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January 24, 2020

The Honorable Alex Azar  
Secretary  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, D.C. 20201

**Re: Georgia Section 1115 Demonstration Waiver Application**

Dear Secretary Azar:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Georgia's Section 1115 Demonstration Waiver Application. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

ACS CAN commends Georgia for expanding Medicaid coverage for many of its low-income residents earning up to 100 percent of the federal poverty level (FPL) through the *Georgia Pathways to Coverage* ("Georgia Pathways"). However, we strongly urged the state to consider expanding coverage to 138 percent of FPL for **all** Georgians, regardless of whether they are working or not, to ensure that Georgia residents have access to critical health insurance coverage. Over 55,190 people in Georgia are expected to be diagnosed with cancer this year<sup>1</sup> and there are nearly 446,900 cancer survivors in the state<sup>2</sup> – many of whom rely on Medicaid or would greatly benefit from receiving their health care through a full expansion of the program. Research has demonstrated that individuals who lack health insurance coverage are more likely to be diagnosed with advanced-stage cancer, which is costly and often leads to worse outcomes.<sup>3,4</sup> Research has also shown that individuals in expansion states are more frequently

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<sup>1</sup> American Cancer Society. *Cancer Facts & Figures: 2020*. Atlanta: American Cancer Society, 2020.

<sup>2</sup> American Cancer Society. *Cancer Treatment & Survivorship Facts & Figures 2019-2021*. Atlanta, GA: American Cancer Society; 2019.

<sup>3</sup> Ward E, Halpern M, Schrag N, et al. Association of insurance with cancer care utilization and outcomes. *CA Cancer J Clin*. 2008; 58(1):9-31.

<sup>4</sup> American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2019-2020*. Atlanta: American Cancer Society; 2019.

diagnosed with cancer at earlier stages than those in non-expansion states.<sup>5,6</sup> Additionally, individuals enrolled in Medicaid prior to their diagnosis have better survival rates than those who enroll after their diagnosis.<sup>7</sup>

ACS CAN wants to ensure that cancer patients, survivors, and those who will be diagnosed have adequate access and coverage and that any requirements included in the waiver do not create unintentional barriers to care for low-income cancer patients and survivors. While we appreciate that the Georgia Department of Community Health may expand access to coverage to thousands of low-income Georgians in the coverage gap, we have serious concerns with how Georgia has decided who is eligible for the expansion and the requirements that those eligible individuals will need to complete to receive coverage. Our letter details some of these issues. We strongly urge the Centers for Medicare and Medicaid Services (CMS) deny Georgia's waiver application until stakeholder concerns are addressed.

The following are our specific concerns with the Georgia's Medicaid section 1115 demonstration waiver application:

#### **Georgia Pathways to Coverage Eligibility**

ACS CAN opposes Georgia's proposed eligibility pathway that would only allow those Georgians ages 19 to 64 with incomes under 100 percent of the Federal Poverty Level (FPL) who are working or participating in employment-related activities for 80 hours per month be eligible for Medicaid coverage through Georgia Pathways. This leaves hundreds of thousands of low-income uninsured and underinsured Georgians who do not have employment or educational opportunities without coverage, including countless cancer patients and survivors who may be unable to comply with the employment related activity requirements.

ACS CAN opposes tying access to affordable health care for lower income persons to work or participate in community engagement requirements because cancer patients, survivors, and those who will be diagnosed with the disease - as well as those with other complex chronic conditions - would likely find that they are ineligible for coverage through the state's Medicaid program. Cancer patients and recent survivors may not be eligible for Georgia Pathways if they are told by their doctors not to work or to limit their work hours during their treatment protocol. Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.<sup>8</sup> If work and community engagement is required as a condition of eligibility, many cancer patients, recent survivors, and those with other chronic illnesses could find that they are ineligible for the lifesaving care and treatment services

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<sup>5</sup> Jemal A, Lin CC, Davidoff AJ, Han X. Changes in insurance coverage and stage at diagnosis among non-elderly patients with cancer after the Affordable Care Act. *J Clin Oncol*. 2017; 35:2906-15.

