To Whom It May Concern:

The AIDS Institute, a national, non-partisan, non-profit organization dedicated to supporting and protecting health care access for people living with HIV/AIDS, hepatitis and other serious and chronic conditions, is pleased to submit comments to CMS regarding Oklahoma’s Sooner Care 2.0 1115 Demonstration waiver. We are greatly concerned that this proposal will do more harm than good, under the guise of expanding coverage to low-income adults, and therefore we urge CMS to reject this amendment in its entirety.

Medicaid is an extremely important source of health care coverage for people living with, and at risk for, HIV/AIDS and hepatitis. Forty-two percent of adults living with HIV are covered by Medicaid, compared to just thirteen percent of the general population. Ensuring uninterrupted access to effective HIV care and treatment is incredibly important to the health of people living with HIV and to the public’s health.

When HIV is effectively managed and individuals stay in treatment and virally suppressed, there is no risk of transmission.

The implications of changing Medicaid funding should be of particular concern to Oklahoma and this Administration as the program is a key component in the fight to end HIV. In 2019, President Trump declared his Administration’s commitment to Ending the HIV Epidemic (EtE) in the US by 2030. This bold plan leverages critical scientific advances in prevention, diagnosis, and treatment, but is reliant on a coordinated response from the public health infrastructure and health insurance coverage systems. HIV disproportionately burdens the South, with over half of all new HIV diagnoses in the United States occurring in Southern states like Oklahoma. In fact, HHS identified Oklahoma as one of the 7 target states in phase 1 of the EHE initiative to receive additional resources due to the overwhelming rate of rural HIV transmission.

In 2017, approximately 6,000 people in Oklahoma were living with HIV. An estimated additional 1,500 individuals are unaware they have HIV. With only two federally qualified HIV clinics in the state, access

---


to healthcare for people living with, and at risk for, HIV is a challenge.\(^6\) Oklahoma also currently has the second highest uninsured rate in the nation. Expanding Medicaid is crucial to increase access to care for people with low incomes who have no other source of coverage, but building barriers to care into that expansion – such as the unaffordable premium payments and work requirements proposed in the waiver application – will undermine the goal of expansion and ensure the Administration’s failure at meeting the goals of the EtE initiative.

Oklahoma has also been very hard hit by the hepatitis epidemic. Oklahoma reported the highest number and rate of hepatitis C (HCV) infection in the nation; from 2013-2016, the estimated number of people in Oklahoma living with HCV was 53,300 or a rate of 1,820 per 100,000.\(^7\) Poor health outcomes in the state, such as the rate of HCV, underscore the need for strong access to healthcare for citizens, not more restrictions.

**We are extremely concerned that if Oklahoma moves forward with the Section 1115 Demonstration, Sooner Care beneficiaries living with and at risk of HIV and hepatitis will not have access to the life-saving and curative health care they need to keep them healthy and alive.** Section 1115 waivers are required to promote the objectives of the Medicaid program. However, Oklahoma’s proposal runs contrary to the purpose of the program, which is to provide access to necessary health care for those who cannot otherwise afford it. Despite the state’s claims, implementing numerous restrictions and block-granting the Medicaid program will ultimately financially hamstring the state, forcing reductions in benefits and eligibility that will jeopardize the health of low-income, chronically ill, and disabled Oklahomans. We urge CMS to reject this waiver proposal, which as it stands, violates current law and would undermine the Medicaid program not only for Oklahoma, but potentially throughout the country.

**Per Capita Caps Do Not Meet the Intent of the Medicaid Act**

Although we are sympathetic to the concern that rising healthcare costs place strain on state budgets, we disagree with the proposal’s intent to radically restructure the financing mechanism for Sooner Care. Like all state Medicaid programs, Sooner Care is funded through a partnership between the state and the federal government, with the government paying 65% of the costs of the program. The financial matching from the federal government has allowed the state to increase help to those most in need.

The proposed financing structure violates current Medicaid law. Section 1115 of the Social Security Act allows the federal government to waive provisions in Section 1902 of the Act, which defines eligibility, enrollment, benefits, beneficiary protections, and delivery system requirements. The program’s financing structure is defined in Section 1903 of the Act, which is not waivable via a Section 1115 waiver.

