October 26, 2018

Submitted via the Federal Medicaid.gov Portal

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comments for Section 1115 Demonstration Extension Application: Healthy Michigan Plan

To Whom It May Concern:

We are writing on behalf of the Chronic Illness and Disability Partnership (CIDP). CIDP consists of national organizations representing people living with a wide range of chronic illnesses and disabilities, including cancer, cystic fibrosis, diabetes, HIV, Hepatitis B and C, multiple sclerosis, and mental health and substance use disorders. We represent the 117 million Americans estimated to be living with a chronic illness and/or disability, many of whom rely upon Medicaid to obtain needed care.[1] While our organizations are national in scope, we also affiliate with strong regional, state, and community based advocacy networks.

CIDP appreciates the opportunity to comment on Michigan's Section 1115 Demonstration Extension Application (the "Michigan Application") under Section 1115 of the Social Security Act. While CIDP understands and supports the value of work, we are concerned that polices put forth in the Michigan Application would decrease meaningful access to care for low-income people living with chronic illnesses and disabilities. This misguided proposal will not achieve the laudable objectives of supporting greater independence and promoting economic opportunities

[1] U.S. Centers for Disease Control and Prevention, Chronic Disease Overview (February 23, 2016), available at https://www.cdc.gov/chronicdisease/overview/.

for low-income vulnerable populations, nor does it promote the objectives of the Medicaid program. For the reasons discussed in detail below, we strongly oppose the South Dakota Application and urge the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS) to reject it.

I. Michigan's proposal would result in a loss of coverage that would violate the core objectives of the Medicaid program and is therefore unlawful

If approved, the Michigan's Application would violate the basic conditions required for approval of a section 1115 waiver. Section 1115(a) of the Social Security Act, codified at 42 U.S.C. § 1315(a), allows a federal waiver to facilitate a State's "experimental, pilot, or demonstration project" that, "in the judgment of the Secretary, is likely to assist in promoting the objectives" of the Medicaid program. One of the primary objectives of Medicaid, as explained by § 1901 of the Social Security Act, is to enable each State to furnish "medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and costs are insufficient to meet the costs of medically necessary services."

Michigan's proposal would achieve the exact opposite result intended by this objective. Michigan's own projections estimate that anywhere from 27,000 – 54,000 individuals would lose coverage as a result of the work requirement, premiums, and noncompliance penalties contemplated by the Michigan Application.[2] The actual number of individuals losing coverage is likely to be higher than this, as Michigan has not grappled with the administrative complexity this new system would require. This devastating loss of coverage cannot be reconciled with the core purpose of Medicaid to furnish medical assistance. Approving policies that cause coverage losses, increase the number of uninsured individuals, and leaves vulnerable individuals without access to health services cannot be justified as a lawful and proper use of Section 1115's waiver authority. Medicaid is a lifeline for many individuals living with chronic health conditions, and losing Medicaid coverage would be particularly harmful for these individuals.

In order to determine the experimental value of the project, HHS must make a judgment "that the project has a research or a demonstration value" – a simple benefits cut is not sufficient.[3] Michigan's proposal to implement a work requirement has no research or demonstration value – requiring people to satisfy work requirements in order to receive public benefits is a mandate that has been well-researched, with studies finding that work requirements do not lead to

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[2] Kevin Koorstra, *Legislative Analysis on Healthy Michigan Work Requirements and Premium Payment Requirements,* Michigan House Fiscal Agency (http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-78EF78F9.pdf)

[3] *Newton-Nations v. Betlach*, 655 F.3d 1066, 1074 (9th Cir. 2011)

significantly higher labor force participation or lift people out of poverty.[4] Similarly, extensive research (including research from Medicaid demonstration projects conducted prior to health reform) shows that premiums significantly reduce low-income people's participation in health coverage programs and make individuals more likely to drop coverage due to premium obligations.[5]

If implemented, the Michigan Application would take away health coverage for many who would otherwise be eligible. Far from addressing the health needs of vulnerable low-income populations, work requirements, premiums, and attendant lockouts would decrease access to health coverage for these populations by creating new barriers to health care. As a result, individual and public health in the state will suffer, undermining the progress that Michigan has made on these issues and placing residents at unnecessary risk. As such, the Michigan application would harm Michigan's Medicaid beneficiaries and restrict access to care, in direct conflict with the objectives of the Medicaid program. Accordingly, given the multitude of ways in which these proposals will take health care away from individuals and worsen health outcomes, HHS should reject Michigan Application for failing to promote the objectives of the Medicaid program, thereby violating the requirements of section 1115.[6]

