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October 17, 2018

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

Re: Healthy Michigan Plan Project No. 11-W-00245/5 – Section 1115 Demonstration Extension Application

Dear Secretary Azar:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Michigan's proposal to extend the Healthy Michigan Plan (HMP) 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.

ACS CAN supports Michigan's goal to improve access to healthcare for uninsured or underinsured low-income Michigan residents through the HMP program, but we are concerned with many of the proposals included in the waiver extension. Nearly 57,000 Michigan residents are expected to be diagnosed with cancer this year[1] – many of whom are receiving health care coverage through the HMP 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.[2,3] Additionally, individuals enrolled in Medicaid prior to their diagnosis have better survival rates than those who enroll after their diagnosis.[4]

It is imperative that low-income Michigan residents continue to have access to comprehensive health care coverage under the HMP program, and that specific requirements do not create barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer. We urge the Centers for Medicare and Medicaid Services (CMS) to address the following concerns or reject this waiver in its current form.

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[1] American Cancer Society. *Cancer Facts & Figures 2018*. Atlanta, GA: American Cancer Society; 2018.
[2] 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.
[3] American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2016-2017*. Atlanta: American Cancer Society; 2017.
[4] 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.

Following are our specific comments on Michigan's 1115 waiver application:

Workforce Engagement Requirements

Michigan seeks to require that all able-bodied HMP enrollees be employed, receive job training, be in school, or participate in community engagement activities for at least 80 hours per month as a condition of eligibility. We are concerned this policy could unintentionally disadvantage patients with complex chronic conditions, including cancer patients and recent survivors. We understand the intent of the proposal is to incentivize employment, but many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[5,6,7]

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 - could find themselves without Medicaid coverage because they physically are unable to comply. 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.[8] Recent cancer survivors often require frequent follow-up visits and maintenance medications to prevent recurrence,[9] and suffer from multiple comorbidities linked to their cancer treatments.[10,11] Cancer survivors are often unable to work or are limited in the amount or kind of work they can participate in because of health problems related to their cancer diagnosis.[12,13,14,15] If work and community engagement is required as a condition of eligibility, many cancer patients, recent survivors, and those with other chronic illnesses

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[5] 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.

[6] 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.

[7] 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.

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

[9] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed October 2018. https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care.

[10] 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.

[11] Dowling E, Yabroff R, Mariotto A, et al. Burden of illness in adult survivors of childhood cancers: Findings from a population-based national sample. *Cancer.* 2010; 116:3712-21.

[12] Ibid.

[13] Guy GP Jr, Berkowitz Z, Ekwueme DU, Rim SH, Yabroff R. Annual economic burden of productivity losses among adult survivors of childhood cancers. *Pediatrics*. 2016; 138(s1):e20154268.

[14] Zheng Z, Yabroff KR, Guy GP Jr, et al. Annual medical expenditures and productivity loss among colorectal, female breast, and prostate cancer survivors in the United States. *JNCI J Natl Cancer Inst.* 2016; 108(5):djv382.

[15] Kent EE, Davidoff A, de Moor JS, et al. Impact of sociodemographic characteristics on underemployment in a longitudinal, nationally representative study of cancer survivors: Evidence for the importance of gender and marital status. *J Psychosoc Oncol*. 2018; 36(3):287-303.

could find that they are ineligible for the lifesaving care and treatment services provided through the State's Medicaid program. We also note that imposing work or community engagement requirements on lower income individuals as a condition of coverage could impede individuals' access to preventive care, including cancer screenings.

We appreciate the State's acknowledgement that not all people are able to work and the decision to include several exemption categories and good cause exemptions from the community engagement requirement and associated lock-out period. However, the waiver does not go far enough to protect vulnerable individuals, including recent cancer survivors, and other serious chronic diseases often linked to cancer treatments.[16,17] The increase in administrative requirements for enrollees to attest monthly to their working status would likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt.[18]

As an example, in the fourth month of implementation of the *Arkansas Works* work requirement (September 2018) eight percent of the nearly 18,300 Medicaid enrollees, who did not declare an exemption, were able to navigate the complex reporting system and satisfy the state's reporting requirement.[19] As of October 8, 2018, an additional 4,109 *Arkansas Works* enrollees have been locked out of coverage through the end of the calendar year due to noncompliance with the work requirement.[20] The number is in addition to the 4,353 individuals the state removed from the program last month, totaling 8,462 Arkansans losing coverage in the last two months. Some of these individuals may have been eligible for an exemption but did not realize they were exempt or were unable to successfully navigate Arkansas' reporting system. Given the experience with Arkansas' work requirement, the Department should consider the number of Michigan residents whose health could be negatively impacted and the coverage losses that could occur due to this proposal.

