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June 26, 2020

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

SUBMITTED ELECTRONICALLY VIA MEDICAID.GOV

RE: Oklahoma SoonerCare 2.0 Medicaid Section 1115 Demonstration Waiver

Dear Secretary Azar:

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on Oklahoma's Sooner Care 2.0 Medicaid Section 1115 Demonstration Waiver application. While we support state Medicaid expansions, we believe that the U.S. Department of Health and Human Services (HHS) should reject the Sooner Care 2.0 Demonstration application as being inaccurate, incomplete, outside of the scope of the Secretary's authority, not in keeping with the purpose of Medicaid, and against the interests of the Medicaid population and program—as well as health systems and public health generally—in Oklahoma and nationally.

Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly three million people with Medicare, including individuals who are dually eligible for both Medicare and Medicaid, family caregivers, and professionals.

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General Comments

The Medicaid program, now over a half century old, is a success story. Through Medicaid, millions of Americans have built well-being and gained greater economic security via access to health insurance coverage. This coverage has guaranteed health care to those who are unable to find work, whose employers or job types do not grant access to health insurance, or who are caregivers, students, or who have disabling conditions that interfere with regular work.

As an organization that focuses on the health coverage and well-being of older Americans and people with disabilities, we have a particular interest in how this waiver—and similar proposals—would harm the pre-Medicare population, including people over age 50 and people with functional limitations and chronic conditions of all ages who are not administratively classified as "disabled."

As individuals approach Medicare eligibility, their health is often compromised. This is especially true for those who have unmet health care needs from being un- or underinsured. The absence of quality coverage can lead to reduced well-being for entire families;[1] poorer health;[2] lack of access to care;[3] economic devastation;[4] and higher Medicare costs when they are ultimately eligible.[5]

As the above resources demonstrate, the stakes are very high for those approaching Medicare eligibility and their families. Many aspects of this waiver proposal, if granted, would undermine access to health care coverage and services. The purpose of Medicaid 1115 demonstrations is to approve "experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program." [6] Demonstrations that do not support Medicaid's central objective must be rejected.

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[1] Committee on the Consequences of Uninsurance, Board on Health Care Services, "Health Insurance is a Family Matter," INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, Chapter 5 (2002), https://www.ncbi.nlm.nih.gov/books/NBK221016/pdf/Bookshelf_NBK221016.pdf.

[2] David W Baker, et al., "Changes in Health for the Uninsured After Reaching Age-eligibility for Medicare," J Gen Intern Med. 2006 Nov; 21(11): 1144–1149 (2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831646/.

[3] Committee on the Consequences of Uninsurance, Board on Health Care Services, "Health Insurance is a Family Matter," INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, pp 91-106 (2002), https://www.ncbi.nlm.nih.gov/books/NBK221016/pdf/Bookshelf_NBK221016.pdf.

[4] Rohan Khera, et al., "Burden of Catastrophic Health Expenditures for Acute Myocardial Infarction and Stroke Among Uninsured in the United States," CIRCULATION, 2018;137:00–00 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5780190/.

[5] David W Baker, et al., "Changes in Health for the Uninsured After Reaching Age-eligibility for Medicare," J Gen Intern Med. 2006 Nov; 21(11): 1144–1149 (2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831646/.

[6] 42 U.S.C. § 1315(a) (also note that under the statute, the Secretary may only waive compliance a) with requirements in 42 U.S.C. § 1396a; and b) to the extent and for the period necessary to carry out the experiment; *see also* Medicaid.gov, "About Section 1115 Demonstrations" (last accessed June 8, 2020), https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html.

The central objective of Medicaid is to enable states to furnish medical assistance to individuals who are unable to meet the costs of necessary medical care and to furnish rehabilitation and other services to help these individuals attain or retain capability for independence or self-care.[7] Far from promoting these objectives, the SoonerCare 2.0 proposal would terminate or reduce Medicaid coverage for many low-income Oklahomans while upending the program's entire financing structure, leading to inexorable changes in the state's ability to cover care for Medicaid populations of all ages. Oklahoma's proposed project includes work requirements, premiums, a per-capita cap, and other harmful provisions that would, by Oklahoma's own reckoning, reduce coverage and access to care.[8] As such, it is inconsistent with the provisions of § 1115 and the Medicaid Act.

In addition to including many of the same proposals that the courts have repeatedly found illegal,[9] Oklahoma also seeks to be the first state to implement a block grant or per-capita cap per recent federal guidance.[10] Both this document and Oklahoma's proposal represent a drastic departure from traditional Medicaid financing and involve statutory provisions beyond those states can request to waive.[11] Specifically, the request for a per-capita cap is not permitted pursuant to the statute and thus must be rejected. Further, the lack of detail on the per-capita cap and on other aspects of the proposal makes it impossible to fully analyze and provide comments. Accordingly, the Administration should not have approved the state's application as complete.

