Division of TennCare

TennCare II Demonstration

Project No. 11-W-00151/4

Amendment 38

December 28, 2018

Table of Contents

Amendment 38 to the TennCare II Demonstration

I. Description of the Amendment

Tennessee has a long history of innovation in its Medicaid program. Since 1994, Tennessee has operated one of the longest-lasting and most comprehensive Medicaid managed care programs in the nation. In so doing, Tennessee has become a recognized leader in the use of managed care to provide broad access to care, deliver high-quality care that promotes improved health outcomes, and manage the cost of care effectively. Tennessee operates its managed care program under the authority of an 1115 demonstration waiver known as TennCare.

Tennessee continually seeks to build on its history of innovation by identifying new ways to improve the TennCare program. In the proposed waiver amendment outlined below, Tennessee proposes an enhanced program design for certain members that is intended to support participants' ability to obtain and maintain employment, promote improved health outcomes, and ultimately serve as a pathway to independence that supports program participants in their transition from public assistance to private health insurance.

This proposed amendment is consistent with guidance released by CMS on promoting work and community engagement among Medicaid beneficiaries[1], and is submitted in accordance with Public Chapter No. 869, enacted by the Tennessee General Assembly in 2018.

Amendment Objective and Overview

One of the core objectives of the TennCare demonstration is to improve health outcomes for individuals enrolled in TennCare.[2] A growing body of evidence points to a link between productive work or community engagement and improved health outcomes. One comprehensive review of existing studies found strong evidence that unemployment is generally associated with negative health outcomes, including higher mortality, poorer general health, poorer mental health, and higher medical consultation and hospital admission rates.[3] In general, employed individuals are both physically and mentally healthier, as well as more financially stable, than unemployed individuals.[4] Due to the strong connection between employment and overall health, people who are unemployed have higher mortality

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf
[2] See Section II of the TennCare demonstration, available at https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf
[3] Waddell, G. & Burton, A.K. (2006). *Is work good for your health and well-being?* EurErg Centre for Health and Social Care Research, University of Huddersfield, UK.
[4] McKee-Ryan, F.M., Song, Z., Wanberg, C.R., & Kinicki, A.J. (2005). Psychological and physical well-being during unemployment: a meta-analytic study. *Journal of Applied Psychology*, 90 (1), 53-76.; Paul, K.I., Geithner, E., & Moser, K. (2009). Latent deprivation among people who are employed, unemployed, or out of the labor force. *Journal of Psychology*, 143 (5), 477-491.

and poorer health outcomes, and, further, longitudinal studies have found that these effects of unemployment exist regardless of any pre-existing health conditions.[5]

Given this growing body of research, a well-designed process to connect individuals to employment in a way that promotes positive health outcomes will serve to advance the goals of the TennCare demonstration. This is true whether the individual obtaining employment remains enrolled in TennCare or is able to transition to private insurance.

Accordingly, Amendment 38 is designed to promote improved health outcomes for TennCare members, and to support member efforts to achieve independence and potentially facilitate their transition off of the TennCare program and into private insurance. To this end, Amendment 38 will establish workforce participation and community engagement as an expectation for some program members, and provide corresponding supports to help members achieve their education- or employment-related goals.

Impacted Population

The workforce participation and community engagement requirements will be applicable to non-pregnant,[6] non-disabled, non-elderly adults enrolled in TennCare in the parent/caretaker relative eligibility category described at 42 CFR § 435.110. The requirement will apply to members of this eligibility category ages 19-64 who do not qualify for one of the exemptions described below.

Qualifying Activities

Impacted adults will be required to engage in qualifying work or community engagement activities for 20 hours per week (averaged monthly).

These individuals can fulfill this requirement in a variety of ways. These include:

- Working in paid employment or self-employment; [7]
- General education (e.g., high school or high school equivalency, college, English as a second language, etc.);
- Vocational education and training;
- Participation in job search or job skills training activities sponsored by the Tennessee Department of Labor & Workforce Development;
- Accredited homeschooling; and
- Community service (volunteering) in approved settings.

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[5] Egerter, S., Dekker, M., An, J., Grossman-Kahn, R., & Braveman P. (2008). *Work matters for health* (Issue Brief No. 4). Robert Wood Johnson Foundation, Commission to Build a Healthier America. Retrieved from http://www.commissiononhealth.org/PDF/0e8ca13d-6fb8-451d-bac8-7d15343aacff/Issue%20Brief%204%20Dec%2008%20-%20Work%20and%20Health.pdf

[6] The workforce participation and community engagement requirement does not apply to pregnant women, or to women during their period of postpartum coverage.

[7] If self-employed, an individual must be able to demonstrate income that is consistent with working at least 20 hours per week (averaged monthly).

In addition, individuals subject to and complying with the work requirements of another public assistance program (i.e., SNAP or TANF) will be deemed to be in compliance with the TennCare community engagement requirement. This includes individuals who are enrolled in another public assistance program and who have been determined to be exempt from that program's work requirements.

Exemptions

TennCare acknowledges there are circumstances that may limit or prevent a member's ability to comply with the community engagement requirement. Members will be exempt from the requirement in any month in which any one of the following conditions is met:

- Individuals who are at least 65 years old
- Individuals who are physically or mentally incapable of work, as certified by an appropriate medical professional
- Individuals who are determined to be medically frail
- Individuals with a short-term or long-term disability or an acute medical condition validated by a medical professional that would prevent them from complying
- Individuals participating in inpatient or residential treatment or an Intensive Outpatient Program (IOP) for a substance use disorder
- Individuals who are the primary caregiver of a child younger than six years of age (one exemption per household)
- Individuals who are providing caregiver services for a household member (child or adult) with a disability or incapacitation, or with a medical frailty that prevents the caretaker from fulfilling the community engagement requirement
- Individuals receiving unemployment benefits
- Individuals who have recently been directly impacted by a catastrophic event such as a natural disaster

In addition to the standard exemptions listed above, TennCare may grant a good cause exemption from the community engagement requirement based on a determination that there are acute or short-term individual circumstances that warrant special consideration (e.g., individuals experiencing homelessness, victims of domestic violence, victims of human trafficking, etc.). TennCare will work with individuals in these circumstances to connect them to education- and employment-related resources on a voluntary basis and as desired by the individual.

In addition, TennCare reserves the right to temporarily modify or waive the community engagement requirement in counties that are determined to be economically distressed.

Supports

In order to support members' success in achieving their education- and employment-related goals, Tennessee will implement a number of strategies to make assistance and supports available to members who desire such assistance, with an emphasis on linking individuals to existing community resources. TennCare will partner with the Tennessee Department of Labor & Workforce Development and other entities as needed to provide members with access to information and services designed to prepare and support persons in obtaining and maintaining employment.

Where lack of postsecondary education or training is determined to be a barrier to employment, TennCare will connect members to resources such as Tennessee Reconnect, the state's program to support adults who do not already have a postsecondary credential attend a community college or technical college and complete a postsecondary degree or credential.[8] Individuals needing to complete secondary education will be connected to adult education opportunities sponsored by the Tennessee Department of Labor & Workforce Development.

In addition to this demonstration amendment and pursuant to Tennessee Public Chapter No. 869, Tennessee will seek the necessary approval from the U.S. Department of Health & Human Services to utilize funds from the state's TANF program to implement the TennCare workforce participation and community engagement activities, and to provide additional supports to individuals subject to the work requirement.

Impact on Member Benefits

TennCare members subject to the community engagement requirement will document their compliance to TennCare on a monthly basis. Affected members must meet the requirement for four months out of every six-month period in order to maintain coverage. TennCare will assess member compliance after six months of eligibility, and every six months thereafter. At that time, members who have not demonstrated compliance for at least four months of the six-month reporting period will be subject to suspension of benefits. Benefits for these members will remain suspended until they demonstrate compliance with the requirement for one month. TennCare may offer additional opportunities for members to leave suspended status and regain full coverage through participating in an activity that supports the goals of the community engagement program (e.g., taking a state-approved health or financial literacy course).

If a member's benefits are suspended, he or she will receive a notice explaining the reason for the suspension and the steps the member must take to have benefits reinstated. Members subject to suspension due to failure to comply with the community engagement requirement will retain their rights to appeal their suspension at a state fair hearing.

[8] For more information about Tennessee Reconnect, see https://www.tnreconnect.gov/

II. Description of the Proposed Health Care Delivery System, Eligibility Requirements, Benefit Coverage, and Cost Sharing

Amendment 38 will not entail any changes to the package of benefits covered under the TennCare demonstration, or to the health care delivery system used to administer those benefits. Under Amendment 38, benefits for certain members may be suspended for failure to comply with community engagement requirement as described in Section I.

Amendment 38 will not entail any changes to cost sharing under the TennCare demonstration. Nominal cost sharing for TennCare members will continue to be implemented in accordance with Section VII of the TennCare demonstration.

Eligibility requirements for the TennCare demonstration are unaffected by Amendment 38. As noted elsewhere, under Amendment 38 receipt of benefits for certain members of the parent/caretaker relative eligibility category will be conditioned on compliance with the community engagement requirement. The requirements for members in other TennCare eligibility categories are unchanged.

III. Expected Impact on Budget Neutrality

The TennCare program's current budget neutrality demonstration will not be affected by Amendment 38. The state is not requesting any new expenditure authorities under Section 1115 of the Social Security Act to implement Amendment 38. As required by the state's authorizing legislation, the state will seek federal approval to use TANF funds to fund eligible costs associated with the workforce participation and community engagement initiative.[9]

Of the members who will be impacted by the community engagement requirement, it is estimated that a significant number are already working, or will be deemed to be in compliance with the requirement by virtue of their participation in the SNAP or TANF work program, or will qualify for an exemption to the requirement. For the remaining members, the state intends to provide linkages to resources to assist individuals in complying with the requirement, as desired by the individual and as described in Section I. Some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, it is not possible to reliably project the magnitude of this decrease in enrollment at this time.

[9] See Tennessee Code Annotated § 71-5-158.

IV. Waiver and Expenditure Authorities Requested

All waiver and expenditure authorities currently approved for the TennCare demonstration will continue to be in effect. To implement Amendment 38, the state requests the following additional waiver authority, pursuant to Section 1115(a)(1) of the Social Security Act.

Provision of Medical Assistance **Section 1902(a)(8) and 1902(a)(10)**

To the extent necessary to enable the state to suspend benefits for, and not make medical assistance available to, beneficiaries who fail to comply with workforce participation and community engagement requirements.

V. Research Hypotheses and Evaluation

The table below presents an overview of the state's preliminary plan for evaluating its workforce participation and community engagement initiative. This evaluation plan is subject to change and will be further refined to reflect operational details as the program is implemented.

Hypothesis	Methodology	Data Sources and Metrics
Goal 1: Improve health outcomes for the impacted adult population.		
Implementation of work and community engagement requirements will decrease hospital stays for the impacted adult population.	Track member use of inpatient hospitalizations.	Encounter data
Implementation of work and community engagement requirements will decrease emergency room visits for the impacted adult population.	Track member use of emergency room.	Encounter data
Goal 2: Improve education, employment, and community engagement outcomes for the impacted adult population.		
Implementation of work and community engagement requirements will encourage members to seek and obtain employment.	Track members who report participating in job search or employment activities.	Administrative data • Member reports of job search activities • Members reporting paid employment activities that are sustained for more than 90 days

Hypothesis	Methodology	Data Sources and Metrics
Implementation of work and community engagement requirements will encourage members to obtain high school equivalency or other needed educational credentials.	Track members who report participating in educational activities.	Administrative data • Member reports of education activities • Members earning high school equivalency diplomas or other educational credentials
Implementation of work and community engagement requirements will increase community engagement.	Track members who report participating in volunteer or community engagement activities.	Administrative data • Member reports of volunteer or community engagement activities

The evaluation design of the TennCare demonstration will be modified to incorporate these hypotheses and metrics.

VI. Documentation of Public Notice and Input

Summary of Public Notice Processes

The state has implemented multiple mechanisms for notifying interested parties about Amendment 38 and for soliciting public input on Amendment 38. These public notice and input procedures are informed by—and comply with—the requirements specified at 42 CFR § 431.408.

The state's public notice and comment period began on September 24, 2018, and lasted through October 26, 2018. During this time, a comprehensive description of the amendment to be submitted to CMS was made available for public review and comment on an amendment-specific webpage on the TennCare website. An abbreviated public notice—which included a summary description of Amendment 38; the locations, dates, and times of three public hearings; and a link to the full public notice on the state's amendment-specific webpage—was published in the newspapers of widest circulation in Tennessee cities with a population of 50,000 or more. TennCare disseminated information about the proposed amendment, including a link to the relevant webpage, via its social media (i.e., Twitter, Facebook). TennCare also notified the members of the Tennessee General Assembly of Amendment 38 via an electronically transmitted letter.

The state held three public hearings to seek public comment on Amendment 38. The first hearing took place on October 8, 2018, at 11:00 a.m. Central Time at the Bordeaux branch of the Nashville Public Library, 4000 Clarksville Pike in Nashville. The second hearing took place on October 9, 2018, at 1:00 p.m. Eastern Time at the Burlington branch of the Knox County Public Library, 4614 Asheville Highway in Knoxville. The third hearing took place on October 11, 2018, at 11:00 a.m. at the Jackson Madison County Library, 433 East Lafayette Street in Jackson. Members of the public also had the option to submit comments throughout the notice period by mail and/or email. Documentation of the state's public notice process is included as Appendix B.

The state notes that—in addition to the public notice mechanisms described above—Amendment 38 implements Tennessee Code Annotated § 71-5-158, which was enacted by the 110th General Assembly of the state of Tennessee in 2018, and was the product of a public legislative process.

Summary of Public Input

The state received comments from approximately 160 individuals and organizations in response to its public notice for Amendment 38. In addition, 33 individuals attended one of the state's three public hearings on Amendment 38. All comments were reviewed and considered by the state in the development of the final amendment application. The comments received, along with the state's responses, are summarized below.

The written comments received by the state are also included as Appendix C.

The state appreciates the wide range of thoughtful comments received during the public comment period for Amendment 38. As described below, the state has made some changes based on the comments received. In many other cases, the comments pertained to how the program should be implemented after Amendment 38 is approved or to a level of detail that is beyond the scope of this document. Where appropriate, the state will consider these recommendations and ideas as the operational features of the program are developed further.

General Comments

The state received a number of comments in opposition to Amendment 38. These commenters cited a wide range of reasons for their opposition, from personal religious beliefs to administrative burden to the state, to concerns about harm for TennCare members. One commenter expressed support for the amendment, because it will provide an increase in self-worth and motivation.

The state maintains its commitment to promoting productive work and meaningful community engagement among affected TennCare members. In addition, the state notes that the submission of Amendment 38 is required by state law. See Tennessee Code Annotated § 71-5-158. No changes were made to the amendment based on these comments.

A number of commenters requested additional information on how the state will operationalize the community engagement program (e.g., computer systems that will be used to implement the program, the interaction of this program with other benefit programs, compliance documentation requirements, verification of exemptions, and staffing needs related to the program).

The state's amendment is based on federal requirements and presents an overall description of the state's proposed program, goals, proposed activities, waiver and expenditure authorities requested, and evaluation hypotheses. Specific operational details of the program (e.g., systems design, documentation format) will be developed in greater detail as the state continues its work to implement the program. In developing the technical specifications of the program, the state intends to design its program in a manner that is consistent with the objectives of the overall TennCare demonstration and this particular amendment. No changes were made to the amendment based on these comments.

A few commenters requested alternative programs to a community engagement requirement that utilize positive incentives to encourage employment but do not require work or community engagement as a condition of Medicaid coverage.

The state believes that the policies outlined in Amendment 38 are an effective framework for promoting productive work and community engagement, and intends to conduct an evaluation of the extent to which Amendment 38 achieves these objectives. The state further notes that the submission of Amendment 38 is required by state law. See Tennessee Code Annotated § 71-5-158. No changes were made to the waiver amendment as a result of these comments.

Impacted Population

A few commenters requested clarification that former foster care youth, individuals receiving treatment for breast and cervical cancer, and refugees will be exempted from the work and community engagement requirements.

As noted in the state's public notice and draft amendment, the community engagement requirement will apply only to non-pregnant, non-disabled, non-elderly adults enrolled in the parent/caretaker relative eligibility category described at 42 CFR § 435.110. The requirement will not apply to members in other eligibility categories (e.g., members in the former foster care youth eligibility category, members enrolled in TennCare to receive treatment for breast or cervical cancer). Refugees enrolled in the parent/caretaker relative eligibility category will be subject to the community engagement requirement in the same manner as other TennCare members. Prior to suspending a member's benefits, the state will conduct a review to ensure he is not eligible to continue receiving benefits in another TennCare eligibility category. No changes were made to the amendment as a result of this comment.

Qualifying Activities

One commenter stated that the proposed community engagement requirement is too high of a burden for families with children who have school breaks and holidays and limited access to transportation and child care.

The state maintains that its proposed requirement—engaging in qualifying activities for 20 hours per week in four months out of every six-month period—is a reasonable expectation. In crafting Amendment 38, the state has sought to identify a number of qualifying activities that can be used to satisfy the requirement, including work, education, job search, and community service. The state believes this approach will maximize the opportunities for affected individuals to be successful in satisfying the requirement. No changes were made based on this comment.

A few commenters suggested counting the time of participating in certain SUD recovery support programs in the required community engagement hours. One commenter suggested that probation and parole meetings should be included as an approved setting to count towards community service hours.

It is the state's intent to identify specific community service activities that promote the goals of the community engagement initiative. The state will take the commenters' suggestions into consideration as it continues to design this aspect of the program. No changes were made to the amendment as a result of these comments.

One commenter proposed counting the time that individuals spend commuting to/from a job or community service setting toward compliance with the requirement.

The state believes that the employment, education, job training, job search, and community service activities identified in the draft amendment are the activities most likely to advance the state's objectives of promoting productive work and meaningful community engagement. No changes were made based on this comment.

One commenter recommended that caregiving activities for a household member under the age of six, or who is disabled or incapacitated, should be counted as qualifying activities rather than exemptions.

The state law directing TennCare to submit Amendment 38 exempts the parents of children under age six from the work and community engagement requirement (see Tennessee Code Annotated § 71-5-158), and the state determined to adopt a similar approach for individuals caring for a disabled or incapacitated household member. The state believes that an exemption for individuals in this circumstance will require less administrative burden than treating these activities as qualifying activities. No changes were made to the amendment based on this comment.

One commenter recommended that TennCare extend approved job search or job skills training activities beyond those sponsored by the Tennessee Department of Labor & Workforce Development. The commenter believed that the times and locations for programs such as Tennessee Reconnect are too restrictive to serve the needs of the TennCare population.

The state will take the commenters' suggestion into consideration in defining the job search activities that meet the program requirements. No changes were made to the amendment as a result of these comments.

One commenter recommended that caregiving activities to any other person (regardless of their age or health status) should be counted as qualifying activities.

The state believes that the employment, education, job training, job search, and community service activities identified in the draft amendment are the activities most likely to advance the state's objectives of promoting productive work and meaningful community engagement. No changes were made based on this comment.

Many commenters expressed concerns that the process of documenting compliance with the community engagement requirement will create barriers to accessing or maintaining coverage for patients, resulting in the suspension of TennCare benefits for eligible members because of documentation or paperwork errors. Several commenters recommended having multiple options to report compliance, arguing that an online portal alone is not adequate due to lack of computer literacy or internet connectivity among TennCare members. Commenters also recommended hiring additional staff to assist members in reporting community engagement hours and having a good cause exemption for those who have difficulty with reporting. Other related suggestions included streamlining the reporting, extending the period for reporting to six months or yearly, and synchronizing reporting periods with DHS. Several commenters requested TennCare accept self-attestation of compliance with the community engagement requirement rather than require documentation. These commenters noted that this approach would be consistent with the manner in which the Internal Revenue Service implemented several components of the Affordable Care Act and would involve the least amount of bureaucracy and administrative costs. Other commenters

encouraged the state to rely on data from the Social Security Administration, the Internal Revenue Service, Tennessee Department of Labor and Workforce Development, and other sources wherever possible to validate an individual's compliance with the requirement of exemption status.

As the program is operationalized, the state will determine the processes for documenting compliance with the community engagement requirement and exemptions. The state will seek to ensure accuracy and minimize the administrative burden on members to the extent possible, understanding that the state will need to strike a balance between these two goals. As the program is operationalized, TennCare will consider these comments when determining a compliance reporting plan. No changes were made to the amendment as a result of these comments.

Exemptions

One commenter suggested that the state partner with Managed Care Organizations (MCOs) to identify members who may be exempt from the community engagement requirement through the creation of an "exemption consideration file." This file could flag potential individuals subject to community engagement requirement who may meet the necessary criteria for a clinical exemption.

As the community engagement program is operationalized, the state will explore ways in which TennCare may partner with MCOs to identify potential members who may be exempt from the community engagement requirement due to medical conditions or diagnoses. No changes were made to the amendment as a result of this comment.

One commenter suggested that a single point of contact (e.g. the state or a designated third-party contractor) should make all exemption decisions and communicate these to all stakeholders. This commenter suggested that MCOs could assist this decision-maker through identifying individuals who may be exempt, but that the final decision should be made by the point of contact.

The state will take this suggestion into consideration as the program is being operationalized. No changes were made to the amendment as a result of this comment.

A number of commenters expressed concern that obtaining certification of a mental or physical illness from an appropriate medical professional represents an undue burden on the member. For example, several commenters expressed concern that being able to find and access a mental health provider in some areas of the state could be a barrier to obtaining such documentation. In addition, many commenters were concerned that members may have difficulty receiving necessary documentation from a medical professional, due to difficulty in meeting with the provider or the provider's unwillingness to assist with documentation. A few other commenters were concerned that members suffering from undiagnosed conditions that prevent them from working would be negatively impacted. Finally, one commenter was concerned that there are not enough physicians familiar with rare diseases to convey the extent of their symptoms on a standard form.

All TennCare members have access to a network of healthcare providers by virtue of their enrollment in TennCare. TennCare monitors the adequacy of MCO provider networks on an ongoing basis. As the community engagement program is operationalized, the state will determine the processes for documenting exemptions to the community engagement requirement. The state's goal will be to ensure accuracy and minimize the administrative burden on members and providers to the extent possible, understanding that the state will need to strike a balance between these two goals. No changes were made to the amendment as a result of these comments.

The state received numerous comments regarding exemptions for caregiver parents and relatives. Many commenters recommended exempting all families with children under age 18, while several others suggested exempting individuals who are caregivers for family members who have a mental illness or are parents of children with behavioral health issues. A few commenters also requested exemptions for caretakers of elderly adult relatives. TennCare received individual recommendations for the following caretaker exemptions: parents whose children have an Individual Education Program (IEP); caregivers of a family member whose mental illness causes a sudden health crisis; and primary caregivers of a child with a medically complex disease.

In Amendment 38, the state has proposed to exempt individuals from the community engagement requirement if they are the primary caregiver of a child younger than age six and/or of a disabled or incapacitated household member. The state recognizes that that there are other circumstances that may call on individuals to care for children or other family members, but these circumstances would not necessarily preclude an individual from participating in work or community engagement activities. For example, an IEP does not necessarily require caregiving during school hours and therefore should not prevent a caregiver from participating in community engagement. The state notes that its proposed community engagement requirement is 20 hours per week in four months out of every six-month period, and can be satisfied in a variety of settings.

The amendment already includes a proposed exemption for individuals who are the primary caregiver for a household member (child or adult) with a disability or incapacitation. For clarity, the amendment has been updated to indicate that individuals who provide caregiver services for a household member with a medical frailty that prevents the caretaker from fulfilling community engagement requirement will also be exempt from the requirement.

One commenter requested an exemption for parents and caretaker relatives if they have recent indications of employment: a) Have recently-reported wages in the New Hires database b) Have other indicia of employment with credit reporting services such as Experian, TransUnion, etc. c) Received the Earned Income Credit (EIC) on their federal return for the most recent tax year, for which earned income through employment is required d) Report earnings on their federal return for the most recent tax year.

A number of people who will be affected by the new community engagement requirement are already working. As the program is operationalized, the state will consider these suggestions as potential sources of data for verifying compliance the requirement. No changes were made to the amendment based on this comment.

Several commenters suggested that the currently proposed exemption to the community engagement requirement for "individuals participating in inpatient or residential treatment for substance use disorder" should also exempt other individuals receiving treatment for substance use disorders. These commenters variously recommended exempting individuals actively participating in, or who have recently participated in, SUD treatment in outpatient settings, as well as individuals residing in sober living facilities, engaged in substance abuse treatment support groups, receiving medication assisted treatment (MAT), those in intensive outpatient programs (IOP), and those who have a diagnosis of opioid use disorder and/or documented overdose on or before September 30, 2018.

The state recognizes the importance of maintaining access to treatment for individuals with substance use disorders. In the midst of the current opioid crisis, the state is working to increase the availability of treatment options for individuals with SUD. In response to these comments, TennCare has modified the

list of proposed exemptions in Amendment 38 to include individuals who are participating in Intensive Outpatient Programs (IOPs) in addition to those who are participating in inpatient or residential treatment for a substance use disorder.

Many commenters requested additional detail about how the state intends to define "medically frail" and "mentally incapable of work." These commenters recommended that the conditions that would fall under these categories should be outlined and information about how one will prove that he or she is medically frail should be communicated. Several commenters requested clarification on whether severe mental illness will be included in the definition of medically frail, and if so, how will it be defined. Several commenters requested exemptions for specific diseases: end-stage renal disease, HIV, Cystic Fibrosis, bleeding disorders, and cancer. A few commenters also suggested specific language for defining "medically frail" as well as "medically complex" diseases.

The state intends to develop a definition of medical frailty that is consistent with federal requirements, and that acknowledges severe illness and limitations to daily living caused by a physical, mental, or emotional health condition. The state appreciates the commenters' suggestions and will take these recommendations into consideration as it develops and communicates its operational definition of medically frail. No changes were made to the amendment based on these comments.

A few commenters requested that medical frailty be based on self-attestation, with a retrospective review and assessment.

As the community engagement program is operationalized, the state will determine the processes for documenting exemptions to the community engagement requirement. The state will seek to ensure accuracy and minimize the administrative burden on members to the extent possible, understanding that the state will need to strike a balance between these two goals. No changes were made to the amendment based on this comment.

Several commenters requested additional clarification on how "economically distressed counties" will be defined or identified. Several commenters suggested definitions of "economically distressed" that included regions, municipalities, or counties that have an unemployment rate higher than the state average. A few commenters requested that the "economically distressed" definition be applied to municipalities, rather than counties as a whole. These noted that exempting rural "economically distressed" counties while not exempting "economically distressed" municipalities within a county could result in a disparate impact of the waiver falling on African American members in urban counties.

The state will consider these suggestions when determining when it might be appropriate to temporarily waive the community engagement requirement, as the state recognizes the need for flexibility in responding to various economic situations. No changes were made to the amendment based on these comments.

Several commenters recommended lowering the maximum applicable age of the community engagement requirement to 50. These commenters noted that this is the maximum age at which the SNAP program's work requirement for able-bodied adults without dependents (ABAWDs) applies.

The state believes that adults above age 50 who are able to work will also benefit from work or community engagement. No changes were made to the amendment based on this comment.

One commenter suggested that individuals receiving unemployment benefits should not be exempted from the community engagement requirements but that the work activities required for unemployment should instead count towards the qualifying activities required each week or month.

Individuals receiving unemployment benefits in Tennessee are already subject to job search requirements, and the Tennessee Department of Labor & Workforce Development tracks their compliance. Federal guidance to states discourages applying work requirements to people who already have a work requirement in another program. Therefore, no changes to the amendment were made as a result of this comment.

Another commenter approved of the proposed unemployment benefit exemption, but requested it be expanded to include people receiving unemployment benefits from other states in addition to Tennessee.

Amendment 38 provides an exemption for "individuals receiving unemployment benefits." This includes individuals from states other than Tennessee. No changes were made to the amendment based on this comment.

One commenter requested that TennCare develop a reciprocal relationship with SNAP and TANF where anyone who is compliant with TennCare community engagement requirements is deemed eligible for TANF and SNAP.

This comment is outside the scope of the amendment. The purpose of Amendment 38 is to promote work and community engagement among certain TennCare members, as well as improved health outcomes. Eligibility for other public assistance programs is not the subject of Amendment 38. No changes were made to the amendment based on this comment.

One commenter objected to the proposed exemption for individuals with a pending SSI/SSDI application, pointing out that if someone has a severe medical condition validated by a medical professional, they should qualify for one of the other proposed exemptions.

The state agrees with the commenter's suggestion that people who meet this criterion would also qualify for other types of exemptions: physically or mentally incapable of work, medically frail, short-term or long-term disability, or other good cause. The amendment was updated to remove the proposed exemption for individuals with a pending SSI/SSDI application, because it is duplicative of other exemptions.

One commenter suggested that if an individual attests that he or she does not have access to transportation to and from a job, child care, or educational or volunteer opportunities, that he or she should be exempt from the work and community engagement requirement.

In order to support members' success in achieving their education- and employment-related goals, the state intends to implement strategies to make assistance and supports available to members who desire such assistance, with an emphasis on linking individuals to existing community resources. No changes were made to the amendment based on this comment.

One commenter recommended that TennCare exempt people with intellectual and/or developmental disabilities and their caregivers.

As a practical matter, most TennCare members with intellectual disabilities are in eligibility categories that are unaffected by the community engagement requirement. Other members with an intellectual or

developmental disability may qualify for one of the proposed exemptions to the community engagement requirement. No changes were made to the amendment based on this comment.

One commenter recommended exempting individuals who lack regular access to internet or cellular service, because these individuals will be unable to report compliance with community engagement requirements.

The state will take this comment into consideration as it continues to design the methods for documenting compliance with the community engagement requirement. No changes were made to the amendment based on this comment.

Several commenters described challenges experienced by people with mental illness, noting that many people with mental illness are currently undiagnosed, yet face great challenges to working due to their mental illness. These commenters recommended TennCare carefully examine and exempt populations who have a severe mental illness.

The state notes that, in accordance with federal guidance, it has proposed to exempt individuals who have been determined to be medically frail from the community engagement requirement. Under federal regulations, medical frailty includes adults with serious mental illness. (See 42 CFR § 440.315.) The state has further proposed to exempt individuals who are certified as physically or mentally incapable of work by an appropriate medical professional. No changes were made to the amendment based on these comments.

A few commenters requested an exemption for recently incarcerated individuals, citing the difficulty these individuals have in obtaining employment and recognizing that they often have mental illnesses that need to be treated.

The state believes that recently incarcerated individuals will benefit from the transition to work and meaningful community engagement in the same manner as other members. As noted in the state's public notice and draft amendment, the state intends to implement strategies to make assistance and supports available to members who desire such assistance, with an emphasis on linking individuals to existing community resources. No changes were made to the amendment based on this comment.

One commenter requested that the circumstances warranting a good cause exemption to the community engagement requirement be explicitly identified and listed in the amendment. Another commenter provided a list of recommendations that should qualify an individual for a good cause exemption.

The state does not believe it is possible to specify in advance all circumstances that could warrant a good cause exemption, although the amendment does provide some examples. The state intends that good cause exemptions may be granted based on individual circumstances that necessitate special consideration or which could temporarily prevent members from complying with the community engagement requirement. No changes were made to the amendment based on these comments.

<u>Supports</u>

Many commenters wrote about the barriers and complexities of low-wage jobs: seasonal workers who work some parts of the year but not others, lack of control over work hours being suddenly reduced or other unpredictable work schedules, lack of fair and flexible schedules, or too few jobs near where they live. Other commenters described challenges and potential barriers to employment

faced by TennCare members, including low education levels; limited literacy and English proficiency; a lack of work skills among certain populations; challenges related to substance use disorder; limited access to oral and vision care; previous incarceration records or default judgements including wage garnishments, revoked drivers licenses, limited access to transportation; and lack of safe and affordable child care.

Individuals transitioning to employment can face a number of challenges. However, the state is committed to promoting work and community engagement among adults who are capable of working. In order to support members' success in achieving their education- and employment-related goals, the state intends to implement strategies to make assistance and supports available to members who desire such assistance, with an emphasis on linking individuals to existing community resources. No changes were made to the amendment based on these comments.

A few commenters described the challenges to maintaining employment faced by people who are experiencing domestic violence.

In addition to the list of standard exemptions, the state has proposed a good cause exemption from the community engagement requirement to address individual circumstances that affect an individual's ability to comply with the requirement or otherwise warrant special consideration. The recent experience of domestic violence is an example of the type of circumstance that could qualify an individual for a good cause exemption from the community engagement requirement. No changes were made to the amendment based on this comment.

Many commenters expressed concern for how people with disabilities will fare in a community engagement requirements program. Commenters had questions about what information and accommodations will be available for people with disabilities, how disabilities will be assessed, what supports will be in place for people with disabilities, and how the specific needs of the individuals will be addressed within the program and the workplace.

The state is not proposing to apply the community engagement requirement to individuals eligible for TennCare on the basis of a disability, individuals who are physically or mentally incapable of work, individuals determined to be medically frail, or individuals with a short-term or long-term disability or acute medical condition that would prevent them from complying with the requirement. In addition, Tennessee intends to provide reasonable accommodations related to meeting the community engagement requirement for members with disabilities protected by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Patient Protection and Affordable Care Act, when necessary, to enable them to have an equal opportunity to participate in and benefit from the community engagement initiative. No changes were made to the amendment based on these comments.

Several commenters urged TennCare to ensure that the communication and information sharing strategies regarding the community engagement program provide adequate support to ensure that all members can fully participate in the process. Commenters recommended that notices clearly explain the program requirements, implementation details, a list of exemptions, and specific examples of qualifying activities. Some specific suggestions included: ensuring the reading level of written materials is at an accessible level for the majority of members and that languages other than English are represented. One commenter also recommended the creation of a toll-free referral and information hotline that would be available across the state, including in rural areas.

As the community engagement program is operationalized, the state intends to implement communication, outreach, and education plans to support its implementation. The state will consider the commenters' suggestions as it develops its communication plans. No changes were made to the amendment based on these comments.

Many commenters stressed the importance of supportive case management services. Several commenters suggested TennCare develop partnerships with various organizations in order to provide case management. Some recommended utilizing specific programs and resources to assist individuals in developing work-readiness skills, such as expanded supported employment and expanded availability of Individual Placement and Support (IPS) and comprehensive educational opportunities. One commenter recommended modeling a public-private employment partnership currently piloted in Indiana. Another commenter suggested that counseling may be needed by some families as well.

As the community engagement program is operationalized, the state will consider these comments when creating a plan for connecting members to existing supports. The state will consider partnerships to support the goals of the program. No changes were made to the waiver amendment based on this comment.

Impact on Member Benefits

Several commenters expressed concern about community engagement requirements acting as a barrier to individuals accessing healthcare when they are recovering from a debilitating injury or living with a chronic illness. These commenters assert that people who experience lapses in coverage will not be able to obtain the consistent treatment needed for chronic diseases and may prevent them from controlling their disease in order to get healthy and move forward. A few commenters also expressed concern about patients not receiving necessary screenings during periods of TennCare suspension, thus resulting in late diagnoses of diseases that should have been treated early. Several commenters asserted that an acute illness, flair up of chronic disease, or other health setback may prevent someone from having consistent 20 hour-per-week employment. These commenters expressed concern that the loss of a job or inability to work 20 hours will lead to these members losing health coverage. Many commenters also expressed concern about community engagement requirements leading to unintended consequences of children being harmed, citing reports that parents' health care coverage improves children's access to needed care, improves a parent's mental health outcome, and strengthens families' financial security.

The policy framework that the state has proposed would exempt members who have a debilitating injury that prevents them from complying with the community engagement requirement. Additionally, as part of the community engagement initiative, the state intends to implement strategies to make assistance and supports available to members who desire such assistance, with an emphasis on linking individuals to existing community resources. One of the core objectives of this program is to improve health outcomes for TennCare members, and work or community engagement can help achieve this goal. No changes were made to the waiver amendment based on this comment.

Some commenters expressed concern about the potential impact of Amendment 38 on healthcare providers. Several commenters speculated that a suspension of Medicaid coverage will lead to increased reliance on safety net clinics and hospitals, placing a burden on these safety nets and leading to disjointed care for the patients. Other commenters suggested Amendment 38 will lead to increased administrative and medical costs for providers due to "churn," a pattern of short-term or repeated enrollment, disenrollment, and reenrollment in Medicaid. A few commenters requested

TennCare direct MCOs to continue paying claims for FQHC patients who have lost coverage due to failure to demonstrate compliance with work and community engagement requirements. One commenter requested the reimbursement rate to providers be increased because of the additional administrative requirements they expect providers to face due to this program.

The goal of Amendment 38 is to promote work and community engagement among TennCare members, as well as improve health outcomes for the affected population. The state believes it has proposed a reasonable framework for achieving this goal. This framework includes multiple methods/activities by which individuals can comply with the requirement, appropriate exemptions for those who may be unable to comply with the requirement, and links to resources and supports for those who desire such assistance. No changes were made to the amendment based on these comments.

Several commenters expressed concerns about implementing work requirements before the state's new eligibility determination system is fully operational.

The state agrees that implementation of Amendment 38 will require the new eligibility system to be operational. No changes were made to the amendment based on this comment.

One commenter asked: If DHS determines a TANF member exempt from the work requirements for six months, will TennCare also determine this same member exempt for the same amount of time? Another commenter requested clarification that if someone on SNAP or TANF fails to meet the higher SNAP/TANF work requirement, are they still able to keep their TennCare if they meet the 20hr/week Community Engagement requirement?

As noted in the draft amendment, individuals subject to and complying with or receiving an exemption from the work requirements of another assistance program (including SNAP and TANF) will be deemed to be in compliance with the TennCare community engagement requirement. If an individual is removed from the SNAP or TANF program due to not meeting any requirements of those programs, then that individual would need to meet the TennCare community engagement requirement described in this amendment. No changes were made to the amendment based on this comment.

Several commenters expressed concern that there will be a gap in coverage for working members who earn too much money to qualify for TennCare but cannot afford other insurance. One commenter suggested an earned income disregard of 50-100% for their first year in this program.

The state's objective in Amendment 38 is to promote work and community engagement in order to help affected members achieve their education- and employment-related goals, in which case some members may experience an increase in their earnings. Members of the parent/caretaker relative eligibility category who experience increases in their income can generally continue to receive TennCare coverage on a transitional basis for 12 months. In many cases, members in the parent/caretaker relative category whose incomes exceed TennCare's income limit will qualify for subsidized coverage on the individual insurance market. No changes were made to the amendment based on this comment.

One commenter described a federal requirement specified at 42 CFR § 435.112 that requires the state to continue Medicaid coverage for TANF enrollees for four months if the family loses TANF benefits because of increased income from employment or increased work hours. The commenter recommended that the state consider a similar "soft landing" for TennCare members who lose coverage because of increased income or not complying with the work requirements.

The state is aware of its obligation to provide transitional medical assistance to families that lose eligibility in specified categories due to increased work hours or earnings. The state provides transitional medical assistance for qualifying families for 12 months. This policy is unaffected by Amendment 38. No changes were made to the amendment based on this comment.

Expected Impact on Enrollment and Expenditures

Several commenters expressed concern over the program's funding. Many commenters objected to the state using TANF funds to pay for community engagement requirements. Some commenters are skeptical that TANF funds will pay for the entirety of the program, and they are concerned about the administrative and programmatic costs to the state. Several commenters requested TennCare streamline the program as much as possible and take steps to mitigate the costs of the program. Many commenters expressed the opinion that the costs of this program will outweigh any benefits to the state or to members.

State law requires TennCare to seek federal approval to use TANF funds to implement Amendment 38. (See Tennessee Code Annotated § 71-5-158.) One of the primary purposes of federal TANF block grants is to reduce the dependence of needy parents on government benefits by promoting job preparation, work, and marriage (see Section 401 of the Social Security Act), which aligns fully with the objectives of Amendment 38. No changes were made to the amendment as a result of these comments.

A number of comments requested additional information on the impact of this amendment. They requested additional information on the impact of the community engagement program on the demonstration's budget neutrality and coverage and the number of members subject to the community engagement requirement. They also object to no budget being described for program evaluation or case management.

As noted in the state's public notice and draft amendment, Amendment 38 will not impact the budget neutrality of the TennCare demonstration. The state is not requesting any additional expenditure authorities under Title XIX to implement Amendment 38. As required by state law, the state will seek federal approval to use TANF funds to fund eligible costs associated with the work and community engagement initiative. (See Tennessee Code Annotated § 71-5-158.) As also noted in the state's public notice and draft amendment, it is possible that some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, the state is not aware of any methodology by which to reliably project the magnitude of this decrease in enrollment. No changes were made to the amendment based on these comments.

Research Hypotheses and Evaluation

Several commenters objected to the proposed metrics in the waiver amendment, stating that inpatient hospitalization and emergency department utilizations are not adequate metrics for determining the health status of a population. These commenters suggested TennCare find alternate evaluation measures that will more fully assess the community engagement requirements' impact on health status. Some metrics suggested by commenters included: utilization of preventive, primary health, and mental health care services; improved health behaviors; household incomes as a percentage of poverty levels before and after engagement in the program; attainment of additional educational and skill certifications; changes in job titles; changes in housing status; utilization of other supports in the community; and mental and emotional health status indicators. Several commenters suggested tracking those who are suspended from the program due to the community engagement requirements to evaluate the impact on their health status as well. One commenter requested that

the full evaluation plan, rather than a preliminary plan, be developed prior to the implementation of any work requirements.

The state agrees with comments indicating the need to conduct a robust evaluation of the work and community engagement requirement and intends to develop an evaluation design for the program in accordance with federal requirements that will define the evaluation metrics with more specificity. The state will consider the commenters' suggestions in the evaluation design process. No change was made to the amendment based on these comments.

Other

Several commenters noted that there are pending legal challenges in other states that have sought to implement community engagement requirements for Medicaid beneficiaries. These commenters speculated that Tennessee will face similar legal challenges to its community engagement program.

Amendment 38 seeks to promote the objectives of the Medicaid program to promote improved health outcomes and to help individuals attain and maintain employment. The submission of Amendment 38 is also required by state law. (See State Medicaid Director Letter 18-002 and Tennessee Code Annotated § 71-5-158.) The federal agency with oversight of the Medicaid program—the Centers for Medicare & Medicaid Services (CMS)—has invited states to develop programs that seek to improve member health and well-being through incentivizing work and community engagement. The state will work with CMS to ensure its program meets all federal standards and requirements. No changes were made to the amendment as a result of these comments.

A number of commenters requested TennCare expand Medicaid coverage. One commenter requested that, instead of community engagement requirements for TennCare members, the state enact a law requiring companies to pay employees a living wage with healthcare benefits.

Both of these comments are outside the scope of Amendment 38. No changes were made to the amendment based on these comments.

Appendix A

Tennessee Public Chapter No. 869

State of Tennessee

PUBLIC CHAPTER NO. 869

HOUSE BILL NO. 1551

By Madam Speaker Harwell, Representatives Howell, Boyd, Ragan, Terry, Weaver, Zachary, Powers, Vaughan, Tillis, Gant, Jerry Sexton, Johnson, Reedy, Sherrell, Calfee, Dawn White, Moody, Daniel, Keisling

Substituted for: Senate Bill No. 1728

By Senators Roberts, Bell, Green, Stevens, Bowling, Pody

AN ACT to amend Tennessee Code Annotated, Title 71, relative to imposing requirements on recipients of medical assistance.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, Part 1, is amended by adding the following new section to be appropriately designated:

An amendment to the existing TennCare II waiver shall be submitted to the federal centers for medicare and medicaid services (CMS) authorizing the bureau of TennCare to create reasonable work and community engagement requirements for able-bodied working age adult enrollees without dependent children under the age of six (6). The waiver shall be consistent with the most recent guidance to state medicaid directors provided by CMS concerning opportunities to promote work and community engagement in demonstration projects authorized under § 1115 of the federal social security act (42 U.S.C. § 1315). The state shall seek the necessary approval from the United States department of health and human services to utilize funds from the temporary assistance to needy families (TANF) program under the Families First Act of 1996, compiled in chapter 3, part 1 of this title, for eligible expenditures related to the waiver. Implementation of the waiver shall be contingent upon the available use of TANF funds or other federal appropriations to meet the requirements of the waiver.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

HOUSE BILL NO. 1551

PASSED: April 19, 2018

BETH HARWELL, SPEAKER
HOUSE OF REPRESENTATIVES

RANDY MCNALLY
SPEAKER OF THE SENATE

APPROVED this 3rd day of May 2018

BILL HASLAM, GOVERNOR

Appendix B

Documentation of Public Notice

Published on September 24, 2018

Notice of Change in TennCare II Demonstration: Amendment 38

The Commissioner of the Tennessee Department of Finance & Administration is providing official notification of intent to file an amendment to the TennCare II Demonstration. This amendment, which will be known as "Amendment 38," is being filed with the Centers for Medicare & Medicaid Services (CMS).

Description of Amendment and Affected Populations

TennCare is a comprehensive managed care program that provides the full range of Medicaid benefits to approximately 1.4 million Medicaid and demonstration eligibles in Tennessee. One of the core objectives of the TennCare demonstration is to improve health outcomes for individuals enrolled in TennCare. A growing body of evidence points to a link between productive work or meaningful community engagement and improved health outcomes.

Accordingly, Amendment 38 is designed to promote improved health outcomes for TennCare members, and to support member efforts to achieve their education- and employment-related goals. To this end, Amendment 38 will establish workforce participation and community engagement as an expectation for some program enrollees.

The workforce participation and community engagement requirement will be applicable to non-pregnant, non-disabled, non-elderly adults enrolled in TennCare in the parent/caretaker relative eligibility category described at 42 CFR § 435.110 without dependent children under the age of six.

Impacted adults will be required to engage in qualifying work or community engagement activities for an average of 20 hours per week. Qualifying activities can include paid employment, certain educational activities, job search or job skills training activities, and community service in approved settings. TennCare will also seek to link individuals to resources and supports whenever possible to help members achieve their education- and employment-related goals. Impacted members who fail to comply with the requirement will be subject to suspension of benefits until compliance is demonstrated.

This proposed waiver amendment is consistent with guidance released by CMS on promoting work and community engagement among Medicaid beneficiaries, and is submitted in accordance with Public Chapter No. 869, enacted by the Tennessee General Assembly in 2018.

Expected Impact on Enrollment and Expenditures

Amendment 38 is not expected to have an impact on enrollment in the TennCare demonstration. As described above, certain eligible members may be subject to suspension of benefits if they fail to comply with the work and community engagement requirement.

In accordance with Public Chapter No. 869, the state will seek federal approval to use funds from the state's Temporary Assistance for Needy Families (TANF) program to fund any costs associated with the work and community engagement initiative. The state is not requesting any new expenditure authorities under the Medicaid program to implement Amendment 38.

Hypothesis and Evaluation Parameters

The state will work with CMS to identify or develop appropriate evaluation measures for this demonstration amendment. The state's evaluation will focus on 1) the extent to which the demonstration is associated with improved education, employment, and community engagement outcomes for impacted members, and 2) the extent to which the demonstration is associated with improved health outcomes for impacted members.

Waiver and Expenditure Authorities Requested

All waiver and expenditure authorities currently approved for the TennCare demonstration will continue to be in effect. To implement Amendment 38, the state will request to waive the requirements of Title XIX of the Social Security Act to the extent necessary to suspend benefits for, and not make medical assistance available to, beneficiaries who fail to comply with the work and community engagement requirement.

Public Notice Process

TennCare has taken a variety of steps to ensure that members of the public are notified of Amendment 38. These measures include the development and maintenance of this webpage, as well as notices published in the newspapers of widest circulation in Tennessee cities with 50,000 or more residents. TennCare has disseminated information about the proposed amendment via its social media accounts (e.g., Facebook, Twitter). TennCare has also notified members of the Tennessee General Assembly of its intent to submit Amendment 38.

Public Input Process

TennCare is seeking feedback on Amendment 38 prior to its submission to CMS. Members of the public are invited to offer comments regarding Amendment 38 from September 24, 2018, through October 26, 2018.

Members of the public who wish to comment on the proposed amendment may do so through either of the following options:

- Comments may be sent by email to public.notice.tenncare@tn.gov.
- Comments may be mailed to

Dr. Wendy Long, Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243.

Individuals who prefer to make their comments in person may attend one of the following public hearings to comment on Amendment 38:

Monday, October 8, 2018
11:00 a.m. CT
Bordeaux Branch of the Nashville Public Library, Large Meeting Room
4000 Clarksville Pike
Nashville, Tennessee

Tuesday, October 9, 2018
1:00 p.m. ET
Burlington Branch of the Knox County Library, Community Meeting Room
4614 Asheville Highway
Knoxville, Tennessee

Thursday, October 11, 2018
11:00 a.m. CT
Jackson-Madison County Library, Program Center
433 East Lafayette Street
Jackson, Tennessee

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

TennCare always appreciates input. In order to be considered for the final draft of Amendment 38, feedback must be received no later than October 26, 2018. Individuals wishing to view comments submitted by members of the public may submit their requests to the same physical address and/or email address at which comments are being accepted.

Draft of Amendment 38

A draft of TennCare's proposed demonstration amendment is located at https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment38.pdf. Copies of the draft amendment are also available in each county office of the Tennessee Department of Health. Once comments received during the public input period have been reviewed and considered, a final draft of the amendment will be prepared. The final draft will be submitted to CMS and will then be made available through the webpage located at located at https://www.tn.gov/tenncare/policy-guidelines/waiver-and-state-plan-public-notices.html.

TennCare Page on CMS Web Site

As the federal agency with oversight authority over all Medicaid programs, CMS offers its own online resources regarding the TennCare Demonstration. Interested parties may view these materials at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.

TN Division of TennCare

September 24, 2018

The Honorable Randy McNally
Lt. Governor and Speaker of the Senate
Suite 1 Legislative Plaza
Nashville, Tennessee 37243-0219

The Honorable Beth Harwell
Speaker of the House of Representatives
Suite 19 Legislative Plaza
Nashville, Tennessee 37243-0219

Dear Speaker McNally and Speaker Harwell:

This letter is written to inform you that the Division of TennCare plans to submit to CMS an amendment to the TennCare demonstration. This amendment will be known as "Amendment 38."

In 2018, the Tennessee General Assembly enacted Public Chapter No. 869, directing TennCare to submit a waiver amendment to CMS to authorize the creation of work and community engagement requirements for certain TennCare enrollees. Accordingly, in Amendment 38, TennCare will request authority to establish reasonable work and community engagement requirements for non-pregnant, non-elderly, non-disabled adults enrolled in the TennCare program, who do not have dependent children under the age of six.

Under TennCare's proposal, affected enrollees will be expected to engage in qualifying work or community engagement activities for an average of 20 hours per week. Qualifying activities can include paid employment, certain educational activities, job search or job skills training activities, and community service in approved settings. TennCare will seek to align its community engagement requirement with the requirements of other public assistance programs (i.e., SNAP and TANF) to the extent possible. TennCare will also seek to link individuals to existing community resources and supports whenever possible to help members achieve their education- and employment-related goals. Impacted members who fail to comply with the requirement will be subject to suspension of benefits until compliance is demonstrated.

In accordance with Tennessee Public Chapter No. 869, TennCare will seek the necessary approval from the U.S. Department of Health & Human Services to utilize funds from the state's TANF program to fund any costs associated with the work and community engagement initiative.

Copies of this letter are being sent electronically to all members of the General Assembly, in accordance with T.C.A. § 71-5-104(b). Additional information about Amendment 38 is available on the TennCare website located at http://www.tn.gov/tenncare/.

Please let us know if you have comments or questions.

Sincerely,

Wendy Long MD

Wendy Long, M.D., M.P.H.
Director, Division of TennCare

cc: The Honorable Members of the General Assembly

Account #: 105178
Company: BUREAU OF TENNCARE
Client:
Ad number: 118378
PO#:
Note:

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Before me personally appeared Jim Stevens, who being duly sworn that he is the Legal Sales Representative of the CHATTANOOGA TIMES FREE PRESS, and that the Legal Ad of which the attached is a true copy, has been published in the above named newspaper and on the corresponding newspaper website on the following dates, to-wit:

Chattanooga Times Free Press: 09/26/18; TimesFreePress.com: 09/26/18.

And that there is due or has been paid the CHATTANOOGA TIMES FREE PRESS for publication the sum of $448.70. (Includes $10.00 Affidavit Charge).

Jim Stevens

Sworn to and subscribed before me this date: 09/27/2018

Jacqueline Mansueto

My Commission Expires 03/07/2021

JACQUELINE MANSUETO
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY
MY COMMISSION EXPIRES MARCH 7, 2021

Chattanooga
Times Free Press

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Chattanooga Times Free Press

NOTICE OF CHANGE IN TENNCARE II DEMONSTRATION AMENDMENT 38

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and 59 Fed. Reg. 49249, of intent to file an amendment to the TennCare II Demonstration. The amendment, which will be known as "Amendment 38," is being filed with the Centers for Medicare and Medicaid Services (CMS), a federal agency located in Baltimore, Maryland, with a Regional Office in Atlanta, Georgia.

Amendment 38 is designed to promote improved health outcomes for TennCare members, and to support member efforts to achieve their education- and employment-related goals. To this end, Amendment 38 will establish workforce participation and community engagement as an expectation for some program enrollees.

The workforce participation and community engagement requirement will be applicable to non-pregnant, non-disabled, non-elderly adults enrolled in TennCare in the parent/caretaker relative eligibility category described at 42 CFR § 435.110 without dependent children under the age of six.

Impacted adults will be required to engage in qualifying work or community engagement activities for an average of 20 hours per week. Qualifying activities can include paid employment, certain educational activities, job search or job skills training activities, and community service in approved settings. TennCare will also seek to link individuals to resources and supports whenever possible to help members achieve their education- and employment-related goals. Impacted members who fail to comply with the requirement will be subject to suspension of benefits until compliance is demonstrated.

This proposed demonstration amendment is consistent with guidance released by CMS on promoting work and community engagement among Medicaid beneficiaries, and is submitted in accordance with Public Chapter No. 869, enacted by the Tennessee General Assembly in 2018. In accordance with this legislation, the State will seek federal approval to use funds from Tennessee's Temporary Assistance for Needy Families (TANF) program to fund any costs associated with the work and community engagement initiative.

The full public notice associated with this amendment, including a comprehensive description of the amendment, is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment38ComprehensiveNotice.pdf.

Pursuant to 42 CFR § 431, Subpart G, the State is providing the following opportunities to the public to comment on the proposed amendment in person:

- A public hearing on October 8, 2018, at 11:00 a.m. CT in the Large Meeting Room of the Bordeaux branch of the Nashville Public Library, 4000 Clarksville Pike in Nashville.
- A public hearing on October 9, 2018, at 1:00 p.m. ET in the Community Meeting Room of the Burlington branch of the Knox County Library, 4614 Asheville Highway in Knoxville.
- A public hearing on October 11, 2018, at 11:00 a.m. CT in the Program Center of the Jackson Madison County Library, 433 East Lafayette Street in Jackson.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Members of the public who prefer to submit written comments may send them by mail to Dr. Wendy Long, Director, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is Friday, October 26, 2018.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

The Commercial Appeal
Affidavit of Publication

STATE OF TENNESSEE
COUNTY OF SHELBY

Personally appeared before me, Glenn W. Edwards, a Notary Public, Helen Curl, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached advertisement was published in the following editions of The Commercial Appeal, to-wit:

September 27, 2018

Helen Curl

Subscribed and sworn to before me this 17th day of October, 2018.

Glenn W. Edwards Notary Public

My commission expires January 20, 2020.

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06) who is now the owner of said debt; andWHEREAS, the undersigned,Rubin Lublin TN, PLLC, having been appointed as Substitute Trustee by instrument to be filed for record in the Register's Office of Shelby County, Tennessee. NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable, and that the undersigned, Rubin Lublin TN, PLLC, as Substitute Trustee or his duly appointed agent, by virtue of the power, duty and authority vested and imposed upon said Substitute Trustee will, on October 11, 2018 at 10:00 AM in the Auction.com Room of the Comfort Inn Downtown, 100 N. Front Street, Memphis, TN 38103, proceed to sell at public outcry to the highest and best bidder for cash or certified funds ONLY, the following described property situated in Shelby County, Tennessee, to wit:LOT 18, THIRD ADDITION, HIGHLAND OAKS SUBDIVISION, AS SHOWN ON PLAT OF RECORD IN PLAT BOOK 149, PAGE 60, IN THE REGISTER`S OFFICE OF SHELBY COUNTY, TENNESSEE, TO WHICH PLAT REFERENCE IS HEREBY MADE FOR A MORE PARTICULAR DESCRIPTION OF SAID PROPERTY. PROPERTY ADDRESS: 5346 WAGNON COVE MEMPHIS, TN 38125 AND BEING THE SAME PROPERTY CONVEYED FROM MICHAEL SWIFT AND WIFE JEANNETTE D SWIFT TO YOLANDA GUNN, A SINGLE WOMAN BEING RECORDED IN INSTRUMENT #04093436, SAID REGISTER`S OFFICE FOR SHELBY COUNTY, TENNESSEE. BEING THE SAME PROPERTY CONVEYED TO MICHAEL SWIFT AND WIFE, JEANNETTE D. SWIFT BY WARRANTY DEED FROM FAXON GILLIS HOMES, INC., DATED 1/16/98, FILED IN BOOK HC, PAGE 4768, SAID REGISTER`S OFFICE.Parcel ID: D0255F D00018PROPERTY ADDRESS: The street address of the property is believed to be 5346 WAGNON COVE, MEMPHIS, TN 38125. In the event of any discrepancy between this street address and the legal description of the property, the legal description shall control. CURRENT OWNER(S): YOLANDA GUNNOTHER INTERESTED PARTIES: The sale of the above-described property shall be subject to all matters shown on any recorded plat; any unpaid taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose. This property is being sold with the express reservation that it is subject to confirmation by the

Legal Notices

NOTICE OF SUBSTITUTE TRUSTEE S SALE WHEREAS, default has occurred in the performance of the covenants, terms and conditions of a Deed of Trust dated June 30, 2003, executed by BARBARA RUSSELL, conveying certain real property therein described to ACCURATE TITLE, as Trustee, as same appears of record in the Register's Office of Shelby County, Tennessee recorded July 10, 2003, at Instrument Number 03135614; and WHEREAS, the beneficial interest of said Deed of Trust was last transferred and assigned to PNC Bank, National Association who is now the owner of said debt; andWHEREAS, the undersigned,Rubin Lublin TN, PLLC, having been appointed as Substitute Trustee by instrument to be filed for record in the Register's Office of Shelby County, Tennessee. NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable, and that the undersigned, Rubin Lublin TN, PLLC, as Substitute Trustee or his duly appointed agent, by virtue of the power, duty and authority vested and imposed upon said Substitute Trustee will, on **October 18, 2018 at 10:00 AM** at the Front Entrance Steps of the Shelby County Courthouse, Memphis, Tennessee, proceed to sell at public outcry to the highest and best bidder for cash or certified funds ONLY, the following described property situated in Shelby County, Tennessee, to wit:LOT 14, SECTION "A", AIR LINE ESTATES SUBDIVISION, OF RECORD IN PLAT BOOK 36, PAGE 24, OF THE REGISTER`S OFFICE OF SHELBY COUNTY, TENNESSEE TO WHICH REFERENE IS HEREBY MADE FOR A MORE PARTICULAR DESCRIPTION OF SAID PROPERTY.Parcel ID: A0142J0A000140PROPERTY ADDRESS: The street address of the property is believed to be **5723 AIRLINE RD, ARLINGTON, TN 38002.** In the event of any discrepancy between this street address and the legal description of the property, the legal description shall control. CURRENT OWNER(S): BARBARA RUSSELLOTHER INTERESTED PARTIES: NATIONAL CITY BANKThe sale of the above-described property shall be subject to all matters shown on any recorded plat; any unpaid taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose. This property is being sold with the express reservation that it is subject to confirmation by the

Legal Notices

NOTICE OF SUBSTITUTE TRUSTEE S SALE WHEREAS, default has occurred in the performance of the covenants, terms and conditions of a Deed of Trust dated November 22, 2011, executed by BARBARA J. MABRY, conveying certain real property therein described to ALAN E. SOUTH, as Trustee, as same appears of record in the Register's Office of Shelby County, Tennessee recorded December 7, 2011, at Instrument Number 11121079; and WHEREAS, the beneficial interest of said Deed of Trust was last transferred and assigned to FINANCE OF AMERICA STRUCTURED SECURITIES ACQUISITION TRUST 2017-HB1, WILMINGTON SAVINGS FUND SOCIETY, FSB, NOT INDIVIDUALLY, BUT SOLELY AS TRUSTEE who is now the owner of said debt; andWHEREAS, the undersigned,Rubin Lublin TN, PLLC, having been appointed as Substitute Trustee by instrument to be filed for record in the Register's Office of Shelby County, Tennessee. NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable, and that the undersigned, Rubin Lublin TN, PLLC, as Substitute Trustee or his duly appointed agent, by virtue of the power, duty and authority vested and imposed upon said Substitute Trustee will, on **October 4, 2018 at 10:00 AM** at the Front Entrance Steps of the Shelby County Courthouse, Memphis, Tennessee, proceed to sell at public outcry to the highest and best bidder for cash or certified funds ONLY, the following described property situated in Shelby County, Tennessee, to wit:LOT 74, SECTION A, WILLIFORD ESTATES SUBDIVISION, AS SHOWN ON PLAT OF RECORD IN PLAT BOOK 30, PAGE 52, IN THE REGISTERS OFFICE OF SHELBY COUNTY, TENNESSEE, TO WHICH PLAT REFERENCE IS HEREBY MADE FOR A MORE PARTICULAR DESCRIPTION OF SAID LOT. Parcel ID: 089008 00025PROPERTY ADDRESS: The street address of the property is believed to be **6272 CHEEKWOOD AVENUE, BARTLETT, TN 38134.** In the event of any discrepancy between this street address and the legal description of the property, the legal description shall control. CURRENT OWNER(S): BARBARA J. MABRYOTHER INTERESTED PARTIES: Crye Leike Realtors Inc, SECRETARY OF HOUSING AND URBAN DEVELOPMENT The sale of the above-described property shall be subject to all matters shown on any recorded plat; any unpaid taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or

Legal Notices

NOTICE OF SUBSTITUTE TRUSTEE S SALE WHEREAS, default has occurred in the performance of the covenants, terms and conditions of a Deed of Trust dated May 29, 2015, executed by CLARENCE E MALONE, conveying certain real property therein described to KATHRYN L. HARRIS, as Trustee, as same appears of record in the Register's Office of Shelby County, Tennessee recorded June 4, 2015, at Instrument Number 15053304; and WHEREAS, the beneficial interest of said Deed of Trust was last transferred and assigned to FREEDOM MORTGAGE CORPORATION who is now the owner of said debt; andWHEREAS, the undersigned,Rubin Lublin TN, PLLC, having been appointed as Substitute Trustee by instrument to be filed for record in the Register's Office of Shelby County, Tennessee. NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable, and that the undersigned, Rubin Lublin TN, PLLC, as Substitute Trustee or his duly appointed agent, by virtue of the power, duty and authority vested and imposed upon said Substitute Trustee will, on **October 18, 2018 at 12:00 PM** at the Shelby County Courthouse, 140 Adams Avenue, Memphis, TN, proceed to sell at public outcry to the highest and best bidder for cash or certified funds ONLY, the following described property situated in Shelby County, Tennessee, to wit:LOT 50, REVISED FINAL PLAN, CONCORD PLACE SUBDIVISION, AS SHOWN ON PLAT OF RECORD IN PLAT BOOK 111, PAGE 31 IN THE REGISTER`S OFFICE OF SHELBY COUNTY, TENNESSEE, TO WHICH PLAT REFERENCE IS HEREBY MADE FOR A MORE PARTICULAR DESCRIPTION OF SAID PROPERTY.Parcel ID: D0241A D00050PROPERTY ADDRESS: The street address of the property is believed to be **4385 WALDEN CV, MEMPHIS, TN 38125.** In the event of any discrepancy between this street address and the legal description of the property, the legal description shall control. CURRENT OWNER(S): CLARENCE E MALONEOTHER INTERESTED PARTIES: Secretary of Housing and Urban DevelopmentThe sale of the above-described property shall be subject to all matters shown on any recorded plat; any unpaid taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose. This property is being sold with the

Legal Notices

Notice of Change in TennCare II Demonstration Amendment 38

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and 59 Fed. Reg. 49249, of intent to file an amendment to the **TennCare II Demonstration. The amendment, which will** be known as "Amendment 38," is being filed with the Centers for Medicare and Medicaid Services (CMS), a federal agency located in Baltimore, Maryland, with a Regional Office in Atlanta, Georgia.

Amendment 38 is designed to promote improved health outcomes for TennCare members, and to support member efforts to achieve their education- and employment-related goals. To this end, Amendment 38 will establish workforce participation and community engagement as an expectation for some program enrollees.

The workforce participation and community engagement requirement will be applicable to non-pregnant, non-disabled, non-elderly adults enrolled in TennCare in the parent/caretaker relative eligibility category described at 42 CFR § 435.110 without dependent children under the age of six.

Impacted adults will be required to engage in qualifying work or community engagement activities for an average of 20 hours per week. Qualifying activities can include paid employment, certain educational activities, job search or job skills training activities, and community service in approved settings. TennCare will also seek to link individuals to resources and supports whenever possible to help members achieve their education- and employment-related goals. Impacted members who fail to comply with the requirement will be subject to suspension of benefits until compliance is demonstrated.

This proposed demonstration amendment is consistent with guidance released by CMS on promoting work and community engagement among Medicaid beneficiaries, and is submitted in accordance with Public Chapter No. 869, enacted by the Tennessee General Assembly in 2018. In accordance with this legislation, the State will seek federal approval to use funds from Tennessee's Temporary Assistance for Needy Families (TANF) program to fund any costs associ-

ated with the work and community engagement initiative.

The full public notice associated with this amendment, including a comprehensive description of the amendment, is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment38ComprehensiveNotice.pdf.

Pursuant to 42 CFR § 431, Subpart G, the State is providing the following opportunities to the public to comment on the proposed amendment in person:

- A public hearing on October 8, 2018, at 11:00 a.m. CT in the Large Meeting Room of the Bordeaux branch of the Nashville Public Library, 4000 Clarksville Pike in Nashville.
- A public hearing on October 9, 2018, at 1:00 p.m. ET in the Community Meeting Room of the Burlington branch of the Knox County Library, 4614 Asheville Highway in Knoxville.
- A public hearing on October 11, 2018, at 11:00 a.m. CT in the Program Center of the Jackson Madison County Library, 433 East Lafayette Street in Jackson.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Members of the public who prefer to submit written comments may send them by mail to Dr. Wendy Long, Director, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is Friday, October 26, 2018.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

NOTICE OF FORECLOSURE SALE

STATE OF TENNESSEE, SHELBY COUNTY

WHEREAS, Lesteen M. Wiggins executed a Deed of Trust to FT Mortgage Companies dba First Tennessee Mortgage Company, Inc., Lender and Thomas F. Baker, IV, Trustee(s), which was dated October 29, 1999 and recorded on November 2, 1999 in Instrument No. JV1356, Shelby County, Tennessee Register of Deeds.

WHEREAS, default having been made in the payment of the debt(s) and obligation(s) thereby secured by the said Deed of Trust and the current holder of said Deed of Trust, Tennessee Housing Development Agency, (the "Holder"), appointed the undersigned, Brock & Scott, PLLC, as Substitute Trustee, with all the rights, powers and privileges of the original Trustee named in said Deed of Trust; and

NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable as provided in said Deed of Trust by the Holder, and that as agent for the undersigned, Brock & Scott, PLLC, Substitute Trustee, by virtue of the power and authority vested in it, will on October 25, 2018, at 10:00AM at the usual and customary location at the Comfort Inn Downtown, 100 N. Front Street, Memphis, TN 38103, proceed to sell at public outcry to the highest and best bidder for cash, the following described property situated in Shelby County, Tennessee, to wit:

Lot 8, Pontotoc Place in Memphis, Shelby County, Tennessee being property in the name of the City of Memphis recorded in Instrument Number FP 3618.

Commencing at the intersection of the north line of Pontotoc Street (40' Right-of-Way) with the west line of Lauderdale Street (48' Right-of-Way); thence north 85 degrees 59 minutes 34 seconds west with the north line of Pontotoc Street, 195.55 feet; thence north 04 degrees 00 minutes 26 seconds east, 0.45 feet to a point in the north line of Pontotoc Street as established by existing back of sidewalk; thence north 85 degrees 59 minutes 34 seconds west with the north line of Pontotoc Street as established by existing back of sidewalk, 12.88 feet to a set iron pin with plastic cap in the east line of property recorded in Instrument No. FP 3618, said point being the Point of Beginning; thence north 85 degrees 59 minutes 34 seconds west with the north line of Pontotoc Street as established by existing back of sidewalk, 50.00 feet to a set iron pin with plastic cap, said point being in the west line of property recorded in Instrument No. FP 3618; thence north 04 degrees 02 minutes 56 seconds east with the west line of property recorded in Instrument No. FP 3618 and with the now or fomerly Clarence T. Dye and wife, Minnie S. Cianciolo property, 145.35 feet to a set iron pin with plastic cap in the south line of a 15 foot wide alley; thence south 85 degrees 59 minutes 34 seconds east with the south line of said alley and the north line of property recorded in Instrument No. FP 3618, 50.00 feet to a point in the east line of property recorded in Instrument No. FP 3618, thence south 04 degrees 02 minutes 56 seconds west with the east line of property recorded in Instrument No. FP 3618 and the west line of property recorded in Instrument No. FE 2089, 145.35 feet to the point of beginning.

Parcel ID Number: 00701200000170

Address/Description: 528 East Pontotoc Avenue, Memphis, TN 38126.

Current Owner(s): Lesteen M. Wiggins.

Other Interested Party(ies): The Division of Housing and Community; St. Patrick's Neighborhood Housing Development Corporation, Inc.; and Secretary of Housing and Urban Development.

The sale of the property described above shall be subject to all matters shown on any recorded plat; any and all liens against said property for unpaid property taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; a deed of trust; and any matter than an accurate survey of the premises might disclose; and

All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above.

This office is attempting to collect a debt. Any information obtained will be used for that purpose.

Brock & Scott, PLLC, Substitute Trustee
c/o Tennessee Foreclosure Department
4360 Chamblee Dunwoody Road, Ste 310
Atlanta, GA 30341
PH: 404-789-2661 FX: 404-294-0919
File No.: 17-15133 FC01

NOTICE OF FORECLOSURE SALE

STATE OF TENNESSEE, SHELBY COUNTY

WHEREAS, Julius Lewis executed a Deed of Trust to Mortgage Electronic Registration Systems, Inc., As Nominee For Wilmington Finance, Inc., Lender and Preferred Title & Escrow, LLC, Trustee(s), which was dated August 9, 2006 and recorded on August 25, 2006 in Instrument No. 06139732, Shelby County, Tennessee Register of Deeds.

WHEREAS, default having been made in the payment of the debt(s) and obligation(s) thereby secured by the said Deed of Trust and the current holder of said Deed of Trust, The Bank of New York Mellon, as Trustee for CIT Mortgage Loan Trust 2007-1, (the "Holder"), appointed the undersigned, Brock & Scott, PLLC, as Substitute Trustee, with all the rights, powers and privileges of the original Trustee named in said Deed of Trust; and

NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable as provided in said Deed of Trust by the Holder, and that as agent for the undersigned, Brock & Scott, PLLC, Substitute Trustee, by virtue of the power and authority vested in it, will on October 25, 2018, at 10:00AM at the usual and customary location at the Comfort Inn Downtown, 100 N. Front Street, Memphis, TN 38103, proceed to sell at public outcry to the highest and best bidder for cash, the following described property situated in Shelby County, Tennessee, to wit:

Lot 1, Section A, Lake Forest Subdivision, as shown on plat of record in Plat Book 21, Page 33 in the Register's Office of Shelby County, Tennessee, to which plat reference is hereby made for a more particular description of said property.

Being the same property conveyed to grantor, Julius C. Lewis, herein by Warranty Deed of record at Instrument No. 03178499, dated August 27, 2003, filed September 9, 2003, in the Register's Office of Shelby County, Tennessee.

Parcel ID Number: 084020 00002

Address/Description: 3787 South Lakewood Drive, Memphis, TN 38128.

Current Owner(s): Julius C. Lewis.

Other Interested Party(ies): Landmark Community Bank and Renasant Bank.

The sale of the property described above shall be subject to all matters shown on any recorded plat; any and all liens against said property for unpaid property taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; a deed of trust; and any matter than an accurate survey of the premises might disclose; and

All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above.

This office is attempting to collect a debt. Any information obtained will be used for that purpose.

Brock & Scott, PLLC, Substitute Trustee
c/o Tennessee Foreclosure Department
4360 Chamblee Dunwoody Road, Ste 310
Atlanta, GA 30341
PH: 404-789-2661 FX: 404-294-0919
File No.: 18-11620 FC01

NOTICE OF FORECLOSURE SALE

STATE OF TENNESSEE, SHELBY COUNTY

WHEREAS, Israel Ishmael Britt-Taylor and Vince Taylor executed a Deed of Trust to Regions Bank d/b/a Regions Mortgage, Lender and FMLS, Inc., Trustee(s), which was dated November 30, 2012 and recorded on December 7, 2012 in Instrument No. 12139862, Shelby County, Tennessee Register of Deeds.

WHEREAS, default having been made in the payment of the debt(s) and obligation(s) thereby secured by the said Deed of Trust and the current holder of said Deed of Trust, Regions Bank d/b/a Regions Mortgage, (the "Holder"), appointed the undersigned, Brock & Scott, PLLC, as Substitute Trustee, with all the rights, powers and privileges of the original Trustee named in said Deed of Trust; and

NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable as provided in said Deed of Trust by the Holder, and that as agent for the undersigned, Brock & Scott, PLLC, Substitute Trustee, by virtue of the power and authority vested in it, will on October 25, 2018, at 10:00AM at the usual and customary location at the Comfort Inn Downtown, 100 N. Front Street, Memphis, TN 38103, proceed to sell at public outcry to the highest and best bidder for cash, the following described property situated in Shelby County, Tennessee, to wit:

Lot 88, Part of Parcels 3 & 4, GERLAND CREEK PD, PHASE 6 (Whisper Ridge), as shown on plat of record in Plat Book 227, Page 42, in the

AFFIDAVIT OF PUBLICATION

0003174864
Newspaper

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

BUREAU OF TENNCARE
310 GREAT CIRCLE RD
NASHVILLE, TN
37243

TEAR SHEET ATTACHED

Jackie Cooper Sales Assistant for the above mentioned newspaper, hereby certify that the attached advertisement appeared in said newspaper on the following dates:

09/27/18

Jackie Cooper

Subscribed and sworn to before me this 17th day of Oct 2018.

Donna Walker
Notary Public

DONNA WALKER
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES MAY 3, 2021

Affidavits Requested:
1

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Public Notices

0003146156

NOTICE OF SUBSTITUTE TRUSTEE'S SALE

WHEREAS, default has occurred in the performance of the covenants, terms and conditions of a Deed of Trust dated August 9, 2013, executed by PERCY LEE ROBERTSON, conveying certain real property therein described to JOSEPH B. PITT, JR., as Trustee, as same appears of record in the Register's Office of Madison County, Tennessee recorded September 24, 2013, in Deed Book T1963, Page 1482; and WHEREAS, the beneficial interest of said Deed of Trust was last transferred and assigned to Reverse Mortgage Solutions, Inc. who is now the owner of said debt; and WHEREAS, the undersigned, Rubin Lublin TN, PLLC, having been appointed as Substitute Trustee by instrument to be filed for record in the Register's Office of Madison County, Tennessee. NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable, and that the undersigned, Rubin Lublin TN, PLLC, as Substitute Trustee or his duly appointed agent, by virtue of the power, duty and authority vested and imposed upon said Substitute Trustee will, on October 25, 2018 at 1:00 PM at the North Entrance of the Madison County Courthouse, Jackson, Tennessee, proceed to sell at public outcry to the highest and best bidder for cash or certified funds ONLY, the following described property situated in Madison County, Tennessee, to wit:LAND SITUATED IN THE CITY OF JACKSON IN THE COUNTY OF MADISON IN THE STATE OF TN: BEGINNING AT AN IRON PIN IN THE SOUTH MARGIN OF ROBIN LANE, SAID PIN BEING LOCATED 25 FEET FROM THE CENTERLINE OF SAID LANE AND AT THE NORTHEAST CORNER OF LOT NO. 41, SECTION I, OF WOODLAND HILLS SUBDIVISION A PLAT OF WHICH APPEARS OF RECORD IN PLAT BOOK 2, PAGE 90, IN THE REGISTERS OFFICE OF MADISON COUNTY TENNESSEE; RUNS THENCE SOUTH 88 DEGREES 55 MINUTES EAST WITH THE SOUTH MARGIN

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OF ROBIN LANE A DISTANCE OF 105 FEET TO AN IRON PIN: RUNS THENCE IN A SOUTHERLY DIRECTION AND FOLLOWING A CURVE TO THE RIGHT HAVING A RADIUS OF 15 FEET A DISTANCE OF 23.6 FEET TO AN IRON PIN IN THE WEST MARGIN OF CALDWELL PLACE; RUNS THENCE SOUTH 01 DEGREE 05 MINUTES WEST WITH THE WEST MARGIN OF CALDWELL PLACE A DISTANCE OF 160 FEET TO AN IRON PIN IN HEDGE ROW, SAID POINT BEING THE NORTHEAST CORNER OF LOT NO. 45 IN SAID SUBDIVISION; RUNS THENCE NORTH 88 DEGREES 55 MINUTES WEST WITH THE NORTH BOUNDARY LINE OF LOT NO. 45 A DISTANCE OF 120 FEET TO AN IRON PIN IN HEDGE ROW, SAID POINT BEING THE SOUTHEAST CORNER OF LOT NO. 41; RUNS THENCE NORTH 01 DEGREE 05 MINUTES EAST WITH THE EAST LINE OF LOT NO. 41 A DISTANCE OF 175 FEET TO THE POINT OF BEGINNING. BEING LOT NO. 44, SECTION I OF WOODLAND HILLS SUBDIVISION, PLATTED AS AFORESAID.Parcel ID: 65B-D-9.00PROPERTY ADDRESS: The street address of the property is believed to be 44 ROBIN LN, JACKSON, TN 38305. In the event of any discrepancy between this street address and the legal description of the property, the legal description shall control. CURRENT OWNER(S): PERCY LEE ROBERTSON OTHER INTERESTED PARTIES: Secretary of Housing and Urban DevelopmentThe sale of the above-described property shall be subject to all matters shown on any recorded plat; any unpaid taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose. This property is being sold with the express reservation that it is subject to confirmation by the lender or Substitute Trustee. This sale may

Continued to next column

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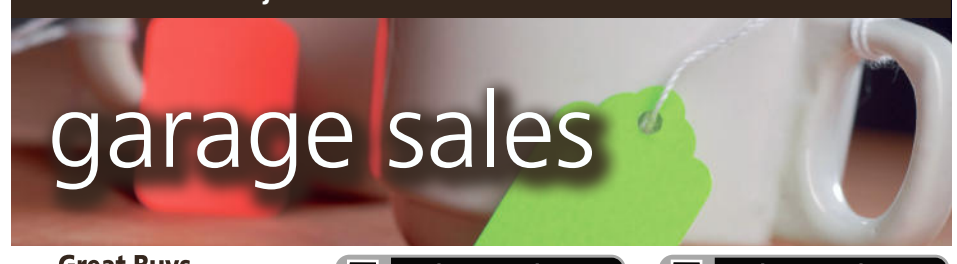
be rescinded at any time. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The Property is sold as is, where is, without representations or warranties of any kind, including fitness for a particular use or purpose.- THIS LAW FIRM IS ATTEMPTING TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE. Rubin Lublin TN, PLLC, Substitute Trustee 119 S. Main Street, Suite 500 Memphis, TN 38103rubinlublin.com/property-listingTel: (877) 813-0992 Fax: (404) 601-5846 Ad #143993 09/27/2018, 10/04/2018, 10/11/2018

Continued from last column

0003175134

LEGAL NOTICE

Notice is herby given that on Thursday October 11, 2018 U-Haul,will be offering for sale under the judicial lien process,by public auction the following storage units,the goods to be sold are generally described as household goods.the terms of the sale are CASH ONLY.u-haul reserves the right to refuse any and all bids,the auction will start at approximately 10:00a.m at 173 airways blvd.following is a list of rooms to be sold, kamara murphy#1008, toyna bell#2015, janice bell#2019, london martin#2003, keya childress#1165
U-haul Co.



Great Buys
Yard Sale
neighborly deals...

Madison Central

JACKSON- 104 Hillary Dr. Thurs 9/27 & Fri 9/28. 8am-6pm. Many items for sale. hh items, furn, carpet & more.

JACKSON. 612 Gettysburg Dr . Subdivision in North Park. Fri & Sat. 28th and 29th. 8am-6pm. Four Family Yard Sale! Too Many Itmes to List.

Madison North

Fri 9/28 - Sun 9/30, 7-3pm
38 Millsap Dr, Jackson TN
Everything must go! glassware, upright freezer, washer, french door fridge, table & chairs, antique furniture, Christmas decorations

JACKSON, MOVING SALE!
144 Emerald Lake Dr. Friday and Saturday, 7-12, Couches, chairs, dinning room set, armoire, Lots of home decor and miscellaneous, civil war replicas.

JACKSON: Shepherd's Field will be having their annual community yard sale! Fri 9/28, 12-5 & Sat 9/29, 7-2, **MULTIPLE FAMILIES!**

Madison North

NORTH JACKSON-15 London Parkplace- Fri 9/28 7a-5p & Sat 9/29 7a-1p. Tools, fishing lures, old records, clothes, hh items & more

Madison South

Estate Sale
JACKSON Sat 9/29; 7am-3:30pm
30 Camellia Dr. (off Harts Bridge Rd)
60 YEAR SALE!
Antiques: China cabinets, 100yr old buffet, kitchen/Dng tbls & chrs, 1930's ice box, 108yr old wht oak tbl, mirrors, art, sofa, tools, beds, dressers, chest of drawers, glassware, home decor..plus

Public Notices

0003174864

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We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

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204 W. Main Street
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AFFIDAVIT OF PUBLICATION

AD# 1441383

DATES: 9-26-2018

Notice of Change in TennCare II Demonstration

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The full public notice associated with this amendment, including a comprehensive description of the amendment, is available on the TennCare website at https://www.tn.govcontent/dam/tn/tenncare/documents2/Amendment38ComprehensiveNotice.pdf.

State of Tennessee)
Carter County)
Washington County)

Teresa Hicks makes the oath that she is a Representative of The Johnson City Press, a daily newspaper published in Johnson City, in said County and State, and that the advertisement was published in said paper for 1 insertion (s) commencing on 9-26-2018 and ending on 9-26-2018.

Teresa Hicks

Sworn to and Subscribed before me this 9 27 2018
Month Day Year

CONNIE N. GUINN
STATE OF TENNESSEE
NOTARY PUBLIC
WASHINGTON COUNTY
MY COMMISSION EXPIRES 3-3-2021

Connie N. Guinn
Notary Public

My commission expires on 03/03/2021

This legal notice was published online at www.johnsoncitypress.com and www.publicnoticeads.com during the duration of the run dates listed. This publication fully complies with Tennessee Code Annotated 1-3-20

JOHNSON CITY PRESS
204 W. Main Street
Johnson City, TN 37604
AFFIDAVIT OF PUBLICATION

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Notice of Change in TennCare II Demonstration Amendment 38

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and 59 Fed. Reg. 49249, of intent to file an amendment to the TennCare II Demonstration. The amendment, which will be known as "Amendment 38," is being filed with the Centers for Medicare and Medicaid Services (CMS), a federal agency located in Baltimore, Maryland, with a Regional Office in Atlanta, Georgia.

Amendment 38 is designed to promote improved health outcomes for TennCare members, and to support member efforts to achieve their education- and employment-related goals. To this end, Amendment 38 will establish workforce participation and community engagement as an expectation for some program enrollees.

The workforce participation and community engagement requirement will be applicable to non-pregnant, non-disabled, non-elderly adults enrolled in TennCare in the parent/caretaker relative eligibility category described at 42 CFR § 435.110 without dependent children under the age of six.

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Attn:
To: STATE OF TN BUREAU OF TENNCARE

(Advertising) Notice of Change in TennCare II Demo (**Ref No:** 2124660)

P.O.#:

PUBLISHER'S AFFIDAVIT

State of Tennessee }
s.s
County of Knox }

Before me, the undersigned, a Notary Public in and for said county, this day personally came Natalie Zollar first duly sworn, according to law, says that he/she is a duly authorized representative of *The Knoxville News-Sentinel*, a daily newspaper published at Knoxville, in said county and state, and that the advertisement of:

(The Above-Referenced)

of which the annexed is a copy, was published in said paper on the following date(s):

09/27/2018

and that the statement of account herewith is correct to the best of his/her knowledge, information, and belief.

Natalie Zollar
_____

Subscribed and sworn to before me this September 27, 2018

Karol E Kangas
_____
Notary Public

My commission expires _____ 20_____

KAROL E KANGAS
Notary Public - State of Florida
Commission # GG 126041
My Comm. Expires Jul 29, 2021
Bonded through National Notary Assn.

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AFFIDAVIT OF PUBLICATION

0003174919
Newspaper Leaf Chronicle

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

BUREAU OF TENNCARE
310 GREAT CIRCLE RD
NASHVILLE, TN
37243

TEAR SHEET ATTACHED

Jackie Cooper Sales Assistant for the above mentioned newspaper,

hereby certify that the attached advertisement appeared in said newspaper on the following dates:

09/27/18

Jackie Cooper

Subscribed and sworn to before me this 27 day of September 2018

Angela Murray
Notary Public

ANGELA MURRAY
STATE OF TENNESSEE
NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 1-6-2020

Affidavits Requested:
1

0003174919NOTICEOFCHANGEINTENNCAREIIDEMONS
Re: Amendment 38

Continued from last column

ises might disclose. This property is being sold with the express reservation that it is subject to confirmation by the lender or Substitute Trustee. This sale may be rescinded at any time. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The Property is sold as is, where is, without representations or warranties of any kind, including fitness for a particular use or purpose.THIS LAW FIRM IS ATTEMPTING TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.Rubin Lublin TN, PLLC, Substitute Trustee119 S. Main Street, Suite 500Memphis, TN 38103rubinlublin.com/property-listingTel: (877) 813-0992 Fax: (404) 601-5846 Ad #143951 09/13/2018, 09/20/2018, 09/27/2018

0003161927

NOTICE OF SUBSTITUTE TRUSTEE'S SALE

WHEREAS, default has occurred in the performance of the covenants, terms and conditions of a Deed of Trust dated October 23, 2013, executed by ASHLEY CRAIG, DANIEL J. CRAIG, conveying certain real property therein described to SCOTT R. VALBY, as Trustee, as same appears of record in the Register's Office of Montgomery County, Tennessee recorded October 29, 2013, in Deed Book 1538, Page 826-842; and WHEREAS, the beneficial interest of said Deed of Trust was last transferred and assigned to PennyMac Loan Services, LLC who is now

Continued to next column

Continued from last column

the owner of said debt; and-WHEREAS, the undersigned, Rubin Lublin TN, PLLC, having been appointed as Substitute Trustee by instrument to be filed for record in the Register's Office of Montgomery County, Tennessee. NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable, and that the undersigned, Rubin Lublin TN, PLLC, as Substitute Trustee or his duly appointed agent, by virtue of the power, duty and authority vested and imposed upon said Substitute Trustee will, on October 25, 2018 at 10:00 AM at the Front Steps of the Montgomery County Courthouse, Clarksville, Tennessee, proceed to sell at public outcry to the highest and best bidder for cash or certified funds ONLY, the following described property situated in Montgomery County, Tennessee, to wit: LAND SITUATED IN THE 3RD CIVIL DISTRICT OF MONTGOMERY COUNTY, TENNESSEE DESCRIBED AS: TRACT 1: BEGINNING AT AN IRON PIN LOCATED IN THE SOUTHERN RIGHT OF WAY OF LAFAYETTE RD, SAID PIN BEING THE NORTHEAST CORNER OF THIS PARCEL; THENCE LEAVING SAID SOUTH 6 DEGREES 30 MINUTES EAST 195 FEET TO A PIN; THENCE NORTH 84 DEGREES EAST 110 FEET TO A PIN IN THE WEST RIGHT OF WAY OF A PRIVATE DRIVE; THENCE WITH SAID DRIVE SOUTH 7 DEGREES 30 MINUTES EAST 155 FEET TO A PIN; THENCE LEAVING SAID DRIVE NORTH 88 DEGREES WEST 271 FEET TO A PIN; THENCE NORTH 11 DEGREES 45 MINUTES EAST 125 FEET TO A PIN; THENCE NORTH 5 DEGREES WEST 179 FEET TO A PIN IN THE SOUTHERN RIGHT OF WAY OF LAFAYETTE RD., BEING

Continued to next column

Continued from last column

THE NORTHWEST CORNER OF THIS PARCEL; THENCE WITH SAID ROAD NORTH 74 DEGREES 30 MINUTES EAST 114 FEET TO THE POINT OF BEGINNING. TRACT 2: BEGINNING AT AN IRON PIN, SAID IRON PIN BEING LOCATED SOUTH 10 DEGREES 24 MINUTES 10 SECONDS EAST OF THE NORTHEAST CORNER OF SMITH'S PROPERTY WHICH NORTHEAST CORNER IS LOCATED IN THE SOUTHERLY RIGHT OF WAY LINE OF LAFAYETTE ROAD AND BEING 0.45 MILES PLUS OR MINUS TO WALNUT GROVE ROAD; THENCE FROM THE POINT OF BEGINNING SOUTH 3 DEGREES 11 MINUTES 13 SECONDS EAST 84.23 FEET TO AN IRON PIN; THENCE NORTH 88 DEGREES 15 MINUTES 35 SECONDS EAST 30.07 FEET TO AN IRON PIN; THENCE NORTH 07 DEGREES 12 MINUTES 56 SECONDS WEST 80.52 FEET TO AN IRON; THENCE NORTH 81 DEGREES 46 MINUTES 14 SECONDS WEST 35.86 FEET TO THE POINT OF BEGINNING AND CONTAINING 0.06 ACRES, AH ACCORDING TO A SURVEY DATED SEPTEMBER 25, 2002, BY WEAKLEY BROTHERS, LAND SURVEYORS. Parcel ID: 044 05202 000000 PROPERTY ADDRESS: The street address of the property is believed to be **1176 LAFAYETTE RD, CLARKSVILLE, TN 37042.** In the event of any discrepancy between this street address and the legal description of the property, the legal description shall control. CURRENT OWNER(S): ASHLEY CRAIG, DANIEL J. CRAIGOTHER INTERESTED PARTIES: The sale of the above-described property shall be subject to all matters shown on any recorded plat; any unpaid taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose. This property is being sold with the express reservation that it is subject to confirmation by the lender or Substitute Trustee. This sale may be rescinded at any time. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The Property is sold as is, where is, without representations or warranties of any kind, including fitness for a particular use or purpose.THIS LAW FIRM IS ATTEMPTING TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.Rubin Lublin TN, PLLC, Substitute Trustee119 S. Main Street, Suite 500 Memphis, TN 38103rubinlublin.com/property-listingTel: (877) 813-0992 Fax: (404) 601-5846 Ad #144466 09/27/2018, 10/04/2018, 10/11/2018

JANRIC CLASSIC SUDOKU

Fill in the blank cells using numbers 1 to 9. Each number can appear only once in each row, column and 3x3 block. Use logic and process elimination to solve the puzzle. The difficulty level ranges from Bronze (easiest) to Silver to Gold (hardest).

1		8		5	6		7	
		6				1		2
3				7	1	5		
	2		4				3	9
		9		2		7		
5	3				9		2	
		5	6	3				7
2		1				4		
	6		1	4		2		8

9/27/18

Rating: BRONZE

Solution to 9/28/18

6	9	4	5	2	3	7	8	1
5	1	3	7	8	6	2	9	4
8	2	7	9	1	4	5	3	6
3	7	9	4	5	8	1	6	2
1	6	5	2	3	9	4	7	8
2	4	8	1	6	7	9	5	3
4	5	6	8	7	2	3	1	9
9	8	1	3	4	5	6	2	7
7	3	2	6	9	1	8	4	5

Continued from last column

TENNESSEE, DESCRIBED AS FOLLOWS TO-WIT: TRACT I: BEING LOT NO. 10 ON THE PLAN OF MCCLURE ESTATES, SECTION -A, AS SHOWN BY PLAT BOOK 13, PAGE NUMBER(S) 932, PLAT NUMBER(S) 932 & 932A, REGISTER'S OFFICE FOR MONTGOMERY COUNTY, TENNESSEE, TO WHICH REFERENCE IS MADE FOR A COMPLETE DESCRIPTION. TRACT II: BEING A PORTION OF LOT NO. 9, ON THE PLAN OF MCCLURE ESTATES, SECTION A, AS SHOWN BY PLAT BOOK 13, PAGE NUMBER(S) 932, PLAT NUMBER(S) 932 & 932A, REGISTER'S OFFICE FOR MONTGOMERY COUNTY, TENNESSEE AND BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS: BEGINNING AT AN OLD IRON PIN IN THE EASTERLY RIGHT OF WAY MARGIN OF OLD HIGHWAY 48, SAID IRON PIN BEING THE MOST SOUTHWESTERLY CORNER OF LOT 9, MCCLURE ESTATES, SECTION A, AS SHOWN IN PLAT BOOK 13, PAGE NUMBER 932, PLAT NUMBER 932-932A, ROMCT; THENCE AS MEASURED ALONG THE SAID RIGHT OF WAY MARGIN OF OLD HIGHWAY 48, NORTH 04 DEGREES 10 MINUTES 06 SECONDS EAST 75.03 FEET TO A POINT; THENCE LEAVING THE SAID RIGHT OF WAY MARGIN OF OLD HIGHWAY 48, SOUTH 84 DEGREES 21 MINUTES 32 SECONDS EAST 735.85 FEET TO A POINT; THENCE SOUTH 05 DEGREES 36 MINUTES 52 SECONDS WEST 75.04 FEET TO AN OLD IRON PIN; THENCE NORTH 84 DEGREES 21 MINUTES 21 SECONDS WEST 733.96 FEET TO THE POINT OF BEGINNING, ALL ACCORDING TO SURVEY BY DAVID N. YOUNG, TN LICENSE NO. 1562, DATED 10/26/2000. Parcel ID: 112M-A-00600-000 PROPERTY ADDRESS: The street address of the property is believed to be **2985 Old Hwy 48, Clarksville, TN 37040.** In the event of any discrepancy between this street address and the legal description of the property, the legal description shall control. CURRENT OWNER(S): Ashley E Harp, Garry M HarpOTHER INTERESTED PARTIES: TIMOTHY AND TAMMY MARTZThe sale of the above-described property shall be subject to all matters shown on any recorded plat; any unpaid

Continued from last column

Trustee119 S. Main Street, Suite 500Memphis, TN 38103rubinlublin.com/property-listingTel: (877) 813-0992 Fax: (404) 601-5846 Ad #144600 09/27/2018, 10/04/2018, 10/11/2018

0003169490

NOTICE OF SUBSTITUTE TRUSTEE'S SALE

WHEREAS, default has occurred in the performance of the covenants, terms and conditions of a Deed of Trust dated November 30, 2016, executed by ADABELLE REYNOLDS, conveying certain real property therein described to SCOTT R. VALBY, as Trustee, as same appears of record in the Register's Office of Montgomery County, Tennessee recorded December 1, 2016, in Deed Book 1713, Page 35-45; and WHEREAS, the beneficial interest of said Deed of Trust was last transferred and assigned to PennyMac Loan Services, LLC who is now the owner of said debt; andWHEREAS, the undersigned,Rubin Lublin TN, PLLC, having been appointed as Substitute Trustee by instrument to be filed for record in the Register's Office of Montgomery County, Tennessee. NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable, and that the undersigned, Rubin Lublin TN, PLLC, as Substitute Trustee or his duly appointed agent, by virtue of the power, duty and authority vested and imposed upon said Substitute Trustee will, on October 25, 2018 at 10:00 AM at the Front Steps of the Montgomery County Courthouse, Clarksville, Tennessee, proceed to sell at public outcry to the highest and best bidder for cash or certified funds ONLY, the following described property situated in Montgomery County, Tennessee, to wit: BEING LOT NUMBER 9, ON THE PLAN OF SUNRISE ESTATES, SECTION 1, AS SHOWN BY PLAT OF RECORD IN PLAT BOOK 13, PAGE 136, PLAT 136-136A, IN THE REGISTER'S OFFICE FOR MONTGOMERY COUNTY, TENNESSEE, TO WHICH PLAT REFERENCE IS HEREBY MADE FOR A MORE COMPLETE LEGAL DESCRIPTION. BEING THE SAME PROPERTY CONVEYED TO ADABELLE REYNOLDS , AN UNMARRIED WOMAN, BY DEED FROM PATRICK F. GATES AND CHONG H. GATES, CO-TRUSTEES OF THE GATES

Continued from last column

to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The Property is sold as is, where is, without representations or warranties of any kind, including fitness for a particular use or purpose.THIS LAW FIRM IS ATTEMPTING TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.Rubin Lublin TN, PLLC, Substitute Trustee119 S. Main Street, Suite 500Memphis, TN 38103 rubinlublin.com/property-listing Tel: (877) 813-0992 Fax: (404) 601-5846 Ad #144688 09/27/2018, 10/04/2018, 10/11/2018

0003173162

Public Notice Auction held at Cables Automotive on 10/19/2018 9:00 A.M. 130 Kraft st Clarksville Tn 37040
2004 Cadillac
Vin: 3GYEK62N64G161850

0003175569

TC Towing
1420 Ashland City Rd
Clarksville TN 37040
931-561-0800
October 13 2018
10:00 am

2014 Chrysler Town and Country
VIN:2C4RC1HG2ER453264

0003175776

This is to advise that household and personal property belonging to the following:
Unit# 2015 Lovely Lancaster
Unit# 1049 Antonio Youngblood
Unit# 1094 Ashley Mckissick
At Safe Place Storage, 1950 Peachers Mill Road, Clarksville, TN 37042 will be sold to the highest bidder at www.storageauctions.com before October 2nd 2018 to satisfy owner's lien for rent in accordance with TN Code 66-31-101 et.seq. All articles sold "as-is" and by unit only. Seller neither warrant title to any items sold and do not make any express or implied warranties to any items sold. We reserve the right to refuse any and all bids.
72 hours to pick up items

Public Notices

0003174919

Notice of Change in TennCare II Demonstration Amendment 38

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and 59 Fed. Reg. 49249, of intent to file an amendment to the TennCare II Demonstration. The amendment, which will be known as "Amendment 38," is being filed with the Centers for Medicare and Medicaid Services (CMS), a federal agency located in Baltimore, Maryland, with a Regional Office in Atlanta, Georgia.

Amendment 38 is designed to promote improved health outcomes for TennCare members, and to support member efforts to achieve their education- and employment-related goals. To this end, Amendment 38 will establish workforce participation and community engagement as an expectation for some program enrollees.

The workforce participation and community engagement requirement will be applicable to non-pregnant, non-disabled, non-elderly adults enrolled in TennCare in the parent/caretaker relative eligibility category described at 42 CFR § 435.110 without dependent children under the age of six.

Impacted adults will be required to engage in qualifying work or community engagement activities for an average of 20 hours per week. Qualifying activities can include paid employment, certain educational activities, job search or job skills training activities, and community service in approved settings. TennCare will also seek to link individuals to resources and supports whenever possible to help members achieve their education- and employment-related goals. Impacted members who fail to comply with the requirement will be subject to suspension of benefits until compliance is demonstrated.

This proposed demonstration amendment is consistent with guidance released by CMS on promoting work and community engagement among Medicaid beneficiaries, and is submitted in accordance with Public Chapter No. 869, enacted by the Tennessee General Assembly in 2018. In accordance with this legislation, the State will seek federal approval to use funds from Tennessee's Temporary Assistance for Needy Families (TANF) program to fund any costs associated with the work and community engagement initiative.

The full public notice associated with this amendment, including a comprehensive description of the amendment, is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment38ComprehensiveNotice.pdf.

0003166523

NOTICE OF SUBSTITUTE TRUSTEE'S SALE

WHEREAS, default has occurred in the performance of the covenants, terms and conditions of a Deed of Trust dated March 27, 2010, executed by Ashley E Harp, Garry M Harp, conveying certain real property therein described to KERRY WEBB, as Trustee, as same appears of record in the Register's Office of Montgomery County, Tennessee recorded April 5, 2010, in Deed Book 1328, Page 2790-2799; and WHEREAS, the beneficial in-

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ises might disclose. This property is being sold with the express reservation that it is subject to confirmation by the lender or Substitute Trustee. This sale may be rescinded at any time. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The Property is sold as is, where is, without representations or warranties of any kind, including fitness for a particular use or purpose.THIS LAW FIRM IS ATTEMPTING TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.Rubin Lublin TN, PLLC, Substitute Trustee119 S. Main Street, Suite 500Memphis, TN 38103rubinlublin.com/property-listingTel: (877) 813-0992 Fax: (404) 601-5846 Ad #143951 09/13/2018, 09/20/2018, 09/27/2018

0003161927

NOTICE OF SUBSTITUTE TRUSTEE'S SALE

WHEREAS, default has occurred in the performance of the covenants, terms and conditions of a Deed of Trust dated October 23, 2013, executed by ASHLEY CRAIG, DANIEL J. CRAIG, conveying certain real property therein described to SCOTT R. VALBY, as Trustee, as same appears of record in the Register's Office of Montgomery County, Tennessee recorded October 29, 2013, in Deed Book 1538, Page 826-842; and WHEREAS, the beneficial interest of said Deed of Trust was last transferred and assigned to PennyMac Loan Services, LLC who is now

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the owner of said debt; and-WHEREAS, the undersigned, Rubin Lublin TN, PLLC, having been appointed as Substitute Trustee by instrument to be filed for record in the Register's Office of Montgomery County, Tennessee. NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable, and that the undersigned, Rubin Lublin TN, PLLC, as Substitute Trustee or his duly appointed agent, by virtue of the power, duty and authority vested and imposed upon said Substitute Trustee will, on October 25, 2018 at 10:00 AM at the Front Steps of the Montgomery County Courthouse, Clarksville, Tennessee, proceed to sell at public outcry to the highest and best bidder for cash or certified funds ONLY, the following described property situated in Montgomery County, Tennessee, to wit: LAND SITUATED IN THE 3RD CIVIL DISTRICT OF MONTGOMERY COUNTY, TENNESSEE DESCRIBED AS: TRACT 1: BEGINNING AT AN IRON PIN LOCATED IN THE SOUTHERN RIGHT OF WAY OF LAFAYETTE RD, SAID PIN BEING THE NORTHEAST CORNER OF THIS PARCEL; THENCE LEAVING SAID SOUTH 6 DEGREES 30 MINUTES EAST 195 FEET TO A PIN; THENCE NORTH 84 DEGREES EAST 110 FEET TO A PIN IN THE WEST RIGHT OF WAY OF A PRIVATE DRIVE; THENCE WITH SAID DRIVE SOUTH 7 DEGREES 30 MINUTES EAST 155 FEET TO A PIN; THENCE LEAVING SAID DRIVE NORTH 88 DEGREES WEST 271 FEET TO A PIN; THENCE NORTH 11 DEGREES 45 MINUTES EAST 125 FEET TO A PIN; THENCE NORTH 5 DEGREES WEST 179 FEET TO A PIN IN THE SOUTHERN RIGHT OF WAY OF LAFAYETTE RD., BEING

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THE NORTHWEST CORNER OF THIS PARCEL; THENCE WITH SAID ROAD NORTH 74 DEGREES 30 MINUTES EAST 114 FEET TO THE POINT OF BEGINNING. TRACT 2: BEGINNING AT AN IRON PIN, SAID IRON PIN BEING LOCATED SOUTH 10 DEGREES 24 MINUTES 10 SECONDS EAST OF THE NORTHEAST CORNER OF SMITH'S PROPERTY WHICH NORTHEAST CORNER IS LOCATED IN THE SOUTHERLY RIGHT OF WAY LINE OF LAFAYETTE ROAD AND BEING 0.45 MILES PLUS OR MINUS TO WALNUT GROVE ROAD; THENCE FROM THE POINT OF BEGINNING SOUTH 3 DEGREES 11 MINUTES 13 SECONDS EAST 84.23 FEET TO AN IRON PIN; THENCE NORTH 88 DEGREES 15 MINUTES 35 SECONDS EAST 30.07 FEET TO AN IRON PIN; THENCE NORTH 07 DEGREES 12 MINUTES 56 SECONDS WEST 80.52 FEET TO AN IRON; THENCE NORTH 81 DEGREES 46 MINUTES 14 SECONDS WEST 35.86 FEET TO THE POINT OF BEGINNING AND CONTAINING 0.06 ACRES, AH ACCORDING TO A SURVEY DATED SEPTEMBER 25, 2002, BY WEAKLEY BROTHERS, LAND SURVEYORS. Parcel ID: 044 05202 000000 PROPERTY ADDRESS: The street address of the property is believed to be **1176 LAFAYETTE RD, CLARKSVILLE, TN 37042.** In the event of any discrepancy between this street address and the legal description of the property, the legal description shall control. CURRENT OWNER(S): ASHLEY CRAIG, DANIEL J. CRAIGOTHER INTERESTED PARTIES: The sale of the above-described property shall be subject to all matters shown on any recorded plat; any unpaid taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose. This property is being sold with the express reservation that it is subject to confirmation by the lender or Substitute Trustee. This sale may be rescinded at any time. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The Property is sold as is, where is, without representations or warranties of any kind, including fitness for a particular use or purpose.THIS LAW FIRM IS ATTEMPTING TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.Rubin Lublin TN, PLLC, Substitute Trustee119 S. Main Street, Suite 500 Memphis, TN 38103rubinlublin.com/property-listingTel: (877) 813-0992 Fax: (404) 601-5846 Ad #144466 09/27/2018, 10/04/2018, 10/11/2018

0003166523

NOTICE OF SUBSTITUTE TRUSTEE'S SALE

WHEREAS, default has occurred in the performance of the covenants, terms and conditions of a Deed of Trust dated March 27, 2010, executed by Ashley E Harp, Garry M Harp, conveying certain real property therein described to KERRY WEBB, as Trustee, as same appears of record in the Register's Office of Montgomery County, Tennessee recorded April 5, 2010, in Deed Book 1328, Page 2790-2799; and WHEREAS, the beneficial interest of said Deed of Trust was last transferred and assigned to Nationstar Mortgage LLC d/b/a Mr. Cooper who is now the owner of said debt; and WHEREAS, the undersigned, Rubin Lublin TN, PLLC, having been appointed as Substitute Trustee by instrument to be filed for record in the Register's Office of Montgomery County, Tennessee. NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable, and that the undersigned, Rubin Lublin TN, PLLC, as Substitute Trustee or his duly appointed agent, by virtue of the power, duty and authority vested and imposed upon said Substitute Trustee will, on October 25, 2018 at 12:00 PM at the Montgomery County Courthouse, 2 Millennium Plaza, Clarksville, TN, proceed to sell at public outcry to the highest and best bidder for cash or certified funds ONLY, the following described property situated in Montgomery County, Tennessee, to wit: A CERTAIN TRACT OR PARCEL OF LAND LOCATED IN THE SEVENTEENTH (17TH) CIVIL DISTRICT OF MONTGOMERY COUNTY,

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TENNESSEE, DESCRIBED AS FOLLOWS TO-WIT: TRACT I: BEING LOT NO. 10 ON THE PLAN OF MCCLURE ESTATES, SECTION -A, AS SHOWN BY PLAT BOOK 13, PAGE NUMBER(S) 932, PLAT NUMBER(S) 932 & 932A, REGISTER'S OFFICE FOR MONTGOMERY COUNTY, TENNESSEE, TO WHICH REFERENCE IS MADE FOR A COMPLETE DESCRIPTION. TRACT II: BEING A PORTION OF LOT NO. 9, ON THE PLAN OF MCCLURE ESTATES, SECTION A, AS SHOWN BY PLAT BOOK 13, PAGE NUMBER(S) 932, PLAT NUMBER(S) 932 & 932A, REGISTER'S OFFICE FOR MONTGOMERY COUNTY, TENNESSEE AND BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS: BEGINNING AT AN OLD IRON PIN IN THE EASTERLY RIGHT OF WAY MARGIN OF OLD HIGHWAY 48, SAID IRON PIN BEING THE MOST SOUTHWESTERLY CORNER OF LOT 9, MCCLURE ESTATES, SECTION A, AS SHOWN IN PLAT BOOK 13, PAGE NUMBER 932, PLAT NUMBER 932-932A, ROMCT; THENCE AS MEASURED ALONG THE SAID RIGHT OF WAY MARGIN OF OLD HIGHWAY 48, NORTH 04 DEGREES 10 MINUTES 06 SECONDS EAST 75.03 FEET TO A POINT; THENCE LEAVING THE SAID RIGHT OF WAY MARGIN OF OLD HIGHWAY 48, SOUTH 84 DEGREES 21 MINUTES 32 SECONDS EAST 735.85 FEET TO A POINT; THENCE SOUTH 05 DEGREES 36 MINUTES 52 SECONDS WEST 75.04 FEET TO AN OLD IRON PIN; THENCE NORTH 84 DEGREES 21 MINUTES 21 SECONDS WEST 733.96 FEET TO THE POINT OF BEGINNING, ALL ACCORDING TO SURVEY BY DAVID N. YOUNG, TN LICENSE NO. 1562, DATED 10/26/2000. Parcel ID: 112M-A-00600-000 PROPERTY ADDRESS: The street address of the property is believed to be **2985 Old Hwy 48, Clarksville, TN 37040.** In the event of any discrepancy between this street address and the legal description of the property, the legal description shall control. CURRENT OWNER(S): Ashley E Harp, Garry M HarpOTHER INTERESTED PARTIES: TIMOTHY AND TAMMY MARTZThe sale of the above-described property shall be subject to all matters shown on any recorded plat; any unpaid taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose. This property is being sold with the express reservation that it is subject to confirmation by the lender or Substitute Trustee. This sale may be rescinded at any time. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The Property is sold as is, where is, without representations or warranties of any kind, including fitness for a particular use or purpose.THIS LAW FIRM IS ATTEMPTING TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.Rubin Lublin TN, PLLC, Substitute

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Trustee119 S. Main Street, Suite 500Memphis, TN 38103rubinlublin.com/property-listingTel: (877) 813-0992 Fax: (404) 601-5846 Ad #144600 09/27/2018, 10/04/2018, 10/11/2018

0003169490

NOTICE OF SUBSTITUTE TRUSTEE'S SALE

WHEREAS, default has occurred in the performance of the covenants, terms and conditions of a Deed of Trust dated November 30, 2016, executed by ADABELLE REYNOLDS, conveying certain real property therein described to SCOTT R. VALBY, as Trustee, as same appears of record in the Register's Office of Montgomery County, Tennessee recorded December 1, 2016, in Deed Book 1713, Page 35-45; and WHEREAS, the beneficial interest of said Deed of Trust was last transferred and assigned to PennyMac Loan Services, LLC who is now the owner of said debt; andWHEREAS, the undersigned,Rubin Lublin TN, PLLC, having been appointed as Substitute Trustee by instrument to be filed for record in the Register's Office of Montgomery County, Tennessee. NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable, and that the undersigned, Rubin Lublin TN, PLLC, as Substitute Trustee or his duly appointed agent, by virtue of the power, duty and authority vested and imposed upon said Substitute Trustee will, on October 25, 2018 at 10:00 AM at the Front Steps of the Montgomery County Courthouse, Clarksville, Tennessee, proceed to sell at public outcry to the highest and best bidder for cash or certified funds ONLY, the following described property situated in Montgomery County, Tennessee, to wit: BEING LOT NUMBER 9, ON THE PLAN OF SUNRISE ESTATES, SECTION 1, AS SHOWN BY PLAT OF RECORD IN PLAT BOOK 13, PAGE 136, PLAT 136-136A, IN THE REGISTER'S OFFICE FOR MONTGOMERY COUNTY, TENNESSEE, TO WHICH PLAT REFERENCE IS HEREBY MADE FOR A MORE COMPLETE LEGAL DESCRIPTION. BEING THE SAME PROPERTY CONVEYED TO ADABELLE REYNOLDS , AN UNMARRIED WOMAN, BY DEED FROM PATRICK F. GATES AND CHONG H. GATES, CO-TRUSTEES OF THE GATES REVOCABLE LIVING TRUST, DATED JUNE 1ST 2010 OF RECORD IN BOOK VOLUME 1713, PAGE 33, SAID REGISTER'S OFFICE.Parcel ID: 068AB00200000000 PROPERTY ADDRESS: The street address of the property is believed to be **964 MERRITT LEWIS LN, CLARKSVILLE, TN 37042.** In the event of any discrepancy between this street address and the legal description of the property, the legal description shall control. CURRENT OWNER(S): ADABELLE REYNOLDS OTHER INTERESTED PARTIES: The sale of the above-described property shall be subject to all matters shown on any recorded plat; any unpaid taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose. This property is being sold with the express reservation that it is subject to confirmation by the lender or Substitute Trustee. This sale may be rescinded at any time. The right is reserved to adjourn the day of the sale

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Continued from last column

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0003173162

Public Notice Auction held at Cables Automotive on 10/19/2018 9:00 A.M. 130 Kraft st Clarksville Tn 37040
2004 Cadillac
Vin: 3GYEK62N64G161850

0003175569

TC Towing
1420 Ashland City Rd
Clarksville TN 37040
931-561-0800
October 13 2018
10:00 am

2014 Chrysler Town and Country
VIN:2C4RC1HG2ER453264

0003175776

This is to advise that household and personal property belonging to the following:
Unit# 2015 Lovely Lancaster
Unit# 1049 Antonio Youngblood
Unit# 1094 Ashley Mckissick
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72 hours to pick up items
No Dumpster privileges
$100 cleanup deposit required
Contact facility to schedule pickup
(931) 572-0999
All personal items (pictures, financial info, social security cards, etc.) must be returned to the facility immediately.

