NCCN National Comprehensive Cancer Network®

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February 09, 2023

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

RE: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program and Medicare Prescription Drug Benefit Program (CMS-4201-P)

Dear Administrator Brooks-LaSure:

The National Comprehensive Cancer Network® (NCCN®) appreciates the opportunity to comment on the Center for Medicare and Medicaid Services (CMS) Proposed Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program and Medicare Prescription Drug Benefit Program (CMS-4201-P) as it relates to NCCN's mission of improving and facilitating, quality, effective, equitable, and accessible cancer care so all patients can live better lives. NCCN thanks CMS for its attention to addressing inequities in care and to ensuring appropriate network adequacy standards. NCCN is pleased to provide information and resources as CMS pursues these efforts and will focus on the role of clinical practice guidelines as a tool for establishing appropriate care.

NCCN Background

As an alliance of 32 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 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.

NCCN imposes strict policies to shield the guidelines development processes from 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 are available through a multitude of health information technology (HIT) vendors.

Health Equity and Language Access Proposals

Within the proposed rule, CMS includes several proposals intended to further health equity among Medicare beneficiaries. First, CMS proposes to clarify an existing requirement for MA plans to provide culturally competent care by expanding the list of populations that MA organizations must provide services to in a culturally competent manner. This includes people: (1) with limited English proficiency or reading skills; (2) of ethnic, cultural, racial, or religious minority groups; (3) with disabilities; (4) who identify as lesbian, gay, bisexual, or other diverse sexual orientations; (5) who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex; (6) who live in rural areas and other areas with high levels of deprivation; and (7) otherwise adversely affected by persistent poverty or inequality. NCCN acknowledges that inequities in care persist across these demographic groups and thanks CMS for this important clarification.

CMS also includes important proposals related to measuring and incentivizing equity efforts among Medicare Advantage Organizations (MAOs). CMS proposes to introduce a health equity index (HEI) reward for the 2027 Star Ratings to further incentivize Parts C and D plans to focus on improving care for enrollees with social risk factors (SRFs) including dually eligible and low-income beneficiaries, and beneficiaries with disabilities. Additionally, CMS acknowledges that MA organizations' existing quality improvement (QI) programs are an optimal vehicle to develop and implement strategies and policies designed to reduce disparities in health and health care. As such, CMS proposes to require MA organizations to incorporate one or more activities into their overall QI program that reduce disparities in health and health care among their enrollees. NCCN applauds CMS for taking these important steps to more meaningfully measure and reward health equity efforts across MAOs.

NCCN has embarked on efforts to more meaningfully measure the equity of care delivery and is pleased to share information on these initiatives as a resource. In 2020, NCCN, the National Minority Quality Forum (NMQF), and the American Cancer Society Cancer Action Network (ACS CAN) launched the Elevating Cancer Equity (ECE) initiative. The ECE initiative sought to better understand patient experiences of racial disparities in access to guideline adherent cancer care in the United States through surveys of patients, caregivers, and oncologists, and then to address these disparities through a framework of actionable policy and practice change recommendations developed by a working group of national experts. The ECE Working Group (ECEWG), comprised of 17 national experts on racial disparities in cancer care including patients, caregivers, physicians, researchers, and industry, arose from the initiative (see Appendix A for full membership list). Convened in January 2021, the ECEWG developed two products: 1.) the Health Equity Report Card (HERC) as a means to put forth both best practice recommendations and ensure appropriate and necessary accountability for health systems and 2.) a Policy Framework to advance more equitable systems of care (see Appendix B for the HERC and Policy Framework). In early 2022, NCCN launched a feasibility pilot of the HERC across 5 academic cancer centers and is in the process of launching an additional pilot in community settings in 2023. NCCN believes the HERC can be an important and useful tool for providers, health systems, payers, developers of value-based models of care, and accreditation entities seeking to advance more equitable care delivery among their constituencies. NCCN would be happy to engage in further conversation and information sharing around these efforts.