The Administration also lacks the legal authority to accept this application as submitted because many of the waiver's proposals and enrollment projections were based on an expectation that Oklahoma would have implemented a Medicaid expansion by July 1, 2020 that covered adults ages 19-64 with incomes up to 133% of the Federal Poverty Level (FPL).[12] However, Oklahoma has since withdrawn the State Plan Amendment (SPA) that would have enabled that expansion.[13] This makes the SoonerCare 2.0 application inaccurate and incomplete. When the state withdrew the SPA, the Administration should have withdrawn its

[7] 42 U.S.C. § 1396-1; *see also* Gresham v. Azar, 950 F.3d 93 (D.C. Cir. 2020).
[8] Oklahoma Health Care Authority, "SoonerCare 2.0 Healthy Adult Opportunity (HAO) Section 1115 Demonstration Application," p. 18 (last accessed June 8, 2020), https://1115publiccomments.medicaid.gov/jfe/form/SV_ai0xoKWT9eelJsN.
[9] *See, e.g.*, Gresham v. Azar, 950 F.3d 93 (D.C. Cir. 2020).
[10] Centers for Medicare & Medicaid Services, "Re: Healthy Adult Opportunity" (January 30, 2020), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf.
[11] 42 U.S.C. § 1315(a).
[12] Oklahoma Soonercare 2.0 1115 Application, p. 17.
[13] Associated Press, "Oklahoma Scraps Plan to Expand Medicaid on July 1" (May 29, 2020), https://www.usnews.com/news/best-states/oklahoma/articles/2020-05-29/oklahoma-scraps-plan-to-expand-medicaid-on-july-1.

certification of the proposal and returned the waiver to the state to develop new enrollment and other projections.

For all of these reasons, we urge the Administration to reject the SoonerCare 2.0 application and, instead, support and incentivize program features known to improve coverage and care.

Work Requirements

Oklahoma's proposed project would require Medicaid enrollees ages 60 and below to complete at least 80 hours of work or work-related activities per month.[14] Enrollees who do not comply would lose their coverage and be prevented from re-enrolling until they could either meet the work requirements or one of the stated exemptions. As a result, many people would likely not be able to re-enroll. Keeping people from enrolling in Medicaid cannot be said to promote the objective of furnishing medical assistance to individuals who are unable to meet the costs of necessary medical care.

Oklahoma itself predicts that the combination of work requirements and premiums would trigger a 5% reduction in enrollment.[15] This is likely a low estimate. Similar work requirements implemented in other states provide evidence that the losses would be far more substantial. When Arkansas implemented a similar work requirement in June 2018, roughly 23% of Medicaid enrollees subject to the requirement—over 18,000 people—lost coverage by the end of 2018 for failure to comply.[16] Five months after their lockout period ended, fewer than 1 in 4 Arkansans who were terminated for failure to meet the work requirements had re-enrolled.[17] Similarly, in New Hampshire, nearly two-thirds of enrollees who needed to report work activities, or 17,000 people, had not reported sufficient hours and were at risk for coverage loss before the state suspended the work requirements due to litigation.[18]

The vast majority of Medicaid enrollees are already working, or have good reason for not doing so.[19] However, many low-wage workers struggle to maintain consistent hours each month due

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[14] Oklahoma Soonercare 2.0 1115 Application, p. 11.

[15] Oklahoma Soonercare 2.0 1115 Application, p. 18.

[16] Jennifer Wagner, "Medicaid Coverage Losses Mounting in Arkansas from Work Requirement," Center on Budget and Policy Priorities (Jan. 17, 2019), https://www.cbpp.org/blog/medicaid-coverage-losses-mounting-in-arkansas-from-work-requirement.

[17] Harris Meyer, "More Arkansans Uninsured, Unemployed Post-Medicaid Work Requirement," Modern Healthcare (June 19, 2019), https://www.modernhealthcare.com/medicaid/more-arkansans-uninsured-unemployed-post-medicaid-work-requirement.

[18] Letter from Jeffrey A. Meyers, Commissioner New Hampshire Dep't of Health & Human Servs. to Gov. Christopher T. Sununu et al. (July 8, 2019), https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-findings.pdf.

[19] Rachel Garfield, et al., "Kaiser Family Foundation, Understanding the Intersection of Medicaid and Work: What Does the Data Say?" (Aug.8, 2019), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/.

to the unpredictable nature of hourly employment.[20] As a result of the churn and volatility in the low-wage labor market, studies estimate that almost half of low-income workers nationally would fail a work-hours test in at least one month over the course of the year.[21] Volunteering is not a reasonable alternative for Medicaid enrollees due to a variety of factors, including, again, the volatility of the low-wage market. Since many individuals are unable to predict their employment hours with much consistency, they are also unable to schedule regular volunteer hours. This may leave them short just a few compliance hours at the end of the month with little time to make them up, either through work or non-work activities. In addition, many low-income Medicaid enrollees face challenges accessing reliable internet service and transportation.[22] These factors not only make it difficult for enrollees to find and maintain stable employment, but also likely prevent many from taking part in volunteer activities.

