

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

June 26, 2020

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Submitted online via [Medicaid.gov](https://www.Medicaid.gov)

Justice in Aging appreciates the opportunity to provide comments on Oklahoma's proposed SoonerCare 2.0 Healthy Adult Opportunity Section 1115 demonstration waiver. For the reasons discussed below, we strongly urge the Centers for Medicare & Medicaid Services (CMS) not to approve this waiver application, which would reduce coverage and services and undermine Medicaid for all Oklahomans, including older adults.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older Oklahomans and older adults nationwide. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources, particularly populations that have been marginalized and excluded from justice such as women, people of color, LGBTQ individuals, and people with limited English proficiency. We have decades of experience with Medicaid and working with advocates who represent low-income older adults. Justice in Aging conducts trainings and engages in advocacy regarding Medicare and Medicaid, provides technical assistance to attorneys in Oklahoma and across the country on how to address problems that arise under these programs, and advocates for strong consumer protections at both the state and federal level.

At the outset, we urge CMS not to approve Oklahoma's application because its vagueness, especially with respect to the proposal to implement a per capita cap, means that we cannot meaningfully comment. Likewise, we are concerned that the application's proposals and enrollment projections are no longer accurate because they were based on a State Plan Amendment to expand Medicaid beginning in July 2020 that the Governor has since withdrawn. CMS should withdraw its certification of completeness for the proposal and return the application to the state.

The remainder of our comments address our opposition to the proposals to take away Medicaid coverage from individuals who do not meet work reporting requirements and pay premiums; to eliminate retroactive coverage and presumptive eligibility; to limit the scope of benefits; and impose a per capita cap. Not only are these proposals impermissible under Medicaid law and pursuing waivers that courts have consistently found to be illegal, if implemented they would directly harm low-income older Oklahomans and their families by cutting health care coverage.

WASHINGTON

1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES

3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND

1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

We have cited research demonstrating the harms of these proposals and we respectfully request that CMS review each of the sources cited and made available to the agency through active hyperlinks. We further request that the full text of each of the sources cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

I. Work Reporting Will Leave Many Older Adults & Family Caregivers Uninsured

A. Work Reporting Requirements Will Bar Older Adults with Disabilities from Medicaid

Oklahoma is proposing to take away coverage from individuals between the ages of 19 and 60 who fail to report at least 80 hours of work or work-related activities per month. The proposed work reporting requirements will be particularly harmful to older adults with disabilities who are not eligible for Medicare and others with serious health conditions and functional limitations, because they face additional challenges in meeting such requirements. And the health consequences of losing or being denied access to Medicaid coverage for these older adults are likely to be especially severe.

First, these requirements do not consider the actual health care needs of older adults. Although Medicaid eligibility rules classify a person as “disabled” or “aged”, disability and health challenges that accompany age are a continuum. A Medicaid beneficiary may not be “disabled” under Medicaid law or over age 65, but nonetheless face significant health-related challenges. For example, data from the National Center for Health Statistics shows that approximately 40% of working-age Medicaid beneficiaries “have broadly defined disabilities, most of whom are not readily identified as such through administrative records.”¹ Similarly, data from the March 2017 Current Population Survey (reflecting 2016 health insurance coverage) show that, among Oklahoma’s non-elderly Medicaid population not receiving Supplemental Security Income due to disability, 29% cited being ill or disabled as the reason for not being employed.² Moreover, prevalence of chronic conditions, including both physical and mental health conditions, increases significantly with age. For example, a study by AARP analyzed data for the age 50–64 population, finding that 72.5% have at least one chronic condition, and almost 20% suffer from some sort of mental illness.³

The proposed exemption for enrollees who are “medically certified as physically or mentally unfit for employment” or have a disability as defined under the Americans with Disability Act, Section 504 of the Rehabilitation Act, or Section 1557 of the Affordable Care Act will not resolve

¹ H. Stephen Kaye, Community Living Policy Ctr., How Do Disability and Poor Health Impact Proposed Medicaid Work Requirements? 2 (Feb. 2018), <https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/Disability%20%26%20Medicaid%20Work%20Requirements.pdf>.

² Kaiser Family Found., Understanding the Intersection of Medicaid and Work 10 (App. Table 2) (Jan. 2018), <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>.