<sup>6</sup> Soni A, Simon K, Cawley J, Sabik L. Effect of Medicaid Expansion of 2014 on overall and early-stage cancer diagnoses. *Am J Public Health*. 2018; 108:216-18.

<sup>7</sup> Adams E, Chien LN, Florence CS, et al. The Breast and Cervical Cancer Prevention and Treatment Act in Georgia: effects on time to Medicaid enrollment. *Cancer*. (2009); 115(6):1300-9.

<sup>8</sup> Ramsey SD, Blough DK, Kirchhoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy than People Without a Cancer Diagnosis," *Health Affairs*, 32, no. 6, (2013): 1143-1152.

provided through the state's Medicaid program. Additionally, the increase in administrative requirements for enrollees to attest to their working status on a monthly basis, as well as provide supporting documentation, would likely prevent or decrease the number of individuals with Medicaid coverage, regardless of whether they are given exceptions or not, as seen in the first year of implementation of Arkansas' work requirement.<sup>9</sup>

Given the recent experience with Arkansas' work requirement, where state uninsured rates were driven up and employment actually declined since the work requirement went into effect,<sup>10</sup> we urge CMS to consider the number of Georgians whose health could be negatively impacted, and coverage lost due to this proposal.

#### *Suspension and Disenrollment for Non-compliance*

We are also concerned about the proposed suspension period and eventual disenrollment from the program for non-compliance with the work and other eligibility requirements (discussed in more detail below). Non-compliance with the work requirement would result in a suspension of benefits after one month and disenrollment after three months. The state offers exceptions for "certain life events," but the waiver does not go far enough to protect vulnerable individuals, including recent cancer survivors, and those with other serious chronic diseases linked to cancer treatments.<sup>11</sup>

It is also unclear if an appeals process is provided for individuals the state may assume are not meeting the requirements but who, in fact, are in compliance. We urge CMS to require the state to provide additional information regarding the appeals process (if it exists), including information regarding whether the individual will retain the right to coverage pending the outcome of the appeal. If individuals are suspended from coverage during the appeals process, they will likely have no access to health care coverage, making it difficult or impossible to continue treatment or pay for their maintenance medication until it is determined that they have "certain life events" to meet the exception. For those cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Being denied access to one's cancer care team could be a matter of life or death for a cancer patient or survivor, and the financial toll that the lock-out would have on individuals and their families could be devastating.

Finally, we note the state failed to provide disenrollment estimates for failure to comply with the work requirement and other eligibility requirements, as required by CMS. We urge CMS to require the state to provide these numbers to stakeholders before moving forward with the waiver application so as to allow stakeholders and the state to better evaluate the effects this proposal may have on low-income Georgians, particularly since one of the state's stated goals is to "reduce the number of uninsured Georgians."

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<sup>9</sup> Sommers BD, Goldman AL, Blendon RJ, Orav EJ, Epstein AM. Medicaid work requirements – Results from the first year in Arkansas. *NEJM*. 2019; DOI: 10.1056/NEJMSr1901772.

<sup>10</sup> Ibid.

<sup>11</sup> Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

### *Request for Enhanced Federal Funding for Partial Expansion*

We note that the state is requesting the enhanced federal funding from CMS for expanding the Medicaid program for working individuals up to 100 percent of FPL. We note that in CMS' January 2018 State Medicaid Director letter, CMS clearly states that workforce training activities are not eligible for federal Medicaid match.<sup>12</sup> Therefore, we strongly urge CMS to deny the state the requested enhanced federal funding match unless the state chooses to expand up to 138 percent of FPL.

### **Employer Sponsored Insurance and Cost Sharing**

In our state comments, we commended the state for offering individuals in the demonstration group premium reimbursement for their employer-sponsored insurance (ESI), but are disappointed Georgia is mandating the use of ESI and not offering wrap-around services to enrollees in the premium assistance program. We are concerned that even with the premium assistance, low-income Medicaid adults could still be unable to pay their share of ESI cost sharing. The enrollee would be subject to the cost sharing terms and conditions of the plan into which they are enrolled, such as coinsurance or deductibles.

