



Center for Public  
Representation

June 26, 2020

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

Dear Secretary Azar,

The Center for Public Representation (CPR) writes to express our strong opposition to Oklahoma's proposed SoonerCare 2.0 Healthy Adult Opportunities (HAO) Section 1115 Demonstration Waiver. CPR is a national legal advocacy organization that promotes the full integration and community participation of people with disabilities. We are deeply concerned by Oklahoma's proposal to convert its Medicaid financing into a per capita cap financing model, the massive reduction in federal oversight sought by the State, and the proposals to implement work requirements, premiums, benefit exclusions, and other harmful policies that will have an outsized impact on Oklahomans with disabilities.<sup>1</sup> While we support Oklahoma's decision to expand coverage to low-income adults, we urge you to reject the SoonerCare 2.0 Demonstration.

**Oklahoma's request should be rejected because it is too vague and outdated for effective public comment and stakeholders lacked a full opportunity to comment on the proposal at the state level.**

While there are a number of concerning elements in the proposal, the per capita cap and other elements lack specific details necessary to make an educated determination of how exactly they will affect stakeholders. Stakeholders also are prevented from providing full and accurate comments because many of the waiver's proposals and enrollment projections were based on an expectation that Oklahoma would have implemented a Medicaid expansion in July 2020 pursuant to a State Plan Amendment (SPA). For example, the application states, "The State emphasizes the per capita cap model will have no impact on enrollment and that as the initial expansion implementation effective July 1, 2020 ramps up, there will be claims and demographic data to better inform these projections for the per capita cap financing model." But this and other aspects of the proposal are now outdated following the Governor's decision to withdraw the expansion SPA. Stakeholders are thus left to comment on a proposal that lacks an explanation of how the State plans to inform projections for the per capita cap model and

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<sup>1</sup> Oklahoma Health Care Authority, SoonerCare 2.0 Healthy Adult Opportunity (HAO) Section 1115 Demonstration Application, (May 2020) (hereinafter Oklahoma Application).

other aspects of SoonerCare 2.0 without the anticipated expansion data beginning in July 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.

Furthermore, stakeholders were not given a full opportunity to comment on the proposal during the state public comment period because, as explained in an April letter to Administrator Verma,<sup>2</sup> the State cancelled the scheduled public hearings on the SoonerCare 2.0 proposal due to the COVID-19 emergency and held “virtual meetings” instead. This procedure did not satisfy Oklahoma’s notice obligations under Section 1115 and CMS’ implementing regulations.<sup>3</sup> It also disproportionately excluded populations directly affected by the proposal: people with low incomes and/or disabilities who are less likely than others to have internet access or comfort with technology.<sup>4,5</sup> Without more detail and specificity or a full opportunity to participate in the comment process at the state level, stakeholders, including people with disabilities and service providers, have not been given an opportunity for meaningful public comment. Furthermore, it seems that Oklahoma’s responses to those public comments that did get submitted were at times inaccurate. The application itself does not reference shared savings from the per capita cap proposal and the HAO guidance only makes shared savings available to states that adopt an aggregate (rather than a per capita) cap.<sup>6</sup> However, the state justified the proposal in response to multiple public comments with the assertion that the state would be able to “share in the savings achieved through these measures with CMS up to 50/50,”<sup>7</sup> which is an incorrect and inadequate response. Given all of these problems with the comment process, CMS should not have approved the State’s application as complete and should now reject the application.

**HHS lacks authority to approve Oklahoma’s per capita cap proposal because it waives Medicaid requirements that are not waivable under 1115 authority and does not promote the objectives of Medicaid.**

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<sup>2</sup> Letter from Jane Perkins to Seema Verma, National Health Law Program (April 23, 2020), <https://healthlaw.org/resource/letter-calls-on-seema-verma-to-reject-oklahomas-section-1115-request-as-incomplete/>.

<sup>3</sup> *Id.*

<sup>4</sup> Camille Ryan & Jamie Lewis, *American Community Survey Reports, Computer and Internet Use in the United States: 2015* (U.S. Census Bureau 2017),

<https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-37.pdf>.

