

## American Cancer Society Cancer Action Network

### Comments Submitted to the Centers for Medicare & Medicaid Services regarding its 2022 Request for Information on Access to Coverage and Care in Medicaid & CHIP

Submitted via URL: [https://cmsmedicaidaccessrfi.gov1.qualtrics.com/jfe/form/SV\\_6EYj9eLS9b74Npk](https://cmsmedicaidaccessrfi.gov1.qualtrics.com/jfe/form/SV_6EYj9eLS9b74Npk)

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Following is the text of the RFI survey, with ACS CAN responses to questions where indicated. Note that ACS CAN did not respond to every question in the survey, and questions to which we did not respond have been omitted below.

#### Objective 1 of 5

**Objective 1: Medicaid and CHIP reaches people who are eligible and who can benefit from such coverage.** CMS is interested in identifying strategies to ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and how to apply for and retain coverage. Eligible individuals should be able to apply, enroll in, and receive benefits in a timely and streamlined manner that promotes equitable coverage.

**1. What are the specific ways that CMS can support states in achieving timely eligibility determination and timely enrollment for both modified adjusted gross income (MAGI) and non-MAGI based eligibility determinations? In your response, consider both eligibility determinations and redeterminations for Medicaid and CHIP coverage, and enrollment in a managed care plan when applicable.**

American Cancer Society Cancer Action Network Response:

This is an important area of focus for CMS, as Medicaid enrollees in certain states are experiencing firsthand how the eligibility determination and enrollment processes can fail – and how patients can be left without coverage as a result. We are particularly concerned about the current state of enrollment in Missouri, which recently expanded Medicaid. It has been reported (see [https://www.stltoday.com/lifestyles/health-med-fit/health/patients-perilous-months-long-waiting-for-medicaid-coverage-is-a-sign-of-what-s-to-come/article\\_70b0e887-8a34-5972-ad4e-b98025559d8e.html](https://www.stltoday.com/lifestyles/health-med-fit/health/patients-perilous-months-long-waiting-for-medicaid-coverage-is-a-sign-of-what-s-to-come/article_70b0e887-8a34-5972-ad4e-b98025559d8e.html)) that applications are taking an average of 119 days to process – much longer than the 45 days federal law allows. Not only does this situation leave Missouri Medicaid out of compliance with federal law, but more importantly it leaves patients who are eligible for coverage functionally uninsured and without access to care. Research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive (<https://acsjournals.onlinelibrary.wiley.com/doi/10.3322/CA.2007.0011>). We are concerned these problems with delayed processing and enrollment could happen – or are happening – in other states and preventing eligible enrollees from receiving care.

CMS should consider pandemic-era eligibility policies that have worked well and make these policies permanent through regulatory or administrative action, or if statutory authority is needed, work with Congress to make them permanent.

These policies include:

- Reduced need for interviews and in-person meetings;
- Self-attestations of income;
- Establishing Express Lane Eligibility pathways; and
- Increasing enrollment opportunities via telephone, online applications, or mobile-friendly formatting.

We also encourage CMS to closely evaluate states that currently waive presumptive eligibility and retroactive coverage provisions, and to consider revoking these waivers and not approving additional requests (see more information here: <https://www.urban.org/research/publication/section-1115-waivers-retroactive-medicaid-eligibility>). Presumptive eligibility and retroactive coverage provisions are an important way to facilitate timely enrollment, as well as to lessen the impact of medical debt in low-income populations. ACS CAN recently conducted a survey of cancer survivors that showed that roughly half (51%) of patients surveyed say they have incurred cancer-related medical debt, the majority of whom (53%) report having their debt go into collections, and 46% of whom say the debt has negatively impacted their credit (see more here: [https://www.fightcancer.org/sites/default/files/national\\_documents/survivor\\_views\\_cancer\\_debt\\_0.pdf](https://www.fightcancer.org/sites/default/files/national_documents/survivor_views_cancer_debt_0.pdf)).

