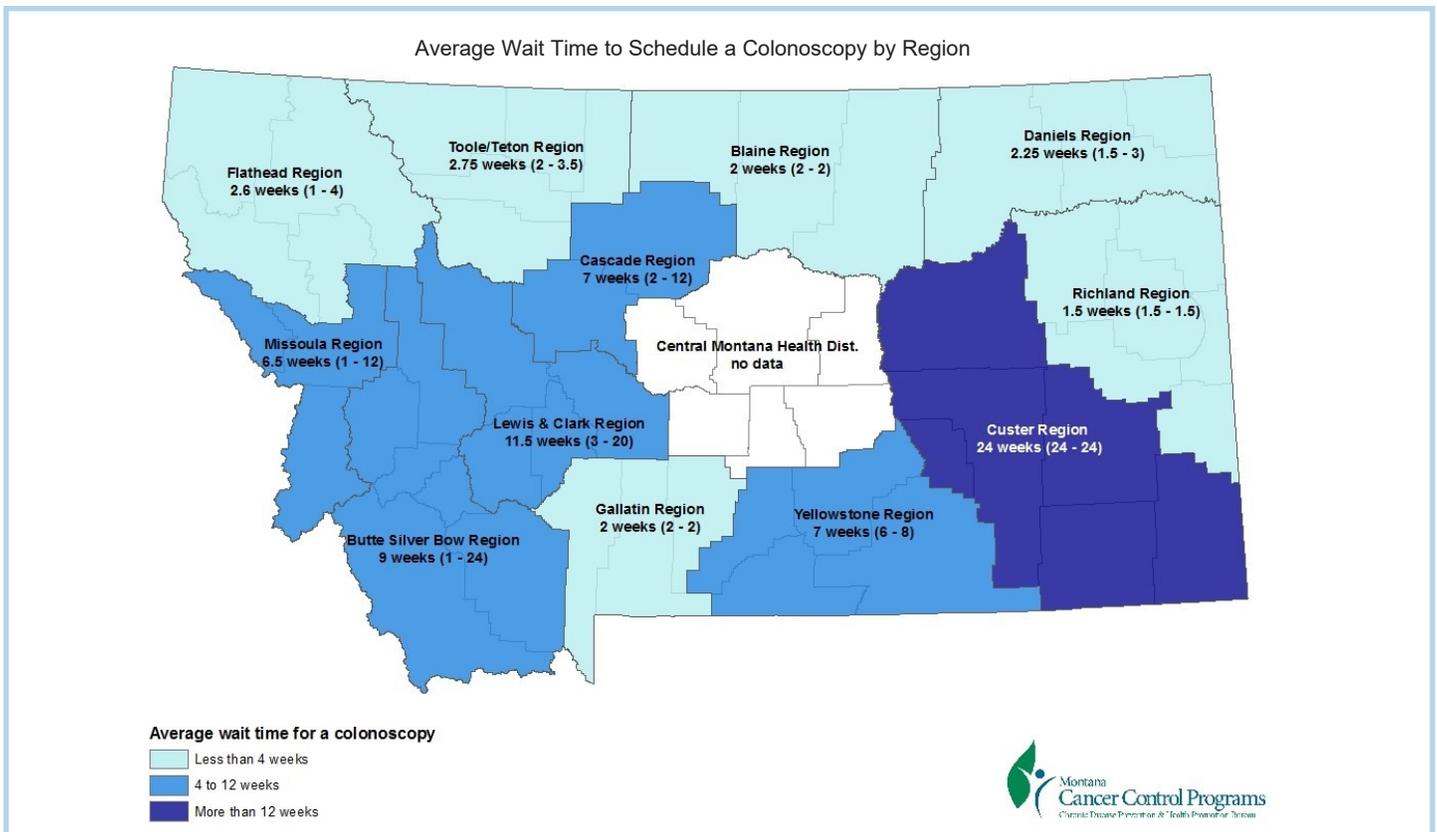


Figure 18: 2016 Montana Colonoscopy Capacity Study

APPENDIX: LINKS AND EXAMPLES

MINNESOTA: SPECIFICATIONS FOR MN COMMUNITY MEASUREMENT



Colorectal Cancer Screening Specifications 2019 Report Year

01/01/2018 to 12/31/2018 Dates of Service

| | | |
|----------------------------|---|--|
| Summary of Changes | <ul style="list-style-type: none"> Exclusion added for age > 65 with Institutional Special Needs Plan (SNP) or <u>specific</u> POS CPT code modifiers denoting their definition of long term care during the measurement period (see code list). <ul style="list-style-type: none"> Change was made by NCQA, the steward of the Quality Payment Program (QPP) for MIPS registry measure, for 2018 dates of service. Change implemented in this specification for the purposes of alignment. Eliminated exclusion “Patient had only urgent care visits during the measurement period” for purposes of alignment. | |
| Description | The percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer | |
| Measurement Period | January 1, 2018 through December 31, 2018 | |
| Eligible Population | Eligible Specialties | Family Medicine, Internal Medicine, Geriatric Medicine, Obstetrics/Gynecology |
| | Eligible Providers | Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Advanced Practice Registered Nurses (APRN) |
| | Ages | 50 years or older at the start of the measurement period AND less than 76 years at the end of the measurement period |
| | Event | At least one eligible patient visit (<i>CRC Screening Visit Value Set</i>) performed or supervised by an eligible provider in an eligible specialty for any reason during the measurement period |
