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Families USA appreciates the opportunity to provide comments on Oklahoma's proposed SoonerCare 2.0 Healthy Adult Opportunity Section 1115 demonstration waiver. Families USA is a national, non-partisan health care policy and advocacy organization that supports policies and programs at the state and federal levels to ensure the best health and health care are equally accessible and affordable to all, with a particular focus on actions that affect lower-income individuals. Please note that in addition to my current role at Families USA, I was formerly the Health Division Director at the bipartisan National Governors Association's Center for Best Practices, where I worked with governors of both parties to improve their Medicaid programs.

This proposed 1115 waiver includes multiple elements that are both legally problematic and poor policy choices for the state, especially during the current COVID-19 public health crisis. Oklahoma Health Care Authority should dedicate its staff time and resources to ensuring everyone in the state can access testing and treatment instead of pursuing a waiver that will limit coverage.

We support Oklahoma's decision to accept federal funds to expand Medicaid coverage; however, Oklahoma does not need a waiver and does not need to wait until July to implement expansion. In fact, pursuing this waiver will jeopardize Oklahoma's ability to receive those enhanced expansion funds because the state must comply with the requirements of Medicaid law. Much of this waiver request fails to meet that test. Therefore, we encourage the Oklahoma Health Care Authority (OHCA) not to submit its application for this waiver and instead work with the Centers for Medicare and Medicaid Services (CMS) to expand Oklahoma's Medicaid program immediately in response to the COVID-19 public health crisis. The elements of the waiver request that fail to meet federal requirements are discussed in greater detail below.

### **Comments on Specific Provisions in the Amendment Request**

#### ***1. Per Capita Cap on Federal Funding***

As part of the misleadingly named "Healthy Adult Opportunity," OHCA is proposing to set a "per capita cap" that limits the amount of federal funding available to the state depending on the number of enrollees in the waiver. Under this per capita cap funding arrangement, the state will have much less financial flexibility and is at significantly greater financial risk. The state receives a 90 percent federal matching rate only for Medicaid spending below the limit set by the cap, and if spending exceeds the per capita cap, the state will be fully responsible for covering the additional costs. The state would be more likely to exceed the per capita cap in a scenario such as the current COVID-19 public health crisis, with insufficient protections for Oklahomans.

The proposed per capita cap funding arrangement is fundamentally different than the arrangement for a straightforward Medicaid expansion, as proposed in the State Plan Amendment OHCA submitted to CMS on March 6, 2020. Under a straightforward Medicaid expansion, the state will receive the enhanced 90 percent federal medical assistance percentage (FMAP) regardless of enrollment levels or per-enrollee cost. In other words, for every one dollar the state spends on Medicaid, the federal government contributes nine dollars, no matter how many people enroll or how much the state spends per enrollee. This funding arrangement provides the state and taxpayers a level of financial security to ensure that, as Medicaid spending fluctuates from year to year, the state and its taxpayers are not made solely responsible for covering any increased costs. During a public health emergency, such as the current COVID-19 crisis, when spending per enrollee is atypical, it is especially important to have the financial security and flexibility provided by a straightforward Medicaid expansion. Under the traditional funding arrangement, the state can spend what is needed on Medicaid knowing that its match rate is fixed in statute and not capped.

**The state will not save money or increase federal funding under the proposed per capita cap.**

OHCA is entrusting CMS to set the per capita cap based on nonexistent per member per month costs. As a non-expansion state with no historical claims data for this new eligibility group, CMS will arbitrarily set a cap. There is no reason to expect this arbitrary per capita to be generous, since it will be set by an administration that has repeatedly tried to cut trillions of dollars in federal Medicaid funding to states by capping federal obligations. In addition, the annual increase in the capped amount is unlikely to keep up with the real cost of care, compounding the risk to the state year over year and increasing the state dollars spent on healthcare.

