



Kevin Corbett
Chief Operating Officer/Director
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Dear Director Corbett,

Oklahoma Policy Institute thanks you for the opportunity to comment on Oklahoma's proposed SoonerCare 2.0 Healthy Adult Opportunity Section 1115 demonstration waiver. Oklahoma Policy Institute (OK Policy) is a nonpartisan, nonprofit public policy think tank that promotes adequate, fair, and fiscally responsible funding of public services and expanded opportunity for all Oklahomans by providing timely and credible information, analysis, and ideas. We urge the Oklahoma Health Care Authority (OHCA) to withdraw the waiver based on its bad public policy, as well as its deeply flawed public comment process.

If enacted, the proposed Healthy Adult Opportunity waiver will threaten access to needed health care for low-income Oklahomans. The Medicaid expansion envisaged by this waiver will needlessly keep Oklahomans from the care they need. Under the proposed SoonerCare 2.0, members of the expansion population will have full Medicaid expansion for one year before the waiver takes effect. Under the waiver, federal funding for the expansion will be ultimately converted to a block grant after briefly spending time as a per capita cap; certain guaranteed benefits (EPSDT, NEMT, possibly others under the terms of the proposal) will be removed; and enrollees will have to pay symbolic premiums and report certain levels of work or volunteerism in order to keep their health coverage. SoonerCare 2.0 creates artificial barriers to care at unknown expense.

In addition, the OHCA's handling of the public comment period meant that Oklahoma patients, providers, and advocates were unable to fully participate in its 30-day public comment period that coincided with the start of a global pandemic. As a result, Oklahomans were unable to provide OHCA the level of analysis that such an important policy proposal requires. Additionally, the OHCA's pivot to "virtual public hearings" was mishandled, which created needless confusion during the rollout of online meetings. The "virtual public meetings" consistently lacked transparency, including: how many participants were in the meeting, which questions OHCA did or did not respond to during the meeting, incomplete answers provided by OHCA representatives, and no opportunity for participants to clarify the record. The meetings also

lacked representation as the online platform used by OHCA required broadband connection to participate, which is troubling in a state where a third of Oklahomans lack such connectivity¹.

The Need for Medicaid Expansion in Oklahoma

Few health care interventions have been as scrupulously studied as Medicaid expansion. Medicaid expansion results in lower mortality among older adults. It slows health declines. It improves access to opioid addiction treatment. It begins to close racial equity gaps in health outcomes. It reduces the share of low-birthweight babies. It results in lower rates of anxiety and fewer medical bankruptcies. It increases the number of people getting all recommended screenings. It dramatically decreases the uninsured rate and through the welcome mat effect, its effects extend beyond the Medicaid expansion population: for instance, child uninsured rates are lower in expansion states.²

Medicaid expansion can address many health care needs for Oklahoma residents. Oklahoma's uninsured rate is the second highest in the U.S., with 1 in 5 working-age adults uninsured³. Its child uninsured rate is the fourth-highest in the U.S.⁴. Nearly one in three American Indians in Oklahoma is uninsured; the Census Bureau does not consider individuals only with Indian Health Service coverage to be insured because such coverage is underfunded and inconsistently available⁵. Oklahomans are less likely than residents of some states to be diagnosed with conditions such as diabetes and heart disease, but are more likely than their counterparts in other states to die from them⁶. The state spends less than half the national

¹ Denwalt, Dale, "A third of Oklahomans lack broadband internet choice, report shows." *The Oklahoman*. 9 August, 2019.
<https://oklahoman.com/article/5638192/a-third-of-oklahomans-lack-broadband-internet-choice-report-shows>

² Guth, Madeline, Rachel Garfield and Robin Rudowitz, "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review." Kaiser Family Foundation. 17 March, 2020.
<https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/> ; <https://okpolicy.org/oklahomas-progress-on-child-uninsured-rate-has-stalled/>

³ "Health Insurance Coverage of Adults 19-64." Kaiser Family Foundation.
<https://www.kff.org/other/state-indicator/adults-19-64/?currentTimeframe=0&selectedRows=%7B%22state%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22collId%22:%22Uninsured%22,%22sort%22:%22desc%22%7D>

⁴ "Health Insurance Coverage of Children 0-18." Kaiser Family Foundation.
<https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22collId%22:%22Uninsured%22,%22sort%22:%22desc%22%7D>

⁵ "Uninsured Rates for the Nonelderly by Race/Ethnicity." Kaiser Family Foundation.
<https://www.kff.org/uninsured/state-indicator/rate-by-raceethnicity/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22oklahoma%22:%7B%7D%7D%7D&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁶ "Adults Who Report Ever Being Told by a Doctor that They Have Diabetes." Kaiser Family Foundation.
<https://www.kff.org/other/state-indicator/adults-with-diabetes/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>; "Number of Diabetes Deaths per 100,000 Population." Kaiser Family Foundation.

average on behavioral health according to the most recent data available, and incarcerates more people than almost any other state, in large part for conditions that would result in treatment or probation rather than incarceration in other states⁷.

