



National Comprehensive  
Cancer Network®

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**NCCN Member Institutions**

- Abramson Cancer Center  
at the University of Pennsylvania
- Fred & Pamela Buffett  
Cancer Center
- Case Comprehensive Cancer  
Center/University Hospitals  
Seidman Cancer Center and  
Cleveland Clinic Taussig  
Cancer Institute
- City of Hope National Medical Center
- Dana-Farber/Brigham and  
Women's Cancer Center  
Massachusetts General Hospital  
Cancer Center
- Duke Cancer Institute
- Fox Chase Cancer Center
- Huntsman Cancer Institute  
at the University of Utah
- Fred Hutchinson Cancer  
Research Center/  
Seattle Cancer Care Alliance
- The Sidney Kimmel  
Comprehensive Cancer  
Center at Johns Hopkins
- Robert H. Lurie Comprehensive  
Cancer Center of Northwestern  
University
- Mayo Clinic Cancer Center
- Memorial Sloan Kettering  
Cancer Center
- Moffitt Cancer Center
- The Ohio State University  
Comprehensive Cancer Center -  
James Cancer Hospital and  
Solove Research Institute
- O'Neal Comprehensive  
Cancer Center at UAB
- Roswell Park Comprehensive  
Cancer Center
- Siteman Cancer Center  
at Barnes Jewish Hospital  
and Washington University  
School of Medicine
- St. Jude Children's  
Research Hospital/  
The University of Tennessee  
Health Science Center
- Stanford Cancer Institute
- UC San Diego  
Moore's Cancer Center
- UCSF Helen Diller Family  
Comprehensive Cancer Center
- University of Colorado  
Cancer Center
- University of Michigan  
Rogel Cancer Center
- The University of Texas  
MD Anderson Cancer Center
- University of Wisconsin  
Carbone Cancer Center
- Vanderbilt-Ingram  
Cancer Center
- Yale Cancer Center/  
Smilow Cancer Hospital

February 28, 2020

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

RE: HHS Notice of Benefit and Payment Parameters for 2021

Dear Administrator Verma:

The National Comprehensive Cancer Network® (NCCN®) is pleased to comment on the US Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters (NBPP) for 2021 as it relates to NCCN's mission to improve and facilitate quality, effective, efficient, and accessible cancer care. NCCN appreciates the opportunity to respond and will focus our comments on how NCCN content may be used as a tool for enhancing value-based insurance design (V-BID) as well as how the proposal to change auto-enrollment for beneficiaries receiving Advanced Premium Tax Credits (APTC) may impact exchange enrollees with cancer.

**NCCN Background**

As an alliance of 28 leading academic cancer centers in the United States that treat hundreds of thousands of patients with cancer annually, NCCN is a 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.

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 clinical professionals in the commercial payer 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. NCCN was recognized by CMS in 2016 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

NCCN imposes strict policies to shield the guidelines development processes from inappropriate external influences. The “firewall” surrounding the NCCN Guidelines processes includes: financial support policies; panel participation and communication policies; guidelines disclosure policies; and policies regarding relationships to NCCN’s other business development activities. The guidelines development is supported exclusively by the Member Institutions’ dues and does not accept any form of industry or other external financial support for the guidelines development program. The NCCN Guidelines are updated at least annually in an evidence-based process integrated with the expert judgment of multidisciplinary panels of expert physicians from NCCN Member Institutions. The NCCN Guidelines are transparent, continuously updated, available free of charge online for non-commercial use, and available through a multitude of HIT vendors.

#### **Promoting Value-based Insurance Design (V-BID)**

In the proposed rule, HHS seeks to promote the development of value-based insurance design (V-BID) by Qualified Health Plan (QHP) issuers. CMS specifically encourages QHP issuers within the Federally-Facilitated Marketplace (FFM) and State-Based Exchanges (SBE) to improve value by creating cost effective drug tiering structures; dis-incentivizing overutilization of higher cost health services; and incentivizing enrollees to use higher quality, lower cost, care when medically appropriate. HHS solicits comment on minimum standards that HHS could adopt as principles for determining what constitutes a value-based plan, as well as obstacles to implementation.