<sup>5</sup> Monica Anderson & Andrew Perrin, *Disabled Americans are Less Likely to Use Technology* (Pew Research Center 2017), <https://www.pewresearch.org/fact-tank/2017/04/07/disabled-americans-are-less-likely-to-use-technology/>.

<sup>6</sup> Letter from Calder Lynch, Deputy Adm’r & Dir. Ctrs. for Medicare & Medicaid Servs., U.S. Dep’t of Health & Human Servs., to State Medicaid Dirs. (Jan. 30, 2020), <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf>

<sup>7</sup> Oklahoma Application 133-174.

In addition to including many of the same proposals that the courts have repeatedly found illegal, Oklahoma also seeks to be the first state to implement a block grant or per capita cap per CMS' recent guidance.<sup>8</sup> Section 1115 allows waiver of a variety of Medicaid requirements relating to mandatory coverage and services, optional coverage and services, eligibility processes, service delivery, and beneficiary protections. However, the per capita cap would require a waiver of Medicaid's financing mechanism, which is not among the requirements waivable under Section 1115. This means that HHS cannot approve the per capita cap financing system that Oklahoma proposes.

HHS also lacks authority to approve the per capita cap proposal because it does not promote the objectives of Medicaid. Section 1115 waivers must be "likely to assist in promoting the objectives" of Medicaid in order to be approvable under the law.<sup>9</sup> Those objectives are to enable states to provide "medical assistance" to people with disabilities, seniors, and families with dependent children, "whose income and resources are insufficient to meet the costs of necessary medical services" and to provide services to help such individuals and families "attain or retain...independence and self-care."<sup>10</sup>

Oklahoma's proposal provides almost no information about the funding transformation the State seeks, making it impossible to offer specific comments on how the transformation will affect people with disabilities and other stakeholders. The state itself seems unclear about how the proposal would work, given the inaccurate responses to state public comments described above that suggested the state could access shared savings under the proposed waiver. However, per capita caps in general work against Medicaid's objectives. Under a per capita cap, the State would receive a fixed amount of money based on the number of enrollees, and then would be liable for any costs should the State exceed its allotted cap. For example, in the instance of a national disaster or emergency, the State could easily exceed its capitated funding. While CMS' guidance contains a Special Circumstances Adjustment, it is unclear from either CMS' guidance or this application whether that adjustment would fully compensate those costs and do so in a manner timely enough to meet the state's needs in an unforeseen crisis. Capitated funding could also limit access to new, innovative, and intensive medical treatments, which could be especially devastating during the current COVID-19 pandemic and predicted economic downturn.

In addition, over time, it is likely that Oklahoma's costs will grow faster than the State's proposed inflation rate (Consumer Price Index-Medical).<sup>11</sup> While it seems Oklahoma is limiting

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<sup>8</sup> Letter from Calder Lynch to State Medicaid Directors, Centers for Medicaid & CHIP Services (January 30, 2020), <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf>.

<sup>9</sup> 42 U.S.C. § 1315.

<sup>10</sup> 42 U.S.C. § 1396-1.

<sup>11</sup> Rachel Garfield et al., *Data Note: What if Per Enrollee Medicaid Spending Growth Had Been Limited to CPI-M from 2001-2011?* (Kaiser Family Foundation 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/>.

the per capita cap proposal to the expansion population, any overspending could have consequences for the entire Medicaid program in Oklahoma depending on the size of the overspending. By their very nature, per capita caps are designed to control spending and reduce access to care. Facing funding restrictions, Oklahoma would likely turn to Medicaid program cuts to eligibility, benefits, and reimbursement to providers in order to keep spending under the cap.<sup>12</sup> These cuts would put populations and providers that disproportionately rely on Medicaid at risk, including individuals with disabilities.<sup>13</sup> Like the other provisions discussed in these comments, per capita caps do not serve a demonstration purpose and run counter to the provisions of the Medicaid Act.

