

Questions included in the Request for Information: Access to Coverage and Care in Medicaid & CHIP

February 2022

Objective 2. Redeterminations

Objective 2: Medicaid and CHIP beneficiaries experience consistent coverage. *CMS is seeking input on strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs. These strategies are particularly important during and immediately after the COVID-19 Public Health Emergency (PHE) and can include opportunities that promote beneficiaries' awareness of requirements to renew their coverage as well as states' eligibility assessment processes, which can facilitate coverage continuity and smooth transitions between eligibility categories or programs (e.g., students eligible for school-based Medicaid services are assessed for Supplemental Security Income (SSI)/Medicaid eligibility at age 18, or youth formerly in foster care are assessed for other Medicaid eligibility after age 26).*

3. What actions could CMS take to promote continuity of coverage for **beneficiaries transitioning** between Medicaid, CHIP, and other insurance affordability programs; between different types of Medicaid and CHIP services/benefits packages; or to a dual Medicaid-Medicare eligibility status? For example, how can CMS promote coverage continuity for beneficiaries moving between eligibility groups (e.g., a child receiving Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] qualified supports who transitions to other Medicaid services such as home and community-based services [HCBS] at age 21, etc.); between programs (Medicaid, CHIP, Basic Health Program, Medicare, and the Marketplace); or across state boundaries? Which of these actions would you prioritize first?

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. 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 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.

Objective 3. Access—Federal Standards

Objective 3: Whether care is delivered through fee-for-service or managed care, Medicaid and CHIP beneficiaries have access to timely, high-quality, and appropriate care in all payment systems, and this care will be aligned with the beneficiary’s needs as a whole person. *CMS is seeking feedback on how to establish minimum standards or federal “floors” for equitable and timely access to providers and services, such as targets for the number of days it takes to access services. These standards or “floors” would help address differences in how access is defined, regulated, and monitored across delivery systems, value-based payment arrangements, provider type (e.g., behavioral health, pediatric subspecialties, dental, etc.), geography (e.g., by specific state regions and rural versus urban), language needs, and cultural practices.*

1. What would be the most important areas to focus on if CMS **develops minimum standards** for Medicaid and CHIP programs related to access to services? For example, should the areas of focus be at the national level, the state level, or both? How should the standards vary by delivery system, value-based payment arrangements, geography (e.g., sub-state regions and urban/rural/frontier areas), program eligibility (e.g., dual eligibility in Medicaid and Medicare), and provider types or specialties?

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. One of the most important areas CMS could focus on for beneficiaries who are receiving cancer treatment is adherence to NCCN Guidelines® which myriad studies have demonstrated improves outcomes while reducing cost to the system and the patient.

NCCN Guidelines® and Library of Compendia products help ensure access to appropriate care, clinical decision-making, and assessment of quality improvement initiatives. The NCCN Drugs & Biologics Compendium (NCCN Compendium®) has been recognized by CMS and commercial payers setting since 2008 as an evidence-based reference for establishment of coverage policy and coverage decisions regarding off-label use of anticancer and cancer-related medications. Today, NCCN Guidelines are used by payers representing more than 85% of covered lives in the United States. Additionally, NCCN was recognized by CMS in 2016 and renewed in 2021 as a qualified Provider Led Entity (PLE) for the Medicare Appropriate Use Criteria (AUC) Program for the development of AUC and the establishment of policy and decision-making for diagnostic imaging in patients with cancer and NCCN Guidelines are regularly used as a benchmark for quality across value-based care models.

