May 9, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Arizona Section 1115 Waiver Amendment Request: AHCCCS Works

Dear Secretary Kennedy and Administrator Oz:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the request to amend the Arizona Section 1115 Waiver Amendment Request titled AHCCCS Works, submitted on March 28, 2025. 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 more determined than ever to end cancer as we know it, for everyone.

ACS CAN urges CMS to reject the proposed AHCCCS Works Demonstration. Access to health care is essential for people with cancer: research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[1] and 2 million Arizonans rely on Medicaid for their coverage, and in fiscal year 2024, 64,000 enrollees received cancer treatment.[2] Yet, based on the information in the proposal and the outcomes from other states that have tried similar approaches access to cancer screenings and treatment in Arizona could actually be diminished if this waiver is approved.

Why Medicaid Work Requirements are not Successful

The AHCCCS Works Demonstration seeks to implement work reporting requirements for adults in the Medicaid expansion population aged 19-55 with incomes up to 138% of the federal poverty level (FPL), which is just over $3,000 per month for a family of three. Unfortunately, these requirements don't promote work but instead add another layer of red tape that jeopardizes patients' access to care. The vast majority of those with Medicaid who can work already do so; nationally, 92% of individuals with Medicaid coverage under age 65 who do not receive Social Security disability benefits are either workers, caregivers, students, or unable to work due to illness.[3]

ACS CAN opposes tying access to affordable health care for lower income persons to employment or income as a proxy for employment, because cancer patients and survivors – as well as those with other complex chronic conditions – could be unable to comply and find themselves without Medicaid coverage at a time when they need it most. Many cancer patients in active treatment are often unable to work or require

significant work modifications due to their treatment.[4,5,6,7,8] 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.[9,10] Recent cancer survivors often require frequent follow-up visits[11] and suffer from multiple comorbidities linked to their cancer treatments.[12,13] 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 and treatment.[14,15,16,17,18]

When work is required as a condition of eligibility for needed health care coverage, 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 Arizona's Medicaid program. We also note that imposing work requirements on lower income individuals as a condition of coverage impedes individuals' access to prevention and early detection care, including cancer screenings and diagnostic testing. Work requirements further decrease the number of individuals with Medicaid coverage, regardless of whether they are or should be exempt.[19,20] This is particularly concerning, given that health insurance is one of the most important factors in determining whether a patient survives cancer.[21]

We are also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from working. For example, individuals who have survived cancer – and are no longer undergoing cancer treatment that might flag them for an exemption in claims data – often continue to suffer from long-term treatment side effects or late- and long-term effects of their cancer. Some of these circumstances make cancer survivors unable to work, or unable to go back to the job they had before cancer treatment. Kicking a cancer survivor off Medicaid because they cannot work, or cannot find a job is not only unfair, but it also takes away crucial access to follow-up and survivorship care.

Additional processes to determine patient eligibility and participation in program requirements inherently create opportunities for administrative errors that jeopardize access to care. The waiver is unclear on reporting and enforcement of the work reporting requirements and good cause circumstances. The state does not have a clear process for how it will ensure that reporting is accessible to all enrollees, nor does it clarify if compliance will be solely determined with data matching. If the state intends to rely on data matching, there will undoubtedly be individuals whose data is incomplete, outdated, or not accurately captured by the systems in use. Individuals undergoing intense cancer treatment often have difficulty keeping up with paperwork or opening their mail and therefore will be particularly vulnerable to being cut off from coverage by mistake.

Time Limits on Medicaid Jeopardize Coverage.

The state's proposed five-year time limit on how long someone can maintain Medicaid coverage does not promote the objectives of Medicaid. It is an arbitrary, harmful policy and could limit patients' access to critical treatment when they need it most. The federal government did not approve a nearly identical version of this policy proposed by Arizona in 2019,[22] and CMS should not approve this request.

ACS CAN strongly opposes any proposal that limits the amount of time an eligible individual can be enrolled in Medicaid. If individuals are suspended from coverage, 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. 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[23] and who suffer from multiple comorbidities linked to their cancer treatments.[24] It would also be a problem for individuals in active cancer treatment if they are not exempted – or do 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 patient or survivor and the financial toll that of this gap in coverage would have on individuals and their families could be devastating.

When individuals lose coverage, even for a short amount of time, it is difficult or impossible for those with cancer to continue treatment. For cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. The loss of coverage can be devastating to cancer patients and their families. Mostly recently, the link between disruptions in Medicaid coverage and worsened health outcomes was established among Medicaid-insured children and adolescents with blood cancers: lack of continuous Medicaid coverage was associated with advanced-stage diagnosis of lymphoma,[25] and poorer survival.[26]

ACS CAN is concerned about the costs of implementing this proposal.
There will likely be large administrative costs to the state given the complexity of tracking work activities, tracking months countable toward the time limit, implementing a new data collection process, and having a system in place to identify and track exemptions. For example, a GAO study of work reporting requirements estimated that the administrative costs could be up to $272 million.[27] In Georgia, the state spent over $86 million within a year of implementing the Georgia Pathways to Coverage Program,[28] despite the low enrollment, and it is estimated that 90% of this was for administrative and consulting costs.[29] Furthermore, the aforementioned changes in coverage status are likely to lead to churn, placing greater administrative burden on Arizona's Medicaid program. The administrative cost of churn is estimated to be between $400 and $600 per person.[30] Arizona's Medicaid program is unprepared for the cost and administrative disruption of the proposed requirements.

ACS CAN opposes imposing copays for 'non-emergent' use of Emergency Departments or ambulance transport.
The Department's request to impose a copay for "non-emergent" use of the emergency department (ED) or ambulance transport could increase costs for cancer patients and deter them from seeking care. 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. One study estimates there are 4 million adult cancer–related ED visits each year in the US.[31] The most frequent reasons cancer patients receive care in the ED are pain, fever, and weakness[32] – symptoms that are understandably alarming for patients undergoing

invasive or toxic treatments like chemotherapy. This study also found that 77% of cancer patients did not make the decision to go to the ED alone: healthcare providers (40%, most commonly oncologists) and caregivers (36%) were the other reported decision-makers in these cases.[33]

Low-income cancer patients should not be financially penalized for being directed to seek care through or transport to the ED, regardless of their eventual diagnosis or how their visit was ultimately coded by the ED. Imposing this copay may dissuade an individual from seeking any care from an ED setting – even when it is appropriate for them to go to an ED. Penalizing enrollees, such as cancer patients, by requiring this copay could become a significant financial hardship for these low-income patients. We urge CMS to reject this request.

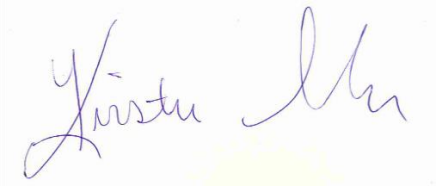
Conclusion

The goal of the Medicaid program is to provide health coverage and access to care for people who need it. We do not believe this proposal meets this goal, and we urge CMS to reject it.

Please note we have included numerous citations to supporting research, including direct links to the research, below. We provide HHS with each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act.

If you have any questions, please feel free to contact Jennifer Hoque at jennifer.hoque@cancer.org

Sincerely,



Kirsten Sloan
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American Cancer Society Cancer Action Network

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