Medicaid expansion would not be a panacea for the multitude of health issues Oklahoma residents face, but it would give hundreds of thousands of uninsured or underinsured people access to the health care they need. OK Policy has been a staunch advocate of Medicaid expansion since the option became available to states and applauds Gov. Stitt's decision to submit a State Plan Amendment for full Medicaid expansion effective July 1, 2020.⁸

Why SoonerCare 2.0 is bad policy and bad for Oklahomans

While we are supportive of full Medicaid expansion, we oppose the effective contraction of that program that this waiver would set in motion in 2021. Creating artificial barriers to health care through work requirements, premiums, and other measures runs counter to the statutory purpose of the Medicaid program. Furthermore, the block grant proposal significantly shifts financial risk to the state, in turn putting access to care for hundreds of thousands of people at risk.

The proposal lacks detail on how Oklahoma will fund the state share of Medicaid expansion

Gov. Stitt and OHCA have failed to identify the funding source of the state's share to finance his health care proposal. The OHCA claims in the waiver that no new taxpayer dollars will be used in putting up the state's 10 percent, but it also does not specify the sources of existing revenue.

<https://www.kff.org/other/state-indicator/diabetes-death-rate-per-100000/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>;

"Number of Deaths Due to Diseases of the Heart per 100,000 Population." Kaiser Family Foundation.

<https://www.kff.org/other/state-indicator/number-of-deaths-due-to-diseases-of-the-heart-per-100000-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>; "Percent of Adults Who Have Ever Been Told by a Doctor that They Have Hypertension." Kaiser Family Foundation.

<https://www.kff.org/other/state-indicator/percent-of-adults-who-have-ever-been-told-by-a-doctor-that-they-have-hypertension/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁷ "State Mental Health Agency (SMHA) Per Capita Mental Health Services Expenditures." Kaiser Family Foundation.

<https://www.kff.org/other/state-indicator/smha-expenditures-per-capita/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>;

Genzler, Ryan, "Accepting our highest-in-the-world incarceration rate means believing that Oklahomans are the worst people." Oklahoma Policy Institute. 19 June, 2018.

"<https://okpolicy.org/accepting-our-highest-in-the-world-incarceration-rate-means-believing-that-oklahomans-are-the-worst-people/>

⁸ <http://okhca.org/sooner-care2>

The governor has not solidified his plans for financing any aspect of the state share, which is projected to be up to \$150 million. He has mentioned using increased hospital fees called SHOPP or even portions of the TSET trust, because he refuses to increase state revenues. However, there's good reason to believe that the governor's office has not actually had these conversations with the stakeholders that oversee these funds, nor has he publicly shared his plans for this part of his plan.

The state will declare a revenue failure in spring 2020 and has to draw upon Rainy Day funds just to fund existing core services through the end of this fiscal year, June 30, 2020. For State Fiscal Year 2021, agencies will most likely be cutting their budgets up to 3%. The proposal does not address the funding source for this \$150 million if the governor does not raise revenue.

Terminating Medicaid coverage for not meeting a work requirement takes health coverage from people who need it

Under this proposal, Oklahoma Medicaid enrollees in the expansion population who are not part of particular groups or not subject to particular exemptions would have their health coverage terminated if they do not adequately document 80 hours per month of work, volunteering, or other so-called "community engagement." In states where this strategy has been tested, the results have been catastrophic. Despite significant exemptions, nearly 1 in 4 Arkansas subject to the requirement lost coverage in less than a year while the policy was in effect. Efforts in other states were suspended before penalties could take effect when indicators showed that even greater coverage losses were likely⁹. According to research by Kaiser Family Foundation, between 62 and 91 percent of coverage losses are anticipated to be enrollees who "remain eligible but lose coverage due to not reporting work activity or exemption."¹⁰ Furthermore, work requirements can most generously be described as an unnecessary intervention: ample research shows that most people who can work already do, and that those who don't have good reasons for not working, such as illness, disability, or caregiving responsibilities.¹¹ The waiver

