American Society of Clinical Oncology Position Statement:

Implications for Cancer Care in a New Medicaid Era

Approved by the ASCO Board of Directors February 18, 2026

INTRODUCTION

ASCO has a long history of policy interest in the Medicaid program. In 2014, the American Society for Clinical Oncology (ASCO) published a Policy Statement on Medicaid Reform as the Affordable Care Act's (ACA) Medicaid expansion provisions had recently gone into effect.[1] The statement highlighted policy priorities such as improving access to quality cancer care and robust reimbursement. Several years later in response to an increase in the use of Section 1115 waivers to implement work requirements for Medicaid beneficiaries, ASCO published a Position Statement largely opposing work requirements for patients with cancer in 2018[2] and subsequently followed up with a 2020 Position Statement opposing block granting or otherwise capping federal spending for the Medicaid program.[3]

In 2025, significant Medicaid reforms were signed into law via the budget reconciliation bill known as H.R. 1. ASCO's Health Policy Committee requested a new ASCO position statement in response to H.R. 1's passage. ASCO views Medicaid as a critical program to provide care to a substantial proportion of patients with cancer, and the bill is set to implement sweeping new changes to program administration in the coming years that will impact these patients. This statement updates and expounds on ASCO's policy positions.

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[1] Polite BN, Griggs JJ, Moy B, et al. American Society of Clinical Oncology Policy Statement on Medicaid Reform. *J Clin Oncol*. 2014;32(36):4162-4167. doi:10.1200/JCO.2014.56.3452

[2] American Society of Clinical Oncology Position Statement: Addressing Medicaid Waivers & Their Impact on Cancer Care. American Society of Clinical Oncology. 2018. https://cdn.bfldr.com/KOIHB2Q3/as/bpv9n93m85ghm53zrsv4scj4/2018-ASCO-Medicaid-Waivers-Statement

[3] American Society of Clinical Oncology Position Statement Block Grants in Medicaid & Their Impact on Cancer Care-Grant-Statement. American Society of Clinical Oncology. 2020. https://cdn.bfldr.com/KOIHB2Q3/as/tt9t83pkmps9nq5kr62kb668/2020-Block-Grant-Statement

BACKGROUND

Medicaid plays a key role in the U.S. cancer care delivery system, serving as the largest insurer of low-income individuals diagnosed with cancer. Approximately one in five non-elderly adults newly diagnosed with cancer are covered by Medicaid at the time of diagnosis or enroll shortly thereafter, reflecting the program's function as both a primary source of coverage and a critical safety net for individuals who experience income loss or insurance disruption following a cancer diagnosis.[4] In pediatric oncology, Medicaid and the Children's Health Insurance Program (CHIP) together insure one-third of children with cancer, underscoring the program's importance for rare cancers requiring specialized care.[5] Overall, Medicaid coverage is disproportionately concentrated among populations that may face elevated cancer risk and worse outcomes.

The importance of Medicaid's role in cancer care was reinforced by the expansion of the program under the Affordable Care Act, which extended coverage to low-income adults previously excluded from eligibility. Numerous studies have associated Medicaid expansion with improvements in cancer outcomes, including: insurance coverage stability, earlier stage diagnosis, increased receipt of guideline-concordant care, and reductions in cancer-related disparities.[6,7] For this reason, ASCO has long advocated for policies to ensure that cancer care delivered to Medicaid beneficiaries remains easily accessible, comprehensive, and high quality.[1,2]

Recent Federal Policy Changes

Changes to the Medicaid program enacted through the Budget Reconciliation Act of 2025, H.R. 1, significantly restructure eligibility, renewal, and accountability requirements, with important implications for individuals with cancer. Central among these changes are mandatory community engagement requirements for adult beneficiaries aged 19-64 with incomes at or below 138% of the federal poverty level that allow them to qualify for Medicaid in expansion states. Under these requirements, individuals must demonstrate compliance with work, education, or volunteer activities both prior to enrollment and on an

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[4] Hu X, Yang NN, Fan Q, Yabroff KR, Han X. Health insurance coverage among incident cancer cases from population-based cancer registries in 49 US states, 2010–2019. *Health Affairs Scholar*. 2024;2(1):qxad083. doi:10.1093/haschl/qxad083

[5] Ji X, Hu X, Castellino SM, Mertens AC, Yabroff KR, Han X. Narrowing Insurance Disparities Among Children and Adolescents With Cancer Following the Affordable Care Act. JNCI Cancer Spectr. 2022 Jan 5;6(1):pkac006. doi: 10.1093/jncics/pkac006. PMID: 35699500; PMCID: PMC8877169.

