



January 7, 2022

Dana Hittle  
Interim Deputy State Medicaid Director  
500 Summer St. NE, E65  
Salem, OR 97301

Dear Deputy Director Hittle,

The Cancer Support Community (CSC), an international nonprofit organization that provides support, education, and hope to cancer patients, survivors, and their loved ones, appreciates the opportunity to submit comments on the Oregon 1115 Demonstration Waiver for the Oregon Health Program. As the largest provider of social and emotional support services for people impacted by cancer, CSC has a unique understanding of the cancer patient experience. In addition to our direct services, our Research and Training Institute and Cancer Policy Institute are industry leaders in advancing the evidence base and promoting patient-centered public policies.

CSC is committed to ensuring that Oregon's Medicaid program provides quality and affordable healthcare coverage. We appreciate the focus that the Oregon Health Program has placed on equitable access to healthcare in the waiver. In addition, Oregon's request to provide continuous eligibility for all beneficiaries ages six and over will help to eliminate gaps in coverage.

Unfortunately, this waiver contains multiple proposals that undermine access to care for cancer patients and survivors. We are concerned with the proposed closed formulary for adult beneficiaries, which will make it harder for patients to access the medications they need to stay healthy. We also oppose Oregon's proposals to limit retroactive coverage for nearly all Medicaid beneficiaries, as the proposal jeopardizes access to care for cancer patients and survivors.

We offer the following comments and suggested changes on the 1115 demonstration waiver for the Oregon Health Program.

#### *Continuous Eligibility*

We support the request for continuous enrollment for children under six and two-year continuous eligibility for beneficiaries over the age of six. Continuous eligibility reduces gaps in coverage that prevent patients from accessing the care that they need. Continuous eligibility increases equitable access to care, as studies show that children of color are more likely to be affected by gaps in coverage (Osorio & Alker, 2021). Research has also shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits (Sugar et al., 2021). Continuous eligibility will help reduce these negative health outcomes.

#### *Closed Formulary*

We are strongly concerned by the proposal to transition to a closed prescription drug formulary for adult beneficiaries. A closed formulary limits the ability of providers to make the best medical decisions for their patients, based on the patient's individual needs. A formulary that may only cover one or two drugs in a class could harm patients and potentially raise medical costs as patients do not react, or react poorly, to the limited medications that can be prescribed to them. This is particularly true for cancer patients who

often receive personalized or combination therapy. Rather, providers should be prescribing based on clinical guidelines and a shared decision-making process with the patient.

We are disappointed that Oregon's proposal does not even include an appeals process for patients to access non-formulary medications. However, even an appeals process or exemptions for certain classes of drugs would not eliminate the barriers to care that patients would face with a closed formulary. The closed formulary has the potential to create delays in appropriate care, cause patients to forgo care completely, increase patient distress, and ultimately even contribute to higher health care costs. In CSC's *Access to Care in Cancer 2016* study, we found that 25% of patients experience delays in accessing needed care (due to policy barriers such as prior authorization or step therapy), with Medicaid patients experiencing the greatest care delivery delays.

Additionally, Oregon's proposal to exclude prescription drugs that the state deems to have "limited or inadequate evidence of clinical efficacy," including those approved through the U.S. Food and Drug Administration's (FDA's) accelerated approval process, may also harm patients by restricting access to novel and lifesaving therapies. In the past few years, many new treatments have been approved through an accelerated approval process which makes therapeutically-important drugs available sooner without compromising the standards of safety and effectiveness of drugs for serious conditions like cancer. All patients enrolled in Oregon's Medicaid program should have the opportunity to access treatments that could extend or improve their quality of life.

We request that the Oregon Health Program remove these requests and provide a robust, open prescription drug formulary for all beneficiaries that will allow patients to access the medications that their providers believe are best for them.

#### *Retroactive Coverage*

The demonstration waiver also continues to eliminate retroactive coverage for nearly all beneficiaries, excluding the aged, blind, and disabled. We have serious concerns with the continued limitations to retroactive coverage and encourage the state to expand retroactive coverage to include all Medicaid beneficiaries.

Medicaid's retroactive eligibility prevents gaps in health care coverage by covering individuals for up to 3 months prior to a beneficiary's application date, provided that the individual would have been eligible for Medicaid coverage during that period. Many people only become aware that they are eligible for Medicaid when they get diagnosed with a serious illness, such as cancer, or have a major health emergency and cannot complete the application process while undergoing treatment. Retroactive eligibility allows patients in these situations to begin treatment without being financially burdened prior to their official eligibility determination. In Indiana, Medicaid recipients were responsible for an average of \$1,561 in medical costs with the elimination of retroactive eligibility (CMS, 2016). Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. Retroactive coverage is especially important during the COVID-19 pandemic, protecting patients and providers by ensuring that medical bills are paid even if a Medicaid application is not filed until the calendar month following a health crisis.

Patients with underlying health conditions who are unable to access regular care are often forced to go to emergency rooms and hospitals if their conditions worsen, leading health systems to provide more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver (Dickson, 2016). Increased uncompensated care costs are especially concerning as safety net hospitals and other providers continue to deal with limited resources and capacity during the

COVID-19 pandemic. Limiting retroactive coverage increases the financial hardships to rural hospitals that absorb uncompensated care costs.

Thank you again for the opportunity to provide comments. Should you have any questions, please contact Phylicia L. Woods, Executive Director of the Cancer Policy Institute at the Cancer Support Community at [pwoods@cancersupportcommunity.org](mailto:pwoods@cancersupportcommunity.org).

Sincerely,



Phylicia L. Woods, JD, MSW  
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Cancer Support Community Headquarters

## References

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