FEDERAL AIDS POLICY PARTNERSHIP
HIV HEALTH CARE ACCESS WORK GROUP

June 27, 2020

Submitted via the Federal Medicaid.gov Portal

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comments for SoonerCare 2.0 1115(a) Research and Demonstration Waiver Amendment Request

To Whom It May Concern:

The HIV Health Care Access Working Group (HHCAWG) appreciates the opportunity to comment on Oklahoma's Sooner Care 2.0 Medicaid Section 1115 Demonstration Waiver Application (the "Oklahoma Application") under Section 1115 of the Social Security Act. HHCAWG is a coalition of over 100 national and community-based HIV service organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV- and Hepatitis C (HCV) related health care and support services.

The Medicaid program is a critical source of health coverage for life-saving care for people living with HIV. Forty-two percent of adults living with HIV are covered by Medicaid, compared to just 13% of the general population.[1] These individuals count on the Medicaid program for the health care and treatment that keeps them healthy. Ensuring uninterrupted access to effective HIV care and treatment is important to the health of people living with HIV and to public health.[2] When HIV is effectively managed, the risk of transmitting the virus drops to zero.[3]

HHCAWG is concerned about multiple aspects of the Oklahoma Application described in more detail below. However, as a threshold issue, we state our objection to being forced to submit

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[1] *Medicaid and HIV*, KAISER FAMILY FOUND. (Oct. 1, 2019), https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.

[2] Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. Available at http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL. pdf.

[3] Cohen, MS., et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. N Engl J Med 2016; 375:830-839. September 1, 2016.

comments on a vague and incorrect application that the Centers for Medicare & Medicaid Services (CMS) should rightly return as incomplete.

After CMS certified the Oklahoma Application as complete, the state took multiple actions that now render the Application incorrect. Most importantly, Oklahoma states in its Application that it has submitted a state plan amendment to expand eligibility to adults ages 19-64 with incomes up to 133% of the federal poverty level effective July 1, 2020, projecting enrollment of 128,703 individuals in the first year. Subsequently Oklahoma Governor Kevin Stitt vetoed the legislation authorizing funding for this expansion, and on May 28 the state formally withdrew the state plan amendment. As a result, the state will not be expanding coverage effective July 1. This undermines the heart of the application, as these projections were used in calculating the state's required budget neutrality estimates.

The federal comment period, as required by 42 CFR § 431.416, is to allow members of the public a meaningful opportunity to comment on the application being reviewed. The changes made by Oklahoma subsequent to CMS certifying the Application as complete render this impossible. While we state our objections as best we can below, it is difficult to assess the impact the Oklahoma Application will have on beneficiaries due to its vague, incomplete, and incorrect nature. **We request that CMS withdraw its certification of completeness as improperly granted and return the application to the state for correction.**

Should CMS continue with the review process, our remaining comments point out why the waiver should be rejected.

I. Oklahoma's proposed work requirement would violate the core objective of the Medicaid program

While HHCAWG understands and supports the value of work, we object to Oklahoma's proposal to impose a work requirement as a condition of eligibility for the new adult expansion group. Oklahoma's proposal would require that enrollees complete at least 80 hours of work or work-related activities, or else be disenrolled and lose their coverage unless and until they can verify their compliance, meaning many will not be able to re-enroll.

If approved, the Oklahoma Application would violate the basic conditions required for approval of a section 1115 waiver. Section 1115(a) of the Social Security Act, codified at 42 U.S.C. § 1315(a), allows a federal waiver to facilitate a State's "experimental, pilot, or demonstration project" that, "in the judgment of the Secretary, is likely to assist in promoting the objectives" of the Medicaid program. One of the primary objectives of Medicaid, as explained by § 1901 of the Social Security Act, is to enable each State to furnish "medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and costs are insufficient to meet the costs of medically necessary services."[4] This core objective

[4] 42 U.S.C. § 1396-1.

