AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: Oklahoma SoonerCare 2.0 Healthy Adult Opportunity Section 1115 Demonstration Application

Dear Administrator Verma:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to submit comments on the Oklahoma SoonerCare 2.0 Healthy Adult Opportunity (HAO) Section 1115 Demonstration Application. The waiver proposes to, among other things, place a per-capita cap on federal funding of Oklahoma's Medicaid expansion program and condition Medicaid eligibility on an individual's work and community engagement activities.

The AMA believes everyone deserves quality health care. As physicians, we regularly confront the effects of lack of access to adequate care and know that Medicaid is an important—and often the only—source of consistent care for low-income individuals. The medical literature demonstrates the importance of Medicaid coverage for improving the health and welfare of low-income patients, particularly when compared to uninsured patients. Medicaid coverage is associated with improved long-term health, lower rates of mortality, better health outcomes and fewer hospitalizations, better educational outcomes, and greater financial security.[1]

The AMA encourages policymakers to work together to identify realistic coverage options and, in doing so, believes it is important for states to develop and test new Medicaid models that best

[1] Benjamin Sommers, Katherine Baicker & Arnold Epstein, Mortality and Access to Care among Adults after State Medicaid Expansions, 367 New England Journal of Medicine 11, 1025-34 (Sep. 2012); Henry J. Kaiser Family Foundation, What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence (Aug. 2013); Alisa Chester & Joan Alker, Georgetown University Health Policy Institute Center for Children and Families, Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid (Jul. 2015).

meet the needs and priorities of low-income patients. While encouraging state flexibility, we emphasize the need for safeguards to protect low-income patients and emphatically support Medicaid's role as an indispensable safety net for the most vulnerable patients.

Per Capita Cap Financing Model

The AMA opposes caps on federal Medicaid funding and the per capita cap model proposed in the SoonerCare 2.0 demonstration. If the demonstration is approved and implemented, Oklahoma's Medicaid program will receive a fixed amount of federal funding based on enrollment in the demonstration and the medical inflation rate. Expenditures exceeding the allotted amount of federal funding will be the responsibility of the state. While the AMA supports flexibility in Medicaid and encourages the Centers for Medicare and Medicaid Services (CMS) to work with states to develop and test new Medicaid models, artificially limiting the growth of Medicaid expenditures will hinder Oklahoma's ability to address the health care needs of its most vulnerable citizens. We urge CMS to reject this model.

The current structure of Medicaid ensures that states can react to economically driven changes in enrollment, as well as increased health care needs driven by external factors, including natural disasters, public health emergencies, epidemics, or break-through treatments for serious medical conditions, such as hepatitis C. We fear that changing Medicaid's structure to a per-capita cap model will limit the ability of the state to respond to increased demand for certain services and force the state to limit coverage. Per capita caps fail to take into account unanticipated costs of new medical innovations or the fiscal impact of public health emergencies, the importance of which has been so starkly demonstrated in recent months by the 2019 novel coronavirus (COVID-19) pandemic. Per capita caps will curb Oklahoma's ability to respond to similar crises in the future.

Though the HAO program offers adjustments for "special circumstances" such as a public health crisis or major economic event, nothing in the HAO guidance or the SoonerCare 2.0 proposal describes what events would be eligible for exemption from the funding caps or guarantees that such adjustments will be made. While we recognize the inherent challenges in planning for the unforeseeable, we ask that, at a minimum, CMS detail circumstances for which the funding cap will not apply, such as when a public health emergency or state of emergency has been declared. Changes to the financing of Medicaid must guarantee it maintains its indispensable role as a dependable safety net able to respond quickly to changing circumstances.

The AMA is also concerned about how Oklahoma will use the funding it receives to advance the objectives of the Medicaid program. Unfortunately, the waiver proposal offers few details. The state claims that caps on spending "advance the triple aim of improving patient experience of care, improving the health of the population and reducing the per capita cost of health care." But the proposal offers no details about how that will be achieved. The proposal merely says the state will leverage care coordination and develop new value-based payment methodologies. We urge

CMS to require Oklahoma to further develop its plans so that stakeholders can meaningfully assess and comment on the proposal.

Community Engagement Requirements

We are also concerned that restrictive policies in the SoonerCare 2.0 Waiver requiring certain enrollees to participate in mandatory work, community engagement, education or volunteerism hours, i.e., provisions commonly known as work requirements, jeopardize the health and welfare of Medicaid patients. The AMA opposes work requirements as a condition of Medicaid eligibility as we believe that such requirements will negatively affect access to care and lead to significant negative consequences on individuals' health and well-being. As physicians, we are especially concerned about interrupting the continuity of care for our patients who are subject to the requirements and expect increased rates of churning in and out of the program. Studies have shown that most Medicaid enrollees were uninsured prior to enrollment and we are concerned that most will be uninsured again if their Medicaid coverage is terminated.[2] Employment status should not determine whether anyone receives the health care he or she needs.

