

June 26, 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” Proposed Section 1115 Demonstration Project

Dear Secretary Azar,

The undersigned organizations appreciate the opportunity to comment on Oklahoma’s section 1115 demonstration project, called “SoonerCare 2.0,” which the state proposes to implement in accordance with Center for Medicare & Medicaid Services (CMS) “Healthy Adult Opportunity” (HAO) guidance. Oklahoma would expand adult eligibility for Medicaid while capping the federal Medicaid funding the state receives for expenditures on many adult Medicaid enrollees and imposing significant eligibility restrictions that would prevent many people from enrolling in and keeping Medicaid coverage.

Oklahoma’s submission violates procedural requirements governing section 1115 demonstration projects, which should have led CMS to return the proposal to Oklahoma as incomplete. The proposal is vague and lacks a full description of the impact it would have on beneficiaries. Moreover, its enrollment and financing assumptions are based on incorrect data. These flaws make it impossible for the public to determine the full impact of the proposal and effectively comment.

Assuming CMS proceeds with its review of the proposal despite its errors in fact and other shortcomings, our comments explain why the proposal is deeply flawed and should be rejected. The proposal would undermine the effectiveness of its long overdue expansion of coverage by restructuring its financing and operation and imposing a work requirement and steep premiums among other coverage restrictions. The proposal requests changes to Oklahoma’s Medicaid program that can’t be approved under section 1115, and it fails to promote the objectives of the Medicaid program.

Capping funding and restricting eligibility would be harmful for Medicaid enrollees and providers under any circumstances, but especially so in the current public health and economic crisis, where Medicaid programs, including Oklahoma’s are filling gaps in coverage and adapting through telehealth and multiple streamlined processes to ensure low-income people can get the care they need. In particular, the proposal to require Oklahomans with Medicaid coverage to report a minimum number of working hours while the state is facing skyrocketing unemployment would leave many otherwise eligible adults uninsured and make it harder for individuals who are able to work to do so by limiting their access to needed medical care.

Oklahoma’s Proposal is Incomplete

Oklahoma’s application was originally submitted on April 20, 2020, subsequently withdrawn and resubmitted, and eventually certified as complete on May 20. After certification, the state took actions that conflict with significant representations in the application. The application asserts facts

that are completely at odds with the facts on the ground in Oklahoma, making it impossible for the public to submit informed comments.

The application states on page 21 that:

OHCA submitted a state plan amendment [SPA] on March 6, 2020 to add adults ages 19-64 with income up to 133% of the FPL as a covered population effective July 1, 2020. ... It is anticipated that enrollment under the SPA expansion will begin July 1, 2020. ... The total estimated state plan population in year 1 is 128,703. ... In July 2021, if approved, the state plan expansion population will transition to the HAO demonstration waiver.

But on May 21, the day *after* CMS certified the application, Governor Stitt vetoed the bill passed by the Oklahoma legislature to fund the state share of the cost of the expansion that had been scheduled to start on July 1. On May 28, Oklahoma withdrew the SPA that had been submitted on March 6 to add the expansion population to the state's Medicaid program. Thus, contrary to the representations in the application, expansion will not begin on July 1, 2020, and Oklahoma will not transition adults eligible under expansion to the HAO demonstration in July 2021.

The failure to expand in July 2020 goes to the core of the application, including its budget neutrality estimates. As noted, the state estimates that 128,703 people would be enrolled in year 1. That estimate is the basis for the estimated enrollment in year 2, as stated on page 21:

If continued with state plan expansion without the HAO demonstration, the State projects an additional 15% of uninsured individuals will enroll as newly eligible to increase enrollment to 151,879. In July 2021, if approved, the state plan expansion population will transition to the HAO demonstration waiver. The demonstration proposes to introduce premiums and community engagement, which prior experience has shown to depress enrollment. Although it is difficult to predict, the State estimates an approximate 5% reduction of projected enrollment with demonstration from 151,879 to 144,285.

