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June 22, 2020

The Honorable Alex Azar
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Oklahoma's SoonerCare 2.0 Health Adult Opportunity Section 1115 Demonstration Application

Dear Secretary Azar:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Oklahoma's SoonerCare 2.0 Health Adult Opportunity (HAO) Section 1115 Demonstration Application. 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 critical to the fight for a world without cancer.

ACS CAN is disappointed that the Oklahoma Governor has rescinded the state plan amendment to expand Medicaid coverage to low-income state residents earning up to 138 percent of the federal poverty level (FPL). Over 20,530 people in Oklahoma are expected to be diagnosed with cancer this year[1] and there are over 207,260 cancer survivors in the state[2] – many of whom rely on Medicaid or would greatly benefit from receiving their health care through expansion of the program. Research has demonstrated that individuals who lack health insurance coverage are more likely to be diagnosed with advanced-stage cancer, which is costly and often leads to worse outcomes.[3,4] Research has also shown that individuals in expansion states are more frequently diagnosed with cancer at earlier stages than

[1] American Cancer Society. *Cancer Facts & Figures: 2020*. Atlanta: American Cancer Society, 2020.
[2] American Cancer Society. *Cancer Treatment & Survivorship Facts & Figures 2019-2021*. Atlanta, GA: American Cancer Society; 2019.
[3] Ward E, Halpern M, Schrag N, et al. Association of insurance with cancer care utilization and outcomes. *CA Cancer J Clin*. 2008; 58(1):9-31.
[4] American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2019-2020*. Atlanta: American Cancer Society; 2019.

those in non-expansion states.[5,6] Additionally, individuals enrolled in Medicaid prior to their diagnosis have better survival rates than those who enroll after their diagnosis.[7]

ACS CAN wants to ensure that cancer patients, survivors, and those who will be diagnosed have adequate access and coverage and that any requirements included in the waiver do not create unintentional barriers to care for low-income cancer patients and survivors. We have serious concerns with the Oklahoma Health Care Authority's (OHCA) request for a capped Medicaid funding structure and the requirements that eligible individuals will need to complete to receive and maintain coverage. We note the state waiver fails to provide sufficient detail on the per capita cap and other proposals (as discussed further below), making it impossible to fully evaluate the proposal. This comment letter details some of these issues. We are also significantly concerned with Governor Stitt's insistence in moving forward with the HAO waiver as the full consequences of the COVID-19 pandemic continue to unfold, the impact of which are not fully known. We strongly urge the Centers for Medicare and Medicaid Services (CMS) to deny the HAO waiver, as the nation continues to grapple with the health care and economic fallout of the COVID-19 pandemic.

ACS CAN has significant concerns with the federal HAO guidance and this waiver application as a whole, and following are the most egregious provisions of the SoonerCare 2.0 HAO section 1115 demonstration waiver application:

Capped Funding Can Limit Eligibility and Access to Services

ACS CAN strongly opposes any aggregate payments or per-capita caps on the Medicaid program. Changing the state's financing structure to either an aggregate or per-capita cap for their Medicaid programs' optional adult populations, including the parent and caretaker relatives and the National Breast and Cervical Cancer Early Detection Program (NBCCEDP)-eligible women in *Oklahoma Cares*, could endanger access to vital health care for truly vulnerable populations, such as those fighting cancer and recent cancer survivors.

Unfortunately, the waiver application provides insufficient information in which to reasonably evaluate the waiver. It is unclear from the waiver application which capped funding approach the state intends to take after CMS' required two year per-capita cap post-expansion, but details in the waiver appear to point towards a block grant approach. There is also no detail as to how the state intends to implement the capped funding. ACS CAN has concerns with both aggregate and per-capita cap approaches to funding, as any capped funding structure on the Medicaid program will negatively impact the beneficiaries that rely on the program for affordable and accessible health care coverage.