[6] Hotca A, Bloom JR, Runnels J, et al. The Impact of Medicaid Expansion on Patients with Cancer in the United States: A Review. *Current Oncology*. 2023;30(7):6362-6373. doi:10.3390/curroncol30070469

[7] Ermer T, Walters SL, Canavan ME, et al. Understanding the Implications of Medicaid Expansion for Cancer Care in the US: A Review. *JAMA Oncol*. 2022;8(1):139-148. doi:10.1001/jamaoncol.2021.4323

ongoing basis. These are paired with more frequent eligibility redeterminations; previously, redeterminations were required on an annual basis, but H.R. 1 mandates that these redeterminations take place at least every six months for expansion-eligible adults.

The 40 states (and the District of Columbia) that have expanded Medicaid are required to streamline these new requirements via use of available sources such as claims or clinical encounter data before requesting documentation from patients or providers. The statute also provides exemptions for beneficiaries who are "medically frail" or who have a serious or complex medical condition. Whether these provisions prevent inappropriate coverage loss will depend upon guidance from the Centers for Medicare & Medicaid Services (CMS) and state implementation efforts. That said, early estimates of coverage losses number in the millions of individuals once H.R. 1's work requirement provisions take effect in 2027, with concomitant negative outcomes including increases in missed cancer screenings and rising proportions of advanced cancer stage at diagnosis, among others.[8]

Persistent System-level Challenges

Medicaid programs have faced longstanding system-level challenges that complicate access to care and contribute to coverage instability. Administrative churn—when Medicaid-eligible enrollees are denied or disenrolled from coverage erroneously, often due to procedural or paperwork issues—has well-documented negative impacts for Medicaid beneficiaries with cancer.[9] This is because even brief gaps in coverage may delay diagnostic testing, interrupt chemotherapy or radiation therapy, or disrupt access to supportive and palliative services.

Provider participation in the Medicaid program remains a longstanding challenge. Medicaid reimbursement for oncology services has historically lagged behind Medicare and commercial payment rates, placing financial strain on oncology practices that serve a high proportion of Medicaid beneficiaries.[1] These issues persist against the backdrop of rising health care costs and constrained state budgets, forcing difficult tradeoffs in program design and administration which risk impeding beneficiary access to cancer care.

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[8] Shubeck SP, Diaz A. Projected Cancer Screening and Outcomes Under the 2025 Federal Medicaid Eligibility Restrictions. *JAMA Oncol*. 2026. doi:10.1001/jamaoncol.2025.5774

[9] Yabroff KR, Reeder-Hayes K, Zhao J, et al. Health Insurance Coverage Disruptions and Cancer Care and Outcomes: Systematic Review of Published Research. *J Natl Cancer Inst*. 2020;112(7):671-687. doi:10.1093/jnci/djaa048

IMPACT ON PATIENTS WITH CANCER

Establishing Exemptions for Patients and Caregivers

ASCO believes that community engagement requirements are inappropriate for patients with cancer, as well as their caregivers. Patients with cancer are often medically frail in a practical sense, suffering treatment-related fatigue, facing increased risk of infection due to compromised immune systems, and being physically unable to perform job duties due to neuropathy or other treatment associated conditions. Cancer is invariably a serious and complex condition, requiring specialized oncology care, hospitalizations, and regimented pharmaceutical management, all of which would be present in claims data or clinical encounter summaries.

