

RFI DUE NOVEMBER 4th

Overview

The Centers for Medicare & Medicaid Services (CMS) is committed to engaging with partners, communities, and individuals across the health system to understand their experiences with CMS payment policies and quality programs, particularly how existing and proposed CMS payment policies and quality programs impact the experience of healthcare. Through this RFI, CMS is seeking public input on accessing healthcare and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 Public Health Emergency (PHE). CMS will use the comments received in response to this RFI to identify potential opportunities for improvement and increased efficiencies across CMS policies, programs, and practices. In addition, CMS hopes to learn how specific policies have benefited providers, practices, and the people we serve as we work to continually improve our programs.

I. Accessing Healthcare and Related Challenges

CMS wants to empower all individuals to efficiently navigate the healthcare system and access comprehensive healthcare. We are interested in receiving public comment on personal perspectives and experiences, including narrative anecdotes, describing challenges individuals currently face in understanding, choosing, accessing, paying for, or utilizing healthcare services (including medication) across CMS programs.

Examples may include, but are not limited to:

- Challenges accessing comprehensive and timely healthcare services and medication, including primary care, long-term care, home and community-based services, mental health and substance use disorder services;
- Challenges in accessing care in underserved areas, including rural areas;
- Receiving culturally and linguistically appropriate care (e.g., tailoring services to an individual's culture and language preferences);
- Challenges with health plan enrollment;
- Challenges of accessing reproductive health services;
- Challenges of accessing maternal health services;
- Challenges of accessing oral health services and the impact on overall health;
- Understanding coverage options, and/or technology to support access to coverage; and,
- Perspectives on how CMS can better communicate quality standards and accessibility information to individuals, particularly those with social risk factors.

Answer Here

NCCN is an alliance of 32 leading academic cancer centers in the United States that treat hundreds of thousands of patients with cancer annually. The organization is the developer of authoritative information regarding cancer prevention, screening, diagnosis, treatment, and supportive care that is widely used by clinical professionals and payers alike. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) are a comprehensive set of guidelines detailing the sequential management decisions and interventions that currently apply to 97 percent of cancers affecting patients in the United States.

Access to Guideline Concordant Care: Numerous independent studies have found adherence to NCCN Guidelines improves care outcomes including overall survival and quality of life measures for patients with cancer. Medicare as well as many payers currently use NCCN Guidelines for coverage determinations. NCCN encourages CMS to ensure Medicaid beneficiaries have the same access to optimal cancer care as patients in Medicare and commercial insurance by directing states to use CMS compendia as a minimum standard for Medicaid and CHIP programs across the nation.

Guideline adherent care has also been shown to decrease costs. A study by United, eviCore, and NCCN entitled “Transforming Prior Authorization to Decision Support” demonstrated mandatory adherence to NCCN Guidelines and NCCN Compendium[®] using a real-time Clinical Decision Support Mechanism significantly reduced total and episodic costs of care while also reducing denials and increasing access to guideline-concordant care. In Florida, United Healthcare adopted a prior authorization tool using NCCN real-time decision support over one year and explored 4,274 eligible cases. At the conclusion of the study, United Healthcare found that adding decision support to prior authorization reduced denials to 1 percent. Additionally, despite reducing denials, when compared to United Healthcare’s cancer drug cost trends nationwide, the study found that mere adherence to NCCN Guidelines and Compendium within the pilot reduced chemotherapy drug costs trends by 20 percent; a savings of more than \$5.3 million in the state of Florida.

Culturally and linguistically appropriate care: NCCN partnered with ACS CAN and NMQF to convene the Elevating Cancer Equity (ECE) Working Group in an effort to address racial disparities in cancer care. The ECE Working Group was charged with developing actionable practice change solutions, meaning interventions targeted to oncology practices and cancer hospitals, to reduce racial disparities in cancer care. The ECE Working Group developed 17 practice change recommendations in a Health Equity Report Card for use by payers, accreditation entities, and providers seeking to advance equitable care practices and 16 policy change recommendations. This includes recommendations for culturally and linguistically appropriate care. The Health Equity Report Card is currently being piloted in academic centers and there will be a pilot launched in community settings in 2023. The recommendations in the Equity Report Card can be found here: https://www.nccn.org/docs/default-source/oncology-policy-program/2021_recommendations_for_elevating_cancer_equity.pdf?sfvrsn=5d2c0d84_2

Transportation as a barrier to healthcare access: Patients and their caregivers can face many issues around medical transportation and access to appropriate specialist providers. Numerous studies have found transportation is a significant barrier to access for cancer care in the United States.¹ NCCN Members report that transportation when serving out of state Medicaid patients is typically limited in scope. NCCN encourages CMS to consider new reimbursement mechanisms

¹ Guidry JJ, Aday LA, Zhang D, Winn RJ. Transportation as a barrier to cancer treatment. *Cancer Pract.* 1997;5(6):361-366.

to ensure beneficiary access to transportation for medically necessary services including when transitioning back to lower levels of care.