In addition to the above health equity provisions, CMS puts forth several proposals to improve access to necessary information among Medicare beneficiaries with Limited English Proficiency (LEP). It's estimated that 8% of Medicare beneficiaries have Limited English Proficiency (LEP).[1] Studies have indicated that Medicare beneficiaries who have LEP are less likely to have access to a consistent source of care and less likely to receive important preventive care, including cancer screening tests.[2] As such, NCCN recognizes that supporting linguistically appropriate care is a crucial component of high-quality health care. The Elevating Cancer Equity Working Group also recognized this when including in the HERC the recommendation that marketing and educational materials should be both culturally and linguistically representative of the community served. CMS proposes to "*specify in Medicare regulations that MA organizations, cost plans, and Part D sponsors must provide materials to enrollees on a standing basis in any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package service area or accessible format using auxiliary aids and services upon receiving a request for the materials or otherwise learning of the enrollee's preferred language and/or need for an accessible format using auxiliary aids and services.*" Additionally, CMS proposes to codify the current recommendation that Medicare Advantage organizations include information on non-English languages spoken by providers as well as information on disability accessibility of the provider location in their provider manuals. NCCN thanks and supports CMS in these important proposals to ensure all beneficiaries can access critical health plan information.

Prior Authorization Proposals

Several studies and inquiries have explored the use of prior authorization in Medicare Advantage plans in recent years. A 2022 report from the HHS Office of the Inspector General (OIG) on prior authorization in Medicare Advantage concluded "*among the prior authorization requests that MAOs denied, 13 percent met Medicare coverage rules—in other words, these services likely would have been*

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[1] Center for Medicare and Medicaid Services Office of Minority Health. Understanding communication and language needs of Medicare beneficiaries. April 2017. Retrieved February 7, 2023 from https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf

[2] The Commonwealth Fund. (2007). Language barriers to health access among Medicare beneficiaries. Retrieved on February 1, 2022 from https://www.commonwealthfund.org/publications/journal-article/2007/feb/language-barriers-health-care-access-among-medicare

approved for these beneficiaries under original Medicare.".[3]Another analysis released in February 2023 from KFF (formerly Kaiser Family Foundation) found that over 35 million prior authorization requests were submitted to Medicare Advantage in 2021 with 2 million of those requests denied.[4] Of the denied requests, just 11% were appealed and of those appealed, 82% had the original denial fully or partially overturned. This demonstrates significant administrative burden and cost for both providers and MAOs. This may impose delays or outright denials of appropriate care for patients, some of whom may not have the resources or time to pursue appeals. NCCN member institutions frequently report significant administrative burden associated with prior authorization for Medicare beneficiaries in Medicare Advantage plans compared with traditional Medicare. NCCN members report that these onerous policies frequently lead to inappropriate and unnecessary delays in care. Within the proposed rule, CMS proposes several regulatory changes to address ongoing concerns with the use of prior authorization in Medicare Advantage. NCCN shares these concerns and thanks CMS for its attention to this important issue. NCCN also seeks clarification on the clinical practice guideline provisions within the proposed rule, and is pleased to provide additional information on how clinical practice guidelines can play an important role in advancing these efforts.

Within the proposed rule, CMS states that "*We propose that when there is no applicable coverage criteria in Medicare statute, regulation, NCD, or LCD, MA organizations may create internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available to CMS, enrollees, and providers.* ". CMS proposes to establish *§ 422.101(b)(6)* which would state that that when coverage criteria are not fully established in applicable Medicare statute, regulation, NCD or LCD, an MA plan may create internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature that is made publicly available. In creating these internal policies, CMS proposes that MA organizations must follow similar rules that CMS and MACs must follow when creating NCDs or LCDs by affording the public an opportunity for comment. NCCN supports this proposal to reduce inappropriate prior authorization burden by relying on high-quality clinical practice guidelines. NCCN further urges CMS to encourage Medicare Advantage plans to adopt the use of real-time Clinical Decision Support Mechanisms (CDSMs) to ensure care is guideline adherent and timely. A wide body of literature indicates that greater use of simple guideline adherence through real-time Clinical Decision Support Mechanisms (CDSMs) can lead to improved cancer care outcomes, reduced costs to Medicare Advantage plans and individual patients, reduced administrative burden, improved timeliness of care, and reduced disparities in care.

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

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[3] HHS Office of the Inspector General. Some Medicare Advantage Organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care. April 2022. Retrieved August 19, 2022 from https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

[4] Fuglestein Biniek, J and Sroczynski, N. Over 35 million prior authorization requests were submitted to Medicare Advantage plans in 2021. February 2023. Retrieved February 7, 2023 from https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/

improved pain control.[5,6,7,8,9,10] Non-adherence to guidelines has also been identified as a key contributor to inequities in care outcomes across race and ethnicity with some studies finding these disparities greatly reduced or eliminated when guideline adherent care is received.[11,12] As such, guideline adherence is a key tool to combat inequities in care outcomes across race and ethnicity.

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.[13]

NCCN Guidelines have also been shown to lower healthcare costs to the patient. 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

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5 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

6 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

7 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

8 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

9 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

10 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.