| Denominator | The eligible population | |
| Numerator | The number of patients in the denominator who met ANY of the following criteria: <ul style="list-style-type: none"> had a colonoscopy (<i>Colonoscopy Value Set</i>) performed during the measurement period or prior nine years had a sigmoidoscopy (<i>Sigmoidoscopy Value Set</i>) performed during the measurement period or prior four years had a CT colonography (<i>CT Colonography Value Set</i>) performed during the measurement period or prior four years had a FIT-DNA test (<i>FIT-DNA Value Set</i>) performed during the measurement period or prior two years had a stool blood test (<i>Stool Blood Test Value Set</i>) performed during the measurement period | |

Helpline: 612-746-4522 | E-mail: support@mncm.org | Data Portal: <https://data.mncm.org/login>

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ARIZONA: SAMPLE SYSTEMS CHANGE PRESENTATION

Increasing Screening Rates: Systems Change and Evidence Based Strategies

Virginia Warren
Office Chief,
Cancer Prevention and Control

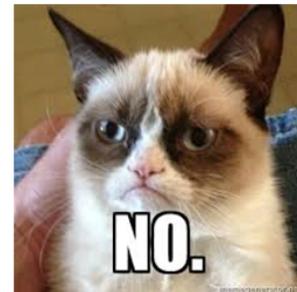


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Health and Wellness for all Arizonans

Cancer Math

- 209 Arizonans die each week
 - 10,881 in 2012
- 30 per day
- All ages, races
- Equal Opportunity disease
- Risk increases with age



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Health and Wellness for all Arizonans

Today's Challenges

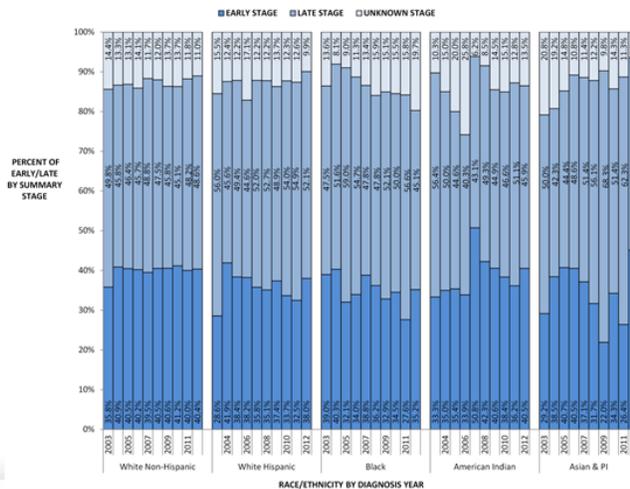
- Increasing screening rates
 - Breast and cervical: 40%,35%
 - Colorectal: 30%***
 - Prostate: talk to your provider
 - Lung: for those at high risk
- Increasing HPV immunization rates: 31%
- Encouraging and supporting healthy lifestyles



