American Lung Association.

June 24, 2020

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

Re: Oklahoma SoonerCare 2.0 Application

Dear Secretary Azar:

Thank you for the opportunity to submit comments on the SoonerCare 2.0 Section 1115 Demonstration Application.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the more than 36 million Americans living with lung diseases including asthma, lung cancer and COPD, including more than 562,000 Oklahomans. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and the American Lung Association is committed to ensuring that SoonerCare provides quality and affordable healthcare coverage. Unfortunately, the SoonerCare 2.0 proposal is not a sufficient solution to improve access to quality and affordable healthcare for low-income Oklahomans. This proposal would create a capped funding structure which would reduce patients' access to critical benefits and services and add administrative and financial barriers to the program that would undoubtedly lead to coverage losses.

Many of the waiver's proposals and enrollment projections are based on an expectation that Oklahoma would have implemented Medicaid expansion in July 2020 pursuant to a State Plan Amendment (SPA). In the SoonerCare 2.0 application, the state assumes that the expansion population will roll over into SoonerCare 2.0 on July 1, 2021. The state also claims that the first year of the expansion will provide the necessary data for the expenditure estimates for the per capita cap. However, Oklahoma withdrew its SPA on May 28, 2020. When the Governor withdrew the SPA, CMS should have returned the waiver to the State to develop new enrollment and other projections and withdrawn its certification of the proposal as complete.

The Lung Association would oppose this proposal under any circumstance, but it is especially dangerous to move forward with this proposal during a public health emergency such as the current COVID-19 pandemic. As of June 24, Oklahoma had 11,510 confirmed cases, 1,319 hospitalizations and 372 deaths as result of COVID-19.[i] This disease has already put an enormous burden of our nation's healthcare system, including the Medicaid program, and is expected to do so for weeks and months to come. The economic impact of COVID-19 is also likely to increase the need for Medicaid coverage long-term; the unemployment rate has already increased significantly and Medicaid enrollment in Oklahoma is expected to increase by an additional 135,000 to 320,000 individuals.[ii] This waiver would make it much

harder for the state to respond to this public health and economic crisis and have grave consequences for the patients in Oklahoma. Earlier this year, a group of leading patient organizations issued a statement expressing our serious concerns with this waiver application.[iii] The American Lung Associations urges CMS to reject this proposal and offers the following comments:

Per Capita Cap
While the state uses an application template for its proposal which is to be used by states "applying to use either an aggregate or a per capita cap financing model for certain populations" the proposal includes no details about the cap, how it would work or how much capped funding the state would receive. The Lung Association is extremely concerned with the lack of detail in Oklahoma's proposal. Such a drastic change in Oklahoma's Medicaid program will undoubtedly have a dramatic impact on patients, but without additional details, it is impossible to fully comment on all of the possible impacts of a per capita cap on the patients we represent.

As the Lung Association and other partners explained in detail in our March 9th letter, we oppose the use of block grants and per capita caps in the Medicaid program.[iv] Neither financing structure will protect either the state or patients from enormous financial risk. As the gap between the capped allotment and actual costs of patient care increases over time, states will likely limit enrollment, reduce benefits, lower provider payments or increase cost-sharing, all of which would cause significant harm to the patients we represent. For example, cuts to provider payments could make it harder for patients with lung disease – who rely on prompt access to primary care providers as well as specialists like pulmonologists and oncologists – to get appointments with providers who can help them find the best treatments and manage their conditions. Similarly, additional barriers put in place for ground-breaking but expensive treatments could restrict patients' access to lifesaving care. Since 2015, 35 treatments have been approved for lung cancer patients; these treatments have extended the lives of patients, as will treatments that are currently in the approval pipeline, but they need to be accessible to continue to have a positive impact.

Many situations could lead Oklahoma to exceed a funding cap. A public health emergency like COVID-19 will greatly increase healthcare costs above negotiated caps, and an economic recession would similarly increase enrollment in, and costs associated with, SoonerCare, putting patients' access to care at risk. This is particularly concerning given how Oklahoma has previously attempted to cut healthcare programs in the past; for example, Oklahoma has previously looked to cut home and community-based service programs in response to budget pressures, and nothing in this proposal would prevent Oklahoma from seeking to cut services or eligibility in other areas of the Medicaid program if it exceeds the cap for the demonstration population.[v] Our organizations urge you to reject Oklahoma's request for a per capita cap.