**Oklahoma’s proposed work requirement does not support Medicaid’s objectives and is likely to result in large coverage losses, particularly among people with disabilities.**

Oklahoma’s proposed demonstration would require enrollees to complete at least 80 hours of work or work-related activities per month to maintain Medicaid coverage. Enrollees who do not complete and report their work hours monthly or successfully navigate the exemption process would lose their coverage. States have a variety of policy options available to support employment through the Medicaid program without conditioning eligibility on a work hours requirement,<sup>14</sup> and evidence suggests that Medicaid expansion under the ACA alone is linked to increased employment,<sup>15</sup> particularly among people with disabilities.<sup>16</sup> Yet instead of supporting Oklahomans’ ability to work by facilitating easy access to Medicaid expansion coverage or targeting other barriers to employment (which are likely to pose especially large challenges in the economic downturn resulting from the coronavirus pandemic), Oklahoma proposes imposing a punitive work requirement policy that is likely to significantly decrease coverage without affecting employment.<sup>17</sup>

Evidence from Arkansas, the first state to implement a work requirement policy (before the policy was set aside by court), showed that thousands of people lost coverage during the first

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<sup>12</sup> Robin Rudowitz, *Five Key Questions: Medicaid Block Grants & Per Capita Caps* (Kaiser Family Foundation 2017), <https://www.kff.org/medicaid/issue-brief/5-key-questions-medicaid-block-grants-per-capita-caps/>.

<sup>13</sup> *Id.*

<sup>14</sup> Cornelia Hall and Elizabeth Hinton, *Supporting Work Without the Requirement: State and Managed Care Initiatives* (Kaiser Family Foundation, December 2019), <https://www.kff.org/report-section/supporting-work-without-the-requirement-state-and-managed-care-initiatives-issue-brief/>.

<sup>15</sup> Madeline Guth, Rachel Garfield, and Robin Rudowitz, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* (Kaiser Family Foundation, March 2020), <https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/>.

<sup>16</sup> Jean Hall, Adele Shartzter, Noelle Kurth, and Kathleen Thomas, “Medicaid Expansion as an Employment Incentive Program for People With Disabilities,” *American Journal of Public Health* 108, 1235-1237, (September 2018), <https://pubmed.ncbi.nlm.nih.gov/30024794/>.

<sup>17</sup> Benjamin Sommers, Anna Goldman, Robert Blendon, E. John Orav, and Arnold Epstein, “Medicaid Work Requirements – Results from the First Year in Arkansas,” *The New England Journal of Medicine Special Report* 381, 1073-1082, (June 2019), <https://www.nejm.org/doi/full/10.1056/NEJMSr1901772>.

six months of the policy even though more than 95% of the target population appeared to meet the requirements or qualify for an exemption.<sup>18</sup> People with disabilities are particularly likely to fall into the unintentional coverage loss category described above given the particular challenges they may face in navigating complex exemption qualification or hours reporting processes.<sup>19</sup>

The degree of the administrative barrier that the exemption qualification process will pose is difficult to assess because Oklahoma’s proposal provides few details on how an individual will receive notice or find out they qualify for a disability exemption, what verification will be required, or how long the exemption will last. In fact, the proposal’s only reference to duration is where the State lists the ADA disability exemption in its description of “good cause” exemptions. These appear to apply for just a single month. News accounts from Arkansas described individuals with chronic conditions who lost their coverage due to confusion about the work requirements.<sup>20</sup> A recent Kaiser Family Foundation study similarly found that despite the purported exemptions and safeguards, significant numbers of individuals with a disability still lost coverage. The study found that safeguards were complex and difficult to navigate and so exempted very few enrollees.<sup>21</sup> Mass coverage losses occurred despite Arkansas “using existing data sources when possible” to confirm disability status.<sup>22</sup> Oklahoma’s proposal provides no reason to expect a different result—it is likely to negatively impact coverage and counteract the objectives of the Medicaid program.

### **Oklahoma’s proposed demonstration will create a huge administrative burden.**

Several other states, including Tennessee,<sup>23</sup> Virginia,<sup>24</sup> and Pennsylvania<sup>25</sup> all estimate tens of millions of dollars in administrative costs involved in establishing and running work requirement

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<sup>18</sup> *Id.*

<sup>19</sup> Center on Budget and Policy Priorities, *Taking Away Medicaid for Not Meeting Work Requirements Harms People With Disabilities* (March 2020), <https://www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-people-with>.