Since the state plan expansion will not start on July 1, 2020, the expansion population cannot under any scenario reach 128,703 in year 1, and the estimates of enrollment and spending based on that assumption throughout the proposal have no basis in fact. Under current circumstances, expansion enrollment would be zero when the waiver takes effect

The purpose of the federal public comment period is to give CMS the benefit of input from interested members of the public regarding the application before the agency. The public cannot properly understand Oklahoma's application, much less provide information that is useful to CMS in deciding whether to approve it, because the application is inaccurate and misleading as to enrollment and expenditures.

Oklahoma's Proposal Fails to Meet the Requirements of Section 1115

Section 1115 of the Social Security Act (the Act) provides the Secretary of Health and Human Services with authority to approve demonstration projects that promote Medicaid's objectives. To the extent needed to carry out such demonstrations, the Secretary can allow states to waive certain provisions of the Medicaid statute and provide federal matching funds for expenditures that aren't usually allowed under Medicaid, often called "expenditure authority."

Before the Affordable Care Act (ACA), CMS approved demonstration projects that expanded coverage to low-income adults without children who couldn't be covered under the Medicaid statute. These demonstration projects often included limits on coverage that weren't generally permissible under Medicaid law, such as enrollment caps, limited benefit packages, and higher than

nominal cost-sharing, in large part to keep spending on the demonstration projects budget neutral to the federal government. Most states covering adults without children, for example, put limits on the number of adults they would cover, because open-ended coverage would have likely increased federal spending above their budget neutrality limits. These adults, who didn't have a pathway to Medicaid coverage in the statute, were covered through expenditure authority. In other words, state expenditures on the services they received were matched even though they were not eligible for Medicaid. These demonstration projects promoted the objectives of Medicaid because they provided coverage to people who couldn't otherwise have it.

With the ACA's expansion of coverage to adults with incomes at or below 138 percent of the poverty line, expenditure authority is no longer needed to match state expenditures on coverage for adults without children. There is now a direct pathway to coverage for all adults, unlike in the pre-ACA days when expenditure authority was needed to provide federal match for expenditures on a group that was not specifically mentioned in the Medicaid statute. Yet CMS continues to undermine the ACA's Medicaid expansion by approving restrictions on coverage for such adults that abrogate the coverage Congress intended in the ACA. Oklahoma's proposal goes even further by conditioning eligibility on work and paying premiums for adults with incomes above about 40 percent of the poverty line as well as eliminating benefits mandated by Congress.

As noted, Oklahoma submitted a SPA to CMS on March 6, 2020, which would have fully expanded its Medicaid program to adults with incomes at or below 138 percent of the federal poverty line. Now it is attempting to use expenditure authority in lieu of state plan authority to impose significant and unlawful conditions on eligibility for adults. The Supreme Court's NFIB decision held that states could choose whether to take up the ACA's Medicaid expansion. However, once the state takes up expansion, it can't pick and choose how to cover adults who would be eligible. As the District Court said in *Stewart v. Azar*, nothing in the court's analysis in NFIB "allows for 'additional discretion' in how the states comply with Medicaid requirements for the expansion population as compared to the traditional one."¹ In judging whether Oklahoma's proposal promotes the purposes of Medicaid, the baseline is full expansion, and the coverage restrictions Oklahoma proposes that would limit who is eligible means Oklahoma's proposal fails the test.

Oklahoma's Proposed Eligibility Restrictions Would Impede Access to Care

Oklahoma's proposal to impose a work requirement and premiums on newly eligible adults directly conflicts with federal District and Circuit Court decisions vacating HHS' approval of demonstrations taking Medicaid coverage away from people who don't meet work requirements or pay premiums. These decisions found that furnishing medical assistance to Medicaid enrollees is a "central objective" of the Medicaid program, and work requirements and premiums fail to promote coverage.²

As noted above, Oklahoma took initial steps to expand its Medicaid program, which would have benefited more than 127,000 Oklahomans, according to the state's estimates. Fully expanding Medicaid would have substantial benefits for Oklahomans. Medicaid expansion improves access to

¹ *Stewart v. Azar*, United States District Court for the District of Columbia, Civil Action No. 18-152 (JEB), June 29, 2018.

