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:

The Center for Medicare Advocacy (Center) is pleased to provide comments regarding the Sooner Care 2.0 Medicaid Section 1115 Demonstration. The Center is unequivocally opposed to this proposal, as it would cause immense harm and jeopardize coverage. We urge you to reject this proposal.

The Center, founded in 1986, is a national, non-partisan education and advocacy organization that works to ensure fair access to Medicare and to quality healthcare. At the Center, we educate older people and people with disabilities to help secure fair access to necessary health care services. We draw upon our direct experience with thousands of individuals to educate policy makers about how their decisions affect the lives of real people. At the Center, we focus on matters regarding access to health care for lower-income people, including the rights of those dually eligible for Medicare and Medicaid. Additionally, we provide legal representation to ensure that people receive the health care benefits to which they are legally entitled, and to the quality health care they need.

We urge HHS to reject this proposal because of the harms it would cause those who rely on Medicaid to access health care and long-term services and supports, including older adults and people with disabilities who are dually eligible for Medicare and Medicaid. The proposal would jeopardize coverage and set a harmful precedent for other states and the Medicaid program as a whole. The Center strongly opposes capped funding of any sort as it would fundamentally alter the Medicaid program, threatening Sooner Care and the integrity of the Medicaid program nationwide.

Inconsistent with the Medicaid Act

The Secretary may only approve a Section 1115 project that is experimental and likely to promote the objectives of the Medicaid Act.[1] The central objective of Medicaid is to enable states to furnish medical assistance to individuals who are unable to meet the costs of necessary medical care and to furnish rehabilitation and other services to help these individuals attain or retain capability for independence or self-care. [2] Oklahoma's proposed project includes work requirements, premiums, a per-capita cap, and other harmful provisions that would reduce coverage and access to care, particularly for older adults ages 50-64.

As such, it is inconsistent with the provisions of § 1115 and the Medicaid Act. Instead of creating barriers to care, Oklahoma should invest in program features known to improve coverage and care, especially for older adults living in the state of Oklahoma. Disruptions in health coverage and health care are particularly devastating for older adults because of their high rates of chronic health needs. Disruptions can lead to worsening health and result in more emergency room visits, hospitalizations, and higher overall health costs.[3]

In addition to including many of the same proposals that the courts have repeatedly found illegal, Oklahoma also seeks to be the first state to implement a block grant or per capita cap per CMS' recent guidance. CMS' guidance and Oklahoma's proposal represent a drastic departure from traditional Medicaid financing. Since altering Medicaid's financing is not within the statutory provisions states can request to waive, the request for a per capita cap is not permitted pursuant to the statute and thus illegal. Further, the lack of detail on the per capita cap and on other aspects of the proposal makes it impossible to provide comments, and CMS should not have approved the state's application as complete.

We also are concerned that many of the waiver's proposals and enrollment projections were based on an expectation that Oklahoma would have implemented a Medicaid expansion in July 2020 pursuant to a State Plan Amendment (SPA). When the Governor withdrew the SPA, CMS should have returned the waiver to the State to develop new enrollment and other projections.

Retroactive Coverage

Oklahoma proposes eliminating retroactive coverage for enrollees in the Medicaid expansion population. Waiving retroactive coverage poses substantial harm for both enrollees and health care providers. It reduces access to coverage and leaves enrollees with substantial medical debt that they cannot afford to pay. Older adults have a high prevalence of chronic health conditions that can require regular clinical visits, prescription medications, and more intensive services. Retroactive coverage can help protect older adults from serious financial debt. [4] Retroactive coverage also helps ensure the financial stability of health care providers and reduces uncompensated hospital care. Evidence from states that have eliminated retroactive coverage reinforces that these waivers cause widespread coverage loss and create significant problems for health care providers.[5]

Capped Medicaid Funding

The SoonerCare 2.0 demonstration would implement a per-capita cap on the state's Medicaid program. However, the application is extremely vague, missing key information that would allow for specific and detailed feedback. For example, we cannot offer meaningful comments on Oklahoma's request to use per-capita caps because the proposal provides almost no information about the funding transformation the state seeks. Moreover, the proposal does not explain how the program transformation would affect stakeholders such as beneficiaries and health care providers. This lack of detail does not provide true notice to the public—including older adults, people with disabilities, and aging and disability advocates—to comment in response.