<sup>20</sup> Oklahoma Application 11.

<sup>21</sup> MaryBeth Musumeci, *Disability and Technical Issues Were Key Barriers to Meeting Arkansas’ Medicaid Work and Reporting Requirements in 2018* (Kaiser Family Foundation, June 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/>.

<sup>22</sup> Sommers et al., *Medicaid Work Requirements – Results from First Year in Arkansas*, at 8.

<sup>23</sup> Blake Farmer, Nashville Public Radio, *Tennessee Intends To Raid Welfare Funding To Enforce Medicaid Work Requirement*, Mar. 21, 2018, <http://www.nashvillepublicradio.org/post/tennessee-intends-raid-welfare-funding-enforce-medicaid-work-requirement#stream/0>.

<sup>24</sup> Michael Martz, Richmond Times-Dispatch, *Bill gets bigger in revised analysis of Medicaid work requirement*, Feb. 5, 2018, [https://www.richmond.com/news/virginia/government-politics/general-assembly/bill-gets-bigger-in-revised-analysis-of-medicaid-work-requirement/article\\_882a5762-d57d-5edb-b6e4-ff079ace7b38.html](https://www.richmond.com/news/virginia/government-politics/general-assembly/bill-gets-bigger-in-revised-analysis-of-medicaid-work-requirement/article_882a5762-d57d-5edb-b6e4-ff079ace7b38.html).

<sup>25</sup> Lindsay C. VanAsdalan, York Dispatch, *York lawmaker: Medical assistance recipients need 'bit of a kick' sometimes*, Apr. 20, 2018, <https://www.yorkdispatch.com/story/news/2018/04/20/york-gop-votes-work-requirements-aims-fix-broken-safety-net-system/524193002>.

programs. Oklahoma provides no estimate of administrative costs. And even if it intends to utilize existing structures, that does not immunize it from these costs, as it still needs to account for both the intricacies involved in implementing a new work requirement and the influx of participants. Oklahoma should instead prioritize spending limited funding on services for Medicaid participants, not funding the administrative costs of a program that would create barriers to care.

**The premiums sought by the State would harm people with disabilities and cannot be approved under Section 1115 authority.**

Oklahoma proposes to require many individuals in the expansion adult population, including some individuals with incomes below the poverty level, to make sliding scale monthly premium payments.<sup>26</sup> Coverage would not begin for individuals subject to premiums until they make the first premium payment,<sup>27</sup> which would create a default waiting period for people who cannot or do not know how to pay their initial premium. After enrollment, individuals are required to keep paying premiums or be disenrolled after three months of nonpayment.<sup>28</sup> The State itself projects that Medicaid expansion enrollment would be five percent lower under the premium and work requirement policies than it would be without those policies,<sup>29</sup> and research from other states suggest that the coverage losses due to premiums would be even higher. For example, when Indiana implemented premium payments for individuals and households above 100% FPL, 23% of individuals who were found eligible for Medicaid and required to pay premiums to obtain coverage failed to pay the initial premium, and as a result, did not enroll in coverage.<sup>30</sup> In addition, 7% of people who successfully enrolled and were required to pay premiums to maintain their eligibility were later removed from Medicaid for failing to pay premiums.<sup>31</sup> Unlike Indiana, Oklahoma plans to impose premiums on individuals falling below 100% FPL, meaning the coverage loss will be even more severe. The abrupt loss of access to care caused by this disenrollment would have a disproportionate impact on people with disabilities, who have higher rates of interaction with the healthcare system in general and often have medical needs that require consistent access to care.

While Oklahoma claims that these premiums and non-payment policies are meant to “educate and prepare members for private commercial health insurance coverage,”<sup>32</sup> research shows that premiums end up being a barrier to participation. Premiums significantly reduce the

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<sup>26</sup> Oklahoma Application 8-11.

<sup>27</sup> *Id.* at 10.

<sup>28</sup> *Id.* at 10.

<sup>29</sup> *Id.* at 18.

<sup>30</sup> 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>.

