ASCO®
AMERICAN SOCIETY OF CLINICAL ONCOLOGY

Medicaid and Cancer Care Access

POLICY BRIEF

KEY TERMS

Federal Medical Assistance Percentages (FMAP) – rates expressed as a percentage that indicate the proportion of federal financial support for a state Medicaid program (as well as other safety net programs). These rates vary by state, taking into account per capita state income compared to the national average, and by law are never less than 50%.

Medicaid work requirements – Prior policy in some states, which have had their approvals rescinded by the current administration. Specifics of past work requirements varied by state, but most states required enrollees to work approximately 20 hours per week or 80 hours per month as a condition to receive Medicaid benefits. Examples of work include full- or part time employment, job training programs, secondary or college education, technical school, some caregiving activities, and community service.

Medicaid block grants – A policy proposal for **f**ederally funded block grants which are subject to an annual cap. Meaning, federal funding for Medicaid would provide a pre-determined, fixed amount of money (with an established annual limit) to the states to administer their Medicaid program. This capped amount would be the only contribution from the federal government, and it is unclear whether or how it would be adjusted for changes in enrollment, costs or program needs.

Routine patient care costs - Routine costs include the non-experimental costs of treating a patient who is participating in a clinical trial, such as the cost of physician visits or laboratory tests. These costs are part of the standard of care and would be incurred regardless of whether a patient participates in a clinical trial. The cost of any investigative device or drug would continue to be covered by the trial sponsor.

Background

Medicaid is the largest health insurance program in the U.S., providing coverage for over 71 million Americans, including to millions of low income individuals and their families.[1] The Medicaid program is the principal source of long-term care coverage for Americans who lack access to other affordable health insurance. Under the COVID-19 Public Health Emergency (PHE), Medicaid enrollment grew due to requirements that allow states to receive a 6.2 percent point increase in federal Medicaid match rate ("FMAP") by maintaining eligibility for beneficiaries during the PHE. This critical safety net insurer covers a broad array of health services and limits out-of-pocket costs for enrollees. Medicaid is also a major source of health care financing in the U.S., funding a sixth of total national spending on health care. Medicaid creates a vital path to early cancer detection, mitigates barriers to treatment availability, and contributes to favorable cancer outcomes for beneficiaries.

Several areas of Medicaid reform are still needed as beneficiaries in current Medicaid programs continue to experience access barriers and disparities in outcomes. Recent growth in the Medicaid

[1] https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

program was driven largely by expansion of coverage for childless adults, made possible by the Affordable Care Act (ACA). Research suggests that, in states where Medicaid expansion has occurred under this option, there has been increased access to care, including improved early-stage cancer diagnosis, increased utilization of certain types of cancer surgery, and reduced health disparities.[2,3] To date, 39 states including Washington, D.C. have expanded their Medicaid programs, with 12 states currently against expansion.[4]

Prior to the COVID-19 PHE, the large coverage gains resulting from the ACA's Medicaid expansion had stalled and may have begun to reverse. This was in part the result of previous Administration efforts to impose work requirements as a condition of Medicaid eligibility, place caps on funding (Medicaid block grants), and decrease resources for outreach and enrollment assistance.[5]

More recently, increased Medicaid coverage tied to the COVID-19 PHE is on track to begin unwinding. CMS released guidance in March 2022 allowing states 14 months to complete the redetermination process for all enrollees and suggested several strategies for transitioning beneficiaries from Medicaid coverage to a Marketplace plan or other option. While states are working on plans for transitions, it remains unknown how many individuals will successfully retain some form of coverage.[6] As health care reform continues to evolve, any efforts at the national, state, or local levels should ensure that individuals can continue to access the health care system without interruption.

Concerns for ASCO Members & the Cancer Community

Current state of Medicaid reform proposals

Medicaid is structured to provide states flexibility in customizing programs to their specific needs and environment. Through Section 1115 of the Social Security Act, the Secretary of Health and Human Services is given the authority to approve experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program. In some cases, states have requested Section 1115 waivers that allow stricter requirements for eligibility and limits on coverage or benefits.

During the previous administration, several states sought a new approach to waivers, seeking approval from CMS to implement programmatic changes that would condition eligibility, continued coverage, cost sharing, and other benefits on work status. At the time, CMS was committed to supporting state efforts to incentivize certain Medicaid populations to participate in work and community engagement activities. These could include requirements for employment, time spent on a job search or in training, volunteering or community service, or education.

Some states have submitted waivers requesting authority to enforce non-coverage penalties, or "lock-outs," connected to premium payments, eligibility redeterminations and work requirements. Certain waivers state that if beneficiaries are unable to pay premiums, fail to meet the requirements for work, fail to comply with other eligibility requirements, and/or fail to report income changes in a timely

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[2] Jemal A, Lin CC, Davidoff AJ, et al: Changes in insurance coverage and stage at diagnosis among nonelderly patients with cancer after the Affordable Care Act. Journal of Clinical Oncology 35:3906-3915, 2017.
[3] Adamson BJS, Cohen AB, Estevez M, et al: Affordable Care Act (ACA) Medicaid expansion impact on racial disparities in time to cancer treatment. Journal of Clinical Oncology 37:LBA1-LBA1, 2019.
[4] https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/
[5] https://www.cbpp.org/research/health/trump-administrations-harmful-changes-to-medicaid
[6] https://www.nashp.org/how-states-are-getting-ready-to-unwind-medicaids-continuous-coverage-requirement/

fashion, they can be locked out of Medicaid coverage for a specified period. Other strategies under discussion included drug screening and lifetime limits on eligibility.