Individuals who are shifted from the Medicaid program to ESI could experience higher out-of-pocket costs and may be more likely to forgo needed care. Imposing cost sharing on low-income populations has been shown to decrease the likelihood that they will seek health care services, including preventive screenings.<sup>13,14,15</sup> Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.<sup>16</sup> Uninsured and underinsured individuals already have lower screening rates resulting in a greater risk of being diagnosed at a later, more advanced stage of disease.<sup>17</sup> Proposals that place greater financial burden on the lowest income residents create barriers to care and could negatively impact Medicaid enrollees – particularly those individuals who are high service utilizers with complex medical conditions.

Moving cancer patients and survivors out of the more robust Medicaid program and into ESI if it is “cost-effective for the State” could result in reduced benefits and a significant increase in out-of-pocket cost sharing – even with premium and copayment assistance – making coverage less comprehensive and unaffordable. We are concerned that the proposal would leave individuals exposed to significant cost-sharing, beyond what is permitted under current federal requirements.

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<sup>12</sup> Centers for Medicare & Medicaid Services. Opportunities to promote work and community engagement among Medicaid beneficiaries. Baltimore, MD. Department of Health and Human Services. SMD: 18-002. Published January 11, 2018. Accessed January 2018.

<sup>13</sup> Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research*. 2000; 34: 1331-50.

<sup>14</sup> Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. *Med Care*. 2011; 49: 865-71.

<sup>15</sup> Trivedi AN, Rakowski W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med*. 2008; 358: 375-83.

<sup>16</sup> American Cancer Society. *Cancer prevention & early detection facts & figures 2019-2020*. Atlanta: American Cancer Society; 2020.

<sup>17</sup> Ibid.

Premiums and cost sharing above the five percent of family income maximum for Medicaid enrollees would be particularly burdensome for a high-utilizer of health care services, such as an individual in active cancer treatment or a recent survivor. Cancer patients in active treatment require many services shortly after diagnosis and thus incur a significant portion of cost sharing over a relatively short period of time.<sup>18</sup> It can be challenging for an individual – particularly an individual with limited means – to be able to afford their cost sharing requirements. Likewise, a recent survivor may require frequent follow-up visits to prevent cancer recurrence. Having to pay the full cost up front would likely result in many cancer patients and survivors delaying their treatment and could result in them forgoing their treatment or follow-up visits altogether. We strongly urge CMS to deny the state’s request to mandate low-income individuals to enroll in their ESI and the waiver of critical wrap-around coverage for these individuals.

#### *Questions Regarding Mandated Employer-Sponsored Insurance*

In our state comments, we had several clarifying questions about the requirement that individuals enroll in their ESI or be ineligible for Medicaid/the Georgia Pathways Program. Specifically, it is not clear how the state would verify ESI coverage and the individual’s premium. If an individual fails to report their ESI coverage status for a period of time, would that individual be denied Medicaid coverage? Or would there be a grace period given to individuals to report their status? It is also not clear what safeguards the state will have in place to ensure that someone is not inadvertently denied Medicaid coverage due to an individual or state error.

It is unclear how an individual could be disenrolled from coverage for noncompliance and how the disenrollment would work with ESI open enrollment periods. We are concerned that the disenrollment period could occur after the individual has missed the opportunity to enroll in ESI, thus leaving the individual with a gap in affordable coverage for as much as a year until their next ESI open enrollment period.

What if the individual accidentally misses an enrollment period? Would they and their dependents lose coverage and be denied access to Medicaid coverage? As mentioned previously, a loss of health care coverage for a cancer patient who is mid-treatment could seriously jeopardize their chance of survival. Being denied access to one’s cancer care team could be a matter of life or death for a cancer patient or survivor and the financial toll that the lock-out would have on individuals and their families could be devastating.

The state did not adequately answer these questions in their stakeholder responses. Therefore, we urge CMS to require the state to answer the above questions before allowing them to move forward with this proposal.