Accordingly, we strongly urge the Administration to reject Oklahoma's application as inaccurate and incomplete.

Although we lack information about the specific per-capita cap proposals in the SoonerCare 2.0 application, we can address the harms of capped Medicaid funding generally. Implementing a per-capita cap would eliminate the federal Medicaid guarantee of coverage. Block granting or capping federal Medicaid funding, as outlined in the HAO, would lead to significant cuts in the federal share of Medicaid over time—resulting, in turn, in commensurate cuts in state Medicaid spending and benefits and, possibly, to limits on the number of beneficiaries eligible for Medicaid coverage. As these cuts unfold, older adults enrolled in Medicaid would likely be significantly and adversely affected.

Regardless of the specific details, Oklahoma's request for a per capita cap is illegal. The Social Security Act constrains what provisions of the Medicaid Act states can seek to waive. [6] It only permits waivers of sections of the Medicaid Act included in 42 U.S.C. § 1396a. Medicaid's funding mechanism is not included in this section. Thus the very structure of the Social Security Act makes it very clear that Congress did not grant CMS the authority to authorize PCC/block grant funding.

As we understand per capita caps in general, the State would receive a fixed amount of money based on the number of enrollees. The State would be liable for any costs should the State exceed its allotted cap. For example, in the instance of a national disaster or emergency, the State could easily exceed its capitated funding. Capitated funding could also limit access to new, innovative, and intensive medical treatments. The current COVID-19 pandemic and predicted economic down turn should serve as warning signals to Oklahoma about the potentially devastating consequences of a per capita cap.

By their very nature, per capita caps are designed to control spending and reduce access to care. Like the other provisions discussed in these comments, they do not serve a demonstration purpose and run counter to the provisions of the Medicaid Act.

Harm to Nursing Home Residents

The Center has advocated on behalf of nursing home residents for decades, and released an Issue Brief in 2017, "Nursing Home Residents in Jeopardy if Medicaid Becomes a Block Grant," outlining the catastrophic consequences of a Medicaid block grant proposals for residents and their families. The limited Medicare benefit for nursing home care means that many current Medicare beneficiaries rely primarily on the Medicaid program to help pay for their nursing home care. Block grants and per capita caps in Medicaid would eliminate the financial and quality of care protections that residents have relied on for decades.

Medicare covers skilled nursing facility care for a limited category of people – those needing skilled nursing (not custodial) care – and only for a limited period of time (no more than 100

days in a benefit period).[7] Private insurance does not generally cover nursing home care at all. As a result, people who need nursing home care, but who are not covered by Medicaid, must pay the facility's charges out-of-pocket. With limited state exceptions, nursing homes can charge private-paying residents whatever they choose.

Medicare pays for only limited nursing home care. Nearly a million and a half people live in nursing facilities and most rely on Medicare or Medicaid or both. However, while the Medicare program pays for many residents at the beginning of their stay,[8] it covers only short-term nursing home care. On average, in 2014, Medicare paid for only 27.6 days of care in a benefit period.[9] Nationwide, Medicare was the primary payer for only 14.18% of all nursing home residents.[10] The number of residents relying on Medicare actually declined 1.4% between 2013 and 2014, "paralleling the decline in inpatient hospital use,"[11] as hospitals increase their use of observation status and call hospitalized patients "outpatients" rather than "inpatients."[12]

