September 26, 2018

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

Re: South Dakota Career Connector 1115 Waiver Application

Dear Secretary Azar:

Thank you for the opportunity to submit comments on the South Dakota Career Connector 1115 Waiver Application.

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. Unfortunately, several 1115 waiver proposals submitted to and approved by the Centers for Medicare and Medicaid Services (CMS) in recent months have jeopardized patients' access to this coverage.[i] South Dakota's proposed waiver similarly threatens access to healthcare by requiring certain people enrolled in the state's Medicaid program to either prove they work at least 80 hours per month or meet exemptions. This requirement would apply to parents and caregivers living in Minnehaha and Pennington counties and between the ages of 19 and 59 with incomes below 51 percent of the federal poverty level ($866 per month for a family of three), a

vulnerable population that cannot afford additional barriers to healthcare coverage. Our organizations therefore ask HHS to reject this proposal.

One major consequence of the waiver will be to increase the administrative burden on all patients in these counties. Individuals will need to either prove that they meet certain exemptions or provide evidence of the number of hours they have worked and other "monthly milestones" they have met that are not fully defined. The case managers that South Dakota outlines in the application will not be sufficient to avoid placing this paperwork burden on patients, especially since the state proposes to use existing staff and resources to provide this case management.

Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. Arkansas is currently implementing a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. As of September 1, three months into implementation, the state has terminated coverage for 4,353 individuals and locked them out of coverage until January 2019.[ii] An additional 11,250 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[iii] 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.[iv] 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.

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, they will have 30 days to prove their compliance or will be locked out of coverage for 90 days. 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.

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 Dakota's "good cause" exemption that includes circumstances like hospitalizations or serious illnesses is still not sufficient to protect patients. In Arkansas, many individuals were unaware of the new requirements and therefore unaware that they needed to apply for such an exemption,[v] and in August the state granted just 45 good cause exemptions while terminating coverage for 4,353 individuals at the end of that month.[vi] Ultimately, even enrollees who meet the qualifications for "good cause" or other exemptions will likely have to provide documentation of their illness during the application and reassessment process, creating opportunities for administrative error that could jeopardize their coverage. No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

Administering these requirements will be expensive for South Dakota. States such as Michigan, Pennsylvania, Kentucky, Tennessee and Virginia have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[vii] These costs would divert resources from Medicaid's core goal – providing health coverage to those without access to care.

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. Many of the hypotheses that the waiver proposes to test – particularly 2.1 through 2.5 – are connected to employment outcomes but have no direct link to improving individuals' health. Additionally, most people on Medicaid who can work already do so.[viii] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[ix] 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).[x] Terminating individuals' Medicaid coverage for non-compliance with these requirements will therefore hurt rather than help people search for and obtain employment.

If certain beneficiaries who do obtain work through this program increase their incomes above current Medicaid eligibility levels and meet additional requirements, South Dakota proposes to provide a year of Transitional Medical Benefits and up to one year of premium assistance. This provision is both a temporary fix and insufficient one, as individuals could still lose coverage if they get caught up in red tape trying to prove their continued compliance. Additionally, this premium assistance is capped and may not cover the full cost of individuals' premiums and cost-sharing such as copayments, coinsurance, and deductibles. Research has shown that cost-sharing for low-income populations limits the use of necessary healthcare services.[xi] Access to affordable, accessible and adequate health coverage for patients with serious and chronic illnesses therefore remains at risk.

Since the state comment period, South Dakota has updated its application with an estimate that fifteen percent of beneficiaries will lose their Medicaid coverage as a result of this program. However, the state's budget neutrality spreadsheets still do not reflect any changes in enrollment. This is especially concerning given the evidence from Arkansas and other sources clearly demonstrating that there would be coverages losses as a result of this waiver that need to be reflected in these estimates. The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. Therefore, CMS should at a minimum send the proposal back to South Dakota to update the budget neutrality information and reopen the state comment period for an additional 30 days before it makes any determination. A number of our organizations previously raised this issue with South Dakota during the state comment period.[xii]

Our organizations believe that healthcare should affordable, accessible and adequate. South Dakota's Career Connector 1115 Waiver Application does not meet that standard, and we urge HHS to reject this proposal. Thank you for the opportunity to provide comments.

Sincerely,

Arthritis Foundation
American Heart Association
American Liver Foundation
American Lung Association
Chronic Disease Coalition
Crohn's and Colitis Foundation
Cystic Fibrosis Foundation

Epilepsy Foundation
Family Voices
Global Healthy Living Foundation
Hemophilia Federation of America
Leukemia and Lymphoma Society
Lutheran Services in America
NAMI, National Alliance on Mental Illness
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
March of Dimes
United Way Worldwide

CC: The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services

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[i] 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.

[ii] Arkansas Department of Health and Human Services, Arkansas Works Program, August 2018. Accessed at: https://ccf.georgetown.edu/wp-content/uploads/2018/09/091218_AWReport_Final.pdf.

[iii] Arkansas Department of Health and Human Services, Arkansas Works Program, August 2018. Accessed at: https://ccf.georgetown.edu/wp-content/uploads/2018/09/091218_AWReport_Final.pdf.

[iv] 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.

[v] 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/.

[vi] Arkansas Department of Health and Human Services, Arkansas Works Program, August 2018. Accessed at: https://ccf.georgetown.edu/wp-content/uploads/2018/09/091218_AWReport_Final.pdf.

[vii] 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.

[viii] 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/.

[ix] 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

[x] 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

[xi] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, 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/.

[xii] Letter from Health Groups to William Snyder, Director, Medical Services, South Dakota Department of Social Services, May 23, 2018. Available at http://www.lung.org/assets/documents/advocacy-archive/partners-letter-to-sd-dss-re-1115-proposal.pdf.