ARIZONA DEPARTMENT OF HEALTH SERVICES

Health and Wellness for all Arizonans

Colorectal Cancer – Arizona Stage of Dx, 2003-2012



ARIZONA DEPARTMENT OF HEALTH SERVICES

Health and Wellness for all Arizonans

Screening Rates

- Health Plan X – **Targets**
 - Colorectal – 34.5% HP2020 – 70.5%
- FQHCs [Healthy People 2020](#)
 - Colorectal – 30%
 - One over 60% [80% by 2018](#)



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Health and Wellness for all Arizonans

Systems Change

- The process of improving the capacity of the public health system to work with many sectors to improve the health status of all people within a community.
- Community is defined as your geographic area with a strong focus on those using services from your providers or within your health plan.



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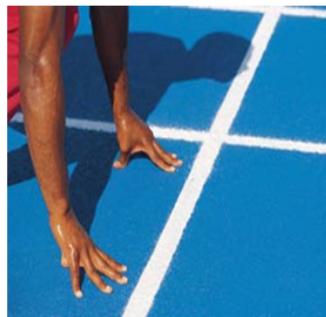
Health and Wellness for all Arizonans

The Starting Point

Start Small and Start Smart

- Decide on the area of focus;
 - Mammography, CRC Screening, Pneumonia/Flu Shots, Tobacco Cessation, Blood Pressure, Cholesterol, Diabetes
- Prioritize the focal point through clinic policy
- Support, monitor, report
- This is a process

Pace Yourself



Health and Wellness for all Arizonans

Determining Baseline

- How many people 50 and older use the clinic?
- At what age are you going to cap the review?
- What type of screening? FIT? Colonoscopy? In office DRE? (Really?)
- Make the decisions and maintain consistency as you monitor screening levels year to year.



Health and Wellness for all Arizonans

Review and Discuss Baseline

- Baseline results will not be what you expect
 - Our research has found rates from 19-30%, Healthy People 2020 has a goal of 70.5%
- Providers may disagree with the results
 - This is expected and normal
 - Use this as an opportunity to educate about the process and the goals
- Providers in a large practice may believe their results will be different than the groups; determine their baseline separately – they may become a champion of the project
- The results will lead to a realization that:
 - The screening rate leaves room for improvement
 - Evidence based strategies are necessary
 - Many insured patients are not being screened
 - Many insured patients are not even having annual visits – this is a missed opportunity
- It is important to make and take time for discussion and disagreement up front



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Baseline Determined

- Preserve Process
- Share Results
- Schedule the same process for the subsequent year or every ½ year
- Assign responsibility for next steps



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Evidence Based Strategies

- Research Evidence Based Strategies
 - [Community Guide To Preventive Services](#)
 - Client Oriented or Provider Oriented
- Decide on EB strategies providing best fit
- Use them
- Monitor and Report
- *If it is monitored it will be done*



InSure FIT

- No dietary or drug restrictions
- Done once per year when results are normal, negative
- If positive, the patient must receive a follow-up colonoscopy
- Higher compliance than with other tests – when combined with patient navigation, our screening program had a 90% return rate
- [Patient Instruction Video](#)



SimpliPro Colon Test

- New, FDA-approved test for higher-risk, symptomatic patients
- Administered like a regular blood draw
- [About the Test](#)
- [SimpliPro Colon Test Instructions](#)



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Questions?



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ARIZONA DEPARTMENT
OF HEALTH SERVICES

Health and Wellness for all Arizonans

MARYLAND: TEMPLATE FOR MCO MAILING TO HEALTH CARE PROVIDERS

Dear [PARTICIPATING PROVIDER]:

As a health care provider, you are well aware that colorectal cancer (CRC) is a preventable disease that often starts with no symptoms. Unfortunately, CRC is also the second leading cause of cancer-related deaths in Maryland, with 2,360 new cases and 860 deaths estimated in 2015 (American Cancer Society, 2015). Age- and risk-appropriate CRC screening can both prevent new CRC cases and reduce morbidity and mortality from CRC through early detection and treatment.

