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June 28, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20001

Submitted Electronically at www.regulations.gov

Re: Medicaid Program; Medicaid and Children's Health Insurance Program
(CHIP) Managed Care Access, Finance, and Quality (CMS–2439–P)

Dear Administrator Brooks-LaSure,

I am pleased to submit these comments on behalf of the Association for Clinical
Oncology (ASCO) in response to the Managed Care Access, Finance, and Quality
proposed rule (CMS–2439–P) that was published in the Federal Register on
May 3, 2023.

ASCO is a national organization representing more than 45,000 physicians and
other health care professionals specializing in cancer treatment, diagnosis, and
prevention. We are also dedicated to conducting research that leads to
improved patient outcomes, and we are committed to ensuring that evidence-
based practices for the prevention, diagnosis, and treatment of cancer are
available to all Americans.

We are pleased to offer our comments below.

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Implement Access Remedy Plans

The proposed rule would require states to develop a remedy plan to address an
identified access issue with specific steps, timelines for implementation and
completion, and responsible parties. When CMS, the state, or the managed
care plan identifies an area in which access to care could be improved, the
proposed rule would require the state to submit the remedy plan to CMS no
later than 90 calendar days following the date that the State becomes aware of
a plan's potential access violation. In that plan, the State would have to identify
specific steps to compliance, timelines for implementation and completion, and
responsible parties to address the identified issue within 12 months.

**ASCO supports CMS' proposal to require states to address all Medicaid and
CHIP access issues in a timely and effective manner. We urge CMS to require**

States to address the following issues that can prevent timely access to services within the Medicaid program.

Prior Authorization

To address access concerns and to encourage clinician participation in the Medicaid program ASCO urges CMS to address prior authorization. Prior authorization programs are having a detrimental impact on oncology care. They can lead to delays in starting physician-recommended treatment leading to detrimental outcomes for cancer patients; treatment changes or abandonment; unexpected out of pocket costs; and rejection of physician-recommended treatment. Additionally, physicians have identified prior authorization requirements as a primary factor leading to physician burden and burnout, which is a growing concern as the nation faces mounting oncology workforce challenges.

Prolonged prior authorization waiting periods can lead to significant barriers to care by delaying clinical trial enrollment and initiation of treatment, regardless of whether the treatment takes place as part of the study. Cancer patients, especially those in stage IV, are exceptionally vulnerable and they may not be able to wait for prolonged periods to access treatment whether through a trial or not. Additionally, clinical trials can fill up while a patient is waiting for a response from the insurer thus eliminating, in some cases, a patient's only option for treatment. Prior authorization is consistently identified as the largest barrier to care for insured patients. The administrative burdens associated with prior authorization contribute to major delays and denials of necessary, appropriate—in many cases, lifesaving—care.

For additional information, please read our affiliate The Society's, Position Statement on Prior Authorization, which can be found [here](#).¹ According to this Statement, ASCO provides the following recommendations that Regulatory Agencies should:

- **Monitor and remedy the predictable, adverse consequences that individuals with cancer may experience from barriers or delays in receiving preferred oncology therapies as a result of prior authorization requirements, including suboptimal clinical outcomes, increases in adverse events, increases in emergency department visits, and disparities in treatment or outcomes.**
- **For patients enrolling in a new health plan, prohibit mandatory substitution or interruptions in treatment that is already underway.**
- **Require payers to improve transparency by mandating payers to report to CMS and the public on the extent to which they use prior authorization by disclosing the process by which they evaluate and determine prior authorization and hold payers accountable for the timeliness of determinations.**

¹ <https://old-prod.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2022-PA-Statement-FINAL.pdf>

- **Require payers to ensure that during “peer-to-peer” discussions or other discussions of clinical circumstances, the treating oncologist has direct access to an oncologist employed by or otherwise authorized by the payer to make prior authorization determinations in cancer care.**
- **Establish efficient and responsive appeals processes, including 48-hour completion of review/decision on appeals for oncology and expedited review for patients whose clinical circumstances require urgent treatment.**
- **Develop and implement a provider complaint portal to report and monitor payer practices that negatively impact patients.**

Provider Payment

As CMS acknowledges in the “Ensuring Access to Medicaid” proposed rule that insufficient Medicaid provider payments jeopardize Medicaid beneficiary access to care, and we reiterate our comments to the Agency in this letter. The Kaiser Family Foundation published a report in 2019 on the Medicaid-to-Medicare fee index. The Medicaid-to-Medicare fee index measures the Medicaid physician fees relative to Medicare fees of each state. Fee indexes for all services range from a low of 0.37 in Rhode Island to a high of 1.18 in Delaware.² A 2019 study found that physicians in states that pay above the median Medicaid-to-Medicare fee ratio accepted new Medicaid patients at higher rates than those in states that pay below the median³ which would put more than 1/3 of state’s beneficiaries at risk of decreased access to services.

A physician survey found that only 72% of specialty physicians accepted new Medicaid patients, compared with 91% who accepted new Medicare patients.⁴ The lack of participating physicians leaves many patients scrambling to find a physician or obtaining their care in emergency departments. This is especially problematic for patients with cancer because delay in treatment may have life-threatening consequences. Expanding the number of community-based oncologists who accept Medicaid patients would not only improve access but also increase patient choice and autonomy. **To this end, we support a payment model that increases Medicaid payment rates to equal those for Medicare while providing incentives to address meaningful quality metrics specific to patients with cancer⁵.**

² <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22All%20Services%22,%22sort%22:%22asc%22%7D>

³ Physician Acceptance Of New Medicaid Patients: What Matters And What Doesn’t”, Health Affairs Blog, April 10, 2019. DOI: 10.1377/hblog20190401.678690

⁴ Decker SL: In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help. Health Aff (Millwood) 31:1673-1679, 2012

⁵ Polite, Blase N., et al. "American Society of Clinical Oncology policy statement on Medicaid reform." Journal of Clinical Oncology 32.36 (2014): 4162.

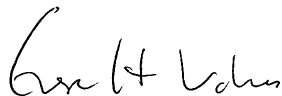
Network Adequacy

Cancer patients and survivors are a particularly vulnerable subset of the population. They require timely access to cancer specialists, facilities, and supportive care. Narrowed networks^{6,7} are linked to delays in cancer care, delays that adversely affect cancer control and survival.⁸ Network adequacy standards should promote access based on specific patient needs, availability of care and providers, and appropriate utilization of services. The inclusion of oncology specialties network standards may better assure cancer patients and survivors have meaningful access to medically necessary cancer care services in a timely manner.

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We appreciate the opportunity to comment on the proposed rule. Please contact Gina Hoxie (gina.hoxie@asco.org) with any questions or for further information.

Sincerely,



Everett Vokes, MD, FASCO
Chair of the Board
Association for Clinical Oncology

⁶ Wharam JF, Zhang F, Lu CY, et al: Breast cancer diagnosis and treatment after high-deductible insurance enrollment. *J Clin Oncol* 36:1121-1127, 2018

⁷ Wharam JF, Zhang F, Wallace J, et al: Vulnerable and less vulnerable women in high-deductible health plans experienced delayed breast cancer care. *Health Aff (Millwood)* 38:408-415, 2019

⁸ Eriksson L, Bergh J, Humphreys K, et al: Time from breast cancer diagnosis to therapeutic surgery and breast cancer prognosis: A population-based cohort study. *Int J Cancer* 143:1093-1104, 2018