³ AARP Public Policy Institute, Chronic Care: A Call to Action for Health Reform 11–12, 16 (March 2009), www.aarp.org/health/medicare-insurance/info-03-2009/beyond_50_hcr.html.

these concerns. The state’s application 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, based on the application’s inclusion of the ADA disability exemption in its description of “good cause” exemptions, such exemptions appear to last for only a month. Moreover, this proposal is imposing more red tape on the individual to understanding the work requirements and apply for an exemption—perhaps on a monthly basis.

The state acknowledges that these illegal requirements would take away coverage from thousands of Oklahomans who are eligible now or would become eligible under expansion, even without the COVID-19 crisis. Lost months of Medicaid coverage have a human cost, especially for this population that would most benefit from coverage: less preventive care, greater decline, and avoidable deterioration in physical and mental health. A recent study showed that 476 older Oklahomans, ages 55 to 64 died between 2014 and 2017 because the state chose not to expand Medicaid.⁴ With the COVID-19 crisis, this number is likely growing daily and disproportionately among people of color. In fact, over 15% of deaths from COVID-19 in Oklahoma are among 50-64 year olds and about 20% of deaths are among people of color.⁵ Instead of mitigating this unconscionable situation, the SoonerCare 2.0 proposal would continue to bar these older adults from coverage, leading to even more preventable deaths.

B. Work Requirements Will Bar Family Caregivers from Medicaid & Harm the People They Care For

Work reporting requirements would also unnecessarily jeopardize the health and well-being of low-income individuals who care for family members or others who cannot live independently. Many family caregivers, especially older women and people of color, leave the workforce or reduce their hours to provide informal care to their children, aging parents, other family, friends and neighbors. These caregivers are likely to be Medicaid eligible because they are low-income and unlikely to have access to health insurance through a job or spouse.⁶ In fact, 40% of non-elderly Medicaid enrollees not receiving SSI in Oklahoma cite caretaking as their reason for not engaging in the type of work activities the state is proposing to require of them.⁷ The narrow exemption for people who caring for an individual who has been determined “incapacitated” does not reflect the reality of nor enormous economic value of family caregiving. Given these realities, many family caregivers who qualify for Medicaid would be

⁴ Ctr. on Budget & Policy Priorities, Medicaid Expansion Has Saved at Least 19,000 Lives, New Research Finds (Nov. 6, 2019), <https://www.cbpp.org/research/health/medicaid-expansion-has-saved-at-least-19000-lives-new-research-finds>.

⁵ OSDH Dashboard, <https://looker-dashboards.ok.gov/embed/dashboards/76>

⁶ Justice in Aging, Medicaid Work Requirements: The Impact on Family Caregivers and Older Adults (Nov. 2018), www.justiceinaging.org/wp-content/uploads/2018/11/JusticeInAging-Medicaid-IssueBrief-November19-11am-2018.pdf.

⁷ Kaiser Family Found., Understanding the Intersection of Medicaid and Work 10 (App. Table 2) (Jan. 2018), <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>.

forced to choose between providing care for their loved ones and maintaining their own health.⁸

C. Work Requirements Would Actually Impede Older Adults' Ability to Work

Finally, this policy would be counterproductive to the purported goal of encouraging work, especially during a profound economic and public health crisis. We are experiencing historic unemployment rates and disproportionate impacts on older adults.⁹ In fact, Utah, the only state that had active work reporting requirements, suspended implementation due to the crisis. These effects are unlikely to go away soon, and regaining employment is likely to be slowest among older adults.¹⁰

Taking away coverage from low-income Oklahomans for not reporting work could cause their health to deteriorate, which in turn will make it harder for them to become or remain employed.¹¹ Reports consistently show that Medicaid can reduce health barriers to finding or holding a job for beneficiaries who are not working.¹² For example, in Michigan, 55% of those who were out of work said Medicaid coverage made them better able to look for a job while 69% of those who had jobs said they did better at work once they got coverage.¹³ Ohio Medicaid enrollees reported similarly that Medicaid coverage made it easier to both seek employment and continue working.¹⁴

Consider a 59-year-old woman who is caring for an aging parent who lives nearby. As her caregiving obligations grew, she was laid off because she could not work the consistent hours her employer asked her to. She is not yet eligible for Medicare and will have a difficult time finding employment given the economy, her age and constraints on her time as a caregiver. She is at risk of being barred from Medicaid, her only possible source of health coverage, if work requirements are implemented.