If the capped funds are exhausted and Oklahoma lacks sufficient funds in the state budget to adjust, the state may be forced to stop providing certain benefits and/or services until the next years' capped funds become available. It is possible the state could see a reduction in overall federal funding for the optional

[5] Jemal A, Lin CC, Davidoff AJ, Han X. Changes in insurance coverage and stage at diagnosis among non-elderly patients with cancer after the Affordable Care Act. *J Clin Oncol*. 2017; 35:2906-15.
[6] Soni A, Simon K, Cawley J, Sabik L. Effect of Medicaid Expansion of 2014 on overall and early-stage cancer diagnoses. *Am J Public Health*. 2018; 108:216-18.
[7] Adams E, Chien LN, Florence CS, et al. The Breast and Cervical Cancer Prevention and Treatment Act in Georgia: effects on time to Medicaid enrollment. *Cancer.* (2009); 115(6):1300-9.

adult populations in a capped funding structure, which could necessitate the state to use other cost-saving measures. These could include enrollment freezes, waiting lists, and increased co-pays and premiums for enrollees – all of which would negatively impact the health and wellbeing of Oklahomans, when the stated goal of the demonstration is to "promote efficient, coordinated, quality health care that drives better health outcomes for Oklahomans."[8] Enrollment freezes and waiting lists mean some Medicaid enrollees will not have the opportunity to receive early detection services that could prevent certain forms of cancer from developing, diagnose cancers an earlier stage, or provide timely and appropriate access to cancer treatments, diminishing their odds of survival.

Economic downturns, epidemics, or major state disasters, like the Oklahoma tornadoes and floods in 2019, could create greater need for Medicaid coverage among state residents. This is particularly relevant now as the number of COVID-19 cases in the U.S. and Oklahoma increases, making timely access to care imperative for detection, treatment, and preventing further spread of the disease. Under aggregate caps the federal payments are fixed and would remain the same, leaving the state and its enrollees financially vulnerable when they need help the most to respond to these types of public health emergencies or state disasters. While we acknowledge the HAO guidance released by CMS allows states who experience a public health crisis or major economic event to apply for a special circumstance adjustment, these funds are not guaranteed, and states would have to wait for the Administration to approve their request. Unfortunately, cancer patients who are in active treatment do not have the luxury to postpone their treatments while the state and federal government debate additional funding to help with rising costs.

Finally, greatly reducing federal Medicaid funding and allowing states to determine eligibility levels would not necessarily reduce underlying program costs. Instead, it is likely that reduced federal financial support through capped funding would result in a shift of additional costs to health systems, providers, and enrollees through uncompensated care. Many public hospitals, children's hospitals, rural providers, and community health centers in Oklahoma make up the "safety net" for low-income individuals and families battling cancer. These health systems greatly rely on Medicaid revenue to provide services. Reduced federal and state funding could result in Oklahoma hospital systems, community health centers, and providers reducing the number of Medicaid patients or uninsured patients they treat due to lower reimbursement rates and greater uncompensated care costs. Not only would this mean less access for Medicaid enrollees and the uninsured, but it could also hinder Oklahoma's efforts to improve the quality of health care, particularly during a pandemic like COVID-19.

Impact on NBCCEDP-Eligible Women

ACS CAN strongly supports the NBCCEDP, which provides vital cancer screenings to low-income women. Through the enactment of the federal Breast and Cervical Cancer Prevention and Treatment Act in 2000, all women diagnosed through the NBCCEDP are presumptively eligible for Medicaid coverage for their treatment – which in program year 2018 alone included over 10,000 eligible women.[9] The per-capita cap or aggregate payment the state is requesting would also include women eligible for Medicaid through *Oklahoma Cares*. If the state caps enrollment or reduces benefits, a woman who is diagnosed with cancer through *Oklahoma Cares* may have to wait to receive treatment (during which time her cancer

[8] See waiver pg. 4.

[9] Centers for Disease Control and Prevention. National Breast and Cervical Cancer Early Detection Program: About the program. Updated October 18, 2019. Accessed June 2020 at www.cdc.gov/cancer/nbccedp/about.htm.

could spread) or may have access to limited treatment options (which could hinder her likelihood of a successful outcome).

Increased State Flexibility without Appropriate Stakeholder Feedback Could Disadvantage Cancer Patients

The state requests a number of flexibilities to choose to implement at a future date during the demonstration period. We appreciate the state reiterating their intent to first go through the proper comment periods before making some of the possible changes. But we urge CMS to require that any significant changes made from the original implementation go through both a state and federal comment period to allow impacted stakeholders the ability to provide critical feedback. The state could inadvertently cut or eliminate important enrollee benefits and protections without stakeholders, or the Administration providing any counsel or feedback. It is imperative that enrollees and other stakeholders have the ability to provide feedback to the state and CMS before any policies are continued or newly implemented under a HAO waiver.