Evidence suggests that by recommending CRC screening to your patients verbally and in writing, you increase the likelihood that they will get screened. Many patients are willing to be screened for CRC but have not had screening recommended to them. To help you make the most of your limited time to discuss preventive health services with your patients, the Maryland Colorectal Cancer Control Program, in conjunction with Maryland Medicaid, is offering a free tool to aid discussion about CRC screening. This tool has already been implemented in several provider offices that serve a variety of clients, including Medicaid enrollees.

The tool, a few simple questions for patients to answer about their CRC screening history, can be provided to your patients at check-in to complete while they wait for their exam. When your patient meets you in the exam room, you can review and discuss their responses to help you assess the patient's need and preferences for CRC screening. Following that discussion, you can use the bottom tear-off portion to give your patient written recommendations for the next step to arrange this preventive care. As an additional resource, the reverse side of the questionnaire includes questions to assess your patients' need for breast and cervical cancer screening. Most Maryland counties and Baltimore City have resources to help eligible clients navigate to or pay for colorectal cancer screening. Please refer to the attached list of Maryland county and Baltimore City programs.

This tool is provided at no cost to you. To order copies, please visit <http://goo.gl/5aegTr> and complete the online order form. You will receive your copies within 1 to 2 weeks of ordering.

We look forward to working with you to best serve your patients. If you have questions about this tool or other ways you can increase cancer screening rates among your patients, please call the Maryland Cancer Line at 1-800-477-9774.

Sincerely,

[SIGNATORY]

MARYLAND: SAMPLE MEMBER NEWSLETTER ARTICLES

Colorectal Cancer Screening Newsletter Articles

Please use the following templates to share colorectal cancer screening promotion messages with your partner providers and MCO members:

Provider Newsletter Articles

Brief:

Colorectal cancer is the second leading cause of cancer death in Maryland, yet it can be detected early and can often be prevented with appropriate screening. Two simple ways you can encourage your patients to get screened are to *recommend colorectal cancer screening* to them and *give them a choice of screening methods*. Talk to your patients about colonoscopy, sigmoidoscopy, or fecal occult blood test for colorectal cancer screening when they turn 50 years old or sooner if they are at high risk.

Extended:

Colorectal cancer is the second leading cause of cancer death in Maryland and the United States. One out of three Marylanders between 50 and 75 years of age are not up-to-date with screening. Patients most often report that they have not been screened because their provider did not recommend it. Many of your patients may be in need of colorectal cancer screening.

By assessing your patients need for colorectal cancer screening and recommending a test that they are likely to complete, you increase the likelihood of them completing screening. Two important ways you can encourage your patients to get screened are to *recommend colorectal cancer screening* to them and *give them a choice of screening methods*. Talk to your patients about colonoscopy, sigmoidoscopy, or fecal occult blood test for colorectal cancer screening when they turn 50 years old or sooner if they are at high risk.

Member Newsletter Articles

Brief:

Colorectal cancer often starts with no symptoms and is the second leading cancer killer. There are tests that can help prevent colorectal cancer or detect it early when it can best be treated. If you're of average risk, you should be screened for colorectal cancer when you turn 50 years old. Talk to your primary care provider to determine which screening test is best for you. You can prevent colorectal cancer before it starts.

Extended:

Colorectal cancer is the second leading cancer killer in Maryland and often starts with no symptoms. Both men and women can get colorectal cancer and your risk goes up as you get older. There are tests that can help prevent colorectal cancer or detect it early when it can best be treated. If you are of average risk, screening for colorectal cancer should begin when you turn 50 years old. Your doctor can help you determine if you are average or high risk.

Colorectal cancer screening is painless and certain methods of screening can find and remove precancerous polyps before they turn into cancer. You can prevent colorectal cancer before it starts by talking with your doctor about which screening test is best for you.

This information is brought to you by the Maryland Colorectal Cancer Control Program. For technical assistance and resources regarding colorectal cancer screening promotion, please call us at 1-800-477-9774.



