
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 undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the Department of Health and Human Services (HHS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and our organizations are 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.

Our organizations are also concerned that many of the waiver's proposals and enrollment projections were based on an expectation that Oklahoma would have implemented Medicaid expansion in July 2020 pursuant to a State Plan Amendment (SPA). In this 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withdrew the SPA, CMS should have returned the waiver to the State to develop new enrollment and other projections and withdrawn its certification of the proposal as complete.

Our organizations would oppose this proposal under normal circumstances, 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.[1] 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.[2] 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. Our organizations urge the CMS not to approve this proposal and offer 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. Our organizations are 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 many of our organizations explained in detail in our March 9 letter, we oppose the use of block grants and per capita caps in the Medicaid program.[3] 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 chronic illness – who rely on prompt access to primary care providers as well as specialists– 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.

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. 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.[4] Our organizations oppose a waiver of retroactive coverage and urge you to reject this waiver 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.[5] For individuals with chronic disease, maintaining access to comprehensive coverage is vital to access physicians, medications and other treatments and services needed to manage their health. Our organizations believe 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, heart pain, 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.[6] 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.[7] Our organizations oppose 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. Our organizations urge 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,[8] and in New Hampshire, nearly 17,000 individuals would have lost coverage if the state had not suspended implementation of its requirement.[9] 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.[10]

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. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

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.[11] 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.[12,13] Evaluations of Arkansas's waiver demonstrate that it did not lead to increased employment among the Medicaid population.[14] 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).[15] Terminating individuals' Medicaid coverage for non-compliance with work requirements will hurt rather than help people search for and obtain employment. Additionally, in an analysis of five states seeking to implement work requirements, researchers found work requirements would disproportionately affect African American mothers and families.[16] Our organizations urge you to reject Oklahoma's waiver request to impose a Medicaid work requirement.

*Benefit Package*

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

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.[17] Our organizations oppose this policy and urge you to reject it.

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

Sincerely,

American Heart Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Chronic Disease Coalition
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Leukemia & Lymphoma Society
Lutheran Services in America
March of Dimes
National Alliance on Mental Illness
National Health Council
National Hemophilia Foundation
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Susan G. Komen
The AIDS Institute
The American Liver Foundation
United Way Worldwide

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