² *Gresham v. Azar*, United States Circuit Court for the District of Columbia, Civil Action No. No. 19-5094, February 14, 2020; *Stewart v. Azar*, *supra*.

care and saves lives, extensive studies have shown.³ For example, Medicaid expansion in Arkansas and Kentucky resulted in larger gains in access for low-income adults than in Texas, a non-expansion state.⁴ In Louisiana, more than 355,000 people have visited a doctor since Medicaid was expanded, and tens of thousands of people have received screenings for breast or colon cancer.⁵ In contrast, the restrictions Oklahoma proposes would limit coverage for eligible people who would otherwise qualify.

Taking Coverage Away from People Who Don't Meet A Work Requirement Will Restrict Coverage and Cause Harm

Oklahoma proposes to take coverage away from people who don't meet a work requirement. Adults in the demonstration would be required to “provide verification of participation in at least an average of 80 hours per month” of approved activities, such as work or work training. The hourly requirements phase in over the first 12 months of Medicaid eligibility. The state also requests authority to modify the hourly requirements at any time, without submitting a demonstration amendment to CMS.

Oklahoma estimates that five percent of enrollees subject to the work requirement and premiums will be unable to meet the requirements and will lose their coverage. Experience in Arkansas — where over 18,000 people lost their Medicaid coverage, or 23 percent of those subject to the requirement — suggests that coverage loss in Oklahoma from the work requirements along would likely be considerably higher than the state projects.⁶

Arkansas' experience shows that the reporting aspect of the work requirement is a substantial barrier for Medicaid enrollees who should remain eligible for coverage. Arkansas determined that more than 80 percent of beneficiaries qualified for an exemption and didn't have to take action to maintain their coverage. Of those who were required to take action, the vast majority — over 75 percent — did not claim an exemption or satisfy the reporting requirement and saw their coverage terminated.⁷ As a result, nearly 18,000 Arkansans lost Medicaid coverage before the waiver was vacated by a federal judge.

³ Matt Broaddus and Aviva Aron-Dine, “Medicaid Expansion Has Saved at Least 19,000 Lives, New Research Finds,” Center on Budget and Policy Priorities, November 6, 2019, <https://www.cbpp.org/research/health/medicaid-expansion-has-saved-at-least-19000-lives-new-research-finds>.

⁴ Benjamin D. Sommers, Robert J. Blendon, E. John Orav, “Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance,” *Journal of the American Medical Association*, October 2016, <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2542420>

⁵ “Healthy Louisiana Medicaid Expansion Dashboard,” Louisiana Department of Health, December 16, 2019, <http://www.ldh.la.gov/HealthyLaDashboard/>

⁶ Benjamin D. Sommers, *et al.*, “Medicaid Work Requirements — Results from the First Year in Arkansas,” *New England Journal of Medicine*, September 12, 2019, <https://www.nejm.org/doi/full/10.1056/NEJMSr1901772>.

⁷ Jennifer Wagner, “Commentary: As Predicted, Arkansas' Medicaid Waiver Is Taking Coverage Away From Eligible People,” Center on Budget and Policy Priorities, December 18, 2018, <https://www.cbpp.org/health/commentary-as-predicted-arkansas-medicaid-waiver-is-taking-coverage-away-from-eligible-people>.

About 3 or 4 percent of Arkansans subject to the work requirement were not working and did not qualify for exemptions, according to several studies.⁸ Yet each month, 8 to 29 percent of those subject to the requirement failed to report sufficient work hours, most of them not reporting any hours,⁹ suggesting that many people losing coverage were working or would have qualified for an exemption, but lost coverage due to the administrative burden of meeting the work requirement or a lack of awareness that it even existed.

In New Hampshire, the second state to implement a work requirement, state officials insisted they would do a better job than Arkansas. Yet New Hampshire experienced similar problems communicating with beneficiaries about the work requirement policy. Despite multiple outreach efforts, including mail notifications, town halls, phone calls, text messages, and door-to-door outreach, the state failed to reach 20,000 of the 50,000 people potentially subject to the requirement to inform them about the new policy. New Hampshire's governor suspended the work requirement, preventing almost 17,000 people from potentially losing coverage in August.¹⁰ The waiver was vacated by the federal court in *Philbrick v. Azar*.¹¹

Oklahoma proposes to take coverage away from people who don't meet work requirements because the state hypothesizes that it will increase enrollees' employment and income. This is not an objective of Medicaid, as the District of Columbia Circuit Court of Appeals unanimously found in *Gresham v. Azar*, stating "Congress has not conditioned the receipt of Medicaid benefits on fulfilling work requirements or taking steps to end receipt of governmental benefits."