The high age limit of the Oklahoma work requirement highlights another significant issue. Ageism in hiring affects workers as they enter middle age, and the effect increases as they approach retirement age. Women are especially penalized.[23]

These factors, including the time spent unemployed, act as a drag on further opportunities, especially for older workers.[24] This means those who are nearing retirement age are at great risk of not being able to find suitable employment to meet an arbitrary deadline.

Even if older enrollees do successfully find employment, their struggles would likely continue, as the waiver's administrative hurdles could still drive them off the program. The state's 5% estimate, discussed above, does not account for other administrative issues such as inability to report due to technological barriers. People between ages 50 and 60 are less likely to have internet access or to use the internet regularly, likely making compliance reporting more difficult. As a result, they would likely make up a disproportionate number of those losing coverage. (*see* Figure 1, Statista, Share of adults in the United States who use the internet in 2018, by age group, https://www.statista.com/statistics/266587/percentage-of-internet-users-by-age-groups-in-the-us/).

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[20] *See* Kristin F. Butcher & Diane Whitmore Schanzenbach, "Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs," figure 6 (2018), https://www.cbpp.org/sites/default/files/atoms/files/7-24-18pov.pdf.

[21] Aviva Aron-Dine et al., "Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements," Center on Budget and Policy Priorities (2018), https://www.cbpp.org/sites/default/files/atoms/files/4-11-18health.pdf.

[22] Camille Ryan & Jamie Lewis, "Computer and Internet Use in the United States: 2015," American Community Survey Reports, at 9 (2017), https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-37.pdf; Federal Highway Admin., "National Household Travel Survey Brief: Mobility Challenges for Households in Poverty" (2014), https://nhts.ornl.gov/briefs/PovertyBrief.pdf.

[23] David Neumark, et al., "FRBSF Economic Letter: Age Discrimination and Hiring of Older Workers," Fed. Res. Bank of San Francisco (February 27, 2017), https://www.frbsf.org/economic-research/publications/economic-letter/2017/february/age-discrimination-and-hiring-older-workers/.

[24] Christina Smith FitzPatrick, "Discrimination against the Unemployed," AARP Public Policy Institute (September 2014), https://www.aarp.org/content/dam/aarp/ppi/2014-10/unemployed-discrimination-fact-sheet-aarp.pdf.