#### **Prospective Eligibility and Continuity of Care**

The state also proposes that eligibility will be prospective, where individuals must first meet the 80 hours per month and pay a proposed premium before they can gain access to Medicaid benefits under Georgia Pathways. Enrollment will then begin the start of the month following the initial premium payment. We are concerned this proposal could cause a gap in coverage for beneficiaries. Cancer

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<sup>18</sup> American Cancer Society Cancer Action Network. *The costs of cancer: Addressing patient costs*. Washington, DC: American Cancer Society Cancer Action Network: 2017.

patients undergoing an active course of treatment for a life-threatening health condition need uninterrupted access to the providers and facilities from whom they receive treatment. Disruptions in primary cancer treatment care, as well as longer-term adjuvant therapy, such as hormone therapy, can result in negative health outcomes. Additionally, recent cancer survivors often require frequent follow-up visits and maintenance medications as part of their survivorship care plan to prevent recurrence,<sup>19</sup> and suffer from multiple comorbidities linked to their cancer treatments.<sup>20</sup> Ensuring both cancer patients and recent survivors receive the care they need is critical to positive health outcomes.

We also note that the 1115 waiver fails to provide specific provisions to ensure that individuals transitioning on or off the Georgia Pathway program, the Health Insurance Premium Payment (HIPP) program, or between managed care organizations (MCO) can continue to see their health care provider, if medically necessary. Failure to consider the care delivery and/or treatment regimen of patients, especially those managing a complex, chronic condition like cancer, could have devastating effects on patients, their families, and providers. We urge CMS to require that state to ensure any transition periods allow cancer patients and recent survivors to maintain their cancer care treatment regimen and continue to see their providers in the same health care systems through the end of their treatment.

#### *Waiving Presumptive Eligibility*

Patients rely on presumptive eligibility to receive affordable health care, particularly if they did not realize they were eligible for affordable coverage through Medicaid. Safety net hospitals and providers also rely on presumptive eligibility for reimbursement of provided services, allowing these facilities to keep the doors open.<sup>21,22</sup> Waiving presumptive eligibility for the adult population could result in either an individual facing significant out-of-pocket expenses for care that they believed would be covered by their presumed eligibility or a provider being responsible for the cost of the provided services should the patient be unable to pay for them. Therefore, we urge CMS to deny this request, as it could negatively impact patients, hospitals, and providers in the state.

#### *Waiving Retroactive Eligibility*

Medicaid currently allows retroactive coverage if: 1) an individual was unaware of his or her eligibility for coverage at the time a service was delivered; or 2) during the period prospective enrollees were preparing the required documentation and Medicaid enrollment application. Policies that would reduce or eliminate retroactive eligibility could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals battling cancer.

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<sup>19</sup> National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed November 2019. <https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care>.

<sup>20</sup> Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

<sup>21</sup> Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed November 2019. <https://www.cms.gov/regulations-and-guidance/legislation/emtala/>.

<sup>22</sup> National Association of Community Health Centers. Maine health center fact sheet. Published March 2017. Accessed January 2020. [http://www.nachc.org/wp-content/uploads/2016/03/ME\\_17.pdf](http://www.nachc.org/wp-content/uploads/2016/03/ME_17.pdf).

Many uninsured or underinsured individuals who are newly diagnosed with a chronic condition already do not receive recommended services and follow-up care because of cost.<sup>23,24</sup> In 2018, nearly one in five uninsured adults went without care because of cost.<sup>25</sup> Waiving retroactive eligibility could mean even more people are unable to afford care and forgo necessary care due to cost.

Safety net hospitals and providers also rely on retroactive eligibility, similar to presumptive eligibility, for reimbursement of provided services, allowing these facilities to keep the doors open. For example, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.<sup>26</sup> Retroactive eligibility allows hospitals to be reimbursed if the individual treated is eligible for Medicaid coverage. Likewise, Federally Qualified Health Centers (FQHCs) offer services to all persons, regardless of that person's ability to pay or insurance status.<sup>27</sup> Community health centers also play a large role in ensuring low-income individuals receive cancer screenings, helping to save the state of Georgia from the high costs of later stage cancer diagnosis and treatment. Therefore, we urge CMS to consider these providers and their contribution to Georgia's safety net, as well as the patients who rely on Medicaid for health care coverage and deny the state's request to waive retroactive eligibility for the adult expansion group.