was re-affirmed in recent court decisions vacating approval of waivers that similarly condition eligibility on satisfying a work requirement. These decisions found providing health coverage to Medicaid enrollees is a "central objective" of the Medicaid program, and that work requirements of this sort fail to promote or provide coverage.[5]

Oklahoma estimates that around five percent of enrollees subject to the work requirement (and other eligibility barriers, such as enforceable premiums) will be unable to meet them, and will therefore lose coverage. This estimate is likely grossly understated. Experience from Arkansas, the first state to implement a work requirement is instructive: the Arkansas demonstration has resulted in over 18,000 individuals losing coverage.[6] New Hampshire, the second state to try implementing work requirements, had a similarly poor experience by failing to reach 20,000 of the 50,000 individuals subject to the new requirement. As a result, New Hampshire's governor suspended the demonstration and prevented coverage losses, after which the waiver was vacated in federal district court.[7] A work requirement that will inevitably lead to otherwise eligible individuals being removed from the Medicaid rolls cannot be reconciled with the core purpose of Medicaid to furnish medical assistance.

Oklahoma's Application proposes to take coverage away from people who can't meet a work requirement because the demonstration hypothesizes that it will increase employment rates and income of enrollees. This is not an objective of Medicaid, as the District of Columbia Circuit Court of Appeals unanimously found in *Gresham v. Azar*, stating "Congress has not conditioned the receipt of Medicaid benefits on fulfilling work requirements or taking steps to end receipt of governmental benefits.[8]" Approving policies that cause coverage losses, increase the number of uninsured individuals, and leaves individuals without access to health services cannot be justified as a lawful and proper use of Section 1115's waiver authority.

II. Work requirements threaten to disproportionately harm individuals living with HIV and other chronic health conditions

Individuals living with chronic illnesses stand to be disproportionately harmed by this proposal. Many individuals who live with a chronic illness that makes maintaining employment impossible are not considered "disabled" by Medicaid standards, and would be subject to the work requirement. Chronic illnesses can produce symptoms or disabilities that are not visible, yet serve as impediments to steady employment. Additionally, some chronic conditions like multiple sclerosis produce periods of inability to work due to medication side effects or symptom flare-ups; employees with these conditions require flexible work arrangements that can be hard to find or keep. Episodic disabilities can produce an uneven work history, which in turn can make it more difficult for a person to find consistent employment. These burdens

[5] *See, e.g. Gresham v. Azar,* 950 F.3d 93 (D.C. Cir. 2020); *Philbrick v Azar,* 397 F.Supp.3d 11 (D.D.C. 2019).
[6] Benjamin D. Sommers, *et al.,* "Medicaid Work Requirements — Results from the First Year in Arkansas," New England Journal of Medicine, September 12, 2019, https://www.nejm.org/doi/full/10.1056/NEJMsr1901772.
[7] *Philbrick v Azar,* 397 F.Supp.3d 11 (D.D.C. 2019).
[8] *Gresham v. Azar,* 950 F.3d 93, 102 (D.C. Cir. 2020)

particularly affect people living with chronic illnesses or disabilities, as consistent access to medical care is key to the management of symptoms and overall long-term wellness.

While the Oklahoma Application ostensibly notes 12 enrollee categories that will be exempt from the work requirement, the state gives little clarity as to who would qualify in many of the categories. For example, the Application notes that individuals "medically certified as physically or mentally unfit for employment" will be exempt, but does not specify what kinds of conditions would qualify, how difficult it will be to obtain medical certification, or how long an exemption lasts. At a minimum, people living with HIV should not be forced to re-certify that they are HIV positive and therefore qualify for an exemption once secured.

