



November 1, 2022

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

Re: CMS-2421-P: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes

Dear Secretary Becerra:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the notice of proposed rulemaking to streamline the Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program application, eligibility determination, enrollment, and renewal processes. 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 supports the changes proposed in this rule because it will make it easier for individuals – including those with cancer, cancer survivors, and those needing cancer screening – to enroll in Medicaid and CHIP and stay enrolled as appropriate. It is critical that all individuals have access to affordable, comprehensive health insurance, and Medicaid and CHIP play a key role in providing this access to many individuals with limited incomes and under other circumstances. Extensive evidence shows that expanding access to Medicaid increases early-stage diagnosis rates among cancer patients.¹ Several studies have also shown that expanding access to Medicaid resulted in patients having timelier access to treatment,^{2,3,4} and improvements in cancer mortality rates.^{5,6,7} One recent study showed that expanding access to Medicaid was associated with increases in overall cancer survival, and the increase was prominent among non-Hispanic Blacks and in rural areas – highlighting the role expanding Medicaid access has in increasing health equity.⁸

ACS CAN also believes the proposed changes are likely to reduce gaps in coverage (sometimes called coverage disruptions or 'churn') for Medicaid and CHIP enrollees. In 2018, 1 in 10 Medicaid or CHIP beneficiaries disenrolled and re-enrolled in less than one year.⁹ Such churning is associated with disruptions in physician care and medication adherence,^{10,11} increased administrative costs for providers, Medicaid managed care organizations, and states;¹² and in some cases higher health care costs when delayed care results in more expensive health care needs.¹³

Gaps in coverage can be detrimental to a person undergoing cancer treatment. Having health insurance

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coverage makes surviving cancer more likely, and the effects of insurance coverage on cancer survival are even more pronounced in disadvantaged communities.¹⁴ Gaps in insurance coverage have been shown to cause delays or inability to obtain prescription drugs¹⁵ – which are an important part of most cancer treatment plans. Evidence-based protocols for chemotherapy and other cancer treatments often require treatment on a proscribed timeline. Interruptions to the timeline because of coverage gaps can be detrimental. A gap in coverage can also cause delay in initiation of a treatment protocol. For example, research shows that delays in the initiation of chemotherapy for breast cancer patients result in adverse health outcomes.¹⁶

Research also shows the detrimental impact of coverage gaps on Medicaid enrollees who have a history of cancer: individuals who had coverage disruptions in the previous year were less likely to report that they used preventive services, and more likely to report problems with care affordability and any cost-related medication nonadherence.¹⁷ A 2020 systematic review of evidence found that among patients with cancer, those with Medicaid disruptions were statistically significantly more likely to have advanced stage and worse survival than patients without disruptions.¹⁸

As the end of the Covid-19-related public health emergency (PHE) nears, ACS CAN is concerned that it also means an end to current requirements prohibiting Medicaid agencies from terminating coverage for most enrollees during the PHE. This creates the potential for many Medicaid enrollees to lose coverage because their eligibility changes, or they fall through cracks in the system and do not know how else to seek out or afford insurance coverage.

CMS is proposing this rule at a crucial time, and we encourage the agency to finalize these proposals quickly and in manner that will prevent the most enrollees from experiencing coverage gaps when the PHE ends. Specifically, we support the following policy changes:

- Requirements for states to take proactive steps to resolve returned mail: Upon receiving returned mail, some states do not make any attempts to find the correct address or contact the enrollee, and simply disenroll the individual from coverage. This policy is very concerning, especially given recent disruptions in the U.S. mail system, the prevalence of other communication types (i.e. phone and email), and the likelihood of the Covid 19 pandemic having resulted in changed addresses. We strongly support the provisions in the rule that require states to proactively attempt to correct addresses and contact the enrollee via other methods, after mailing an initial notice requesting address verification and providing 30 days for a response.
- Improvements in coordination of eligibility between Medicaid and CHIP: According to a recent analysis, 1 in 5 children experience a gap in coverage moving between Medicaid and CHIP and vice versa.¹⁹ We are especially concerned that these gaps will occur for children who are transitioning off of Medicaid when the PHE ends. We support the provisions in the rule that require CHIP programs to accept eligibility determinations made by the corresponding Medicaid agency, and vice versa, and require the state to issue a combined notice that informs families about their status of eligibility in

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both programs and any needed next steps.

- Elimination of enrollment barriers and benefit caps in CHIP: Currently 14 states require a child to be uninsured for a defined waiting period before receiving CHIP coverage,²⁰ and 14 states apply lockouts to families who miss a premium payment.²¹ These policies by definition cause coverage disruptions, and we strongly support their prohibition. We also support the proposed rule's prohibition on annual or lifetime limits on CHIP benefits.
- Standardizing timeliness standards for the communication process between enrollees and state agencies: The proposal establishes standards for how long an enrollee must be given to respond to requests for information, and time allowed for the agency to process this information. We support this standardization, as it more fairly allocates time in such a way that should increase enrollment continuity. However, we urge that enrollees be given up to 30 days to respond to any request for information from agencies, recognizing not only challenges enrollees have in receiving and processing mail, but also the fact that some of these requests include necessary responses or documentation from other entities over which the enrollee has no control. For example, an enrollee should not lose their Medicaid coverage because their doctor's office failed to fill out a necessary form.
- Simplifying application and renewal processes for certain enrollees: Currently states are able to make the application and renewal processes harder and more complicated for enrollees who qualify for Medicaid based on something other than their income (most frequently, individuals over the age of 65 dually eligible for Medicare, disabled individuals – which can include cancer patients and survivors – and blind individuals). We support the policies in this proposal that align the process for these individuals with the streamlined Affordable Care Act requirements for application and renewal process for income-based categories. This will create consistency and efficiencies in these processes, which may alleviate long wait times for eligibility determinations, and will create fewer barriers for enrollees.

