



Max Richtman, Chair

June 26, 2020

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

Submitted via Medicaid.gov

Dear Secretary Azar:

The undersigned members of the Leadership Council of Aging Organizations (LCAO) urge the Centers for Medicare and Medicaid Services (CMS) to reject the proposed SoonerCare 2.0 Healthy Adult Opportunity Section 1115 Demonstration Application. The application is vague, inaccurate, incomplete, and contrary to Medicaid law. Furthermore, approval of the application would be inappropriate and beyond the scope of the authority of the Secretary of the U.S. Department of Health and Human Services (HHS).

LCAO is a coalition of national nonprofit organizations concerned with the well-being of America's older population and committed to representing their interests in the policy-making arena. The coalition serves as a source of information about issues affecting older adults and provides leadership and vision as the United States works to meet the opportunities and challenges associated with our aging society. LCAO member organizations have expertise in health care, economic security, nutrition and food security, housing, elder justice, and other issues facing older adults and people with disabilities. Much of the work of LCAO members focuses on preserving and strengthening Medicaid.

Now more than half a century old, the Medicaid program is a tremendous success story, particularly for older adults. Thanks to Medicaid, millions of Americans with low incomes have access to needed health care and greater economic security.

The Medicaid program's central objective is to provide health insurance coverage to individuals and families with low incomes.¹ The purpose of Medicaid 1115 demonstrations is to approve "experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the

¹ Gresham v. Azar, 950 F.3d 93 (D.C. Cir. 2020).

objectives of the Medicaid program.”² Therefore, demonstrations that do not support Medicaid’s central objective must be rejected.

Oklahoma submitted a deeply flawed Healthy Adult Opportunity (HAO) Section 1115 Demonstration application to HHS.³ We believe that the Administration lacks the legal authority to accept this application as is. In the application, Oklahoma has claimed that adults between the ages of 19 and 64 with incomes up to 133 percent of the federal poverty level would be a covered population effective July 1, 2020.⁴ However, Oklahoma has since withdrawn the State Plan Amendment that would have enabled that expansion.⁵ This action renders the SoonerCare 2.0 application both inaccurate and incomplete.

The SoonerCare 2.0 demonstration would implement a per-capita cap on the state’s Medicaid program. However, the application is extremely vague, missing key information that would allow for specific and detailed feedback. For example, we cannot offer meaningful comments on Oklahoma’s request to use per-capita caps because the proposal provides almost no information about the funding transformation the state seeks. Moreover, the proposal does not explain how the program transformation would affect stakeholders such as beneficiaries and health care providers. This lack of detail does not provide true notice to the public—including older adults, people with disabilities, and aging and disability advocates—to comment in response. Accordingly, we strongly urge the Administration to reject Oklahoma’s application as inaccurate and incomplete.

Although we lack information about the specific per-capita cap proposals in the SoonerCare 2.0 application, we can address the harms of capped Medicaid funding generally. Implementing a per-capita cap would eliminate the federal Medicaid guarantee of coverage. Block granting or capping federal Medicaid funding, as outlined in the HAO, would lead to significant cuts in the federal share of Medicaid over time—resulting, in turn, in commensurate cuts in state Medicaid spending and benefits and, possibly, to limits on the number of beneficiaries eligible for Medicaid coverage. As these cuts unfold, older adults enrolled in Medicaid would likely be significantly and adversely affected.

Capped federal Medicaid funding also creates major financial risk for states and removes states’ accountability to provide the coverage Medicaid is explicitly designed to provide. Once the capped funds fall short, states would start rolling back, without federal oversight, coverage for older adults, people with disabilities, and families. A recent Commonwealth Fund study of the HAO’s impact on states found

² Medicaid.gov, “About Section 1115 Demonstrations” (last accessed June 8, 2020), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html>.

³ Oklahoma Health Care Authority, “SoonerCare 2.0 Healthy Adult Opportunity (HAO) Section 1115 Demonstration Application” (last accessed June 8, 2020), https://1115publiccomments.medicaid.gov/jfe/form/SV_ai0xoKWT9eelJsN.

⁴ See, e.g., Oklahoma Health Care Authority, “SoonerCare 2.0 Healthy Adult Opportunity (HAO) Section 1115 Demonstration Application,” p. 17 (last accessed June 8, 2020), https://1115publiccomments.medicaid.gov/jfe/form/SV_ai0xoKWT9eelJsN.

⁵ Associated Press, “Oklahoma Scraps Plan to Expand Medicaid on July 1” (May 29, 2020), <https://www.usnews.com/news/best-states/oklahoma/articles/2020-05-29/oklahoma-scraps-plan-to-expand-medicaid-on-july-1>.

that a median state would face a reduction of 5.7 percent in fiscal year 2021, growing to 14.6 percent by fiscal year 2025.⁶ The same study examined various scenarios associated with the HAO demonstration model and predicted even larger reductions in federal funding to states.

