Access to Coverage and Care in Medicaid and CHIP

The Association for Clinical Oncology (ASCO) is a national organization representing more than 45,000 physicians and other health care professionals specializing in cancer treatment, diagnosis, and prevention. We are dedicated to conducting research that leads to improved patient outcomes, and we are committed to ensuring that evidence-based practices for the prevention, diagnosis, and treatment of cancer are available to all Americans. Since its founding more than 50 years ago, ASCO has been committed to advancing health equity in cancer care. Today, that commitment is even stronger as we strive to ensure that all individuals with cancer, regardless of race, ethnicity, age, geographic location, sex, or socioeconomic status, benefit from research advances.

Response to CMS Objective 1:

Access
ASCO strongly agrees with CMS that all eligible individuals should be able to apply, enroll in, and receive Medicaid coverage benefits in a timely and streamlined manner that promotes equitable coverage. ASCO does not support policies that have the potential to restrict or otherwise hinder access to Medicaid, especially for individuals with a cancer diagnosis, or who are at increased cancer risk. Enrollment delays or restrictions result in disruptions in care, unanticipated treatment delay, and delays in screening and care, all of which are linked to worse cancer care outcomes. When patients are no longer able to access screening or other preventative care services, they may (knowingly or not) delay seeking treatment until their disease is at an advanced stage. The benefits of screening and early detection are well documented for many types of cancer, and the evidence is clear that those with health care access through insurance coverage are more likely to receive cancer screenings. ASCO’s guiding principles and policies to provide access to high-quality cancer care for all low-income individuals are described in more detail here.

Clinical Trials
Congress took a giant step forward to reduce health disparities by expanding clinical trial access to more than 41.6 million Medicaid beneficiaries through passage of the CLINICAL TREATMENT Act. As of January of 2022, millions of patients with Medicaid coverage are now able to participate in trials that often provide the best—and sometimes only—treatment option for their disease. Medicaid coverage benefits are crucial for standard oncology care and to access cancer clinical trials.

Medicaid serves a large portion of individuals from racial and ethnic minority groups who are not well-represented in clinical trials. Participation levels in cancer clinical trials have historically been far lower and less diverse than the actual demographics of patients living with cancer and the prevalence of the disease. Racial and ethnic minority populations, sexual and gender minorities, and older adults are all dramatically underrepresented in clinical trials, often despite
equal or higher cancer incidence rates compared to the general population.\textsuperscript{1,2,3} Recent analyses of cancer therapeutic trials found that only 4\% to 6\% of trial participants are Black and 3\% to 6\% are Hispanic, despite representing 15\% and 13\% of all patients with cancer, respectively.\textsuperscript{4}

Financial toxicity, defined as the negative patient-level impacts of the cost of cancer care, has been implicated as causing distress that can reduce the patient’s ability to enroll or continue with participation in a clinical trial.\textsuperscript{5,6,7,8,9} In addition to direct medical costs (eg, treatment, imaging), direct nonmedical or ancillary costs (eg, transportation and lodging, child care), and indirect costs (including patient time and the costs related to toxicities and lost wages) contribute to financial toxicity. Monetary reimbursement from an institution, charitable foundation, or a research sponsor for a patient’s ancillary, out-of-pocket, or other direct costs could help mitigate financial barriers to trial enrollment. However, ethical concerns about patient coercion or undue inducement and legal concerns about kickbacks and false claims compliance (eg, billing fraud) have hampered the uptake of such financial assistance programs. ASCO recommends that CMS reduce concerns about inducement by defining appropriate mechanisms to provide targeted financial support for clinical trial participants at risk of financial hardship.

ASCO supports policies that remove impediments to ethically appropriate financial compensation for trial-related out-of-pocket costs; provision of such financial support should not be considered undue inducement.

Enrolling Medicaid beneficiaries in clinical trials will improve diversity in research and help remove barriers for Medicaid enrollee participation in clinical trials. A more diverse representation will improve the validity of clinical research data and better demonstrate the safety and effectiveness of new treatments for all segments of our population. Diversifying clinical trial participation will address multiple areas of concern: improving the overall conduct of clinical research, improving the evidence base for high-quality cancer care and helping to resolve health concerns related to underrepresentation in clinical trials.