MARYLAND: TEMPLATE FOR PROVIDER MAILING TO MEDICAID BENEFICIARIES

[DATE]

Dear [PATIENT]:

Your health is important to us and to your loved ones. Since you are over the age of 50, I recommend you be screened for colorectal cancer. As you get older, your chances of getting colorectal cancer go up. Colorectal cancer is cancer of the colon or rectum and is the second leading cause of cancer deaths in Maryland.

The good news is that you can prevent colorectal cancer or detect it early when treatment works best by getting screened before you have any signs of the disease. There are several screening tests available, including simple take-home tests that don't require time off of work. One of the other tests, a colonoscopy, needs to be done only once every 10 years for most people. People at higher risk for colorectal cancer may need to be screened more often.

Colorectal cancer screening doesn't have to be expensive. If you have Maryland Medical Assistance, most of the screening tests available are covered at no cost to you. Many other insurance plans also cover colorectal cancer screening.

If you'd like to know more about colorectal cancer or how to get screened for it, I would be happy to talk with you about it. I hope that you'll schedule your screening test soon. Getting screened is too important to delay and may even save your life. Please call the office today to schedule an appointment to discuss colorectal cancer screening.

Sincerely,

[Provider]

OREGON: MEDICAID CCO FIT MAILING

[DATE]

[Member Name]

[Address]

[City, ST ZIP]

Si usted necesita servicios de intérprete, por favor llame al teléfono [phone number] si vive en [location of health plan].

You can get this letter in another language, large print, or another way that's best for you. Call [phone number], TTY [phone number].

Re: Free colon cancer screening kit enclosed

Dear [Member Name]:

[Plan name] wants to help you live a long, healthy life. That's why we've joined up with [vendor name] to give you an easy way to do your colon cancer screening.

Here is a test kit that allows you to screen for colon cancer. You can take this test from the comfort of your home. This test checks for hidden blood in your stool, which is a common sign of cancer. It is quick, easy to use, and is **provided to you for free by [Plan Name]**.

Colon cancer is the second-leading cause of cancer death in the U.S. The good news is you can test for this disease, and this kind of cancer is highly treatable when it is found early. Colon cancer screening looks for cancer before you have symptoms.

Screening is easy: Please follow the instructions carefully. This test does not require you to stop eating or drinking. Please take your medications as normal.

Some helpful hints for using the kit:

- Keep your kit in the bathroom where you will collect your sample.
- Write the date of collection on the patient label.

When you are done, mail your test in the prepaid envelope we included. The [vendor name] Lab will process your sample. Your test results will be mailed to you and your doctor within [your turnaround time] business days.

We would like you to complete this screening. However, taking the test is not required. It will not affect your health coverage, either way. If you have any questions, call [fill in who you would like your members to contact] at:

- [phone number]
- TTY users call 711
- [hours]

Thank you for taking the time to complete this life-saving test.

OREGON: CRC MEASURE TECHNICAL SPECIFICATIONS



Colorectal Cancer Screening

Measure Basic Information

Name and date of specifications used:

HEDIS® 2017 Technical Specifications for Health Plans (Volume 2).

URL of Specifications: N/A

Measure Type:

HEDIS PQI Survey Other Specify:

Measure Utility:

CCO Incentive Core Performance CMS Adult Set CHIP Set State Performance
Other Specify:

Data Source: MMIS/DSSURS, medical records

Measurement Period: January 1, 2017 – December 31, 2017

2013 Benchmark: N/A improvement target only

2014 Benchmark: 47%, Metrics & Scoring Committee consensus.

2015 Benchmark: 47%, Metrics & Scoring Committee consensus.

2016 Benchmark: 47%, Metrics & Scoring Committee consensus.

2017 Benchmark: 50.8%, 2015 CCO 90th percentile.

Incentive Measure changes in specifications from 2016 to 2017:

OHA is using HEDIS 2017 specifications for all 2017 measurement. Changes from HEDIS 2016 to 2017 include¹:

- Clarification about when pathology reports can be used for the numerator.
- Added one LOINC code to the FOBT Value Set. Note HEDIS 2017 Value Set Directory workbook does not document the changes to the Colonoscopy Value Set.
- Added the CT Colonography and FIT-DNA Value Sets. **These two screening types are added to both administrative and hybrid (chart review/EHR extraction) methods.**

OHA continues to adopt the full HEDIS hybrid specifications for 2017. It is the CCO's responsibility to identify numerator compliance using any of the data sources allowed under the HEDIS hybrid method. Information may be abstracted from administrative data (claims), paper medical records, and audited supplemental databases or from automated systems such as electronic medical records (EMRs), registries, or claims systems.

