Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

June 26, 2020

VIA ELECTRONIC SUBMISSION

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 Section 1115 Demonstration Application

Dear Secretary Azar:

Thank you for the opportunity to comment on Oklahoma's "SoonerCare 2.0" section 1115 demonstration application. The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005. As part of the McCourt School of Public Policy, CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, especially those with low and moderate incomes.

By letter dated today, CCF joins with 19 other organizations in requesting that you reject Oklahoma's proposal because it violates section 1115 demonstration procedural requirements and is not likely to promote the core objective of the Medicaid program—which is to promote coverage. I reaffirm CCF's support for that request and the reasons set forth in that letter— i.e., the proposal is incomplete; the proposal does not meet the requirements of section 1115; work requirements and premiums would impede access to coverage and care; the proposal requests unprecedented authority to change eligibility restriction requirements without federal approval; and capping federal funds would risk beneficiaries' access to care.

I want to emphasize at the outset that CCF strongly supports the expansion of Medicaid to all adults under 65 with incomes at or below 138 percent of the federal poverty level. Medicaid expansion would enable Oklahoma to provide coverage to over 127,000 uninsured low-income parents and other adults while improving the financial stability of its safety net providers, especially those in rural areas. Extending Medicaid coverage for low-income Oklahomans who are currently uninsured would demonstrably improve their access to needed care, reducing health disparities.[1] These benefits are particularly

[1] Oklahoma State Department of Health, "2019 Oklahoma Minority Health at a Glance," https://www.ok.gov/health2/documents/2019%20Oklahoma%20Minority%20Health%20At%20A%20Glance.pdf.

important during the current COVID-19 pandemic and deep recession, when the number of uninsured Oklahomans has increased, the burden of the disease is falling more heavily on racial and ethnic minority populations, and the patient care revenues that support Oklahoma providers serving those populations have declined sharply. Medicaid expansion would also reduce the number of uninsured parents, which positively impacts their children as well as research is clear children are more likely to be insured and have better access to care when their parents have coverage.[2]

Oklahoma does not need a section 1115 demonstration in order to realize these benefits -- Medicaid expansion is an option available to it under current law. In fact, Oklahoma's "SoonerCare 2.0" proposal would dramatically *undermine* the ability of Medicaid expansion to help uninsured low-income Oklahomans and their providers. In these comments, we address two of the proposal's most important failures: the application is inaccurate and incomplete, and the proposed per capita cap is not approvable.

Oklahoma's application is inaccurate and incomplete.

As we indicated in our letters to Administrator Verma dated May 1, 2020, and again on June 8, 2020, Oklahoma's "SoonerCare 2.0" proposal is incomplete and inaccurate, and therefore not approvable. CMS certified the proposal as complete on May 20, 2020. It was not complete at that time, and eight days later, with Governor Stitt's withdrawal of the previously submitted State Plan Amendment to expand Medicaid, the proposal became inaccurate. The proposal assumes that Medicaid expansion begins on July 1, 2020, and that the Medicaid expansion population transitions into "SoonerCare 2.0" on July 1, 2021. This assumption is now plainly incorrect. We repeat our request that CMS withdraw its certification of completeness and return the proposal to the state for correction and resubmission so that the public has the opportunity to comment on a complete and accurate proposal. I also request that our letter, which is attached, be considered as part of these comments and incorporated into the administrative record on this proposal.

In addition to its plain inaccuracy, Oklahoma's proposal is fundamentally incomplete. The proposal is the first submitted in response to the CMS "Healthy Adult Opportunity" guidance of January 30, 2020. What separates this guidance from any previous guidance on section 1115 demonstrations is the explicit condition that federal funding would be capped. As I explain below, the Secretary does not have the authority under section 1115 to cap federal funding, even at state request. But even if the Secretary had such authority, Oklahoma's proposal is incomplete because it does not explain how the per capita cap it proposes would work, much less how it would work in the context of a COVID-19 pandemic and a deep recession. Moreover, the proposal does not explain the implications of the per capita cap for Medicaid expansion adults, the health disparities that many of them face, or the safety net providers that serve them.

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[2] Julie L. Hudson and Asako S. Moriya, "Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects on Their Children," *Health Affairs,* 2017; 36(9), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0347.

Oklahoma's proposal to cap federal Medicaid funds is not approvable.

Under Oklahoma's proposal, federal matching payments for the costs of furnishing services to Medicaid expansion adults would be capped using a "per capita cap" methodology (p. 50). This proposal is not approvable for the following reasons. The Secretary does not have the authority to approve a per capita cap. The proposal does not explain its per capita cap, and it is therefore not complete. The state's justifications for a per capita cap are inadequate. Finally, a per capita cap is not necessary for Oklahoma to expand Medicaid to adults with incomes at or below 138 percent of the Federal Poverty Level.