[11] 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.

[12] 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.

[13]. 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

guideline-discordant care versus patients who received guideline-concordant care. NCCN again thanks CMS for its attention to this important issue and would be pleased to serve as a resource moving forward.

Colorectal Cancer Screening Measure

CMS proposes to update the existing colorectal cancer screening measure within the STAR ratings to account for NCQA's change to the measure following updated United Services Preventive Task Force recommendations. In 2021, the USPSTF updated their recommendation to include a rating of B for colorectal cancer screening for individuals aged 45-49. As such, the updated measure will newly account for individuals age 45-75 rather than 50-75. This recommendation aligns more closely with the NCCN Guidelines for Colorectal Cancer Screening® which recommend that screening for average risk individuals begin at age 45 for individuals who might have a life expectancy of 10 years or greater. Additionally, while there is no specified upper age limit within NCCN Guidelines, the panel does note that screening between ages 76 and 85 should be individualized and include a discussion of the risks and benefits based on comordbidity status and estimated life expectancy. NCCN supports this change and thanks CMS for the proposed update to the measure.

Network Adequacy Proposals

Within the proposed rule, CMS proposes to strengthen network adequacy through the expansion of requirements for behavioral health services. NCCN applauds CMS for its attention to the importance of network adequacy and behavioral health by including several proposals to advance access to behavioral health services including the addition of Clinical Psychology Licensed Clinical Social Worker and Prescribers of Medication for Opioid Use Disorders as specialty types to be evaluated within network adequacy review. NCCN urges additional, similar action to improve access to high-quality academic cancer centers and tertiary or quaternary referral centers for all patients. Access to a robust provider network is a critical component of high-quality cancer care.

NCCN would like to highlight the importance of including academic cancer centers within these provider networks. They frequently see higher severity cases and offer best in class and innovative therapies as well as access to clinical trials. Academic cancer centers remain the backbone of oncology care, providing essential resources that patients with cancer may not be able to access in other settings of care. 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

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[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/jamaon- col.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

care at these sites are particularly problematic for patients with rare, complex, or advanced cancers, who would most benefit from comprehensive and multidisciplinary treatment.

However, NCCN also recognizes that not all patients will be able to access an NCI-designated cancer 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.

NCCN appreciates the opportunity to comment on the CMS Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program and Medicare Prescription Drug Benefit Program (CMS-4201-P). NCCN is happy to serve as a resource and looks forward to working together to advance access to equitable, high-quality cancer care.

Sincerely,

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Appendix A

Elevating Cancer Equity Working Group Members

- **Chair:** Shonta Chambers, MSW, Patient Advocate Foundation
- **Chair:** Robert Winn, MD, VCU Massey Cancer Center
- Zeke Aguilera, ACT Lead, ACS CAN
- Nadine Barrett, PhD, Duke University School of Medicine
- Linda Burhansstipanov, DrPH, MSPH, Native American Cancer Research Corporation
- Christina Chapman, MD, MS, Michigan Medicine
- Moon Chen, MPH, PhD, UC Davis Health
- Thomas Farrington, Prostate Health Education Network
- Carmen Guerra, MD, MSCE, Penn Abramson Cancer Center
- Chanita Hughes-Halbert, PhD, Medical University of South Carolina
- Marjorie Kagawa Singer, PhD, UCLA Fielding School of Public Health
- Mel Mann, MBA M.Ed, Patient Advocate
- Regina Martinez, Volunteer, ACS CAN
- Kris Rhodes, MPH(Anishinaabe), Retired Founding CEO, American Indian Cancer Foundation
- Brian Rivers, PhD, MPH Cancer Health Equity Institute, Morehouse School of Medicine
- Gerren Wilson, PharmD, Genentech
- Karen Winkfield, MD, PhD, Meharry-Vanderbilt Alliance

Appendix B

Elevating Cancer Equity: Recommendations to Reduce Racial Disparities in Access to Guideline Adherent Cancer Care