Numerous 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.^{1,2,3,4,5,6} 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 peer-reviewed, published 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. Administrative burden was also reduced through the integration of the decision-making tool as oncologists obtained immediate approvals online for 58 percent of cases without further interaction with the health plan required. Approval was granted for 95 percent of the remaining cases requiring further interaction in less than 24 hours.⁷

Additionally, NCCN Guidelines have been shown to lower healthcare costs caused by overutilization and inappropriate use of services and therapeutics. A recently published study "Guideline Discordance and Patient Cost Responsibility in Medicare Beneficiaries With Metastatic Breast Cancer" by Williams, et.al found median cost for metastatic breast cancer patients receiving guideline-discordant treatment was \$7,421 versus \$5,171 for those receiving guideline-concordant care. This study found an additional \$1,841 in out-of-pocket costs for patients receiving guideline concordant care versus patients who received guidelines-concordant care. Non-adherence to guidelines has also been identified as a key contributor to inequities in

1 Erickson Foster J, Velasco JM, Hieken TJ. Adverse outcomes associated with noncompliance with melanoma treatment guidelines. *Annals of Surgical Oncology*. 2008;15(9):2395-2402. doi:10.1245/s10434-008-0021-0

2 Visser BC, Ma Y, Zak Y, Poultsides GA, Norton JA, Rhoads KF. Failure to comply with NCCN guidelines for the management of pancreatic cancer compromises outcomes. *HPB*. 2012;14(8):539-547. doi:10.1111/j.1477-2574.2012.00496.x

3 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*. 2013;105(11):823-832. doi:10.1093/jnci/djt065

4 Bristow RE, Chang J, Ziogas A, Randall LM, Anton-Culver H. High-volume ovarian cancer care: Survival impact and disparities in access for advanced-stage disease. *Gynecologic Oncology*. 2014;132(2):403-410. doi:10.1016/j.ygyno.2013.12.017

5 Mearis M, Shega JW, Knoebel RW. Does adherence to National Comprehensive Cancer Network guidelines improve pain-related outcomes? An Evaluation of Inpatient Cancer Pain Management at an Academic Medical Center. *Journal of Pain and Symptom Management*. 2014;48(3):451-458. doi:10.1016/j.jpainsymman.2013.09.016

6 Schwam ZG, Sosa JA, Roman S, Judson BL. Receipt of care discordant with practice guidelines is associated with compromised overall survival in nasopharyngeal carcinoma. *Clinical oncology (Royal College of Radiologists (Great Britain))*. <https://www.ncbi.nlm.nih.gov/pubmed/26868285>. Published June 2016.

7. 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

care outcomes across race and ethnicity with some studies finding these disparities greatly reduced or eliminated when guideline adherent care is received.⁸⁹

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 would be happy to meet with CMS to discuss how we can serve as a resource in this area.

⁸ Fang P, He W, Gomez D, Hoffman KE, Smith BD, Giordano SH, Jagsi R, Smith GL. Racial disparities in guideline-concordant cancer care and mortality in the United States. *Adv Radiat Oncol*. 2018 May 4;3(3):221-229. doi: 10.1016/j.adro.2018.04.013. PMID: 30202793; PMCID: PMC6128037.

⁹ 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 Feb;17(2):186-194. doi: 10.1513/AnnalsATS.201901-094OC. PMID: 31672025; PMCID: PMC6993802.

2. How could CMS **monitor states' performance against those minimum standards**? For example, what should be considered in standardized reporting to CMS? How should CMS consider issuing compliance actions to states that do not meet the thresholds, using those standards as benchmarks for quality improvement activities, or recommending those standards to be used in grievance processes for beneficiaries who have difficulty accessing services? In what other ways should CMS consider using those standards? Which of these ways would you prioritize as most important?

As referenced in our response to Objective 3, Question 1, care that adheres to NCCN Guidelines has been proven to result in superior care outcomes while also reducing overall cost to the healthcare system. As such, 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 HER technology utilized throughout the patient care continuum and offers a helpful tool for ensuring quality care within value-based models.

3. How could CMS consider the **concepts of whole person care or care coordination** across physical health, behavioral health, long-term services and supports (LTSS), and health-related social needs when establishing minimum standards for access to services? For example, how can CMS and its partners enhance parity compliance within Medicaid for the provision of behavioral health services, consistent with the Mental Health Parity and Addiction Equity Act? How can CMS support states in providing access to care for pregnant and postpartum women with behavioral health conditions and/or substance use disorders? What are other ways that CMS can promote whole person care and care coordination?