II. Work requirements will disproportionately harm individuals living with chronic health conditions

Individuals living with chronic illnesses stand to be disproportionately harmed by the combined effect of these proposals. Many individuals who live with a chronic illness that is not classified severe enough by the Medicaid program to be considered a disability but that make maintaining employment impossible would be subject to the work requirement. Chronic illnesses can produce symptoms or disabilities that are not visible, yet serve as impediments to steady employment. Additionally, some chronic conditions like multiple sclerosis produce periods of inability to work due to medication side effects or symptom flare-ups; employees with these conditions require flexible work arrangements that can be hard to find or keep. Episodic disabilities can produce an uneven work history, which in turn can make it more

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[4] LaDonna Pavetti, *Work Requirements Don't Cut Poverty, Evidence Shows,* Center on Budget and Policy Priorities, June 2016, https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows.

[5] Samantha Artiga, Petry Ubri, and Julia Zur, *The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings,* The Kaiser Family Foundation, June 2017, http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations.

[6] *See, e.g.*, *Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994) (striking down a section 1115 waiver due, in part, to an inadequate determination by HHS that the plan was likely to promote the Act's objectives). Furthermore, the law requires that the Secretary's decision is based solely on a substantive "judgment" as to whether the waiver "is likely to assist in promoting the objectives" of Medicaid. As the Supreme Court has made clear in *Massachusetts v. EPA*, "the use of the word 'judgment' is not a roving license to ignore the statutory text. It is but a direction to exercise discretion within defined statutory limits." 549 U.S. 497, 533 (2007).

difficult for a person to find consistent employment. These burdens particularly affect people living with chronic illnesses or disabilities, as consistent access to medical care is key to the management of symptoms and overall long-term wellness.

While Michigan's Application states that individuals determined "medically frail," will be exempted from the new work requirements and loss of coverage due to noncompliance with premium obligations, the definition of this term is narrow and will leave out many individuals living with chronic illnesses and disabilities that need consistent access to health services. For example, the Healthy Michigan beneficiary survey found that nearly 70 percent of enrollees have a chronic physical or mental health condition such as diabetes, hypertension, or depression.[7] Work requirements in other contexts have been the subject of rich research. This research demonstrates that work requirements carry high administrative costs and the complexity required to administer them yields high error rates that deny otherwise eligible individuals benefits, including individuals living with disabilities and chronic illnesses.[8] There is no reason to think that Michigan's proposed work requirements is designed in a way that avoids those pitfalls

Further, even individuals that qualify for an exemption may be unable to prove that they do. Imposing additional paperwork requirements has been shown to reduce Medicaid enrollment overall, and individuals living with chronic health conditions will face added hardships in meeting these requirements.[9] Navigating the complex process of obtaining physician testimony, medical records, and other required documents may prove unduly burdensome, particularly if individuals do not have health coverage while securing an exemption.

While Michigan has provided more detail than many other states on the process of identifying medically frail individuals, the reality is that exemptions are an imperfect solution to the problem created by work requirements, premiums, and lockouts. Even if people living with chronic conditions are formally exempt, experience shows that the process of securing an exemption is likely to be error prone and potentially lead to gaps in coverage and treatment. The history of administering exemptions to work requirements in other public benefits, such as the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy

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[7] Susan Dorr Goold and Jeffrey Kullgren, *Report on the 2016 Healthy Michigan Voices Enrollee Survey,* University of Michigan Institute for Healthcare Policy & Innovation, January 17, 2018, https://www.michigan.gov/documents/mdhhs/2016_Healthy_Michigan_Voices_Enrollee_Survey_-_Report__Appendices_1.17.18_final_618161_7.pdf.

[8] USDA Office of Inspector General, FNS Controls over SNAP Benefits for Able-Bodied Adults Without Dependents, September 2016, https://www.usda.gov/oig/webdocs/27601-0002-31.pdf. ("[I]mplementation of ABAWD requirements can be error prone, and when ABAWD policy is applied inaccurately, eligible ABAWDs are denied SNAP benefits, while otherwise ineligible ABAWDs are provided benefits.")