Lock-Out Period
We are deeply concerned about the proposed lock-out period or suspension of coverage for non-compliance with the workforce engagement requirement; particularly the proposed one-year lock-out period if the Michigan Department of Health & Human Services believes an individual has misrepresented his or her compliance with the requirement or an exemption. The Department offers individuals who have failed to participate in the requirement "good cause" exemptions, but it is unclear

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[16] 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.
[17] Dowling E, Yabroff R, Mariotto A, et al. Burden of illness in adult survivors of childhood cancers: Findings from a population-based national sample. *Cancer.* 2010; 116:3712-21.
[18] Garfield R, Rudowitz R, Musumeci M. Implications of a Medicaid work requirements: National estimates of potential coverage losses. Kaiser Family Foundation. Published June 2018. Accessed October 2018. http://files.kff.org/attachment/Issue-Brief-Implications-of-a-Medicaid-Work-Requirement-National-Estimates-of-Potential-Coverage-Losses.
[19] Arkansas Department of Human Services. Arkansas Works Program: September 2018 Report. Accessed October 2018. https://d31hzlhk6di2h5.cloudfront.net/20181015/d9/50/39/04/d3b5bd23a6cef7ccec3e4716/101518_AWreport.pdf.
[20] Ibid.

how long the appeals process would take and whether the beneficiary would lose health coverage during the process. It is also unclear from the waiver if individuals that are determined by the Department to have misrepresented his or her compliance will be given an appeals process.
Those with acute health care conditions who apply for an exemption to avoid the suspension period will still have to verify their exemption and undertake a burdensome documentation process. This could lead to instances where those who should be able to maintain coverage are disenrolled, jeopardizing access to life-saving treatment. If individuals are locked out of coverage for the one-month period, one-year period, or during any appeals process they will likely have no access to affordable health care coverage, making it difficult or impossible for a cancer patient or recent survivor to continue treatment or pay for their maintenance medication until they come into compliance with the requirement or they are determined to be exempt. This is particularly problematic for cancer survivors who require frequent follow-up visits and maintenance medications as part of their survivorship care plan to prevent recurrence[21] and who suffer from multiple comorbidities linked to their cancer treatments.[22] 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.

Workforce Engagement Requirement Does Not Meet CMS Criteria
We note that Michigan's proposed waiver does not appear to meet the criteria established by CMS for approval of work and community engagement proposals under the guidance that was sent to state Medicaid Directors on January 11, 2018. The guidance specifically states that "…states will need to link these community engagement requirements to those outcomes and ultimately *assess the effectiveness of the demonstration in furthering the health and wellness objectives* of the Medicaid program [emphasis added]."[23] In contrast, the State's reported objective of the workforce engagement requirement is to "promote work and community engagement…and further the positive physical and mental health benefits associated with work" and to determine the "extent to which workforce engagement requirements impact individuals who transition from Medicaid obtain employer sponsored or other health insurance coverage and how such transitions affect health and wellbeing." The State's reported hypotheses used to evaluate the outcomes of the requirement do not address health and wellness of the Medicaid enrollees in the program itself or those who may lose Medicaid eligibility due to noncompliance.

Further, the State has neglected to provide projections of the number of beneficiaries who may lose coverage due to the workforce requirement or the entire demonstration waiver. Instead, the State suggests that "400,000 of the enrolled beneficiaries could be impacted by the waiver amendment

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[21] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed October 2018. https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care.
[22] 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.
[23] 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 October 2018.

changes." Federal rules for the state public notice process for 1115 waivers require states to include, "an estimate of the estimated increase or decrease in annual enrollment" and expenditures for the demonstration requested by the State.[24] The state has provided projected enrollment and demonstration costs but has not presented the information in a way that would clearly delineate anticipated coverage losses. This important information allows stakeholders and CMS to adequately assess the impact the demonstration waiver may have on state residents. Therefore, we strongly urge CMS to require the State to include these projections, as required by federal law, so that the public has an opportunity to comment on the impact of the proposed waiver demonstration with adequate information.

