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July 6, 2017

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

Re: HIP 2.0 1115 Demonstration Waiver Extension and Amendment

Dear Secretary Price:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Indiana's proposal to extend and modify the Healthy Indiana Plan (HIP) 2.0 demonstration waiver. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

We value the transparent process the Centers for Medicare and Medicaid Services (CMS) utilizes to seek input and comments on 1115 demonstration waiver proposals. An open and transparent process provides organizations like ACS CAN an opportunity to share our views on how waiver proposals will affect people with chronic conditions, like cancer. We are concerned however, that in the case of the Indiana waiver, CMS accepted the state's application as complete and moved forward with the federal comment period roughly three weeks before the state comment period actually closed. Moving forward with the federal comment period before a state comment period closes precludes stakeholders at the state level from responding to the proposed waiver amendments and prevents the state from making changes based on stakeholder input. We are concerned that this could create a dangerous precedence at the state level, where states could initially send nondescript state applications to avoid public review of controversial waiver program changes and then submit amendments with more controversial changes that might bypass the public review process.

We acknowledge Indiana's decision to maintain health care coverage for low-income Hoosier's through HIP 2.0, but as indicated in our March 16, 2017 comment letter, we have a number of concerns with the pending waiver extension and the proposed amendments to the extension. In 2017, over 36,000[1] Hoosiers are expected to be diagnosed with cancer and many of them are receiving cancer screening, diagnostic, treatment, and survivorship care through the HIP program. We urge CMS to consider our comments as it weighs Indiana's proposed waiver modifications to ensure that low-income Hoosiers have uninterrupted access to quality, affordable, and comprehensive health insurance.

[1] American Cancer Society. *Cancer Facts & Figures 2017*. Atlanta, GA: American Cancer Society; 2017.

The following comments build on our previous communication with the Department of Health and Human Services (HHS) and CMS, as well as Indiana policymakers, but we are unclear on how Indiana will consider our concerns and requests for clarification, as the amendment has been accepted by CMS for review and approval prior to the close of the state comment period. ACS CAN wants to ensure that cancer patients and survivors in Indiana will have adequate access and coverage under the HIP program, and that specific requirements do not have the effect of creating barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer.

The following are our specific comments on the state's HIP 2.0 waiver extension application and recently added amendment:

Tobacco Use Question on Application and Surcharge

Earlier this year, ACS CAN urged CMS to deny the state permission to impose a tobacco surcharge on enrollees, noting that this penalty would create more barriers to low-income Hoosiers to quit smoking. The proposed amendment seeks approval to include a question regarding tobacco use on the HIP program application. We are not opposed to the addition of this question on the HIP application, as it could help identify tobacco users and help facilitate their participation in Indiana's comprehensive tobacco cessation program. However, we remain concerned that the state's proposed tobacco surcharge could penalize low-income HIP enrollees who are tobacco users.

Requiring HIP enrollees who are known tobacco users to pay a monthly tobacco use surcharge equal to three percent of income after their first year of enrollment in HIP is not an evidence-based approach to discourage tobacco use or encourage participation in the expanded voluntary tobacco cessation incentive initiative. As detailed in our previous comments, research shows 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.[2,3] We also noted that preserving access to affordable health care for individuals receiving care through Medicaid is particularly important, as tobacco users are disproportionately low-income[4] and at higher risk for chronic diseases associated with tobacco addiction, including lung cancer.[5] Cost is a major barrier to individuals obtaining health insurance coverage and prevention services;[6] therefore, the surcharge will likely have the opposite effect on Indiana's Medicaid beneficiaries.

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[2] 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. doi: 10.1377/hlthaff.2015.1540. Accessed at: http://content.healthaffairs.org/content/35/7/1176.abstract

[3] 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. July 2016. Accessed at: https://publichealth.wustl.edu/wp-content/uploads/2016/07/The-Effects-of-Smoking-on-Health-Insurance-Decisions-under-the-ACA.pdf

[4] 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.

[5] 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/.

[6] Kaiser Family Foundation. *Preventive Services Covered by Private Health Plans Under the Affordable Care Act*. Aug. 4, 2015. Available at http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/.

We once again urge that CMS not permit the state to impose a monthly tobacco use surcharge on low-income HIP enrollees. 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 Indiana Family and Social Services Administration (FSSA) to broadly promote the tobacco cessation benefits and services available to enrollees – using evidence-based interventions included in The Community Guide – and to ensure HIP enrollees have access to these services without any barriers to access such as copayments, step therapy, or prior authorization. Additionally, FSSA should be encouraged to continuously evaluate the benefits and services of their tobacco cessation program to ensure its effectiveness.

Gateway to Work Enhancements and Lockout Period

Work Requirement

The requirement that all "able-bodied" working age adult HIP members must be employed 20 hours per week over eight months of an eligibility cycle, be enrolled in full-time or part-time education, or participate in the *Gateway to Work* initiative to maintain eligibility or enrollment in HIP does not recognize the unique situation faced by patients with serious illnesses, such as cancer. Many cancer patients in active treatment are often unable to work or require significant work modifications due to multiple physical, cognitive, and psychological effects of their treatment.[7,8,9] Including a work or activity requirement as a condition of eligibility for coverage could result in cancer patients being ineligible for the lifesaving cancer treatment services provided through HIP.