Work and Community Engagement Requirement

Oklahoma's waiver includes the requirement that all non-exempt adults aged 19 through 60 years must be employed or participating in job search/training or community service activities for 80 hours per month to maintain eligibility or enrollment in the Medicaid program. Non-exempt individuals will have a 90-day grace period from the time of SoonerCare 2.0 application or transition to verify compliance with the requirements. We are concerned this policy could unintentionally disadvantage patients with serious illnesses, such as cancer. While we understand the intent of the proposal is to "promote upward mobility, greater independence, and improved quality of life among individuals," many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[10,11,12]

ACS CAN opposes tying access to affordable health care for lower income persons to work or participation in community engagement because cancer patients, survivors, and those who will be diagnosed with the disease - as well as those with other complex chronic conditions - would likely find that they are ineligible for coverage through the state's Medicaid program. Cancer patients and recent survivors may not be eligible for SoonerCare 2.0 if they are told by their doctors not to work or to limit their work hours during their treatment protocol. 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.[13] If work and community engagement is required as a condition of eligibility, many cancer patients, recent survivors, and those with other chronic illnesses

[10] Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv.* 2016; 10:241. doi: 10.1007/s11764-015-0470-y.

[11] de Boer AG, Taskila T, Tamminga SJ, et al. Interventions to enhance return to work for cancer patients. *Cochrane Database Syst Rev.* 2011; 16(2): CD007569. doi: 10.1002/14651858.CD007569.pub2.

[12] Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. *J Cancer Surviv*. 2016; 10:480. doi:10.1007/s11764-015-0492-5.

[13] Ramsey SD, Blough DK, Kirchhoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy then People Without a Cancer Diagnosis," Health Affairs, 32, no. 6, (2013): 1143-1152.

could find that they are ineligible for the lifesaving care and treatment services provided through the state's Medicaid program. Additionally, the increase in administrative requirements for enrollees to attest to their working status on a monthly basis and provide supporting documentation, even with the use of a phased-in approach, would likely prevent or decrease the number of individuals with Medicaid coverage, regardless of whether they are given exceptions or not. This scenario was seen in the first year of implementation of Arkansas' work requirement.[14]

Given the experience with work requirements in Arkansas, where state insured rates declined after the policy was implemented[15] and the likelihood that thousands of Oklahomans will likely be unemployed due to COVID-19 and the recession, we urge CMS to consider the number of Oklahomans whose health could be negatively impacted and coverage lost due to this proposal. More importantly, the federal courts have made it clear that CMS cannot approve demonstrations that will result in coverage losses,[16] and OHCA estimates 7,600 fewer adults (which includes expansion numbers) will be enrolled in the first demonstration year if the premium and work requirements are implemented.[17] This number will clearly be different now that the state has chosen not to move forward with expansion. Therefore, the application should be considered incomplete by CMS.

Disenrollment for Non-compliance

The proposed disenrollment from the program for non-compliance with the work and other eligibility requirements (discussed in more detail below) penalizes patients. Non-compliance with the work requirement would result in termination of eligibility effective the first day of the month following the month in which the state determined the member was non-compliant with the community engagement hours, unless an appeal is timely filed or the member requests good cause. Even with the "good cause exemptions," the waiver does not go far enough to protect vulnerable individuals, including recent cancer survivors, and those with other serious chronic diseases linked to cancer treatments.[18]

Although the state mentions in the waiver the possibility of an appeal process, not enough information is provided. Therefore, we ask that additional information regarding the appeal process be provided, including what constitutes a "timely"[19] appeal and information regarding whether the individual will retain the right to coverage pending the outcome of the appeal. If an enrollee fighting cancer was suspended from coverage during the appeal process, they will likely have no access to health care coverage, making it difficult or impossible to continue their treatment or pay for their maintenance medication until it is determined that they have "good cause" or meet an exemption category. For cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Being denied access to one's cancer care team could be a matter of life or death for a

[14] Sommers BD, Goldman AL, Blendon RJ, Orav EJ, Epstein AM. Medicaid work requirements – Results from the first year in Arkansas. *NEJM*. 2019; DOI: 10.1056/NEJMsr1901772.
[15] Ibid.
[16] US Court of Appeals for the District of Columbia Circuit, Gresham v. Azar, Feb. 14, 2020. Accessed June 2020. https://healthlaw.org/wp-content/uploads/2020/02/Gresham-v.-Azar-DC-Circuit-Ruling-Feb-14.pdf.
[17] See waiver pg. 18.
[18] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.
[19] See waiver at pg. 13.

cancer patient or survivor, and the financial toll that the lock-out would have on individuals and their families could be devastating.