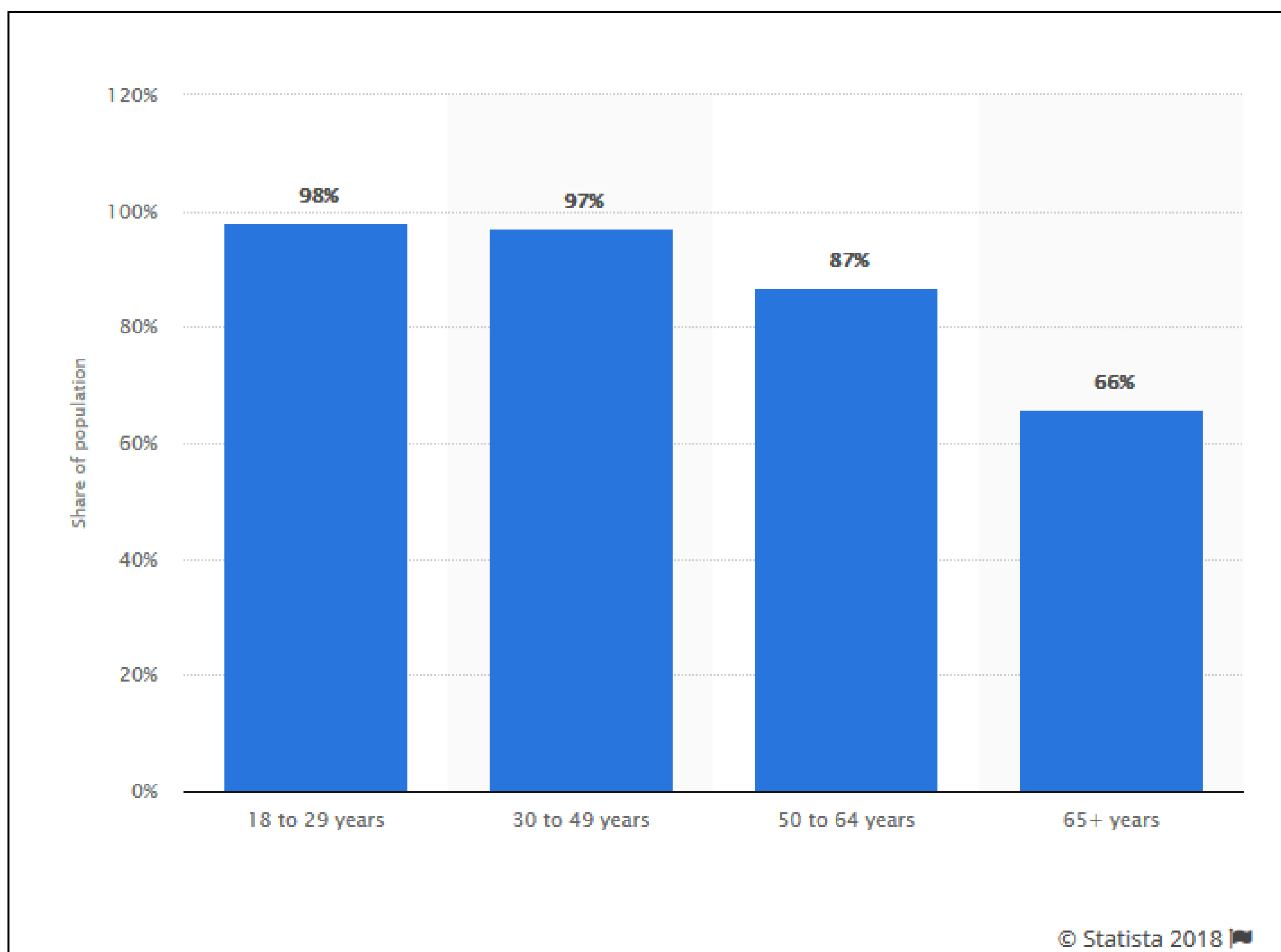

Figure 1: Share of adults in the United States who use the internet in 2018, by age group

This suggests we can anticipate even steeper declines in compliance for older enrollees in Oklahoma than the state acknowledges—and a more devastating loss of health insurance coverage.

The state does provide an exemption for "persons with a disability under the definitions of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, or Section 1557 of Affordable Care Act," but this still falls short. Disability is a continuum. A person may not be administratively classified as "disabled," but may face significant health challenges that drive un- or underemployment. Data from the National Center for Health Statistics show approximately 40% of working-age Medicaid beneficiaries "have broadly defined disabilities, most of whom are not readily identified as such through administrative records."[25]

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[25] H. Stephen Kaye, "How do disability and poor health impact proposed Medicaid work requirements?," COMMUNITY LIVING POLICY CENTER, UNIVERSITY OF CALIFORNIA SAN FRANCISCO (February 12, 2018), https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/Disability%20%26%20Medicaid%20Work%20Requirements.pdf.

Other proposed exemption categories are overly ambiguous and do not give sufficient detail about how individuals would demonstrate that they are eligible. For example, there are stated exemptions for "individuals who are medically certified as physically or mentally unfit for employment" and "individuals diagnosed with a serious mental illness and actively receiving behavioral health treatment services," but these terms are not defined.[26] Many older adults who could qualify for an exemption may lose coverage because they are not aware that they need an exemption, do not understand that they qualify for one, or do not know how to seek one. The state's proposal provides few details on how an individual would receive notice or find out they qualify for a disability exemption, what verification would be required, or how long the exemption would last. "Good cause" exemptions appear to apply for just a single month.[27]

The state also fails to describe in any detail how it would make reporting mechanisms, including requests for exemptions, accessible for people with disabilities who require accommodations.[28] Even substantial portions of the state's application are not screen-readable.[29]

These risks are not academic. News accounts from Arkansas described individuals with chronic conditions who lost their coverage due to confusion about that state's work requirements.[30] A recent Kaiser Family Foundation study similarly found that despite the purported exemptions and safeguards, significant numbers of Arkansans with disabilities still lost coverage. The study found that purported safeguards were complex and difficult to navigate and so exempted very few enrollees.[31] Mass coverage losses occurred despite Arkansas "using existing data sources when possible" to confirm disability status.[32] Oklahoma's proposal provides no reason to expect a different result.