Additionally, The AIDS Institute is concerned that without sufficient detail from Oklahoma regarding the per capita cap proposal there is a chance the state would be set up for a disaster if an unforeseen public health crisis arose, causing a sudden increase in medical needs or an influx of enrollment as the current funding structure permits. For example, as the number of coronavirus cases continue to rise and more people lose employer-sponsored coverage due to the impact on the economy, we could see a perfect storm brew for the Medicaid program. Likewise, as more individuals seek testing and treatment as a result of the EtE initiative, these individuals may be likely to have higher-than-average medical costs.

---


\(^7\) HepVu, Hepatitis Local Data:Oklahoma, https://hepvu.org/state/oklahoma/
even after adjusting for the cost of prescription drugs. If innovations in medical technology or other delivery system innovations result in cost increases that CBO does not anticipate, the state will be “on the hook” for these expenses. However, it is difficult to anticipate how the state envisions this proposal and provide thoughtful feedback due to a lack of information in the application, which should have been deemed incomplete by CMS.

In general, a per capita payment for individuals that is not based on actual healthcare expenditures jeopardizes the fiscal integrity of the Medicaid program. Unlike the traditional claims-based Medicaid program, the state would receive federal reimbursement for enrollees without any guarantee that these individuals are receiving care commensurate with said reimbursement. Under the state’s proposal, Oklahoma would not see any reduction in its block grant amount if it spends less than projected. This financing system would incentivize the state to reduce services rather than increase access to care. 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.

**OK Proposals Restrict Access to Care**

**Work Requirements**

Approving a policy that will undoubtedly cause coverage losses, further increase the number of uninsured individuals, and leave vulnerable populations without access to healthcare cannot be a justifiable use of Section 1115 waiver authority. Oklahoma proposes that enrollees complete at least 80 hours of work or work-related activities per month to maintain health coverage in Medicaid. Enrollees who do not complete and report their work hours monthly would lose their coverage. In addition, individuals who fail to complete work requirements cannot re-enroll in the Medicaid program unless they complete the work requirements or meet one of the stated exemptions, meaning many people will not be able to re-enroll. This proposal would unquestionably threaten vital access to healthcare for vulnerable populations, without providing any benefits. An eligibility requirement such as this, that will cause otherwise eligible individuals to be removed from Sooner Care rolls, cannot be reconciled with the core purpose of Medicaid to furnish medical assistance as it was designed.

The vast majority of Medicaid enrollees work, or otherwise have a good reason why they are unable to work. An analysis of Oklahoma’s Medicaid enrollees reveals that 67% of non-SSI, non-elderly adults live in working families, 16% work full time, and 35% maintain part-time work. Of those who do not work, 29% cited an illness or disability as the barrier to employment. Medicaid coverage is the exact reason why many individuals are able to look for work or work; because their health needs were met and they were in good enough health to sustain employment. This application, if approved, could be the cause for keeping people from finding gainful employment because without continued health services it will be more difficult to find and hold a job.

Oklahoma’s proposal also creates administrative reporting barriers that will cause many—including those who are working or fall within one of the state’s proposed exemption categories—to lose coverage. The state gives little clarity as to who would qualify in many of the categories. For example, the application notes that individuals who are 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.

The churn a work requirement will create in the Medicaid program goes against one of the main efforts of the EtE plan: achieving 90% viral suppression nationally. To achieve that goal, people living with HIV must have consistent, uninterrupted access to care.

**Premium Payments**

Oklahoma also intends to impose premiums on Medicaid enrollees in the expansion population. Individuals with household income that falls between the parent/caretaker income standard and 100% FPL would pay $5 every month ($7.50 for families). Individuals with household income from 100-133% FPL would pay $10. ($15 for families). Coverage will not begin until an individual has paid the first premium. Individuals who successfully enroll in coverage but fail to pay subsequent premiums will lose their Medicaid coverage after a ninety-day grace period.