<sup>31</sup> *Id.*

<sup>32</sup> Oklahoma Application 9.

participation of low-income individuals, including individuals with disabilities, in health coverage programs, meaning that the very Oklahomans this plan claims to be “preparing for commercial health insurance” are unlikely to benefit from it.<sup>33</sup> A core objective of the Medicaid program, which 1115 waivers are supposed to further, is to furnish “medical assistance” to certain populations, not to prepare enrollees for commercial health insurance. A demonstration that only seeks to create barriers to coverage cannot be approved under 1115 authority.

The State offers limited exemptions from premiums, including individuals diagnosed with HIV/AIDS, a substance use disorder (SUD), or serious mental illness (SMI). These are narrower than the exemptions for Medically Frail individuals in Indiana and Michigan, which will lead to greater loss of coverage due to premiums for people with disabilities. Nor does the State provide any information on how new applicants will know about these limited exemptions, how they will be screened and verified, or how applicants and enrollees will be identified as eligible for an exemption. Because premiums must be paid prior to enrollment, this omission could result in people with these conditions who should be exempt never accessing coverage because they are forced, inappropriately, to pay premiums just to enroll.

**Oklahoma’s proposals to eliminate Non-Emergency Medical Transportation (NEMT), long-term care (LTC) services, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for 19- and 20-year-olds, presumptive eligibility, and retroactive coverage for the Medicaid expansion population, as well as the request for flexibility to impose a limited prescription drug formulary without a SPA or waiver amendment, are dangerous for people with disabilities.**

Oklahoma provides little explanation for these drastic proposals, other than its intent to “more closely align [Medicaid] with the benefits offered via commercial coverage.”<sup>34</sup> But the lack of coverage of these services in private insurance plans is exactly what makes their coverage in Medicaid so essential—even people with the means to access private insurance have long relied on Medicaid to fill in the gaps in private insurance coverage.

***Non-Emergency Medical Transportation (NEMT)***

People with disabilities often rely on NEMT to get to and from health appointments. Based on the experience of states that have previously eliminated NEMT for the expansion population, Oklahoma can expect that excluding this service will cause participants, particularly those with disabilities, to miss medically necessary appointments or report unmet health needs as a result

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<sup>33</sup> Samantha Artiga, Petry Ubri, and Julia Zur, *The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings* (Kaiser Family Foundation, June 2017), <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations>.

<sup>34</sup> Oklahoma Application 26.

of transportation barriers.<sup>35</sup> Notably, data from Iowa indicates 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.<sup>36</sup> Introducing this barrier to transportation in Oklahoma will result in poorer health, more emergency room visits, and expensive and otherwise unnecessary hospitalizations, particularly among people with disabilities who have higher rates of interaction with the healthcare system. NEMT has been found to be either cost-effective or cost-saving for a variety of health conditions,<sup>37</sup> producing a positive return on investment for people with disabilities.<sup>38</sup> Oklahoma may argue that people who truly lack transportation alternatives will still be able to access NEMT services through the limited case-by-case NEMT policy exception that Oklahoma “may” choose to offer (based on an individualized assessment of need and in accordance with a care coordination plan).<sup>39</sup> But the reality is that this is a narrow exception that the State could decline to offer at its discretion, and even if it is offered it poses a major administrative barrier that will likely prevent even people who rely most heavily on NEMT services from applying.

### ***Long-Term Care (LTC)***

Long-term care services are absolutely critical to health and well-being for individuals with disabilities and chronic-health conditions.<sup>40</sup> The ACA’s Medicaid expansion has enabled millions of Americans with chronic health conditions and disabilities, who do not qualify for Medicaid through a disability pathway, to gain coverage and access to state plan long-term services and supports (LTSS). While the Alternative Benefit Package that applies to most expansion enrollees can differ from state plan services, states are required under the Medicaid Act to provide Medicaid expansion enrollees who are Medically Frail the option to select state plan coverage. Oklahoma’s state plan coverage encompasses an array of important LTSS, including state plan personal care services.

Most states avoid having to identify Medically Frail expansion enrollees by fully aligning the

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<sup>35</sup> See, e.g., Suzanne Bentler et al., Univ. of Iowa Pub. Policy Ctr., *Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan*, 26 (Mar. 2016), [https://ir.uiowa.edu/cgi/viewcontent.cgi?article=1131&context=ppc\\_health](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-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-nemt-final-evl-rpt-11022016.pdf>.

