American Cancer Society
Cancer Action Network
555 11th Street, NW
Suite 300
Washington, DC 20004
202.661.5700
www.fightcancer.org

December 21, 2018

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

Re: Virginia COMPASS: Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency

Dear Secretary Azar:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Commonwealth of Virginia's Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency (COMPASS) Section 1115 research and demonstration waiver extension request. 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 applauds the Commonwealth of Virginia for expanding the Commonwealth's Medicaid program. Expansion of Virginia's Medicaid program will allow thousands of low-income Virginians to gain access to affordable, comprehensive health care coverage. Over 42,400 Virginians are expected to be diagnosed with cancer this year[1] – many of whom will gain access to health care coverage as a result of Virginia's Medicaid expansion. ACS CAN wants to ensure that cancer patients and survivors in Virginia will have adequate access and coverage under the traditional and Medicaid expansion programs and that specific requirements do not create barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer.

After reviewing the COMPASS waiver, we believe that some of the proposed policies in the waiver could potentially limit eligibility and access to care for some of the most vulnerable Virginians, including those with cancer, cancer survivors, and those who will be diagnosed with cancer in their lifetime. We urge the Centers for Medicare and Medicaid Services (CMS) to address the following concerns or reject this waiver in its current form.

The following are our specific comments on the Commonwealth's COMPASS 1115 waiver extension request:

[1] American Cancer Society. *Cancer Facts & Figures 2018*. Atlanta, GA: American Cancer Society; 2018.

The Training, Education, Employment and Opportunity Program (TEEOP)

The Commonwealth's waiver includes the requirement that all adults aged 19 through 64 years must be employed or participating in job search/training, chronic disease management classes, nutrition education classes, or community service activities for 20 hours per month for the first three months (up to 80 hours per month after 12 months of enrollment) to maintain eligibility or enrollment in the Medicaid program. We are concerned the TEEOP policy could unintentionally disadvantage patients with serious illnesses, such as cancer. While we understand the intent of the proposal is to "empower individuals to improve their health and well-being and gain employer sponsored coverage or other commercial health insurance coverage" among Medicaid enrollees, but many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[2,3,4]

ACS CAN opposes tying access to affordable health care for lower income persons to work or 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 are physically 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.[5] Recent cancer survivors often require frequent follow-up visits and maintenance medications to prevent recurrence,[6] and suffer from multiple comorbidities linked to their cancer treatments.[7,8] 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.[9,10,11,12] If work and/or participation in community engagement activities is required as a condition of eligibility, many cancer patients, recent survivors, and those with other chronic illnesses could become ineligible for the lifesaving treatment services provided through Medicaid. We also note that imposing work or community engagement requirements on lower income

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[2] 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.

[3] 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.

[4] 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.

[5] 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.

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

[7] 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.

[8] 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.

[9] Ibid.

[10] 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.

[11] 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.

[12] 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.

individuals as a condition of coverage could impede individuals' access to preventive care, including cancer screenings.

We appreciate the Commonwealth's acknowledgement that not all people are able to work and the decision to include several exemption categories and "good cause" exemptions from the work requirement and associated suspension from the program. However, we are concerned that the waiver does not go far enough to protect vulnerable individuals, including cancer patients, recent cancer survivors, those with conditions that put them at risk for cancer, and other serious chronic diseases often linked to cancer treatments.[13,14] We are concerned with the Commonwealth's lack of specificity about how often enrollees would be required to either verify their exemption to the employment requirement or prove they are meeting the work requirement. All the State provides is that "the specific length of time for which a standard exemption applies will depend on the exemption" and the time periods will be "guided by and correspond with… industry standard, federal guidance…, and previously approved 1115 Demonstration Special Terms and Conditions." The increase in administrative requirements for enrollees and the uncertainty around how often an enrollee may need to attest to their working status and exemptions would likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt.[15]

As an example, in the sixth month of implementation of the *Arkansas Works* work requirement (November 2018) only 14 percent of the over 9,800 Medicaid enrollees, who did not declare an exemption, were able to navigate the complex reporting system and satisfy the state's reporting requirement.[16] As of December 7, 2018, an additional 4,655 *Arkansas Works* enrollees have been locked out of coverage through the end of the calendar year due to noncompliance with the work requirement.[17] The number is in addition to the 12,277 individuals the state removed from the program in the last three months, totaling 16,932 Arkansans losing coverage since September. 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, CMS should consider the number of Virginians whose health could be negatively impacted and the coverage losses that could occur due to this proposal.