As a non-expansion state with no historical claims data, Oklahoma will be required to spend at least two years in the per capita cap option to before the state will have the ability to generate any savings under that aggregate cap. After generating at least two years of historical data, the state could potentially pursue an aggregate cap, which is an even riskier financing option where the state relinquishes financial protections associated with upward fluctuations in enrollment. This is especially risky during a public health crisis and economic downturn when enrollment in Medicaid increases. If enrollment increases to a point at which total spending exceeds the aggregate cap, then the state will be forced to cover all additional costs above the cap.

Even after implementing an aggregate cap, the state may also not be eligible for shared savings in the third year of the waiver because it would be the first year of the aggregate cap, especially if the two years of historical data are unreliable due to uncharacteristic enrollment and utilization due to COVID-19. The fourth year may be the first and only year in which the state could potentially generate savings. CMS does not offer shared savings in the fifth and final year of the demonstration, unless the state renews its demonstration.

As detailed in our earlier analysis of CMS's "Health Adult Opportunity" guidance, state spending under a traditional Medicaid expansion would result in a greater federal contribution for the Medicaid

population than state spending under the proposed aggregate or per capita cap arrangements, even under the best case-scenario for capped financing.<sup>1</sup> Rather than gambling with a more complicated and riskier capped arrangement, the state should simply pursue expansion with a traditional federal match rate to maximize the federal funding for expansion. This can be accomplished without an 1115 waiver by simply implementing Medicaid expansion as requested in the state’s recently submitted State Plan Amendment.

**The per capita cap funding arrangement is illegal and will likely be challenged and blocked in court.**

The federal courts have found that Medicaid waivers, limited to “promoting the objectives” of Medicaid in Section 1115 of the Social Security Act, must actually promote Medicaid coverage to be approvable under the statutory waiver authority. A demonstration that effectively limits federal funding and relies on new extra-statutory state authorities to cut Medicaid benefits and eligibility manifestly fails to meet that standard.

The Medicaid Section 1115 waiver authority only allows waivers of some provisions of Medicaid law under Title XIX of the Social Security Act. Section 1115 authority cannot be used to waive the statutory sections governing federal match to states, including Section 1903 of the Social Security Act, which defines the federal financial matching rate. The principle that CMS can’t waive federal match has always been a fundamental guardrail for Medicaid waivers. Indeed, changing the financing structure of Medicaid would require congressional authority.

Oklahoma will not avoid these legal issues by requesting a different waiver authority — Section 1115(a)2, which allows states to make some non-Medicaid expenditures eligible for Medicaid match if they promote the objectives of the program. This provision is clearly intended to allow CMS to add new Medicaid benefits and programs, not to impose a per capita cap on federal funding and limit eligibility and benefits.

## **2. Work Reporting Requirements**

Following in the misguided footsteps of other states, the proposed waiver requires non-exempt beneficiaries to report their participation in “qualifying activities” related to work. As evidenced by other states, these work reporting requirements are confusing and onerous for patients and providers, administratively burdensome and costly for the state, and –per multiple federal court decisions to date – illegal.

In its application, OHCA acknowledges that, based on other states’ experiences, the work reporting requirement “will likely depress enrollment” and assumes a 5% decrease in enrollment among the expansion population. In the same application, OHCA also notes that it “does not anticipate substantial enrollment decreases” related to the waiver. But, as evidenced in the state’s application, even a 5% decrease in enrollment would result in 7,595 newly eligible beneficiaries losing coverage in the first year of the waiver. A substantial coverage loss to be sure.

