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

September 6, 2017

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

Re: MaineCare 1115 Demonstration Project Application

Dear Secretary Price,

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Maine's 1115 demonstration waiver application. 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 giving states appropriate flexibility to improve their Medicaid programs. Nearly 9,000 Mainers are expected to be diagnosed with cancer this year – many of whom rely on MaineCare for their coverage.[1] ACS CAN wants to ensure that cancer patients and survivors in Maine have adequate access and coverage under the MaineCare program, and that specific requirements do not create barriers to care for low-income cancer patients and survivors. To this end, we are concerned that Maine's 1115 Demonstration Project, which would impact the most vulnerable residents in Maine, could have a particularly negative affect on lower income cancer patients and survivors.

Maine's proposed waiver does not meet the statutory criteria established by the Centers for Medicare and Medicaid Services (CMS) for approval under section 1115. Specifically, the waiver does not expand or strengthen eligibility; stabilize or strengthen Medicaid provider networks; improve health outcomes for low-income populations; or increase program efficiency or quality of care for low-income populations through a service delivery network.[2] Additionally, the demonstration is not budget neutral. Therefore, we urge CMS not to approve the waiver until specific improvements are made.

The following are our specific comments on the State's MaineCare 1115 waiver application.

---

[1] American Cancer Society. *Cancer Facts & Figures 2017*. Atlanta, GA: American Cancer Society; 2017.
[2] Centers for Medicare and Medicaid Services. Medicaid.gov. *About Section 1115 Demonstrations*. Accessed May 2017. https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.

<u>Community Engagement and Work Requirements</u>

The waiver proposes to require all "able-bodied" adults aged 19-64 be employed, receive unemployment benefits, attend school at least half time, participate in a job search or readiness assistance program, or participate in a "Department-approved" work program for 20 hours-per-week or a workfare or volunteer community service activity for 24 hours-per-month to maintain eligibility or enrollment in MaineCare. Unfortunately, it may not be possible for some cancer patients to meet these requirements. Cancer patients in active treatment are often unable to work for periods of time or require significant work modifications due to the side effects commonly associated with treatment.[3,4,5] If this requirement is included as a condition of eligibility for coverage, some cancer patients could be ineligible for the lifesaving cancer treatment services provided through MaineCare.

We appreciate the State's acknowledgement that not all eligible individuals are able to work and have laid out exemptions from the work requirement and the associated eligibility time limits. For example, we are pleased that the State clarified that women diagnosed through the Maine's Breast and Cervical Health Program (MBCHP) are exempt from the community engagement and work requirement provision. However, we remain concerned that cancer patients and recent survivors may not fit into the "physically or mentally unable to work" exemption as detailed in this waiver. Therefore, if CMS approves this requirement as a condition of eligibility, we encourage the agency to require the State to utilize the federal medically frail designation (42 CFR §440.315(f)), which would allow certain individuals with serious and complex medical conditions be exempt from this requirement. Further, we ask that Maine be required to include in its definition of medically frail or alternative exemption criteria 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.

<u>Penalty for Non-Payment of Premiums</u>

We appreciate the State taking into account stakeholder input and eliminating premiums for those below 50 percent of the Federal Poverty Level (FPL). We remain concerned that the establishment of a tiered premium requirement and related penalties for non-payment will likely deter enrollment or result in a high number of people dropping coverage. This could cause significant disruptions in care, especially for cancer survivors and those newly diagnosed. Studies have shown that imposing even modest premiums or cost sharing on low-income individuals is likely to deter enrollment in the Medicaid

---

[3] 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.
[4] 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.
[5] 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.

program.[6,7,8] Proposals that place greater financial burden on the lowest income residents, especially those under 100 percent of the FPL, create barriers to care and will negatively impact MaineCare enrollees – particularly those individuals who are high service utilizers with complex medical conditions, like cancer. Therefore, if the State maintains a premium requirement we urge that those under 100 percent of the poverty level be exempted.