Suspension from the Medicaid Program
We are deeply concerned about the proposed suspension period for non-compliance with the work requirement for three consecutive or non-consecutive months within a 12-month period. According to the Department's estimates, approximately 120,000 enrollees will be subject to TEEOP when the work

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[13] 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.
[14] 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.
[15] 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 December 2018. http://files.kff.org/attachment/Issue-Brief-Implications-of-a-Medicaid-Work-Requirement-National-Estimates-of-Potential-Coverage-Losses.
[16] Arkansas Department of Human Services. Arkansas Works Program: November 2018 Report. Accessed December 2018. https://humanservices.arkansas.gov/images/uploads/newsroom/181217_AWreport.pdf.
[17] Ibid.

and community engagement requirements go into effect.[18] Roughly 18 percent of those enrollees are estimated to lose Medicaid coverage due to noncompliance with the work and community engagement requirements.[19] The Department specifies that Medicaid coverage can be reinstated if the individual demonstrates compliance with work and community engagement requirements for one month or at the end of the 12-month period of an enrollee's coverage year. If individuals are locked out of coverage for even a month, 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[20] and who suffer from multiple comorbidities linked to their cancer treatments.[21] It may also be a problem for individuals in active cancer treatment who may not realize they are exempt. Being denied access to one's cancer care team could be a matter of life or death for a cancer survivor and the financial toll that a suspension of coverage would have on individuals and their families could be devastating.

Premium Requirements

The Virginia Department of Medical Assistance Services ("the Department") requests permission to implement a *Health and Wellness Program* with associated premium requirements to encourage "certain newly eligible adults to take greater responsibility for their personal health and well-being while preparing for the financial requirements of ESI [employer sponsored insurance] or other private health insurance coverage." ACS CAN supports Virginia's goal of encouraging newly eligible adults to seek preventive care and encourage the adoption of health behaviors through the *Health and Wellness Program,* as a substantial proportion of cancers could be prevented or caught at an earlier more treatable stage through preventive care and screening.[22]

We are concerned that the lock out period for non-payment of one's monthly premium could create administrative burdens for enrollees, that could deter enrollment or result in a high number of disenrollment, causing 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.[23,24,25] 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,

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[18] Joint Legislative Audit and Review Commission. *Fiscal impact review: 2018 general assembly session*. Published February 9, 2018. Accessed December 2018. http://lis.virginia.gov/cgi-bin/legp604.exe?181+oth+HB338JH1110+PDF.
[19] Ibid.
[20] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed November 2018. https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care.
[21] 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.
[22] Ibid.
[23] 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.
[24] 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.
[25] 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 October 2018. http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty.

including preventive screenings.[26,27,28] Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.[29] 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.[30] Proposals that place greater financial burden on low-income residents create barriers to care and will negatively impact enrollees – particularly those individuals who are high service utilizers with complex medical conditions.

It is unclear from the waiver whether the sliding scale premiums 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 CMS require the premium contributions 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 hourly/seasonal workers or individuals who must spend down before meeting the Medicaid eligibility criteria.

Health and Wellness Account (HWA) and Health Rewards
The Department will require enrollees to pay monthly premiums to a health and wellness account (HWA), which will constitute a fulfillment of the HWA deductible obligation ($50 deductible obligation for enrollees with income between 100 to 125 percent of the FPL and $100 deductible obligation for enrollees with income between 126 and 138 percent of the FPL). Individuals who meet their deductible obligation AND engage in at least one healthy behavior will receive a rebate from their HWA to be used towards non-covered medical or health-related services for the following coverage year. Enrollees who do not meet their deductible obligation and do not participate in a healthy behavior will forfeit any accrued HWA funds (i.e., they are not eligible for health rewards or HWA fund rollover).

While we appreciate the Commonwealth's focus on healthy behaviors among the newly eligible population, we strongly advised against the Department requiring beneficiaries with incomes between 100 and 138 percent of FPL with complex, chronic conditions to complete an annual healthy behavior or forfeit any accrued HWA funds, as it could negatively impact these individuals. A wellness program of this type could unfairly penalize low-income State residents managing complex, chronic diseases, like cancer. Therefore, we ask CMS not to approve this type of proposal as currently written.

Copayments for Non-Emergent Emergency Department Use
The Department's request to impose copayments for each "non-emergent or avoidable" emergency department (ED) use 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

[26] 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.
[27] 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.
[28] 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.
[29] American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2017-2018*. Atlanta: American Cancer Society; 2018.
[30] Ibid.

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 that the Department define the terms "non-emergent" or "avoidable" use of the ED, as they are not included in the waiver. Additionally, when evaluating ED cost sharing requirements, we request that CMS 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.

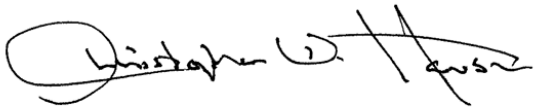
Conclusion

We appreciate the opportunity to provide comments on Virginia's COMPASS Section 1115 demonstration waiver application. The expansion of eligibility for the Commonwealth's Medicaid program will dramatically improve the health and well-being of thousands of low-income Virginians. The Medicaid program is critically important for many low-income Virginians 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 Virginians' access to lifesaving health care coverage, particularly for 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 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