Even if increasing employment was a proper purpose of Medicaid, research published in the *New England Journal of Medicine* found that "implementation of the first-ever work requirements in Medicaid in 2018 was associated with significant losses in health insurance coverage in the initial 6 months of the policy but no significant change in employment. Lack of awareness and confusion about the reporting requirements were common, which may explain why thousands of persons lost coverage even though more than 95% of the target population appeared to meet the requirements or qualify for an exemption."¹²

Moreover, Oklahoma's proposal fails to acknowledge the current economic conditions. CMS' 2018 guidance recognized that states "will need flexibility to respond to the local employment market by phasing in and/or suspending program features, as necessary."¹³ However, while Oklahoma's unemployment rate in May is 13.3 percent, Oklahoma's proposal does not acknowledge

⁸Anuj Gangopadhyaya *et al.*, "Medicaid Work Requirements in Arkansas," Urban Institute, May 24, 2018, <https://www.urban.org/research/publication/medicaid-work-requirements-arkansas>; *see also* Sommers 2019, *op cit.*

⁹Jennifer Wagner, "New Arkansas Data Contradict Claims That Most Who Lost Medicaid Found Jobs," Center on Budget and Policy Priorities, March 19, 2019, <https://www.cbpp.org/blog/new-arkansas-data-contradict-claims-that-most-who-lost-medicaid-found-jobs>.

¹⁰Jessica Schubel, "NH Medicaid Work Requirement Suspension Confirms: Policy Can't Be Fixed," Center on Budget and Policy Priorities, July 9, 2019, <https://www.cbpp.org/blog/nh-medicaid-work-requirement-suspension-confirms-policy-cant-be-fixed>.

¹¹Memorandum Opinion, *Philbrick v. Azar*, United States District Court for the District of Columbia, Civil Action No. 19-773 (JEB), July 29, 2019.

¹²Sommers 2019, *op cit.*

¹³Centers for Medicare and Medicaid Services, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," January 18, 2018, <https://www.medicare.gov/sites/default/files/federal-policy-guidance/downloads/smd18002.pdf>.

the impact of high unemployment on Medicaid enrollees, which will make it more likely they lose coverage. In addition, unemployment is higher among communities of color,¹⁴ which means work requirements will likely have a disparate racial impact, exacerbating racial and ethnic disparities in health care access and outcomes.¹⁵

Taking Coverage Away from People Who Don't Pay Premiums Will Restrict Access to Coverage

Oklahoma proposes to take coverage away from people with incomes above the parent/caretaker income standard (about 40 percent of the poverty line) who don't pay premiums amounting up to 2 percent of family income. For new enrollees, the state will not initiate coverage until the individual pays their first month's premium. Individuals who are unable to pay for three months will be disenrolled until they can pay one month's premium. In addition to premiums, enrollees will be required to pay copayments "up to the 5% out of pocket maximum."

Extensive research (including research from Medicaid demonstration projects conducted prior to the passage of the Affordable Care Act) shows that premiums significantly reduce low-income people's participation in health coverage programs. These studies clearly show that the lower a person's income, the less likely they are to enroll and the more likely they are to drop coverage due to premium obligations. In fact, research has found that "Even relatively small levels of [Medicaid] cost sharing in the range of \$1 to \$5 are associated with reduced use of care, including necessary services..."¹⁶ Moreover, people who lose coverage most often end up uninsured and unable to obtain needed health care services.¹⁷

Oklahoma's proposal states, "These premium payments are critical to member engagement, as studies have shown that making regular monthly premiums may lead to better health outcomes for members. For example, in Indiana, where Medicaid eligible adults are required to pay monthly premiums, members making contributions had higher satisfaction rates, higher primary and preventative care utilization, higher prescribed drug adherence, and lower emergency room use than those who did not. (The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016))." This statement incorrectly assumes that premium payments *caused* Medicaid enrollees to have higher satisfaction rates and access to care, which inaccurately describes the evidence from Indiana. In contrast, it is more likely that individuals who were able to pay premiums were already more likely to have higher satisfaction rates and to use primary and preventive care.