Further, the complexity involved in tracking and applying exemptions is likely to prove unduly burdensome and has the potential to disrupt coverage for individuals that require continuity of care. The history of administering exemptions to work requirements in other public benefits program shows that states often make mistakes and end up sanctioning beneficiaries that are not formally subject to the requirement. The administrative challenges associated with implementing work requirements would be more pronounced in Medicaid than in the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) programs, which have struggled with implementation. SNAP and TANF require substantial interactions with participants, including interviews and frequent reporting. States have encountered numerous obstacles to accurately applying these policies. States' administration of these policies in the SNAP program was error prone, applied inaccurately, and led to eligible individuals being denied benefits.[9] When first implemented, a U.S. Food and Nutrition Service analysis found that policies were "difficult to administer and too burdensome for the States." One of the biggest shifts was tracking benefit receipt over time, rather than circumstances in a single month, which was a fundamental change to program administration.[10] Historical analysis of state experience implementing work requirements in TANF suggests that adding similar requirements to Medicaid could cost states thousands of dollars per beneficiary.[11]

Oklahoma has not adequately considered the disproportionate effect these harmful policies will have on individuals living with chronic health conditions, despite numerous state comments speaking directly to this issue. Accordingly, Oklahoma has not satisfied the requirement that issues raised during the public notice procedure are considered during development of the final application.[12]

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[9] USDA Office of Inspector General, FNS Controls over SNAP Benefits for Able-Bodied Adults Without Dependents, September 2016, https://www.usda.gov/oig/webdocs/27601-0002-31.pdf.

[10] Mathematica Policy Research, Inc., Imposing a Time Limit on Food Stamp Receipt: Implementation of the Provisions and Effects on Food Stamp Participation (2001).

[11] Gayle Hamilton et al., "National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs," Manpower Demonstration Research Corporation, December 2001, Table 13.1.

[12] 42 C.F.R. § 431.412(a)(1)(viii).

III. Capping federal Medicaid funding is will risk access to care

Pursuant to CMS' "Healthy Adult Opportunity" guidance (which we have previously objected to[13]), Oklahoma seeks to limit its federal Medicaid funding for the new adult expansion group via a per-member amount multiplied by the number of individuals enrolled (or projected to be enrolled). Perhaps more than elsewhere in the Application, it is particularly difficult to provide comment on the request to implement a per-capita cap, as the Application provides little information as to how this fundamental shift in funding will affect enrollees, providers, facilities, etc. Furthermore, the Application provides no details about how the cap will functionally work or even how much capped funding the state can expect to receive. As discussed above, the state's enrollment and expenditure estimates rest on the false assumption that expansion began in July 2020 with the waiver taking effect in July 2021.

Particularly during a pandemic that is placing tremendous burdens on the health care system and Medicaid in particular, this proposal is unwise at best. Unemployment in Oklahoma is expected to rise beyond current level by up to an additional 320,000 individuals, which is likely to be accompanied by an increase in Medicaid enrollment.[14] Limiting the amount of funding Oklahoma receives from the federal government to run its Medicaid program will make is drastically harder to respond to the ongoing public health crisis and ensuing economic downturn, and will unavoidably harm patients. As we noted previously, capping federal Medicaid funding has the likely potential to undermine the President's Ending the HIV Epidemic Initiative announced just last year.[15]

Regardless, we note that the request to transition funding to a per-capita cap is illegal and cannot be approved under Section 1115. Medicaid's funding mechanisms are outlined in Section 1903 of the Social Security Act, codified at 42 U.S.C. § 1396b. Section 1903 states that the HHS Secretary "shall pay to each State…the [federal match] of the total amount expended…as medical assistance under the State plan...."[16] Section 1903, however, is not a waivable provision. Under Section 1115(a) of the Social Security Act, codified at 42 U.S.C. § 1315(a), the Secretary may waive certain requirements of Medicaid; namely, those found in sections 2, 402, 454, 1002, 1402, 1602, and 1902. If Congress had intended Section 1903 to be waivable as well, it would have listed it in the statute. The Centers for Medicare and Medicaid Services (CMS) itself has unambiguously stated that "Section 1115(a)(i) waiver authority extends only to provisions of section 1902 of the Act."[17] In 2018, CMS denied a Section 1115 waiver request that would have partially changed North Carolina's federal matching rate by

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[13] HIV Health Care Access Working Group, Letter to Secretary Azar and Administrator Verma (February 28, 2020): https://www.chlpi.org/wp-content/uploads/2013/12/HHCAWG-Block-Grant-Letter.pdf

[14] COVID-19 Impact on Medicaid, Marketplace, and the Uninsured by State. Health Management Associates. April 3, 2020. Accessed at: https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf.