#### **Premiums and Copayments for Adult Expansion and Transitional Medicaid Assistance Beneficiaries**

ACS CAN opposes the proposed mandated monthly premiums and copayments for individuals with incomes above 50 percent of FPL (50 percent FPL is \$10,860 a year for a family of three) in the Georgia Pathways program, including those in the Transitional Medicaid Assistance (TMA) program. We are concerned the cost sharing and related penalties for non-payment for the adult populations could create administrative burdens for enrollees, deter enrollment or result in a high number of disenrollment, and potentially cause significant disruptions in care, especially for cancer survivors and those newly diagnosed. Studies have shown that imposing even modest premiums on low-income

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<sup>23</sup> Hadley J. Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. *JAMA*. 2007; 297(10): 1073-84.

<sup>24</sup> Foutz J, Damico A, Squires E, Garfield R. The uninsured: A primer – Key facts about health insurance and the uninsured under the Affordable Care Act. *The Henry J Kaiser Family Foundation*. Published January 25, 2019. Accessed January 2020. <https://www.kff.org/report-section/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-under-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-health-care/>.

<sup>25</sup> The Henry J. Kaiser Family Foundation. Key facts about the uninsured population. Updated December 13, 2019. Accessed January 2020. <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

<sup>26</sup> Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed January 2020. <https://www.cms.gov/regulations-and-guidance/legislation/emtala/>.

<sup>27</sup> National Association of Community Health Centers. Maine health center fact sheet. Published March 2017. Accessed January 2020. [http://www.nachc.org/wp-content/uploads/2016/03/ME\\_17.pdf](http://www.nachc.org/wp-content/uploads/2016/03/ME_17.pdf).

individuals is likely to deter enrollment in the Medicaid program.<sup>28,29,30</sup> Imposing cost sharing on low-income populations has been shown to decrease the likelihood that they will seek health care services, including preventive screenings.<sup>31,32,33</sup> Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.<sup>34</sup> Uninsured and underinsured individuals already have lower screening rates resulting in a greater risk of being diagnosed at a later, more advanced stage of disease.<sup>35</sup> Proposals that place greater financial burden on low-income residents create barriers to care and could negatively impact enrollees – particularly those individuals who are high service utilizers with complex medical conditions.

#### *Loss of Eligibility for Non-Payment*

We are deeply concerned about the loss of eligibility for adults with incomes over 50 percent of FPL for non-payment of premiums after three months. Denying individuals health coverage for non-payment of a premium could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for cancer survivors (who require frequent follow-up visits) and individuals in active cancer treatment. Low-income cancer patients or survivors will likely have no access to health care coverage if their eligibility is suspended after two months for non-payment (until they can pay the outstanding premiums) or disenrolled after three months, making it difficult or impossible to continue treatment or pay for their maintenance medication.

While we appreciate that the individual may regain eligibility at any point after being disenrolled if he/she meets the hours and activities threshold, income eligibility requirement, and any premium obligations in a single month, it is unclear whether the individual will be responsible for paying any outstanding premiums from the previous months. The state notes that they *may* seek to recoup the capitation payments from the months when the member was suspended.<sup>36</sup> For those cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Being denied access to one's cancer care team for three months could have a significant impact on an individual's cancer prognosis and the financial toll that the disenrollment would have on individuals and their families could be devastating.

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<sup>28</sup> Hendryx M, Onizuka R, Wilson V, Ahern M. Effects of a Cost-Sharing Policy on Disenrollment from a State Health Insurance Program. *Soc Work Public Health*. 2012; 27(7): 671-86.

<sup>29</sup> Wright BJ, Carlson MJ, Allen H, Holmgren AL, Rustvold DL. Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out. *Health Affairs*. 2010; 29(12):2311-16.

<sup>30</sup> Office of the Assistant Secretary for Planning and Evaluation. Financial Condition and Health Care Burdens of People in Deep Poverty. Published July 16, 2015. Accessed January 2020. <http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty>.

<sup>31</sup> Solanki G, Schauflyer HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research*. 2000; 34: 1331-50.

<sup>32</sup> Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. *Med Care*. 2011; 49: 865-71.