Work requirements would also harm family caregivers who rely on Medicaid for health coverage. Family caregivers are more likely to be low-income, older, women, and people of color who do not have access to health coverage through a spouse or employer.[33] In fact, 40%

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[26] Oklahoma Soonercare 2.0 1115 Application, at 14.
[27] Oklahoma Soonercare 2.0 1115 Application, at 14.
[28] Oklahoma Soonercare 2.0 1115 Application, at 11.
[29] The attached Alternative Benefit Plan and parts of the summary of comments received are not accessible.
[30] PBS News Hour, "With New Work Requirement, Thousands Lose Medicaid Coverage in Arkansas" (November 19, 2018), https://www.pbs.org/newshour/show/with-new-work-requirement-thousands-lose-medicaid-coverage-in-arkansas; Benjamin Hardy, "Locked out of Medicaid: Arkansas's Work Requirement Strips Insurance from Thousands of Working People," ARKANSAS TIMES (November 19, 2018), https://www.arktimes.com/arkansas/when-arkansas-works-doesnt/Content?oid=25890378.
[31] MaryBeth Musumeci, "Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018," Kaiser Family Foundation (Jun. 11, 2019), https://www.kff.org/medicaid/issue-brief/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018/.
[32] Benjamin Sommers, et al., "Medicaid Work Requirements – Results from First Year in Arkansas," N Engl J Med 2019; 381:1073-1082 (September 12, 2019), https://www.nejm.org/doi/full/10.1056/NEJMsr1901772.
[33] Justice in Aging, Medicaid Work Requirements: The Impact on Family Caregivers and Older Adults (Nov. 2018), www.justiceinaging.org/wp-content/uploads/2018/11/JusticeInAging-Medicaid-IssueBrief-November19-11am2018.pdf.

of non-elderly Medicaid enrollees not receiving Supplemental Security Income (SSI) in Oklahoma cite caretaking as their reason for not engaging in the type of work activities the state is proposing to require of them.[34] The proposed narrow exemption for caretakers who are providing support for an "incapacitated" person is simply not robust enough to ensure that caretakers for aging family members will be protected, jeopardizing the wellbeing of both the caretaker and the older adult who depends on such care.

Administrative Burdens

By increasing administrative hurdles and paperwork, Oklahoma will almost certainly increase "churn," where people lose coverage, often briefly, then re-enroll in the program after resolving documentation or mailing address issues. Churn within the Medicaid program is increasing, largely because of state decisions to increase administrative barriers to participation, and as states add more layers of bureaucracy, or increase the frequency of redeterminations, they force many eligible individuals out of the program.[35]

People with low incomes can face multiple challenges in completing burdensome paperwork and avoiding churn. The lower the incomes, the more extreme the problems often become. Some of the many issues those with extremely low incomes may face include difficulty receiving mail, lack of a fixed address, and chronic or intermittent homelessness. Adding the stress of a risk of loss of coverage to an already complex or harrowing situation is a mistake. For example, an enrollee may be suffering from an acute illness and unable to fill out paperwork to maintain coverage precisely when coverage is critically needed. The risk of losing coverage is especially troubling for people being treated for chronic illness, mental illness, or substance use disorder.

Paperwork burdens do not provide health coverage. They serve no purpose other than reducing the number of eligible people who are able to access Medicaid, making it even more difficult for them to get back on their feet. In the meantime, the lack of coverage would create disruptions in care, leading to poorer health outcomes and increased costs for Oklahoma residents. The vast majority of Medicaid enrollees locked out of coverage would become uninsured, because they would not have access to other affordable coverage, including the Marketplace or Medicare. Multiple studies have found that regular and ongoing access to health care reduces preventable hospitalizations for people with chronic diseases such as

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[34] Kaiser Family Found., Understanding the Intersection of Medicaid and Work 10 (App. Table 2) (Jan. 2018), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

[35] Emmett Ruff & Eliot Fishman, "The Return of Churn: State Paperwork Barriers Caused More Than 1.5 Million Low-Income People to Lose Their Medicaid Coverage in 2018" (April 2019), https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf.

diabetes and heart disease.[36] The direct, foreseeable consequence of this policy would be worse health for Oklahoma's lowest-income residents.

The Administration must not approve a waiver to allow work requirements and administrative hurdles that could drive thousands of Oklahomans out of the Medicaid program.

Premiums

Oklahoma proposes to impose premiums on Medicaid enrollees in the expansion population. Individuals with household income that falls between the parent/caretaker income standard and 100% FPL would pay $5 every month ($7.50 for families). Individuals with household income from 100-133% FPL would pay $10 ($15 for families). Coverage would not begin until an individual paid the first premium. Individuals who successfully enroll in coverage but fail to pay subsequent premiums would lose their Medicaid coverage after a ninety-day grace period. Such an approach would create a default waiting period for those who cannot or do not know how to pay their initial premium, while causing many more to lose coverage after they enroll.

Decades of research has repeatedly and consistently confirmed that premiums deter and reduce enrollment among low-income individuals.[37] As noted above, the state itself admits that it expects the implementation of premiums and work-requirements to depress enrollment by at least 5%. Troublingly, recent evidence from states that have enacted similar premiums indicates the coverage losses would be much higher. For example, when Indiana implemented premium payments for those above 100% FPL, 23% failed to pay the initial premium and therefore were not enrolled. In addition, 7% who successfully enrolled were later removed for failing to pay premiums.[38] Unlike Indiana, Oklahoma plans to impose premiums on individuals falling below 100% FPL, meaning the coverage loss will likely be even more severe. Studies have shown that the impacts of cost-sharing in Medicaid become more pronounced as income decreases.[39] Imposing premiums does not serve an experimental purpose. It simply reduces enrollment and is not consistent with the objectives of the Medicaid Act.

