Lutheran Services in America

June 25, 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

Dear Secretary Azar:

On behalf of Lutheran Services in America, I appreciate the opportunity to submit comments on the Sooner Care 2.0 Medicaid Section 1115 Demonstration Waiver. While we support efforts to expand Medicaid coverage for low-income adults, the Sooner Care 2.0 proposal is not a sufficient solution to improve access to quality and affordable healthcare for low-income Oklahomans and we urge you to reject it. We are especially concerned that this proposal would create a capped funding structure which would reduce patients' access to critical benefits and services and add administrative and financial barriers to the program that would undoubtedly lead to coverage losses.

For context, Lutheran Services in America leads one of the largest health and human services networks in the U.S., made up of over 300 Lutheran social ministry organizations that operate with over $22 billion in annual revenue. Efforts of the dedicated people who make up our national network help improve the lives of one in 50 Americans each year. Guided by God's call to love and serve our neighbors, we empower our faith-based member organizations in their mission to lift up the nation's most vulnerable people. In providing services to seniors, children and people with disabilities, along with veterans, refugees and the homeless, our members work in 1,400 communities throughout the country—in rural and urban areas—as shown on this map.

As a large non-profit provider of services to all of the groups relying on Medicaid—children, youth and families, seniors, and people with disabilities, as well as adults in the expansion population—the Lutheran Services in America network recognizes the importance of Medicaid in providing health coverage to millions of Americans. Indeed, Medicaid provides access to critically important preventive care, early identification and

intervention services for children, health coverage for low-income adults, and long-term services and supports for vulnerable seniors and people with disabilities.

Unfortunately, the proposal submitted by Oklahoma requests many policies that threaten healthcare coverage for the people we serve such as a per capita cap and work requirements, and includes many of the same proposals the courts have repeatedly rejected and that we have opposed in other states.

Per Capita Caps

Oklahoma is the first state to apply for a waiver under the block grant guidance that CMS issued in January as the "Healthy Adult Opportunity." While the state uses an application template for its proposal which is to be used by states "applying to use either an aggregate or a per capita cap financing model for certain populations" the proposal includes no details about the cap, how it would work or how much capped funding the state would receive. We are concerned with the lack of detail in Oklahoma's proposal. Such a drastic change in Oklahoma's Medicaid program will undoubtedly have a dramatic impact, but without additional details, it is impossible to fully comment on all of the possible impacts of a per capita cap on the people our nonprofit HHS member organizations serve.

Nevertheless, **we are gravely concerned that implementation of per capita caps like those being proposed would almost surely lead to cuts in Medicaid eligibility, funding, and services.** These types of funding changes are designed to reduce federal Medicaid funding to states by providing a capped allotment of funds. States are forced to make up for the loss of federal funding either by covering the gap with state funds, or by making cuts to Medicaid programs or enrollment. Especially vulnerable to cuts are optional Medicaid benefits such as prescription drug coverage, occupational and physical therapy, and home-and community-based services for seniors and people with disabilities. These benefits are especially important to our member organizations who help serve chronically ill seniors in need of medication, children in need of developmental services that include occupational and physical therapy, and people with disabilities who want to live, work, and participate fully in their communities.

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Medicaid block grants and per capita caps also can put states at serious financial risk. Many situations could lead Oklahoma to exceed a funding cap. Capitated payments are not calculated to account for economic downturns or other possible developments. A public health emergency like COVID-19 will greatly increase healthcare costs above negotiated caps, and an economic recession would similarly increase enrollment in, and costs associated with, Sooner Care, putting patients' access to care at risk. In the long run, this is likely to lead to cuts in enrollment, provider reimbursements, and quality and breadth of Medicaid services. Providers like those in our network already are facing workforce shortages and there remain, in many states, waitlists for Medicaid services. Now is a time when we should be reinforcing – not cutting – Medicaid services. Therefore, we urge you to reject Oklahoma's request for a per capita cap.

Work Requirements

Under the application, individuals between the ages of 19 and 60 would be required to prove that they work up to 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, when Arkansas implemented a similar policy, the state terminated coverage for over 18,000 individuals[1], and in New Hampshire, nearly 17,000 individuals would have lost coverage if the state had not suspended implementation of its requirement.[2] The U.S. Court of Appeals for the District of Columbia recently reaffirmed that the purpose of the Medicaid program is to provide healthcare coverage and that Arkansas's restrictive waiver, including the work requirement policy, did not

[1] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at February State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Accessed at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf.

[2] New Hampshire Department Health and Human Services, DHHS Community Engagement Report, June 2019. Available at: https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf.

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meet that objective.[3] Given that Oklahoma's proposed work requirements would seem also not to meet the core Medicaid objective, we urge you to reject these work requirements.

Per capita caps should not be implemented under Section 1115 Waiver Demonstration Authority.

We understand these proposals are likely to face legal challenges. Recently, federal courts have struck down restrictive 1115 waivers that included work requirements, finding that these waivers did not advance the core principle of Medicaid: providing health coverage for low-income people.[4] 1115 waiver requests for block grants and per capita caps are likely to face similar legal challenges. Rather than spending time and money litigating restrictive Medicaid waivers, we invite CMS to work with states and advocates to design innovative Medicaid systems that would improve outcomes and quality of care.

Once again, Lutheran Services in America wishes to express our commitment to working with policymakers on a nonpartisan basis to ensure that Medicaid is affordable, adequate, and accessible for everyone eligible. **We have grave concerns about the Administration's decision to invite states including Oklahoma to apply for block grants or per capita cap waivers under an 1115 demonstration waiver, since such programs would reduce access, stymie innovation, and reduce Medicaid enrollment. These changes would impact the health and well-being of people who rely on Medicaid for health coverage, and over time would likely drive up costs for states.**

We would oppose this proposal under any circumstance, but it would be especially dangerous to move forward with it during a public health emergency such as the COVID-19 pandemic. This waiver would make it much harder for the state to

[3] US Court of Appeals for the District of Columbia Circuit, Gresham v. Azar, Feb. 14, 2020. Available at: https://healthlaw.org/wp-content/uploads/2020/02/Gresham-v.-Azar-DC-Circuit-Ruling-Feb-14.pdf.

[4] *Philbrick v. Azar*, 2019 WL 3414376 (D.D.C. 2019) (slip opinion only); *Gresham v. Azar*, 363 F. Supp. 3d 165, 169 (D.D.C. 2019); *Stewart v. Azar*, 366 F. Supp. 3d 125, 131 (D.D.C. 2019); *Stewart v. Azar*, 313 F. Supp. 3d 237, 243 (D.D.C. 2018)

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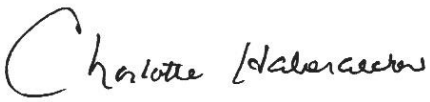
respond to this public health and economic crisis and would have grave consequences for the health and lives of Oklahomans.

Thank you for your consideration. We look forward to continuing to work with you on Medicaid issues.

Respectfully,



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