⁹ Wagner, Jennifer, and Jessica Schubel, "States' Experiences Confirming Harmful Effects of Medicaid Work Requirements." Center on Budget and Policy Priorities. 22 October, 2019. <https://www.cbpp.org/health/states-experiences-confirming-harmful-effects-of-medicaid-work-requirements>; Lawler, Emily, "100k could lose Medicaid coverage in 2020 due to new work requirements, Michigan estimates." MLive. 28 February, 2020. <https://www.mlive.com/public-interest/2020/02/100k-could-lose-medicaid-coverage-in-2020-due-to-new-work-requirements-michigan-estimates.html>

¹⁰ Garfield, Rachel, Robin Rudowitz, and MaryBeth Musumeci, "Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses." Kaiser Family Foundation. 27 June, 2018. <https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/>

¹¹ Garfield, Rachel, Robin Rudowitz, Kendal Orgera, and Anthony Damico, "Understanding the Intersection of Medicaid and Work: What Does the Data Say?" Kaiser Family Foundation. 8 August, 2019. <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say/>

proposal also does not address how the agency will document work requirements, or personnel needs to manage the process, both during implementation and moving forward. It is also likely an expensive intervention, given implementation costs in other states, which range from \$10 million to \$250 million. Notably, this application's proposal gives no suggestion of what the costs of implementing Oklahoma's work requirement might be.¹²

In addition to being expensive and unnecessary, work requirements are unlawful. They have been thrown out in every state where they have been challenged in court, and other states have backpedaled on efforts to implement them given practical and legal considerations.¹³ Section 1115 demonstration waivers are intended to be used to test health care delivery in Medicaid. Work requirements are not a health care delivery mechanism; on the contrary, they keep people from getting the health care they need.¹⁴ Oklahoma should not be pursuing this failed policy and this proposal should be withdrawn.

Premiums create needless barriers to coverage

This proposal would also implement symbolic, graduated premiums for Medicaid coverage for members of the expansion population. Imposing premiums on low-income enrollees is counterproductive. The experiences of other states show that states spend far more attempting to collect premiums than they actually recoup. In Arkansas, the state spent more than \$9 million to collect \$426,000, spending \$21 for every \$1 collected.¹⁵ OHCA has not fully answered questions about expected costs or labor for implementing such systems, including possible retrofitting or reprogramming existing OHCA systems to collect these premiums.

What's more, for low-income people, even a very small premium is a barrier to health care. Members of the expansion population by definition cannot earn more than \$17,608 per year. Even small premiums will force enrollees to choose between paying their Medicaid premium and putting food on the table. Data clearly show that even very small costs on enrollees results in fewer people getting needed care. In a review of more than 65 papers on the effects of premiums and cost-sharing, the Kaiser Family Foundation concluded that "premiums serve as

¹² "Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements." U.S. Government Accountability Office. 10 October, 2019.
<https://www.gao.gov/products/GAO-20-149>

¹³Schubel, Jessica."More States Reconsidering Medicaid Work Requirements." Center on Budget and Policy Priorities. 9 January, 2020.
<https://www.cbpp.org/blog/more-states-reconsidering-medicaid-work-requirements>;

" "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State." Kaiser Family Foundation. 7 April, 2020.
<https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/>

¹⁴ https://twitter.com/nicholas_bagley/status/1228355158922407937

¹⁵ Thompson, Joseph, Anthony Goudie, Jeral Self, Anuj Shah, J. Mick Tilford. "Arkansas Experience with Health Savings Accounts in a Medicaid Expansion Population." AcademyHealth Annual Research Meeting. 26 June, 2017.
<https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/18272>

a barrier to obtaining and maintaining Medicaid and [Children’s Health Insurance Program] coverage among low-income individuals.” Additionally, the study found that “even relatively small levels of cost sharing in the range of \$1 to \$5 are associated with reduced use of care, including necessary services.”¹⁶

The state’s justification for this barrier is not sufficient. The proposal suggests that the premiums are intended to introduce enrollees to the idea of a monthly health insurance premium. It defies belief that adults living in or near poverty need the state to teach them that goods and services cost money. This notion would be laughable if the consequences of not paying that premium weren’t their lost health coverage. In addition, given that 1 in 5 Oklahoma households are underbanked and 6.5 percent are unbanked, it’s not clear how OHCA expects members to pay these premiums.¹⁷ Although OHCA does say that premiums may be paid by other individuals or organizations on behalf of enrollees, it’s unclear how this fulfills the state’s goal of teaching poor people about financial responsibility. It is further unclear if the state consulted with providers or nonprofits before signing them up to pay these symbolic premiums, and whether providers/nonprofits have the ability and/or inclination to pay them.