We also note that the state decided to move forward with the work requirement proposal and anticipated disenrollments, despite the state's acknowledgement of other state experiences of significant coverage losses.[20] Oklahoma has a higher than national average uninsured rate[21] and should prioritize getting as many people covered as quickly as possible during the COVID-10 pandemic and likely economic recession rather than creating barriers to coverage.

Modifying Community Engagement Requirements Over Time
The state requests authorization to be able to modify the work hour requirements and modify the exemptions and qualifying activities in later years of the demonstration, as well as temporarily reduce or pause the requirements in response to "unforeseen and acute challenges." As mentioned previously, we urge CMS to ensure that any significant changes made from the original implementation go through both a state and federal comment period to allow impacted stakeholders the ability to provide critical feedback.

Waiving Presumptive Eligibility
OHCA requests authorization to waive presumptive eligibility to "help align with private coverage policies." Low-income, Medicaid-eligible individuals rely on presumptive eligibility to receive affordable health care, particularly if they did not realize they were eligible for affordable coverage through Medicaid. Safety net hospitals and providers also rely on presumptive eligibility for reimbursement of provided services, allowing these facilities to keep the doors open.[22] Waiving presumptive eligibility for the HAO adult population could result in either an individual facing significant out-of-pocket expenses for care that they believed would be covered by their presumed eligibility or a provider being responsible for the cost of the provided services should the patient be unable to pay for them. This could be particularly true for those women who are screened through *Oklahoma Cares*, who are presumed eligible for the program and may not have a direct path to other insurance coverage for treatment of their breast or cervical cancer diagnosis.

Presumptive eligibility is also critical during public health emergencies and economic downturns like we are experiencing now with COVID-19, by ensuring individuals have an uninterrupted and expedited path to enrollment and coverage. Therefore, we urge CMS to deny the state's request and consider how approving this type of policy could negatively impact patients, hospitals, and providers in the state.

Waiving Retroactive Eligibility
OHCA requests to waive retroactive eligibility and have coverage start after enrollees with a premium obligation pay that premium. Policies that would reduce or eliminate retroactive eligibility could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for

[20] See waiver pg. 20.
[21] United States Census Bureau. *State-by-state health insurance coverage in 2018*. Published November 7, 2019. Accessed June 2020. https://www.census.gov/library/stories/2019/11/state-by-state-health-insurance-coverage-2018.html.
[22] National Association of Community Health Centers. Maine health center fact sheet. Published March 2017. Accessed June 2020. http://www.nachc.org/wp-content/uploads/2016/03/ME_17.pdf.

individuals recently diagnosed with cancer. Many uninsured or underinsured individuals who are newly diagnosed with a chronic condition delay primary and preventive care visits, as well as follow-up care or diagnostic testing, because of cost.[23] In 2018, one in five uninsured adults went without care because of cost.[24] Waiving retroactive eligibility could mean even more people are unable to afford care and forgo necessary care due to cost.

Safety net hospitals and providers in the state rely on retroactive eligibility for reimbursement of provided services. For example, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.[25] Retroactive eligibility allows hospitals to be reimbursed if the individual treated is eligible for Medicaid coverage. Likewise, Federally Qualified Health Centers (FQHCs) and community health centers offer services to all persons, regardless of that person's ability to pay or insurance status, and also rely on retroactive eligibility.[26] Community health centers also play a large role in ensuring low-income individuals receive cancer screenings, helping to save the state of Oklahoma from the high costs of later stage cancer diagnosis and treatment. Therefore, we urge CMS to consider these providers and their contribution to Oklahoma's safety net, as well as the patients who rely on Medicaid for health care coverage, and deny the state's request to waive retroactive eligibility for the HAO eligibility groups.