The Secretary does not have the authority under section 1115(a)(2) to approve a per capita cap.

The state's proposal at p. 51 requests section 1115(a)(2) expenditure authority for Medicaid expansion adults (populations described in 42 CFR 435.119). Section 1115(a)(2) authorizes the Secretary to make federal matching funds available for costs that are not otherwise matchable under section 1903 of the Social Security Act in the case of a demonstration project that "is likely to assist in promoting the objectives of" Medicaid.

As the state's application indicates, under 42 CFR 435.119, the costs of covering the Medicaid expansion adults are matchable under section 1903. Section 1115(a)(2), which speaks to costs that are not otherwise matchable, therefore does not authorize the Secretary to approve the state's proposal.

Even if the costs of covering Medicaid expansion adults were not matchable, *the state's proposal to cap federal matching payments for these costs using a per capita cap methodology would not be "likely to assist in promoting the objectives of " Medicaid*. As the D.C. Circuit Court of Appeals has held, a "central objective" of Medicaid is to furnish medical assistance to eligible individuals.[3] A cap on federal Medicaid matching payments for the costs of covered services for Medicaid expansion adults does not, and indeed cannot, promote that objective, and the Secretary therefore does not have the authority to approve it.

A cap, by definition, would eliminate the federal government's contribution to the costs of medical assistance for the expansion adults in the event those costs exceed the cap. Any excess costs would therefore be paid 100% by the state. That, in turn, would create a powerful incentive for the state to reduce its payments for medical assistance to keep its spending under the cap. Protecting the federal government from sharing in the costs of medical assistance is not an objective of the Medicaid program—especially when the costs in question are clearly otherwise matchable.

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[3] *Gresham v. Azar,* United States Circuit Court for the District of Columbia, Civil Action No. No. 19-5094, February 14, 2020.

The state does not explain its per capita cap.

Capping federal funding, even for just one eligibility group, would be a radical, foundational change in the Medicaid program. In order for the public to comment on this proposed change, it needs to understand how the per capita cap would work. This is especially true in the case of a proposal being advanced during a pandemic and a deep recession, when the uninsured low-income Oklahomans who would be covered under Medicaid expansion are at risk not just for health disparities but for infection with coronavirus and unemployment. (Oklahoma's unemployment rate in May 2020 was 13.3 percent and the number of COVID-19 cases as of June 26 was 12,343).[4]

The state does not explain the most basic elements of the per capita cap it is proposing. Would caps be imposed on an annual basis, and if so, how would they be determined? Would all expenditures for Medicaid expansion adults be subject to the cap, or would some be excluded (e.g., expenditures for services for AI/ANs or for high-cost drugs or for administration)? When in each demonstration year would the state Medicaid agency know what the cap amount for that year was? What would happen if expenditures exceeded the cap in any given year? Without any information about these basic mechanics of the state's proposed per capita cap, the public cannot possibly understand what the state is proposing and therefore cannot comment meaningfully on the proposal.

The absence of this information is particularly problematic because the proposal assumes that the state would accrue "savings" underneath the cap, and that the federal government would share those "savings" on a 50-50 basis with the state. (Attachment F at p. 5). How would the state achieve these "savings"? The state projects that the use of "managed coordinated care"—policies independent of the per capita cap—would reduce per member per month spending without the demonstration by 5 percent (p. 22). Where would the additional "savings" come from? Oklahoma is already managing its Medicaid costs very tightly; in 2013-2014, the latest year for which MACPAC presents data, Oklahoma ranked in the bottom quarter of states in terms of per enrollee spending on benefits.[5] The state's failure to explain its potential sources of "savings" on the costs of care for Medicaid expansion adults makes its proposal fundamentally incomplete.

The state does not explain how its per capita cap would promote the objectives of Medicaid.

Oklahoma does not explain how its proposed per capita cap would be "likely to assist in promoting the objectives of" Medicaid. Expanding Medicaid to cover all adults with incomes at or below 138 percent of the poverty level would manifestly promote the core

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[4] U.S. Bureau of Labor Statistics, "The Employment Situation – May 2020," June 5, 2020, https://www.bls.gov/news.release/pdf/empsit.pdf; Oklahoma State Department of Health, "COVID-19 Cases," https://coronavirus.health.ok.gov.