NCCN appreciates HHS’ support for the development of value-based insurance plans. As an organization dedicated to improving and facilitating quality, effective, efficient, and accessible cancer care so patients can live better lives, we firmly believe in the role V-BID plays to ensure appropriate access and use of cancer care services and therapies. Within the Proposed NBPP, HHS outlines what are considered High Value Services, High Value Generic and Brand Drug Classes, Low Value Services, and Commonly Overused services. HHS includes a recommendation to issuers to offer higher value services and drugs at zero or reduced cost-sharing to enrollees and low value and commonly overused services at increased cost-sharing to enrollees.

NCCN supports the advancement of value models to ensure patients have access to high-quality, high-value care. However, a key component of value is safeguarding quality. NCCN notes that when HHS lists “commonly overused services” including outpatient specialist services, outpatient labs, outpatient surgery, and imaging services, the question should not be how often the service is being used, but how often it is being

inappropriately used. In fact, services like outpatient surgical procedures may frequently save money and be the most appropriate level of care for the patient. Offering these services at higher-cost sharing without accounting for the clinical appropriateness of the care may hinder patient access to quality care.

Clinical practice guidelines can be used to ensure the quality and appropriateness of care delivered within V-BID. An excellent example of guidelines being used to safeguard quality while reducing waste is the Appropriate Use Criteria program established under the Protecting Access to Medicare Act (PAMA) of 2014. As noted above, NCCN is a PLE under AUC and supports programs that use guideline concordance to ensure quality while reducing waste and inappropriate care.

NCCN strongly encourages HHS to include adherence to nationally recognized, continuously updated, clinical practice guidelines as a minimum standard issuers should embrace in V-BID. Numerous independent studies have proven that adherence to NCCN Guideline concordant care improves care delivery and outcomes for patients. Impacts proven through concordance with our 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.<sup>1,2,3,4,5,6</sup> These studies underscore the importance of guideline adherence as a baseline to ensure patient access to appropriate clinical care.

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. Furthermore, guidelines presence within Center for Medicare & Medicaid Innovation (CMMI) value-based models like the Oncology Care Model (OCM) Model and Oncology Care First (OCF)

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1 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>

2 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>

3 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>

4 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>

5 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>

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

model support their ability to improve efficiency of care, affordability of care, and appropriateness for V-BID.

### **Auto Re-enrollment for Beneficiaries Receiving Advanced Premium Tax Credits**

Consistent with broader industry practice, FFM and SBE enrollees are automatically re-enrolled in the same plan as the previous plan year if they take no action. In the proposed rule, CMS seeks to modify automatic re-enrollment processes for enrollees with APTCs that cover the enrollee's entire premium. Specifically, CMS proposes to:

- (1) Remove all APTC's from beneficiaries with a zeroed APTC from the previous plan year if they do not return to the exchanges to update their eligibility determination; or,
- (2) Significantly reduce the amount of APTC's for beneficiaries with a zeroed APTC from the previous plan year if they do not return to the exchanges to update their eligibility determination.

CMS solicits comment on both variations of modifying automatic re-enrollment processes for consumers with zero-dollar plans after APTCs are applied.

NCCN has significant concern about the impact of modifications to automatic re-enrollment processes on cancer patients, survivors, and beneficiaries who may develop cancer or benefit from screening and prevention services. As HHS notes within the proposed rule "*Automatic re-enrollment significantly reduces issuer administrative expenses, makes enrolling in health insurance more convenient for the consumer, and is consistent with general health insurance industry practice*". Additionally, CMS notes within the proposed NBPP that automatic enrollment generally supports participation in the exchanges by healthier beneficiaries as these individuals would arguably be the least likely to proactively re-enroll. The elimination of automatic re-enrollment for these individuals will increase administrative costs and likely reduce the number of healthy enrollees within the risk pools for exchange plans.

HHS notes that under the proposed plans, if enrollees fail to pay a premium, their coverage would be terminated. HHS does not clearly outline plans and apportioned resources to educate and inform these enrollees, to assist them with additional paperwork processes, or processes for appeal or recourse upon improper termination. NCCN has concern about the impact of these proposals on patient access to cancer care. This proposal increases issuer and enrollee paperwork burden and will likely decrease coverage, particularly among healthy enrollees. As such, NCCN urges CMS not to finalize the proposal to modify automatic re-enrollment processes for enrollees receiving APTC that covers their entire premium.

NCCN appreciates the opportunity to comment on the impact of the proposed HHS Notice of Benefit and Payment Parameters for 2021 on Americans with cancer. We welcome the opportunity to discuss our comments further and look forward to working together to ensure timely access to high-quality cancer care.

Sincerely,



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