Premiums and Copayments for Adult Expansion and Adult Optional Enrollees

ACS CAN opposes the proposed mandated tiered monthly premiums and copayments for non-exempt individuals with household income over the parent/caretaker income standard (41 percent of FPL or $742 per month for a family of three) to initiate and maintain their coverage. The waiver application estimates that 81,400 enrollees (including the expansion group) would be subject to premiums.[27] This number will clearly be different now that the state has chosen not to move forward with expansion. Therefore, the application should be considered incomplete by CMS.

We are concerned the cost sharing and related penalties for non-payment for the adult populations could create administrative burdens for enrollees, deter enrollment or result in a high number of disenrollment (including other members of their household), and potentially cause significant disruptions in care, especially for cancer survivors and those newly diagnosed. Studies have shown that imposing even modest premiums on low-income individuals is likely to deter enrollment in the Medicaid

[23] Hadley J. Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. *JAMA*. 2007; 297(10): 1073-84.
[24] The Henry J. Kaiser Family Foundation. Key facts about the uninsured population. Updated December 13, 2019. Accessed June 2020. https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.
[25] Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed June 2020. https://www.cms.gov/regulations-and-guidance/legislation/emtala/.
[26] National Association of Community Health Centers. Maine health center fact sheet. Published March 2017. Accessed June 2020. http://www.nachc.org/wp-content/uploads/2016/03/ME_17.pdf.
[27] See waiver at pg. 18.

program.[28,29] Imposing cost sharing on low-income populations has been shown to decrease the likelihood that they will seek health care services, including preventive screenings.[30,31] Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.[32] Uninsured and underinsured individuals already have lower screening rates resulting in a greater risk of being diagnosed at a later, more advanced stage of disease.[33] Proposals that place greater financial burden on low-income residents create barriers to care and could negatively impact enrollees – particularly those individuals who are high service utilizers with complex medical conditions.

While we appreciate individuals will not lose coverage for non-payment of copayments, the state does not provide any detail about how much the copayments would be or what services would be subject to copayments. The only detail provided is that copayments would be collected at the point of service up to the five percent of out-of-pocket limit (including premium obligations) for all non-exempt enrollees with household income over 41 percent FPL. We urge CMS to require the state provide more details regarding how it intends to implement copayments for SoonerCare 2.0 enrollees.

Loss of Eligibility for Non-Payment of Premiums

The requirement that non-exempt adults with household income above 41 percent FPL (which, in 2020, is only $5,232 per year; only $436 per month) must pay a premium to begin their coverage or lose coverage for non-payment of premiums after a three-month grace period is concerning. OHCA estimates that 7,600 fewer adults (again, including the expansion population) will be enrolled in the first demo year due to premium and work requirements.[34] This number will clearly be different now that the state has chosen not to move forward with expansion. Therefore, the application should be considered incomplete by CMS. This number is also likely inaccurate, as indicated in the Indiana HIP 2.0 demonstration evaluation results. Research in Indiana, who has a similar 1115 demonstration waiver that applies premiums to its HIP 2.0 enrollees,[35] indicates that 46,000 people were determined eligible

[28] Hendryx M, Onizuka R, Wilson V, Ahern M. Effects of a Cost-Sharing Policy on Disenrollment from a State Health Insurance Program. *Soc Work Public Health*. 2012; 27(7): 671-86 and Wright BJ, Carlson MJ, Allen H, Holmgren AL, Rustvold DL. Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out. *Health Affairs*. 2010; 29(12):2311-16.

[29] Office of the Assistant Secretary for Planning and Evaluation. Financial Condition and Health Care Burdens of People in Deep Poverty. Published July 16, 2015. Accessed June 2020. http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty.

[30] Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research.* 2000; 34: 1331-50.

[31] Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. *Med Care.* 2011; 49: 865-71 and Trivedi AN, Rakowsi W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med.* 2008; 358: 375-83.

[32] American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2019-2020.* Atlanta: American Cancer Society; 2019.

[33] Ibid.

[34] See waiver pg. 18.

[35] In Indiana, those with incomes from 101-138% FPL who fail to pay premiums after a 60-day grace period were disenrolled from coverage.

for HIP 2.0 but never enrolled in coverage because they never paid their first premium.[36] Another 13,550 individuals enrolled, but lost coverage for failing to pay a premium during the first two years of the demonstration.[37]

Denying individuals health coverage for non-payment of a premium could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for cancer survivors (who require frequent follow-up visits) and individuals in active cancer treatment. Low-income cancer patients or survivors will likely have no access to health care coverage if they are unable to pay the initial premium to receive coverage or their eligibility is suspended after three months for non-payment, making it difficult or impossible to continue treatment or pay for their maintenance medication. For those cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Being denied access to one's cancer care team for three months could have a significant impact on an individual's cancer prognosis and the financial toll that the disenrollment would have on individuals and their families could be devastating.