Moreover, Indiana's evaluation showed the harmful effects of premiums on individuals who were unable to pay. The state's 2018 evaluation showed that more than half (55 percent) of all of those eligible to pay premiums under HIP 2.0 during the first two years of implementation failed to do so, resulting in negative consequences. Over 46,000 people never enrolled in coverage because they never paid their first premium and another 13,550 people successfully enrolled in HIP 2.0 but later lost coverage for failing to pay a premium during the first two years of HIP 2.0. Moreover, the top

¹⁴ Patricia Cohen and Ben Casselman, "Minority Workers Who Lagged in a Boom Are Hit Hard in a Bust," *New York Times*, June 6, 2020, <https://www.nytimes.com/2020/06/06/business/economy/jobs-report-minorities.html>.

¹⁵ Georgetown Center on Children and Families, "Racial Health Inequities and Medicaid Work Requirements," June 2, 2020, <https://ccf.georgetown.edu/2020/06/02/racial-health-inequities-and-work-requirements/>.

¹⁶ Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings," The Kaiser Family Foundation, June 2017, <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations>.

¹⁷ *Ibid.*

two reasons cited by people who never enrolled in or lost HIP 2.0 coverage were affordability and confusion about the payment process. And many people who never got or lost HIP 2.0 coverage for failing to pay a premium were uninsured.¹⁸

In proposing these premiums, Oklahoma isn't claiming to test anything that hasn't been tried before — either before the ACA, or in states like Indiana and Michigan that have been granted permission to charge premiums to people with incomes above the poverty line. Evidence from these experiments clearly shows that charging premiums makes it more likely that Medicaid beneficiaries lose their health coverage and become uninsured, or that they are less likely to sign up for coverage in the first place.¹⁹

Unprecedented Authority to Change Requirements Without Federal Approval

In addition to the specific eligibility restrictions described above, Oklahoma requests authority to make changes to the number of hours individuals are required to work in order to maintain their coverage, as well as the amount of the enforceable premiums, without submitting an amendment to its demonstration to CMS. This proposal is inconsistent with the intent of public notice and comment requirements for Medicaid demonstration applications and renewals as well as the procedures set forth in 59 Federal Register 49249 (September 27, 1994) that govern the public notice and comment process for a state seeking to amend its demonstrations, all of which provide the public with time to weigh in on changes that would affect beneficiaries before the state submits its proposal.²⁰

Moreover, the state requests authority to increase premiums up to five percent of enrollees' household income, which would amount to more than twice what near-poor adults pay for health coverage in the state health insurance marketplaces. These requirements would be prohibitive for many Oklahomans, resulting in many losing access to coverage or being unable to enroll. Additionally, this request misinterprets the prohibition against imposing out of pocket costs for Medicaid enrollees above five percent of their household income. This five percent maximum should be a protection for a very small group of beneficiaries with catastrophic health care costs — not an expectation that enrollees will as a matter of course contribute five percent of their income to pay for health coverage and the care they need.

Capping Federal Funds Would Risk Oklahomans' Access to Care

Oklahoma is making its proposal under CMS' HAO guidance, which would allow Oklahoma to limit its federal Medicaid funding for the new expansion group to a capped per-person amount multiplied by the number of people enrolled. The guidance proposes to set the initial caps for groups not previously covered by relying on the national average of Medicaid expenditures for the population and services, taking into account geographic and other necessary information. After two

¹⁸ The Lewin Group, "Health Indiana Plan 2.0: POWER Account Contribution Assessment," March 31, 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>; see also Robin Rudowitz, MaryBeth Musumeci, and Elizabeth Hinton, "Digging Into the Data: What Can We Learn from the State Evaluation of Healthy Indiana (HIP 2.0) Premiums," March 8, 2018, <https://www.kff.org/medicaid/issue-brief/digging-into-the-data-what-can-we-learn-from-the-state-evaluation-of-healthy-indiana-hip-2-0-premiums/>.

¹⁹ *Ibid.*

²⁰ Centers for Medicare and Medicaid Services, 1115 Transparency Requirements, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-transparency-requirements/index.html>.

years, CMS may rebase the estimate. CMS would increase the caps each year based on the projected growth in the medical care component of the consumer price index (CPI-M).