Patient Navigation and Care Coordination Services: NCCN understands the importance of care planning and coordination when it comes to high quality cancer care. CMS can promote whole person care and care coordination through supporting and implementing billable patient navigation services. The ECE Working Group cited patient navigation services as a critical intervention to reduce inequity in cancer care.

Mental Health: While cancer care and treatment have a significant physical component, patients often experience cancer-related distress as well. The NCCN Distress Thermometer focuses specifically on distress management, given the larger implications that a patient's mental health can have on their overall treatment success. Patients experiencing distress may find it harder to make decisions on their care, their willingness to take prescribed medications and attend appointments, or take steps to improve their lifestyle. Tools like the NCCN Distress Thermometer can be employed to better understand patient needs and, once identified, refer them to appropriate services.

Recommendations for how CMS can address these challenges through our policies and programs: Answer Here

Access to Guideline Concordant Care: The NCCN Guidelines are transparent, continuously updated, available free of charge online for non-commercial use, and available through a multitude of HIT vendors. As such, they provide an excellent standard to determine appropriateness of care across geographies. NCCN recommends instituting rates of concordance to nationally recognized guidelines (i.e. CMS compendia) as a quality tracking mechanism in state Medicaid programs. NCCN Guidelines are available free of charge online for non-commercial use and are licensed by more than 80 health information technology (HIT) vendors, ensuring ease of use within a variety of HIT systems. NCCN collaborates with HIT vendors to integrate the NCCN Guidelines and compendia products allowing for access to evidence-based recommendations in the cloud or through Electronic Health Records (EHR) systems and chemotherapy treatment management modules. The integration of NCCN products into HIT helps to standardize cancer treatment protocols for use at point of care across all EHR technology utilized throughout the patient care continuum and offers a helpful tool for ensuring quality care within value-based models.

Culturally and linguistically appropriate care: The ECE Working Group recommends that payers create reimbursement mechanisms for linguistically and culturally reflective patient navigators and/or community health workers. Investing in patient navigators and/or community health workers can help bridge language and cultural gaps that can impact access to care. NCCN asks that CMS consider the implementation of recommendations such as these so that Medicaid and CHIP programs can better address cultural competency and language barriers.

Transportation as a barrier to healthcare access: CMS should encourage payment policies and contracting arrangements that provide for the coverage of transportation costs across state lines

in cases of rare or particularly complex cancers. This will ensure patients and their caregivers are not restricted when it comes to accessing care at locations that are far away from their homes or in different states. Additionally, CMS should address the current reimbursement gap related to travel costs for transitions back to lower levels of care.

Patient Navigation and Care Coordination Services: Employing a billing mechanism for both patient navigation services and care coordination services across CMS programs will enable cancer care providers to develop comprehensive cancer care plans at the initiation of treatment, at critical points in the cancer care continuum, and the beginning of cancer survivorship. Cancer care planning is an element of quality cancer care that has also been endorsed by the Institute of Medicine (now the National Academy of Medicine) and was included as a practice improvement initiative in the Oncology Care Model. Additionally, patient navigation services have been shown to reduce inequities in cancer detection and treatment but cannot be brought to scale until a billing mechanism is in place.

Mental Health: Having the appropriate tools, such as the NCCN Distress Thermometer and care to manage this distress could improve outcomes for a cancer patient. Ensuring access to mental health providers that can help with cancer-related distress is another way CMS can improve whole person care. NCCN recommends offering providers a shared library of free resources like the NCCN Distress Thermometer to support comprehensive care delivery.