The state seeks to waive important Medicaid benefits

The proposal seeks to waive coverage of non-emergency medical transportation (NEMT). NEMT helps enrollees without access to reliable transportation to attend medical appointments.¹⁸ Public transportation access is quite limited even in Oklahoma’s urban centers, particularly for individuals who live outside the more expensive downtown core. Public transportation is virtually nonexistent outside them. Removing NEMT will keep enrollees from being able to obtain the care they need. One study found that NEMT is cost-effective or cost-saving, including for preventive services such as prenatal care, and chronic conditions such as asthma, heart disease, and diabetes.¹⁹ NEMT is particularly crucial for preventive care and behavioral health

¹⁶ Artiga, Samantha, Petry Ubri, and Julia Zur, “The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings.” Kaiser Family Foundation. 1 June, 2017.

<https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>

¹⁷ “Outcome Measures in Financial Assets and Income.” Prosperity Now.

<https://scorecard.prosperitynow.org/data-by-location#state/ok>

¹⁸ Musumeci, MaryBeth and Robin Rudowitz, “Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers.” 24 February, 2016.

<https://www.kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/>

¹⁹Wallace, Richard et al, “Access to Health Care and Nonemergency Medical Transportation: Two Missing Links.” 1924 Transportation Research Record: Journal of the Transportation Research Board 76-84 (2005), http://www.researchgate.net/publication/39967547_

https://www.researchgate.net/publication/39967547_
Access_to_Health_Care_and_Nonemergency_Medical_Transportation_Two_Missing_Links

care, two areas that state leadership has claimed to value.²⁰ Ending coverage for NEMT will block Oklahoma enrollees from getting needed health care.

For enrollees up to age 21, it seeks to remove Medicaid's mandated coverage of early periodic screening, treatment, and diagnosis (EPSDT). EPSDT provides access to needed services for young people beyond what's available in the standard adult Medicaid package. By covering everything from prescription eyeglasses to behavioral health treatments, EPSDT saves states money by investing in needed care.²¹

Both NEMT and EPSDT are small investments that reap large dividends for enrollees by maximizing access to needed health care services, while also improving the state's overall health outcomes. Oklahoma should not be seeking to end coverage for these important services.

Exemptions are arbitrary, vacuous

The waiver seeks to exempt a number of groups, including people with HIV and those with mental illness. However, the waiver is silent on how these exemptions will be granted. Additionally, the waiver provides no support for what characteristics make certain groups more deserving of exemptions than others. Given that these groups are presumably eligible for exemptions only with diagnoses, it's unclear how people seeking diagnoses will be able to obtain them or what other processes individuals and providers will need to undergo in order to obtain exemptions.

The waiver's block grant structure puts Oklahomans' health care at risk

Despite substantial public relations hype²² about the new flexibilities Oklahoma is supposedly afforded through the Healthy Adult Opportunity option, its financing is the only part of this option that is in fact new. By converting Oklahoma's federal Medicaid funding from an entitlement to a block grant, the state voluntarily accepts substantially less funding from the federal government while assuming much greater financial risk. However, the state's proposal gives virtually no detail on this new funding mechanism.

²⁰ Musumeci, MaryBeth and Robin Rudowitz, "Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers." 24 February, 2016. <https://www.kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/>

²¹ Mahan, Dee, "Medicaid's Children's Benefit—EPSDT—Supports the Unique Needs and Healthy Development of Children." Families USA. November 2018. https://familiesusa.org/wp-content/uploads/2018/11/Report-EPSDT_Supports_the_Unique_Needs_and_Healthy_Development_of_Children.pdf

²² Forman, Carmen, "Gov. Kevin Stitt looks to implement Trump-supported Medicaid expansion in Oklahoma." The Oklahoman. 31 January, 2019. <https://oklahoman.com/article/5653672/stitt-trump-administration-officials-unveil-medicaid-block-grant-plan>