JANRIC CLASSIC SUDOKU

Fill in the blank cells using numbers 1 to 9. Each number can appear only once in each row, column and 3x3 block. Use logic and process elimination to solve the puzzle. The difficulty level ranges from Bronze (easiest) to Silver to Gold (hardest).

1		8		5	6		7	
		6				1		2
3				7	1	5		
	2		4				3	9
		9		2		7		
5	3				9		2	
		5	6	3				7
2		1				4		
	6		1	4		2		8

Rating: BRONZE

Solution to 9/26/18

6	9	4	5	2	3	7	8	1
5	1	3	7	8	6	2	9	4
8	2	7	9	1	4	5	3	6
3	7	9	4	5	8	1	6	2
1	6	5	2	3	9	4	7	8
2	4	8	1	6	7	9	5	3
4	5	6	8	7	2	3	1	9
9	8	1	3	4	5	6	2	7
7	3	2	6	9	1	8	4	5

9/27/18

Public Notices

0003174919

Notice of Change in TennCare II Demonstration Amendment 38

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Amendment 38 is designed to promote improved health outcomes for TennCare members, and to support member efforts to achieve their education- and employment-related goals. To this end, Amendment 38 will establish workforce participation and community engagement as an expectation for some program enrollees.

The workforce participation and community engagement requirement will be applicable to non-pregnant, non-disabled, non-elderly adults enrolled in TennCare in the parent/caretaker relative eligibility category described at 42 CFR § 435.110 without dependent children under the age of six.

Impacted adults will be required to engage in qualifying work or community engagement activities for an average of 20 hours per week. Qualifying activities can include paid employment, certain educational activities, job search or job skills training activities, and community service in approved settings. TennCare will also seek to link individuals to resources and supports whenever possible to help members achieve their education- and employment-related goals. Impacted members who fail to comply with the requirement will be subject to suspension of benefits until compliance is demonstrated.

This proposed demonstration amendment is consistent with guidance released by CMS on promoting work and community engagement among Medicaid beneficiaries, and is submitted in accordance with Public Chapter No. 869, enacted by the Tennessee General Assembly in 2018. In accordance with this legislation, the State will seek federal approval to use funds from Tennessee's Temporary Assistance for Needy Families (TANF) program to fund any costs associated with the work and community engagement initiative.

The full public notice associated with this amendment, including a comprehensive description of the amendment, is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment38ComprehensiveNotice.pdf.

Pursuant to 42 CFR § 431, Subpart G, the State is providing the following opportunities to the public to comment on the proposed amendment in person:

- A public hearing on October 8, 2018, at 11:00 a.m. CT in the Large Meeting Room of the Bordeaux branch of the Nashville Public Library, 4000 Clarksville Pike in Nashville.
- A public hearing on October 9, 2018, at 1:00 p.m. ET in the Community Meeting Room of the Burlington branch of the Knox County Library, 4614 Asheville Highway in Knoxville.
- A public hearing on October 11, 2018, at 11:00 a.m. CT in the Program Center of the Jackson Madison County Library, 433 East Lafayette Street in Jackson.

Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Members of the public who prefer to submit written comments may send them by mail to Dr. Wendy Long, Director, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is Friday, October 26, 2018.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

AFFIDAVIT OF PUBLICATION

0003174854
Newspaper

State of Tennessee

Account Number NAS-00381001
Advertiser BUREAU OF TENNCARE

BUREAU OF TENNCARE
310 GREAT CIRCLE RD
NASHVILLE, TN
37243

TEAR SHEET ATTACHED

Jackie Cooper Sales Assistant for the above mentioned newspaper,

hereby certify that the attached advertisement appeared in said newspaper on the following dates:

09/27/18

Jackie Cooper

Subscribed and sworn to before me this 17th day of Oct 2018.

Donna Walker
Notary Public

DONNA WALKER
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES MAY 3, 2021

Affidavits Requested:

1

0003174854NOTICEOFCHANGEINTENNCAREIIDEMONS
Re: Amendment 38

CLASSIFIED ads

Continued from last column

ing pursuant to 40 CFR Part 1504 has submitted a written finding that the project is unsatisfactory from the standpoint of environmental quality. Objections must be prepared and submitted in accordance with the required procedures of 24 CFR Part 58 and shall be addressed to the Department of Housing & Urban Development, 710 Locus Street, Suite 300 Knoxville, TN 37902-2526. Potential objectors should contact HUD to verify the actual last day of the objection period.
David Briley, Mayor of the Metropolitan Government of Nashville & Davidson County.

Public Notices

0003174854

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Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.

Members of the public who prefer to submit written comments may send them by mail to Dr. Wendy Long, Director, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is Friday, October 26, 2018.

Copies of this notice will be available in each county office of the Tennessee Department of Health.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).

We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

Real Estate Rentals
great places to live...

Farms for Rent

AMAZING DUCK HUNTING Property In Western Tennessee nr. an established Federal Refuge. 600 bucks a year average. $15k yearly. Call 731-571-5050 for details.

Homes For Rent

Nashville: 3831 Boatner Dr. Nice 3 BR/ 1 BA. hdwd flrs., lg. kit. fenced in bsck yard, nice neighborhood, appls., $875/mo. Avail 10/15 .Call 615-397-4395.

Apt Furnished

Rivergate - Furnished & unfurnished. wkly/mo, 1 Bdrms, Util, Appl. Call 573-7377 943-7236

Public Notices

Apt Unf-Davidson East

Germantown $1200+, 1 br, 1 ba, gated community, in-grnd pool, 615-815-4289 evergreenwerthanmgr@elmingtonpm.com

Apt Unf-Davidson North

★ ★ MADISON ★ ★
1 BR Apts Avail. Summer Specials!! Call for Details...481-5988

Office Space

DENTAL OFFICE- in No. Nashville area. 3 dental chairs, dark room, x-ray, plaster room, seating area, prvt offices,dental tools incl. Retiring. Call 615-541-3855 antoine2016r@gmail.com

Rooms For Rent

KNIGHTS INN - weekly/monthly rates & efficiencies- Free local calls, free HBO & WIFI $200 & up. **Call 259-9160**

OLD HICKORY OR DONELSON - Male wanted to share a nice 4 Bdrm, fully furnished, sober living House at either location. Incl cable & W/D, utils incl. $140/wk + deposit. 615-202-8671

Rooms for rent: 946 TS Jackson Ave 3 blocks from TSU Campus. Common area includes: stove/refrigerator, W/D, WiFi & lrg. TV. Nice & quiet area. $525 or $575/mo and $200 deposit. 615-310-8767 or 615-228-9999

STADIUM INN Weekly Rates $199 & Up. Also Monthly Rates. ★615-244-6052★ or ★615-244-6053★

Real Estate Homes
starting fresh...

Montgomery County

Clarksville- 715 Heatherhurst Ct. Stunning custom built home on Eastland Green golf course. Beautiful pool. 4BR, 3BA. 90% of Furniture stays with full price offer. 35 mins to Nashville airport $591,000 Call: 931-933-1927 or 931-320-2057.

Todd County

6048 Allensville Rd. $398,000, 7 Bds, 4.5ba, sits on 13.71 acres Call Tammy Higgins CRYE-LEIKE cell - 270-887-4827, office - 931-647-3400

Land-Other Counties

Trigg Co, KY - 1.6 to 3.45 acres city water & electric avail. Owner financing **www.dixielandco.com 615-792-5176**

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AUCTION
377 Acres Home & Land Auction
30 Beautiful Tracts
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Automotive Cars
best deal for you...

Autos Wanted

Don't Miss This One

123 Recyclers WE BUY JUNK VEHICLES , IN ANY CONDITION.NO TITLE NEEDED.WE PICKUP $$$$$$$$$, (615)935-5023 jantzen119@gmail.com

All Autos Wanted! Cash Paid for Junk Cars, any cond. 615-766-6460

Cars

2007 Corvette ; torch red w/ blk interior, ONLY 22,000 actual miles, seen rain twice, pristine cond., radio upgrade & 5 spoke chrome corvette wheels w/ Targa top - $25,000 firm 615-415-4096

CHRYSLER 300 SRT8 2006 - 6.1L Fully loaded, replaced eng, clean title. $6995. b/o Call/txt: 615-293-8789

NISSAN MAXIMA 2006 - Red/tan hwy mi, new eng & trans installed $3995 Call/txt: 615-293-8789

Classic and Antique

Porsche 911. I am looking to buy any Air-Cooled Porsche in any condition, running or not running. I live in the Knoxville TN area but am a serious buyer. Please call Jason 865-621-4012

Classic and Antique

WOW!

CHOOSE ANY OR ALL HIGH QUALITY '50's CHEVY'S

#1 '57 CORVETTE
Venetian Red, both tops, 283 engine, 270 HP w/2 four barrels, 4 spd., restored, TN car. Perfect gaps & show paint. Everything new, drives new. Owned since 1962. $95,000.

#2. '57 CHEVY BEL AIR
2 dr hard top. original un-restored. Black , orignal red & black interior, Wonderbar radio, factory 283 HP. fuel injection with all original components. Police pkg. front sway bar & vented backing plates on brakes. Very rare! Close ratio, 3 spd, trans, 4:11 posi-traction rear end, only 1530 cars equipped this way. $65,000.

#3. '55 CHEVY NOMAD
Staton Wagon. Red with white top. Frame off- restored. original California car. Correct red & beige waffle inter., wide white wall radial tires, factory tinted glass & pwr windows, drive train updated to 350 cu.in. engine & turbo hydromatic trans. and front disc brakes, & 605 Pwr steering. Very high quality paint & block straight body. $75,000.

ALL 3 CARS are very high quality & must be seen to believe! Retirement & age dictates sale! Cars located in Bowling Green, Kentucky. Call 270-418-7726. Bad cell service lvg msg slowly & I'll return calls, if not call back.

SUV

Chevy Tahoe 2005, 97K mi, 4 wheel dr., well maintained, automatic, $2600, call 901-501-6465

Classic and Antique

48TH SEMI-ANNUAL MUSIC CITY CLASSIC
THE SOUTH'S PREMIER COLLECTOR CAR AUCTION
Buy or sell your vintage vehicle here!
SATURDAY, OCTOBER 20th; 10 AM
★ Located at DAA of Murfreesboro, TN ★
For buy/sell info call: GEORGE EBER - 615-496-2277
★ www.southernclassicauctions.com ★ ☆ ★ TN Lic #5549 ★

Trucks

'13 Chevy Silverado 1500, Crew Cab, 4x4, One Owner, $13,350, New Tires. Call 9013526254

Honda 2006 Ridgeline, Truck, 4 dr., Automatic, Silver ext., Charcoal int., 06 Cylinders, 4WD, 121k, well maintained, very nice truck, $7500.00. (615)330-5777

Vans

CHEVY EXPRESS Van G3500 2012 6.0L 2 owner, mint cond. Hwy miles $7750. Call/txt: 615-293-8789

Motorcycle Scooter

Don't Miss This One

2016 Slingshot SL LE, Immaculate, 8500 miles, Gull wing top, front splitter, rear spoiler, to many opts to list! $26,900 Contact for pictures, (931)212-6212 sue.adams0722@gmail.com

Boats

2003 Flying Scot Sailboat #5518- dry sail, excellent cond, comes covered & has aluminum trailer, 4 stroke, 2hp honda motor, all sails, master helper, life jacket & accessories $10,000. 931-484-6818

Recreational Vehicle

2010 GRAND JUNCTION M-355RL 5TH WHL. EXLCOND 4SLIDES NEW TRK TIRES POLAR PKG W/DRY H/U Q--BED F/PLACE 2TVS NADA LIST $50K ASKING $29K OBO, (615)330-0107 bgs09m@yahoo.com

Classic and Antique

service directory

Professional Service
all your needs...

Business Service

DIVORCE-$50 DOWN
(both sign)
DUI, Criminal,
Any County in TN, Divorce!
Brian O. Bowhan
Attorney
615-333-5878

JIM'S CLOCK SERVICE
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•Repairs •Set-Up
30 years exp.
Reasonable Rates
I Make House Calls
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- Landscaping Designs
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- Hedge Trimming
- Beds Mulched
- Aerating & Power Seeding
- Erosion Control
- Lawn Maintenance
- Retaining Walls
- Patios & Decks
- Tree Service
- Irrigation Systems
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DRYWALL & PLASTER REPAIR SPECIALIST
All Work Fully Guaranteed
No Dust or Mess.
Rid your home of potentially dangerous plaster cracks
40 Years of Prompt, Reliable Service with no Complaints with the BBB
Free Estimates & References
No job too small!
Senior Discounts
615-227-2969
Call Anytime

Home Improvement

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ENGLISH HOME IMPROVEMENTS
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• A+ Rating with the BBB
• Named a top 3 Nashville Contractor
• Licensed TN # 00068088 & Insured Complete Contractor
"We do it all from Roofs to Additions"
•Window Special•
Buy 10 - Get 2 FREE
Tell us you saw us in the Tennessean & save $500 off your home improvement.
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EnglishHomeImprovements.com

Hertz Asphalt and Concrete Services
Parking Lots, Driveways, Seal Coating, and Repairs
• 2 Free Estimates for Asphalt or Concrete
• No Job Too Large or Too Small
Mention This Ad and Get $100 Off!
BBB A+ Member
615-941-2941 or
615-498-6008

Home Improvement

MIKE'S DRIVES
Parking Lots
Asphalt Paving
10% Off in Sept.
Seal Coating
FREE ESTIMATES
Aggregate & Concrete
Repairs & Sealing
615-768-1154

Lawn - Garden Care

ALL LANDSCAPING SERVICES
Lawn Maintenance, Mulching, Tree Trimming & Removal, Gutter Cleaning & MORE!
Free Estimates.
Alejandro Lopez
615-482-4683
allandscaping@hotmail.com

DANIEL'S TREE & LANDSCAPING
15 Years Exp. All Tree Service Needs & Any & All Landscaping. Boned & Ins.
Call 615-943-0791, 615-881-6116

Dirt, Top Soil & Will Spread, Stone. 30 Mile Radius, Call Donnie
615-498-6008

Lawn - Garden Care

PENTECOST Tree Services
• Tree Removal
• Trimming
• Stump Grinding
• Pruning • Dead wooding
24 Hour Emergency Services
Licensed Insured
Residential & Commercial
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Moving

AtYourDoor Junk Hauling & Moving Service
Hauling Starting at $60
Professional Moving:
Mon. - Wed. 2 HR/Truck $180 Thurs. - Sat. 2HR/ Truck $210
Free Estimates!
★ 615-398-9588 ★

State of Tennessee
County of Obion

AFFIDAVIT OF PUBLICATION

Personally appeared before me, the undersigned Notary Public for Obion County, Tenn., DAVID CRITCHLOW, who, on oath, says he is the publisher of the Union City Daily Messenger, a daily newspaper of general circulation, published at Union City in said county and state, and that the hereto attached

Notice of Change in TennCare

Notice was published in said paper for 1 consecutive ~~weeks~~ day as follows: 9/25/, _____, _____, 2018

Publisher _____

Printer's Fee $ 219.10

Subscribed and sworn to before me this 15th day of October 2018

Notary Public Donna L Gibson

DONNA L. GIBSON
STATE OF TENNESSEE NOTARY PUBLIC
OBION COUNTY

CLASSIFIEDS

Misc. For Sale • Services • Real Estate • Help Wanted

Appliances

FOR SALE:
Used GE dryer
Dark Gray

Works great!
$100

731-514-9070

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DIRECTV SELECT PACKAGE! Over 150 Channels, ONLY $35/month (for 12 mos.) Order Now! Get a $100 AT&T Visa Rewards Gift Card (some restrictions apply) CALL 1-844-230-4803 (TnScan)

DISH TV $59.99 For 190 Channels $14.95 High Speed Internet. Free Installation, Smart HD DVR Included, Free Voice Remote. Some restrictions apply. Call 1-844-274-6074 (TnScan)

SPECTRUM TRIPLE PLAY TV, Internet & Voice for $29.99 ea. 60 MB per second speed. No contract or commitment. We buy your existing contract up to $500! 1-855-710-8320 (TnScan)

Travel

BUS TRIP TUNICA $35
September 29th

INCLUDES:
LUNCH BUFFET
& $25
FREE SLOT PLAY

731-446-9140

Misc. For Sale

FOR SALE:
Chest- type Deep Freeze
For more information call
731-223-1278

EARTHLINK HIGH Speed Internet. As Low As $14.95/month (for the first 3 months.) Reliable High Speed
Fiber Optic Technology. Stream Videos, Music and More! Call Earthlink Today 1-888-337-9611 (TnScan)

Misc. For Sale

FOR SALE: Country Line 22 ton wood splitter, 901-848-2818

SAWMILLS FROM only $4397.00-MAKE & SAVE MONEY with your own bandmill-Cut lumber any dimension. In stock ready to ship! FREE Info/DVD: www.NorwoodSawmills.com 800 567-0404 Ext.300N (TnScan)

Lawn-Garden

FOR SALE: Cub Cadet Zero Turn Mower, 50in, 2yrs old, $1,950.00, 731-819-3268

Health

ATTENTION VIAGRA users: Generic 100 mg blue pills or Generic 20 mg yellow pills. Get 45 plus 5 free $99 + S/H. Guaranteed, no prescription necessary. Call 866-569-5390 (TnScan)

DENTAL INSURANCE. Call Physicians Mutual Insurance Company for details. NOT just a discount plan, REAL coverage for 350 procedures. 844-278-8285 or http://www.dental50plus.com/tnpress Ad# 6118 (TnScan)

LUNG CANCER? And Age 60+? You And Your Family May Be Entitled To Significant Cash Award. 866-590-3496 for Information. No Risk. No Money Out Of Pocket. (TnScan)

OXYGEN - Anytime. Anywhere. No tanks to refill. No deliveries. The All-New Inogen One G4 is only 2.8 pounds! FAA approved! FREE info kit: 844-280-2602 (TnScan)

Health

SLEEP APNEA Patients - If you have Medicare coverage, call Verus Healthcare to qualify for CPAP supplies for little or no cost in minutes. Home Delivery, Healthy Sleep Guide and More - FREE! Our customer care agents await your call. 1-866-451-4648 (TnScan)

Want to Buy

WANT TO BUY:

Nice telescope wanted

E-mail
scritch@ucmessenger.com

Truck Van SUV

FOR SALE

2008 Chevrolet Tahoe
125 K Miles
2 WD
Brand New Tires

$12,500.00
Call Or Text,
270-978-8562

Notice

AFFORDABLE DIVORCE with or without children pro se $85.00. Includes child support, property settlement and name change agreements. Credit cards, bank debit cards accepted. Call 865-424-1414 (TnScan)

DONATE YOUR CAR TO CHARITY! FAST FREE PICKUP-24 HR RESPONSE! Help Children in Need, Support Breast Cancer Education/Prevention or Veterans. Tax Deduction 866-559-9602 (TnScan)

Notice

NOTICE
The Messenger screens all classified ads prior to publishing in order to protect our readers from scams.

Our customers are important to us. If you see an ad that you are unsure of or if you respond to an ad that is a scam, please contact us.

The Messenger
Classifieds Department
731-885-0744

Legal

IN THE CHANCERY COURT OF OBION COUNTY, TENNESSEE
Dillion Forrest Hamil and Samantha Elizabeth Hamil
Plaintiff
Vs.
Unknown Father of Kensley Brooke Elkins
Defendant
Case No.33,667
ORDER OF PUBLICATION

In the above styled cause it appearing to the Clerk and Master from the original bill of complaint that the defendant,Unknown Father, is a non-resident of the State of Tennessee, and is a resident of the State of Unknown.
IT IS THEREFORE hereby ordered that the above named defendant serve upon Beau Pemberton, P.o.Box 789, Dresden, TN., 38225, Attorney for Plaintiff, an answer to this complaint within 30 days from the last date of publication and also file a copy of said answer with the Clerk and Master of the Chancery Court of Union City, Tennessee, and make defense to said complaint, or the same will be taken as confessed by plaintiff, and the cause set for hearing ex parte as to the defendant.
IT IS FURTHER ORDERED that publication of this notice be made for four consecutive weeks in the Union City Daily Messenger, a daily newspaper published in Obion County, Tennessee.
This 29th day of
August 2018
Beau Pemberton
Solicitor
Paula Rice,
Clerk & Master
9/11/2018, 9/18/2018, 9/25/2018, 10/2/2018

IN THE CHANCERY COURT OF OBION COUNTY, TENNESSEE
Guadalupe Ramirez
Plaintiff
Vs.
Jose Refugio Tejeda
Defendant
Case No. 33,668
ORDER OF PUBLICATION

In the above styled cause it appearing to the Clerk and Master from the original bill of complaint that the defendant, Jose Refugio Tejeda, is a non-resident of the State of Tennessee, and is a resident of the State of Unknown.
IT IS THEREFORE hereby ordered that the above named defendant serve upon Jason Jackson, 107 Howell Rd., Martin, Tn., 38237, Attorney for Plaintiff, an answer to this complaint within 30 days from the last date of publication and also file a copy of said answer with the Clerk and Master of the Chancery Court of Union City, Tennessee, and make defense to said complaint, or the same will be taken as confessed by plaintiff, and the cause set for hearing ex parte as to the defendant.
IT IS FURTHER ORDERED that publication of this notice be made for four consecutive weeks in the Union City Daily Messenger, a daily newspaper published in Obion County, Tennessee.
This 27th day of
August, 2018
Jason Jackson
Solicitor
Paula Rice,
Clerk & Master
9/11/2018, 9/18/2018, 9/25/2018, 10/2/2018

NOTICE OF PUBLIC MEETING

The Union City Board of Zoning Appeals does hereby give public notice of a regular meeting to be held on Friday, October 5th, 2018, at 8:30 AM in the courtroom of the Municipal Building located at 408 S. Depot St. for the purpose of hearing the following appeal: Variance request for John David Moffatt on 3317 West Main Street and a request for a Residential Transient Rental Unit for Katie Keathley at 317 Sterling Court.
A copy of the request may be viewed in the office of the Building Inspectors during regular business hours. All interested parties are invited and encouraged to attend.
It is the policy of the City of Union City, Tennessee not to discriminate on the basis of race, color, national origin, age, sex or disability in its hiring and employment practices, or in admission to, access to, or operation of its programs, services, and activities. If special accommodations are needed in order to fully participate in this meeting, please contact City Hall at least 48 hours in advance.
9/25/2018

NOTICE OF Change in TennCare II Demonstration Amendment 38

The Commissioner of the Tennessee Department of Finance and Administration is providing official notification, pursuant to 42 CFR § 431.408 and 59 Fed. Reg. 49249, of intent to file an amendment to the TennCare II Demonstration. The amendment, which will be known as "Amendment 38," is being filed with the Centers for Medicare and Medicaid Services (CMS), a federal agency located in Baltimore, Maryland, with a Regional Office in Atlanta, Georgia.
Amendment 38 is designed to promote improved health outcomes for TennCare members, and to support member efforts to achieve their education- and employment-related goals. To this end, Amendment 38 will establish workforce participation and community engagement as an expectation for some program enrollees.
The workforce participation and community engagement requirement will be applicable to non-pregnant, non-disabled, non-elderly adults enrolled in TennCare in the parent/caretaker relative eligibility category described at 42 CFR § 435.110 without dependent children under the age of six.
Impacted adults will be required to engage in qualifying work or community engagement activities for an average of 20 hours per week. Qualifying activities can include paid employment, certain educational activities, job search or job skills training activities, and community service in approved settings. TennCare will also seek to link individuals to resources and supports whenever possible to help members achieve their education- and employment-related goals. Impacted members who fail to comply with the requirement will be subject to suspension of benefits until compliance is demonstrated.
This proposed demonstration amendment is consistent with guidance released by CMS on promoting work and community engagement among Medicaid beneficiaries, and is submitted in accordance with Public Chapter No. 869, enacted by the Tennessee General Assembly in 2018. In accordance with this legislation, the State will seek federal approval to use funds from Tennessee's Temporary Assistance for Needy Families (TANF) program to fund any costs associated with the work and community engagement initiative.
The full public notice associated with this amendment, including a comprehensive description of the amendment, is available on the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment38ComprehensiveNotice.pdf.
Pursuant to 42 CFR § 431, Subpart G, the State is providing the following opportunities to the public to comment on the proposed amendment in person:
• A public hearing on October 8, 2018, at 11:00 a.m. CT in the Large Meeting Room of the Bordeaux branch of the Nashville Public Library, 4000 Clarksville Pike in Nashville.
• A public hearing on October 9, 2018, at 1:00 p.m. ET in the Community Meeting Room of the Burlington branch of the Knox County Library, 4614 Asheville Highway in Knoxville.
• A public hearing on October 11, 2018, at 11:00 a.m. CT in the Program Center of the Jackson Madison County Library, 433 East Lafayette Street in Jackson.
Individuals with disabilities or individuals with limited English proficiency who wish to participate in one of the hearings and who may require language or communication assistance to do so should contact Talley Olson of TennCare's Office of Civil Rights Compliance by phone at (855) 857-1673 or by email at HCFA.fairtreatment@tn.gov prior to the date of the hearing.
Members of the public who prefer to submit written comments may send them by mail to Dr. Wendy Long, Director, Division of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243, or by email to public.notice.tenncare@tn.gov. Persons wishing to review copies of written comments received may submit their requests to the same email and/or physical address. The last day on which comments will be accepted is Friday, October 26, 2018.
Copies of this notice will be available in each county office of the Tennessee Department of Health.
We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html
9/25/2018

Real Estate

FOR SALE:
2BR, 1BA home
180 acres Farmland
125 tillable
City water
1544 Reese Alexander Road, Union City
3 miles from Walmart
Great hunting spot

MAKE OFFER!
731-446-7188

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And meet your family's needs. Find the home just right for you by reading the classified real estate and for rent ads everyday.

Real Estate

FOR SALE

3BR 1BA
Brick home
KENTON

REDUCED!!!!!!!!
$69,900

BRAND NEW CH/A

This house is vacant and ready to take possession!!!

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Large kitchen & dining combo, living room, step-down den, carpet, vinyl and hardwood, new Ch/A, 1 car carport and a detached workshop Covered patio and is Convenient to school and shopping

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2013 Single wide mobile home
(13.ft.6inX66ft)
3BR, 2BA, Ch/A,

Must move from property
5mi east of Martin

731-504-8783

FOR SALE:
3BR, 2BA Mobile Home
Owner Financing
$40,000
446-9130

It is the policy of The Messenger that all advertising for the sale, rental or financing of residential real estate advertising appearing herein comply with the Federal Fair Housing Act which prohibits "any preference, limitation, discrimination because of race, color, religion, sex, handicap, familial status, or national origin, or intention to make any such preference, limitation or discrimination." In addition, the Human Rights Act prohibits such discrimination. No advertising for the sale, rental or financing of residential real estate will be refused or rejected because of race, color, religion, sex handicap, familial status or origin.
It is also the policy of this newspaper not to require different charges or terms for such advertising because of race, color, religion, sex, handicap, familial status or national origin.

SAVE YOUR HOME! Are you behind paying your MORTGAGE? Denied a Loan Modification? Is the bank threatening foreclosure? CALL Homeowner's Relief Line! FREE CONSULTATION! 877-643-1408 (TnScan)

For Sale or Rent

FOR SALE
OR RENT TO OWN:

South Fulton, 3BR, 2BA brick house, living room, family room, dining room, two garages,

$79,900 Sale Price
$5,000 Down
$700mo Rent to Own

Serious inquiries only
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Evenings

Want to Buy

FREON R12 WANTED: CERTIFIED BUYER will PAY CA$H for R12 cylinders or cases of cans. (312) 291-9169; www.refrigerantfinders.com (TnScan)

For Rent

FOR RENT:

3BR, 1BA house
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NO PETS

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FOR RENT: 116 Wade Union City, Johnson Rental Properties, 885-8325

RENT WEEKLY!!
LET US HELP YOU

DEPOSITS $120!

2BR and 3BR
Mobile Homes

Section 8 Accepted

Troy, 731-536-0200

FOR RENT:

1 Bedroom house,
Martin
All appliances

2BR house
UC area

731-335-1920

Help Wanted

HELP WANTED:
Union City Business seeking
Experienced Secretary with computer skills

Send resumes to:
The Messenger
Box 325
PO Box 430
Union City, TN 38281

HELP WANTED:

CAR DETAILER
Immediate opening
Must know how to run a buffer, have valid driver's license and dependable transportation

731-588-5524

NOW HIRING:
Clerical/ Office Assistant
30-40 hours. Experience a plus, but not required
Send resume to :
The Messenger
Box 327
PO Box 430
Union City, TN 38281

HELP WANTED:

Part time housekeeping for local office

Monday-Friday,
3pm-6pm

Must be self starter and dependable and have references

Send Resumes to:
Housekeeping Position
PO Box 430
#279
Union City, TN 38281

Truck Drivers

HELP WANTED:
CDL Drivers Needed
Phoenix Gin Company
731-253-8091

DRIVERS NEEDED CDL-A, 3 months experience, Benefits Start Day 1, OTR, Reg, Local, Flex Home Time - Mileage + per diem Ozark Motor Lines 800-264-2033 (TnScan)

FAST TRACKS
SEEKING FULL TIME AND PART TIME OTR DRIVERS

Run dedicated areas home every weekend

885-3115, 446-3660

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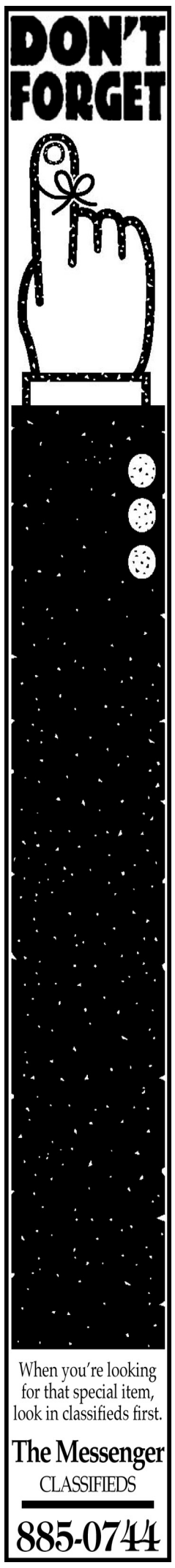

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Appendix C

Public Comments Received

Jonathan Reeve

From: Susanna Barron <sbarron@abetterbalance.org>
Sent: Friday, October 26, 2018 4:04 PM
To: Public Notice. Tenncare
Subject: TennCare Waiver Amendment 38
Attachments: ABB TennCare Comments--Final.pdf

Good afternoon,

Attached are comments on Waiver Amendment 38, submitted on behalf of A Better Balance

Thank you!

Best,
Susanna Barron
Legal Fellow
A Better Balance

a better balance
the work and family legal center

2301 21st Ave. South, Suite 355, Nashville, TN 37212 | t: 615.915.2417 | info@abetterbalance.org | abetterbalance.org

Dr. Wendy Long, Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

via email to: **public.notice.tenncare@tn.gov**

RE: TennCare Waiver Amendment 38

Dear Dr. Long,

A Better Balance writes in response to the public notice inviting public comments on proposed Waiver Amendment 38. A Better Balance (ABB) is a legal advocacy organization with an office in Nashville dedicated to promoting fairness in the workplace. Our mission is to promote equality and expand choices for men and women at all income levels so they may care for themselves and their families without sacrificing their economic security. We employ a range of legal strategies to promote flexible workplace policies, end discrimination against caregivers and value the work of caring for families. Our free and confidential legal helpline receives calls from low-wage workers across the state, who often rely on Medicaid for healthcare.

Our organization is unequivocally opposed to this proposal, which would take health coverage away from people who do not work a set number of hours per month. Imposing work requirements on Medicaid recipients would jeopardize health coverage for thousands of Tennesseans and would cause immense harm to their health and economic security. ABB is particularly concerned about the impact that new work requirements would have on people with children or other caregiving responsibilities, as well as those with chronic health conditions, who

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make up a significant portion of our client population, as the vast majority of TennCare recipients are children, parents or other caretaker relatives, seniors, and people with disabilities.[1]

This waiver would require "all able-bodied working age adult enrollees without dependent children under the age of six" to fulfill "reasonable work and community engagement requirements."[2] The majority of Medicaid recipients in Tennessee are already working either full-time or part-time, and 77% are in a family with a working adult.[3] Of Medicaid recipients in the state who do not work, 41% are ill or disabled, 27% are caring for a child or family member and 17% are going to school.[4] This leaves less than 7% of the total population of Tennessee Medicaid recipients not working, which includes those who are unable to find work. While some of these non-working adults will be exempted under the new requirements, exactly which groups will be exempt remains unclear, and bill sponsors have been inconsistent on this topic.

Furthermore, it is important to note that those with the most serious mental and physical health conditions, for whom access to medical care is a matter of life and death, are the most likely to have difficulty *actually obtaining* an exemption, because of the burdensome requirements and significant barriers. Exemptions simply are not sufficient to protect those who are unable to work from the substantial negative effects of these requirements. The unnecessary hurdles that these work requirements would place between Tennesseans and their healthcare will hurt the very people that Medicaid was explicitly designed to help. Individuals who are eligible for an exemption will still need to verify their status, and practical barriers are very likely to lead to "exempted" beneficiaries losing coverage, not because they are ineligible, but because they are unable to provide the necessary documentation. People with physical and mental health

[1] R. Garfield, R. Rudowitz, and A. Damico, Appendix, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation (Dec. 7, 2017), https://www.kff.org/report-section/understanding-the-intersection-of-medicaid-and-work-appendix/
[2] 2018 Tennessee Laws Pub. Ch. 869 (H.B. 1551).
[3] Garfield, *supra* n. 1
[4] *Id.*

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conditions that may interfere with their ability to work but who are not considered severe enough to qualify them for an exemption are also likely to face coverage loss.

Although these work requirements would, in theory, only affect coverage for those who are not exempt and do not fulfill the 20-hour requirement, in practice, many Tennesseans who can and do work are also at risk of losing coverage. Low-wage workers are more likely to be underemployed and to face unpredictable work schedules over which they often have no control.[5] Lack of fair and flexible scheduling is just one of the challenges that many of our clients and others like them already face in balancing work and their responsibilities in caring for children and other family members. Rather than doing anything to alleviate these problems and enable these people to work to their full potential, these work requirements will add an unnecessary burden to the lives of working families and are likely to leave many such families without essential health coverage.

The implementation of Medicaid work requirements in Arkansas clearly demonstrates the pitfalls associated with such a policy. Since these requirements went into effect in September 2018, over nearly 8,500 Medicaid beneficiaries in the state have lost their coverage, and another 4,841 are at risk of losing coverage in the next month.[6] Of the 73,266 people subject to the new policy, 23% were not exempt and failed to meet the 80-hour monthly work requirement in September, and the majority of those reported no hours at all.[7] *Only 2%* of enrollees actually successfully reported meeting the 80-hour requirement.[8] Analysis shows that many of the enrollees who failed to fulfill the requirements are slipping through the cracks because they are unaware that they are subject

[5] A Better Balance, Fact Sheet: The Need for Fair Schedules (December 14, 2016), https://www.abetterbalance.org/resources/fair-schedules-factsheet/
[6] R. Rudowitz and M. Musumeci, "A Look at State Data for Medicaid Work Requirements in Arkansas" (Oct. 16, 2018), https://www.kff.org/medicaid/issue-brief/a-look-at-state-data-for-medicaid-work-requirements-in-arkansas/
[7] *Id.*
[8] *Id.*

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to them. Low literacy and English proficiency, inaccurate contact information, and limited internet access make outreach and education difficult and costly, particularly in rural areas and among vulnerable populations. [9] Many of these structural barriers, particularly lack of internet access and computer literacy, combined with complex reporting procedures, present compliance problems for enrollees even when they are aware of the requirements.[10] Lack of transportation and limited jobs for workers with low educational attainment also present significant barriers to enrollees seeking work or other means of fulfilling the requirements.[11] Tennessee should learn from this example and avoid these unnecessary coverage losses by declining to pursue a similar waiver.

The Centers for Medicaid and Medicare (CMS) have attempted to justify allowing these waivers by citing data indicating that people with jobs have better health outcomes than those without jobs. This is disingenuous, as it assumes that working makes people healthier, when in fact those who are healthy are more likely to be able to work. In fact, a study cited by CMS in its new guidance on work requirements stated that "interventions which simply force claimants off benefits are more likely to harm their health and well-being."[12] Many Medicaid recipients with chronic health conditions state that Medicaid coverage is essential in supporting their ability to work, and an analysis of Medicaid expansions in Ohio and Michigan found that most expansion enrollees who were unemployed but looking for work reported that Medicaid enrollment made it

[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] G. Waddell and A.Burton, Is Work Good For Your Health and Well-Being?, at 30 (2006) (quoted in Statement of Review by LaDonna Pavetti, January 11, 2018), http://www.healthlaw.org/publications/browse-all-publications/nhelp-letter-to-cms-regarding-workrequirements#.WlfE2TdG201)

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easier to seek employment. [13] Additionally, most working Medicaid enrollees said it made it easier for them to work and be better at their jobs.[14]

The coverage losses that would result from implementing work requirements will be extremely harmful to Tennesseans, particularly to those with chronic health conditions (who are likely to make up a large fraction of those affected), for whom gaps in access to treatment and medications can be catastrophic. These losses will also lead to people delaying or foregoing care, particularly essential preventive care, and relying on emergency rooms for care.[15] This leads not only to worse health outcomes, but also to increased uncompensated care costs for providers.[16]

This waiver is inherently and fundamentally flawed and should be rejected in its entirety. It is completely inconsistent with the goals and purposes of the Medicaid program, which is intended to serve as a vital safety net for vulnerable low-income citizens. Undermining this safety net would be contrary to the best interests of all Tennesseans. We therefore respectfully urge you not to move forward with this proposal.

Sincerely,

A Better Balance

---

[13] R. Garfield, R. Rudowitz, and A. Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation (Dec. 7, 2017), https://www.kff.org/report-section/understanding-the-intersection-of-medicaid-and-work-appendix/

[14] H. Katch, J. Wagner and A. Aron-Dine, "Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes," Ctr. on Budget and Policy Priorities (Aug. 13, 2018), https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce

[15] *Id.*

[16] A. Inserro, "Medicaid Work Rules to Increase Uncompensated Care Costs for Hospitals, Report Says," AJMC (May 23, 2018), https://www.ajmc.com/newsroom/medicaid-work-rules-to-increase-uncompensated-care-costs-for-hospitals-report-says

Jonathan Reeve

From: Emily Ogden <emily.ogden@cancer.org>
Sent: Friday, October 19, 2018 2:37 PM
To: Public Notice. Tenncare
Cc: Brooks Daverman
Subject: ACS CAN comment letter re: Amendment 38
Attachments: ACS CAN Comment Letter re Amendment 38 to TennCare II Demonstration.pdf

Dear Dr. Long and Mr. Daverman,

Please see attached the official comment letter from the American Cancer Society Cancer Action Network regarding Amendment 38 to the TennCare II Demonstration. An original copy of this letter was also place in the mail this afternoon.

Thank you for this opportunity to provide feedback on the proposal.

Emily Ogden

Emily Ogden
Tennessee Government Relations Director
(615) 477.4150 | m: (615) 477.4150

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October 19, 2018

Dr. Wendy Long
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: Amendment 38 to the TennCare II Demonstration

Dear Director Long:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Tennessee's amendment to its Medicaid Section 1115 Demonstration Waiver application. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

ACS CAN supports Tennessee's goal to improve health outcomes for individuals enrolled in TennCare, but we believe the proposed Amendment 38 to the TennCare II Demonstration could negatively impact the adult Medicaid population, particularly cancer patients, survivors, and those who will be diagnosed with cancer in their lifetime. Over 36,700 Tennesseans are expected to be diagnosed with cancer this year[1] – many of whom are receiving health care coverage through the TennCare Medicaid program. ACS CAN wants to ensure that cancer patients and survivors in Tennessee will have adequate access and coverage under the Medicaid program, and that specific requirements do not create barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer. We strongly urge the Tennessee Department of Finance & Administration's Division of TennCare ("the Department") to address the following concerns or reject this waiver in its current form.

The following are our specific comments on the TennCare 1115 waiver application:

Encouraging Work and Community Engagement

Tennessee seeks to require that all non-pregnant, non-disabled, non-elderly adults enrolled in TennCare's parent/caretaker relative eligibility category and aged 19-64 be employed 20 hours per week (averaged monthly) in order to maintain eligibility or enrollment in the Medicaid program. We are concerned this policy could unintentionally disadvantage patients with complex chronic conditions, including cancer patients, recent survivors, and those women diagnosed with cancer through the State's *Breast and Cervical Screening Program*. We understand the intent of the proposal is to incentivize

[1] American Cancer Society. *Cancer Facts & Figures 2018*. Atlanta, GA: American Cancer Society; 2018.

to cancer treatments.[13,14] The increase in administrative requirements for enrollees to attest to their working status on a monthly basis would likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt.[15]

As an example, in the fourth month of implementation of the *Arkansas Works* work requirement (September 2018) eight percent of the nearly 18,300 Medicaid enrollees, who did not declare an exemption, were able to navigate the complex reporting system and satisfy the state's reporting requirement.[16] As of October 8, 2018, an additional 4,109 *Arkansas Works* enrollees have been locked out of coverage through the end of the calendar year due to noncompliance with the work requirement.[17] The number is in addition to the 4,353 individuals the state removed from the program last month, totaling 8,462 Arkansans losing coverage in the last two months. Some of these individuals may have been eligible for an exemption but did not realize they were exempt or were unable to successfully navigate Arkansas' reporting system. Given the experience with Arkansas' work requirement, the Department should consider the number of Tennesseans whose health could be negatively impacted and the coverage losses that could occur due to this proposal.

Suspension of Coverage

We are deeply concerned about the proposed Medicaid coverage suspension period if they do not comply with the work requirement for four out of six months. The Department specifies that Medicaid coverage can be reinstated if the individual demonstrates compliance with work and community engagement requirements for one month. The Department also suggests that they may offer additional opportunities for beneficiaries to regain full coverage through participating in an activity that "supports the goals of the community engagement program (e.g., taking a state-approved health or financial literacy course)." Additionally, the State offers "good cause" exemptions for enrollees who have failed to meet the work requirements. However, it is unclear how long the appeals process would take for good cause exemptions and whether the beneficiary would lose health coverage during the process.

Those with acute health care conditions who apply for an exemption to avoid the suspension period will still have to verify their exemption and undertake a burdensome documentation process. This could lead to instances where those who should be able to maintain coverage are disenrolled, jeopardizing access to life-saving treatment. If individuals are locked out of coverage for a month they will likely have no access to affordable health care coverage, making it difficult or impossible for a cancer patient or recent survivor to continue treatment or pay for their maintenance medication until they come into

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[13] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

[14] Dowling E, Yabroff R, Mariotto A, et al. Burden of illness in adult survivors of childhood cancers: Findings from a population-based national sample. *Cancer.* 2010; 116:3712-21.

[15] Garfield R, Rudowitz R, Musumeci M. Implications of a Medicaid work requirements: National estimates of potential coverage losses. Kaiser Family Foundation. Published June 2018. Accessed September 2018. http://files.kff.org/attachment/Issue-Brief-Implications-of-a-Medicaid-Work-Requirement-National-Estimates-of-Potential-Coverage-Losses.

[16] Arkansas Department of Human Services. Arkansas Works Program: September 2018 Report. Accessed October 2018. https://d31hzlhk6di2h5.cloudfront.net/20181015/d9/50/39/04/d3b5bd23a6cef7ccec3e4716/101518_AWreport.pdf.

[17] Ibid.

demonstration requested by the State.[23] This allows stakeholders and CMS to adequately assess the impact the demonstration waiver may have on state residents. Therefore, we strongly urge the State to include these projections, as required by federal law, so that the public has an opportunity to comment on the impact of the proposed waiver demonstration with adequate information.

Conclusion

We appreciate the opportunity to provide comments on Tennessee's 1115 waiver demonstration proposal. The preservation of eligibility and coverage through Medicaid remains critically important for many low-income Tennesseans who depend on the program for cancer and chronic disease prevention, early detection, diagnostic, and treatment services. We ask the Department to weigh the potential impact this proposal could have on low-income Tennesseans' access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors, and we look forward to working with the Division of TennCare to ensure that all Tennesseans' are positioned to win the fight against cancer. If you have any questions, please feel free to contact me at 615.477.4150 or emily.ogden@cancer.org

Sincerely,

Emily Ogden
Tennessee Government Relations Director
American Cancer Society Cancer Action Network

[23] 42 CFR 431.408 (a)(1)(i)(C).

Jonathan Reeve

From: Gary Dougherty <GDougherty@diabetes.org>
Sent: Wednesday, October 24, 2018 1:31 PM
To: Public Notice. Tenncare
Subject: Comments - TennCare II Amendment 38
Attachments: ADAComments-TennCareAmd38-102418.pdf

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

Dr. Long:

Please accept the attached letter from the American Diabetes Association with comments regarding the proposed Medicaid Section 1115 Demonstration Waiver for TennCare II Amendment 38.

Thank you and please let me know if you have any questions at all.

Gary Dougherty
Director – State Government Affairs and Advocacy

American Diabetes Association.

Phone: 1-800-676-4065 x 4832 (office)
Mobile: 614-726-0801
diabetes.org
1-800-DIABETES (800-342-2383)

American Diabetes Association®

October 24, 2018

Dr. Wendy Long
Director, Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: TennCare II Amendment 38

Via email: public.notice.tenncare@tn.gov

Dear Dr. Long:

On behalf of the more than 30 million Americans living with diabetes and the 84 million more with prediabetes, the American Diabetes Association (ADA) provides the following comments based on the information available in the State of Tennessee's Department of Health and Human Services' (Department) Section 1115 Demonstration Waiver for the TennCare II Amendment 38.

As the global authority on diabetes, the ADA funds research to better understand, prevent and manage diabetes and its complications; publishes the world's two most respected scientific journals in the field, *Diabetes* and *Diabetes Care*; sets the standards for diabetes care; holds the world's most respected diabetes scientific and educational conferences; advocates to increase research funding, improve health care, enact public policies to stop diabetes, and end discrimination against those denied their rights because of the disease; and supports individuals and communities by connecting them with the resources they need to prevent diabetes and better manage the disease and its devastating complications.

According to the Centers for Disease Control and Prevention, over 11.4% of adults in Tennessee have diagnosed diabetes.[1] Access to affordable, adequate health coverage is critically important for all people with, and at risk for, diabetes. Adults with diabetes are disproportionally covered by Medicaid.[2] For low-income individuals, access to Medicaid coverage is essential to managing their health. As a result of inconsistent access to Medicaid across the nation, these low-income populations experience great disparities in access to care and health status, which is reflected in geographic, race and ethnic differences in morbidity and mortality from preventable and treatable conditions.

Expanding Medicaid Eligibility

Medicaid expansion made available through the Affordable Care Act (ACA) offers promise of significantly reducing disparities in access to care and health status. Specifically, in Medicaid expansion states, more individuals are being screened for and diagnosed with diabetes than states that haven't expanded.[3]

Additionally, a new study found expansion states have a higher rate of prescription fills for diabetes medications than non-expansion states.[4] Regular medication use with no gap in health insurance coverage leads to fewer hospitalizations and less use of acute care facilities.[5,6] **Rather than implementing changes that impose significant barriers to obtaining and maintaining Medicaid coverage, the ADA recommends the state work to ensure all low-income individuals in Tennessee have access to adequate, affordable health care coverage.**

Lack of Information on Impact of Waiver

Federal rules require the state include within the proposal an estimate of increase or decrease in enrollment and expenditures. The proposal presented by the Department does not provide any prediction of potential impact of the waiver on enrollment or cost over the next five years. Based on the information provided by the Department, the public does not have adequate information to comment and assess the potential impact of Amendment 38. In order to meet these transparency requirements, the Department must include updated projections of the impact on budget neutrality and the coverage. If the Department intends to move ahead with the proposal, it should at minimum provide the required information to the public and reopen the comment period for an additional 30 days.

Work Requirements

The ADA is deeply concerned by the Department's proposal to limit or revoke certain Medicaid beneficiaries' enrollment if they do not meet proposed work or community engagement standards. This type of coverage limit is in direct conflict with the Medicaid program's objective to offer health coverage to those without access to care. Most people with Medicaid who can work, do so. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60% are working themselves. Of those not working, more than one-third reported that illness or disability was the primary reason, 28% reported they were taking care of home or family, and 18% were in school.[7] For people who face major obstacles to employment, harsh Medicaid requirements will not help to overcome them. In addition, research shows work requirements are not likely to have a positive impact on long-term employment.[8] Instead, instituting a work requirement would lead to higher uninsured rates and higher emergency room visits by uninsured individuals who would have been eligible for Medicaid coverage, and increase the administrative burden for the state and its Medicaid managed care plans.[9,10]

A study by the National Bureau of Economic Research concluded Medicaid coverage increases utilization of primary and preventative services, lowers out-of-pocket medical spending and medical debt, and results in better self-reported physical and mental health.[11] CDC data show prevention programs and early detection can prevent the onset of type 2 diabetes and reduce state spending.[12] Tennessee's proposal to limit access to Medicaid services through the implementation of work requirements will decrease access to care for low-income Tennessee residents with diabetes and increase state health care costs.

American Diabetes Association®

Administrative Burden

Under this proposed waiver, individuals will need to either prove they meet certain exemptions or provide evidence of the number of hours they have worked which significantly increases the administrative burden of health care. Even though the Department has not provided an estimate of the impact Amendment 38 will have on enrollment, it is highly likely that increasing the administrative requirements to maintain eligibility will result in fewer individuals with Medicaid coverage, even for those who meet the requirements or qualify for an exemption. An analysis of expected Medicaid disenrollment rates after implementation of work requirements shows most disenrollment would be due to administrative burdens or red tape.[13,14] Medicaid enrollees who are working may experience difficulty obtaining the required documentation from their employer on a timely basis.

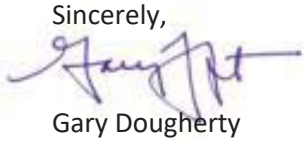
Diabetes is a complex, chronic illness that requires continuous medical care,[15] so Medicaid enrollees with diabetes cannot afford a sudden gap in health insurance coverage. A recent study found that patients with type 1 diabetes who experience a gap or interruption in coverage, are five times more likely to use acute care services (i.e. urgent care facilities or emergency departments).[16] Adding administrative barriers and burdens will impede access to health services that Tennessee residents with diabetes need.

Conclusion

Research shows work requirements are not likely to have a positive impact on long-term employment.[17] Instead, instituting a work requirement would lead to higher uninsured rates and higher emergency room visits by uninsured individuals who would have been eligible for Medicaid coverage, and increase the administrative burden for the state and its Medicaid managed care plans. **We strongly urge the state to retract and modify the 1115 Demonstration Waiver for Amendment 38 as it creates barriers to accessible, affordable, and adequate healthcare for low-income Tennesseans with diabetes who rely on the program.**

The ADA appreciates the opportunity to comment on the Department's Waiver. Our comments include numerous citations to supporting research, including direct links to the research for the benefit of the Department in reviewing our comments. We direct the Department to each of the studies cited – made available 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. If you have any questions, please contact Gary Dougherty, Director of State Government Affairs and Advocacy at GDougherty@diabetes.org or 800-676-4065 x4832.

Sincerely,



Gary Dougherty
Director, State Government Affairs and Advocacy

American Diabetes Association®

[1] Center for Disease Control and Prevention, Diagnosed Diabetes. Available at: https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html
[2] Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid for People with Diabetes, November 2012. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_d.pdf.
[3] Kaufman H., Chen Z., Fonseca V. and McPhaul M., "Surge in Newly Identified Diabetes Among Medicaid Patients in 2014 Within Medicaid Expansion States Under the Affordable Care Act," Diabetes Care, March 2015. Available at: http://care.diabetesjournals.org/content/early/2015/03/19/dc14-2334
[4] [4] Myerson R., Tianyi L., Tonnu-Mihara I., and Huang E.S., Health Affairs, Medicaid Eligibility Expansions May Address Gaps in Access to Diabetes Medications, August 2018. Available at: https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.0154
[5] Id.
[6] Rogers M, Lee J, Tipirneni R, Banerjee T, and Kim C, Health Affairs, Interruptions in Private Health Insurance and Outcomes In Adults with Type 1 Diabetes: A Longitudinal Study. July 2018. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0204
[7] Garfield R, Rudowitz R and Damico A, Understanding the Intersection of Medicaid and Work, Kaiser Family Foundation, February 2017. Available at: http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work
[8] Kaiser Family Foundation, Are Uninsured Adults Who Could Gain Medicaid Coverage Working?, February 2015. Available at: https://www.kff.org/medicaid/fact-sheet/are-uninsured-adults-who-could-gain-medicaid-coverage-working/
[9] Rector R, Work Requirements in Medicaid Won't Work. Here's a Serious Alternative, Heritage Foundation, March 2017. Available at: https://www.heritage.org/health-care-reform/commentary/work-requirements-medicaid-wont-work-heres-serious-alternative
[10] Katch H, Medicaid Work Requirements Would Limit Health Care Access Without Significantly Boosting Employment, Center on Budget and Policy Priorities, July 2016. Available at: https://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly
[11] National Bureau of Economic Research, The Medicaid Program, July 2015, available at: http://www.nber.org/papers/w21425.pdf.
[12] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, At A Glance 2016, available at: https://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2016/nccdphp-aag.pdf
[13] Kaiser Family Foundation, Implications of Work Requirements in Medicaid: What Does the Data Say?, June 2018, available at: https://www.kff.org/medicaid/issue-brief/implications-of-work-requirements-in-medicaid-what-does-the-data-say/
[14] Kaiser Family Foundation, A Look at State Data for Medicaid Work Requirements in Arkansas, October 2018, available at: https://www.kff.org/medicaid/issue-brief/a-look-at-state-data-for-medicaid-work-requirements-in-arkansas/
[15] American Diabetes Association, Standards of Medial Care in Diabetes – 2018, Diabetes Care, January 2018, available at: http://care.diabetesjournals.org/content/41/Supplement_1.
[16] Rogers M, Lee J, Tipirneni R, Banerjee T, and Kim C, Health Affairs, Interruptions in Private Health Insurance And Outcomes In Adults with Type 1 Diabetes: A Longitudinal Study. July 2018. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0204
[17] Kaiser Family Foundation, Are Uninsured Adults Who Could Gain Medicaid Coverage Working?, February 2015, available at: http://kff.org/medicaid/fact-sheet/are-uninsured-adults-who-could-gain-medicaid-coverage-working/.

Jonathan Reeve

From: Nathan Mick <Nathan.Mick@heart.org>
Sent: Friday, October 26, 2018 1:38 PM
To: Public Notice. Tenncare
Subject: TN 1115 comments from AHA
Attachments: TN 1115 State Waiver Comments to state.pdf

Please find attached public comments from the American Heart Association regarding the TN 1115 State Waiver.

Thank you.

Warm regards,

-NM

Nathan Mick
Vice President, Advocacy
Greater Southeast Affiliate
American Heart Association
1818 Patterson Street
Nashville | TN | 37203
O 800.257.6941 | M 859.339.1414

American Heart Association.

October 26, 2018

Dr. Wendy Long
Director, Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Dr. Long:

On behalf of the American Heart Association and American Stroke Association (AHA), we would like to thank you for the opportunity to provide written comments on the proposed TennCare II Demonstration Waiver, Amendment 38. As the nation's oldest and largest organization dedicated to fighting heart disease and stroke, we would like to express our significant concerns with the proposal to set work requirements as a condition of TennCare eligibility and participation.

The AHA represents over 100 million patients with cardiovascular disease (CVD) including many who rely on Medicaid as their primary source of care.[1] In fact, twenty-eight percent of adults with Medicaid coverage have a history of cardiovascular disease[2] and the Medicaid program provides critical access to prevention, treatment, disease management and care coordination services for these individuals. Because low-income populations are disproportionately affected by CVD – with these adults reporting higher rates of heart disease, hypertension, and stroke – Medicaid provides the coverage backbone for the healthcare services these individuals need.

The connection between health coverage and health outcomes is clear and well documented. Americans with CVD risk factors who lack health insurance or are underinsured, have higher mortality rates[3] and poorer blood pressure control[4] than their insured counterparts. Further, uninsured stroke patients suffer from greater neurological impairments,

[1] RTI. Projections of Cardiovascular Disease Prevalence and Costs: 2015–2035, Technical Report. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491513.pdf Accessed June 19, 2017.
[2] Kaiser Family Foundation. The Role Of Medicaid For People With Cardiovascular Diseases. 2012. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_cd.pdf. Accessed August 15, 2016.
[3] McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. Health Affairs 2004; 23(4): 223-233.
[4] Duru OK, Vargas RB, Kerman D, Pan D, Norris KC. Health Insurance status and hypertension monitoring and control in the United States. Am J Hypertens 2007;20:348-353.

longer hospital stays,[5] and a higher risk of death[6] than similar patients covered by health insurance.

The inclusion of a work requirement to qualify for Medicaid coverage is deeply troubling to the AHA. The intent of the 1115 Demonstration Wavier program is to increase access and test innovative approaches to delivering care.[7] This provision does not appear to satisfy either requirement and could significantly harm patients, including those with CVD, by reducing their access to healthcare services both in the short and long term. To treat and prevent heart disease and stroke, it is critically important to ensure that everyone in Tennessee – regardless of employment status – has access to affordable, quality healthcare. The Medicaid statute currently defines the factors states can consider in determining eligibility for Medicaid, such as income, citizenship and immigration status, and state residence. The statute does not include an individual's employment status or ability to work, whether they are seeking work, or their ability to engage in work-related activities as a permissible factor in determining Medicaid eligibility.[8]

Most people on Medicaid who can work, do so. Nearly 8 in 10 non-disabled adults with Medicaid coverage are members of working families, and nearly 60 percent are working themselves. Of those not working, more than one-third reported that illness or a disability was the primary reason; 28 percent reported that they were taking care of home or family; and 18 percent were in school.[9]

Additionally, individuals with CVD often experience lapses in employment due to their condition or may have been directed by a physician to take time away from work as part of their treatment and recovery. Therefore, participation in work or work searches as a condition of Medicaid eligibility could discriminate against these individuals and create inappropriate and unwarranted barriers to medical care. The AHA is further troubled that this new requirement is being levied on parents and caretakers, endangering both their ability to maintain coverage as well as those they care for.

Of additional and significant concern is the proposed benefit suspension if someone is unable to meet the requirement for 4 out of 6 months. It is unclear how this would be implemented, meaning that those who fail to navigate new administrative requirements to report hours worked, or those who work seasonal occupations, risk serious health consequences. People who are in the middle of treatment, rely on regular visits with health care providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

The process of documenting eligibility and compliance is likely to create barriers to accessing or maintaining coverage for patients. Battling administrative red tape to keep coverage should not detract from a patient's focus on maintaining their or their family's

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[5] Rice T,LaVarreda SA,Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. Med Care Res Rev 2005; 62(1): 231-249.

[6] McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare coverage. JAMA. 2007; 298:2886 –2894.

[7] https://www.medicaid.gov/medicaid/section-1115-demo/index.html

[8] Jane Perkins, "Medicaid Work Requirements: Legally Suspect," National Health Law Program, (March 2017).

[9] 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-ofmedicaid-and-work/.

health. Implementing work requirements will also necessitate new administrative processes and programs, which will require considerable financial resources that would be far better used to provide care. Furthermore, programs similar to this proposal, when implemented, have not been proven to increase employment or access to care.[10] According to the Medicaid and CHIP Payment and Access Commission (MACPAC), any employment gains that followed TANF work requirements tended to be temporary and short-lived, with limited positive effect on income.[11] We therefore oppose this measure and strongly recommend that the state refocus its Medicaid resources on improving the health of the patients it serves, rather than imposing additional and unjustified administrative burdens with little or no proven return on investment.

The imposition of new requirements demands tedious reporting, which means more red tape for beneficiaries. Language barriers, disabilities, mental illness, insecure work opportunities, frequent moves and temporary or chronic homelessness are more prevalent among the Medicaid population and are significant barriers to fulfilling the requirements that Tennessee is proposing. Preventing these individuals from obtaining and maintaining coverage will exacerbate the many barriers to care they already face and which Medicaid is intended to help beneficiaries overcome. Hinging health care coverage on the ability to find and maintain work penalizes the Medicaid population for their poverty. Eliminating their access to healthcare coverage could perpetuate further the barriers that prevented them from holding work in the first place.

Thank you for reviewing our comments. We appreciate the opportunity to provide feedback on this application. If you have any questions, please contact me at 859-339-1414 or Nathan.Mick@Heart.org.

Sincerely,

Nathan Mick
Vice President, Advocacy
Greater Southeast Affiliate
American Heart Association

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[10] Garfield, R, Rudowitz, R, Damico, A. Kaiser Family Foundation Issue Brief: Understanding the Intersection of Medicaid and Work. Revised December 2017. Accessed January 5, 2018 at: http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work

[11] Work as a Condition of Medicaid Eligibility: Key Take-Aways from TANF. *MACPAC.* October 2017. At: https://www.macpac.gov/wp-content/uploads/2017/10/Work-as-a-Condition-of-Medicaid-Eligibility-Key-Take-Aways-from-TANF.pdf

Jonathan Reeve

From: Shannon Baker <Shannon.Baker@lung.org>
Sent: Friday, October 26, 2018 9:02 AM
To: Public Notice. Tenncare
Cc: Anne DiGiulio; Lance Boucher
Subject: 1115 Waiver Amendment 38 to the TennCare II Demonstration
Attachments: TN - 1115 Waiver Comments.pdf

The American Lung Association in Tennessee appreciates the opportunity to submit the attached comments.

Sincerely,

Shannon Baker
Director, Advocacy KY, TN, AR
American Lung Association
10168 Linn Station Rd, Suite 100 | Louisville, KY 40223
O: 502-242-1065 | C: 502-500-0482
Lung HelpLine: 1-800-LUNGUSA
Lung.org | shannon.baker@lung.org

AMERICAN LUNG ASSOCIATION®

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long:

The American Lung Association in Tennessee appreciates the opportunity to submit comments on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration."

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD, including nearly 994,000 Tennesseans. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The American Lung Association believes everyone, including TennCare enrollees, should have access to quality and affordable health coverage. Unfortunately, this waiver creates new administrative barriers that will jeopardize patients' access to quality and affordable health coverage, and the Lung Association therefore opposes the proposed waiver.

The Tennessee Amendment 38 seeks to add a work and community engagement requirement for most TennCare enrollees. This would increase the administrative burden on all TennCare patients. Individuals will need to either report that they meet certain exemptions or the number of hours they have worked. Increasing administrative requirements will likely decrease the number of individuals with TennCare 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 October 1, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[i] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[ii] 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.[iii] 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 two months out of a six-month period, they will be locked out of coverage until they demonstrate their compliance. 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.

The American Lung Association in Tennessee is 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, Tennessee's "good cause" exemption 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.[iv] 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 Tennessee. States such as Michigan, Pennsylvania, Kentucky 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.[v] Tennessee's fiscal impact statement estimated the program would cost the state and federal government approximately $39.8 million over the course of the waiver.[vi] 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. Most people on Medicaid who can work already do so.[vii] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[viii] 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 a report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that being enrolled in Medicaid made it easier to work or look for work (83.5 percent and 60 percent, respectively).[ix] Terminating individuals' TennCare coverage for non-compliance with these requirements will therefore hurt rather than help people search for and obtain employment. Tennessee has experience with this. In 2005, when the state changed the TennCare program's eligibility and 170,000 people lost Medicaid coverage, there was no increase in employment and self-reported health and access to medical care declined.[x] The American Lung Association in Tennessee opposes the work and community engagement requirement.

The Lung Association in Tennessee also wishes to highlight that 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. However, on page 5 of this proposal, the Department states that "*Some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, it is not possible to reliably project the magnitude of this decrease in enrollment at this time.*" We urge the TennCare to update the waiver amendment with the estimated expenditure and estimated enrollment change and reopen the state comment period for an additional 30 days.

The American Lung Association believes healthcare should be affordable, accessible, and adequate. Tennessee's Amendment 38 does not meet that standard. Thank you for the opportunity to provide comments.

Sincerely,

Shannon Baker
Director of Advocacy in Tennessee

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[i] 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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[iii] 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.

[iv] 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/.

[v] 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.

[vi] Tennessee General Assembly Fiscal Review Committee. Fiscal Note HB 1551- SB 1728. February 12, 2018. Accessed at: http://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf

[vii] 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/

[viii] 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

[ix] 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

[x] DeLeire, Thomas. The National Bureau of Economic Research. NBER Working Paper No. 24899: The Effect of Disenrollment from Medicaid on Employment, Insurance Coverage, Health and Health Care Utilization. August 2018. Accessed at: https://www.nber.org/papers/w24899

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of amyaber@gmail.com
Sent: Sunday, October 07, 2018 3:50 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Amy Harris-Aber
3315 Yorkshire Court
Murfreesboro, TN 37130

Jonathan Reeve

From: Ann <jlucas60@comcast.net>
Sent: Tuesday, October 09, 2018 2:59 PM
To: Public Notice. Tenncare
Subject: TennCare Waiver Amendment 38

Dear Dr. Long.

I am writing in response to inviting public comments on the waiver mentioned above.

Since 2013 I have worked with people either enrolling them in health care through the Affordable Care Act or answering calls on the 844 Hotline.

This proposal would cause harm to thousands of Tennesseans. Having spoken to many people over the past 5 years I have heard their problems. This waiver just escalates the difficulties the state already has with its computer system.We have seen how people have often lost TennCare eligibility because of failure to meet reporting requirement and other errors. Limited literacy or language and people with disabilities already lose access to healthcare.

This proposal leaves many unanswered questions. Since Tennessee is already the ONLY state in the nation to use the federal marketplace to determine eligibility for TennCare this proposal would only add more obstacles to many people who desperately need healthcare. The new work requirement would negatively impact many of our poorest citizens as well as their communities.

Having made my comments regarding the waiver proposal I respectfully urge you not go forward with its implementation.

Sincerely,

Ann Lucas

1736 Gull Rd.

Mount Juliet, TN 37122.

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of strangersrus@gmail.com
Sent: Tuesday, October 09, 2018 12:02 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Ann Strange
307 Lake Forest Drive
Knoxville, TN 37920

Jonathan Reeve

From: Ann Watkins <awatkins@mccallie.org>
Sent: Friday, October 26, 2018 12:42 PM
To: Public Notice. Tenncare
Subject: TennCare Waiver Amendment 38

Dear Dr. Wendy Long,

I am responding to your invitation for comment on the proposed Waver Amendment 38. My name is Ann Watkins, my husband and I are both high school teachers for 25 years, and have raised 2 sons -- both now working in the health care field. We have been active in outreach efforts for many y ears through out church, our school, and community groups. Health care and edcucation for all are our missions. We live and vote in Chattanooga.

We are unequivocally opposed to any proposal that will take health care coverage away from people because they do not work a set number of hours per week. Thousands of our fellow Tennesseans would be harmed by such a measure. Research and experience shows that states cannot safely and fairly administer those requirements, and many stand to lose their coverage due to bureaucratic mistakes or confusion.

How will the reporting process accommodate people with disabilities, limited literacy or language? How can TennCare administer this complex eligibility determination without an eligibility determination computer system? What criteria will be used to exempt "economicaly distressed" counties? What about "economically distressed" communities within wealthy counties? The red tape can be daunting for our most vulnerable Tennesseans, and for this and other reasons, people will lose coverage even when they remain eligible.

The proposal is flawed and goes against the goals and purpose of the Medicaid program. Let's call it what it is -- a proposal to take health coverage away from people who are unemployed. We respectfully urge you to not go forward with this harmful proposal.

Ann Watkins

Ann Watkins
McCallie Upper School Learning Center
Academic Counselor
Tutoring Coordinator
423-493-5891

Jonathan Reeve

From: Anne Puckett <anne.puckett55@gmail.com>
Sent: Friday, October 26, 2018 11:54 AM
To: Public Notice. Tenncare
Subject: Wavier

I don't believe that those with any kind of disability should be forced to work. Most can't work. The people on tncare that should work legibant jobs are the prostitutes and drug dealers. Criminals can be trained to work.

Jonathan Reeve

From: jhscrs@bellsouth.net
Sent: Tuesday, October 09, 2018 3:11 PM
To: Public Notice. Tenncare
Subject: Public Chapter 869, Waiver Proposal

It is inhumane to deny people basic health care based on artificial criteria. Please approach this plan by looking in their mirror.

Sent from Mail for Windows 10

Jonathan Reeve

From: Benjamin Chandhok <bchandhok@arthritis.org>
Sent: Friday, October 26, 2018 8:59 AM
To: Public Notice. Tenncare
Subject: 1115 Waiver Amendment 38 to the TennCare II Demonstration
Attachments: AF Comment Letter - TN 1115 Waiver.pdf

Good morning,

Please consider the attached comments on behalf of the Arthritis Foundation.

Thank you!

Ben Chandhok
Arthritis Foundation
Senior Director of State Legislative Affairs
29 Crafts Street, #100
Newton, MA 02458
Mobile (preferred): 513.484.7623
Office: 617-795-3888
| bchandhok@arthritis.org

Arthritis Foundation™ | Yes
arthritis.org

24/7 Helpline (1-844-571-4357)

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long:

The Arthritis Foundation appreciates the opportunity to submit comments on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration."

The Arthritis Foundation is the Champion of Yes. Leading the fight for the arthritis community, the Foundation helps conquer everyday battles through life-changing information and resources, access to optimal care, advancements in science and community connections. We work on behalf of the over 1.6 million people in Tennessee who live with the chronic pain of arthritis every day.

The Arthritis Foundation believes everyone, including TennCare enrollees, should have access to quality and affordable health coverage. Unfortunately, this waiver creates new administrative barriers that will jeopardize patients' access to quality and affordable health coverage, and the Arthritis Foundation therefore has serious concerns about the proposed waiver.

The Tennessee Amendment 38 seeks to add a work and community engagement requirement for most TennCare enrollees. This would increase the administrative burden on all TennCare patients. Individuals will need to either report that they meet certain exemptions or the number of hours they have worked. Increasing administrative requirements will likely decrease the number of individuals with TennCare 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 October 1, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[i] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[ii] 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.[iii] 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 two months out of a six-month period,

they will be locked out of coverage until they demonstrate their compliance. 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.

The Arthritis Foundation is 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, Tennessee's "good cause" exemption 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.[iv] 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 Tennessee. States such as Michigan, Pennsylvania, Kentucky 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.[v] Tennessee's fiscal impact statement estimated the program would cost approximately the state and federal government $39.8 million over the course of the waiver.[vi] 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. Most people on Medicaid who can work already do so.[vii] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[viii] 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 a 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).[ix] Terminating individuals' TennCare coverage for non-compliance with these requirements will therefore hurt rather than help people search for and obtain employment. Tennessee has experience with this. In 2005, when the state changed the TennCare program's eligibility and 170,000 people lost Medicaid coverage, there was no increase in employment and self-reported health and access to medical care declined.[x] The Arthritis Foundation opposes the work and community engagement.

The Arthritis Foundation also wishes to highlight that 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. However, on pages 5 of this proposal, the Department states that "*Some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, it is not possible to reliably project the magnitude of this decrease in enrollment at this time*." We urge the TennCare to update the waiver amendment with the estimated expenditure and estimate enrollment change and reopen the state comment period for an additional 30-days.

The Arthritis Foundation believes healthcare should affordable, accessible, and adequate. Tennessee's Amendment 38 does not meet that standard. Thank you for the opportunity to provide comments.

Sincerely,

Benjamin Chandhok

Ben Chandhok
Senior Director of State Legislative Affairs
Arthritis Foundation

[i] 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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[iii] 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.

[iv] 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/.

[v] 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.

[vi] Tennessee General Assembly Fiscal Review Committee. Fiscal Note HB 1551- SB 1728. February 12, 2018. Accessed at: http://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf

[vii] 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/

[viii] 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

[ix] 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

[x] DeLeire, Thomas. The National Bureau of Economic Research. NBER Working Paper No. 24899: The Effect of Disenrollment from Medicaid on Employment, Insurance Coverage, Health and Health Care Utilization. August 2018. Accessed at: https://www.nber.org/papers/w24899

Jonathan Reeve

From: Anness, Nancy <nanness@ascension.org>
Sent: Friday, October 26, 2018 9:12 AM
To: Public Notice. Tenncare
Subject: Comment Letter from Ascension Saint Thomas regarding Work Requirements and TennCare
Attachments: Ascension Saint Thomas Work Requirements Comment Letter 10.25.18.pdf

On behalf of Ascension Saint Thomas, thank you for the opportunity to provide comments on the draft Amendment 38 to Section 115 TennCare II Demonstration (proposed waiver amendment). Please see the attached letter from Tim Adams, President and CEO Ascension Saint Thomas. Please free to contact me for further information and as needed.

My Best Always,
Nancy

Nancy Anness
Chief Advocacy Officer
Ascension Saint Thomas
Ascension Tennessee
102 Woodmont Blvd. Suite 700
Nashville, TN 37205
(615) 284-6819
nanness@ascension.org

Saint Thomas Health | ASCENSION

October 25, 2018

Wendy Long, M.D.
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Dr. Long:

On behalf of Ascension, we appreciate the Opportunity to provide input on the draft of Amendment 38 to the Section 115 TennCare II Demonstration (the "proposed waiver amendment"), which opened for public comment on September 24, 2018.

As you know, Ascension Saint Thomas is a nine-hospital faith-based health system in Tennessee with more than 550 employed physicians serving in over 100 sites of care providing 28 individual specialties. We serve all counties in Tennessee as well as Southern Kentucky. We are the largest nonprofit health system in Tennessee and part of Ascension. Ascension is a faith-based healthcare organization dedicated to transformation through innovation across the continuum of care. Ascension is the largest nonprofit health system in the United States with 151 hospitals serving in 21 states and the District of Columbia with more than 2600 sites of care across the United States.

Ascension Saint Thomas supports the comments submitted by the Tennessee Hospital Association on the proposed wavier amendment. As a faith-based organization, we care for all individuals who come to us, with special attention to those who are most vulnerable. We have a long history of advocating for policies that protect human dignity and are concerned that the proposed waiver amendment, as drafted, may create barriers to coverage and healthcare access for a population that is living in poverty. We respectfully submit the comments below for consideration by the Tennessee Department of Finance and Administration.

Work and community engagement requirements will likely result in substantial coverage losses for low-income parents. To date, CMS has approved work and community engagement requirements in four states (Arkansas, Indiana, Kentucky, and Indiana). Arkansas, the first state to implement work requirements, has experienced substantial declines in enrollment. Work requirements, as outlined in the proposed waiver amendment, can be expected to result in coverage losses in Tennessee, as well.

New administrative processes related to implementing work and community engagement requirements create barriers to coverage – especially for the most vulnerable, who may qualify for exemptions, but have trouble gathering the right paperwork and navigating the system to secure an exemption. In Arkansas, the first state to implement work requirements, 8,462 individuals have been terminated from the Medicaid program (4,353 in early September and 4,109 early October) for failure to report that they had completed 80 hours of work or community engagement activities or claim an exemption in the previous three months.[i] These coverage losses would have been much higher in Arkansas if the state had not used administrative data to identify participants who are employed for at least 80 hours per month based on their income or that met one of the exemption criteria; Arkansas's use of administrative data lifted the monthly reporting obligation for approximately two-thirds of participants subject to the requirements.[ii] Tennessee, on the other hand, has not proposed to use administrative data to identify exemptions or compliance, meaning coverage losses in Tennessee could be more dramatic than those seen in Arkansas.

Coverage losses and increases in gaps in coverage will make it more challenging for hospitals and other providers to effectively manage care, especially for individuals with complex health and social needs. Effective care management is dependent on continuity of care and coverage, which work and community engagement requirements would put at risk. Disruptions in care management for individuals with complex health needs will increase the cost of care, for both the state and providers, and will lead to poorer health outcomes. Increases in costs for health care providers and the state as a result of work requirements distract from targeted efforts to improve care and drive value. In particular, Tennessee has increasingly focused its attention and resources on improving care coordination and care management for Medicaid enrollees with complex health care needs. The disruptions in care resulting from the proposed work and community engagement requirements are contrary to these efforts and will set back Tennessee's important work.

Work requirements are expensive to implement and continue to face legal challenges; Tennessee risks expending significant funds to plan for work requirements, only to be stopped by the courts. Implementation of work requirements is costly – Tennessee will have to develop new administrative and IT capabilities to monitor compliance and discontinue and reinstate coverage. In February 2018, the General Assembly's Fiscal Review Committee estimated the state would need to spend $5.6 million in state funds to establish the IT capabilities to track and administer work requirements (the state expects to receive a 90% federal matching rate for the development). In addition, Tennessee expects to spend $22.3 million in recurring annual costs to administer and enforce the work and community engagement requirement (the state expects to receive a 50% federal matching rate for ongoing administration of the program).[iii]

While states are required to have strategies to help beneficiaries meet work requirements, federal Medicaid funds cannot be used to help fund things like childcare, transportation, and training that make work possible. Tennessee will need to spend additional state funds to finance these beneficiary supports.

At the same time, the legality of work and community engagement requirements has been called into question; a federal judge concluded that CMS had not provided an adequate explanation for its approval of Kentucky's work requirements (thus invalidating CMS's approval of Kentucky's waiver) and Arkansas Medicaid enrollees sued CMS on August 14 to challenge that state's work requirements. Similar legal challenges are likely in other states seeking to implement work and community engagement requirements. As a result, Tennessee could invest significant resources to plan for and implement work requirements in the state, only to have its efforts stopped by the courts.

Ascension Saint Thomas greatly appreciates the opportunity to provide feedback on the proposed waiver amendment as part of our on-going dialogue to transform our healthcare delivery system. If you have any questions, please do not hesitate to contact Nancy Anness, Chief Advocacy Officer Ascension Saint Thomas at nanness@ascension.org or (615) 429-7410

Sincerely,

Tim P. Adams, FACHE
President/CEO, Saint Thomas Health
Ministry Market Executive, Ascension Tennessee
102 Woodmont Blvd., Suite 800
Nashville, TN 37205

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[i] Available at: https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment38.pdf
[i] Arkansas Department of Human Services, "Arkansas Works Program September 2018 Report," September 2018. Available at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.
[i] Arkansas Department of Human Services, "Arkansas Works Program August 2018 Report," August 2018. Available at: https://ccf.georgetown.edu/wp-content/uploads/2018/09/091218_AWReport_Final.pdf.
[i] Tennessee General Assembly Fiscal Review Committee, Fiscal Note HB 1551 - SB 1728, February 12, 2018. Available at: http://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf
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Jonathan Reeve

From: Katherine Flannigan <Katherine.Flannigan@asco.org>
Sent: Thursday, October 25, 2018 10:21 AM
To: Public Notice. Tenncare
Subject: ASCO and TOPS TennCare Comments on Amendment 38 Medicaid Waiver
Attachments: TN TennCare Amendment State Comment Final.pdf

Good morning,

Please find attached the American Society of Clinical Oncology (ASCO) and the Tennessee Oncology Practice Society (TOPS) comments on the proposed amendment 38 to the TennCare section 1115 Medicaid Waiver.

Sincerely,
Kate

Katherine Flannigan
Administrator, State Advocacy
Policy & Advocacy
American Society of Clinical Oncology
2318 Mill Road, Suite 800
Alexandria, VA 22314
T: 571-483-1677

asco.org • cancer.net • conquercancerfoundation.org • cancerlinq.org

Making a world of difference in cancer care

Via Electronic Submission

25 October 2018

Wendy Long, MD
Director
TennCare
310 Great Circle Rd.
Nashville, TN 37243

RE: TennCare II Demonstration Project No. 11-W-00151/4, Amendment 38

Dear Doctor Long,

Thank you for the opportunity to comment on behalf of the American Society of Clinical Oncology (ASCO) and the Tennessee Oncology Practice Society (TOPS) on the recently amended TennCare Demonstration Waiver. Together with oncologists in the state of Tennessee, we urge the Tennessee Medicaid Program to modify Amendment 38 requiring workforce participation and community engagement before submitting the final notice to the Centers for Medicare and Medicaid Services (CMS) as the waiver will have a potential negative impact on patients with cancer.

ASCO is the national organization representing over 45,000 physicians and other healthcare professionals specializing in cancer treatment, diagnosis, and prevention. Our core mission is to ensure that cancer patients have meaningful access to high quality cancer care. TOPS is an organization for oncologists and other oncology professionals that promotes high quality care for cancer patients through educational programs and advocacy efforts.

In August 2018, ASCO released a position statement entitled Addressing Medicaid Waivers and Their Impact on Cancer Care, which includes recommendations designed to assure that all patients with cancer have timely access to high-quality cancer care—regardless of payer. As such, we are deeply concerned with the new restrictions on access to care that are being proposed by some state Medicaid programs.

Specifically, ASCO and TOPS are concerned with language in the amendment requesting the authority to require beneficiaries to participate in work and community engagement of at least 20 hours a week as requirement to continued Medicaid eligibility. Although Amendment 38 exempts "Individuals who are determined to be medically frail," it fails to list conditions that qualify as such. It also does not specify whether enrollees may self-report their condition.

Without a clear exemption for cancer patients, there is no guarantee that access to essential care for patients with cancer will not be hindered under a broad medical frailty definition. As such, to avoid

confusion and delayed access to essential care, we ask that the state of Tennessee revise Amendment 38 in the following way:

- Exempt cancer patients from proposed work requirements before submitting the final amendment to the CMS,
- Apply such exemption to patients with cancer who are undergoing active treatment, and,
- Allow such exemption to remain in place for one year after the last treatment.

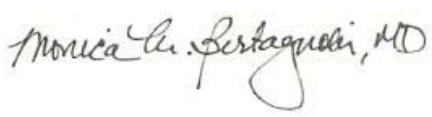
Additionally, ASCO and TOPS are concerned with the potential "lockouts" that may arise from language in this amendment. Currently, the amendment states that enrollees must meet the requirement for four months of every six-month period to maintain coverage. Any non-compliance will cause benefits to be suspended and coverage for those affected will remain suspended until they have complied with the requirement for one month. More restrictive eligibility policies, resulting in later enrollment in Medicaid or other insurance programs, have been found to lead to later disease state at diagnosis and worse outcomes.

Finally, ASCO and TOPS are concerned about the feasibility of this amendment in practice. We urge the Tennessee Medicaid Program to more closely examine administrative requirements imposed by the Amendment's provisions, including the physician's responsibility to notify patients of their exempted category and specific requirements for re-certification of patients once they are designated "medically frail." Introduction of frequent or administratively burdensome processes for achieving and/or verifying continuing need for this status will worsen existing access barriers for vulnerable populations and add to the already unsustainable administrative burden facing clinicians today. ASCO and TOPS urge the Tennessee state government to develop a reporting system and plan for implementation prior to applying for this amendment.

Workforce participation and community engagement requirements as proposed in Amendment 38 of the TennCare plan may jeopardize access and quality of care for patients facing a life-threatening illness like cancer. As such, we urge you to reconsider the amendment as currently drafted.

Thank you for the opportunity to provide comments on the proposed Amendment 38. If you have questions or would like assistance on any issue involving the care of individuals with cancer, please contact Katherine Flannigan at Katherine.Flannigan@asco.org.

Sincerely,



Monica M. Bertagnolli, MD, FACS, FASCO
President, American Society of Clinical Oncology

Jill Gilbert, MD
President, Tennessee Oncology Practice Society

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of galee@king.edu
Sent: Monday, October 08, 2018 8:09 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

The purpose of the federal Medicaid law is to provide medical assistance for people who do not earn enough to meet their own healthcare needs. Imposing work requirements only act as a barrier for people who qualify and runs a high risk of kicking people off who are unable to meet the reporting requirement through no fault of their own. Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Aubrey Lee

Dr.
3314 Berkshire Circle
Johnson City, TN 37604

Jonathan Reeve

From: Barbara <1barbarac@gmail.com>
Sent: Friday, October 19, 2018 3:56 PM
To: Public Notice. Tenncare
Subject: Mental health work requirements

I am the mother of a now deceased mentally ill son. I am a member of NAMI and have been for nearly 30 years. Please listen to their views on this issue. They represent those of us who will be most affected by your decisions. We are mostly silent. They are our voice.

Barbara Christian

Mobile: 615-504-3412
Email: 1barbarac@gmail.com

Sent from my iPhone

Jonathan Reeve

From: Stephanie Whitt <stephanie@beacontn.org>
Sent: Wednesday, October 24, 2018 1:12 PM
To: Public Notice. Tenncare
Subject: Public Comment Regarding Work and Community Engagement Requirements- Beacon Center of Tennessee

The Beacon Center of Tennessee would officially like to enter the following public comments:

1) If an individual has a condition validated by a medical professional, we should not also exempt those who have applied, but have not received approval of SSI or SSDI without validation.

2) Caregiving should count as an approved activity that counts toward the amount of hours required each week/month, it should not be an exemption.
*Individuals who are providing caregiver services for a household member (child or adult) with a disability or incapacitation

3) The good cause exemption should be based on specific exemptions listed out in the amendment and not a blanket approval for whatever the division decides.

4) We should not exempt individuals receiving unemployment benefits, but count any work activities towards the required amount of hours per week/month.

5) Economically distressed should be specifically defined in the amendment and not left open ended.
*In addition, TennCare reserves the right to temporarily modify or waive the community engagement requirement in counties that are determined to be economically distressed.

--

Stephanie Whitt
Executive Vice President

615.383.6431 | Stephanie@BeaconTN.org | BeaconTN.org

Jonathan Reeve

From: Bonnie Craig <craig.b@att.net>
Sent: Wednesday, October 24, 2018 2:41 PM
To: Public Notice. Tenncare
Subject: Work Requirements Proposal

Oppose, oppose, oppose! Too many expensive issues, i.e. how will people show they are exempt, how will this be implemented when Tennessee has a record of computer problems, failures, and contractor errors? What kind of burden will this proposal place on businesses, the self-employed, and workers????

Bonnie Data Craig
Nolensville, TN 37135
Cell 815-325-8922
E-mail: craig.b@att.net

Some people look for a beautiful place. Others make a place beautiful.

Jonathan Reeve

From: Brady Watson <brady.watson22@gmail.com>
Sent: Friday, October 26, 2018 1:20 PM
To: Public Notice. Tenncare
Subject: RE: TennCare Waiver Amendment 38

Dear Dr. Wendy Long,

I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38. I am a political activist and organizer and have worked with impacted communities on a number of issues. Work requirements would negatively affect the thousands of Tennesseans who rely on Tenncare every day, the majority of whom are either already working or can't work because they are primary caregivers for a loved one who is disabled. I am unequivocally opposed to this proposal that would take health coverage away from people who do not work a set number of hours per month. This proposal would cause immense harm and jeopardize coverage for thousands of Tennesseans.

Abuse of the system is so infinitesimally small that the cost of implementing this program will be higher than any money lost due to misuse. Failure to meet reporting requirements and paperwork errors will result in suspension of coverage for thousands of Tennesseans. We already have hundreds of thousands of Tennesseans who do not have access to healthcare because the state has refused to expand Medicaid and this would exacerbate that. Reasons include TennCare's lack of computer system, the barriers to working like lack of reliable transportation and child care, and barriers to reporting. Any disruption of treatment or loss of access to health care is literally a matter of life and death for folks with cancer or other serious illnesses. In addition, this proposal leaves many unanswered questions.

- How do people report compliance?
- How can TennCare administer this complex eligibility determination without an eligibility determination computer system, which is not yet complete?
- How will the reporting process accommodate people with disabilities, limited literacy or language?
- What is "good cause" for waiving compliance by certain individuals?
- What criteria will be used to exempt "economically distressed" counties?

This is unacceptable in any circumstance, but especially so given the importance of this particular service.

This waiver is fundamentally flawed and cannot be fixed. It goes against the goals and purpose of the Medicaid program. I respectfully urge you to not go forward with this harmful proposal.

sincerely,

Brady Watson

Jonathan Reeve

From: Brent Peterson <brent-peterson@att.net>
Sent: Friday, October 26, 2018 4:38 PM
To: Public Notice. Tenncare
Subject: public comments on proposed Waiver Amendment 38

Dr. Wendy Long Division of TennCare via email to: public.notice.tenncare@tn.gov

RE: TennCare Waiver Amendment 38

Dear Dr. Wendy Long,

I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38. I am writing as a concerned citizen of Tennessee.

I am opposed to this proposal that would take health coverage away from people who do not work a set number of hours per month. This proposal would cause immense harm and jeopardize coverage for thousands of Tennesseans.

In my opinion, this is a solution in search of problem, would create unnecessary bureaucracy and have little to no benefit to Tennesseans.

This waiver is fundamentally flawed and cannot be fixed. It goes against the goals and purpose of the Medicaid program. I respectfully urge you to not go forward with this harmful proposal.

Sincerely,

Brent Peterson
1416 Woodland St.
Nashville, TN 37206

Jonathan Reeve

From: Shelby Berger <sberger@cancersupportcommunity.org>
Sent: Friday, October 26, 2018 2:28 PM
To: Public Notice. Tenncare
Subject: Cancer Support Community Comments on Amendment 38 to TennCare II Demonstration
Attachments: CSC Comments TN 1115 Waiver Request.pdf

Hello,
Please find attached the comments from the Cancer Support Community on the proposed amendment to the TennCare II Demonstration. We are happy to address any questions or concerns.

Thank you,
Shelby Berger

SHELBY BERGER | Manager, Policy & Advocacy
Cancer Support Community
Uniting The Wellness Community & Gilda's Club Worldwide
734 15th Street NW | Suite 300 | Washington, D.C. | 20005
T: 202.650.5371 | F: 202.974.7999
www.CancerSupportCommunity.org

CANCER SUPPORT COMMUNITY.
A Global Network of Education and Hope

Headquarters Office:
734 15th Street, NW, Suite 300, Washington DC 20005
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New York City Office:
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Research & Training Institute:
4100 Chamounix Drive, Fairmount Park, Philadelphia, PA 19131
267.295.3000 **Phone** 215.883.2580 **Fax**

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long:

On behalf of the Cancer Support Community (CSC), an international nonprofit organization that provides support, education, and hope to cancer patients, survivors, and their loved ones, we appreciate the opportunity to provide comments on the Section 1115 Demonstration Waiver amendment to the TennCare II Demonstration. Our comments address our concerns with the proposed work requirement that will ultimately limit access to care for low-income individuals in Tennessee living with cancer. For the reasons outlined in this letter, we have serious concerns with Tennessee's 1115 waiver request and the department to reject it.

As the largest direct provider of social and emotional support services for people impacted by cancer, and the largest nonprofit employer of psychosocial oncology professionals in the United States, CSC has a unique understanding of the cancer patient experience. Overall, we deliver more than $40 million in free, personalized services each year to individuals and families affected by cancer nationwide and internationally. Additionally, CSC is home to the Research and Training Institute— the only entity of its kind focused solely on the experiences of cancer patients and their loved ones. The Research and Training Institute has contributed to the evidence base regarding the cancer patient experience through its Cancer Experience Registry, various publications and peer-reviewed studies on distress screening, and the psychosocial impact of cancer and cancer survivorship.

Cancer patients face a wide variety of barriers in access to quality and comprehensive care. Almost all patients report experiencing barriers in accessing care, regardless of their income-level, location, and health plan. Low-income cancer patients however are particularly at risk as they face obstacles in qualifying for, accessing, and maintaining health care coverage for essential services. Of the patients surveyed in the *Access to Care in Cancer 2016* study conducted by CSC, only 4.8% had gained access to coverage through Medicaid. Of the patients who reported being uninsured, 43% said they could not afford health insurance, and 31% said they were not eligible for Medicaid. Any additional barriers in access to care for cancer patients will set back progress and harm cancer patients and their families already facing significant

difficulty in securing and maintaining coverage while undergoing difficult, life threatening, and time consuming treatment regimens.

I. Work Requirements do not meet the requirements for a Section 1115 Waiver

Federal law does not permit the implementation of work requirements in the Medicaid program, as the core mission of the Medicaid program is to provide comprehensive health coverage to people whose income and resources are "insufficient to meet the costs of necessary medical services." Section 1115(a) of the Social Security Act was created to allow the Secretary of the Department of Health and Human Services to waive certain provisions of the Medicaid program as long as the initiative is "likely to assist in promoting the objectives of the program". The Tennessee proposal does not fulfil the requirement as it will create significant access barriers for low-income Tennesseans.

The state is seeking to implement work requirements to promote improved outcomes for TennCare members, and to support member efforts to achieve independence and potentially facilitate their transition off the TennCare program and into private insurance. However, according to a 2017 study by the Kaiser Family Foundation, 8 in 10 Medicaid recipients already live in working families and a majority are working themselves. The Medicaid program is designed to provide coverage for those that are unable for a variety of reasons, to find or maintain employment that can provide for their health care needs. Medicaid enrollees who are not working most often reported that the major impediments to their ability to work included illness, disability, or caregiving responsibilities. In a study done by The Ohio Department of Medicaid, it was reported that three-quarters of Medicaid beneficiaries who were looking for work said that Medicaid made it easier for them to do so. For those who were currently working, more than half said that Medicaid made it easier to keep their jobs.

II. Vague exemption categories will harm individuals living with cancer and their caregivers

The Tennessee waiver is likely to be disproportionately detrimental to cancer patients. The application outlines 10 categories of enrollees that would be exempt from the 20 hour per week (average) work requirements. These exceptions are ill-defined and vague, likely leaving many patients unsure of whether they will qualify as exempt. Though the proposal includes exemptions for those determined to be "medically frail," or those who are "physically or mentally incapable of work, as certified by an appropriate medical professional," there is no clear exemption for cancer patients, survivors, or caregivers, nor any detail as to how participants must document or qualify for these exemptions. Many individuals living with cancer are not classified as "severe" enough by the Medicaid program to qualify for a disability exemption, but are facing significant health problems that would make it extremely difficult or impossible to fulfil these requirements. Treatment for cancer may not always produce "severe physical or mental impairments" that will easily and explicitly qualify patients for disability or medical frailty, but can greatly impede their health and ability to maintain steady employment. Patients often face symptoms of their disease as well as difficult side effects of medications such as extreme nausea, fatigue, diarrhea or constipation, nerve damage, heart problems, pain, etc.

CANCER SUPPORT COMMUNITY.
A Global Network of Education and Hope

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Research & Training Institute:
4100 Chamounix Drive, Fairmount Park, Philadelphia, PA 19131
267.295.3000 **Phone** 215.883.2580 **Fax**

Tennessee's proposal includes a "good cause" exemption that includes such circumstances as homelessness, domestic violence, or human trafficking, but this is not sufficient to protect cancer patients. Under a similar waiver demonstration recently implemented in Arkansas, many individuals were unaware of the new requirements and therefore unaware that they needed to apply for such an exemption. In August, the state granted just 45 good cause exemptions while terminating coverage for 4,353 individuals at the end of that month. No exemption criteria can circumvent this problem and the serious risk to the health of cancer patients and survivors.

III. Conclusion

Health care and the ability to maintain good health is itself critical to an individual's ability to retain employment. A 2018 Kaiser Family Foundation study concluded that, "access to affordable health insurance has a positive effect on people's ability to obtain and maintain employment, while lack of access to needed care, especially mental health care and substance abuse treatment, impedes employment." It goes on to explain that low-income adult Medicaid enrollees have high rates of chronic conditions, and that these individuals are better able to hold a steady job if these conditions are treated or controlled, but work may become impossible if these conditions go untreated. Health setbacks often lead to job loss, which would lead to loss of access to health care and treatment, which would in turn make it more difficult for individuals to retain employment. The Tennessee proposal operates under the assumption that steady employment is vital to health, but in reality, low-income residents in Tennessee, particularly those impacted by cancer, absolutely need access to health care to maintain employment.

We appreciate the opportunity to provide comments on Amendment 38 to the TennCare II Demonstration. For the reasons above, we urge the withdrawal of this proposal, to ensure that vulnerable populations retain access to necessary and affordable healthcare. A program that was designed provide for the health care needs of low-income individuals without other options, should never be provisional based on unattainable goals or detrimental to the health of its citizens. Please reach out to me at efranklin@cancersupportcommunity.org if you would like to discuss any of the above in more detail.

Respectfully Submitted,

Elizabeth Franklin, LGSW, ACSW
Executive Director, Cancer Policy Institute
Cancer Support Community

References

Antonisse, L., Garfield, R. (2018). *The Relationship Between Work and Health: Findings from a Literature Review.* Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/

Artiga, S.,Ubri, P., & Zur, J. (2017). *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings.* Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

Cancer Support Community. (2016). *Access to Care in Cancer 2016: Barriers and Challenges.* Retrieved from https://www.cancersupportcommunity.org/sites/default/files/uploads/policy-and-advocacy/patientaccess/access_to_care_in_cancer_2016_barriers_and_challenges_final.pdf?v=1

Garfield, R., Rudowitz, R., & Damico, A. (2017). *Understanding the Intersection of Medicaid and Work.* Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/

Garfield, R., et.al. (2018). *Estimates of Eligibility for ACA Coverage among the Uninsured in 2016.* Kaiser Family Foundation. https://www.kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/

Greene, J. (2018). Medicaid Recipients' *Early Experience With the Arkansas Medicaid Work Requirement.* Health Affairs. https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/.

The Ohio Department of Medicaid. (2015). *Ohio Medicaid Group VIII Assessment: A Report to*

CANCER SUPPORT COMMUNITY.
A Global Network of Education and Hope

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the Ohio General Assembly. (2015). Retrieved from

http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf

Jonathan Reeve

From: Carol Rabideau <rabideauca@gmail.com>
Sent: Friday, October 26, 2018 4:22 PM
To: Public Notice. Tenncare

Dr. Wendy Long
Division of TennCare

Dear Dr. Wendy Long,

I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38. I am a medical social worker and reside in Nashville. I am writing as a constituent and not as a representative of the medical center that employees me.

I am unequivocally opposed to this proposal that would take health coverage away from people who do not work a set number of hours per month. This proposal would cause immense harm and jeopardize coverage for thousands of Tennesseans for the following reasons:

1. Failure to meet reporting requirements and paperwork errors will result in suspension of coverage for thousands of Tennesseans.
2. People will lose coverage even though they remain eligible. Reasons include TennCare's lack of computer system, the barriers to working like lack of reliable transportation and child care, and barriers to reporting.
3. The disruption of treatment or loss of access to health care would affect a particular group (e.g., cancer patients, people with addiction, people with diabetes, etc.) This would cause undue suffering, will contribute to greater medical needs, and early deaths.
4. Less Medicaid coverage will contribute to even more hospital closings in Tennessee, especially in rural areas, making medical treatment access harder for thousands. Instead of dropping people from coverage, Tennessee should be expanding Medicaid.

People whom I serve and people whom I know would be negatively impacted by this proposal to take away coverage from people who don't meet the new work requirement. Tennessee should not make the mistake that Arkansas has done.

In addition, this proposal leaves many unanswered questions.

1. How do people report compliance?
2. How can TennCare administer this complex eligibility determination without an eligibility determination computer system, which is not yet complete?
3. How will the reporting process accommodate people with disabilities, limited literacy or language?
4. What is "good cause" for waiving compliance by certain individuals?
5. What criteria will be used to exempt "economically distressed" counties?

This waiver is fundamentally flawed and cannot be fixed. It goes against the goals and purpose of the Medicaid program. I respectfully urge you to not go forward with this harmful proposal.

Sincerely,
Carol Rabideau, LCSW

Jonathan Reeve

From: Carolyn Jones <jones8195@att.net>
Sent: Friday, October 26, 2018 1:50 PM
To: Public Notice. Tenncare
Subject: Medicaid expansion

I support Medicaid expansion. Everyone needs health insurance and good health care. Rural areas and small towns need health care facilities. Imagine it would be like to drive 30-60 miles to a hospital and maybe not be able to drive.
Carolyn Jones

Sent from my iPhone

Jonathan Reeve

From: Cathy Puhr <ctpuhr@gmail.com>
Sent: Saturday, October 20, 2018 4:59 PM
To: Public Notice. Tenncare
Subject: HB 155

As the parent of a young woman with severe mental health issues, and a member of NAMI, I oppose the blanket work requirements for this population of the TennCare insurance. Many clients with mental illness would love to work, but their illness limits their ability to make judgements, be present at their job every day, and cope with the normal stressors in the work place. For those who are able to navigate these problems, they are probably already working, but for many more, it would be impossible, and they would then lose their health care altogether. So, a blanket rule is cruel, inhumane and simply wrong. Cathy Puhr

Jonathan Reeve

From: Lauren Mcgrath <Lauren.Mcgrath@centerstone.org>
Sent: Friday, October 12, 2018 12:24 PM
To: Public Notice. Tenncare
Cc: Bob Vero
Subject: Centerstone Comment Submission: Amendment 38
Attachments: Centerstone Comments - Amendment 38 TennCare.pdf

Dear Dr. Long and TennCare staff members;

Attached, please find Centerstone's response, to the request for public comments on Amendment 38. Please feel free to reach out to us with any additional questions, or if we can be of further assistance.

Regards;
Lauren

Lauren Conaboy, MSSW
Vice President of National Policy, Centerstone
cell: 202.731.4373 /crisis: 502.589.4313
Lauren.McGrath@centerstone.org
Website / Facebook / LinkedIn

CENTERSTONE

October 12th, 2018

Dr. Wendy Long, Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Public comments submitted via email to public.notice.tenncare@tn.gov on October 12th, 2018.

RE: Public Comments on Amendment 38

Centerstone would like to thank the Division of TennCare for this opportunity to comment on Amendment 38 to establish workforce participation and community engagement requirements.

Last year 1,776 Tennesseans lost their lives from drug overdoses - the highest fatality rate since reporting began in Tennessee. Moreover, at least seventy five percent of those deaths were attributable to opioids[1]. Today, 3 Tennesseans die each day as a result of the preventable chronic disease of addiction - disrupting whole families and communities statewide. As a provider of evidence-based behavioral health services to more than 65,000 Tennesseans annually, the majority of whom are low-income and Medicaid eligible, we know firsthand how access to TennCare has impacted the lives of the communities we serve.

As one of the nation's leading experts in mental health and addiction treatment, we know that early intervention, effective care coordination, and evidence-based treatments save money and increase patient outcomes. Today, it is well documented that one of the most significant drivers of cost is fragmentation of care within a siloed health care system. To illustrate this point, the top 5% of Medicaid utilizers account for half of all Medicaid expenses[2]. Furthermore, this dynamic is not unique to Medicaid. HHS found that 5% of the overall population, including patients with commercial insurance, accounted for 50% of health care spending[3]. The more fragmented care is, the less likely it is that a person will improve, and the more likely it is that they will continue to utilize excessive, costly services *over and over again*. More succinctly stated, the most expensive form of care is care that does not work.

Additionally, social determinants of health play a critical role in addressing health outcomes, as well as in bending the cost curve for health care expenditures. A recent study conducted by WellCare and the University of South Florida revealed a 10% reduction in health care spending among their Medicaid and Medicare beneficiaries when those beneficiaries were connected to appropriate social services[4]. Thus, when beneficiaries have access to preventative, comprehensive, evidence-based services, they are more likely to remain stable, employed, and at home in their communities.

[1] https://www.tn.gov/health/news/2018/8/20/tennessee-deaths-from-drug-overdoses-increase-in-2017.html
[2] https://www.gao.gov/assets/680/670112.pdf
[3] https://meps.ahrq.gov/data_files/publications/st354/stat354.shtml
[4] https://www.liebertpub.com/doi/10.1089/pop.2017.0199

As such, Centerstone supports Medicaid reform that ensures consistent access to care, rewards clinical outcomes, addresses gaps in social determinants of health, and incents effective treatment coordination. Relatedly, Centerstone applauds the recent HHS and CMS announcements to focus on outcomes-based measures for clinical processes, as well as incent interoperability within health records; we hope this will occur not only on the medical side, but also on the behavioral health side. Ensuring contiguous care, tracking meaningful measures that can be shared amongst electronic health systems, and addressing social determinants of health, will be the true drivers of cost containment in the context of offering more robust, outcomes-driven, and patient-centered care.

Thus, while the proposed amendment to TennCare has specific elements geared to incentivize outcomes via increasing beneficiary involvement in the workforce, we are concerned that elements of the proposed changes will inadvertently *shift administrative costs to providers* and *place undue burden on consumers*. Below, we outline specific concerns and recommendations for consideration as state and federal leaders evaluate Amendment 38.

The Work/Community Engagement Requirement

Centerstone supports the Administration's overarching goals of encouraging engagement and responsibility for one's health care and of increasing patient outcomes. With regard to addressing barriers within the workforce, we are very supportive of deploying and evaluating innovative pilot programs to garner workforce development, such as those launched in Indiana for current and potential employees who have failed drug screens[5]. Initiatives such as these demonstrate how public and private entities can work together to address both treatment needs and workforce challenges, simultaneously.

Populations Excepted from Community Engagement Requirement

Centerstone supports TennCare's decision to include *medically frail* beneficiaries as well as *individuals participating in inpatient or residential treatment for a substance use disorder* as exceptions to the Community Engagement requirement. In addition to the exceptions listed in the draft amendment, we suggest adding another exception that would include patients actively participating in and adhering to outpatient substance use disorder (SUD) treatment. Recovery can be quite unpredictable for individuals in treatment. Therefore, the less burden and the more predictability we can ensure during the process, the better.