**2. What additional capabilities do states need to improve timeliness for determinations and enrollment or eligibility processes, such as enhanced system capabilities, modified staffing arrangements, tools for monitoring waiting lists, or data-sharing across systems to identify and facilitate enrollment for eligible individuals? Which of these capabilities is most important? How can CMS help states improve these capabilities?**

American Cancer Society Cancer Action Network Response:

CMS should do all it can to encourage and facilitate information sharing between various systems so that as much enrollee data as possible can be confirmed via existing databases/data sources. This contributes to a smoother enrollment and eligibility re-determination process, and reduces the burden on the enrollee. One example of this is the current new state plan option to automatically renew Medicaid eligibility for beneficiaries under age 65 who receive assistance from the Supplemental Nutrition Assistance Program (SNAP) (see more info here: [https://familiesusa.org/wp-content/uploads/2022/03/MCD-2022-48\\_SNAP-Issue-Brief\\_final.pdf](https://familiesusa.org/wp-content/uploads/2022/03/MCD-2022-48_SNAP-Issue-Brief_final.pdf)). We encourage CMS to explore more streamlined policies like this (working with Congress as necessary).

**4. What key indicators of enrollment in coverage should CMS consider monitoring? For example, how can CMS use indicators to monitor eligibility determination denial rates and the reasons for denial? Which indicators are more or less readily available based on existing data and systems? Which indicators would you prioritize?**

American Cancer Society Cancer Action Network Response:

To identify and rectify concerns about delays in processing and enrollment like the current problems in Missouri, CMS should collect and publicly track several key data points from all states, including:

- Demographic data on enrollment, including race/ethnicity/language, sexual orientation and gender information;

- Total number of pending applications/renewals;
- Number of renewals determined ex parte;
- Number of applications renewed using a pre-populated form;
- Number of applications/renewals found ineligible;
- Number of applications terminated for procedural reasons; and
- Number of fair hearings pending more than 90 days.

These data should be reported both throughout and after the unwinding of the COVID-19 public health emergency (PHE) continuous eligibility period. As part of this effort, CMS should also adopt standardized reason codes for procedural denials and disenrollment so CMS and other stakeholders can identify problem states or areas, increase oversight, and take action when a state has a high rate of procedural disenrollments.

## Objective 2 of 5

**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).

**1. How should states monitor eligibility redeterminations, and what is needed to improve the process? How could CMS partner with states to identify possible improvements, such as leveraging managed care or enrollment broker organizations, state health insurance assistance programs, and Marketplace navigators and assisters to ensure that beneficiary information is correct and that beneficiaries are enabled to respond to requests for information as a part of the eligibility redetermination process, when necessary? How could CMS encourage states to adopt existing policy options that improve beneficiary eligibility redeterminations and promote continuity of coverage, such as express lane eligibility and 12-month continuous eligibility for children?**

American Cancer Society Cancer Action Network Response:

As the Public Health Emergency (PHE) ends and states return to regular rules for determining and reassessing eligibility, many beneficiaries will face coverage disruptions due to the requirement that beneficiaries report income changes and to states' periodic data checks (42 CFR 435.916(c) and (d)). In January 2019, 28 states reported conducting data matches between annual redeterminations (see [https://www.kff.org/report-section/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage-issue-brief-9351-update/#endnote\\_link\\_436890-17](https://www.kff.org/report-section/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage-issue-brief-9351-update/#endnote_link_436890-17)). Because low-income families' income often varies from month to month, these policies can cause unnecessary and counterproductive disruptions in coverage, interrupting care such as courses of treatment for cancer

patients, and disincentivizing work. States that conduct frequent periodic data checks may be erroneously disenrolling beneficiaries who are not able to respond to or fulfill requests for information in the limited timeframe they are given. This can be particularly hard for cancer patients in active treatment – many of whom cannot check their mail frequently because the demands of treatment may prove too onerous for individuals to then travel to a post office box for mail or because patients may be temporarily staying with friends or family who can provide care while the individual undergoes treatment. We encourage CMS to do what it can to discourage such use of data matching between annual redetermination cycles, as it wastes precious resources and contributes to churn that harms patient access to care.

Many enrollees who have lost coverage due to these policies will re-enroll in a relatively short period of time, creating unnecessary burden for beneficiaries, states, plans and providers. For a cancer patient in active treatment, even the threat of being uninsured while their application is being reviewed is a huge stressor, as having a lapse in coverage could interrupt their treatment and cause their cancer to advance. The share of beneficiaries affected by unnecessary churning is growing (prior to implementation of the PHE continuous-coverage requirement for Medicaid enrollees, which is expected to expire later this year). MACPAC found that approximately 8 percent of Medicaid and CHIP beneficiaries disenrolled and reenrolled within a year, “higher than MACPAC’s previous estimates.” (<https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf>)

