Colorectal Cancer Screening
Medicaid Draft Policy Comment Responses

The draft Colorectal Cancer Screening policy was posted for public comment January 21, 2020 through February 11, 2020. During this period, HHSC received several comments from stakeholders. Most of the comments included positive feedback regarding proposed policy changes. A summary of comments received and HHSC’s responses follow.

Comment: One Commenter inquired as to the next steps required for policy approval. Specifically, if the policy will need to be reviewed by the Medical Care Advisory Committee (MCAC), and when is the expected effective date.
Response: HHSC thanks the Commenter for their inquiry regarding the next steps for approving the colorectal cancer screening policy. The next step will include policy revisions in response to comments from the public, where appropriate. A rate hearing is expected in Fall 2020 and HHSC is targeting early 2021 for implementation. Medical policy changes are distributed to MCAC members for review when the policy is posted for public comment. Outside of the public comment process, MCAC’s role is to formally review quarterly changes to the Texas Administrative Code (TAC) governing the Medicaid program. This policy update did not necessitate TAC changes.

Comment: Several commenters noted their support for the updated policy’s coverage of all colorectal cancer screening modalities outlined in the United States Preventive Services Task Force (USPSTF), alignment with the American Cancer Society (ACS) recommendation to initiate screening for colorectal cancer in average risk patients at age 45, and the addition of Cologuard as a new screening benefit to increase colorectal cancer screening rates and result in earlier treatment.
Response: HHSC thanks the Commenters for their support.

Comment: One commenter requested that criteria for both “average risk” and “high risk” colorectal cancer screening population be defined in the policy. The commenter specified that the population in good health with a life expectancy of greater than 10 years should continue with regular colorectal cancer screening through age 75 and considers this population to be of average risk for colorectal cancer. The commenter specified that the population from age 76 through 85 should make their colorectal cancer screening decision based on the person’s preferences, overall health, life expectancy, and previous screening history. The commenter stated that the population over age 85 should not be screened for colorectal cancer.
Response. HHSC declines to revise the policy in response to this comment. The policy defines the high-risk patient population for colorectal cancer screening, and therefore an individual not meeting the high-risk criteria would be considered at average risk. HHSC recognizes the importance of shared decision-making between patients and their
provider at any age, based on individual circumstances and risk. The policy does not exclude coverage for screening in the population over age 85 when it is determined appropriate by the provider and the patient through a shared decision-making process.

**Comment:** One commenter suggested that the policy should specify all three types of accepted colorectal cancer screening stool tests: Fecal immunochemical test (FIT) every year, Highly sensitive guaiac-based fecal occult blood test (HSgFOBT) every year, and Multi-targeted stood DNA test (mt-sDNA) every three years.

**Response:** HHSC declines to revise the policy in response to this comment as these have been described in the posted policy draft. The procedure codes designated for FOBT testing in the policy include HSGFOBT, as per the standard of care.

**Comment:** One commenter recommended changing the proposed language in policy line 1 to reduce confusion with subsequent language in policy line 2.

**Response:** HHSC agrees to revise the policy in response to this comment. To reduce potential confusion, HHSC has updated policy line 2 to read: “Fecal occult blood test, multi-targeted stood DNA (mt-sDNA) test, screening colonoscopies, and sigmoidoscopies are evidence-based methods of colorectal cancer screening.”

**Comment:** One commenter commended HHSC’s addition of coverage of mt-sDNA in the policy, as well as reducing the screening age from 50 to 45 years. This commenter also requested adding the Epi proColon blood test to the screening policy.

**Response:** HHSC declines to revise the policy in response to this comment as it is not within the scope of the current policy review to consider coverage of the Epi proColon blood test. HHSC invites the Commenter to complete the topic nomination form located on the Medicaid Medical and Dental Policies [https://hhs.texas.gov/services/health/medicaid-chip/about-medicaid-chip/medicaid-medical-dental-policies] webpage for consideration of adding the Epi proColon blood test to annual blood work in the future.

**Comment:** Two commenters expressed concern regarding the implications of the USPSTF’s ongoing evidence review of colorectal cancer recommendations in the updated policy language. One commenter suggested that the proposed striking of existing language referencing the USPSTF may imply that these recommendations were not considered in the development of the updated policy. Another commenter recommended delaying implementation of policy changes pending the results of the current evidence review by the USPSTF.

**Response:** HHSC declines to revise the policy in response to this comment. The reference to USPSTF’s recommended age to initiate screening was removed from policy line 4 to address the conflict in the currently published USPSTF guidelines and the more recent recommended age to start screening in the updated ACS guidelines.
**Comment:** One commenter requested policy language to “emphasize the physician’s role in determining patient risk that may not be captured in the proposed policy and support appropriate screening methods based on the patient’s unique health needs.” The commenter’s organization “opposes any policy that hinders the autonomous clinical decision-making authority of a physician or prevents a physician from providing evidence-based, empathetic, and comprehensive treatment options to a patient.”

**Response:** HHSC declines to revise the policy in response to this comment. HHSC appreciates the important role of the physician in clinical decision-making. The intent of the policy language is to allow patient autonomy with informed decision-making guided by the healthcare provider and supported by evidence-based guidelines.