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[36] Andrew B Bindman, et al., "Preventable Hospitalizations and Access to Health Care," JAMA 274(4):305–311 (July 26, 1995), https://jamanetwork.com/journals/jama/article-abstract/389289; Xuanping Zhang, et al., "Access to Health Care and Control of ABCs of Diabetes," Diabetes Care; 35(7): 1566-1571 (July 2012), https://care.diabetesjournals.org/content/35/7/1566.
[37] Samantha Artiga, et al., "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation (2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-incomepopulations-updated-review-of-research-findings/.
[38] The Lewin Group, "HIP 2.0: POWER Account Contribution Assessment," ii (2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.
[39] Samantha Artiga, et al., "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation (2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-incomepopulations-updated-review-of-research-findings/.

Premium payment also contributes to the administrative burden described above, particularly for un- or under-banked families and individuals.

Heightened Copayments for Non-Emergency Use of the Emergency Room

Oklahoma also proposes to implement copayments for various types of health services, including non-emergency use of the Emergency Department (ED). Initially, this would be $8, though the state wants to increase the copay in the future.

Oklahoma argues that these copayments would reduce unnecessary ED visits. However, research has shown that very few Medicaid enrollees access the ED for non-urgent conditions.[40] In addition, data shows that such copayments do not reduce use of the ED.[41] HHS itself has flagged non-punitive strategies, such as improving access to primary care services and providing targeted case management services for enrollees who frequently use the emergency room, as effective in reducing emergency room use among Medicaid enrollees.[42]

Retroactive Coverage

Oklahoma proposes eliminating retroactive coverage for enrollees in the Medicaid expansion population. Waiving retroactive coverage poses substantial harm for both enrollees and health care providers by reducing access to coverage and leaving enrollees with substantial medical debt that they cannot afford to pay. Retroactive coverage is key to helping protect older adults from serious financial debt, as they have a high prevalence of chronic health conditions that can require regular clinical visits, prescription medications, and intensive services.[43] Retroactive coverage also helps ensure the financial stability of health care providers and reduce uncompensated hospital care. Evidence from states that have eliminated retroactive coverage reinforces that these waivers cause widespread coverage loss and create significant problems for health care providers.[44]

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[40] Anna S. Somers, et al., "Research Brief No. 23, Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are For Urgent or More Serious Symptoms," Center for Studying Health System Change (2012), http://www.hschange.org/CONTENT/1302/1302.pdf.

[41] Karoline Mortenson, "Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of the Emergency Departments," 29 HEALTH AFFAIRS 1643 (2010), https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0906.

[42] *See, e.g.*, Centers for Medicaid & CHIP Services, "Informational Bulletin, Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings" (Jan. 16, 2014), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-16-14.pdf.

[43] Natalie Kean, "Medicaid Retroactive Coverage: What's at Stake for Older Adults When States Eliminate this Protection?," Justice in Aging (September 2019), https://www.justiceinaging.org/wp-content/uploads/2019/09/Medicaid-Retroactive-Coverage-Issue-Brief.pdf.

[44] MaryBeth Musumeci & Robin Rudowitz, "Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers, and States," Kaiser Family Foundation, p. 4 (2017), https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/.

Non-Emergency Medical Transportation

Oklahoma proposes to exclude coverage of non-emergency medical transportation (NEMT) for the Medicaid expansion population. Doing so would make it harder for low-income Medicaid enrollees to get the appropriate care at the appropriate time.[45] Many low-income Medicaid enrollees simply cannot afford to buy a car or hire a transportation service, and some lack access to affordable and reliable public transit. These issues—when compounded with still widespread physical accessibility barriers—make the NEMT benefit particularly critical for persons with chronic conditions or functional limitations. Indeed, the Government Accountability Office (GAO) found that "excluding the NEMT benefit would impede... enrollees' ability to access health care services, particularly individuals living in rural or underserved areas, as well as those with chronic health conditions."[46]

Research shows that NEMT significantly improves access to health care and is cost-effective for states.[47] Transportation barriers are often associated with reduced medication adherence,[48] and studies demonstrate that enrollees with chronic conditions are more likely to participate in care-management visits when they have access to reliable transportation.[49] In addition, by reducing costly hospitalizations and emergency department visits, NEMT actually saves states money.[50]

Data from states that have eliminated NEMT for the Medicaid expansion population has shown that individuals have missed medically necessary appointments or reported unmet health needs as a result of transportation barriers.[51] Notably, data from Iowa indicates that women,

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[45] Paul T. Cheung, et al., "National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries," Annals of Emergency Medicine, Volume 60, Issue 1, 4 - 10.e2 (July 2012), https://pubmed.ncbi.nlm.nih.gov/22418570/.