[9] Margot Sanger-Katz, "Hate Paperwork? Medicaid Recipients Will Be Drowning in It," *The New York Times,* January 18, 2018, https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html

Families (TANF) programs shows that states often make mistakes and end up sanctioning beneficiaries that are not formally subject to the requirement, including individuals living with disabilities.[10]

The administrative challenges associated with implementing work requirements would be more pronounced in Medicaid than in the SNAP and TANF programs, which have struggled with implementation. SNAP and TANF require substantial interactions with participants, including interviews and frequent reporting. States have encountered numerous obstacles to accurately applying these policies. States' administration of these policies in the SNAP program was often applied inaccurately and led to eligible individuals being denied benefits.[11] When first implemented, the U.S. Food and Nutrition Service did a study and found that policies were "difficult to administer and too burdensome for the States." One of the biggest shifts was tracking benefit receipt over time, rather than circumstances in a single month, which was a fundamental change to program administration.[12] Historical analysis of state experience implementing work requirements in TANF suggests that adding similar requirements to Medicaid could cost states thousands of dollars per beneficiary.[13] Michigan has not adequately considered the disproportionate effect these harmful policies will have on individuals living with chronic illnesses and disabilities.

III. Michigan's proposal would likely decrease individuals' ability to work, particularly those living with chronic health conditions

Research on work requirements in other programs finds that they generally have only modest and temporary effects on employment and fail to increase long-term employment or reduce poverty. Results in Medicaid are likely to be worse, for several reasons. Most of those affected by the requirements are either already working or face major barriers to work. Many enrollees work in industries such as retail, home health, and construction, and they have volatile hours and little flexibility, so they may not be able to work 80 hours every month. Illness, family emergencies, or child care or transportation barriers can also lead to job loss. Medicaid

[10] LaDonna Pavetti, Michelle K. Derr, Heather Hesketh Zaveri, "Review of Sanction Policies and Research Studies: Final Literature Review," Mathematica Policy Research Reports, https://ideas.repec.org/p/mpr/mprres/acfb6f4539184fbf9847236c75f1fb36.html

[11] USDA Office of Inspector General, FNS Controls over SNAP Benefits for Able-Bodied Adults Without Dependents, September 2016, https://www.usda.gov/oig/webdocs/27601-0002-31.pdf.

[12] Mathematica Policy Research, Inc., Imposing a Time Limit on Food Stamp Receipt: Implementation of the Provisions and Effects on Food Stamp Participation (2001).

[13] Gayle Hamilton et al., "National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs," Manpower Demonstration Research Corporation, December 2001, Table 13.1.

enrollees already have a strong incentive to work and typically do not lack motivation but rather work supports such as job search assistance, job training, child care, and transportation assistance; they may also face challenges such as an undiagnosed substance use disorder, domestic violence, the need to care for an ill family member, or a housing crisis.

Michigan's application could even end up keeping people from gaining employment, because without health services, it will be more difficult for them to find and hold a job. Ohio's Department of Medicaid found that three-quarters of Medicaid expansion enrollees who were looking for work reported that Medicaid made it easier to do so, and more than half of those who were working said that Medicaid made it easier to keep their jobs.[14] It is precisely *because* Medicaid meets enrollees' health needs that they are able to focus on finding and keeping employment. An analysis of Michigan's Medicaid enrollees reveals the majority of the program already works: 75% of non-SSI, nonelderly enrollees live in working families, 42% work full-time, and 18% maintain part-time employment.[15] Further, among non-SSI, nonelderly enrollees that do not work, most face some significant barrier to work, with 39% citing an illness or disability as reasons for not working.[16] These individuals depend on consistent access to care and treatment in order to stay healthy and lead productive lives. The policies contemplated by the Michigan Application will place access to these services in jeopardy, worsening health outcomes for those affected and removing any chances of economic mobility.

We appreciate the opportunity to provide comments on the Michigan Application. Our comments include numerous citations to supporting research, including direct links to the research for the benefit of HHS in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

For the reasons described above, we urge HHS to reject the Michigan Applicaiton in order to ensure that the 1115 waiver program promotes, rather than undermines, the objectives of the Medicaid program, and that vulnerable populations retain access to crucial medications and

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[14] Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[15] Rachel Garfield, Robin Rudowitz, Anthony Damico, Kaiser Family Foundation, *Understanding the Intersection of Medicaid and Work* (http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work (Updated Jan. 2018)

16 Id.

health care services. With any further questions, please contact Robert Greenwald with the Treatment Access Expansion Project (rgreenwa@law.harvard.edu), Amy Killelea with the National Alliance of State & Territorial AIDS Directors (akillelea@nastad.org), or Jean McGuire at Northeastern University (j.mcguire@neu.edu) if we can be of assistance.

Respectfully submitted by the co-chairs of the Chronic Illness and Disability Partnership:

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