July 10, 2019

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: South Carolina 1115 Demonstration Waiver Application – South Carolina Medicaid Community Engagement

Dear Secretary Azar:

Thank you for the opportunity to submit comments on South Carolina's Section 1115 Demonstration Waiver Application – South Carolina Medicaid Community Engagement.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the Department of Health and Human Services (HHS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Medicaid provides adequate, affordable and accessible healthcare coverage. Several 1115 waiver proposals submitted to and approved by the Centers for Medicare and Medicaid Services (CMS) in recent months have threatened patients' access to quality and affordable healthcare coverage.[1] While we appreciate some of the coverage expansions for specific populations included in the South Carolina Department of Health and Human Services' (SCDHHS) waiver, we are concerned that the waiver will ultimately jeopardize many patients' access to care.

Under this application, individuals between the age of 19 and 64 would be required to demonstrate that they work an average of at least 80 hours per month or meet exemption requirements. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Individuals will need to demonstrate that they meet certain exemptions or have worked the required number of hours. The proposal does not clearly state how individuals will be able to verify their exemption or employment. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. During the first six months of implementation, the state terminated

coverage for over 18,000 individuals and locked them out of coverage until January 2019.[2] In another case, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.[3]

Our organizations are also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from working. Additionally, South Carolina's "case specific basis" exemption as "determined by SCDHHS" is vague and does not provide sufficient detail on how this exclusion would be implemented. The outlined exemptions are not sufficient to protect patients. Furthermore, in Arkansas, many patients were unaware of the new requirements and therefore unaware that they needed to apply for such an exemption.[4] No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases. If the state finds that individuals have failed to comply with the new requirements for three months, their coverage could be suspended for up to three months. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care. Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health.

Most people on Medicaid who can work already do so. [5] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[6] The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work. In another report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that that being enrolled in Medicaid made it easier to work or look for work (83.5 percent and 60 percent, respectively).[7] The report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Suspending individuals' Medicaid coverage for non-compliance with these requirements will hurt rather than help people search for and obtain employment.

Additionally, recent research shows that the work reporting requirement in Arkansas did not lead to increased employment among the Medicaid population. A study in *The New England Journal of Medicine* found that the implementation of Arkansas's work requirement was associated with a significant loss of Medicaid coverage and significant increase in the number of uninsured individuals.[8] The study found no corresponding increase in employment, which negates the state's argument that Medicaid enrollment is down because individuals are finding jobs and gaining other coverage. The study also estimates that 95 percent of Arkansans subject to the requirements already worked enough hours to meet the requirements or qualified for an exemption, which further confirms that most Medicaid beneficiaries are working if they are able to do so.

Administering these requirements will be expensive for South Carolina and burden SCDHHS staff as well as Medicaid beneficiaries. States such as Michigan, Pennsylvania, Kentucky and Tennessee have estimated that setting up the administrative systems to track and verify exemptions and work activities

will cost tens of millions of dollars.[9] These costs would divert resources from Medicaid's core goal – providing health coverage to those without access to care.

Our organizations are also troubled that SCDHHS was not receptive to public feedback. The state received 290 comments during the first comment period, 97 percent of which opposed the demonstration. In the second comment period, the state received 60 comments, with over three-fourths opposed. The state made no changes in response.

The revised waiver application does include some targeted changes in income levels for certain eligibility groups. While our organizations appreciate these efforts to expand coverage, South Carolina would be better served by expanding its Medicaid program to 138 percent of the federal poverty level ($17,236 for an individual in 2019) which would make coverage available to 240,000 low-income individuals and families in the state at the enhanced federal match rate.[10] This coverage would help patients access medications to manage chronic conditions, preventive services like cancer screenings and many other treatments needed to stay healthy.

Ultimately, the requirements outlined in this waiver do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Our organizations believe that everyone should have access to quality and affordable healthcare coverage. We urge CMS to reject South Carolina's community engagement reporting requirement. Thank you for the opportunity to provide comments.

Sincerely,

American Heart Association
American Lung Association
Arthritis Foundation
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Leukemia & Lymphoma Society
March of Dimes
National Alliance on Mental Illness
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Psoriasis Foundation
Susan G. Komen

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[1] American Lung Association, A Coordinated Attack: Reducing Access to Care in State Medicaid Programs, July 2018. Accessed at http://www.lung.org/assets/documents/become-an-advocate/a-coordinated-attack.pdf.
[2] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November 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

[3] Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.

[4] Jessica Greene, "Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement," Health Affairs, Sept. 5, 2018. Accessed at: https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/.

[5] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[6] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

[7] Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Accessed at: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf

[8] Benjamin D. Sommers, MD, et al. "Medicaid Work Requirements—Results from the First Year in Arkansas," *New England Journal of Medicine*. Published online June 18, 2019, https://cdf.nejm.org/register/reg_multistep.aspx?promo=ONFGMM02&cpc=FMAAALLV0818B

[9] Michigan House Fiscal Agency, Legislative Analysis of Healthy Michigan Plan Work Requirements and Premium Payment Requirements, June 6, 2018, http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-5CEEF80A.pdf; House Committee on Appropriations, Fiscal Note for HB 2138, April 16, 2018, http://www.legis.state.pa.us/WU01/LI/BI/FN/2017/0/HB2138P3328.pdf; Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018, https://www.rollcall.com/news/politics/medicaid-kentucky.

[10] Rachel Garfield, Kendal Orgera and Anthony Damico, "The Coveage Gap: Uninsured Poor Adults in State that Do Not Expand Medicaid," March 2019, https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.