Medically Frail Beneficiaries

While we support multiple pathways towards identifying *medically frail* beneficiaries, we are weary of the new administrative burdens this will place on our staff. Utilizing staff time and energy for this administrative task will place financial burdens on organizations aiming to invest their capital in other projects, namely in direct patient care. Moreover, due to historically low reimbursement rates, providers are already facing robust productivity requirements, leaving little to no room for additional clinical documentation. Given that CMS has recently launched a "patients over paperwork" initiative, we suggest further streamlining any new processes and reporting requirements around *medically frail* designations so that providers can use their capital to invest in patient care. We predict that new administrative burdens, which translate into increased costs, will inevitably arise as a result of implementing this Amendment. As such, we strongly support increasing reimbursement rates, which, incidentally, are not yet aligned with the actuarial cost of delivering care.

[5] https://money.cnn.com/2018/05/22/news/economy/employers-opioid-rehab-belden/index.html

Conclusion

With overdose rates rising and the number of children in need of foster care increasing, access to a full continuum of evidence-based care is paramount to avoiding an even costlier, deadlier, public health epidemic in Tennessee. To combat the effects of these trends, we recommend that state and federal leaders take prudent and proactive steps to ensure this waiver increases access to evidence-based care for those who need it, and ultimately, improves health care outcomes. Furthermore, special attention should be given to patients who do meet the *medically frail* designation to ensure they have the infrastructure supports they need to navigate the designation process, and are not inadvertently locked out of care. Additionally, we ask that you take steps to mitigating the costs of this waiver implementation, which will be heavily shouldered by already overburdened, underpaid provider networks. Overall, Centerstone supports the goal of developing a healthy workforce, promoting sound fiscal policies, and incentivizing health care policies that drive outcomes and value for patients. However, new initiatives should be introduced with ample time to allow for provider and beneficiary planning, and should be designed to reduce or eliminate inadvertent lapses in coverage, as well as streamline reporting. Should CMS or TennCare wish to discuss elements of this waiver and/or its implementation, Centerstone stands ready to be of further assistance.

Thank you again for this opportunity to submit additional comments regarding Amendment 38.

Sincerely,

Dr. Robert Vero, Regional CEO, Tennessee

About Centerstone:

Centerstone is a not-for-profit health care organization dedicated to delivering care that changes people's lives. We are a nationally recognized leader, providing mental health and substance use treatment, related crisis care, education and support to people of all ages in communities in Florida, Illinois, Indiana, Kentucky and Tennessee. Nationally, we offer specialized care for service members, veterans and their loved ones, and develop employee assistance programs for businesses of all sizes. Our research institute improves behavioral health care through research, evaluation and technology, and our foundation secures philanthropic resources to support our work. For more about Centerstone, please call (888) 291-4357 or visit centerstone.org.

Jonathan Reeve

From: Chris Durand <durand_chattanooga@yahoo.com>
Sent: Wednesday, October 10, 2018 10:10 PM
To: Public Notice. Tenncare
Cc: kfranks@tnjustice.org
Subject: my opposition to proposed TennCare Waiver Amendment 38

165 Woodcliff Circle
Signal Mountain, TN 37377-3142
durand_chattanooga@yahoo.com

October 10, 2018

Dr. Wendy Long
Division of TennCare
via email to: public.notice.tenncare@tn.gov

RE: TennCare Waiver Amendment 38

Dear Dr. Long,

I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38.

I am opposed to this proposal that would take health coverage away from people who do not work a set number of hours per month. This proposal would cause immense harm and jeopardize coverage for thousands of Tennesseans.
• Failure to meet reporting requirements and paperwork errors will result in suspension of coverage for thousands of Tennesseans.
• People will lose cover even though they remain eligible. Reasons include TennCare's lack of a computer system, the barriers to working like lack of reliable transportation and child care, and barriers to reporting.
• Disruption of treatment or loss of access to health care would affect cancer patients, people with addiction, people with diabetes, etc.

In addition, this proposal leaves many unanswered questions.
• How do people report compliance?
• How can TennCare administer this complex eligibility determination without an eligibility determination computer system, which is not yet complete?
• How will the reporting process accommodate people with disabilities, limited literacy or language?
• What is "good cause" for waiving compliance by certain individuals?
• What criteria will be used to exempt "economically distressed" counties?

Thousands of Tennesseans would be negatively impacted by this proposal to take away coverage from those who don't meet the new work requirement. This waiver is fundamentally flawed and cannot be

fixed, as it goes against the goals and purpose of the Medicaid program. I respectfully urge you to not go forward with this harmful proposal.

Sincerely,
Chris Durand

Copy to:
Keila Franks, Field Director
Tennessee Justice Center
kfranks@tnjustice.org

Jonathan Reeve

From: Ryan, Lauren <lryan@cff.org>
Sent: Friday, October 26, 2018 3:26 PM
To: Public Notice. Tenncare
Subject: 1115 Waiver Amendment Comments - Cystic Fibrosis Foundation
Attachments: CFF Tennessee 1115 Waiver Amendment - State Comments.pdf

Dr. Long,

Thank you for the opportunity to comment on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration." On behalf of people with cystic fibrosis (CF), we write to express our concern that work and community engagement requirements are barriers to accessing the high-quality care that people with CF need. Please see attached for our full comments.

Best,
--
Lauren A. Ryan
Sr. Specialist, State Policy
Cystic Fibrosis Foundation
lryan@cff.org
301-841-2632

CYSTIC FIBROSIS FOUNDATION
ADDING TOMORROWS

CYSTIC FIBROSIS FOUNDATION
ADDING TOMORROWS

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long:

The Cystic Fibrosis Foundation appreciates the opportunity to submit comments on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration." On behalf of people with cystic fibrosis (CF), we write to express our concern that work and community engagement requirements are barriers to accessing the high-quality care that people with CF need. As such, we ask the state to specifically and automatically exempt people with cystic fibrosis from these requirements.

Cystic fibrosis (CF) is a life-threatening genetic disease that affects 340 adults in Tennessee, approximately 30 percent of whom rely on Medicaid for all or some of their health care coverage. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. For those with CF, health care coverage is a necessity and interruptions in coverage can lead to lapses in care, irreversible lung damage, and costly hospitalizations—compromising the health and well-being of those with the disease. Removing an individual from Medicaid coverage if they are unable to comply with work and community engagement requirements will leave these patients without coverage they depend upon to maintain their health. Explicitly exempting Cystic Fibrosis will minimize the number of individuals who are disenrolled from coverage due to these new requirements.

Specifically, within the state's 1115 Waiver Amendment, we are concerned with the following provisions:

Work and Community Engagement Requirements
The Tennessee Amendment 38 seeks to add a work and community engagement requirement for most TennCare enrollees. This would increase the administrative burden on all TennCare patients. Individuals will need to either report that they meet certain exemptions or the number of hours they have worked. Increasing administrative requirements will likely decrease the number of individuals with TennCare coverage.

Arkansas is currently implementing a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. As of October 2018, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[i] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[ii] 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.[iii] 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.

CYSTIC FIBROSIS FOUNDATIONNATIONAL
4550 MONTGOMERY AVENUE, SUITE 1100N BETHESDA, MD 20814
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Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with cystic fibrosis. If the state finds that individuals have failed to comply with the new requirements for two months out of a six-month period, they will be locked out of coverage until they demonstrate their compliance. People with cystic fibrosis rely on daily treatments, regular visits with healthcare providers, and multiple medications to manage their conditions; they cannot afford a sudden gap in care.

Exemption Determination Process

We appreciate the state's decision to exempt from community engagement requirements those determined to be medically frail, which reflects the important reality that health status can significantly affect an individual's ability to search for and sustain employment. While an individual with CF may fall into this exemption category, we are unsatisfied with the specificity of this language and potential bureaucratic hurdles involved in obtaining an exemption for someone with CF.

We ask the state to specifically and automatically exempt people with CF from the work and community engagement requirements; to minimize the risk of inappropriate disenrollment and administrative burden on recipients, we also ask that you use your own data to identify people with CF for exemption.

As experts in cystic fibrosis care and research, please consider us a resource during the rulemaking and implementation process to minimize unintended errors and ensure our population is exempt. In particular, we can provide clinical expertise on service utilization, co-morbidities, and other factors that may help the state ensure people with CF are accurately captured by the state's algorithm.

Estimate of Expected Change in Annual Enrollment

The Cystic Fibrosis Foundation also wishes to highlight that 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. However, on pages 5 of this proposal, the Department states that "*Some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, it is not possible to reliably project the magnitude of this decrease in enrollment at this time*." We urge the TennCare to update the waiver amendment with the estimated expenditure and estimate enrollment change and reopen the state comment period for an additional 30-days.

We believe healthcare should be affordable, accessible, and adequate. As proposed, Tennessee's Amendment 38 does not meet that standard for people with CF.

The Cystic Fibrosis Foundation appreciates the opportunity to provide input on these important policy changes. As the health care landscape continues to evolve, we look forward to working with the state of Tennessee to ensure access to high-quality, specialized CF care and improve the lives of all people with cystic fibrosis. Please consider us a resource moving forward.

Sincerely,

Mary B. Dwight
Senior VP of Policy & Patient Assistance Programs
Cystic Fibrosis Foundation

Lisa Feng, DrPH
Senior Director of Access Policy & Innovation
Cystic Fibrosis Foundation

[i] 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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[iii] 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.

Jonathan Reeve

From: David Reeves <dhreeves50@gmail.com>
Sent: Saturday, October 20, 2018 8:07 AM
To: Public Notice. Tenncare
Subject: Work requirements

This is an absurd proposal for those who are barely able to hang onto their sanity in this insane administration.

Jonathan Reeve

From: Jennifer McMullen <Jennifer.McMullen@davita.com>
Sent: Thursday, October 25, 2018 1:16 PM
To: Public Notice. Tenncare
Cc: Anna M. Richardson; Caroline Straight
Subject: Work Requirements comment letter
Attachments: DaVita Comment Letter on Tennessee Medicaid Waiver 10.25.18final.docx

Thank you for allowing DaVita to submit this comment letter on behalf of all of the patients we serve in TN.

Thank you –
Jennifer

Jennifer McMullen
Director, State Government Affairs
Davita, Inc.

October 26, 2018

Dr. Wendy Long, Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: Automatic Exemption under Tennessee's 1115 Medicaid Waiver for ESRD Patients

Dear Director Long:

We respectfully submit the following comments regarding the State of Tennessee's Section 1115 Demonstration Application, Amendment 38, dated September 24, 2018. The DaVita patient population includes more than 194,600 patients who have been diagnosed with kidney failure or end-stage renal disease (ESRD), a group representing approximately one-third of all Americans receiving dialysis services. Spanning all 50 States and the District of Columbia, the DaVita Kidney Care network includes more than 2,445 locations. In Tennessee, 1,361 DaVita teammates (employees) have the privilege of serving 3,497 patients. Our comprehensive, care team includes nephrologists, nephrology nurses, patient care technicians, pharmacists, clinical researchers, dieticians, social workers, and other highly-trained kidney care specialists.

BACKGROUND

Kidney failure, or ESRD, is the last stage (stage five) of chronic kidney disease (CKD). This stage is reached when an individual's kidneys are functioning at 10%–15% of their normal capacity or below and, therefore, cannot sustain life. Kidneys are vital organs that remove toxins from the blood and perform other functions that support the body, such as balancing fluid and electrolytes, and producing certain hormones. When kidneys fail, they cannot effectively perform these functions, and renal replacement therapy, such as dialysis or a kidney transplant, is necessary to sustain life.

Currently there are primarily three types of dialysis. These are peritoneal, home hemodialysis and hemodialysis. The most common type of dialysis is hemodialysis, which is predominantly performed in specialized outpatient facilities. Hemodialysis is a therapy that filters waste products, removes extra fluid, and balances electrolytes (sodium, potassium, bicarbonate, chloride, calcium, magnesium and phosphate), replacing the mechanical functions of the kidney. Traditional in-center hemodialysis is generally performed a minimum of three times a week for approximately four hours each session.

REQUEST FOR AUTOMATIC EXEMPTION FROM WORK REQUIREMENTS FOR INDIVIDUALS WITH KIDNEY FAILURE

As explained in the application, the objective of the Tennessee 1115 Medicaid Demonstration is to support participants' ability to obtain and maintain employment, promote improved health outcomes, and ultimately serve as a pathway to independence that supports program participants in their transition from public assistance to private health insurance. Specifically, Tennessee is proposing that under the demonstration, impacted adults would be required to engage in qualifying work or community activities for 20 hours per week (averaged monthly). Individuals can fulfill this requirement through employment, on the job training, job search activities, attendance in high school, community service, and other activities. However, this requirement does include a number of exemptions, including for "individuals who are determined to be medically frail."

Kidney Failure Patients Are Inherently "Medically Frail"

According to the Clinical Journal of the American Society of Nephrology, only 50% of patients who receive hemodialysis are of working age (18-64). For those who can work, the clinical benefits are significant. But overall, the typical dialysis patient is in treatment 3 times a week for 4 hours, suffers from the common post dialysis side effects (dizziness, nausea, vomiting, and fatigue) and has multiple co-morbidities that require various specialist visits. In addition, patients with kidney failure are often reliant on government or family members for transportation which means their visit to the dialysis center is prolonged.

It is the general consensus of the medical community that the above stresses of dialysis, combined with multiple co-morbidities classify a patient as medically frail. The American Society of Anesthesiologists (ASA), categorizes kidney failure patients as having health scores of ASA 3 (patient with severe systemic disease with definite functional limitation) or ASA 4 (patient with severe systemic disease that is a constant threat to life.[1] ESRD patients are an extremely vulnerable patient population whose health is measured day by day and, as such, they are much more appropriately categorized as "automatically medically frail." While we have no doubt that ESRD patients ultimately *should* qualify under the waiver's exemption, we would be very concerned about the well-being of our ESRD patients in the interim, given the lack of a specific exemption for ESRD patients and a lack of specificity regarding how such patients would be determined to be medically frail.

Evidence that is currently being collected from the Arkansas Works Program gives us reason to be concerned. In its September 2018 report, Arkansas reported that in the month of September the Arkansas Work Program had 15,276 "cases closed," where the patient was removed from the Medicaid program.[2] While some of these closed cases are understandable (e.g. moved out of the state), several categories raise significant concerns, including:

- Non-compliance (27% or 4,109 patients);
- Failed to return requested information (26% or approximately 3,872 patients); and
- Other (18% or approximately 2,750 patients).

Due to a lack of an automatic exemption for ESRD patients, and notwithstanding the 8,020 patients who were exempted as medically frail, we are very concerned about how many vulnerable ESRD patients could have been caught up as part of the more than 10,000 patients removed from the Arkansas Works Program in one month alone for various issues. As noted, the reasons for

[1] G. Beathard, et al., The Risks of Sedation/Analgesia in Hemodialysis Patients Undergoing Interventional Procedures, February 22, 2011
[2] Arkansas Department of Human Services, *Arkansas Works Program*, September 2018 Report

such removal might not only relate to a lack of clarity with respect to non-compliance with work requirements, but also a failure to return requested information or for some "other" unspecified reasons.

Proposed Specific Model for Determining "Medically Frail"

We note that other states have put forth models that also might be considered by Tennessee as a user-friendly model (for both the patient and the state) in the exact determination of "medically frail." Specifically, under these models, individuals (1) may self-report medically frail status or (2) be identified through a retrospective review and assessment as follows:

- **Self-Reporting of Medically Frail Status**
  - Individuals could self-attest to their medically frail status through an application. Answering "yes" to either of the following questions would designate an individual as "medically frail":
    - 1) Does the applicant "have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?" (Paper Application)
    - 2) Does the applicant: a) "have a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs?" or b) "need help with activities of daily living (like bathing, dressing, and using the bathroom), or live in a medical facility or nursing home?" (Online Application)
- **Retrospective Review and Assessment**
  - To support the above self-attestation process, health care claims data review of the preceding 12 months could be conducted for the presence of select diagnosis codes to identify individuals considered medically frail.
    - Among the list of diagnosis codes that would identify an individual as "medically frail" are N185 (Chronic Kidney Disease Stage 5) and N186 (End-Stage Renal Disease).

We also would support an approach similar to the one highlighted above as Tennessee and CMS continue to consider the Tennessee Medicaid waiver. As part of this model, we would respectfully request Tennessee use its authority under the waiver to include ESRD patients as an automatically medically frail category under the waiver due to the fact that they have a "serious and complex medical condition" consistent with 42 CFR §440.315(f).

CONCLUSION

We appreciate Tennessee's efforts to improve the Medicaid program while appropriately considering the needs of medically frail individuals. Our comments reflect our sincere desire to make sure that the Tennessee Medicaid program is updated through the 1115 waiver in a way that best serves the disparate needs of its enrollees. Once again, we thank you for providing the opportunity to provide comments on the Tennessee Medicaid waiver and we look forward to continuing to work with the Division to ensure high-quality Medicaid coverage.

Sincerely,

Jennifer McMullen

Jennifer Lancaster McMullen
Director, State Government Affairs
DaVita, Inc.

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of Dbakernurse@msn.com
Sent: Friday, October 05, 2018 11:59 AM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Diana Baker
THCC
5179 Normandy Lane
Memphis , TN 38117

Jonathan Reeve

From: Nathan Walsh <nathanw@disabilityrightstn.org>
Sent: Friday, October 26, 2018 11:39 AM
To: Public Notice. Tenncare
Subject: Amendment 38 Public Comment
Attachments: DRTAmendment38PublicComment.docx

Please find our comments attached.

Thank you,

Nathan Walsh | Staff Attorney
nathanw@disabilityrightstn.org
voice 615.298.1080 | fax 615.298.2046
2 International Plaza, Suite 825 Nashville, TN 37217
www.disabilityrightstn.org |

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DISABILITY RIGHTS TN

800.342.1660 | www.disabilityrightstn.org | gethelp@disabilityrightstn.org

Middle Tennessee Regional Office
Administration & Legal Department
2 International Plaza, Suite 825
Nashville, TN 37217
615.298.1080 phone
615.298.2046 fax

October 26, 2018

Dr. Wendy Long, Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Dr. Long:

I am an attorney at Disability Rights Tennessee (DRT) who focuses on employment issues. At DRT, we are all too familiar with the employment gap that plagues individuals with disabilities as a whole. In 2018, only 40 percent of adults with disabilities in their prime working years have a job, compared to 79 percent of all prime-age adults.[1] Time and time again, our agency hears from clients with disabilities who are desperate for a job but encounter discrimination, lack of needed accommodations, or lack of transportation. We would be enthusiastically supportive of a TennCare proposal that helped the individuals with disabilities we serve find competitive integrated employment. Yet Amendment 38 is scant on details on how it would help any Tennessean find a job.

Amendment 38 at least recognizes the difficulties faced by individuals with disabilities in Tennessee in that it exempts them from the work requirements. But despite the considerable expense and high level of government oversight that keeping track of exemptions on a monthly basis would entail, there is no guarantee that this new oversight mechanism would be accurate. We fear that many individuals with disabilities, particularly those with invisible disabilities such as mental illness, would lose their healthcare even though they are not the intended targets of the requirements.

Furthermore, since Amendment 38 states that exemptions only apply "in any month" in which an exempting condition is met, we fear that the burden monthly documentation requirements would place on individuals with disabilities and their providers would cause still more unintended targets of the requirements to lose their healthcare.

Amendment 38 threatens substantial harm to the population we serve while promising little benefit. So it is particularly distressful that Amendment 38 proposes to use Temporary Assistance for Needy Families (TANF) funds "to fund any costs associated" with the requirements. These funds are intended to help families during times of need. They could be

[1] Martha Ross and Nicole Bateman, *Only Four out of Ten Working-age Adults with Disabilities are Employed*, Brookings (Jul. 25, 2018), https://www.brookings.edu/blog/the-avenue/2018/07/25/only-four-out-of-ten-working-age-adults-with-disabilities-are-employed/

used to help close the employment gap by providing supports to individuals with disabilities looking for competitive integrated employment. They should not be allowed to be used take healthcare away from individuals with disabilities, thereby creating another barrier to employment.

Respectfully,

Nathan Walsh, Staff Attorney
Disability Rights Tennessee

Jonathan Reeve

From: Dave Buchanan <dbuch37@aol.com>
Sent: Tuesday, October 09, 2018 1:36 PM
To: Public Notice. Tenncare
Cc: kfranks@tnjustice.org
Subject: Proposed Waiver per Public Chapter 869

I am writing to express my opposition to the waiver TennCare proposes as provided under Public Chapter 869 recently enacted by the Tennessee Legislature. This is the attempt to eliminate care under TennCare for the unemployed.

I am not an insider and it has been many years since I have expressed an opinion regarding government activity. The legislature's actions and your proposal to implement them however, exceed any test or reasonableness and cannot be allowed to pass without at least a modicum of outrage.

Current governmental trends are to reduce regulations in an effort to save burdens and expense on those being regulated. Most of these efforts relate to activities of large organizations, primarily for-profit corporations, and the result is to do two things: 1. increase the benefits in financial terms for corporate executives and stockholders (i.e., rich people) : and 2. To expose the general public to an increased risk of whatever the "excessive" regulation was intended to protect us (the general public) from. Whether any particular one of these efforts is, on balance, in the public interest must be judged case by case buy many are naturally suspect.

In the current situation what we have is the opposite of the situation just described. First you are adding regulations, not reducing them. And you are adding them on the poor, not the rich. Is the irony not obvious.
We run our governments by reducing regs to benefit the influential and we increase regulations to disadvantage the poor.

Rich corporations have the resources to cope with most regulations. Do we think poor people can do the same?

The idea that you can write a set of regulations that can be simply and evenly applied to a set of individuals each with a unique, usually complex, situation most of whom are struggling to cope with the problems of daily lives that neither you nor I can even imagine, strikes me as totally over the top.

Instead of working to organize a health care system that can readily meet the needs of the all Tennessee citizens you simply add another layer of complexity on the poor and those who would try to serve them.

Whenever I think about this my bottom line is always, "Those people ought to be ashamed." And you should.

Thank you for receiving my comments.

E. David Buchanan
824 Stirrup Drive
Nashville, TN 37221
615-646-0211
dbuch37@aol.com

Jonathan Reeve

From: Lisa Carroll <lcarroll@icx.net>
Sent: Friday, October 26, 2018 3:45 PM
To: Public Notice. Tenncare
Subject: Reasons for Objecting to a Medicaid Work Requirement

October 26, 2018

Dr. Wendy Long, Director
Bureau of TennCare
Tennessee Department of Finance and Administration
310 Great Circle Road Nashville, TN 37243State of Tennessee

RE: TennCare Waiver Amendment 38

Dear Dr. Long:

I write to strongly oppose the work requirement for Tennessee's Medicaid recipients, which feels to me like just another way to punish the poor. Let me tell you why I object:

1. The poor people I know go through periods of irregular work, which will put them at risk of being removed from Medicaid. Early in the century, I tutored children in State custody for about five years and remain in contact with several of them and their friends and families, As teenagers, many of these children were already being treated for chronic physical and psychological diseases (asthma and bipolar disorder being common), problems which continue to afflict them in adulthood. From my contact with this group of Tennesseans, I know how difficult it is for people with marginal jobs, low incomes, heavy family demands, and other stressors to meet bureaucratic requirements. Almost every former student I know about has lost at least one job because of transportation. They ride the bus or drive junkers—a late bus or a car problem have cost them jobs. The poor people I know are among the large group of Americans for whom one flat tire can be a financial disaster.

2. Many of those eligible for Medicaid face barriers to easy reporting. Few of my former students have regular access to the Internet. Others have low literacy or learning disabilities. Some, trying to avoid outright homelessness or while waiting for subsidized housing, go through periods of "couch surfing," which means their addresses change frequently. And others, trying to find jobs that align with available child care or trying to earn more by switching to higher wage jobs are sometimes between jobs for a week or more at a time. All of these situations are likely to make it extremely difficult for them to provide the kind of data that will be required of them to report work hours regularly. As a consequence, I expect many to be unjustly removed from Medicaid—which can begin a downward spiral: without a dependable way to obtain medical care, their well-being and their work hours will decline.

3. The administrative and downstream costs of implementing a work requirement can be large. Beyond my personal experience with people on Medicaid (or those who would be if Tennessee ever expands its

program), I have taxpayer concerns about the real costs of a work requirement. First of all, what will the administration of such a program actually cost? And how will implementation be managed? The Arkansas program has apparently had great difficulty reaching people. The Kentucky program began this past January. By July 95,000 citizens had been removed from the Medicaid rolls in a manner the courts found “arbitrary and capricious.” Reinventing a badly planned and implemented program costs money.

The downstream costs could be significant. The people removed from Medicaid for noncompliance won’t stop getting sick. Lacking access to care through Medicaid, they will return to the emergency room—the costliest way possible to receive medical care. The Kaiser Family Foundation report on the Arkansas experience noted: “the potential that coverage losses will result in gaps in care and increased uncompensated care costs.” Moreover, there is research demonstrating an interaction between health and employment—employed people are healthier and healthier people are employed. Data from numerous studies suggest improved health outcomes and better economic outcomes for Medicaid recipients compared to their peers. (See, for example, B. Sommers et al., Changes in Mortality After Massachusetts Health Care Reform: A Quasi-Experimental Study, *Ann Intern Med.* 2014;160(9):585-593.)

For these and other reasons I am alarmed by the idea that Tennessee will implement a Medicaid work requirement.

Sincerely,

Elizabeth W. Carroll
4315 Hiawatha Drive
Knoxville, TN 37919

Jonathan Reeve

From: Ellen Finney <ellenfinney60@gmail.com>
Sent: Tuesday, October 02, 2018 1:51 PM
To: Public Notice. Tenncare
Subject: Proposed TennCare Work Requirement

I oppose a work requirement which would require enrollees to seek or maintain work in order to keep Medicaid benefits. For one, this requirement would require extensive record-keeping which the state is not now equipped to do properly and which would be expensive to institute. Two, this is a mean-spirited proposal even though it would apply to a relatively small proportion of the TennCare recipients. Three, is step backward from increasing the numbers of the insured in Tennessee. We need to be finding ways to insure more people, not fewer. Uninsured Tennesseans are more expensive to us, not less.

Ellen Finney
199 Broadwell Circle
Franklin, TN 37067

Jonathan Reeve

From: Roudebush, Abbey <aroudebush@efa.org>
Sent: Friday, October 26, 2018 3:47 PM
To: Public Notice. Tenncare
Cc: Elisa Hertzan; Pam Hughes; Mickey McCamish
Subject: Epilepsy Foundation Medicaid 1115 Waiver Comment
Attachments: Epilepsy Foundation Letter - TN 1115 Waiver - October 2018.pdf

Good afternoon,

Attached please find a public comment from the Epilepsy Foundation, Epilepsy Foundation of East Tennessee, Epilepsy Foundation of Southeast Tennessee, and Epilepsy Foundation Middle & West Tennessee regarding the recent Medicaid 1115 Waiver.

Thank you,

Abbey Roudebush
Government Relations Manager
Epilepsy Foundation
Phone: (301) 918-3784
Email: aroudebush@efa.org
www.epilepsy.com
advocacy.epilepsy.com

EPILEPSY FOUNDATION

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long:

The Epilepsy Foundation, and our local affiliates Epilepsy Foundation of East Tennessee, Epilepsy Foundation of Southeast Tennessee, and Epilepsy Foundation Middle & West Tennessee appreciate the opportunity to submit comments on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration."

The Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of the at least 3.4 million Americans with epilepsy and seizures. The local affiliates, Epilepsy Foundation of East Tennessee, Epilepsy Foundation of Southeast Tennessee, and Epilepsy Foundation Middle & West Tennessee advocate and provide services for the almost 74,000 individuals living with epilepsy throughout the state. Collectively, we foster the wellbeing of children and adults affected by seizures through research programs, educational activities, advocacy, and direct services. Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. Approximately 1 in 26 Americans will develop epilepsy at some point in their lifetime. According to the CDC figures there are 84,800 people living with epilepsy in Virginia. For people living with epilepsy, timely access to appropriate, physician-directed care, including epilepsy medications, is a critical concern.

The Epilepsy Foundation, Epilepsy Foundation of East Tennessee, Epilepsy Foundation of Southeast Tennessee, and Epilepsy Foundation Middle & West Tennessee believe everyone, including TennCare enrollees, should have access to quality and affordable health coverage. Unfortunately, this waiver creates new administrative barriers that will jeopardize patients' access to quality and affordable health coverage, and we therefore oppose the proposed waiver.

The Tennessee Amendment 38 seeks to add a work and community engagement requirement for most TennCare enrollees. This would increase the administrative burden on all TennCare patients. Individuals will need to either report that they meet certain exemptions or the number of hours they have worked. Increasing administrative requirements will likely decrease the number of individuals with TennCare 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 October 1, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[i] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[ii] 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

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35,000 fewer children were enrolled in the program by the end of 2004.[iii] 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 two months out of a six-month period, they will be locked out of coverage until they demonstrate their compliance. 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.

The Epilepsy Foundation, Epilepsy Foundation of East Tennessee, Epilepsy Foundation of Southeast Tennessee, and Epilepsy Foundation Middle & West Tennessee are also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions like epilepsy that may prevent them from working. Additionally, Tennessee's "good cause" exemption 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.[iv] 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 Tennessee. States such as Michigan, Pennsylvania, Kentucky 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.[v] Tennessee's fiscal impact statement estimated the program would cost approximately the state and federal government $39.8 million over the course of the waiver.[vi] 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. Most people on Medicaid who can work already do so.[vii] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[viii] 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 a 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).[ix] Terminating individuals' TennCare coverage for non-compliance with these requirements will therefore hurt rather than help people search for and obtain employment. Tennessee has experience with this. In 2005, when the state changed the TennCare program's eligibility and 170,000 people lost Medicaid coverage, there was no increase in employment and self-reported health and access to medical care declined.[x] The Epilepsy Foundation, Epilepsy Foundation of East Tennessee, Epilepsy Foundation of Southeast Tennessee, and Epilepsy Foundation Middle & West Tennessee oppose the work and community engagement.

The Epilepsy Foundation, Epilepsy Foundation of East Tennessee, Epilepsy Foundation of Southeast

Tennessee, and Epilepsy Foundation Middle & West Tennessee also wish to highlight that 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. However, on pages 5 of this proposal, the Department states that "*Some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, it is not possible to reliably project the magnitude of this decrease in enrollment at this time*." We urge the TennCare to update the waiver amendment with the estimated expenditure and estimate enrollment change and reopen the state comment period for an additional 30-days.

The Epilepsy Foundation, Epilepsy Foundation of East Tennessee, Epilepsy Foundation of Southeast Tennessee, and Epilepsy Foundation Middle & West Tennessee believe healthcare should affordable, accessible, and adequate. Tennessee's Amendment 38 does not meet that standard. Thank you for the opportunity to provide comments.

Sincerely,

Pam Hughes
Executive Director
Epilepsy Foundation of East Tennessee

Mickey McCamish
Executive Director
Epilepsy Foundation of Southeast Tennessee

Elisa Hertzan
Executive Director
Epilepsy Foundation Middle & West Tennessee

Philip M. Gattone, M.Ed.
President & CEO
Epilepsy Foundation

[i] 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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[iii] 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.

[iv] 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/.

[v] 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.

[vi] Tennessee General Assembly Fiscal Review Committee. Fiscal Note HB 1551- SB 1728. February 12, 2018. Accessed at: http://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf

[vii] 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/

[viii] 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

[ix] 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

[x] DeLeire, Thomas. The National Bureau of Economic Research. NBER Working Paper No. 24899: The Effect of Disenrollment from Medicaid on Employment, Insurance Coverage, Health and Health Care Utilization. August 2018. Accessed at: https://www.nber.org/papers/w24899

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of Erin Morgan <mailagent@thesoftedge.com>
Sent: Friday, October 26, 2018 1:12 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

As a Nurse Practitioner in the urgent care environment, I care for individuals who cannot access healthcare due to lack of health insurance due to a multitude of factors. These individuals are more sick and have worse outcomes than their peers who have insurance. Requiring a work requirement may only increase the number of individuals who fall into this group, leaving the cost of care to hospitals and the greater healthcare system.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Erin Morgan
Nurse Practitioner
640 Hickory Woods Rd
Knoxville, TN, TN 37934

Jonathan Reeve

From: Corey Greenblatt <cgreenblatt@ghlf.org>
Sent: Thursday, October 25, 2018 11:53 AM
To: Public Notice. Tenncare
Subject: GHLF Patient Group Opposes 1115 Waiver
Attachments: GHLF_TN 1115 Waiver.pdf

Hello,

The Global Healthy Living Foundation (GHLF) is a 501 (c)(3) patient group that works to improve the quality of life for people with chronic disease. GHLF advocates for and supports chronically ill patients across the country, many of whom live rely on prescription medications, and struggle to pay for them.

It is on their behalf that **we are writing to express our opposition to the proposed 1115 waiver.** Attached please find a more detailed formal letter of opposition for your consideration. We would be happy to connect you with advocates that would be negatively impacted by this waiver should you need to hear their perspective on the issue.

Thank you for your time and consideration.

Sincerely,

Corey Greenblatt, MPH | Manager, Policy and Advocacy
Global Healthy Living Foundation
515 N. Midland Ave - Upper Nyack, NY 10960
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Improving the lives of people with chronic disease through better access to care, education, support, advocacy and patient-centered research.

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October 25, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long:

The Global Healthy Living Foundation (GHLF) appreciates the opportunity to submit comments on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration."

GHLF is a 20-year-old 501(c)(3) non-profit patient centered organization representing people who have chronic disease and their caregivers across the U.S. We work to improve the quality of life for people living with these chronic diseases, including many of Tennessee's residents, by making sure their voices are heard and advocating for improved access to care at the community level.

GHLF believes everyone, including TennCare enrollees, should have access to quality and affordable health coverage. Unfortunately, this waiver creates new administrative barriers that will jeopardize patients' access to quality and affordable health coverage, and GHLF therefore opposes the proposed waiver.

The Tennessee Amendment 38 seeks to add a work and community engagement requirement for most TennCare enrollees. This would increase a personal administrative burden on all TennCare patients – many of whom are not familiar with performing these kinds of tasks. Individuals will need to either report that they meet certain exemptions or the number of hours they have worked. Common sense tells us that increasing these personal administrative hurdles will likely decrease the number of individuals with TennCare 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 October 1, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[i] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[ii] 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.[iii] 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. Even the most casual interpretation of these numbers has to conclude that they are a ruthless instrument to refuse healthcare to otherwise qualified sick individuals. If these thousands of individuals were malingerers,

then our healthcare providers, our hospitals, and our clinics are part of a massive fraud, and we know this is not the case.

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 two months out of a six-month period, they will be locked out of coverage until they demonstrate their compliance. 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.

The Global Healthy Living Foundation is 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, Tennessee's "good cause" exemption 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.[iv] 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 Tennessee. States such as Michigan, Pennsylvania, Kentucky 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.[v] Tennessee's fiscal impact statement estimated the program would cost the state and federal government approximately $39.8 million over the course of the waiver.[vi] 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. Most people on Medicaid who can work already do so.[vii] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[viii] 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 a 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).[ix] Terminating individuals' TennCare coverage for non-compliance with these requirements will therefore hurt rather than help people search for and obtain employment. Tennessee has experience with this. In 2005, when the state changed the TennCare program's eligibility and 170,000 people lost Medicaid coverage, there was no increase in employment and self-reported health and access to medical care declined.[x] GHLF opposes the work and community engagement requirement.

GHLF also wishes to highlight that 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. However, on pages 5 of this proposal, the Department states that "*Some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, it is not possible to reliably project the magnitude of this decrease in enrollment at this time.*" We urge the TennCare to update the waiver amendment with the estimated expenditure and estimate enrollment change and reopen the state comment period for an additional 30-days.

The Global Healthy Living Foundation believes healthcare should affordable, accessible, and adequate. Tennessee's Amendment 38 does not meet that standard. Thank you for the opportunity to provide comments.

Sincerely,

Corey Greenblatt
Manager, Policy and Advocacy
Global Healthy Living Foundation

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[i] 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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[iii] 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.

[iv] 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/.

[v] 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.

[vi] Tennessee General Assembly Fiscal Review Committee. Fiscal Note HB 1551- SB 1728. February 12, 2018. Accessed at: http://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf

[vii] 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/

[viii] 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

[ix] 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

[x] DeLeire, Thomas. The National Bureau of Economic Research. NBER Working Paper No. 24899: The Effect of Disenrollment from Medicaid on Employment, Insurance Coverage, Health and Health Care Utilization. August 2018. Accessed at: https://www.nber.org/papers/w24899

Jonathan Reeve

From: Harriger, Hannah <hharrige@vols.utk.edu>
Sent: Friday, October 26, 2018 11:51 AM
To: Public Notice. Tenncare
Subject: Ammendment 38

To Whom It May Concern,

I am writing to formally voice opposition to the proposed Ammendment 38 Medicaid Work Requirement. I am a registered voter in Davidson County, a social work graduate student, former case manager, and Vanderbilt Kennedy Center employee. I have, through all these roles and arenas, learned about and witnessed firsthand how changes to Medicaid impact the day-to-day lives of Tennesseans dependent upon Medicaid for needed medical care. I am well aware that the proposed ammendment creates conditions for exemptions for those who are, in fact, not able-bodied or unable to work due to the care they provide for someone else, but I also know how difficult it is to actually gather required paperwork, submit documentation, and actually have TennCare receive and review said paperwork.

TennCare still does not have an electronic system which means all the additional work of verifying exemptions or proof of work will have to be done manually; this will undoubtedly be a time-consuming process and, as is often the case when TennCare does their annual recertifications, paperwork will be lost, overlooked, and human error made resulting in termation of coverage. This is expected and understandable given the high volume of paperwork and insufficient workers, but it does have the end result of eligible individuals losing their TennCare coverage due to these errors; this is unacceptable when loss of coverage will have serious negative health consequences. I have seen this happen far too many times with my clients to not be concerned that the same would happen with passage of this work requirement.

Given that the majority of individuals enrolled in TennCare Medicaid are not among those targeted by this ammendment (the Kaiser Family Foundation estimates that 6% of enrollees are actually able-bodied and not working), the benefits here seem to be far outweighed by the associated costs and potential risks to eligible Medicaid enrollees. I hope you will consider voting against passage of Ammendment 38 in consideration of the legitimately eligible majority whose very lives depend on keeping TennCare Medicaid coverage. Thank you for your time.

Respectfully,
--
Hannah Harriger
University of Tennessee
MSSW Candidate
hharrige@vols.utk.edu

Jonathan Reeve

From: Deema Tarazi <d.tarazi@hemophiliafed.org>
Sent: Friday, October 26, 2018 9:30 AM
To: Public Notice. Tenncare
Subject: Comment Letter for 1115 Waiver
Attachments: HFA TN 1115 Waiver Comment Letter.pdf

To Whomever It May Concern,

Attached is Hemophilia Federation of America's comment letter regarding Tennessee's 1115 Waiver. If you have any further questions please email Miriam Goldstein at m.goldstein@hemophiliafed.org.

Thanks,
Deema

Deema Tarazi, JD | Senior Policy Analyst | Hemophilia Federation of America
999 North Capitol Street NE, Suite 201 | Washington DC | 20002
DC Office: 202.675.6984 | Mobile: 248.227.6148
www.hemophiliafed.org

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long:

Hemophilia Federation of America (HFA) appreciates the opportunity to submit comments on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration."

HFA is a national non-profit organization that represent individuals with bleeding disorders across the United States. Our mission is to ensure that individuals affected by hemophilia and other inherited bleeding disorders have timely access to quality medical care, therapies, and services, regardless of financial circumstances or place of residence.

HFA believes everyone, including TennCare enrollees, should have access to quality and affordable health coverage. Unfortunately, this waiver creates new administrative barriers that will jeopardize patients' access to quality and affordable health coverage, and HFA therefore opposes the proposed waiver.

The Tennessee Amendment 38 seeks to add a work and community engagement requirement for most TennCare enrollees. This would increase the administrative burden on all TennCare patients. Individuals will need to either report that they meet certain exemptions or the number of hours they have worked. Increasing administrative requirements will likely decrease the number of individuals with TennCare 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 October 1, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[i] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[ii] 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.[iii] 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 two months out of a six-month period, they will be locked out of coverage until they demonstrate their compliance. 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.

HFA is 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, Tennessee's "good cause" exemption 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.[iv] 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 Tennessee. States such as Michigan, Pennsylvania, Kentucky 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.[v] Tennessee's fiscal impact statement estimated the program would cost approximately the state and federal government $39.8 million over the course of the waiver.[vi] 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. Most people on Medicaid who can work already do so.[vii] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[viii] 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 a 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).[ix] Terminating individuals' TennCare coverage for non-compliance with these requirements will therefore hurt rather than help people search for and obtain employment. Tennessee has experience with this. In 2005, when the state changed the TennCare program's eligibility and 170,000 people lost Medicaid coverage, there was no increase in employment and self-reported health and access to medical care declined.[x] HFA opposes the work and community engagement.

HFA also wishes to highlight that 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. However, on pages 5 of this proposal, the Department states that "*Some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, it is not possible to reliably project the magnitude of this decrease in enrollment at this time*." We urge the TennCare to update the waiver amendment with the estimated expenditure and estimate enrollment change and reopen the state comment period for an additional 30-days.

HFA believes healthcare should affordable, accessible, and adequate. Tennessee's Amendment 38 does not meet that standard. Thank you for the opportunity to provide comments.

Sincerely,

Associate Director, Policy
Hemophilia Federation of America

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[iv] 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/.

[v] 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.

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[x] DeLeire, Thomas. The National Bureau of Economic Research. NBER Working Paper No. 24899: The Effect of Disenrollment from Medicaid on Employment, Insurance Coverage, Health and Health Care Utilization. August 2018. Accessed at: https://www.nber.org/papers/w24899

Jonathan Reeve

From: jshrago@comcast.net
Sent: Friday, October 26, 2018 2:41 PM
To: Public Notice. Tenncare
Subject: Comments on TennCare Waiver Amendment 38
Attachments: TennCare WorkWavierProposal_10-7-2018.pdf

Attached are my comments opposing the TennCare Amendment 38.

I am also inserting them below in this email.

Dr. Wendy Long
Division of TennCare
via email to: public.notice.tenncare@tn.gov

RE: TennCare Waiver Amendment 38

I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38

I am submitting the following comments to The TennCare Work Waiver Proposal. My experience with many TennCare recipients indicates that the proposal is unworkable and unfair to thousands of Tennesseans who actually qualify for TennCare and for very serious reasons are not working. I am opposed to this proposal in all aspects as it would take healthcare away from adults who very much need it to support their families.

My Background and experience: I work consistently with about 1000 people per year enrolling new families each year who are eligible for TennCare or the Affordable Care Act. While some return to me for assistance each year, about 75% are new each year. TennCare does not provide any staff at the State who can help a family complete the application. Instead, families must either depend entirely on a phone call to the Federal Marketplace to complete an application designed for the Affordable Care Act or depend on a volunteer, such as me, to assist them. While other states allow the Federal Marketplace as an *option* to apply, TN is the only state that uses the Federal marketplace as its **sole** portal to apply for Medicaid. TN's approach, relying on the Federal Marketplace requires (a) some considerable computer skill, (b) regular use of an email and most importantly (c) a minimum of 6 hours of training and an ability to project total annual income for the current year. This income projection is often quite a challenge with employer-defined variable hours by week, no available printed pay stubs (as corporations rely most often on electronic portals). I know from experience that such people require a 15 to 30-minute dialogue to accurately calculate and report their income. The online Marketplace often just takes the hourly wage, and then assumes a 40 hour week and 52 weeks a year for the annual income. This dramatically overstate ACTUAL income. Annual amounts with variations by week, by season, variable overtime, and by changes in employers must be calculated with much more detail to get an accurate picture. And those who are self-employed, typically do the calculations annually at tax time.

Problem with proposal: considerable difficulty, even when working to accurately report income, hours, employer and prove monthly working requirement.

Rationale: These TennCare recipients are the same ones who meet with a great challenge to accurately complete the TennCare Renewal or Redetermination package or apply through the Federal Marketplace. Similar to developing an electronic system to allow people to apply directly for TennCare, It will be a great challenge for the State of TN to create an electronic system to capture the data to prove work and income every month that a parent is working. In addition, the State is requesting people who don't usually use the internet except some occasional use on their phones. Flip phones are impossible to use for such applications. Smart phones require downloading applications, logging in and highly sophisticated software to work easily for users whose math skills are often at a 6th grade level. Precisely BECAUSE TennCare recipients are working and caring for children and making household ends meet on such limited income, their time to accomplish these infrequent tasks can easily be forgotten, frustrating and inaccurate. The greater the variability in work hours, the greater likelihood of mis-stating hours, wages and accurately reporting. The likely outcome is many people losing coverage, even though they are working and are actually ELIGIBLE. This increases the likely use of the emergency room as the most expensive and the only option to get care for children or the adult become sick. This does not benefit the health of the children and teaches people to avoid the use of primary care to solve health issues.

Problem with proposal: too few jobs with enough income occur during school hours.

Rationale: A very high percentage of families on TennCare are single parent. These single parents are often struggling with elementary, middle school and high school students who need attention when the children are not in school. And yet, the jobs do not occur during school hours, and often extend into the evening or night. How can such single parents be responsible for their children, above age 6 to 18 when TennCare is expecting them to work after-school hours? This does not benefit the health and appropriate development of the children nor the health of the single parent providing for the family.

Problem with proposal: A second caretaker often has health problems. This is often the reason they have child-caretaker responsibility rather than working outside the home.

Rationale: The premise of this proposed waiver is that the caretakers of children over 6 years of age and 19 who not working are not healthy because they are not working. While there is certainly a relationship between health and work, the reason for *not working often begins with health problems, not the* ***result of health problems****. Health problems are often the reason a second family member* takes on a child caretaker role in the family. It is my experience that families who seek health insurance through TennCare or through the Affordable Care Act, definitely WANT TO EARN MORE INCOME FOR THEIR FAMILIES. If they can find work they can successfully do while also caring for their families, they take the work. Often the physical labor that they have done for years becomes impossible because of the health issues. The prior work typically causes physical ailments making the work impossible. They can't stand all day, they can't do housekeeping kinds of jobs all day. They have not been in school for 30 years so learning new skills, new jobs is an overwhelming challenge. They do not have experience with computers, they do not type. They often can no longer do warehouse work, restaurant work, basic health worker jobs, administrative jobs. But they can help a single parent who *is working by* assuring that school-age children are cared for after-school hours. Removing these people from TennCare services does not promote the health of the family, it often increases the challenges of the working single parent and does not promote the healthy development of the children.

Problem with proposal: medically frail or acute medical condition assumes the person had medical care when this situation began but this is often not the case in TN with hundreds of thousands of people ineligible for health insurance.

Rationale: the proposal excludes those who are medically frail or have an acute medical condition. However, often these are people who *were working before becoming medically frail. They had no employer-based insurance or regular health care* because their job didn't offer insurance. They did not meet the minimum 100% poverty level to obtain Affordable Care Act insurance ($12,100 for a single adult, $16,000 for a couple). Or, they may have had employer-based insurance, but now because they are unable to work they don't have income. How do they provide proof of a medical condition? Do they wait to go to the emergency room and incur emergency TennCare costs? This is a catch-22, it certainly doesn't promote the health of recipients and likely increases TennCare costs using the emergency room. With hundreds of thousands of single adults (whose children are often grown and now with children of their own) in the uninsured category in TN, we have increased the likelihood of medically frail and acute medical conditions. These folks rely on families for help, but they can often give help to their grown children with the care-taker role of school-age children.
It is for the reasons, stated above, that I believe this proposal is flawed and not workable for Tennessee.

Respectfully submitted by:
Jacqueline B. Shrago
jshrago@comcast.net
3604 Woodmont Blvd
Nashville, TN 37215

Dr. Wendy Long
Division of TennCare
via email to: public.notice.tenncare@tn.gov

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Rationale: The premise of this proposed waiver is that the caretakers of children over 6 years of age and 19 who not working are not healthy because they are not working. While there is certainly a relationship between health and work, the reason for *not working often begins with health problems, not the* ***result of health problems****. Health problems are often the reason a second family member* takes on a child caretaker role in the family. It is my experience that families who seek health insurance through TennCare or through the Affordable Care Act, definitely WANT TO EARN MORE INCOME FOR THEIR FAMILIES. If they can find work they can successfully do while also caring for their families, they take the work. Often the physical labor that they have done for years becomes impossible because of the health issues. The prior work typically causes physical ailments making the work impossible. They can't stand all day, they can't do housekeeping kinds of jobs all day. They have not been in school for 30 years so learning new skills, new jobs is an overwhelming challenge. They do not have experience with computers, they do not type. They often can no longer do warehouse work, restaurant work, basic health worker jobs, administrative jobs. But they can help a single parent who *is working by* assuring that school-age children are cared for after-school hours. Removing these people from TennCare services does not promote the health of the family, it often increases the challenges of the working single parent and does not promote the healthy development of the children.

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It is for the reasons, stated above, that I believe this proposal is flawed and not workable for Tennessee.

Respectfully submitted by:

Jacqueline B. Shrago
jshrago@comcast.net
3604 Woodmont Blvd
Nashville, TN 37215

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of Jacy.warrell@gmail.com
Sent: Thursday, October 11, 2018 1:21 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer.

I am concerned that children who are aging out of the foster care system are not going to have health coverage. Teens in the foster care system have a number of physical, social, and emotional issues and have do not have the benefit of being covered the same as other teens and young adults.

Transitioning out of foster care is a difficult thing to do. Through no fault of their own these youth have been placed in positions of having to learn to navigate the world on their own. The state has been responsible for their care and then to be abruptly cut off will be detrimental to their health.

Please do not leave these kids without protections.

Respectfully,

Jacy Warrell
3018 Argyle ave
Murfreesboro, TN 37127-8330

Jonathan Reeve

From: Powers, James <james.powers@vumc.org>
Sent: Monday, October 01, 2018 5:17 PM
To: Public Notice. Tenncare
Subject: TennCare Work Requirement

To the TennCare Bureau:
I write as a physician expressing great concern over TennCare's seeking to seek a waiver to impose work requirements on TennCare recipients. The proposed waiver does not adequately define the criteria for or good cause for exemption. It does not define how caregivers for infirm individuals will be treated and what criteria for disability will be permitted for exemption.

While the goal of assisting low income families to become healthy and self-sufficient is laudable, imposing arbitrary work requirements on low income parents and caregivers may jeopardize their healthcare access. Punishing people who are unable to find a steady living wage job or lose a seasonal job by taking away their access to medical care, mental health care, and medications will only jeopardize their long-term health and their ability to provide for their families.

TennCare estimates over 22,000 parents and caregivers could lose their TennCare coverage as result of imposing work requirements. This creates a barrier to healthcare for these individuals. The number of illiterate and non-computer savvy individuals is large making the individual reporting process inequitable. The cost of monitoring TennCare recipients regarding work requirements is enormous, and the Bureau does not have the electronic capability to accurately process eligibility.

Sincerely,
James S Powers M.D.
714 Darrow Dr.
Pleasant View, TN 37146
615-746-8916

Jonathan Reeve

From: Stan & Jennie <beantree2@charter.net>
Sent: Friday, October 26, 2018 4:19 PM
To: Public Notice. Tenncare
Subject: TennCare work requirements comment

Please register my opposition to work requirements for TennCare. There are already qualifications in place to filter out unworthy recipients. I believe this effort to be just one more means to take away a very important safety net program in our state, based on ideology not reality. Thank you for your consideration. Jennie Young, 1393 Broad Street, Elizabethton, TN 37643

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of jjecht@gmail.com
Sent: Friday, October 19, 2018 1:40 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Jim Echt
NAMI member
5480 N Angela Rd
Memphis, TN 38120

Public Hearing of October 8, 2018 *Name (optional)* Joel Alex

AMENDMENT 38 TO THE TENNCARE DEMONSTRATION

Comments:

There is NO evidence to suggest this Amendment will improve health of low-income TN. IF are wanted to support work in TennCare enrollees, why not use or work and expand a program like Family Focused Solutions.

- They work w/ TANF.

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of trainisloud@gmail.com
Sent: Monday, October 22, 2018 3:30 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

What I am most concerned about is most of the people that will lose TennCare will be eligible for TennCare. The people who get exemptions will likely lose coverage, much like the 100s (probably 1000s) of children that have lost coverage due to the your unnecessarily complicated and lengthy Recertification packets. I personally know families that have lost coverage because they were never sent a redetermination packet or didn't "fill it out" correctly.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Joel Alex
Community Member
4502 Old Hickory Blvd
Nashville, TN 37218

Jonathan Reeve

From: Graves, John A <john.graves@Vanderbilt.Edu>
Sent: Friday, October 26, 2018 4:46 PM
To: Public Notice. Tenncare
Subject: Comment on TennCare Work Requirement Waiver

October 26, 2018

Dr. Wendy Long
Director Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Dr. Long,

Thank you for the opportunity to comment on TennCare's proposed waiver amendment for work and community engagement requirements (Amendment 38). While I recognize that TennCare's approach to work requirements for its members are less onerous than other states' efforts and ultimately work to aid members in reaching improved health outcomes and independence from public assistance, I believe there are points that can be made clear for TennCare to successfully implement Amendment 38. I believe that addressing issues of pre-communication and methods of reporting are of importance in going forward.

Pre-Communication
The published notice of change in TennCare II Demonstration lists methods of public notice for recipients to become aware of the amendment (e.g. TennCare webpage, notices in widely circulate newspapers, TennCare's social media accounts, etc.). Additional actions should be taken to ensure that those who need to fulfill work requirements receive notice of their new responsibility, since they may not see the updates on the TennCare webpage or social media due to lack of access to home broadband connections. In January 2018, only 45% of US adults with less than $30,000 incomes were home broadband users.[i] 31% of those that didn't use broadband at home, but owned smartphones. Physical letters should also be sent to registered addresses of TennCare recipients, while also taking into consideration that some recipients may not have fixed addresses and may not be able to receive it.

Methods of Reporting
For Amendment 38 to be successful, affected enrollees must have a reliable, easy-to-access method to report their participation. This was an important takeaway from initial results of Arkansas' Medicaid work requirements, where as of October 8th, an additional 4,109 Arkansans were removed from its Medicaid rolls.[ii] In a state where 21-31% of enrollees reported having no access to internet in their household, limiting reporting to an online portal, while streamlining the administrative process, did not fare well overall. Tennessee should take these results into consideration seeing as the state had 70% of household with broadband internet subscription, just a few more points than Arkansas (64%) and below the US national average.[iii]

I look forward to continued discussion with the Division of TennCare on this matter.

Sincerely,

John A. Graves, Ph.D.
Associate Professor
Department of Health Policy
Vanderbilt University School of Medicine
john.graves@vanderbilt.edu

[i] Internet/Broadband Fact Sheet. *Pew Research Center*. Feb 5, 2018. Retrieved from http://www.pewinternet.org/fact-sheet/internet-broadband/.

[ii] Goldberg D. Arkansas removes another 4,000 from Medicaid rolls. *Politico Pro.* Oct 15, 2018. Retrieved from https://subscriber.politicopro.com/health-care/whiteboard/2018/10/arkansas-removes-another-4-000-from-medicaid-rolls-2069183.

[iii] Ryan C, Lewis JM. Computer and Internet Use in the United States: 2015. *American Community Survey Reports*. Sept 2017. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-37.pdf.

Jonathan Reeve

From: Jon Wolfe <jonwolfe123@yahoo.com>
Sent: Friday, October 26, 2018 5:41 PM
To: Public Notice. Tenncare
Subject: TNCare Work Requirement

Dear Sir/Ma'm
The proposal to take away health coverage from people who don't work a set number of hours per month is not fair for those with debilitating illnesses.

Imagine that you have cancer, undergoing chemo, feeling weak and sick as a dog and you have to sweep the courthouse steps to get your TNCare payment.

This is not humane. Please stop this action. I have a friend who recently passed and she was suffering terribly and TNCare helped her get by and care for her children as best she could.

To make her work while sick is not humane.

Thank you for reading this.
SIncerely,

Jon Wolfe
2721 Druid Dr.
Nashville 37210

Jonathan Reeve

From: Joseph Coco <josephcoco@protonmail.ch>
Sent: Sunday, October 07, 2018 10:51 PM
To: Public Notice. Tenncare
Subject: Amendment 38 concerns

How does TennCare plan to track work and how much would this cost in administrative fees to monitor work activity of the current Medicaid recipients?

Is Tennessee currently lacking in community participation, and if so, how much value will having additional workers bring to Tennessee?

Joseph Coco
Vanderbilt University Medical Center

225-892-5041

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of Kathy Eckhardt <mailagent@thesoftedge.com>
Sent: Sunday, October 07, 2018 11:38 AM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Kathy Eckhardt
220 Meadow Rd
Friendsville, TN 37737

Jonathan Reeve

From: katy blasingame <katyb88@hotmail.com>
Sent: Thursday, October 25, 2018 10:20 PM
To: Public Notice. Tenncare; katy blasingame
Subject: I oppose TennCare Work Requirements

Dear Dr. Long,

I strongly oppose the implementation of TennCare work requirements because they would be particularly harmful to some of Tennessee's most vulnerable citizens: those with behavioral health disorders.

Tennessean's eligible for TennCare are disproportionately affected by mental health issues and this proposal puts families at risk of losing mental health care.

When parents lose health care, children get hurt. TennCare improves access to needed care, improves parents' mental health outcomes, and strengthens families' financial security; taking away would do the reverse.

The loss of TennCare coverage will increase health care system costs and contribute to poor mental health, including premature mortality and increased mental health morbidity.

The bottom line: There is no evidence that this requirement will improve health outcomes. This proposal is penny wise pound foolish. It is fundamentally flawed and cannot be fixed. It goes against the goals and purpose of the Medicaid program. I respectfully urge you to not go forward with this detrimental proposal.

Thank you for the work you have done to provide quality care to low-income Tennesseans with behavioral health conditions. Please don't stop that work now.

Sincerely,

Katy Blasingame
Nashville, TN 37211

Jonathan Reeve

From: Kay Grossberg <ksayhey@comcast.net>
Sent: Tuesday, October 09, 2018 4:46 PM
To: Public Notice. Tenncare
Subject: TennCare Waiver Amendment 38

RE: TennCare Waiver Amendment 38

Dear Dr. Wendy Long:

As a Tennessean I am writing to oppose proposed Waiver Amendment 38. I am concerned this amendment will complicate TennCare and hurt Tennesseans who are on TennCare. Here are some unanswered questions or unclear parts of

the amendment:

What are the costs of all the added paperwork?

What happens if a person who has Tenncare and fails to get coverage because of the amendment needs treatment? Just go without treatment? Go to the emergency room?

What are waivers and exceptions? This does not seem clear.

What are other states doing to protect their poor and working poor who need healthcare? There must be better solutions.

I would like to see Tennessee simplify the healthcare system for Tenncare, not complicate it.

Sincerely,

Kay Grossberg

Robertson County
ksayhey@comcast.net

Jonathan Reeve

From: Kay Norman <kay.norman@comcast.net>
Sent: Friday, October 26, 2018 2:54 PM
To: Public Notice. Tenncare
Subject: TennCare Waiver Amendment 38

I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38. I am unequivocally opposed to this proposal because it will take health care away from people who do not work a set number of hours per week. Most people of TennCare already work if they are physically able, so this plan attempts to solve a non-existing problem. Instead it will create real problems by depriving people of health care, thereby making it harder for them to work.

Seeking exemptions to a work requirement will impose red tape and administrative burdens on families, the state, and employers which will result in people who eligible for exemptions being unable to get them.
Plus even among those who meet work requirements, this red tape will result in many losing coverage because of lack of proper reporting.

This waiver is fundamentally flawed and cannot be fixed. It is an example of an unnecessary set of rules which make the situation far worse that it was and goes against the goals and purpose of the Medicaid program. I urge you to stop this harmful proposal.

Kay Norman

5958 Manchester Pike

Murfreesboro, TN 37127

Jonathan Reeve

From: Kelly McCurry <kdmccurry@gmail.com>
Sent: Friday, October 26, 2018 8:56 AM
To: Public Notice. Tenncare

Dear Dr. Wendy Long,

My name is Kelly McCurry. I've lived in Mt. Juliet, TN, for over 16 years. I have a child in the public school system, attend a community-minded local church with my family, and have been involved with a local food pantry for over ten years. **I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38.**

I am unequivocally opposed to this proposal that would take health coverage away from people who do not work a set number of hours per month. This proposal would cause immense harm and jeopardize coverage for thousands of Tennesseans. Failure to meet reporting requirements and paperwork errors will result in suspension of coverage for thousands of Tennesseans. People will lose coverage even though they remain eligible due to TennCare's lack of computer system, because of the online portal's problems, and because many can't comply with the complex reporting requirements, among others. There are real life barriers to working such as lack of reliable transportation and child care, and the very real fact that many are caregivers to children with disabilities and/or elderly parents and can't afford the care it would require for them to have a job. There are also barriers to reporting, using Arkansas as an example.

These coverage losses WILL cause harm. The disruption of treatment or loss of access to health care would affect Tennesseans experiencing a range of health crises and problems, including cancer patients, people with addiction, people suffering with diabetes, etc.

There are too many unanswered questions to move forward with the work requirements at this time:
• How do people report compliance?
• How can TennCare administer this complex eligibility determination without an eligibility determination computer system, which is not yet complete?
• How will the reporting process accommodate people with disabilities, limited literacy or language?
• What is "good cause" for waiving compliance by certain individuals?
• What criteria will be used to exempt "economically distressed" counties?

This waiver is fundamentally flawed and cannot be fixed. It goes against the goals and purpose of the Medicaid program. We respectfully urge you to not go forward with this harmful proposal.

Sincerely,

Kelly McCurry
Concerned Tennessean

Jonathan Reeve

From: Kimberly Schofinski <schofinski@gmail.com>
Sent: Friday, October 05, 2018 10:03 AM
To: Public Notice. Tenncare
Subject: Work requirement public comment

Hello,

I am writing to share my comments about the looming work requirement for TennCare recipients. I understand that public comments must be technical in nature to affect the outcome of the plan, if at all.

According to legislative estimates, compliance is expected to cost $38 million - far more money than this change would save the government. This would be a financially wasteful endeavor.

Evidence from other state programs shows that work requirements do not work. The Center on Budget and Policy Priorities published in February 2018 a report that found work requirements instituted in Kansas did not positively impact a recipient's situation in regards to poverty.

Lastly, this policy is in conflict with American and Tennessee values. We should support one another, not punish those who are in poverty, many of which are children who cannot provide for themselves.

Please take these comments into consideration.

Thank you,
Kim Schofinski
Davidson Co. resident

Jonathan Reeve

From: D Moore <dmoore@komencentraltennessee.org>
Sent: Friday, October 26, 2018 11:27 AM
To: Public Notice. Tenncare
Subject: TennCare Amendment 38
Attachments: Comments ReTennCare Amendment 38.pdf

Good morning,

The Susan G. Komen Central Tennessee affiliate was recently informed of the intent to file an amendment to the TennCare II Demonstration. A letter addressing our concerns is attached.

Thank you for your time!

Daveisha Moore, MPH
Mission/Education Director
Susan G. Komen Central Tennessee Affiliate
P: 615-383-0017 | F: 615-383-0067
4009 Hillsboro Pike, Suite 209 | Nashville, TN 37215
www.komencentraltennessee.org
dmoore@komencentraltennessee.org
Facebook / Twitter / Instagram

Click here to register today for Race for the Cure® - Greater Nashville (Brentwood), Chattanooga, or Cookeville!

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long:

Thank you for the opportunity to submit comments on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration."

Susan G. Komen (Komen), is the world's largest breast cancer organization, funding more breast cancer research than any other nonprofit outside of the federal government while providing real-time help to those facing the disease. Since its founding in 1982, Komen has funded more than $988 million in research and provided more than $2.2 billion in funding to screening, education, treatment and psychosocial support programs serving millions of people in more than 30 countries worldwide. Locally, through events like Race for the Cure®, Komen Central Tennessee has invested $9,825,542 in our communities' breast health programs.

Komen believes everyone should have access to high-quality, affordable health care. Unfortunately, if approved, this waiver would adversely affect breast cancer patients' access to adequate and affordable, high-quality health care by requiring certain individuals to either prove they work an average of 20 hours per week or meet exemptions. This vulnerable population cannot afford additional barriers to care.

According to the state's own projections, approximately 3,700 individuals will lose coverage. Additionally, if rural counties are designated as "economically disadvantaged", and provided exemptions, a disparate impact of the waiver will fall on the African-American beneficiaries in the urban counties.

A major consequence of the waiver will be increased administrative burden for all beneficiaries. This will be especially true for women going through breast cancer treatment, as they will likely experience difficulty complying with the required 20 hours per week- ultimately creating additional barriers- eventually leading to increased costs for treating late-stage breast cancer.

4009 Hillsboro Pike, Suite 209, Nashville, Tennessee 37215 | 615-383-0017 Helpline 1-877 GO KOMEN
Serving the Greater Nashville, Upper Cumberland, Chattanooga and North Georgia regions.
www.komencentraltennessee.org | Be #MoreThanPink

Failing to navigate these burdensome requirements will have grave consequences for women with breast cancer and people with serious, chronic illnesses. Individuals will be required to comply with the new requirements for four months out of a six-month period. If an individual fails to comply, they will be locked out of coverage until they are able to demonstrate compliance. Women in the middle of breast cancer treatment simply cannot afford a sudden gap in their treatment regimens or a delay in required visits with their health care providers.

We believe the waiver will have a negative effect for individuals in Tennessee as many of the state's most fragile citizens will become ineligible for coverage, face the very real reality of foregoing treatment or facing devastating medical debt.

We urge the administration to keep in mind the needs of breast cancer patients and others with serious illnesses. The breast cancer patients we represent rely on access to health care coverage to fight their disease, and the proposed waiver will undermine such access. We strongly urge the Administration to reject this waiver.

Thank you for the opportunity to comment. We are happy to serve as a resource in any capacity. Please contact Rebecca Birch, Senior Advisor of State Policy & Advocacy at rbirch@komen.org with any questions.

Sincerely,

Daveisha Moore

Daveisha Moore, MPH
Mission/Education Director
Susan G. Komen Central Tennessee

Jonathan Reeve

From: Jessica Waddell <jwaddell@komeneasttn.org>
Sent: Thursday, October 25, 2018 10:41 AM
To: Public Notice. Tenncare
Subject: Comments on TennCare Amendment 38
Attachments: Comments ReTennCare Amendment 38.docx

Hello,

Please see attached for our comments on the proposed amendment.

Jessica M. Waddell

Director of Community Programs
jwaddell@komeneasttn.org

Knoxville Office:
P: 865-588-0902 | F: 865-588-0921
318 Nancy Lynn Lane #13 | Knoxville, TN 37919

Tri-Cities Office:
P: 423-765-9313 F: 423-765-9314
301 Louis St. #304 | Kingsport, TN 37660
www.komeneasttennessee.org | 1-877 GO KOMEN
Socialize w/us: **Facebook** | **Twitter** | **Instagram**
Our goal: Reduce current number of breast cancer deaths by 50% by 2026.

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long:

Thank you for the opportunity to submit comments on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration."

Susan G. Komen (Komen), is the world's largest breast cancer organization, funding more breast cancer research than any other nonprofit outside of the federal government while providing real-time help to those facing the disease. Since its founding in 1982, Komen has funded more than $988 million in research and provided more than $2.2 billion in funding to screening, education, treatment and psychosocial support programs serving millions of people in more than 30 countries worldwide. Komen East Tennessee is working to better the lives of those facing breast cancer in the local community. Through events like the Knoxville Race for the Cure®, Komen East Tennessee has invested over $10.3 million in community breast health programs in 24 East Tennessee counties and has helped contribute to the more the $988 million invested globally in research.

Komen believes everyone should have access to high-quality, affordable health care. Unfortunately, if approved, this waiver would adversely affect breast cancer patients' access to adequate and affordable, high-quality health care by requiring certain individuals to either prove they work an average of 20 hours per week or meet exemptions. This vulnerable population cannot afford additional barriers to care.

According to the state's own projections, approximately 3,700 individuals will lose coverage. Additionally, if rural counties are designated as "economically disadvantaged", and provided exemptions, a disparate impact of the waiver will fall on the African-American beneficiaries in the urban counties.

A major consequence of the waiver will be increased administrative burden for all beneficiaries. This will be especially true for women going through breast cancer treatment, as they will likely experience difficulty complying with the required 20 hours per week- ultimately creating additional barriers- eventually leading to increased costs for treating late-stage breast cancer.

Failing to navigate these burdensome requirements will have grave consequences for women with breast cancer and people with serious, chronic illnesses. Individuals will be required to comply with the new requirements for four months out of a six-month period. If an individual fails to comply, they will be locked out of coverage until they are able to demonstrate

compliance. Women in the middle of breast cancer treatment simply cannot afford a sudden gap in their treatment regimens or a delay in required visits with their health care providers.

We believe the waiver will have a negative effect for individuals in Tennessee as many of the state's most fragile citizens will become ineligible for coverage, face the very real reality of foregoing treatment or facing devastating medical debt.

We urge the administration to keep in mind the needs of breast cancer patients and others with serious illnesses. The breast cancer patients we represent rely on access to health care coverage to fight their disease, and the proposed waiver will undermine such access. We strongly urge the Administration to reject this waiver.

Thank you for the opportunity to comment. We are happy to serve as a resource in any capacity. Please contact Jessica Waddell, Director of Community Programs at jwaddell@komeneasttn.org with any questions.

Sincerely,
Jessica Waddell
Director of Community Programs
Susan G. Komen East Tennessee
Ph: 865-588-0902
jwaddell@komeneasttn.org

Jonathan Reeve

From: Mischke, Lisa <lmischke@komenmemphisms.org>
Sent: Friday, October 26, 2018 9:27 AM
To: Public Notice. Tenncare
Subject: Amendment 38
Attachments: Amendment 38.docx

Please find our comments attached,

Thank you,

Elaine Hare, CEO and Lisa Mischke, LMSW, Grant Director
Susan G. Komen Memphis-MidSouth Mississippi
6645 Poplar Ave., Suite 211
Germantown, TN 38138
Office/cell: (901) 233-7290

www.komenmemphisms.org

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long:

Thank you for the opportunity to submit comments on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration."

Susan G. Komen (Komen), is the world's largest breast cancer organization, funding more breast cancer research than any other nonprofit outside of the federal government while providing real-time help to those facing the disease. Since its founding in 1982, Komen has funded more than $988 million in research and provided more than $2.2 billion in funding to screening, education, treatment and psychosocial support programs serving millions of people in more than 30 countries worldwide.

Komen believes everyone should have access to high-quality, affordable health care. Unfortunately, if approved, this waiver would adversely affect breast cancer patients' access to adequate and affordable, high-quality health care by requiring certain individuals to either prove they work an average of 20 hours per week or meet exemptions. This vulnerable population cannot afford additional barriers to care.

According to the state's own projections, approximately 3,700 individuals will lose coverage. Additionally, if rural counties are designated as "economically disadvantaged", and provided exemptions, a disparate impact of the waiver will fall on the African-American beneficiaries in the urban counties.

A major consequence of the waiver will be increased administrative burden for all beneficiaries. This will be especially true for women going through breast cancer treatment, as they will likely experience difficulty complying with the required 20 hours per week- ultimately creating additional barriers- eventually leading to increased costs for treating late-stage breast cancer.

Failing to navigate these burdensome requirements will have grave consequences for women with breast cancer and people with serious, chronic illnesses. Individuals will be required to comply with the new requirements for four months out of a six-month period. If an individual fails to comply, they will be locked out of coverage until they are able to demonstrate compliance. Women in the middle of breast cancer treatment simply cannot afford a sudden gap in their treatment regimens or a delay in required visits with their health care providers.

We believe the waiver will have a negative effect for individuals in Tennessee as many of the state's most fragile citizens will become ineligible for coverage, face the very real reality of foregoing treatment or facing devastating medical debt.

We urge the administration to keep in mind the needs of breast cancer patients and others with serious illnesses. The breast cancer patients we represent rely on access to health care coverage to fight their disease, and the proposed waiver will undermine such access. We strongly urge the Administration to reject this waiver.

Thank you for the opportunity to comment. We are happy to serve as a resource in any capacity. Please contact **Rebecca Birch,** Sr. Advisor, State Policy & Advocacy, 972-701-2037, 5005 LBJ Freeway, Suite 526 |Washington, DC 20036 with any questions.

Sincerely,

Elaine Hare, CEO

Lisa Mischke, Grant Director

Susan G. Komen Memphis-MidSouth Mississippi
P: 901.757.8686 | F: 901.757.8372 | C: 901-826-2530
6645 Poplar Ave., Ste. 211 | Germantown, TN 38138

Jonathan Reeve

From: Kristen Dinger <kristen.dinger@gmail.com>
Sent: Tuesday, October 16, 2018 9:25 PM
To: Public Notice. Tenncare
Subject: TennCare Waiver Amendment 38

RE: TennCare Waiver Amendment 38

Dear Dr. Long,

I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38. I work in the health field in collaboration with multiple nonprofit clinics and providers that serve patients who qualify for TennCare.

I am opposed to this proposal that would take health coverage away from people who do not work a set number of hours per month. This proposal would cause immense harm and jeopardize coverage for thousands of Tennesseans.

- ***Failure to meet reporting requirements and paperwork errors will result in suspension of coverage for thousands of Tennesseans.***
- ***Our state does not have an online eligibility determination system and adding another layer of continuous eligibility monitoring will ultimately result in many losing coverage who are eligible. We have already seen coverage losses like this in Arkansas.***

There are many unanswered questions in the proposal. It is unclear in this proposal how people will report compliance; how TennCare will administer this complex eligibility determination without an eligibility determination computer system; how will the reporting process accommodate people with disabilities, limited literacy or language; and what criteria will be used to exempt "economically distressed" counties.

This waiver is fundamentally flawed and cannot be fixed. It goes against the goals and purpose of the Medicaid program. We respectfully urge you to not go forward with this harmful proposal.

Sincerely,

Kristen Keely-Dinger, LAPSW

Jonathan Reeve

From: Kristen Stewart <kstewart@gmail.com>
Sent: Monday, October 08, 2018 2:06 PM
To: Public Notice. Tenncare
Subject: Amendment 38

Dear Dr. Long,

As a taxpayer in Tennessee, I am very concerned about the proposed changes to TennCare. It seems likely that people who are trying to comply will have trouble reporting their work or other qualified activities due to lack of access to the internet or shifting work schedules. It is one more burden placed on individuals who already have their fair share of difficulties.

Most Tennesseans want to work, or pursue education that makes them more attractive to the work force. I am not sure that taking TennCare away is the right motivator for the small minority who do not. If benefits are suspended, we, as taxpayers, will bear the burden of emergency medical care regardless. Without access to preventative care, this effort could end up costing taxpayers more than if we simply covered people in the first place.

If this policy must be enforced, how can it be enforced in ways that show Tennesseans the greatest dignity and compassion?

With respect,

Kristen Stewart
3909 Cambridge Avenue
Nashville, TN 37205

Jonathan Reeve

From: marian.t.ott@gmail.com
Sent: Wednesday, October 24, 2018 12:06 PM
To: Public Notice. Tenncare
Subject: League of Women Voters comments on Amendment 38 Work Rule Requirements
Attachments: League of Women Voters' comments on Amendment 38 work rule requirements.pdf

Please find below and attached comments from the League of Women Voters of Tennessee on the proposed work rule requirements.

LWV LEAGUE OF WOMEN VOTERS® OF TENNESSEE

Thank you for this opportunity to comment on TennCare Waiver Amendment 38, which is the Bureau of TennCare's effort to respond to legislation passed by the Tennessee General Assembly mandating the imposition of work requirements on the current, non-expansion Medicaid eligible population in Tennessee. Achieving universal access to health care in our nation has been and continues to be a priority for the League of Women Voters nationally and the League of Women Voters Tennessee (LWV TN) for over three decades.

Medicaid as enacted in 1965 and amended over the years was intended to promote the health and well-being of low-income persons with disabilities, parents with dependent children under 19, pregnant women, and seniors needing long-term care. The Patient Protection and Affordable Care Act of 2010 enabled states to expand Medicaid Coverage to low-income, able-bodied adults without dependents under 19. To date, 31 states have enacted expansion programs. Although Tennessee's Governor proposed an innovative program to enable coverage expansion, the General Assembly has consistently refused to fully debate and vote on it. However, the General Assembly moved quickly to require our state's Medicaid program, TennCare, to figure out a way to implement the work requirements enabled by the CMS Guidance SMD: 18-002 in January 2018 on *Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries*. We feel it is important at the outset to distinguish that, in contrast to other work requirement proposals that CMS has considered and approved, TennCare's waiver request applies solely to the traditional Medicaid eligible population, not to an expansion population. The application of work requirements to traditional Medicaid-eligible populations is currently being challenged legally, and the LWVTN feels strongly that TennCare should wait for the outcome of those challenges before submitting this waiver request.

The LWVTN appreciates TennCare's efforts in Amendment 38 to extend options for exemptions to proposed work requirements beyond the language of the original state legislation which only excluded able-bodied working age adult enrollees with dependent children under the age of six. TennCare has also more broadly

defined community engagement activities to include participation in general education, vocational education and training, job skills training and job search activities, and community service in approved settings. In addition, TennCare has acknowledged the need for non-exempt recipients to have access to supportive services to enable them to maintain employment and health coverage although the amount needed to adequately sustain support services has neither been fully estimated nor secured. Funding of such supports is contingent on approval of excess but limited TANF funding for this purpose.

However, the LWVTN continues to have serious objections to the specifics of this waiver. The following comments specify and explain our major concerns:

1. Work requirements as proposed in Amendment 38 still have the potential to undermine the ability of many current TennCare recipients to maintain health and access to needed care, violating the intent of the Medicaid program and CMS Guidance SMD 18-002 RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries issued on January 11, 2018.

The current version of Amendment 38 extends the following exemptions to work and community engagement requirements:

a. one parent or caregiver per household with a child under age six
b. one parent or caregiver of a household member (child or adult) that has a disability or incapacitation that requires caregiver services
c. a person who is medically frail
d. a person who is 65 or older or under 19
e. a person who has a physical or mental condition that makes them incapable of work or would otherwise prevent them from complying
f. a person who is participating in an inpatient or residential treatment program for a substance use disorder
g. a person who has been recently impacted by a catastrophic event such as a natural disaster
h. a person receiving unemployment benefits
i. a person who has a pending application for SSI or SSDI
j. a woman who is pregnant
k. a person who is fulfilling the work requirements under TANF or SNAP

However, and significantly, there are additional vulnerable groups who need to be considered for exemption from these work requirements:

- **Parents or caregivers of a child over six or incapacitated adult for whom there are no affordable or accessible day or night care options available during the hours of work or community engagement available to that parent or caregiver, or who have no reliable options for transportation to or from work and engagement activities.** CMS Guidance SMD 18-002 specifically calls on states submitting waiver requests to align with other federally mandated programs: *"Based on states' experiences with their TANF or SNAP employment programs, they may wish to consider aligning Medicaid requirements with certain aspects of the TANF or SNAP programs, such as: Exempted populations (e.g., pregnant women, **primary caregivers of dependents**, individuals with disabilities or health-related barriers to employment, individuals participating in tribal work programs, **victims of domestic violence**, other populations with extenuating circumstances, full time students)"*(page 4)[1]. The Guidance goes on to also list alignment with *"The availability of work support programs (e.g. **transportation or child care**) for individuals subject to work and community engagement requirements"* and also notes *"**lack of viable transportation**"* (page 7) as a structural barrier that should be addressed[1] [emphasis in bold added].

Tennessee's TANF program, Families First, specifically recognizes that primary caregivers of dependents of any age need special supports including *"transportation and child care"* to enable them to access and maintain employment and provide those supports as part of TANF care coordination services[1], yet these supports are never specifically referenced in Amendment 38. The LWVTN believes that transportation and child or adult care supports need to be specifically incorporated in Amendment 38, both to align with Families First and to mitigate these recognized barriers to sustainable employment.

- **Victims of domestic violence and human trafficking, persons or families who are homeless.** Amendment 38 mentions that TennCare *"may grant a good cause exemption from the community engagement requirement based on a determination that there are acute or short-term individual circumstances that warrant special consideration"* and lists as examples "*persons experiencing homelessness, victims of domestic violence, victims of human trafficking,* etc." so it is clear TennCare recognizes the difficulty that these persons would have in meeting the 20 hour per week work and community engagement requirement and monthly reporting requirements without stable housing, reliable transportation, and dependable access to a computer, smart phone, internet. Recipients in these groups could also find it difficult to comply with an additional but as yet unspecified "good cause exemption" determination process. The LWVTN feels persons falling into these groups should be automatically exempted from work requirements until they have reestablished stable homes and support networks.

- **Persons being treated for substance use disorders in non-residential treatment programs.** Given the magnitude of the crisis of opioid addiction in Tennessee and the acknowledged deficit of residential treatment facilities it seems counter-productive to limit exemptions to those able to access residential treatment. Active treatment in many non-residential programs, particularly those offering medication-assisted therapy, requires daily check-in for medications and regular group and individual counseling sessions that are not always able to be scheduled around a normal work day. The LWVTN encourages TennCare to broaden the exemption related to substance use treatment for all recognized treatment modalities.

- **Recently incarcerated persons re-entering their family and community.** TennCare has reached out to other branches of state government in an effort to coordinate education and support services for recipients who will be subject to these work requirements. Recently incarcerated persons are another group that may need special supports as well, some of which can be provided by community-based re-entry programs. However, many employers are reluctant to hire persons with a criminal record, even after their debt to society is paid. A high percentage of incarcerated populations have mental health needs and many had previous substance abuse problems, so being able to maintain health care and health coverage is especially important to their physical, mental and emotional well-being. While previously incarcerated persons may not be a large proportion of TennCare members, the LWVTN encourages TennCare to address the needs of this population in Amendment 38.

- **Persons with certain mental health conditions may require supported employment opportunities** such as those provided to persons with intellectual and developmental disabilities through the TennCare's innovative Employment and Community First (ECF) CHOICES program. Additional supports that ECF programs provide include opportunities to try out different jobs, and ongoing job coaching once work has been identified. The LWVTN feels the needs of persons in this group also should be addressed in Amendment 38 and factored into the budget of this proposal.

2. **There remain significant questions about the adequacy of funding needed to fully support this program at a level that would prevent substantial number of households from losing their TennCare**

coverage. The success of this program in achieving CMS' stated goals of promoting "*better mental, physical and emotional health"* and helping *"individuals and families rise out of poverty and attain independence"* (page 1)[1] hinges in large part on the approval of and continued availability of sufficient TANF funding to enable the coordination of support services that TennCare recognizes are needed by non-exempt populations to sustain employment. The LWVTN continues to be deeply troubled by the lack of specificity in how many parents and caregivers will be subject to work requirement, how much funding will be needed to support those families, and how much funding is actually available. At this writing no other funds have been appropriated by the State of Tennessee to sustain this program.

A recent Policy Brief reviewing Tennessee's TANF program, Families First, by the non-partisan Sycamore Institute[2] indicates that even with fully funded and coordinated supports in place, in 2016 only 34% of the approximately 12,600 adults required to participate in Families First work program were able to fulfill the work requirements. Sixteen percent (16%) left the program because they failed to meet work requirements. Another 11% participated in work but were unable to achieve the total number of hours needed, which in TennCare's Amendment would result in suspension of health benefits. While TANF requires more weekly work hours than TennCare is proposing (30 hrs for TANF vs. 20 hrs for TennCare), given this experience it seems reasonable to expect that at between 15% to 30% of TennCare recipients enrolled in work or community engagement programs would have similar problems to TANF recipients and could be in jeopardy of losing their TennCare at some point in the program, which LWV TN finds unacceptable.

It also needs to be pointed out that Families First serves a total of 56,000 Tennesseans of which 12,600 were subject to work requirements while TennCare serves over 1.4 million Tennesseans[2]. In 2017, approximately 597,036 TennCare recipients are adults between the ages of 19-64[3]. While not all of these adults will be subject to work requirements, it is reasonable to expect that at least 10% (59,700) will be, which would mean that the remnants of the TANF budget which is the only approved source of funds to sustain work-related supports would have to be stretched over at least fourfold the number of participants in the Families First work program. These reserve funds are not limitless nor is it clear they are recurring. Without specific projections of numbers and costs it seems inevitable that needed individual and family supports would be jeopardized without significant additional appropriations.

TennCare's inability or reluctance to estimate the number of individuals who would be subject to Amendment 38 work requirement, or to project an adequate budget amount to sustain this program, or to estimate how many persons are at risk of losing their TennCare coverage, are serious flaws in this Amendment and do not meet the CMS Guidance tests of budget neutrality. The LWV TN feels strongly that until specifics are available, and it can be demonstrated that residual TANF funds are adequate to support TennCare families in finding and maintaining rewarding work, this Amendment should not be presented to CMS for consideration.

3. Monitoring requirements proposed in Amendment 38 may pose undue burden for many TennCare beneficiaries. TennCare members subject to work or other community engagement will be required to document that they have devoted 20 hours per week to approved activities every month. It is not clear in the Amendment if this will be done through self-attestation or if additional proof of employment and community participation must be submitted. It is not clear if submission will be on-line, via app, via fax, via mail or through multiple modalities. Non-exempt TennCare members must meet the requirement for four months out of every six-month period. Their continued eligibility for TennCare will need to be assessed every six months. If members fail to meet the requirements their benefits will be suspended, they will receive a notice explaining what they need to do to reinstate their benefits, and can appeal their suspension through a fair hearing.

TennCare has just invested millions of dollars in a new computerized enrollment and program evaluation system that will now need to be reprogrammed at additional expense to accommodate work requirement monitoring and assessment. Staff will need to be diverted to conduct initial outreach to and

education of adult TennCare recipients who will be subject to this waiver. Outreach will also be needed to other agencies who will be supporting recipients and most-importantly to potential employers and non-profits that might be sites for community service to explain the program. In addition, existing staff will need to be diverted from current tasks to assess compliance twice a year. Inevitably there will be suspensions of recipients and the rate of appeals will increase. New hearing officers may be required to enable timely appeals. None of these anticipated costs have been described in this Amendment.

4. The proposed evaluation metrics are inadequate to fully assess the impact of these requirements. The CMS guidance[2] is premised on the assertion that employment improves general mental, physical and emotional health and lowers mortality, rates of medical consultations, and rates of hospital admissions. There is also the assertion that such programs may also "help individuals and families rise out of poverty and attain independence, also in furtherance of Medicaid program objectives" (page 1)[1].

The guidance also clearly states that states seeking waivers to conduct demonstration projects are required to "evaluate health and other outcomes of individuals that have been enrolled in and subject to the provisions of the demonstration, and will be required to conduct robust, independent program evaluations" (page 9)[1].

The only health outcomes that TennCare currently proposes to track in the Research Hypotheses and Evaluation section of this Amendment are decreased hospital stays and decreased emergency room visits which seems inadequate for evaluating the impact on physical, mental and emotional health improvements. Appropriate preventive and primary health care and mental health care services utilization, improved health behaviors, and mental and emotional health status indicators could be assessed.

The only other metrics are process metrics of rates of participation in job search, employment activities, and educational activities which are inadequate for evaluating whether this is helping individuals and families rise out of poverty and attain independence. Yet other outcome measures are available. Household incomes as a percentage of poverty levels before and after engagement in the program, attainment of additional educational and skill certifications, changes in job titles, changes in housing status, utilization of other supports in the community, could and should also be tracked. Also, the *"robust, independent program evaluation"* required by CMS guidance[1] (page 9) has not been mentioned or budgeted.

In summary, although the LWVTN appreciates the work that TennCare has done to introduce additional exemptions and a coordinated structure of supports around a very minimal and underfunded directive from the General Assembly, we can not lend support to, and doubt that CMS would be able to approve, Amendment 38 as currently proposed. We urge TennCare delay submission not only to ascertain the outcome of legal challenges, but to improve program coordination and design, and to fully estimate the cost-effectiveness of this proposal in improving the health and well-being of Tennesseans eligible for the TennCare program.

Submitted October 24, 2018
Marian Ott
President
LWV of Tennessee

References:

1. CMS Guidance to State Medicaid Directors SMD: 18-002 RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries. January 11, 2018

2. Medicaid Work Requirements in Tennessee, Part 2 of 3: Lessons from Tennessee's Welfare-to-Work Experience. The Sycamore Institute of Tennessee. December 6, 2017

3. TennCare Bureau website [https://www.tn.gov/content/dam/tn/tenncare/documents2/fte_201712.pdf] accessed 10/17/2018]

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However, and significantly, there are additional vulnerable groups who need to be considered for exemption from these work requirements:

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child care" to enable them to access and maintain employment and provide those supports as part of TANF care coordination services[1], yet these supports are never specifically referenced in Amendment 38. The LWVTN believes that transportation and child or adult care supports need to be specifically incorporated in Amendment 38, both to align with Families First and to mitigate these recognized barriers to sustainable employment.

- **Victims of domestic violence and human trafficking, persons or families who are homeless.** Amendment 38 mentions that TennCare *"may grant a good cause exemption from the community engagement requirement based on a determination that there are acute or short-term individual circumstances that warrant special consideration"* and lists as examples "*persons experiencing homelessness, victims of domestic violence, victims of human trafficking*, etc." so it is clear TennCare recognizes the difficulty that these persons would have in meeting the 20 hour per week work and community engagement requirement and monthly reporting requirements without stable housing, reliable transportation, and dependable access to a computer, smart phone, internet. Recipients in these groups could also find it difficult to comply with an additional but as yet unspecified "good cause exemption" determination process. The LWVTN feels persons falling into these groups should be automatically exempted from work requirements until they have reestablished stable homes and support networks.

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disabilities through the TennCare's innovative Employment and Community First (ECF) CHOICES program. Additional supports that ECF programs provide include opportunities to try out different jobs, and ongoing job coaching once work has been identified. The LWVTN feels the needs of persons in this group also should be addressed in Amendment 38 and factored into the budget of this proposal.

2. **There remain significant questions about the adequacy of funding needed to fully support this program at a level that would prevent substantial number of households from losing their TennCare coverage.** The success of this program in achieving CMS' stated goals of promoting "*better mental, physical and emotional health"* and helping *"individuals and families rise out of poverty and attain independence"* (page 1)[1] hinges in large part on the approval of and continued availability of sufficient TANF funding to enable the coordination of support services that TennCare recognizes are needed by non-exempt populations to sustain employment. The LWVTN continues to be deeply troubled by the lack of specificity in how many parents and caregivers will be subject to work requirement, how much funding will be needed to support those families, and how much funding is actually available. At this writing no other funds have been appropriated by the State of Tennessee to sustain this program.

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It also needs to be pointed out that Families First serves a total of 56,000 Tennesseans of which 12,600 were subject to work requirements while TennCare serves over 1.4 million Tennesseans[2]. In 2017, approximately 597,036 TennCare recipients are adults between the ages of 19-64[3]. While not all of these adults will be subject to work requirements, it is reasonable to expect that at least 10% (59,700) will be, which would mean that the remnants of the TANF budget which is the only approved source of funds to sustain work-related supports would have to be stretched over at least fourfold the number of participants in the Families First work program. These reserve funds are not limitless nor is it clear they are recurring. Without specific projections of numbers and costs it seems inevitable that needed individual and family supports would be jeopardized without significant additional appropriations.

TennCare's inability or reluctance to estimate the number of individuals who would be subject to Amendment 38 work requirement, or to project an adequate budget amount to sustain this program, or to estimate how many persons are at risk of losing their TennCare coverage, are

serious flaws in this Amendment and do not meet the CMS Guidance tests of budget neutrality. The LWV TN feels strongly that until specifics are available, and it can be demonstrated that residual TANF funds are adequate to support TennCare families in finding and maintaining rewarding work, this Amendment should not be presented to CMS for consideration.

3. Monitoring requirements proposed in Amendment 38 may pose undue burden for many TennCare beneficiaries. TennCare members subject to work or other community engagement will be required to document that they have devoted 20 hours per week to approved activities every month. It is not clear in the Amendment if this will be done through self-attestation or if additional proof of employment and community participation must be submitted. It is not clear if submission will be on-line, via app, via fax, via mail or through multiple modalities. Non-exempt TennCare members must meet the requirement for four months out of every six-month period. Their continued eligibility for TennCare will need to be assessed every six months. If members fail to meet the requirements their benefits will be suspended, they will receive a notice explaining what they need to do to reinstate their benefits, and can appeal their suspension through a fair hearing.

TennCare has just invested millions of dollars in a new computerized enrollment and program evaluation system that will now need to be reprogrammed at additional expense to accommodate work requirement monitoring and assessment. Staff will need to be diverted to conduct initial outreach to and education of adult TennCare recipients who will be subject to this waiver. Outreach will also be needed to other agencies who will be supporting recipients and most-importantly to potential employers and non-profits that might be sites for community service to explain the program. In addition, existing staff will need to be diverted from current tasks to assess compliance twice a year. Inevitably there will be suspensions of recipients and the rate of appeals will increase. New hearing officers may be required to enable timely appeals. None of these anticipated costs have been described in this Amendment.

4. The proposed evaluation metrics are inadequate to fully assess the impact of these requirements. The CMS guidance[2] is premised on the assertion that employment improves general mental, physical and emotional health and lowers mortality, rates of medical consultations, and rates of hospital admissions. There is also the assertion that such programs may also "help individuals and families rise out of poverty and attain independence, also in furtherance of Medicaid program objectives" (page 1)[1].

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The only health outcomes that TennCare currently proposes to track in the Research Hypotheses and Evaluation section of this Amendment are decreased hospital stays and decreased emergency room visits which seems inadequate for evaluating the impact on physical, mental and emotional health improvements. Appropriate preventive and primary health care

and mental health care services utilization, improved health behaviors, and mental and emotional health status indicators could be assessed.

The only other metrics are process metrics of rates of participation in job search, employment activities, and educational activities which are inadequate for evaluating whether this is helping individuals and families rise out of poverty and attain independence. Yet other outcome measures are available. Household incomes as a percentage of poverty levels before and after engagement in the program, attainment of additional educational and skill certifications, changes in job titles, changes in housing status, utilization of other supports in the community, could and should also be tracked. Also, the *"robust, independent program evaluation"* required by CMS guidance[1] (page 9) has not been mentioned or budgeted.

In summary, although the LWVTN appreciates the work that TennCare has done to introduce additional exemptions and a coordinated structure of supports around a very minimal and underfunded directive from the General Assembly, we can not lend support to, and doubt that CMS would be able to approve, Amendment 38 as currently proposed. We urge TennCare delay submission not only to ascertain the outcome of legal challenges, but to improve program coordination and design, and to fully estimate the cost-effectiveness of this proposal in improving the health and well-being of Tennesseans eligible for the TennCare program.

Submitted October 24, 2018
Marian Ott
President
LWV of Tennessee

References:

1. CMS Guidance to State Medicaid Directors SMD: 18-002 RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries. January 11, 2018
2. Medicaid Work Requirements in Tennessee, Part 2 of 3: Lessons from Tennessee's Welfare-to-Work Experience. The Sycamore Institute of Tennessee. December 6, 2017
3. TennCare Bureau website [https://www.tn.gov/content/dam/tn/tenncare/documents2/fte_201712.pdf] accessed 10/17/2018]

Jonathan Reeve

From: Allison Jones <ajones@las.org>
Sent: Friday, October 26, 2018 6:06 PM
To: Public Notice. Tenncare
Subject: Legal Aid Society Comments on Amendment 38
Attachments: Legal Aid Society Comments on Amendment 38 10.26.18.pdf

Please find Legal Aid Society's comments to the proposed Amendment attached.

Thank you.

Legal Aid Society
of Middle Tennessee & the Cumberlands
Working Together. Doing Justice. Restoring Hope.

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October 26, 2018

Dr. Wendy Long, Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243
Via email to public.notice.tenncare@tn.gov

Re: Comments on Proposed TennCare II Demonstration Amendment 38—Work Requirements

Dear Dr. Long,

We are writing on behalf of Legal Aid Society of Middle Tennessee and the Cumberlands (LAS) clients in response to proposed Amendment 38 to the TennCare II Demonstration, which seeks to introduce new eligibility requirements with respect to work activities. A public hearing was held in Nashville on October 8, 2018. These comments supplement our testimony on that date.

Amendment 38 will not improve health outcomes because it is very likely that more Tennesseans will lose TennCare than will obtain work.

Amendment 38 says that its core objective is to improve health outcomes for those enrolled in TennCare. While TennCare cites studies that suggest working increases beneficial health outcomes, none of these studies address mandatory work programs and the impact they have on the health of those subject to them. The unstated assumption of Amendment 38 is that TennCare recipients who are not working face no barriers to work except motivation and if they are threatened with the loss of their TennCare, they will go to work. This assumption ignores issues with respect to the availability of child care and transportation, health, disability, and care for disabled family members. Moreover, the experience of the State of Arkansas indicates that far more Medicaid recipients will lose Medicaid than will find employment. Losing Medicaid will surely have an adverse effect on the health of those persons and will make it even more difficult for them to find work.

Research indicates that employment increases among recipients subject to work requirements were modest and faded over time.[1] Stable employment among recipients subject to work requirements proved the exception, not the norm and most recipients with significant barriers to employment never found work.[2] There was little difference in the percentage of persons working who were subject to work requirements and those who were not.[3] The data from the Arkansas Works program shows that very few people have found work as a result of the

[1] LaDonna Pavetti, *Policy Futures : Work Requirements Don't Cut Poverty, Evidence Shows*, Center on Budget and Policy Priorities (June 7, 2016) https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows.
[2] *Id.*
[3] *Id.* at Table 1.

Arkansas Medicaid mandatory work program. Of over 20,000 persons subject to work requirements, less than 2,000 reported any work activities at all.[4]

While it is very unlikely that Amendment 38 will result in a significant increase in the number of TennCare recipients who are working, the evidence from the Arkansas Medicaid work programs shows that far greater numbers will lose Medicaid. Over 8,000 people between the ages of 19 and 29 have lost Medicaid in Arkansas due to Medicaid work requirements.[5] The Arkansas work requirements will be imposed on persons from 30 to 49 next year which will most likely cause a similar number of people to be cut off. Uninsured adults have less access to recommended care, receive poorer quality of care and experience worse health outcomes.[6]

The loss of health insurance will also negatively affect their ability to find work and get back on TennCare. A study by the Ohio Department of Medicaid found that most enrollees reported that being enrolled in Medicaid made them better able to look for a job and over 50% said it made continuing to work easier.[7] Similarly, a study on Medicaid in Michigan showed 69% of participants reported better work performance once they enrolled in Medicaid and 55% of unemployed participants said having the healthcare made looking for a job easier.[8] Further, an in-depth look into the Medicaid expansion in Montana showed an increase in participation by low-income, non-disabled citizens in the labor force while there was a decrease in participation among citizens with higher-income.[9]

Amendment 38 reporting requirements will reduce enrollment of eligible individuals and increase administrative and medical costs due to churn.

Medicaid churning involves a pattern of short-term enrollment, disenrollment, and reenrollment that often repeats itself. While churn may be caused by changes in income that move individuals in and out of Medicaid eligibility over time, Amendment 38 is likely to create significant because of obstacles to meeting the administrative reporting requirements rather than substantive eligibility changes.

Amendment 38 will require that TennCare enrollees subject to the work requirement document their compliance on a monthly basis, and must meet the requirements for four out of every six month period. If suspended, enrollees are subject to a one-month shut-out period during which they must demonstrate compliance. The logistical challenges to verifying one's continuing eligibility can be significant, and it is commonplace for eligible enrollees to lose benefits for this reason, even when eligibility is screened only on an annual basis. The frequency of reporting requirement under Amendment 38 will increase the risks that eligible people are suspended or disenrolled not because they do not meet the work requirement, but because reporting that work is too onerous.

Churn creates substantial administrative costs for Medicaid programs and their managed care organizations. In 2015, the estimated administrative cost of one person churning once (disenrolling and reenrolling) was $400 to

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[4] *A Look at State Data for Medicaid Work Requirements in Arkansas,* Kaiser Family Foundation (October 16, 2018) https://www.kff.org/report-section/a-look-at-state-data-for-medicaid-work-requirements-in-arkansas-issue-brief/#endnote_link_374665-1

[5] *Id.*

[6] *Health Consequences of Uninsurance among Adults in the United States:Recent Evidence and Implications* The Milbank Quarterly (2009) (citing an Institute of Health study) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881446/

[7] The Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* (The Ohio Department of Medicaid, January 2017).

[8] University of Michigan Institute for Healthcare Policy & Innovation, *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches* (June 2017), http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches.

[9] Bureau of Business and Economic Research, *The Economic Impact of Medicaid Expansion in Montana* (University of Montana Bureau of Business and Economic Research, Prepared for the Montana Healthcare Foundation and Headwaters Foundation, April 2018), https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf.

$600.[10] Churning also contributes to increased Medicaid expenditures for medical care, as people who experience lapses may reenroll with more serious medical conditions that could have been avoided with better ongoing care.[11]

In Arkansas, in September 2018, 16,757 people or 23% of those subject to the work activities requirement did not report 80 hours of qualifying work activities. Nearly all of those 16,757 enrollees did not report any work activities.[12] Because Arkansas only accepts reporting through an online portal, and because low-income people are less likely to have home internet access[13], many or most of these enrollees may have been unable to access the reporting system.

Questions raised by the reporting requirements outlined in Amendment 38 include:

- Will enrollees be required to report their work activities using the internet-based TEDS system, once it is operational?
- What alternate reporting processes will be available for those without access to an online system or who are otherwise unable to use it?
- Will there be good cause exemptions to the reporting requirement for those with difficulty reporting in order to minimize churn for eligible enrollees?
- Will there be additional staff hired to assist enrollees in reporting?
- What verifications will be accepted for enrollees who may be self-employed or work in non-traditional settings where paystubs or timesheets are not provided?
- What accommodations will be made for workers who are employed and unavailable for other employment but may not control their hours (e.g. retail or service employees who may have shifts unexpectedly canceled, home health aides whose clients may be temporarily hospitalized, agricultural or construction workers who may lose shifts due to weather or seasonal fluctuations)?

The exceptions identified in Amendment 38 are insufficient to cover a number of vulnerable individuals and communities who will be unable to comply with the work requirement.

Individuals often experience many barriers to work that do not qualify them for an exemption. For example, studies on low-income Temporary Assistance for Needy Families (TANF) enrollees provide evidence for multiple barriers to employment including, mental and physical health conditions, low educational attainment, limited work background, addiction, criminal histories that decrease chances of employment, domestic violence and no access to affordable childcare.[14] Similarly, studies show enrollees often need extra supports and resources to combat these barriers including mental or physical health treatment, expungement, education or

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[10] Swartz, K., Farley Short, P., Roempke Graefe, D., & Uberoi, N. *Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End Of Calendar Year Is Most Effective*, Health Affairs 34 No. 7 (2015), 1180-1187, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1204.

[11] *Id.*

[12] *A Look at State Data for Medicaid Work Requirements in Arkansas,* Kaiser Family Foundation, supra note 4.

[13] Ryan, C., American Community Survey Reports, *Computer and Internet Use in the United States: 2016* (August 2018), https://www.census.gov/content/dam/Census/library/publications/2018/acs/ACS-39.pdf.

[14] Bloom, D., Loprest, P., & Zedlewski, S., *TANF Recipients with Barriers to Employment* (Washington, DC: Urban Institute, May 2012), http://www.urban.org/research/publication/tanf-recipients-barriers-employment; Druss, B.& Reisinger Walker, E., *Mental disorders and medical comorbidity,* (Princeton, NJ: The Robert Wood Johnson Foundation, February 2011), http://www.integration.samhsa.gov/workforce/mental_disorders_and_medical_comorbidity.pdf; Cook, J., "Employment Barriers for Persons with Psychiatric Disabilities: Updated of a Report for the President's Commission," *Psychiatric Services* 57, 10 (2006): 1391-405; Meara, E. "Welfare Reform, Employment, and Drug and Alcohol Use Among Low-Income Women," *Harvard Review of Psychiatry* 14, 4(2006): 223-32.

training and child care subsidies in order to be able to work.[15] A report prepared for the U.S. Department of Health and Human Services found that research consistently shows TANF enrollees penalized for not meeting a work requirement are more likely to have a disability compared to those that are not penalized.[16]

In the Amendment 38 draft, TennCare acknowledges there are circumstances that may prevent a TennCare enrollee from complying with the work requirement. TennCare lists several exemptions to the work requirements. These exemptions are problematic for several reasons, and raise the following questions.

1. **Duration of Exemptions**

The Amendment 38 draft states: "members will be exempt from the requirement in any *month* in which any one of the following conditions is met." (emphasis added). The inclusion of the month time period suggests that an enrollee must renew his or her exemption on a month by month basis. If so, this places a heavy administrative burden on the enrollee, who must submit proof of an exemption each month, and the agency, who must process this paperwork each month. Monthly exemption renewals will cause many enrollees who do meet the exemptions to lose coverage due to the challenge of submitting paperwork.

- If a TennCare enrollee is found eligible for an exemption, how long does that exemption last? How often will TennCare reassess whether someone is still eligible for an exemption?

2. **Age range for Exemptions**

One of the exemptions is "individuals who are at least 65 years old." The Department of Human Services (DHS) implemented work requirements and time limits for food stamps ("SNAP") in select counties beginning in 2016. According to federal food stamps regulations, a person 50 and older is exempt from the work requirements. Many TennCare enrollees also receive SNAP. It is incongruous that a person on food stamps and TennCare would be exempt from food stamp work requirements at age 50, but would not be exempt from TennCare work requirements until age 65.

- Will TennCare change the age range of enrollees subject to work requirements from 18-64 to 18-49 in order to be consistent with federal food stamp regulations?
- Why did TennCare make the decision to set the upper age limit at 65 rather than 50?

3. **Data matching with the Department of Human Services**

With the exception of the age range as discussed above, many of the Amendment 38 work requirements exemptions mirror the work requirement exemptions for SNAP. Amendment 38 states "individuals subject to and comply with the work requirements of another public assistance program (i.e., SNAP or TANF) will be deemed to be in compliance" with the TennCare work requirements.

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[15] Martinez, J. et al., *Results from the Substance Abuse Case Management Program in New York City* (New York, NY: MDRC, May, 2009), https://www.mdrc.org/sites/default/files/full_551.pdf; The National Center on Addiction and Substance Abuse at Columbia University, *CASASARD Intensive Case Management for Substance-Dependent Women Receiving Temporary Assistance for Needy Families* (New York, NY: The National Center on Addiction and Substance Abuse at Columbia University, January 2009), https://www.centeronaddiction.org/addiction-research/reports/casasard-intensive-case-management-substance-dependent-women-receiving; Bloom, D. et al., *Alternative Welfare-to-Work Strategies for the Hard-to-Employ* (New York, NY: MDRC, October 2009), http://www.mdrc.org/sites/default/files/full_19.pdf; Bloom, D., Miller, C., & Azurdia, G., *Results from the Personal Roads to Individual Development and Employment (PRIDE) Program in New York City* (New York, NY: MDRC, July 2007), http://www.mdrc.org/sites/default/files/full_547.pdf.

[16] Mathematica Policy Research, *Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments* (Feb. 2008), https://www.acf.hhs.gov/sites/default/files/opre/conducting_in_depth.pdf.

- How will the data matching system work between the anticipated TennCare TEDS system and the DHS Accent system in order to deem compliance?
- Families First TANF incapacity determinations typically last between four (4) months and a year. Food stamp SNAP eligibility is determined on a yearly basis with a certification form sent out at the six month mark. If DHS determines a Families First enrollee exempt from the work requirements for six (6) months, will TennCare also determine this same enrollee exempt for the same amount of time?
- Will TennCare sync reporting periods with DHS?

4. Medical Professional Certification and Validation

For several exemptions, a TennCare enrollee must rely on a medical professional to certify or validate his or her incapacity for work. Physical or mental incapacity for work must be "certified by a medical professional" and individuals with a short-term or long-term disability or an acute medical condition must get "validation by a medical professional that would prevent them from complying" with the work requirements. This is problematic because many low-income persons do not have ready access to medical providers, and even if they do, the medical providers are often not willing to fill out these forms.

We represent hundreds of clients every year who are seeking disability benefits. We routinely ask medical professionals to compete a form with respect to functional abilities. In most cases we are told it is the policy of the office not to complete disability forms. We also run into this same issue with our Families First TANF clients. Many doctors are simply unwilling to provide a statement in these cases. In one case, a doctor agreed that our client was physically and mentally unfit for work but charged us $200.00 for 15 minutes of his time to tell us that and sign a form. TennCare enrollees simply do not have the resources to obtain, and most doctors are not willing to provide the certification envisioned by Amendment 38. Therefore, the medical professional certification and validation process often presents an insurmountable barrier for low-income clients on TennCare.

- Will TennCare provide assistance to enrollees in finding medical professionals that are willing to sign statements? If a TennCare enrollee does not have a medical provider, will TennCare assist in finding a medical provider and scheduling an appointment?
- If a medical provider charges for his or her time in filling out the certification or validation, will TennCare cover this cost?
- Will there be a certain form that TennCare will require the medical provider to sign?
- If a TennCare enrollee's medical provider is unwilling or unable to sign a statement, will TennCare accept medical records to show physical or mental incapacity?

5. Assessment of Exemptions

Prior to terminating a TennCare enrollee's benefits for failure to meet the work requirement, TennCare must assess whether the enrollee meets any exemption.