- If using administrative data to identify numerator compliance, CCOs must follow HEDIS 2017 specifications for allowable codes and measure logic.

¹ This section was updated February 3, 2017, and on February 1 2018; see 'Version Control' section for detail.



- If using medical record data to identify numerator compliance, CCOs must follow HEDIS 2017 specifications to conduct the chart review.

See the guidance document for additional information on allowable data sources. OHA will provide updated guidance to CCOs on the hybrid methodology for 2017 in fall 2017 and samples in early 2018. Guidance will be posted online at <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.apx>.

HEDIS specifications are written for multiple lines of business and include a broad set of codes that could be used for measurement. Codes OHA is not using include, but are not limited to, LOINC, CPT, and HCPCS codes that are not open to Medicaid in Oregon. A general rule of thumb is that only CPT/HCPCS codes associated with the prioritized list will be used to calculate the measures; however as some measure specifications include denied claims, a claim that was denied because it included codes not on the prioritized list might still be counted toward the measure.

OHA is following HEDIS guidelines for Effectiveness of Care, Access/Availability of Care, Experience of Care, and Utilization measures to determine which services count. OHA is not using all codes listed in the HEDIS specifications.

Denied claims: Included Not included

Member type: CCO A CCO B CCO G

Measure Details

Data elements required denominator: Medicaid enrollees age 51-75 years as of December 31st of the measurement year. OHA will provide CCOs with the sampling frame for the chart review.

Required exclusions for denominator: Either of the following any time during the member's history through December 31 of the measurement year²:

| Colorectal Cancer Value Set | | |
|-----------------------------|--|--|
| HCPCS | ICD-9-CM Diagnosis | ICD-10-CM Diagnosis |
| G0213-G0215, G0231 | 153, 154.0, 154.1, 197.5, V10.05, V10.06 | C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048 |

OR

| Total Colectomy Value Set | | |
|---------------------------------------|---------------------|------------------------------------|
| CPT | ICD-9-PCS Procedure | ICD-10-PCS Procedure |
| 44150-44153, 44155-44158, 44210-44212 | 45.81-45.83 | ODTE0ZZ, ODTE4ZZ, ODTE7ZZ, ODTE8ZZ |

Deviations from cited specifications for denominator: None.

² To note, OHA's claims data only goes back to 2002.



Data elements required numerator: Unique number of individuals receiving at least one of the following screenings for colorectal cancer either during the measurement year or years prior to the measurement year (see table). See **medical record review** section.

Appropriate screenings are defined by:

| FOBT Value Set | | |
|---|-------|---|
| Fecal occult blood test during the measurement year | | |
| CPT | HCPCS | LOINC |
| 82270, 82274 | G0328 | 2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6 |

OR

| Flexible Sigmoidoscopy Value Set | | | |
|--|-------|--------------------|----------------------------------|
| Flexible sigmoidoscopy during the measurement year or four years prior to the measurement year | | | |
| CPT | HCPCS | ICD-9-CM Procedure | ICD-10-CM Procedure ³ |
| 45330-45335, 45337-45342, 45345, 45346, 45347, 45349, 45350 | G0104 | 45.24 | -- |

OR

| Colonoscopy Value Set | | | |
|--|--------------|-----------------------------------|----------------------------------|
| Colonoscopy during the measurement year or nine years prior to the measurement year | | | |
| CPT | HCPCS | ICD-9-CM Procedure | ICD-10-CM Procedure ² |
| 44388-44394, 44397, 44401-44408, 45355, 45378-45387, 45388-45390, 45391, 45392, 45393, 45398 | G0105, G0121 | 45.22, 45.23, 45.25, 45.42, 45.43 | -- |