⁸ Justice in Aging, Medicaid Work Requirements: The Impact on Family Caregivers and Older Adults (Nov. 2018), www.justiceinaging.org/wp-content/uploads/2018/11/JusticeInAging-Medicaid-IssueBrief-November19-11am-2018.pdf.

⁹ AARP, Devastating Job Losses May Be Pushing Older Workers into Retirement (June 8, 2020), <https://blog.aarp.org/thinking-policy/job-losses-may-be-pushing-older-workers-into-retirement?cmp=SNO-TW-CPPI&socialid=3408035323>.

¹⁰ *See id.* (explaining that many older workers who are newly unemployed are not looking for jobs and being forced to retire early).

¹¹ Coverage interruptions could lead to increased emergency room visits and hospitalizations, admissions to mental health facilities, and health care costs, research has shown. Leighton Ku & Erika Steinmetz, Association for Community Affiliated Plans, "Bridging the Gap: Continuity and Quality of Coverage in Medicaid," (Sept. 10, 2013), www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%209-10-13.pdf.

¹² Kaiser Family Found., "The Relationship between Work and Health: Findings from a Literature Review" (Aug. 7, 2018), www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.

¹³ Kara Gavin, "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches," University of Michigan Health Lab (Jun. 27, 2017), <http://labblog.uofmhealth.org/industry-dx/medicaid-expansion-helped-enrollees-do-better-at-work-or-job-searches>.

¹⁴ Ohio Dept. of Medicaid, Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly (Jan. 2017), <http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf>.

II. Charging Premiums & Cost-Sharing Will Cause Medicaid Eligible Individuals to Lose Coverage and Limit Access to Care

Oklahoma is proposing to require enrollees whose income exceeds the parent/caretaker standard to pay monthly premiums and terminate coverage after three months of non-payment despite an extensive body of research demonstrating that premiums are a barrier to coverage for low-income people.¹⁵ For example, over half of individuals eligible for the Healthy Indiana Plan waiver program's comprehensive coverage either did not make their first premium payment or missed a payment.¹⁶

Not only is this proposal misguided, enhancing alignment between Medicaid policies and the commercial health insurance market, as the application indicates is the goal, is not an objective of the Medicaid program. Medicaid beneficiaries are financially strained already. 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), arguing it will reduce unnecessary ED visits. Studies of Medicaid nonemergency ED copayments consistently show that: (1) Medicaid enrollees use the ED at comparable rates to private pay patients if you factor in their health status, and are no more likely to use the ED for non-urgent visits; and (2) copayments are ineffective at reducing nonemergency ED use.¹⁷

Moreover, such cost-sharing would be especially punitive towards older adults ages 50 to 64, since they are more likely to experience health issues that would lead a prudent layperson to go to the ED. It would be entirely unfair to penalize a layperson for choosing emergency room care when they are experiencing breathing difficulty, weakness, or pain.

III. Eliminating Retroactive Coverage & Hospital Presumptive Eligibility Will Deprive Low-Income Oklahomans of Needed Coverage

We oppose Oklahoma's proposals to waive the federal protection that provides up to three months of retroactive Medicaid coverage for people eligible for SoonerCare 2.0. Eliminating Medicaid's three-month retroactive coverage protection will harm the health and financial well-being of Oklahomans who are in fact eligible for Medicaid, as well as harm providers, the state, and all Oklahomans by increasing the uncompensated care burden. This is an impossible burden for individuals, hospitals, and the state to bear amid a public health crisis.

¹⁵ Kaiser Family Found., The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings (June 2017), <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations>.

¹⁶ *Id.*

¹⁷ *Id.*; Mona Siddiqui et al., The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005, 175 JAMA INTERNAL MED. 393 (2015); Karoline Mortensen, Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments, 29 HEALTH AFFAIRS 1643 (2010); David J. Becker et al., Co-payments and the Use of Emergency Department Services in the Children's Health Insurance Program, 70 MED. CARE RES. REV. 514 (2013).