The American Cancer Society has compiled data demonstrating that patients who cannot access health insurance are much more likely to receive their cancer diagnoses at later stages, which is both more expensive to treat and has a much lower rate of survival.[10] Patients who are diagnosed with cancer are often forced to take leave from work or otherwise reduce the number of hours they work due to the time required for appointments, travel, chemotherapy, radiation, surgery and recovery, imaging, and related interventions, all of which in tandem make up the phenomenon of time toxicity.[11]

As a result of this toxicity, a large proportion of cancer patients are forced to stop working while receiving cancer treatment. An American Cancer Society Cancer Action Network (ACS CAN) survey found that 74% of cancer patients and survivors reported missing work due to their diagnosis.[12] Much of this can be attributed to the significant side effects associated with chemotherapy. Issues such as cognitive impairment, chemotherapy-induced peripheral neuropathy, fatigue, and memory loss often afflict those undergoing treatment, while mental health challenges such as depression also contribute to difficulty in working.[13,14]

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[10] Medicaid Work Requirements Jeopardize Cancer Patients & Survivors. American Cancer Society Cancer Action Network. 2025. https://www.fightcancer.org/policy-resources/medicaid-work-requirements-jeopardize-cancer-patients-survivors

[11] Doshi SD, Rappaport JA, Bange EM. Time Toxicity of Cancer Care—A Call to Action. *JAMA Netw Open*. 2025;8(12):e2547930. doi:10.1001/jamanetworkopen.2025.47930

[12] New Survey Shows Clear Need for Paid Leave Among Cancer Patients and Survivors. American Cancer Society Cancer Action Network. 2021. https://www.fightcancer.org/releases/new-survey-shows-clear-need-paid-leave-among-cancer-patients-and-survivors

[13] Cancer in the Workplace and the ADA. U.S. Equal Employment Opportunity Commission. 2013. https://www.eeoc.gov/laws/guidance/cancer-workplace-and-ada

[14] López-Faneca L, Ruiz-Frutos C, Gómez-Salgado J, et al. Prognostic factors affecting return to work in cancer patients: a systematic review. *Occup Environ Med*. 2025;82(6):305-312. doi:10.1136/oemed-2025-110212

H.R. 1 assumes that some individuals would not be required to meet the new, 80-hour-a-month community engagement requirement, so long as they meet certain criteria and are approved by their state. The statute allows for exemptions for individuals who are medically frail or otherwise have special medical needs, including individuals who have a physical or intellectual disability that significantly impairs their ability to perform one or more activities of daily living, or who have a serious or complex medical condition.[15]

This definition is open to state-by-state interpretation and the variation in language found in existing Section 1115 waivers proposed by states over time highlights this lack of uniformity. A 2025 study published in JAMA[16] examined the characteristics of beneficiaries projected to lose Medicaid coverage due to H.R. 1's community engagement requirements (also referred to as work requirements) and found that 41% of this population had three or more chronic conditions, while 45.7% had one or two and only 13.7% were free of any chronic conditions. In the population of adults aged 50 to 64, the disparity grew larger as nearly two-thirds of these adults had three or more chronic conditions.

A related concern is that beneficiaries with these conditions may find it more challenging to document their conditions in trying to qualify for a "medically frail" exemption. Guidance from CMS and state regulators is necessary to ensure medically frail or complex medical condition exemptions apply to patients with these and other symptoms stemming from their diagnosis. Without the establishment of uniform guardrails around the definitions of medical frailty and/or complex medical conditions, and automated processes to ascertain cancer diagnosis and treatment, ASCO is concerned that beneficiaries who require life-saving cancer care will face uncertainty on the status of their coverage, or even discontinuation of life-saving cancer care.