NCCN understands the importance of care planning and coordination when it comes to high quality cancer care. This is only possible when patients are well informed on their treatment options and engaged in a shared decision-making process with their healthcare provider. CMS can promote whole person care and care coordination through supporting and implementing billable patient navigation services. Currently, care coordination is not billable across all state Medicaid plans and, as such, may be financially burdensome to provide, particularly for smaller and lower resourced providers. Employing a billing mechanism 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.

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. Having the appropriate tools 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.

Additionally, NCCN supports the encouragement of 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. The implementation of Medicaid expansion under the Affordable Care Act (ACA) has resulted in insurance coverage for more than 17 million Americans as of 2017.¹⁰ 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%).¹¹ Studies examining

¹⁰ Kaiser Family Foundation. State health facts: Medicaid expansion enrollment. <https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>. Published 2017. Accessed February 7, 2019.

¹¹ 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

rates of breast and cervical cancer screening among low-income adults find similar gains in Medicaid expansion states compared to non-expansion states.¹² 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.¹³ An expansion of these programs could help increase access to cancer screening, early detection and care at a larger scale.

¹² 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

¹³ 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

4. In addition to existing legal obligations, how should CMS address **cultural competency and language preferences** in establishing minimum access standards? What activities have states and other stakeholders found the most meaningful in identifying cultural and language gaps among providers that might impact access to care?

NCCN applauds CMS for considering actions that will address cultural competency and language preferences to ensure equitable access to care. NCCN partnered with the American Cancer Society Cancer Action Network (ACS CAN) and the National Minority Quality Forum (NMQF) to convene the Elevating Cancer Equity (ECE) Working Group in an effort to address racial disparities in cancer care. This initiative aimed to go beyond the exploration of causes to identify and promote actionable solutions through the combined experience and expertise of patients, survivors, caregivers, practitioners, researchers, and manufacturers. The Elevating Cancer Equity (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 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.

5. What are specific ways that CMS can support states to **increase and diversify the pool of available providers** for Medicaid and CHIP (e.g., through encouragement of service delivery via telehealth, encouraging states to explore cross-state licensure of providers, enabling family members to be paid for providing caregiving services, supporting the effective implementation of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, implementing multi-payer value-based purchasing initiatives, etc.)? Which of these ways is the most important?

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

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 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.

Access to a robust provider network is a critical component of high-quality cancer care. NCCN supports network adequacy standards that allow health insurance companies to negotiate appropriate rates with all high quality, high value providers. In addition to access to more community-oriented care and assistance, NCCN would also 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. While encouraging engagement and partnership with organizations and institutions that work with underserved communities is vital, provider networks should also strive to ensure patients on Medicaid can access the high-quality care offered by academic cancer centers.

Objective 4. Access—Federal Standards

Objective 4: CMS has data available to measure, monitor, and support improvement efforts related to access to services (i.e., potential access; realized access; and beneficiary experience with care across states, delivery systems, and populations). CMS is interested in feedback about what new data sources, existing datasources (including Transformed Medicaid Statistical Information System [T-MSIS], Medicaid and CHIP Core Sets, and home and community based services (HCBS) measure set), and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.

2. What **measures of potential access**, also known as care availability, should CMS consider as most important to monitor and encourage states to monitor (e.g., provider networks, availability of service providers such as direct service workers, appointment wait times, grievances and appeals based on the inability to access services, etc.)? How could CMS use data to monitor the **robustness of provider networks across delivery systems** (e.g., counting a provider based on a threshold of unique beneficiaries served, counting providers enrolled in multiple networks, providers taking new patients, etc.)

NCCN supports network adequacy standards that promote robust provider networks across delivery systems. This can be achieved through allowing 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 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.

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.^{14,15,16} Barriers to accessing care at these sites is particularly problematic for patients with rare, complex, or advanced cancers, who would most benefit from comprehensive and multidisciplinary treatment.

In 2014, the Department of Health and Human Services Office of the Inspector General (OIG) conducted a study aiming to evaluate access to care across state Medicaid managed care

¹⁴ 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/cncr.29576.

¹⁵ 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.