Most residents remain in a nursing home far longer than the few weeks covered by Medicare. As a result, for most residents, Medicaid quickly becomes the primary payer for long-term care. The Kaiser Family Foundation reports that in 2014, Medicaid was the primary payer for 63% of nursing home residents.[13] In five states (Alaska, Georgia, Louisiana, Mississippi, and West Virginia) and the District of Columbia, more than 70% of residents relied on Medicaid.[14] Nursing home residents using Medicaid already pay for a considerable portion of the nursing home charges for their care. Nursing home residents are already required to contribute virtually all of their income toward the cost of their nursing home care, usually retaining only a small monthly personal needs allowance.[15] In addition, states can recapture the cost of a Medicaid resident's nursing home care by placing a lien on the resident's property and by collecting from the resident's estate after the resident's death.[16] Only long-term care Medicaid beneficiaries are required to repay the Medicaid program in this way for Medicaid benefits they received.

Nursing home residents could lose Medicaid coverage of their nursing home care. Under a Medicaid block grant program, many people who are currently entitled to comprehensive nursing home care could lose coverage entirely. States could change the income, resource, and medical need eligibility rules, making some current residents completely ineligible for any further coverage.

More likely, under block grants, states would continue Medicaid coverage of nursing home care to some extent. However, there could be substantial changes in who would be covered, what type of care and services residents would receive, and how long coverage would continue. Under a block grant, states could limit coverage to only the poorest and sickest people and even then, for only limited periods of time.

Even if states choose to pay for nursing home care under a block grant program, Medicaid's current financial rules and protections for residents and their families would disappear, since Medicaid block grants will not require states to continue current federal protections for Medicaid coverage of nursing home care. Four of the most significant current financial protections enacted over the 50+-year history of the Medicaid program could be lost under a block grant. They are:

- Relative Responsibility. Since 1965, the Medicaid program has prohibited nursing facilities from requesting or requiring contributions from residents' families.[17] Adult children have never been legally responsible for their parents' nursing home care under the Medicaid program. That provision disappears if Medicaid is repealed. States could require residents' families to contribute to the cost of their relatives' care, even as they address their own health care needs, plan for their own retirement, or seek to help a child attend college.
- Supplementation. Currently, the Medicaid program requires that nursing homes accept the Medicaid rate as payment in full for covered services.[18] This provision means that nursing homes are not allowed to ask residents or their families to pay any amount above the Medicaid rate for services that are covered by Medicaid – to "supplement" the Medicaid rate. Loss of this protection means that residents receiving Medicaid coverage could be asked to pay an additional amount to the facility, over and above the Medicaid payment, using their (or their families') personal funds. If a resident or prospective resident failed to pay these additional charges, the facility could deny admission (or discharge a resident who did not pay).
- Liens and Estate Recovery. Under current law, states cannot place a lien on a home where a Medicaid beneficiary's spouse, dependent or disabled children, or certain siblings live. States cannot foreclose on a lien on a beneficiary's home if adult children live there who cared for the Medicaid beneficiary before the beneficiary received Medicaid. Similarly, states cannot recover from a deceased beneficiary's estate while a spouse or dependent child is living. These protections are lost if Medicaid becomes a block grant program. States could place liens on residents' homes and force foreclosure, or recover from a deceased resident's estate, depriving the resident's spouse and dependent or disabled children of their home or other assets on which they may depend.
- Spousal Impoverishment. Since 1987, the Medicaid program has recognized that the spouse of a nursing home resident needs to retain some of the couple's income and assets in order to be able to continue living in the community.[19] The loss of this statutory protection could return the country to the time when all of a couple's money was required to be used for nursing home care and the spouse in the community was left with, literally, no income at all.
- Prescription drug cost-sharing. Under current federal law, residents with Medicaid have no cost-sharing obligation for their prescription drugs. If Medicaid is block-granted, residents could be required to pay for prescription drug coverage under Medicare Part D.

Conclusion

The Center appreciates the opportunity to submit these comments. We respectfully urge you to reject this harmful proposal. We request that the full text of each of the sources cited, and the full text of our comments be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

For additional information, please contact Kata Kertesz, Policy Attorney, kkertesz@MedicareAdvocacy.org, at 202-293-5760.