Congress designed the retroactive coverage protection to help Medicaid meet the unique needs and circumstances of low-income, uninsured individuals. In many instances, a person who needs health care cannot be expected to apply for Medicaid coverage at the exact moment they become eligible: they may be hospitalized for COVID-19 or after an accident; they may be struggling to cope with the shock of a diagnosis or sudden decline in functional ability; they may also be unfamiliar with Medicaid, or unsure about when their declining financial resources might fall within the Medicaid eligibility threshold. Right now, people who are becoming eligible for the first time after losing a job are simultaneously dealing with unprecedented financial and health issues, childcare obligations, and multiple other pressing needs. The impossibility of an immediate Medicaid application has never been more apparent.

Medicaid's three-month retroactivity window is a rational and humane response to these concerns. We emphasize that retroactive eligibility is only available to persons who would have met the Medicaid eligibility standards for the month[s] in question had they applied sooner.¹⁸ This vital protection enables access to necessary care and treatment by giving providers assurance that Medicaid will reimburse them, and it can be the difference between financial ruin and being able to recover from an unexpected health emergency. Under Oklahoma's proposal, however, a person could experience severe COVID-19 symptoms or have a heart attack on the evening of June 29th and be liable for thousands of dollars of hospital expenses due to the "failure" to file a Medicaid application within 36 hours, when June becomes July. This catastrophic situation would be even more likely because Oklahoma is also proposing to eliminate hospital presumptive eligibility.

In addition to preventing access to necessary care and exposing people who, by definition, cannot afford and are not eligible for other health coverage to crushing debt, eliminating retroactive coverage is bad policy because it is costlier for providers and the state.¹⁹ Eliminating retroactive coverage increases uncompensated care, jeopardizing the ability of providers, especially rural hospitals, to continue to serve their communities.²⁰ In turn, this decreases access to care for all Medicaid enrollees and, in the case of medically underserved areas, all Oklahomans, leading to poorer health and necessitating costlier care.

IV. Cutting & Limiting Benefits Is Shortsighted & Harms Older Adults

We are deeply concerned about the limited benefit package the state is proposing to provide to SoonerCare enrollees. Cutting out long-term care from the benefits is shortsighted. Older adults and others who are not eligible for either Medicare or Medicaid based on disability or age can experience short-term disability, and Medicaid would be their only source of coverage for the supports and services they need—whether that be in a nursing facility or at home. Disability applications and determinations can take months or even years to assemble and process. Yet, these individuals have immediate long-term care coverage needs that Medicaid should cover.

¹⁸ 42 U.S.C. § 1396a(a)(34).

¹⁹ Justice in Aging, Medicaid Retroactive Coverage: What's at Stake for Older Adults When States Eliminate this Protection? (Sept. 2019), <https://www.justiceinaging.org/wp-content/uploads/2019/09/Medicaid-Retroactive-Coverage-Issue-Brief.pdf?eType=EmailBlastContent&eid=a7bb9cdd-1ce1-4012-b154-7981533a4875>.

²⁰ *Id.*

It is unclear whether Oklahoma intends to cut this benefit completely for all expansion enrollees, including those who are “Medically Frail.” The application fails to provide details about how the state would identify expansion enrollees who are Medically Frail and thus have the option, under Medicaid law, to select state plan coverage, including the long-term services and supports (LTSS) that Oklahoma Medicaid covers. Without these details, we cannot provide meaningful comment on the extent of this additional barrier to coverage.

The request to waive non-emergency medical transportation (NEMT) would also harm low-income Oklahomans, including older adults ages 50 to 64. NEMT is critical for older adults and people with chronic conditions or functional impairments who cannot otherwise access transportation to their medical appointments. Many low-income Oklahomans simply cannot afford to buy a car or hire a transportation service, and many if not most lack access to affordable and reliable public transit. Moreover, as people age, they are more likely to experience vision and cognitive decline, reduced strength, arthritis, and many other ailments that diminish their ability to drive safely. Notably, data from Iowa indicates that women, people of color, and people in relatively poorer health, with multiple physical ailments (63%), or who have any functional deficit (245%) were all much more likely to report unmet transportation needs.²¹

For these reasons, older adults are often dependent on others for transportation. NEMT is most often used to access preventive health services, behavioral health services, and care for chronic conditions. Medicaid enrollees use NEMT to attend appointments for dialysis, visits to a primary care physician or specialist, physical therapy, and more.²²