<sup>33</sup> Trivedi AN, Rakowski W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med*. 2008; 358: 375-83.

<sup>34</sup> American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2019-2020*. Atlanta: American Cancer Society; 2019.

<sup>35</sup> Ibid.

<sup>36</sup> See waiver at pg. 14.



ACS CAN urges CMS to require the state to implement a medical or hardship exemption that would exclude individuals managing complex medical conditions, like cancer, from any suspension or disenrollment penalties. Additionally, we urge CMS to require the state to allow enrollees and/or their health care providers to proactively attest to any change in their health status that could qualify them for the medical or hardship exemption, preventing any unnecessary gaps in coverage.

*Copayment for Non-emergent Use of the Emergency Department*

The state's request to impose a \$30 copayment for each "non-emergent" emergency department (ED) use for those with incomes above 50 percent of FPL could increase costs for cancer patients. Imposing copayments may dissuade an individual from seeking care from an ED setting – even if the case is medically warranted. Cancer patients undergoing chemotherapy and/or radiation often have adverse drug reactions or other related health problems that require immediate care during evenings or weekends. If primary care settings and other facilities are not available, these patients are often directed to the ED. Penalizing enrollees, such as cancer patients, by requiring copayments for non-emergent use of the ED could become a significant financial hardship for these low-income patients.

We urge CMS to require the state to define the term "non-emergent" use of the ED, as a definition is not included in the waiver. Additionally, when evaluating ED cost sharing requirements, we urge CMS, if they were to accept this proposal, to require the state to evaluate the impact it has on patients with complex chronic conditions, such as cancer, not just evaluate the financial impact of this type of requirement.

*Tobacco Surcharge*

ACS CAN urges CMS to deny the state's request to impose a tobacco surcharge on adult enrollees. A tobacco premium surcharge of \$3 to \$5, on top of the sliding scale premium requirements and copayments, will create more barriers to low-income Georgians to quit smoking. Requiring adult enrollees who are known tobacco users to pay a monthly tobacco use surcharge is not an evidence-based approach to discourage tobacco use or encourage participation in tobacco cessation. Research demonstrates that penalizing smokers with higher insurance costs would result in a reduced likelihood of being able to afford coverage with no significant benefits for smoking cessation.<sup>37,38</sup> Preserving access to affordable health care for individuals receiving care through Medicaid is particularly important, as tobacco users are disproportionately low-income<sup>39</sup> and at higher risk for chronic diseases associated

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<sup>37</sup> Friedman, A.S., Schpero, W. L., Busch, S.H. Evidence Suggests That The ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation. *Health Aff* 2016; 35:1176-1183.

<sup>38</sup> Monti, D., Kusemchak, M., Politi, M., Policy Brief: The Effects of Smoking on Health Insurance Decisions Under the Affordable Care Act. Center for Health and Economics Policy Institute for Public Health at Washington University. Published July 2016. Accessed November 2019. <https://publichealth.wustl.edu/wp-content/uploads/2016/07/The-Effects-of-Smoking-on-Health-Insurance-Decisions-under-the-ACA.pdf>.

<sup>39</sup> Centers for Disease Control and Prevention: Current Cigarette Smoking Among Adults—United States, 2005–2015. *Morbidity and Mortality Weekly Report*. 2016;65(44):1205–11.

with tobacco addiction, including lung cancer.<sup>40</sup> Cost is a major barrier to individuals obtaining health insurance coverage and prevention services;<sup>41</sup> therefore, the surcharge will likely have the opposite effect on Georgia's Medicaid beneficiaries.

There is not strong evidence that a surcharge discourages people from smoking. Further, imposing a surcharge could price enrollees – who are by definition low-income – out of the very coverage they need to help them quit. We believe the more cost-effective approach is for the state to broadly promote the tobacco cessation benefits and services available to enrollees – using evidence-based interventions included in The Community Guide<sup>42</sup> – and to ensure Medicaid enrollees have access to these services without any barriers to access such as copayments, step therapy, or prior authorization. Additionally, CMS should encourage the state to continuously evaluate the benefits and services of their tobacco cessation program to ensure its effectiveness.