- Does TennCare plan to send out a notice informing enrollees about the implementation of work requirements and listing all of the exemptions?
- Will this notice be written at a reading level accessible to the majority of enrollees?
- Will this notice be written in languages other than English?
- How does TennCare plan to assess whether a current enrollee meets one of the exemptions before terminating the enrollee's benefits? Will this screening take place over the phone, or be part of the TEDS online system?

6. Exemption Questions

Finally, the rest of exemptions raise the following questions:

- How does TennCare define "medically frail"? How will an enrollee prove that he or she is medically frail? How will TennCare determine whether a person is medically frail?
- What is an "acute medical condition"? How will an enrollee prove that he or she has an acute medical condition? How will TennCare determine whether the acute medical condition prevents the enrollee from complying with the work requirements?
- Inpatient or residential treatment facilities often have long wait lists due to shortage of beds. If a person has applied for a bed at an inpatient or residential treatment facility but has not been approved yet, does this count as an exemption?
- How will TennCare determine if a person is the "primary caregiver" of a child younger than six years of age? What legal documentation, if any, will an enrollee need to present in order to show primary caregiver status?
- How will TennCare determine good cause exemptions?
- What does an enrollee need to show to prove that he or she is experiencing homelessness? Does an enrollee need to be staying in a shelter in order to be considered homeless? Does the shelter need to provide verification of residence?
- What does an enrollee need to show to prove that he or she is a victim of domestic violence? Does an enrollee need to have an order of protection in order to prove that he or she has been a victim of domestic violence? What documentation does an enrollee need to present in order to meet this good cause exemption?
- What does an enrollee need to show to prove that he or she is a victim of human trafficking? What documentation does an enrollee need to present in order to meet this good cause exemption?
- Will refugees and asylees without young children be exempt from the work requirement?
- If an enrollee has difficulty obtaining requisite paperwork in order to show that he or she is homeless, a victim of domestic violence, or a victim of human trafficking, will TennCare provide a caseworker in order to help the enrollee obtain the paperwork?
- How will TennCare "work with individuals in these circumstances" to connect them to education and employed-related resources on a voluntary basis?
- Will TennCare be hiring new staff to assist with administrating the work exemption program? Will TennCare be hiring new Administrative Judges to hear work requirement related cases?
- What information and accommodations as required by the Americans with Disabilities Act will be made available, and how will these accommodations be accessed?

Amendment 38 is unlikely to have any meaningful effect on the number of TennCare recipients who are able to find work. However, as the experience of Arkansas demonstrates, thousands of Tennesseans will lose their TennCare. This will not only cause them to have worse health outcomes, but it will also make it more difficult for them to work and get back on TennCare. The administrative costs created by the reporting requirements are likely to be significant and will lead to eligible individuals losing health coverage. Finally, the limited exemptions outlined in the Amendment raise significant questions as to the deleterious effects of this policy on some of the most vulnerable individuals enrolled in TennCare. Thank you for the opportunity to provide comments to the proposed Amendment.

Sincerely,

Emma W. Sholl
Attorney at Law

Allison E. Jones
Attorney at Law

Russell J. Overby
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Jonathan Reeve

From: Balog, Sarah (National Office) <Sarah.Balog@lls.org>
Sent: Thursday, October 25, 2018 11:17 AM
To: Public Notice. Tenncare
Cc: Lee, Marialanna (National Office)
Subject: The Leukemia & Lymphoma Society comments on 1115 waiver
Attachments: 10_18 TN 1115 waiver comments FINAL.pdf

Please find attached LLS' comments on the proposed Amendment 38. Thank you for the opportunity to submit feedback and please do not hesitate to contact me if I can answer any questions.

Thank you.

Sarah Balog | Regional Director, Government Affairs
The Leukemia & Lymphoma Society | Office of Public Policy
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LEUKEMIA & LYMPHOMA SOCIETY®

BEATING CANCER IS IN OUR BLOOD.

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October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long:

The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to submit comments on Amendment 38 to the TennCare II demonstration, as proposed by the Tennessee Division of TennCare (the Division). At LLS, our mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and improve the quality of life of patients and their families. LLS exists to find cures and ensure access to treatments for blood cancer patients. In light of that mission, and recognizing the serious impact this proposal will have on some of Tennessee's most vulnerable patients, LLS urges the Division to withdraw the proposed amendment.

Amendment 38 seeks to add a work and community engagement requirement for most TennCare enrollees. Individuals will need to report either the number of hours they have worked or that they meet certain exemptions – a requirement that will impose a serious administrative burden on TennCare patients. That burden is significant because, as detailed in our comments below, it will almost certainly result in many low-income Tennesseans losing their only source of reliable coverage, despite the state's assertion that "Amendment 38 is not expected to have an impact on enrollment in the TennCare demonstration"[1].

LLS believes firmly that all patients and consumers should have access to high quality, stable coverage to ensure that they are able to receive appropriate and timely care. Medicaid serves a vital role in making sure that no one is left without access to such coverage. In contrast, Amendment 38 proposes sweeping changes in the way TennCare operates, to the detriment of patients and families. In short, the proposal is overly complex, burdensome to beneficiaries, and would be expensive to implement. Most troubling, as we mention above, its adoption will lead to a significant number of eligible adults losing TennCare coverage.

MEDICAID: A VITAL SOURCE OF COVERAGE

Medicaid guarantees access to life-saving care for low-income Americans

[1] https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment38ComprehensiveNotice.pdf

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As the nation's public health insurance program for low-income children, adults, seniors, and people with disabilities, Medicaid covers 1 in 5 Americans.[2] Many of them have complex and costly health care needs, making Medicaid a critical access point for disease management and care for many of the poorest and sickest people in our nation.[3] More than 1,334,000 Tennesseans were in enrolled in TennCare as of September 2018, according to data from the Tennessee Department of Finance and Administration.[4]

Thanks to Medicaid coverage, enrollees have access to screening and preventive care, which translates into well-child care and earlier detection of health and developmental problems in children, earlier diagnosis of cancer, diabetes, and other chronic conditions in adults, and earlier detection of mental illness in people of all ages.[5] Medicaid also ensures access to physician care, prescription drugs, emergency care, and other services that – like screening and prevention – are critical to the health and well-being of any American.

Medicaid is a crucial source of coverage for specialty care too, including cancer care. Evidence suggests that public health insurance has had a positive impact on cancer detection: researchers have determined that states that expanded Medicaid experienced a 6.4 percent increase in early detection of cancer from pre-Affordable Care Act (ACA) levels.[6] Evidence also shows better survival rates among individuals who were enrolled in Medicaid prior to being diagnosed with cancer, relative to those who enroll in Medicaid after their diagnosis.[7] In Tennessee, an estimated 3,740 people will receive a new diagnosis of blood cancer in 2018.[8] For many of them, TennCare will be their only source of affordable coverage.

WORK REQUIREMENTS

Making coverage contingent on work will disrupt access to care

Medicaid's core mission is to provide comprehensive coverage to low-income people so they can obtain the health care services they need.[9] In service of that mission, the ACA streamlined Medicaid enrollment and renewal processes across all states.[10] The intent was to reduce the number of uninsured and keep individuals covered over time by reducing the burden of paperwork. But in contrast, Tennessee's proposed work requirement will initiate a return to increased bureaucracy and paperwork and, in turn,

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[2] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, January 2018, https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.
[3] Julia Paradise, "Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid," March 23, 2017, https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/.
[4] TennCare Enrollment Report for September 2018, accessed October 22, 2018 https://www.tn.gov/content/dam/tn/tenncare/documents2/fte_201809.pdf.
[5] Julia Paradise, "Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid," March 23, 2017, https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/.

[6] A Soni, K Simon, J Cawley, L Sabik, Effect of Medicaid expansions of 2014 on overall and early-state cancer diagnoses [published online December 21, 2017]. *Am J Public Health*, doi: 10.2105/AJPH.2017.304166.
[7] E Adams, LN Chien, CS Florence, et al. The Breast and Cervical Cancer Prevention and Treatment Act in Georgia: effects on time to Medicaid enrollment. *Cancer.* 2009; 115(6):1300-9.
[8] *American Cancer Society*, "Cancer Statistics Center," 2018, https://cancerstatisticscenter.cancer.org.
[9] 42 U.S.C. 1396.
[10] Kaiser Family Foundation, "Implication of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Processes," February 2018, https://www.kff.org/medicaid/fact-sheet/implications-of-emerging-waivers-on-streamlined-medicaid-enrollment-and-renewal-processes/.

coverage losses. It's because of those losses that LLS firmly opposes making Medicaid coverage contingent on work requirements.

In states without Medicaid expansion, such as Tennessee, Medicaid enrollees who comply with a work requirement may face what CMS administrator Seema Verma called a "subsidy cliff." In this Catch-22 situation, compliant enrollees earn too much to remain eligible for Medicaid coverage, but are unlikely to be able to afford private health insurance or find employer-based coverage.[11]

Prior to extending its transitional coverage to 18 months in duration, Alabama (a state with income requirements of only 18 percent of the federal poverty level) was projected to yield a drop of 8,700 beneficiaries in adult Medicaid enrollment in its first year alone. These beneficiaries will still lose their coverage, only a few months later; simply put, this approach is not a meaningful solution to the subsidy cliff. The impact will fall disproportionately on mothers, will hit rural communities harder, and will increase the odds that children in these families will face economic and health-related hardships.[12]

Indeed, work requirements will result in some enrollees losing coverage not because they failed to maintain employment but because of difficulty navigating compliance processes or satisfying the burden of additional paperwork. When Washington State required increased reporting as part of its Medicaid renewal process, approximately 35,000 fewer children were enrolled in the program, despite the fact that many remained eligible. Families reported that they had simply lost track of the paperwork.[13] It's important to note that many in the Medicaid population face barriers associated with disability, mental illness, insecure work, frequent moves, and homelessness – all factors that pose significant challenges to successfully navigating any system.

Early reports from Arkansas on their work requirement validate concerns over widespread confusion and significant coverage losses. In the first month of implementation of its *Arkansas Works* program, nearly 75 percent of beneficiaries who were required to take action online to report their work hours or an exemption failed to do so.[14] This is not surprising given that Arkansas ranks 46th in the nation with respect to internet access;[15] in fact, 31 percent of Arkansas Medicaid beneficiaries who are likely to not be exempt from the work requirement and are not currently working have no access to the internet in their household.[16] It is also highly likely that many people simply did not receive the notices stating that they would be subject to a work requirement, given that low income households move at twice the rate of

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[11] Colby Itkowitz, "The Health 202: There's a Medicaid 'subsidy cliff' health-care officials are worried about," *Washington Post*, July 19, 2018, https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/07/19/the-health-202-there-s-a-medicaid-subsidy-cliff-health-care-officials-are-worried-about/5b4f9a571b326b1e64695455/

[12] *Georgetown University Center for Children and Families*, "The Impact of Alabama's Proposed Medicaid Work Requirement on Low-Income Families with Children," March 2018, https://ccf.georgetown.edu/wp-content/uploads/2018/03/AL-Work-Requirements-3-19.pdf

[13] Margot Sanger-Katz, "Hate Paperwork? Medicaid Recipients Will Be Drowning In It," *The New York Times*, January 18, 2018.

[14] Joan Alker and Maggie Clark, "One Month into Medicaid Work Requirement in Arkansas, Warning Lights are Already Flashing." July 20, 2018, Georgetown University Health Policy Institute: Center for Children and Families, https://ccf.georgetown.edu/2018/07/20/one-month-into-arkansas-medicaid-work-requirement-the-warning-lights-are-already-flashing/

[15] U.S. News & World Report, Internet Access Ratings, https://www.usnews.com/news/best-states/rankings/infrastructure/internet-access.

[16] Anuj Gangopadhyaya, Genevieve Kenney, Rachel Burton, and Jeremey Marks, "Medicaid Work Requirements in Arkansas: Who Could Be Affected, and What Do We Know About Them?" May 24, 2018, Urban Institute Research Report, https://www.urban.org/research/publication/medicaid-work-requirements-arkansas.

higher income households.[17] As of October 1, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[18] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[19]

This effect has been borne out in other contexts too: data shows that in Temporary Assistance for Needy Families (TANF), for example, many people who were working or should have qualified for exemptions from work requirements lost benefits because they did not complete required paperwork or were unable to document their eligibility for exemptions.[20]

The fact is loss of coverage is a grave prospect for anyone, in particular a patient living with a serious disease or condition. People in the midst of cancer treatment, for example, rely on regular visits with healthcare providers, and many of those patients must adhere to frequent, if not daily, medication protocols. Thus LLS is seriously concerned that individuals who are unable to satisfy work requirements may end up going without necessary care, perhaps for an extended period of time. LLS is equally concerned about Medicaid enrollees who do not currently live with a cancer diagnosis; if during a lock-out period an individual develops blood cancer, it's likely the disease won't be diagnosed early enough to ensure the best possible health outcomes.

It's important to note that exempting some beneficiaries from having to comply with work requirements will not sufficiently mitigate the access barriers that will result from making coverage contingent on work. Under commercial health insurance, exemption and exceptions procedures have a long track record of limiting or delaying access to care for patients living with serious medical needs. At times this is due to the slow pace of the determination process. At other times, the challenge is simply understanding the exemption process itself or having the time and resources to pursue appeals. It's highly likely that, where it concerns exemptions from work requirements, Medicaid enrollees will find it similarly complicated, time-consuming, and expensive to secure and maintain an exemption.

Implementation will strain already-limited government resources

Implementation of work requirements will obligate the state to devote significant resources to tracking work program participation and compliance or, alternatively, incur the cost of contracting out that function.[21] A draft operational protocol prepared for the implementation of Kentucky's proposed waiver

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[17] Brett Theodos, Sara McTarnaghan, and Claudia Coulton, "Family Residential Instability: What Can States and Localities Do?" May 2018, Urban Institute, https://www.urban.org/sites/default/files/publication/98286/family_residential_instability_what_can_states_and_localities_do_1.pdf.

[18] 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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[19] ibid

[20] Judith Solomon, "Kentucky Waiver Will Harm Medicaid Beneficiaries," January 16, 2018, Center on Budget and Policy Priorities, https://www.cbpp.org/research/health/kentucky-waiver-will-harm-medicaid-beneficiaries.

[21] MaryBeth Musumeci and Julia Zur, "Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience," Kaiser Family Foundation, August 2017, https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/.

illustrates the costs involved: nearly $187 million in the first six months alone.[22] Similarly, during the debate over SB 1728 – the legislation which directed the Department of Finance & Administration to add work requirements to TennCare – the legislature's own estimates show that the implementation of a Medicaid work requirement would cost the state an estimated $19.4 million each year, in addition to the estimated $20+ million annual cost to federal taxpayers.[23]

If the state is willing to increase its spending on Medicaid, those additional dollars ought to be prioritized for uses that are directly related to access to care, not the creation of a work requirements bureaucracy.

DISCLOSURE OF ENROLLMENT & EXPENDITURES

Federal rules at 431.408 pertaining to the state public comment process require at (a)(1)(i)(C) that a state publish an estimate of the expected increase or decrease in annual enrollment and expenditures associated with its Section 1115 waiver proposals. The intent of this section of the regulations is to allow the public to comment fully on a Section 1115 proposal, with the information in hand that is critical to understanding the full extent of a proposal's impact.

However, on page 5 of this proposal, the Department states that "Some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, it is not possible to reliably project the magnitude of this decrease in enrollment at this time." We urge the TennCare to update the waiver amendment with the estimated expenditure and estimate enrollment change and reopen the state comment period for an additional 30-days.

Ultimately, the requirements outlined in Amendment 38 do not further the goals of the Medicaid program. Instead, they needlessly compromise access to care for a very vulnerable population. LLS urges you to focus instead on solutions that can promote adequate, affordable, and accessible Medicaid coverage for all Tennesseans.

Thank you for your consideration of LLS's comments on this important matter. If we can address any questions or provide further information, please don't hesitate to contact me at sarah.balog@lls.org or 678-852-6383.

Regards,

Sarah Balog
Regional Director, Government Affairs
The Leukemia & Lymphoma Society

[22] *Roll Call*, "Medicaid Changes Require Tens of Millions in Upfront Costs," Feb. 26, 2018, https://www.rollcall.com/news/politics/medicaid-kentucky.
[23] Tennessee General Assembly, Fiscal Review Committee. Fiscal Memorandum SB 1728, March 6, 2018. http://mediad.publicbroadcasting.net/p/wpln/files/201803/FM2313.pdf?_ga=2.74759760.319117714.1539980113-555280874.1539794033

Jonathan Reeve

From: Miller, Nathan <NMiller@mauryregional.com>
Sent: Tuesday, October 23, 2018 10:59 AM
To: Public Notice. Tenncare
Subject: TN Care proposal
Attachments: Scan.pdf

Please see attached

Nathan Miller, PT, MMHC
Executive Director
Lewis Health Center
931-796-6201 Office

LEWIS
HEALTH CENTER

Dr. Wendy Long
Director, Division of TennCare
310 Great Circle Road
Nashville, TN 37243

October23, 2018

Dear Dr. Long,

I am submitting the following comments in response to TennCare II Demonstration Waiver Amendment 38. The Lewis Health Center serves Lewis, Maury, Marshall, and Wayne counties which serve greater than 14,000 patients annually.

The Lewis Health Center is very concerned about the proposal that TennCare has outlined in Amendment 38. The proposed work and community engagement requirements have the capacity to result in the loss of Medicaid coverage for some of our Medicaid patients, many of whom do not have access to other forms of health insurance. As a Federally Qualified Health Center, the Lewis Health Center provides care to all patients, regardless of ability to pay or insurance status. We will always be here for our patients, but if those with Medicaid lose this coverage they will no longer be able to access services such as specialty care, hospitalizations, surgeries, etc.

The Lewis Health Center has concerns about the vague definitions in the drafted amendment, the administrative burden of verifying coverage, patients' ability to navigate the employment verification system, patients' ability to find transportation to a job, and patients' ability to find affordable child care. The draft waiver amendment proposes very little in way of support for patients who have difficulty meeting the requirements or navigating the system.

I understand that TennCare has drafted Amendment 38 in response to legislation but I believe the plan that TennCare has proposed does not adequately safeguard people from losing Medicaid benefits through no fault of their own and will not result in improved health outcomes. I urge TennCare to reconsider the proposed approach and to design a program that assists Medicaid patients in achieving better health.

Sincerely,

Nathan Miller, PT, MMHC
Executive Director
Lewis Health Center
931-796-6201

Jonathan Reeve

From: Linda Hockaday <linda.hockaday@gmail.com>
Sent: Friday, October 26, 2018 5:19 PM
To: Public Notice. Tenncare
Subject: Extend medicaid

We must be able to extend Medicaid in some way. Many people are unable to work the required amount of hours there must be something that can be done. We can't just sit back and allow this to happen I am republican but I know for a fact there are a ton of human people that benefit from the service.

Linda M. Hockaday M.Ed.
Exceptional Educator
Community House Coordinator
615-545-4778

Jonathan Reeve

From: Linda Pearce <lindalpearce@gmail.com>
Sent: Friday, October 26, 2018 12:24 PM
To: Public Notice. Tenncare
Subject: Stop hospital closures

Requiring work for people unable to work is cruel and punishing to sick people. We need expanded medical.

Linda L. Pearce

Jonathan Reeve

From: Linda Sherman <lindasherman1910@gmail.com>
Sent: Saturday, October 27, 2018 6:59 AM
To: Public Notice. Tenncare
Subject: healthcare for ALL

It defies logic to make TN Care recipients to work on terms that they are very unlikely to be able to meet. The idea of offering help to people who are struggling is to SUPPORT them, whether they are well or ill, for the reasons they know more about than most of us who are not on TN Care do.

Please understand that as a taxpayer, I wish my resources to be shared with those who are less able, in the hopes that they can be restored to a position of physical, mental, and economic health. If that is impossible, I pray God not see me subjecting those who are most in need to even more pressures and less support.

Please do not enact draconian tortuous measures upon those who are already suffering. I have a daughter who wants in the worst way to return to her former health status and is trying with all her might to do so. She at least can work part time and has understanding bosses, while living with us, her parents. Why would I ever suggest that because I am giving a small portion of my money to support those in need, that they owe me! To whom much is given, much is required and that's not from those in need, but from those like you and me who have our health and good enough resources to support ourselves.

Cruelty comes in many forms. Let's not contribute to it.

Linda Sherman

Jonathan Reeve

From: Liza Ramage <ramagel@comcast.net>
Sent: Friday, October 26, 2018 12:49 PM
To: Public Notice. Tenncare
Subject: No work requirement, please.

Hello friends,

I am a retired school teacher and a Christian who believes in the admonition to help "the least of these". For that reason I have done some work to understand why so many neighbors in our state do not have health care, and what this means to our state.

Certainly these hospital closures mean loss of jobs and loss of buying power in the communities where the jobs are lost, as well as the loss of health care in some of the regions where the need is greatest.

MOST IMPORTANTLY, THE REQUIREMENT TO WORK TO HAVE HEALTHCARE IS EXACTLY BACKWARDS. THERE IS SOLID DATA TO CONFIRM THAT AFTER PEOPLE RECEIVE HEALTHCARE, THEY ARE ABLE AND WILLING TO GET JOBS. PEOPLE WITH CRONIC DISEASES OR CONDITIONS CAN OFTEN GET HELP WITH THE PROBLEM THAT HAS BEEN PREVENTING THEN FROM WORKING, AND THEY DO GO OUT AND GET THE JOBS THEY CAN NOW PERFORM. IT IS NOT THAT PEOPLE DON'T WANT TO WORK, IT IS THAT POOR PEOPLE WITH FEW RESOURCES NEED A LITTLE MEDICAL HELP TO BE ABLE TO GO TO WORK.

This data comes from states that have expanded Medicaid and are finding more and more of their citizens able to join the workforce.

Please do not place work requirements on healthcare

Thank you,
Liza Ramage
1400 Rosa L Parks
NASHVILLE 37208

Jonathan Reeve

From: Lori Tubbs-Douglas <ltdouglas.acc@gmail.com>
Sent: Friday, October 05, 2018 3:17 PM
To: Public Notice. Tenncare

-- I think the requirement to go to work or school is essential. It will provide an increase in self worth and motivation. This can only help our consumers.

--
Thank you,
Lori Tubbs-Douglas, BS/LADAC2/NCAC2/QCS
Director
Alternative Choice Counseling Center, LLC
(o) 731-784-8814

Jonathan Reeve

From: Lydia Burris <lydiabburris@gmail.com>
Sent: Wednesday, October 24, 2018 4:18 PM
To: Public Notice. Tenncare
Subject: Opposition for Tenn-Care Work Requirements

Dear Dr. Wendy Long,

I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38.

My name is Lydia Burris, and I am a social worker in Nashville. I provide educational adovcacy for parents of children with disabilities and mental health needs, who are at-risk or currently involved in the juvenile court system. My goal is to keep students out of juvenile court by keeping them in school and on track to graduate with a high school diploma.

Because of the work that I do, **I unequivocally oppose the proposal** to require so-called reasonable work requirements on non-disabled adults under 65 without children under age 6. I also believe it is **inhumane** to takes health coverage away from people who are unemployed.

This proposal would take health coverage away from people who do not work a set number of hours per month, which would **cause immense harm** and jeopardize coverage for thousands of Tennesseans.

The clients whom I serve would be negatively impacted by this proposal to take away coverage from people who don't meet the new work requirement. The parents of the clients I work wiht do work when they are capable of doing so-- oftentimes more hours than I do in my 40-hour work week. **As I stated the students I work all have behavioral challenges at school due to their mental health needs and disabilities, and therefore they are frequently suspended or sent home.**

Their parents are then required to come pick their child up from school or keep them at home, which impedes the parent's ability to attend work. I often hear from parents that they lose their jobs due to having to pick up their child from school or from the many meetings that they need to attend to ensure the child's educational and mental health needs are being met.

It is not appropriate to remove a family's insurance if the parent cannot keep consistent work due to their child's disability. We cannot say that we are meeting the child's physical and mental health needs if we are removing medical insurance and resources from caregivers that need MORE, not less, access to resources.

In addition, this proposal leaves too many questions that have not been resolved.

- How will compliance be reported?
- How can TennCare administer this complex eligibility determination without an eligibility determination computer system, which is not yet complete?
- **How will the reporting process accommodate people with disabilities**, limited literacy or language?
- What is "good cause" for waiving compliance by certain individuals?

- What criteria will be used to exempt “economically distressed” counties?

This waiver is fundamentally flawed and cannot be fixed. It goes against the goals and purpose of the Medicaid program. **I respectfully urge you to not go forward with this harmful proposal.**

Sincerely,

Lydia Burris
3124 Kinross Avenue
Nashville, TN 37211
(865)599-5657

Jonathan Reeve

From: Lynn Fritz <lynnmfritz@gmail.com>
Sent: Thursday, October 25, 2018 9:43 AM
To: Public Notice. Tenncare
Subject: My comments on the proposed Waiver Amendment 38

October 25, 2018

Dr. Wendy Long
Division of TennCare
via email to: public.notice.tenncare@tn.gov

Dear Dr. Wendy Long,

Please consider my comments below on the proposed Waiver Amendment 38. I am the parent of an adult child who is living a very successful recovery with a serious mental illness. I also am a volunteer legislative advocate/lobbyist for NAMI Davidson County, the National Alliance on Mental Illness. Because of the experiences of my family navigating mental health crises, treatment, and recovery, I am passionate about the importance of accessible and affordable treatment for serious mental health conditions, as well as substance abuse treatment.

I am completely opposed to this proposal that would result in the stripping of health coverage from vulnerable populations. Fundamentally, it makes no sense to me that the state would seek to circumvent the goal of the Medicaid program, which is to “provide health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities” (Medicaid.gov). Medicaid is a health insurance program, not an employment program. I fail to see how removing health coverage promotes health.

This is a negative approach to creating an incentive to work, which will work against the stated goal of Medicaid, versus a more desirable positive approach to supporting employment, that should be provided by an agency with the stated goal of decreasing unemployment and supporting employment. Individual Support Programs (ISP) to provide supportive employment to individuals with mental health issues are growing, but still are not available in many areas of our state. Expanding these programs would be a much more effective and positive way of increasing employment.

In addition, depriving people of health care will make it more difficult for them to work and to maintain employment. It is especially imperative for those dealing with mental illness to have access to treatment in order to stay healthy and be able to work.

While the draft of Amendment 38 includes an exemption for “individuals who are physically or mentally incapable of work, as certified by an appropriate medical professional,” this is little comfort for the following reasons:

- When it is already a challenge to obtain treatment for mental illness, given the lack of mental health providers (which is especially pronounced in rural areas of our state), the individual will have the burden of obtaining the certification of an “appropriate medical professional.”

- A definition of “appropriate medical professional” is not provided, leaving the possibility that, even if a patient had access to a medical professional, that professional may not be deemed “appropriate” to grant an exemption.

- The burden will lie with the individual dealing with a mental illness to prove that they qualify for this exemption. Navigating the necessary paperwork and obtaining the necessary documentation from a medical professional is a barrier that will be too difficult for many dealing with mental illness to overcome.

- Mental illness can often result in intermittent periods of crisis in between periods of calm. This nature of mental illness can make ongoing employment challenging. This proposal sets up the potential of a person dealing with mental illness falling in and out of compliance with the work requirement, thereby seriously jeopardizing the continuing health care needed to keep those dealing with mental illness stable and healthy.

- It is short sighted and financially irresponsible to place a burden on people that endangers their necessary ongoing health care, and potentially creates, through losing access to health care, a crisis situation requiring intervention. Intervention at a crisis level of care is much more expensive than routine outpatient treatment. With the cost of managing and monitoring this program, and the potential for creating stress and anxiety that exacerbates mental health symptoms, any potential financial benefits become nil. Monies would be better spent in supportive case management programs that progressively step people down from a crisis episode and gradually build them into readiness for an ISP program.

While an exemption is also included in the draft for “individuals participating in inpatient or residential treatment for a substance use disorder,” this does not help any individuals who have been unable to secure a bed in a residential treatment center because of lack of enough facilities or because of their location in an area with not enough beds. It also leaves vulnerable those struggling with a substance abuse disorder who are receiving intensive outpatient treatment or other modes of treatment that will not qualify. It is hard enough for those with substance use disorders and their families to get the treatment they need, without introducing additional barriers.

The draft proposal also lists an exemption for “individuals who are providing caregiver services for a household member (child or adult) with a disability or incapacitation.” There is no detail given, however, to ensure that, for example, the caregiver of a family member whose mental illness causes a sudden health crisis, will qualify for this exemption.

In short, regarding the exemptions noted above, an “exemption” is not a “protection,” and there is no assurance that those who qualify for the exemptions will be able to maintain their health coverage.

I have many specific concerns about this proposal, in addition to my basic disagreement with its goal and premise and my concern about the implementation of the exemptions discussed above. These concerns include:

- The studies cited in the proposal draft to justify a link between work and improved health outcomes are significantly outdated and not based on Tennessee's Medicaid population. They range from 2005 to 2008, and one of the studies is from outside the U.S.A. (from the UK).
- The draft proposal says that Amendment 38 will "provide corresponding supports to help enrollees achieve their education or employment-related goals," but no detail about these supports is provided.
- While the document states that "individuals subject to and complying with the work requirements of another public assistance program (i.e., SNAP or TANF) will be deemed to be in compliance," the exemptions listed in this proposal are much narrower than those of the SNAP program. The minimum of 65 years of age is older than the SNAP requirement and older than other state minimums.
- No detail is provided about how "counties that are determined to be economically distressed" will be defined or identified.
- No detail is provided about how individuals will be linked to existing community resources to achieve education- and employment-related goals, especially in rural areas.
- No detail is provided about how individuals will document either their qualifying for an exemption or their compliance with the work requirements. This is especially concerning given that TennCare still does not have an operational computer system for eligibility determination. In addition to being fundamentally misguided, there seems to be a rush to implement this proposal when there is not a system in place to handle it.
- No consideration is given to the problem of lack of the computer or internet access (and ability to use the technology) that will be necessary to document exemptions or compliance. This is a problem for those living in rural areas of our state without adequate internet service, those who cannot afford a computer, those who do not have ready access to public computers, or transportation to places with computers they can use, and those who do not have the computer literacy to use the systems, once they are created.
- No consideration is given to the obstacle of lack of transportation, both in rural areas and among those who lack the financial resources to have a car or to pay for public transportation. This is a problem related both to the ability to hold a job, as well as the ability to document exemptions or compliance, for those who need to use public computers to do so.
- Since Tennessee has not expanded Medicaid, this proposal sets up a Catch-22 for individuals who obtain employment to meet the work requirements, but then will lose their health coverage anyway, because their jobs will not provide private health insurance and will only pay enough to put the individual just above the poverty level.
- Creating a system to handle this proposal will cost a great deal of money. In my opinion, the cost of the bureaucracy and systems to manage this program far outweighs any theoretical benefit.
- How this proposal will be funded has not been assured. The draft amendment states that "Tennessee will seek the necessary approval from the U.S. Department of Health & Human Services to utilize funds from the state's TANF program." This funding proposal is not a "done deal," and if it were, it is especially egregious that the proposal seeks to take funds away from TANF, which focuses on needy families "gaining self-sufficiency through employment" (www.tn.gov/humanservices/for-families/families-first-tanf.html) to create a system to remove health insurance from those who are unemployed.
- Since the proposal states that "it is estimated that a significant number are already working, or will be deemed to be in compliance with the requirement by virtue of their participation in the SNAP or TANF work program, or will qualify for an exception to the requirement," AND further states that "it is not possible to reliably project the magnitude of the decrease of [TennCare] enrollment at this time," this whole proposal seems to be a misguided way of spending a great deal of money, creating a great deal of

bureaucracy and red tape, and most importantly, putting an undue and unnecessary burden on our most vulnerable populations, without even an estimated benefit to our state.

Why go to such lengths when the target population is so small, and the risk to the health and wellbeing of those who are unable to comply or to document their compliance is so great? In short, this proposal seems to be a misguided solution in search of a problem. According to the Kaiser Family Foundation, “Just six percent of non-SSI, non-elderly Medicaid adults are not already working, are not potentially medically frail, and do not report not working for a reason likely to meet an exemption.” Further, the Kaiser Family Foundation states, “This target population is much smaller than the group of enrollees who are already working but would need to comply with new reporting requirements and those who could be exempt and would have to navigate the exemption process. States will need to set up complex systems to handle the reporting and exemption processes which could divert resources away from administrative dollars that could assist individuals in finding work in voluntary programs.”

Because of all of the reasons stated above, I urge you to reconsider this proposal.

Sincerely,

Lynn Fritz
Volunteer, NAMI Davidson County

Jonathan Reeve

From: Currin, Tamara <TCurrin@marchofdimes.org>
Sent: Friday, October 26, 2018 12:49 PM
To: Public Notice. Tenncare
Subject: Public Comments - 1115 Waiver Amendment, Amendment 38
Attachments: March of Dimes TN 1115 Waiver Comments.pdf

March of Dimes, Tennessee appreciates the opportunity to submit the attached comments on Tennessee's 1115 Waiver Amendment, Amendment 38 to the TennCare II Demonstration.

Sincerely,

TAMARA CURRIN, MS, MCHES
Director of Maternal Child Health & Government Affairs
Tennessee

MARCH OF DIMES

OFFICE OF GOVERNMENT AFFAIRS
T (615) 800-7181
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TAMARA CURRIN
Director
Maternal Child Health & Government Affairs
TENNESSEE

T (615) 800-7181
E tcurrin@marchofdimes.org
MARCHOFDIMES.ORG

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long,

March of Dimes appreciates the opportunity to submit comments on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration."

For 80 years, the March of Dimes has led the fight for the health of all moms and babies. Moms and babies in this country are facing an urgent health crisis. Premature birth and its complications are the largest contributor to infant mortality in the United States and globally. Mothers of color are up to 50 percent more likely to give birth prematurely and their children face a 130 percent higher infant death rate. In addition to the human toll, the societal cost of this issue exceeds $26 billion annually.

March of Dimes believes everyone, including TennCare enrollees, should have access to quality and affordable health coverage. Unfortunately, this waiver creates new administrative barriers that will jeopardize patients' access to quality and affordable health coverage, and March of Dimes therefore opposes the proposed waiver.

The Tennessee Amendment 38 seeks to add a work and community engagement requirement for most TennCare enrollees. This would increase the administrative burden on all TennCare patients. Individuals will need to either report that they meet certain exemptions or the number of hours they have worked. Increasing administrative requirements will likely decrease the number of individuals with TennCare 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 October 1, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[i] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[ii] 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

MARCH OF DIMES

TAMARA CURRIN
Director
Maternal Child Health & Government Affairs
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program by the end of 2004.[iii] 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 two months out of a six-month period, they will be locked out of coverage until they demonstrate their compliance. 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.

March of Dimes is 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, Tennessee's "good cause" exemption 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.[iv] 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 Tennessee. States such as Michigan, Pennsylvania, Kentucky 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.[v] Tennessee's fiscal impact statement estimated the program would cost approximately the state and federal government $39.8 million over the course of the waiver.[vi] 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. Most people on Medicaid who can work already do so.[vii] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[viii] 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 a 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).[ix] Terminating individuals' TennCare coverage for non-compliance with these requirements will therefore hurt rather than help people search for and obtain employment. Tennessee has experience with this. In 2005, when the state changed the TennCare program's eligibility and 170,000 people lost Medicaid coverage, there was no increase

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in employment and self-reported health and access to medical care declined.[x] March of Dimes opposes the work and community engagement.

March of Dimes also wishes to highlight that 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. However, on pages 5 of this proposal, the Department states that "*Some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, it is not possible to reliably project the magnitude of this decrease in enrollment at this time*." We urge the TennCare to update the waiver amendment with the estimated expenditure and estimate enrollment change and reopen the state comment period for an additional 30-days.

March of Dimes believes healthcare should affordable, accessible, and adequate. Tennessee's Amendment 38 does not meet that standard. Thank you for the opportunity to provide comments.

Sincerely,

Tamara Currin

Tamara Currin
Director of Maternal Child Health and Government Affairs
March of Dimes, Tennessee

---

[i] 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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[iii] 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.

[iv] 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/.

[v] 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-

MARCH OF DIMES

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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.

[vi] Tennessee General Assembly Fiscal Review Committee. Fiscal Note HB 1551- SB 1728. February 12, 2018. Accessed at: http://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf

[vii] 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/

[viii] 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

[ix] 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

[x] DeLeire, Thomas. The National Bureau of Economic Research. NBER Working Paper No. 24899: The Effect of Disenrollment from Medicaid on Employment, Insurance Coverage, Health and Health Care Utilization. August 2018. Accessed at: https://www.nber.org/papers/w24899

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of margaretaxelrod@gmail.com
Sent: Sunday, October 07, 2018 8:54 AM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

As a medical student, I am opposed to any new requirements which would limit access to care for vulnerable populations. I am concerned that work requirements would place an undue burden on vulnerable patients and cause many to unfairly lose access to crucial care.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Margaret Axelrod

395 Oman St
Nashville, TN 37203

Jonathan Reeve

From: Marissa Cornelious <labreagal@gmail.com>
Sent: Wednesday, October 24, 2018 1:57 PM
To: Public Notice. Tenncare
Subject: Medicaid work requirements

I live in Montgomery Co TN.
I have lived in both Montgomery and Davidson Counties while working for the Department of Human Services as an Eligibility Counselor. I worked in that department for five years, evaluating participants for eligibility and their compliance with policy.
I was a member of the Families First Unit in both counties.
I issued food stamps, cash, medical assistance and child care for five years.
The program changed drastically while I was a member of the department and we got to see the before and after effects as those changes were implemented.

I have had an extended family sit in my cubicle and apply for medical assistance and had to tell them that they had to apply for welfare for the adults to be covered. If they didn't, grandpa may be eligible because he had a work connection, but since grandma never worked after the kids were born and she isn't yet 65yrs old, she doesn't qualify for medical assistance.
I've had to tell a 55yr old woman who stayed at home and raised her children and is now raising her grandchildren that in order to get medical coverage, she'll have to do a work activity. I remember her case especially because she needed surgery on her feet, had diabetes and couldn't afford her meds. I remember attempting to get her covered, give her the opportunity to recover before requiring that she show up at the salvation army to sort clothes as her "work activity" shortly after having surgery on her feet. It was torture for her.
I've had to tell a single mom who's working and going to college that she needed an additional job or work activity to keep the benefits helping them stay above water.

These work requirements more often than not are the barriers thrown up, get in the way of those attempting to work their way out of poverty.
They are unnecessary.
They add no value to the lives of those required to do them or the community.
They are penalties for needing help.

American Citizens shouldn't have to grovel to their government for the basic need of healthcare.
We are the richest nation in the world.
Our priorities are terribly mixed up if we feel the need to make the poor prove their worthiness to receive healthcare.
They are worthy by dint of being Americans.
Their government should not impose harsh and arbitrary obstacles to the benefits they need just to survive.

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Marissa Cornelious
Star Independent Scentsy Consultant
615-589-0766
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Jonathan Reeve

From: Mary H. Clarke <mhclarke@icloud.com>
Sent: Wednesday, October 17, 2018 5:47 PM
To: Public Notice. Tenncare
Subject: TennCare Work Requirements Proposal comment

Please reject this proposal.
It will add more bureaucracy to the process of administering TennCare and it will cause people to lose their healthcare insurance.
This will cost us more in the long run.

Thank you for your consideration,
Mary Clarke
Nashville TN

Jonathan Reeve

From: Mary Frances Clark <mfclarkbar@comcast.net>
Sent: Friday, October 26, 2018 9:31 AM
To: Public Notice. Tenncare
Subject: Proposed Amendment 38

ATTN: Dr. Wendy Long, Division of Tenncare

Dear Dr. Long,

I adamantly oppose the proposal (draft Amendment 38) to deny health care coverage to people who do not work a set number of hours a month.

I am an attorney, and a resident of Tennessee. I can speak to this issue personally: Many years ago, my unemployed parents received Medicaid benefits that enabled them to live long enough to finish raising their children. I and my seven siblings have seven college degrees and many advanced degrees among us. All of us are affluent, tax-paying citizens of this country.

The additional qualifying and reporting requirements would impose complex administrative burdens on people and their families who already are stressed. Furthermore, taking health care coverage away from the unemployed, which is the intent of the proposed amendment, undermines the goals of the Medicaid program and also the aim of the proposal itself. Unemployed people who are deprived of health care are less able to look for work and less able to work; if their health issues are left untreated, those people are less attractive to potential employers and thus more likely to remain unemployed.

The administrative costs of implementing the proposed amendment are staggering. Those amounts would be better used to pay health care-related expenses. I object to my tax dollars being used to deprive otherwise-eligible people of health care.

I strongly urge you not to proceed with a bad proposal.

Very truly yours,

Mary Frances Clark
1690 Kindra Ct.
Brentwood, TN 37027

Jonathan Reeve

From: Mary Hock <hockmary@gmail.com>
Sent: Friday, October 26, 2018 9:58 PM
To: Public Notice. Tenncare
Subject: Public Chapter 869

I oppose the proposed Public Chapter 869, which requiresTennCare to submit a waiver proposal for "reasonable" work requirements for non-disabled adults under 65 without children under 6 yrs old.

I am a social worker in Tennessee, and I have seen how the bureaucracy, red-tape, and inability of the state's computer systems to adequately update the TennCare roles have negatively impacted thousands of needy TennCare-eligible citizens. Additionally, "reasonable" is a very subjective and non-specific term which will most likely cause a lot of glitches, clogging up the system with appeal processes, etc.

Our legislature is definitely non-supportive of needy families across Tennessee, particularly regarding their health needs. Adequate health coverage, and convenient hospitals in rural areas will in the long run save the state many dollars. Instead, hospitals are being closed and people are becoming sicker who WERE once able to work.

Please, DO NOT APPROVE Public Chapter 869!

Sincerely,

Mary Hock, LCSW
Nashville TN 37217

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of mary.hunt@fcsnashville.org
Sent: Tuesday, October 09, 2018 10:46 AM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Mary Moore
1337 Cheyenne Blvd
Madison, TN 37115

Mental Health America of Middle Tennessee

October 8, 2018

Dear TennCare Bureau:

Mental Health America of Middle Tennessee (MHAMT) believes that every Tennessean should have an opportunity for employment, however, we feel that the work requirements are harsh and punitive to our most vulnerable Tennesseans. Park Center, just one community mental health center in Nashville, has over 100 people on a waiting list for IPS supportive employment, and everyone on the waiting list has a mental health diagnosis and wants to work. Investing in employment supports is more fruitful than mandates. Tennessee's older adults ages 60-64, may serve as primary caregivers for someone with Alzheimer's or for an adolescent with disabilities, and they would be discriminated against for their general lack of experience with computers and technology.

While against the work requirement as a whole, Waiver Amendment 38 contains a specific provision affecting people with Substance Use Disorder (SUD) that violates CMS guidance. Nevertheless, conforming the waiver proposal to the CMS guidance will not cure the inherent problems with the concept of work requirements.

Here is the conflict. On page 6 of the January 11, 2018 CMS letter inviting states to submit work requirements waiver requests, it specifically states:

> CMS also recognizes that many states currently face an epidemic of opioid addiction, which has been declared a national public health emergency by the Secretary. States will therefore **be required** to take certain steps to ensure that eligible individuals with opioid addiction and other substance use disorders (who may not be defined as disabled for Medicaid purposes but may be protected by disability laws) have access to appropriate Medicaid coverage and treatment services

Waiver Amendment 38 (page 3) exempts "individual participating in inpatient or residential treatment for a substance use disorder," which is far too narrow for compliance.

Obviously, Waiver Amendment 38 does not "ensure that eligible individuals with opioid addiction and other substance use disorders ... have access to appropriate Medicaid coverage and treatment services." Especially in light of the well-documented shortage of residential or institutional treatment Tennessee, Waiver Amendment 38 exemption does not adhere to CMS guidance and state initiatives to get people with SUD into treatment.

Respectfully submitted,

Tom Starling, EdD
President/CEO

446 Metroplex Dr, Ste. A-224 ~ Nashville, TN 37211 ~ (615) 269-5355 ~ Fax: (615) 269-5413

Jonathan Reeve

From: Meredith <meri2244@yahoo.com>
Sent: Friday, October 26, 2018 12:42 PM
To: Public Notice. Tenncare
Subject: New Work Requirement for TennCare

Please do not add a new work requirement to people depending on TennCare for the healthcare. Healthcare is a human right.

Thank you,
Meredith Robinson
815 Shelby Ave
Nashville, Tn. 37206

Sent from my iPhone

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of Plaugeness@sol.com
Sent: Thursday, October 25, 2018 9:58 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Merrilee Laugeness
Nami Tn
215 Chelsea ct
Clarksville , TN 37043

Jonathan Reeve

From: Michael Heinrich <heinrich@mcil.org>
Sent: Friday, October 26, 2018 1:20 PM
To: Public Notice. Tenncare
Subject: I unequivocally oppose the proposal to take health coverage away from people who are unemployed

Dr. Wendy Long
Division of TennCare
via email to: public.notice.tenncare@tn.gov
RE: TennCare Waiver Amendment 38
Dear Dr. Wendy Long,
I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38.

I am unequivocally opposed to this proposal that would take health coverage away from people who do not work a set number of hours per month. This proposal would cause immense harm and jeopardize coverage for thousands of Tennesseans.
Failure to meet reporting requirements and paperwork errors will result in suspension of coverage for thousands of Tennesseans.
The proposed waiver would lead to large coverage losses even though they remain eligible. Reasons include TennCare's lack of computer system, the barriers to working like lack of reliable transportation and child care, and barriers to reporting.

These coverage losses will cause harm. Disruption of treatment or loss of access to health care would affect cancer patients, people with addiction, and people with diabetes among others.

In addition, this proposal leaves many unanswered questions.
How do people report compliance?
How can TennCare administer this complex eligibility determination without an eligibility determination computer system, which is not yet complete?
How will the reporting process accommodate people with disabilities, limited literacy or language?
What is "good cause" for waiving compliance by certain individuals?
What criteria will be used to exempt "economically distressed" counties?
I serve/people whom I know would be negatively impacted by this proposal to take away coverage from people who don't meet the new work requirement.

This waiver is fundamentally flawed and cannot be fixed. It goes against the goals and purpose of the Medicaid program.
I respectfully urge you to not go forward with this harmful proposal.
Sincerely,

Michael J Heinrich
3712 Carrington Rd
Memphis, TN 38111

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of suziemcbroom@gmail.com
Sent: Friday, October 19, 2018 2:59 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Micki McBroom
1965
233 Carr Ave
Cookeville, TN 38501

Jonathan Reeve

From: nancy cri <nightngale_37918@yahoo.ca>
Sent: Tuesday, October 09, 2018 10:55 AM
To: Public Notice. Tenncare

I am aware that this proposal would cause immense harm and jeopardize coverage
RE: TennCare Waiver Amendment 38

I am Nancy Crider-Cook. I have a Doctorate in Psychology and work as a Licensed Professional Counselor in East TN counties.
I am responding to a recent email that came out in awareness to the Amendment 38. I am aware of the work requirement changes that thousands of Tennesseans will face in regards to their health and mental health coverage with this legal action. My response is approach this change with a conscience of positive change to empower people and fine tune the details toward the change for it to succeed. We have all sorts of advocates and workers that can work together if brought into the picture.

I am told that the reporting system of the hours is to be complicated electronically and must be completed on an online method of communication. Lets face it, most of the Tenncare families do not have computers, they may have cell phones but its limited services and minutes, and a lot of them do not have vehicles. These families need case management services that can make sure that they can complete their documents, know how to read and write, and get it turned in time, as well as be helped in finding work, volunteer activities, or some method to meet their requirements. For people over in Hancock area for example, its 45 minutes over a switch back mountain to get to a Walmart. They do not have any means to find work, no transportation that can go over a mountain weekly, and do not have cell phone signal in most of that mountain region. I have difficulty even seeing clients as a provider over in those rural areas once a month due to these issues. We got to have a method in place otherwise, failure and sickness will occur.

Yes a lot of the people on Tenncare can work (I have seen that personally) or have ability to contribute physically/ mentally back to the state in some form but there are those cases with cancer, extreme physical impairment, extreme mental impairment, etc. that will not be able to do the hours most days then not. A safe way to monitor through case management once again should be in place to assess this process and identify that population. I know that if a person contacts their caseworker of their Tenncare Health insurance that they can set up medical appointments for them. Why are the same case managers not assessing and helping the population at same time to meet these requirements. I think the issue lies in that the case workers are focuesed on setting up a health service and do not know what else is expected of the person to

receive their free health insurance. The goal is about about receiving the benefit, getting back on a healthier track of living, maybe find productive work, maybe find private health insurance that is affordable and get off the Tenncare system. This takes me to another issue, food stamps, this free benefit is to help supplement food in a family, and hopefully give a person a chance to get back on their feet and self provide for their family if possible. This leads to the same issue of employment, transportation, and a means of doing it. If the jobs are not there and the transportation if lacking than the person cant succeed.

If the loss of a service causes a person further physical harm then as a state we need to step in and offer help to that individual if they are wanting it. That gets to my next issue, there are people that do not want help and sadly it is their choice. If they do not follow drug and alcohol treatment programs for example, and meet timely detox requirements, and clean drug testing, then why are we continuing to support the person. I am sure my fellow practitioners would look upon me stating this as harsh and uncaring but I feel like we are contributing to the drug epidemic by not making people accountable for a drug addiction. A person has to want to help themselves to get better or we are continuing to hinder and create dependence upon us as the caretaker and provider. It is an unethical practice to continue to offer services when a person is not agreement in the goals of the service of care.

Well I think that makes my points very clear and hopefully gives some food for thought as they say! Sincerely and eagerly excited for positive reforms and changes! Nancy Crider-Cook

Jonathan Reeve

From: Naomi Goodin <intp.125@gmail.com>
Sent: Friday, October 05, 2018 8:13 PM
To: Public Notice. Tenncare
Subject: Opposed - TennCare work requirement

The proposed TennCare work requirement would unnecessarily cause many people to lose coverage. I know this is the real purpose behind it, but by not expanding Medicaid (TennCare) in this state we already have 280,000 people without any kind of health insurance, and this would just add more. Most people who can work are working, and those are not have to take care of family members or have no transportation to jobs. It would also create another level of bureaucracy that would be expensive on the state's part and hard to access on recipients' parts, because many don't have Internet access. Stop this bill and let it die.

Sincerely,

Naomi Goodin
Nashville, TN 37205

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of natasha@deanefoundation.com
Sent: Sunday, October 07, 2018 1:55 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

Thank you for taking public comment on amendment 38 to our state managed care system known as TennCare. TennCare is one of the country's most innovative and low-cost state run indigent health care systems and periodic review of the program is both good and necessary.

My understanding of the demographic for TennCare participants is that the majority of participants already meet the minimum threshold for work or education, and that the intent of the amendment is to increase the proportion who are actively working or seeking education to a minimum of 20 hours per week with the expected benefit of improved healthcare outcomes.

As a retired medical professional and co-founder of the John and Natasha Deane Foundation, I oppose amendment 38 because many TennCare participants are low income single parents or caregivers of elders at high risk for chronic stress related disease. Imposing government mandated work requirements for this population has the very real potential to remove the strongest community members from vital non-paid community work such as caregiving and accountability partnering. This mandate will accelerate the downward spiral of families faced with difficult choices in at-risk, high-poverty environments and ultimately hurt communities throughout the state more than help.

In addition, amendment 38 will cause a significant number of TennCare participants to loose coverage due to circumstances already contributing to their unemployment. These are non-exempt persons with low educational achievement, poor health, lacking access to home internet, or lacking reliable transportation. Thus, the most vulnerable people covered by TennCare are at highest risk for losing coverage under amendment 38. Without access to preventive managed care, these individuals can be expected to show up in expensive area emergency care facilities when their medical conditions progress, a cost that is ultimately transferred to taxpayers.

If the purpose of TennCare is to protect our state's most vulnerable population at the lowest cost, then Amendment 38 weakens a program that is highly regarded in its current form.

For this reason, I oppose adoption of amendment 38 and so should you.

Respectfully,

Natasha Deane
Dr.
1212 Laurel St. #1901
Nashville, TN 37203

Jonathan Reeve

From: Jake Coffey <JCoffey@namitn.org>
Sent: Thursday, October 25, 2018 3:36 PM
To: Public Notice. Tenncare
Cc: Jeff Fladen
Subject: Re: TennCare Waiver Amendment 38
Attachments: 2018.10.26 NAMI Comments on TN 1115 Waiver.pdf

Dr. Long,

On behalf of NAMI Tennessee, the state chapter of the National Alliance on Mental Illness, I am submitting the attached letter in response to the public notice inviting public comments on proposed Waiver Amendment 38 urging the Division of TennCare to withdraw this proposal. Regards,

Jake

Jake Coffey, MPH, MA
Director of Advocacy and Planning
NAMI Tennessee
1101 Kermit Drive Suite 605
Nashville, TN 37217
p. 615-361-6608 ext. 315 c. 615-496-2943
jcoffey@namitn.org | www.namitn.org

1101 Kermit Drive Suite 605
Nashville, TN 37217

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Dr. Long:

NAMI Tennessee, the state chapter of the National Alliance on Mental Illness, appreciates the opportunity to submit comments on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration." NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

Access to coverage and care is essential for people with mental illness to successfully manage their condition and get on a path of recovery. Medicaid is the lifeline for much of that care, as the nation's largest payer of behavioral health services,[i] which provides health coverage to 27 percent of adults with a serious mental illness[ii]. TennCare is the largest payer for mental health and substance use treatment services in the state. While Amendment 38 would apply new work requirements for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer, NAMI remains concerned that the demonstration proposal would jeopardize access to care and would have broader, harmful implications for individuals living with mental health conditions in Tennessee. Therefore, NAMI Tennessee urges the Division of TennCare to withdraw this proposal.

Unnecessary Risks for People with Mental Health Conditions, Diagnosed and Undiagnosed

NAMI appreciates Tennessee's goal to "support member efforts to achieve their education- and employment-related goals." However, Tennesseans who receive coverage through TennCare often have significant obstacles to employment that are not erased by taking away their health care. NAMI also recognizes that people with mental illness are disproportionately unemployed. Only 1 in 5 adults with mental health conditions who receive community mental health services are competitively employed—and the numbers drop to only 6.7% for adults with a diagnosis of schizophrenia.[iii] Employment offers many benefits to people with mental illness, and most people who live with mental health conditions want to work. However, work requirements present unnecessary risks for people with mental health conditions.

NAMI recognizes that Tennessee's proposal includes exemptions for "individuals…mentally incapable of work," "medically frail," and "individuals with…an acute medical condition validated by a medical professional that would prevent them from complying." While these exemption may capture some people with mental health conditions, NAMI remains concerned that the exemptions will not capture all

people with mental health conditions who would otherwise be adversely impacted by work requirements. Serious mental illnesses are, by their very nature, chronic and recurring conditions that fluctuate in severity over time. This means that an individual could be in a state of recovery at the time they are assessed and face few obstacles to working. However, the person's condition could change rapidly, impacting their ability to alert TennCare of their decline. Consequently, the beneficiary experiencing a crisis or decline in their condition could lose both their employment and health care coverage at the very time they need access to mental health care the most. Sadly, we know what happens when people with a mental illness don't get treatment; they end up in hospital emergency rooms, in jail, or on the streets with worse long-term outcomes and at greater cost to the state and the federal government.

Arkansas is currently implementing a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. As of October 1, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[iv] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[v] 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.[vi] We have additional concerns about implementing work requirements before the Tennessee Eligibility Determination System (TEDS) is fully operational. Battling technical issues and 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.

Unnecessary Administrative Costs

NAMI is also concerned about the cost of implementing this demonstration proposal. Studies show that work requirements do not lead to long-term, stable employment. Instead, they increase state administrative costs and complexity.[vii] States such as Michigan, Pennsylvania, Kentucky, 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.[viii] Tennessee's fiscal impact statement estimated the program would cost approximately the state and federal government $39.8 million over the course of the waiver.[ix] These costs would divert resources from TennCare's core goal – providing health coverage to those without access to care. Rather than spending scarce public resources on the administration of new requirements, NAMI urges the state to instead implement evidence-based supported employment programs, which have proven effective in helping vulnerable populations, such as people with mental illness recover and return to work.[x] This meets the intent of the demonstration proposal without the adverse consequences presented by a mandatory work requirement.

Incomplete Application

NAMI Tennessee also notes that 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. However, on pages 5 of this proposal, the Department states that "*Some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, it is not possible to reliably project the magnitude of this decrease in enrollment at this time*." We urge TennCare to update the waiver amendment with the estimated expenditure and estimate enrollment change and reopen the

state comment period for an additional 30-days.

Ultimately, we believe that imposing work requirements will take Tennessee backwards without furthering the goals of the Medicaid program. NAMI urges Tennessee to withdraw this proposal as it will not promote patient care and will likely harm patients with mental health conditions. We encourage the department to focus on solutions to implement evidence-based supported employment for TennCare recipients. Thank you for the opportunity to provide comments.

Sincerely,

Jake Coffey, MA, MPH
Director of Advocacy

On behalf of NAMI Tennessee

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[i] Medicaid and CHIP Payment and Access Commission, "Behavioral Health in the Medicaid Program—People, Use, and Expenditures," June 2015, https://www.macpac.gov/publication/behavioral-health-in-the-medicaid-program%E2%80%95people-use-and-expenditures/

[ii] Rebecca Ahrnsbrak, Jonaki Bose, Sarra Hedden, Rachel N. Lipari, and Eunice Park-Lee, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration, September 2017, https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf

[iii] Tim Knettler, Ted Lutterman et al, NRI, *Latest Trends in State Mental Health Agencies.* https://www.nasmhpd.org/sites/default/files/latest-trends-in-state-mental-health-agencies.pdf (August 8, 2016).

[iv] 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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[v] 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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[vi] 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.

[vii] Jane Perkins, Mara Youdelman & Ian McDonald, National Health Law Program, *Work Requirements: Not a Healthy Choice*, http://www.healthlaw.org/publications/browse-all-publications/medicaid-work-requirementsnot-

[viii] Senate Fiscal Agency, Bill Analysis for SB 897, March 21, 2018, http://www.legislature.mi.gov/documents/2017-2018/billanalysis/Senate/pdf/2017-SFA-0897-S.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.

[ix] Tennessee General Assembly Fiscal Review Committee. Fiscal Note HB 1551- SB 1728. February 12, 2018. Accessed at: http://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf

[x] Examples of successful evidence-based programs include IPS Supported Employment (which places people with mental illness in competitive jobs in the community) and the comprehensive service array in First Episode Psychosis programs (FEP) that

includes supported employment. Both these interventions have been shown to improve the employment outcomes of people with mental illness at rates far higher than the national average.

Jonathan Reeve

From: Robin Nobling <rnobling@namidavidson.org>
Sent: Thursday, October 25, 2018 10:17 PM
To: Public Notice. Tenncare
Subject: NAMI Davidson Commentary Amendment 38
Attachments: Lynn Fritz NAMI Davidson Medcaid TennCare Work Requirements for Benefits Commentary.pdf

Please note the attached letter by mom and NAMI Davidson Policy and Advocacy Volunteer Lynn Fritz. Lynn has shared some of her personal story. She has also explicitly laid out why she and NAMI Davidson County oppose the Amendment as it stands. Lynn has been eloquent and well researched in her commentary. Please review and accept this as NAMI Davidson County's commentary on the Waiver.

Thank you,

Robin Nobling

NAMI
National Alliance on Mental Illness
Davidson Co.
We talk about it

Robin Nobling
Executive Director
615.891.4724 x 304
Cell: 828.606.0465
1101 Kermit Dr.
Ste 506 (NEW)
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educate advocate listen lead

"Be kind whenever possible. It is always possible."

- His holiness The Dali Llahma

October 25, 2018

RE: Comments on Medicaid TennCare Work for Benefits Requirements
https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment38.pdf

Dear Dr. Wendy Long,

Please consider my comments below on the proposed Waiver Amendment 38. I am the parent of an adult child who is living a very successful recovery with a serious mental illness. I also am a volunteer legislative advocate/lobbyist for NAMI Davidson County, the National Alliance on Mental Illness. Because of the experiences of my family navigating mental health crises, treatment, and recovery, I am passionate about the importance of accessible and affordable treatment for serious mental health conditions, as well as substance abuse treatment.

I am completely opposed to this proposal that would result in the stripping of health coverage from vulnerable populations. Fundamentally, it makes no sense to me that the state would seek to circumvent the goal of the Medicaid program, which is to "provide health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities" (Medicaid.gov). Medicaid is a health insurance program, not an employment program. I fail to see how removing health coverage promotes health.

This is a negative approach to creating an incentive to work, which will work against the stated goal of Medicaid, versus a more desirable positive approach to supporting employment, that should be provided by an agency with the stated goal of decreasing unemployment and supporting employment. Individual Support Programs (ISP) to provide supportive employment to individuals with mental health issues are growing, but still are not available in many areas of our state. Expanding these programs would be a much more effective and positive way of increasing employment.

In addition, depriving people of health care will make it more difficult for them to work and to maintain employment. It is especially imperative for those dealing with mental illness to have access to treatment in order to stay healthy and be able to work.

While the draft of Amendment 38 includes an exemption for "individuals who are physically or mentally incapable of work, as certified by an appropriate medical professional," this is little comfort for the following reasons:

- When it is already a challenge to obtain treatment for mental illness, given the lack of mental health providers (which is especially pronounced in rural areas of our

state), the individual will have the burden of obtaining the certification of an "appropriate medical professional."

- A definition of "appropriate medical professional" is not provided, leaving the possibility that, even if a patient had access to a medical professional, that professional may not be deemed "appropriate" to grant an exemption.

- The burden will lie with the individual dealing with a mental illness to prove that they qualify for this exemption. Navigating the necessary paperwork and obtaining the necessary documentation from a medical professional is a barrier that will be too difficult for many dealing with mental illness to overcome.

- Mental illness can often result in intermittent periods of crisis in between periods of calm. This nature of mental illness can make ongoing employment challenging. This proposal sets up the potential of a person dealing with mental illness falling in and out of compliance with the work requirement, thereby seriously jeopardizing the continuing health care needed to keep those dealing with mental illness stable and healthy.

- It is short sighted and financially irresponsible to place a burden on people that endangers their necessary ongoing health care, and potentially creates, through losing access to health care, a crisis situation requiring intervention. Intervention at a crisis level of care is much more expensive than routine outpatient treatment. With the cost of managing and monitoring this program, and the potential for creating stress and anxiety that exacerbates mental health symptoms, any potential financial benefits become nil. Monies would be better spent in supportive case management programs that progressively step people down from a crisis episode and gradually build them into readiness for an ISP program.

While an exemption is also included in the draft for "individuals participating in inpatient or residential treatment for a substance use disorder," this does not help any individuals who have been unable to secure a bed in a residential treatment center because of lack of enough facilities or because of their location in an area with not enough beds. It also leaves vulnerable those struggling with a substance abuse disorder who are receiving intensive outpatient treatment or other modes of treatment that will not qualify. It is hard enough for those with substance use disorders and their families to get the treatment they need, without introducing additional barriers.

The draft proposal also lists an exemption for "individuals who are providing caregiver services for a household member (child or adult) with a disability or incapacitation." There is no detail given, however, to ensure that, for example, the caregiver of a family member whose mental illness causes a sudden health crisis, will qualify for this exemption.

In short, regarding the exemptions noted above, an "exemption" is not a "protection," and there is no assurance that those who qualify for the exemptions will be able to maintain their health coverage.

I have many specific concerns about this proposal, in addition to my basic disagreement with its goal and premise and my concern about the implementation of the exemptions discussed above. These concerns include:

- The studies cited in the proposal draft to justify a link between work and improved health outcomes are significantly outdated and not based on Tennessee's Medicaid population. They range from 2005 to 2008, and one of the studies is from outside the U.S.A. (from the UK).
- The draft proposal says that Amendment 38 will "provide corresponding supports to help enrollees achieve their education or employment-related goals," but no detail about these supports is provided.
- While the document states that "individuals subject to and complying with the work requirements of another public assistance program (i.e., SNAP or TANF) will be deemed to be in compliance," the exemptions listed in this proposal are much narrower than those of the SNAP program. The minimum of 65 years of age is older than the SNAP requirement and older than other state minimums.
- No detail is provided about how "counties that are determined to be economically distressed" will be defined or identified.
- No detail is provided about how individuals will be linked to existing community resources to achieve education- and employment-related goals, especially in rural areas.
- No detail is provided about how individuals will document either their qualifying for an exemption or their compliance with the work requirements. This is especially concerning given that TennCare still does not have an operational computer system for eligibility determination. In addition to being fundamentally misguided, there seems to be a rush to implement this proposal when there is not a system in place to handle it.
- No consideration is given to the problem of lack of the computer or internet access (and ability to use the technology) that will be necessary to document exemptions or compliance. This is a problem for those living in rural areas of our state without adequate internet service, those who cannot afford a computer, those who do not have ready access to public computers, or transportation to places with computers they can use, and those who do not have the computer literacy to use the systems, once they are created.
- No consideration is given to the obstacle of lack of transportation, both in rural areas and among those who lack the financial resources to have a car or to pay for public transportation. This is a problem related both to the ability to hold a job, as well as the ability to document exemptions or compliance, for those who need to use public computers to do so.
- Since Tennessee has not expanded Medicaid, this proposal sets up a Catch-22 for individuals who obtain employment to meet the work requirements, but then will lose their health coverage anyway, because their jobs will not provide private health insurance and will only pay enough to put the individual just above the poverty level.

- Creating a system to handle this proposal will cost a great deal of money. In my opinion, the cost of the bureaucracy and systems to manage this program far outweighs any theoretical benefit.
- How this proposal will be funded has not been assured. The draft amendment states that "Tennessee will seek the necessary approval from the U.S. Department of Health & Human Services to utilize funds from the state's TANF program." This funding proposal is not a "done deal," and if it were, it is especially egregious that the proposal seeks to take funds away from TANF, which focuses on needy families "gaining self-sufficiency through employment" (www.tn.gov/humanservices/for-families/families-first-tanf.html) to create a system to remove health insurance from those who are unemployed.
- Since the proposal states that "it is estimated that a significant number are already working, or will be deemed to be in compliance with the requirement by virtue of their participation in the SNAP or TANF work program, or will qualify for an exception to the requirement," AND further states that "it is not possible to reliably project the magnitude of the decrease of [TennCare] enrollment at this time," this whole proposal seems to be a misguided way of spending a great deal of money, creating a great deal of bureaucracy and red tape, and most importantly, putting an undue and unnecessary burden on our most vulnerable populations, without even an estimated benefit to our state.

Why go to such lengths when the target population is so small, and the risk to the health and wellbeing of those who are unable to comply or to document their compliance is so great? In short, this proposal seems to be a misguided solution in search of a problem. According to the Kaiser Family Foundation, "Just six percent of non-SSI, non-elderly Medicaid adults are not already working, are not potentially medically frail, and do not report not working for a reason likely to meet an exemption." Further, the Kaiser Family Foundation states, "This target population is much smaller than the group of enrollees who are already working but would need to comply with new reporting requirements and those who could be exempt and would have to navigate the exemption process. States will need to set up complex systems to handle the reporting and exemption processes which could divert resources away from administrative dollars that could assist individuals in finding work in voluntary programs."

Because of all of the reasons stated above, I urge you to reconsider this proposal.

Sincerely,

Lynn Fritz
Volunteer, NAMI Davidson County

Jonathan Reeve

From: Franklin, Karen <kfranklin.naswtn@socialworkers.org>
Sent: Friday, October 26, 2018 3:43 PM
To: Public Notice. Tenncare
Subject: NASW, Tennessee Chapter Comments
Attachments: NASW-TN Comments- MedicaidWorkRequirementsWaiver.pdf

Please see the attached comments.

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NASW TENNESSEE CHAPTER
National Association of Social Workers

October 26, 2018

Dr. Wendy Long
Director, Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Dr. Long,

I am writing on behalf of the Tennessee Chapter of the National Association of Social Workers (NASW-TN) to share comments on proposed Waiver Amendment 38. We understand that the TennCare Bureau was mandated by the legislature to submit an amendment to the existing TennCare waiver to create reasonable work and community engagement requirements for able-bodied working age adult enrollees without dependent children.

NASW-TN was pleased to support the input provided earlier this week by the Tennessee Coalition for Mental Health and Substance Abuse Services on the draft amendment. We also commend the comments submitted by the League of Women Voters.

NASW-TN opposes the implementation of Medicaid work requirements, and believes work requirements do not promote the objectives of the Medicaid statute. 1115 waivers must promote the objectives of the Title XIX (the Medicaid title) of the Social Security Act. The core objective of Title XIX is assisting low-income people to get medical services. The experience of other states illustrate that work requirements lead to low-income people losing their health coverage, an outcome totally at odds with the purposes of the Act.

We know other groups have addressed specific concerns related to the waiver, and our brief comments will focus on the potential impact on families with children up to age 18. We initially understood that the legislative intent of Public Chapter 869 exempted caregivers with children up to age 18, but the draft waiver does not reflect this. We urge you to take into consideration the attached analysis from the Sycamore Institute on *Obstacles To Work Among TennCare Enrollees Potentially Affected by A Work Requirement*. This analysis specifically looks at non-disabled parents or caretaker relatives of children age 6 and older.

Professional social workers have also been involved in a variety of ways with the Families First program. From that, and other experiences, we know the challenges caregivers face in moving into permanent employment. To engage in work, caregivers need to have access to child care, dependable transportation and other supports many of us often take for granted. Providing those supports to low income families is expensive, but necessary. Case management is also crucial to developing a plan that helps those on TennCare make a successful transition to long term employment. Counseling may also be needed by some families.

If we truly want to help low income families achieve self sufficiency we cannot simply implement TennCare Work Requirements, but we must commit to providing comprehensive education, employment and support services that help families achieve success. If we have available TANF funds, we urge those funds be utilized in that manner and not simply for a Waiver Amendment for TennCare work requirements.

Best regards,

Karen L. Franklin, LAPSW
Executive Director

OBSTACLES TO WORK AMONG TENNCARE ENROLLEES POTENTIALLY AFFECTED BY A WORK REQUIREMENT

Challenges Could Include Education, Internet Access, Transportation & Health

KEY TAKEAWAYS

- Most TennCare enrollees subject to the forthcoming work requirement would likely be among 53,000 parents and caretakers of children age 6 and older. That figure (probably an overestimate) accounts for less than 4% of all enrollees.
- 54% of the TennCare enrollees in this group reported having worked in the past year.
- This group has lower-than-average educational attainment, which can be an obstacle to work and self-sufficiency.
- Many in this group are in poor health, lack home internet access, and/or do not have access to a personal vehicle. These obstacles could also hinder their ability to get a job, keep it, and/or meet reporting requirements.

A new Tennessee law directs TennCare, the state's Medicaid program, to seek federal approval to require certain enrollees to work or engage in activities like school, caregiving, or volunteering. Judging by programs approved in 4 other states, TennCare will have flexibility to negotiate the details within the bounds of state law and federal guidance. Those details include: who is affected, what counts as work, what supports affected enrollees receive, and how to monitor compliance.

This brief examines obstacles to employment for the TennCare enrollees most likely to be subject to a work requirement. Understanding this population may help TennCare avoid unintended consequences as it considers specific exemptions, support services, and compliance and monitoring. Research shows a TennCare work requirement may help encourage progress towards self-sufficiency, but potential unintended consequences include the loss of health coverage for some low-income Tennesseans.

TENNCARE WORK REQUIREMENT MOST LIKELY TO AFFECT PARENTS & CARETAKERS OF KIDS 6+

Based on currently available information, most TennCare enrollees subject to a work requirement would likely be non-disabled parents or caretaker relatives of children age 6 and older. We based this conclusion on a combination of federal guidance, state law, legislative history, and our understanding of TennCare's preliminary work on drafting a proposal.

Federal guidance limits Medicaid work requirements to "non-elderly, non-pregnant adult beneficiaries who are eligible for Medicaid on a basis other than disability." (1) Tennessee law further limits the scope to "able-bodied working age adult enrollees without dependent children under the age of 6." (2) Using information provided by TennCare, the fiscal note for that law assumed the requirement would only apply to 1 TennCare eligibility category – adult parents and caretaker relatives of dependent children. (3) Childless adults without disabilities are largely ineligible for TennCare.

Reminder: The scope of the final work requirement could be broader or narrower than we assume in this brief. While evidence from 4 other states suggests the constraints mentioned above will hold true in Tennessee, neither the federal guidance nor the fiscal note have the force of law.

Other interpretations of the federal guidance also exist. Some interpret the guidance to say that anyone enrolled in and exempt from work requirements for the Supplemental Nutrition Assistance Program (SNAP) must also be exempt from a TennCare work requirement. That would include every adult enrolled in both TennCare and SNAP with a dependent child in the house, making very few individuals subject to TennCare's work requirement.

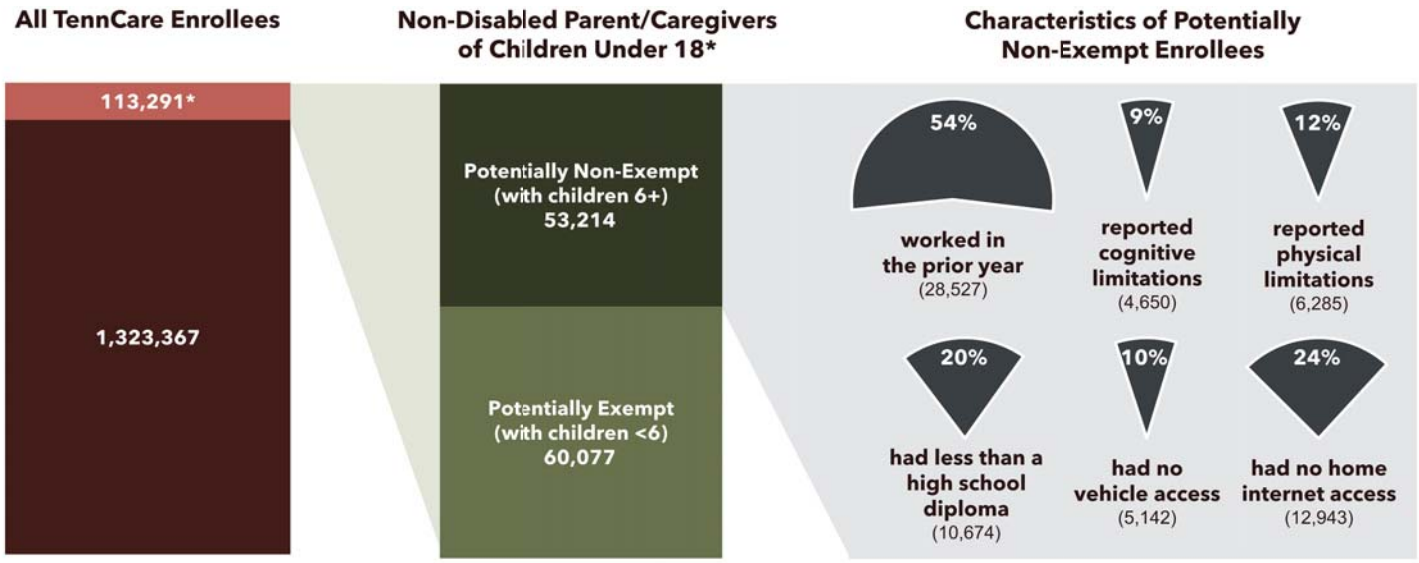
4 KEY FACTS ABOUT THESE PARENTS & CARETAKERS

Our analysis of data and research on this subset of enrollees revealed 4 key facts relevant to the discussion about TennCare work requirements. To see the details of our analysis, see the **Summary of Methods & Limitations** below and the separate **Appendix**.

1. This group represents about 4% of TennCare enrollees.

Non-disabled parents and caretakers of children ages 6 and older accounted for an estimated 53,000 TennCare enrollees in 2016. That amounts to 3.7% of all TennCare enrollment that year. (**Figure 1**) (4) This number likely overestimates the total number of people who would be subject to the work requirement. Due to limitations in the data, we are unable to exclude some individuals who may already meet work requirements in other programs or who are eligible for TennCare through a different category (see **Summary of Methods & Limitations** for more details).

FIGURE 1. TENNCARE ENROLLEES POTENTIALLY AFFECTED BY A WORK REQUIREMENT (2016)

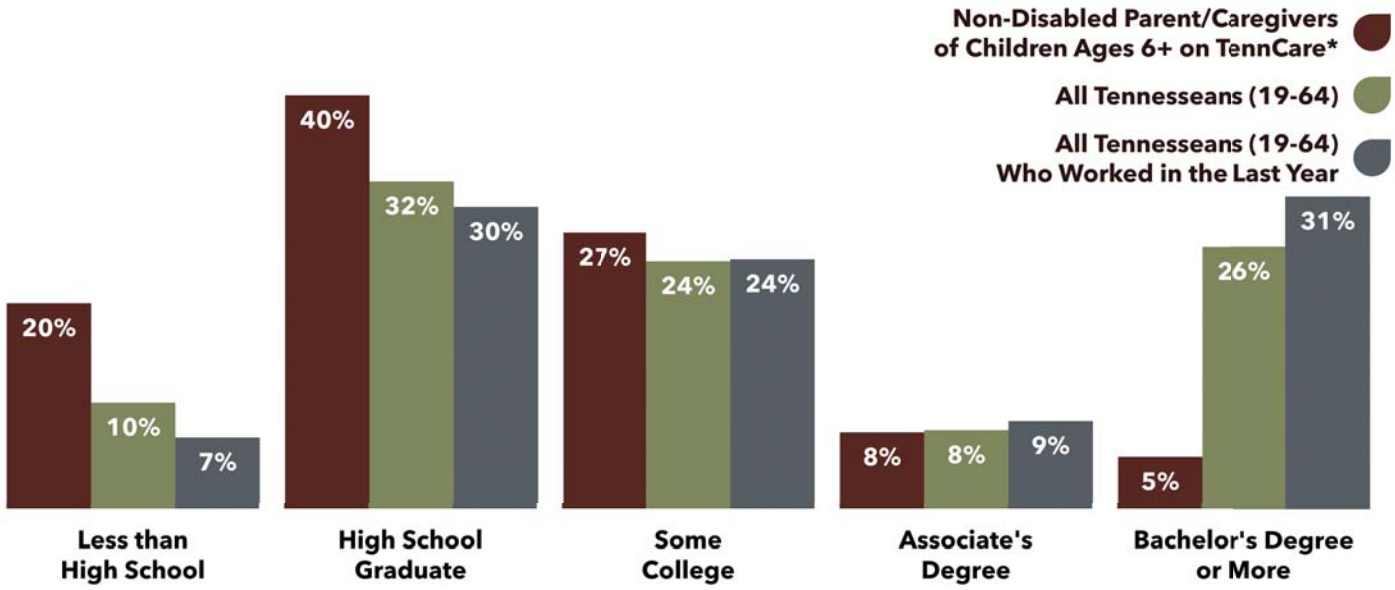


**Includes non-SSI, non-dual eligible adults 19-64 with dependent children under 18 whose incomes are under 98% of the federal poverty level.*
Source: The Sycamore Institute's analysis of 2016 American Community Survey via University of Minnesota IPUMS-USA (4)

2. A little more than half of them reported having worked in the prior year.

About 29,000 of the enrollees in this group (54%) reported that they had worked in the prior year (**Figure 1**). Of those who reported working, about 9,100 (32%) worked 20 hours or more per week. Among those who reported not working, about 4,400 (18%) were looking for work.

FIGURE 2. HIGHEST LEVEL OF EDUCATION COMPLETED (2016)



**Includes non-SSI, non-dual eligible adults 19-64 on TennCare with dependent children ages 6+ and whose incomes are under 98% of the federal poverty level.*
Source: The Sycamore Institute's analysis of 2016 American Community Survey via University of Minnesota IPUMS-USA (4)

3. Lower levels of educational attainment within this group could be an obstacle to work and self-sufficiency.

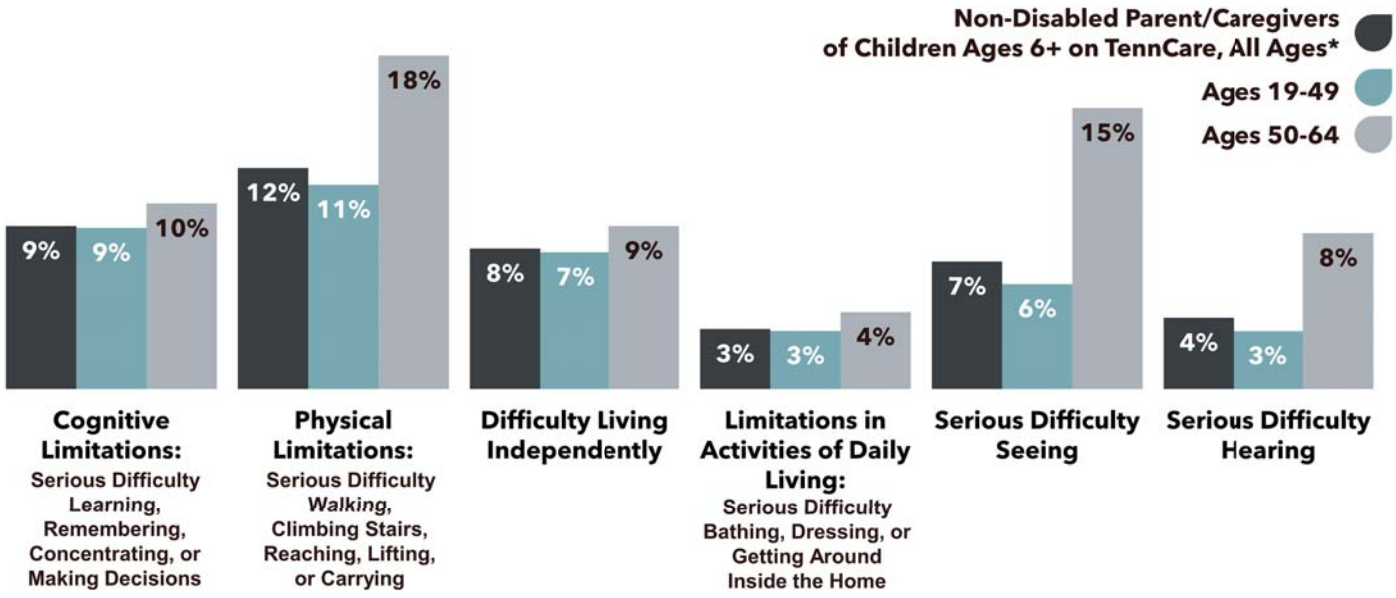
About 11,000 of these TennCare enrollees (20%) do not have a high school diploma, while about 7,000 (13%) have completed an associate's degree or more – compared to 7% and 39%, respectively, among all working Tennesseans ages 19-64 (**Figure 2**). (4) Individuals with higher levels of education are more likely to have jobs, earn higher wages, and have better health outcomes. (5) In addition, a growing number of jobs require some level of postsecondary education. By 2020, an estimated 58% of jobs in Tennessee will require some postsecondary education. (6)

4. Poor health status and lack of internet access or a personal vehicle may hinder the ability of many to get and keep a job.

Over 6,000 people in this group (12%) report serious physical health limitations, and nearly 5,000 (9%) report serious cognitive limitations (**Figure 3**). (4) Mental and physical health problems can limit a person's ability to work as well as the type of jobs available to them. (7) In many cases, these individuals' ability to work varies over time.

Physical limitations are even more common among the nearly 7,000 people in this group (13%) between the ages of 50-64 (**Figure 3**). Among the 4 current states with federal approval for a Medicaid work requirement, Indiana and Arkansas plan to exempt individuals over the age of 60 and 50, respectively. (8) (9)

FIGURE 3. LIMITATIONS OF TENNCARE ENROLLEES POTENTIALLY AFFECTED BY A WORK REQUIREMENT, BY AGE (2016)



**Includes non-SSI, non-dual eligible adults 19-64 on TennCare with dependent children ages 6+ and whose incomes are under 98% of the federal poverty level.*
Source: The Sycamore Institute's analysis of 2016 American Community Survey via University of Minnesota IPUMS-USA (4)

Nearly 13,000 enrollees in this group (24%) do not have any internet access at home (**Figure 1**). (4) Lack of internet access could affect enrollees' ability to find and apply for jobs and send compliance information to TennCare. Research shows not having broadband internet access at home is associated with greater difficulty contacting potential employers, completing online job applications, and creating a resume. Individuals with broadband internet access also have shorter bouts of unemployment and higher overall employment rates. (10) For example, Arkansas' approved work requirement will require enrollees to go online to confirm exemptions and requirements. (11)

Over 5,000 people in this group (10%) do not have access to a personal vehicle (**Figure 1**). (4) Lack of transportation is a significant obstacle to work. An evaluation of Tennessee's Families First work requirement found that participants with access to a car were more likely to be employed, find higher paying jobs, maintain employment, and leave the program. (12)

PARTING WORDS

Other states' Medicaid work requirements vary in significant ways – including who must fulfill them, who is exempt, what counts as work, and how enrollees will confirm exemptions and/or compliance. TennCare has the flexibility to negotiate these details within the boundaries set by state law and federal guidance.

Federal guidance also calls on states to outline their strategies for helping enrollees meet a Medicaid work requirement (e.g. linking individuals to support services, such as transportation, childcare, and job placement). Understanding who would most likely be subject to a TennCare work requirement and what obstacles to employment they face may help TennCare weigh the trade-offs of each decision and avoid unintended consequences.

SUMMARY OF METHODS & LIMITATIONS

We analyzed publicly available data from 2016 to better understand the demographics, employment history, health limitations, and potential obstacles to employment and compliance for individuals most likely to be subject to a TennCare work requirement. We used survey data because TennCare enrollee data are not publicly available.

Our methods reflect previous studies in this area. (13) (14) Our analysis consisted of the following steps (see **Appendix Figure 1**):

1. Limited the study population to most closely reflect TennCare's parent/caretaker relative eligibility category. Based on information provided by TennCare during the legislative process, a work requirement is likely to be targeted to this eligibility category. Among Tennesseans who reported receiving TennCare, our analysis:
    - Includes only adults ages 19-64 who are parents or caretakers of dependent children under the age of 18 and whose incomes are under 98% of poverty, and
    - Excluded individuals in this group who may qualify for TennCare because they have a disability – including any individuals who reported receiving Supplemental Security Income (SSI) or who are dually enrolled in Medicare and TennCare.

2. Divided the study population into 2 groups: potentially exempt parents/caretakers (with dependents under 6) and potentially non-exempt parents/caretakers (with dependents over the age of 6). Our analysis primarily focused on the potentially non-exempt parents/caretakers.

3. Examined available demographics, employment history, health limitations, and obstacles to employment/compliance for each group.

The primary limitation of our approach is that our study population is likely overestimated. Due to limitations in the data, we are unable to exclude some individuals who may already be meeting work requirements in other programs (e.g. TANF or SNAP). We are also unable to exclude some individuals who are eligible for TennCare through a category other than the parent/caretaker relative category. For example, some individuals in the following eligibility categories may be included in our study population if they also fit the criteria outlined above:

- Pregnant women
- Individuals in need of care traditionally provided in nursing homes
- Uninsured women who have had breast or cervical cancer detected by the Tennessee Breast and Cervical Cancer Screening Program
- Individuals up to age 26 who age out of the foster care system

See the **Appendix** for more information about the data, methods, limitations, and findings of our analysis.

THE SYCAMORE INSTITUTE

The Sycamore Institute is an independent, nonpartisan public policy research center for Tennessee.

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RELATED WORK BY THE SYCAMORE INSTITUTE

Medicaid Work Requirements in TN (1 of 3): What, Why, and Who?
(September 14, 2017) Explains what Medicaid work requirements are, why there is interest, and who in Tennessee they could likely affect.

Medicaid Work Requirements in TN (2 of 3): Lessons from TN's Welfare-to-Work Experience
(December 6, 2017) Explores insights in the work requirement for Families First – another state-run, federally-sanctioned program.

Medicaid Work Requirements in TN (3 of 3): Key Considerations for Policymakers
(December 8, 2017) Lays out the key points to consider in the debate over whether to add a work requirement to TennCare – from goals and details to support services and potential unintended consequences.

Digesting the Feds' New Guidance & 1st Approval of Medicaid Work Requirements
(January 22, 2018) Provides an overview and analysis of the federal government's new guidance on Medicaid work requirements and the approval of Kentucky's plan.

6 Insights for the Debate over TennCare Work Requirements
(February 19, 2018) Provides key points to Tennessee policymakers to consider as they work on legislation directing TennCare to submit a waiver to impose work requirements.

Who is Exempt from Proposed TennCare Work Requirements?
(March 28, 2018) Summarizes exemptions to Medicaid work requirements in Tennessee and other states.

References

1. **U.S. Department of Health and Human Services.** RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries. *Centers for Medicare and Medicaid Services*. [Online] January 11, 2018. [Accessed on January 12, 2018.] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.
2. **State of Tennessee.** Public Chapter No. 869. [Online] 2018. [Accessed on June 29, 2018.] https://publications.tnsosfiles.com/acts/110/pub/pc0869.pdf.
3. **Tennessee General Assemble Fiscal Review Committee.** Fiscal Note HB 1551 - SB 1728. [Online] February 12, 2018. [Accessed on February 13, 2018.] http://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf.
4. **Ruggles, Steven, et al.** Integrated Public Use Microdata Series: Version 7.0 [dataset]. *University of Minnesota*. [Online] 2017. https://doi.org/10.18128/D010.V7.0.
5. **Watson, Audrey L.** Employment trends by typical entry-level education requirement. *Bureau of Labor Statistics*. [Online] September 2017. https://www.bls.gov/opub/mlr/2017/article/pdf/employment-trends-by-typical-entry-level-education-requirement.pdf.
6. **Carnevale, Anthony P, Smith, Nicole and Strohl, Jeff.** Recovery: Job Growth and Education Requirements Through 2020 State Report. *Georgetown Public Policy Institute, Center on Education and Workforce, Georgetown University*. [Online] June 2013. https://1gyhoq479ufd3yna29x7ubjn-wpengine.netdna-ssl.com/wp-content/uploads/StateProjections_6.1.15_agc_v2.pdf.
7. **Garfield, Rachel, et al.** Implications for Work Requirments in Medicaid: What Does the Data Say? *Kaiser Family Foundation*. [Online] June 12, 2018. http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say.
8. **Department of Health and Human Services.** Approval Package for Indiana's Section 1115 Demonstration Project. *Center for Medicare and Medicaid Services*. [Online] February 1, 2018. [Accessed on March 22, 2018.] https://www.in.gov/fssa/hip/files/IN-HIP-1115-Approval-Package_2-1-2018.pdf.
9. —. Approval Package for Arkansas' Section 1115 Demonstration Projects. *Centers for Medicare & Medicaid Services*. [Online] March 5, 2018. [Accessed on March 22, 2018.] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf.
10. **Whitehouse Council of Econmic Advisers.** The digital divide and economic benefits of broadband access. [Online] March 2016. https://obamawhitehouse.archives.gov/sites/default/files/page/files/20160308_broadband_cea_issue_brief.pdf.
11. **Garfield, Rachel, et al.** Implications of Work Requirements in Medicaid: What Does the Data Say? *Kaiser Family Foundation*. [Online] June 12, 2018. https://www.kff.org/medicaid/issue-brief/implications-of-work-requirements-in-medicaid-what-does-the-data-say.
12. **Richards, Tami and Bruce, Donald.** Car Access and Employment Outcomes for Tennessee Welfare Recipients: A Report to the Tennessee Department of Human Services. *Center for Business and Economic Research, College of Business Administration, The University of Tennessee Knoxville*. [Online] June 2004. http://cber.haslam.utk.edu/TDHS/ffjun0400.pdf.
13. **Li, Linda, Kemper, Leah and McBride, Timothy.** The Demographics of Missouri Medicaid: Implications for Work Requirements. *Center for Health Economics and Policy, Institute for Public Health at Washington University*. [Online] March 2018. [Accessed on August 13, 2018.] https://publichealth.wustl.edu/wp-content/uploads/2018/06/MO-Medicaid-Demographics-and-Work-Requirement_2.pdf.
14. **Gangopadhyaya, Anuj and Kenney, Genevieve M.** Updated: Who Could Be Affected by Kentucky's Medicaid Work Requirements, and What Do We Know about Them? *Urban Institute*. [Online] March 2018. https://www.urban.org/sites/default/files/publication/96576/3.26-ky-updates_finalized_1.pdf.
15. **Melton, Courtnee.** How Socioeconomic Factors Affect Health in Tennessee. *The Sycamore Institute*. [Online] June 2018. https://www.sycamoreinstitutetn.org/2018/06/06/how-socioeconomic-factors-affect-health/.
16. **Melton, Courtnee and Pellegrin, Mandy.** Medicaid Work Requirements in Tennessee Part 2 of 3: Lesson's from Tennessee's Welfare-to-Work Experience. *The Sycamore Institute*. [Online] Decemeber 6, 2017. https://www.sycamoreinstitutetn.org/2017/12/06/medicaid-work-reqs-welfare-to-work/.

Jonathan Reeve

From: Abby Emanuelson <Abby.Emanuelson@nmss.org>
Sent: Thursday, October 25, 2018 4:18 PM
To: Public Notice. Tenncare
Cc: Steffany Stern; Ashley Kenneth
Subject: National MS Society Tennessee 1115 waiver state comments October 2018 Revised
Attachments: National MS Society Tennessee 1115 waiver state comments October 2018 Revised.pdf

Attached please find the National Multiple Sclerosis Society's Comments on the 1115 Waiver Amendment 38 to the TennCare II Demonstration.
Thank you in advance for your consideration of our concerns.

Abby

Abby Carter Emanuelson
AVP, Advocacy and Activist Engagement

National Multiple Sclerosis Society
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National Multiple Sclerosis Society

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National
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Society

October 24, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long:

The National Multiple Sclerosis Society (Society) appreciates the opportunity to submit comments outlining our concerns with Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration." The Society wants Tenncare to provide adequate, affordable and accessible health care coverage. If Amendment 38 is implemented TennCare enrollees with serious, acute and chronic diseases such as multiple sclerosis (MS) could lose vital access to coverage.

MS is an unpredictable disease of the central nervous system, with symptoms ranging from numbness and tingling to blindness and paralysis. For people with MS, access to needed health care services and early and consistent control of disease activity plays a key role in preventing accumulation of disability and allows people with MS to remain active in their communities. The Society believes everyone, including TennCare enrollees, should access to quality and affordable health coverage, free of administrative barriers.

Amendment 38 seeks to add a work and community engagement requirement for most TennCare enrollees. This would increase the administrative burden on all enrollees. Enrollees will need to either report that they meet certain exemptions or the number of hours they have worked. Increasing administrative requirements will likely decrease the number of individuals with TennCare 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 October 1, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[i] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[ii] 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.[iii] 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 consequences for people with serious, acute and chronic diseases. If the state finds that individuals have failed to comply with the new requirements for two months out of a six-month period, they will be locked out of coverage until they

National
Multiple Sclerosis
Society

demonstrate their compliance. 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.

The Society is 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. Tennessee's "good cause" exemption is still not sufficient to protect patients. The Society has learned from Arkansas that many individuals were unaware of the new requirements and therefore unaware that they needed to apply for such an exemption.[iv] 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 Tennessee. States such as Michigan, Pennsylvania, Kentucky 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.[v] Tennessee's fiscal impact statement estimated the program would cost approximately $39.8 million over the course of the waiver.[vi] These costs would divert resources from Tenncare's core goal: providing health coverage to those without access to care.

Ultimately, the requirements outlined in Amendment 38 do not further the goals of the Tenncare or help low-income individuals improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[vii] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[viii] 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 a 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).[ix] Terminating individuals' TennCare coverage for non-compliance with these requirements will therefore hurt rather than help people as they search for and obtain employment. Tennessee has experience with this. In 2005, when the state changed the TennCare program's eligibility and 170,000 people lost Medicaid coverage, there was no increase in employment and self-reported health and access to medical care declined.[x]

The Society also wishes to highlight that 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. However, on page 5 of this proposal, the Department states that "*Some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, it is not possible to reliably project the magnitude of this decrease in enrollment at this time*." We urge the state to update the waiver amendment with the estimated expenditure and estimate enrollment change and reopen the state comment period for an additional 30 days.

The National Multiple Sclerosis Society believes healthcare should affordable, accessible, and adequate. Tennessee's Amendment 38 does not meet that standard. Thank you for the opportunity to provide comments.

National
Multiple Sclerosis
Society

Sincerely,

Abby Carter Emanuelson
Associate Vice President, Advocacy and Activist Engagement
National MS Society

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[i] 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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[iii] 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.

[iv] 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/.

[v] 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.

[vi] Tennessee General Assembly Fiscal Review Committee. Fiscal Note HB 1551- SB 1728. February 12, 2018. Accessed at: http://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf

[vii] 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] 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

[x] DeLeire, Thomas. The National Bureau of Economic Research. NBER Working Paper No. 24899: The Effect of Disenrollment from Medicaid on Employment, Insurance Coverage, Health and Health Care Utilization. August 2018. Accessed at: https://www.nber.org/papers/w24899

Jonathan Reeve

From: Melanie Buzzelli <mbuzzelli@rarediseases.org>
Sent: Friday, October 26, 2018 8:59 AM
To: Public Notice. Tenncare
Cc: Tim Boyd; terryjo.bichell@rareaction.org
Subject: Comments on Amendment 38 to the TennCare II Demonstration
Attachments: NORD Comments on TN 1115 Demonstration.docx.pdf

Good Morning,

Please see the attached comments for submission.

Thank you.

Best,
Melanie

Melanie Buzzelli (Swick)
Policy Associate
National Organization for Rare Disorders
p: (202) 545-3826 f: (202) 588-5701
a: 1779 Massachusetts Ave., NW, Suite 500, Washington, D.C. 20036
w: rarediseases.org e: orphan@rarediseases.org

October 26, 2018

Wendy Long, M.D.
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Transmitted via email to public.notice.tenncare@tn.gov

Re: Amendment 38 to the TennCare II Demonstration

Dear Director Long:

On behalf of the 30 million Americans with one of the approximately 7,000 known rare diseases, the National Organization for Rare Disorders (NORD) thanks TennCare for the opportunity to submit comments on Amendment 38 to the TennCare II Demonstration.

NORD is a unique federation of voluntary health organizations dedicated to helping people with rare "orphan" diseases and assisting the organizations that serve them. Since 1983, we have been committed to the identification, treatment, and cure of rare disorders through programs of education, advocacy, research, and patient services.

NORD appreciates Tennessee's stated goal of "improv[ing] health outcomes for individuals enrolled in TennCare."[1] However, after reviewing the proposal, we are concerned that Amendment 38 will threaten access to care for many within Tennessee's rare disease community.

Tennessee's Proposal to Implement Work Requirements:

We oppose the implementation of work requirements within TennCare for several reasons, the most basic of which being that work requirements do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care.

Further, this would increase the administrative burden on all Medicaid patients. Individuals will need to either attest to the number of hours they have worked or that they meet certain exemptions. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt. Arkansas is

[1] Amendment 38 to the TennCare II Demonstration Pg. 1

currently implementing a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. As of October 1, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[2] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[3] 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 rare diseases. If the state finds that individuals have failed to comply with the new requirements for more than two months out of a six-month period, they will be locked out of coverage until they demonstrate their compliance.[4] 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.

We are also concerned that the exemptions to these requirements will not be nuanced or precise enough to avoid harming the health and wellbeing of Tennessee rare disease patients and their families. While the list of exemptions appears comprehensive, we can still easily envision many scenarios in which individuals with rare diseases or their caregivers will be unduly subjected to onerous and inappropriate work requirements. With a scarcity of physicians familiar with rare diseases and the prevalence of undiagnosed conditions, it is often difficult, even impossible, for rare disease patients to convey the extent of their symptoms on a standard form.

For example, it remains unclear from the given information within the proposal what would happen to caregivers of those with a rare disease. The Amendment notes that a beneficiary who is "providing caregiver services for a household member (child or adult) with a disability or incapacitation" would be exempt.[5] The Amendment does not say, however, how that would be adjudicated. It is not clear in this context what it means to be disabled. Consequently, it is not difficult to imagine a scenario in which this exemptions process would leave out a deserving caregiver.

Similarly, the Amendment proposes to exempt beneficiaries who, "are physically or mentally incapable of work, as certified by an appropriate medical professional…[or have] a short-term or long-term disability or an acute medical condition validated by a medical professional that would prevent them from complying."[6] Yet, once again, the Amendment does not articulate how such a

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[2] Arkansas Department of Health and Human Services, Arkansas Works Program, August 2018 and September 2018. Accessed at: https://humanservices.arkansas.gov/newsroom/toolkits.
[3] Ibid.
[4] Amendment 38 to the TennCare II Demonstration Pg. 4
[5] Amendment 38 to the TennCare II Demonstration Pg. 3
[6] Ibid.

determination would be made. It is not obvious from the Amendment what it will involve to have something "certified" or "validated" by an "appropriate medical professional."[7]

Finally, TennCare's "good cause" exemption is not sufficient to protect rare disease patients. In Arkansas, many individuals were unaware of the new requirements and, therefore, unaware that they needed to apply for such an exemption.[8] In August, the state granted just 45 good cause exemptions while terminating coverage for 4,353 individuals at the end of the month.[9] No exemption criteria can circumvent this problem and the serious risk posed to the health of the rare disease community.

These are just a handful of ways in which rare disease patients and their loved ones could slip through the cracks and lose access to their healthcare. In order to avoid the kind of delay or termination of care that could gravely impact the lives of Tennessee's rare disease patients and their families, we urge TennCare to reconsider this provision.

NORD strongly believes healthcare should affordable, accessible, and adequate. Amendment 38 does not meet that standard, and we urge TennCare to withdraw this proposal. Thank you again for the opportunity to provide comments.

Sincerely,

Tim Boyd
Director of State Policy
tboyd@rarediseases.org

Terry Jo Bichell
NORD Volunteer State Ambassador for Tennessee
terryjo.bichell@rareaction.org
www.RareTN.org

[7] Ibid.
[8] 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/.
[9] Arkansas Department of Health and Human Services, Arkansas Works Program, August 2018. Accessed at: https://humanservices.arkansas.gov/images/uploads/newsroom/091218_AWReport_Final.pdf.

Jonathan Reeve

From: Angie Thies <athies@psoriasis.org>
Sent: Friday, October 26, 2018 3:21 PM
To: Public Notice. Tenncare
Cc: Amy Prentice
Subject: TennCare II Demonstration, Amendment 38 Comments - National Psoriasis Foundation
Attachments: TNAmendment38_NPFcomments_2018.pdf

Good afternoon –

Thank you for the opportunity to provide comment on the proposed amendment to TennCare II Demonstration – amendment 38. Please find attached comments from the National Psoriasis Foundation. If we may be of assistance with further information, don't hesitate to email or call.

Thank you!

Angie Thies
State Government Relations Manager- Central Region
National Psoriasis Foundation
6600 SW 92nd Ave., Suite 300
Portland, OR 97223
O: (503) 546-5560
C: (614) 208-3794
athies@psoriasis.org | www.psoriasis.org

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment to the TennCare II Demonstration, Amendment 38

Dear Dr. Long:

On behalf of the more than 8 million Americans living with psoriasis and psoriatic arthritis, the National Psoriasis Foundation (NPF) appreciates the opportunity to comment on the proposed amendment to the TENNCare II Demonstration, Amendment 38.

We applaud the state's efforts to innovate and improve the TennCare program with the intention being to promote improved health outcomes. However, the NPF has concerns that some of the proposed changes could lead to reduced access and diminished quality of care for the more than 235,000 individuals experiencing psoriatic disease in the state. We offer the following comments on the amendment request.

Background on Psoriasis

The National Psoriasis Foundation exists to find a cure for psoriasis and psoriatic arthritis and to eliminate the devastating effects of psoriatic disease by supporting research, advocacy and education. Psoriasis is the most prevalent autoimmune disease in the United States, affecting approximately 3 percent of the adult U.S. population.[i] Up to 30 percent of individuals with psoriasis may also develop psoriatic arthritis, an inflammatory form of arthritis that can lead to irreversible joint damage if left untreated.[ii] Beyond the physical pain and discomfort of these diseases, individuals living with psoriatic disease also face higher incidence of comorbid health conditions including cardiovascular disease,[iii] diabetes[iv], hypertension[v], and stroke[vi]. A higher prevalence of atherosclerosis[vii], Crohn's disease[viii],

cancer[ix], metabolic syndrome[x], obesity[xi] and liver disease[xii] are also found in people with psoriasis, as compared to the general population.

Due to the heterogeneous characteristics of this chronic autoimmune disease, psoriatic disease requires sophisticated medical care. Treatments that work for one person may not work for others, and many patients cycle through numerous accepted treatment options.[xiii] Without the tools to control their symptoms, people with psoriatic disease cycle through periods of intense pain; fatigue; unbearable itch; whole-body inflammation; flaking and bleeding of large swaths of the skin; and joint degradation. Recent research also suggests that the risk for comorbidities such as cardiovascular disease may increase with the severity of psoriatic disease, thereby magnifying the critical need for patient access to effective treatment options.[xiv]

TennCare II Demonstration, Amendment 38 Comments:

While the NPF is supportive of programs that aim to promote health, wellness, and greater financial stability and self-sufficiency, we are concerned that placing conditions of work and community engagement in order to receive access to medical coverage and care through Medicaid or other programs, could significantly hinder the ability of patients with psoriatic disease to appropriately access and maintain critical health services needed to properly manage their conditions. Studies of Medicaid work requirements identify why these standards are burdensome to the patient population and can lead to negative health outcomes.[xv]

Patients living with psoriasis or psoriatic arthritis dedicate a significant amount of time and effort to maintaining their disease, and comorbid conditions, while managing work and family life. Similarly, most Medicaid enrollees facing work requirements are employed but have trouble with reporting requirements. While exceptions to work requirements may apply, as many psoriatic disease patients know, exceptions processes can also be overly burdensome. Data shows one in three Medicaid adults never use a computer or the internet and four in ten do not use email.[xvi] Therefore, we would appreciate more details on how this exception process would work and the turnaround time for approval.

In addition, compelled employment and community engagement may not be enough to overcome poverty while worsening a patients condition.[xvii] Most employed Medicaid enrollees are working full-time for the full year, but their annual incomes are still low enough to qualify for Medicaid. In addition, studies have shown there is a strong correlation between jobs with high level stressors, likely encountered in compelled employment or community engagement, that can lead to worsened health.[xviii] When significant effort does not achieve commensurate rewards, emotional stress rises and illness increases. Such workplace imbalances are associated with increased rates of cardiovascular disease and smoking, which already pose a significant risk to psoriatic disease patients.

These challenges, among others, are likely to contribute to a significant loss of Medicaid coverage and negative health impacts for the Medicaid patient population. Arkansas is seeing similar results, where implementation of work requirements have currently led to over 8,000 individuals losing Medicaid benefits due to noncompliance.

Again, we appreciate the opportunity to comment on the proposed amendment to the TennCare II Demonstration, amendment 38. We thank you for your attention to this important matter and hope that our feedback will help inform your final consideration of amendment language and ensure changes to the TennCare program maintain critical accessibility and affordability for those living with psoriatic disease. If you have any questions about these comments, please contact Angie Thies, State Government Relations Manager, (athies@psoriasis.org, 503-546-5560).

Thank you in advance for your consideration.

Sincerely,

Patrick Stone
Vice President, Government Relations and Advocacy

---

[i] Helmick CG, Lee-Han H, Hirsch SC, Baird TL, Bartlett CL. Prevalence of Psoriasis Among Adults in the U.S: 2003–2006 and 2009–2010 National Health and Nutrition Examination Surveys. American journal of preventive medicine. 2014;47(1):37-45. doi:10.1016/j.amepre.2014.02.012.

[ii] Gladman DD, Antoni C, Mease P, et al. Psoriatic arthritis: epidemiology, clinical features, course, and outcome. Ann Rheum Dis. 2005;64(suppl 2):ii14–ii17. - See more at: http://www.rheumatologynetwork.com/psoriatic-arthritis/classification-criteria-psoriatic-arthritis-caspar#sthash.Or6zBLgM.dpuf

[iii] Neimann AL, Shin DB, Wang X, Margolis DJ, Troxel AB, Gelfand JM. Prevalence of cardiovascular risk factors in patients with psoriasis. Journal of the American Academy of Dermatology. 2006; 55(5):829-35. **And:** Prodanovich S, Kirsner RS, Kravetz JD, Ma F, Martinez L, Federman DG. Association of psoriasis with coronary artery, cerebrovascular, and peripheral vascular diseases and mortality. Archives of Dermatology. 2009 Jun; 145(6):700-3.

[iv] Armstrong AW, Harskamp CT, Armstrong EJ. Psoriasis and the risk of diabetes mellitus: a systematic review and meta-analysis. JAMA Dermatology. 2013 Jan; 149(1): 84-91.**And:** Neimann AL, Shin DB, Wang X, Margolis DJ, Troxel AB, Gelfand JM. Prevalence of cardiovascular risk factors in patients with psoriasis. Journal of the American Academy of Dermatology. 2006; 55(5):829-35.

[v] Robinson D Jr., Hackett M, Wong J, Kimball AB, Cohen R, Bala M; the IMID Study Group. Co-occurrence and comorbidities in patients with immune-mediated inflammatory disorders: an exploration using US healthcare claims data, 2001-2002. Current medical research and opinion. 2006; 22(5):989-1000. **And:** Armstrong AW, Harskamp CT, Armstrong EJ. The association between psoriasis and hypertension: a systematic review and meta-analysis of observational studies. Journal of Hypertension. 2012 Dec 15. [Epub ahead of print]

[vi] Gelfand JM, Dommasch ED, Shin DB, Azfar RS, Kurd SK, Wang X, Troxel AB. The Risk of Stroke in Patients with Psoriasis. Journal of Investigative Dermatology. 2009; 129, 2411–2418.