Medicaid expansion: NCCN supports CMS encouraging state governors and legislatures to expand their state Medicaid programs. A variety of studies have been published demonstrating the impact of Medicaid expansion on the prevention and early detection of cancer as well as improving overall survival from cancer. In 2019, the *American Journal of Preventive Medicine* published a study finding that the 5 states and District of Columbia that were early adopters of Medicaid expansion saw significantly larger increases in rates of colorectal cancer (CRC) screening than states that did not expand Medicaid. Between 2012 and 2016, the proportion of low-income adults ages 50 to 64 who were up-to-date with CRC screening grew by 8.8 percentage points in very early adopters of expansion (from 42.3% to 51.1%) compared to just 3.8 percentage points in non-expansion states (from 44.2% to 48.0%).² Studies examining rates of breast and cervical cancer screening among low-income adults find similar gains in Medicaid expansion states compared to non-expansion states.³ Additionally, studies analyzing rates of cancer surgery have concluded that low-income adults in expansion states are more likely to have access to necessary cancer surgery than those in non-expansion states.⁴ An expansion of these programs could help increase access to cancer screening, early detection and care at a larger scale.

² Fedewa, SA, et al. Changes in breast and colorectal cancer screening after Medicaid expansion under the Affordable Care Act. *Am J Prevent Med* 2019; 57(1):3-12 doi: 10.1016/j.amepre.2019.02.015

³ Sabik, LM, Tarazi, WW, Bradley, CJ. State Medicaid Expansion Decisions and Disparities in Women's Cancer Screening. *Am J Prevent Med* 2015; 48(1): 98-103

⁴ Equia, E, et al. Impact of the Affordable Care Act (ACA) Medicaid expansion on cancer admissions and surgeries. *Ann Surg.* 2018 Oct; 268(4): 584–590. doi: 10.1097/SLA.0000000000002952

II. Understanding Provider Experiences

CMS wants to better understand the factors impacting provider well-being and learn more about the distribution of the healthcare workforce. We are particularly interested in understanding the greatest challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, documentation and reporting requirements, operations, or communications on provider well-being and retention.

Examples may include, but are not limited to:

Key factors that impact provider well-being and experiences of strained healthcare workers (e.g., compassion fatigue, retention, maldistribution);

The increasing use of digital health technology on provider well-being and attrition;

Feedback regarding compliance with payment policies and quality programs, such as provider enrollment requirements on healthcare worker participation in underserved populations, and what improvements can be made;

Impact of CMS policies on patient panel selection, and on providers' ability to serve various populations; and

Factors that influence providers' willingness or ability to serve certain populations, particularly those that are underserved and individuals dually eligible for Medicare and Medicaid.

Answer Here

Network Adequacy Standards: Access to a robust provider network is a critical component of high-quality cancer care. NCCN would like to highlight the importance of including academic cancer centers within these provider networks. They frequently see higher severity cases and offer best in class and innovative therapies as well as access to clinical trials. Academic cancer centers remain the backbone of oncology care, providing essential resources that patients with cancer may not be able to access in other settings of care.

Administrative Burden: A crucial component of high-quality cancer care is access to a robust provider network. However, potential providers for Medicaid and CHIP programs can be deterred from participating by unnecessary administrative burdens. It is common for Medicaid patients to face difficulties in finding physicians that are willing to treat them.⁵ Clinicians faced with issues from billing and claims to Medicaid may be more reluctant to treat lower income Americans on Medicaid and CHIP programs, further exacerbating access issues for those on these types of programs.¹³

Out of State Patients: NCCN Member Institutions, as representatives of large academic medical centers and tertiary referral centers for which coordinated pediatric care is required, report barriers related to providing care for out-of-state Medicaid patients. A significant barrier noted by Members is the state-by-state variability around enrollment and authorization as a Medicaid

⁵ Dunn A, Gottlieb J, Shapiro A, Sonnenstuhl D, Tebaldi P. A denial a day keeps the doctor away. 2021. doi:10.3386/w29010

provider. Specifically, Members note that enrollment variation and complexity delays the timing of care, which can cause increased stress and discomfort among patients and their loved ones.

Prior Authorization: NCCN also has concerns regarding prior authorization as traditionally implemented. Prior authorization creates significant administrative burden and often unnecessarily delays patient access to care. NCCN supports guideline adherence using real-time decision support as a coverage mechanism to ensure appropriateness of care, reduce costs to the patient and the health system, improve quality of care, and reduce administrative burden

Continuous Coverage: Continuity of coverage for beneficiaries receiving cancer treatment is critical to ensure timely and optimal care. NCCN appreciates CMS' attention to the unique challenges associated with out-of-state care, a particular challenge in cancer care. NCCN Member Institutions, leading academic cancer centers, report barriers related to providing care for out-of-state Medicaid patients. A significant barrier noted by Members is the state-by-state variability around enrollment and authorization as a Medicaid provider. Specifically, Members note that enrollment variation and complexity delays the timing of care, which can cause increased stress and discomfort among patients and their loved ones.