OR

| CT Colonography Value Set | | | |
|---|-------|--------------------|----------------------------------|
| CT colonography during the measurement year or four years prior to the measurement year | | | |
| CPT | HCPCS | ICD-9-CM Procedure | ICD-10-CM Procedure ² |
| 74263 | -- | -- | -- |

OR

| FIT-DNA Value Set | | | |
|--|--|--|--|
| FIT-DNA during the measurement year or two years prior to the measurement year | | | |

³ HEDIS 2017 does not include ICD-10 procedure codes for this measure, as ICD-10-PCS is intended for coding procedures performed in inpatient settings, whereas colorectal cancer screenings typically occur in outpatient settings.



| CPT | HCPCS | ICD-9-CM Procedure | LOINC |
|-------|-------|--------------------|------------------|
| 81528 | G0464 | -- | 77353-1, 77354-9 |

Note: In office FOBT is not a USPSTF recommended procedure.

Required exclusions for numerator: None. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria: The measurement year and the year prior to the measurement year.

What are allowable gaps in enrollment: No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.

Define Anchor Date (if applicable): December 31 of the measurement year.

Medical Record Review:

Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

A pathology report that indicates the type of screening (e.g. colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria for inclusion in the measure.

For pathology reports that do not indicate the type of screening and for incomplete procedure:

- Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy.
- Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (FIT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.

- If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
- If the medical record does not indicate the type of test and the number of returned samples is specified, the member meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion.
- FIT tests may require fewer than three samples. If the medical record indicates that an FIT was done, the member meets the screening criteria, regardless of how many samples were returned.



- If the medical record indicates that a gFOBT was done, follow the scenarios below:
 - If the medical record does not indicate the number of returned samples, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
 - If the medical record indicates that three or more samples were returned, the member meets the screening criteria for inclusion in the numerator.
 - If the medical record indicates that fewer than three samples were returned, the member does not meet the screening criteria.

Do not count digital rectal exam (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

CT colonography during the measurement year or the four years prior to the measurement year.

FIT-DNA during the measurement year or the two years prior to the measurement year.

For more information: The Colorectal Cancer Screening guidance document and other supporting documents can be found at <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx> and <http://www.oregon.gov/oha/Transformation-Center/Pages/Resources-Metric.aspx>

Version Control

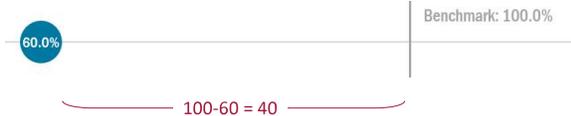
- The specifications were updated on February 3, 2017 due to corrections made to the OHA 2016 specification sheet. The remaining differences between 2016 and 2017 specifications are:
 - Added one LOINC code to the FOBT Value Set.
 - Added the CT Colonography and FIT-DNA Value Sets.
- The specifications were updated on February 3, 2018 to clarify that the two additional screening methods, CT colonography and FIT-DNA can be applied to both administrative and hybrid (chart review/EHR extraction) methods.

OREGON: INCENTIVE MEASURE PAYMENT CALCULATION

ABOUT BENCHMARKS AND IMPROVEMENT TARGETS

Incentive measure benchmarks are selected by the Metrics and Scoring Committee and are meant to be aspirational goals. That is, CCOs are not expected to meet the benchmark each year, but rather to *make improvement toward* the benchmark. To demonstrate this, CCOs can earn quality pool payment for a) achieving the benchmark or b) achieving their individual *improvement target*. Improvement targets are based on the Minnesota Department of Health Quality Incentive Payment System (“Minnesota method”), which requires at least a 10 percent reduction in the gap between baseline and the benchmark to qualify for incentive payments.