[vii] Prodanovich S, Kirsner RS, Kravetz JD, Ma F, Martinez L, Federman DG. Association of psoriasis with coronary artery, cerebrovascular, and peripheral vascular diseases and mortality. Archives of Dermatology. 2009 Jun; 145(6):700-3.

[viii] Najarian DJ, Gottlieb AB. Connections between psoriasis and Crohn's disease. Journal of the American Academy of Dermatology 2003; 48:805-21.

[ix] Gelfand JM, Shin DB, Neimann AL, Wang X, Margolis DJ, Troxel AB. The risk of lymphoma in patients with psoriasis. Journal of Investigative Dermatology. 2006 Oct; 126(10):2194-201.

[x] Azfar RS, Gelfand JM. Psoriasis and metabolic disease: epidemiology and pathophysiology. Current Opinion in Rheumatology. 2008; 20(4)416-22. **And:** Armstrong AW, Harskamp CT, Armstrong EJ. Psoriasis and metabolic syndrome: A systematic review and meta-analysis of observational studies. Journal of the American Academy of Dermatology. 2013 Apr; 68(4):654-62.

[xi] Ogden CL, Fryar CD, Carroll MD, Flegal KM. Mean body weight, height and body mass index, United States 1960-2002. Advance Data 2004; 347:1-17.

[xii] Robinson D Jr., Hackett M, Wong J, Kimball AB, Cohen R, Bala M; the IMID Study Group. Co-occurrence and comorbidities in patients with immune-mediated inflammatory disorders: an exploration using US healthcare claims data, 2001-2002. Current medical research and opinion. 2006; 22(5):989-1000.

[xiii] Stern RS, Nijsten T, Feldman SR, Margolis DJ, Rolstad T. Psoriasis is common, carries a substantial burden even when not extensive, and is associated with widespread treatment dissatisfaction. Journal of Investigative Dermatology Symposium Proceedings. 2004 Mar; 9(2):136-9

[xiv] Naik HB, Natarajan B, Stansky E, Ahlman MA, Teague H, Salahuddin T, Ng Q, Joshi AA, Krishnamoorthy P, Dave J, Rose SM, Doveikis J, Playford MP, Prussick RB, Ehrlich A, Kaplan MJ, Lockshin BN, Gelfand JM, Mehta NN. Severity of Psoriasis Associates With Aortic Vascular Inflammation Detected by FDG PET/CT and Neutrophil Activation in a Prospective Observational Study. Arterioscler Thromb Vasc Biol. 2015 Dec;35(12):2667-76. doi: 10.1161/ATVBAHA.115.306460. Epub 2015 Oct 8.

[xv] https://www.kff.org/medicaid/issue-brief/implications-of-work-requirements-in-medicaid-what-does-the-data-say/

[xvi] https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html?login=email&auth=login-email

[xvii] https://www.ncbi.nlm.nih.gov/pubmed/15589679

[xviii] https://www.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf

Jonathan Reeve

From: Brian Haile <bhaile@neighborhoodhealthtn.org>
Sent: Friday, October 26, 2018 3:12 PM
Cc: pfoster@tcsw.org; Barbara.Quinn@parkcenternashville.org; Renata Soto; Jacy Warrell; Sharon Hurt (shurt@street-works.org); Joe Interrante; McGinley, Janie; Jenny Dittes; Marsha Edwards; Ingrid McIntyre; Michael.McSurdy@fcsnashville.org; Terri Sabella; libby.thurman@tnpca.org; Mary Bufwack; Mary Linden; Wendy Long; Public Notice. Tenncare; aaron.butler@tn.gov
Subject: Comments re: Amendment 38
Attachments: Cmts on TC Amend 38 Work Req (final).pdf

Dr. Long,

I am pleased to submit the attached comments in response to TennCare's draft proposal for new work and community engagement requirements in the draft Amendment 38 of the TennCare II Demonstration. I submit these comments on behalf of my organization and:

Paula Foster
Executive Director, Tennessee Conference on Social Welfare (TCSW)

Barbara Quinn
Chief Executive Officer, Park Center

Renata Soto
Co-Founder & Executive Director, Conexión Américas

Jacy Warrell
Executive Director, Tennessee Health Care Campaign (THCC)

Sharon Hurt
Executive Director, Street Works

Joe Interrante
Chief Executive Officer, Nashville CARES

Janie McGinley
Chief Executive Officer, Lifespan Health

Jenny Dittes
Chief Executive Officer, HOPE Family Health

Marsha Edwards
President & Chief Executive Officer, Martha O'Bryan Center

Ingrid McIntyre
Executive Director & Co-Founder, Open Table Nashville

Michael McSurdy
President & Chief Executive Officer, Family and Children's Service

We thank you for the opportunity to comment and for your consideration of our input. Please let us know how we can remain actively engaged in this process.

Sincerely,
Brian

Brian Haile | Chief Executive Officer
bhaile@neighborhoodhealthtn.org
(615) 944-4404 (cell)
(615) 227-3000 (to schedule clinic appointments)
Neighborhood Health Business Office
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www.neighborhoodhealthtn.org

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2711 Foster Avenue
Nashville, TN 37210
October 26, 2018

Wendy Long, M.D., M.P.H.
Director, Division of TennCare
310 Great Circle Road
Nashville, TN 37243.

Transmitted by email to public.notice.tenncare@tn.gov

Dear Dr. Long:

We write in response to TennCare's draft proposal for new work and community engagement requirements in the draft Amendment 38 of the TennCare II Demonstration. If implemented, Amendment 38 would apply new work requirements to certain individuals enrolled in TennCare's parent/caretaker relative eligibility group.

We appreciate the chance to offer comment on the draft Amendment 38. The text of the Amendment is quite vague, which makes it difficult to offer substantive feedback. Nonetheless, we worked to draft a detailed response that may help inform the policy-making process. Again, we are grateful for the opportunity to offer this input.[1]

Value of Work and Community Engagement

We believe two key things, which inform our comments below. First, evidence suggests work (either in employment or through volunteer service) can be beneficial for both physical and mental health.[2] As we would expect, survey data reveals the majority of such parent/caretaker relatives already work. Based on our direct experience and statewide data, most of those who do not currently have a job very much want to be employed.[3] If we can work together to address their remaining barriers to employment, we can help the few remaining out-of-work individuals to find and keep a job – and help them improve both their health outcomes and quality of life. This is central to our work and our missions.

Second, an incorrectly-designed policy or poorly-implemented program can do much harm. Such policies or programs can remove the source of care on which many of the most vulnerable rely in order to have any hope of future employment.[4] In addition, any reduction in enrollment in TennCare would further erode the stability of the safety net,[5] which provides other critical services not funded by TennCare but which are essential for the successful integration of these individuals into the workforce. For these reasons, we have taken the time to provide detailed comments below. Our hope is to enhance state policy makers' "line of sight" into the challenges that lower-income parents and caretakers relatives face – and illustrate some of the supports individuals may need to surmount these issues and truly succeed.

Conceptual Concerns

We note several conceptual issues from the outset:

1. **Qualitative Differences:** TennCare rightfully chose to exempt TANF and SNAP enrollees from duplicative work and community engagement requirements, but it may also need to acknowledge that the parents and caretakers who do not receive these benefits are qualitatively different from the parents and caretaker who do. All individuals in the parent/caretaker relative eligibility almost certainly meet the income requirements for SNAP, but those who are not currently enrolled in SNAP may have already "failed out" because they could not adhere to the work requirements in those programs – or they could not comply with the reporting or other administrative requirements. Thus, the population not in receipt of TANF or SNAP may be much more challenging (and expansive) on average to serve than those in receipt of material benefits.

2. **Alternative to Benefits Suspension:** There is a middle ground between all-or-nothing if TennCare believes that an enrollee is both subject to work requirements and does not comply. Instead of suspending benefits, TennCare could move the individual to a less generous benefit plan (either one with fewer covered benefits and/or high cost-sharing). We strongly recommend this course – and reserving suspension or disenrollment for cases of more chronic or consistent noncompliance. (See Recommendation #1 on p. 4 below.)

3. **Informal Employment:** Many lower-income individual are engaged in employment-related activities that may be "off the books" both with respect to taxation and regulatory compliance. For example, many may play as "gig" musicians or be engaged in sales activities (e.g., at flea markets or Amway). Others may perform activities that under some instances may require licensure these individuals may not possess (e.g., to do nails, hair, babysitting/childcare, etc.).[6] In order for individuals to feel as if they can avoid self-incrimination, TennCare may need to rely on a simple "yes/no" self-attestation as to whether the individual complied with a work activity requirement. (See Recommendations #3-4 on p. 4 below.)

4. **Eligibility Cliff:** The SNAP and TANF programs generally have generous disregards for earned income so as to promote employment. However, TennCare uses a gross income test – meaning that all earned income counts in the eligibility determination. Thus, parents and caretaker relatives may face the reality that working results in the loss of TennCare – as will remaining unemployed. To address this and prevent such disincentives, TennCare may need to seek federal approval to disregard at least some earned income when re-determining eligibility. (See Recommendation #5 on pp. 4-5 below.)

5. **Cart Before the Horse:** We strongly urge TennCare not to implement any such work requirements until its Tennessee Eligibility Determination System (TEDS) is fully operational and all individuals can apply or recertify by all of the methods required by 42 CFR § 435.907.

The design of the work and community engagement requirements must address **each** of these issues if TennCare is to successfully implement such a program. We stand ready to help TennCare formulate a policy response, but we do not believe Amendment 38 should proceed until **all** these issues are addressed and the policy details are codified.

Barriers to Employment/Community Engagement

During the stakeholder meeting on August 20, 2018, representatives of organizations who serve lower-income Tennessee repeatedly raised concerns about the lack of **reliable public transportation** (even in urban areas) and **affordable child care**. We strongly agree with these clearly valid concerns. We also note several related barriers to employment and community engagement:

1. **Lack of Drivers Licenses:** Many individuals do not have drivers licenses because the State had revoked licenses due to outstanding court costs, etc. While a federal judge has blocked such revocations, many individuals may not have had their licenses reinstated – and may need considerable assistance in doing so. Also, getting a new license may require the individual to provide a birth certificate or passport (or other proof of citizenship or legal alienage), proof of identification, and two forms of Tennessee residency. Many lower-income individuals may not have ready access to this documentation.

2. **Arrests:** Some individuals will have arrest records (with or without disposition of charges), and employers and even volunteer service agencies have noted their internal policies may exclude many of these individuals from employment or volunteer work. While some individuals may be eligible for expungement of their records, the process is time-intensive and varies substantially by county – and the fees may be up to $450. If the individual is not eligible for expungement, then he or she may experience substantial limitations as to the ability to comply with work or community engagement requirements. Note, too, that multiple arrests for certain charges may be indicative of undiagnosed and/or untreated substance use or mental health concerns – and TennCare may need to scrutinize individuals with such histories with law enforcement to determine whether they may meet exemption criteria from any new work or community engagement requirements.

3. **Lack of Access to Vision and Eyeglasses:** Our direct experience is that vision limitations and lack of corrective lenses substantially hampers the ability of many lower-income individuals to secure employment. Since TennCare does not cover vison services and eyeglasses for this population, it is unclear how such individuals would overcome these barriers. We are exploring potential partnerships with the Lion's Clubs and other entities that promote access to vision services, but the resources here appear to be insufficient to meet even the current demand.

4. **Lack of Access to Dental Services:** Several recent summaries of the evidence suggest that appearance and oral health are critical for employment success.[7] This concern is particularly pronounced in the service sector, which is the likely source of employment for many individuals. Since TennCare does not cover adult dental or dentures for this population, it is unclear how individuals with oral health concerns may surmount these barriers. This is particularly concerning given that the State's funding for the "Smile 180" dental program for adults may not even meet the current demand.

5. **Outstanding Judgements:** Many lower-income individuals may have outstanding judgments and wage garnishments from creditors that may decrease their take-home income. Many of these may be default judgments for failing to appear, which may relate to a failure to receive service of process. These individuals may need substantial

assistance (and potentially bankruptcy counsel) to remove these judgments – and ensure they have a material incentive to work.

Again, we stand ready to help TennCare formulate a policy response, but we do not believe Amendment 38 should proceed until these issues are addressed and the policy details are fully fleshed out.

Recommended Approach

We request TennCare:

1. **Establish Payment Exception for FQHCs:** Under federal law, federally-qualified health centers (FQHCs) are legally required to provide comprehensive primary care services to individuals, even if their TennCare coverage has been suspended. Unlike other providers, we cannot and would not turn a patient away for lack of coverage or ability to pay. Further, we cannot limit the services we provide as hospitals can and do under EMTALA. Given this unique set of circumstances particular to FQHCs, TennCare should continue to reimburse FQHCs for encounters of individuals whose coverage is in suspended status (for noncompliance with the work requirements).[8]

2. **Establish Reciprocity:** We appreciate TennCare's pledge to exempt current enrollees in the TANF and SNAP programs who are complying with the work requirements in those programs. We also ask that TennCare establish reciprocal relationships with those programs such that TennCare enrollees who comply with its program requirements are likewise exempt from the work requirements in TANF and SNAP if they enroll in those programs.

3. **Rely on Data:** TennCare should **rely on data from interfaces** with the Social Security Administration, the Internal Revenue Service (via the federal datahub), Tennessee Department of Labor and Workforce Development (for unemployment benefits), etc. wherever possible to validate an individual's self-attestation (of compliance or exemption) if the individual is part of a sample subject to verification. In this fashion, TennCare should approach compliance monitoring activities in the same was it does the *ex parte* process for eligibility redeterminations.

4. **Accept Self-Attestation:** TennCare should allow parent/caretaker relatives to **self-attest** to compliance with or exemption from the work and community engagement requirements **at the time these individuals complete their annual redeterminations**. TennCare should accept said self-attestation for a period not less than 12 months. TennCare could validate compliance or exemption using a variety of data sources (e.g., recently-reported wages on the New Hire database, etc.), and then select a sample for audit and verification of compliance. This would be consistent with the manner in which the IRS implemented several components of the Affordable Care Act related to both individual tax payers and employers – and it would involve the least amount of bureaucracy and administrative costs. Also, we strongly believe TennCare should require such attestations only when TennCare has exhausted the use of all data sources referenced above.

5. **Adopt Earned Income Disregards:** To avoid the eligibility cliff described above, TennCare should secure federal authority to disregard 50-100% of earned income

reported by enrollees for at least their first redetermination event. This is consistent with the approach in many state TANF programs and was the standard for Medicaid prior to the implementation of the Affordable Care Act. Adopting such earned income disregards would allow individuals who secure employment to continue their TennCare coverage for a transitional period (as existed prior the enactment of the Affordable Care Act). After this 12-month "grace" period, such individuals could transition to employer-based insurance or marketplace coverage if their earnings remained unchanged.

6. **Start with a Pilot Program:** TennCare focus on a rollout of the requirements in a **pilot with individuals who are perhaps best able to comply** and least likely to claim exemptions – and then refine/improve the program and upgrade infrastructure before extending the requirements to the harder-to-serve populations. For example, TennCare may wish to focus on individuals who *inter alia* (i) have high school diploma or GED, (ii) have no arrest record or criminal history, (iii) have no claims themselves for serious medical or behavioral health conditions or other evidence indicative of an exemption, (iv) have children age 12+ who have no claims for serious medical or behavioral health conditions or have other evidence indicative of an exemption, and (v) live in a particular geographic area with more reliable, accessible public transit – and who face no or very short waiting lists for subsidized child care.

7. **Provide Advance Notice to Enrollees:** We recommend that TennCare **not** apply work requirements in first 90 days from the date of a new enrollee's eligibility determination – or from the date on which the work requirements may arguably begin to apply. Rather, TennCare should provide each existing and new enrollee at least 90-day advance written notice that (a) the enrollee would be subject to the work requirements; and (b) the enrollee may request an exemption or file an appeal. For example, a SNAP or TANF enrollee should be afforded 90-day advance written notice that they are now subject to TennCare's work requirements if the individuals are no longer compliant with or exempt from the standards in those programs. Likewise, new enrollees in TennCare should be allowed the opportunity to understand the new program requirements – and figure out whether their current or future participation in the SNAP or TANF programs may affect their status. This would also allow for the inevitable lag in data reporting between TANF, SNAP, and TennCare.

8. **Formalize Obvious Exceptions:** TennCare should not apply work requirements during any period of retroactive eligibility (i.e., between the individual's date of application and date of determination). While this latter point should be self-evident, it still merits formal clarification.

Recommended Operational Details

We also recommend TennCare expressly:

1. Reduce the bureaucratic monthly reporting component and rely instead on quarterly reporting periods collected on a six- or 12-month basis.

2. Allow for reporting lag with SNAP or TANF noncompliance – and provide 90-day advance written notice that the enrollee will be subject to the work requirements and allow an appeal for that determination

3. Allow individuals who have suspended benefits to change their managed care organization (MCO) if the individual was in a suspension status during the Annual Change Period.

4. Allow enrollee to claim an exemption at any time and enable them to do so on any application, recertification, or work requirement reporting mechanism.

Recommended Exemptions

In addition to the draft exemptions TennCare shared, we urge TennCare to exempt the following individuals from any new requirements:

1. **Recent Evidence of Homelessness:** Parents and caretaker relatives should be exempt from the new requirements if they have any recent indications of homelessness. While TennCare states it may grant a "good case" exemption to such individuals, it should formally and categorically exempt them from the work requirements.

   Past Diagnosis of Opioid Use Disorder: Parents and caretaker relatives who have a diagnosis of opioid use disorder and/or documented overdose on or before September 30, 2018 should be and remain exempt from the requirements. This exemption should remain in effect at least 12 months after TennCare's opioid use disorder treatment network is fully established and these individuals have the opportunity to get care and treatment. Otherwise, TennCare would create a Catch-22 by penalizing individuals with opioid use disorder for not having received the drug treatment they could not access. [9]

2. **Parents and Caretaker Relatives Age 50+:** While TennCare proposes to exempt individuals age 65+, we strongly recommend TennCare lower the age threshold to 50. This would be more consistent with the manner in which the SNAP program is administered.

3. **Parents and Caretaker Relatives of Children age 7+ with IEP:** Parents and caretaker relatives with children age 7+ should be exempt from the requirements if they self-report having children with serious emotional disturbances or classroom behavioral concerns that require frequent school visits or more intensive school engagement by the parents and caretaker relatives. Otherwise, parents and caretaker relatives will inevitably have repeated disruptions to their work or volunteer schedule – limiting their ability to maintain employment, etc. We therefore recommend any parent and caretaker relative whose child has an individualized education plan (IEP) be exempt from the new requirements.

4. **Overlapping Eligibility Groups:** We seek formal clarification that former foster youth, victims of human trafficking, and refugees/asylees will not be subject to these requirements, even if these individuals are currently included in the parent/caretaker relative eligibility group. We strongly recommend they be exempt.

5. **Recent Family Trauma/Transitions:** Parents and caretaker relatives should be exempt from the new requirements, at least for a specified period if they or their spouses self-report they:

   a) Have recently filed an order of protection against another individual
   b) Have been the victims of domestic violence

c) Recently were discharged or separated from the military
d) Recently were deployed in active duty military, National Guard, or Reserves
e) Currently serve in the military, National Guard, or Reserves
f) Recently experienced the death of a spouse or child
g) Recently experienced a divorce or abandonment
h) Recently experienced a stillbirth, miscarriage, or loss of pregnancy
i) Currently serve as a foster parent
j) Recently married
k) Recently adopted a child
l) Qualify for FMLA (or would qualify if they were working for an employer subject to the federal law)
m) Recently experienced an eviction or displacement from housing
n) Currently receive unemployment benefits (from any state, not just Tennessee)
o) Currently receive for worker compensation benefits
p) Currently receive short-term disability benefits
q) Currently are or recently were incarcerated
r) Currently are or recently were admitted at a psychiatric hospital or institution for mental disease

While TennCare states it may grant a "good case" exemption to some of these individuals, it should formally and categorically exempt all of them from the work requirements for not less than 12 months upon receipt of the self-attestation.

6. **Recent Evidence of Employment:** Parents and caretaker relatives should be exempt from the new requirements if they have recent indications of employment:

    a) Have recently-reported wages in the New Hires database
    b) Have other indicia of employment with credit reporting services such as Experience, TransUnion, etc.
    c) Received the Earned Income Credit (EIC) on their federal return for the most recent tax year, for which earned income through employment is required
    d) Report earnings on their federal return for the most recent tax year

    Again, TennCare should exhaust all administrative datasets referenced above (including but not limited to IRS tax records, Unemployment Compensation System, and New Hires Database) before requesting further information from any enrollee.

7. **Residents of Economically Distressed Cities:** While the proposal explains TennCare may grant exemptions form communities that are economically distressed, TennCare should not limit this exemption to counties with an unemployment rate above a specific threshold. Also, if TennCare were to adopt an unemployment threshold, it should apply it to both counties and municipalities for which the U.S. Bureau of Labor Statistics reports such rate (e.g., any city with 25,000 + residents). Otherwise, residents of Memphis (as an example) may be grouped with residents of the larger (and generally more prosperous) Shelby County.

Positive Notes

We believe TennCare made the correction choice by bypassing the option to impose premiums. TennCare's history with collecting premiums from enrollees suggests that such an enterprise

would be administratively infeasible. This is largely because the population in question is both very low income and has unpredictable fluctuations in income. Their lack of liquidity and cash flow challenges does not mean they cannot pay premiums at times; rather, it means they cannot do so with consistency. Evidence from a variety of states suggests that even low premium amounts leads to frequent and substantial disruptions in continuity of coverage and, thus, to interruptions in care and treatment. For these reasons, we applaud TennCare's decision to avoid imposition of premiums as being far-sighted and mindful of efficiency.

We also applaud TennCare's decision to exempt disabled individuals as well as individuals who have applied for SSI or SSDI. In so doing, TennCare appropriately acknowledges the median time to SSI approval in Tennessee exceeds 23 months – and individuals typically need to complete the initial application, file a reconsideration, and seek a hearing before an administrative law judge in order to get their SSI entitlement. Interestingly, about 80% of applicants who have a hearing before an ALJ are ultimately approved for SSI – so the key barrier to recognition of their disability is with the very broken, back-logged Social Security Administration's process. Thus, SSI applicants must be treated as exempt for purposes of any new requirements provided they have an open SSI application or pending case. We appreciate TennCare's sensitivity to this issue.

Working collaboratively with its community partners, TennCare must develop a plan and secure funding to address these barriers and related issues. We stand ready to work with TennCare on a comprehensive solution, but we believe strongly any such solution must substantively address each of these challenges before finalizing and implementing Amendment 38.

Please let us know how we can help to advance such a solution.

Sincerely,

Brian Haile
Chief Executive Officer, Neighborhood Health

Paula Foster
Executive Director, Tennessee Conference on Social Welfare (TCSW)

Barbara Quinn
Chief Executive Officer, Park Center

Renata Soto
Co-Founder & Executive Director, Conexión Américas

Jacy Warrell
Executive Director, Tennessee Health Care Campaign (THCC)

Sharon Hurt
Executive Director, Street Works

Joe Interrante
Chief Executive Officer, Nashville CARES

Janie McGinley
Chief Executive Officer, Lifespan Health

Jenny Dittes
Chief Executive Officer, HOPE Family Health

Marsha Edwards
President & Chief Executive Officer, Martha O'Bryan Center

Ingrid McIntyre
Executive Director & Co-Founder, Open Table Nashville

Michael McSurdy
President & Chief Executive Officer, Family and Children's Service

Endnotes

[1] We commend the comments submitted separately by Terri Sabella of the Tennessee Primary Care (TPCA) Association and Mary Linden Salter of the Tennessee Association of Alcohol, Drug, and other Addiction Services (TAADAS). We urge you to consider seriously their input and recommendations as well.

[2] As other commenters note, this general statement may currently lack empirical validation for the specific population subject to the proposed Amendment 38. Further, the issue posed by Amendment 38 is not whether work is beneficial, but whether denying health care to people based on work status is beneficial. To be perfectly clear, we believe health coverage and access to health care is foundational to promoting an individual's ability to work.

[3] *See generally* Melton, Courtney. "Obstacles to Work among TennCare Enrollees Potentially Affected by a Work Requirement." The Sycamore Institute, August 24, 2018. *Available at* https://www.sycamoreinstitutetn.org/2018/08/24/obstacles-to-work-among-tenncare-enrollees/.

[4] *See generally* "Medicaid Work Requirements in Tennessee." The Sycamore Institute, 2017. *Available at* https://www.sycamoreinstitutetn.org/medicaid-work-requirements-in-tennessee/.

[5] TennCare's contribution to safety net funding has already declined precipitously in the past two years. For example, TennCare enrollment declined from a statewide total of above 1.55 million in June 2016 to below 1.42 million in June 2018 – and TennCare aggregate payments to providers has fallen in a commensurate fashion. For this reason, we are especially concerned about the effect of Amendment 38 for those we serve – and the sustainability of the broader safety net on which all Tennesseans rely. The sources for these data are TennCare's enrollment statistics available at https://www.tn.gov/tenncare/information-statistics.html.

[6] *See, e.g.,* Venkatesh, Sudhir. *Off the Books: The Underground Economy of the Urban Poor*. Harvard University Press, 2009. *See also* Keefe, Patrick Radden. "Ghetto Capitalism: Sudhir Venkatesh's new book unravels the mystery of the underground economy." *Slate*, December 6, 2008.

[7] *See, e.g.*, Otto, Mary. *Teeth: The Story of Beauty, Inequality, and the Struggle for Oral Health in America*. New Press, 2018. *See also* Jaffe, Sarah. "The Tooth Divide: Beauty, Class and the Story of Dentistry." *The New York Times*, March 23, 2017, p. 21 of the Sunday Book Review.

[8] There are at least two options available to TennCare to implement such an FQHC exception. TennCare currently moves individuals who have been incarcerated for 90+ days into a "suspended" status, and the managed care organizations (MCOs) deny claims until the suspension is lifted (when the individual is released). Similarly, TennCare could suspend coverage for persons subject the work requirements but who appear not be in compliance. However, TennCare could direct the MCOs to pay claims for this subset of individuals – and/or limit such payments to providers such as FQHCs. Second (and alternatively), TennCare could move such individuals into a new but highly restricted "benefit plan" within the eligibility system such that the only claims that the MCOs would pay are those submitted by FQHCs. Either way, the individual effectively loses broad coverage but still has access to at least primary care, and the FQHCs receive appropriate compensation for providing such care.

[9] We also call your attention to the broader comments made by the TPCA and TAADAS about special considerations for all persons in recovery from addiction. We do not restate those excellent comments here but instead refer you to their submissions. *See* n. 1 above.

Jonathan Reeve

From: Nicole Pratt <nicole.roberts.pratt@gmail.com>
Sent: Friday, October 26, 2018 2:52 PM
To: Public Notice. Tenncare
Subject: TennCare Waiver Amendment 38 Comment

Dear Dr. Long,

I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38. I am a wife, mother, and educator. I see the families that will be effected by this TennCare amendment and worry about the impact on children and families.

I am opposed to this proposal that would take health coverage away from people who do not work a set number of hours per month. This proposal would cause immense harm and jeopardize coverage for thousands of Tennesseans. There are many barriers to working including lack of reliable transportation and child care, especially in Nashville affordable and quality childcare options are limited.

Coverage losses will cause harm. The disruption of treatment or loss of access to health care would affect many people including women and their families. In addition, this proposal leaves many unanswered questions.

- How do people report compliance?
- How will the reporting process accommodate people with disabilities, limited literacy or language?
- What is “good cause” for waiving compliance by certain individuals?
- What criteria will be used to exempt “economically distressed” counties?
- Would disadvantaged subgroups (e.g. those experiencing generational poverty, limited English proficiency, immigrants) be exempted in the same or similar way to "economically distressed counties?

People whom I know would be negatively impacted by this proposal to take away coverage from people who don’t meet the new work requirement. Some single mothers in the preschool my daughter attends have difficulty finding jobs that pay enough to fund the cost of childcare.

This waiver is fundamentally flawed and cannot be fixed. It goes against the goals and purpose of the Medicaid program. We respectfully urge you to not go forward with this harmful proposal.

Sincerely,
Nicole Pratt

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of p_weston@bellsouth.net
Sent: Monday, October 08, 2018 11:14 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Pammela Weston
Progressive Rural Overhill Women for Democracy p o box 545 sweetwater, TN 37874

Jonathan Reeve

From: Pan Awsumb <pawsumb42@me.com>
Sent: Friday, October 26, 2018 10:50 PM
To: Public Notice. Tenncare
Subject: TennCare Waiver Amendment 38

- Dr. Wendy Long
  Division of TennCare

  RE: TennCare Waiver Amendment 38

  Dear Dr. Long,

  I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38.

  I am unequivocally opposed to this proposal that would take health coverage away from people who do not work a set number of hours per month. This proposal would cause immense harm and jeopardize coverage for thousands of Tennesseans.

  I am concerned because people I have worked with would be seriously adversely impacted. I live in Memphis, TN, where there is a great deal of poverty. There are also jobs, but our transportation system is so dysfunctional that people taking some of these jobs would have to travel more than two hours each way, and change busses at odd hours of the night in dangerous areas. One person I helped was excited about a job with Nike, and willing to do all the traveling. But on his third week on the job he was mugged as he waited for a bus at night, and had to be hospitalized. Other people I know have small children and day care is so expensive that it negates the pay they receive.

  Failure to meet reporting requirements and paperwork errors might result in suspension of coverage, and this could effect thousands of Tennesseans. I am also concerned

  that disruption of treatment of loss of access to health care would be particularly dangerous for cancer patients, people struggling with addiction, and people with diabetes.

  For these reasons, I strongly urge you not to enact this policy. The people I know are not trying shirk work or beat the system.

  Thank you for your consideration.

  Pan Awsumb

  Citizen of Memphis, TN

Jonathan Reeve

From: Ashley Comer <patsy.benge@icloud.com>
Sent: Wednesday, October 17, 2018 1:16 PM
To: Public Notice. Tenncare
Subject: Tenn care amendment 38

I oppose this amendment because it will devastate our community.A poor community that already s has so many hardships . Family members such as myself that are in poor health an still trying to take care of disabled family members at home .I do without health care everyday . Medical issues I have that go unchecked due to lack of health care .Please expand Tenn care Medicaid .An do not implement the work for Medicaid change. There are so many elderly & poor & disabled in our community that this would put so much burden &hardship on . There is also not enough employment opportunities in these small rural communities & lack of transportation &lack of opportunity for disabled Americans . This law I believe would lead to worse hardships . And I believe it would not be implemented right & would not be fair . Stand in the shoes of the poor and hurting with no opportunity & that are doing without & realize that they are hurting enough already . Please stand for those people . Help those people . Do away with that amendment 38 & expand Medicaid to people like me An the people that are hurting . Thank you Mrs. Benge

Sent from my iPhone

Jonathan Reeve

From: phardimo@aol.com
Sent: Wednesday, October 24, 2018 3:35 AM
To: Public Notice. Tenncare
Subject: TennCare's Work Requirements Proposal

IMPORTANT WARNINGS from Experts 1. Exemptions are not Protections! Research and experience show that work requirements impose complex administrative burdens on families, employers and the state. States cannot safely and fairly administer those requirements, and many people are at risk of losing their coverage due to confusion or bureaucratic mistakes. For that reason, even people who are supposed to be exempt may not be able to claim exemption. That's because of daunting red tape (a particular risk for people with disabilities) or because of bureaucratic errors on the part of the state or its contractors. 2. Many people who meet the work requirements will still lose coverage! That's because of: • Barriers to reporting their work hours, or resistance by employers. • State contractors or systems errors will result in wrongful terminations. • They make too much money to qualify for TennCare any longer, but their low wage jobs don't provide health insurance. They are left with nothing.

Rev. Pattie Hardimon
Pastor

Jonathan Reeve

From: Coffield, Ashley <acoffield@pptnm.org>
Sent: Friday, October 26, 2018 11:22 AM
To: Public Notice. Tenncare
Subject: TennCare II Section 1115 Demonstration Waiver, Amendment 38
Attachments: TN 1115 Waiver Work Requirements_State Comments_October 2018.pdf

Dear Dr. Long,
Please see comments on Amendment 38 attached to this email.

Thank you,

Ashley Coffield
President and CEO
Pronouns: she/her

Planned Parenthood of Tennessee and North Mississippi
D: 901-725-3003
P: 866-711-1717
plannedparenthood.org/tennessee

Planned Parenthood®
Care. No matter what.
Tennessee and North Mississippi

October 26, 2018

VIA ELECTRONIC SUBMISSION - *public.notice.tenncare@tn.gov*

Dr. Wendy Long
Director, Division of TennCare
310 Great Circle Road
Nashville, TN 37243

RE: TennCare II Section 1115 Demonstration Waiver, Amendment 38

Dear Director Long:

As a trusted and high-quality reproductive health care provider and advocate, Planned Parenthood of Tennessee and North Mississippi ("Planned Parenthood") submits the following comments on the proposed TennCare II Section 1115 Demonstration Waiver Amendment 38 ("Waiver Amendment") that proposes to require work as a condition of Medicaid coverage for TennCare parent and caretaker relatives.

For more than 75 years, Planned Parenthood has been a trusted provider of quality, compassionate, and affordable health care in Tennessee. Planned Parenthood is a vital part of Tennessee's health care system and a major provider of reproductive health care in the state. In 2016, through our three health centers in Tennessee—in Knoxville, Memphis, and Nashville[1]—Planned Parenthood provided more than 15,000 patients with comprehensive family planning services, including contraceptive services, lifesaving cancer screenings, and testing and treatment for sexually transmitted infections ("STIs"). We also provide a range of critical preventive and primary care services and referrals to other expert providers for patients that require additional health care. Women comprise 92 percent of our patients, and many of our patients have incomes below 150 percent of the federal poverty level. Individuals across the state trust us to provide them with quality, expert care in a confidential and non-judgmental setting. We believe it is important that each individual be able to access the medical care they need from the providers they trust regardless of their insurance source, their income, or their residence.

Medicaid is a vital part of our nation's health care system and plays a major role in ensuring access to family planning and other primary health care services for women and men. As Tennessee knows, 58 percent of Medicaid enrollees in our state are women and rely on Medicaid coverage for essential primary and preventive care, including lifesaving cancer

[1] Three of four Planned Parenthood health centers in Tennessee are located in areas with formally-recognized provider shortages. *See*, Health Resources and Services Administration, Data Warehouse. https://datawarehouse.hrsa.gov/tools/analyzers/geo/ShortageArea.aspx.

screenings and birth control.[2] As of 2016 (the most recent year for which data is available), Medicaid funds over half of all births in the state of Tennessee.[3] Due to racism and other systemic barriers that have contributed to income inequality, women of color disproportionately comprise the Medicaid population; 30 percent of African-American women and 24 percent of Hispanic women are enrolled in Medicaid, compared to only 14 percent of white women.[4] Medicaid, as designed by Congress, is critical to improving the health and well-being of women and families with low-incomes across Tennessee and the rest of the nation.

We are concerned that Tennessee's latest proposal to condition Medicaid coverage on mandatory participation in work or work-like activities will undermine health care access for individuals with low incomes in our state, including many of the patients that we serve. While the State claims that the goal of this Section 1115 demonstration waiver is to improve health outcomes, we fear the result will be less access to care and people's health will suffer. In fact, states themselves have projected significant coverage losses as a result of work requirements. Our neighbors in Kentucky estimate that 15 percent of all Medicaid enrollees — at least 97,000 — will lose coverage due to work requirements and other provisions of its Section 1115 Waiver.[5] Indeed, data from the first few months of the implementation of Arkansas' work requirement waiver found that nearly 8,500 people have been disenrolled from Medicaid coverage to date for failure to meet the strict requirements.[6] Unfortunately, women of color will be harmed the most by efforts to roll back Medicaid coverage since, due to the intersections of race, poverty, and gender in our country, women of color are most likely to be low-income and have Medicaid coverage.

We urge Tennessee to rescind its proposal to impose punitive work requirements as a condition of Medicaid coverage, as such proposal is inconsistent with and contrary to the requirements of Section 1115 waivers and would harm the health and well-being of women and families across our state.

1. ***The State of Tennessee Should Rescind its Proposal that Requires Employment or Other Work-Like Activities as a Condition to Medicaid Coverage.***

Planned Parenthood is aware that CMS has already issued guidance supporting Medicaid enrollment restrictions, including conditioning Medicaid coverage on compliance with work

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[2] Kaiser Family Foundation, Fiscal Year 2013, "Medicaid Enrollment by Gender." https://www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-gender/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[3] Kids Count Data Center, TennCare or Medicaid Moms, https://datacenter.kidscount.org/data/tables/9074-tenncare-or-medicaid-moms#detailed/2/any/false/870,573,869/any/18288,18058.

[4] Hannah Katch, Jessica Schubel, and Matt Broaddus, Medicaid Works for Women — But Proposed Cuts Would Have Harsh, Disproportionate Impact, Center on Budget and Policy Priorities (May 11, 2017). https://www.cbpp.org/research/health/medicaid-works-for-women-but-proposed-cuts-would-have-harsh-disproportionate-impact.

[5] Hannah Katch, Jennifer Wagner, and Aviva Aron-Dine, Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes, Center on Budget and Policy Priorities (Aug. 13, 2018). https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce.

[6] Robin Rudowitz and MaryBeth Musumeci, A Look at State Data for Medicaid Work Requirements in Arkansas, Kaiser Family Foundation (Oct. 16, 2018). https://www.kff.org/medicaid/issue-brief/a-look-at-state-data-for-medicaid-work-requirements-in-arkansas/.

activities.[7] However, Tennessee seeking to move such proposal is not only misguided and dangerous, but will threaten access to critical health coverage for many women and families with low incomes. For over 50 years, Medicaid has provided benefits for all eligible individuals—with eligibility being determined by income and/or special characteristic (e.g., pregnancy, being a child under 19, or having a disability). Under Tennessee's proposed waiver amendment, the state would be allowed to narrow eligibility and limit enrollment for adults in the TennCare parent/caretaker relative eligibility category who are under the age of 64 based on a person's participation in state-approved work activities, with limited exceptions. This proposal clearly contravenes the objectives of Medicaid and does not serve a legitimate experimental purpose.

First, in order to be approved pursuant to Section 1115 of the Social Security Act, Tennessee's application must:

- propose an "experiment[], pilot or demonstration";
- waive compliance only with requirements in 42 U.S.C. § 1396a;
- be likely to promote the objectives of the Medicaid Act; and
- be approved only "to the extent and for the period necessary" to carry out the experiment.[8]

The purpose of Medicaid is to enable states to furnish medical assistance to individuals with low incomes who are unable to meet the costs of medical care and to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care.[9] Conditioning Medicaid eligibility on participation in work activities would block access to care and services that help individuals attain and retain independence or self-care and, as a result, be able to work.[10] Research confirms that Medicaid coverage helps individuals to obtain and maintain employment. In a recent study of Ohio's Medicaid program, 74.8 percent of unemployed Medicaid expansion enrollees reported Medicaid made it easier to secure and maintain employment.[11] As an example, Medicaid coverage helped an Ohio woman who was suffering from a severe hernia and was previously unable to get out of bed to receive the surgery she needed to improve her health and go back to work.[12] Medicaid enrollees also report less financial stress and depression, and greater financial security than individuals who are uninsured.[13]

Second, imposing Medicaid work requirements is a policy proposal to address a non-existent problem, as the vast majority of people with Medicaid coverage work or have a reason for not

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[7] SMD 18-002, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," (Jan. 11, 2018). https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.

[8] 42 U.S.C. § 1315(a).

[9] 42 U.S.C. § 1396a-1.

[10] By contrast, as far back as the 1970s, states obtained Section 1115 waivers to test work requirements in the AFDC program (which, unlike Medicaid, does have work promotion as a purpose of the program). These waivers required states to conduct "rigorous evaluations of the impact," typically requiring the random assignment of one group to a program operating under traditional rules and another to a program using the more restrictive waiver rules. United States Dep't of Health & Human Servs., *State Welfare Waivers: An Overview*, http://aspe.hhs.gov.hsp/isp/waiver2/waivers.htm.

[11] The Ohio Department of Medicaid. Ohio Medicaid Group VIII Assessment. http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[12] The Ohio Department of Medicaid. Ohio Medicaid Group VIII Assessment. http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[13] The Commonwealth Fund. *Does Medicaid Make a Difference?* http://www.commonwealthfund.org/publications/issue-briefs/2015/jun/does-medicaid-make-a-difference.

working. According to the Kaiser Family Foundation, 60 percent of Medicaid enrollees are already working.[14] Of those not working, 36 percent reported that illness or a disability was the primary reason, 30 percent reported that they were taking care of home or family, and 15 percent were in school.[15] Further, almost two-thirds (62 percent) of those who could lose Medicaid coverage due to work requirements are women.[16] Women will be disproportionately harmed by the state's proposal, as they are more likely to provide informal and undervalued caregiving to family members—including spouses and parents—work that typically would not fulfill the work requirement.[17] Creating burdensome red tape and administrative hurdles to getting Medicaid coverage will inevitably result in eligible people losing needed coverage, causing the health of Tennesseans across the state to suffer.

Finally, experience has shown that imposing work requirements as a condition of receipt of public benefits is particularly harmful for women and families and does nothing to help people secure employment. For example, work requirements were a key feature of the 1996 Temporary Assistance for Needy Families ("TANF") legislation. Rigorous review of data over the last several decades found that TANF employment mandates did not boost the job prospects of low-income women;[18] rather, they led to women losing TANF benefits and more children living in poverty.[19] Further, mandatory work requirements could also have harmful spillover effects for children whose parents or caretakers lose coverage. Research shows that expanding coverage to parents and caretakers is associated with increased receipt of recommended pediatric preventive care for their children.[20] That study noted an "independent relationship between parental Medicaid enrollment and children's primary care use in low-income families" and cautions that "our results reveal the potential for reductions in adult Medicaid coverage to have unintended spillover effects on children's health care use."[21]

Rather than imposing these harmful requirements on Medicaid enrollees, the state of Tennessee should instead focus on voluntary, evidence-based anti-poverty efforts that will provide legitimate and equitable opportunities for women and families, such as family planning access, educational assistance, job training, and affordable child care.[22] The State should also

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[14] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, January 5, 2018, https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[15] *Id.*

[16] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, January 5, 2018, https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[17] *Id.*

[18] Elizabeth Lower-Basch. *Adding Stumbling Blocks in the Path to Health Care*, CLASP (March 2017). http://www.clasp.org/resources-and-publications/publication-1/Adding-Stumbling-Blocks-in-the-Path-to-Health-Care.pdf.

[19] 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.

[20] Maya Venkataramani, Craig Evan Pollack, Eric T. Roberts, *Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services*, 140 Pediatrics 1 (Dec. 2017), http://pediatrics.aappublications.org/content/140/6/e20170953.

[21] *Id.*

[22] Studies show that voluntary employment programs increase employment and income among individuals with low incomes. Howard Bloom et al., MDRC, *Promoting Work in Public Housing: The Effectiveness of Jobs-Plus* (2005), https://www.doleta.gov/research/pdf/jobs_plus_3.pdf; James A. Riccio,

consider expanding Medicaid to provide needed coverage for more people with low incomes. We urge the state of Tennessee to rescind its proposal to impose work requirements as it will have the impact of making people lose health coverage, thus threatening their health and economic circumstances.

***

Thank you for the opportunity to submit these comments on the proposed TennCare II Waiver Amendment 36. If you have any questions, please do not hesitate to contact me at: 901.725.3003 or acoffield@pptnm.org.

Sincerely,

Ashley Coffield
President and CEO
Planned Parenthood of Tennessee and North Mississippi
2430 Poplar Avenue, Ste. 100
Memphis, TN 38112

MDRC, *Sustained Earnings Gains for Residents in a Public Housing Jobs Program: Seven-Year Findings from the Jobs-Plus Demonstration* (2010), http://files.eric.ed.gov/fulltext/ED514703.pdf.

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of doneganre@gmail.com
Sent: Sunday, October 07, 2018 3:47 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

Additionally, the amount of money it would take to verify said work requirements would cost more money than this initiative would theoretically save. It simply doesn't make sense from a financial perspective either.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Rachel Donegan

1050 Stanley Drive
MOUNT JULIET, TN 37122-4110

Jonathan Reeve

From: Rebecca Terrell <terrellrebecca@gmail.com>
Sent: Tuesday, October 09, 2018 9:52 AM
To: Public Notice. Tenncare; Terrell Rebecca; Rebecca Terrell
Subject: Opposed to Work Requirement for TennCare

Dr. Wendy Long
Division of TennCare v
ia email to: public.notice.tenncare@tn.gov

RE: TennCare Waiver Amendment 38

Dear Dr. Long,

I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38. I am the director of a small nonprofit community health clinic in Memphis and we see many low income patients who depend on TennCare for their medical care. **I am unequivocally opposed to this proposal that would take health coverage away from people who do not work a set number of hours per month.** This proposal would cause immense harm and jeopardize coverage for thousands of Tennesseans.

Research and experience show that work requirements impose complex administrative burdens on families, employers and the state. States cannot safely and fairly administer those requirements, and many people are at risk of losing their coverage due to confusion or bureaucratic mistakes. For that reason, **even people who are supposed to be exempt may not be able to claim exemption.** That's because of daunting red tape (a particular risk for people with disabilities) or because of bureaucratic errors on the part of the state or its contractors.

I respectfully urge you **to not go forward with this harmful proposal.**

Sincerely,
--
Rebecca Terrell
901-517-6914

Jonathan Reeve

From: oldgrezmonke@aol.com
Sent: Friday, October 26, 2018 1:27 PM
To: Public Notice. Tenncare
Subject: Tenncare work requirement

Re: Public Chapter 869 , Draft Amendment 38 - please don't do this . You want people to be working to get health care but a person can't work if sick or caring for a loved one or simply can't find employment or look for it because they are sick . It's a nice little viscous cycle which I have personally experienced in another state that trotted out this hurtful idea . Please don't do this .
Respectfully , Richard E. Zook , Jr.

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of rhenighan@igc.org
Sent: Tuesday, October 09, 2018 8:10 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

Richard Henighan

I am presenting this comment on TennCare Waiver Amendment 38 as a personal comment. I am retired from The Tennessee Department of Health where I was a Family Nurse Practitioner. I worked for over 30 years in various publicly funded Primary Care locations in East Tennessee offering care to the uninsured. I still volunteer one day per week at a local "Safety Net" clinic for the uninsured. I am also a Board member of the Tennessee Health Care Campaign.This organization has already submitted a comment . These are my personal concerns.

The Waiver document (Pg 1-2) cites several studies that show the harm that unemployment causes health. A good lesson to remember. Unfortunately, that is not the same as documenting that any employment or community engagement benefits the average person not working or engaged. There is no documentation that the whole concept that is laid out here will benefit anyone, an essential for a Waiver of this sort. In fact, at the end of the Waiver text (Pg 6-7) the benefits that should be a given up front are laid out like hypotheses to be proven, as if this were some large scale social science experiment. But an unethical one, since the subjects have not given their permission to be a part of it.

Let's imagine that such an experiment might be a good idea on a small scale and with detailed mechanisms to insure that the social, financial, transportation and health care supports needed were in place. Sadly the Waiver does just the opposite, claiming supports will be there but offering no credible details or evidence that they are real. Will the TANF funds be available? In the Waiver, It's all just TBD, to be determined.(Pg. 4)

I learned very quickly in my professional work that broad health care coverage, while not sufficient in itself, is essential for real access to the up-to-date, effective, and value-based services that can really make a difference, on both the individual and community levels, to the large health disparities that we know exist in our State. I learned over and over again, when people lost their coverage their journey to reach stability or cure was most often derailed. Access to essential medicines to treat chronic illness & to prevent complications is lost. Access to follow-up care, often very expensive, is lost. Financial stability or the path to it is lost. And, yes, lives are lost.

The harm of lost coverage hangs over not just the roughly 86,000 individuals (that the Fiscal Note of HB 1551 that became Public Chapter #869) estimated to be potential targets for this Waiver, but other parts of the entire 1.5 Million TennCare enrollee population are at risk because the Waiver does not make clear in sufficient detail how the proposal will be implemented. Will it only be the Caregiver Category as is claimed? (Pg. 2) Will there not be pressure to gather the same information about other categories such as the Breast & Cervical Cancer Program or the former foster child category, or from all new enrollees? How

do enrollees document compliance? How will the reporting process accommodate clients with disabilities, limited literacy, or language barriers? What about exemptions? (Pg. 3) Those listed in the Waiver are narrower than many other States I am familiar with, but wide or narrow, exemptions are not protections. Many can be eligible for exemption but due to inability to report or document their situations will not be able to claim them. How will the Waiver program ensure this does not happen?

In this context, TennCare continues to be the only State Medicaid program without an on-line eligibility system, a problem that has remained unresolved for over five years, despite repeated assurances that it will be solved in a few months more. The most recent redetermination process that has been ongoing has revealed large communication difficulties with clients. Don't these issues have to be proven resolved before an experiment like this is started?

I want to end by noting that the purpose in law of Medicaid waivers is to "promote the objectives" of Medicaid, of which the provision of coverage for individuals eligible for the program is foremost. A Waiver such as this that can only guarantees to take coverage away is not appropriate.

Richard Henighan, APRN, FNP,BC
619 Mt. View Dr., Seymour, TN, 37865
rhenighan@igc.org

Respectfully,

Richard Henighan
THCC
619 Mt. View Dr.
Seymour, TN 37865

Jonathan Reeve

From: Ron Flippen <ronflippen@yahoo.com>
Sent: Tuesday, October 09, 2018 10:43 AM
To: Public Notice. Tenncare
Subject: health care benefits

ok look some people are no able to do any work related activities due to illness so I'm against any mandatory work requirements for health care benefits when we offer free health care benefits for anyone else that is not even a taxpayer or a citizen of the U.S.A.

Sent from Yahoo Mail on Android

Jonathan Reeve

From: Rebecca Jolley <rebecca@rhat.org>
Sent: Thursday, October 25, 2018 1:06 PM
To: Public Notice. Tenncare
Subject: TennCare II Demonstration Amendment 38 (Project No 11-W-00151/4) Comment Letter
Attachments: TennCare Amendment 38 Comment Letter RHA of TN.pdf

Dr. Long,

Thank you for the opportunity to provide comments on proposed Amendment 38 (Project No. 11-W-00151/4). Please find the attached comment letter submitted on behalf of the Rural Health Association of TN's members. If you have any questions or need clarification on any of the information contained within, please feel free to contact me directly via the information listed below.

Sincerely,

Rebecca Jolley, MBA
Executive Director
Rural Health Association of Tennessee
PO Box 656
Decaturville, TN 38329
615-624-0082 office
Rebecca@RHAT.org

SAVE THE DATE
RHA of TN 24th Annual Conference
Nov 14-16, 2018
Music Roads Resort
Pigeon Forge, TN

RURAL HEALTH ASSOCIATION OF TENNESSEE

Rebecca Jolley, MBA | Executive Director

PO Box 656 | Decaturville | TN 38329 | office: 615-907-9707

October 24, 2018

Wendy Long, M.D.
Director
Division of TennCare
310 Great Circle Rd
Nashville, TN 37243

RE: Division of TennCare – TennCare II Demonstration Amendment 38 (Project No. 11-W-00151/4)

Dear Dr. Long:

The Rural Health Association of Tennessee (RHA of TN), on behalf of our more than 600-member healthcare facilities and providers, appreciates the opportunity to comment on the draft TennCare II Demonstration, Amendment 38 (Project No. 11-W-00151/4). The RHA of TN is a non-profit, membership driven organization focused on effecting a positive change in the health and well-being of all rural Tennesseans. Our membership is comprised of individuals that are passionate about access to high quality healthcare delivery in rural areas of Tennessee. We represent hospitals, clinics, health departments, school health, emergency medical services, medical students and healthcare professionals that serve the rural residents of Tennessee.

In reviewing the proposed amendment, our members have several areas of concern for how the Medicaid work requirements will be implemented and impact those beneficiaries that live in the rural and remote parts of our state. Our primary concerns include the impact this change will have on providers and the impact it will have on rural beneficiaries that often lack access to public transportation, childcare, broadband connectivity and employment opportunities.

Impact to providers

It is a well-known fact that the rural hospitals in Tennessee are struggling to survive in the current healthcare climate. With 8 hospital closures, TN leads the nation in per capita loss of access to healthcare in rural counties. Our rural healthcare providers are in the midst of addressing the opioid crisis, obesity epidemic, mental health crisis and significant health disparities to name just a few. This modification to the Medicaid program will add an administrative burden to our rural healthcare providers that will detract from the focus on improving the health of their patient population. With this change, the process for caring for Medicaid beneficiaries that could transition in and out of coverage will be exacerbated. While we appreciate TennCare will only be analyzing compliance on a 6-month process initially, it is

unclear how this process will continue once a person is initially removed from Medicaid coverage for non-compliance. Additional clarification on this process is needed to determine the exact impact to providers, however, the current information provides detail to recognize this will add significantly to the overhead operating costs of our rural providers not to mention the uncompensated care costs for individuals that lose coverage and seek care in rural emergency departments. Due to TennCare's current inability to project the impact of this draft amendment, **the RHA of TN recommends that TennCare consider refraining from implementation of any unenrollment from Medicaid coverage until after the first full year of implementation**.

Impact to Rural Medicaid Beneficiaries

Rural areas of Tennessee have unique challenges in relation to the implementation of Medicaid work requirements that need to be taken into consideration when rolling out a program change of this type. These include access to employment, internet connectivity, transportation and childcare.

While Tennessee celebrates a statewide average of 3.6% unemployment, this is not the reality of our rural communities. A chart released in January 2018 by the TN Dept. of Labor & Workforce Development shows the top 10 counties with the highest unemployment rate are at or higher than double the state average. Another notable fact, is all of the counties with the highest rates of unemployment are rural.

Highest County Unemployment Rates

Rank	County	Jan, 2018 Pre. Rate (%)
95	Houston	6.8
94	Rhea	6.8
93	Cocke	6.5
92	Benton	6.5
91	Lake	6.4
90	Lauderdale	6.3
89	Bledsoe	6.2
88	Sevier	6.1
87	Unicoi	6.1
86	McNairy	5.9

The information presented in January of 2018 is important in that it highlights the portion of the year where seasonal employment opportunities are at their lowest. This is important to note as seasonal employment makes up a large portion of the work opportunities in our rural areas. It also highlights the volatility in access to stable employment in rural Tennessee**. The RHA of TN recommends the TennCare Bureau take this information into account for the**

implementation in rural areas and provide for exclusions in counties where the unemployment rate is higher than the statewide average.

Another issue in our rural areas is access to Community Service (volunteering) in approved settings. The draft amendment stops short of providing any information on what would be included in the definition of "approved settings". Tennessee's rural areas do not have an abundance of volunteer organizations where a person could seek to supplement an absence of worked hours with volunteer work. **The RHA of TN encourages the TennCare Bureau to clarify the definition of approved volunteer settings and how the approval process will be rolled out before submission of a final draft to CMS. It is also recommended that a survey be completed of our rural counties on the availability of volunteer sites that would allow an individual to comply with the requirements of the proposed draft.**

In a report released to Gov. Haslam by the TN Dept of Economic and Community Development on July 19, 2016, as part of the TNECD Broadband Initiative, one of the key findings of the study found, "The vast majority of the areas in Tennessee without access are located in rural regions of the state. For example, only 2 percent of urban citizens do not have access to 25/3 broadband connectivity in Tennessee compared to 34 percent of rural citizens." This information is key in evaluating the ability of rural residents to comply with the monthly self-reporting requirements outlined in the proposed amendment. Although the draft is largely silent on how the self-reporting will be deployed, it is highly probable that is will be disproportionally burdensome on rural Medicaid enrollees to comply with this provision on a monthly basis. **The RHA of TN recommends the TennCare Bureau should take the limited access to reliable cellular coverage and lack of access to basic internet services that is a reality in our rural communities into account when implementing the self-reporting requirements. Penalties should be waived for rural areas that are unable to comply with monthly compliance deadlines.**

Rural areas of our state completely lack any type of public transportation infrastructure. A review of the Tennessee Poverty Rate by County reflects that 42 counties in Tennessee have at least 20% poverty rate if not higher. Lake County has the highest poverty rate of 31.7%. The RHA of TN appreciates that the implementation of work requirements is aimed at getting people out of poverty, however the hard fact is that does not happen by simply requiring it to happen. Without the proper social supports, like access to transportation, individuals will not rise out of poverty, they will simply lose their healthcare coverage for non-compliance with this proposed work requirement, thus sinking them deeper into poverty.

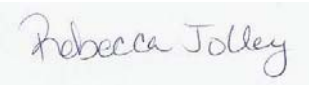
A second barrier to satisfying these requirements is access to affordable childcare. While Tennessee does not have a legal age for children to stay at home alone, the Tennessee Juvenile and Family Court website's FAQs includes guidance that states, "Younger children have a greater need for supervision and care than older children. Obviously, young children under age 10 should not be left without supervision at any time. In most cases, older teenage children may be left alone for short periods of time." The TN Work Requirement Act and this draft

amendment would put caregivers of small children in a position of choosing to care for their children or satisfy these requirements to continue to have insurance coverage.

The RHA of TN would encourage the TennCare Bureau to review the HELP-Link program implemented in Montana for as an example of a Medicaid Work Program that is a successful model. This program is quoted by the Center on Budget and Policy Priorities as a promising program that offers services to help Medicaid enrollees succeed in the workforce, "Montana's Health and Economic Livelihood Partnership Link (HELP-Link) program targets outreach and services to the minority of Medicaid enrollees who do not have disabilities or similarly severe barriers to work but who are not working, often due to challenges such as limited skills and lack of access to transportation, child care, and other needed work supports. Montana's approach targets Medicaid enrollees who are looking for work or better jobs, linking them with services such as career counseling, on-the-job training programs, and subsidized employment. In its first two years, the program has shown promise and has generated strong participation among enrollees, likely because the state has engaged in intensive outreach, offered meaningful services, and provided trainings to service providers and partners in how to meet the needs of low-income Medicaid enrollees."

In summary, the RHA of TN is committed to working with the TennCare Bureau to provide additional information on the impact these draft requirements will have on our rural residents and healthcare providers. Due to the fact that TennCare cannot forecast the expected impact on enrollment these changes will have, we encourage the Bureau to proceed slowly without penalties until a greater understanding of the potential impact can be assessed. **We strongly encourage a period of in-depth education of Medicaid beneficiaries and a grace period where penalties will not be implemented for at least the first-year post rolling out these proposed requirements.** If you have any questions or if we can be of any further assistance, please don't hesistate to contact me at Rebecca@RHAT.org or 615-624-0082.

Sincerely,



Rebecca Jolley, MBA
Executive Director
Rural Health Association of Tennessee

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of scott.springcreekfoods@gmail.com
Sent: Saturday, October 13, 2018 12:36 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Scott Turner
340 Rocky Hill Way
Bolivar, TN 38008

Jonathan Reeve

From: S K <shaakir55@gmail.com>
Sent: Tuesday, October 09, 2018 10:18 PM
To: Public Notice. Tenncare
Subject: TennCare Waiver Amendment 38

Dr. Wendy Long
Division of TennCare
public.notice.tenncare@tn.gov
RE: TennCare Waiver Amendment 38
Dear Dr. Wendy Long,
I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38.
I am unequivocally opposed to this proposal that would take health coverage away from people who do not work a set number of hours per month. This proposal would cause immense harm and jeopardize coverage for thousands of Tennesseans.

Failure to meet reporting requirements and paperwork errors will result in suspension of coverage for thousands of Tennesseans. The waiver would lead to large coverage losses. People will lose coverage even though they remain eligible.TennCare's lack of computer system, the barriers associated with obtaining reliable transportation and child care, and barriers to reporting are all examples of why I do not support TennCare Waiver Amendment 38. Like Arkansas, TennCare's Waiver Amendment 38 will cause massive coverage losses. Ex. The disruption of treatment or loss of access to
health care would affect a particular group (e.g., cancer patients, people with addiction, people with diabetes, etc.). In addition, this proposal leaves many unanswered questions. The man
• How do people report compliance?
• How can TennCare administer this complex eligibility determination without an eligibility determination computer system, which is not yet complete?
• How will the reporting process accommodate people with disabilities, limited literacy or language?
• What is "good cause" for waiving compliance by certain individuals?
• What criteria will be used to exempt "economically distressed" counties?
The people whom I know would be negatively impacted by this proposal to take away
coverage from people who don't meet the new work requirement. (Include stories of people who would be negatively impacted by this proposal and the harm that this proposal would cause.
This waiver is fundamentally flawed and cannot be fixed. It goes against the goals and purpose of the Medicaid program. I respectfully urge you to not go forward with this harmful proposal.

Sincerely,
Shakura D. Kharif, Ed.S, Ed. D

Jonathan Reeve

From: Sharon Cox <esharoncox@aol.com>
Sent: Friday, October 26, 2018 9:45 PM
To: Public Notice. Tenncare
Subject: Work requirements

I am opposed to the work requirements proposal and hope this will be denied by CMS or dealt with in the courts.
This is shameful public policy.
Sharon Cox

Sent from my iPad

Jonathan Reeve

From: Rakhit, Shayan <shayan.rakhit@vanderbilt.edu>
Sent: Monday, October 01, 2018 7:43 PM
To: Public Notice. Tenncare
Subject: Feedback on Amendment 38

Dear Tenncare,

Does the State of Tennessee and Tenncare have a plan to compensate safety net hospitals for the increase in uninsured Tennesseans seeking care at safety net hospital emergency departments, which is required by the Emergency Medical Treatment and Active Labor Act, the federal law signed by Ronald Reagan in 1986?

Safety net hospitals, such as Vanderbilt University Medical Center, operate on razor thin margins and thus are dependent on as many funded patients as possible, of which ensuring as many insured low-income Tennesseans as possible. Amendment 38 will reduce the number of insured low-income Tennesseans, resulting in a financial loss to safety net hospitals, such as Vanderbilt University Medical Center, for which all Tennesseans, rich or poor, rely upon, including members of the Tennessee Legislature and employees of the State of Tennessee.

Will the State of Tennessee make safety net hospitals, such as Vanderbilt University Medical Center, financially whole for the effective reductions in revenue that it is proposing with Amendment 38?

While the question of how these low-income Tennesseans will continue to access healthcare is also on the mind of myself, a registered Tennessee voter, I believe that many other concerned members of the public are asking this question, and thus I will not go into more detail regarding this second question.

Thank you for your time and consideration.

Sincerely,
Shayan Rakhit

Shayan Rakhit
Vanderbilt University School of Medicine
M.D. Candidate, Class of 2019
shayan.rakhit@vanderbilt.edu
770-298-0959

Jonathan Reeve

From: sherrie raymond <sgraymond@outlook.com>
Sent: Tuesday, October 09, 2018 5:42 PM
To: Public Notice. Tenncare
Subject: TN Care Amendment 38

With all the exceptions that will be granted, will there be more than a few dozen people who will actually be affected by this? In order to be eligible for TN Care in the first place, I was under the impression that individuals had to fall into one or more of those categories already.

Jonathan Reeve

From: Sue Bolling <sbol123@gmail.com>
Sent: Friday, October 26, 2018 1:48 PM
To: Public Notice. Tenncare
Subject: TennCare Proposal Comments - Oppose

Research and experience show that work requirements impose **complex administrative burdens on families, employers and the state**. States cannot safely and fairly administer those requirements, and many people are at risk of losing their coverage due to confusion or bureaucratic mistakes. For that reason, even people who are supposed to be exempt may not be able to claim exemption. That's because of daunting red tape (a particular risk for people with disabilities) or because of bureaucratic errors on the part of the state or its contractors. Many people who meet the work requirements will still lose coverage. That's because of: • Barriers to reporting their work hours, or **resistance by employers**. • **State contractors or systems errors will result in wrongful terminations.** • Some folks make too much money to qualify for TennCare any longer, but their low wage jobs don't provide health insurance. We are left with nothing.

This proposal isn't about putting people to work. It's about depriving people of health care, which actually makes it harder for them to work.

--

Thanks for your consideration of my comments

Jonathan Reeve

From: Mary Linden <Marylinden@taadas.org>
Sent: Wednesday, October 24, 2018 3:30 PM
To: Wendy Long; Public Notice. Tenncare
Cc: Brooks Daverman; aaron.butler@tn.gov
Subject: TAADAS Comments on Amendment 38
Attachments: Amendment 38 waiver proposal TAADAS comments 10-24-18 FINAL.pdf

Dr. Long,

Please accept the attached letter as TAADAS' comments on the proposed amendment 38 to the TennCare program.

Thank you for your time and attention to our concerns.

Mary-Linden Salter, LCSW
Executive Director
Tennessee Association of Alcohol, Drug & other Addiction Services
Airport Executive Plaza
1321 Murfreesboro Pike Suite 155
Nashville, TN 37217
Office: 615-780-5901, ex **118**
Note new phone extension
Cell: 615-579-8808
https://smile.amazon.com/

TAADAS
Tennessee Association of Alcohol, Drug & other Addiction Services

Dr. Wendy Long, Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

RE: Proposed Amendment 38 of the TennCare Program

Dear Dr. Long,

TAADAS is a statewide association of alcohol and drug abuse, recovery and prevention professionals and organizations across Tennessee. We represent over 68 agencies statewide and over 36 individual member professionals. On behalf of the Tennessee Association of Alcohol, Drug and other Addiction Services (TAADAS), I am pleased to submit comments concerning the proposed amendment to the current TennCare program submitted to comply with Public Chapter No. 869, as enacted by the Tennessee General Assembly in 2018. I attended the Community Engagement Meeting on August 20th as well as the Public Hearing on Monday, October 8, at the Bordeaux Branch of the Nashville Public Library. Several of the comments I made at these two events are reiterated in this letter.

Our collective experience addressing substance use disorders leads us to the conclusion that denying health coverage and access to treatment for people who are unemployed will undermine efforts to address Tennessee's public health addiction crisis. Lack of access to treatment, chiefly through the inability to pay, is one of the chief reasons people do not seek services. Based on 2010-2013 combined data (http://thinkprogress.org/health/2015/05/26/3662873/addiction-treatment-hard-to-find/), among persons aged 12 or older who needed but did not receive illicit drug or alcohol use treatment, felt a need for treatment, and made an effort to receive treatment, commonly reported reasons for not receiving treatment were:

(a) no health coverage and could not afford cost (37.3 percent),
(b) not ready to stop using (24.5 percent),
(c) did not know where to go for treatment (9.0 percent),
(d) had health coverage but did not cover treatment or did not cover cost (8.2 percent), and
(e) No transportation or inconvenient (8.0 percent).

Lack of treatment is often a reason that people cannot obtain or keep a job. Many fail pre-employment or random drug screens on the job, yet without health care coverage, they can not afford to access treatment.

TAADAS is also concerned that several assurances given by lawmakers and officials promoting a work requirement were these requirements and exceptions would mirror the SNAP process but many of the SNAP requirements have not been articulated in this proposal. Importantly, the proposal does not apply the SNAP definition of "able-bodied," as promised by lawmakers. For example, the draft's exemptions do not include those with children through 18 years of age and those over 50. There is no explicit declaration that this

program will follow the state's requirements for the SNAP program as was indicated in the legislative intent during the hearing process.

One of the primary concerns with the proposal that TAADAS found is the overall lack of specificity, including the definition of terms. It prevents us from gauging the impact of some of the provisions, or from providing meaningful comments, given the vagueness of the draft and its lack of definitions. An example of the need for more clarity and specificity is the proposal's use of the term "medical professional." It is a term that is used several times in the document, most notably in the Exceptions section in the 4th bullet, "...condition validated by a medical professional ..." For behavioral health conditions, TAADAS would advocate that behavioral health professionals such as licensed psychologists, LCSWs, LPCs, LADACs and others, as they are defined elsewhere in administrative code and rules as Qualified Mental Health and Addiction Professionals, be designated as evaluators for exemptions. SNAP guidelines allow "a licensed or certified psychologist, a social worker, or any other medical personnel the State agency determines appropriate" to provide the determination. Because this term is not defined, we are unclear if evaluations by such professionals will be considered appropriate. There are other undefined terms that are equally problematic, such as "homelessness," "medically frail" and "approved settings." In the tenth bullet of this section, "Individuals who have recently been impacted by a catastrophic event..." are listed as an exception but the term 'recently' is undefined. Homelessness is defined very differently by several Federal and State programs. The term can be a rigid definition that does not include a lack of permanent, stable housing, which is common for those transitioning from an addiction treatment program or from state custody. For participants in these kinds of informal housing, the additional supports provided by TennCare coverage are greatly needed as transient situations can put participants at risk of relapse as well as at risk of losing a mechanism to report their job or community service work. There is no process defined to designate the "approved settings" for community service so we are unable to determine if the process and definition are appropriate. Another undefined concept is "mentally incapable of work" as an exception. TAADAS cannot determine if the standards for incapacity are such that we could support the process. The section titled Impact on Member Benefits states that TennCare members will document their compliance to TennCare on a monthly basis, but this process is also undefined and we cannot comment on any barriers to this compliance documentation without more specific definitions of the process.

In the section titled Encouraging Work and Community Engagement, we are unclear on several components that needed further definition as noted above. TAADAS would also like to encourage a broader definition of qualifying activities to include recovery support programs such as AA, NA, Celebrate Recovery, Peer Support Centers and others. We also feel that it would be important to include probation and parole meetings and required activities such as community service hours (which may or may not meet this program's standard as an "approved setting."

The exception section states that "Individuals participating in inpatient or residential treatment for a substance use disorder" would not be required to participate. However, TAADAS does not feel that this meets the full requirement of the CMS guidance – "States will therefore be required to take certain steps to ensure that eligible individuals with opioid addiction and other substance use disorders (who may not be defined as disabled for Medicaid purposes but may be protected by disability laws) have access to appropriate Medicaid coverage and treatment services." Access to appropriate Medicaid coverage for participants who have addiction treatment needs should include coverage for those participating in medication assisted treatment (MAT) and those in intensive outpatient programs (IOP), some of which include a 'sleepover' option that resembles residential treatment. MAT, especially during the induction phase and often in the maintenance

phase, requires regular, sometimes daily, oversight, treatment and medication administration for participants. Meeting the requirements for travel and childcare for MAT participation alone can be barrier to MAT treatment and adding additional work participation requirements for TennCare participants could also mean managing additional transportation and child care barriers that could be insurmountable. Many MAT participants, as well as others, also participate in IOP with sleepover arrangements to avoid issues with daily transportation. There are addiction treatment programs in Tennessee that provide on-site housing to women with children in order to avoid issues with child care and transportation and this housing is typically provided through a Housing and Urban Development (HUD) program or private grant dollars that support the addiction treatment services being provided by TennCare. There are not enough such programs and many participants cannot access treatment because housing, transportation and child care supports cannot be provided. People who cannot access treatment because of these barriers are unlikely to be able to have the means to access work or a community engagement opportunity without assistance through case management with housing, child care and transportation.

Transportation access is also limited for many with addiction issues because they may have lost their driver's licenses due to DUI and other addiction related charges. Such requirements are magnified in rural communities where public transportation is non-existent and driving or having a driver to and from any activity is necessary for most residents. Work opportunities are limited for those with a past criminal charge as some employers will not consider such applicants for openings and there are limitations on the work environments that can legally employ participants with certain legal charges. Outstanding fees and court fines as well as garnishments and judgements reduce the take home pay of any participant and then limit their ability to pay for child care, gas or other transportation that would enable them to access treatment and recovery support.

Thank you for your attention to our comments and concerns regarding Amendment 38 to the TennCare program. I am happy to answer any questions you may have regarding our comments and would welcome the opportunity to discuss the impact of this proposal on those seeking or in addiction treatment or recovery programs. We appreciate your commitment to making this proposal responsive to the realities of community engagement in our state. I can be reached at marylinden@taadas.org or by phone at 615-780-5901, x-118 to respond to questions on this proposal or any other issues related to addictions treatment at any time.

Yours Sincerely,

Mary Linden Salter, LCSW
Executive Director

Jonathan Reeve

From: ewilbur@tamho.org
Sent: Friday, October 26, 2018 1:49 PM
To: Public Notice. Tenncare; Wendy Long
Subject: Comments on Amendment 38
Attachments: Comments on Amendment 38 Work Requirements.doc

Attached are TAMHO's comments on Amendment 38. We appreciate the opportunity to provide feedback on this Amendment.

Ellyn Wilbur
Executive Director

Follow us on Facebook!

Tennessee Association of Mental Health Organizations
42 Rutledge Street
Nashville, TN 37210-2043
ewilbur@tamho.org
www.tamho.org
(615) 244-2220, ext.12
(800) 568-2642 toll free in TN
(615) 254-8331 facsimile

tamho
tennessee association of
mental health organizations

October 26, 2018

Dr. Wendy Long
Director, TennCare
310 Great Circle Rd
Nashville, TN

Submitted via email and to public.notice.tenncare@tn.gov

Dear Dr. Long,

We are writing today to provide comments regarding Amendment 38 of the TennCare ll Demonstration which will impose work requirements on certain individuals enrolled in the TennCare program.

TAMHO represents the community behavioral health providers who are the cornerstone of the public behavioral health system and the TennCare behavioral health network. The majority of individuals served by our members are TennCare eligible. Our experience with this population suggests that many individuals want to work and would work if inherent barriers could be removed. Those barriers include availability of jobs close to where people live, availability of public transportation to and from the job site, the introduction of or re-familiarization of work skills that are consistent with available employment opportunities, the reluctance of employers to hire individuals with felonies or other criminal charges in their past, and lack of child care for individuals with children over the age of 6 but still too young to stay at home alone. Removing these barriers would lead to more individuals getting and keeping jobs and we believe that resources should be devoted to address them.

We would like to see the exemptions expanded to include 1) individuals who are the sole caretaker for another person 2) individuals who have been in opioid treatment anytime in the past 12 months and 3) individuals who are in substance abuse treatment after a hospitalization or residential treatment stay. Based on best practices for substance abuse treatment and the commitment that is required to remain in recovery, we believe a 12-month period following an IP or RTC stay should be the time period covered by the exemption.

We also recommend:

- that a pilot project be implemented to identify any unanticipated issues
- full implementation be postponed until the TennCare Eligibility Determination System is fully functional in order to assure that information can be properly collected and verified.
- that the Administration implement a self- attestation process to reduce the significant administrative and financial requirements that will be borne by members, providers and the TennCare system overall

Thank you for letting us provide comment on this Amendment.

Sincerely,

Ellyn Wilbur

Ellyn Wilbur
Executive Director

42 Rutledge Street
Nashville, TN 37210-2043

www.tamho.org

(615) 244-2220
(800) 568-2642 toll free in TN
Fax: (615) 254-8331

Jonathan Reeve

From: Carrie Hobbs Guiden <cguiden@thearctn.org>
Sent: Wednesday, October 24, 2018 4:54 PM
To: Public Notice. Tenncare
Subject: The Arc TN feedback on Amendment 38
Attachments: feedback on amendment 38 (1).docx

Greetings-

Attached is the public comment for Amendment 38 from The Arc TN. Thank you.

Carrie Hobbs Guiden
Executive Director
The Arc Tennessee
545 Mainstream Drive, Suite 100
Nashville, TN 37228
1-800-835-7077 or 615-248-5878 ext. 14
cguiden@thearctn.org

The Arc Tennessee

Achieve with us.

October 23, 2018

Dr. Wendy Long, Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Dr. Long:

Thank you for the opportunity to comment on Amendment 38- the proposed changes to TennCare based upon the guidance released by CMS on promoting work and community engagement among Medicaid beneficiaries and drafted in accordance with Public Chapter No. 869, enacted by the Tennessee General Assembly in 2018. The Arc Tennessee staff and board of directors appreciate the ongoing dialogue with stakeholders and your consideration of our comments. Below is a summary of our feedback:

Amendment 38

1. Although The Arc Tennessee board and staff realize that TennCare has drafted this waiver amendment in accordance with Public Chapter 869 enacted by the Tennessee General Assembly in 2018, we state for the record that we believe these work requirements to be unnecessary for the TennCare program. TennCare already substantially limits enrollment, and to create such an administratively burdensome process that will impact such as small number of TennCare recipients (an estimated 48,000) is a waste of time and resources.
2. We are concerned that unused TANF funds would be used to fund the administration of these work requirements. Why would there be unused TANF funds and even if there was, it seems that there would be more effective ways to use them. Furthermore, what if the TANF funds are not sufficient to ensure this program is adequately implemented? Where would the money come from at that point?
3. We are concerned about the administrative burden these work requirements place on TennCare and, in turn, on the recipients of TennCare. TennCare does not have a strong track record for roll out and implementation of efficient and accurate database tracking systems. An overly burdensome system may discourage recipients from participating in TennCare altogether, which would result in the exact opposite outcome stated at the beginning of this document – which is to ***improve*** health outcomes.

151 Athens Way, Suite 100, Nashville, TN 37228
Phone 615-248-5878 - Toll free 800-835-7077 – Fax 615-248-5879
http://www.thearctn.org

4. We are concerned that individuals will not have the support they need to access services that will help them become employed. Though TennCare states that they will partner with the Tennessee Department of Labor and Workforce Development and other entities (page 4), simply giving someone a list of resources will not be enough. The reality is that most people do want to work. Economic self-sufficiency brings many benefits. If someone is chronically unemployed, there are likely other factors at work – including health factors. TennCare will need to develop robust partnerships with community-based organizations to help provide the support this population needs to become gainfully employed and remain gainfully employed. We strongly recommend creation of a well-staffed and well-funded toll-free referral and information hot line. Individuals in all parts of the state, including the rural counties, should have equal access to resources and supports. We cannot rely strictly on computer-based technology in a state that still faces challenges with internet access and cell phone connectivity.
5. We recommend that TennCare track the number of people that become disenrolled from the program once the work requirements are implemented (hypotheses and evaluation, page 6). For many people, the additional administrative burden may lead them to disenroll. This means that for these individuals their access to health care will be limited to emergency rooms and free clinics – not exactly the way to improve health outcomes. It is important to track the potential negative impacts of implementing the work requirements as well as the positive ones.
6. The Arc Tennessee is grateful that TennCare has recognized and included exceptions to the work requirements for individuals who are providing caregiver services for a household member with a disability or incapacitation (page 3). We know so many families where an individual is prevented from working because they have to be home to care for their adult child with IDD. Thank you for recognizing this challenge for families.
7. We are also grateful that TennCare has recognized and included exceptions for people with IDD that may be unable to meet the full work requirements. We are aware that as advocates, this is a challenging position for us. We advocate for and believe that the majority of people with IDD are capable of working and want to work. We stand by that belief. However, there are some people with IDD that simply cannot meet a 20 hour per week requirement. We want people with IDD to work to the extent that they are able – and to be able to maintain the health coverage they so critically need.

Once again, The Arc Tennessee staff and board thank you for the opportunity to comment on Amendment 38. Should you have any questions about the comments or wish to discuss them further, please do not hesitate to contact me at cguiden@thearctn.org or 615-248-5878 x14.

Sincerely,

Carrie Hobbs Guiden

Carrie Hobbs Guiden
Executive Director

Jonathan Reeve

From: Theresa Moore <sunflower1964tmoore@gmail.com>
Sent: Tuesday, October 23, 2018 10:54 AM
To: Public Notice. Tenncare
Subject: Health insurances/ Healthcare /Older / Mental Health

Tennessee is Very Disappointing when it comes to Health care Especially Mental Health Care ! Emphasis on income is just overwhelming to a person trying to get ahead to better themselves and their families !!!

Sent from my iPhone

Jonathan Reeve

From: Anthony Fox <afox@tmhca-tn.org>
Sent: Thursday, October 25, 2018 4:30 PM
To: Public Notice. Tenncare
Subject: Tennessee Mental Health Consumers' Association's opposition to TennCare Amendment 38

October 25, 2018

Dr. Wendy Long
Bureau of TennCare
310 Great Circle Road
Nashville, TN

Dear Dr. Long;

On behalf of the Tennessee Mental Health Consumers' Association I am writing to share our opposition to TennCare's Amendment 38 that will create a Medicaid Work Requirement in TennCare. The waiver places a harmful requirement on people receiving TennCare that are living with a mental health condition considered SMI or SPMI. As you well know people with mental health conditions on TennCare are using the service for a reason. Using a "catch all" method without carefully exempting certain populations clearly shows that the amendment is not an option for people that we care about and serve.

I say this because it is unclear in the amendment if people with severe and persistent mental illness will be exempted. Are they determined as "medically frail or are they good cause exemptions?" And if so what is the definition of "medically frail" and if someone meets the definition who determines "medically frail?" And what are good cause exemptions and who determines good cause exemptions?

Other concerns that are not defined are:

- Who is an appropriate medical professional?
- What are explicit examples of "community engagement activities" which will qualify as exemptions?
- How will Tennessee define "homeless" persons?"
- Who qualifies for SNAP / TANF?
- What are approved settings for community service engagement? This is not defined, nor is it specific to who determines a setting is appropriate, or where these locations are at throughout the state.

Also missing from Amendment 38 are plans for resources for evidence based-supported employment programs for SMI and SPMI populations; and there are no specific resources for vocational training or job search training.

And finally, there is no clear path or understanding on how reporting community engagement will occur. Most people using TennCare are indigent or the working poor. Many have co-occurring mental health and intellectual disabilities. Very few have access to a computer and the internet or a smart phone. Mailing documents to and from TennCare is unreliable as well. A person could lose their insured status because of the inability to communicate with the Bureau.

Adding extra cost to the state to monitor this process and for the reasons stated above I ask that you withdraw the amendment and carefully consider clarifying the vague or undetermined areas prior to moving forward with this process in Tennessee.

Respectfully,

Anthony Fox, CEO

Anthony Fox
Tennessee Mental Health Consumers' Association
Chief Executive Officer
3931 Gallatin Pike
Nashville, Tennessee 37216
(615) 835-2223 main
(615) 810-9451 fax
Email: afox@tmhca-tn.org
www.tmhca-tn.org

Jonathan Reeve

From: Mary Kiger - TCCN <mary@tccnetwork.org>
Sent: Monday, October 08, 2018 3:49 PM
To: Public Notice. Tenncare
Subject: Attention: Dr. Wendy Long, Division of Tenncare

Dear Dr. Long,

I am writing to submit comments on the proposed Waiver Amendment 38. The Tennessee Charitable Care Network is opposed to the this proposal because it will invariably harm an already disadvantaged population. Our members (50 free and charitable clinics across Tennessee) provide services to uninsured, under-insured and/or underserved Tennesseans either free of charge or on a sliding scale basis. Our clinics (with a very few exceptions) do not accept any form of insurance but are deeply committed to securing health care coverage for all Tennesseans.

As a state that has not expanded Medicaid, we are already talking about a relatively small group of individuals who would be subject to the proposed work requirements. Based on fiscal estimates to date on the implementation costs, it would cost a staggering amount to withhold benefits from this group based on the proposed work requirements. The means to submit documentation may well elude many of these individuals (lack of access to internet, transportation, etc.) and many people who meet the requirements are likely to be disenrolled mistakenly though not necessarily be able to skillfully the engage the governmental levers needed to be re-enrolled. Discontinuity of health care services can have devastating and long term impacts on the very people that Medicaid was designed and funded to help.

On behalf of the 50 member clinics of the Tennessee Charitable Care Network, I respectfully ask that you not proceed with this harmful proposal.

Best regards,

Mary

TCCN
www.tccnetwork.org

Mary Kiger, Executive Director
Tennessee Charitable Care Network
(615) 414-8345 • mary@tccnetwork.org
1515B Hayden Dr., Nashville, TN 37206

Jonathan Reeve

Subject: RE: Amendment 38

From: Ben Harrington [mailto:ben@mhaet.com]
Sent: Wednesday, October 24, 2018 9:33 AM
To: Wendy Long
Subject: Amendment 38
Importance: High

Dr. Long – Thanks again for including us at the public hearing. Attached are our concerns moving forward.

Best – Ben Harrington

THE TENNESSEE COALITION FOR MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Ensuring mental health and alcohol and drug treatment and support services are accessible to all individuals, regardless of age, and maintained at a funding level that assures quality care to those in need.

mailing address: P.O. Box 32731, Knoxville, TN 37930
phone: 865.584.9125 | fax: 865.824.0040 | email: tncoalition@tamho.org

October 23, 2018

Dr. Wendy Long
Tenncare
310 Great Circle Rd
Nashville, TN 37243

Dear Dr. Long:

Thank you for the opportunity to provide feedback on this waiver. As we recalled the legislative hearing, we understood the sponsors to say the bill would be consistent with SNAP / TANF guidelines. We are concerned that the waiver as currently written is not consistent with the stated intent.

We are also concerned that there is no mention how individuals will be supported if they have specific challenges such as low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system. We believe additional supports are necessary for these and possibly other high-risk groups.

In addition, we recommend that additional detail be provided, particularly in defining key terms:

- Appropriate medical professional: what type of professional is included?
- Medically Frail: what is the definition and who can make the decision?
- Community engagement activities: what activities are included?
- Homeless persons: what is the definition?
- Community service engagement: what are approved settings?
- What are good cause exemptions?

We recommend the following be added to the list of exclusions:

- Individuals attending mental health or substance abuse IOP programs
- Individuals residing in sober living facilities
- Individuals engaged in substance abuse treatment support groups

We recommend that additional resources be made available to assist individuals develop their work readiness skills including expanded supported employment and expanded availability of IPS.

And finally, we ask for more clarity in these statements:

- TN will consider SNAP/TANF Guidelines: how and when will this decision be made?
- Economically Distressed Counties Exemptions – how and when will this decision be made?
- TennCare "reserves the right to temporarily modify or waive community engagement requirements" – how and when will these decisions be made?
- Community engagement – how and when these decisions will be made?

Thank you for letting us provide comment on this important waiver to the TennCare program. We look forward to continued dialogue about how we can support the legislative intent.

Sincerely,

Ben Harrington
Chairman

Jonathan Reeve

Subject: RE: TDMHSAS Comments on Amendment 38

From: Marie Williams
Sent: Friday, October 26, 2018 7:23 PM
To: Brooks Daverman <Brooks.Daverman@tn.gov>
Cc: Matt Yancey <Matt.Yancey@tn.gov>
Subject: TDMHSAS Comments on Amendment 38

Brooks,

Thank you so much for asking for feedback. We very much appreciate it.

My best,
Marie

Marie Williams, LCSW| Commissioner
Andrew Jackson Building, 6th Floor
500 Deaderick Street, Nashville, TN 37243
p. 615-532-6500
Marie.Williams@tn.gov
tn.gov/behavioral-health

STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
6th FLOOR ANDREW JACKSON BUILDING
500 DEADERICK STREET
NASHVILLE, TENNESSEE 37243

BILL HASLAM
GOVERNOR

MARIE WILLIAMS
COMMISSIONER

October 26, 2018

Re: Amendment 38 Feedback

Dear Brooks,

First and foremost, the Tennessee Department of Mental Health and Substance Abuse Services (DMHSAS) would like to express our appreciation to TennCare for soliciting feedback on Amendment 38. As Tennessee's behavioral health authority, DMHSAS provides, plans for, and promotes a comprehensive array of quality prevention, early intervention, treatment, habilitation, and recovery support services for Tennesseans living with mental illness and substance abuse issues. We aim to be the nation's most innovative and proactive state behavioral health authority, and clearly recognize the importance of competitive, integrated employment and its relationship with overall health, well-being, independence, and long-term recovery. Based on our review of Amendment 38 and our experience serving Tennesseans with serious mental illness, substance use disorders, and co-occurring disorders, DMHSAS would like to submit the following feedback:

1. DMHSAS recommends that in addition to "*individuals participating in inpatient or residential treatment for a substance use disorder*" being an "*exempt member*" from the work requirements, Tennesseans covered by TennCare who are participating in intensive outpatient substance use treatment and mental health inpatient or residential treatment be excluded as well. Related to this recommendation, DMHSAS is not clear on what "*mentally incapable of work*" or "*medically frail*" includes. These exemptions should be further clarified, as research supports most people living with serious mental illness (SMI) want to work, yet there is approximately 80% unemployment rate among individuals with SMI. By further investing in evidence-based programs and practices, such as Individual Placement and Support (IPS), we can collectively help more Tennesseans with SMI gain employment. IPS is a model of supported employment designed to support people living with a serious mental illness (e.g., schizophrenia spectrum disorder, bipolar, depression). IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing, while focusing on the following practice principles: *competitive employment, systematic job development, rapid job search, integrated rehabilitation and mental health services, benefits planning, zero exclusion, time-unlimited supports, and worker preferences*. DMHSAS is partnering with 13 community mental health centers across the state to offer IPS services. This model has proven to help Tennesseans better control symptoms, reduce substance use, reduce hospitalization, improve overall quality of life, and most pertinently, secure and sustain employment. Further investment that results in the expansion of this program would go a long way to ensuring that individuals living with mental illness have access to helpful resources that keep them employed.

2. DMHSAS requests to continue to work collaboratively with TennCare around work requirements in the event individuals with behavioral health needs lose or have a lapse in their TennCare coverage. As you are aware, DMHSAS through the use of state and federal resources supports the Behavioral Health Safety Net, the Substance Abuse Continuum, the Crisis Continuum, and numerous other treatment and recovery programs. As the public safety net for Tennesseans with behavioral health needs, our department will need to plan accordingly should there be an increase in uninsured, indigent citizens to ensure continuity of care.

3. Based on our Department's work with individuals living with serious mental illness, substance use disorder, and co-occurring disorder, we strongly recommend TennCare to facilitate and offer supports related to reporting requirements. These individuals often need adjunct supports in completing administrative paperwork and frequently rely on user-friendly processes and technology. One approach would be to ensure that Tennessee Health Link care coordinators are trained to support individuals in meeting work requirement administrative tasks (i.e. documentation submission, compliance checks, etc.).

4. Related to Amendment 38's qualifying work or community engagement activities, DMHSAS encourages TennCare to consider recovery court participation, peer support center membership, and other wellness activities (e.g. My Health, My Choice, My Life) to be considered as approved community engagement activities.

In closing, DMHSAS looks forward to working with TennCare regarding Amendment 38 specific to Tennesseans living with behavioral health needs. We are eager to partner on topics including: exclusion criterion, expansion and reimbursement of IPS supported employment, contingency plans for TennCare members who have a lapse or lose their Medicaid coverage, facilitating necessary supports for reporting, as well as supporting community engagement activities relative to this vulnerable population. DMHSAS also looks forward to discussion with TennCare around recruiting and hiring current TennCare members to assist in operationalizing work requirements. DMHSAS and its provider network have a long history of hiring individuals who have lived experience with behavioral health within its workforce, enriching the quality of care it provides. Utilizing a similar method toward implementing Medicaid work requirements, TennCare could further ensure system design is positioned for success by taking a "nothing about us without us" approach.

Again, we appreciate the opportunity to provide feedback and for our continued partnership in supporting the health and welfare of individuals with behavioral health needs.

Regards,

Marie Williams, LCSW
Commissioner

Jonathan Reeve

From: Carol Westlake <carol_w@tndisability.org>
Sent: Friday, October 26, 2018 1:25 PM
To: Public Notice. Tenncare
Subject: Comments on Amendment 38
Attachments: TN Disability comments Amendment 38.pdf

Thank you for this opportunity.

TENNESSEE DISABILITY COALITION
Carol Westlake | Executive Director
Tennessee Disability Coalition
955 Woodland St
Nashville, TN 37206
615.383.9442
www.tndisability.org

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Twitter: https://twitter.com/tndisability

TENNESSEE DISABILITY COALITION

The lifting power of many wings can achieve twice the distance of flying alone.

Via Electronic Submission

October 26, 2018

Wendy Long, MD
Director
TennCare
310 Great Circle Rd.
Nashville, TN 37243

RE: TennCare II Demonstration Project No. 11-W-00151/4, Amendment 38

Dear Doctor Long,

Thank you for the opportunity to comment on the proposed Amendment 38 to the TennCare Demonstration Waiver. The Tennessee Disability Coalition and its 35 member organizations followed the legislative debate about proposed work requirements closely. During hearings on the bill that ultimately directed the Bureau to develop a work requirement program the sponsors and supporters clearly stated that the program was intended to be the same as SNAP/TANF guidelines. However, Amendment 38 is not consistent with those guidelines. As such, many vulnerable individuals with disabilities may be placed at risk. Although Amendment 38 exempts TANF and SNAP enrollees from duplicative work and community engagement requirements, it fails to use consistent guidelines for TennCare and fails to recognize the many individuals who are eligible and who have the same characteristics as enrollees, but who are not currently enrolled in SNAP or TANF for a variety of reasons.

While the amendment lists some disability-related exceptions, there is lack of information about how the terms and conditions are defined, as well as about how these exceptions will be implemented. We are concerned about the feasibility of this amendment in practice. Introducing frequent or administratively burdensome processes for achieving and/or verifying an exemption will exacerbate existing access barriers for vulnerable populations and add to the already challenging administrative burdens they face.

Data unequivocally show that people with disabilities want to work. Based on our direct experience, most of those who do not currently have a job very much want to be employed but often face tremendous barriers to work. Data and studies exist about the barriers to employment that people with disabilities face, and Tennessee's work as an *Employment First* state has supplemented and upheld this evidence. Even with the extraordinary investments and collaborative public/private partnerships of *Employment First*, the employment rate of people with disabilities stays persistently low. The imposition of work requirements in TennCare, including exceptions that require burdensome processes, will actually discourage employment or work. In order to protect access to health care in the face of employment barriers and bureaucratic red tape, the safest route for those with disabilities will be to rely on SSI and SSDI and forego the risk. This directly counteracts the

stated purpose of Amendment 38 and Tennessee's Employment First initiatives. It also exacerbates the under-class of individuals who are forced to live in poverty to protect their health.

For those who would be subject to work requirements, Amendment 38 provides neither adequate information about the supports necessary to make this program successful nor details about how the distinct needs and barriers faced by people with disabilities will be addressed in order to help them achieve their "education and employment-related goals." As referenced above, Tennessee has a robust network of support services for people with disabilities, involving agencies and organizations with long histories and deep expertise that has helped make progress for people with disabilities. However, despite these years-long efforts, employment rates and educational attainment for people with disabilities continues to lag significantly behind those of others.

There is nothing in Amendment 38 that give us confidence that the TennCare Bureau has the skill or background to solve the employment barriers people with disabilities face. If these employment barriers remain or are exacerbated by this Amendment, vulnerable Tennesseans, already struggling for independence, inclusion, and real lives in the community, will be faced with a loss of health care access.

We urge the TennCare Bureau to work collaboratively with community partners to revisit a plan and to adequately address flaws in the Amendment which, as exists, will hurt rather than help vulnerable people. We stand ready to work with TennCare on a solution. We believe strongly any solution must substantively address the challenges identified here before finalizing and implementing Amendment 38.

Sincerely,

Carol Westlake

Carol Westlake
Executive Director

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of Hawkins02@live.com
Sent: Monday, October 08, 2018 5:53 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Andrew Hawkins
TENNESSEE HEALTH CARE CAMPAIGN
396 Deerfield Circle
Manchester, TN 37355

Jonathan Reeve

From: jacy@thcc2.org
Sent: Tuesday, October 09, 2018 8:16 AM
To: Public Notice. Tenncare
Cc: Jacy Warrell
Subject: Amendment 38 Waiver
Attachments: 181009 Comments on Amendment 38 - THCC.pdf

October 9, 2018
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

RE: Amendment 38 – Work and community engagement requirements

Dr. Long,

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. As a nonprofit who works directly with TennCare beneficiaries, Tennessee Health Care Campaign is concerned implementing this action will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment. We believe legislators blindly followed the lead of other states that expanded Medicaid and did not fully understand Tennessee's Medicaid population.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is not sufficient evidence that this requirement will improve health outcomes, there will be barriers in reporting compliance, and there is no mention of supports to make the program successful.

In the "Objective and Overview" section of the Amendment 38, it states there is a growing body of evidence that points to a link between productive work or community engagement and improved health outcomes. The references provided however, are either outdated and/or apply to a very different population than the one in Tennessee. Specifically:

- "Is work good for your health and well-being?" by Waddell and Burton of the Centre for Health and Social Care Research, University of Huddersfield is from the United Kingdom (citation 3). This publication is dated 12 years ago and is based on the UK's welfare system which is very different than Tennessee. The UK offers income supports, job seeker allowance, and tax credits. Additionally, this study notes that beneficial health effects of working depend on the nature and quality of work and that social context matters.
- "The Psychological and Physical Well-Being During Unemployment: A Meta-Analytic Study" by McKee-Ryan, et al (citation 4) is an outdated study (2005) that looked at even older studies. It acknowledges there are significant gaps in the research and that "within unemployed samples, work-role centrality, coping

resources (personal, social, financial, and time structure), cognitive appraisals, and coping strategies displayed stronger relationships with mental health than did human capital or demographic variables." The research does not apply specifically to the Medicaid population or Tennessee.

- "Work matters for health" published by Robert Wood Johnson Foundation (RWJF) (citation 5) does not apply to the Medicaid population. When describing the health outcomes associated with being employed and then losing a lob, RWJF reports negative health outcomes such as reductions living standards, increased stress, and behavioral risks like increased alcohol consumption, smoking, and drug use. It does not address people with the same social economic barriers as TennCare beneficiaries. Furthermore, this report is more about the health variations associated with the types of employment. It indicates people who work evening shifts and hold multiple jobs can be detrimental to health. Long commutes, as will likely be experienced by TennCare beneficiaries in rural communities, are associated with greater levels of stress, increase likelihood of obesity, etc. Health is improved only in jobs that offer insurance, have wellness programs, and are in safe environments.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." There is no evidence that "existing community resources" need assistance in connecting with their local population and we object to using state dollars for implementing another referral assistance program. There are no supports to TennCare enrollees mentioned and no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." Through our statewide hotline for low-income Tennesseans looking for health care, we know the current system is already burdensome to TennCare beneficiaries. THCC receives between 200-400 calls each month from people who need in-person assistance with the current application. In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult. We encourage you to connect directly with TennCare enrollees to better understand the impact of this waiver.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits. We appreciate the opportunity to share our concerns and look forward to discussing other ways to potentially improve the health and well-being of Tennesseans. Please contact me if you would like to discuss these points further.

Respectfully,

Jacy Warrell, MPA
Executive Director
Tennessee Health Care Campaign
1321 Murfreesboro Pike, Ste. 311
Nashville, TN 37217

August 30, 2018

Division of TennCare
310 Great Circle Road
Nashville, TN 37243

RE: Amendment 38 – Work and community engagement requirements

Dr. Long,

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. As a nonprofit who works directly with TennCare beneficiaries, Tennessee Health Care Campaign is concerned implementing this action will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment. We believe legislators blindly followed the lead of other states that expanded Medicaid and did not fully understand Tennessee's Medicaid population.

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Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits. We appreciate the opportunity to share our concerns and look forward to discussing other ways to potentially improve the health and well-being of Tennesseans. Please contact me if you would like to discuss these points further.

Respectfully,

Jacy Warrell, MPA
Executive Director
Tennessee Health Care Campaign

Tennessee Health Care Campaign (THCC) · 1321 Murfreesboro Pike, Suite 311, Nashville, TN 37217
(615) 227-7500 · Fax: (615) 866-5656 · Toll-free: 1-877-431-7083 · www.thcc2.org

Jonathan Reeve

From: Deema Tarazi <d.tarazi@hemophiliafed.org>
Sent: Friday, October 26, 2018 12:47 PM
To: Public Notice. Tenncare
Subject: THBDF Comment Letter for 1115 Waiver
Attachments: THBDF TN 1115 Waiver Comment Letter.pdf

To Whomever It May Concern,

Attached is Tennessee Hemophilia Foundation & Bleeding Disorders Foundation's comment letter regarding Tennessee's 1115 Waiver. If you have any further questions please email Samuel Doughty at sam.doughty@thbdf.org.

Thanks,
Deema

Deema Tarazi, JD | Senior Policy Analyst | Hemophilia Federation of America
999 North Capitol Street NE, Suite 201 | Washington DC | 20002
DC Office: 202.675.6984 | Mobile: 248.227.6148
www.hemophiliafed.org

October 26, 2018

Wendy Long, MD
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: 1115 Waiver Amendment 38 to the TennCare II Demonstration

Dear Dr. Long:

Tennessee Hemophilia Foundation & Bleeding Disorders Foundation (THBDF) appreciates the opportunity to submit comments on Tennessee's 1115 Waiver Amendment, "Amendment 38 to the TennCare II Demonstration."

THBDF is a non-profit organization that enhances the lives of those affected by bleeding disorders and supports the bleeding disorders community in Tennessee.

THBDF believes everyone, including TennCare enrollees, should have access to quality and affordable health coverage. Unfortunately, this waiver creates new administrative barriers that will jeopardize patients' access to quality and affordable health coverage, and THBDF therefore opposes the proposed waiver.

The Tennessee Amendment 38 seeks to add a work and community engagement requirement for most TennCare enrollees. This would increase the administrative burden on all TennCare patients. Individuals will need to either report that they meet certain exemptions or the number of hours they have worked. Increasing administrative requirements will likely decrease the number of individuals with TennCare 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 October 1, four months into implementation, the state has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[i] An additional 12,589 individuals had one or two months of noncompliance and are at risk for losing coverage in the coming months.[ii] 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.[iii] 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 two months out of a six-month period, they will be locked out of coverage until they demonstrate their compliance. 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.

THBDF is 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, Tennessee's "good cause" exemption 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.[iv] 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 Tennessee. States such as Michigan, Pennsylvania, Kentucky 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.[v] Tennessee's fiscal impact statement estimated the program would cost approximately the state and federal government $39.8 million over the course of the waiver.[vi] 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. Most people on Medicaid who can work already do so.[vii] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[viii] 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 a 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).[ix] Terminating individuals' TennCare coverage for non-compliance with these requirements will therefore hurt rather than help people search for and obtain employment. Tennessee has experience with this. In 2005, when the state changed the TennCare program's eligibility and 170,000 people lost Medicaid coverage, there was no increase in employment and self-reported health and access to medical care declined.[x] THBDF opposes the work and community engagement.

THBDF also wishes to highlight that 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. However, on pages 5 of this proposal, the Department states that "*Some number of individuals may transition off of TennCare and into other coverage options as their earnings increase; however, it is not possible to reliably project the magnitude of this decrease in enrollment at this time*." We urge the TennCare to update the waiver amendment with the estimated expenditure and estimate enrollment change and reopen the state comment period for an additional 30-days.

THBDF believes healthcare should affordable, accessible, and adequate. Tennessee's Amendment 38 does not meet that standard. Thank you for the opportunity to provide comments.

Sincerely,

Samuel Doughty
Board President
Tennessee Hemophilia and Bleeding Disorders Foundation

---

[i] 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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.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.; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[iii] 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.

[iv] 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/.

[v] 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.

[vi] Tennessee General Assembly Fiscal Review Committee. Fiscal Note HB 1551- SB 1728. February 12, 2018. Accessed at: http://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf

[vii] 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/

[viii] 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

[ix] 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

[x] DeLeire, Thomas. The National Bureau of Economic Research. NBER Working Paper No. 24899: The Effect of Disenrollment from Medicaid on Employment, Insurance Coverage, Health and Health Care Utilization. August 2018. Accessed at: https://www.nber.org/papers/w24899

Jonathan Reeve

From: Joe Burchfield <jburchfield@tha.com>
Sent: Friday, October 26, 2018 9:19 AM
To: Public Notice. Tenncare
Subject: Comments on Waiver Amendment 38
Attachments: 10-26-18 THA Work Requirements Comment Letter FINAL.pdf

Good morning,

Please find attached THA's comment letter on TennCare's waiver amendment 38 regarding work requirements for program enrollees.

If you have questions, please don't hesitate to contact me.

Thanks,
JB

Joe Burchfield
Senior Vice President | Government Affairs and Communications
Tennessee Hospital Association
O: (615) 401-7472 | M: (615) 306-8333

Oct. 26, 2018

Wendy Long, M.D.
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Dr. Long:

The Tennessee Hospital Association (THA), on behalf of its more than 140 member hospitals and health systems, appreciates the opportunity to comment on the draft of Amendment 38 to the TennCare II Demonstration.

THA has identified five areas of primary concern based on the information included in the waiver amendment. These areas include the applicability of a work requirements program to the existing TennCare population, the ability to achieve the stated goals of the proposed program, TennCare members' ability to comply with such a program, consistency in such requirements across multiple social service programs administered by the state and the ability to evaluate the full impact of the work requirements on all covered enrollees. Following are specific comments related to each of these topics.

Applicability to Existing TennCare Population
While the Centers for Medicare & Medicaid Services (CMS) has approved work requirements in four states, all of which expanded Medicaid, the applicability of such requirements in the current TennCare environment remains a significant concern for THA. Given Tennessee's lack of Medicaid expansion, there is a limited population within the current TennCare membership who would be subject to work requirements.

Other states that already have implemented work requirements have done so within the context of expanded Medicaid populations where non-disabled adults qualify for Medicaid coverage as a result of economic status rather than meeting categorical eligibility criteria for a traditional Medicaid program. Tennessee's status as a non-expansion state with limited adult Medicaid enrollment makes work requirements an odd fit for the program.

State estimates have indicated as few as 30,000 TennCare enrollees – or 5.6 percent of the program's non-elderly adult members – would be subject to the requirements outlined in the waiver amendment. This tracks below the most recent national data available from the 2017 U.S. Census Bureau's Current Population Survey, which suggest 60 percent of non-elderly Medicaid adults already are working. According to the data, only 7 percent would be subject to work requirements based on commonly accepted exemptions like those included in the TennCare waiver amendment.

Under the current program, the state is likely to incur a sizable expense. The recurring expense would be matched at the basic administrative federal match rate of 50 percent to administer and enforce a work requirement for non-disabled adult members. In February 2018, the General Assembly's Fiscal Review Committee estimated the state's recurring annual net cost of administering and enforcing a work and community engagement requirement at $22.3 million for

a population of just more than 37,100. These costs were estimated to primarily cover case management of the work requirements. The state cost was offset by an estimated savings that would be generated if 10 percent of the covered enrollees are disenrolled for at least a six-month period to derive the final state annual impact of $18.7 million.

CMS also requires states to develop strategies to assist enrollees in meeting work requirements and link them to additional resources for training, child care assistance, transportation and other supports, but Medicaid funding cannot be used to fund these services which will create an additional expense for the state budget.

The state would pay an administrative cost for the work requirements on top of the current cost of providing healthcare coverage to individuals who already are categorically eligible to receive the benefit. Persons in the group subject to the work requirements are eligible for TennCare because they actively are caring for a child or disabled adult who is eligible for Medicaid. While THA understands the benefits of trying to encourage Medicaid enrollees to work, it is hard to see the benefit of incurring the additional cost of participation in these efforts when so few members ultimately would be subject to the requirements.

Ability to Achieve Stated Goals

The rationale for the new requirement to promote improved health outcomes for members includes language that TennCare will support member efforts to achieve independence and potentially facilitate a transition from the TennCare program into private insurance. THA is concerned individuals who become employed will earn enough to be ineligible for TennCare but not have access to employer sponsored insurance or earn enough to qualify for financial assistance on the insurance exchange. Losing coverage negatively will impact an enrollee's ability to access appropriate healthcare services.

The ability to access care that will enable a person to gain and maintain physical and mental health is of critical importance when trying to enter and stay in the workforce. TennCare coverage makes work possible. Requirements that place affordability and access to care at risk would run counter to the goal of helping individuals and their families gain financial independence through employment opportunities.

One of the stated objectives is to improve health outcomes for individuals enrolled in TennCare. The draft amendment states "a growing body of evidence" points to a link between productive work or community engagement and improved health outcomes. The studies referenced are for general populations, not a low-income Medicaid population.

There also are studies on work and health that found the quality and stability of work are key factors in the work-health relationship. This research indicates low-quality, unstable or poorly-paid jobs lead to or are associated with adverse effects on health. August 2018 information from the Tennessee Department Human services indicates the average monthly wage for employed participants in Families First is $918.28, or roughly $11,000 per year, which is 91 percent of the federal poverty level for an individual. Similar low-paying employment potentially could reduce the health status of TennCare enrollees.

THA believes there will be multiple supports needed for those attempting to comply with work requirements. The mention of supports in the amendment does not include any specificity about the kinds of supports the Bureau will provide. There are certain types of support that will be essential, including transportation for the member to get to and from work or community

engagement opportunities and childcare for children over 6 years old in the household. Without supports from the TennCare program, both transportation and childcare present financial obligations that may be unattainable for a member who is actively working or seeking education, training or employment. The waiver request should either identify a way to address those needs or allow the members to include lack of transportation or childcare as a new exception.

The exceptions to the requirement listed in the amendment provide for a number of circumstances where a parent or caretaker relative may be too ill to hold a position that would satisfy the work requirement or is trying to address a substance abuse issue that would impair the member's ability to find or keep a job. The exceptions also exclude members who are mentally incapable of meeting the requirement or providing care for a household member who is disabled or incapacitated. THA agrees it is essential to acknowledge the many realities of life that could serve as a barrier to compliance with the work requirements as well as include the flexibility for the Bureau to work with individuals to grant additional exemptions.

Consistency in Work Requirements Across Programs

The waiver amendment references work requirements already in place for recipients of Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) benefits, programs with individual requirements that differ from those proposed for TennCare members. One major difference is caretakers under SNAP and TANF are exempted if they have a dependent child under the age of 18 in the household, not under age 6, as proposed for TennCare. Another significant variation is the proposed TennCare requirement of 20 hours per week, while SNAP and TANF require 30 hours.