OHCA is right to look to other states’ experiences, which demonstrate substantial coverage losses as a result of similar work requirement waivers. In Arkansas, the only state to begin enforcement of its work

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<sup>1</sup> [https://familiesusa.org/wp-content/uploads/2020/02/MCD\\_CMS-Guidance-on-Block-Grants\\_Analysis.pdf](https://familiesusa.org/wp-content/uploads/2020/02/MCD_CMS-Guidance-on-Block-Grants_Analysis.pdf)

reporting requirement, over 18,000 beneficiaries lost coverage within the first seven months of the waiver. In New Hampshire, despite extensive efforts to inform beneficiaries of the work reporting requirement, the state failed to obtain compliance information for nearly 17,000 beneficiaries who were at risk of losing coverage, prompting the state to suspend its work reporting requirements.<sup>2</sup> In Michigan, 100,000 beneficiaries were projected to lose coverage before a U.S. District Court Judge blocked the work requirement.<sup>3</sup> Based on other states' experiences, Oklahoma's proposed work requirements will more likely result in a decrease in enrollment ranging from 15% to 45%, which amounts to approximately 22,500 to 67,500 beneficiaries losing coverage.<sup>4</sup>

Moreover, Oklahoma would be taking on an additional and unprecedented risk since no other state has an active work requirement program during this current public health crisis. Utah, which implemented a Medicaid work reporting requirement in January 2020, has suspended the program due to the COVID-19 crisis. There is reason to believe that coverage losses related to the work reporting requirement could be exacerbated by the crisis and exceed the projections from other states. The COVID-19 public health crisis has already devastated the job market. During this public health crisis and the persisting economic downturn, fewer Oklahomans will be able to find jobs or work for the number of hours necessary to comply with the work reporting requirement. As a result, they will lose Medicaid coverage during a time they need it the most.

#### **A work reporting requirement is contrary to Medicaid law.**

Section 1115 of the Social Security Act gives the Secretary the authority to "waive compliance with any of the requirements of section [...] 1902" of the Social Security Act for any experimental, pilot, or demonstration project which, in the judgment of the Secretary, "is likely to assist in promoting the objectives of title [...] XIX."<sup>5</sup>

Medicaid's objectives are outlined in Section 1901 of the Social Security Act. It states that federal Medicaid dollars are for the purpose of enabling states "to furnish (1) medical assistance on behalf of [statutorily eligible individuals], and (2) rehabilitation and other services to help such [individuals] attain or retain capability for independence or self-care...."<sup>6</sup> In the context of the statute, it is absolutely clear that "independence or self-care" refers to federal funding enabling states to provide care that can help individuals attain or retain physical independence.

While HHS has updated its Medicaid.gov website to redefine the objectives of the Medicaid program, that has no legal import. Statutory language has precedence over any website language, no matter how official the website.

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<sup>2</sup> <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/granite-advantage-health-care-program/nh-granite-advantage-health-care-program-temp-delay-20190709.pdf>

<sup>3</sup> <https://www.courthousenews.com/wp-content/uploads/2020/03/gordon-declaration.pdf>

<sup>4</sup> This projection is based on The Commonwealth Fund's analysis of nine states' work reporting requirement programs. [https://www.commonwealthfund.org/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-coverage?redirect\\_source=/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-medicaid](https://www.commonwealthfund.org/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-coverage?redirect_source=/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-medicaid)

<sup>5</sup> Social Security Act, section 1115 [42 U.S.C. 1315].

<sup>6</sup> Social Security Act Sec. 1901. [42 U.S.C. 1396].

- A work reporting requirement is unrelated to Medicaid’s objectives as defined in statute. The language in the statute is clear. Federal Medicaid dollars are to be used to *furnish* medical, rehabilitation, and long-term services. Requiring work or community service as a condition of coverage is not in any way related to the *state furnishing* medical services or to the *state furnishing* rehabilitative or other services—indeed it achieves the opposite goal by withdrawing medical services from otherwise eligible low-income people if they do not meet the work reporting requirement. It is therefore outside of CMS’s authority to approve under section 1115 authority.