By implementing 12-month continuous eligibility, state Medicaid and CHIP programs can ignore monthly fluctuations in income and use those administrative resources for other activities. According to RAND, 12-month continuous-eligibility policies reduce coverage losses and improve health outcomes at a modest cost increase (<https://www.rand.org/blog/2021/12/twelve-month-continuous-eligibility-for-medicaid-adults.html>). MACPAC also found “beneficiaries in states with 12-month continuous eligibility and states that do not conduct midyear data checks for changes in circumstances were more likely to be enrolled in coverage for at least 12 months and were less likely to experience churn.” (<https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf>)

Currently, a state-plan option exists for states to implement 12-month continuous eligibility for children in Medicaid and CHIP, which has been implemented by 24 states (see <https://www.kff.org/health-reform/state-indicator/state-adoption-of-12-month-continuous-eligibility-for-childrens-medicaid-and-chip/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>). No state-plan option exists to implement 12-month continuous eligibility for adults; however, two states (Montana and New York) have instituted it using Section 1115 demonstration authority.

ACS CAN encourages CMS to work with states to implement the state plan option to extend continuous eligibility to children, and work with Congress to give states the same option to implement continuous eligibility in adult populations without applying for a waiver. In the meantime, we also support the use of waiver authority to establish continuous eligibility: we recently submitted comments to CMS in support of Oregon’s request to widely expand the use of multi-year continuous eligibility, and we hope other states will follow their example. ACS CAN also supports congressional action that would make continuous eligibility a requirement in children and/or adult Medicaid populations.

Additionally, we encourage CMS to continue to prohibit states from conditioning Medicaid eligibility or re-eligibility on work requirements, participation in ‘community engagement’ activities, ‘personal

responsibility' requirements, or participation in wellness programs. CMS should reject any waivers containing these provisions, as they waste program resources to implement while also endangering patient access to care by kicking enrollees off Medicaid for not meeting requirements. While cancer patients are sometimes exempted from these requirements, seeking or qualifying for an exemption may create bureaucratic challenges for cancer patients. Additionally, cancer survivors who may continue to have health challenges may not be exempted. Additionally, any individual disenrolled from Medicaid for not meeting such a requirement is less likely to get their recommended cancer screenings and preventive services.

Regarding state tracking of terminations and disenrollment, we encourage states to create their processes now to closely track terminations of coverage at the end of the PHE. States should post disaggregated disenrollment data publicly, as well as other performance indicators like call center statistics. Data should be updated weekly so that patient and consumer advocates, CMS, and other stakeholders can closely monitor the situation. States must also ensure that their plans for the end of the PHE include flexibility to change course if data show that terminations of coverage are disproportionately impacting certain populations, including communities of color or people with disabilities. CMS should closely monitor these data in every state and use penalties or other enforcement mechanisms to ensure that all administrative denials are legitimate.

**2. How should CMS consider setting standards for how states communicate with beneficiaries at-risk of disenrollment and intervene prior to a gap in coverage? For example, how should CMS consider setting standards for how often a state communicates with beneficiaries and what modes of communication they use? Are there specific resources that CMS can provide states to harness their data to identify eligible beneficiaries at-risk of disenrollment or of coverage gaps?**

American Cancer Society Cancer Action Network Response:

It is important that states do as much work through automatic processes so that renewals rely as little as possible on contact with and information/documents from the enrollee. This increases efficiency for the use of state resources, as well as makes enrolling/re-enrolling easier for individuals who may find the process confusing or burdensome. CMS should encourage states in these efforts and provide them with the resources and authorities needed as possible, including information on how to coordinate with other safety net programs to ensure they are sharing information when appropriate. Any efficiencies that have been developed during the PHE and proved beneficial should continue, such as allowing enrollee self-attestation for certain eligibility information.

CMS should require states to proactively update mailing addresses for their enrollee lists, as some enrollees are likely to have changed addresses during the PHE. States should be required to make multiple attempts at contact via postal mail, allowing enrollees adequate time to respond to requests for information or their changed situation. States should also be required to attempt to contact enrollees in other formats, like texting and emails, to ensure enrollees receive the information they need to maintain coverage. Communications with enrollees should be clear (i.e. "your coverage will end if you don't respond") and provide support for non-English speakers and those who may need in-person or additional consumer assistance.

CMS should encourage Medicaid programs to use their websites, social media and other communications platforms to conduct public awareness campaigns about the end of the PHE and how to stay enrolled or transition to other quality coverage. Targets of the public awareness campaigns should include enrollees, providers, managed care organizations, consumer groups and other advocates.