Retroactive Coverage
Oklahoma has requested the authority to waive retroactive eligibility, a policy that prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that timeframe. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as cancer, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often times confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. When Ohio was considering a similar provision in 2016, one estimate predicted that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[vi] The Lung Association oppose a waiver of retroactive coverage and urge you to reject this waiver request.

Presumptive Eligibility
Oklahoma proposes to eliminate hospitals' option to make presumptive eligibility (PE) determinations for the waiver population, thereby preventing hospitals from providing temporary Medicaid coverage to individuals likely to qualify for Medicaid. This is an important entry point for individuals who qualify for Medicaid but are not yet enrolled to receive access to coverage promptly and helps to protect patients from large medical bills. Eliminating PE is particularly egregious when combined with the State's request to eliminate retroactive coverage. While Oklahoma asserts that the State will continue to use its Notification of Date of Service (NODOS) process to determine eligibility, that process includes restrictions and deadlines far less protective than hospital presumptive eligibility. Additionally, eliminating presumptive eligibility would increase uncompensated care for hospitals that are already facing economic hardship in light of the COVID-19 pandemic. The Lung Association urges CMS to reject this request.

Premiums and Cost-Sharing
Under Oklahoma's application, individuals with incomes above 42 percent of the federal poverty level would have to pay premiums ranging from $5 to $15 per month. Individuals could not enroll in coverage until they pay their first premium and could lose their coverage if they are unable to pay future premiums. This policy would likely both increase the number of enrollees who lose Medicaid coverage and also discourage eligible people from enrolling in the program. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[vii] For individuals with lung disease, maintaining access to comprehensive coverage is vital to access physicians, medications and other treatments and services needed to manage their health. The Lung Association believes that these premiums will create significant financial barriers for patients that jeopardize their access to needed care and therefore opposes this policy.

Oklahoma's application also includes copays for its Medicaid program, including an $8 copay for non-emergent use of the emergency department (ED). This policy could deter people from seeking necessary care during an emergency. People should not be financially penalized for seeking lifesaving care for a breathing problem, complications from a cancer treatment or any other critical health problem that requires immediate care. Furthermore, evidence suggests this type of cost sharing may not result in the intended cost savings.[viii] For example, a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[ix] The Lung Association opposes this punitive proposal for a $8 copayment for non-emergent use of the ED and urge you to reject this waiver request.

Finally, Oklahoma requests the authority to increase premiums and cost-sharing up to five percent of household income. This would put an enormous financial burden on patients that would again

jeopardize their coverage. Additionally, any future increases in cost-sharing should go through a full public comment process and review by CMS, which are important opportunities for the public to provide feedback on how the program is working for key stakeholders before any policies are implemented or continued. It is especially important that beneficiaries impacted by the demonstration waiver have the ability to provide feedback to the state and CMS. The Lung Association urges CMS to deny this request.

Work Requirements

Under the application, individuals between the ages of 19 and 60 be required to prove that they work up to 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, when Arkansas implemented a similar policy, the state terminated coverage for over 18,000 individuals,[x] and in New Hampshire, nearly 17,000 individuals would have lost coverage if the state had not suspended implementation of its requirement.[xi] The U.S. Court of Appeals for the District of Columbia recently reaffirmed that the purpose of the Medicaid program is to provide healthcare coverage and that Arkansas' restrictive waiver, including the work requirement policy, did not meet that objective.[xii]

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases. If the state finds that individuals have failed to comply with the new requirements after one month, they will be disenrolled from coverage. For patients with COPD or other chronic health conditions, a lapse in coverage can mean a lapse in medication, permanently worsening the patient's prognosis. This is unacceptable for our patients.

Our organizations are also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from working. Regardless, even exempt enrollees may have to report their exemption, creating opportunities for administrative error that could jeopardize their coverage. In Arkansas, many individuals were unaware of the new requirements and therefore unaware that they needed to apply for such an exemption.[xiii] No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

The evidence is clear that most people on Medicaid who can work already do so, and those who are unable to work often have physical or mental health conditions that interfere with their ability to work.[xiv,xv] Evaluations of Arkansas's waiver demonstrate that it did not lead to increased employment among the Medicaid population.[xvi] In contrast, continuous Medicaid coverage can actually help people find and sustain employment. For example, a report examining Medicaid expansion in Ohio found that the majority of enrollees reported that being enrolled in Medicaid made it easier to work or look for work (83.5 percent and 60 percent, respectively).[xvii] Terminating individuals' Medicaid coverage for non-compliance with work requirements will hurt rather than help people search for and obtain employment.