There have been cost cutting proposals that include establishment of annual limits on federal funding for Medicaid, primarily through the use of block grants. Block grants could result in inadequate benefit design, decreased provider reimbursement, and reduced access to care. A transition to block grants also could transform the Medicaid program from its status as a safety net designed to meet basic health needs of low-income Americans, into a program with funding limits that drive rationing of care for the most vulnerable.

While ASCO recognizes that state and federal budgets are confronted with mounting fiscal pressures, imposing ill-considered eligibility restrictions, or transforming the Medicaid program into a capped block grant program, have significant potential to jeopardize the health and outcomes for people with cancer. Reduced access to care could add to its program cost, as patients would present with more complex and late stage illness if they were not able to obtain recommended cancer screenings.

Clinical Trials and Diversity of Clinical Trial Populations

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 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 demographics of patients living with cancer and 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.[7,8,9] 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.[10]

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

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[7] Duma, Narjust, et al. "Representation of minorities and women in oncology clinical trials: review of the past 14 years." Journal of oncology practice 14.1 (2018): e1-e10.
[8] Murthy, Vivek H., Harlan M. Krumholz, and Cary P. Gross. "Participation in cancer clinical trials: race-, sex-, and age-based disparities." Jama 291.22 (2004): 2720-2726.
[9] Hutchins, Laura F., et al. "Underrepresentation of patients 65 years of age or older in cancer-treatment trials." New England Journal of Medicine 341.27 (1999): 2061-2067.
[10] Duma, Narjust, et al. "Representation of minorities and women in oncology clinical trials: review of the past 14 years." Journal of oncology practice 14.1 (2018): e1-e10.

participation in a clinical trial.[11,12,13] 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 in Medicaid beneficiaries. While Medicaid does provide a mechanism for non-emergency medical transportation, there is no such provision to reimburse a patient's ancillary, out-of-pocket, or other direct costs which negatively impact trial enrollment. In fact, 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, including Medicaid beneficiaries. 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.

Where ASCO Stands on Medicaid and Cancer Care Access

In the 2014 American Society of Clinical Oncology Policy Statement on Medicaid Reform, ASCO called for major changes to the Medicaid program to ensure access to high-quality cancer care for all low-income individuals. ASCO believes that Medicaid beneficiaries should: 1) have access to cancer care delivered by a cancer specialist, 2) receive the same timely and high-quality cancer care as patients with private insurance, and 3) have access to cancer screening and diagnostic follow up without copays. The 2014 statement also addresses insufficient Medicaid provider payments, which jeopardizes Medicaid beneficiary access to care. ASCO recommends that Medicaid programs focus on and reward care that emphasizes 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.

In 2017, ASCO also released Principles for Patient-Centered Health Care Reform, which stated that every American should have access to affordable and sufficient health care coverage, regardless of their income or health status. As health care reform evolves, any efforts at the national, state, or local levels should ensure that individuals can continue to access the health care system without interruption.

ASCO's 2018 American Society of Clinical Oncology Position Statement on Addressing Medicaid Waivers & Their Impact on Cancer Care highlights the society's deep concern with previously proposed Medicaid eligibility requirements that could result in reduced access to care, recommending that CMS should not approve any waivers or state plan amendments that would serve to create delays or barriers to timely and appropriate access to cancer care. ASCO also recommended against approval of any waivers that

[11] Unger JM, Gralow JR, Albain KS, et al: Patient income level and cancer clinical trial participation: A prospective survey study. JAMA Oncol 2:137-139, 2016.
[12] Wong YN, Schluchter MD, Albrecht TL, et al: Financial concerns about participation in clinical trials among patients with cancer. J Clin Oncol 34:479-487, 2016
[13] Zafar SY, Peppercorn JM, Schrag D, et al: The financial toxicity of cancer treatment: A pilot study assessing out-of-pocket expenses and the insured cancer patient's experience. Oncologist 18:381-390, 2013

place additional uncompensated burdens on cancer care providers, as well as ensuring that all 1115 waiver applications and amendments are open to a full and transparent public comment period.

Similarly, in the 2020 American Society of Clinical Oncology Position Statement on *Block Grants in Medicaid & Their Impact on Cancer Care*, ASCO states that a capped block grant program has significant potential to jeopardize the health and outcomes for people with cancer, reducing access to care while adding program cost. In the position statement, ASCO recommends against block grant structures for Medicaid, and encourages states not to seek waivers or other proposals that would establish block grant funding structures, enact lockout periods, lifetime limits, or eliminate retroactive eligibility for beneficiaries.

ASCO's Policy Statement on Cancer Disparities and Health Equity commits ASCO to "support and promote policies, systems, environments, and practices to address persistent barriers to equitable receipt of high-quality cancer care across the care continuum." The statement acknowleges the evidence to date that the uneven expansion of Medicaid may create geographic disparities between patients with access to expanded coverage and those without. Thus, the statement calls for the full expansion of Medicaid in every state.

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.[14] 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.

For More Information

American Society of Clinical Oncology Position Statement: Block Grants in Medicaid & Their Impact on Cancer Care

American Society of Clinical Oncology Position Statement: Addressing Medicaid Waivers & Their Impact on Cancer Care

American Society of Clinical Oncology Policy Statement on Medicaid Reform

ASCO Principles for Patient-Centered Healthcare Reform

Cancer Disparities and Health Equity: A Policy Statement From the American Society of Clinical Oncology

Addressing Financial Barriers to Patient Participation in Clinical Trials: ASCO Policy Statement

[14] Ghebre RG, Jones LA, Wenzel JA, Martin MY, Durant RW, Ford JG. State-of-the-science of patient navigation as a strategy for enhancing minority clinical trial accrual. Cancer 2014; 120: Suppl 7: 1122-30.