The waiver states members dually-enrolled in two or more of these programs who satisfy either the SNAP or TANF requirements would not be subject to those under TennCare. It is not clear if a TennCare enrollee subject to the SNAP or TANF work requirements who is not meeting those requirements would be disenrolled under TennCare or would be allowed to meet the lower 20-hour-a-week threshold and remain on TennCare. There also is a federal requirement specified at 42 CFR 435.112 that requires the state to continue Medicaid coverage for TANF enrollees for four months if the family loses TANF benefits because of increased income from employment or increased work hours. The waiver amendment fails to address how such a circumstance would be handled. However, THA would recommend the bureau consider a similar "soft landing" for TennCare enrollees who lose coverage because of increased income or not complying with the work requirements.

While the proposed waiver amendment indicates distressed counties may be excluded at the Bureau's discretion, SNAP requirements exclude any persons living in distressed counties because those counties have very limited opportunities for employment. This exclusion should be consistently applied to TennCare requirements as well.

While using compliance with SNAP and TANF work requirements for TennCare should reduce the administrative expense of the program, this creates different categories and expectations for compliance that will lead to greater confusion and inconsistency for TennCare enrollees. THA believes any work requirements placed on TennCare members should be evenly and uniformly applied.

TennCare Member Education and Compliance

The waiver amendment is largely silent on how TennCare members will be educated about a work requirement, the process by which they will participate in such a program and the methods

for demonstrating compliance with requirements. Given recent experience in other states with fully-implemented work requirements where significant numbers of enrollees have fallen off the rolls due to lack of reporting – not necessarily lack of compliance – THA believes it is essential to establish an information process that educates and provides adequate support and administrative access to ensure members can fully participate in the program.

In Arkansas, use of an online portal to inform enrollees about the program and reporting compliance has been a problem because not all Medicaid enrollees have access to the Internet and the use of the portal was complicated. Of the 26,000 initially enrolled in work requirements in Arkansas in June 2018, more than 4,000 – or 17 percent – lost coverage for failing to comply with the requirements. While the mechanisms for educating enrollees and reporting compliance is not specified in the proposed amendment, THA recommends enrollees have multiple options for reporting so lack of access to the Internet or the inability to navigate a portal does not result in disenrollment from TennCare.

Research Hypotheses and Evaluation
The stated core objectives of the proposed amendment are to promote improved health outcomes for TennCare members and support member efforts to achieve independence. While there only is a preliminary plan for evaluating the impact, the full evaluation plan should be developed prior to implementation of any work requirements.

In the preliminary plan, however, the data are all from current member encounter data or member reported data. It will be as important to track the health impact on those who lose coverage as a result of the work requirement to determine if losing coverage reduces access to care and negatively impacts health status. Similarly, if a member no longer is eligible because they do work and their income is too high to qualify for TennCare, there will be no encounter data or self-reported activity data for those members. Therefore, the evaluation will be limited to those who meet the work requirement but stay enrolled in the program, which will not adequately reflect the impact on the population subjected to work requirements.

Although it is reasonable to expect a healthy population will not experience the same rate of inpatient hospitalization or emergency department (ED) utilization as a less healthy population, there are a number of legitimate reasons that a healthy enrollee may access hospital inpatient or ED services. These include accidents or circumstances where a primary care physician is unavailable and sends the patient to the ED. These situations do not relate to overall health status of the enrollee and, as such, THA believes other measures that better reflect overall health status should be developed and tracked.

Conclusion
THA recognizes TennCare is meeting its legislatively required responsibility to develop a work requirement and community engagement program for the current TennCare population by submitting this waiver amendment. THA appreciates the attention given by TennCare staff to many of the challenges that members who would be subject to the requirement face on a daily basis. This consideration largely is reflected in the design of the program, and we believe those considerations are critical to ensure the new requirements do not create a new population of low-income uninsured adults who will lack access to appropriate healthcare services.

THA does not believe the benefits, of the program as currently proposed, will outweigh the cost of administering the program, and believe it is necessary to carefully weigh the financial considerations of the program against its impact on the ability of current TennCare members to

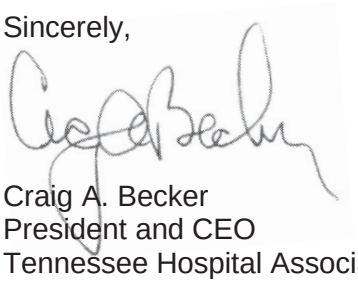
access care. Implementing the work requirement and community engagement program described in this amendment is premature and should not be considered until the program has added coverage for adults without dependent children or family members, a group for which the work and community engagement requirements may be more applicable.

Finally, remembering the impact of past lawsuits on the TennCare budget and enrollees, THA is concerned that, like Arkansas and Kentucky, this requirement will subject the program to lawsuits that will impact the state's ability to operate TennCare and control expenditures. The same objections raised in lawsuits in other states – that work requirements become new eligibility criteria that only can be implemented by Congress and the program is contrary to the central goal of Medicaid to provide medical assistance to citizens –likely will apply to the proposed TennCare program.

Again, thank you for the opportunity to share our thoughts and comments on the proposed amendment.

If you have any questions concerning THA's comments, please contact me at 615-256-8240, cbecker@tha.com.

Sincerely,



Craig A. Becker
President and CEO
Tennessee Hospital Association

Jonathan Reeve

From: Gordon Bonnyman <gbonnyman@tnjustice.org>
Sent: Thursday, October 25, 2018 4:19 PM
To: Public Notice. Tenncare
Subject: Comment re. draft TennCare Waiver Amendment 38
Attachments: 2018-10-25 TJC LTR to Dr. Long re. Waiver Amendmt. 38.pdf

Please find comments attached. Thank you for your consideration.

Sincerely yours,

Gordon Bonnyman
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Direct: 615-846-4708
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October 25, 2018

Wendy Long, M.D., Director *via email:* public.notice.tenncare@tn.gov
Division of TennCare
310 Great Circle Rd.
Nashville, TN 37228

RE: Proposed TennCare Waiver Amendment 38

Dear Dr. Long:

I write in response to the September 24, 2018 notice by the Commissioner of the Tennessee Department of Finance & Administration inviting public comments on proposed TennCare Waiver Amendment 38, which would permit the Division of TennCare to deny TennCare coverage based on an individual's employment status. The amendment purports to implement Tennessee Public Chapter 869, enacted by the Tennessee General Assembly during its 2018 session. As explained below, the proposal is fundamentally flawed as a matter of health policy, and it conflicts with both state and federal law. For those reasons, the amendment should not be submitted to the Centers for Medicare and Medicaid Services (CMS), or further steps taken toward its implementation.

By its own terms, Public Chapter 869's implementation is conditioned on two requirements: (1) The state must receive a necessary waiver from CMS; and (2) the state must be able to use federal Temporary Assistance for Needy Families (TANF) or other federal funds to cover the costs of implementation. Federal law does not authorize CMS to grant such a waiver, and the state cannot be assured that the use of TANF funds will be approved by federal auditors. Implementation is therefore not legally possible.

CMS cannot lawfully grant a waiver permitting the denial of Medicaid based on employment status.

As you know, employment status is not among the federally approved criteria for Medicaid eligibility. States cannot deny Medicaid coverage to individuals who are eligible under federal law or impose state eligibility criteria more restrictive than those authorized by the Medicaid Act. CMS's waiver authority does not extend to permitting states to deny Medicaid to federally eligible individuals based on their employment status. Specifically, Section 1115 of the Social Security Act does not authorize CMS to waive Section 1902(a)(8) [42 U.S.C. § 1396a(a)(8)] or Section 1902(a)(10) [42 U.S.C. § 1396a(1)(10)] of the Act, as you propose to request. Denial of coverage to the unemployed would accord employment status primacy over health needs, essentially transforming Medicaid from a health program into an employment

program. Neither CMS nor states can alter the Medicaid program in that way. Only Congress may do so.

The conflict between the design and purpose of the Medicaid Act and the effects of a mandatory employment requirement is especially stark in states, like Tennessee, that have not expanded coverage to adults made eligible by the Affordable Care Act. As the Supreme Court observed in *NFIB v. Sibelius*, "The original program [still administered in non-expansion states] was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children." Tennessee's Medicaid program still meets that description and thus is comprised of individuals who generally are excluded from the workforce by age, disability or family care responsibilities.

The draft amendment would apply to non-pregnant, non-disabled, non-elderly adults enrolled in TennCare in the parent/caretaker relative eligibility category. In order for such individuals to be eligible, they must have household incomes below the poverty level. Given the limited economic prospects of individuals living in poverty, jobs would often increase their incomes above Medicaid's income eligibility caps, but without affording them access to private coverage. As you know, workers in low-wage jobs or in the "gig economy" typically do not receive employer sponsored insurance. Marketplace subsidies are not set at a level sufficient to make individual coverage affordable to such low-income workers, because the Affordable Care Act anticipated that such workers would be covered through the expansion of Medicaid to families with incomes up to 138% of the poverty level. The proposed waiver would therefore create situations where individuals who take jobs in response to the new requirements would no longer be financially eligible for TennCare but would not have access to private coverage either.

CMS has implicitly acknowledged that work requirements have no place in non-expansion states. CMS guidance directs states seeking a waiver to consider excluding the very people who comprise the Medicaid populations of non-expansion states like Tennessee. In its State Medicaid Director letter of January 11, 2018 (SMD 18-002), CMS expressed its support for aligning Medicaid work requirements with exemptions and exclusions applied in the Supplemental Nutrition Assistance Program (SNAP or "food stamps") and TANF program. Under SNAP rules, parent/caretaker relatives are exempt from work requirements. Please see 7 C.F.R. § 273.24(c)(3),(4). If CMS were to grant a waiver that denied exemption to parent/caretaker relatives, it would be violating its own longstanding interpretations of the Medicaid Act and of its own waiver authority.

Tennessee cannot be assured that use of TANF funds will be allowed by federal auditors.

The General Assembly also stipulated in Chapter 869 that, "Implementation of the waiver shall be contingent upon the available use of TANF funds or other federal appropriations to meet the requirements of the waiver." To that end, the statute directs the state to "seek the necessary approval from the United States department of health and human services [HHS] to utilize [TANF] funds" for that purpose.

The draft proposal acknowledges at page 4 that Tennessee has not obtained HHS approval to use TANF funds, and that, indeed, a request is yet to be submitted ["…Tennessee *will seek* the necessary approval of the U.S. Department of Health & Human Services to utilize funds from the state's TANF program to implement the TennCare workforce participation and community engagement activities…"]. Neither does the proposal identify any "other federal appropriations to meet the requirements of the waiver."

Even if HHS were to approve the use of TANF funds to implement Chapter 869, there would be no assurance that the state can satisfy the statute's provision making implementation contingent upon TANF or other federal funding. That is because the state could get permission to use TANF funds to implement the bill, and after the bill is implemented, federal audit and cost allocation rules could still require that some or all of the actual costs be allocated to Medicaid.

That risk is substantial. In the 1990's, HHS issued guidance to states about how they were required to allocate TANF costs in similar situations where more than one federal funding program was being used to support a state activity or program. In accordance with OMB Circular No. A-87, (which has since been incorporated into 2 CFR, Part 225) States were required to allocate costs to each "benefiting program": "A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with the relative benefits received." Thus, costs that benefit multiple programs may not be allocated to a single program.

To determine whether multiple programs benefit from costs is to ask, for example: In the absence of the TANF program, would another program still have to undertake the function? If the answer is yes, there is a benefit to each program and the costs should be allocated using the "benefiting programs" cost allocation method. HHS says, "it would be inconsistent with and contrary to these appropriation principles to allow TANF funds to be used to pay for costs allocable to other programs."

Tennessee was one of several states, including Arizona, that filed a lawsuit challenging those restrictions, claiming that the restrictions should have been promulgated as an agency rule under the federal Administrative Procedures Act. Then, as now, Tennessee wanted to use unexpended TANF funds to cover some Medicaid-related costs. After the states prevailed and the restrictions were invalidated in *Arizona v. Thompson*, 281. F.3d. 248. (D.C. Cir. 2002), HHS ultimately promulgated the allocation requirements as an agency rule, so that it is now binding. The rule is 45 CFR § 263.14 which applies allocation principles in 45 CFR § 75.405. Consistent with the OMB regulations in 2 CFR, Part 225, the benefiting program principle is now enshrined in the following language:

> **45 CFR 75.405 Allocable costs.**
> …
>
> (c) Any cost allocable to a particular Federal award under the principles provided for in this part may not be charged to other Federal awards to overcome fund deficiencies, to

> avoid restrictions imposed by Federal statutes, regulations, or terms and conditions of the Federal awards, or for other reasons. …
>
> (d) Direct cost allocation principles. If a cost benefits two or more projects or activities in proportions that can be determined without undue effort or cost, the cost must be allocated to the projects based on the proportional benefit. …

None of the TennCare enrollees who would be subject to work requirements are TANF beneficiaries, because CMS requires that anyone who meets TANF's work requirements be exempt from separate Medicaid work requirements. Therefore, the benefits of the work requirements accrue exclusively to people who are enrolled in TennCare but not in TANF.

The General Assembly was evidently concerned about the legality of using TANF funds to implement Chapter 869, because implementation costs are not to be incurred unless the state obtains HHS's permission. The HHS Office of Family Assistance may be able, as an abstract matter, to tell the Tennessee Department of Human Services that it is permissible to use TANF funds to cover TennCare work requirement costs. That begs the question of *how much* of those costs can be allocated to TANF. It will not be HHS Office of Family Assistance personnel, but OMB's binding audit and cost allocation rules that will determine, based on the "benefitting program" principle, how much of the costs can be allocated to TANF and, therefore, how much of the costs TANF will actually be allowed to cover.

Because of these binding cost allocation rules, the state could be required after the fact to fund all or a substantial part of the implementation costs with Medicaid funds, which are of course subject to a state matching requirement. In addition, there is the possibility that misallocation of TANF funds could result in the assessment of significant financial penalties against the state. See 45 CFR § 263.10.

Chapter 869 requires that implementation be consistent with CMS guidance.

Chapter 869 directs that the waiver to be developed for submission to CMS "shall be consistent with the most recent guidance to state Medicaid directors provided by CMS." When the legislature adopted Chapter 869, that guidance was contained in the State Medicaid Director letter of January 11, 2018 (SMD 18-002), discussed above. As noted, the guidance supports alignment of Medicaid work requirements with SNAP and TANF work requirements. Our state legislators made clear that such alignment is part and parcel of Chapter 869.

Specifically, the sponsors repeatedly, adamantly, insisted that the definition of "able-bodied" TennCare enrollees subject to work requirements would be the same as the term is defined by SNAP, and the same exemptions would apply. See, e.g., Sen. Kerry Roberts statements on the Senate floor at the time of passage on April 19, 2018, or Rep. Ryan Williams' statements in the House Health Committee on February 20, 2018. As discussed above, the SNAP definition of "able-bodied" excludes parent/caretaker relatives.

Even if proposed Waiver Amendment 38 were not legally objectionable for the reasons just stated, there would be additional legal obstacles to its implementation. The great majority of TennCare enrollees would be exempt from work requirements due to age, disability or other factors outlined in the proposal. Implementation would require the state to have the capacity to reliably identify and protect the coverage of those exempt enrollees. For non-exempt individuals, TennCare would also have to be able to reliably track their compliance with the work and community engagement requirements. At a minimum, the Bureau will need:

- A fully functional TennCare Eligibility Determination System programmed to support those complex new rules;
- All application portals and processes, including in-person application portals for both initial applications and eligibility redeterminations, required by 42 U.S.C. § 18083 and 42 C.F.R. §§ 435.907, 911 and 916;
- The ability to provide individualized assistance and supports as required by 42 C.F.R. § 435.908 and the Americans with Disabilities Act, 42 U.S.C. §§ 12131-12134; 28 C.F.R. § 35.130.

The state currently lacks all of these resources, which would be essential for Waiver Amendment 38's implementation.

For all of these reasons, implementation of Waiver Amendment 38 would be harmful to Tennesseans and is unlawful. The proposal should not go forward.

Respectfully submitted,

Gordon Bonnyman
Attorney

Jonathan Reeve

From: Libby Thurman <libby.thurman@tnpca.org>
Sent: Thursday, October 25, 2018 11:31 AM
To: Public Notice. Tenncare
Subject: Comments on Amendment 38
Attachments: TPCA Comments Amendment 38_10-24-18.pdf

TPCA's comments on Amendment 38 are attached.

Libby Thurman, Health Policy Director
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The Tennessee Primary Care Association improves access to health care through leadership, advocacy, and support as the voice of Community Health Centers.

tpca
TENNESSEE PRIMARY CARE ASSOCIATION

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615.329.3836 | fax: 615.329.3823

Dr. Wendy Long
Director, Division of TennCare
310 Great Circle Road
Nashville, TN 37243

October 24, 2018

Dear Dr. Long:

TPCA appreciates the opportunity to offer comments on Amendment 38, which proposes to require Medicaid beneficiaries to participate in work and community engagement activities. These comments represent the concerns of Tennessee's Federally Qualified Health Centers (FQHCs), which provided care to approximately 437,000 people in Tennessee in 2017, including over 147,000 Medicaid patients. Medicaid coverage is a lifeline to health care for our patients – it is essential for ensuring that they can access primary care for acute and chronic conditions, behavioral health and substance abuse services, specialty care, surgeries, and hospital services. We have several grave concerns about TennCare's proposal to mandate work and community engagement requirements as a condition of coverage. Our concerns focus on the inability of some individuals to meet the requirements, individuals who actually are compliant being deemed non-compliant due to technical or administrative challenges, and administrative and financial burden for FQHCs. Although the draft waiver amendment does not quantify the number of people who will be subject to the requirements or who will lose coverage, results from other states indicate that making work and community engagement requirements a condition of eligibility does indeed result in individuals losing coverage.

January 2018 CMS guidance to states indicates that 1115 waiver demonstrations requiring work and community engagement activities should improve Medicaid enrollee health and well-being. TennCare's draft waiver amendment proposes to disenroll individuals from Medicaid for non-compliance with work and community engagement requirements, which will actually worsen health outcomes for these individuals. We urge TennCare to reassess the proposed punitive approach and instead consider providing incentives for beneficiaries to participate in work and community engagement activities. If the outlined approach is pursued, we recommend a gradual phase-in so that TennCare has the opportunity to adequately educate providers and Medicaid beneficiaries about the new requirements.

A summary of our specific concerns and recommendations is outlined below.

Undefined Terms in Waiver Amendment Language

We believe that the proposed changes to TennCare are substantial and more detail is needed for the public and impacted populations to provide meaningful comments. There is a lack of definitions and operational detail throughout the amendment. Key examples include "approved settings" on page 2, conditions that render an individual "incapable" of work as certified by an "appropriate" medical professional on page 3, "medically frail" on page 3, and "economically distressed" counties on page 3. Many of these terms are subject to a high degree of interpretation and need to be clearly defined in advance of submission of the waiver amendment to CMS.

Financial Burden on FQHCs

While we appreciate that individuals that are disenrolled due to failure to prove compliance with the work requirements can regain benefits after proving compliance for one month, we are concerned about high levels of churning off and on Medicaid and the operational and financial pressure this will put on health centers. Unlike other providers, FQHCs are statutorily required to see all patients without regard for insurance status or ability to pay. Given this requirement, FQHCs will likely suffer disproportionate financial strain from the proposed work and community engagement requirements, relative to other providers. **We request that TennCare direct the MCOs to continue paying claims for FQHC patients who have lost coverage due to failure to demonstrate compliance with work and community engagement requirements.** While TennCare is best equipped to determine how this could be achieved, if benefits for FQHC patients are placed into suspended status instead of disenrollment status, the MCOs could feasibly still pay claims for these patients. Alternatively, it may be possible to place FQHC patients who do not prove compliance into separate benefit or plan category in TennCare's eligibility system, for which the MCOs could pay claims.

Operational Challenges

The draft waiver amendment indicates that members will be expected to verify employment or community engagement compliance on a monthly basis. We strongly urge TennCare to reconsider this requirement; monthly documentation will prove challenging for many individuals and may result in individuals losing TennCare coverage simply because they cannot submit information to TennCare on the specified schedule and the manner prescribed, which has yet to be defined. It is our understanding that some individuals work a patchwork of jobs, some of which may not result in documentation of hours worked for an employer (mowing lawns, babysitting, etc.). In addition, imposing certification or submission requirements on non-profit organizations that might otherwise be appropriate community engagement sites will most likely have a chilling effect and significantly limit the number of appropriate options available for compliance. **We request that an individual be permitted to submit information to TennCare on a less frequent schedule, that members are provided with a variety of methods to submit information**

including by phone, mail, and online portal, and that members be permitted to self-attest work hours.

Exemptions

The list of exemptions in the draft waiver amendment language is narrow and omits several needed exemptions.

Age Range

We request that the age range for compliance with the requirements be broadened to be consistent with the SNAP work requirements age range of 18-49. This would increase alignment of the programs, which was encouraged by CMS in the January 2018 letter.

Individuals in Treatment for a substance or alcohol abuse disorder

We appreciate that State's willingness to exempt individuals in inpatient care for substance abuse disorder, but we believe this narrow definition will force some individuals in recovery to choose between treatment and Medicaid coverage. Attending therapy sessions, group meetings, and medical appointments to overcome a substance or alcohol abuse disorder can be time consuming and prohibit an individual from consistently working or engaging in community service 20 hours a week. **We request that the substance abuse treatment exemption be expanded to limited residential and outpatient treatment** so that Tennesseans focusing on recovery can continue to do so. This will help TennCare achieve its stated goal of improving health outcomes for individuals enrolled in Medicaid and will improve individuals' chances of working consistently in the future.

Individuals Communities with a lack of employment or volunteer opportunities

Opportunities for work, volunteering, and education are lacking in some areas across the state. Beneficiaries should not be penalized failure to comply if their county truly cannot offer the opportunities to meet the requirements. **We request that TennCare widen the economically distressed county exemption to include counties in which individuals cannot readily access educational or volunteer opportunities. Additionally, municipalities (defined by the Bureau of Labor Statistics) with unemployment rates higher than the state unemployment rate should be eligible for the economic hardship exemption.**

Individuals that Lack Reliable Transportation

Medicaid beneficiaries in both urban and rural areas experience transportation challenges. Urban areas have more options for public transportation but even so, lack of reliable transportation from one's home to where work is available can be a barrier. Rural areas have greater transportation challenges; in many cases there are few or no options for public transportation or ride sharing, and individuals without access to vehicles may need to ravel fairly long distances to reach work places. **We request that if an individual attests that they do not have transportation to and from a job, educational or volunteer opportunities, that they be exempt from these requirements.**

Individuals that Lack Affordable Childcare

Given that the waiver amendment language exempts primary caregivers with children up to age six, many other caregivers will need to find childcare for their children that have surpassed this age. Additionally, caregivers with children six and under will still need to locate additional childcare when school is not in session (early mornings, evenings, overnight, weekends, school breaks, and summers). In each case, affordable childcare is difficult, if not impossible, to come by for an individual at the income levels of a Tennessee Medicaid beneficiary. It is common that childcare costs outweigh the minimum-wage hourly income that a beneficiary receives from their job. Also, low-income jobs tend to be shift jobs – shifts that could take place around the clock, not from 8:00 – 3:00 when kids are in school. **We request that if an individual attests that they cannot locate safe, affordable childcare that coincide with the hours of their work or community engagement opportunities, that they be exempt from the work requirements.**

Needed Supports

The draft waiver amendment fails to outline the specific supports that TennCare will offer to Medicaid beneficiaries who wish to comply with the work and community engagement requirements but who have barriers to doing so. Many Medicaid patients have poor social determinants of health and will need extensive, individual case management to comply with work and community engagement requirements. In addition, individuals who have a history that includes interaction with the criminal justice system may face significant barriers in obtaining work or community engagement opportunities. These individuals will require significant case management support to identify suitable opportunities. **TennCare should outline a detailed plan for how the Bureau will provide robust assistance to individuals that need it. If TennCare cannot provide the needed supports, TennCare should exempt the individual from the work requirements.**

Research Hypotheses and Evaluation

TPCA has significant concerns with the proposed hypotheses and methodologies outlined in the draft waiver amendment. Decreased hospital stays and decreased ER visits are health care utilization measures that do not equate to improved health outcomes. Instead they demonstrate the potential for a dangerous shift in responsibility from TennCare supported primary and preventive care to unfunded emergency access at our already burdened rural and safety net hospitals. Worse yet, we may find these individuals, many of whom live in communities that have recently seen the closure of their local hospital, presenting to our Tennessee health centers with conditions of inappropriate acuity after making decisions to forego unfunded primary and preventive care. TennCare should propose evaluation measures that will assist the State in assessing whether mandating work and community engagement truly improves health outcomes, keeping in mind this will require monitoring the utilization measures reflecting the health status of those individuals who lose coverage as well as those who comply with the work and community engagement requirements.

In addition to TPCA's comments, individual Tennessee FQHCs will submit comments on Amendment 38. I encourage TennCare to consider these submissions since each health can offer a unique perspective regarding their communities and patients. If you or your team would like to discuss TPCA's input, please contact me at terri.sabella@tnpca.org or 615-425-5841.

Sincerely,

Terri Sabella, CEO
Tennessee Primary Care Association

Jonathan Reeve

From: Tom Wilemon <tomwilemon@gmail.com>
Sent: Friday, October 26, 2018 3:35 PM
To: Public Notice. Tenncare
Subject: Amendment 38

Every dollar Tenncare has is precious. Please don't waste any more money on a computer system, especially for one that is not needed. The $38 million estimate to implement a monitoring system for the work requirement is too expensive, won't pay for itself in savings and will probably cost more based on past history with computer system overruns. Let's be fiscally conservative. Let's not do this.

Thanks,
Tommy Wilemon
118 East Due West
Madison TN 37115

Jonathan Reeve

From: Tonia Andaluz <tmahotiere@hotmail.com>
Sent: Friday, October 05, 2018 9:59 PM
To: Public Notice. Tenncare
Subject: Public feedback Amendment 38

There should not be added barriers for those who are already struggling to get health care in this state. This added provision will cause more to be uninsured but will still need to use health care facilities when they get sick. Many of hose on the plan can't work, and this provision it to help big business get bigger by allowing to stay on welfare. If these people are working they should be getting an honorable wage so that they can afford the healthcare in TN. Why should the American public pay for the welfare of these corporations. They suggest in order to get government subsidized health care they have to work at a for profit company, the majority of the time. Why not make an amendment that states companies have to pay their employees a living wage with health care.
As a Tennessee resident and a health care worker I am opposed to this amendment. It comes from the same place that refused to expand Medicaid which ultimately resulted in the closure of almost 10 hospitals in rural TN over the last decade. This amendment will only create a wider healthcare disparity between the haves and have nots.

A concerned TN citizen,

Tonia Andaluz

Sent from my iPhone

Jonathan Reeve

From: mailagent@thesoftedge.com on behalf of traceystansberry@icloud.com
Sent: Thursday, October 25, 2018 9:10 PM
To: Public Notice. Tenncare
Subject: Amendment 38: Work Requirement Waiver

Dear Dr. Long:

I am writing in response to the Division of TennCare's Amendment 38 aimed to implement a work reporting requirement for TennCare beneficiaries who mainly consist of children and their caregivers, pregnant women, and women with breast or cervical cancer. I am part of a network of organizations that work directly with TennCare beneficiaries and we are concerned implementing this waiver will put the health of the parents of Medicaid eligible children at risk.

As you know through advocacy efforts before this waiver amendment was released, public health and nonprofit stakeholders who work directly with the TennCare population are not in support of this waiver amendment.

Our primary concern is that people who need health insurance will lose it, whether they meet 20 hours of work per week or not. There is no evidence that this requirement will improve health outcomes.

I am a nurse practitioner in rural Scott County on the Cumberland Plateau. While our unemployment situation has recently improved, it was not too long ago that our county topped this list of the state's highest unemployment rates. Our community has experienced our hospital closing on two occasions in the past six years. Currently the doors are open, but the financial strain that will likely result from a reduction in the state's Medicaid program (via Amendment 38) could easily result in a permanent closure of the hospital, leaving many of our citizens more than one hour away from the nearest hospital. This would not only put our community's physical health at risk (once more), it would likely result in another downward economic spiral, as it is very difficult to attract industry and tourism to a community without hospital and emergency services.

Amendment 38 does not provide adequate information about the supports to make this program successful. Page 4 states there will be "an emphasis on linking individuals to existing community resources." That will not be enough to make this program successful and there is no guaranteed that the U.S. Department of Health and Human services will use TANF funds to implement needed supports.

Lastly, we are concerned about the Amendment 38 statement that "it is not possible to reliably project the magnitude of this decrease in enrollment at this time." In the Amendment 38 draft there is no mention how people will be protected or supported if they have certain disabilities, experience low literacy, are returning to work after being incarcerated, experience homelessness, are victims of violence, or are leaving the foster care system and for the first time ever must navigate the workforce without the guidance of a caring adult.

Simply put, the risks to families are not adequately addressed in this draft amendment and far outweigh any hypothetical benefits.

Thank you for work you do to provide care to low-income Tennesseans.

Respectfully,

Tracey Stansberry
258 Woodland Place
Huntsville, TN 37756

Jonathan Reeve

From: Trudy Stringer <trudy.stringer@gmail.com>
Sent: Tuesday, October 09, 2018 2:11 PM
To: Public Notice. Tenncare
Subject: Proposed Waiver Amendment 38

Dr. Wendy Long
Division of TennCare
via email to: **public.notice.tenncare@tn.gov**

RE: TennCare Waiver Amendment 38

Dear Dr. Wendy Long,

I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38. I am a minister in the Christian tradition and former hospital chaplain. The mandate in my tradition is to love neighbor, the Holy and, the self. Simply put, this proposal, for me, desecrates the ethical mandate to love our neighbors as ourselves. Loving neighbor is not confined to those who live proximate to us nor to those who look, speak and dress like us.

This proposal read like a solution in search of a problem. It reads like a document drafted to further harm neighbors who have the least resources, the least power, and receive the least respect in our current culture that worships the god of wealth. The proposal is based on the false and harmful trope that people who live in poverty are lazy and do not want to work. Further, it is not clear that there is a substantive abuse of the current system and there is no substantive information on the cost of implementing this system. One is left with the question of cost and efficiency: Will this system cost more and cover fewer of our neighbors?

I am unequivocally opposed to this proposal that would take health coverage away from people who do not work a set number of hours per month. This proposal would cause immense harm and jeopardize coverage for thousands of Tennesseans. People are not interchangeable cogs. Each situation is unique. The proposal lacks any sense of nuance in dealing with the lives of real human beings.

This waiver is fundamentally flawed and cannot be fixed. It goes against the goals and purpose of the Medicaid program. I respectfully urge you to not go forward with this harmful proposal.

- Sincerely,
  Trudy Hawkins Stringer

Jonathan Reeve

From: Mary Graham <mary.graham@uwtn.org>
Sent: Monday, October 22, 2018 12:36 PM
To: Public Notice. Tenncare
Subject: comments on the waiver

Thank you for this opportunity to submit comments on the proposed waiver. United Way supports work as a core American value, and the main way to provide for our families and bring dignity to our daily lives. Instead of taking away a person's healthcare because they don't work enough hours in a month, we need to focus on policies that improve our economy, provide more jobs at a sustainable wage and help train people for those jobs. Medicaid makes it possible for millions of low income children and adults to get and stay healthy, making sure they can work and take care of their families. It allows them to see a doctor whey they are sick, get check-ups, buy medications and go to the hospital without fear of choosing between their health and groceries or paying rent. Medicaid makes the difference for millions of hard-working Americans who don't' earn enough to pay for health insurance or aren't offered health insurance through their jobs. It fills the gap when people fall on hard times and ensures they have access to healthcare as they recover from an illness or care for a sick child. If people are going to get back on their feet, find a job with a sustainable wage or recover from a debilitating injury, they need access to healthcare so they can get healthy and move forward.

#1
Medicaid supports hard working low-wage Americans
who don't earn enough to pay for health insurance
or aren't offered it through their employer.

- Many low-wage jobs have inconsistent work hours, high rates of involuntary part-time work, and inflexibility that results in job loss or gaps between jobs when people experience illness, family emergencies, childcare or transportation disruptions.
- Many low-wage workers could be harmed because of circumstances beyond their control. If they do not have sick leave, they may unable to work and not meet the monthly work requirements, or lose their job if they get sick or need to care for a sick child.
- If people are going to get back on their feet, find a job with a livable wage or recover from a debilitating injury or illness, they need access to healthcare to get healthy & move forward.

#2
Work requirements on adults will harm children too

- Work requirements make it hard for parents in low-wage jobs who must balance work with childcare responsibilities, and can't always work enough hours each month.
- When parents lose coverage, children are harmed. Medicaid coverage improves access to needed care, improves a parent's mental health outcomes, and strengthens families' financial security. Taking away healthcare does the opposite.
- When parents have health insurance, children are more likely to be insured and more likely to get important developmental and preventative care.

#3
People with disabilities & serious chronic illnesses
can be harmed

- While states provide exemptions for people who are 'medically frail', many people with chronic conditions either won't qualify for these exemptions or will struggle to provide physician testimony, medical records, or other documents to prove they do.

- In other federal programs, studies have found that people with disabilities, mental illness and substance use disorders were disproportionately likely to be penalized and lose benefits.

#4

Taking away coverage is the wrong approach
to helping people find and keep jobs

- Work is a core American value, and the main way to provide for our families and bring dignity to our daily lives. We need to look at policies that improve our economy, provide more jobs at a livable wage and help train people for those jobs.
- Politicians are out of touch. Many Americans are struggling to make ends meet with multiple part time or seasonal jobs. At the same time, healthcare, childcare, transportation and housing costs are going through the roof.
- We need to focus on policies that address the high cost of childcare and housing to better support working families, not take away their healthcare for not working enough hours in a month.
- Medicaid is a health insurance program that protects the lowest income Americans when the unexpected happens and drains their budget.

#5

The proposed changes will create more red tape and government bureaucracy

- These proposed changes to Medicaid will create more red tape and government bureaucracy and force state and local governments to spend millions of taxpayer dollars just to implement them.
- While most Medicaid enrollees will be exempt from these requirements, everyone will have to regularly fill out burdensome paperwork to prove it. People will be at risk of losing coverage due to their inability to navigate the system or some other breakdown in the administration process beyond their control.
- In the end, there will be millions spent with little to show for it except more uninsured people.

Mary Graham
President and CEO, United Ways of Tennessee
Lead Staff, Tennessee Afterschool Network
209 Gothic Court, Suite #107
Franklin, TN 37067
615-495-9970

Jonathan Reeve

Subject: RE: TennCare II Amendment 38_UHC Community Plan Comments_FINAL 10-25-18.pdf

From: Payet, Keith C [mailto:keith_c_payet@uhc.com]
Sent: Thursday, October 25, 2018 11:47 AM
To: Wendy Long
Subject: TennCare II Amendment 38_UHC Community Plan Comments_FINAL 10-25-18.pdf

Good morning Dr. Long,

I wanted to take this opportunity to follow up with you based on the discussions we had pertaining to Work Requirements. Leveraging our national footprint, I worked with our experts to outline how MCO's/UnitedHealthcare can best support the execution of the Work Requirements program. Please find attached an overview of opportunities where our expertise and infrastructure can help shape a successful program.

Again, thank you for your continued partnership. Please do not hesitate to reach out to me with any further thoughts or questions.

Have a wonderful day,

Keith Payet
President and CEO
UnitedHealthcare Community Plan of Tennessee
Keith_C_Payet@uhc.com
O-615-493-9614
C-615-418-2756

OUR UNITED CULTURE The way forward
Integrity | Compassion | Relationships | Innovation | Performance

October 26, 2018

Dr. Wendy Long, Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

RE: TennCare II Demonstration: Amendment 38

Dear Dr. Long:

UnitedHealthcare Community Plan appreciates the opportunity to provide feedback to the Division of TennCare on the draft TennCare II Demonstration: Amendment 38 application as well as offer recommendations on how the managed care organizations (MCOs) can partner with the state to support administration of the proposed program.

It is apparent that TennCare has put considerable effort into the development of this program design and the process for inclusion of public comment. We appreciate your commitment to engaging stakeholders, and thank you for the opportunity to offer our perspective.

The comments and recommendations offered in the following pages are built on the principles of easing implementation burden for stakeholders and striving for simplicity to encourage compliance.

We appreciate the opportunity to provide feedback to TennCare and look forward to speaking with you about our recommendations. Should you have any questions or seek further information, please do not hesitate to contact me by phone at 615-493-9614 or by email at keith_c_payet@uhc.com.

Sincerely,

Keith Payet

Keith Payet

President & Chief Executive Officer

UnitedHealthcare Community Plan of Tennessee

BACKGROUND

UnitedHealthcare currently serves over 400,000 members in the TennCare program. We support the state's goal to develop a well-designed process to connect individuals to employment in a way that promotes positive health outcomes that will serve to advance the goals of the TennCare demonstration.

Several states are exploring community engagement requirements and the Trump Administration has approved Section 1115 Demonstration waivers with these requirements, but court challenges have slowed implementation of these programs in certain states.

Our experience with community engagement initiatives involves supporting individuals with disabilities navigate vocational rehabilitation services and access Medicaid waiver services for supported employment (including Iowa and Kansas). Additionally, we participate in job fairs and provide referrals to community resources. We are exploring opportunities to support needed education and training. Rooted in this experience, we offer the following recommendations for your consideration.

UNITEDHEALTHCARE RECOMMENDATIONS

TennCare should consider the level of complexity for implementation and administration of the program design to deliver the greatest value for the state's Medicaid dollars. Early adopters of personal responsibility programs, such as Indiana, have learned from their experience that simpler is better. Streamlined program designs will help increase transparency into the program levers for impacted consumers and drive value for TennCare's investment.

We appreciate the Commonwealth's efforts to align requirements for other public benefits accessed by similar populations such as TANF or SNAP, and leverage the capacity of the state's existing employment support programs to provide linkages to resources and training to afford impacted TennCare enrollees opportunities to secure employment.

Eligibility & Exemptions

We recommend that the state (or a designated third-party contractor) should make eligibility determinations and communicate eligibility decisions to all stakeholders.

Taking such an approach would allow the state to maintain eligibility determination decisions and provide a streamlined user experience as well as eliminate potential discrepancies between MCOs.

A single point of contact for eligibility also eliminates the financial risk and administrative burden of reconciling information with MCOs for members who enroll and are later determined not to meet eligibility requirements. Information collected via the eligibility process, including information about requirements and/or exemptions should be shared with the MCO with which an individual enrolls to inform care management strategies.

How MCO Partners Can Support TennCare

Supporting Exemption Efforts

Tennessee can work with its MCOs to identify individuals who **may** meet criteria for clinical exemptions.

MCOs can provide recommendations, based on claims data, to the state on individuals who may qualify for an exemption from community engagement requirements based on clinical status. MCOs could provide an 'exemption consideration' file to the state on a monthly basis (or another period as determined by the state).

The purpose of the file would be to flag potential individuals subject to community engagement requirements who may meet the necessary criteria for a clinical exemption. The state (or third party contractor) would make the ultimate determination as to whether an individual meets the criteria for an exemption.

The 'exemption consideration' file could include information on certain members with claims that indicate a potential exemption to the community engagement requirement (e.g. pregnancy, serious mental illness (SMI), substance use disorder treatment, as determined by the state). The state should already know an individual's plan type (e.g. SMI) based on their eligibility determination, but the MCO can update the state on specific conditions based on identification in clinical systems or from claims.

This process could mirror one UnitedHealthcare Community & State has adopted as a part of long term services and supports (LTSS) programs for certain state partners. In those states, we provide recommendations to the state on individuals whose assessments indicate a higher level of care. This information is then reviewed by the state, which makes and communicates the final eligibility determination.

Supporting Assessment Efforts

If TennCare is considering implementing some type of work readiness evaluation that includes a functional assessment of members, MCO partners can support in the administration of such an assessment as a part of our member engagement strategies. We recommend that if TennCare were to adopt this tactic, that the following recommendations be considered:

- Assessors should include individuals with vocational training experience. This will require additional staff and/or contracting with organizations with this expertise.
    - If included as a part of the MCO scope, the state should consider the administrative costs associated with adding this new assessment into actuarially-sound capitation rates.
- Tennessee should weigh implications of "work ready" classifications to individuals who may be exempt but still desire the opportunity to work. The state would not want to deter employers from hiring individuals who are not impacted by work requirements.

Supporting Member Outreach and Communication

By nature of their role, MCOs are well-suited to serve as a critical information conduit between TennCare and consumers subject to community engagement requirements. The MCOs can leverage their tools and touch points, such as text and email alerts, mailers, and interactions with care coordinators to communicate information regarding the design of the program, expectations of the consumer, and qualifications for exemptions. MCOs can also conduct proactive outreach to remind impacted consumers about their requirements and deadlines to report to the state.

To support these types of coordination and outreach efforts to our membership about community engagement requirements, we request that the state's 834 enrollment file clearly indicate the following information to MCOs:

- Individuals who are required to meet a community engagement requirement to maintain Medicaid eligibility;
- Individuals are exempt from the community engagement requirement and the rationale for the exemption;
- Individuals who have failed to meet a community engagement requirement but are seeking to "reactivate" through training or education could support continuity in care;
- Individuals who fail to meet their community engagement requirements and information on when they are eligible to reapply for Medicaid benefits;
- Individuals who no longer meet the financial eligibility requirements; and
- Cell phone numbers and email addresses of all members. MCOs could use this information to provide reminders to report hours.

SUMMARY

TennCare has envisioned a number of strategies that collectively can promote workforce participation and community engagement activities. We support the state's mission to use this new program to further improve health outcomes and enhance individuals' economic stability and look forward to discussing further as the state moves through the waiver process with CMS.

Jonathan Reeve

From: Kyle Kamrath <Kyle_Kamrath@vrtx.com>
Sent: Thursday, October 25, 2018 2:44 PM
To: Public Notice. Tenncare
Cc: Brooks Daverman
Subject: TennCare Draft Amendment 38 Comments
Attachments: TennCare Draft Waiver Amendment 38 - Vertex Pharmaceuticals Comments.pdf

Director Daverman,

On behalf of Vertex Pharmaceuticals, I am pleased to share our comments to TennCare's Draft Waiver Amendment 38. As mentioned in our attached letter, we greatly appreciate the opportunities TennCare has provided stakeholders to provide input on the proposed waiver amendment.

Please do not hesitate to let me know if we can be a resource to you and your staff, or if we can provide additional information related to our comments.

Respectfully,
Kyle Kamrath

Kyle Kamrath
Director, State Governmental Affairs
Vertex Pharmaceuticals
50 Northern Avenue
Boston, MA 02210
C: 832.741.6188
kyle_kamrath@vrtx.com
www.vrtx.com

Vertex Pharmaceuticals Incorporated
50 Northern Ave
Boston, MA 02210
www.vrtx.com

October 25, 2018

Brooks Daverman
Director, Strategic Planning & Innovation
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

BY ELECTRONIC FILING (public.notice.tenncare@tn.gov)

Re: Exempting Medically Complex Patients from Proposed Section 1115 Demonstration

Dear Director Daverman:

Vertex Pharmaceuticals, Inc. (Vertex) appreciates the opportunity to submit comments regarding Draft Amendment 38 to Tennessee's Section 1115 Demonstration waiver. Furthermore, we are grateful for the opportunity to have participated in the recent Work and Community Engagement Requirements stakeholder meeting. We certainly support implementing the most cost-effective approaches to improving quality, accessibility and health outcomes in Medicaid. Carrying out this demonstration amendment in appropriate populations will help ensure its success and sustainability over time.

Vertex discovered and developed the first and only medicines to treat the underlying cause of cystic fibrosis (CF), a rare and medically complex disease. Today, Vertex has three FDA-approved products for the treatment of CF in certain patients: SYMDEKO® (tezacaftor/ivacaftor and ivacaftor), KALYDECO® (ivacaftor), and ORKAMBI® (lumacaftor/ivacaftor). CF is one of many medically complex diseases that require individualized treatment plans supervised by specialists and a team of health care professionals trained in addressing the disease. Management of CF may require a combination of several therapy options (for example, airway clearance techniques, inhaled medicines to open the airways, pancreatic enzyme supplement capsules to improve absorption of vital nutrients, and potentially one of Vertex's therapies if indicated for the patient).

For medically complex patients with severe, chronic diseases like CF, avoiding disruptions in the treatment regimen is critically important to preserving and promoting patients' health and well-being. Coverage interruptions resulting from an inability to comply with certain demonstration requirements designed for individuals without the same need for specialized care may lead to increased emergency room visits, hospitalizations, and overall health care costs.

We appreciate TennCare's recognition that "there are circumstances that may limit or prevent a member's ability to comply with the community engagement requirement." Amendment 38 references the January 2018 State Medicaid Director Letter (SMDL) announcing support for waiver demonstrations that include work and community engagement requirements "among non-elderly, pregnant adult Medicaid Beneficiaries who are eligible for Medicaid on a basis other than disability."[1] The SMDL further directed states to exempt individuals "determined by the state to be medically frail" and "any individuals with acute medical conditions validated by a medical professional that would prevent them from complying with the requirements."[2] While federal Medicaid regulations do define "medically frail" to include "individuals with serious and complex medical conditions,"[3] how individuals are determined to be "medically complex" is not well-defined. We fully support the exemption for "medically frail" individuals, but would also ask TennCare to consider a specific exemption in the waiver amendment for individuals living with a "medically complex" disease/condition. We would suggest the following definition for "medically complex," which is based, in part, on the Advancing Care for Exceptional (ACE) Kids Act of 2017[4] as well as Utah House Bill 100:[5]

> *"Medically complex" patients are defined as having a physical or developmental condition that: (1) is life threatening, chronic, and present at birth, affects multiple systems, and requires multidisciplinary specialized care and related coordination to avoid hospitalizations or emergency department visits; or (2) meets the criteria for medical complexity using risk adjustment methodologies (such as Clinic Risk Groups) agreed upon by a national panel of pediatric experts*.

We would further encourage TennCare to consider an exemption from the demonstration for the primary caregiver of a child who is living with a medically complex disease. Caregivers play a vital role in ensuring the health and well-being of children living with a medically complex disease, and our concern is that the proposed work requirement could negatively impact these vulnerable individuals and could make it more difficult for them to follow treatment plans consistently.

We believe that these exemptions can help ensure that the proposed section 1115 demonstration is implemented in a way that advances Medicaid's core objective: to serve the health and wellness needs of the state's most vulnerable individuals and families. In addition to ensuring that the proposed demonstration does not inadvertently create hardship and health

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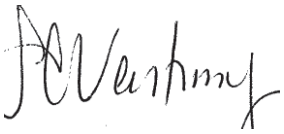
[1] Ctrs. for Medicare & Medicaid Servs., SMDL 18-0002, Community Engagement SMDL (Jan. 11, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.
[2] SMDL 18-0002.
[3] 42 C.F.R. § 440.315(f).
[4] Advancing Care for Exceptional (ACE) Kids Act of 2017, S. 428, 115th Cong. (2017), https://www.congress.gov/bill/115th-congress/senate-bill/428/text.
[5] Utah House Bill 100 (Medically Complex Children With Disabilities Waiver Program, H.B. 100 (2018), https://le.utah.gov/~2018/bills/static/HB0100.html) was signed into law and requires the Utah Department of Health to establish, through a Medicaid waiver, a program for children with complex medical conditions.

risks for patients with complex diseases, this exemption will promote Tennessee's goals of improving quality, accessibility and health outcomes in the most cost-effective manner.

* * *

Vertex appreciates the opportunity to comment on TennCare's draft waiver amendment and for TennCare's efforts to incorporate stakeholder input throughout the waiver amendment process. We would be glad to provide any additional information on these topics if that would be helpful. Please do not hesitate to contact me with any questions you may have.

Sincerely,



Samantha Ventimiglia
Vice President, Government Affairs & Public Policy
Vertex Pharmaceuticals, Inc.

Jonathan Reeve

From: Victoria Medaglia <papermaven@gmail.com>
Sent: Friday, October 26, 2018 6:30 PM
To: Public Notice. Tenncare

Dr. Wendy Long
Division of TennCare
via email to: **public.notice.tenncare@tn.gov**

RE: TennCare Waiver Amendment 38

Dear Dr. Wendy Long,

I am submitting the following comments in response to the public notice inviting public comments on proposed Waiver Amendment 38. I am a Tennessee resident and 67 year old breast cancer patient. I am alive today because of Medicaid. And, though I now have Medicare coverage, it is possible I would be eligible for Medicaid expansion, because the illness and treatment left me without enough stamina to hold down a full time job.

I am unequivocally opposed to this proposal that would take health coverage away from people who do not work a set number of hours per month. This proposal would cause immense harm and jeopardize coverage for thousands of Tennesseans. I know that, for most of the 36 months I as on TennCare, I was unable to work. For much of that time, I couldn't drive myself or look after my own care. People who are ill are not lazy; they are ILL. I now have stage IV cancer and, while I intend to work as long as I'm able, I know a time will come when I will be too ill to work. What then? Will I no longer deserve even palliative care? That seems to be what you're telling others in my position who don't have access to the resources I have. Resources which, by the way, may run out before I die.

Specifically burdens Waiver Amendment 38 puts on ill people include:Failure to meet reporting requirements and paperwork errors will result in suspension of coverage for thousands of Tennesseans. I still have trouble keeping up with paperwork; when I was in treatment the first time, it was beyond my capabilities.

Research and experience show that work requirements impose complex administrative burdens on families, employers and the state. States cannot safely and fairly administer those requirements, and many people are at risk of losing their coverage due to confusion or bureaucratic mistakes. For that reason, even people who are supposed to be exempt may not be able to claimexemption. That’s because of daunting red tape (a particular risk for people with disabilities) or because of bureaucratic errors on the part of the state or its contractors.

Many people who meet the work requirements will lose coverage because of barriers to reporting their work hours, or resistance by employers. State contractors or systems errors may result in wrongful terminations. Recipients may make too much money to qualify for TennCare any longer, but their low wage jobs don’t provide health insurance. What then? They are left with no access to medical care, let alone preventive services.

People who ARE eligible may lose coverage because of TennCare's lack of a computer system, lack of reliable transportation or child care, and barriers to reporting.

Disruption in care has adverse effects for people with cancer, diabetes, addiction, PTSD, mental illness, and myriad other chronic conditions. Results, aside from poorer health, include extending treatment schedules and delaying return to the work force, if possible. Both are expensive for business and society.

In addition to the obvious harms, the proposal leaves many questions unanswered:

- How do people report compliance?
- How can TennCare administer this complex eligibility determination without an eligibility determination computer system, which is not yet complete?
- How will the reporting process accommodate people with disabilities, limited literacy or language?
- What is “good cause” for waiving compliance by certain individuals?
- What criteria will be used to exempt “economically distressed” counties?

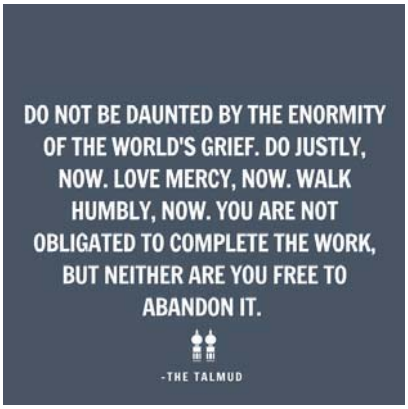
I know and work with many people who would be negatively impacted by this proposal to take away coverage from those who don’t meet the new work requirement. One mother has taken months longer than anticipated to recover from stomach surgery. She was very, very ill and consumed with concern for her teen-aged daughter. What if she had been unable to meet requirements or late in reporting compliance? She was facing a second surgery; would she have been discarded by the system and her daughter orphaned?

This waiver is fundamentally flawed and cannot be fixed. It goes against the goals and purpose of the Medicaid program. We respectfully urge you to not go forward with this harmful proposal.

Please note my sig line, below, lifted from the Talmud. Please do not contribute to the enormity of the world's grief. It is about all we can bear already.

Sincerely,
Victoria J. Medaglia

Oak Ridge, TN



Jonathan Reeve

From: Holly Kilness Packett <holly.k.packett@gsk.com>
Sent: Friday, October 26, 2018 3:22 PM
To: Public Notice. Tenncare
Cc: Cindy Snyder
Subject: Comments re: TennCare II Demonstration Project No. 11-W-00151/4 Amendment 38
Attachments: ViiV Healthcare Comments - Tennessee Work Requirement - final.pdf

Dear Director Long,

ViiV Healthcare appreciates the opportunity to submit the attached comments to the State of Tennessee regarding proposed amendment (Amendment 38) to its TennCare program.

Please feel free to contact me or ViiV Healthcare Community Government Relations Director Cindy Snyder at (919) 323-9084 or Cindy.C.Snyder@viivhealthcare.com with any questions.

Thanks,

Holly Kilness Packett
Manager, HIV Policy
Public Policy US

GlaxoSmithKline (GSK)
1050 K Street NW, Washington, DC 20001
holly.k.packett@gsk.com
phone: 1-202-715-1073
work cell: 1-202-339-2385

gsk.com | Twitter | YouTube | Facebook | Flickr

October 11, 2018

Submitted via: public.notice.tenncare@tn.gov

Dr. Wendy Long
Director Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: TennCare II Demonstration Project No. 11-W-00151/4 Amendment 38

Dear Director Long,

ViiV Healthcare (ViiV) appreciates the opportunity to submit comments to the State of Tennessee regarding proposed amendment (Amendment 38) to its TennCare program.

ViiV is the only pharmaceutical manufacturer devoted exclusively to supporting the needs of people living with or affected by HIV. From ViiV's inception in 2009, we have had a singular focus to improve the health and quality of life of people affected by this disease and have worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to our HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment.

As a manufacturer of HIV medicines, we are proud of the scientific advances in the treatment of this disease. These advances have transformed HIV from a terminal illness to a manageable chronic condition. Effective HIV treatment can help people living with HIV (PLWH) to live longer, healthier lives, and has been shown to reduce HIV-related morbidity and mortality.[1, 2] Furthermore, effective HIV treatment can also prevent the transmission of the disease. In a sponsored study by the National Institutes of Health (NIH) (published in 2016), the investigators reported that when treating the HIV-positive partner in a serodiscordant couple with antiretroviral therapy,[3] there were no linked infections observed when the infected partner's HIV viral load was below the limit of detection.

Medicaid has played a critical role in HIV care since the epidemic began, and it is the largest source of coverage for PLWH.[4] In 2015, there were 16,425 people living with HIV in Tennessee.[5] In 2016, there were 715 new HIV diagnoses in the state.[6] Tennessee is moving forward in meeting the Center for Disease Control & Prevention's (CDC) prevention goals for 2016, with a 49.6 percent increase in HIV testing. Although the state lags behind in indicators for HIV Status Awareness and Linkage to Care, Tennessee

[1] Severe P, Juste MA, Ambroise A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med*. Jul 15 2010;363(3):257-265. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=20647201

[2] Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med.* Apr 30 2009;360(18):1815-1826. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=19339714

[3] Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med* 2011;365:493-505. See also http://www.cdc.gov/hiv/prevention/research/art/.

[4] Kaiser Family Foundation. Medicaid and HIV, http://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.

[5] AIDS Vu, Tennessee: https://aidsvu.org/state/tennessee

[6] AIDS Vu, Tennessee: https://aidsvu.org/state/tennessee

has exceeded goals for increased retention in care (58 percent) and has met the goal of an overall 80 percent rate of viral suppression.[7] These are notable accomplishments.

ViiV wishes to comment on some of possible ramifications the proposed amendment will have for PLWH in Tennessee. ViiV respectfully submits the following comments:

Effective HIV Treatment

Treatment of HIV is a dynamic area of scientific research, and treatment protocols are evolving to reflect advances in medical science. PLWH often face a variety of medical challenges that impede access to, retention in, and adherence to HIV care and treatment.

Strict adherence to antiretroviral treatment (ART) – taking HIV medicines every day and exactly as prescribed – is essential to sustained suppression of the virus, reduced risk of drug resistance, and improved overall health.[8] The Health Resources and Services Administration (HRSA) stated in its *Guide for HIV/AIDS Clinical Care* that "adherence to ART is the major factor in ensuring the virologic success of an initial regimen and is a significant determinant of survival."[9] Nonadherence – or skipping HIV medicines – may lead to drug-resistant strains of the virus for which HIV medicines are less effective.[10] In fact, the World Health Organization (WHO) recently reported that resistance among people retained on ART ranged from four to 28 percent, while among people with unsuppressed viral load on first-line ART regimens, resistance ranged from 47 to 90 percent.[11] Treatment-related costs have been shown to increase with drug resistance as subsequent treatment options become limited.[12,13,14]

Federal HIV clinical treatment guidelines (DHHS Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents[15]) emphasize the importance of adherence to ensure long-term treatment success.[16] The effective treatment of HIV is highly individualized and accounts for a patient's size, gender, treatment history, viral resistance, comorbid conditions, drug interactions, immune status, and side effects.[17] Aging beneficiaries who are living with HIV often experience non-HIV related comorbidities.[18] Clinically significant drug interactions have been reported in 27 to 40 percent of HIV patients taking antiretroviral therapy requiring regimen changes or dose modifications.[19] Medical challenges for PLWH also include an increased risk for, and prevalence of, comorbidities such as depression and substance use disorders,[20] as well as cardiovascular disease, hepatic and renal disease, osteoporosis, metabolic

[7] AIDS Vu, Tennessee: https://aidsvu.org/state/tennessee

[8] Chesney MA. The elusive gold standard. Future perspectives for HIV adherence assessment and intervention. J Acquir Immune Defic Syndr. 2006;43 Suppl 1:S149-155, http://www.ncbi.nlm.nih.gov/pubmed/17133199.

[9] HRSA, Guide for HIV/AIDS Clinical Care (April 2014), https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf. Accessed October 13, 2017.

[10] AIDS Info, HIV Treatment Fact Sheet (March 2, 2017), https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/56/drug-resistance. Last accessed October 13, 2017.

[11] WHO, HIV Drug Resistance Report 2017, http://apps.who.int/iris/bitstream/10665/255896/1/9789241512831-eng.pdf?ua=1. Accessed October 13, 2017.

[12] Broder MS, Juday T, Chang EY, Jing Y, Bentley TG. Using administrative claims data to estimate virologic failure rates among human immunodeficiency virus-infected patients with antiretroviral regimen switches. *Med Decis Making.* 2012;32(1):118-131.

[13] Krentz HB, Ko K, Beckthold B, Gill MJ. The cost of antiretroviral drug resistance in HIV-positive patients. *Antivir Ther.* 2014;19(4):341-348.

[14] Stansell J, Barrett C, De Guzman C, Holtzer C, Lapins D. Incremental costs of HIV suppression in HIV therapeutic failure [abstract]. *7th Conference on Retroviruses and Opportunistic Infections.* 2000;Abstract 761.

[15] DHHS Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, NIH.gov https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf accessed: Dec. 5, 2017

[16] DHHS guidelines for the use of antiretroviral agents in adults and adolescents living with HIV. May 30, 2018. Accessible at https://aidsinfo.nih.gov/guidelines (accessed June 2018)

[17] HHS, Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, p. 183, https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-treatment-guidelines/0. Accessed October 13, 2017.

[18] Schouten J, et al. Clin Infect Dis. 2014 Dec 15;59(12):1787-97.

[19] Evans-Jones JG et al. Clin Infect Dis 2010;50:1419–1421; Marzolini C et al. Antivir Ther 2010;15:413–423.

[20] CDC, Medical Monitoring Project, United States, 2013 Cycle (June 2013–May 2014

disorders, and several non–AIDS-defining cancers.[21,22] The most common non-infectious co-morbidities of HIV are hypertension, hyperlipidemia, and endocrine disease.[23]

Prevention

Effective treatment of HIV also helps to prevent new transmissions of the virus. Broad access to life-saving HIV treatments is equally important to reduce transmission rates. According to the Centers for Disease Control and Prevention (CDC), however, less than half of diagnosed PLWH are virally suppressed.[24] Viral load suppression means that the virus has been reduced to an undetectable level in the body.[25]

A 2011 clinical study from the National Institutes of Health (NIH), found that treating HIV-positive people with ART reduces the risk of transmitting the virus to HIV-negative sexual partners by 93 percent.[26] Reduced transmissions not only improve public health but also save money. It is estimated PLWH who are not retained in medical care may transmit the virus to an average of 5.3 additional people per 100-person years.[27] Other studies estimate that each HIV positive patient may approach $338,400 in additional costs to the healthcare system over his or her lifetime even if diagnosed early and retained in care.[28] Successful treatment with an antiretroviral regimen results in virologic suppression and virtually eliminates secondary HIV transmission to others. As a result, it is possible to extrapolate that successful HIV treatment and medical care of each infected patient may save the system up to $1.79 million by preventing[29] further transmission to others. These savings can only occur, however, if PLWH are diagnosed, have access to medical care, receive treatment, and remain adherent to their prescribed therapy.

HIV & Medical Frailty

ViiV encourages the state to protect HIV patients from potential disruptions in care and treatment under the proposed Amendment 38. One way to do this is through designation of all PLWH as "medically frail." Uninterrupted access to medical care and drug treatment benefits is directly linked to the health and wellness of PLWH covered by public health programs. In a study, PLWH who faced drug benefit design changes were found to be nearly six times more likely to face treatment interruptions than those with more stable coverage, which can increase virologic rebound, drug resistance, and increased morbidity and mortality.[30] For this reason, PLWH should be exempted from penalties that create potential disruptions in access to necessary medications or care, similar to other complex medical conditions through a designation of medical frailty.

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[21] Joel Gallant, Priscilla Y Hsue, Sanatan Shreay, Nicole Meyer; Comorbidities Among US Patients With Prevalent HIV Infection—A Trend Analysis, The Journal of Infectious Diseases, Volume 216, Issue 12, 19 December 2017, Pages 1525–1533, https://doi.org/10.1093/infdis/jix518

[22] Rodriguez-Penney, Alan T. et al. "Co-Morbidities in Persons Infected with HIV: Increased Burden with Older Age and Negative Effects on Health-Related Quality of Life." AIDS Patient Care and STDs 27.1 (2013): 5–16. PMC. Web. 21 June 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3545369/

[23] Joel Gallant, Priscilla Y Hsue, Sanatan Shreay, Nicole Meyer; Comorbidities Among US Patients With Prevalent HIV Infection—A Trend Analysis, The Journal of Infectious Diseases, Volume 216, Issue 12, 19 December 2017, Pages 1525–1533, https://doi.org/10.1093/infdis/jix518

[24] CDC. MMWR. Vol 67 No.4 Feb. 2, 2018. https://www.cdc.gov/mmwr/volumes/67/wr/pdfs/mm6704a2-H.pdf.

[25] National Institutes of Health (NIH) "Ten things to Know about HIV Suppression" https://www.niaid.nih.gov/news-events/10-things-know-about-hiv-suppression. Accessed July 7, 2018

[26] Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med* 2011;365:493-505, http://www.nejm.org/doi/full/10.1056/NEJMoa1600693#t=article.

[27] Skarbinski, et al. *JAMA Intern Med*. 2015;175(4):588-596.

[28] Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. Medical care. 2015;53(4):293–301, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/

[29] Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. Medical care. 2015;53(4):293–301, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/

[30] Das-Douglas, Moupali, et al. "Implementation of the Medicare Part D prescription drug benefit is associated with antiretroviral therapy interruptions." AIDS and Behavior 13.1 (2009): 1

Eligibility Requirements

ViiV appreciates the state's goals to "provide broad access to care, deliver high-quality care that promotes improved health outcomes, and manage the cost of care effectively," as stated in its amendment request.[31]

A material concern for ViiV is the proposed penalty for failing to meet these requirements is loss of eligibility for the program, and therefore loss of covered benefits such as medical care and drug treatment.

According to the proposal ….

> *"Affected members must meet the requirement for four months out of every six-month period in order to maintain coverage. TennCare will assess member compliance after six months of eligibility, … At that time, members who have not demonstrated compliance for at least four months of the six-month reporting period will be subject to suspension of benefits. Benefits for these members will remain suspended until they demonstrate compliance with the requirement for one month. …."*[32]

For PLWH, uninterrupted access to benefits is important because adherence to antiretroviral medication is paramount in maintaining their health, avoiding viral resistance, and preventing medical complications and co-morbidities. Adherence to treatment for PLWH is also important to maintaining viral load suppression which helps to prevent new transmissions of the virus. Access to regular medical care from qualified medical care providers is also highly important for PLWH in order to monitor disease progression and screen for signs of viral resistance.

Although the proposal exempts medically frail individuals from these penalties, it is not specified in the proposal that all PLWH would be included in this definition or exempt from these penalties. Given the fact that their health and wellness is entirely dependent on uninterrupted access to medical care and treatment, PLWH should be exempted from penalties that would threaten this important coverage. ViiV encourages the state to consider including specific provisions to designate PLWH as medically frail under the amendment.

Best Practices

Two other states have recently proposed to implement engagement requirements, while ensuring that PLWH were exempted from potentially harmful benefit loss penalties: Michigan and Arizona.

In 2018, Michigan proposed a waiver to implement work requirements, but designated certain populations as medically frail using claims analysis, specifically ICD-10 diagnosis codes. [33],[34] ViiV Healthcare recommended that ICD codes related HIV and AIDS should be included in the state's list, a recommendation adopted in their final proposal. There are two main ICD-10 categories for coding HIV and they have subsequent clarifying details with extra digits added to the category number. These two main codes are:

> *B20 – Human immunodeficiency virus [HIV] disease resulting in infectious and parasitic diseases*
>
> *Z21 – Asymptomatic human immunodeficiency virus [HIV] infection status*[35]

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[31] P.1 https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment38.pdf
[32] P.4 https://www.tn.gov/content/dam/tn/tenncare/documents2/Amendment38.pdf
[33] Section 1115 Demonstration Extension Application, Healthy Michigan Plan, Project No. 11-W-00245/5, AMENDED: JULY 9, 2018
[34] Attachment L, "Medically Frail Identification Process Proposed Amendment: Revised July 9, 2018"
https://www.michigan.gov/documents/mdhhs/Attachment_L_Medically_Frail_Process_DRAFT_070518_627125_7.pdf
[35] ICD-10 codes for HIV https://www.ncbi.nlm.nih.gov/books/NBK236995/bin/annex2-m1.pdf

ViiV recommends that Tennessee consider use of these codes as a means to identify PLWH in order the provide a medical frailty exemption. These codes would include many PLWH whose condition is well controlled through medications; therefore, these patients are not easily identified through codes for more severe comorbidities and conditions. However, these individuals are dependent on uninterrupted access to medical treatment due to the complexity of the disease and should be included in the state's efforts to define medical frailty through claims analysis.

Another best practice is Arizona's Health Care Cost Containment System 1115 waiver request, which exempts PLWH from potential disruptions in access to necessary medications or disrupt their ability to be adherent to those medications through an expansion of the definition of medically frailty:

> AHCCCS will work with [Center for Medicare and Medicaid Services] CMS to develop a comprehensive definition of what members would be considered medically frail. This list will include, but is not limited to, members with cancer, HIV/AIDS, chronic substance abuse disorder, hemophilia, and end-stage renal disease (ESRD). Members will be identified through claims and encounter data, which is lagged, as well as a process by which members or providers can notify AHCCCS of the diagnosis to ensure timely application of their exemption.

ViiV applauds states that seek to protect medically frail patients from potential disruptions in care and treatment. However, this type of statutory protection should extend beyond patients who are defined as "medically frail" or "disabled" to also encompass patients with complex medical conditions, including those with chronic conditions, deadly diseases, or require strict adherence to drug therapy to see benefit.

Conclusion

ViiV thanks the state for its consideration of its comments and supports the commitment to improving health outcomes for its most vulnerable patients. As indicated above, ViiV requests that the state maintain Medicaid coverage for PLWH by including HIV in the medically frail designation. ViiV looks forward to working with the state, and other stakeholders to ensure that Tennessee's public programs continue to ensure PLWH have access to quality care and to improve health outcomes.

Please feel free to contact me at (919) 323-9084 or Cindy.C.Snyder@viivhealthcare.com with any questions.

Sincerely,

Cindy Snyder
Community Government Relations Director
ViiV Healthcare

Jonathan Reeve

From: Hannah Cornfield <hannah.cornfield@ywcanashville.com>
Sent: Wednesday, October 17, 2018 11:59 AM
To: Public Notice. Tenncare
Subject: ATTN: Comments on Amendment 38
Attachments: Letter of opposition - TennCare work requirements.pdf

Dear Dr. Wendy Long,

I am submitting the attached comments on behalf of YWCA Nashville & Middle Tennessee in response to the public notice inviting public comments on proposed Waiver Amendment 38.

Best,

Hannah Cornfield

Hannah Cornfield, she/her/hers I Social Justice Sr. Manager
YWCA Nashville & Middle Tennessee
1608 Woodmont Blvd I Nashville, Tennessee 37215
(615) 983-5129 I www.ywcanashville.com
24-Hour Crisis & Support Helpline 1-800-334-4628

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Nashville & Middle Tennessee

24 Hour Crisis & Support Helpline 1-800-334-4628

October 16, 2018

Dr. Wendy J. Long
310 Great Circle Rd.
Nashville, TN 37228

Subject: TennCare work requirements

Dear Dr. Long,

The YWCA Nashville & Middle Tennessee appreciates the opportunity to comment on the proposed TennCare work requirements. We have been a part of the Nashville community for over 120 years. The YW operates the largest emergency domestic violence shelter in the state of Tennessee. The 51-bed (soon to be 65-bed) Weaver Domestic Violence Center serves almost 500 women and children each year who flee their homes and uproot their lives to escape domestic violence. We also offer trauma informed counseling services and transitional housing support. The women and children we serve access our services after calling the 24-hour Crisis and Support Helpline. We received more than 7,500 calls to this number last year.

Only a handful of survivors come to the YWCA Weaver Center with private insurance. About forty percent of the women we serve have no insurance at all. That means nearly half of the survivors trying to heal from the physical and emotional wounds of domestic violence receive their insurance through TennCare.

All of the women and children we serve have experienced trauma. Many have lived with and through the abuse for months and even years. Their wounds are both visible and, in many cases, invisible. The women and children we serve need consistent, reliable health insurance.

The YWCA absolutely supports the idea that everyone who can work should work. The vast majority of women and families we serve need health care and want to work. We work with our survivors to help them rebuild their lives. But typically, many are physically and mentally unable to work unless they get

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Nashville & Middle Tennessee

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health care first. If survivors don't have access to medical care, they're even more vulnerable than when they call our crisis line or come through our shelter doors. That's why tying an individual's access to health insurance with a work mandate is unnecessarily punitive.

Work requirements are inherently harmful because they discriminate against groups of people who are, to no fault of their own, unable to work. Here are a few important points we want the Bureau of TennCare to know and consider:

- Victims of domestic violence are fleeing their homes and may even have to leave their jobs to escape the abuse. Many even move to a different city where their abuser can't find them.
- Victims of domestic violence aren't usually thinking about updating their addresses as they seek safety in a shelter or with a family member or friend.
- Victims of domestic violence are often physically injured and cannot work.
- Victims of domestic violence often suffer from PTSD and are unable to work.
- How does a woman prove that she is a victim of domestic abuse? It is difficult for a domestic violence victim to meet the proof standard often required by such requirements.
- With many legal proceedings, survivors often lose their jobs or have to quit their jobs because they have to be in court and spend so much time meeting with the District Attorney's office.
- How long would a domestic violence victim be able to claim a good cause exemption?

We urge you to consider the negative impact mandatory work requirements will have on the lives they are trying to rebuild.

Sincerely,

Sharon K. Roberson

Sharon K. Roberson

1608 Woodmont Boulevard | Nashville, TN 37215 | Phone 615-269-9922 | Fax 615-385-9754 | www.ywcanashville.com

Jonathan Reeve

From: Nicole Braccio <nicole.braccio@npaf.org>
Sent: Friday, October 26, 2018 1:44 PM
To: Public Notice. Tenncare
Cc: Rebecca Kirch
Subject: NPAF Comments on Amendment 38 (Project No. 11-W-00151/4)
Attachments: 102618_NPAF_TennCare Amendment 38 Comment SUBMISSION.pdf

Hello,

National Patient Advocate Foundation is pleased to submit comments to Amendment 38 of the TennCare II Demonstration. Please do not hesitate to reach out to me at the email/phone number below if NPAF can provide further details or assistance.

Thank you for the opportunity to provide feedback.

Sincerely,
Nicole

Nicole Braccio, PharmD
Policy Director
202-516-5212 • nicole.braccio@npaf.org

NPAF
National Patient Advocate Foundation
1100 H Street, NW,
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Washington, DC 20005
202.347.8009 • www.npaf.org

October 26, 2018

Wendy Long, MD
Director, Division of TennCare
310 Great Circle Road
Nashville, TN 32743

Re: Amendment 38 to the TennCare II Demonstration

Dear Dr. Long,

National Patient Advocate Foundation (NPAF) appreciates the opportunity to comment on Amendment 38 to the TennCare II Demonstration. NPAF supports policies that sustain and expand Medicaid to meet the health care needs of low-income adults and children. We are concerned that requiring the most vulnerable patients and families in Tennessee to report completing work and community engagement hours to maintain their health benefits may lead to negative health consequences and further financial distress.

NPAF represents the voices of millions of adults, children and families coping with serious and chronic illnesses as the advocacy affiliate of Patient Advocate Foundation (PAF). PAF provides direct case management, financial support, and educational services to tens of thousands of primarily low-income patients and caregivers nationwide each year who are experiencing distressing financial, employment, insurance coverage, or household material hardships because of their health conditions. Over the past ten years, PAF has served as an important safety net to nearly 6,000 patients and families in Tennessee.

Overall, we oppose Amendment 38 because it would create new administrative and financial barriers for 300,000 low-income parents and caregivers[1] living below 98 percent of federal poverty level. Parents focused on their family's health and well-being should not be burdened by monthly reporting requirements to prove they're working or that they qualify for an exemption. We echo the concerns of the broader patient community that conditioning Medicaid coverage on 20 hours of work activities per week may jeopardize equitable access to affordable, quality care.

We understand that Tennessee seeks to support beneficiaries in obtaining and maintaining employment, however, research indicates that work requirements do not necessarily encourage work or reduce poverty and a growing body of evidence demonstrates that such policies could result in reduced access to care, adverse health outcomes and increased health disparities.[2] We have seen the initial impact of this type of proposal in Arkansas, where as of October 8, 2018, the state has terminated Medicaid coverage for over 8,000 beneficiaries as a result of their work requirement policy implemented just four months ago.[3,4]

[1] Tennessee General Assembly Fiscal Review Committee. Fiscal Note HB 1551 – SB 1728. February 12, 2018. Available at: http://www.capitol.tn.gov/Bills/110/Fiscal/HB1551.pdf
[2] Kaiser Family Foundation. Issue Brief. The Relationship Between Work and Health: Findings from a Literature Review. Aug 7, 2018. Available at: http://files.kff.org/attachment/Issue-Brief-The-Relationship-Between-Work-and-Health-Findings-from-aLiterature%20Review
[3] Sum of cases closed as of September 9, 2018. Available at: https://ccf.georgetown.edu/wp-content/uploads/2018/09/091218_AWReport_Final.pdf
[4] Sum of cases closed as of October 8, 2018. Available at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf

Alleviating the stress of securing health coverage would allow able-bodied adults to prioritize employment. In fact, surveys of unemployed Medicaid beneficiaries in other states indicate that having health coverage facilitated their job search.[5] While Tennessee aims to provide assistance and supports to help beneficiaries meet the requirements, we are concerned that it will be difficult to deliver on this promise. Our PAF case managers already help Tennessee patients navigate the health and social service system and any additional supports will likely require professional help to attain.

We appreciate that several exemptions would be made for primary caregivers for a child under six or an incapacitated household member, the medically frail, and individuals with disabilities or acute conditions that would prevent them from working. Inadequate communication and outreach about these requirements, however, may lead to confusion and place undue burden on people with serious or chronic conditions to establish a good cause exemption. This has been the case in Arkansas, where many beneficiaries were unaware of the new requirements and their responsibility to apply for an exemption.[6]

In practice, written communication to inform people about new requirements and eligibility may not suffice without supplemental outreach such as in-person or telephonic assistance with the opportunity for people to ask questions. As beneficiaries do become aware of the requirements, the paperwork burden coupled with any existing household material hardships they may be experiencing can preclude them from complying even if they are pursuing work activities.

We urge TennCare to reconsider whether the potential benefit of instituting a work requirement applicable to the most vulnerable Tennesseans outweighs the risk of terminating coverage for parents and families relying on Medicaid as a lifeline. We understand that Tennessee is under significant pressure to reduce Medicaid spending and has taken steps to use 1115 waivers to implement changes that reign in health care costs. While fiscal sustainability is important, it cannot take precedence over the wellbeing and health of patients and their families.

A variety of factors lead people to enroll in and rely on Medicaid. We oppose Amendment 38 because the proposed work requirement runs counter to Tennessee's goal of improving health, education, employment and community engagement outcomes of people affected by the new requirements. We request that TennCare protect patients from losing their health care and encourage efforts that sustain equitable access to quality health coverage for the people it covers including parents and caregivers, their children, people with disabilities and the elderly. Thank you for the opportunity to provide person-centered feedback on Amendment 38 to TennCare II demonstration.

Respectfully submitted,

Rebecca A. Kirch
EVP Health Care Quality and Value

[5] CLASP. Fact Sheet. The Evidence Builds: Access to Medicaid Helps People Work. Updated Dec 2017. Available at: https://www.clasp.org/sites/default/files/publications/2017/04/The-Evidence-Builds-Access-to-Medicaid-Helps-PeopleWork.pdf
[6] 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/.

SUPPORTING DOCUMENTATION ATTACHED

TENNESSEE GENERAL ASSEMBLY
FISCAL REVIEW COMMITTEE

FISCAL NOTE

HB 1551 - SB 1728

February 12, 2018

SUMMARY OF BILL: Directs the Commissioner of the Department of Finance and Administration to submit a waiver amendment to the existing TennCare II waiver to the federal Centers for Medicare and Medicaid Services (CMS) imposing reasonable work requirements upon able-bodied working age adult enrollees without dependent children under the age of six, and if approved, implement the waiver amendment.

ESTIMATED FISCAL IMPACT:

Increase State Expenditures - $646,600/FY19-20
Net Impact $18,733,300/FY20-21 and Subsequent Years

Increase Federal Expenditures - $5,126,600/FY19-20
Net Impact $15,338,200/FY20-21 and Subsequent Years

Other Fiscal Impact – There will be additional savings as the program continues to grow and additional enrollees either no longer qualify due to income limits or do not meet work requirements. There could be additional costs related to staffing needs of the Division of TennCare. The exact amounts and timing of such amounts cannot be quantified due to the uncertainty of the program parameters.

Assumptions:

- Based on the language of the proposed legislation, the Division of TennCare (TennCare) will have flexibility in drafting the proposed waiver including flexibility in negotiations with CMS on the final waiver document.
- According to TennCare, there are currently no parameters of the proposed program that have been considered to an extent to guarantee they will be included in the waiver proposal. Therefore, the basis of this analysis is from CMS guidance (letter dated January 11, 2018) and proposals approved or currently being considered by CMS for similar programs in other states.
- TennCare assumes any work requirements will not be fully implemented until July 1, 2020.
- CMS guidance instructs states to align Medicaid work and community involvement requirements with those of Temporary Assistance for Needy Families (TANF) or

Supplemental Nutrition Assistance Program (SNAP) including excepted populations, protections and supports for individuals with disabilities, allowable activities and required hours of participation, allowable activities due to economic or environmental factors, enrollee reporting requirements, and the availability of work support programs.

Eligible Enrollees:

- As of January 1, 2018, there were approximately 307,700 total enrollments in the TennCare adult parent and caretaker relative eligibility category. For purposes of this analysis, it is assumed there are at least 300,000 enrollees in TennCare in the effected population at any given point and this number will remain constant.
- CMS requires enrollees meeting TANF/SNAP work requirements, as well as individuals exempt from TANF/SNAP work requirements, to be considered as compliant with Medicaid work requirements. Based on information from TennCare, this will reduce the effected population by approximately 50 percent to 150,000 individuals (300,000 x 50.0%).
- Approximately 47 percent have children under the age of five and are considered exempted based on the proposed language of the legislation. TennCare cannot currently determine how many of these individuals are part of a two parent home.
- In 2016, the U.S. Census Bureau reported approximately 69 percent of children lived in two parent households. Therefore, it is assumed that 69 percent of the 47 percent (69.0% x 47.0%) or 32.43 percent will be exempted.
- The effected population without children under six years of age is estimated to be 101,355 [150,000 x (100% - 32.43%)].
- Further, approximately two percent of this population is over the age of 65 and assumed to be exempted resulting in an effected population of 99,328 [101,355 x (100% - 2%)].
- According to the U.S. Census Bureau, approximately 11.2 percent of Tennesseans under the age of 65 have a disability. Therefore, it is assumed 11.2 percent of the effected population will be exempt. It is assumed approximately 88,203 [99,328 x (100% - 11.2%)] will be effected by the work requirements.
- CMS guidance further suggests states consider drug addiction treatment as an exempted population. The Department of Mental Health and Substance Abuse Services is quoted as estimating 82,000 Tennesseans addicted to drugs. [https://www.tennessean.com/story/news/politics/2018/01/22/gov-bill-haslams-plan-combat-opioid-crisis-include-boosts-prevention-treatment-and-law-enforcement/1054217001/ (last visited 2/11/2018)]. This equates to 1.22 percent of the state population based on July 2017 U.S. Census Bureau estimates (82,000/6,715,984).
- For purposes of this analysis, it is assumed approximately two percent will be exempted for drug treatment.
- The total population effected by Medicaid work and community involvement requirements is estimated to be 86,439 [88,203 (100% - 2%)].

Tennessee Eligibility Determination System (TEDS)

- TennCare is in the final year of development of the Tennessee Eligibility Determination System (TEDS). The system is scheduled to go live on January 1, 2019.
- The current structure of TEDS will collect a great deal of information on each enrollee. TennCare can construct the work program requirements to only apply to categories that

will be collected by TEDS. Therefore, it is assumed no additional enrollment categories will need to be constructed within the TEDS program.

- Based on currently approved waivers and the guidance from CMS, TennCare will be required to implement new reporting standards. This will require reporting functions to be added to the TEDS system.
- Based on information provided by TennCare, approximately $5,600,000 in systems changes will be necessary. These one-time changes will occur in FY19-20 and will receive a 90 percent federal match; therefore the one-time increase in expenditures will be $560,000 state ($5,600,000 x 10.0%) and $5,040,000 federal funds ($5,600,000 x 90.0%).

Appeals:

- According to TennCare, the new work requirements will result in an increased number of appeals.
- Since the reverification activity was increased, appeals have also increased greatly.
- Annual appeals have been as follows: 39,193 in 2015; 68,903 in 2016; and 138,486 in 2017. Total appeals for 2018 indicate that appeals will surpass 2016 appeals numbers.
- TennCare established 250 temporary positions in 2014 and an additional 200 temporary positions in 2015 for eligibility verification and appeals. These positions were made permanent in FY17-18 and FY18-19.
- TennCare has not provided any information as to a tentative verification schedule, but it is assumed that verification for compliance with the work requirements will correspond with each enrollee's reverification.
- Based on information from the Kaiser Family Foundation, 57 percent of non-SSI and non-elderly TennCare enrollees are working. Therefore, approximately 49,270 (86,439 x 57.0%) will not be dis-enrolled because they will meet the work requirements and therefore not appeal.
- Of the remaining 37,169 (86,439 – 49,270), it is unknown how many will meet the work or other requirements due to a lack of data related to this population. For purposes of this analysis, it is assumed an additional 40 percent, or 14,868 (37,169 x 40.0%), will meet the new work requirements for the program.
- Therefore, it is assumed approximately 22,301 (37,169 – 14,868) will not meet requirements, be dis-enrolled and will appeal the dis-enrollment decision.
- It is assumed appeals will not exceed 2017 numbers of 138,486 with the additional dis-enrollments; therefore any increase in expenditures can be accommodated within existing resources.

Case Management Costs:

- Based on projections from other states for the per-member per-month (pmpm) case management of the work requirement, these costs are dependent on current programs that are in place and the degree of assistance provided enrollees.
- It is assumed that at a minimum, TennCare will incur a $100 pmpm case management cost.
- The total case management costs are based on the total work requirement population that is not currently working of 37,169. The estimated increase in expenditures will be $44,602,800 (37,169 x $100 x 12 months).

- It is assumed these costs will receive a 50 percent federal match due to CMS's encouragement to implement work requirements; therefore $22,301,400 is state funds ($44,602,800 x 50.0%) and $22,301,400 is federal funds. These increased expenditures will not be realized until FY20-21 due to the work requirement implementation date of July 1, 2020.

Staffing:

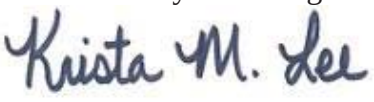
- TennCare will need two program administrator positions to assist in the implementation and oversight of the program. It is assumed salary and benefits for each position will be $86,642. The total increase in expenditures for the additional positions will be $173,284.
- It is assumed these expenditures will not be realized until FY19-20 and will receive a 50 percent federal match resulting in an increase of $86,642 in state funds ($173,284 x 50.0%) and $86,642 in federal funds ($173,284 x 50.0%).
- TennCare may need to hire additional staff in future years, but due to the uncertainty of the program and the waiver requirements approved by CMS it is not possible to quantify with any certainty.

Savings:

- There will be savings from TennCare enrollees being dis-enrolled from the program from not meeting the work requirements or for reaching an income level in which they no longer qualify for TennCare assistance.
- The amount of savings is difficult to quantify due to the uncertainty of the requirements of the program that will be approved by CMS. It is also unknown as to the timeframe in which a dis-enrolled individual is able to prove compliance with the new requirements and re-enroll into the program.
- The 2017 medical and pharmacy costs for someone enrolled in TennCare is $380 pmpm.
- Should 10 percent of the 37,169 enrollee population be dis-enrolled for at least a six month period, the estimated savings would be $10,704,672 [(37,169 x 10.0%) x ($380 pmpm medical and pharmacy costs x $100 case management) x 6 months]. Of this amount, the federal match is 65.858.
- There will be $3,654,789 ($10,704,672 x 34.142%) reduction in state funds and $7,049,883 ($10,704,672 x 65.858%) reduction in federal funds.
- These potential savings will not be realized until FY20-21 due to the work requirement implementation date of July 1, 2020.

CERTIFICATION:

The information contained herein is true and correct to the best of my knowledge.



Krista M. Lee, Executive Director

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August 2018 | Issue Brief

The Relationship Between Work and Health: Findings from a Literature Review

Larisa Antonisse and Rachel Garfield

Summary

A central question in the current debate over work requirements in Medicaid is whether such policies promote health and are therefore within the goals of the Medicaid program. Work requirements in welfare programs in the past have had different goals of strengthening self-esteem and providing a ladder to economic progress, versus improving health. This brief examines literature on the relationship between work and health and analyzes the implications of this research in the context of Medicaid work requirements. We review literature cited in policy documents, as well as additional studies identified through a search of academic papers and policy evaluation reports, focusing primarily on systematic reviews and meta-analyses. Key findings include the following:

- **Being in poor health is associated with increased risk of job loss, while access to affordable health insurance has a positive effect on people's ability to obtain and maintain employment.**
- **There is limited evidence on the effect of *employment* on health, with some studies showing a positive effect of work on health yet others showing no relationship or isolated effects.** There is strong evidence of an association between *unemployment* and poorer health outcomes, but authors caution against using these findings to infer that the opposite relationship (work causing improved health) exists. While unemployment is almost universally a negative experience and thus linked to poor outcomes, especially poor mental health outcomes, employment may be positive or negative, depending on the nature of the job (e.g., stability, stress, hours, pay, etc.). Further, most studies note major limitations in our ability to draw broad conclusions on health and work, including:
    - Job availability and quality are important modifiers in how work affects health; transition from unemployment to poor quality or unstable employment options can be detrimental to health.
    - Selection bias in the research (e.g., healthy people being more likely to work) and other methodological limitations restrict the ability to determine a causal work-health relationship.
- **Studies note several caveats to and implications of the research on work and health that are particularly relevant to work requirements in Medicaid.** For example:
    - The work-health relationship may differ for the Medicaid population compared to the broader populations studied in the literature, as Medicaid enrollees report worse health than the general population and face significant challenges related to social determinants of health.
    - Limited job availability or poor job quality may moderate or reverse any positive effects of work.
    - Work or volunteering to fulfill a requirement may produce different health effects than work or volunteer activities studied in existing literature.
    - Loss of Medicaid coverage under work requirements could negatively impact health care access and outcomes, as well as exacerbate health disparities.

Introduction

On January 11, 2018, CMS issued a State Medicaid Director Letter providing new guidance for Section 1115 waiver proposals that would impose work requirements (referred to as community engagement) in Medicaid as a condition of eligibility. On January 12, 2018, CMS approved the first work requirement waiver in Kentucky, and three additional work requirement waiver approvals followed in Indiana (February 1, 2018), Arkansas (March 5, 2018), and New Hampshire (May 7, 2018). The new guidance and work requirement approvals reverse previous positions of both Democratic and Republican Administrations, which had not approved work requirement waiver requests on the basis that such provisions would not further the Medicaid program's purposes of promoting health coverage and access. However, in both the new guidance and work requirement waiver approvals, CMS explains its policy reversal by maintaining that employment leads to improved health outcomes, and policies that condition Medicaid eligibility on meeting a work requirement will further this objective. Though the structure of work requirements is similar to those used in other programs, the administration's stated goal of improving health through Medicaid work requirements is different from the goals of welfare reform work requirements in the past, which were to strengthen self-esteem and provide a ladder to economic progress.

On June 29, 2018, the DC federal district court vacated HHS's approval of the Kentucky Section 1115 waiver program. The court held that consideration of whether the waiver would promote beneficiary health in general is not a substitute for considering whether the waiver promotes Medicaid's primary purpose of providing affordable health coverage and remanded to HHS to consider how the waiver would help furnish medical assistance consistent with Medicaid program objectives. However, the court also noted that plaintiffs and their *amici* assert that proclaimed health benefits of employment are unsupported by substantial evidence. Thus, there is likely to be ongoing debate and policy discussion over whether work requirements will further the aims of Medicaid.

To address whether work will further the aims of Medicaid, we examine the literature on the relationship between work and health and analyze the implications of this research in the context of Medicaid work requirements. Due to the large number of studies in this field spanning decades, this literature review focuses primarily (although not exclusively) on findings from other literature or systematic reviews rather than individual studies on these topics. We drew on studies cited in policy documents on work requirements in Medicaid, results of keyword searches of PubMed and other academic health/social policy search engines, and snowballing through searches of reference lists in previously pulled papers. In total, we reviewed more than 50 sources, the vast majority of which were published academic studies or program evaluations and most of which are reviews of multiple studies themselves. A more detailed description of the methods underlying this analysis is provided in the Methods box at the end of this brief.

What effect do health and health coverage have on work?

Not surprisingly, research has demonstrated that being in poor health is associated with an increased risk of job loss or unemployment.[1,2,3,4,5] A meta-analysis of longitudinal studies on the relationship between health measures and exit from paid employment found that poor health, particularly

self-perceived health, is associated with increased risk of exit from paid employment.[6] Another study that simultaneously examined and contrasted the relative effects of unemployment on mental health and mental health on employment status in a single general population sample found mental health to be both a consequence of and a risk factor for unemployment. However, the evidence for men in particular suggested that mental health was a stronger predictor of subsequent unemployment than unemployment was a predictor of subsequent mental health.[7] Additional research suggests that, in some cases, individual characteristics such as income, race, sex, or education level may mediate the relationship between poor health and unemployment.[8,910] Research also demonstrates that an unmet need for mental health or substance use disorder treatment results in greater difficulty with obtaining and maintaining employment.[11,12,13,14,15]

Additional research suggests that, in addition, access to affordable health insurance and care, which may help people maintain or manage their health, promotes individuals' ability to obtain and maintain employment. For example, in an analysis of Medicaid expansion in Ohio, most expansion enrollees who were unemployed but looking for work reported that Medicaid enrollment made it easier to seek employment, and over half of employed expansion enrollees reported that Medicaid enrollment made it easier to continue working.[16] Similarly, a study on Medicaid expansion in Michigan found that 69% of enrollees who were working said they performed better at work once they got coverage, and 55% of enrollees who were out of work said the coverage made them better able to look for a job.[17] A study on Montana's Medicaid expansion found a substantial increase of 6 percentage points in labor force participation among low-income, non-disabled Montanans ages 18-64 following expansion, compared to a decline in labor force participation among higher-income Montanans.[18] National research found increases in the share of individuals with disabilities reporting employment and decreases in the share reporting not working due to a disability in Medicaid expansion states following expansion implementation, with no corresponding trends observed in non-expansion states.[19] Additional literature suggests that access to health insurance and care promotes volunteerism, finding that the expansion of Medicaid under the ACA was significantly associated with increased volunteerism among low-income adults.[20,21]

What effect does work have on health and health coverage?

Overall, the body of literature examining whether work affects health shows mixed results, with some studies showing a positive effect of work on health yet others showing no relationship or isolated effects. A 2006 literature review found that, while "there is limited amount of high quality scientific evidence that directly addresses the question [of whether work is good for your health]… there is a strong body of indirect evidence that work is generally good for health and well-being."[22] That assessment was based on comprehensive review of the literature, including other systematic reviews as well as narrative and opinion pieces. A more focused 2014 systematic review about the health effects of employment, which included 33 longitudinal studies,[23] found strong evidence that employment reduces the risk of depression and improves general mental health, yet it found insufficient evidence for an effect

on other health outcomes due to a lack of studies or inconsistent findings of the studies.[24] A 2015 review of 22 longitudinal studies found an association between employment and re-employment with better physical health.[25]

In contrast, research shows a strong association between *unemployment* and poor health outcomes, though researchers caution that these findings do not necessarily mean the reverse is true (e.g. employment causes improved health). The effect of unemployment on health has long been an area of research focus, and a substantial body of research from the U.S. and abroad consistently demonstrates a strong association between unemployment and poorer health outcomes,[26,27,28,29 30,31,32] with some evidence suggesting a causal relationship in which unemployment leads to poor health.[33,34,35] The bulk of the research in the unemployment and health field focuses on mental health outcomes.[36] Examples of negative health outcomes associated with unemployment include increases in depression, anxiety, mixed symptoms of distress, and low self-esteem.[37,38] A more limited body of research suggests an association of unemployment with poorer physical health (including increases in cardiovascular risk factors such as hypertension and serum cholesterol as well as increased susceptibility to respiratory infections), and mortality.[39,40] A 2006 literature review noted that there is continuing debate about the relative importance of possible mechanisms involved in this relationship, and adverse effects of unemployment may vary in nature and degree for different individuals in different social contexts.[41] Some evidence also indicates that cumulative length of unemployment is correlated with deteriorated health and health behavior.[42] However, despite the evidence of a relationship between unemployment and health, researchers caution against using findings to infer that an opposite relationship (employment causing improved health) exists.[43,44] In addition, researchers note that the literature on unemployment tends to study more negative than positive health outcome variables,[45] which may skew our understanding of the health effects of unemployment.[46]

Another related area of research is studies examining the relationship between re-employment (i.e., returning to work) and health, which find some association between re-employment and mental health. A 2012 systematic review on this topic found support for a beneficial health effect of returning to work, with most of the 18 studies included in this review focusing on mental health-related outcomes.[47] The review also tried to assess to what extent the relationship was causal (i.e., reemployment caused health improvements) versus due to selection (e.g., people with poor health were more likely to remain unemployed) and concluded that both were at play. The review did not reach a definitive conclusion about mechanisms linking re-employment to improved health (due to lack of evidence), and it noted that it is still unclear whether health effects of reemployment are moderated by factors such as socioeconomic status, reason for unemployment, and the nature of employment.[48] The 2006 literature review described above also analyzed research findings on re-employment and found strong evidence that re-employment leads to improved psychological health and measures of general well-being, with a dearth of information on physical health and some but not all studies showing that re-employment/health relationship is at least partly due to health selection. However, these authors also cite

evidence from numerous studies suggesting that "the beneficial effects of re-employment depend mainly on the security of the new job, and also on the individual's motivation, desires, and satisfaction"[49]

Studies on work and health have found that the quality and stability of work is a key factor in the work-health relationship: research finds that low-quality, unstable, or poorly-paid jobs lead to or are associated with adverse effects on health.[50,51,52,53,54,55,56] For example, a 2014 meta-analysis of studies published after 2004 found that job insecurity can pose a comparable (and even modestly increased) risk of subsequent depressive symptoms compared to unemployment.[57] A 2011 longitudinal analysis found that while unemployed respondents had poorer mental health than those who were employed, the mental health of those who were unemployed was comparable or more often superior to those in jobs of poor psychosocial quality (based on measures of job control, perceived job security, and job demands and complexity) and the mental health of those in poor quality jobs declined more over time than the mental health of those who were unemployed. Moreover, while moving from unemployment into a high quality job led to improvement in mental health, the transitioning from unemployment to a poor quality job was more detrimental to mental health than remaining unemployed.[58] Additionally, a 2003 study that examined the association of different employment categories with physical health and depression found a consistent association between less than optimal jobs (based on economic, non-income, and psychological aspects of the jobs) and poorer physical and mental health among adults.[59]

It is possible that the work-health association reflects people in good health being more likely to work, versus work causing good health. Some researchers caution against the possibility that selection bias has occurred in many of the studies on work and health. The existence of a "healthy worker effect"—in which relatively healthy individuals are more likely to enter the workforce whereas those with health problems are at increased risk to withdraw from and remain outside of the workforce—has been documented in multiple studies.[60,61,62,63 64 ,65] Authors of both individual studies and literature reviews on this topic explain that the healthy worker effect is difficult to control for even in studies that attempt to do so, and thus this effect may cause an overestimation of the findings in the literature on health effects of work.[66,67] As authors of a 2014 systematic review of studies on health effects of employment point out, there are no randomized controlled trials on this topic available in the literature because performing such trials would be unethical,[68] yet randomized controlled trials are the gold standard for determining a causal relationship.

Most study authors specifically note additional caveats to drawing broad conclusions about work and health. The 2006 review concluding a general positive effect of work on health emphasized three major provisos to this conclusion: (1) findings are about average or group affects, and a minority of people may experience contrary health effects from work, (2) the beneficial health effects of work depend on the nature and quality of work (described above), and (3) the social context must be taken into account, particularly social gradients in health (i.e. inequalities in population health status related to inequalities in social status) and regional deprivation.[69] These caveats could explain the seemingly contradictory findings about employment and unemployment: While unemployment is almost universally a negative experience and thus linked to poor outcomes, especially poor mental health outcomes,

employment may be positive or negative, depending on the nature of the job (e.g., stability, stress, hours, pay, etc.). As discussed below, these provisos have implications for the applicability of research to Medicaid work requirements.

While work can help people access employer-sponsored health coverage, many jobs—especially low-wage jobs—do not come with an affordable offer of employer coverage. In 2017, just over half (53%) of firms offered health coverage to their employees,[70] and workers in low-wage firms are less likely than those in higher wage firms to be eligible for coverage through their employer.[71] In 2017, less than a third of workers who worked at or below their state's minimum wage had an offer of health coverage through their employer.[72] Though most employees take up employer-sponsored coverage when offered, workers in low-wage firms are less likely to be covered by their employer even if coverage is offered, likely reflecting the fact that workers in such firms pay a larger share of the premium than workers in higher-wage firms.[73] The fact that work does not always lead to health coverage is further demonstrated by the large majority of uninsured people who are in a family with either a full-time (74%) or part-time (11%) worker.[74]

What is the effect of volunteerism on health?

In the January 2018 guidance, CMS includes volunteering as a "community engagement" activity that may improve health outcomes,[75] and the Medicaid work requirement waivers approved to date all permit volunteer activities to count towards the required weekly/monthly hours of work activity.

However, there is limited existing evidence that volunteer activities benefit health outcomes. One literature review on the health effects of volunteering "did not find any consistent, significant health benefits arising through volunteering" based on experimental studies available at the time of the literature review.[76] The authors' analysis of cohort studies revealed limited benefits of volunteering on depression, life satisfaction, and well-being (with no significant benefits on physical health). In addition, the cohort studies focused primarily on volunteers ages 50 and over, with some of the studies suggesting that the association between volunteerism and improved health outcomes may be limited to older volunteers and that that the health benefits of volunteering may diminish as hours of volunteering increase.[77] Another study (published in 2018) examined the health benefits of "other-oriented volunteering" (other-regarding, altruistic, and humanitarian-concerned volunteering) compared to "self-oriented volunteering" (volunteering focused on seeking benefits and enhancing the volunteers themselves in return). While the authors found beneficial effects of both forms of volunteer activity on health and well-being, other-oriented volunteering had significantly stronger effects on the health outcomes of mental and physical health, life satisfaction, and social well-being than did self-oriented volunteering.[78] As discussed below, this finding may indicate that health benefits of volunteering are likely to be weaker when individuals are compelled to engage in volunteering.

What does this research mean for Medicaid work requirements?

The body of literature summarized above includes several notable caveats and conclusions to consider in applying findings to a work requirement in Medicaid. Limitations and implications that are particularly relevant include:

Effects found for the general population may not apply to Medicaid, as the link between work and health is not universal across populations or social contexts. In general, the studies examined above analyze the relationship between work and health among broad populations of all income levels. However, several authors suggest that population differences may modify the relationship between work and health. A 2003 study found that nationally, older adults, women, blacks, and individuals with low education levels were more likely to be employed in jobs viewed as "barely adequate" or "inadequate" (the types of jobs that the study found to be independently associated with poorer physical health and higher rates of depression) compared to other populations.[79] Authors of a 2006 literature review qualify their broad findings on the work/health relationship with the proviso that the social context must be taken into account (particularly social inequities in health and regional deprivation), and also cite evidence that the strong association between socioeconomic status and physical and mental health and mortality likely outweighs (and is confounded with) all other work characteristics that influence health.[80] Authors of a 2005 review on unemployment and health found a strong association between deprived areas, poor health, poverty and unemployment (although the exact relationship is not clear), and highlight the need for more research on the geographical dimension on unemployment and health.[81] These findings imply that the work/health relationship may differ significantly for the low-income Medicaid population, who report worse health status compared to the total US population and often face more significant challenges related to housing, food security, and other social determinants of health.[82,83,84] In addition, some volunteerism research suggests that the association between volunteerism and improved health outcomes may be limited to older volunteers, yet approved and pending Section 1115 Medicaid work requirement waiver requests all include exemptions for individuals above a certain age (which varies by state but ranges from 50 to 65 years).[85]

Work or volunteering undertaken to fulfill a requirement may produce different health effects than work and volunteer activities studied in existing literature. For example, research on health effects of work requirements in Temporary Assistance for Needy Families (TANF) suggests that they did not benefit and sometimes negatively affected health among enrollees and their dependents.[86] Another study found that welfare reform was associated with increases in self-reported poor health and self-reported disability among white single mothers without a high school diploma or GED.[87] These adverse effects could reflect different relationships between work and health for low-income populations, as described above, or different effects of work undertaken voluntarily versus as a requirement. Authors of a 2006 literature review on work and health found that forcing claimants off benefits and into work without adequate supports would more likely harm than improve their health and well-being.[88] Similarly, most studies on volunteerism and health define volunteerism as an act of free-will (essentially, a voluntary act), a

definition that may not be applicable to volunteer activity undertaken for the purpose of meeting work/community engagement requirements in order to maintain eligibility for Medicaid. Volunteer activities undertaken to retain Medicaid appear more closely aligned with the self-oriented form of volunteerism (volunteering focused on seeking benefits and enhancing the volunteers themselves in return), which research shows has weaker health effects than the other-oriented form (other-regarding, altruistic, and humanitarian-concerned volunteering).

Limited job availability, low demand for labor, or poor job quality may moderate any positive health effects of employment. Authors of a 2014 systematic review of prospective studies on health effects of employment commented that most studies in this field do not adjust for quality of employment and include all kinds of jobs in their analysis (e.g. part- and full-time employment, self-employment, and both blue- and white-collared jobs) despite the possibility that different forms of employment have different health effects.[89] Under Medicaid work requirement programs, the population subject to Medicaid work requirements may have access to only low-wage, unstable, or low-quality jobs to meet the weekly/monthly hours requirement, as these are the types of positions adults with Medicaid who currently work hold.[90] In discussing the policy implications of their findings, multiple researchers have concluded that such policies could be detrimental to health, with authors of one study asserting that, "Policies that promote job growth without giving attention to the overall adequacy of the jobs may undermine health and well-being."[91]

Long-term effects of work on health are unclear. Much of the evidence on the work/health relationship is about short-term effects after about one year, which, as authors of one literature review point out, is a short period when assessing health impacts.[92] There is less evidence on longer-term effects over a lifetime perspective.[93] In addition, research on work requirements in other public programs shows little evidence of long-term impacts on employment or income. Studies on welfare recipients subject to work requirements generally have found that any initial increase in employment after an imposition of a work requirement faded over time.[94,95,96] After five years, one study showed those who were not required to work were just as likely or more likely to be working compared to those who were subject to a work requirement, suggesting that these work requirements had little impact on increasing employment over the long-term.[97] Other research has found that employment among people who left welfare was unsteady and did not lift them out of poverty.[98] Thus, even short-term effects are likely to disappear as short-term boosts in employment fade over time.

Loss of health insurance coverage due to not meeting reporting or work requirements under waivers could affect access to health care and health. Low-wage workers typically work in small firms and industries that often have limited employer-based coverage options, and very few have an offer of coverage through their employer. Work requirements in Medicaid could lead to large Medicaid coverage losses, especially among people who would remain eligible for the program but lose coverage due to new administrative burdens or red tape versus those who would lose eligibility due to not working.[99] Several studies on individuals leaving TANF following welfare reform show reductions in insurance coverage across this "welfare leaver" population, with significant decreases in Medicaid coverage that were not fully

offset by the smaller increases in private coverage.[100,101,102,103,104] A study evaluating welfare-to-work interventions found that some programs led to a reduction in health insurance coverage for both children and parents.[105] Given the evidence of Medicaid's positive impact on access to care and health outcomes,[106] as well as data demonstrating that uninsured individuals go without needed care due to cost at much higher rates than those with Medicaid coverage,[107] widespread coverage losses as a result of Medicaid work requirements are likely to result in adverse effects on health outcomes. In TANF evaluations, for example, studies found that children of TANF enrollees who lose benefits for failure to comply with a work requirement experience adverse health effects such as behavioral health problems[108] or hospitalization.[109]

Policies that have disproportionate effects on certain Medicaid enrollees could widen health disparities. Data demonstrate the persistence of clear disparities in health insurance coverage, access to care, and health outcomes for certain vulnerable populations in the US, including people with disabilities (compared to their non-disabled counterparts)[110] and people of color (compared to whites).[111] Research shows that people with disabilities and people of color are face disproportionate challenges in meeting and are disproportionately sanctioned under existing work requirement programs.[112, 113] If racial minority groups, people with disabilities, or other vulnerable populations face similarly disproportionate challenges in meeting work requirements when they are attached to the Medicaid program, these policies could result in wider disparities in health insurance coverage and health outcomes.

Looking Ahead

Taken as a whole, the large body of research on the link between work and health indicates that proposed policies requiring work as a condition of Medicaid eligibility may not necessarily benefit health among Medicaid enrollees and their dependents, and some literature also suggests that such policies could negatively affect health. While it is difficult to determine a causal relationship between employment and health status (largely due to challenges controlling for health selection bias and the inability to conduct randomized controlled trials on this topic), there is strong evidence of an association between employment and good health. However, research suggests that factors like job availability and quality, as well as the social context of workers, mediate the effect of work or work requirements on health. Given the characteristics of the Medicaid population, research indicates that policies could lead to emotional strain, loss of health coverage, or widening of health disparities for vulnerable populations. As debate considers the question of whether policies to promote health—versus health coverage—are the aim of the Medicaid program, the question of whether work requirements will promote health also will remain key to the ongoing debate over the legality of work requirements in Medicaid.

Methods

This brief is based on a review of existing research on the relationship between work and health. To collect relevant studies, we began by drawing on studies cited in policy documents on work requirements in Medicaid, including the January 2018 guidance from CMS, comments and reactions to the guidance, and documents related to the *Stewart v. Azar* litigation and decision. We then conducted keyword searches of PubMed and other academic health/social policy search engines to compile relevant studies and program evaluations. Due to the large number of studies in this field spanning decades, we focused primarily (although not exclusively) on findings from other literature or systematic reviews rather than individual studies on these topics. We then used a snowballing technique of pulling additional studies from reference lists in previously pulled papers. In areas with limited evidence or in which reviews indicated conflicting or unclear results, we looked at original source studies to understand findings and assess the strength of the evidence.

In total, we reviewed more than 50 sources, the vast majority of which were published academic studies or program evaluations and most of which are reviews of multiple studies themselves. In weighing evidence, we prioritized recent research and research based in the United States over older research and research based on experiences in other countries, though we did include older and international studies if they were highly cited, directly relevant, or included in systematic reviews that also included US-based studies. We excluded commentaries (as compared to original work or comprehensive literature reviews) and studies that were not directly focused on the link between health and work (e.g., we excluded studies of workplace wellness programs).

Endnotes

[1] Sarah Olesen, Peter Butterworth, Liana Leach, Margaret Kelaher, and Jane Pirkis, “Mental Health Affects Future Employment as Job Loss Affects Mental Health: Findings from a Longitudinal Population Study,” *BMC Psychiatry* 13 (2013), https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-13-144

[2] Peter Butterworth, Liana Leach, Jane Pirkis, and Margaret Kelaher, ”Poor Mental Health Influences Risk and Duration of Unemployment: A Prospective Study,” *Social Psychiatry and Psychiatric Epidemiology* 47 no. 6 (June 2012): 1013-1021, https://link.springer.com/article/10.1007/s00127-011-0409-1

[3] Rogier van Rijn, Suzan Robroek, Sandra Brouwer, and Alex Burdorf, “Influence of Poor Health on Exit from Paid Employment: A Systematic Review,” *Occupational & Environmental Medicine* 71 no. 4, (2014): pp. 295-301, https://oem.bmj.com/content/71/4/295

[4] Merel Schuring et al., “The Effect of Ill Health and Socioeconomic Status on Labor Force Exist and Re-Employment: A Prospective Study with Ten Years Follow-Up in the Netherlands,” *Scandinavian Journal of Work, Environment, and Health* 39 no. 2 (March 2013): pp. 134.