Referring back to the EtE plan, the goal is to test, diagnose, and link individuals to care as rapidly as possible. Imposing premiums will automatically create a default waiting period for many individuals who cannot or do not know how to pay their initial premium. This will cause individuals to be dropped at a critical point in the HIV care continuum – linkage to care. Premiums will also cause thousands more to lose coverage after they enroll. While many people might think the low monthly fee is surely an amount that anyone can come up with; it is important to note that it is not the fee itself, but the administrative burden the premium presents that will prevent individuals from being enrolled or maintaining enrollment in Sooner Care. Decades of research has repeatedly confirmed the obvious—premiums deter and reduce enrollment among low-income individuals.

The state itself predicts that the combination of work requirements and premiums will trigger a 5% reduction in enrollment. Research and evidence from similar work requirements implemented in other states indicate that the coverage losses will be far more substantial. When Arkansas implemented a similar work requirement in June 2018, roughly 23% of Medicaid enrollees subject to the requirement—over 18,000 people—lost coverage by the end of 2018 for failure to comply. And when Indiana implemented premium payments for individuals and households above 100% FPL, 23% of individuals who were found eligible for Medicaid and required to pay premiums to obtain coverage failed to pay the initial premium, and as a result, did not enroll in coverage. In addition, 7% of people who successfully enrolled and were required to pay premiums to maintain their eligibility were later removed from Medicaid for failing to pay premiums.

**Copayments**

The AIDS Institute has tracked the impact rising copayments have had on access to care and treatment in private health insurance. As out-of-pocket costs increase, medication adherence decreases. It can be expected that a similar effect will be seen if Oklahoma is permitted to implement copayments for various types of health services, including non-emergency use of the Emergency Department. Individuals

---


will forgo necessary care because of the out-of-pocket cost imposed. Additionally, the state wants to be able to increase the copay in the future from the proposed $8 fee. Research indicates that very few Medicaid enrollees utilize the ED for non-urgent conditions, despite the state’s claim that a copay will deter unnecessary visits.\textsuperscript{13} Investing in improved primary care access and support services for those who have relied on emergency departments for non-emergency care are successful strategies in reducing emergency room use among Medicaid enrollees. Furthermore, charging a heightened copay for use of the ED is simply not permissible under the Medicaid statute.

As we’ve outlined, the proposals by Oklahoma will simply add to enrollee confusion and unfairly burden low-income individuals, while effectively decreasing enrollment of eligible individuals into Sooner Care. These actions stand to disrupt coverage for people who require continuity of care and derail the Administrations progress toward ending the HIV epidemic.

\textbf{Elimination of Critical Services for Youth}

Oklahoma proposes to eliminate EPSDT services for 19 and 20-year-olds in the expansion population. Congress included EPSDT in the Medicaid program to ensure comprehensive coverage of screening, diagnosis and treatment for individuals under the age of 21. According to the CDC, youth ages 13-24 made up 21% of new HIV diagnoses in 2018.\textsuperscript{14} Serious health conditions could be detected and caught early by EPSDT services for this vulnerable demographic. EPSDT provides an opportunity to identify significant health conditions, allows for early intervention, and can dramatically improve health outcomes. Eliminating EPSDT will lead to unmet care needs, leaving young adults without necessary screening and treatment services that could help prevent irreversible disease progression and costly conditions as they age.

The Medicaid program is intended to provide health coverage to low-income people. The intention of Section 1115 waiver is to facilitate a state’s unique projects that would assist in promoting the objectives of the Medicaid program. Oklahoma’s application fails to advance that core objective by erecting barriers to enrolling in Medicaid. Restricting access to healthcare coverage under the guise of Medicaid expansion will have detrimental effects on people living with serious chronic health conditions such as HIV and hepatitis, and will put additional strain on Oklahoma’s medical system in the long-run. HHS has an obligation to the citizens of Oklahoma and to advance the President’s initiative to end the HIV epidemic, and therefore must reject this proposal.

We appreciate the opportunity to submit comments on this proposal. Please feel free to contact me at rklein@taimail.org, if you have any questions.

Sincerely,

Rachel Klein
Deputy Executive Director
The AID Institute

\textsuperscript{13} Anna S. Somers et al., Ctr. for Studying Health System Change, Research Brief No. 23, Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are For Urgent or More Serious Symptoms (2012), \url{http://www.hschange.org/CONTENT/1302/1302.pdf}.

\textsuperscript{14} HIV and Youth. CDC. \url{https://www.cdc.gov/hiv/group/age/youth/index.html}