We appreciate that the FSSA includes exemption categories, which includes the medically frail and "members with a certified temporary illness or incapacity," to protect certain populations from the work requirement and its associated lock-out period. However, it is unclear whether FSSA would include cancer patients and recent survivors in the definition of medically frail or the temporary illness exemption. With respect to cancer, the definition of medically frail should explicitly include individuals who are currently undergoing active cancer treatment –including chemotherapy, radiation, immunotherapy, and/or related surgical procedures – as well as new cancer survivors who may need additional time following treatment to transition back into the workplace. As CMS considers this work and activity requirement, we request that CMS ensure that Indiana clarifies its definition of medically frail and "temporary illness or incapacity" before approving the waiver extension.

Lock-Out Period

We are deeply concerned about the proposed lock-out period for failure to meet the work or activity requirements until the requirement is met for one full month. Subjecting enrollees to a proposed lock-

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[7] Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv.* 2016; 10:241. doi: 10.1007/s11764-015-0470-y.

[8] de Boer AG, Taskila T, Tamminga SJ, et al. Interventions to enhance return to work for cancer patients. *Cochrane Database Syst Rev.* 2011; 16(2): CD007569. doi: 10.1002/14651858.CD007569.pub2.

[9] Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. *J Cancer Surviv*. 2016; 10:480. doi: 10.1007/s11764-015-0492-5.

out without exception – even for a month – could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals battling cancer and survivors (who require frequent follow-up visits). During the proposed lock-out period, low-income cancer patients or survivors would likely have no access to health care coverage, making it difficult or impossible to continue treatment or pay for their maintenance medication until they meet the one-month work or activity requirement. For those cancer patients who are mid-treatment, a loss of health care coverage – even for a month – 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 and the financial toll that the lock-out would have on individuals and their families could be devastating. Therefore, ACS CAN urges CMS to deny the proposed lock-out period for failing to complete the specified number of required *Gateway to Work* participation hours.

Indiana's amendment request included the Milliman Client Report, which estimates that approximately 25 percent of those referred to the *Gateway to Work* program will choose not to participate in *Gateway to Work* and will be subject to the lock-out period. This estimate is especially troubling and we hope CMS will consider the impact that such policies/penalties may have on individuals attempting to access lifesaving health care coverage, particularly those individuals managing complex chronic conditions, like cancer.

Healthy Incentive Initiative
Penalizing enrollees for non-compliance or failing to reach care or disease management goals through an outcomes-based incentive program would not likely generate cost savings or improve the health of low-income Hoosiers. Additionally, outcomes-based programs could unfairly penalize individuals managing complex, chronic diseases like cancer. As an alternative, CMS should urge FSSA to support a participatory healthy incentive program, as evidence shows that unhealthy behaviors can be changed or modified by incentives, as long as they are combined with adequate medical services and health promotion programs.[10]

Open Enrollment and Six Month Lock-Out Period
We urge CMS to require FSSA to include an option for a non-medically frail individual to apply for an exemption to the six-month lock-out. Subjecting enrollees to the lock-out without exception could have overwhelming effects on individuals and families, especially those facing a new cancer diagnosis or a cancer reoccurrence. Being denied access to one's cancer care team for six-months could be a matter of life or death for a cancer patient and the financial toll that the lock-out would have on individuals and their families could be devastating.

Copayments for Non-Emergent Emergency Department Use
Imposing graduated copayments may dissuade an individual from seeking care from an emergency department (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

[10] 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.

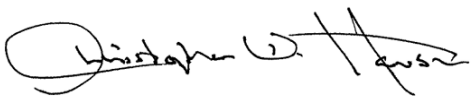
require immediate care during evenings or weekends. If primary care settings and other facilities are not available, these patients are often directed to the ED. We request that CMS scrutinize the impact the requirement has on patients with complex chronic conditions, such as cancer, when determining whether to accept the proposal.

Non-Emergency Medical Transportation (NEMT)
We continue to oppose Indiana's request to waive NEMT services for members who are not medically frail. We are concerned the continued use of the NEMT waiver would create barriers to HIP members accessing primary care and preventive services, such as cancer screenings and diagnostic testing services. In our March comments, we provided evidence to why CMS should deny Indiana's request to continue waiving NEMT to non-medically frail Indiana HIP enrollees.

Conclusion
We appreciate the opportunity to provide comments on Indiana's HIP 2.0 waiver amendment application. Upon further consideration of the policies that will be included in the final waiver extension application, we ask CMS to weigh the impact such policies may have on access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

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 the Administration to ensure that all Americans 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 DelFavero of our policy team at Michelle.DelFavero@cancer.org or 202-585-3266.

Sincerely,



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