<sup>36</sup> Suzanne Bentler et al., *Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan*, (University of Iowa Public Policy Center, March 2016), [https://ir.uiowa.edu/cgi/viewcontent.cgi?article=1131&context=ppc\\_health](https://ir.uiowa.edu/cgi/viewcontent.cgi?article=1131&context=ppc_health).

<sup>37</sup> National Academies of Sciences, Engineering, and Medicine, *Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation*, The National Academies Press (2005), <http://www.trb.org/Publications/Blurbs/156625.aspx>.

<sup>38</sup> Michael Adelberg et al., *NEMT ROI Study*, Medical Transportation Access Coalition (2005), <https://mtacoalition.org/wp-content/uploads/2018/07/NEMT-ROI-Methodology-Paper.pdf>.

<sup>39</sup> Oklahoma Application 26.

<sup>40</sup> Center on Budget and Policy Priorities, *Medicaid Works for People with Disabilities* (CBPP August 2017), <https://www.cbpp.org/sites/default/files/atoms/files/8-29-17health.pdf>.



expansion benefit package with state plan benefits. But Oklahoma proposes to not provide LTSS through SoonerCare 2.0, meaning it would have to develop a process to identify expansion enrollees who are Medically Frail. The project proposal fails to acknowledge this requirement or clarify key details about this process, including how the state will identify applicants and enrollees who are Medically Frail; how people with disabilities will be notified about the Medically Frail pathway and the state plan alternative; how they will be screened and verified; and whether such a screening will exempt them from certain conditions of eligibility. Without these details, we cannot provide meaningful comment on how severe of a barrier this additional hurdle will create for expansion enrollees who need state plan LTSS.

It also seems possible from the waiver proposal's text that the state intends simply to exclude access to state plan LTSS for all expansion enrollees, including the Medically Frail. If that is the state's plan, that would require a waiver that amounts to no more than a simple benefit cut for expansion enrollees with disabilities and chronic conditions who need state plan LTSS. Such a benefit cut would be inconsistent with the purpose of the Medicaid Act and would not be approvable.

#### ***Early and Periodic Screening, Diagnostic and Treatment (EPSDT)***

Oklahoma's proposal to eliminate EPSDT for 19- and 20-year-olds in the expansion population would also be especially harmful to people with disabilities. Congress included EPSDT in the Medicaid program to provide comprehensive coverage of screening, diagnosis and treatment for individuals under the age of 21. Although 19- and 20-year-olds are at the older end of the EPSDT age spectrum, EPSDT services are critically important at that age in supporting individuals' health and independence as they make the difficult transition to adulthood. Young adults in this age range experience high rates of mental health conditions,<sup>41</sup> with first onset of such conditions often taking place in individuals' late teens or early twenties.<sup>42</sup> EPSDT provides an opportunity to identify these and other significant health conditions when they first occur, allows for early intervention, and can dramatically improve health outcomes. Eliminating EPSDT for this age group will lead to unmet care needs, especially among young adults with disabilities, leaving these individuals without necessary services that could help prevent more serious and costly conditions as they age.

#### ***Presumptive Eligibility and Retroactive Coverage***

Oklahoma also seeks to eliminate presumptive eligibility and retroactive coverage, both of which protect states against uncompensated care costs and ensure prompt access to

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<sup>41</sup> Substance Abuse and Mental Health Services Administration, Results from the 2016 National Survey on Drug Use and Health: Mental Health Detailed Tables, Adult Mental Health Tables, Table 8.1B, <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs2016.htm#lotsect9pe>.

<sup>42</sup> Ronald Kessler et al., *Age of Onset of Mental Disorders: A Review of Recent Literature* 20 *Current Opinion in Psychiatry* 359–364 (2007), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1925038/>.

healthcare for Medicaid participants.<sup>43</sup> Evidence from states that have eliminated retroactive coverage illustrates how these waivers cause widespread coverage loss and create significant problems for health care providers.<sup>44</sup> Given the higher healthcare costs typically borne by people with disabilities, they will almost undoubtedly be disproportionately affected by the elimination of these eligibility and coverage protections.