Although this lack of transparency makes the funding model difficult to evaluate, several factors suggest that this approach would result in loss of health care both for expansion enrollees and the general Medicaid population. Both Gov. Stitt and OHCA representatives have referenced the “shared savings” available to states by electing this approach, but Oklahoma would only ever be able to access those savings by cutting within the expansion population alongside the state’s Medicaid program as a whole.²³

Furthermore, this approach forces the state to spend more of its own funds to cover the expansion population when compared to the typical entitlement process.²⁴ It is difficult to imagine a scenario where the state could address a shortfall by cutting funding to the Medicaid expansion population without cutting funding to the program as a whole. The expansion population includes adults who are relatively inexpensive to cover, especially assuming the federal government pays on net 90 percent of their care costs. The balance of the program covers more medically fragile individuals whose care costs substantially more and for whom the government pays, on average, only 60 percent of the care costs.

Finally, under the proposed block grant, Oklahoma would be responsible for covering 100 percent of the enrollees’ care costs above the limit set, whether a per capita cap or an aggregate cap. In the event of an economic downturn, the state will then be on the hook for cost overruns that the federal government would otherwise cover under traditional expansion for an expansion population that studies show will initially be costly as these individual’s stabilize their health. Oklahoma would have to generate additional dollars or cut the program when needed most. Given the state’s three-quarters majority requirement for legislators to raise revenues, the state will likely not be able to raise the funds. Alternative funding models that shift costs to the providers would provide an unfair burden to Oklahoman’s health care providers that are already struggling to keep their lights on and doors open to Medicaid patients. Far from creating flexibility for the state in administering the program, the block grant would incentivize deep state funding cuts while also shifting risk to states during crises.²⁵

The proposal does not address how Oklahoma will handle outreach and education

The waiver draft, as posted for public comment, does not give enough information for the public to adequately understand what the agency intends to do. Other states’ experiences clearly show

²³ Fishman, Eliot, and Joe Weissfield. “Healthy Adult Opportunity: An Empty Promise from the Trump Administration.” Families USA. February 2020. https://familiesusa.org/wp-content/uploads/2020/02/MCD_CMS-Guidance-on-Block-Grants_Analysis.pdf#page=6

²⁴ Mann, Cindy, Jocelyn Guyer, Adam Striar, and Devin Stone, “The Fiscal Impact of the Trump Administration’s Medicaid Block Grant Initiative.” The Commonwealth Fund. 6 March, 2020. <https://www.commonwealthfund.org/publications/issue-briefs/2020/mar/fiscal-impact-trump-administration-medicaid-block-grant-initiative>

²⁵ Mann, Cindy, Jocelyn Guyer, Adam Striar, and Devin Stone, “The Fiscal Impact of the Trump Administration’s Medicaid Block Grant Initiative.” The Commonwealth Fund. 6 March, 2020. <https://www.commonwealthfund.org/publications/issue-briefs/2020/mar/fiscal-impact-trump-administration-medicaid-block-grant-initiative>

that states struggle to communicate work requirements, premiums, and other changes to the program with significant effects to coverage to enrollees. The waiver draft gives no detail on what communication efforts from the state agency will prevent Oklahoma from seeing the same degree of confusion and miscommunication as other states.

The state asserts it will be able to open Medicaid to the new population as soon as July 2020. Then a year later, members will be transitioned to a new program with complex new expectations to maintain eligibility. We have strong concerns about OHCA's ability to efficiently reach these communities for smooth enrollment, particularly as the economic effects of COVID-19 pandemic and its recession could last through 2021. The reliance on digital communication for this population is not based on sound research or data. OHCA will be required to provide outreach to those who would be newly included in coverage under the proposal. With recent agency changes, we are concerned the agency lacks staff, expertise, and resources to proactively reach out and inform Oklahomans who could get coverage from this health care proposal before they are enrolled. Specifically:

- The Medicaid population in Oklahoma will have decreased access to digital communications during the public health crisis, with public access points for internet and workplaces closed. Even providers' offices, which often offer help with enrollment and outreach, are impacted by the public health crisis. OHCA has not detailed its outreach plans to publicize and enroll this population for the first expansion on July 1, 2020.
- In the lead up to the start of the Health Adult Opportunity, OHCA has not delineated what it will do to ensure newly enrolled adults understand the changes coming in July 2021 as a consequence of their enrollment in SoonerCare. Will the burden continue to fall upon community partners for this outreach and education? OHCA has stated in virtual meetings they do not expect to add FTEs as part of this program.
- Will OHCA continue to rely on telephone-only contact and complex phone trees through their Member Services unit in order to trouble-shoot with members and educate them regarding the complexities of the new plan?
- There is no public evidence OHCA has conducted any research with current members to gauge their understanding and feedback on the Healthy Adult Opportunity program.
- There is also no public evidence or posting of the minutes from the Tribal Consultation on this waiver application to gauge feedback from the tribal nations on these changes.
- Education about exemptions: it's unclear what OHCA is basing their exemptions on and why. There's also no information about how enrollees would obtain those exemptions and what outreach OHCA intends to do to ensure that medically vulnerable enrollees can obtain those exemptions. Of particular concern is how disabled Oklahomans who do not qualify for Medicaid on the basis of their disability will be accommodated. In a Q&A document, OHCA suggested those members should seek Supplemental Security Income (SSI) disability determinations, displaying a staggering level of misunderstanding of the agency's legal obligations towards Oklahomans with disabilities.

The waiver draft does not adequately defend its conclusions

The waiver draft strongly implies that OHCA believes that the waiver will have little impact on coverage when it takes effect, with only a five percent drop in enrollment after it kicks in. When asked, the agency said that it had based that estimate on “other states’ experiences,” while declining to name the other states. No state that has begun to implement a work requirement has seen a coverage drop that small, and Kaiser Family Foundation estimated that the best-case scenario for coverage losses for states implementing a work requirement would be six percent.²⁶ Without further explanation from the state and given all available data, the agency’s five percent coverage loss projection is so optimistic as to be naive. This creates larger concerns about what other assumptions OHCA is building into its projections - but we don’t know what they are because OHCA has generally chosen not to show their work.

As previously noted, the waiver draft is short on data to substantiate its conjectures. However, the few references cited indicate that the agency has significantly misinterpreted data to fit its conclusions. For instance, the state points to a report to argue that work has a causal link with health care improvements to support its work requirement proposal. In 2018, when the state asserted the same link, the author of the study the state cited strongly disputed the conclusion, referring to it as “a gross distortion.”²⁷ Similarly, OHCA points to an evaluation of Indiana’s Medicaid expansion waiver to support use of symbolic premiums. In fact, a cursory reading of that study shows that Indiana’s experiment with premiums was by all accounts a failure - not something Oklahoma should seek to emulate.²⁸ OHCA asserted that it already had the infrastructure to collect premiums due to the Insure Oklahoma program, but declined to respond to questions on the state’s return on investment for those premiums in a public meeting. In addition, the state’s supposition that the same premium structure that supports a few thousand people in Insure Oklahoma can support hundreds of thousands of lower-income people in Medicaid expansion is dubious at best.

The state’s public comment process did not allow for sufficient public engagement

The waiver’s policy shortcomings aside, the public comment process was chaotic, lacked transparency, and failed to allow the public a chance to clarify important information.

²⁶ Garfield, Rachel, Robin Rudowitz, and MaryBeth Musumeci, “Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses.” Kaiser Family Foundation. 27 June, 2018.

<https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/>

²⁷ Fortiér, Jackie, “Oklahoma’s Medicaid work requirement targets poor caregivers.” StateImpact Oklahoma. 20 December, 2018.

<https://stateimpact.npr.org/oklahoma/2018/12/20/oklahomas-medicaid-work-requirement-targets-poor-caregivers/>

²⁸ “Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report.” The Lewin Group, Inc. 6 July, 2016.

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf>

The start of the public comment period demonstrated the chaotic nature of this rollout. The OHCA released the health care proposal on March 16, the day after Gov. Stitt declared a statewide emergency due to the pandemic. The first public comment period was initially scheduled for March 18, but officials initially said the meeting would be cancelled due to social distancing concerns related to the COVID-19 pandemic and filed a cancellation notice with the Secretary of State's office. The OHCA then published a media notification the following day (March 17) about planned "public hearings," but didn't provide dates. Around 10:30 a.m., Wednesday, March 18, media members received notification about a virtual "public meeting" to be held at 3:00 p.m. that same day. Information about the March 18 "public meeting" was not shared with the public or added to the OHCA website until 11:45 a.m. on the day of the meeting. No OHCA public communication told registrants how they would be able to provide comment for this process until shortly before the event began. The OHCA erroneously stated in the answers to its March 18 Q&A that the meeting notice was posted on March 16; however, meeting details such as time, place, and procedure weren't shared with the public until about three hours before the meeting started. Also, early links to the meeting registration went to the wrong virtual event. OHCA representatives have said that all questions and responses from the "virtual public hearings" would be posted on its website, but as of April 13, only responses from two of the four hearings (March 18 and March 20) have been posted. These issues are compounded by the state Medicaid agency's comportment throughout the public comment process, which did not maximize public participation and should have been substantially expanded to account for the magnitude of the waiver, the unprecedented public engagement with the public comment period, and the fact that both advocates and agency employees were notably preoccupied by the unprecedented and concurrent global health crisis.