Administrative Complexity and Continuity of Care Risks

ASCO is concerned that not every patient eligible for an exemption may receive one; many patients will be subject to burdensome administrative requirements that they may be unable to complete in time. Patients newly diagnosed with cancer face a daunting set of decisions while dealing with a life-altering condition. The process of collecting and submitting up to three months of work history as a prerequisite to applying for Medicaid coverage creates another hurdle for newly diagnosed and previously under or uninsured patients unable to access immediate treatment. Even for those actively enrolled in Medicaid, a cancer diagnosis now comes with increased out-of-pocket costs such as

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[15] Health Coverage Provisions in One Big Beautiful Bill Act (H.R. 1). (2026, January 22). https://www.congress.gov/crs-product/R48569

[16] Chetty AK, Ross JS, Chen AS. Clinical Characteristics of Adults at Risk of Medicaid Disenrollment Due to HR 1 Work Requirements. *JAMA*. 2025;334(20):1850-1853. doi:10.1001/jama.2025.16533

deductibles, copayments, and cost-sharing for essential tests, treatments, and specialty drugs, all of which ASCO considers inappropriate in the context of cancer care.[17] Even nominal Medicaid cost-sharing can be prohibitive for patients with cancer.

Previous state experiences with implementation of work or community engagement requirements, primarily in Arkansas and Georgia, clearly indicate that great care must be taken to ensure coverage is preserved for eligible beneficiaries. For example, Arkansas' previous 20-hour-a-week work requirement, known as Arkansas Works, was described by enrollees as confusing and/or challenging to access, while many others remained unaware of the requirement altogether.[18] Indeed, Arkansans with chronic conditions were linked with higher disenrollment rates for Medicaid despite the original Arkansas Works program including a medical exemption.[19]

Similarly, Georgia's Pathways to Coverage program outlined the administrative costs necessary to implement work requirements that legislators championed as a means of insuring more of Georgia's low-income population. Patient enrollment has been far lower than what the program had heralded.[10] While the program projected that 25,000 individuals would gain access to Medicaid through the program, as of May 2025, only 7,500 individuals have successfully enrolled in the program. The low enrollment has been attributed to glitches with the online enrollment platform as well as an understaffed state agency charged with enrollment.[20]

Despite the challenges outlined above, approximately 54% of working-age cancer survivors report working full time.[21] H.R. 1 requires up to three months of proof that applicants have met the 80 hours of work or community engagement. However, many low-income workers who receive a cancer diagnosis are likely already experiencing symptoms and may have been forced to reduce work hours prior to knowing they have cancer.[22] These persons are more likely to have been facing circumstances such as uneven work hours, unpredictable work schedules, and challenges such as lack of transportation or childcare

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[17] American Society of Clinical Oncology Position Statement: Out-of-Pocket Costs for Cancer Care. ASCO. 2024. https://cdn.bfldr.com/KOIHB2Q3/as/m685rhhtkhk7h4nmhtrxm9hz/Out-Of-Pocket-Costs-Position-Statement

[18] Coleman A, Federman S. Work Requirements for Medicaid Enrollees. The Commonwealth Fund. 2025. doi:10.26099/ccxk-9682

[19] Chen L, Sommers BD. Work Requirements and Medicaid Disenrollment in Arkansas, Kentucky, Louisiana, and Texas, 2018. *Am J Public Health*. 2020;110(8):1208-1210. doi:10.2105/AJPH.2020.305697

[20] Government Accountability Office. Medicaid Demonstrations: Information on Administrative Spending for Georgia Work Requirements. Published online 2025. https://www.gao.gov/assets/gao-25-108160.pdf

[21] Blinder VS, Gany FM. Impact of Cancer on Employment. *J Clin Oncol*. 2020;38(4):302-309. doi:10.1200/JCO.19.01856

[22] Malcarney MB. Federal Officials Have Spoken, and Now it's the States' Turn: "Lookback Period" for Medicaid Work Reporting Requirements. Families USA. 2025. https://familiesusa.org/resources/federal-officials-have-spoke-and-now-its-the-states-turn-lookback-period-for-medicaid-work-reporting-requirements/

that prevent them from attaining 80 hours of work or community engagement in a given month prior to a diagnosis.