\textsuperscript{8} Zafar SY, Abernethy AP: Financial toxicity, Part I: A new name for a growing problem. Oncology (Williston Park) 27:80-81, 149, 2013
Communication
Lack of awareness of clinical trials due to linguistic, cultural, or literacy-related barriers often prevent patient participation in clinical trials, resulting in failure to enroll. ASCO supports the development of Medicaid and clinical trial enrollment documents and educational and advertising materials to be written at no higher than a 6th grade reading level and in languages representative of the population in the coverage area. Under any scenario, individuals should be able to refer to unambiguous, clear explanations about how to access coverage. Additionally, ASCO supports the expansion of patient navigator programs, as they have the potential to increase Medicaid enrollment and participation and retention of minority patients in clinical trials. Targeted communication strategies alert patients to the opportunity for clinical trial participation and Medicaid enrollment. Support for patient navigator programs could be a tremendous opportunity to remove obstacles for underserved populations who may not independently seek to enroll in Medicaid or in clinical trials.

Response to CMS Objective 2:

Coverage
Consistent coverage without disenrollment or a gap in benefits is essential for Medicaid beneficiaries with a cancer diagnosis or for those who have recently finished treatment. Even one day without coverage can halt cancer treatment or stop treatment altogether. Likewise, beneficiaries transitioning between coverage programs may face a number of challenges including changes in the list of covered drugs, cost-sharing requirements, and the network of providers. For those that have recently finished treatment, follow-up visits with their provider for on-going monitoring must remain covered.

CMS released guidance in March stating that states can start the redetermination process up to two months before the public health emergency ends and suggests several strategies for transitioning beneficiaries from Medicaid and CHIP to an exchange plan.

ASCO appreciates that CMS is providing guidance for states to transition those who will no longer be eligible for Medicaid and CHIP to marketplace coverage. We agree with CMS that the state must transfer the beneficiary’s electronic account, including any eligibility information, to the marketplace in a timely fashion to prevent delays or gaps in enrollment. We encourage CMS to work with states to ensure maintenance of coverage benefits for cancer patients to avoid disrupting treatment protocols currently in place.

To help ensure that all beneficiaries complete all necessary administrative tasks, such as renewal paperwork, ASCO supports states’ work with community-based organizations, beneficiary advocates, and patient navigators enabling consumers to get the assistance and

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information they need to navigate the transition. Individuals with cancer face significant physical and emotional burden and rely heavily upon other individuals, family, and friends for help, and CMS should consider these barriers to prevent loss of coverage.

Response to CMS Objective 3:

Network Adequacy
Cancer patients and survivors are a particularly vulnerable subset of the population. They require timely access to cancer specialists, facilities, and supportive care. Narrowed networks\textsuperscript{11,12} are linked to delays in cancer care, delays that adversely affect cancer control and survival.\textsuperscript{13} To ensure that cancer patients have immediate access to the necessary anti-cancer therapies, we recommend the inclusion of medical, radiation, surgical, and gynecological oncology in network standards.

Our membership includes oncology practices in every state and across a wide range of settings, including urban, rural, and underserved areas. ASCO supports network adequacy standards that promote access based on specific patient needs, availability of care and providers, and appropriate utilization of services. The inclusion of oncology specialties network standards will better assure cancer patients and survivors have meaningful access to medically necessary cancer care services in a timely manner.

Cross-state Licensure
ASCO developed its Interim Position Statement: Telemedicine in Cancer Care to recommend specific actions for applying telemedicine in cancer care. During that time, cross-state licensure raised questions of appropriate state-based safeguards and unintended consolidation of healthcare providers. ASCO encourages a policy that strikes a balance between expanding telemedicine access in underserved areas and wider populations while maintaining an environment in which local and community practices can continue to thrive. Above all, the goal should be expanding access to care for all patients. Relevant policy recommendations are listed below. For additional information, please review ASCO's Position Statement: Telemedicine Cross-State Licensure, found \textit{here}.

- All states should participate in the Interstate Medical Licensure Compact (IMLC). In states that do not participate, lawmakers should enact legislation to join. ASCO will work with state medical associations and State Affiliates to support these efforts.
- State and federal policies permitting telemedicine to cross state lines should include a provision requiring that the doctor-patient relationship be established prior to provision of any telemedicine service.

\textsuperscript{12}Wharam JF, Zhang F, Wallace J, et al: Vulnerable and less vulnerable women in high-deductible health plans experienced delayed breast cancer care. \textit{Health Aff} (Millwood) 38:408-415, 2019
- Medical liability providers should include telemedicine and data security related risks in their policies. Prior to the delivery of any telemedicine service, physicians should verify that their medical liability insurance includes comprehensive coverage for telemedicine services, including telemedicine across states in which they practice.
- The Federal Trade Commission should monitor telehealth practice patterns and prevent unfair methods of competition as well as unfair or deceptive acts or practices.