ACS CAN urges CMS to require the state to implement a medical or hardship exemption that would exclude individuals managing complex medical conditions, like cancer, from any suspension or disenrollment penalties if CMS chooses to approve this section of the HAO waiver. Additionally, we urge CMS to require the state to allow enrollees and/or their health care providers to proactively attest to any change in their health status that could qualify them for the medical or hardship exemption, preventing any unnecessary gaps in coverage.

Request for Flexibility to Adjust Premiums and Copayments
The state requests to be able to adjust premiums and/or copayments as high as five percent of the individual's household income or the freedom to temporarily pause premium or copayment policies in response to "unforeseen and acute challenges." The flexibility to adjust premiums and copayments as high as five percent of income is troubling. Low-income individuals may be unable to afford critical health care coverage if cost sharing is imposed. As previously mentioned, we urge CMS to ensure that any changes, especially proposals that could result in an increase in cost sharing, made from the original implementation go through both a state and federal comment period to allow impacted stakeholders the ability to provide critical feedback.

Copayment for Non-emergent Use of the Emergency Department
The state's request to impose an $8 copayment for each "non-emergent" emergency department (ED) use for SoonerCare 2.0 enrollees could increase costs for cancer patients. Imposing copayments may dissuade an individual from seeking care from an ED setting – even if the case is medically warranted. 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. Penalizing

[36] Rudowitz R, Musumeci MB, Hinton E. *Digging into the data: What can we learn from the state evaluation of healthy Indiana (HIP 2.0) premiums*. Published March 2018. Accessed June 2020. http://files.kff.org/attachment/Issue-Brief-Digging-Into-the-Data-What-Can-We-Learn-from-the-State-Evaluation-of-Healthy-Indiana-HIP-20-Premiums.
[37] Ibid.

enrollees, such as cancer patients, by requiring copayments for non-emergent use of the ED could become a significant financial hardship.

We urge CMS to deny the state's requested ED non-emergent copayment. Should consideration be given to the state's request, we ask that OHCA be required to define the term "non-emergent" use of the ED, as this definition is not included in the final waiver application. Additionally, when evaluating ED cost sharing requirements, we urge CMS to require the state to evaluate the impact it has on patients with complex chronic conditions, such as cancer, not just evaluate the financial impact of this type of requirement if CMS were allow the state to move forward with this proposal.

Managed Care and Benefits Package

SoonerCare 2.0 enrollees would be enrolled in a Medicaid managed care plan similar to the state's current Patient Centered Medical Home delivery system. In general, we are supportive of Oklahoma's decision to provide health care coverage to the SoonerCare 2.0 population through managed care. However, we are concerned with the state's requested flexibility to implement "a unique managed care solution" including new payment methodologies, as the state does not provide details on this solution. ACS CAN believes it is important that enrollees have access to all basic services provided under Medicaid to ensure the greatest health outcomes for Oklahomans and are therefore concerned with the benefit modifications made by OHCA to "more closely align with benefits covered in the commercial market."[38]

The federal standards and requirements for Medicaid managed care plans are important safeguards that ensure Medicaid Managed Care Organizations (MCOs) must meet certain requirements related to patient care, so we implore CMS to not allow the state to make any changes to these standards. For example, the Medicaid managed care rule sets standards related to the adequacy of plan networks, including time and distance standards, so patients have access to the appropriate providers and receive the care they need. For an individual undergoing cancer treatment, timely and uninterrupted access to services is critical. ACS CAN urges the state to provide clarification on how it intends to ensure that managed care plan networks include an adequate number of specialists to guarantee that enrollees have access to the specialists necessary to treat their medical conditions, especially oncologists, cancer surgeons, and radiologists.

In addition, we are concerned about the extent to which the state will provide needed education and notice to individuals whose care will be provided through managed care. We urge CMS require the state to provide additional information on the education and awareness processes it intends to implement to notify current and future adult Medicaid enrollees of the change to managed care.