Regarding CMS' request for comments regarding implementation dates of policies in this proposal, ACS CAN recognizes that these changes will require time for state agencies to implement, and that these same state agencies are already challenged by preparing for the end of the PHE. However, many of these policy changes take important steps to safeguard the losses of and gaps in coverage that we fear will result from the end of the PHE. Therefore, we encourage CMS to make the effective date 30 days after publication of the final rule and prioritize the policy changes that prevent coverage losses and gaps when the PHE ends for earlier implementation dates – ideally, dates that occur before the end of the continuous coverage requirement. In particular, we recommend that the requirements for resolving returned mail and for coordinating between Medicaid and CHIP programs be implemented earlier, as they will help to prevent coverage loss at the end of the PHE.

Conclusion

We appreciate the opportunity to provide comments on this proposal. We strongly support this proposed rule and encourage CMS to finalize and implement its provisions quickly – particularly the provisions that will prevent coverage losses and gaps when the PHE ends. Maintaining access to quality, affordable, accessible,

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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 CMS to ensure that all people are positioned to win the fight against cancer. If you have any questions, please feel free to contact Jennifer Hoque at jennifer.hoque@cancer.org

Sincerely,

A handwritten signature in black ink that reads "Lisa A. Lacasse". The signature is fluid and cursive, with the first name "Lisa" being the most prominent.

Lisa A. Lacasse, MBA
President
American Cancer Society Cancer Action Network

¹ Kaiser Family Foundation. Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021. Published May 6, 2021. Accessed October 20, 2022. <https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/>

² Adam B. Weiner et al., "Insurance Coverage, Stage at Diagnosis, and Time to Treatment Following Dependent Coverage and Medicaid Expansion for Men With Testicular Cancer," PLOS ONE 15 no. 9 (September 2020), <https://doi.org/10.1371/journal.pone.0238813>

³ Benjamin B. Albright et al., "Impact of Medicaid Expansion on Women with Gynecologic Cancer: a Difference-in-Difference Analysis," American Journal of Obstetrics and Gynecology 224 no. 2 (February 2021): 1-17, <https://doi.org/10.1016/j.ajog.2020.08.007>

⁴ Johanna Catherine Maclean, Michael T. Halpern, Steven C. Hill, and Michael F. Pesko, "The Effect of Medicaid Expansion on Prescriptions for Breast Cancer Hormonal Therapy Medications," Health Services Research, 55 no. 3 (April 2020): 399-410, <https://doi.org/10.1111/1475-6773.13289>

⁵ Ji X, Shi K, Castellino SM, et al. Association between the Affordable Care Act Medicaid expansion and survival in young adults newly diagnosed with cancer. JCO. 2022;40(16_suppl):1502-1502. doi:10.1200/JCO.2022.40.16_suppl.1502

⁶ David Barrington et. al., "Where You Live Matters: A National Cancer Database Study of Medicaid Expansion and Endometrial Cancer Outcomes," Gynecologic Oncology 158 no. 2 (August 2020): 407-414, <https://doi.org/10.1016/j.ygyno.2020.05.018>

⁷ Miranda B. Lam, Jessica Phelan, John Orav, Ashish K. Jha, and Nancy L. Keating, "Medicaid Expansion and Mortality Among Patients With Breast, Lung, and Colorectal Cancer," Jama Network Open 3 no. 11 (November 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772535>

⁸ Han X, Zhao J, Yabroff KR, Johnson CJ, Jemal A. Association Between Medicaid Expansion Under the Affordable Care Act and Survival Among Newly Diagnosed Cancer Patients. J Natl Cancer Inst. 2022 Aug 8;114(8):1176-1185. doi: 10.1093/jnci/djac077. PMID: 35583373; PMCID: PMC9360456.

⁹ Xuesong Han, PhD, Jingxuan Zhao, MPH, K Robin Yabroff, PhD, Christopher J Johnson, MPH, Ahmedin Jemal, DVM, PhD,

Association Between Medicaid Expansion Under the Affordable Care Act and Survival Among Newly Diagnosed Cancer Patients, *JNCI: Journal of the National Cancer Institute*, Volume 114, Issue 8, August 2022, Pages 1176–1185, <https://doi.org/10.1093/jnci/djac077>

¹⁰ Ben Sommers et al., “Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower than Expected But Still Harmful for Many,” *Health Affairs*, Vol. 35, No. 10 (2016): 1816–1824, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0455>.

¹¹ Yabroff KR, Zhao J, Halpern MT, et al. Health Insurance Disruptions and Care Access and Affordability in the U.S. *American Journal of Preventive Medicine*. 2021;0(0). doi:10.1016/j.amepre.2021.02.014

¹² Katherine Swartz et al., “Evaluating State Options for Reducing Medicaid Churning,” *Health Affairs*, July 2015, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4664196/>.

¹³ Anthem Public Policy Institute, “Continuity of Medicaid Coverage Improves Outcomes for Beneficiaries and States,” June 2018, https://www.communityplans.net/wp-content/uploads/2019/04/13_Report_Continuity-of-Medicaid-Coverage-Improves-Outcomes-for-Beneficiaries-and-States.pdf.

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¹⁵ Yabroff KR, Kirby J, Zodet M. Association of Insurance Gains and Losses With Access to Prescription Drugs. *JAMA Intern Med*. 2017 Oct 1;177(10):1531-1532. doi: 10.1001/jamainternmed.2017.4011. PubMed PMID: 28892527; PubMed Central PMCID: PMC5820691.

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