Furthermore, taking away NEMT has consequences. As the Government Accountability Office (GAO) found, “excluding the NEMT benefit would impede . . . enrollees’ ability to access health care services, particularly individuals living in rural or underserved areas, as well as those with chronic health conditions.”²³ Without affordable and reliable transportation, older adults do not receive needed health care, which increases the risk of hospitalization, nursing-home admission, or institutionalization. This creates unnecessary and preventable cost burdens on health care providers and the state. In other words, NEMT not only leads to better health outcomes for beneficiaries, it is also more cost-effective and can even result in cost-savings for the state.²⁴

We are also disappointed that Oklahoma’s proposal would limit dental coverage to extractions. Failing to provide comprehensive oral health services is short-sighted—it is essentially sending

²¹ Univ. of Iowa Pub. Policy Ctr., Non-Emergency Medical Transportation & the Iowa Health and Wellness Plan, 26 (Mar. 2016), https://ir.uiowa.edu/cgi/viewcontent.cgi?article=1131&context=ppc_health.

²² Kaiser Family Found., Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers (Feb. 2016), www.kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/view/footnotes/#footnote-177328-11.

²³ U.S. Gov’t Accountability Office, GAO-16-221, Medicaid: Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage (Jan. 2016), <https://www.gao.gov/products/GAO-16-221>.

²⁴ National Academies of Sciences, Engineering, & Medicine, Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation (2005), http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf.

people to the ER to get routine dental care. Not only is that expensive and inefficient, we can see how a public health crisis makes it dangerous.

V. A Per Capita Cap on Federal Medicaid Funding Is Impermissible & Would Undermine the Medicaid Program for All Enrollees

The proposal to cap federal Medicaid funding is misguided, harmful to older adults and all Oklahomans who rely on Medicaid, and not permissible under federal law. First, Medicaid demonstration waivers cannot be used to alter the basic funding structure of the program because the sections of the law governing funding cannot be waived. Changes to how Medicaid is financed must be made by Congress. And Congress recently voted against legislation that would have provided states with capped funding instead of the existing federal matching funds. Oklahoma cannot bypass Congress and federal law. Second, as confirmed by federal courts multiple times,²⁵ Medicaid's primary objective is to furnish medical assistance to low-income persons.²⁶ However, capping funding would lead to cuts in coverage and therefore undermine Medicaid's main objective. Much of the state's discussion of the purpose of the waiver is around saving the state money, which is not an objective of the Medicaid program.

Because Oklahoma has not expanded Medicaid, the cap will be set arbitrarily and is unlikely to be generous enough to meet Oklahoma's Medicaid funding needs today, much less in several years. The growth rates of such caps cannot account for unexpected growth in health care costs or pandemics like we are experiencing now. Moreover, capping federal Medicaid funding to the state cannot be accomplished without harming all Oklahomans who rely on SoonerCare currently or may one day need it. It will inhibit Medicaid's capacity to serve older adults and people with disabilities not included in the SoonerCare demonstration, especially as needs increase with the unprecedented growth of the older adult population and the simultaneous increases in senior poverty. Because the state cannot go into debt to cover growing and changing needs of its Medicaid population, it will be forced to cut services, restrict eligibility, or both.²⁷

VI. Conclusion

For all these reasons, we urge CMS not to approve this proposal and instead work with Oklahoma to fully expand Medicaid under the ACA as soon as possible. Medicaid expansion has been proven to save lives of older adults ages 55-64 in every state that has taken it up and to provide a multitude of other benefits to the state and its residents.

²⁵ See, e.g., Memorandum Opinion, *Stewart v. Azar*, Civil Action No. 1:18-cv-152 (JEB) (June 29, 2018).

²⁶ See 42 U.S.C. § 1396-1.

²⁷ Justice in Aging, Medicaid Funding Caps Would Harm Older Americans (Feb. 2017), <https://www.justiceinaging.org/wp-content/uploads/2017/02/Medicaid-Funding-Caps-Would-Harm-Older-Americans.pdf?eType=EmailBlastContent&eId=443776c8-cb7a-4c89-991a-85ede6f99509>.

If any questions arise concerning this submission, please contact Natalie Kean, Senior Staff Attorney, at nkean@justiceinaging.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Goldberg". The signature is fluid and cursive, with the first name "Jennifer" being more legible than the last name "Goldberg".

Jennifer Goldberg
Deputy Director