[46] Government Accountability Office, "MEDICAID: Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage" (January 2016), *see attached*, https://www.gao.gov/products/GAO-16-221).

[47] P. Hughes-Cromwick, et al.; J. Joseph Cronin, Jr., et al., Florida State Univ., "Florida Transportation Disadvantaged Programs Return on Investment Study" (2008), https://ctd.fdot.gov/docs/AboutUsDocs/roi_final_report_0308.pdf.

[48] Timothy E. Welty et al., "Effect of Limited Transportation on Medication Adherence in Patients with Epilepsy," 50 J. AM. PHARM. ASSOC. 698 (2010), https://pubmed.ncbi.nlm.nih.gov/21071313/.

[49] Jinkyung Kim, et al., "Transportation Brokerage Services and Medicaid Beneficiaries' Access to Care," 44 HEALTH SERVS. RES. 145 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2669622/; P. Hughes-Cromwick et al., "Cost Benefit Analysis of Providing Non-Emergency Medical Transportation," Transportation Research Board (Oct. 2005), https://altarum.org/sites/default/files/uploaded-publication-files/05_project_report_hsd_cost_benefit_analysis.pdf.

[50] P. Hughes-Cromwick et al., "Florida Transportation Disadvantaged Programs Return on Investment Study," Florida State University (2008), https://ctd.fdot.gov/docs/AboutUsDocs/roi_final_report_0308.pdf; The Stephen Group, "Recommendations to the Ark," Health Reform Task Force (2015), https://www.stephengroupinc.com/images/engagements/Final-Report-Volume-II.pdf.

[51] *See, e.g.*, Suzanne Bentler, et al., "Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan," University of Iowa Public Policy Center, 26 (Mar. 2016), https://ir.uiowa.edu/cgi/viewcontent.cgi?article=1131&context=ppc_health; The Lewin Group, "Indiana HIP 2.0: Evaluation of Non-Emergency Medical Transportation (NEMT) Waiver" (Nov. 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-

people of color, and younger people are significantly more likely to report a transportation barrier. In addition, people in relatively poorer health (58% higher odds), with multiple physical ailments (63%), or who have any functional deficit (245%) were all much more likely to report unmet transportation needs.[52] Eliminating NEMT in Oklahoma would lead to unmet care needs and exacerbate health disparities in the state.[53]

A lack of NEMT has harmful consequences. When transportation is unavailable, the person does not receive needed health care and the risk of hospitalization, nursing-home admission, or institutionalization increases.

Per-Capita Caps

The SoonerCare 2.0 demonstration would impose a per-capita cap on the state's Medicaid program. This cap proposal is in response to the Health Adult Opportunity (HAO) guidance which encouraged states to implement caps or block grants in their Medicaid programs.[54]

The Commonwealth Fund conducted a study of the impact a demonstration based on the HAO guidance would have on states.[55] They found that a typical state would face a reduction of 5.7% in the first year of implementation, increasing to 14.6% by year four.[56] Under various scenarios, the Commonwealth Fund predicted even larger reductions in federal funding to states.

We cannot be more precise in our comments because the application is extremely vague and missing key information that would allow for specific and detailed feedback. The proposal provides almost no information about the funding transformation the state seeks or about how this change would affect stakeholders from enrollees to health care providers. This lack of detail does not provide true notice to the public, including advocates for older adults, to

Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-nemt-final-evl-rpt-11022016.pdf.

[52] Suzanne Bentler, et al., "Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan," University of Iowa Public Policy Center, 26 (Mar. 2016), https://ir.uiowa.edu/cgi/viewcontent.cgi?article=1131&context=ppc_health.

[53] While Oklahoma suggests that it might cover NEMT "in limited cases," the application does not provide enough detail to determine the extent to which (if at all) this potential exception could mitigate the harm. See Application at 24.

[54] Centers for Medicare & Medicaid Services, "Re: Healthy Adult Opportunity" (January 30, 2020), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf.

[54] 42 U.S.C. § 1315(a).

[55] Cindy Mann, et al., "The Fiscal Impact of the Trump Administration's Medicaid Block Grant Initiative" (March 6, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/mar/fiscal-impact-trump-administration-medicaid-block-grant-initiative.

[56] Cindy Mann, et al., "The Fiscal Impact of the Trump Administration's Medicaid Block Grant Initiative" (March 6, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/mar/fiscal-impact-trump-administration-medicaid-block-grant-initiative.

comment in response. Accordingly, we strongly urge the Administration to reject Oklahoma's application as inaccurate and incomplete.