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[1] 42 U.S.C. § 1315(a) (also note that under the statute, the Secretary may only waive compliance a) with requirements in 42 U.S.C. § 1396a; and b) to the extent and for the period necessary to carry out the experiment.

[2] 42 U.S.C. § 1396-1.

[3] Ctr. For Budget and Policy Priorities, Taking Away Medicaid for Not Meeting Work Requirements Harms Older Americans (March 10, 2020), file:///C:/Users/ddouglas/Downloads/Justice%20in%20Aging%20SoonerCare%202.0%20comments%20to%20Oklahoma%20Medicaid%20Director%20(3).pdf.

[4] Natalie Kean, Justice in Aging, Medicaid Retroactive Coverage:What's at Stake for Older Adults When States Eliminate this Protection?, https://www.justiceinaging.org/wp-content/uploads/2019/09/Medicaid-Retroactive-Coverage-Issue-Brief.pdf

[5] MaryBeth Musumeci & Robin Rudowitz, Kaiser Family Found., Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers, and States 4 (2017), https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/

[6] 42 U.S.C. § 1315 (Section 1115 of the Medicaid Act).

[7] 42 U.S.C. §1395d(a)(2)(A).

[8] The National Nursing Home Survey reported in November 2010, that in 2004, 543,100 of 1,492,200 residents used Medicare at the time of admission. At the time of their interview, however, only 189,400 were using Medicare. Many residents had shifted to Medicaid. 518,700 residents used Medicaid at admission, but by the time of their interview, 890,200 relied on Medicaid. Table 8, "Number of nursing home residents by selected resident characteristics according to all sources of payment at time of admission and at time of interview: United States, 2004," http://www.cdc.gov/nchs/nnhs/nnhs_products.htm (click on Series 13, No. 167).

[9] Medicare Payment Advisory Commission (MedPAC), *A Data Book: Health Care Spending and the Medicare Program*, 112, Chart 8-4 (June 2016), http://medpac.gov/docs/default-source/data-book/june-2016-data-book-health-care-spending-and-the-medicare-program.pdf?sfvrsn=0.
[10] *Id.*8.
[11] Medicare Payment Advisory Commission (MedPAC), *Health Care Spending and the Medicare Program (A Data Book)* 112, Chart 8-4 (June 2016), http://medpac.gov/docs/default-source/data-book/june-2016-data-book-health-care-spending-and-the-medicare-program.pdf?sfvrsn=0.
[12] HHS Inspector General, *Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy*, OEI-02-15-00020 (Dec. 2016), https://oig.hhs.gov/oei/reports/oei-02-15-00020.pdf.
[13] Charlene Harrington, Helen Carrillo, University of California, San Francisco, and Rachel Garfield, Kaiser Family Foundation, *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2009-2014* (Aug. 2015) 7, Figure 6, https://kaiserfamilyfoundation.files.wordpress.com/2015/08/8761-nursing-facilities-staffing-residents-and-facility-deficiencies.pdf.
[14] *Id.*
[15] Nursing home residents receiving Medicaid and those receiving Medicaid-financed home and community based services are the only Medicaid beneficiaries who have a second financial determination made *after* they are found eligible for Medicaid. In the "post-eligibility" financial determination, the state determines how much of his or her income the Medicaid beneficiary must contribute to the cost of nursing home or community based care. All income must be contributed, with limited deductions for health insurance premiums, costs of maintaining the home while a spouse or dependent child lives there, and a monthly personal needs allowance of $30 (which some states supplement). 42 C.F.R. §§435.832, 436.832 ("Post-eligibility treatment of income of institutionalized individuals; Application of patient income to the cost of care").
[16] 42 U.S.C. §1396p.
[17] 42 U.S.C. §1307a(a)(17)(D).
[18] 42 C.F.R. §447.15
[19] 42 U.S.C. §1396r-5.