For patients who choose or are able to work during or after their treatment for cancer, administrative glitches and confusing systems should not serve as an obstacle towards continuous coverage. CMS must work with states to ensure simple, efficient, and automatic (whenever possible) verification of reporting requirements and enable processes that prevent coverage loss during episodes of treatment. Medicaid claims or clinical encounter data could serve this purpose; for new Medicaid beneficiaries or other contexts a role may exist for self-attestation, at CMS's discretion.

Hardship Exceptions: Travel to Clinical Trial Sites

Medicaid beneficiaries diagnosed with cancer often must travel to a National Cancer Institute (NCI)-designated center to enroll and participate in clinical trials. These centers offer specialized treatment plans that may not otherwise be available to Medicaid beneficiaries in their communities. NCI centers can require significant travel for patients who live in rural communities. One analysis found that over one-third of the U.S. population over 35 would have to travel more than 50 miles to reach an NCI center.[23] H.R. 1's new pre-application "look-back" requirements and the loss of continuous eligibility would exacerbate difficulties in accessing clinical trials. ASCO is concerned that many such patients would lose eligibility for these trials when they are unable to successfully juggle competing demands from their cancer treatment, employment, trial-related travel, and the new reporting requirements.

Furthermore, even upon successful enrollment in a clinical trial, participation itself is often extremely demanding, requiring frequent visits to clinics that would likely cut into a beneficiary's work hours. To mitigate this potential conflict, CMS should encourage states to offer hardship exceptions or automated approval for qualifying oncology cases. Doing so would allow patients to access their trial sites and maintain a normal trial schedule while potentially easing some of the administrative burden.

IMPACT ON PROVIDERS

Provider Participation and Reimbursement Challenges

At least one major study has concluded that private insurers pay on average approximately 143% of Medicare rates, which, extrapolated to the lower Medicaid reimbursement,

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[23] New Paper Finds Travel Distance Remains Barrier for Patients to Access National Cancer Center-Funded Sites. American Cancer Society Cancer Action Network. 2025. https://www.fightcancer.org/releases/new-paper-finds-travel-distance-remains-barrier-patients-access-national-cancer-center

indicates that private reimbursement rates can come close to doubling what Medicaid would pay for the same service.[24] Current trends indicate declining participation in Medicaid by oncology specialists, and policymakers must work to preserve access to specialty cancer care for Medicaid beneficiaries.[25] The often-lower reimbursement coupled with state-by-state variability can create a barrier to care for low-income patients reliant on Medicaid. Evidence clearly demonstrates a link between increases in Medicaid reimbursement for office visits and screening tests and increases in receipt of guideline-concordant cancer screenings by Medicaid beneficiaries.[26]

Prior Authorization and Administrative Burden

Prior authorizations continue to be a significant barrier to care for insured patients. ASCO has opposed inappropriate prior authorization due to overwhelming evidence demonstrating that it contributes to major delays and denials of medically necessary care which is uniquely time-sensitive for oncology patients.[27] A recent study revealed that 75 percent of oncology patients experience at least one prior authorization. In over half of the reported cases, patients and their families were forced to intervene to obtain their prescribed care, after delays of days or weeks.[28] Data on the impact of prior authorizations in Medicaid specifically are mixed; some studies demonstrate increased use of prior authorization in Medicaid relative to other coverage types, but negative outcomes such as increased time to receipt of therapy or higher rates of denials are not currently borne out by the evidence.[29,30]

Nevertheless, prior authorization remains a time-consuming impediment to the receipt of cancer care, and ASCO's 2018 Position Statement on Medicaid Work Requirements

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[24] Lopez E, Neuman T, Jacobson G, Levitt L. How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature. KFF. 2020. https://www.kff.org/medicare/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/

[25] Vichare A, Bodas M, Erikson C, Chalasani P, Luo QE. Enumerating the Oncology Specialist Workforce in Medicaid: Applying a Triangulated Approach. *Health Serv Res*. Published 2025:e70029. doi:10.1111/1475-6773.70029

[26] Halpern, M.T., Romaire, M.A., Haber, S.G., Tangka, F.K., Sabatino, S.A. and Howard, D.H. (2014), Impact of state-specific Medicaid reimbursement and eligibility policies on receipt of cancer screening. Cancer, 120: 3016-3024. https://doi.org/10.1002/cncr.28704