[5] MACPAC, "MACStats: Medicaid Benefit Spending per Full-Year Equivalent Enrollee by State and Eligibility Group, FY 2013," December 2019, https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-22.-Medicaid-Benefit-Spending-Per-Full-Year-Equivalent-Enrollee-by-State-and-Eligibility-Group-FY-2013-FY-2014.pdf.

objective of the Medicaid program: coverage. The state does not need a demonstration to accomplish this objective; it simply needs to submit a State Plan Amendment to cover the 42 CFR 435.119 eligibility group. Nor does the state need a per capita cap to cover this group; federal matching payments are available on an open-ended basis at an enhanced matching rate of 90 percent. Nonetheless, Oklahoma is proposing a demonstration that is grounded on a per capita cap. The state therefore has an obligation to explain how its proposal meets the statutory criterion for a demonstration under section 1115. Its proposal fails to do so.

In its response to comments received during the state public comment period, the Oklahoma Health Care Authority (OHCA) states that the per capita cap financing model is "geared at *incentivizing OHCA* and providers to improve the overall health of SoonerCare 2.0 members through care coordination, health promotion and increased use of primary care." (Attachment F, p. 5), (emphasis added). The agency does not explain why it needs to be incentivized to promote care coordination and increased use of primary care. As the agency makes clear at p. 2 of its proposal, it currently offers "a managed care delivery system of enhanced primary care case management" under SoonerCare Choice, and it is proposing to extend its Patient Centered Medical Home system to the Medicaid expansion population (pp. 4-5), an option it has under current law. Even if OHCA needed to be incentivized, it does not explain how its proposed per capita cap (which it does not explain) would do so. Similarly, it does not explain how its per capita cap (which it does not explain) would incentivize providers who participate in its Patient Centered Medical Home system.

OHCA asserts that a cap on federal Medicaid spending would "advance the triple aim of improving patient experience of care, improving the health of the population, and reducing the per capita cost of health care." (Attachment F, p. 5). The agency offers no evidence that capping federal Medicaid matching funds improves patient experience of care or the health of the population. As the agency notes on p. 3 of its proposal, *Oklahoma ranks 46th among states in the 2019 America's Health Rankings. There is no reason to believe—and the agency offers no evidence—that imposing a cap on federal funding for the Medicaid expansion population would enable the state to improve that ranking*. Nor does the state provide any evidence that capping federal matching funds would reduce the per capita cost of health care for Medicaid expansion adults. Instead, a cap would simply shift some of the costs of their care from the federal government to Oklahoma.

The state's proposal acknowledges that a cap on federal matching funds for the expansion population would disadvantage the state. Attachment F, p. 5, specifies that "expenditures for public health emergencies, such as COVID-19" would not be subject to the proposed cap. The state here is recognizing that there are events beyond the state's control, such as an epidemic or pandemic, that would drive state Medicaid spending, that the state would be at risk financially if such expenditures were subjected to the cap, and that the current, uncapped financing arrangements are the best approach for sharing the financial risk with the federal government. There are other foreseeable expenditures over

which the state has little if any control, such as the costs of responding to natural disasters (e.g., tornadoes) or the costs of expensive new drugs or therapies or health care inflation generally. The proposal does not explain how these costs would be treated under a per capita cap. Nor does it explain why the state is proposing to limit the federal government's contribution to these costs.

The state's proposal sets forth five goals (pp. 4-6): (1) improve access to high-quality, person-centered services; (2) strengthen beneficiary engagement in their personal health plan; (3) enhance alignment between Medicaid and commercial health insurance products; (4) support coordinated strategies that address certain health determinants that promote upward mobility; and (5) promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long run. None of these goals bears any rational relationship to a cap on federal funding for the costs of services to Medicaid expansion adults. In fact, most of these goals are inconsistent with a limit on federal financial participation in the cost of Medicaid for expansion adults. The proposal does not explain, much less justify, this inconsistency.

Similarly, the proposal at pp. 57-58 sets forth a total of 10 different hypotheses relating to these 5 goals. None of these hypotheses, which the state proposes to test in its demonstration, has anything to do with a per capita cap. Put another way, *the state is proposing a demonstration that is based on a fundamental change in the financing of Medicaid coverage for the expansion adults but it offers no hypotheses about the change and it is not proposing to evaluate it.* This underscores that the state's proposal for a per capita cap is not a legitimate objective of its proposed demonstration, much less a legitimate objective of Medicaid.

Conclusion

Our comments include citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS 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.

For these reasons, as well as those detailed in the organizational letter referenced above, we urge you to disapprove Oklahoma's proposal. We strongly support expanding Medicaid coverage to low-income adults in the state without requirements or restrictions and without a cap on federal matching funds Thank you for the consideration of our comments. If you need any additional information, please contact Joan Alker (jca25@georgetown.edu).

Joan Alker

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Attachment: Letter to CMS Administrator May 1, 2020

Attachment: Letter to CMS Administrator June 8, 2020.