Recommendations for CMS policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations: Answer Here

Network Adequacy Standards: NCI-designated centers offer specialized services often unavailable elsewhere, including interdisciplinary team-based care, the latest therapies and advancements in cancer treatment, cutting-edge technology, and greater access to clinical trials. Multiple studies have found that treatment at NCI-designated and academic cancer centers is tied to higher overall survival.^{6,7,8} Barriers to accessing care at these sites are particularly problematic for patients with rare, complex, or advanced cancers, who would most benefit from comprehensive and multidisciplinary treatment.

NCCN supports network adequacy standards that allow health insurance companies to negotiate appropriate rates with all high quality, high value providers, including academic cancer centers, which frequently see higher severity cases and offer best in class and innovative therapies as well as access to clinical trials. However, NCCN recognizes that not all patients will be able to access an NCI-designated center due to location or other barriers and that other academic medical centers or tertiary referral centers for comprehensive cancer care also play a key role in cancer care access. As such, NCCN urges CMS to include an additional facility criterion requiring each

⁶ Wolfson JA, Sun CL, Wyatt LP, Hurria A, Bhatia S. Impact of care at comprehensive cancer centers on outcome: results from a population based study. *Cancer*. 2015;121(21):3885-3893. doi:10.1002/encr.29576.

⁷ Pfister DG, Rubin DM, Elkin EB, et al. Risk adjusting survival outcomes in hospitals that treat patients with cancer without information on cancer stage. *JAMA Oncol*. 2015;1(9):1303-1310. doi:10.1001/jamaoncol.2015.3151.

⁸ Shulman, LN, Palis, BE, et al. Survival as a quality metric of cancer care: Use of the National Cancer Data Base to assess hospital performance. *Journal of Oncology Practice* 2018 14:1, e59-e72

plan to offer at least one local NCI-designated cancer center or, in the absence of an NCI-designated cancer center, a tertiary or quaternary referral center for patients with rare or advanced cancers. NCCN recognizes that defining this type of provider may present challenges and encourages CMS to work with the provider and payer community to develop a standardized definition.

Administrative Burden: Unnecessary administrative burdens can deter potential providers from participating in Medicaid and CHIP programs. Reducing these burdens could encourage more provider participation, leading to more robust networks and thus leading to more access for beneficiaries of these programs. CMS should work to address the administrative issues around claims and payments so that providers can enter the networks knowing that these programs are functioning efficiently.

Out of State Patients: Cancer care tends to be multidisciplinary and often multisite, requiring close care coordination and adherence to evidence-based guidelines to optimize outcomes in the highest quality and most cost-effective way. NCCN recommends CMS include guidance to streamline the process for care delivery organizations and providers to enroll as a Medicaid provider in the reimbursing state. The most streamlined solution may be to direct states to recognize the enrollment status of providers enrolled in their own state Medicaid program, thereby circumventing burdensome and often duplicative paperwork requirements.

Prior Authorization: NCCN believes the use of a real-time clinical decision support mechanism (CDSM) that is informed by nationally recognized, evidenced-based guidelines can alleviate administrative burden as CMS seeks to do, as well as ensures proper payment prospectively and patient access to clinically appropriate, high quality care. A peer-reviewed, published study by UnitedHealthcare, eviCore, and NCCN entitled “Transforming Prior Authorization to Decision Support” found that administrative burden could be reduced by the addition of decision support to prior authorization. In Florida, UnitedHealthcare adopted an integrated prior authorization tool using NCCN real-time decision support over a one-year period and explored 4,272 eligible cases; only 42 denials occurred. Specifically, the study found that adding decision support to prior authorization reduced denials from 4 to 1 percent. Administrative burden was also reduced through the integration of the decision-making tool as the majority of prior authorization requests were approved immediately; the remaining requests were approved within 24 hours.⁹ (The model has been expanded to several additional national and regional private payers. NCCN encourages CMS to consider the implementation of this model throughout Medicaid programs to reduce unnecessary administrative burden as it relates to prior authorization.

Continuous Coverage: Medicaid does not offer a nationally recognized provider number like Medicare does, which leads to significant challenges obtaining approval for out of state care. NCCN

⁹ Newcomer LN, Weininger R, Carlson RW. Transforming prior authorization to decision support. *Journal of Oncology Practice*. 2017;13(1). doi:10.1200/jop.2016.015198

supports CMS implementing a more standard and consistent approach to enrollment and authorization as a Medicaid provider across the states in an effort to minimize disruptions to care.