Additionally, researchers have found that work requirements disproportionately affect African American mothers and families. For example, an analysis of Oklahoma's proposal to add work requirements for its traditional Medicaid population found that 19 percent of the adults who

would be affected were African American, compared to 7.2 percent of the state's population.[xviii] The Lung Association is therefore concerned that this policy could worsen the serious disparities in access to care that already exist for African Americans. The Lung Association urges CMS to reject Oklahoma's request to impose a work requirement on the SoonerCare 2.0 population.

Benefit Package

Oklahoma's application also jeopardizes access to vital services for low-income patients served by the Medicaid program, particularly those with lung disease and other chronic conditions.

Oklahoma's application proposes to waive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for individuals aged 19 and 20. EPSDT provides access to critical services and treatments for kids and young adults living in poverty. As these young adults transition to higher education or jobs, it is important that they receive the same medical care for any illness or chronic disease they might have. Disruption in medical treatment could have negative consequences for their long-term health and economic security. We oppose this provision and urge you to deny it.

Oklahoma has also requested to eliminate Non-Emergency Medical Transportation (NEMT) benefits. Low-income patients may not own a car and may lack access to reliable public transportation, especially in rural areas. Removing this benefit will therefore harm patients who need to attend regular visits with their providers to manage their medications and treatments. For example, one study found patients with asthma, hypertension or heart disease who needed multiple visits to a medical professional were more likely to keep their appointments if they had NEMT.[xix] The Lung Association opposes this policy and urge you to reject it.

Finally, the proposal also states that Oklahoma will "continue to investigate the potential benefits of a limited prescription drug formulary and request the flexibility to make changes to our prescription drug benefit, following appropriate advance notice procedures." Our organizations believe that any changes to the prescription drug benefit that limit access to medications will be detrimental to patients with acute and chronic disease. Prescription drugs have different indications, different mechanisms of action, and different side effects, depending on the person's diagnosis and comorbidities. Restricting prescription drug benefits would limit the ability of providers to make the best medical decisions for the care of their patients.

Public Comment Process

A robust public comment process is an essential component on any Section 1115 demonstration proposal. As the Lung Association outlined in comments submitted during the state-level comment period on this proposal,[xx] Oklahoma's public comment process was rushed and it was difficult for individuals to participate, especially given the additional complexities created by COVID-19. For example, information on how to join the first public webinar was not available on the Soonercare website and while questions could be submitted via a chat box, people were not able to share statements in support or opposition of the waiver as they normally would at a public meeting. This has made meaningful comment impossible for many critical stakeholders.

The core objective of the Medicaid program is to furnish healthcare to low-income populations. This demonstration application does not further that goal and the Lung Association urges CMS not to approve this proposal. Thank you for the opportunity to submit comments.

Sincerely,

Harold P. Wimmer
National President and CEO

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[iii] Public Health Groups Admonish Timing of Oklahoma's Medicaid Expansion Waiver Proposal, March 20, 2020. Available at: https://www.fightcancer.org/releases/public-health-groups-admonish-timing-oklahoma%E2%80%99s-medicaid-expansion-waiver-proposal.

[iv] Patient and Consumer Advocacy Organizations' Response to CMS Block Grant Guidance, March 9, 2020. https://www.lung.org/getmedia/d10f6d78-3304-485c-a7fc-b6a3a6ca1091/health-partner-response-to-cms-block-grant.pdf

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[x] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at February State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Accessed at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf.

[xi] New Hampshire Department Health and Human Services, DHHS Community Engagement Report, June 2019. Available at: https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf.

[xii] US Court of Appeals for the District of Columbia Circuit, Gresham v. Azar, Feb. 14, 2020. Available at: https://healthlaw.org/wp-content/uploads/2020/02/Gresham-v.-Azar-DC-Circuit-Ruling-Feb-14.pdf.

[xiii] Jessica Greene, "Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement," Health Affairs, Sept. 5, 2018. Available at: https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/.

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