### **Member Rewards Account**

ACS CAN supports Georgia's goal of encouraging beneficiaries to adopt healthy behaviors through the *Member Rewards Account*. A substantial proportion of cancers can be prevented or caught at an earlier, more treatable stage through preventive care and screening.<sup>43</sup> In our state comments, ACS CAN commended the state for proposing an incentive-based program rather than using a mandatory, outcome-based program.

Research indicates that penalizing enrollees for non-compliance or failing to meet outcomes dictated by the state will not likely generate cost savings or improve the health of low-income Medicaid enrollees.<sup>44</sup> We believe state residents would be best served by a comprehensive, evidence-based participatory wellness program based on incentives, like the one proposed in the waiver, as long as it also provides adequate and comprehensive coverage of preventive services (including tobacco cessation, weight loss, and cancer screenings) and emphasizes evidence-based interventions to educate, promote, and encourage patients to participate in prevention, early detection, and wellness. Evidence shows that unhealthy behaviors can be changed or modified by modest incentives, rather than penalties, as long as they are combined with adequate medical services and health promotion programs.<sup>45</sup> Providing enrollees incentives could lead to a change in behavior whereas penalties do little to improve health,

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<sup>40</sup> U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*, 2014. Available at <https://www.surgeongeneral.gov/library/reports/50-years-of-progress/>.

<sup>41</sup> Kaiser Family Foundation. *Preventive Services Covered by Private Health Plans Under the Affordable Care Act*. Aug. 4, 2015. Accessed January 2020. <http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/>.

<sup>42</sup> The Department of Health and Human Services. *The Community Guide*. Accessed January 2020. [https://www.thecommunityguide.org/topic/tobacco?field\\_recommendation\\_tid=7476&items\\_per\\_page=All](https://www.thecommunityguide.org/topic/tobacco?field_recommendation_tid=7476&items_per_page=All).

<sup>43</sup> American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2019-2020*. Atlanta: American Cancer Society; 2019.

<sup>44</sup> Consensus statement of the Health Enhancement Research Organization, American College of Occupational and Environmental Medicine, American Cancer Society and American Cancer Society Cancer Action network, American Diabetes Association, and American Heart Association. Guidance for a reasonably designed, employer-sponsored wellness program using outcomes-based incentives. *JOEM*. 2012; 54(7): 889-96.

<sup>45</sup> Ibid.

and could reduce access to necessary health care services, including preventive care. We do, however, have some concerns and sought clarification from the state regarding the *Member Rewards Account*.

According to the waiver, the state will set a series of criteria for awarding points for the account and include a couple of examples, such as “being a non-smoker or quitting smoking” or “completing annual well care visits.” Again, we urge CMS to ensure the state offers beneficiaries the full range of tobacco cessation benefits and services, including all FDA-approved tobacco cessation medications, and that individuals be incentivized to quit smoking rather than penalized for doing so. We also urge CMS to require the state to include recommended cancer screenings to the criteria list, as screening for cancer can help prevent and detect cancers at earlier, more treatable stages.

We are concerned the monthly invoice members will receive regarding their required copayment amounts and the deduction of those copayments from their *Member Rewards Account* could be confusing to beneficiaries, particularly if they have a negative balance in their rewards account. For example, the beneficiary may think that he/she must pay these copayments to the state if they see a negative balance in the rewards account. We urge CMS to require the state to clearly indicate in the monthly invoice to members that future premiums and healthy incentive points will be used to pay any negative balances, as not to deter beneficiaries from receiving necessary care over concerns with paying their copayments.

### **Non-Emergency Medical Transportation**

Non-emergency medical transportation (NEMT) is a critical service for many low-income Medicaid beneficiaries who do not have the financial means or the access to needed transportation services.<sup>46</sup> Without transportation benefits, chronically ill Medicaid beneficiaries may go without the lifesaving health services they need, leading to delayed care, an increase in avoidable hospitalizations, and poorer health outcomes.<sup>47</sup> The American Community Survey estimates that nearly 9 percent of occupied housing units in Georgia report having no access to a vehicle.<sup>48</sup>