### ***Prescription Drug Coverage***

The State's request for flexibility to adopt a commercial-style closed formulary for its prescription drugs at some time in the future without seeking additional CMS approval is particularly concerning for people with disabilities.<sup>45</sup> Such a formulary could allow the State to cover as little as one drug per therapeutic class and/or limit access to life-saving or life-changing medications until it deems them cost-effective, which would disproportionately impact people with relatively rare health conditions for whom new treatments are often very expensive. A limited prescription drug formulary is likely to have limited effect in terms of cost-saving,<sup>46</sup> and could seriously harm many disabled beneficiaries who may not be able to tolerate or benefit from the drug covered in a particular therapeutic class. Even if the State were to include an exceptions process, the bureaucratic barrier to accessing necessary medications that would create is likely to lead to confusion and lack of access to those necessary treatments among many beneficiaries, which can lead to serious health consequences. One survey across ten states found that nearly half of Medicaid-enrolled people with psychiatric disabilities had difficulty accessing clinically-indicated medication in the previous year, and those enrollees were 3.6 times more likely to experience an adverse event than enrollees who did not have problems accessing their medication.<sup>47</sup> A closed prescription drug formulary would only worsen the disparities that people with disabilities face in access and health.

Furthermore, Section 1115 permits the Secretary to waive only requirements in § 1396a of the Social Security Act. The statutory authority for Medicaid formulary protections lies outside § 1396a. The Secretary lacks the authority to approve the State's request for "flexibility" to impose unilaterally an undefined closed formulary at some future date.

### **HHS does not have the authority to grant Oklahoma's request for undefined, sweeping authority to make changes to many of the proposed SoonerCare 2.0 program elements**

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<sup>43</sup> Georgia Application 5, 10.

<sup>44</sup> MaryBeth Musumeci and Robin Rudowitz, *Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers, and States* (Kaiser Family Foundation, November 2017), <https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/>.

<sup>45</sup> Oklahoma Application 27.

<sup>46</sup> Joyce C. West et al., *Medicaid Prescription Drug Policies and Medication Access and Continuity: Finding from Ten States*, 60 *Psychiatric Services* 601, 601-602 (2009).

<sup>47</sup> *Id.* at 608.

**without seeking additional CMS approvals via State Plan Amendments or demonstration amendments.**<sup>48</sup>

The State requests flexibility to, at its discretion and without seeking additional federal approval, increase required premiums up to five percent of household income,<sup>49</sup> adjust the work hour requirements or modify the work requirement exemptions and qualifying activities,<sup>50</sup> make changes to the prescription drug benefit (including the option to implement a limited prescription drug formulary),<sup>51</sup> and adjust the \$8 copay for non-emergency use of the emergency department.<sup>52</sup> There is next to no detail from Oklahoma that would help stakeholders determine how the State plans to use that authority, why it believes such authority to be necessary, and how it may impact beneficiaries. Approval of this requested authority would allow the State illegal and unprecedented flexibility to impose increased costs and restrictions on eligibility or benefits without federal oversight. Congress did not intend to give HHS the authority to grant states such broad exemptions from federal oversight.

Oklahoma's request for unprecedented flexibility and restrictive policies that do not promote the objectives of the Medicaid program would place low-income Oklahomans, and particularly Oklahomans with disabilities, at risk. While we support the expansion of Medicaid under the ACA, Oklahoma fails to provide any evidence that Medicaid expansion under a per capita spending cap and the other restrictive policies included in the waiver would serve the objectives of Medicaid more effectively than a traditional Medicaid expansion program without such policies. The requested lack of federal oversight and reporting requirements and the corresponding limitations on public comment place alarming restrictions on the opportunities beneficiaries and other stakeholders, including people with disabilities, their families, and service providers, will have to address issues and few assurances that Oklahoma will continue to meet their needs. We ask that you reject this proposal.

Sincerely,



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<sup>48</sup> Oklahoma Application 10, 15, 27, 35.

<sup>49</sup> *Id.* at 10.

<sup>50</sup> *Id.* at 15.

<sup>51</sup> *Id.* at 27.

<sup>52</sup> *Id.* at 35.