October 23, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

**Re: ARHOME Section 1115 Demonstration Application**

Dear Secretary Becerra,

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Arkansas's proposal to renew and amend the state's 1115 demonstration waiver, renamed "Arkansas Health and Opportunity for Me (ARHOME)." 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 supports the Arkansas Medicaid program goals of ensuring access to quality healthcare to members. However, the proposed cost sharing provisions could limit – rather than improve – access to care for some of the most vulnerable Arkansans, including those with cancer, cancer survivors, and those needing preventive care and cancer screenings. We are also concerned about the reduced length of retroactive eligibility and its impacts on continuity of care. While we strongly support Medicaid expansion overall in Arkansas, we urge HHS to reject these elements of the demonstration application.

More than 17,980 Arkansas residents are expected to be diagnosed with cancer this year,[1] and there are more than 143,320 cancer survivors in the state[2] – many of whom rely on healthcare provided through the Medicaid program. ACS CAN wants to ensure that enrollees have adequate access and coverage under the Medicaid program, and that specific requirements do not create barriers to care for cancer patients, survivors, and those who will be diagnosed with cancer.

Following are our specific comments on Arkansas's 1115 demonstration application:

**Cost Sharing**

Higher out-of-pocket costs decrease the likelihood that a lower income person will seek health care services, including preventive screenings.[3,4,5] Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.[6] 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.[7] 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. Although enrollees determined to be Medically Frail are not subject to these cost sharing provisions, we are concerned that many cancer patients and survivors as well as others with complex and/or chronic health care needs will not be classified as Medically Frail, and therefore will be harmed by these policies.

Premiums and cost sharing can 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.[8] 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. Seemingly nominal copayment amounts could very quickly add up for a patient with multiple provider visits, treatments, and tests in a single week and represent high costs for households with very limited incomes.

Requiring enrollees to pay up to five percent of household income each quarter could result in many cancer patients and survivors delaying their treatment and could result in them forgoing their treatment or follow-up visits altogether. Although the payment of premiums and copayments is not a condition of eligibility, allowing providers to deny service for failure to pay cost-sharing could result in individuals losing access to their care during cancer treatment. We strongly urge the Department to reject the proposal to require low-income individuals, including those earning just 21% FPL, to pay cost-sharing up to five percent of household income.

We note that qualified health plans (QHPs) can exclude some enrollees from cost sharing provisions "as a reward" for participation in "health improvement or economic independence initiatives". We support efforts to incentivize health improvement but are concerned that enrollees who are not able to engage in these initiatives (because, for example, they can't take time off work) are charged cost-sharing punitively. As discussed above, this can deter enrollees from seeking or receiving needed healthcare, like routine screenings, and may actually accomplish the opposite of the stated goal of 'health improvement.' Additionally, the Division states that the purpose of implementing this initiative is to "evaluate whether individuals value coverage as 'insurance.' Traditionally, Medicaid is considered medical assistance..."[9] We note that the primary goal of the Medicaid program is to provide affordable health insurance coverage, and this goal should not be sacrificed in order to evaluate citizens' perceptions of the program. We encourage the Department to reject this piece of the proposal as it runs counter to the purpose of Medicaid.

*Surcharge for Non-emergent Use of the Emergency Department*
The Division's request to impose a $9.40 fee for each "non-emergent" or "inappropriate" use of the emergency department (ED) for those with incomes at and above 21 percent of FPL could increase costs for cancer patients. We note that despite our request for clarification, the Division did not include a clear definition of "non-emergent" or "inappropriate" ED use in its application, and it is therefore not clear which situations will result in these fees. If it is not clear in the Division's application, it is not likely to be clear to enrollees who are making healthcare decisions – particularly when they are deciding whether a situation is an emergency.

Imposing this surcharge 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 a surcharge for non-emergent use of the ED could become a significant financial hardship for these low-income patients. We urge the Department to reject this provision of the waiver.

**Reduce retroactive coverage to 30 days**

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. Therefore, we are concerned about the Division's request to reduce retroactive eligibility to 30 days from the allowed 90 days.

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.[10,11] In 2017, one in five uninsured adults went without care because of cost.[12] Reducing 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 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.[13] 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.[14] Community health centers also play a large role in ensuring low-income individuals receive cancer screenings, helping to save the state of Arkansas from the high costs of later stage cancer diagnosis and treatment. Therefore, we urge the Department to consider these providers and their contribution to Arkansas's safety net, as well as the patients who rely on Medicaid for health care coverage, before allowing Arkansas to reduce retroactive eligibility for Medicaid enrollees.

**Community Engagement Activities**

We appreciate that this demonstration application does not include work and community engagement (WCE) requirements, but are concerned that the state will seek to amend the Demonstration if federal law or regulations permit the use of these requirements as a condition of eligibility in the future. ACS CAN opposes tying access to affordable health care for lower income persons to employment or community engagement requirements, because cancer patients and survivors – as well as those with other complex chronic conditions – could be seriously disadvantaged and find themselves without Medicaid coverage because they are physically unable to comply. The state's previous experience with WCE requirements - where uninsured rates were driven up and employment actually declined in the state after the requirement went into effect[15] - demonstrates the impact this policy can have on reducing health coverage and not meeting the state's goal of incentivizing employment and increasing the number of employed Arkansas Works enrollees.[16]

Many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[17,18,19] 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.[20] Recent cancer survivors often require frequent follow-up visits[21] and suffer from multiple comorbidities linked to their cancer treatments.[22,23] 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.[24,25] If work and community engagement is required as a condition of eligibility, many newly diagnosed and recent cancer survivors, as well as those with other chronic illnesses 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 prevention and early detection care, including cancer screenings and diagnostic testing.

**Conclusion**

We appreciate the opportunity to provide comments on the Arkansas demonstration application. The preservation of eligibility, coverage, and access to Medicaid remains critically important for many low-income state residents who depend on the program for cancer and chronic disease prevention, early detection, diagnostic, and treatment services. We ask the Department to weigh the impact of these proposals on low-income Arkansans' 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. We look forward to working with you to ensure that coverage through Arkansas Medicaid meets the health care needs of eligible individuals and families and reduces the burden of cancer for lower income Arkansans. If you have any questions, please feel free to contact my staff at 202-839-3531 or Jennifer.Hoque@cancer.org.

Sincerely,

Kirsten Sloan
Managing Director, Public Policy
American Cancer Society Cancer Action Network

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