[5] Merel Schuring et al., “The Effects of Ill Health on Entering and Maintaining Paid Employment: Evidence in European Countries,” *Journal of Epidemiology & Community Health* 61 (2007): pp. 597-604, https://jech.bmj.com/content/61/7/597.full

[6] Rogier van Rijn, Suzan Robroek, Sandra Brouwer, and Alex Burdorf, “Influence of Poor Health on Exit from Paid Employment: A Systematic Review,” *Occupational & Environmental Medicine* 71 no. 4, (2014): pp. 295-301, https://oem.bmj.com/content/71/4/295

[7] Sarah Olesen, Peter Butterworth, Liana Leach, Margaret Kelaher, and Jane Pirkis, “Mental Health Affects Future Employment as Job Loss Affects Mental Health: Findings from a Longitudinal Population Study,” *BMC Psychiatry* 13 (2013), https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-13-144

[8] Victoria Blinder et al., “Women with Breast Cancer Who Work For Accommodating Employers More Likely To Retain Jobs After Treatment,” *Health Affairs* 36 no. 2 (February 2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1196

[9] Merel Schuring et al., “The Effects of Ill Health on Entering and Maintaining Paid Employment: Evidence in European Countries,” *Journal of Epidemiology & Community Health* 61 (2007): pp. 597-604, https://jech.bmj.com/content/61/7/597.full

[10] Victoria Blinder et al., “Women with Breast Cancer Who Work For Accommodating Employers More Likely To Retain Jobs After Treatment,” *Health Affairs* 36 no. 2 (February 2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1196

[11] National Institute on Drug Abuse, Consequences of Drug Misuse (Bethesda, MD: National Institute on Drug Abuse, March 2017), https://www.drugabuse.gov/related-topics/health-consequences-drug-misuse

[12] Neil Jordan et al., “Economic Benefit of Chemical Dependency Treatment to Employers,” Journal of Substance Abuse Treatment 34, 3(2008):311-319

[13] Ronald C. Kessler et al., “Depression in the Workplace: Effects on Short-term Disability,” Health Affairs (Millwood) 18, 5(1999):163-71

[14] Cheryl J. Cherpitel and Yu Ye, “Drug Use and Problem Drinking Associated with Primary Care and Emergency Room Utilization in the US General Population: Data from the 2005 National Alcohol Survey,” Drug and Alcohol Dependence 97 3(2008):226-30

[15] Doris J. James and Lauren E. Glaze, Mental Health Problems of Prison and Jail Inmates (Washington, DC: US Department of Justice, December 2006), https://www.bjs.gov/content/pub/pdf/mhppji.pdf

[16] The Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* (The Ohio Department of Medicaid, January 2017).

[17] University of Michigan Institute for Healthcare Policy & Innovation, *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches* (June 2017), http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches

[18] Bureau of Business and Economic Research, *The Economic Impact of Medicaid Expansion in Montana* (University of Montana Bureau of Business and Economic Research, Prepared for the Montana Healthcare Foundation and Headwaters Foundation, April 2018), https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf

[19] Jean Hall, Adele Shartzer, Noelle Kurth, and Kathleen Thomas, "Medicaid Expansion as an Employment Incentive Program for People With Disabilities," *American Journal of Public Health* epub ahead of print (July 2018), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2018.304536

[20] Heeju Sohn and Stefan Timmermans, "Social Effects of Health Care Reform: Medicaid Expansion under the Affordable Care Act and Changes in Volunteering," Socius: Sociological Research for a Dynamic World 3 (March 2017): 1-12, http://journals.sagepub.com/doi/full/10.1177/2378023117700903

[21] Sohn and Timmermans used the volunteering supplement to the Current Population Survey (CPS) to measure volunteerism. Analyzed changes in formal volunteering based on two CPS questions: "Since September 1st of last year, have you done any volunteering activities through or for an organization?" and, "Sometimes people don't think of activities they do infrequently or activities they do for children's schools or youth organizations as volunteer activities. Since September 1st of last year, have you done any of these types of volunteer activities?" Also separately analyzed changes in informal helping based on one CPS question: "Since September 1st of last year, have you worked with people in your neighborhood to fix or improve something?"

[22] Gordon Waddell and A. Kim Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[23] The authors judged 23 of these studies to be "high quality" studied from a methodological perspective, and they classified the remaining 10 as "low quality" studies from a methodological perspective.

[24] Maaike van der Noordt, Helma IJzelenberg, Mariel Droomers, and Karin Proper, "Health Effects of Employment: A systematic Review of Prospective Studies," *Occupational and Environmental Medicine,* 71 (October 2014): 730-736, https://www.ncbi.nlm.nih.gov/pubmed/24556535

[25] K. Hergenrather, et al., Employment as a Social Determinant of Health: A Systematic Review of Longitudinal Studies Exploring the Relationship Between Employment Status and Physical Health, Rehabilitation Research, Policy, and Education (2015), https://www.researchgate.net/publication/273333771_Employment_as_a_Social_Determinant_of_Health_A_Systematic_Review_of_Longitudinal_Studies_Exploring_the_Relationship_Between_Employment_Status_and_Physical_Health

[26] Gordon Waddell and A. Kim Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[27] Robert Jin, Chandrakant Shah, and Tomislav Svoboda, "The Impact of Unemployment on Health: A Review of the Evidence," *Canadian Medical Association Journal* 153, no. 5 (September 1995), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1487417/

[28] K. Hergenrather, et al., Employment as a Social Determinant of Health: A Systematic Review of Longitudinal Studies Exploring the Relationship Between Employment Status and Physical Health, Rehabilitation Research, Policy, and Education (2015), https://www.researchgate.net/publication/273333771_Employment_as_a_Social_Determinant_of_Health_A_Systematic_Review_of_Longitudinal_Studies_Exploring_the_Relationship_Between_Employment_Status_and_Physical_Health

[29] Jennifer Pharr, Sheniz Moonie, and Timothy Bungum, "The Impact of Unemployment on Mental and Physical Health, Access to Health Care and Health Risk Behaviors," *International Scholarly Research Network Public Health* (2012), https://www.hindawi.com/journals/isrn/2012/483432/

[30] Carl McClean et al., *Worklessness and Health—What do we Know about the Causal Relationship?* (London: Health Development Agency, 2005), http://www.employabilityinscotland.com/media/83147/worklessness-and-health-what-do-we-know-about-the-relationship.pdf

[31] Gregory Murphy and James Athanasou, "The Effect of Unemployment on Mental Health," *Journal of Occupational and Organizational Psychology* 72 (March 1999): 83-99, https://onlinelibrary.wiley.com/doi/pdf/10.1348/096317999166518

[32] Sarah Olesen, Peter Butterworth, Liana Leach, Margaret Kelaher, and Jane Pirkis, "Mental Health Affects Future Employment as Job Loss Affects Mental Health: Findings from a Longitudinal Population Study," *BMC Psychiatry* 13 (2013), https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-13-144

[33] Gordon Waddell and A. Kim Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[34] Karsten Paul and Klaus Moser, "Unemployment Impairs Mental Health: Meta Analyses," *Journal of Vocational Behavior* 74, no.3 (June 2009): 264-282, https://www.sciencedirect.com/science/article/abs/pii/S0001879109000037

[35] Frances McKee-Ryan, Zhaoli Song, Connie Wanberg, and Angelo Kinicki, "Psychological and Physical Well-Being During Unemployment: A Meta-Analytic Study," *Journal of Applied Psychology* 90 no. 1 (January 2005): 53-76, http://psycnet.apa.org/doiLanding?doi=10.1037%2F0021-9010.90.1.53

[36] Frances McKee-Ryan, Zhaoli Song, Connie Wanberg, and Angelo Kinicki, "Psychological and Physical Well-Being During Unemployment: A Meta-Analytic Study," *Journal of Applied Psychology* 90 no. 1 (January 2005): 53-76, http://psycnet.apa.org/doiLanding?doi=10.1037%2F0021-9010.90.1.53

[37] Gordon Waddell and A. Kim Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[38] Karsten Paul and Klaus Moser, "Unemployment Impairs Mental Health: Meta Analyses," *Journal of Vocational Behavior* 74, no.3 (June 2009): 264-282, https://www.sciencedirect.com/science/article/abs/pii/S0001879109000037

[39] Gordon Waddell and A. Kim Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[40] Karsten Paul and Klaus Moser, "Unemployment Impairs Mental Health: Meta Analyses," *Journal of Vocational Behavior* 74, no.3 (June 2009): 264-282, https://www.sciencedirect.com/science/article/abs/pii/S0001879109000037

[41] Gordon Waddell and A. Kim Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[42] Urban Janlert, Anthony Winefield, and Anne Hammarstrom, "Length of Unemployment and Health-Related Outcomes: A Life-Course Analysis," *European Journal of Public Health* 25 no. 4 (August 2015), https://academic.oup.com/eurpub/article/25/4/662/2398865

[43] Steve Crabtree, "In U.S., Depression Rates Higher for Long-Term Unemployed," *Gallup* (June 2014), http://news.gallup.com/poll/171044/depression-rates-higher-among-long-term-unemployed.aspx

[44] Gordon Waddell and A. Kim Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[45] Frances McKee-Ryan, Zhaoli Song, Connie Wanberg, and Angelo Kinicki, "Psychological and Physical Well-Being During Unemployment: A Meta-Analytic Study," *Journal of Applied Psychology* 90 no. 1 (January 2005): 53-76, http://psycnet.apa.org/doiLanding?doi=10.1037%2F0021-9010.90.1.53

[46] Existing research does suggest that for a minority of people, unemployment can lead to improved health and well-being. See Waddell and Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[47] Sergio Rueda et al., "Association of Returning to Work with Better Health in Working-Aged Adults: A Systematic Review," *American Journal of Public Health* 102 no. 3 (March 2012): 541-556, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3487667/

[48] Sergio Rueda et al., "Association of Returning to Work with Better Health in Working-Aged Adults: A Systematic Review," *American Journal of Public Health* 102 no. 3 (March 2012): 541-556, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3487667/

[49] Gordon Waddell and A. Kim Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[50] Peter Butterworth et al., "The Psychosocial Quality of Work Determines Whether Employment Has Benefits for Mental Health: Results From a Longitudinal National Household Panel Survey," *Occupational and Environmental Medicine* 68 no. 11 (2011): pp. 806-812, https://oem.bmj.com/content/68/11/806.long

[51] Marianna Virtanen et al., "Temporary Employment and Health: A Review," *International Journal of Epidemiology* 34 (2005): 610-622, https://www.ncbi.nlm.nih.gov/pubmed/15737968

[52] Pekka Virtanen, Urban Janlert, and Anne Hammarstrom, "Exposure to temporary employment and job insecurity: A Longitudinal Study of the Health Effects," *Occupational and Environmental Medicine,* 68, no. 8 (August 2011): 570-574, https://www.ncbi.nlm.nih.gov/pubmed/21081513

[53] Joseph Grzywacz and David Dooley, "'Good jobs' to 'bad jobs': replicated evidence of an employment continuum from two large surveys," Social Science and Medicine 56 no. 8 (April 2003): 1749-1760, https://www.ncbi.nlm.nih.gov/pubmed/12639591

[54] Gordon Waddell and A. Kim Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[55] David Dooley and JoAnn Prause, "Underemployment and Alcohol Misuse in the National Longitudinal Survey of Youth," *Journal of Studies on Alcohol and Drugs,* 50 no. 6 (1998): 669-680, https://www.jsad.com/doi/pdf/10.15288/jsa.1998.59.669

[56] JoAnn Prause and David Dooley, "Effect of Underemployment on School-Leavers' Self-Esteem," *Journal of Adolescence,* 20 no. 3 (1997): 243-260, http://psycnet.apa.org/record/1997-04916-002

[57] Tae Jun Kim and O von dem Knesebeck, "Perceived job insecurity, unemployment and depressive symptoms: a systematic review and meta-analysis of prospective observational studies," *International Archives of Occupational and Environmental Health* 89 no. 4 (May 2016): 561-573, https://www.ncbi.nlm.nih.gov/pubmed/26715495

[58] Peter Butterworth et al., "The Psychosocial Quality of Work Determines Whether Employment Has Benefits for Mental Health: Results From a Longitudinal National Household Panel Survey," *Occupational and Environmental Medicine* 68 no. 11 (2011): pp. 806-812, https://oem.bmj.com/content/68/11/806.long

[59] Joseph Grzywacz and David Dooley, "'Good jobs' to 'bad jobs': replicated evidence of an employment continuum from two large surveys," Social Science and Medicine 56 no. 8 (April 2003): 1749-1760, https://www.ncbi.nlm.nih.gov/pubmed/12639591

[60] Sergio Rueda et al., "Association of Returning to Work with Better Health in Working-Aged Adults: A Systematic Review," *American Journal of Public Health* 102 no. 3 (March 2012): 541-556, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3487667/

[61] Ritam Chowdhury, Divyang Shah, and Abhishek Payal, "Healthy Worker Effect Phenomenon: Revisited with Emphasis on Statistical Methods – A review," *Indian Journal of Occupational and Environmental Medicine* 21, no. 1 (2017): 2-8, http://www.ijoem.com/article.asp?issn=0973-2284;year=2017;volume=21;issue=1;spage=2;epage=8;aulast=Chowdhury

[62] Pekka Virtanen, Urban Janlert, and Anne Hammarstrom, "Health status and health behaviour as predictors of the occurrence of unemployment and prolonged unemployment," *Public Health* 127 no. 1 (January 2013): 46-52, https://www.publichealthjrnl.com/article/S0033-3506(12)00370-8/fulltext

[63] Silje Kaspersen et al., "Health and Unemployment: 14 Years of Follow-Up on Job Loss in the Norwegian HUNT Study," *European Journal of Public Health,* 26 no. 2 (April 2016): 312-317, https://academic.oup.com/eurpub/article/26/2/312/2570411

[64] Catherine Ross and John Mirowsky, "Does Employment Affect Health?," *Journal of Health and Social Behavior,* 36 (September 1995): 230-243, https://www.researchgate.net/publication/15605496_Does_Employment_Affect_Health

[65] Maaike van der Noordt, Helma IJzelenberg, Mariel Droomers, and Karin Proper, "Health Effects of Employment: A systematic Review of Prospective Studies," *Occupational and Environmental Medicine,* 71 (October 2014): 730-736, https://www.ncbi.nlm.nih.gov/pubmed/24556535

[66] Maaike van der Noordt, Helma IJzelenberg, Mariel Droomers, and Karin Proper, "Health Effects of Employment: A systematic Review of Prospective Studies," *Occupational and Environmental Medicine,* 71 (October 2014): 730-736, https://www.ncbi.nlm.nih.gov/pubmed/24556535

[67] Pekka Virtanen, Urban Janlert, and Anne Hammarstrom, "Exposure to temporary employment and job insecurity: A Longitudinal Study of the Health Effects," *Occupational and Environmental Medicine,* 68, no. 8 (August 2011): 570-574, https://www.ncbi.nlm.nih.gov/pubmed/21081513

[68] Maaike van der Noordt, Helma IJzelenberg, Mariel Droomers, and Karin Proper, "Health Effects of Employment: A Systematic Review of Prospective Studies," *Occupational and Environmental Medicine,* 71 (October 2014): 730-736, https://www.ncbi.nlm.nih.gov/pubmed/24556535

[69] Gordon Waddell and A. Kim Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[70] Kaiser Family Foundation, *2017 Employer Health Benefits Survey* (Washington, DC: Kaiser Family Foundation, September 2017), https://www.kff.org/report-section/ehbs-2017-section-2-health-benefits-offer-rates/

[71] Kaiser Family Foundation, *2017 Employer Health Benefits Survey* (Washington, DC: Kaiser Family Foundation, September 2017), https://www.kff.org/report-section/ehbs-2017-section-3-employee-coverage-eligibility-and-participation/

[72] Kaiser Family Foundation analysis of 2017 Current Population Survey.

[73] Kaiser Family Foundation, *2017 Employer Health Benefits Survey* (Washington, DC: Kaiser Family Foundation, September 2017), https://www.kff.org/report-section/ehbs-2017-section-6-worker-and-employer-contributions-for-premiums/

[74] Julia Foutz, Anthony Damico, Ellen Squires, and Rachel Garfield, *The Uninsured: A Primer - Key Facts about Health Insurance and the Uninsured Under the Affordable Care Act* (Washington, DC: Kaiser Family Foundation, December 2017), https://www.kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-under-the-affordable-care-act/

[75] Centers for Medicare and Medicaid Services, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," (Letter to State Medicaid Directors, CMS, January 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf

[76] Caroline Jenkinson et al., "Is Volunteering a Public Health Intervention? A Systematic Review and Meta-Analysis of the Health and Survival of Volunteers," *BMC Public Health* 13 (2013), https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-773

[77] Caroline Jenkinson et al., "Is Volunteering a Public Health Intervention? A Systematic Review and Meta-Analysis of the Health and Survival of Volunteers," *BMC Public Health* 13 (2013), https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-773

[78] Jerf Yeung, Zhuoni Zhang, and Tae Yeun Kim, "Volunteering and Health Benefits in General Adults: Cumulative Effects and Forms," *BMC Public Health* 18 no. 8 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5504679/

[79] Joseph Grzywacz and David Dooley, "'Good jobs' to 'bad jobs': replicated evidence of an employment continuum from two large surveys," Social Science and Medicine 56 no. 8 (April 2003): 1749-1760, https://www.ncbi.nlm.nih.gov/pubmed/12639591

[80] Gordon Waddell and A. Kim Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[81] Carl Mclean et al., *Worklessness and Health—What do we Know about the Causal Relationship?* (London: Health Development Agency, 2005), http://www.employabilityinscotland.com/media/83147/worklessness-and-health-what-do-we-know-about-the-relationship.pdf

[82] In 2016, 7% of nonelderly adults in Medicaid reported being in "poor" health compared to 2% of the US total nonelderly adult population, and 17% of nonelderly adults in Medicaid reported being in "fair" health compared to 9%

of the US total nonelderly adult population (both differences between the two populations were statistically significant).

A significantly greater percentage of Medicaid nonelderly adults compared to US total nonelderly adults also reported: that they often or sometimes cannot afford to eat balanced meals (26% vs. 11%), that they often or sometimes worry food will run out before they have money to buy more (34% vs. 15%), and that they are very or moderately worried about rent, mortgage, or other housing costs (42% vs. 24%). (Kaiser Family Foundation analysis of 2016 National Health Interview Survey data).

[83] Julia Paradise and Rachel Garfield, *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence* (Washington, DC: Kaiser Family Foundation, https://www.kff.org/medicaid/issue-brief/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence/

[84] Julia Paradise, Barbara Lyons, and Diane Rowland, *Medicaid at 50* (Washington, DC: Kaiser Family Foundation, May 2015), https://www.kff.org/medicaid/report/medicaid-at-50/

[85] For more detailed information on work requirement age exemptions by state, see the detailed work requirement waiver table that is downloadable through the KFF Medicaid Waiver Tracker: https://www.kff.org/medicaid/issue-brief/which-states-have-approved-and-pending-section-1115-medicaid-waivers/

[86] Marcia Gibson et al., "Welfare-To-Work Interventions and their Effects on the Mental and Physical Health of Lone Parents and their Children," *The Cochrane Database of Systematic Reviews* (February 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5846185/

[87] Kimberly Narain et al. "The Impact of Welfare Reform on the Health Insurance Coverage, Utilization, and Health of Low Education Single Mothers," *Social Science and Medicine* 180 (March 2017): pp. 28-35, https://www.ncbi.nlm.nih.gov/pubmed/28319907

[88] Gordon Waddell and A. Kim Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[89] Maaike van der Noordt, Helma IJzelenberg, Mariel Droomers, and Karin Proper, "Health Effects of Employment: A systematic Review of Prospective Studies," *Occupational and Environmental Medicine,* 71 (October 2014): 730-736, https://www.ncbi.nlm.nih.gov/pubmed/24556535

[90] Rachel Garfield, Robin Rudowitz, MaryBeth Musumeci, and Anthony Damico, *Implications of Work Requirements in Medicaid: What Does the Data Say?* (Washington, DC: Kaiser Family Foundation, June 2018), https://www.kff.org/medicaid/issue-brief/implications-of-work-requirements-in-medicaid-what-does-the-data-say/

[91] Joseph Grzywacz and David Dooley, "'Good jobs' to 'bad jobs': replicated evidence of an employment continuum from two large surveys," Social Science and Medicine 56 no. 8 (April 2003): 1749-1760, https://www.ncbi.nlm.nih.gov/pubmed/12639591

[92] Gordon Waddell and A. Kim Burton, *Is Work Good for your Health and Well-Being?,* (2006), https://www.gov.uk/government/publications/is-work-good-for-your-health-and-well-being

[93] Ibid.

[94] MaryBeth Musumeci and Julia Zur, *Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience* (Washington, DC: Kaiser Family Foundation, August 2017), https://www.kff.org/report-section/medicaid-enrollees-and-work-requirements-issue-brief/#endnote_link_232243-20

[95] 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

[96] Marcia Gibson et al., "Welfare-To-Work Interventions and their Effects on the Mental and Physical Health of Lone Parents and their Children," *The Cochrane Database of Systematic Reviews* (February 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5846185/

[97] Gayle Hamilton et al., National Evaluation of Welfare-to-Work Strategies: How Effective are Difference Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs, (Washington, DC: Manpower Demonstration Research Corporation, December 2001), http://www.mdrc.org/sites/default/files/full_391.pdf

[98] Tazra Mitchell, LaDonna Pavetti, and Yixuan Huang, *Life After TANF in Kansas: For Most, Unsteady Work and Earnings Below Half the Poverty Line* (Washington, DC: Center on Budget and Policy Priorities, February 2018), https://www.cbpp.org/sites/default/files/atoms/files/1-23-18kstanf.pdf

[99] Rachel Garfield, Robin Rudowitz, and MaryBeth Musumeci, *Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses* (Washington, DC: Kaiser Family Foundation, June 2018), https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/

[100] John Cawley, Mathis Schroeder, and Kosali Simon, "How Did Welfare Reform Affect the Health Insurance Coverage of Women and Children?," *Health Services Research* 41 no. 2 (April 2006), 486-506, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702522/

[101] Marianne Bitler, Jonah Gelbaxch, and Hilary Hoynes, "Welfare Reform and Health," *The Journal of Human Resources* 40 no. 2 (2005): pp. 309-334, https://www.jstor.org/stable/4129526?seq=1#page_scan_tab_contents

[102] Robert Kaestner and Neeraj Kaushal, "Welfare Reform and Health Insurance Coverage of Low-Income Families," *Journal of Health Economics* 22 (2003): 959-981, https://www.ncbi.nlm.nih.gov/pubmed/14604555

[103] Kaiser Family Foundation, *Participation in Welfare and Medicaid Enrollment* (Washington, DC: Kaiser Family Foundation, August 1998), https://www.kff.org/medicaid/participation-in-welfare-and-medicaid-enrollment/

[104] John Cawley, Mathis Schroeder, and Kosali Simon, "How Did Welfare Reform Affect the Health Insurance Coverage of Women and Children?," *Health Services Research* 41 no. 2 (April 2006), 486-506, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702522/

[105] Gayle Hamilton, Stephen Freedman, and Sharon McGroder, *National Evaluation of Welfare to Work Strategies,* (US Department of Health and Human Services, June 200), https://www.mdrc.org/sites/default/files/do_mandatory_welfare-to-work_programs_affect_fr.pdf

[106] Robin Rudowitz and Rachel Garfield, *10 Things to Know About Medicaid: Setting the Facts Straight* (Washington, DC: Kaiser Family Foundation, April 2018), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/

[107] Kaiser Family Foundation, *Key Facts about the Uninsured Population* (Washington, DC: Kaiser Family Foundation, November 2017), https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/

[108] Brenda J. Lohman et al., "Welfare Reform: What About the Children," Welfare, Children & Families 02-1(2002): 1-8, https://works.bepress.com/brenda_lohman/3/

[109] John Cook et al., "Welfare Reform and the Health of Young Children: A Sentinel Survey in 6 US Cities," *Archives of Pediatrics and Adolescent Medicine* 156 no. 7, (2002): 678-684, https://jamanetwork.com/journals/jamapediatrics/fullarticle/203607

[110] Gloria Krahn, Deborah Walker, and Rosaly Correa-De-Araujo, "Persons with Disabilities as an Unrecognized Health Disparity Population," *American Journal of Public Health* 105 (April 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4355692/

[111] Samantha Artiga, Julia Foutz, Elizabeth Cornachione, and Rachel Garfield, *Key Facts on Health and Health Care by Race and Ethnicity* (Washington, DC: Kaiser Family Foundation, June 2016), https://www.kff.org/disparities-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/

[112] Mathematica Policy Research, Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments (Feb. 2008), https://www.acf.hhs.gov/sites/default/files/opre/conducting_in_depth.pdf

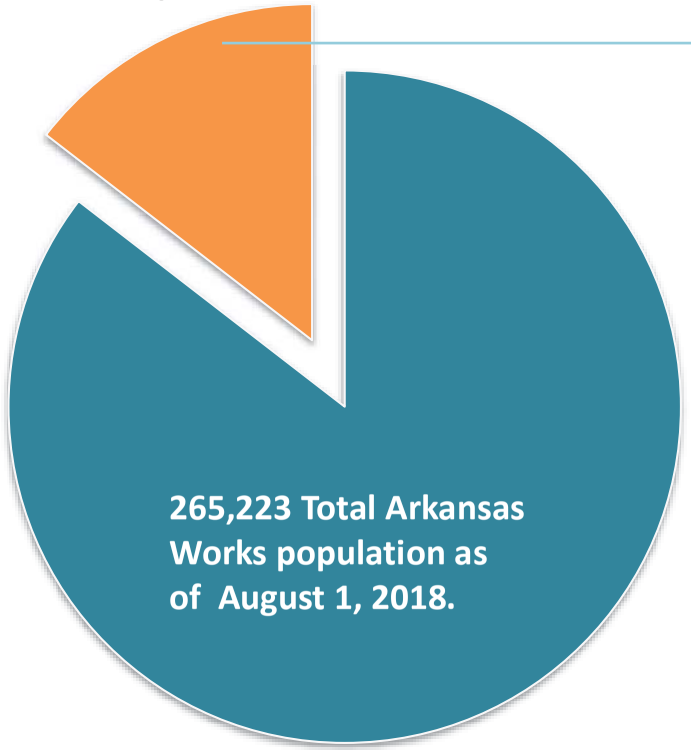
[113] Heather Hahn et al., *Work Requirements in Social Safety Net Programs,* (Washington, DC: The Urban Institute, December 2017), https://www.urban.org/sites/default/files/publication/95566/work-requirements-in-social-safety-net-programs.pdf

Arkansas Works Program

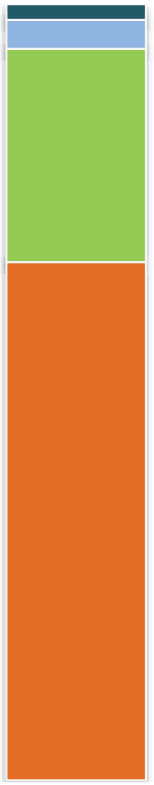
August 2018 Report

As of July 8, DHS data showed just over 62,000 Arkansas Works enrollees were subject to the work requirement in August. Most are already meeting the requirement through work, school, or other life situations that made them exempt from reporting. Numbers below are a point-in-time snapshot of the requirement and some fluctuate daily.

62,635* Originally estimated to be subject to work requirement in August



Between July 8 and Sept. 9, 2018, 2,623 fewer people became subject to the requirement due to case closures unrelated to compliance or a change in circumstances. That left 60,012 subject to the requirement in August.



1,218 Satisfied reporting requirement

2,247 Reported an exemption since receiving notice

16,357 Did not satisfy reporting requirement

40,190 Meeting requirement due to work, training, or other activity. Notices explained these enrollees are exempt from reporting their activities.

One month non-compliance	Two months non-compliance	Three months non-compliance (closed)
6,174**	5,076**	4,353

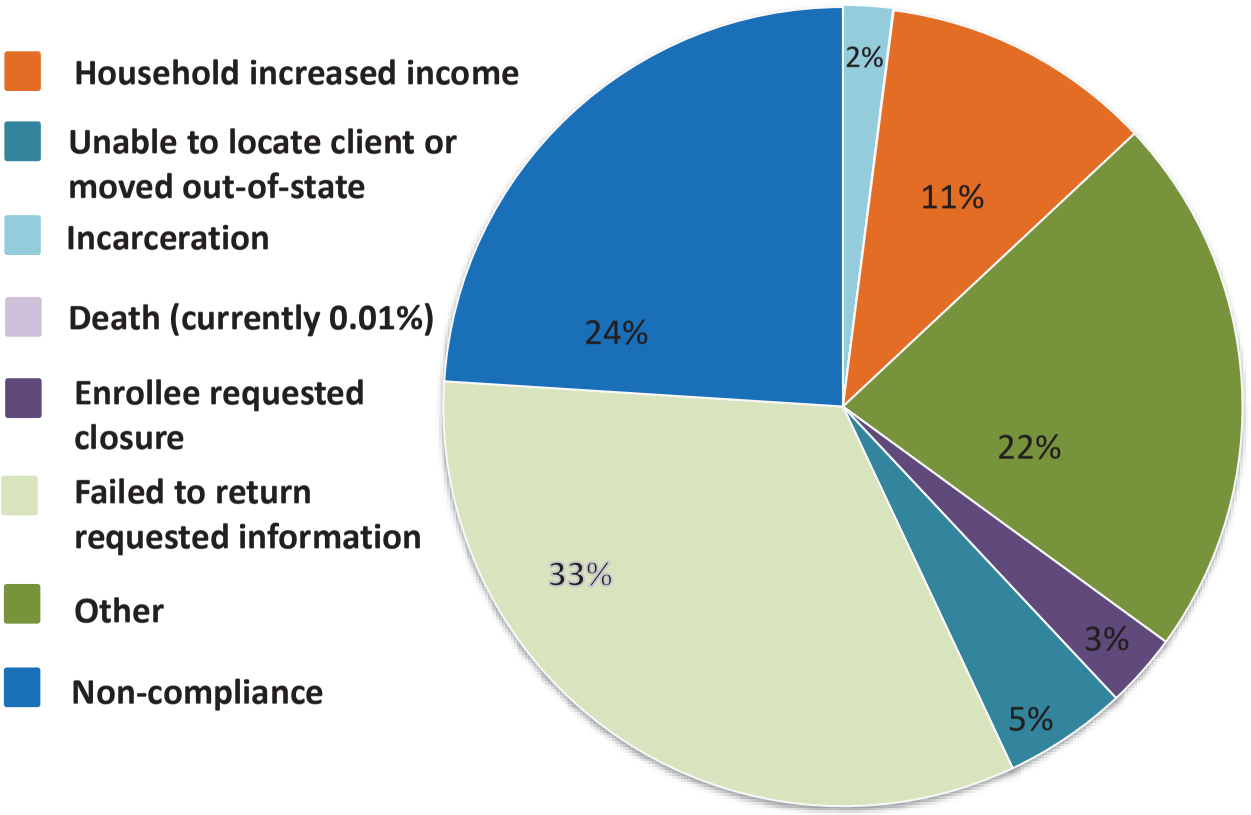
** due to closures unrelated to compliance & as of Sept. 9, 2018

*Enrollees ages 30-49 are being phased into the requirement from June through September 2018. Those 19-29 will roll in starting January 2019.

Arkansas Works Program

August 2018 Report

Every Medicaid program has what is known as “churn,” cases that close for various reasons. It is not uncommon for those individuals to take action and come back on a program after receiving a closure notice. The total number of Arkansas Works cases closed in August was 18,057. Of those, only 4,353 closed due to non-compliance with the work requirement. Below the closures are broken down by type.



Top four reasons people were exempt from reporting in August

Employed at least 80 hours a month	**19,391**
Already meeting SNAP requirement through work or exemption	**7,776**
Medically frail/disabled	**6,273**
At least one dependent child in the home	**5,717**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Works Clients - Subject to the Work Requirement

Reporting Period	Exempt from Reporting	Reported at least 80 Hours	Failed to Report 80 Hours	Total
June 2018	17,906	445	7,464	25,815
July 2018	30,228	844	12,722	43,794
August 2018	42,437	1,218	16,357	60,012
September 2018				-

Arkansas Works Clients - Months of Non-Compliance

As of September 9, 2018

One Month Non-Compliance	Two Months Non-Compliance
6,174	5,076

Arkansas Works Clients - Exemption Reasons

Reporting Period	Employed >80 hours/month	Dependent Child in Home	Pregnant	Medically Frail	Currently Exempt in SNAP	Caring for Incapacitated Person	Short-Term Incapacitated
June 2018	8,375	2,731	15	2,208	3,480	128	164
July 2018	13,951	4,192	21	4,282	5,780	264	385
August 2018	19,391	5,717	40	6,273	7,776	534	776
September 2018							

Reporting Period	Receives Unemployment Benefits	Education and Training	Alcohol or Drug Treatment	American Indian/Alaska Native*	Tea Cash Assistance	Total Exempt
June 2018	187	24	79	515	-	17,906
July 2018	310	56	155	832	-	30,228
August 2018	444	129	207	1,150	-	42,437
September 2018						

If a client has more than one exemption, the client receives the longest exemption he or she meets.

**Clients who are American Indian / Alaska Native are subject to the work requirement. This population will be part of a future phase in.*

Arkansas Works Clients - Good Cause Requests Completed in August

Total Good Cause Requests Completed in August	Good Cause Requests Granted	Good Cause Requests Denied	Not a Good Cause Issue
55	45	4	6

Good Cause requests are reviewed on a case-by-case basis and are currently tracked separately until system updates can be completed. Clients who have another exemption reason are counted in this report where appropriate.

Clients Who Met Requirement - Types of Work Activities Reported

Clients can report more than one type of work activity

		Number of clients who reported the activity						
Reporting Period	**Clients Who Met Requirement**	**Work**	**Education and Training**	**Volunteer**	**Job Search**	**Job Search Training**	**Health Education Class**	**Currently Meeting SNAP Requirement**
June 2018	445	73	8	27	18	1	1	351
July 2018	844	145	20	63	40	4	0	639
August 2018	1,218	279	42	120	90	6	3	828
September 2018								

August 2018 Reporting Period
Clients Who Met Requirement - Types of Work Activities Reported by Hours

Total Clients Who Met Requirement: 1,218

Clients can report more than one type of work activity.

Work Activity*	Clients Who Met Requirement by Hours Reported					# of Clients Reported	Total Hours Reported
	1-20 Hrs	21-40 Hrs	41-60 Hrs	61-80 Hrs	81+ Hrs		
Work	10	15	48	36	170	279	49,405
Education and Training	8	18	9	7	0	42	1,597
Volunteer	11	12	17	41	39	120	8,921
Job Search	18	29	23	4	16	90	5,853
Job Search Training	3	3	0	0	0	6	118
Health Education Class	2	1	0	0	0	3	36
Currently Meeting SNAP Requirement	--	--	--	--	--	828	N/A

While there is no limit to the number of hours a client can report, some work activity types limit the number of hours clients can receive credit for:

-- Job Search and Job Search Training - Clients may count up to 39 total hours from these activities combined each month.

-- Health Education Class - Clients may count up to 20 hours each year from this activity.

Clients Who Failed to Report 80 Hours - Types of Work Activities Reported

Clients can report more than one type of work activity

				Number of clients who reported the activity					
Reporting Period	**Clients Who Did Not Meet Requirement**	**Reported No Work Activities**	**Reported Work Activities**	**Work**	**Education and Training**	**Volunteer**	**Job Search**	**Job Search Training**	**Health Education Class**
June 2018	7,464	7,392	72	27	20	5	23	2	1
July 2018	12,722	12,587	135	49	20	12	73	1	1
August 2018	16,357	16,132	225	78	50	19	98	4	1
September 2018									

August 2018 Reporting Period

Clients Who Failed to Report 80 Hours of Activities - Types of Work Activities Reported by Hours

Total clients who failed to report 80 hours: 16,357

Reported No Work Activities: 16,132

Reported Work Activities: 225

Clients can report more than one type of work activity

Work Activity*	Clients Who Did Not Meet Requirement by Hours Reported					# of Clients Reported	Total Hours Reported
	1-20 Hrs	21-40 Hrs	41-60 Hrs	61-80 Hrs	81+ Hrs		
Work	18	24	20	16	0	78	3,034
Education and Training	10	25	10	5	0	50	1,772
Volunteer	13	4	1	1	0	19	362
Job Search	36	21	6	6	29	98	6,702
Job Search Training	2	0	1	1	0	4	167
Health Education Class	1	0	0	0	0	1	14

While there is no limit to the number of hours a client can report, some work activity types limit the number of hours clients can receive credit for:

-- Job Search and Job Search Training - Clients may count up to 39 total hours from these activities combined each month.

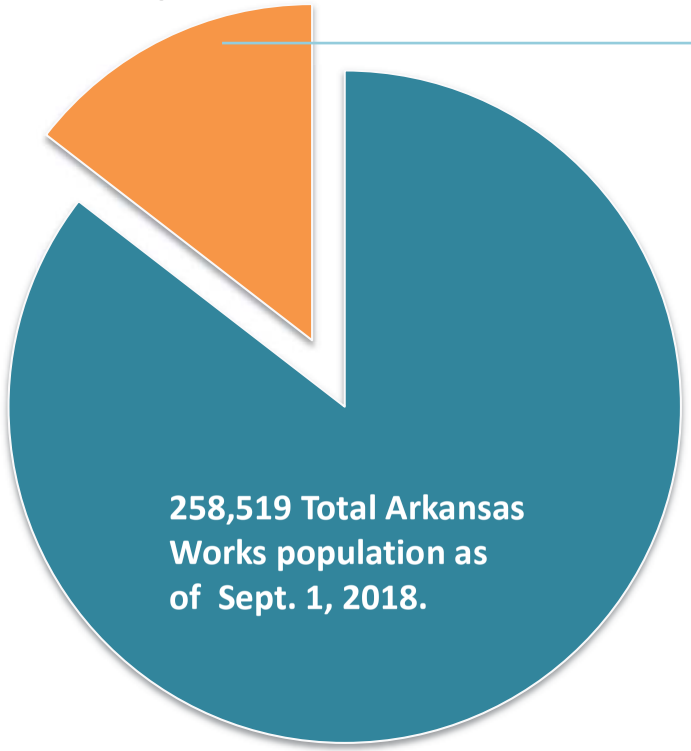
-- Health Education Class - Clients may count up to 20 hours each year from this activity.

Arkansas Works Program

September 2018 Report

As of August 10, DHS data showed just over 76,200 Arkansas Works enrollees were subject to the work requirement in September. Most are already meeting the requirement through work, school, or other life situations that made them exempt from reporting. Numbers below are a point-in-time snapshot of the requirement and some fluctuate daily.

76,222* Originally estimated to be subject to work requirement in September



Between Aug. 10 and Oct. 8, 2018, 2,956 fewer people became subject to the requirement due to case closures unrelated to compliance or a change in circumstances. That left 73,266 subject to the requirement in September.

1,532 Satisfied reporting requirement

2,263 Reported an exemption since Aug. 10, 2018

16,757 Did not satisfy reporting requirement

52,714 Meeting requirement due to work, training, or other activity. These enrollees were exempt from reporting their activities.

One month non-compliance	Two months non-compliance	Three months non-compliance (closed)
7,748**	4,841**	4,109

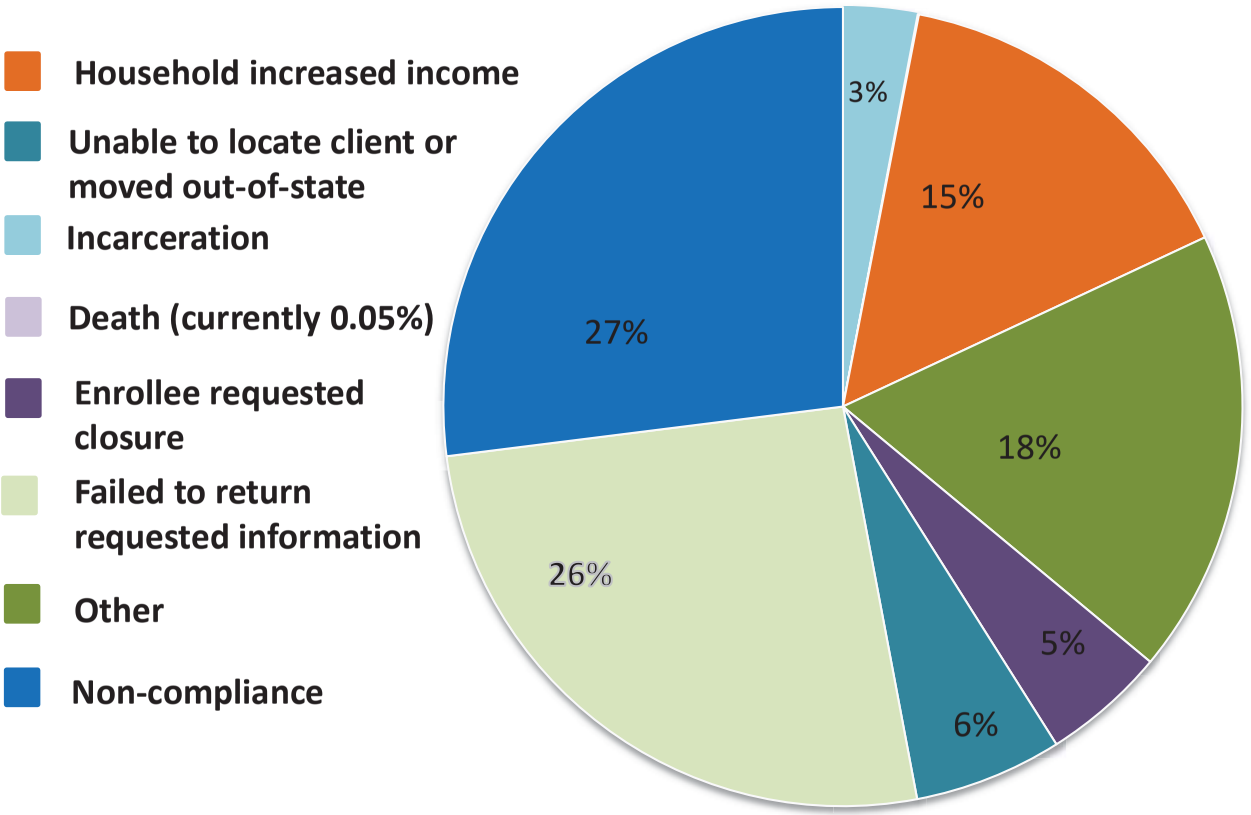
** due to closures unrelated to compliance & as of Oct. 8, 2018

*Enrollees ages 30-49 are being phased into the requirement from June through September 2018. Those 19-29 will roll in starting January 2019.

Arkansas Works Program

September 2018 Report

Every Medicaid program has what is known as “churn,” cases that close for various reasons. It is not uncommon for those individuals to take action and come back on a program after receiving a closure notice. The total number of Arkansas Works cases closed in September was 15,276. Of those, only 4,109 closed due to non-compliance with the work requirement. Below the closures are broken down by type.



Top four reasons people were exempt from reporting in September

Employed at least 80 hours a month	**25,368**
Already meeting SNAP requirement through work or exemption	**9,705**
Medically frail/disabled	**8,020**
At least one dependent child in the home	**7,432**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Arkansas Works Clients - Subject to the Work Requirement

Reporting Period	Exempt from Reporting	Reported at least 80 Hours	Failed to Report 80 Hours	Total
June 2018	17,906	445	7,464	25,815
July 2018	30,228	844	12,722	43,794
August 2018	42,437	1,218	16,357	60,012
September 2018	54,977	1,532	16,757	73,266

Arkansas Works Clients - Months of Non-Compliance

As of October 8, 2018

One Month Non-Compliance	Two Months Non-Compliance
7,748	4,841

Arkansas Works Clients - Exemption Reasons

Reporting Period	Employed >80 hours/month	Dependent Child in Home	Pregnant	Medically Frail	Currently Exempt in SNAP	Caring for Incapacitated Person	Short-Term Incapacitated
June 2018	8,375	2,731	15	2,208	3,480	128	164
July 2018	13,951	4,192	21	4,282	5,780	264	385
August 2018	19,391	5,717	40	6,273	7,776	534	776
September 2018	25,368	7,432	51	8,020	9,705	781	1,113

Reporting Period	Receives Unemployment Benefits	Education and Training	Alcohol or Drug Treatment	American Indian/Alaska Native*	Tea Cash Assistance	Total Exempt
June 2018	187	24	79	515	-	17,906
July 2018	310	56	155	832	-	30,228
August 2018	444	129	207	1,150	-	42,437
September 2018	556	242	230	1,479	-	54,977

If a client has more than one exemption, the client receives the longest exemption he or she meets.

**Clients who are American Indian / Alaska Native are subject to the work requirement. This population will be part of a future phase in.*

Arkansas Works Clients - Good Cause Requests Completed in September

Total Good Cause Requests Completed in September	Good Cause Requests Granted	Good Cause Requests Denied	Not a Good Cause Issue
246	140	32	74

Good Cause requests are reviewed on a case-by-case basis and are currently tracked separately until system updates can be completed. Clients who have another exemption reason are counted in this report where appropriate.

Clients Who Met Requirement - Types of Work Activities Reported

Clients can report more than one type of work activity

		Number of clients who reported the activity						
Reporting Period	**Clients Who Met Requirement**	**Work**	**Education and Training**	**Volunteer**	**Job Search**	**Job Search Training**	**Health Education Class**	**Currently Meeting SNAP Requirement**
June 2018	445	73	8	27	18	1	1	351
July 2018	844	145	20	63	40	4	0	639
August 2018	1,218	279	42	120	90	6	3	828
September 2018	1,532	372	42	152	93	5	5	1,025

September 2018 Reporting Period
Clients Who Met Requirement - Types of Work Activities Reported by Hours

Total Clients Who Met Requirement: 1,532

Clients can report more than one type of work activity.

Work Activity*	Clients Who Met Requirement by Hours Reported					# of Clients Reported	Total Hours Reported
	1-20 Hrs	21-40 Hrs	41-60 Hrs	61-80 Hrs	81+ Hrs		
Work	12	23	56	50	231	372	64,041
Education and Training	10	8	16	8	0	42	1,834
Volunteer	9	8	15	67	53	152	12,186
Job Search	18	35	22	3	15	93	4,497
Job Search Training	3	2	0	0	0	5	108
Health Education Class	3	2	0	0	0	5	90
Currently Meeting SNAP Requirement	--	--	--	--	--	1,025	N/A

While there is no limit to the number of hours a client can report, some work activity types limit the number of hours clients can receive credit for:

-- Job Search and Job Search Training - Clients may count up to 39 total hours from these activities combined each month.

-- Health Education Class - Clients may count up to 20 hours each year from this activity.

Clients Who Failed to Report 80 Hours - Types of Work Activities Reported

Clients can report more than one type of work activity

				Number of clients who reported the activity					
Reporting Period	**Clients Who Did Not Meet Requirement**	**Reported No Work Activities**	**Reported Work Activities**	**Work**	**Education and Training**	**Volunteer**	**Job Search**	**Job Search Training**	**Health Education Class**
June 2018	7,464	7,392	72	27	20	5	23	2	1
July 2018	12,722	12,587	135	49	20	12	73	1	1
August 2018	16,357	16,132	225	78	50	19	98	4	1
September 2018	16,757	16,535	222	69	54	23	97	5	1

September 2018 Reporting Period
Clients Who Failed to Report 80 Hours of Activities - Types of Work Activities Reported by Hours

Total clients who failed to report 80 hours:	16,757
Reported No Work Activities:	16,535
Reported Work Activities:	222

Clients can report more than one type of work activity

Work Activity*	Clients Who Did Not Meet Requirement by Hours Reported					# of Clients Reported	Total Hours Reported
	1-20 Hrs	21-40 Hrs	41-60 Hrs	61-80 Hrs	81+ Hrs		
Work	18	15	16	20	0	69	2,912
Education and Training	8	37	7	2	0	54	1,786
Volunteer	11	6	3	3	0	23	862
Job Search	25	18	15	8	31	97	7,572
Job Search Training	1	4	0	0	0	5	167
Health Education Class	1	0	0	0	0	1	5

While there is no limit to the number of hours a client can report, some work activity types limit the number of hours clients can receive credit for:

-- Job Search and Job Search Training - Clients may count up to 39 total hours from these activities combined each month.

-- Health Education Class - Clients may count up to 20 hours each year from this activity.

CLASP
Policy solutions that work for low-income people

Fact Sheet

Updated December 2017 | Jessica Gehr and Suzanne Wikle

The Evidence Builds:

Access to Medicaid Helps People Work

Untreated illness can make it hard to work. Health insurance is a key work support and tool that provides working-age adults with access to care that helps them get and keep a job. Reports from Ohio[1] and Michigan[2] provide compelling new information about the ability of Medicaid expansion enrollees to seek and maintain employment. These reports add to the growing body of research confirming the benefits of Medicaid expansion.[3]

Under the Affordable Care Act (ACA), states are incentivized to expand Medicaid to provide affordable health insurance to people with incomes below 138 percent of poverty ($16,400 for a single person). A geographically diverse mix of 32 red and blue states[4] took advantage of the ACA's provision to expand Medicaid. As a result, millions of low-income adults in those states now have access to affordable care, resulting in better health, greater financial, physical, and mental stability, and fewer deaths.

Most Adult Medicaid Enrollees are Working

Nationwide, the majority of non-disabled working-age adults who are insured through Medicaid are working or living in a family with a worker. In fact, 60 percent of adult recipients are employed and 79 percent live with someone who is working. Furthermore, among Medicaid recipients who are employed, more than half (51 percent) work full-time for the entire year.[5] However, their positions often offer low wages and/or are in small businesses that do not provide health benefits. Only 12 percent of workers earning the lowest wages had employer-provided health insurance in 2016.[6] Medicaid expansion enrollees typically hold physically demanding jobs[7] clustered in employment settings such as restaurants, construction sites, retail stores, and gas stations.[8]

Without the support of Medicaid, health concerns would threaten employment stability.

Key findings from Ohio and Michigan confirm that providing access to affordable health care helps people maintain employment. **More than half of Ohio Medicaid expansion enrollees report that their health coverage has made it easier to continue working.[9] In Michigan, 69 percent of enrollees said that Medicaid helped them do their job better.[10]** Without the support of Medicaid, health concerns would threaten employment stability.

Medicaid Expansion Reduces Barriers to Employment

Disability and illness are among the main reasons why working-age adults may not be employed. An analysis by the Kaiser Family Foundation found that 36 percent of adults enrolled in Medicaid cited illness or

disability as the primary reason for not working.[11] Similarly, a July 2016 report from the American Enterprise Institute found that for working-age adults without children, illness and disability were the primary barriers to employment.[12] The Ohio report confirms that access to Medicaid reduces these barriers to employment. **The majority of unemployed Medicaid enrollees in Ohio (74.8 percent)[13] and Michigan (55 percent)[14] reported that having Medicaid made it easier to look for employment.**

Ohio study participants noted that Medicaid allowed them to get treated for chronic conditions that previously had prohibited them from working. Additionally, about one-third of enrollees screened positive for depression or anxiety disorders, which can limit employment and other routine activities. Enrollees with depression and anxiety reported greater improvement in access to care and prescriptions—key resources needed to stay in the workforce.

Another way Medicaid expansion supports employment is by eliminating the so-called "cliff effect"—the sudden loss of health insurance if earnings exceed Medicaid eligibility limits. For example, prior to Medicaid expansion, a parent with one child who worked 30 hours per week at the minimum wage with annual earnings of $12,000 was eligible for Medicaid in Ohio. But if that parent worked 35 hours per week and earned $14,000, he or she was not eligible.[15] With Medicaid expansion, parents are now incentivized to continue increasing their earnings, because they no longer risk losing their health care due to additional income. Should their income rise above the Medicaid limit, they become eligible for subsidized private health insurance through the ACA's exchange. By contrast, in non-expansion states, parents can still fall into a coverage gap, where they earn too much to qualify for Medicaid but too little for exchange subsidies. Eliminating the cliff effect by expanding Medicaid allows parents to best provide for their families by continuing to improve their employment prospects.

Supporting Work Leads to Better Financial Stability

Prior studies have shown that financial stress is reduced under Medicaid expansion because it provides clear physical and mental health benefits. The Ohio report found that enrollees were more than twice as likely to note improvements in their financial situation. Medicaid enrollment allowed participants to meet other basic needs. More than half of enrollees reported that health coverage made it easier to buy food; about half stated that it was easier to pay their rent or mortgage, and 44 percent said it was easier to pay off other debts.[16] When families are able to meet their basic needs, they can turn their energy to engaging in the workplace.

When families are able to meet their basic needs, they can turn their energy to engaging in the workplace.

Conclusion

The reports from Ohio and Michigan add to the growing body of research showing that Medicaid expansion improves lives by increasing access to health care, reducing financial burden on low-income families, and supporting employment. A recent survey found that 84 percent of Americans support continuing the funding for Medicaid expansion.[17] Congress should avoid any changes that would roll back these gains or undermine the fundamental structure of Medicaid.

Endnotes

[1] The Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," January 2017, **http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.**
[2] Renuka Tipirneni, Jeffrey Kullgren, John Ayanian, Edith Kieffer, Ann-Marie Rosland, Tammy Chang, Adrianne Haggins, Sarah Clark, Sunghee Lee, and Susan Goold, "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches," University of Michigan, June 2017, **http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches.**
[3] Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga, " The Effects of Medicaid Expansion under the ACA: Findings from a Literature Review," Kaiser Family Foundation, June 20, 2016, **http://kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review/.**
[4] Maine adopted the Medicaid expansion through a ballot initiative in November 2017; the ballot measure requires a state plan amendment to be submitted within 90 days and implementation of expansion within 180 days of the effective date. Maine is not included in this count. Maine's Governor has announced his intent to block implementation of expansion.
[5] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, December 2017, **http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/?utm_campaign=KFF-2017-Medicaid&utm_content=46331383&utm_medium=social&utm_source=twitter.**
6 United States Department of Labor,"Table 9.Healthcare Benefits: Access Participation and Take-Up Rates, Civilian Workers," Bureau of Labor Statistics, March 2016, **https://www.bls.gov/ncs/ebs/benefits/2016/ebbl0059.pdf.** Lowest wages is defined as average wage falling in the bottom 10 percent.
[7] Leighton Ku and Erin Brantley, "Myths About The Medicaid Expansion And The 'Able-Bodied'," Health Affairs Blog, March 6, 2017, **http://healthaffairs.org/blog/2017/03/06/myths-about-the-medicaid-expansion-and-the-able-bodied/.**
[8] Dustin Pugel, "Many Kentucky Workers Have Gained Insurance through the Medicaid Expansion and Are Now at Risk," Kentucky Center for Economic Policy, December 8, 2016, **http://kypolicy.org/many-kentucky-workers-gained-insurance-medicaid-expansion-now-risk/.**
[9] The Ohio Department of Medicaid et al.
[10] Tipirneni et al.
[11] Understanding the Intersection of Medicaid and Work.
[12] Angela Rachidi, "America's Work Problem: How Addressing the Reasons People Don't Work Can Reduce Poverty, " American Enterprise Institute, July 2016, **https://www.aei.org/wp-content/uploads/2016/07/Americas-Work-Problem.pdf.**
[13] The Ohio Department of Medicaid et al.
[14] Tipirneni et al.
[15] Policy Matters Ohio, "Ohio Should Say Yes to Medicaid Expansion," September 13, 2012, **http://www.policymattersohio.org/medicaid-sept2012.**
[16]The Ohio Department of Medicaid et al.
[17] Ashley Kirzinger, Elise Sugarman, and Mollyann Brodie, " Kaiser Health Tracking Poll: Future Directions for the ACA and Medicaid," February 24, 2017, Kaiser Family Foundation, **http://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-future-directions-for-the-aca-and-medicaid/.**

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Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement

Jessica Greene

SEPTEMBER 5, 2018 **DOI:** 10.1377/hblog20180904.979085

In June, Arkansas became the first state to implement a work requirement in its Medicaid program. The initial group subject to the policy were Medicaid expansion recipients aged 30-49 who had no children under 18 in the home, did not have a disability, and who did not meet other exemption criteria, including fulfilling the SNAP work requirement. On a monthly basis, recipients must work, volunteer, go to school, search for work, or attend health education classes for a combined total of 80 hours, and report the hours to the Arkansas Department of Human Services (DHS) through an online portal. Recipients who do not report hours any three months out of the year lose Medicaid health coverage until the following calendar year.

September 5 is the reporting deadline for the third month of the policy, making today the first time that recipients can lose Medicaid coverage as a result of the work requirement. There are 5,426 people who missed the first two reporting deadlines, which is over half of the group of 30-49 year olds subject to the policy beginning in June who had not been identified by the state as being exempt (Note 1). If these enrollees do not log August hours or an exemption into the portal by

September 5, they will lose Medicaid coverage until January 2019 (Note 2).

Making Medicaid health coverage contingent on completing work-related activities is highly contentious. The Obama Administration rejected states' requests for Medicaid work requirements because, they argued, policies that can undermine access "do not support the objectives of the Medicaid program." In March 2017, the Trump administration sent a letter to state governors asserting its support for policies that use Medicaid "to increase employment and community engagement," and in early 2018 the administration approved four states' Medicaid work requirement proposals in 1115 waiver requests (Arkansas, Indiana, Kentucky, and New Hampshire).

In late June, two days before Kentucky's work requirement was to go into effect, U.S. District Judge James Boasberg halted its implementation writing, "… the Secretary never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid." A similar lawsuit challenging the legality of Arkansas' policy, described by Governor Asa Hutchison

as designed to help Medicaid recipients “move out of poverty and up the economic ladder,” has recently been filed.

Interviews With Medicaid Recipients

Little is known to date about how those impacted by the new Medicaid work requirement feel about the policy. To explore Medicaid recipients’ attitudes about Arkansas’ work requirement and their early experiences with the policy, in mid-August I conducted in-depth interviews with 18 adult Medicaid recipients in northeast Arkansas. The interviews were conducted in three counties, one of which is urban (Craighead County) and the other two of which (Greene and Randolph Counties) are rural. All three have higher percentages of white, non-Hispanic individuals than the state as a whole, and all three supported President Trump in the 2016 election at higher rates than the state overall. Half of those interviewed met the age criteria to be subject to the work requirement.

While this group is far too small to provide generalizable results, the interviews do illustrate how the state's policy is interacting with the day-to-day lives of Medicaid

recipients to produce serious potential consequences that have little to do with policy's stated objectives. What I found was a profound lack of awareness about the policy. A number of people were at risk for losing their Medicaid health coverage because of complex life circumstances, not because of a conscious decision related to the work requirement.

Respondents expressed mixed feelings about the idea of a Medicaid work requirement, generally believing that able-bodied people should be working, but wondering how the policy could accommodate those with serious health issues or without transportation. There was substantial concern about having an online portal as the mechanism for submitting monthly work hours.

Lack Of Awareness

Two thirds of the Medicaid recipients (12/18) I interviewed had not heard anything about the new work requirement. “First time I’ve ever heard anything [about it],” a 31-year old man, who had started a vocational training program the day we spoke, said. “You’d think it’d be on the news or something. I ain’t seen it on the news, and I watch Channel 8 news every night.” Others echoed

his surprise: “I’ve never even heard of it” and “I can’t believe I ain’t heard something about it on the news.”

Of the six people who had heard about it, one was very knowledgeable, in fact familiar with the statistics on how many had missed the initial two reporting deadlines. Two others had heard only a little about it from family or friends (“I’ve heard a little bit about it, not a lot”), and three had learned of the policy from their letter from DHS.

At Risk Of Losing Coverage

Of the nine people who, based on their age, should have received a DHS letter letting them know they were subject to the work requirement, four said they had received a letter. Two said the letters indicated they were exempt because they already met the SNAP work requirement.

The other two were at risk for losing Medicaid coverage. One, a 47-year old woman, said she had received her letter about three months earlier; she believed, incorrectly, that she had three months to report her hours. When I asked her if reporting her hours was an obstacle, she said she was struggling with very stressful

life issues, including a mentally ill sister, and as a result the work requirement had not received much of her attention. The other person, a 40-year-old woman, described being overwhelmed by receiving the letter: “Basically… I’m like, okay, I’ve got this letter. I file it and I don’t know what to do with it...”

The other five who should have received a work requirement letter were either not sure if the letter arrived or thought it had not. When asked about receiving a DHS letter, a 42-year-old woman said, “I don’t know, I’m going to have to check and make sure [I didn’t receive the letter], because I need my Medicaid card for my sugar pill and my blood pressure pills.” A 46-year-old man, who had recently completed an inpatient drug treatment program, kicking a multi-decade drug addiction, wasn’t sure either. “I may have [received the letter]…I’m horrible about opening mail….I probably throw’d it away.” While the three others did not believe they received the letter, they were all exempt by either working and/or having children in the home, but likely needed to report their hours and exemptions in the portal to maintain Medicaid coverage.

Policy Not Sparking Work-Related Changes

Of the nine participants who were likely subject to the policy, only two were not meeting the 80 hour work-related activity requirement and did not seem to qualify for an exemption. Both told me that were actively seeking work, and that the work requirement had not at all impacted their job seeking. In addition, those I interviewed between the ages of 19-29, who will be subject to the policy in 2019, either worked, went to school, and/or had children under 18 years old in the home. No one I spoke with reported that the policy had or would spark them to change their work-related activities.

Online Portal Challenging For Many

Participants described a very wide range of computer and online skills and access. Approximately a third said that reporting hours on the online portal would not be possible for them: “I can’t do that. I don’t have a phone. I don’t have a computer.” Another third thought they could figure it out: “It wouldn’t be an issue, but it has been a while since I used one [a computer].” And a third had access and were highly confident of their skills: “I’m very, very computer literate.”

Regardless of their skills, everyone thought that requiring hours to be reported online was an unnecessary obstacle that made the work requirement very difficult for many recipients. Several, who were confident of their own skills, mentioned family members who would struggle. “Half my family probably doesn’t have a smart phone….A lot of people here don’t have internet still,” a 19-year old woman explained. Her 47-year-old mother-in-law had struggled using the portal: “She had to do it online or something, and she didn’t like it at all.”

Mixed Attitudes About Linking Medicaid And Work-Related Activities

Almost all the participants believed that people who could work should be working. “I believe if you are able to work and you want the extra help that Medicaid gives, then you should work,” said a 28-year old woman who was currently working and has young children. But several expressed concern about those who had mental or physical conditions that would prevent them from meeting the requirement. One man raised questions about people who were “borderline” who were not officially considered disabled but still had serious health

conditions. A 42-year-old woman, who works with people with disabilities said, “I think it’ll do more harm than good…. What they supposed to do, just get cut off Medicaid because they can’t meet those requirements?”

Others raised concerns about transportation needed to get to work and volunteering. “Some people don’t have vehicles, and sometimes it’s not necessarily their fault. Sometimes something happens and they lose their money... It’s not fair,” said a 21-year old recipient who is a college student. When I asked a woman who was looking for work whether she had tried to get help from the Department of Workforce Services, she said that she couldn’t get there because it was 30 miles away and there is no public transportation.

Not Going To Lift People Out Of Poverty

Participants were very skeptical about the Governor’s claim that the work requirement policy would help them out of poverty, as many were already working and still struggling financially. Several raised the issue of the low minimum wage in Arkansas ($8.50 per hour) and suggested that raising the minimum wage would be a more effective way to help low-income workers. Others suggested that what was needed to help people move

up the economic ladder was training: “If you got training that helped you get better pay. I think that would help.” One participant argued that the policy was not about getting people to work at all, but about reducing the number of Medicaid recipients: “It seems like a ploy for the state to save money. That’s all it is. It’s nothing about trying to get people back to work…”

Summing Up

The low level of awareness of the Arkansas Medicaid work requirement among the Medicaid recipients I interviewed helps to explain why fewer than half of the first group required to report hours or an exemption on the online portal have done so in the first two months of the policy. Clearly, there has not been adequate communication about the policy to those who are being impacted by it. The state is relying principally on the letter they send to recipients to spark change in recipients’ work-related activities and to report hours or exemptions using an online portal (Note 3). Given that the state is aware that many recipients do not open their mail (the program flyer says in bold text, “Be sure to read mail from DHS as soon as you get it.”), a much broader

educational effort is needed to inform recipients about the policy.

The process for reporting hours and exemptions using an online portal poses a substantial barrier to the more vulnerable Medicaid recipients who have neither technology like phones, computers, and email accounts, nor experience using the technology. DHS Director Cindy Gillespie has argued the online portal will help prepare people for the work world: “We need to help them get an email (address) and learn how to deal in that world, or they will never be successful.” Yet, no training is provided and no one I spoke with was aware of the registered reporter option, where recipients can designate someone to report their hours.

Of the people I interviewed who were at risk of losing Medicaid coverage as a result of the work requirement, most were at risk because they lacked awareness of the policy or were overwhelmed by it, rather than because they were not meeting the 80 hours a month of work-related activities or the terms of an exemption. If this is true more broadly, the state will be ending people’s health coverage for the wrong reasons, adding credence

to those who argue this policy is about reducing the rolls, rather than supporting people to get employment.

A 38-year-old woman who recently had to quit her job to get her niece, who she mothers, a birth certificate and other paperwork to start school argued that the policy does not take into account the complex lives of low-income people. “You are saying this should be possible, but you don’t know my circumstances. You haven’t been here,” she explained.

Author's Note

I would like to thank the people who I interviewed for their openness in sharing their thoughts and experiences with me. I would also like to thank 1st Choice Healthcare, Helping Neighbors Food Pantry, and Mission Outreach of NEA for welcoming me into their organizations to conduct the interviews.

Note 1

The policy was rolled out to one quarter of recipients aged 30-49 each month from June through September. The program will begin for those aged 19-29 in January,

and those 50 years old and older are not subject to the work requirement.

Note 2

If the recipients did not report hours or an exemption by the last day in August they lost coverage on the 1st of September, but it will be reinstated if they report by September 5.

Note 3

DHS has developed a website with videos, flyers, and other information about the policy. There is, however, no link to the website from the main Medicaid beneficiary website, and no one I interviewed said they had used it.

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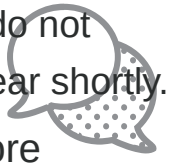

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Jonathan Reeve

From: Renato Rocha <rrocha@clasp.org>
Sent: Friday, October 26, 2018 11:10 AM
To: Public Notice. Tenncare
Cc: Renato Rocha
Subject: Tennessee's Amendment 38 to the TennCare II Demonstration
Attachments: CLASP TN Waiver Comments to State Final.pdf; CLASP TN Citations to State.pdf

Dear Dr. Wendy Long, Director,

On behalf of the Center for Law and Social Policy (CLASP), I submit the attached comments on Tennessee's Amendment 38 to the TennCare II Demonstration. In addition, please find attached supplemental material entitled "CLASP TN Citations to State."

Best regards,
Renato

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CLASP

Policy solutions that work for low-income people

October 26, 2018

Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Re: Amentment 38 to the TennCare II Demonstration

Dear Dr. Wendy Long, Director,

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, anti-poverty nonprofit advancing policy solutions for low-income people. We work at both the federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. CLASP submits the following comments in response to Tennessee's Amendment 38 to the TennCare II Demonstration and raises serious concerns about the effects of the amendment, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Tennessee.

These comments draw on CLASP's deep experience with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where many of the policies proposed in this proposal have already been implemented – and been shown to be significant barriers to low-income people getting and retaining benefits. These comments also draw on CLASP's experience in working with six states under the Work Support Strategies (WSS) project, where these states sought to dramatically improve the delivery of key work support benefits to low-income families, including health coverage, nutrition benefits, and child care subsidies through more effective, streamlined, and integrated approaches. From this work, we learned that reducing unnecessary steps in the application and renewal process both reduced burden on caseworkers and made it easier for families to access and retain the full package of supports that they need to thrive in work and school.

The proposal would have a dramatic and negative impact on access to care for deeply poor parents (leading to negative effects for their children as well). There is no reason to believe that people who lose health coverage for not working a set number of hours per month will be transitioning to employer-sponsored insurance or earning enough to qualify for subsidies under the Affordable Care Act. This waiver thus takes a big step backwards in coverage. We therefore believe that it is inconsistent with the goals of the Medicaid program, notwithstanding the January 11, 2018 guidance from the Centers for Medicare and Medicaid Services (CMS).

Medicaid plays a critical role in supporting the health and well-being of low-income adults and children. In fact, many Medicaid enrollees work in low-wage jobs where employer-sponsored health care is not offered or is prohibitively expensive. Others may have health concerns that threaten employment stability, and without Medicaid, would be denied access to the medical supports they need to hold a job, such as access to critical medications.

The Medicaid statute is clear that the purpose of the program is to furnish medical assistance to individuals whose incomes are not enough to meet the costs of necessary medical care and furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care. States are allowed in limited circumstances to request to "waive" provisions of the rule but the Secretary of Health and Human Services (HHS) may only approve a project which is "likely to assist in promoting the objectives" of the Medicaid Act.[1] A waiver that does not promote the provision of affordable health care would not be permissible.

This waiver proposal's attempt to transform Medicaid and reverse its core function will result in parents losing needed coverage, poor health outcomes, and higher administrative costs. There is extensive and strong literature that shows, as a recent New England Journal of Medicine review concludes, "Insurance coverage increases access to care and improves a wide range of health outcomes."[2] Moreover, losing health coverage will also make achieving work and education goals significantly more difficult for beneficiaries. This amendment is therefore inconsistent with the Medicaid purpose of providing medical assistance and should be rejected. It is also inconsistent with improving health and increasing employment.

It is also important to recognize that limiting parents' access to health care will have significant negative effects on their children as well. Children do better when their parents and other caregivers are healthy, both emotionally and physically.[3] Adults' access to health care supports effective parenting, while untreated physical and mental health needs can get in the way. For example, a mother's untreated depression can place at risk her child's safety, development, and learning.[4] Untreated chronic illnesses or pain can contribute to high levels of parental stress that are particularly harmful to children during their earliest years.[5] Additionally, health insurance coverage is key to the entire family's financial stability, particularly because coverage lifts the burdens of unexpected health problems and related costs. These findings were reinforced in a new study, which found that when parents were enrolled in Medicaid their children were more likely to have annual well-child visits.[6]

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements

CLASP does not support Tennessee's proposal to take away health coverage from parents who do not meet new work requirements. Our comments focus on the harmful impact the proposed work requirements will have on Tennesseans and the state. Tennessee is proposing to implement a work requirement for beneficiaries who are between the ages of 19-64, unless they qualify for an exemption.

Those who are subject to the work requirement will have to work or participate in other qualifying activities for 20 hours per week to stay enrolled in Medicaid. The penalty for not complying with the work requirement four out of every six months is disenrollment from Medicaid for at least one month or until the requirements are met.

CLASP strongly opposes work requirements for Medicaid beneficiaries and urges Tennessee to reconsider their approach to workforce development. Work requirements—and disenrollment for failure to comply—are inconsistent with the goals of Medicaid because they would act as a barrier to access to health insurance, particularly for those with chronic conditions and disabilities, but also for those in areas of high unemployment or who work the variable and unpredictable hours characteristic of many low-wage jobs. The reality is that denying access to health care makes it less likely that people will be healthy enough to work. This provision would also increase administrative costs of the Medicaid program and reduce the use of preventive and early treatment services, ultimately driving up the costs of care while

also leading to worse health outcomes.

In addition, section 1931 of the Social Security Act ensures Medicaid eligibility for adults with children who would have been eligible for the Aid to Families with Dependent Children (AFDC) program according to 1996 income guidelines, regardless of whether they currently receive cash assistance. Tennessee's request to implement a work requirement for this population (if they don't qualify for an exemption) would effectively eliminate this guarantee of coverage. This request by Tennessee appears to be in direct conflict with the law.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Do Not Promote Employment

Lessons learned from TANF, SNAP, and other programs demonstrate that work requirement policies are not effective in connecting people to living-wage jobs that provide affordable health insurance and other work support benefits, such as paid leave.[7] A much better focus for public policy is to develop skills training for jobs that are in high demand and pay living wages, help people get the education they need to climb their career ladder, and foster an economy that creates more jobs.

Another consequence of a work requirement could be, ironically, making it harder for people to work. When additional red tape and bureaucracy force people to lose Medicaid, they are less likely to be able to work. People must be healthy in order to work, and consistent access to health insurance is vital to being healthy enough to work.[8] Medicaid expansion enrollees from Ohio[9] and Michigan[10] reported that having Medicaid made it easier to look for employment and stay employed. Making Medicaid more difficult to access could have the exact opposite effect on employment that supporters of work requirements claim to be pursuing.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Grow Government Bureaucracy and Increase Red Tape

Taking away health coverage from Medicaid enrollees who do not meet new work requirements would add new red tape and bureaucracy to the program and only serve as a barrier to health care for enrollees. Tracking work hours, reviewing proof of work, and keeping track of who is and is not subject to the work requirement is a considerable undertaking that will be costly and possibly require new technology expenses to update IT systems.

One of the key lessons of the Work Support Strategies initiative is that every time that a client needs to bring in a verification or report a change adds to the administrative burden on caseworkers and increases the likelihood that clients will lose benefits due to failure to meet one of the requirements. In many cases, clients remain eligible and will reapply, which is costly to families who lose benefits as well as to the agencies that must process additional applications. The WSS states found that reducing administrative redundancies and barriers used workers' time more efficiently and helped with federal timeliness requirements.

Lessons from the WSS initiative is that the result of Tennessee's new administrative complexity and red tape is that ***eligible*** people will lose their health insurance because the application, enrollment, and monthly processes to maintain coverage are too cumbersome. Recent evidence from Arkansas' first four months of implementing work requirements also suggests that bureaucratic barriers for individuals who already work or qualify for an exemption will lead to disenrollment. More than 4,100 beneficiaries lost coverage on October 1st, likely becoming uninsured because they didn't report their work or work-related

activities.[11] In September, over 4,300 beneficiaries lost coverage. These individuals represent about 17 percent of the state's first cohort of Medicaid beneficiaries subject to the work requirement.[12] In total, more than 8,400 Arkansas Medicaid beneficiaires have lost coverage since the state implemented its work requirements. As reported by the Center on Budget and Policy Priorities, many of those who failed to report likely didn't understand the reporting requirements, lacked internet access or couldn't access the reporting portal through their mobile device, couldn't establish an account and login, or struggled to use the portal due to disability.[13]

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Do Not Reflect the Realities of Our Economy

Proposals to take away health coverage from Medicaid enrollees who do not work a set number of hours per month do not reflect the realities of today's low-wage jobs. For example, seasonal workers may have a period of time each year when they are not working enough hours to meet a work requirement and as a result will churn on and off the program during that time of year. Or, some may have a reduction in their work hours at the last minute and therefore not meet the minimum numbers of hours needed to retain Medicaid. Many low-wage jobs are subject to last-minute scheduling, meaning that workers do not have advance notice of how many hours they will be able to work.[14] This not only jeopardizes their health coverage if Medicaid has a work requirement but also makes it challenging to hold a second job. If you are constantly at the whim of random scheduling at your primary job, you will never know when you will be available to work at a second job.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements are Likely to Increase Churn

Tennessee's proposal to take away health coverage from Medicaid enrollees who do not meet new work requirements is likely to increase churn. As people are disenrolled from Medicaid for not meeting work requirements, possibly because their hours get cut one week or they have primarily seasonal employment (like construction work), they will cycle back on Medicaid as their hours increase or the seasons change. People may be most likely to seek to re-enroll once they need healthcare and be less likely to receive preventive care if they are not continuously enrolled in Medicaid.

Disenrollment and lock out would lead to worse health outcomes, higher costs

Medicaid enrollees must meet the work requirement for four months out of every six-month period in order to maintain coverage. Enrollees who lose exempt or employment status and are no longer complaint with the requirement at least four months of the six-month period will have their benefits suspended. These benefits will remain suspended untul the Medicaid enrollee demonstrates compliance with the requirement for one month.

Once suspended from Medicaid coverage, beneficiaries will likely become uninsured. Needed medical services and prescription drugs, including those needed to maintain positive health outcomes, may be deferred or skipped. Because people without health coverage are less likely to have regular care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health.[15] Further, during the one-month lock-out period, these now-uninsured patients present as uncompensated care to emergency departments, with high levels of need and cost—stretching already overburdened hospitals and clinics. This will only lead to poorer health outcomes and higher uncompensated costs for providers.

The impact of even short-term gaps in health insurance coverage has been well documented. In a 2003 analysis, researchers from the Urban Institute found that people who are uninsured for less than 6 months are less likely to have a usual source of care that is not an emergency room, more likely to lack confidence in their ability to get care and more likely to have unmet medical or prescription drug needs.[16] A 2006 analysis of Medicaid enrollees in Oregon found that those who lost Medicaid coverage but experienced a coverage gap of fewer than 10 months were less likely to have a primary care visit and more likely to report unmet health care needs and medical debt when compared with those continuously insured.[17]

The consequences of disruptions in coverage are even more concerning for consumers with high health needs. A 2008 analysis of Medicaid enrollees in California found that interruptions in Medicaid coverage were associated with a higher risk of hospitalization for conditions such as heart failure, diabetes, and chronic obstructive disorders. In addition to the poorer health outcomes for patients, these avoidable hospitalizations are also costly for the state.[18] Similarly, a separate 2008 study of Medicaid enrollees with diabetes who experienced disruptions in coverage found that the per member per month cost following reenrollment after a coverage gap rose by an average of $239, and enrollees were more likely to incur inpatient and emergency room expenses following reenrollment compared to the period of time before the enrollee lost coverage.[19]

When the beneficiary re-enrolls in Medicaid after their benefits are suspended, they will be sicker and have higher health care needs. Studies repeatedly show that the uninsured are less likely than the insured to get preventive care and services for major chronic conditions.[20] Public programs will end up spending more to bring these beneficiaries back to health.

Support services will be inadequate

Child care is a significant barrier to employment for low-income parents. Many low-income jobs have variable hours from week to week and evening and weekend hours, creating additional challenges to finding affordable and safe child care. Under Tennessee's proposal, parents whose children are older than 5 years are subject to the work requirements. Finding affordable and safe child care for children is difficult and a barrier to employment. Requiring employment in order to maintain health care, but not providing adequate support services such as child care, sets a family up for a no-win situation. Even with the recent increase in federal child care funding, Tennessee does not have enough funding to ensure all eligible families can access child care assistance.[21]

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Will Harm Persons with Illness and Disabilities

Many people who are unable to work due to disability or illness are likely to lose coverage because of the work requirement. Although Tennessee proposes to exempt individuals who are disabled or designated as physically or mentally unfit to work, in reality many people who are not able to work due to disability or unfitness are likely to not receive an exemption due to the complexity of paperwork. A Kaiser Family Foundation study found that 36 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI—reported illness or disability as their primary reason for not working. In Tennessee, this rate increases to 41 percent.[22]

New research shows a correlation between Medicaid expansion and an increased employment rate for persons with disabilities.[23] In states that have expanded Medicaid, persons with disabilities no longer have to qualify for SSI in order to be eligible for Medicaid. This change in policy allows persons with

disabilities to access health care without having to meet the criteria for SSI eligibility, including an asset test. Other research that shows a drop in SSI applications in states that have expanded Medicaid supports the theory that access to Medicaid is an incentive for employment.[24] Jeopardizing access to Medicaid for persons with disabilities by the policies proposed in Tennessee's proposal will ultimately create a disincentive for employment among persons with disabilities. Tennessee will best serve persons with disabilities by not imposing a work requirement in their existing Medicaid program and by expanding Medicaid as intended by the Affordable Care Act (ACA).

Further, an Ohio study found that one-third of the people referred to a SNAP employment program that would allow them to keep their benefits reported a physical or mental limitation. Of those, 25 percent indicated that the condition limited their daily activities,[25] and nearly 20 percent had filed for Disability/SSI within the previous 2 years. Additionally, those with disabilities may have a difficult time navigating the increased red tape and bureaucracy put in place to administer a work requirement, including proving they are exempt. The end result is that many people with disabilities will in fact be subject to the work requirement and be at risk of losing health coverage.

Budget neutrality information is insufficient

The state's proposal does not include budget neutrality information that is necessary to evaluate the anticipated impact of the proposal. The proposal does not provide any estimate of the number of people who are expected to become disenrolled from Medicaid. In particular, the proposal states, "Of the members who will be impacted by the community engagement requirement, it is estimated that a significant number are already working, or will be deemed to be in compliance with the requirement by virtue of their participation in the SNAP or TANF work program, or will qualify for an exemption to the requirement." For all other individuals, Tennessee simply proposes to "provide linkages to resources." As described above, we know from Arkansas' work requirement demonstration that even people who are exempt lose coverage. This lack of information is unacceptable and Tennessee should provide details about the anticipated change in enrollment in the state. Without this detail, it is impossible to fully understand the impact of the proposal.

Conclusion

For all the reasons laid out above, the state should reconsider their approach to encouraging work. If Tennessee is serious about encouraging work, helping people move into jobs that allow for self-sufficiency, and improving its state's health ranking the state would be committed to ensuring that all adults have access to health insurance in order to ensure they are healthy enough to work. Tennessee could opt to expand Medicaid as intended by the ACA, which will ensure that people have consistent access to Medicaid and close the coverage gap. Instead, the state is asking to place additional barriers between the state's most vulnerable families and their health care.

Thank you for considering CLASP's comments. Contact Suzanne Wikle (**swikle@clasp.org**) or Renato Rocha (**rrocha@clasp.org**) with any questions.

All sources accessed October 2018.

[1] Jane Perkins, "Section 1115 Demonstration Authority: Medicaid Act Provisions That Prohibit a Waiver," National Health Law Program, 2017, **http://www.healthlaw.org/issues/medicaid/waivers/sec-1115-demonstration-authority-medicaid-provisions-that-prohibit-waiver#.WhRlBFWnHIU**.
[2] Benjamin D. Sommers, M.D., Ph.D., Atul A. Gawande, M.D., M.P.H., and Katherine Baicker, Ph.D., Health Insurance Coverage and Health — What the Recent Evidence Tells Us, New England Journal of Medicine, July 21, 2017. http://www.nejm.org/doi/full/10.1056/NEJMsb1706645.
[3] Jack Shonkoff, Andrew Garner, "The Lifelong Effects of Early Childhood Adversity and Toxic Stress," Pediatrics, December 2011, http://pediatrics.aappublications.org/content/early/2011/12/21/peds.2011-2663.
[4] Stephanie Schmit and Christina Walker, "Seizing New Policy Opportunities to Help Low-Income Mothers with Depression," CLASP, 2016, http://www.clasp.org/resources-and-publications/publication-1/Opportunities-to-Help-Low-Income-Mothers-with-Depression-2.pdf.
[5] National Scientific Council on the Developing Child and National Forum on Early Childhood Program Evaluation, "Maternal Depression Can Undermine the Development of Young Children," Center on the Developing Child, Harvard University, Working Paper 8, 2009, http://developingchild.harvard.edu/resources/maternal-depression-can-undermine-the-development-of-young-children.
[6] Maya Venkataramani, Craig Evan Pollack, Eric T. Roberts, "Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services," Pediatrics. 2017;140(6):e20170953, http://pediatrics.aappublications.org/content/pediatrics/early/2017/11/09/peds.2017-0953.full.pdf.
[7] LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows," Center on Budget and Policy Priorities, June 2016, http://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows.
[8] Jessica Gehr and Suzanne Wikle, "The Evidence Builds: Access to Medicaid Helps People Work," February 2017, CLASP, https://www.clasp.org/publications/fact-sheet/evidence-builds-access-medicaid-helps-people-work.
[9] The Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," January 2017, http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.
[10] Renuka Tipirneni, Jeffrey Kullgren, John Ayanian, Edith Kieffer, Ann-Marie Rosland, Tammy Chang, Adrianne Haggins, Sarah Clark, Sunghee Lee, and Susan Goold, "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches," University of Michigan, June 2017, http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches.
[11] Jennifer Wagner "4,109 More Arkansans Lost Medicaid in Octover for Not Meeting Rigid Work Requirements," Center on Budget and Policy Priorities, October 2018, https://www.cbpp.org/blog/4109-more-arkansans-lost-medicaid-in-october-for-not-meeting-rigid-work-requirements.
[12] Jennifer Wagner "Over 4,300 Arkansas Beneficiaries Lost Medicaid This Month for Not Meeting Rigid Work Requirements," Center on Budget and Policy Priorities, September 2018, https://www.cbpp.org/blog/over-4300-arkansas-beneficiaries-lost-medicaid-this-month-for-not-meeting-rigid-work.
[13] Jennifer Wagner "Commentary: As Predicted, Eligible Arkansas Medicaid Beneficiaries Struggling to Meet Rigid Work Requirements" Center on Budget and Policy Priorities, July 2018, https://www.cbpp.org/health/commentary-as-predicted-eligible-arkansas-medicaid-beneficiaries-struggling-to-meet-rigid.
[14] Liz Ben-Ishai, "Volatile Job Schedules and Access to Public Benefits" CLASP, September 2015, https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf.
[15] Kaiser Family Foundation, "Key Facts About the Uninsured Population" September 2017, http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.
[16] Jennifer Haley and Stephen Zuckerman, "Is Lack of Coverage A Short or Long-Term Condition?," Kaiser Family Foundation, June 2003, **http://kff.org/uninsured/issue-brief/is-lack-of-coverage-a-short-or/**.
[17] Matthew J. Carlson, Jennifer DeVoe, and Bill J. Wright, "Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results From a Prospective Cohort Study of the Oregon Health Plan," Annals of Family Medicine, 2006, http://www.annfammed.org/content/4/5/391.short.
[18] Andrew Bindman, Amitabha Chattopadhyay, and G. M. Auerback. "Interruptions in Medicaid coverage and risk for hospitalization for ambulatory care-sensitive conditions," Annals of Internal Medicine, 2008, **https://www.ncbi.nlm.nih.gov/pubmed/19075204?dopt=Abstract**.
[19] A.G. Hall, J.S. Harman, and J. Zhang, "Lapses in Medicaid coverage: impact on cost and utilization among individuals with diabetes enrolled in Medicaid," 2008, **https://www.ncbi.nlm.nih.gov/pubmed/19300311?dopt=Abstract**.

[20] Ibid.
[21] Center for Law and Social Policy "Child Care in the FY 2018 Omnibus Spending Bill" (Washington, DC: CLASP, 2018) https://www.clasp.org/sites/default/files/publications/2018/03/Child%20Care%20in%20the%20FY%202018%20Omnibus.pdf.
[22] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work, February 2017, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.
[23] Jean Hall, Adele Shartzer, Noelle Kurth, and Kathleen Thomas, "Medicaid Expansion as an Employment Incentive Program for People with Disabilities."
[24] Aparna Soni, Marguerite Burns, Laura Dague, and Kosali Simon, "Medicaid Expnsion and State Trends In Supplemental Security Income Program Participation", August 2017, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1632.
[25] Ohio Association of Foodbanks, Comprehensive Report: Able-Bodied Adults Without Dependents, 2015, http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_2014-2015-v3.pdf.

Section 1115 Demonstration Authority: Medicaid Act Provisions That Prohibit a Waiver

Prepared by NHeLP-NC (contact: Jane Perkins)
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Section 1115 of the Social Security Act (SSA) provides the Secretary of Health and Human Services (HHS) with limited authority to waive requirements of the Medicaid Act. Section 1115 states, in relevant part:

> (a) In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of subchapter . . . XIX of this chapter [*i.e.,* Medicaid], . . . in a State or States -
>
> (1) the Secretary **may waive compliance with any of the requirements of section . . . 1396a** of this title, . . . to the extent and for the period he finds necessary to enable such State or States to carry out such project, and
>
> (2)(A) costs of such project which would not otherwise be included as expenditures under section . . . 1396b of this title, . . . shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan . . . .

SSA, § 1115, 42 U.S.C. § 1315a (emphasis added). This issue brief addresses requirements that appear in 1396a, but nevertheless cannot be waived by the Secretary.[1]

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By its terms, § 1115(a)(1) authorizes the Secretary to waive only those Medicaid requirements contained in 42 U.S.C. § 1396a. Section 1396a describes the mandatory and optional components of the state Medicaid plan and, as such, is a pivotal Medicaid provision. That said, the Medicaid Act is a complex and lengthy statute that begins with § 1396 (Medicaid and CHIP payment and access commission) and § 1396-1 (appropriations and purpose) and goes through § 1396w-5 (addressing health disparities). Many of these provisions impose important requirements on states. For an example of a provision found outside of § 1396a, see 42 U.S.C. § 1396d(a)(29), which prohibits Medicaid payments for any individual under 65 years old who is

[1] With the exception of § 1115, this memo refers to provisions as they appear in the United States Code (U.S.C.), as opposed to the Social Security Act.

a patient in an institution for mental diseases (facilities with more than 16 beds primarily serving persons with mental diseases).

All told, there are 52 provisions outside of § 1396a. The requirements appearing in these provisions cannot be waived unless they are clearly incorporated by reference into § 1396a. Notably, even when referred to in § 1396a, some requirements cannot be waived according to their own terms or the terms of a separate Medicaid Act provision. The chart below lists such requirements. The chart will be updated as additional provisions are identified.

Medicaid Act Requirements That Cannot Be Waived Under 42 U.S.C. § 1315

Subsection of § 1396a	Provision that Prohibits its Waiver
(**a)(10)(E)** – Medicare cost sharing for qualified Medicare beneficiaries as defined in § 1396d(p)	**§ 1396d(p)(4)** – requires state operating under § 1115 waiver to meet requirement of a(a)(10)(E) as if it were operating under a state plan rather than a waiver
(**a)(14)** – enrollment fee, premium, copayment, and cost sharing limits only as provided in § 1396o.	**Regarding enrollment fees, premiums:** **§ 1396o-1** – independently requires the state plan to contain its mandatory provisions and is not mentioned in § 1396a **Regarding copayments, similar charges:** **§ 1396o(f)** – "Under any waiver authority," no deduction, copayment or similar charge may be imposed unless the demonstration project meets five tightly circumscribed criteria (maintained under § 1396o-1(a)).
(a)(28) – requires Medicaid nursing homes to comply with §§ 1396r(b)-(d), 1396r(f)(7), and the state to comply with requirements of § 1396r(e), 1396r(g), 1396r(h)(2)(B), 1396r(h)(2)(D)	**§ 1396r** – Nursing Home Reform Act: Establishes comprehensive requirements for nursing homes, states, and Secretary of HHS to improve and maintain quality of nursing home care and resident rights, including instances where provisions can be waived and the circumstances for granting those waivers
(a)(34) – retroactive coverage	**§ 1396d(a)**– independently requires medical assistance to include care and services if provided in or after the third month before the month of application
(a)(42) – requirements for state auditing for improper payments & recoupments	**§ 1396a(42)(B)** – applies under any waiver of the state plan

(a)(46)(B) – verification of citizenship & nationality for eligibility purposes (including reasonable opportunity)	**§ 1396a note** (Pub. L. No. 111-3, 123 Stat. 8, CHIPRA Reauth. Act): Notwithstanding § 1115, the Secretary may not waive requirements of § (a)(46)(B).
(a)(51) – community spouse protection requirements of § 1396r-5	**§ 1396r-5(a)(4)(A)** requires states operating under § 1115 waiver to comply with the requirements of the section in the same manner as would be required if the state were operating under a state plan.
(a)(52) – Transitional Medical Assistance requirements of § 1396r-6	**§ 1396r-6(a)(1)** – provides that the state must provide for TMA "notwithstanding any other provision of this subchapter" & specifies the circumstances for a waiver
(a)(63) - eligibility for those deemed eligible because they meet 1996-AFDC eligibility standards based on § 1396u-1	**§ 1396u-1(g)** - provides that "[t]he provisions of this section shall apply notwithstanding any other provision of this chapter."
(a)(69) – Medicaid program integrity requirements established under § 1396u-6	**§ 1396u-6(b)(1)** –requires state operating § 1115 waiver to review actions of providers for fraud, waste, and abuse
(a)(74) – maintenance of effort under ACA in accordance with § 1396a(gg)	**§ 1396a(gg)(2)** – requires continuation of eligibility standards, methodologies, and procedures for children under age 19 through Sept. 30, 2019, MOE under any waiver of the plan
(a)(e)(14) [2d] – required use of modified adjusted gross income (MAGI), no disregards, and no asset test for determining eligibility of most population groups	**§ 1396a(e)(14)(A), (B), (C)** – requires MAGI, no disregards, and no asset test "under any waiver"
(a)(l) – coverage for children, infants, & pregnant women based on income according to federal poverty level	**§ 1396a(l)(4)(A)** – in the case of any state with § 1115 waiver, the Secretary must require the state to provide medical assistance to these groups of children, infants, and pregnant women "in the same manner" as under a state plan

NOTE: In addition to the § 1396a limit, § 1115 places other restrictions on the Secretary's authority. For example, the project must be an experiment that is likely to promote the objectives of the Medicaid Act. Also, the Secretary cannot waive the U.S. Constitution or other statutes, such as the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

SOUNDING BOARD

Health Insurance Coverage and Health — What the Recent Evidence Tells Us

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The national debate over the Affordable Care Act (ACA) has involved substantial discussion about what effects — if any — insurance coverage has on health and mortality. The prospect that the law's replacement might lead to millions of Americans losing coverage has brought this empirical question into sharp focus. For instance, politicians have recently argued that the number of people with health insurance is not a useful policy metric[1] and that no one dies from a lack of access to health care.[2] However, assessing the impact of insurance coverage on health is complex: health effects may take a long time to appear, can vary according to insurance benefit design, and are often clouded by confounding factors, since insurance changes usually correlate with other circumstances that also affect health care use and outcomes.

Nonetheless, over the past decade, high-quality studies have shed light on the effects of coverage on care and health. Here, we review and synthesize this evidence, focusing on the most rigorous studies from the past decade on the effects of coverage for nonelderly adults. Previous reviews have provided a thorough discussion of older studies.[3] We concentrate on more recent experimental and quasi-experimental studies of the ACA and other expansions of public or private insurance. The effects of coverage probably vary among people, types of plans, and settings, and these studies may not all directly apply to the current policy debate. But as a whole, this body of research (Table 1) offers important insights into how coverage affects health care utilization, disease treatment and outcomes, self-reported health, and mortality.

FINANCIAL PROTECTION AND THE ROLE OF INSURANCE

Before we assess these effects, it is worth recognizing the role of insurance as a tool for managing financial risk. There is abundant evidence that having health insurance improves financial security. The strongest evidence comes from the Oregon Health Insurance Experiment, a rare randomized, controlled trial of health insurance coverage.[3,1] In that study, people selected by lottery from a Medicaid waiting list experienced major gains in financial well-being as compared with those who were not selected: a $390 average decrease in the amount of medical bills sent to collection and a virtual elimination of catastrophic out-of-pocket expenses.[4,8] Studies of other insurance expansions, such as Massachusetts' 2006 health care reform,[7] the ACA's 2010 "dependent-coverage provision" enabling young adults to stay on a parent's plan until age 26,[6] and the ACA's 2014 Medicaid expansion,[5] have all revealed similar changes, including reduced bill collections and bankruptcies, confirming that insurance coverage reduces the risk of large unpredictable medical costs.

But from a policy perspective, health insurance is viewed differently from most other types of insurance: there is no push, for example, for universal homeowners' or renters' insurance subsidized by the federal government. We contend that there are two reasons for this difference. First, policymakers may value publicly subsidized health insurance as an important part of the social safety net that broadly redistributes resources to lower-income populations. Second, policymakers may view health insur-

Table 1. Evidence on the Effects of Health Insurance on Health Care and Health Outcomes, 2007–2017.

Domain and Findings	Insurance or Policy Examined*	Studies
Financial security		
Reduction in medical bills sent to collection and in catastrophic medical spending	Medicaid	Baicker et al. 2013[4]; Hu et al. 2016[5]
Reduced out-of-pocket medical spending	DCP, Medicaid	Chua and Sommers 2014[6]; Baicker et al. 2013[4]
Reduced personal bankruptcies and improved credit scores	MA	Mazumder and Miller 2016[7]
Access to care and utilization		
Increased outpatient utilization and rates of having a usual source of care/personal physician	Medicaid, MA	Finkelstein et al. 2012[8]; Sommers et al. 2014[9]; Simon et al. 2017[10]
Increased preventive visits and some preventive services including cancer screening and lab tests	Medicaid, MA	Baicker et al. 2013[4]; Sommers et al. 2014 and 2016[9,11]; Simon et al. 2017[10]
Increased prescription drug utilization and adherence	Medicaid	Ghosh et al. 2017[12]; Sommers et al. 2016[11]
Mixed evidence on emergency department use, with some studies showing an increase and others a decrease	Medicaid, DCP, MA	Taubman et al. 2014[13]; Akosa Antwi et al. 2015[14]; Miller 2012[15]; Sommers et al. 2016[11]
Improved access to surgical care	DCP, MA	Scott et al. 2016[16]; Loehrer et al. 2016[17]
Chronic disease care and outcomes		
Increased rates of diagnosing chronic conditions	Medicaid	Baicker et al. 2013[4]; Wherry and Miller 2016[18]
Increased treatment for chronic conditions	Medicaid	Baicker et al. 2013[4]; Sommers et al. 2017[19]
Improved depression outcomes	Medicaid	Baicker et al. 2013[4]
No significant change in blood pressure, cholesterol, or glycated hemoglobin	Medicaid	Baicker et al. 2013[4]
Mixed evidence on cancer stage at time of diagnosis	MA, DCP	Keating et al. 2013[20]; Robbins et al. 2015[21]; Loehrer et al. 2016[17]
Well-being and self-reported health		
Improved self-reported health in most studies	Medicaid, MA, DCP, ACA	Baicker et al. 2013[4]; Sommers et al. 2012[22]; Van Der Wees et al. 2013[23]; Chua and Sommers 2014[6]; Sommers et al. 2015[24]; Simon et al. 2017[10]; Sommers et al. 2017[19]
Some ACA-specific studies have shown limited or nonsignificant changes	Medicaid, ACA	Courtemanche et al. 2017[25]; Miller and Wherry 2017[26]
Mortality		
Conflicting observational studies on whether lack of insurance is an independent predictor of mortality	Private insurance	Kronick 2009[27]; Wilper et al. 2009[28]
Highly imprecise estimates in randomized trial, unable to rule out large mortality increases or decreases	Medicaid	Finkelstein et al. 2012[8]
Significant reductions in mortality in quasi-experimental analyses, particularly for health care–amenable causes of death	Medicaid, MA	Sommers et al. 2012[22]; Sommers et al. 2014[9]; Sommers 2017[29]

* "Medicaid" includes pre-ACA expansions of Medicaid in selected states and the ACA's 2014 Medicaid expansion. ACA denotes Affordable Care Act (specifically applies here to the 2014 coverage expansions including Medicaid and subsidized marketplace coverage), DCP dependent-coverage provision (the ACA policy enacted in 2010 that allows young adults to remain on their parents' plan until the age of 26 years), and MA Massachusetts statewide health care reform (enacted 2006).

ance as a tool for achieving the specific policy priority of improved medical care and public health. Evaluating the impact of insurance coverage on health outcomes — and whether these benefits justify the costs of expanding coverage — is our focus.

ACCESS TO CARE AND UTILIZATION

For coverage to improve health, insurance must improve people's care, not just change how it's paid for. Several observational studies have found that the ACA's coverage expansion was associated with higher rates of having a usual source of care and being able to afford needed care,[32,33] factors typically associated with better health outcomes.[34] Stronger experimental and quasi-experimental evidence shows that coverage expansions similarly lead to greater access to primary care,[11,24] more ambulatory care visits,[8] increased use of prescription medications,[4,12] and better medication adherence.[11]

There is also strong evidence that coverage expansion increases access to preventive services, which can directly maintain or improve health. Studies of Massachusetts' health care reform[9] and the ACA's Medicaid expansion found higher rates of preventive health care visits,[11] and although the utility of the "annual exam" is uncertain, such visits may facilitate more specific evidence-based screening. For instance, the ACA Medicaid expansion has led to significant increases in testing for diabetes,[11] hypercholesterolemia,[18] and HIV,[10] and the Oregon study revealed a 15-percentage-point increase in the rate of cholesterol screening and 15- to 30-percentage-point increases in rates of screening for cervical, prostate, and breast cancer.[4]

The connection between health outcomes and use of other services, such as surgery, emergency-department (ED) care, and hospitalizations, tends to be more complicated. Much of this utilization serves critical health needs, though some may represent low-value care or reflect poor outpatient care. Thus, it is perhaps not surprising that the evidence on the effects of coverage on ED use and hospitalizations is mixed.[35] Both types of utilization went up in the Oregon study,[8,13] whereas studies of other coverage expansions found reductions in ED use,[11,14,15] and changes in hospital use have not been significant in several ACA studies[11,26] — though these studies may not have had an adequate sample size to examine this less common outcome. Meanwhile, studies of Massachusetts' reform and the ACA's dependent-coverage provision indicate that insurance improves access to some high-value types of surgical care.[16,17]

CHRONIC DISEASE CARE AND OUTCOMES

The effects of coverage are particularly important for people with chronic conditions, a vulnerable high-cost population. Here, the Oregon experiment found nuanced effects. After 2 years of coverage, there were no statistically significant changes in glycated hemoglobin, blood pressure, or cholesterol levels.[4] On the basis of these results, some observers have argued that expanding Medicaid does not improve health and is thus inadvisable.[36] However, the study revealed significant increases in the rate of diagnosis of diabetes that were consistent with findings in two recent post-ACA studies,[18,37] along with a near-doubling of use of diabetes medications,[4] again consistent with more recent data on the ACA's Medicaid expansion.[12] Glycated hemoglobin levels did not improve, but, as the authors note, the confidence intervals are potentially consistent with these medications' working as expected.[4] The investigators did not detect significant changes in diagnosis of or treatment for high cholesterol or hypertension. One recent quasi-experimental study, however, showed that the ACA's Medicaid expansion was associated with better blood-pressure control among community health center patients.[38]

Meanwhile, the Oregon study found substantial improvements in depression, one of the leading causes of disability in the United States.[39] It also found an increased rate of diagnosis, a borderline-significant increase in the rate of treatment with antidepressant medication, and a 30% relative reduction in rates of depressive symptoms.[4]

Other studies have assessed the effects of insurance coverage on cancer, the leading cause of death among nonelderly adults in the United States.[40] Though not all cancer results in chronic illness, most cancer diagnoses necessitate a period of ongoing care, and approximately 8 million U.S. adults under age 70 are currently living with cancer.[41] Beyond increases in cancer screening, health insurance may also facilitate more

timely or effective cancer care. However, evidence on this front is mixed. A study of Massachusetts' reform did not find any changes in breast-cancer stage at diagnosis,[20] whereas the ACA's dependent-coverage provision was associated with earlier-stage diagnosis and treatment of cervical cancer among young women.[21] Another Massachusetts study revealed an increase in rates of potentially curative surgery for colon cancer among low-income patients after coverage expansion, with fewer patients waiting until the emergency stage for treatment.[17]

Coverage implications for many other illnesses such as asthma, kidney disease, and heart failure require additional research. Studies do show that for persons reporting any chronic condition, gaining coverage increases access to regular care for those conditions.[19,30] Overall, the picture for managing chronic physical conditions is thus not straightforward, with coverage effects potentially varying among diseases, populations, and delivery systems.

WELL-BEING AND SELF-REPORTED HEALTH

Although the evidence on outcomes for some conditions varies, evidence from multiple studies indicates that coverage substantially improves patients' perceptions of their health. At 1 year, the Oregon study found a 25% increase in the likelihood of patients reporting "good, very good, or excellent" health, and more days in good physical and mental health.[8] Evidence from quasi-experimental studies indicates that self-reported health and functional status improved after Massachusetts' reform[23] and after several pre-ACA state Medicaid expansions,[22] and that self-reported physical and mental health improved after the ACA's dependent-coverage provision went into effect.[6]

Recent studies of the ACA's 2014 coverage expansion provide more mixed evidence. Multiple analyses have found improved self-reported health after the ACA's coverage expansion, either in broad national trends[24] or Medicaid expansion studies,[10,11] whereas one found significant changes only for select subpopulations[25] and another not at all.[26] Larger coverage gains have generally been associated with more consistent findings of improved self-reported health.[19]

Does self-reported health even matter? It squarely fits within the World Health Organization's definition of health as "a state of complete physical, mental, and social well-being," and improved subjective well-being (i.e., feeling better) is also a primary goal for much of the medical care delivered by health care professionals. In addition, self-reported health is a validated measure of the risk of death. People who describe their health as poor have mortality rates 2 to 10 times as high as those who report being in the healthiest category.[42,43]

MORTALITY

Perhaps no research question better encapsulates this policy debate than, "Does coverage save lives?" Beginning with the Institute of Medicine's 2002 report *Care without Coverage*, some analyses have suggested that lack of insurance causes tens of thousands of deaths each year in the United States.[44] Subsequent observational studies had conflicting findings. One concluded that lacking coverage was a strong independent risk factor for death,[28] whereas another found that coverage was only a proxy for risk factors such as socioeconomic status and health-related behaviors.[27] More recently, several studies have been conducted with stronger research designs better suited to answering this question.

The Oregon study assessed mortality but was limited by the infrequency of deaths in the sample. The estimated 1-year mortality change was a nonsignificant 16% reduction, but with a confidence interval of −82% to +50%, meaning that the study could not rule out large reductions — or increases — in mortality. As the authors note, the study sample and duration were not well suited to evaluating mortality.

Several quasi-experimental studies using population-level data and longer follow-up offer more precise estimates of coverage's effect on mortality. One study compared three states implementing large Medicaid expansions in the early 2000s to neighboring states that didn't expand Medicaid, finding a significant 6% decrease in mortality over 5 years of follow-up.[22] A subsequent analysis showed the largest decreases were for deaths from "health-care–amenable" conditions such as heart disease, infections, and cancer, which are more plausibly affected by access to medical care.[29] Meanwhile, a study of Massachusetts' 2006 reform found significant reductions

in all-cause mortality and health-care–amenable mortality as compared with mortality in demographically similar counties nationally, particularly those with lower pre-expansion rates of insurance coverage.[9] Overall, the study identified a "number needed to treat" of 830 adults gaining coverage to prevent one death a year. The comparable estimate in a more recent analysis of Medicaid's mortality effects was one life saved for every 239 to 316 adults gaining coverage.[29]

How can one reconcile these mortality findings with the nonsignificant cardiovascular and diabetes findings in the Oregon study? Research design could account for the difference: the Oregon experiment was a randomized trial and the quasi-experimental studies were not, so the latter are susceptible to unmeasured confounding despite attempts to rule out alternative explanations, such as economic factors, demographic shifts, and secular trends in medical technology. But — as coauthors of several of these articles — we believe that other explanations better account for this pattern of results.

First, mortality is a composite outcome of many conditions and factors. Hypertension, dyslipidemia, and elevated glycated hemoglobin levels are important clinical measures but do not capture numerous other causes of increased risk of death. Second, the studies vary substantially in their timing and sample sizes. The Massachusetts and Medicaid mortality studies examined hundreds of thousands of people gaining coverage over 4 to 5 years of follow-up, as compared with roughly 10,000 Oregonians gaining coverage and being assessed after less than 2 years. It may take years for important effects of insurance coverage — such as increased use of primary and preventive care, or treatment for life-threatening conditions such as cancer, HIV–AIDS, or liver or kidney disease — to manifest in reduced mortality, given that mortality changes in the other studies increased over time.[9,22]

Third, the effects on self-reported health — so clearly seen in the Oregon study and other research — are themselves predictive of reduced mortality over a 5- to 10-year period.[42,43] Studies suggest that a 25% reduction in self-reported poor health could plausibly cut mortality rates in half (or further) for the sickest members of society, who have disproportionately high rates of death. Finally, the links among mental health, financial stress, and physical health are numerous,[45] suggesting additional pathways for coverage to produce long-term health effects.

DIFFERENT TYPES OF COVERAGE

In light of recent evidence on the benefits of health insurance coverage, some ACA critics have argued that private insurance is beneficial but Medicaid is ineffective or even harmful.[46] Is there evidence for this view? There is a greater body of rigorous evidence on Medicaid's effects — from studies of pre-ACA expansions, from the Oregon study, and from analyses of the ACA itself — than there is on the effects of private coverage. The latter includes studies of the ACA's dependent-coverage provision, which expanded only private insurance, and of Massachusetts' reform, which featured a combination of Medicaid expansion, subsidies for private insurance through Medicaid managed care insurers, and some increase in employer coverage. But there is no large quasi-experimental or randomized trial demonstrating unique health benefits of private insurance. One head-to-head quasi-experimental study of Medicaid versus private insurance, based on Arkansas's decision to use ACA dollars to buy private coverage for low-income adults, found minimal differences.[11,19] Overall, the evidence indicates that having health insurance is quite beneficial, but from patients' perspectives it does not seem to matter much whether it is public or private.[47] Further research is needed to assess the relative effects of various insurance providers and plan designs.

Finally, though it is outside the focus of our discussion, there is also quasi-experimental evidence that Medicare improves self-reported health[48] and reduces in-hospital mortality among the elderly,[49] though a study of older data from Medicare's 1965 implementation did not find a survival benefit.[50] However, since universal coverage by Medicare for elderly Americans is well entrenched, both the policy debate and opportunities for future research on this front are much more limited.