Response to CMS Objective 5:

Payment Policy
ASCO’s 2014 Policy Statement on Medicaid Reform addresses insufficient Medicaid provider payments, which jeopardizes Medicaid beneficiary access to care. ASCO recommends that Medicaid programs focus on and reward care that emphasize the quality rather than the amount of care provided. To this end, we support a payment model that meets the following standards:
- Increases Medicaid payment rates to equal those for Medicare.
- Creates a leadership role for oncologists in developing and testing cancer payment reforms.
- Provides incentives to address meaningful quality metrics specific to patients with cancer.

At the same time, state flexibility in running Medicaid should be coupled with meeting predefined cancer quality outcomes for the Medicaid patient population. Failure to meet quality metrics should be cause for the federal government to intervene. These recommendations are consistent with the published Institute of Medicine (IOM) report, “Delivering High Quality Cancer Care, Charting a New Course for a System in Crisis,” where development of meaningful quality measures for cancer care with a focus on outcome measures and performance targets is emphasized.

ASCO supports policies and practices that protect and promote health care system and payment reforms that improve health equity. ASCO remains strongly committed to the elimination of barriers to access and payment coverage across the continuum of cancer care through policy reforms and advocacy. First steps should include the full expansion of Medicaid in every state, in addition to the expansion of alternative payment models to include incentives that promote access for those populations most at risk of experiencing cancer health inequities across the cancer care continuum. Stakeholders should collaborate to promote the mandatory coverage of essential cancer care services from prevention to diagnosis, treatment, survivorship, and care at the end of life, as well as the expansion of alternative payment models, incentives, and other programs and strategies that can improve equitable high-quality cancer care access across the continuum of care. For additional information, please see ASCO’s policy statement: Cancer Disparities and Health Equity for additional information.
Prior Authorization

CMS seeks feedback on ways to ease provider burden and encourage participation in the Medicaid program. ASCO physicians have identified prior authorization requirements as a primary factor leading to physician burden and burnout. Additionally, prior authorization programs are having a detrimental impact on oncology care. Prior authorization can lead to delays in starting physician-recommended treatment leading to detrimental outcomes for cancer patients; treatment changes or abandonment; unexpected out of pocket costs; and rejection of physician-recommended treatment.

Prolonged prior authorization waiting periods can lead to significant barriers to care by delaying clinical trial enrollment and initiation of treatment, regardless of whether the treatment takes place as part of the study. Cancer patients, especially those in stage IV, are exceptionally vulnerable and they may not be able to wait for prolonged periods to access treatment whether through a trial or not. Additionally, clinical trials can fill up while a patient is waiting for a response from the insurer thus eliminating, in some cases, a patient’s only option for treatment. In addition to this impact on patient care, prior authorization contributes to unnecessary and excessive administrative burden on physicians. A study released by the American Medical Association found that 88% of physicians describe the burden associated with prior authorization as high or extremely high and that physicians and their staff spend nearly two full business days per week completing prior authorization requests. Time that oncologists spend with patients is increasingly limited due to a growing list of administrative demands. Physicians spend 49% of their office hours updating records and files rather than treating patients. CMS should not place additional uncompensated administrative burdens and paperwork on cancer care providers.

ASCO refers CMS to its 2017 policy statement on utilization management in which we recommend an appropriate framework for the design of utilization management programs. We remain committed to working with stakeholder groups to develop and implement policies that benefit patients with cancer while reducing unnecessary or wasteful costs, and we urge CMS to incorporate the principles of the statement. We set forth six critical principles that any utilization management policy must meet to ensure medically necessary care for patients with cancer is not jeopardized or unreasonably delayed:

- Individuals with cancer should have full access to the anti-cancer therapy most appropriate for their disease when used in accordance with current clinical and scientific evidence.
- Cost should not be the primary driver of utilization management policies.
- Utilization management policies should be evidence-based and reflect the most current science and understanding of cancer treatment.

Utilization management processes should result in timely and clear determinations that are consistent with the health insurer’s coverage and other policies.

Payer cost containment strategies and decision-making processes should be transparent and without conflicts of interest.

Payers should implement utilization management policies in a way that minimizes administrative burdens—specifically time and effort—on both providers and patients.