We appreciate that NEMT will remain a covered service for children, pregnant women, and the blind/disabled, but the state neglected to consider the need for NEMT for preventive services for their adult populations. NEMT is used by individuals to access preventive services and cancer screenings – especially colon cancer screenings and mammograms. As mentioned earlier, early detection of cancer results in less expensive treatments and better health outcomes, which could help offset some short-term Medicaid program costs. In addition, some cancer screenings can prevent cancers from developing (such as colonoscopies and Pap tests) by detecting and removing pre-cancerous polyps or lesions. However, lack of transportation to screening services hinders an individual’s ability to obtain the

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<sup>46</sup> Rosenbaum S, Lopez N, Morris MJ, Simon M. Medicaid's medical transportation assurance: Origins, evolution, current trends, and implications for health reform. Washington, D.C.: Department of Health Policy, School of Public Health and Health Services, The George Washington University, 2009.

[https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1035&context=sphhs\\_policy\\_briefs](https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1035&context=sphhs_policy_briefs).

<sup>47</sup> Kim J, Norton EC, Stearns SC. Transportation Brokerage Services and Medicaid Beneficiaries’ Access to Care. *Health Serv Res.* 2009. 44(1):145-61.

<sup>48</sup> United States Census Bureau. *American Community Survey: Vehicles Available*. Accessed January 2020. <https://www.census.gov/acs/www/about/why-we-ask-each-question/vehicles/>.

necessary screening and, for some individuals, could result in detection of tumors at a later stage. Furthermore, the lack of NEMT services could cause more people to cancel appointments last minute, which could result in an enrollee facing the \$30 “non-emergency use of the emergency department” penalty each time an individual is unable to make it to an appointment due to lack of transportation. ACS CAN strongly urges CMS to deny the state’s request to waive NEMT for non-disabled adults in the Medicaid program.

### **Other Concerns**

Georgia’s 1115 waiver proposal is incredibly complicated. The combination of a work requirement, monthly income-based premiums, copayments, the *Member Rewards Account*, a healthy behavior incentive program, and employer premium assistance program will likely result in a great amount of confusion for enrollees, managed care organizations, and providers and in huge administrative costs to the state. We strongly urge CMS to require the state to invest significant time and resources in a public education campaign that is comprehensive and far-reaching for the public, the MCOs, and providers, if CMS were to allow the state to move forward with any of the above proposals. We also note the state will need to provide a great deal of oversight to ensure the MCOs and providers are ensuring beneficiaries are held harmless from any issues in the administration of these proposals. In particular, it is critical that the state ensure a swift and efficient appeals process be provided to the beneficiary before any coverage is lost or penalty is received for not meeting any of the above requirements.

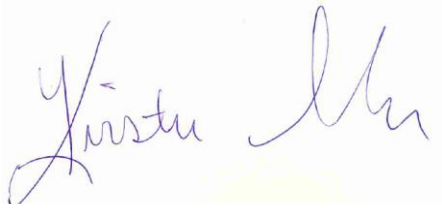
### **Conclusion**

We appreciate the opportunity to provide comments on Georgia’s 1115 waiver amendment. Expanding eligibility and coverage through the Medicaid program is critically important for many low-income Georgians who could greatly benefit from the program for cancer prevention, early detection, diagnostic, and treatment services. However, the proposed eligibility pathway and proposed requirements in this 1115 waiver denies countless low-income Georgians who are in cancer treatment and recent survivors, who are unable to complete the community engagement requirements, access to comprehensive, affordable health care coverage. We ask CMS to weigh the potential impact of this 1115 waiver proposal on low-income Georgians’ access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Our comments include numerous citations to supporting research, including direct links to the research for the benefit of CMS in reviewing our comments. We direct CMS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors, and we look forward to working with CMS to ensure that all people are positioned to win the fight against cancer. If you have any questions, please feel free to contact me or have your staff contact Michelle DeFavero of our policy team at [Michelle.DeFavero@cancer.org](mailto:Michelle.DeFavero@cancer.org) or 202-585-3266.

Sincerely,

A handwritten signature in blue ink that reads "Kirsten Sloan". The signature is written in a cursive style with a large initial "K".

Kirsten Sloan  
Vice President, Public Policy