That is why the AMA urges CMS to reject the proposed work requirements in the SoonerCare 2.0 waiver. If implemented, these provisions will cause otherwise eligible individuals to lose coverage and access to care, putting them at risk of harm. Instead of a focus on the number of hours worked or engagement in specific activities, we urge Oklahoma and CMS to focus on robust social supports to help move people out of poverty and into stable employment. Other states have successfully linked voluntary job training incentive programs with Medicaid, and we believe a similar incentive-based model would serve the interests of Oklahoma better than a punitive model. Allowing enrollees to maintain coverage and access the care they need to improve and maintain their health may itself improve employment rates. Medicaid expansion enrollees in other states report that having health coverage improves their ability to find and keep employment.[3] In contrast, research conducted in Arkansas—the only state that has fully implemented such eligibility restrictions—showed that the state's work requirements did not provide an additional incentive to work or increase rates of employment.[4] Arkansas's experiment with work requirements did, however, cause 18,000 people to lose coverage. We urge CMS to dispense with work and community engagement requirements as a condition of Medicaid eligibility.

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[2] Larisa Antonisse, Rachel Garfield, Robin Rudowitz & Samantha Artiga, Henry J. Kaiser Family Foundation, The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review (Mar. 2018).

[3] The Ohio Department of Medicaid, Ohio Medicaid Group VIII Assessment: A Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment (Aug. 2018); Kara Gavin, Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches, University of Michigan Health Lab (Jun. 27, 2017).

[4] Benjamin Sommers, Anna Goldman, Robert Blendon, et al., Medicaid Work Requirements—Results from the First Year in Arkansas, 381 New England Journal of Medicine 11, 1073-82

Retroactive Eligibility

The AMA strongly urges CMS to disapprove Oklahoma's request to waive 90-day retroactive Medicaid eligibility for SoonerCare 2.0 applicants. Retroactive eligibility is a vital element of the Medicaid safety net, designed to protect vulnerable, low-income patients from further financial hardship and encourage them to seek care when needed, rather than risk exacerbating a health condition by delaying care. This important provision compensates for errors and delays that frequently occur during the Medicaid enrollment process and protects against cost-shifting to providers who would otherwise be forced to absorb the cost of unpaid medical bills incurred by patients who are otherwise eligible for assistance.

Further, we are concerned that Oklahoma seeks waiver of this important protection as a solution to an unrelated problem. The waiver proposal seeks flexibility to eliminate the retroactive coverage period because the states have "found that many members transitioning from public to private coverage are confused by the start dates." We fail to see how retroactive eligibility, which is available to individuals only at the start of their enrollment, helps individuals when they terminate their enrollment and move to private coverage, nor do we agree that limiting this important financial protection aligns with the Medicaid Act's objectives to improve health and facilitate the provision of needed health care services.

Benefit Package

Oklahoma's application proposes to waive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for individuals ages 19 and 20. EPSDT guarantees access to critical screening and treatment services for patients at this age, a group that often experiences high rates of mental health conditions, substance use disorders (SUD), and sexually transmitted infections. EPSDT enables early detection and intervention of these conditions and helps prevent more serious and costly conditions later in adulthood. Continuity of coverage and care is particularly critical for patients with complex medical needs at this stage of life as they transition to higher education or join the workforce. Disruption in care could negatively impact their long-term health and economic security. We urge CMS to reject Oklahoma's request to waive the EPSDT benefit.

We are also concerned that the proposal seeks authority for the state to "investigate the potential benefits of a limited prescription drug formulary and request the flexibility to make changes to our prescription drug benefit, following appropriate advance notice procedures" but without submitting an additional waiver amendment. The AMA understands the need for managing limited budgets and the fiscal strain caused by rising prescription drug costs, but we caution against imposing unnecessary barriers to needed medications. Clinical decisions about the appropriate course of treatment should be made by a physician and patient together, based on the patient's best interest, not by program administrators focused more intently on cost than care. Moreover, implementing a limited drug formulary would represent a fundamental change to Medicaid's approach to prescription drug coverage and we are alarmed that Oklahoma wishes to

circumvent the usual federal administrative approval process that requires close examination of the impact of such changes to Medicaid patients. CMS should not permit Oklahoma to make such drastic policy changes without careful review and robust, detailed safeguards to ensure Medicaid patients will have access to the medications they need on a timely basis.

IMD Exclusion

Finally, we strongly support Oklahoma' plan to expand access to residential services provided in an institution for mental disease (IMD). While strides continue to be made to increase the number of physicians and other providers who can care for patients with mental illness and SUD in the outpatient setting, the existing limit on the size of inpatient facilities continues to hamper access to treatment in those settings. Moreover, at the same time that beds in freestanding psychiatric facilities and psychiatric units in general hospitals have declined in the past several years, the toll of the ongoing opioid epidemic has continued to result in unacceptable numbers of overdoses and death. While this is not a magic bullet and does not take the place of more needed investment in community-based treatment resources and access to all forms of medication assisted treatment for SUD, it is a step in the right direction. The AMA applauds Oklahoma and CMS for your efforts to make access to treatment services available to millions of individuals for whom treatment was previously out of reach.

The AMA appreciates the opportunity to provide our comments on the Oklahoma SoonerCare 2.0 waiver application. Please contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409 with any questions.

Sincerely,

James L. Madara, MD

cc: Oklahoma State Medical Association