Lock-Out Period

We are deeply concerned about the proposed 90-day lock-out period for non-payment of premiums, particularly for enrollees below 100 percent of the FPL. Although we appreciate the State allowing individuals to re-enroll once any unpaid premiums are paid, any lock-out period 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 battling cancer. During the proposed lock-out period, low-income cancer patients or survivors will likely have no access to health care coverage, making it difficult or impossible to continue treatment or pay for their maintenance medications. For cancer patients who are mid-treatment, such a loss of health care coverage could seriously jeopardize their chance of survival. Being denied access to one's cancer care team for 90 days or less 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.

We ask the Department to encourage the State to implement a medical or hardship exemption that would allow individuals managing complex medical conditions, like cancer, to proactively attest to any change in their health status that could qualify them for the medical or hardship exemption from the cost sharing initiative and its related penalties, preventing any unnecessary gaps in coverage.

Copayments for Non-Emergent Emergency Department Use

ACS CAN agrees with the State that the emergency department (ED) is often overutilized for expensive non-emergent care. We appreciate the State's decision to reduce the proposed out-of-pocket cost sharing for Emergency Department (ED) services, recognizing the provision would impact Maine's most vulnerable populations. However, we remain concerned that the provision could still unintentionally impact low-income cancer patients. 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.[9,10] If primary care settings and other facilities are not available, these patients are often directed to the ED. The proposal inadvertently assumes that a serious side effect from cancer

---

[6] 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.

[7] 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.

[8] 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.

[9] Sadik M, Ozlem K, Huseyin M, AliAyberk, Ahmet S, Ozgur O. Attributes of cancer patients admitted to the emergency department in one year. *World J Emerg Med.* 2014; 5(2):85-90.

[10] Numico G, Cristofano A, Mozzicafreddo A, et al. Hospital Admission of Cancer Patients: Avoidable Practice or Necessary Care? Santini D, ed. *PLoS ONE*. 2015;10(3):e0120827. doi:10.1371/journal.pone.0120827.

treatments are somehow not medically justified. If CMS were to approve this proposal, we ask CMS to urge the State to permit cancer patients experiencing serious side effects of treatment to be able to access the ED when necessary without penalty.

Asset Limitations

ACS CAN opposes the proposed $5,000 asset test that would be applied to all households who do not otherwise have an asset test as part of their eligibility determinations. The State gives no justification as to how this asset test promotes the objectives of the Medicaid program or the required criteria for an 1115 waiver approval. The proposal is also counterintuitive. It is likely that an enrollee may have an asset – such as a car – that would trigger the asset test but at the same time be cash poor. For example, if a low-income couple living in a rural area of Maine requires a car to get to and from necessary cancer treatments, the asset test could prevent them from receiving this lifesaving care. Additionally, this provision would add unnecessary administrative costs for both the State and enrollees by increasing the time needed to process eligibility applications, leading to delays in coverage.[11,12] Any delay in health care coverage could seriously jeopardize a cancer patient's chance of survival. Therefore, we highly recommend CMS to deny this provision of the waiver application.

Retroactive Eligibility

ACS CAN is opposed to policies that create any type of time limit on Medicaid eligibility as these could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals battling cancer. Medicaid is a safety net for low-income uninsured individuals and part of that safety net is allowing enrollees to receive coverage retroactively if they did not realize they were eligible for coverage under the program or as they prepare the proper documentation and application to become enrolled in the program. Many uninsured or underinsured individuals who are newly diagnosed with a chronic condition do not receive recommended services and follow-up care because of cost.[13] In 2015, one in five uninsured adults went without care because of cost.[14] Waiving retroactive eligibility could delay necessary care in low-income populations and negatively impact patients with complex medical conditions that require frequent follow-up and maintenance visits to help control their disease process.

In the waiver application, the State indicates that "[p]roviders should determine whether or not they wish to deliver a service based on the insurance status of the individual at the time of the service and not based on potential for future retroactive insurance coverage by MaineCare." What this statement fails to consider is that safety net hospitals and providers also rely on retroactive eligibility for reimbursement of services provided, allowing them to keep their doors open. For example, the

---

[11] The Henry J. Kaiser Family Foundation. Eliminating the Medicaid asset test for families: A review of state experiences. Published April 2001. Accessed May 2017. https://kaiserfamilyfoundation.files.wordpress.com/2001/04/2239-eliminating-the-medicaid-asset-test.pdf.