We also urge CMS to require the state to consider continuity of care provisions that would ensure that individuals in active treatment for life-threatening illnesses, such as cancer, not face significant care disruptions or visit limits that could negatively impact care. For an individual undergoing cancer treatment, timely and uninterrupted access to services is critical. When cancer treatment is delayed or disrupted, the effectiveness of the treatment could be jeopardized, and the individual's chance of survival can be significantly reduced. We note in the Alternative Benefit Plan attachment, as part of the CMS waiver request (and which was not included at the state level comment period), that a four visit per month limit will be assessed for primary care visits to treat injury or illness, specialty visits, and other

[38] See waiver pg. 23.

practitioner office visits on SoonerCare 2.0 enrollees.[39] Although we appreciate that OHCA specifies the amount limits can be exceeded based on medical need, we have some significant concerns and questions we request be answered by the state on the use of amount limits before CMS consider this request from the state:

(1) It is unclear who determines "medical necessity" and whether that determination is left to the treating provider or the MCO.
(2) The waiver is also unclear regarding what process the provider/patient must undertake if more than four visits are necessary (as is often the case for individuals undergoing active cancer treatment) to ensure coverage of the visits.
(3) We are concerned that imposing a limit of any kind on the number of month visits may have a chilling effect on patients who may be reluctant to seek care (particularly for things like preventive care) even when medically necessary due to fear of not being able to obtain coverage for other visits in the month.

Access to comprehensive benefits are also critical for recent cancer survivors. Recent cancer survivors often require frequent follow-up visits and maintenance medications as part of their survivorship care plan to prevent recurrence,[40] and suffer from multiple comorbidities linked to their cancer treatments.[41] Ensuring both cancer patients and recent survivors receive timely and appropriate care is critical to positive health outcomes. Failure to consider the care delivery and/or treatment regimen of patients, especially those managing a complex, chronic condition like cancer, could have devastating effects on patients, their families, and providers. Finally, we recommend that OHCA establish a clearly defined process through which a Medicaid enrollee can inform the state that they are in active treatment. These actions will allow cancer patients to maintain their cancer care treatment regimen and continue to see their providers in the same health care systems through the end of their treatment.

Finally, while we appreciate that the benefits package offered to SoonerCare 2.0 enrollees would include ambulatory patient services, such as chemotherapy and radiation, OHCA neglected to include immunotherapy. In fact, it appears that infusion therapy is considered an optional benefit in the waiver request.[42] We would appreciate clarification as to whether immunotherapy would also be included under the covered ambulatory patient services. Immunotherapy is a critical tool to cancer treatment, as it stimulates or boosts the natural defenses of the immune system, so it works harder or smarter to find and attack cancer cells.[43] We also appreciate that the benefits package includes coverage of preventive services, such as mammography and Pap smears. However, we urge CMS to require the state cover all USPSTF recommended cancer screenings, such as colorectal and lung cancer screening tests.

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[39] See waiver pg. 71.
[40] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed June 2020. https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care.
[41] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.
[42] See waiver pg. 102.
[43] American Cancer Society. *How immunotherapy is used to treat cancer*. Updated December 27, 2019. Accessed June 2020. https://www.cancer.org/treatment/treatments-and-side-effects/treatment-types/immunotherapy/what-is-immunotherapy.html.

Non-Emergency Medical Transportation
For SoonerCare 2.0 enrollees to "experience a more commercial-like benefit package," OHCA requests to waive non-emergency medical transportation (NEMT). NEMT is a critical service for many low-income Medicaid enrollees who do not have the financial means or the access to needed transportation services.[44] Without transportation benefits, chronically ill Medicaid enrollees may go without the lifesaving health services they need, leading to delayed care, an increase in avoidable hospitalizations, and poorer health outcomes.[45]

We appreciate that NEMT will remain a covered service for enrollees who demonstrate need for the service in accordance with their care coordination assessment and care plan through managed care, but the state neglected to consider the need for NEMT for preventive services for their adult populations. NEMT is used by individuals to access preventive services and cancer screenings – especially colon cancer screenings and mammograms. As mentioned earlier, early detection of cancer results in less expensive treatments and better health outcomes, which could help offset some short-term Medicaid program costs.[46] In addition, some cancer screenings can prevent cancers from developing (such as colonoscopies and Pap tests) by detecting and removing pre-cancerous polyps or lesions. However, lack of transportation to screening services hinders an individual's ability to obtain the necessary screening and, for some individuals, could result in detection of tumors at a later stage. Furthermore, the lack of NEMT services could cause more people to cancel appointments last minute, which could result in an enrollee facing the $8 "non-emergency use of the emergency department" penalty each time an individual is unable to make it to an appointment due to lack of transportation. ACS CAN strongly urges CMS to reject the state's request to waive NEMT for non-disabled adults in the Medicaid program.