Suppose CCO A’s performance in **2015** (i.e. baseline) on Measure 1 was 60.0%



The gap between baseline and the benchmark is $[100-60] = 40\%$

Ten percent of $40\% = 4\%$. Thus, CCO A must improve by 4 percentage points in 2016. Their *improvement target* is $[\text{baseline} + 4\%] = [60\% + 4\%] = 64\%$

CCO A’s performance in **2016** is 65%; they *achieved their improvement target and will receive quality pool payment* on Measure 1.



Stated as a formula: $\frac{[\text{Benchmark}] - [\text{CCO baseline}]}{10} = X \longrightarrow [\text{CCO baseline}] + [X] = \text{Improvement target}$

In some cases, depending on the difference between the CCO’s baseline and the benchmark, the Minnesota method may result in a very small improvement that may not represent a statistically significant change. Using the example above, suppose the benchmark was only 75 percent. In this case, CCO A’s improvement target using the formula would be:

$$\frac{75\% - 60\%}{10} = 1.5\% \longrightarrow 60\% + 1.5\% = 61.5\%$$

Where the Minnesota method results in small improvement targets like this, the Metrics and Scoring Committee has established a “floor” or minimum level of required improvement before the CCO would meet its improvement target. In this example, suppose the floor is 3 percentage points. The Minnesota method formula only results in 1.5% increase. Instead of 61.5%, CCO A’s improvement target with the 3% floor applied would be: $[\text{baseline} + \text{floor}] = [60\% + 3\%] = 63\%$.

NEW YORK: 2017 INCENTIVE AWARDS FOR MEDICAID MCOS

| 2017 Quality Incentive Awards Effective Period April 1, 2018 – March 30, 2019 | | | | | | | | |
|--|--|--|----------------------|----------------------|---------------------------------|---------------------|--------------|-------------------------|
| Incentive Tier | Plan Name | Normalized Quality Points = Quality Points/Highest Score | Satisfaction Points | PQI/PDI Points | Compliance Points | Bonus Points | Total Points | Percent of Total Points |
| | | (100 points possible) | (30 points possible) | (20 points possible) | (20 points possibly subtracted) | (6 points possible) | | (up to 100%) |
| Tier 1 | Fidelis Care New York, Inc. | 94.03 | 20 | 10 | -2 | 6 | 128.03 | 85.35 |
| Tier 2 | MVP Health Care | 82.09 | 20 | 12.5 | -2 | 6 | 118.59 | 79.06 |
| Tier 2 | Healthfirst PHSP, Inc. | 100.00 | 10 | 0 | -2 | 6 | 114.00 | 76.00 |
| Tier 2 | MetroPlus Health Plan | 98.51 | 10 | 0 | -2 | 6 | 112.51 | 75.01 |
| Tier 2 | CDPHP | 73.13 | 20 | 15 | -2 | 6 | 112.13 | 74.76 |
| Tier 3 | Independent Health's MediSource | 58.21 | 25 | 7.5 | 0 | 6 | 96.71 | 64.47 |
| Tier 3 | HIP (EmblemHealth) | 68.66 | 15 | 0 | -2 | 6 | 87.66 | 58.44 |
| Tier 3 | Empire BlueCross BlueShield HealthPlus | 68.66 | 15 | 0 | -2 | 6 | 87.66 | 58.44 |
| Tier 3 | HealthNow New York Inc. | 52.70 | 20 | 10 | -2 | 6 | 86.70 | 57.80 |
| Tier 3 | WellCare of New York | 61.19 | 10 | 10 | -2 | 6 | 85.19 | 56.80 |
| Tier 3 | UnitedHealthcare Community Plan | 52.24 | 15 | 17.5 | -6 | 6 | 84.74 | 56.49 |
| Tier 3 | Excellus BlueCross BlueShield | 52.24 | 20 | 7.5 | -2 | 6 | 83.74 | 55.83 |
| Tier 3 | Molina Healthcare | 59.70 | 5 | 10 | -4 | 6 | 76.70 | 51.13 |
| Tier 4 | Affinity Health Plan | 43.28 | 15 | 0 | -2 | 6 | 62.28 | 41.52 |
| Tier 4 | YourCare Health Plan | 31.34 | 15 | 10 | -2 | 6 | 60.34 | 40.23 |
| Tier 5 | | | | | | | | |



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