[12] Cassidy A. Health policy brief: Enrolling more kids in Medicaid and CHIP. *Health Affairs*, January 27, 2011. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_39.pdf.

[13] 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.

[14] The Henry J. Kaiser Family Foundation. Key facts about the uninsured population. Published September 29, 2016. Accessed May 2017. http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

Emergency Medical Treatment and Labor Act (EMTALA) requires EDs to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.[15] Retroactive eligibility allows hospitals to be reimbursed if the individual treated is eligible for MaineCare coverage. Likewise, Federally Qualified Health Centers (FQHCs) offer services to all persons, regardless of that person's ability to pay or insurance status.[16] Community health centers play a large role in ensuring low-income individuals receive cancer screenings, helping to save the State of Maine from the high costs of later stage cancer diagnosis and treatment. We urge CMS to deny the State permission to waive retroactive eligibility in the MaineCare program, as it would not only negatively impact enrollees, but the providers and hospitals that care for them.

Presumptive Eligibility Determinations by Qualified Hospitals

Many low-income, uninsured or underinsured individuals – including cancer patients and survivors[17,18] – utilize the emergency department for various health care needs.[19] The presumptive eligibility determination allows hospitals to assume patients are Medicaid eligible, preventing the patient from having to pay for services out-of-pocket, ensuring timely access to needed care, and allowing hospitals and providers to be reimbursed for services provided.

Maine's proposal to eliminate presumptive eligibility could prevent the uninsured or underinsured – who may be eligible for Medicaid but have not yet enrolled – from enrolling and participating in the program. By enrolling more of the uninsured through the presumptive eligibility determination process, the hospitals and the State could realize more cost-savings by detecting cancers earlier through preventive screenings, when they are less costly and outcomes are better. Similar to waiving the retroactive eligibility provision, waiving presumptive eligibility would negatively impact safety net hospitals that rely on presumptive eligibility determinations to be reimbursed for their services and rely less on charity care.[20] Therefore, we urge CMS to deny the State permission to waive presumptive eligibility determinations by qualified hospitals.

Conclusion

We appreciate the opportunity to provide comments on the MaineCare waiver application. The preservation of eligibility and coverage through MaineCare remains critically important for many low-income State residents who depend on the program for cancer prevention, early detection, diagnostic, and treatment services. Upon further consideration of the policies included in Maine's final waiver

---

[15] Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed May 2017. https://www.cms.gov/regulations-and-guidance/legislation/emtala/.

[16] National Association of Community Health Centers. Maine health center fact sheet. Published March 2017. Accessed May 2017. http://www.nachc.org/wp-content/uploads/2016/03/ME_17.pdf.

[17] Sadik M, Ozlem K, Huseyin M, AliAyberk, Ahmet S, Ozgur O. Attributes of cancer patients admitted to the emergency department in one year. *World J Emerg Med.* 2014; 5(2):85-90.

[18] Zhou Y, Abel GA, Hamilton W, Pritchard-Jones K, Gross CP, Walter MF, et al. Diagnosis of cancer as an emergency: a critical review of current evidence. *Nature Reviews Clinical Oncology.* 2016; 14:45-56. doi:10.1038/nrclinonc.2016.155.

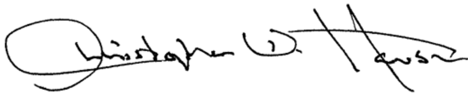
[19] National Center for Health Statistics. *Health, United States, 2015: with special feature on racial and ethnic health disparities*. Hyattsville, MD. 2016. https://www.cdc.gov/nchs/data/hus/hus15.pdf.

[20] Brooks T. Health policy brief: hospital presumptive eligibility. *Health Affairs.* January 9, 2014. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_106.pdf.

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,



Christopher W. Hansen
President
American Cancer Society Cancer Action Network