Request for Flexibility to Modify Benefits and Prescription Drug Coverage
The state would like the flexibility to suspend, eliminate, or modify benefits, as well as "investigate the potential benefits of a limited prescription drug formulary and…make changes to our prescription drug benefit, following appropriate advance notice procedures."[47] As mentioned previously, we urge CMS to ensure that any significant changes made from the original implementation go through both a state and federal comment period to allow impacted stakeholders the ability to provide critical feedback. This is particularly important for any changes made to the prescription drug benefit, as limiting prescription drug formularies could severely negatively impact cancer patients and survivors.

ACS CAN strongly opposes the use of closed or limited formularies for Medicaid enrollees. There is no single oncology drug that is medically appropriate to treat all cancers. Cancer is not just one disease, but hundreds of diseases. Cancer tumors respond different depending on the type of cancer, stage of

[44] Rosenbaum S, Lopez N, Morris MJ, Simon M. Medicaid's medical transportation assurance: Origins, evolution, current trends, and implications for health reform. Washington, D.C.: Department of Health Policy, School of Public Health and Health Services, The George Washington University, 2009. https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1035&context=sphhs_policy_briefs.
[45] Kim J, Norton EC, Stearns SC. Transportation Brokerage Services and Medicaid Beneficiaries' Access to Care. Health Serv Res. 2009. 44(1):145-61.
[46] Powell W, Frerichs L, Townsley R, et al. The potential impact of the Affordable Care Act and Medicaid expansion on reducing colorectal cancer screening disparities in African American males. *PLoS One*. 2020; 15(1): e0226942.
[47] See waiver pg. 24.

diagnosis, and other factors. As such, oncology drugs often have different indications, different mechanisms of action, and different side effects – all of which need to be managed to fit the medical needs of an individual. Oncologists take into consideration multiple factors related to expected clinical benefit and risks of oncology therapies and the patient's clinical profile when making treatment decisions. As such, when enrollees are in active cancer treatment, it can be particularly challenging to manage co-morbid conditions.

Allowing for the use of a closed formulary would severely restrict a physician's ability to prescribe the medically appropriate treatment for an individual without going through a lengthy appeals process. Denying enrollees access to medically appropriate therapies can result in negative health outcomes, which can increase Medicaid costs in the form of higher physician and/or hospital services to address the negative health outcomes. Therefore, the state and federal government would not see money saved, as the state and federal government would pay for limiting or closing formularies through uncompensated care costs to hospitals and providers.

Other Concerns

We note the state will need to provide a great deal of oversight to ensure the MCOs are ensuring enrollees are held harmless from any issues in the administration of these proposals. In particular, it is critical that the state ensure a swift and efficient appeals process be provided to the beneficiary before any coverage is lost or penalty is received for not meeting any of the above requirements.

Conclusion

We appreciate the opportunity to provide comments on Oklahoma's 1115 HAO waiver application. Expanding eligibility and coverage through the Medicaid program is critically important for many low-income Oklahomans who could greatly benefit from the program for cancer prevention, early detection, diagnostic, and treatment services and we are extremely disappointed in the Governor's decision not to move forward with the public ballot results. Additionally, the proposed capped funding and proposed requirements in this 1115 waiver could deny countless low-income Oklahomans who are in cancer treatment and recent survivors, and who are unable to complete the community engagement requirements, access to comprehensive, affordable health care coverage. We ask CMS to weigh the potential impact of this waiver proposal on low-income Oklahoman's access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Our comments include numerous citations to supporting research, including direct links to the research for the benefit of CMS in reviewing our comments. We direct CMS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

Maintaining access to quality, affordable, accessible, 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 with CMS to ensure that all people are positioned to win the fight against cancer. If you have any questions, please feel free to contact me or have your staff contact Kirsten Sloan, director of our policy team at Kirsten.Sloan@cancer.org.

Sincerely,

Lisa A. Lacasse, MBA
President