Medicaid programs should proactively educate these stakeholders on the different categories of eligibility for Medicaid (including special, limited programs like the Breast & Cervical Cancer program), as there is a lack of understanding that enrollees may lose eligibility in one category but gain in it another.

While we encourage CMS to monitor these processes and results in all states, we urge CMS to conduct very close oversight in states that have waived retroactive eligibility. In these states, if an enrollee is dropped from coverage unnecessarily while remaining eligible, but then fixes the issue and re-enrolls, retroactive eligibility would not cover their gap in coverage while the error was fixed – resulting in potentially large unpaid bills and medical debt. CMS should also closely monitor states that have a waiver to lock enrollees out of coverage if they do not respond to notices, like Indiana.

**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?**

American Cancer Society Cancer Action Network Response:

The American Cancer Society (ACS) operates a call center that provides various types of information to cancer patients and their families. One specialized service offered is the Health Insurance Assistance Service (HIAS), where experts in insurance enrollment speak with cancer patients and family members with questions about insurance coverage. Through assisting these patients, ACS and ACS CAN have gained unique and hands-on experience with cancer patients who are experiencing coverage transitions, or having difficulty finding insurance coverage. This question was shared with our call-center specialists, and they had the following recommendations:

1. Medicaid programs should train navigators, Medicaid intake staff, and others who review Medicaid applications or help individuals enroll individuals to assess eligibility for all Medicaid programs and eligibility pathways, not just one. An individual may not qualify under one category of Medicaid but might qualify under a different category/program. The onus should not be on the potential enrollee to know to ask about the specific program. This is a common issue with the Breast and Cervical Cancer program (BCCP) – an individual will be denied traditional Medicaid, and not be offered the opportunity to try to enroll in BCCP, even if they were eligible. Because of particular rules with BCCP, sometimes by the time the patient discovers they are eligible, it is too late to enroll.
2. States should strengthen their processes for connecting Medicaid enrollees with information and resources to enroll in Marketplace coverage, including Navigators and other trusted community partners. Notices to enrollees from the Medicaid program must be clear and explicit that loss of Medicaid coverage creates a special enrollment period (SEP) for them in the Marketplace, and they may qualify for premium subsidies. Every state must add this information to their Medicaid coverage loss notification letter. One call center specialist emphasized the importance of this: “It is heartbreaking to hear from callers that they had no idea that they had a SEP and that it was only for 60 days and has ended. Sometimes this has meant the caller can’t get any other type of plan for the rest of the year until Open Enrollment.” Notices from the

Medicaid program should refer enrollees in danger of losing coverage to healthcare.gov, the HHS call center, or patient organizations like ACS to discuss their options and help choose a plan. “Patients don’t know what they don’t know, so a referral would help them get a good plan.”

3. CMS should establish continuity of care provisions for Medicaid enrollees who move to a different state, and therefore a different Medicaid program. HIAS specialists speak with many patients who qualified for Medicaid in one state, and then were surprised to learn they did not qualify in their new state. This is of particular relevance to cancer patients, who sometimes must move to receive care from a particular provider/facility/cancer center, or to live with family who can care for them during their illness. Medicaid agencies are obligated to “promptly and without undue delay” transfer information when they find a person is ineligible for Medicaid to other insurance affordability programs (42 CFR 435.912(b), 435.1200(e)). Similarly, and consistent with 1902(a)(16), the Secretary should promulgate regulations to ensure that states transfer individuals’ coordinated content [see [https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435#p-435.4\(Coordinated%20content\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435#p-435.4(Coordinated%20content))] when states learn that beneficiaries have moved to another state and could be potentially eligible for Medicaid or other insurance affordability programs in that state.

### Objective 3 of 5

**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?**

American Cancer Society Cancer Action Network Response:

ACS CAN believes that whether care is delivered through fee-for-service (FFS) or managed care, CMS should ensure that all states provide access to timely, high-quality, and appropriate care. Medicaid statute requires states to ensure Medicaid provider payments are “consistent with efficiency, economy, and quality of care and ... *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*” (42 U.S.C. §1396a(a)(30)(A) (emphasis added)). To ensure that the statutory requirement is met, we believe that CMS must establish minimum federal access standards that are

quantitative, measure whether a sufficient number of providers is available to the population in any geographic area, include time and distance minimum thresholds, and are universally applicable. As large and harmful health disparities already exist based on whether a state has expanded Medicaid, we believe national standards are necessary to illuminate these disparities and begin to address them.