[27] ASCO Position Statement: Prior Authorization. 2022. https://society.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/Prior-Auth-Position-Statement.pdf

[28] American Society of Clinical Oncology. Prior Authorization Often Places Burden on Patients With Cancer, Delys Care. ASCO. 2025. https://www.asco.org/about-asco/press-center/news-releases/prior-authorization-often-places-burden-patients-with-cancer-delays-care

[29] Gracie J, Jimenez R, Winkfield KM. The Burden of Insurance Prior Authorization on Cancer Care: A Review of Evidence From Radiation Oncology. *Advances in Radiation Oncology*. 2025;10(1):101654. doi:10.1016/j.adro.2024.101654

[30] Lichtenstein MRL, Beauchemin MP, Raghunathan R, et al. Association Between Copayment Assistance, Insurance Type, Prior Authorization, and Time to Receipt of Oral Anticancer Drugs. *JCO Oncol Pract*. 2024;20(1):85-92. doi:10.1200/OP.23.00205

highlighted how such administrative tasks have increasingly reduced the amount of time oncologists can spend with patients.[2] These include requirements such as compliance and quality reporting, electronic health records maintenance, and obtaining pre-authorization for treatment. One study found that physicians spent 49% of their office hours updating records and files, rather than treating patients, a significant driver of physician burnout.[2]

These burdens must not be exacerbated by the additional determinations or employment/community engagement requirements under H.R. 1. CMS and the states should ensure automatic processes wherever possible and provide easy and streamlined systems for patients and their physicians when their involvement is necessary.

CONCLUSION AND RECOMMENDATIONS

As CMS and the states implement H.R. 1, it is essential to preserve sufficient clinical capacity in Medicaid and to avoid unintended consequences that undermine access for patients with cancer. ASCO makes the following recommendations to CMS and to the states:

- **Preserving access to cancer care under Medicaid is paramount: states should not seek to implement requirements that are more frequent or stringent than statutorily required by H.R. 1.**
- **CMS should require and enable state use of automatic processes for both the establishment of exemptions and the verification of community engagement requirements. In cases where available data sources (e.g., claims data) are insufficient or unavailable, a streamlined process must exist for reporting or applying for exemptions by patients and their oncologists.**
- **Regarding community engagement requirements, CMS guidance on exemptions for "medical frailty" or "complex medical conditions" and state regulations defining exempted individuals should include:**
  - **individuals undergoing testing for cancer diagnosis,**
  - **patients undergoing active treatment for cancer,**
  - **cancer survivors undergoing active surveillance for long-term disease or treatment-related side effects, and**
  - **caregivers of patients receiving testing or treatment for cancer or who are under long-term surveillance for their cancer or side effects.**
- **CMS should give states the flexibility and capacity to prevent barriers to receiving timely and appropriate cancer care, and states should utilize these flexibilities. These flexibilities include, but are not limited to:**

- **ensuring simple and efficient application and processing for exemptions,**
    - **ensuring the maximum duration of retroactive eligibility allowed by law,**
    - **encouraging the use of hardship exceptions to help support travel to and participation in clinical trials,**
    - **creating systems that do not threaten continuity of care during renewal periods or related to reporting requirements, and**
    - **establishing the expectation that cancer is a long-term disruption for patients, and the duration of cancer-related exemptions should reflect medical necessity.**
- **CMS and the states should ensure that reforms to Medicaid financing do not further erode oncologist participation in the program by ensuring robust reimbursement.**
- **To preserve access to timely and high-quality cancer care for Medicaid beneficiaries, CMS and the states should ensure that utilization management policies that impede guideline-concordant treatment, including prior authorization or changes to benefit or formulary design, are not implemented in response to budgetary pressures.**
- **Eliminate out-of-pocket expenses such as copays and coinsurance as well as other cost sharing mechanisms for Medicaid patients undergoing active cancer treatment due to their inappropriateness in the context of cancer care.**

Questions? Contact policy@asco.org