Although the agency has not published official numbers, there are indications that the waiver draft generated unprecedented public interest during the state-level comment period. Advocates with Together Oklahoma recorded more than 2,100 public comments delivered through the organization's online tool, which emailed comments to the email address listed on the waiver's public notice document.

An OHCA spokesperson for the agency stated during a virtual public meeting that more than 600 people had participated in public meetings so far and referred to the participation level as "unprecedented." In 2018, when the state sought a work requirements waiver for low-income parents, a similar policy change of much lower magnitude than the one currently under consideration, public engagement prompted the agency to double the state-level public comment period from 30 days to 60 days.²⁹ With even greater public engagement on this issue and the distraction of a global health crisis, OHCA should have extended the comment period to better allow providers, patients, and advocates to engage on the issue.

²⁹ <http://www.okhca.org/about.aspx?id=22248&parts=22255>

In addition to public comments, public meetings are a crucial part of the waiver process. Allowing the public to weigh in in public forums allow advocates and state agency employees to build important trust and to ensure that both the public and the state agency have opportunity to ensure they understand each other and their concerns. Although OHCA's virtual public meetings somewhat improved over time, virtual public meetings, even at the end of the comment period, still largely failed to accomplish the same aims as in-person public meetings

Shortcomings of the meetings included:

- The virtual public meetings did not follow the agency's typical public meeting procedure, including what is typically a hard-and-fast rule requiring attendees wishing to speak to register at least 24 hours in advance.
- Virtual public meetings typically allow attendees the opportunity to make statements of up to two minutes. This was never an option in the virtual public meetings.
- In early meetings, OHCA's spokesperson paraphrased questions "beyond recognition," in the words of one participant.
- OHCA operated without clarity regarding how questions were to be transmitted (via Zoom app or via email), which meant that in two meetings, the OHCA spokesperson cajoled attendees that he was out of questions even while dozens of questions submitted via email were left unanswered.
- The virtual public meeting format allowed no opportunity for follow-up questions or clarifications in circumstances where question-askers felt their question had been misinterpreted or if they didn't understand the answer.
- In early meetings, before advocates pushed the agency to reconsider, virtual public meeting attendees had no ability to see what questions were being submitted or who was asking them.
- In virtual public meetings, attendees never had the opportunity to see the total number of attendees, who they were, or who they represented. OHCA said it would post on its website a list of who participated in the call, but has not done so as of April 13.

The public hearings lacked reasonable accommodations:

- OHCA declined to make recordings of the virtual public meetings available, claiming that the file of the one-hour video meeting would be too large for the agency to host on its website. This limited attendees' ability to follow up with the agency after meetings.
- Although later virtual public meetings were captioned, the first two virtual public meetings had no accommodations for hearing-impaired attendees.

Acknowledging that the agency was not able to answer all questions submitted during virtual public meetings due to overwhelming attendance, OHCA volunteered to post answers to all submitted questions after the meeting. However, these answers were slow to arrive, and in some cases contradicted each other and statements made by the agency during virtual public meetings. In addition, contrary to agency assurances, not all questions received by the agency were answered.

Conclusion - Bad policy, bad process

In summary, the state's SoonerCare 2.0 proposal will put Oklahomans' health care needlessly at risk. Furthermore, the agency's failure to fully accommodate the public comment process meant that providers, patients, and advocates were not able to fully engage with the waiver draft, leaving the state agency without valuable input. The waiver as drafted puts Oklahoman's health and the state finances at considerable risk, and the public comment process did not allow the agency to sufficiently gather public feedback. The waiver should be withdrawn.

If you have any questions, please do not hesitate to contact me at arose@okpolicy.org or Carly Putnam, Policy Director, at cputnam@okpolicy.org.

Best,



Ahniwake Rose
Executive Director