¹⁶ 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

programs.¹⁷ The OIG report found wide variability across states in terms of provider to enrollee standards. Further, many states had no provider to enrollee standard for specialty care at all. Anecdotally, NCCN Member Institutions report significant challenges to being included in Medicaid provider networks. Care at academic medical centers has been linked to improved care outcomes so this poses significant equity issues in terms of patient access. NCCN encourages CMS to pursue more standardized and transparent network adequacy standards across state Medicaid fee-for-service and managed care plans to ensure patient access to high-quality care. NCCN appreciates CMS' examination of mechanisms to improve network adequacy in Medicaid and CHIP. We encourage CMS to consider adding NCI-designated cancer centers and tertiary/quaternary referral centers to required provider lists as these facilities are central to quality care.

¹⁷ Department of Health and Human Services Office of the Inspector General. (2014) State standards for access to care in Medicaid managed care. Accessed from: <https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>

Objective 5. Access—Provider Rates & Provider Burden

Objective 5: Payment rates in Medicaid and CHIP are sufficient to enlist and retain enough providers so that services are accessible. *Section 1902(a)(30)(A) of the Social Security Act (the “Act”) requires that Medicaid state plans “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” Section 1932 of the Act includes additional provisions related to managed care. Section 2101(a) of the Act requires that child health assistance be provided by States “in an effective and efficient manner....” CMS is interested in leveraging existing and new access standards to assure Medicaid and CHIP payments are sufficient to enlist enough providers to ensure that beneficiaries have adequate access to services that is comparable to the general population within the same geographic area and comparable across Medicaid and CHIP beneficiary groups, delivery systems, and programs. CMS also wants to address provider types with historically low participation rates in Medicaid and CHIP programs (e.g., behavioral health, dental, etc.). In addition, CMS is interested in non-financial policies that could help reduce provider burden and promote provider participation.*

2. How can CMS assess the effect of state payment policies and contracting arrangements that are unique to the Medicaid program on access and encourage payment policies and contracting arrangements that could have a positive impact on access within or across state geographic regions?

One area of focus that CMS can address to have a more positive impact on access within or across state geographic regions is relieving the difficulty that transportation poses. 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.¹⁸ NCCN Members report that transportation when serving out of state Medicaid patients is typically limited in scope; payment systems only allow a patient be transferred from a lower care setting to a higher one, thus barring transfers back to a lower care setting or to their home state for continued treatment. This is a particular concern for Medicaid beneficiaries residing in rural areas across the country and for patients with rare, advanced, or complex cancers that require care at a specialized high-quality academic cancer center. 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.

¹⁸ Guidry JJ, Aday LA, Zhang D, Winn RJ. Transportation as a barrier to cancer treatment. *Cancer Pract.* 1997;5(6):361-366.

4. Some research suggests that, in addition to payment levels, administrative burdens that affect payment, such as claims denials and provider enrollment/credentialing, can discourage provider acceptance of Medicaid beneficiaries. What actions could CMS take to encourage states to **reduce unnecessary administrative burdens that discourage provider participation in Medicaid and CHIP** while balancing the need for program integrity? Which actions would you prioritize first? Are there lessons that CMS and states can learn from changes in provider enrollment processes stemming from the COVID-19 Public Health Emergency?

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. Reducing these burdens can encourage more provider participation, leading to more robust networks and thus leading to more access for beneficiaries of these programs. It is common for Medicaid patients to face difficulties in finding physicians that are willing to treat them.¹⁹ 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 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.

NCCN Member Institutions, leading academic medical 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 and negatively impact care outcomes. 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.

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 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 ensure 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

¹⁹ Dunn A, Gottlieb J, Shapiro A, Sonnenstuhl D, Tebaldi P. A denial a day keeps the doctor away. 2021. doi:10.3386/w29010

remaining requests were approved within 24 hours.²⁰ (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.

²⁰ Newcomer LN, Weinger R, Carlson RW. Transforming prior authorization to decision support. *Journal of Oncology Practice*. 2017;13(1). doi:10.1200/jop.2016.015198