Existing Medicaid regulations include a requirement for states to have in place an access monitoring review plan that provides for an analysis of the availability of a very limited set of at least the following services: primary care services, physician specialist services, behavioral health services, pre- and post-natal obstetric services, home health services, and other services identified by CMS in federal regulations (none so far) or for which there are a high volume of complaints (42 CFR 447.203). These requirements leave considerable flexibility to states to define the specific types of providers to be monitored under each of those general provider categories and to develop the approaches to be used to monitor access in each state. Because needs and resources vary considerably among the states, this approach has had the impact of resulting in a wide variety of effective access standards in some states and in other states, less effective standards that fail to ensure access to necessary medical care for Medicaid beneficiaries.

ACS CAN urges CMS to adopt quantitative access criteria applicable to all state Medicaid programs to ensure that a Medicaid program meets a minimum sufficiency standard. Specifically, ACS CAN recommends a minimum ratio of providers to covered persons for primary care physicians and specialists (including subspecialists), a minimum number of full-time providers to meet the needs of individuals with limited English proficiency, and a maximum time and distance standard to access hospital, emergency care, diagnostic, ancillary services and non-emergency medical transportation services.

Quantitative standards including time and distance minimum thresholds are necessary to determine whether participating providers are geographically accessible to plan enrollees. In addition, nationwide quantitative access standards will help to ensure equitable access to Medicaid and to essential medical care. The assurance that such minimum standards would provide is especially important to persons living with cancer who may need immediate care and access to medical specialists, subspecialists, transplant centers and a variety of providers. Thus, ACS CAN urges that access monitoring rules be developed to ensure access to a sufficient number and type of providers who are accepting new patients (including primary, specialty, and subspecialty providers) to meet the needs of enrollees. It is also critical that the access standards include measures of access to facilities that are important to cancer prevention and treatment, including Essential Community Providers, cancer centers, and children's cancer hospitals.

CMS has already developed comprehensive quantitative access standards that are applicable nationwide in its federal regulations applicable to Medicare Advantage plans (42 CFR 422.116). Under those requirements, plans must ensure that 90% of beneficiaries are able to reach each applicable provider type within the minimum time and distance standards. The provider types subject to review are explicitly defined in federal rules, and the standards take into account different county type sizes.

While Medicare plan standards can provide a starting point for CMS, they would need to be adapted to reflect the needs of the Medicaid population and those of persons living with cancer. For individuals living with cancer, access to the following provider and treatment types is essential: specialty and subspecialty practitioners, cancer centers, transplant centers, drugs (including physician-administered and pharmacy drugs), and biomarker testing. In addition, we strongly recommend that access to pharmacies



and non-emergency medical transportation (NEMT) be included as important measures that impact an individual's ability to access medical care.

**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?**

American Cancer Society Cancer Action Network Response:

Existing Medicaid regulations require states, at least once every three years, to complete a separate access analysis for each provider type and site of service furnishing. We urge CMS to maintain the existing requirements for triennial analysis and to ensure that once those analyses are completed, actions are taken to address any revealed gaps in provider/treatment access, and to make such analyses publicly available. Evaluation of these data should be included as CMS considers any requests for the continuation of waiver demonstration projects that could impact access to Medicaid (for example, in states that request to extend waivers of NEMT requirements). Additionally, we encourage CMS to look for states that perform well on these measures and develop case studies on best practices – or potentially template waivers – so that other states can learn from and use best practices to improve access.

**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 data sources (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.)?**

American Cancer Society Cancer Action Network Response:

We encourage CMS to adopt a multi-pronged approach to monitoring the robustness of provider participation across delivery systems. CMS should require all states to collect data on time and distance standards, appointment wait times, share of providers accepting new patients, share of providers equipped to serve beneficiaries with limited English proficiency, share of providers trained in serving LGBTQ+ populations, and share of providers whose offices meet ADA standards for accessibility. These

metrics should include specialty and sub-specialty providers in addition to primary care providers. These metrics should be reported annually to CMS on a statewide and, in managed care states, on an MCO-specific basis. Additionally, CMS should conduct “surveillance testing,” including secret shopper surveys and provider directory audits which measure both accuracy and accessibility.

Also, as noted in our response to question 3.1, to ensure access to care for cancer patients, measures should include access to the following provider and treatment types is essential: specialty and sub-specialty practitioners, cancer centers, transplant centers, drugs (including physician-administered and pharmacy drugs), and biomarker testing. In addition, we strongly recommend that access to pharmacies and non-emergency medical transportation (NEMT) be included as important measures that impact an individual’s ability to access medical care.