Patient Cost Sharing and the MI Health Accounts

ACS CAN opposes the proposed premiums of five percent of income – and associated mandatory completion of an annual healthy behavior – for individuals with incomes above 100 percent of the Federal Poverty Level (FPL) who have had 48 months of cumulative HMP eligibility coverage. We are concerned the cost sharing and related lock-out period for non-payment will create administrative burdens for enrollees, will likely deter enrollment or result in a high number of disenrollment, and will cause significant disruptions in care, especially for cancer survivors and those newly diagnosed. Studies have shown that imposing even modest premiums on low-income individuals is likely to deter enrollment in the Medicaid program.[25,26,27] Imposing copayments or out-of-pocket costs on low-income populations has been shown to decrease the likelihood that they will seek health care services, including preventive screenings.[28,29,30] Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.[31] 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.[32] Proposals that place greater financial burden on low-income residents create barriers to care and will negatively impact HMP enrollees – particularly those individuals with complex medical conditions who have higher medical needs.

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[24] 42 CFR 431.408 (a)(1)(i)(C).

[25] 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.

[26] 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.

[27] 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 April 21, 2016. http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty.

[28] 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.

[29] 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.

[30] Trivedi AN, Rakowsi W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med.* 2008; 358: 375-83.

[31] American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2016-2017*. Atlanta: American Cancer Society; 2017.

[32] Ibid.

It is unclear from the waiver whether the premiums of five percent of income will be based on a family's monthly or annual income. Low-income populations are more likely to have an inconsistent income throughout the calendar year. Therefore, if CMS were to approve this proposal, we recommend that the premium contribution be based on monthly household income, as it is a more accurate indicator of an individual's income and ability to consistently meet cost sharing requirements – particularly for seasonal workers or individuals who must spend down before meeting the Medicaid eligibility criteria.

The Healthy Behaviors Incentives Program

ACS CAN supports Michigan's goal of encouraging HMP beneficiaries to seek preventive care and encourage the adoption of healthy behaviors through the *Healthy Behaviors Incentives Program,* as a substantial proportion of cancers could be prevented or caught at an earlier, more treatable stage through preventive care and screening.[33] However, we strongly advise against the State's decision to use a mandatory, outcomes-based program that requires beneficiaries with incomes between 100 and 133 percent of FPL and who have had 48 months of HMP eligibility coverage to complete or "actively engage" in an annual healthy behavior assessment – and associated cost sharing requirements – to maintain eligibility for HMP.

We are also opposed to the decision to phase out cost sharing reductions related to healthy behavior completion incentives after 48 months of cumulative HMP eligibility coverage, as beneficiaries would still be required to meet the healthy behavior assessment without the associated incentive. Research indicates that penalizing enrollees for non-compliance or failing to meet outcomes dictated by a Health Risk Assessment (HRA) (or the state) will not likely generate cost savings or improve the health of low-income HMP enrollees.[34] Instead, State residents would be better served by a comprehensive, evidence-based participatory wellness program based on incentives that provides adequate and comprehensive coverage of preventive services (including tobacco cessation, weight loss, and cancer screenings) and that 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.[35]

A mandatory, outcomes-based program will likely not improve the health of low-income Michigan residents. Nationally, significant disparities exist in the prevalence of healthy behaviors by income. For example, adults living below the poverty level are more than one and a half times as likely to smoke cigarettes as those with higher incomes[36] and individuals with incomes less than 100 percent of poverty are 30 percent more likely to be obese than people with much higher incomes (above 400 percent of

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[33] Ibid.

[34] 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.

[35] Ibid.

[36] Centers for Disease Control and Prevention. Cigarette smoking and tobacco use among people of low socioeconomic status. Updated February 3, 2017. Accessed October 2018. https://www.cdc.gov/tobacco/disparities/ low-ses/index.htm.

poverty).[37] Low-income individuals and families often face multiple structural barriers to addressing healthy behaviors, including lack of access to evidence-based tobacco cessation support, few safe places for physical activity in their neighborhoods, lack of access to affordable healthy foods, and lower health literacy.[38] Providing enrollees incentives could lead to a change in behavior whereas penalties do little to improve health, and could reduce access to necessary health care services, including preventive care.