Institutional and Practice Equity Report Card	
Community Engagement	
Incorporates meaningful community involvement in practice leadership through a community/patient advisory committee or designated board position that is reflective of: • the community the health care systems serves or • that is reflective of the community where the healthcare system resides or • is reflective of the demographics identified through the community needs assessment.	
Marketing and educational materials use messaging that is linguistically and culturally appropriate for the community served.	
Contracts with or has formal and equitable partnership with community providers, community-based organizations, and/or faith-based organizations (when mutually appropriate and not harmful) for community engagement and/or patient navigation.	
Demonstrates the results of the community health needs assessments are used as a tool for program development through documented action plan tied to results.	
Accessibility of Care and Social Determinants of Health	
Facilitates access to government, commercial, or community-based non-emergency transportation services or financial support for public transportation where available.	
Collects Social Determinants of Health data at intake and throughout the continuum of care. Population-level data collected (z-codes) helps to guide patient care and population-level health management as documented through the medical record or meeting notes.	
Offers flexible hours for screening and treatment appointments.	
Offers culturally and linguistically representative patient navigators or community health workers through internal hiring or contracting with community-based organizations.	
Establish a process to navigate patients with identified social needs to local and or national resources.	
Training is provided to staff on barriers to clinical trial participation and there are targeted efforts to reduce barriers to clinical trial participation through connection to appropriate services.	
Addressing Bias in Care Delivery	
Diversity, inclusion, and equity is embedded into the practice, institution, or health system policies (Examples: recruitment, hiring, and promotion policies, resource allocation standards).	
Adopts measures related to the recruitment, retention, and promotion of minority researchers and practitioners.	
Implements Health Information Technology or other workflow processes to identify critical moments in shared decision making and care planning when disparate care can occur.	
Incorporates disparities and equity framework into quality improvement activities.	
Provides and requires annual implicit bias training for all employees.	

Quality and Comprehensiveness of Care	
When appropriate, patients are offered or referred to appropriate preventive and supportive care services (e.g. smoking cessation and weight management programs, reducing exposure to environmental hazards).	
Clinical trial options are discussed with all patients as documented through medical records.	
Offers culturally and linguistically representative patient navigators or community health workers through internal hiring or contracting with community-based organizations.	

Elevating Cancer Equity Working Group Policy Change Recommendations
Congressional Recommendations
Clinical Trial Diversity: Congress should pass legislation requiring the FDA to consider clinical trial diversity as an element of the drug approval process in a way that is proportionate to the intended patient population.
Supporting Cancer Prevention: Congress should allocate funds for public awareness campaigns of lifestyle factors impacting cancer risk that are linguistically and culturally reflective.
Supporting Cancer Prevention: Congress should pass legislation allocating funds for public education on the importance of the Human Papillomavirus(HPV) vaccine.
Supporting Access to Screening: Congress should allocate additional funding for CDC screening programs including the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and the Colorectal Cancer Control Program (CCCP). Congress should also allocate funds for screening that prioritizes cancers where disparities are particularly prevalent.
Supporting Access to Screening: Congress should allocate funds to be granted to community-based organizations to connect people with screening, early detection and treatment support. Congress should restore funds for the National Comprehensive Cancer Control Program.
Supporting a Diverse Healthcare Workforce: Congress should allocate funds to Historically Black Colleges and Universities (HBCUs), tribal colleges, and other minority serving institutions (MSIs) because they excel at care, practice, education, and community engagement.
Supporting Patient Navigation: Congress should pass legislation ensuring reimbursement of patient navigators and community health workers in Medicare/Medicaid/Private Insurance markets.
Social Determinants of Health: Congress should allocate funds for the reconnect loan and grant program and eliminate the household threshold requirement. Access to basic infrastructure like electricity has a critical impact on health.
CMS and Commercial Payer Recommendations
Ensuring Equitable Access to Genetic Testing and Cancer Risk Reduction: All payers should cover appropriate genetic counseling and testing for individuals at high risk of cancer as well as related risk reduction services.
Addressing Clinical Trial Participation Barriers: CMS should ensure Medicare, Medicaid, CHIP, and exchange plans offer coverage of the costs of clinical trial participation including parking, transportation, and lodging.
Patient Navigation: CMMI and commercial payers should include reimbursement for patient navigators, community health workers, care coordination, and connection to social support services in alternative payment models.
Federal Agency Recommendations
Data Collection: The Office of Management and Budget should revise their regulations dictating the collection and reporting of federal data on race and ethnicity. Data should be disaggregated from existing methods that fail to recognize the heterogeneity of African Americans, Pacific Islanders, Asians, Hispanics, American Indians and Alaska Natives.
Research: The Department of Health and Human Services should prioritize funds and resources for interdisciplinary research in SDOH and health disparities research. HHS should require health care systems to partner with community-based organizations to conduct research.
Cancer Prevention: The CDC should make the HPV vaccine an opt-out instead of an opt-in vaccine.
Patient Navigation: Create a Department of Labor code for Patient Navigators

State and Local Policymaker Recommendations
Medicaid Expansion: State governors and legislatures should expand their state Medicaid programs to increase access to screening, early detection and care.