In his ruling to vacate the approval of Arkansas’ work reporting requirement, Judge Boasberg affirmed that a work reporting requirement is unrelated to Medicaid’s objectives. Boasberg ruled that, “the Secretary’s approval of the Arkansas Works Amendments is arbitrary and capricious because it did not address – despite receiving substantial comments on the matter—whether and how the project would implicate the “core” objective of Medicaid: the provision of medical coverage to the needy.”<sup>7</sup> Judge Boasberg’s decision was challenged in the U.S. Court of Appeals, where a three-judge panel unanimously ruled to uphold the decision to vacate the approval, affirming that “the Secretary’s approval of Arkansas Works was arbitrary and capricious.”<sup>8</sup>

Similarly, Judge Boasberg ruled in his decision to vacate the approval of New Hampshire’s work reporting requirement, “Medicaid, both as enacted and as later expanded by the ACA, reflects Congress’s desire to ‘mak[e] healthcare more affordable’ for ‘needy populations.’ ... Congress therefore designed a scheme ‘to address not health generally but the provision of care to needy populations.’ ”<sup>9</sup>

- Adding a work reporting requirement is beyond the Secretary’s authority to “waive” requirements in section 1902. Section 1115 gives HHS the authority to waive requirements in Section 1902. It does not allow states to add new program requirements that are not mentioned in 1902 and that are unrelated to the program’s statutory purpose of furnishing medical or rehabilitative services.<sup>10</sup> Section 1902 does not mention engaging in work or community service. States do not have the authority to add new requirements unrelated to the program’s objective of *furnishing* medical care.
- A mere nexus between an activity and health is not a sufficient basis for the Secretary to use 1115 authority to make Medicaid eligibility conditional upon participation in that activity. In its proposal, OHCA states that, by implementing the work reporting requirement, it “promotes a broader concept of individual wellness by encouraging personal and professional development.”<sup>11</sup> However, the mere connection between an activity and health status is not a basis for making receipt of Medicaid benefits conditional upon an individual’s participation in that activity. There are numerous activities

<sup>7</sup> [https://ecf.dcd.uscourts.gov/cgi-bin/show\\_public\\_doc?2018cv1900-58](https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58), page 26.

<sup>8</sup> <https://healthlaw.org/wp-content/uploads/2020/02/Gresham-v.-Azar-DC-Circuit-Ruling-Feb-14.pdf>

<sup>9</sup> [https://ecf.dcd.uscourts.gov/cgi-bin/show\\_public\\_doc?2019cv0773-47](https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv0773-47), page 24.

<sup>10</sup> Social Security Act, section 1115 [42 U.S.C. 1315].

<sup>11</sup> <https://www.okhca.org/soonerare2/>, page 6 of “Healthy Adult Opportunity (HAO) Demonstration Waiver Application.”

that have been shown to improve physical and mental health. Diet<sup>12</sup>, exercise<sup>13</sup>, marital status<sup>14</sup>, and social engagement<sup>15</sup> are only a few of the nearly endless activities that can impact individual health. It is gross regulatory overreach and a misuse of federal and state funds to add extra-statutory conditions that are not within the program's objectives simply because one or more of those activities have been shown to be related to individual health.

Medicaid is a program to furnish medical assistance: it is a health *insurance* program. Health insurance protects people from financial loss associated with medical costs. That is not synonymous with health. That distinction holds true for Medicaid, Medicare, employer sponsored coverage, and any health insurance program. Following a path of adding reporting requirements to Medicaid simply because they arguably promote health is far beyond the program's objectives and could turn the program into a virtual a la carte menu of extra-statutory requirements approved at any administration's whim. It sets up a dynamic that could lead to near unending government micromanagement of the lives of Medicaid enrollees.

Judge Boasberg affirmed that promoting health is not a freestanding objective of Medicaid in his ruling to vacate the approval of Kentucky's work reporting requirement waiver. In his decision, Boasberg notes that, were health to be considered a freestanding objective of Medicaid, "nothing would prevent the Secretary from conditioning coverage on a special diet or certain exercise regime."<sup>16</sup> He also notes that, "Even if health were such an objective, approving Kentucky HEALTH on this basis would still be arbitrary and capricious."<sup>17</sup> If approved, the same could be said for Oklahoma's proposal to add a work reporting requirement.