As the unprecedented COVID-19 public health emergency so clearly demonstrates, states often face significant financial problems when public emergencies arise. Implementation of Medicaid block grants or per-capita caps would exacerbate these financial problems far beyond the capacity of any state. Intense financial pressure from a public health crisis like COVID-19 leads states to cut, first, the most costly and “optional” services, including the home- and community-based services critical for many older adults and people with disabilities. Capping funding for one part of the Medicaid program would only increase this strain and increase the likelihood of cuts to lifesaving services, especially during times of crisis.

Caps significantly weaken both the federal government’s financial commitment to care for the nation’s most at-risk populations and the long-term viability of state Medicaid programs. Ultimately, we believe that altering the program’s fundamental structure in this way would jeopardize Medicaid’s role both as the largest insurance payer for long-term services and supports (LTSS) and as a critical support for millions of beneficiaries. Doing so would jeopardize access to affordable health care and LTSS for millions of older adults, people with disabilities, and families—most especially Black, Indigenous, and other people of color—who rely on the program.⁷

Finally, we believe the Administration lacks the legal authority to waive Medicaid’s financing structure through the 1115 waiver process. A fundamental change to Medicaid’s structure of this magnitude and in this manner would require an act of Congress; yet, Congress recently rejected, on a bipartisan basis, proposals to cap Medicaid.

In addition to the ruinous caps, Oklahoma’s application also seeks to impose work requirements; increase premiums and cost sharing; eliminate retroactive coverage, hospital presumptive eligibility, and nonemergency medical transportation; and limit LTSS benefits. None of these proposed changes would promote Medicaid’s central objective. On the contrary, they would amount to coverage cuts.

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

⁷ For example, “[t]he proportion of dually eligible beneficiaries who are of a minority race/ethnic group increased from 41.1 percent in 2006 to 47.5 percent in 2018. Compared to Medicare-only beneficiaries, the dually enrolled population continues to be more racially and ethnically diverse. For instance, in 2018, 47.5 percent of dually eligible beneficiaries and 21.1 percent of Medicare-only beneficiaries were of a racial or ethnic minority group. More specifically, among dually eligible beneficiaries, 20.4 percent were Black/African American; 17.8 percent were Hispanic/Latino; 6.4 percent were Asian/Pacific Islander; 0.9 percent were American Indian/Alaska Native; and 0.7 percent were “other” race/ethnicity groups.” CMS Medicare-Medicaid Coordination Office, Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2018 (Sept. 2019), <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2018.pdf>

Additionally, past HHS approval of work requirements in several states has been shown to be an arbitrary and capricious overstepping of Secretarial authority.⁸

Linking work reporting requirements with Medicaid eligibility and eliminating coverage of LTSS would be especially harmful to older adults ages 50 through 64, to people with disabilities and chronic health conditions who do not qualify for Medicaid on the basis of disability, and to family caregivers. These populations face additional barriers to work and have higher health care needs. Similarly, eliminating retroactive coverage protections and hospital presumptive eligibility, especially in combination, would put even more older adults and families at risk of incurring crushing medical debt and being unable to access necessary health care.

In summary, these LCAO members strongly oppose SoonerCare 2.0 and urge the Administration to reject Oklahoma’s application in its entirety. We also urge HHS to rescind fully the deeply flawed HAO guidance on which SoonerCare 2.0 is based. Although the HAO initiative promises states “flexibility,” it would—as the COVID-19 pandemic has so clearly demonstrated—surely lead to catastrophic implications for state budgets, Medicaid programs, and our communities. We implore you, instead, to strengthen the Medicaid program in ways that protect the older adults, people with disabilities, and families that rely on Medicaid for health care and LTSS.

Sincerely,

AFL-CIO
AFSCME
Aging Life Care Association
Alliance for Aging Research
Alliance for Retired Americans
American Society on Aging
Association of Jewish Aging Services
Center for Medicare Advocacy
Community Catalyst
Families USA
The Gerontological Society of America
International Association for Indigenous Aging
The Jewish Federations of North America
Justice in Aging
LeadingAge
Lutheran Services in America
Medicare Rights Center
National Academy of Elder Law Attorneys
National Adult Day Services Association (NADSA)
National Adult Protective Services Association
National Association of Area Agencies on Aging
National Association of Nutrition and Aging Services Programs (NANASP)
National Association of Social Workers (NASW)

⁸ Gresham v. Azar, 950 F.3d 93 (D.C. Cir. 2020).

National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Council on Aging
National Indian Council on Aging
National Senior Corps Association
Service Employees International Union
Social Security Works