[15] Ending the HIV Epidemic: A Plan for America, Department of Health and Human Services: https://www.hhs.gov/blog/2019/02/05/ending-the-hiv-epidemic-a-plan-for-america.html.

[16] Social Security Act § 1903(a)(1), 42 U.S.C. § 1396b(a)(1) (2012).

[17] Letter from Seema Verma, Adm'r, U.S. Ctrs. for Medicare & Medicaid Servs., to Dave Richard, Deputy Sec'y for Medical Assistance, N.C. Dep't of Health & Human Servs. (Oct. 19, 2018).

waiving Section 1905(b). In this denial, CMS acknowledged that it lacked the legal authority to change the Medicaid funding structure.[18]

The only legal way to construct Medicaid block grants or per capita caps is through a statutory change. Congress debated this kind of change in 2017,[19] but ultimately decided not to pass it. HHS cannot accomplish through waivers something that the majority of Congress clearly did not intend to achieve. The HHS budget for fiscal year 2020 mentions legislative efforts to convert Medicaid to a block grant or per capita capped funding structure.[20] This indicates that HHS is well aware of the fact that capped funding can only legally be accomplished by statutory change, not through a Section 1115 waiver.[21]

Conclusion

We appreciate the opportunity to provide comments on the Oklahoma Application. Our comments include numerous citations to supporting research, including direct links to the research for CMS' benefit in reviewing our comments. We direct CMS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments and the attached report be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

For the reasons described above, we urge CMS to either de-certify as incomplete or otherwise reject the Oklahoma Application in order to ensure that the 1115 waiver program promotes, rather than undermines, the objectives of the Medicaid program, and that people living with and at risk of HIV and other chronic health conditions retain access to crucial medications and health care services. Please contact HHCAWG co-chairs Phil Waters with the Center for Health Law and Policy Innovation at pwaters@law.harvard.edu, Amy Killelea with the National Alliance of State and Territorial AIDS Directors at akillelea@nastad.org, or Rachel Klein with The AIDS Institute at rklein@taimail.org with any questions.

Respectfully submitted by the undersigned organizations:

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[18] *See* Hannah Katch et al., *Tennessee Block Grant Proposal Threatens Care for Medicaid Beneficiaries*, CENTER FOR BUDGET AND POLICY PRIORITIES (Sept. 25, 2019), https://www.cbpp.org/research/health/tennessee-block-grant-proposal-threatens-care-for-medicaid-beneficiaries.

[19] *See, e.g.,* American Health Care Act of 2017, H.R. 1628, 115th Cong. § 121 (2017); Better Care Reconciliation Act of 2017, S. Amdt. 270 to H.R. 1628, 115th Cong. §§ 132–133 (2017); "Graham-Cassidy amendment," S. Amdt. 1030 to H.R. 1628, 115th Cong. §§ 124–125 (2017).

[20] *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., PUTTING AMERICA'S HEALTH FIRST: FY 2020 PRESIDENT'S BUDGET FOR HHS, 69, 103 (2019).

[21] *See* Letter from Frank Pallone, Jr., Chairman, U.S. House of Representatives Comm. on Energy & Commerce, to Alex M. Azar, Sec'y, U.S. Dep't of Health & Human Servs. (Jun. 27, 2019).

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AIDS Research Consortium of Atlanta
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Communities Advocating Emergency AIDS Relief (CAEAR)
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