Like the work requirement waivers in other states, if approved, this waiver will be vulnerable to legal challenges. To date, five of the states (KY, AR, NH, IN, and MI) that have implemented work reporting requirement waivers have had the approvals of these waivers challenged in court. In four of those states

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<sup>12</sup> See the U.S. Dietary Guidelines, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, for an overview of the near endless number of studies looking at the relationship between diet and health, at <https://health.gov/dietaryguidelines/2015/guidelines/introduction/nutrition-and-health-are-closelyrelated/>.

<sup>13</sup> See the U.S. Physical Activity Guidelines, Office of Disease Prevention and Health Promotion, Department of Health and Human Services, for an overview of the near endless number of studies looking at the relationship between physical activity and health, at <https://health.gov/paguidelines/>

<sup>14</sup> For a summary of the copious data on this topic, see the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, The Effects of Marriage on Health: A Synthesis of Recent Research Evidence. Research Brief, 7/01/2007 online at <https://aspe.hhs.gov/report/effects-marriagehealth-synthesis-recent-research-evidence-research-brief>.

<sup>15</sup> For a summary of the data on the connection between social relationships and health see Debora Umberson, et al., "Social Relationships and Health: A Flashpoint for Health Policy," Journal of Health and Social Behavior, 2010; 51 (Suppl): S55-S66, online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3150158/>.

<sup>16</sup> [https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0\\_2.pdf](https://www.courtlistener.com/recap/gov.uscourts.dcd.192935/gov.uscourts.dcd.192935.132.0_2.pdf), page 27.

<sup>17</sup> *Idem*, page 28.

(KY<sup>18</sup>, AR<sup>19</sup>, NH<sup>20</sup>, and MI<sup>21</sup>) the court has vacated approval of the work requirements. In IN, the state has suspended its work requirement and legal proceedings have been stayed due the COVID-19 crisis.

### **A work reporting requirement will cost millions of dollars to implement.**

In October 2019, the United States Government Accountability Office (GAO) released a report that included five states' estimates of the administrative costs associated with implementing their approved work reporting requirement waivers.<sup>22</sup> Estimated costs were as much as \$271 million for IT systems changes, beneficiary outreach, contracting and other administrative costs.<sup>23</sup> Much of these costs do not appear to be allowable for enhanced federal match and would therefore require significant state spending. Despite the astronomical costs associated with implementing these waivers, the GAO found that states were not required to provide projections of administrative costs when requesting approval of these waivers.<sup>24</sup> Therefore, in the interest of transparency with regards to state and federal spending, we request that CMS require the state to provide projections of administrative costs associated with implementing this waiver.

### **3. Premiums and Copayments**

In a purported attempt to “enhance alignment between Medicaid policies and the commercial health insurance market,” the state is also proposing to require beneficiaries whose income exceeds the parent/caretaker standard to pay monthly premiums. Beneficiaries who do not pay premiums within a three-month grace period will have their coverage terminated. Medicaid beneficiaries are financially strained already.<sup>25</sup> Forcing them to spend what little money they have left on premiums can make their health care unaffordable.

The state is also proposing an additional copayment of \$8 for non-emergency use of the emergency department (ED). Similar provisions have historically been difficult to implement compared to other less punitive strategies to divert unnecessary utilization of the ED. Additionally, high surcharges for non-emergent use of the ED could deter individuals from appropriate use of emergency services, in addition to inappropriate use. During a public health crisis, where numerous states are waiving premiums altogether, it is absurd for Oklahoma to propose this policy that would deter people from getting the health care they need to keep themselves and their communities safe.