The Congressional Budget Office (CBO) projects that per-enrollee costs for adults subject to the guidance will grow considerably faster than the CPI-M.²¹ Thus it's highly likely that Oklahoma will quickly hit the caps unless it makes significant cuts to its program.

The CBO projections of average, nationwide growth rates mask substantial variation. First, nationwide growth rates in particular years will likely substantially exceed the average if there is a recession or serious public health emergency. Second, state growth rates vary widely relative to the national average. For example, from 2000-2011, average annual growth in per-enrollee costs for the relevant group of adult enrollees ranged from about 0 to about 12 percent across states.²² Oklahoma could therefore see growth rates substantially exceed the national average for reasons beyond its control, which would likely require deep cuts to Oklahomans' coverage.

Nearly all states would have experienced at least some decline in federal funding from 2000-2011 if growth in per-enrollee funding for the relevant group of adults had been capped at the CPI-M, a Kaiser Family Foundation analysis found, with 26 states experiencing cuts of more than 20 percent.²³ While Medicaid expansion has changed the population of adults eligible for Medicaid, this calculation still confirms that states agreeing to spending caps would be accepting substantial risk.

While Oklahoma has submitted its proposal for capped funding under the HAO guidance the state has failed to provide information and data necessary to fully evaluate the impact of capped funding. As noted, the state's enrollment and expenditure estimates assume that expansion began in July 2020 with the waiver taking effect in July 2021. Moreover, the state estimates without any

²¹ CBO projects that Medicaid enrollee costs for non-elderly adults not enrolled due to disability are projected to grow by 5.3 percent annually through 2029. Based on projected growth in the CPI and the historic wedge between the CPI and the CPI-M, we project that the CPI-M will grow by about 3.5 percent annually over the same period.

CBO's Medicaid estimates are available at <https://www.cbo.gov/system/files/2019-05/51301-2019-05-medicaid.pdf>, while CBO's CPI projections are available at <https://www.cbo.gov/about/products/budget-economic-data>.

The substantial difference reflects the fact that per-enrollee costs grow due to increases in prices for existing treatments, introduction of new treatments, and increases in health care utilization, while the CPI-M measures only the first of these factors. CBO projects that per-enrollee cost growth in Medicare and the private insurance market will also exceed growth in the CPI-M.

²² The proposed growth rates are also lower than the Medicaid growth rates assumed in the latest President's budget. CMS normally uses the budget baseline growth rates as the basis for evaluating whether Medicaid waivers are budget neutral to the federal government. For further discussion of how the proposed block grant funding caps differ from standard budget neutrality requirements for waivers, see Allison Orris, Patricia Boozang, and Julian Polaris, "CMS Guidance Authorizes Medicaid Demonstration Applications That Cap Federal Funding: Implications for States," published by State Health & Value Strategies, February 2020, <https://www.shvs.org/resource/cms-guidance-authorizes-medicaid-demonstration-applications-that-cap-federal-funding-implications-for-states/>.

²³ Rachel Garfield, Robin Rudowitz, and Katherine Young, "Data Note: What If Per Enrollee Medicaid Spending Had Been Limited to CPI-M From 2000-2011?" Kaiser Family Foundation, 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/>.

explanation that both expenditures and enrollment are flat in the second through fifth year of the demonstration, which is not plausible.

Regardless of the specific 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. It only permits waivers of sections of the Medicaid Act included in Section 1902 of the Social Security Act, and Medicaid's funding mechanism is not included in this section.

Conclusion

Our comments include numerous 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.

AFL-CIO

Autistic Self Advocacy Network

Center on Budget and Policy Priorities

Community Catalyst

Epilepsy Foundation

Families USA

First Focus on Children

Georgetown University Center for Children and Families

Guttmacher Institute

March of Dimes

Medicare Rights Center

Mental Health America

National Alliance on Mental Illness

National Association of Pediatric Nurse Practitioners

National Employment Law Project

National Family Planning & Reproductive Health Association

National Multiple Sclerosis Society

Professor Pamela Herd, Professor of Public Policy, Georgetown University

Service Employees International Union

The Arc of the United States