III. Advancing Health Equity

CMS wants to further advance health equity across our programs by identifying and promoting policies, programs, and practices that may help eliminate health disparities. We want to better understand individual and community-level burdens, health-related social needs (such as food insecurity and inadequate or unstable housing), and recommended strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

Examples may include, but are not limited to:

- Identifying CMS policies that can be used to advance health equity:
 - Recommendations for CMS focus areas to address health disparities and advance health equity, particularly policy and program requirements that may impose challenges to the individuals CMS serves and those who assist with delivering healthcare services;
 - Recommendations on how CMS can better promote and support accommodations, including those from providers and health plans, for people with disabilities and/or language needs or preferences;
 - Input on how CMS might encourage mitigating potential bias in technologies or clinical tools that rely on algorithms, and how to determine that the necessary steps have been taken to mitigate bias. For example, input on how we might mitigate potential bias with clinical tools that have included race and ethnicity, sex/gender, or other relevant factors. Further, input on potential policies to prevent and/or mitigate potential bias in technology, treatments or clinical tools that rely on clinical algorithms.
 - Input on how CMS coverage and payment policies impact providers, suppliers, and patients, especially in the treatment of chronic conditions and the delivery of substance use disorder and mental healthcare, including individuals who are dually eligible for Medicare and Medicaid; and
 - Feedback on enrollment and eligibility processes, including experiences with enrollment and opportunities to communicate with eligible but unenrolled populations.

Answer Here

Racial Disparities in Accessing Guideline Concordant Care: Myriad independent studies have found adherence to NCCN Guidelines improves care delivery and outcomes for patients with cancer. Improved health outcomes proven through concordance with NCCN Guidelines include:

improved rates of survival for colon cancer, ovarian cancer, gastric cancer, nasopharyngeal cancer, and pancreatic cancer; decreased locoregional recurrence of melanoma; and improved pain control.^{10,11,12,13,14,15} Despite this evidence, racial disparities in accessing guideline concordant cancer care persist. A wide body of research has found that cancer care for Black patients is dramatically more likely to diverge from recommended treatment guidelines compared with care for white patients.^{16, 17, 18,19} Despite some progress in recent years, Black Americans in the United States still have the highest death rate and lowest survival rate of any racial or ethnic group for most cancers.²⁰

The root causes of racial disparities in access to guideline adherent cancer care are complex and multifactorial and are not rooted in biology. Contributing factors to racial disparities in care delivery include implicit and explicit bias in care delivery, lack of representation of people of color in the oncology workforce, and homogenous research populations that are not representative of the larger community. Systemic barriers include lack of insurance and under-insurance, costs of cancer treatment and associated costs of care, and disparate access to clinical trials.

Increasing and Diversifying Pool of Available Providers: CMS can support states in increasing and diversifying the pool of available providers for Medicaid and CHIP by working with organizations and institutions that educate underrepresented communities and support racial representation in cancer research. CMS should encourage the cultivation of working relationships with Historically Black Colleges and Universities (HBCUs), Hispanic-Serving Institutions (HSIs), Tribal Colleges and Universities (TCUs), and other Minority Serving Institutions (MSIs). CMS and Medicaid providers should also work with racial equity organizations, professional societies, or other federal agencies to further increase and diversify the pool of available providers. The ECE Working Group referenced above recommends that Congress should allocate “funds to Historically Black Colleges and Universities (HBCUs), tribal colleges, and other minority institutions (MSIs) because they excel at

10 Foster, et al., *Annals of Surgical Oncology* 2008 15:2395-2402; doi: 10.1245/s10434-008-0021-0

<https://www.ncbi.nlm.nih.gov/pubmed/18600380>

11 Visser, et al., *Journal of International Hepato-Pancreato-Biliary Association* 2012 14(8): 539-547; doi: 10.1111/j.1477-2574.2012.00496.x <https://www.ncbi.nlm.nih.gov/pubmed/22762402>

12 Bristow, et al., *Journal of the National Cancer Institute* 2013 105(11):823-832; doi: 10.1093/jnci/djt065 <https://www.ncbi.nlm.nih.gov/pubmed/23539755>

13 Bristow, et al., *Gynecologic Oncology* 2014 132(2):403-410; doi: 10.1016/j.ygyno.2013.12.017 <https://www.ncbi.nlm.nih.gov/pubmed/24361578>