### **4. Eliminating hospital presumptive eligibility and retroactive eligibility**

The state is proposing to waive presumptive eligibility, which helps patients get health care as soon as they arrive at the hospital and ensures that doctors and hospitals are reimbursed for that care. By

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<sup>18</sup> [https://ecf.dcd.uscourts.gov/cgi-bin/show\\_public\\_doc?2018cv0152-74](https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv0152-74)

<sup>19</sup> [https://ecf.dcd.uscourts.gov/cgi-bin/show\\_public\\_doc?2018cv1900-58](https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58)

<sup>20</sup> [https://ecf.dcd.uscourts.gov/cgi-bin/show\\_public\\_doc?2019cv0773-47](https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv0773-47)

<sup>21</sup> <https://www.mlive.com/public-interest/2020/03/us-district-court-blocks-michigans-medicaid-work-requirements.html>

<sup>22</sup> <https://www.gao.gov/assets/710/701885.pdf>

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> <https://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty>



waiving presumptive eligibility, the state would create additional barriers for uninsured patients who receive care at hospitals and are eligible for Medicaid.

The state is also proposing to waive retroactive eligibility, which will make beneficiaries responsible for the entire cost of all care they received prior to their date of enrollment, even if they could have been determined eligible during their care visit or retroactively after receiving care.<sup>26</sup> Retroactive coverage keeps individuals from incurring high medical bills and medical debt by covering the medical bills they incurred in the three months before being determined eligible for Medicaid. Retroactive coverage also encourages doctors and hospitals to treat uninsured Medicaid eligible patients, because they will be compensated for the services they provided once the individual is enrolled.

By waiving both retroactive and presumptive eligibility, the state eliminates a vital pathway for hospitals to be reimbursed after caring for low-income, uninsured patients and for uninsured patients to avoid crippling financial liabilities. During a public health crisis, where numerous states are expanding their presumptive eligibility programs, it is wrongheaded for Oklahoma to propose this policy that limits the state's ability to enroll people into coverage at common points of care.

#### **5. Waiver of Early and Periodic Screening, Diagnostic, and Treatment Benefits**

OHCA is also proposing to eliminate Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits, which covers items such as vision and hearing screening and treatment (e.g., glasses or hearing aids), basic dental, medical, mental health, and developmental services for children and young adults.<sup>27</sup> Young adults ages 19 and 20 who are newly eligible for Medicaid as part of expansion will not be able to these vital benefits.

Congress designed Medicaid with the EPSDT requirement because low-income children and young adults have a distinct need for comprehensive care in order to lead healthy lives. Extending EPSDT to age 21 is critical. The brain does not develop fully until children reach about age 25.<sup>28</sup> As a result, young adults benefit from frequent screenings and access to comprehensive treatment as their medical needs, particular mental health needs, continue to change. Furthermore, EPSDT is cost effective. EPSDT provides sweeping benefits for all Medicaid enrollees under age 21, but it is not a high-cost service. Removing the EPSDT benefits for 19- and 20-year-olds would not produce large savings, and would make it more difficult for these young adults to receive the care they need.

#### **6. Waiver of Non-Emergency Medical Transportation**

The state's proposal to waive non-emergency medical transportation (NEMT) will limit beneficiaries' access to care and does not further the objectives of the Medicaid program. Medicaid's purpose is to provide low-income individuals with access to health care. The program's benefits were designed to address the unique needs of the low-income population. Among those unique needs is a greater need

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<sup>26</sup> <https://www.okhca.org/soonercares2/>, page 3 of "Healthy Adult Opportunity (HAO) Demonstration Waiver Application."

<sup>27</sup> <https://www.okhca.org/soonercares2/>, page 6 of "Healthy Adult Opportunity (HAO) Demonstration Waiver Application."

<sup>28</sup> Massachusetts Institute of Technology, Young Adult Development Project, online at <http://hrweb.mit.edu/worklife/youngadult/brain.html>.



for transportation assistance than among the privately insured population.<sup>29</sup> The NEMT benefit helps address that need, and helps Medicaid fulfill its purpose. By ignoring the unique transportation needs of the Medicaid population and omitting a standard benefit designed to address those needs, OHCA's proposed waiver does not further the objectives of the Medicaid program. Waiving the NEMT benefit would limit access to care for the population that Medicaid is intended to serve.