We urge CMS to consider the impact a mandatory, outcomes-based wellness program will have on low-income Michigan residents, because it could unfairly penalize individuals managing complex, chronic diseases, like cancer. Although the State exempts individuals determined to be medically frail from the 48-month cumulative enrollment suspension of coverage, the increase in administrative requirements for enrollees to attest to their exemption status on a yearly basis could decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. We also ask CMS to require the State to clarify the criteria it intends to use when determining how to assess efforts beneficiaries must take to make their healthy behaviors "incrementally more challenging" in subsequent years, as well as what constitutes "active engagement" in healthy behaviors. Greater specification would be helpful in assessing the possible effects this type of incrementally-based measurement would have on HMP enrollees, particularly how it may affect eligibility and enrollment.

Although, overall, we were glad to see the positive health outcomes reported in the State's HMP Primary Care Practitioner Report and Enrollee Survey, we do have some concerns with the findings. Specifically, we are concerned that only 36 percent of providers reported being very/somewhat familiar with health behavior incentives for patients, only 28.1 percent of enrollees were aware they could reduce the amount they owed by completing an HRA, and that only 49.3 percent of enrollees self-reported completing an HRA.[39] These numbers are extremely concerning if an enrollee's eligibility is predicated on whether they receive an HRA and perform a healthy behavior determined by that HRA. Educating, encouraging, and raising HMP provider and enrollee awareness of the benefits, services, and incentive program requirements through targeted outreach is extremely important to ensure greater participation and health amongst HMP enrollees, while also preventing individuals from being disenrolled due to lack of proper education of the wellness program requirements.

Suspension of Eligibility Coverage and Continuity of Care
The Michigan 1115 waiver amendment states that Medicaid coverage for beneficiaries who have not met the program's cost-sharing or healthy behavior requirements will be suspended until the individual comes into compliance with the requirements, at which point they will be re-enrolled the first day of the next available month. The waiver appears to imply that some individuals may be exempt from this requirement. We seek further clarification and remind CMS that failure to consider the care delivery and/or treatment regimen of patients, especially those individuals managing a complex, chronic

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[37] National Center for Health Statistics. *Health, United States, 2015: with special feature on racial and ethnic health disparities*. Hyattsville, MD. 2016. https://www.cdc.gov/nchs/data/hus/hus15.pdf.
[38] Centers for Disease Control and Prevention – Division of Community Health. *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*. Atlanta, GA: US Department of Health and Human Services; 2013.
[39] Michigan Department of Health and Human Services. *Section 1115 demonstration extension application: Health Michigan Plan Project No. 11-W-00245/*5. Lansing, MI.

condition like cancer or cancer survivorship, could have devastating effects on patients, their families, and providers.

Cancer 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,[40] and suffer from multiple comorbidities linked to their cancer treatments.[41] Ensuring both cancer patients and recent survivors receive the care they need is critical to positive health outcomes.

If CMS were to approve these provisions, we ask CMS to require the State to provide a clear appeals process and additional continuity of care provisions that would minimize disruptions in coverage and care for individuals in active treatment for life-threatening illnesses and individuals with chronic conditions that require frequent follow-up, such as recent cancer survivors. Additionally, the State should establish a clearly defined process through which HMP enrollees or their physician can inform the Michigan Department of Health & Human Services that they are in active treatment or have a serious chronic condition; allowing them to maintain their treatment regimen through any appeals process.

Conclusion

We appreciate the opportunity to provide comments on the Michigan demonstration waiver extension request. The preservation of eligibility, coverage, and access to HMP remains critically important for many low-income Michigan residents who depend on the program for cancer prevention, early detection, diagnostic, and treatment services. We ask CMS to weigh the impact these proposed policy changes could have on low-income Michigan residents' 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 (please see attached addendum) 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 are 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

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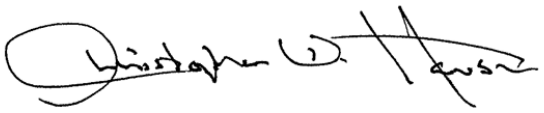
[40] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed October 2018. https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care.

[41] 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.

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,



Christopher W. Hansen
President