Even during ostensibly more normal times, it is likely that Oklahoma's costs will grow faster than the state's proposed inflation rate (Consumer Price Index-Medical),[57] which will cause need to outpace the cap. While it seems Oklahoma is limiting the per-capita cap proposal to the expansion population, any overspending could have consequences for the state's entire Medicaid program, depending on the size of the overspending. By their very nature, per-capita caps eliminate the federal Medicaid guarantee of coverage and are designed to control federal spending and reduce access to care. As these cuts unfold, older adult Medicaid beneficiaries would likely be significantly and adversely affected. Like the other provisions discussed in these comments, caps or block grants do not serve a demonstration purpose and run counter to the provisions of the Medicaid Act.

Such an approach also limits the state's ability to effectively respond to rapidly changing and emergent circumstances. In the instance of a national disaster or emergency, for example, the state could easily exceed its capitated funding or find itself unable to fund new, innovative, and intensive medical treatments. The current COVID-19 pandemic and attendant economic downturn should serve as warning signals to Oklahoma about the potentially devastating consequences of a per-capita cap. Under a block grant or per-capita cap scenario, the state's financial problems would likely escalate even more quickly, far beyond anything it could weather. The intense financial pressure from a public health crisis like COVID-19 can incentivize states to first cut the most costly and "optional" Medicaid services, including home- and community-based services (HCBS), which are critical for many older adults. Although these services are optional for states, they are not optional for those who need them. Capping funding for one part of Medicaid would only increase this strain and make cuts to lifesaving services even more likely, including during times of crisis.

Caps would significantly weaken both the federal government's financial commitment to care for the nation's most at-risk populations and the long-term viability of state Medicaid programs. Ultimately, altering the program's fundamental structure in this way would jeopardize Medicaid's role as both the largest insurance payer for LTSS and as a support for millions of Americans. It puts access to affordable care at risk for older adults, people with

[57] Rachel Garfield et al., Kaiser Family Foundation, Data Note: What if Per Enrollee Medicaid Spending Growth Had Been Limited to CPI-M from 2001-2011? (March 23, 2017), https://www.kff.org/medicaid/issue-brief/data-note-what-if-per-enrollee-medicaid-spending-growth-had-been-limited-to-cpi-m-from-2001-2011/.

disabilities, and families—most especially the Black, Indigenous, and People of Color enrollees who rely on the program.[58]

Regardless of the specific undisclosed details, Oklahoma's request for a per-capita cap is illegal. The Social Security Act constrains what provisions of the Medicaid Act states can seek to waive to those included in 42 U.S.C. § 1396a.[59] Medicaid's funding mechanism is not included in this section. The very structure of the Social Security Act makes it very clear that Congress did not grant HHS the authority to authorize state attempts to cap or block grant federal Medicaid funding.

Conclusion

Thank you for the opportunity to submit comments on this waiver application. As we have noted throughout, Oklahoma's proposal seeks to illegally transform the state's Medicaid financing structure into an unworkable, unsustainable cap that would strain the state's budget. This would likely lead to significant benefit cuts and coverage losses for enrollees in the state's expansion population, and would put health care at risk for thousands more. The proposed project is starkly inconsistent with the provisions of § 1115 and the Medicaid Act in several respects and is also inaccurate and incomplete. Given this, we ask that HHS not approve the current application and, in addition, we urge you to rescind the deeply flawed Healthy Adult Opportunity guidance that spawned it.

Our comments include citations to supporting research and documents for the benefit of HHS in reviewing our comments. We direct HHS to each of the items cited and made available to the agency through active hyperlinks, and we request that these, along with the full text of our comments, be considered part of the formal administrative record on this proposed rule.

Thank you for your time and attention. If you have any questions, please feel free to contact Lindsey Copeland, Federal Policy Director, at lcopeland@medicarerights.org, or Julie Carter, Senior Federal Policy Associate, at jcarter@medicarerights.org.

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[58] For example, "[t]he proportion of dually eligible beneficiaries who are of a minority race/ethnic group increased from 41.1 percent in 2006 to 47.5 percent in 2018. Compared to Medicare-only beneficiaries, the dually enrolled population continues to be more racially and ethnically diverse. For instance, in 2018, 47.5 percent of dually eligible beneficiaries and 21.1 percent of Medicare-only beneficiaries were of a racial or ethnic minority group. More specifically, among dually eligible beneficiaries, 20.4 percent were Black/African American; 17.8 percent were Hispanic/Latino; 6.4 percent were Asian/Pacific Islander; 0.9 percent were American Indian/Alaska Native; and 0.7 percent were "other" race/ethnicity groups." CMS Medicare-Medicaid Coordination Office, Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2018 (Sept. 2019), https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2018.pdf

[59] 42 U.S.C. § 1315 (Section 1115 of the Medicaid Act).

Sincerely,

Fred Riccardi

Frederic Riccardi
President
Medicare Rights Center