### **7. Waiver of Long-Term Care Services**

Similarly, the state's proposal to eliminate long-term care services will deprive especially vulnerable beneficiaries of a standard benefit designed to address their unique needs. Covering long-term care services in Medicaid helps beneficiaries avoid the especially high cost of these services. Home and community-based long-term care services can enable beneficiaries to get care in a more comfortable and less expensive setting. If beneficiaries cannot remain in their homes or communities, long-term care coverage allows low-income beneficiaries to get care in nursing homes and other assisted living facilities.

Many patients who receive ventilator support due to complications from COVID-19 will have long post-hospital home recovery times.<sup>30</sup> These patients will require home-based services to make a full recovery.

### **8. Managed Care Delivery System**

Families USA applauds OHCA for pursuing a managed care delivery system with value-based payment (VBP) methodologies. This approach holds the potential to improve outcomes for beneficiaries and reduce costs. However, this transition to VBP is complex and requires significant planning. Unfortunately, the limited information included in OHCA's application makes it difficult to assess the impact of this proposed delivery system reforms. Moreover, OHCA will need to expend significant staff resources to design, implement, and oversee these reforms – time that will be crowded out by this unnecessary per capita cap proposal.

Specifically, OHCA's application provides little detail beyond requesting flexibilities to create new payment methodologies that focus on behavioral health integration and care coordination, and contracting with a select network of providers. The application does not include specifics on the proposed payment methodologies or type of delivery system. The state does not identify any specific options for managed care flexibilities as outlined in the application template. In other words, it does not check any boxes in the template to indicate how managed care providers will be organized or paid.<sup>31</sup> The application does not indicate that the state will include PCCM entities or MCOs in its delivery system. The application indicates that payment methodologies could potentially include directed or

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<sup>29</sup> A study based on National Health Interview Survey data found that Medicaid enrollees were 10 times more likely to report that transportation was a barrier to accessing timely primary care than were people who were privately insured. P.T. Cheung, et al., "National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries," *Annals of Emergency Medicine* 60, no. 1 (March 2012): 4-10.

<sup>30</sup> <https://www.washingtonpost.com/health/2020/04/03/coronavirus-survivors-recovery/>

<sup>31</sup> <https://www.okhca.org/soonerare2/>, page 39 of "Healthy Adult Opportunity (HAO) Demonstration Waiver Application."

supplemental payments, but again, the application does not include details. OHCA should include more information on its proposed managed care delivery system in its application and re-open the state public comment period so the public has a chance to provide meaningful feedback on a more thorough proposal.

Additionally, OHCA's application does not include a timeline or implementation plan for implementing a managed care delivery system. Implementing the per capita cap simultaneously with the managed care delivery system transformation could result in major setbacks for the state. To most effectively implement a new managed care delivery system, the state will need to create consistency in enrollment and federal financing in order to set rates and get buy-in from managed care entities, which will be made more difficult if it is also planning to implement a per capita cap and limit eligibility and benefits one year after expansion. States like Arizona successfully implemented their managed care delivery systems and VBP approaches by dedicating time, planning, and human capital. They did not include managed care as an afterthought in an 1115 waiver application that creates a separate and brand new Medicaid financing arrangement. If OHCA is serious about effectively implementing managed care, then it should prioritize the development and implementation of its managed care delivery system over the senseless pursuit of a per capita cap.

### ***Conclusion***

Overall, OHCA's waiver application lacks a coherent, data supported rationale showing how approval of the waiver will further the objectives of the Medicaid program. In addition to proposals that limit coverage and access to care for beneficiaries and put the state at great financial risk, the state's application includes several requests that are simply not approvable based on statute and regulation. Therefore, OHCA should not submit this waiver to CMS for approval. Instead, it should focus its resources on responding to the COVID-19 public health crisis and securing approval of its pending State Plan Amendment to expand Medicaid.

Respectfully submitted,

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