14 Mearis, M, Shega, JW, and Knoebel, RW *Journal of Pain and Symptom Management* 2013 48(3) 451-458; doi: 10.1016/j.jpainsymman.2013.09.016 <https://www.ncbi.nlm.nih.gov/pubmed/24439844>

15 Schwam et al., *Clinical Oncology* 2016 28(6):402-409; doi: 10.1016/j.jpainsymman <https://www.ncbi.nlm.nih.gov/pubmed/26868285>

¹⁶ Bristow, RE, Powell, MA Al-Hammadi, N., et al. Disparities in Ovarian Cancer Care Quality and Survival According to Race and Socioeconomic Status, *JNCI: Journal of the National Cancer Institute*, Volume 105, Issue 11, 5 June 2013, Pages 823–832, <https://doi.org/10.1093/jnci/djt065>

¹⁷ Fang P, He W, Gomez D, et al. Racial disparities in guideline-concordant cancer care and mortality in the United States. *Adv Radiat Oncol*. 2018;3(3):221-229. Published 2018 May 4. doi:10.1016/j.adro.2018.04.013

¹⁸ Ubbaonu, C., Chang, J. Ziogas, A., et al. (2020). Disparities in the receipt of National Comprehensive Cancer Network (NCCN) guideline adherent care in triple-negative breast cancer (TNBC) by race/ethnicity, socioeconomic status, and insurance type. *Journal of Clinical Oncology*. 38. 1080-1080. 10.1200/JCO.2020.38.15_suppl.1080.

¹⁹ Blom EF, Ten Haaf K, Arenberg DA, de Koning HJ. Disparities in Receiving Guideline-Concordant Treatment for Lung Cancer in the United States. *Ann Am Thorac Soc*. 2020;17(2):186-194. doi:10.1513/AnnalsATS.201901-094OC

²⁰ DeSantis, C.E., Miller, K.D., Goding Sauer, A., Jemal, A. and Siegel, R.L. (2019), Cancer statistics for African Americans, 2019. *CA A Cancer J Clin*, 69: 211-233. doi:[10.3322/caac.21555](https://doi.org/10.3322/caac.21555)

care, practice, education, and community engagement.” The working group’s recommendation applies specifically to Congress, but NCCN also supports partnerships that can lead to investing in, expanding, and diversifying the available pool of Medicaid providers.

Community-based Organizations: NCCN also notes the important role that community-based organizations, particularly those that are minority-led and operated, can play within Medicaid to expand access to underserved communities. Community-based organizations hold a wealth of knowledge and significant expertise in community engagement and understanding of community needs. Unfortunately, community-based organizations are a significantly underutilized resource within our health care and health research systems. The ECE Working Group’s development of the Health Equity Report Card includes recommendations on how CMS might address better utilization of community-based resources.

Recommendations for how CMS can promote efficiency and advance health equity through our policies and programs → [Answer here](#)

Racial Disparities in Accessing Guideline Concordant Care: The layered nature of the problem demands a comprehensive and multi-pronged solution. To begin to address these issues, NCCN, in conjunction with the American Cancer Society Cancer Action Network and the National Minority Quality Forum, convened the Elevating Cancer Equity (ECE) initiative. This initiative aims to go beyond the exploration of causes and to identify and promote actionable solutions through the combined experience and expertise of racial and ethnic minority patients and caregivers. A multi-stakeholder expert working group was charged with developing actionable policy and practice change recommendations. The working group included physicians, patients, caregivers, researchers, and industry representatives and included representatives from racially and ethnically diverse communities.

The ECE Working Group developed seventeen practice change recommendations in the form of the “Equity Report Card” for use by payers, accreditation entities, and providers seeking to advance equitable care practices, sixteen policy change recommendations for federal agencies, federal and state lawmakers, and payers, and three recommendations for clinical practice guideline organizations. The Health Equity Report Card is currently being piloted in academic centers and there will be a pilot launched in community settings in 2023. The recommendations in the Equity Report Card can be found here: https://www.nccn.org/docs/default-source/oncology-policy-program/2021_recommendations_for_elevating_cancer_equity.pdf?sfvrsn=5d2c0d84_2

Community-based Organizations: The ECE working group recommends that payers should include reimbursement for patient navigators, community health workers, care coordination, and connection to social support services. People in roles like navigators and community health workers can help to not only improve enrollment and retention in these programs but can also help beneficiaries access additional needed services. Medicaid can play a role in supporting the uptake of culturally and linguistically reflective patient navigators.