IMPLICATIONS AND CONCLUSIONS

One question experts are commonly asked is how the ACA — or its repeal — will affect health and mortality. The body of evidence summarized here indicates that coverage expansions

significantly increase patients' access to care and use of preventive care, primary care, chronic illness treatment, medications, and surgery. These increases appear to produce significant, multifaceted, and nuanced benefits to health. Some benefits may manifest in earlier detection of disease, some in better medication adherence and management of chronic conditions, and some in the psychological well-being born of knowing one can afford care when one gets sick. Such modest but cumulative changes — which one of us has called "the heroism of incremental care"[51] — may not occur for everyone and may not happen quickly. But the evidence suggests that they do occur, and that some of these changes will ultimately help tens of thousands of people live longer lives. Conversely, the data suggest that policies that reduce coverage will produce significant harms to health, particularly among people with lower incomes and chronic conditions.

Do these findings apply to the ACA? Drawing on evidence from recent coverage expansions is, in our view, the most reasonable way to estimate future effects of policy, but this sort of extrapolation is not an exact science. The ACA shares many features with prior expansions, in particular the Massachusetts reform on which it was modeled. But it is a complex law implemented in a highly contentious and uncertain policy environment, and its effects may have been limited by policies in some states that reduced take-up,[52] Congress's partial defunding of the provisions for stabilizing the ACA's insurance marketplaces,[53] and plan offerings with high patient cost sharing. Furthermore, every state's Medicaid program has unique features, which makes direct comparisons difficult. Finally, coverage expansions and contractions will not necessarily produce mirror-image effects. For these reasons, no study can offer a precise prediction for the current policy debate. But our assessment, in short, is that these studies provide the best evidence we have for projecting the impact of the ACA or its repeal.

The many benefits of coverage, though, come at a real cost. Given the increases in most types of utilization, expanding coverage leads to an increase in societal resources devoted to health care.[8] There are key policy questions about how to control costs, how much redistribution across socioeconomic groups is optimal, and how tradeoffs among federal, state, local, and private spending should be managed. In none of these scenarios, however, is there evidence that covering more people in the United States will ultimately save society money.

Are the benefits of publicly subsidized coverage worth the cost? An analysis of mortality changes after Medicaid expansion suggests that expanding Medicaid saves lives at a societal cost of $327,000 to $867,000 per life saved.[29] By comparison, other public policies that reduce mortality have been found to average $7.6 million per life saved, suggesting that expanding health insurance is a more cost-effective investment than many others we currently make in areas such as workplace safety and environmental protections.[29,54] Factoring in enhanced well-being, mental health, and other outcomes would only further improve the cost–benefit ratio. But ultimately, policymakers and other stakeholders must decide how much they value these improvements in health, relative to other uses of public resources — from spending them on education and other social services to reducing taxes.

There remain many unanswered questions about U.S. health insurance policy, including how to best structure coverage to maximize health and value and how much public spending we want to devote to subsidizing coverage for people who cannot afford it. But whether enrollees benefit from that coverage is not one of the unanswered questions. Insurance coverage increases access to care and improves a wide range of health outcomes. Arguing that health insurance coverage doesn't improve health is simply inconsistent with the evidence.

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1. Schlesinger R. Trumpcare's got a coverage problem. U.S. News & World Report. March 8, 2017 (http://www.usnews.com/opinion/thomas-jefferson-street/articles/2017-03-08/the-gops-obamacare-repeal-has-a-health-care-coverage-problem).
2. Watson K. GOP congressman: "Nobody dies because they don't have access to health care." CBS News. May 6, 2017 (http://www.cbsnews.com/news/gop-congressman-nobody-dies-because-they-dont-have-access-to-health-care/).
3. McWilliams JM. Health consequences of uninsurance among adults in the United States: recent evidence and implications. Milbank Q 2009;87:443-94.

4. Baicker K, Taubman SL, Allen HL, et al. The Oregon experiment — effects of Medicaid on clinical outcomes. N Engl J Med 2013;368:1713-22.
5. Hu L, Kaestner R, Mazumder B, Miller S, Wong A. The effect of the Patient Protection and Affordable Care Act Medicaid expansions on financial well-being. Cambridge, MA: National Bureau of Economic Research, 2016.
6. Chua KP, Sommers BD. Changes in health and medical spending among young adults under health reform. JAMA 2014; 311:2437-9.
7. Mazumder B, Miller S. The effects of the Massachusetts Health Reform on household financial distress. Am Econ J Econ Policy 2016;8:284-313.
8. Finkelstein A, Taubman S, Wright B, et al. The Oregon Health Insurance Experiment: evidence from the first year. Q J Econ 2012;127:1057-106.
9. Sommers BD, Long SK, Baicker K. Changes in mortality after Massachusetts health care reform: a quasi-experimental study. Ann Intern Med 2014;160:585-93.
10. Simon K, Soni A, Cawley J. The impact of health insurance on preventive care and health behaviors: evidence from the first two years of the ACA Medicaid expansions. J Policy Anal Manage 2017;36:390-417.
11. Sommers BD, Blendon RJ, Orav EJ, Epstein AM. Changes in utilization and health among low-income adults after Medicaid expansion or expanded private insurance. JAMA Intern Med 2016;176:1501-9.
12. Ghosh A, Simon K, Sommers BD. The effect of state Medicaid expansions on prescription drug use: evidence from the Affordable Care Act. Cambridge, MA: National Bureau of Economic Research, 2017.
13. Taubman SL, Allen HL, Wright BJ, Baicker K, Finkelstein AN. Medicaid increases emergency-department use: evidence from Oregon's Health Insurance Experiment. Science 2014;343: 263-8.
14. Akosa Antwi Y, Moriya AS, Simon K, Sommers BD. Changes in emergency department use among young adults after the Patient Protection and Affordable Care Act's Dependent Coverage Provision. Ann Emerg Med 2015;65(6):664-672.e2.
15. Miller S. The effect of insurance on emergency room visits: an analysis of the 2006 Massachusetts health reform. J Public Econ 2012;96:893-908.
16. Scott JW, Rose JA, Tsai TC, et al. Impact of ACA insurance coverage expansion on perforated appendix rates among young adults. Med Care 2016;54:818-26.
17. Loehrer AP, Song Z, Haynes AB, Chang DC, Hutter MM, Mullen JT. Impact of health insurance expansion on the treatment of colorectal cancer. J Clin Oncol 2016;34:4110-5.
18. Wherry LR, Miller S. Early coverage, access, utilization, and health effects associated with the Affordable Care Act Medicaid expansions: a quasi-experimental study. Ann Intern Med 2016; 164:795-803.
19. Sommers BD, Maylone B, Blendon RJ, Orav EJ, Epstein AM. Three-year impacts of the Affordable Care Act: improved medical care and health among low-income adults. Health Aff (Millwood) 2017;36:1119-28.
20. Keating NL, Kouri EM, He Y, West DW, Winer EP. Effect of Massachusetts health insurance reform on mammography use and breast cancer stage at diagnosis. Cancer 2013;119:250-8.
21. Robbins AS, Han X, Ward EM, Simard EP, Zheng Z, Jemal A. Association between the Affordable Care Act dependent coverage expansion and cervical cancer stage and treatment in young women. JAMA 2015;314:2189-91.
22. Sommers BD, Baicker K, Epstein AM. Mortality and access to care among adults after state Medicaid expansions. N Engl J Med 2012;367:1025-34.
23. Van Der Wees PJ, Zaslavsky AM, Ayanian JZ. Improvements in health status after Massachusetts health care reform. Milbank Q 2013;91:663-89.
24. Sommers BD, Gunja MZ, Finegold K, Musco T. Changes in self-reported insurance coverage, access to care, and health under the Affordable Care Act. JAMA 2015;314:366-74.
25. Courtemanche C, Marton J, Ukert B, Yelowitz A, Zapata D. Early effects of the Affordable Care Act on health care access, risky health behaviors, and self-assessed health. Cambridge, MA: National Bureau of Economic Research, 2017.
26. Miller S, Wherry LR. Health and access to care during the first 2 years of the ACA Medicaid expansions. N Engl J Med 2017; 376:947-56.
27. Kronick R. Health insurance coverage and mortality revisited. Health Serv Res 2009;44:1211-31.
28. Wilper AP, Woolhandler S, Lasser KE, McCormick D, Bor DH, Himmelstein DU. Health insurance and mortality in US adults. Am J Public Health 2009;99:2289-95.
29. Sommers BD. State Medicaid expansions and mortality, revisited: a cost-benefit analysis. Am J Health Econ 2017 May 17 (Epub ahead of print).
30. Torres H, Poorman E, Tadepalli U, et al. Coverage and access for Americans with chronic disease under the Affordable Care Act: a quasi-experimental study. Ann Intern Med 2017;166:472-9.
31. Allen H, Baicker K, Finkelstein A, Taubman S, Wright BJ. What the Oregon Health Study can tell us about expanding Medicaid. Health Aff (Millwood) 2010;29:1498-506.
32. Shartzer A, Long SK, Anderson N. Access to care and affordability have improved following Affordable Care Act implementation; problems remain. Health Aff (Millwood) 2016;35:161-8.
33. Collins SR, Gunja M, Doty MM, Beutel S. Americans' experiences with ACA Marketplace and Medicaid coverage: access to care and satisfaction. New York: The Commonwealth Fund, 2016.
34. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q 2005;83:457-502.
35. Sommers BD, Simon K. Health insurance and emergency department use — a complex relationship. N Engl J Med 2017; 376:1708-11.
36. Cannon MF. Oregon study throws a stop sign in front of ObamaCare's Medicaid expansion. Washington, DC: Cato Institute, 2013.
37. Kaufman HW, Chen Z, Fonseca VA, McPhaul MJ. Surge in newly identified diabetes among Medicaid patients in 2014 within Medicaid expansion states under the Affordable Care Act. Diabetes Care 2015;38:833-7.
38. Cole MB, Galárraga O, Wilson IB, Wright B, Trivedi AN. At federally funded health centers, Medicaid expansion was associated with improved quality of care. Health Aff (Millwood) 2017; 36:40-8.
39. Murray CJ, Atkinson C, Bhalla K, et al. The state of US health, 1990-2010: burden of diseases, injuries, and risk factors. JAMA 2013;310:591-608.
40. 10 Leading causes of death by age group, United States — 2015. Atlanta: Centers for Disease Control and Prevention (http://www.cdc.gov/injury/images/lc-charts/leading_causes_of_death_age_group_2015_1050w740h.gif).
41. Cancer treatment & survivorship: facts & figures: 2016–2017. Atlanta: American Cancer Society, 2016 (http://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-treatment-and-survivorship-facts-and-figures/cancer-treatment-and-survivorship-facts-and-figures-2016-2017.pdf).
42. Miilunpalo S, Vuori I, Oja P, Pasanen M, Urponen H. Self-rated health status as a health measure: the predictive value of self-reported health status on the use of physician services and on mortality in the working-age population. J Clin Epidemiol 1997;50:517-28.
43. DeSalvo KB, Bloser N, Reynolds K, He J, Muntner P. Mortality prediction with a single general self-rated health question: a meta-analysis. J Gen Intern Med 2006;21:267-75.
44. Care without coverage: too little, too late. Washington, DC: Institute of Medicine, 2002.
45. Krieger N. Epidemiology and the people's health: theory and

context. Oxford, United Kingdom: Oxford University Press, 2013.
46. Roy A. Romneycare improved health outcomes, thanks to private-sector coverage. Forbes. May 7, 2014 (https://www.forbes.com/sites/theapothecary/2014/05/07/romneycare-improved-health-outcomes-thanks-to-private-sector-coverage/#6bcbd7f1de55).
47. Epstein AM, Sommers BD, Kuznetsov Y, Blendon RJ. Low-income residents in three states view Medicaid as equal to or better than private coverage, support expansion. Health Aff (Millwood) 2014;33:2041-7.
48. McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare coverage. JAMA 2007;298:2886-94.
49. Card D, Dobkin C, Maestas N. Does Medicare save lives? Q J Econ 2009;124:597-636.
50. Finkelstein A, McKnight R. What did Medicare do? The initial impact of Medicare on mortality and out of pocket medical spending. J Public Econ 2008;92:1644-68.
51. Gawande A. The heroism of incremental care. The New Yorker. January 23, 2017 (http://www.newyorker.com/magazine/2017/01/23/the-heroism-of-incremental-care).
52. Sommers BD, Maylone B, Nguyen KH, Blendon RJ, Epstein AM. The impact of state policies on ACA applications and enrollment among low-income adults in Arkansas, Kentucky, and Texas. Health Aff (Millwood) 2015;34:1010-8.
53. Garthwaite C, Graves JA. Success and failure in the insurance exchanges. N Engl J Med 2017;376:907-10.
54. Robinson LA. How U.S. government agencies value mortality risk reductions. Rev Environ Econ Policy 2007;1:283-99.

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TECHNICAL REPORT

The Lifelong Effects of Early Childhood Adversity and Toxic Stress

abstract

FREE

Advances in fields of inquiry as diverse as neuroscience, molecular biology, genomics, developmental psychology, epidemiology, sociology, and economics are catalyzing an important paradigm shift in our understanding of health and disease across the lifespan. This converging, multidisciplinary science of human development has profound implications for our ability to enhance the life prospects of children and to strengthen the social and economic fabric of society. Drawing on these multiple streams of investigation, this report presents an ecobiodevelopmental framework that illustrates how early experiences and environmental influences can leave a lasting signature on the genetic predispositions that affect emerging brain architecture and long-term health. The report also examines extensive evidence of the disruptive impacts of toxic stress, offering intriguing insights into causal mechanisms that link early adversity to later impairments in learning, behavior, and both physical and mental well-being. The implications of this framework for the practice of medicine, in general, and pediatrics, specifically, are potentially transformational. They suggest that many adult diseases should be viewed as developmental disorders that begin early in life and that persistent health disparities associated with poverty, discrimination, or maltreatment could be reduced by the alleviation of toxic stress in childhood. An ecobiodevelopmental framework also underscores the need for new thinking about the focus and boundaries of pediatric practice. It calls for pediatricians to serve as both front-line guardians of healthy child development and strategically positioned, community leaders to inform new science-based strategies that build strong foundations for educational achievement, economic productivity, responsible citizenship, and lifelong health. *Pediatrics* 2012;129:e232–e246

INTRODUCTION

Of a good beginning cometh a good end.

John Heywood, *Proverbs* (1546)

The United States, like all nations of the world, is facing a number of social and economic challenges that must be met to secure a promising future. Central to this task is the need to produce a well-educated and healthy adult population that is sufficiently skilled to participate effectively in a global economy and to become responsible stakeholders in a productive society. As concerns continue to grow about the quality of public education and its capacity to prepare the nation's future workforce, increasing investments are being made in

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KEY WORDS

ecobiodevelopmental framework, new morbidity, toxic stress, social inequalities, health disparities, health promotion, disease prevention, advocacy, brain development, human capital development, pediatric basic science

ABBREVIATIONS

ACE—adverse childhood experiences
CRH—corticotropin-releasing hormone
EBD—ecobiodevelopmental
PFC—prefrontal cortex

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the preschool years to promote the foundations of learning. Although debates about early childhood policy focus almost entirely on educational objectives, science indicates that sound investments in interventions that reduce adversity are also likely to strengthen the foundations of physical and mental health, which would generate even larger returns to all of society.[1,2] This growing scientific understanding about the common roots of health, learning, and behavior in the early years of life presents a potentially transformational opportunity for the future of pediatrics.

Identifying the origins of adult disease and addressing them early in life are critical steps toward changing our current health care system from a "sick-care" to a "well-care" model.[3–5] Although new discoveries in basic science, clinical subspecialties, and high-technology medical interventions continue to advance our capacity to treat patients who are ill, there is growing appreciation that a successful well-care system must expand its scope beyond the traditional realm of individualized, clinical practice to address the complex social, economic, cultural, environmental, and developmental influences that lead to population-based health disparities and unsustainable medical care expenditures.[2,6,7] The science of early childhood development has much to offer in the realization of this vision, and the well-being of young children and their families is emerging as a promising focus for creative investment.

The history of pediatrics conveys a rich narrative of empirical investigation and pragmatic problem solving. Its emergence as a specialized domain of clinical medicine in the late 19th century was dominated by concerns about nutrition, infectious disease, and premature death. In the middle of the 20th century, as effective vaccines, antibiotics, hygiene, and other public health measures confronted the infectious etiologies of childhood illness, a variety of developmental, behavioral, and family difficulties became known as the "new morbidities."[8] By the end of the century, mood disorders, parental substance abuse, and exposure to violence, among other conditions, began to receive increasing attention in the pediatric clinical setting and became known as the "newer morbidities."[9] Most recently, increasingly complex mental health concerns; the adverse effects of television viewing; the influence of new technologies; epidemic increases in obesity; and persistent economic, racial, and ethnic disparities in health status have been called the "millennial morbidities."[10]

Advances in the biological, developmental, and social sciences now offer tools to write the next important chapter. The overlapping and synergistic characteristics of the most prevalent conditions and threats to child well-being—combined with the remarkable pace of new discoveries in developmental neuroscience, genomics, and the behavioral and social sciences—present an opportunity to confront a number of important questions with fresh information and a new perspective. What are the biological mechanisms that explain the well-documented association between childhood adversity and adult health impairment? As these causal mechanisms are better elucidated, what can the medical field, specifically, and society, more generally, do to reduce or mitigate the effects of disruptive early-life influences on the origins of lifelong disease? When is the optimal time for those interventions to be implemented?

This technical report addresses these important questions in 3 ways. First, it presents a scientifically grounded, ecobiodevelopmental (EBD) framework to stimulate fresh thinking about the promotion of health and prevention of disease across the lifespan. Second, it applies this EBD framework to better understand the complex relationships among adverse childhood circumstances, toxic stress, brain architecture, and poor physical and mental health well into adulthood. Third, it proposes a new role for pediatricians to promote the development and implementation of science-based strategies to reduce toxic stress in early childhood as a means of preventing or reducing many of society's most complex and enduring problems, which are frequently associated with disparities in learning, behavior, and health. The magnitude of this latter challenge cannot be overstated. A recent technical report from the American Academy of Pediatrics reviewed 58 years of published studies and characterized racial and ethnic disparities in children's health to be extensive, pervasive, persistent, and, in some cases, worsening.[11] Moreover, the report found only 2 studies that evaluated interventions designed to reduce disparities in children's health status and health care that also compared the minority group to a white group, and none used a randomized controlled trial design.

The causal sequences of risk that contribute to demographic differences in educational achievement and physical well-being threaten our country's democratic ideals by undermining the national credo of equal opportunity. Unhealthy communities with too many fast food franchises and liquor stores, yet far too few fresh food outlets and opportunities for physical activity, contribute to an unhealthy population. Unemployment and forced mobility disrupt the social networks that stabilize communities and families and, thereby, lead to higher rates of violence

and school dropout. The purpose of this technical report is to leverage new knowledge from the biological and social sciences to help achieve the positive life outcomes that could be accrued to all of society if more effective strategies were developed to reduce the exposure of young children to significant adversity.

A NEW FRAMEWORK FOR PROMOTING HEALTHY DEVELOPMENT

Advances in our understanding of the factors that either promote or undermine early human development have set the stage for a significant paradigm shift.[12] In simple terms, the process of development is now understood as a function of "nature dancing with nurture over time," in contrast to the longstanding but now outdated debate about the influence of "nature versus nurture."[13] That is to say, beginning prenatally, continuing through infancy, and extending into childhood and beyond, development is driven by an ongoing, inextricable interaction between biology (as defined by genetic predispositions) and ecology (as defined by the social and physical environment)[12,14,15] (see Fig 1).

Building on an ecological model that explains multiple levels of influence on psychological development,[16] and a recently proposed biodevelopmental framework that offers an integrated, science-based approach to coordinated, early childhood policy making and practice across sectors,[17] this technical report presents an EBD framework that draws on a recent report from the Center on the Developing Child at Harvard University to help physicians and policy makers think about how early childhood adversity can lead to lifelong impairments in learning, behavior, and both physical and mental health.[1,6]

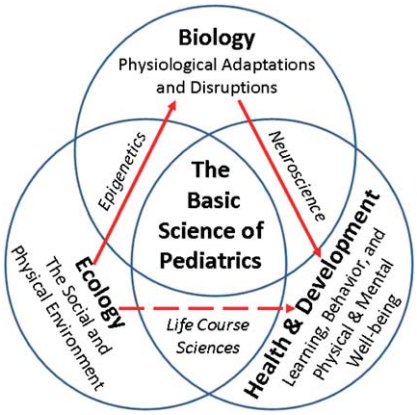

FIGURE 1

The basic science of pediatrics. An emerging, multidisciplinary science of development supports an EBD framework for understanding the evolution of human health and disease across the life span. In recent decades, epidemiology, developmental psychology, and longitudinal studies of early childhood interventions have demonstrated significant associations (hashed red arrow) between the ecology of childhood and a wide range of developmental outcomes and life course trajectories. Concurrently, advances in the biological sciences, particularly in developmental neuroscience and epigenetics, have made parallel progress in beginning to elucidate the biological mechanisms (solid arrows) underlying these important associations. The convergence of these diverse disciplines defines a promising new basic science of pediatrics.

Some of the most compelling new evidence for this proposed framework comes from the rapidly moving field of epigenetics, which investigates the molecular biological mechanisms (such as DNA methylation and histone acetylation) that affect gene expression without altering DNA sequence. For example, studies of maternal care in rats indicate that differences in the quality of nurturing affect neural function in pups and negatively affect cognition and the expression of psychopathology later in life. Moreover, rats whose mothers showed increased levels of licking and grooming during their first week of life also showed less exaggerated stress responses as adults compared with rats who were reared by mothers with a low level of licking and grooming, and the expression of mother-pup interactions in the pups has been demonstrated to be passed on to the next generation.[18–22] This burgeoning area of research is challenging us to look beyond genetic predispositions to examine how environmental influences and early experiences affect when, how, and to what degree different genes are actually activated, thereby elucidating the mechanistic linkages through which gene-environment interaction can affect lifelong behavior, development, and health (see Fig 1).

Additional evidence for the proposed framework comes from insights accrued during the "Decade of the Brain" in the 1990s, when the National Institutes of Health invested significant resources into understanding both normal and pathologic neuronal development and function. Subsequent advances in developmental neuroscience have begun to describe further, in some cases at the molecular and cellular levels, how an integrated, functioning network with billions of neurons and trillions of connections is assembled. Because this network serves as the biological platform for a child's emerging social-emotional, linguistic, and cognitive skills, developmental neuroscience is also beginning to clarify the underlying causal mechanisms that explain the normative process of child development. In a parallel fashion, longitudinal studies that document the long-term consequences of childhood adversity indicate that alterations in a child's ecology can have measurable effects on his or her developmental trajectory, with lifelong consequences for educational achievement, economic productivity, health status, and longevity.[23–27]

The EBD framework described in this article presents a new way to think about the underlying biological mechanisms that explain this robust link between early life adversities (ie, the

new morbidities of childhood) and important adult outcomes. The innovation of this approach lies in its mobilization of dramatic scientific advances in the service of rethinking basic notions of health promotion and disease prevention within a fully integrated, life span perspective from conception to old age.[6] In this context, significant stress in the lives of young children is viewed as a risk factor for the genesis of health-threatening behaviors as well as a catalyst for physiologic responses that can lay the groundwork for chronic, stress-related diseases later in life.

Understanding the Biology of Stress

Although genetic variability clearly plays a role in stress reactivity, early experiences and environmental influences can have considerable impact. Beginning as early as the prenatal period, both animal[28–30] and human[31,32] studies suggest that fetal exposure to maternal stress can influence later stress responsiveness. In animals, this effect has been demonstrated not only in the offspring of the studied pregnancy but also in subsequent generations. The precise biological mechanisms that explain these findings remain to be elucidated, but epigenetic modifications of DNA appear likely to play a role.[31,33,34] Early postnatal experiences with adversity are also thought to affect future reactivity to stress, perhaps by altering the developing neural circuits controlling these neuroendocrine responses.[34,35] Although much research remains to be performed in this area, there is a strong scientific consensus that the ecological context modulates the expression of one's genotype. It is as if experiences confer a "signature" on the genome to authorize certain characteristics and behaviors and to prohibit others. This concept underscores the need for greater understanding of how stress "gets under the skin," as well as the importance of determining what external and internal factors can be mobilized to prevent that embedding process or protect against the consequences of its activation.

Physiologic responses to stress are well defined.[36–38] The most extensively studied involve activation of the hypothalamic-pituitary-adrenocortical axis and the sympathetic-adrenomedullary system, which results in increased levels of stress hormones, such as corticotropin-releasing hormone (CRH), cortisol, norepinephrine, and adrenaline. These changes co-occur with a network of other mediators that include elevated inflammatory cytokines and the response of the parasympathetic nervous system, which counterbalances both sympathetic activation and inflammatory responses. Whereas transient increases in these stress hormones are protective and even essential for survival, excessively high levels or prolonged exposures can be quite harmful or frankly toxic,[39–41] and the dysregulation of this network of physiologic mediators (eg, too much or too little cortisol; too much or too little inflammatory response) can lead to a chronic "wear and tear" effect on multiple organ systems, including the brain.[39–41] This cumulative, stress-induced burden on overall body functioning and the aggregated costs, both physiologic and psychological, required for coping and returning to homeostatic balance, have been referred to as "allostatic load."[38,42–44] The dynamics of these stress-mediating systems are such that their overactivation in the context of repeated or chronic adversity leads to alterations in their regulation.

The National Scientific Council on the Developing Child has proposed a conceptual taxonomy comprising 3 distinct types of stress responses (in contrast to the actual stressors themselves) in young children—positive, tolerable, and toxic—on the basis of postulated differences in their potential to cause enduring physiologic disruptions as a result of the intensity and duration of the response.[17,45] A positive stress response refers to a physiologic state that is brief and mild to moderate in magnitude. Central to the notion of positive stress is the availability of a caring and responsive adult who helps the child cope with the stressor, thereby providing a protective effect that facilitates the return of the stress response systems back to baseline status. Examples of precipitants of a positive stress response in young children include dealing with frustration, getting an immunization, and the anxiety associated with the first day at a child care center. When buffered by an environment of stable and supportive relationships, positive stress responses are a growth-promoting element of normal development. As such, they provide important opportunities to observe, learn, and practice healthy, adaptive responses to adverse experiences.

A tolerable stress response, in contrast to positive stress, is associated with exposure to nonnormative experiences that present a greater magnitude of adversity or threat. Precipitants may include the death of a family member, a serious illness or injury, a contentious divorce, a natural disaster, or an act of terrorism. When experienced in the context of buffering protection provided by supportive adults, the risk that such circumstances will produce excessive activation of the stress response systems that leads to physiologic harm and long-term consequences for health and learning is greatly

reduced. Thus, the essential characteristic that makes this form of stress response tolerable is the extent to which protective adult relationships facilitate the child's adaptive coping and a sense of control, thereby reducing the physiologic stress response and promoting a return to baseline status.

The third and most dangerous form of stress response, toxic stress, can result from strong, frequent, or prolonged activation of the body's stress response systems in the absence of the buffering protection of a supportive, adult relationship. The risk factors studied in the Adverse Childhood Experiences Study[23] include examples of multiple stressors (eg, child abuse or neglect, parental substance abuse, and maternal depression) that are capable of inducing a toxic stress response. The essential characteristic of this phenomenon is the postulated disruption of brain circuitry and other organ and metabolic systems during sensitive developmental periods. Such disruption may result in anatomic changes and/or physiologic dysregulations that are the precursors of later impairments in learning and behavior as well as the roots of chronic, stress-related physical and mental illness. The potential role of toxic stress and early life adversity in the pathogenesis of health disparities underscores the importance of effective surveillance for significant risk factors in the primary health care setting. More important, however, is the need for clinical pediatrics to move beyond the level of risk factor identification and to leverage advances in the biology of adversity to contribute to the critical task of developing, testing, and refining new and more effective strategies for reducing toxic stress and mitigating its effects as early as possible, before irrevocable damage is done. Stated simply, the next chapter of innovation in pediatrics remains to be written, but the outline and plot are clear.

Toxic Stress and the Developing Brain

In addition to short-term changes in observable behavior, toxic stress in young children can lead to less outwardly visible yet permanent changes in brain structure and function.[39,46] The plasticity of the fetal, infant, and early childhood brain makes it particularly sensitive to chemical influences, and there is growing evidence from both animal and human studies that persistently elevated levels of stress hormones can disrupt its developing architecture.[45] For example, abundant glucocorticoid receptors are found in the amygdala, hippocampus, and prefrontal cortex (PFC), and exposure to stressful experiences has been shown to alter the size and neuronal architecture of these areas as well as lead to functional differences in learning, memory, and aspects of executive functioning. More specifically, chronic stress is associated with hypertrophy and overactivity in the amygdala and orbitofrontal cortex, whereas comparable levels of adversity can lead to loss of neurons and neural connections in the hippocampus and medial PFC. The functional consequences of these structural changes include more anxiety related to both hyperactivation of the amygdala and less top-down control as a result of PFC atrophy as well as impaired memory and mood control as a consequence of hippocampal reduction.[47] Thus, the developing architecture of the brain can be impaired in numerous ways that create a weak foundation for later learning, behavior, and health.

Along with its role in mediating fear and anxiety, the amygdala is also an activator of the physiologic stress response. Its stimulation activates sympathetic activity and causes neurons in the hypothalamus to release CRH. CRH, in turn, signals the pituitary to release adrenocorticotropic hormone, which then stimulates the adrenal glands to increase serum cortisol concentrations. The amygdala contains large numbers of both CRH and glucocorticoid receptors, beginning early in life, which facilitate the establishment of a positive feedback loop. Significant stress in early childhood can trigger amygdala hypertrophy and result in a hyperresponsive or chronically activated physiologic stress response, along with increased potential for fear and anxiety.[48,49] It is in this way that a child's environment and early experiences get under the skin.

Although the hippocampus can turn off elevated cortisol, chronic stress diminishes its capacity to do so and can lead to impairments in memory and mood-related functions that are located in this brain region. Exposure to chronic stress and high levels of cortisol also inhibit neurogenesis in the hippocampus, which is believed to play an important role in the encoding of memory and other functions. Furthermore, toxic stress limits the ability of the hippocampus to promote contextual learning, making it more difficult to discriminate conditions for which there may be danger versus safety, as is common in posttraumatic stress disorder. Hence, altered brain architecture in response to toxic stress in early childhood could explain, at least in part, the strong association between early adverse experiences and subsequent problems in the development of linguistic, cognitive, and social-emotional skills, all of which are inextricably intertwined in the wiring of the developing brain.[45]

The PFC also participates in turning off the cortisol response and has an important role in the top-down

regulation of autonomic balance (ie, sympathetic versus parasympathetic effects), as well as in the development of executive functions, such as decision-making, working memory, behavioral self-regulation, and mood and impulse control. The PFC is also known to suppress amygdala activity, allowing for more adaptive responses to potentially threatening or stressful experiences; however, exposure to stress and elevated cortisol results in dramatic changes in the connectivity within the PFC, which may limit its ability to inhibit amygdala activity and, thereby, impair adaptive responses to stress. Because the hippocampus and PFC both play a significant role in modulating the amygdala's initiation of the stress response, toxic stress–induced changes in architecture and connectivity within and between these important areas might account for the variability seen in stress-responsiveness.[50] This can then result in some children appearing to be both more reactive to even mildly adverse experiences and less capable of effectively coping with future stress.[36,37,45,51]

Toxic Stress and the Early Childhood Roots of Lifelong Impairments in Physical and Mental Health

As described in the previous section, stress-induced changes in the architecture of different regions of the developing brain (eg, amygdala, hippocampus, and PFC) can have potentially permanent effects on a range of important functions, such as regulating stress physiology, learning new skills, and developing the capacity to make healthy adaptations to future adversity.[52,53] As the scientific evidence for these associations has become better known and has been disseminated more widely, its implications for early childhood policy and programs have become increasingly appreciated by decision makers across the political spectrum. Notwithstanding this growing awareness, however, discussions about early brain development in policy-making circles have focused almost entirely on issues concerned with school readiness as a prerequisite for later academic achievement and the development of a skilled adult workforce. Within this same context, the health dimension of early childhood policy has focused largely on the traditional components of primary pediatric care, such as immunizations, early identification of sensory impairments and developmental delays, and the prompt diagnosis and treatment of medical problems. That said, as advances in the biomedical sciences have generated growing evidence linking biological disruptions associated with adverse childhood experiences (ACE) to greater risk for a variety of chronic diseases well into the adult years, the need to reconceptualize the health dimension of early childhood policy has become increasingly clear.[1,6] Stated simply, the time has come to expand the public's understanding of brain development and shine a bright light on its relation to the early childhood roots of adult disease and to examine the compelling implications of this growing knowledge base for the future of pediatric practice.

The potential consequences of toxic stress in early childhood for the pathogenesis of adult disease are considerable. At the behavioral level, there is extensive evidence of a strong link between early adversity and a wide range of health-threatening behaviors. At the biological level, there is growing documentation of the extent to which both the cumulative burden of stress over time (eg, from chronic maltreatment) and the timing of specific environmental insults during sensitive developmental periods (eg, from first trimester rubella or prenatal alcohol exposure) can create structural and functional disruptions that lead to a wide range of physical and mental illnesses later in adult life.[1,6] A selective overview of this extensive scientific literature is provided below.

The association between ACE and unhealthy adult lifestyles has been well documented. Adolescents with a history of multiple risk factors are more likely to initiate drinking alcohol at a younger age and are more likely to use alcohol as a means of coping with stress than for social reasons.[54] The adoption of unhealthy lifestyles as a coping mechanism might also explain why higher ACE exposures are associated with tobacco use, illicit drug abuse, obesity, and promiscuity,[55,56] as well as why the risk of pathologic gambling is increased in adults who were maltreated as children.[57] Adolescents and adults who manifest higher rates of risk-taking behaviors are also more likely to have trouble maintaining supportive social networks and are at higher risk of school failure, gang membership, unemployment, poverty, homelessness, violent crime, incarceration, and becoming single parents. Furthermore, adults in this high-risk group who become parents themselves are less likely to be able to provide the kind of stable and supportive relationships that are needed to protect their children from the damages of toxic stress. This intergenerational cycle of significant adversity, with its predictable repetition of limited educational achievement and poor health, is mediated, at least in part, by the social inequalities and disrupted social networks that contribute to fragile families and parenting difficulties.[7,58,59]

The adoption of unhealthy lifestyles and associated exacerbation of socioeconomic inequalities are potent

risk factors for poor health. Up to 40% of early deaths have been estimated to be the result of behavioral or lifestyle patterns,[3] and 1 interpretation of the ACE study data is that toxic stress in childhood is associated with the adoption of unhealthy lifestyles as a coping mechanism.[60] An additional 25% to 30% of early deaths are thought to be attributable to either inadequacies in medical care[3] or socioeconomic circumstances, many of which are known to contribute to health care–related disparities.[61–67]

Beyond its strong association with later risk-taking and generally unhealthy lifestyles, it is critically important to underscore the extent to which toxic stress in early childhood has also been shown to cause physiologic disruptions that persist into adulthood and lead to frank disease, even in the absence of later health-threatening behaviors. For example, the biological manifestations of toxic stress can include alterations in immune function[68] and measurable increases in inflammatory markers,[69–72] which are known to be associated with poor health outcomes as diverse as cardiovascular disease,[69,70,73] viral hepatitis,[74] liver cancer,[75] asthma,[76] chronic obstructive pulmonary disease,[77] autoimmune diseases,[78] poor dental health,[72] and depression.[79–81] Thus, toxic stress in early childhood not only is a risk factor for later risky behavior but also can be a direct source of biological injury or disruption that may have lifelong consequences independent of whatever circumstances might follow later in life. In such cases, toxic stress can be viewed as the precipitant of a physiologic memory or biological signature that confers lifelong risk well beyond its time of origin.[38,42–44]

Over and above its toll on individuals, it is also important to address the enormous social and economic costs of toxic stress and its consequences for all of society. The multiple dimensions of these costs extend from differential levels of civic participation and their impacts on the quality of community life to the health and skills of the nation's workforce and its ability to participate successfully in a global economy. In the realm of learning and behavior, economists argue for early and sustained investments in early care and education programs, particularly for children whose parents have limited education and low income, on the basis of persuasive evidence from cost-benefit analyses that reveal the costs of incarceration and diminished economic productivity associated with educational failure.[82–86] In view of the relatively scarce attention to health outcomes in these long-term follow-up studies, the full return on investments that reduce toxic stress in early childhood is likely to be much higher. Health care expenditures that are paying for the consequences of unhealthy lifestyles (eg, obesity, tobacco, alcohol, and substance abuse) are enormous, and the costs of chronic diseases that may have their origins early in life include many conditions that consume a substantial percentage of current state and federal budgets. The potential savings in health care costs from even small, marginal reductions in the prevalence of cardiovascular disease, hypertension, diabetes, and depression are, therefore, likely to dwarf the considerable economic productivity and criminal justice benefits that have been well documented for effective early childhood interventions.

In summary, the EBD approach to childhood adversity discussed in this report has 2 compelling implications for a full, life span perspective on health promotion and disease prevention. First, it postulates that toxic stress in early childhood plays an important causal role in the intergenerational transmission of disparities in educational achievement and health outcomes. Second, it underscores the need for the entire medical community to focus more attention on the roots of adult diseases that originate during the prenatal and early childhood periods and to rethink the concept of preventive health care within a system that currently perpetuates a scientifically untenable wall between pediatrics and internal medicine.

THE NEED FOR A NEW PEDIATRIC PARADIGM TO PROMOTE HEALTH AND PREVENT DISEASE

In his 1966 Aldrich Award address, Dr Julius Richmond identified child development as the basic science of pediatrics.[87] It is now time to expand the boundaries of that science by incorporating more than 4 decades of transformational research in neuroscience, molecular biology, and genomics, along with parallel advances in the behavioral and social sciences (see Fig 1). This newly augmented, interdisciplinary, basic science of pediatrics offers a promising framework for a deeper understanding of the biology and ecology of the developmental process. More importantly, it presents a compelling opportunity to leverage these rapidly advancing frontiers of knowledge to formulate more effective strategies to enhance lifelong outcomes in learning, behavior, and health.

The time has come for a coordinated effort among basic scientists, pediatric subspecialists, and primary care clinicians to develop more effective strategies for addressing the origins of social class, racial, and ethnic disparities in health and development. To this end, a unified, science-based approach to early childhood policy and practice across multiple sectors (including primary health care, early

care and education, and child welfare, among many others) could provide a compelling framework for a new era in community-based investment in which coordinated efforts are driven by a shared knowledge base rather than distracted by a diversity of traditions, approaches, and funding streams.

Recognizing both the critical value and clear limitations of what can be accomplished within the constraints of an office visit, 21st century pediatrics is well positioned to serve as the primary engine for a broader approach to health promotion and disease prevention that is guided by cutting-edge science and expanded in scope beyond individualized health care.[88,89] The pediatric medical home of the future could offer more than the early identification of concerns and timely referral to available programs, as enhanced collaboration between pediatricians and community-based agencies could be viewed as a vehicle for testing promising new intervention strategies rather than simply improving coordination among existing services. With this goal in mind, science tells us that interventions that strengthen the capacities of families and communities to protect young children from the disruptive effects of toxic stress are likely to promote healthier brain development and enhanced physical and mental well-being. The EBD approach proposed in this article is adapted from a science-based framework created by the Center on the Developing Child at Harvard University to advance early childhood policies and programs that support this vision (see Fig 2).[1] Its rationale, essential elements, and implications for pediatric practice are summarized below.

Broadening the Framework for Early Childhood Policy and Practice

Advances across the biological, behavioral, and social sciences support 2 clear and powerful messages for leaders who are searching for more effective ways to improve the health of the nation.[6] First, current health promotion and disease prevention policies focused largely on adults would be more effective if evidence-based investments were also made to strengthen the foundations of health in the prenatal and early childhood periods. Second, significant reductions in chronic disease could be achieved across the life course by decreasing the number and severity of adverse experiences that threaten the well-being of young children and by strengthening the protective relationships that help mitigate the harmful effects of toxic stress. The multiple domains that affect the biology of health and development—including the foundations of healthy development, caregiver and community capacities, and public and private sector policies and programs—provide a rich array of targeted opportunities for the introduction of innovative interventions, beginning in the earliest years of life.[1]

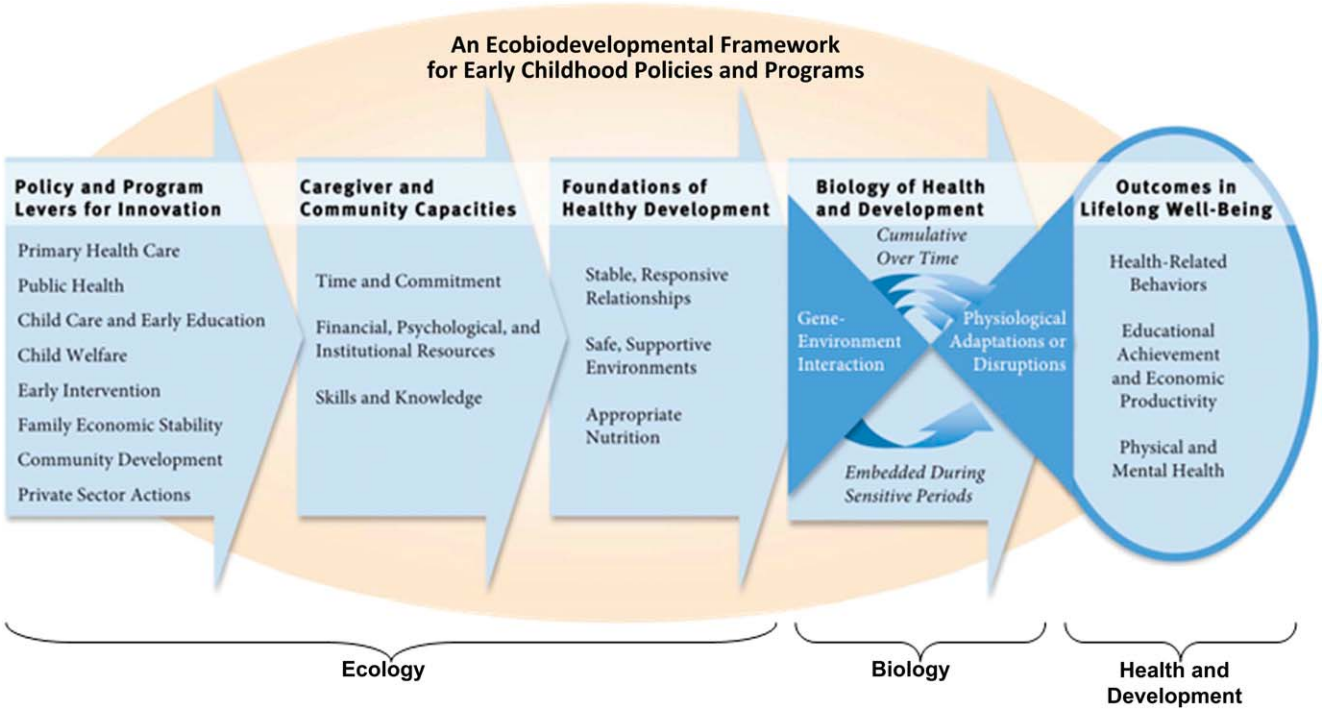

FIGURE 2
An ecobiodevelopmental framework for early childhood policies and programs. This was adapted from ref 1. See text for details.

The biology of health and development explains how experiences and environmental influences get under the skin and interact with genetic predispositions, which then result in various combinations of physiologic adaptation and disruption that affect lifelong outcomes in learning, behavior, and both physical and mental well-being. These findings call for us to augment adult-focused approaches to health promotion and disease prevention by addressing the early childhood origins of lifelong illness and disability.

The foundations of healthy development refers to 3 domains that establish a context within which the early roots of physical and mental well-being are nourished. These include (1) a stable and responsive environment of relationships, which provides young children with consistent, nurturing, and protective interactions with adults to enhance their learning and help them develop adaptive capacities that promote well-regulated stress-response systems; (2) safe and supportive physical, chemical, and built environments, which provide physical and emotional spaces that are free from toxins and fear, allow active exploration without significant risk of harm, and offer support for families raising young children; and (3) sound and appropriate nutrition, which includes health-promoting food intake and eating habits, beginning with the future mother's preconception nutritional status.

Caregiver and community capacities to promote health and prevent disease and disability refers to the ability of family members, early childhood program staff, and the social capital provided through neighborhoods, voluntary associations, and the parents' workplaces to play a major supportive role in strengthening the foundations of child health. These capacities can be grouped into 3 categories: (1) time and commitment; (2) financial, psychological, social, and institutional resources; and (3) skills and knowledge.

Public and private sector policies and programs can strengthen the foundations of health through their ability to enhance the capacities of caregivers and communities in the multiple settings in which children grow up. Relevant policies include both legislative and administrative actions that affect systems responsible for primary health care, public health, child care and early education, child welfare, early intervention, family economic stability (including employment support for parents and cash assistance), community development (including zoning regulations that influence the availability of open spaces and sources of nutritious food), housing, and environmental protection, among others. It is also important to underscore the role that the private sector can play in strengthening the capacities of families to raise healthy and competent children, particularly through supportive workplace policies (such as paid parental leave, support for breastfeeding, and flexible work hours to attend school activities and medical visits).

Defining a Distinctive Niche for Pediatrics Among Multiple Early Childhood Disciplines and Services

Notwithstanding the important goal of ensuring a medical home for all children, extensive evidence on the social determinants of health indicates that the reduction of disparities in physical and mental well-being will depend on more than access to high-quality medical care alone. Moreover, as noted previously, experience tells us that continuing calls for enhanced coordination of effort across service systems are unlikely to be sufficient if the systems are guided by different values and bodies of knowledge and the effects of their services are modest. With these caveats in mind, pediatricians are strategically situated to mobilize the science of early childhood development and its underlying neurobiology to stimulate fresh thinking about both the scope of primary health care and its relation to other programs serving young children and their families. Indeed, every system that touches the lives of children—as well as mothers before and during pregnancy—offers an opportunity to leverage this rapidly growing knowledge base to strengthen the foundations and capacities that make lifelong healthy development possible. Toward this end, explicit investments in the early reduction of significant adversity are particularly likely to generate positive returns.

The possibilities and limitations of well-child care within a multidimensional health system have been the focus of a spirited and enduring discussion within the pediatric community.[88,90,91] Over more than half a century, this dialogue has focused on the need for family-centered, community-based, culturally competent care for children with developmental disabilities, behavior problems, and chronic health impairments, as well as the need for a broader contextual approach to the challenges of providing more effective interventions for children living under conditions of poverty, with or without the additional complications of parental mental illness, substance abuse, and exposure to violence.[10] As the debate has continued, the gap between the call for comprehensive services and the realities of day-to-day practice has remained exceedingly difficult to reduce. Basic recommendations for routine developmental screening and referrals to appropriate community-based services have been particularly difficult

to implement.[92] The obstacles to progress in this area have been formidable at both ends of the process—beginning with the logistical and financial challenges of conducting routine developmental screening in a busy office setting and extending to significant limitations in access to evidence-based services for children and families who are identified as having problems that require intervention.

Despite long-standing calls for an explicit, community-focused approach to primary care, a recent national study of pediatric practices identified persistent difficulties in achieving effective linkages with community-based resources as a major challenge.[92] A parallel survey of parents also noted the limited communication that exists between pediatric practices and community-based services, such as Supplemental Nutrition Program for Women, Infants, and Children; child care providers; and schools.[93] Perhaps most important, both groups agreed that pediatricians cannot be expected to meet all of a child's needs. This challenge is further complicated by the marked variability in quality among community-based services that are available—ranging from evidence-based interventions that clearly improve child outcomes to programs that appear to have only marginal effects or no measurable impacts. Thus, although chronic difficulty in securing access to indicated services is an important problem facing most practicing pediatricians, the limited evidence of effectiveness for many of the options that are available (particularly in rural areas and many states in which public investment in such services is more limited) presents a serious problem that must be acknowledged and afforded greater attention.

At this point in time, the design and successful implementation of more effective models of health promotion and disease prevention for children experiencing significant adversity will require more than advocacy for increased funding. It will require a deep investment in the development, testing, continuous improvement, and broad replication of innovative models of cross-disciplinary policy and programmatic interventions that are guided by scientific knowledge and led by practitioners in the medical, educational, and social services worlds who are truly ready to work together (and to train the next generation of practitioners) in new ways.[88,89] The sheer number and complexity of underaddressed threats to child health that are associated with toxic stress demands bold, creative leadership and the selection of strategic priorities for focused attention. To this end, science suggests that 2 areas are particularly ripe for fresh thinking: the child welfare system and the treatment of maternal depression.

For more than a century, child welfare services have focused on physical safety, reduction of repeated injury, and child custody. Within this context, the role of the pediatrician is focused largely on the identification of suspected maltreatment and the documentation and treatment of physical injuries. Advances in our understanding of the impact of toxic stress on lifelong health now underscore the need for a broader pediatric approach to meet the needs of children who have been abused or neglected. In some cases, this could be provided within a medical home by skilled clinicians with expertise in early childhood mental health. In reality, however, the magnitude of needs in this area generally exceeds the capacity of most primary care practice settings. A report from the Institute of Medicine and National Research Council[15] stated that these needs could be addressed through regularized referrals from the child welfare system to the early intervention system for children with developmental delays or disabilities; subsequent federal reauthorizations of the Keeping Children and Families Safe Act and the Individuals with Disabilities Education Act (Part C) both included requirements for establishing such linkages. The implementation of these federal requirements, however, has moved slowly.

The growing availability of evidence-based interventions that have been shown to improve outcomes for children in the child welfare system[94] underscores the compelling need to transform "child protection" from its traditional concern with physical safety and custody to a broader focus on the emotional, social, and cognitive costs of maltreatment. The Centers for Disease Control and Prevention has taken an important step forward by promoting the prevention of child maltreatment as a public health concern.[95,96] The pediatric community could play a powerful role in leading the call for implementation of the new requirement for linking child welfare to early intervention programs, as well as bringing a strong, science-based perspective to the collaborative development and implementation of more effective intervention models.

The widespread absence of attention to the mother-child relationship in the treatment of depression in women with young children is another striking example of the gap between science and practice that could be reduced by targeted pediatric advocacy.[97] Extensive research has demonstrated the extent to which maternal depression compromises the contingent reciprocity between a mother and her young child that is essential for healthy cognitive, linguistic, social, and emotional development.[98] Despite that well-documented observation, the treatment of depression in women with

young children is typically viewed as an adult mental health service and rarely includes an explicit focus on the mother-child relationship. This serious omission illustrates a lack of understanding of the consequences for the developing brain of a young child when the required "serve and return" reciprocity of the mother-child relationship is disrupted or inconsistent. Consequently, and not surprisingly, abundant clinical research indicates that the successful treatment of a mother's depression does not generally translate into comparable recovery in her young child unless there is an explicit therapeutic focus on their dyadic relationship.[98] Pediatricians are the natural authorities to shed light on this current deficiency in mental health service delivery. Advocating for payment mechanisms that require (or provide incentives for) the coordination of child and parent medical services (eg, through automatic coverage for the parent-child dyad linked to reimbursement for the treatment of maternal depression) offers 1 promising strategy that American Academy of Pediatrics state chapters could pursue. As noted previously, although some medical homes may have the expertise to provide this kind of integrative treatment, most pediatricians rely on the availability of other professionals with specialized skills who are often difficult to find. Whether such services are provided within or connected to the medical home, it is clear that standard pediatric practice must move beyond screening for maternal depression and invest greater energy in securing the provision of appropriate and effective treatment that meets the needs of both mothers and their young children.

The targeted messages conveyed in these 2 examples are illustrative of the kinds of specific actions that offer promising new directions for the pediatric community beyond general calls for comprehensive, family-centered, community-based services. Although the practical constraints of office-based practice make it unlikely that many primary care clinicians will ever play a lead role in the treatment of children affected by maltreatment or maternal depression, pediatricians are still the best positioned among all the professionals who care for young children to provide the public voice and scientific leadership needed to catalyze the development and implementation of more effective strategies to reduce adversities that can lead to lifelong disparities in learning, behavior, and health.

A great deal has been said about how the universality of pediatric primary care makes it an ideal platform for coordinating the services needed by vulnerable, young children and their families. In this respect, the medical home is strategically positioned to play 2 important roles. The first is to ensure that needs are identified, state-of-the-art management is provided as indicated, and credible evaluation is conducted to assess the effects of the services that are being delivered. The second and, ultimately, more transformational role is to mobilize the entire pediatric community (including both clinical specialists and basic scientists) to drive the design and testing of much-needed, new, science-based interventions to reduce the sources and consequences of significant adversity in the lives of young children.[99] To this end, a powerful new role awaits a new breed of pediatricians who are prepared to build on the best of existing community-based services and to work closely with creative leaders from a range of disciplines and sectors to inform innovative approaches to health promotion and disease prevention that generate greater effects than existing efforts.

No other profession brings a comparable level of scientific expertise, professional stature, and public trust—and nothing short of transformational thinking beyond the hospital and office settings is likely to create the magnitude of breakthroughs in health promotion that are needed to match the dramatic advances that are currently emerging in the treatment of disease. This new direction must be part of the new frontier in pediatrics —a frontier that brings cutting-edge scientific thinking to the multidimensional world of early childhood policy and practice for children who face significant adversity. Moving that frontier forward will benefit considerably from pediatric leadership that provides an intellectual and operational bridge connecting the basic sciences of neurobiology, molecular genetics, and developmental psychology to the broad and diverse landscape of health, education, and human services.

SUMMARY

A vital and productive society with a prosperous and sustainable future is built on a foundation of healthy child development. Health in the earliest years—beginning with the future mother's well-being before she becomes pregnant—lays the groundwork for a lifetime of the physical and mental vitality that is necessary for a strong workforce and responsible participation in community life. When developing biological systems are strengthened by positive early experiences, children are more likely to thrive and grow up to be healthy, contributing adults. Sound health in early childhood provides a foundation for the construction of sturdy brain architecture and the achievement of a broad range of skills and learning capacities. Together these constitute the building blocks for a vital and sustainable society that invests in its

human capital and values the lives of its children.

Advances in neuroscience, molecular biology, and genomics have converged on 3 compelling conclusions: (1) early experiences are built into our bodies; (2) significant adversity can produce physiologic disruptions or biological memories that undermine the development of the body's stress response systems and affect the developing brain, cardiovascular system, immune system, and metabolic regulatory controls; and (3) these physiologic disruptions can persist far into adulthood and lead to lifelong impairments in both physical and mental health. This technical report presents a framework for integrating recent advances in our understanding of human development with a rich and growing body of evidence regarding the disruptive effects of childhood adversity and toxic stress. The EBD framework that guides this report suggests that many adult diseases are, in fact, developmental disorders that begin early in life. This framework indicates that the future of pediatrics lies in its unique leadership position as a credible and respected voice on behalf of children, which provides a powerful platform for translating scientific advances into more effective strategies and creative interventions to reduce the early childhood adversities that lead to lifelong impairments in learning, behavior, and health.

CONCLUSIONS

1. Advances in a broad range of interdisciplinary fields, including developmental neuroscience, molecular biology, genomics, epigenetics, developmental psychology, epidemiology, and economics, are converging on an integrated, basic science of pediatrics (see Fig 1).
2. Rooted in a deepening understanding of how brain architecture is shaped by the interactive effects of both genetic predisposition and environmental influence, and how its developing circuitry affects a lifetime of learning, behavior, and health, advances in the biological sciences underscore the foundational importance of the early years and support an EBD framework for understanding the evolution of human health and disease across the life span.
3. The biology of early childhood adversity reveals the important role of toxic stress in disrupting developing brain architecture and adversely affecting the concurrent development of other organ systems and regulatory functions.
4. Toxic stress can lead to potentially permanent changes in learning (linguistic, cognitive, and social-emotional skills), behavior (adaptive versus maladaptive responses to future adversity), and physiology (a hyperresponsive or chronically activated stress response) and can cause physiologic disruptions that result in higher levels of stress-related chronic diseases and increase the prevalence of unhealthy lifestyles that lead to widening health disparities.
5. The lifelong costs of childhood toxic stress are enormous, as manifested in adverse impacts on learning, behavior, and health, and effective early childhood interventions provide critical opportunities to prevent these undesirable outcomes and generate large economic returns for all of society.
6. The consequences of significant adversity early in life prompt an urgent call for innovative strategies to reduce toxic stress within the context of a coordinated system of policies and services guided by an integrated science of early childhood and early brain development.
7. An EBD framework, grounded in an integrated basic science, provides a clear theory of change to help leaders in policy and practice craft new solutions to the challenges of societal disparities in health, learning, and behavior (see Fig 2).
8. Pediatrics provides a powerful yet underused platform for translating scientific advances into innovative early childhood policies, and practicing pediatricians are ideally positioned to participate "on the ground" in the design, testing, and refinement of new models of disease prevention, health promotion, and developmental enhancement beginning in the earliest years of life.

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REFERENCES

1. Center on the Developing Child at Harvard University. The foundations of lifelong health are built in early childhood. Available at: www.developingchild.harvard.edu. Accessed March 8, 2011
2. Knudsen EI, Heckman JJ, Cameron JL, Shonkoff JP. Economic, neurobiological, and behavioral perspectives on building America's future workforce. *Proc Natl Acad Sci U S A*. 2006;103(27):10155–10162
3. McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Aff (Millwood)*. 2002;21(2):78–93
4. Schor EL, Abrams M, Shea K. Medicaid: health promotion and disease prevention for school readiness. *Health Aff (Millwood)*. 2007;26(2):420–429
5. Wen CP, Tsai SP, Chung WS. A 10-year experience with universal health insurance in Taiwan: measuring changes in health and health disparity. *Ann Intern Med*. 2008; 148(4):258–267
6. Shonkoff JP, Boyce WT, McEwen BS. Neuroscience, molecular biology, and the childhood roots of health disparities: building a new framework for health promotion and disease prevention. *JAMA*. 2009;301(21): 2252–2259
7. Braveman P, Barclay C. Health disparities beginning in childhood: a life-course perspective. *Pediatrics*. 2009;124(suppl 3):S163–S175
8. Haggerty RJRK, Pless IB. *Child Health and the Community*. New York, NY: John Wiley and Sons; 1975
9. Committee on Psychosocial Aspects of Child and Family Health; American Academy of Pediatrics. The new morbidity revisited: a renewed commitment to the psychosocial aspects of pediatric care. *Pediatrics*. 2001;108(5):1227–1230
10. Palfrey JS, Tonniges TF, Green M, Richmond J. Introduction: addressing the millennial morbidity—the context of community pediatrics. *Pediatrics*. 2005;115(suppl 4): 1121–1123
11. Flores G, ; Committee On Pediatric Research. Technical report—racial and ethnic disparities in the health and health care of children. *Pediatrics*. 2010;125(4). Available at: www.pediatrics.org/cgi/content/full/125/4/e979
12. Bronfenbrenner U. *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University Press; 1979
13. Sameroff A. A unified theory of development: a dialectic integration of nature and nurture. *Child Dev*. 2010;81(1):6–22
14. Sameroff AJ, Chandler MJ. Reproductive risk and the continuum of caretaking causality. In: Horowitz FD, Hetherington M, Scarr-Salapatek S, Siegel G, eds. *Review of Child Development Research*. Chicago, IL: University of Chicago; 1975:187–244
15. National Research Council, Institute of Medicine, Committee on Integrating the Science of Early Childhood Development; Shonkoff JP, Phillips D, eds. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: National Academies Press; 2000
16. Bronfenbrenner U. *Making Human Beings Human: Bioecological Perspectives on Human Development*. Thousand Oaks, CA: Sage Publications; 2005
17. Shonkoff JP. Building a new biodevelopmental framework to guide the future of early childhood policy. *Child Dev*. 2010;81(1):357–367
18. Bagot RC, Meaney MJ. Epigenetics and the biological basis of gene × environment interactions. *J Am Acad Child Adolesc Psychiatry*. 2010;49(8):752–771
19. National Scientific Council on the Developing Child. Early experiences can alter gene expression and affect long-term development: working paper #10. Available at: www.developingchild.net. Accessed March 8, 2011
20. Meaney MJ. Epigenetics and the biological definition of gene × environment interactions. *Child Dev*. 2010;81(1):41–79
21. Meaney MJ, Szyf M. Environmental programming of stress responses through DNA methylation: life at the interface between a dynamic environment and a fixed genome. *Dialogues Clin Neurosci*. 2005;7(2):103–123
22. Szyf M, McGowan P, Meaney MJ. The social environment and the epigenome. *Environ Mol Mutagen*. 2008;49(1):46–60
23. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245–258
24. Schweinhart LJ. *Lifetime Effects: The High/Scope Perry Preschool Study Through Age 40*. Ypsilanti, MI: High/Scope Press; 2005
25. Flaherty EG, Thompson R, Litrownik AJ, et al. Effect of early childhood adversity on child health. *Arch Pediatr Adolesc Med*. 2006;160(12):1232–1238
26. Koenen KC, Moffitt TE, Poulton R, Martin J, Caspi A. Early childhood factors associated with the development of post-traumatic stress disorder: results from a longitudinal birth cohort. *Psychol Med*. 2007;37(2):181–192
27. Flaherty EG, Thompson R, Litrownik AJ, et al. Adverse childhood exposures and reported child health at age 12. *Acad Pediatr*. 2009;9(3):150–156
28. Cottrell EC, Seckl JR. Prenatal stress, glucocorticoids and the programming of adult disease. *Front Behav Neurosci*. 2009;3:19
29. Darnaudéry M, Maccari S. Epigenetic programming of the stress response in male and female rats by prenatal restraint stress. *Brain Res Brain Res Rev*. 2008;57(2):571–585
30. Seckl JR, Meaney MJ. Glucocorticoid "programming" and PTSD risk. *Ann N Y Acad Sci*. 2006;1071:351–378
31. Oberlander TF, Weinberg J, Papsdorf M, Grunau R, Misri S, Devlin AM. Prenatal exposure to maternal depression, neonatal methylation of human glucocorticoid receptor gene (NR3C1) and infant cortisol

stress responses. *Epigenetics*. 2008;3(2):97–106

32. Brand SR, Engel SM, Canfield RL, Yehuda R. The effect of maternal PTSD following in utero trauma exposure on behavior and temperament in the 9-month-old infant. *Ann N Y Acad Sci*. 2006;1071:454–458
33. Murgatroyd C, Patchev AV, Wu Y, et al. Dynamic DNA methylation programs persistent adverse effects of early-life stress. *Nat Neurosci*. 2009;12(12):1559–1566
34. Roth TL, Lubin FD, Funk AJ, Sweatt JD. Lasting epigenetic influence of early-life adversity on the BDNF gene. *Biol Psychiatry*. 2009;65(9):760–769
35. Szyf M. The early life environment and the epigenome. *Biochim Biophys Acta*. 2009;1790(9):878–885
36. Compas BE. Psychobiological processes of stress and coping: implications for resilience in children and adolescents—comments on the papers of Romeo & McEwen and Fisher et al. *Ann N Y Acad Sci*. 2006;1094:226–234
37. Gunnar M, Quevedo K. The neurobiology of stress and development. *Annu Rev Psychol*. 2007;58:145–173
38. McEwen BS. Physiology and neurobiology of stress and adaptation: central role of the brain. *Physiol Rev*. 2007;87(3):873–904
39. McEwen BS. Stressed or stressed out: what is the difference? *J Psychiatry Neurosci*. 2005;30(5):315–318
40. McEwen BS, Seeman T. Protective and damaging effects of mediators of stress. Elaborating and testing the concepts of allostasis and allostatic load. *Ann N Y Acad Sci*. 1999;896:30–47
41. McEwen BS. Protective and damaging effects of stress mediators. *N Engl J Med*. 1998;338(3):171–179
42. Korte SM, Koolhaas JM, Wingfield JC, McEwen BS. The Darwinian concept of stress: benefits of allostasis and costs of allostatic load and the trade-offs in health and disease. *Neurosci Biobehav Rev*. 2005;29(1):3–38
43. McEwen BS. Mood disorders and allostatic load. *Biol Psychiatry*. 2003;54(3):200–207
44. McEwen BS. Stress, adaptation, and disease. Allostasis and allostatic load. *Ann N Y Acad Sci*. 1998;840:33–44
45. National Scientific Council on the Developing Child. *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper #3*. Available at: developingchild.harvard.edu/resources/reports_and_working_papers/. Accessed March 8, 2011
46. McEwen BS. Protective and damaging effects of stress mediators: central role of the brain. *Dialogues Clin Neurosci*. 2006;8(4):367–381
47. McEwen BS, Gianaros PJ. Stress- and allostasis-induced brain plasticity. Annu Rev Med. 2011;62:431–445
48. National Scientific Council on the Developing Child. Persistent fear and anxiety can affect young children's learning and development: working paper #9. Available at: www.developingchild.net. Accessed March 8, 2011
49. Tottenham N, Hare TA, Quinn BT, et al. Prolonged institutional rearing is associated with atypically large amygdala volume and difficulties in emotion regulation. *Dev Sci*. 2010;13(1):46–61
50. Boyce WT, Ellis BJ. Biological sensitivity to context: I. An evolutionary-developmental theory of the origins and functions of stress reactivity. *Dev Psychopathol*. 2005;17(2):271–301
51. Francis DD. Conceptualizing child health disparities: a role for developmental neurogenomics. *Pediatrics*. 2009;124(suppl 3):S196–S202
52. Juster RP, McEwen BS, Lupien SJ. Allostatic load biomarkers of chronic stress and impact on health and cognition. *Neurosci Biobehav Rev*. 2010;35(1):2–16
53. McEwen BS, Gianaros PJ. Central role of the brain in stress and adaptation: links to socioeconomic status, health, and disease. *Ann N Y Acad Sci*. 2010;1186:190–222
54. Rothman EF, Edwards EM, Heeren T, Hingson RW. Adverse childhood experiences predict earlier age of drinking onset: results from a representative US sample of current or former drinkers. *Pediatrics*. 2008;122(2). Available at: www.pediatrics.org/cgi/content/full/122/2/e298
55. Anda RF, Croft JB, Felitti VJ, et al. Adverse childhood experiences and smoking during adolescence and adulthood. *JAMA*. 1999;282(17):1652–1658
56. Anda RF, Felitti VJ, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci*. 2006;256(3):174–186
57. Scherrer JF, Xian H, Kapp JM, et al. Association between exposure to childhood and lifetime traumatic events and lifetime pathological gambling in a twin cohort. *J Nerv Ment Dis*. 2007;195(1):72–78
58. Wickrama KA, Conger RD, Lorenz FO, Jung T. Family antecedents and consequences of trajectories of depressive symptoms from adolescence to young adulthood: a life course investigation. *J Health Soc Behav*. 2008;49(4):468–483
59. Kahn RS, Brandt D, Whitaker RC. Combined effect of mothers' and fathers' mental health symptoms on children's behavioral and emotional well-being. *Arch Pediatr Adolesc Med*. 2004;158(8):721–729
60. Felitti VJ. Adverse childhood experiences and adult health. *Acad Pediatr*. 2009;9(3):131–132
61. Althoff KN, Karpati A, Hero J, Matte TD. Secular changes in mortality disparities in New York City: a reexamination. *J Urban Health*. 2009;86(5):729–744
62. Cheng TL, Jenkins RR. Health disparities across the lifespan: where are the children? *JAMA*. 2009;301(23):2491–2492
63. DeVoe JE, Tillotson C, Wallace LS. Uninsured children and adolescents with insured parents. *JAMA*. 2008;300(16):1904–1913
64. Due P, Merlo J, Harel-Fisch Y, et al. Socioeconomic inequality in exposure to bullying during adolescence: a comparative, cross-sectional, multilevel study in 35 countries. *Am J Public Health*. 2009;99(5):907–914
65. Reid KW, Vittinghoff E, Kushel MB. Association between the level of housing instability, economic standing and health care access: a meta-regression. *J Health Care Poor Underserved*. 2008;19(4):1212–1228
66. Stevens GD, Pickering TA, Seid M, Tsai KY. Disparities in the national prevalence of a quality medical home for children with asthma. *Acad Pediatr*. 2009;9(4):234–241
67. Williams DR, Sternthal M, Wright RJ. Social determinants: taking the social context of asthma seriously. *Pediatrics*. 2009;123(suppl 3):S174–S184
68. Bierhaus A, Wolf J, Andrassy M, et al. A mechanism converting psychosocial stress into mononuclear cell activation. *Proc Natl Acad Sci U S A*. 2003;100(4):1920–1925
69. Araújo JP, Lourenço P, Azevedo A, et al. Prognostic value of high-sensitivity C-reactive protein in heart failure: a systematic review. *J Card Fail*. 2009;15(3):256–266
70. Galkina E, Ley K. Immune and inflammatory mechanisms of atherosclerosis (*). *Annu Rev Immunol*. 2009;27:165–197
71. Miller GE, Chen E. Harsh family climate in early life presages the emergence of a proinflammatory phenotype in adolescence. *Psychol Sci*. 2010;21(6):848–856
72. Poulton R, Caspi A, Milne BJ, et al. Association between children's experience of socioeconomic disadvantage and adult health: a life-course study. *Lancet*. 2002;360(9346):1640–1645
73. Ward JR, Wilson HL, Francis SE, Crossman DC, Sabroe I. Translational mini-review series on immunology of vascular disease: inflammation, infections and Toll-like

receptors in cardiovascular disease. *Clin Exp Immunol*. 2009;156(3):386–394

74. Heydtmann M, Adams DH. Chemokines in the immunopathogenesis of hepatitis C infection. *Hepatology*. 2009;49(2):676–688
75. Berasain C, Castillo J, Perugorria MJ, Latasa MU, Prieto J, Avila MA. Inflammation and liver cancer: new molecular links. *Ann N Y Acad Sci*. 2009;1155:206–221
76. Chen E, Miller GE. Stress and inflammation in exacerbations of asthma. *Brain Behav Immun*. 2007;21(8):993–999
77. Yao H, Rahman I. Current concepts on the role of inflammation in COPD and lung cancer. *Curr Opin Pharmacol*. 2009;9(4):375–383
78. Li M, Zhou Y, Feng G, Su SB. The critical role of Toll-like receptor signaling pathways in the induction and progression of autoimmune diseases. *Curr Mol Med*. 2009;9(3):365–374
79. Danese A, Moffitt TE, Pariante CM, Ambler A, Poulton R, Caspi A. Elevated inflammation levels in depressed adults with a history of childhood maltreatment. *Arch Gen Psychiatry*. 2008;65(4):409–415
80. Danese A, Pariante CM, Caspi A, Taylor A, Poulton R. Childhood maltreatment predicts adult inflammation in a life-course study. *Proc Natl Acad Sci U S A*. 2007;104(4):1319–1324
81. Howren MB, Lamkin DM, Suls J. Associations of depression with C-reactive protein, IL-1, and IL-6: a meta-analysis. *Psychosom Med*. 2009;71(2):171–186
82. Cuhna F, Heckman JJ, Lochner LJ, Masterov DV. Interpreting the evidence on life cycle skill formation. In: Hanushek EA, Welch F, eds. *Handbook of the Economics of Education*. Amsterdam, Netherlands: North-Holland; 2006:697–812
83. Heckman JJ, Stixrud J, Urzua S. The effects of cognitive and non-cognitive abilities on labor market outcomes and social behavior. *J Labor Econ*. 2006;24:411–482
84. Heckman JJ. Role of income and family influence on child outcomes. Ann N Y Acad Sci. 2008;1136:307–323
85. Heckman JJ. The case for investing in disadvantaged young children. Available at: www.firstfocus.net/sites/default/files/r.2008-9.15.ff_.pdf. Accessed March 8, 2011
86. Heckman JJ, Masterov DV. The productivity argument for investing in young children. Available at: http://jenni.uchicago.edu/human-inequality/papers/Heckman_final_all_wp_2007-03-22c_jsb.pdf. Accessed March 8, 2011
87. Richmond JB. Child development: a basic science for pediatrics. *Pediatrics*. 1967;39(5):649–658
88. Leslie LK, Slaw KM, Edwards A, Starmer AJ, Duby JC, ; Members of Vision of Pediatrics 2020 Task Force. Peering into the future: pediatrics in a changing world. *Pediatrics*. 2010;126(5):982–988
89. Starmer AJ, Duby JC, Slaw KM, Edwards A, Leslie LK, ; Members of Vision of Pediatrics 2020 Task Force. Pediatrics in the year 2020 and beyond: preparing for plausible futures. *Pediatrics*. 2010;126(5):971–981
90. Halfon N, DuPlessis H, Inkelas M. Transforming the U.S. child health system. *Health Aff (Millwood)*. 2007;26(2):315–330
91. Schor EL. The future pediatrician: promoting children's health and development. *J Pediatr*. 2007;151(suppl 5):S11–S16
92. Tanner JL, Stein MT, Olson LM, Frintner MP, Radecki L. Reflections on well-child care practice: a national study of pediatric clinicians. *Pediatrics*. 2009;124(3):849–857
93. Radecki L, Olson LM, Frintner MP, Tanner JL, Stein MT. What do families want from well-child care? Including parents in the rethinking discussion. *Pediatrics*. 2009;124(3):858–865
94. Fisher PA, Gunnar MR, Dozier M, Bruce J, Pears KC. Effects of therapeutic interventions for foster children on behavioral problems, caregiver attachment, and stress regulatory neural systems. *Ann N Y Acad Sci*. 2006;1094:215–225
95. Mercy JA, Saul J. Creating a healthier future through early interventions for children. *JAMA*. 2009;301(21):2262–2264
96. Middlebrooks JS, Audage NC. The effects of childhood stress on health across the lifespan. Available at: www.cdc.gov/ncipc/pubres/pdf/Childhood_Stress.pdf. Accessed July 20, 2009
97. Earls MF, ; Committee on Psychosocial Aspects of Child and Family Health; American Academy of Pediatrics. Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. *Pediatrics*. 2010;126(5):1032–1039
98. Center on the Developing Child at Harvard University. Maternal depression can undermine the development of young children: working paper #8. Available at: www.developingchild.harvard.edu. Accessed March 8, 2011
99. Shonkoff J. Protecting brains, not simply stimulating minds. *Science*. 2011;333(6045):982–983

The Lifelong Effects of Early Childhood Adversity and Toxic Stress

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Seizing New Policy Opportunities to Help Low-Income Mothers with Depression:

Current Landscape, Innovations, and Next Steps

June 2016 | Stephanie Schmit and Christina Walker

Executive Summary

Background

If the nation could get better at identifying and treating maternal depression among low-income women, particularly women with young children, it would be an extraordinary public health opportunity, as the National Research Council (NRC) and Institute of Medicine (IOM) pointed out in their comprehensive 2009 report on depression in parents.[1] One reason is that depression is widespread among low-income mothers—for example, one in nine babies in poverty has a mother suffering from severe depression, and half have a mother experiencing depression at some level of severity.[2] The second reason is the harm untreated depression presents to both mother and child. It hinders a mother's capacity to help her young child develop, places children's safety and cognitive and emotional development at risk, and stymies her own efforts to escape poverty. Unfortunately, even though research shows that effective treatments for depression address these challenges[3], low-income mothers of young children have very high rates of untreated depression.

This paper details information gathered through a scan of federal, state, and local efforts to seize this public health opportunity at a large scale, building on new policy provisions available through the Patient Protection and Affordable Care Act (ACA), recent federal decisions and guidance, and local and state innovations. This brief drew upon interviews of child care and early education, health, and mental health stakeholders. Because the stakes for young children's development are so high, it is important for stakeholders from these particular sectors to understand whether and how advocates and policymakers in the child care and early childhood sector could seize these new levers for change.

Two broad lessons emerged from the work. First, while the provisions of the ACA offer important new routes to finance, expand, and systematize maternal depression identification and treatment, major efforts to take advantage of these positive policy changes are still very rare. The reasons include historical barriers between the health, mental health, and child care and early education systems; the difficulty of understanding and influencing complex policies—particularly in Medicaid; and the lack of national strategy or targeted technical assistance that could help cut through this complexity. Second, many innovative ideas for improving identification and treatment of maternal depression are surfacing from the local and state levels. These include policy initiatives—such as identifying new Medicaid reimbursement strategies to support evidence-based depression treatment, expanding reimbursement for outreach activities, or seeking to reduce gaps in coverage after the perinatal period—as well as initiatives that focus on the structures that make better policy possible—for example, creating new opportunities for stakeholders to collaborate or improving measures and accountability. This suggests that the moment is ripe to learn from and spread these early innovations.

In order to understand multiple stakeholder perspectives in a variety of contexts, the scan included in-depth interviews in four states: Connecticut, Minnesota, Ohio, and Virginia. In addition to more than three dozen interviews, the paper also drew upon a literature and document review as well as insight, advice, and guidance from an expert advisory committee of seven people representing child care and early education, mental health, and Medicaid.

The Landscape

The interviews identified that no state had yet created an effective and comprehensive state-wide approach. Interviewees across the health, mental health, and child care and early education sectors suggested that it is difficult to make systems-level changes when systems are siloed and when each has an approach to serving individuals from either the child or the adult's perspective. In addition, while many stakeholders outside the Medicaid sectors did not report knowledge of or engagement with Medicaid, others were able to identify specific challenges in their state's Medicaid policies that they felt held back progress on depression screening and treatment for low-income mothers with young children.

At the same time, the scan also highlighted a striking level of emerging innovation. In every state, at least one stakeholder could identify a local or state initiative to address maternal depression. Some examples include:

- In New Haven, CT, the Mental Health Outreach for Mothers (MOMS) Partnership—a collaborative of agencies working to improve the wellbeing of mothers and children—supports local mothers serving as Community Mental Health Ambassadors to deliver screening, brief intervention, and referral/linkage to clinical treatment. The Partnership is currently exploring Medicaid reimbursement for this new outreach model with the state of Connecticut.
- In Ohio, an evidence-based maternal depression treatment for mothers who are participating in home visiting programs is provided by mental health clinicians working in partnership with home visitors. The model has expanded to home visiting programs in ten states. In four of those states (South Carolina, Kentucky, West Virginia, and Massachusetts), Medicaid is paying for the program.
- In Minnesota, advocates are exploring strategies to extend Medicaid coverage for mothers to two years postpartum. Because Minnesota covers pregnant women under Medicaid to a higher income level than after they give birth, stakeholders are concerned that a woman whose income falls just over the Medicaid standard could have to shift her insurance coverage to the health exchange right in the midst of depression treatment, potentially requiring co-payments that would discourage her continued participation and/or forcing her to change providers.
- In Virginia, child care and early education and mental health advocates are working with the state's Medicaid office to explore ways to seek Medicaid coverage for maternal depression treatment for a mother and child together (referred to as "dyadic" treatment) when only the child has Medicaid eligibility, making it possible to help more families.
- In all states, stakeholders had ideas and possible solutions to help create the conditions for policy reform. These included bringing stakeholders together to design or implement better approaches to addressing maternal depression, improving cross-training, better integrating primary and behavioral health care, collecting data to understand the state's needs, and exploring quality and outcome measures related to maternal depression.

Additionally, in 2016, the federal government took three significant steps that could galvanize additional state and local activity.

- On January 26, 2016, the U.S. Preventive Services Task Force (USPSTF) determined that

screening for depression in all adults is a preventive service that is well-supported by evidence. This recommendation specifically includes pregnant and postpartum women, and – in a separate opinion - adolescents ages 12-18. This decision means that state Medicaid programs have the opportunity to get an incentive payment if they cover this screening and other preventive services with no cost-sharing to the beneficiary.

- On March 2, 2016, the U.S. Centers for Medicare and Medicaid Services, or CMS (which oversees Medicaid at the federal level), and the Health Resources and Services Administration (which oversees home visiting, among other things) issued a joint guidance letter to help states understand how to appropriately draw on Medicaid funding to support home visiting. The guidance could be helpful for maternal depression initiatives, which may include home visiting components; it also provides a model that CMS could follow for other topics related to maternal depression.
- On May 11, 2016, CMS issued its first guidance directly related to maternal depression treatment, explaining how states can fund maternal depression screening and mother-child dyadic treatment using a child's Medicaid eligibility. Based on our interviews, this guidance directly addresses one of the issues a number of states are considering, and it could offer an excellent opportunity for bringing child care and early education, mental health, health, and other stakeholders together to address maternal depression policies more broadly. In addition, it provides a model that CMS could follow for other policy topics.

Next Steps

To build from the individual innovations identified above and move to a future of systemic success in identifying and treating maternal depression will require new and powerful connections across levels of government and across sectors. At minimum, these sectors must include stakeholders from the health, mental health, and child care and early education sectors. Others who are engaged in improving the lives of low-income families and families of color, such as child welfare, should also be considered as partners in this important work. The recommendations below propose a path forward that combines immediate steps for early successes, the development of infrastructure to sustain the effort, and the creation of a clear policy framework to make it far easier for states to do this work in the future without reinventing the wheel.

<u>For the states</u>:

1. Seize the opportunity of the USPSTF recommendations and the two federal guidance documents (on home visiting and depression screening/dyadic treatment) as catalysts for:
    a. outreach and technical assistance from national experts to state leaders and advocates; and
    b. state convenings that bring together stakeholders from all three sectors to learn about the opportunities and consider next steps.
2. Identify and implement high-priority improvements in Medicaid and related policies to support maternal depression identification and treatment among low-income mothers of young children.

<u>For philanthropy</u>:

3. Bring together leading state and local innovators along with national experts and federal staff from all relevant sectors in an intensive experience such as through a roundtable or convening. The goals should be to broaden the conversation about the most promising next steps—building on the findings of this brief, the new federal opportunities, and the innovations emerging from ground-level—and recruit core partners for the ongoing work needed to better address maternal depression.
4. Support an ongoing learning community of state and local innovation partners that would conduct regular calls, webinars, and potentially in-person meetings.
5. Support the development of a working list of high-priority areas for federal action, including a short list for completion during the Obama Administration and a longer list to be incorporated into transition documents and briefings. This list would likely include specific areas of Medicaid policy that need clarification or policy guidance.
6. Support work towards an overarching state policy framework to improve maternal depression identification and treatment, based on the information gathered from the steps listed above. This policy framework should be developed in partnership with the early adopter states in the learning community and would be a tool other states could use to reform their systems.

For federal agencies:

7. Issue guidance jointly across federal agencies in the high-priority areas identified by states and national partners. For example, just as HRSA and CMS jointly issued the home visiting guidance, the Administration for Children and Families (ACF), the Substance Abuse and Mental Health Services Administration (SAMHSA), CMS, and other agencies as needed could jointly issue other guidance letters—building on the dyadic treatment letter—that address additional policy questions that come up in using Medicaid to support evidence-based maternal depression treatment.
8. Provide ongoing technical assistance jointly supported by the relevant federal agencies. For example, identify a lead agency with a permanent technical assistance center (such as SAMHSA) to convene other relevant agencies to collaborate and provide the necessary technical assistance to the states.
9. Explore, in collaboration with states, the implications for improved maternal depression policies whenever new regulations or decisions affecting the broader Medicaid context for children and families are implemented. For example, as states implement new Medicaid managed care rules, federal agencies should provide assistance to help states identify opportunities for improving maternal depression treatment.

Identifying and treating low-income mothers with depression is an important opportunity to take on a major challenge that faces low-income families, promoting children's learning and successful development and families' economic stability. Now is the time, given the reforms to essential state systems—particularly Medicaid and mental health—afforded by the ACA.

Seizing New Policy Opportunities to Help Low-Income Mothers with Depression:

Current Landscape, Innovations, and Next Steps

June 2016 | Stephanie Schmit and Christina Walker

Introduction

Untreated maternal depression, particularly in mothers of young children, is a major public health problem that can interfere with a parent's capacity to help a child develop, place children's safety and cognitive and emotional development at risk, and stymy families' efforts to escape poverty. Even though research shows that effective treatments for depression address these challenges[4], low-income mothers of young children have very high rates of untreated depression—for reasons that include lack of insurance coverage for mental health care. For these reasons, the National Research Council (NRC) and Institute of Medicine (IOM) concluded in 2009 that fixing the system to support rather than hinder identification and treatment of maternal depression among low-income women is an extraordinary public health opportunity.[5]

Yet very little is known nationally about how well states are doing at seizing this opportunity. On the one hand, the Patient Protection and Affordable Care Act (ACA) and recent federal decisions and guidance, explained in more detail below, offer important new routes to finance and systematize maternal depression identification and treatment. On the other hand, as we entered this project, we heard from many people that major efforts to take advantage of these positive policy changes were not yet being mounted, for many reasons. These include historical barriers between the health, mental health, and child care and early education systems and the difficulty of understanding and influencing complex policies—particularly in Medicaid. Thus, the impetus for this brief was to understand better what opportunities and challenges exist in the states today and to start laying out a framework for action. Throughout this brief there are referrals to "three sectors": the child care and early education sector, the mental health sector, and the Medicaid sector.

To identify the opportunities, challenges, and action opportunities, the brief draws on a detailed look at initiatives in four states (Connecticut, Minnesota, Ohio, and Virginia), which we have placed in a national context through research, interviews with more than three dozen stakeholders, and the expertise of a national advisory board. The goal of the brief is to help state policymakers, advocates, stakeholders, and community practitioners in the health, mental health, and child care and early education sectors by providing them with a road map to identify the systemic barriers and offer early and emerging insights about how to overcome them. As a result, we hope that policymakers and advocates who care about early childhood and families in poverty can join forces with Medicaid and mental health experts to understand and seize the opportunities available through the ACA and related health initiatives to reform state-level

policies and funding mechanisms, and to make large-scale progress on identifying and treating mothers with depression.

Why This Is the Moment to Address Maternal Depression

What Is Known about Maternal Depression & Treatment

Depression is widespread among poor and low-income mothers, including mothers with young children. One in nine poor infants lives with a mother experiencing severe depression and more than half live with a mother experiencing some level of depressive symptoms. Low-income mothers, compared to their higher-income counterparts, experience more severe depression that impacts their everyday life.[6] Moreover, depression is not only linked to the postpartum period. One study showed that 9 percent of low-income mothers with children birth to age 5 had at least one major depressive episode within the previous year.[7] While depression is highly treatable,[8] many low-income mothers do not receive treatment—even for very severe levels of depression. Indeed, one-third of mothers with major depressive disorder get no treatment at all.[9] Additionally, while some people only experience one instance of depression, many others (30-50 percent) experience chronic or recurrent depression requiring the need for long-term support or treatment.[10]

Unfortunately, untreated maternal depression is damaging to children, particularly young children, placing at risk their safety and cognitive and behavioral development. Strong and consistent evidence indicates that a mother's untreated depression undercuts young children's development, including risks to learning, success in school, and adult success. The effects can be life-long, including "lasting effects on [children's] brain architecture and persistent disruptions of their stress response systems."[11] A thorough review of this research by the NRC and IOM finds that maternal depression endangers young children's cognitive, socio-emotional, and behavioral development, as well as their learning and physical and mental health over the long term.[12]

Furthermore, depression can affect a mother's ability to participate fully in society. For example, depression has been linked to making it difficult to get and keep a job, lower income over time, more unemployment, lower productivity at work, and an increased number of absent days from work.[13] A study of mothers participating in Early Head Start programs found that depressed mothers did not increase their participation in education, job training, and employment, while their non-depressed peers did.[14] Depression is also found to occur in patients suffering from a range of other physical, mental, or behavioral health disorders, including heart disease, diabetes, stroke, eating disorders and substance abuse.[15] Research has shown that treatment for the depression can lead to improvements in co-occurring condition as well as overall quality of life.[16]

Many policy and system barriers have contributed to the low treatment rates of maternal depression. However, recent changes offer the opportunity to design and implement reforms that would increase the number of mothers who receive effective treatment. There is evidence that suggests, in addition to benefiting mothers' wellbeing, these reforms could improve children's outcomes—helping families across the country rise out of poverty.

New Policy Opportunities

The enactment of the ACA in 2010 created a set of new policy opportunities for states to address maternal depression. Key changes include increased access to health insurance, strengthened mental health benefits, increased support for preventive services, and improved attention to integration of primary care and mental health. Early evidence hints at the potential for these interlinked changes to improve low-income people's access to mental health treatment. A recent Government Accountability Office (GAO) report found that behavioral health officials in states that have expanded access to Medicaid under the ACA identified increases in the quality and availability of treatment options to low-income people. In contrast, the report found that officials in non-expansion states were still focused on targeting services specifically to those low-income people diagnosed with the most serious and persistent mental illnesses.[17]

One of the challenges that people who are not health policy experts experience in understanding how to seize these policy opportunities is that the specifics differ a great deal depending on state policy choices and depending on whether an individual or family gets health insurance from a state Medicaid program or from a private health insurance provider through the public marketplace. However, this paper is focused on Medicaid, which provides health coverage to almost all poor children and many poor parents, depending on state choices. A sampling of the main opportunities afforded through state Medicaid policy choices are described below (additional detail on the four states included in this brief can be found in Table 1 on page 11; additional details on state choices more generally are included in Appendix I).

The most relevant ACA provisions and regulations include the following:

- *Medicaid Expansion*: The ACA gave states a strong financial incentive to improve access to health insurance through Medicaid for low-income adults, but not all states have taken advantage of that option. Specifically, the ACA supports states by providing financial incentives to expand Medicaid coverage for low-income adults up to 138 percent of the federal poverty level (FPL). To date, 32 states (including the District of Columbia) have expanded Medicaid.[18]
- *Strengthened Mental Health Benefits*: Whether or not states choose to expand Medicaid, the ACA requires strengthening the mental health benefit package for Medicaid-eligible adults. All plans, including Medicaid, must cover behavioral health treatment, mental health inpatient services, and substance abuse treatment. However, specific behavioral health benefits will be dependent upon the state and the particular health plan.[19] In addition, CMS recently finalized long-awaited rules for mental and behavioral health parity in Medicaid, marking a significant milestone for access to mental health care.
- *Preventive Services*: The ACA requires that all insurers cover, at no cost to the beneficiary, preventive services that are identified by the U.S. Preventative Services Task Force (USPSTF), as well as by the Advisory Committee on Immunization Practices, the Health Resources and Services Administration's (HRSA's) Bright Futures Project, and HRSA and the Institute of Medicine (IOM) committee on women's clinical preventive services.[20] State Medicaid programs that choose to cover all the most highly recommended preventive services with no cost-sharing to beneficiaries are eligible for a federal incentive payment.[21] In January 2016, the USPSTF identified depression screening in adults including pregnant and postpartum women as a high-priority preventive service (See Emerging Innovations).

- *Integrated Primary and Behavioral Health Homes*: Health homes coordinate care to individuals with multiple chronic health conditions. An opportunity identified in the ACA is to integrate primary and behavioral care into one collaborative care model, which would support primary care and mental health care providers in coordinating patients' care and monitor patients' improvements. Evidence has shown that integrated primary and behavioral health homes are beneficial to the patients receiving care along with being cost-effective.[22]
- *New Managed Care Organization Regulations:* Many states provide health care to children and families on Medicaid through Managed Care Organizations (MCOs), which contract with the state to provide a package of care, rather than through a typical fee-for-service Medicaid model where the state directly reimburses individual providers for services provided. The state's contracts with the MCOs include an emphasis on quality and accountability standards and can focus attention on issues of particular interest, which could potentially include maternal depression. In April 2016, CMS issued its first update in many years of regulations governing these organizations, potentially providing additional opportunities for states to better address maternal depression.

Seizing these Policy Opportunities through Collaboration across Sectors

This paper was motivated by the belief that engaging child care and early education—as well as health and mental health—stakeholders in decisions about Medicaid and mental health policy could potentially be a catalyst for improvements in the identification and treatment of maternal depression, given that the stakes for young children's development are so high. While later sections of this paper explain what was gathered about the current landscape, this section explains briefly what each group of stakeholders might gain from a collaborative approach to policy reform.

Medicaid, health, and mental health experts stand to gain in a number of ways by including child care, early education, and family services representatives in the design of maternal depression policies. Child care and early education experts and practitioners - who are often interacting with families on a daily basis - already know a great deal about the circumstances of low-income children and families, potentially serving as a crucial source of insights, information, and questions to be addressed through data collection. Child care and early education practitioners may also have a front-line view of the limits of the state's current policies, and they may be able to tell stories and otherwise contribute in communicating to the public and policymakers about the importance of addressing the mental health needs of both children and their parents and the potential negative effects of untreated maternal depression on young children's development and education.

In addition, depending on the state and the specific goals of the initiative, child care and early education practitioners can potentially support health policy goals by playing a role in delivering services, using a variety of funding streams including Medicaid reimbursement—for example, through outreach to mothers or case management services that build on existing relationships. Early childhood providers may be especially successful at engaging mothers, particularly when they provide information to them about the implications for their children.

There are also important reasons for child care and early education providers and stakeholders to collaborate with Medicaid and mental health stakeholders in driving change, even if the Medicaid system

initially seems too complex. Most crucially, by working on a system-wide redesign, child care and early education stakeholders have the opportunity to dismantle barriers they currently face in trying to get mental health treatment for mothers—eventually reducing workload and making the system more responsive to local programs as well as to families. In addition, if a redesigned system genuinely works for mothers, it will lead to real improvements in young children's wellbeing and behavior in early education programs. As the child care and early education sector knows particularly well, mental health concerns in a young child will manifest in disruptive and problematic behaviors by the children while in care, and these mental health concerns can usually be linked back to difficult aspects of the child's life at home.[23] So for example, once a mother has been treated for depression, children show improvements in their development as well as behavior and mental health problems.[24]

A successful redesign that truly improved access to treatment could also help child care and early education providers who themselves experience depression. Very often as low-income working mothers themselves, child care and early education staff are also at risk of experiencing untreated depression.[25] One study found that 7 in 10 of the early childhood teaching staff worried about paying for routine health care costs for both themselves and their family members.[26]

Depending on a specific state's circumstances and the design of its initiative, child care and early education stakeholders could also identify funding through Medicaid for certain aspects of what they do now or would like to do. For example, in recent guidance (See Emerging Innovations), CMS identified that Medicaid funding authorities could reimburse for home visiting activities conducted by those who are not physicians or for preventative services recommended by a licensed professional but furnished by non-licensed professionals.[27]

Methodology & State Context

Our goal in this paper was to provide an updated and rich picture of the current state landscape, reflecting the perspectives of stakeholders in the health, mental health, and child care and early education sectors internal and external to state government. Because understanding multiple stakeholder perspectives was key, we chose to go in-depth in four states (Connecticut, Minnesota, Ohio, and Virginia). We conducted more than three dozen interviews, ranging from 7 in Virginia to 12 in Ohio (See Appendix I). To provide a broader context for these detailed interviews, we drew on a literature and document review (including, for example, federal guidance and policy papers) and on insight, advice, and guidance from an expert advisory committee representing child care and early education, mental health, and Medicaid (See Appendix III).

In choosing the states, we looked for at least some states that were already interested in the issue of maternal depression and that were known for early innovations in the sector, so that we could identify emerging ideas for consideration elsewhere. At the same time, we sought geographic and political diversity and wanted to include at least one state that had not yet expanded Medicaid, to increase the relevance of our findings to varied state circumstances. Table 1 (see next page) gives additional context on the four states chosen, highlighting some of their similarities and differences.

Table I. State Policy and Infrastructure				
	Connecticut	Minnesota	Ohio	Virginia
Number of Children under 6[28]	235,257	419,682	849,992	616,467
Poverty Rate of Children Under 6[29]	16.7%	16.9%	26.9%	17.3%
Medicaid Expansion[30]	Yes - Effective January 2014	Yes - Effective January 2014	Yes - Effective January 2014	No - As of April 2016; up for discussion in FY2017 budget proposal
Medicaid Eligibility Household Income Level for Parents of dependent children (based on FPL)[31]	Up to 196% FPL	Up to 200% FPL	Up to 138% FPL	Up to 49% FPL
Medicaid Eligibility Level for Pregnant Women(based on FPL)[32]	Up to 258% FPL	Up to 278% FPL	Up to 200% FPL	Up to 143%
Past Medicaid Eligibility Levels prior to Medicaid Expansion	Parents with dependent children were eligible up to 185% of poverty and pregnant women were eligible up to 250% of poverty.	Parents with dependent children were eligible up to 100% of poverty.	Parents at or below 90% of the poverty level were eligible.	Up to 49% FPL (No Medicaid expansion)
Lead Early Childhood Education and Care Agencies	The child care subsidy program • CT Care 4 Kids—sponsored by Office of Early Childhood Child care licensing • Office of Early ChildhoodHome visiting • Office of Early Childhood Publicly funded pre-k • Office of Early Childhood Head Start • Department of Education Early Intervention Part C services • Office of Early Childhood	The child care subsidy program • Department of Human Services Child care licensing • Department of Human Services Home visiting • Department of Human Services Head Start • Department of Education • Head Start State Collaboration Office Early Intervention Part C services • Department of Health	The child care subsidy program • Department of Jobs and Family Services Child care licensing • Department of Jobs and Family Services Home visiting • Department of Health Publicly funded pre-k • Department of Education • Department of Jobs and Family Services Head Start • Head Start Association Early Intervention Part C services • Department of Health	The child care subsidy program • Department of Social Services Child care licensing • Department of Social Services Home visiting • Home Visiting Consortium • Department of Health Publicly funded pre-k • Department of Education Head Start • Department of Social Services • Head Start State Collaboration Project • Head Start Association Early Intervention Part C services • Department of Behavioral Health and Developmental Services • Infant and Toddler Connection of VA
Medicaid Agency	Department of Social Services	Department of Human Services	Department of Medicaid	Department of Medical Assistance Services

The Current Landscape: Barriers

The in-depth interviews illustrated the complexity of the current landscape, highlighting two powerful themes. On the one hand, even those stakeholders who were familiar with the opportunities in the ACA to improve mental health care and services for low-income mothers with depression still recognized many barriers to achieving that goal, and no one—even in the states identified as more advanced—believed their state had created an effective and comprehensive state-wide approach. And because each system is so complex and so separate from the others, no single person we interviewed in any state had a comprehensive view of the policy opportunities or challenges. On the other hand, many new initiatives were emerging from the local and state levels, along with new federal actions and guidance that provides new opportunities. Thus, in the in-depth interviews, at least one stakeholder in every state could identify a local or state initiative to address maternal depression. This section highlights the first of those threads, the challenges; the next section below highlights the striking opportunities.

Fragmentation of policies, systems, and expertise hinders progress. Interviewees across the health, mental health, and child care and early education sectors suggested that it is difficult to make systems-level changes when systems are siloed and when each has an approach to serving individuals from either the child's or the adult's perspective. Furthermore, the funding streams dedicated to paying for services for families are extremely different and administered separately among the Medicaid, mental health, and child care and early education sectors. Interviewees found that departments and programs were administered independently and disjointedly, which led to a lack of knowledge, intentionality, and communication between the sectors. Interviewees also stated that when relationships did exist that helped work across systems, these collaborations were tied so distinctly to those personal relationships that personnel turnover could easily derail the work occurring across departments.

> An Ohio stakeholder said that "…systems are not set up to make it easy. When there is already a connection between the mental health and early childhood worlds, then it can work well… In other places, [they] can be two very different entities, and are not working together already."

> A Connecticut stakeholder said that "the [child care and early education sector] would need to know that [addressing maternal depression] is even an opportunity that they need to be thinking of. It is so bifurcated in Connecticut, even though they are trying to get rid of the silos."

Child care and early education stakeholders face particular obstacles in engaging with Medicaid experts and other health and mental health policymakers to identify system changes that could help in addressing maternal depression. With the child care and early education sector stretched so thin already due to policy developments in the sector, as well as being traditionally underpaid and under-resourced, it may be challenging for them to take on policy battles in other sectors, or for their counterparts in the health and mental health sectors to see them as partners in this important work. As a result, interviewees stated that there is a lack of clarity about the child care and early education sector's role in addressing maternal depression. Some suggested that the health and mental health sectors may also not view their child care and early education counterparts as

partners in this important work.

In addition, interviewees recognized that the early care and education sector is often poorly tied to child health and other service providers within the community. For example, in Connecticut, an evaluation on child care and early education services found that while some child care and early education providers conduct maternal depression screenings, they struggle with connecting the families to the services they need. This could be a reason why child care and early education providers would benefit greatly from a more coherent system that would not require them to work so hard to find services. Yetit is also an obstacle to viewing their engagement with health and mental health policy as beneficial, given they may see the cumbersome system but not the opportunities for them if it worked better. One interviewee from the child care and early education sector also suggested that providers may not see their role in addressing maternal depression, as they are experts in child development and may feel that they do not understand the needs of the parents or how to best connect them to the necessary services. Child care and early education providers often have limited or no trainingin identifying or screening for maternal depression.

Medicaid and other health policies can be barriers and opportunities. Medicaid policies are clearly central to whether low-income mothers with young children can gain access to depression screening and treatment. While some aspects of the Medicaid policy framework are national, many are state choices—including whether to expand coverage, what specific benefits to cover (within a context of federal rules that expand mental health parity and preventive services), what providers to authorize (such as licensed health professionals at various levels and/or social services professionals or paraprofessionals), whether to provide coverage through MCOs or fee-for-service payments to individual providers, and what reimbursement payments to provide for what services. Particularly when it comes to eligible populations not previously served (such as low-income adults in many states prior to the ACA expansion) or issues not previously highlighted as a priority (such as maternal depression), the sheer complexity of thinking about all these different policy levers together can create a major barrier in itself—as can the enormous variation by state in the details of what is required, allowed, and reimbursed (See Appendix III). Interviewees confirmed that understanding all of the state Medicaid policies can be difficult, particularly for those not from the Medicaid sector. In many states, MCOs are predominantly the delivery system for the Medicaid population, so stakeholders should recognize that partnering with the MCOs is an important step in making progress on addressing maternal depression.

While developing a full list of policy challenges and opportunities is far beyond the scope of this brief, those interviewed identified a number of current Medicaid policies that often pose particular obstacles to a coherent strategy for tackling depression:

- ***Restrictive Medicaid billing and reimbursement practices.*** Interviewees thought that restrictive billing and reimbursement practices by Medicaid agencies in several states posed a challenge to successful services, particularly because of a system divided between services to the adult and to the child. For instance, pediatricians may be screening mothers for depression at well-child visits, but in some instances, are unable to bill for providing this service and are therefore not getting reimbursed for their time to screen moms. This inability to get paid for their time may deter pediatricians from providing screenings, creating a missed opportunity in identifying additional

mothers with depressive symptoms. And while pediatric office visits were routinely identified as a clear opportunity to identify mothers with mental health concerns, interviewees stated that health insurers, particularly Medicaid in most states, may not reimburse for a screening as a result of issues such as where the mother's medical record exists and what billing code should be used. A forthcoming study by the National Center for Children in Poverty (NCCP), found that nine states allow billing for maternal/caregiver depression screening under the child's Medicaid in pediatrician or family medicine visits, typically multiple times a year.[33]

- ***Focus on screening and not on treatment.*** Interviewees also suggested that, despite these obstacles, there has been more attention focused on how to reimburse for screening than how to promote the follow-up needed after a positive screen for getting the mother connected with a treatment provider. It is important for the system to incentivize providers to connect mothers to services and treatment once depression is identified.
- ***Additional billing and reimbursement issues.*** Other reimbursement issues included the desire to have a package of services for mothers with depression or bundled payments for each period of depression. Interviewees in Minnesota and Connecticut perceived the Medicaid fee schedule in their state as too inflexible and hindering a provider's ability to stratify services and appropriate payments to best meet the needs of the patient. Interviewees recognized that not all patients need the highest level of care intensity—such as what is needed for people suffering from severe and persistent mental illness (SPMI)—and that not all mothers with depression will require the same services. Additional issues were raised related to the type of provider and setting that can be reimbursed. For particular services only a certain level or type of professional is allowed to be reimbursed for services, although this varies by state. For example, one interviewee in Ohio told us that only masters' level clinicians, and not other professionals, providing maternal depression treatment can bill using psychotherapy codes. Additional barriers were raised related to the ability to bill for services provided outside of a medical setting, as many systems are not set up to allow this.
- ***Medicaid eligibility levels and duration of eligibility.*** Even in states that have implemented the Medicaid expansion, Medicaid eligibility remained an issue, particularly for women with income just above the eligibility level. This was particularly an issue because pregnant women in all three expansion states we studied were eligible for Medicaid coverage during pregnancy and for the several weeks immediately following the pregnancy up to a higher income level than for parents in general (See Table 1). After that time period, however, the income level for eligibility drops, causing many women to lose Medicaid coverage at a time when they may still be depressed. For example, in Minnesota, eligibility levels drop for women just 60 days after the birth of their child from 278 percent FPL to 200 percent FPL. While these women who lose Medicaid coverage are able to purchase health insurance through the private health care exchange, and may also qualify for a subsidy to assist with their monthly payments, the transition from Medicaid to another health care insurer can create additional barriers to accessing care and treatment. For instance, several interviewees noted that the new health care plan may require co-payments for each treatment visit, which low-income women may be unable to afford. Further, different providers are often covered on different health insurance plans; therefore the provider a beneficiary was eligible to see through Medicaid may no longer be able to treat her under the mother's new plan. The loss of Medicaid coverage during a demanding time period when women are often still recovering both physically

and emotionally from the birth and arrival of their new child can disrupt a woman's continuity of care or make treatment unaffordable.

- ***Lack of Medicaid expansion.*** In the one state we studied that has not implemented Medicaid expansion, Virginia, interviewees repeatedly mentioned the lack of expansion as the major policy challenge. Because the income eligibility level for Medicaid is so low and because premium tax credits established by the ACA to help purchase insurance in the private health insurance marketplaces are only available to individuals with income between 100 and 400 percent FPL, many parents in the 19 non-expansion states are not eligible for Medicaid or premium tax credits if their incomes exceed the current Medicaid eligibility threshold but remain below 100 percent of the poverty level ($20,160 annual income for a family of three). Therefore, many of the women who need access to and could benefit greatly from Medicaid services do not receive any assistance.

Other direct barriers to accessing treatment. Even when a woman with high levels of depressive symptoms has access to Medicaid or other health coverage, our interviewees highlighted other common access issues. For instance, mental illness still carries with it a lot of stigma and fear, which could hinder people from seeking the treatment they need. In fact, the stigma of seeking mental health treatment has been found to be one of the most common concerns among low-income women and may account for underutilization of mental health treatment, particularly for women of color and for immigrants.[34] These women may also lack a medical home or primary care provider, which means they often show up in urgent care centers and emergency rooms for their health care. Low-income mothers also face many logistical difficulties in getting to a care provider, such as finding quality child care, available appointments, or safe, reliable transportation. Furthermore, most states identified that they have "provider deserts," particularly in rural areas, which would make the process of finding an appropriate provider and transportation to the provider's office even more difficult for most low-income women.

Moreover, even when a provider can be found, the quality of the care may be poor. Interviewees stated the need for more attention to mothers with depression at different stages of the pregnancy and for a time period longer than the postpartum period. Moreover, this attention on the illness should be reflected in better provider trainings and ensuring that mothers with depression are getting connected to evidence-based treatment. All of these issues could be addressed in the context of a state's overall strategy, and many of them suggest specific Medicaid policy and reimbursement solutions—such as investing in case management and outreach to mothers as part of a plan.

The Current Landscape: Emerging Innovations

Despite these considerable barriers, many opportunities emerged from our interviews to take advantage of this federal landscape and change state policies systematically. These included local and state innovations that, while not comprehensive in the view of those we interviewed, pointed towards bigger next steps; promising ideas suggested by interviewees that are not yet implemented on the ground; and new federal decisions and guidance that require or clarify state actions to address maternal depression.

State and Local Innovations and Emerging Ideas

Some state and local innovations focused directly on policy or practice change, while others sought to

create the conditions for ongoing change—for example, tackling the fragmentation of systems by bringing health, mental health, early childhood, and other stakeholders together in new ways.

Collaboration Among Key Stakeholders. Several state and local initiatives have taken on fragmentation directly. Often, these start with direct service connections, but they offer the opportunity to build to policy and system collaborations. As an Ohio stakeholder said, "when [early childhood and health stakeholders] come together to work…they learn a lot about each other." For example, in Connecticut, providers who treat mothers with maternal depression can use the 2-1-1 centralized resource hotline that helps connect people to mental health services. Within the 2-1-1 system, providers who self-identify as having an expertise in treatment of maternal mood disorders are flagged, so that clients can be referred to the most appropriate provider.

Another example, from Ohio, is the Cleveland Regional Perinatal Network (CRPN)'s Perinatal Depression Project, which was created through grant funding to address the gaps and barriers families faced in accessing maternal depression screening and treatment. The project was started in response to the recognition that mothers were not being consistently screened and identified for maternal depression, and if diagnosed, there was no one to refer them to for treatment. All healthcare institutions in the Cleveland area as well as several home-visiting and social service agencies have incorporated a key element of the project, the CarePath—a step-by-step process developed by the project to help providers screen for maternal depression—and currently screen and refer for depression during and after pregnancy. While the training has not yet happened in a child care or preschool setting, the tools are certainly able to be used in these settings. The CRPN Project also formed the Cuyahoga Perinatal Depression Task force in 2007 and since 2010 has developed a data tracking system to measure outcomes. In 2015 there were 11,531 depression screens completed and 1,021 women referred for treatment. The project is currently grant funded through the Ohio Department of Health's Child and Family Health Services Block Grant and Maternal and Child Health grants, and City of Cleveland MomsFirst Project/HRSA. The CRPN Perinatal Depression Project has reached far beyond Cleveland and has been duplicated in other parts of Ohio. While the model is grant funded, many of the recipients of the services provided under the model are Medicaid patients.

Another example of collaboration through direct services is a Minnesota initiative proposed by the governor's Children's Cabinet team to provide mental health consultation grants for on-site consultation to child care and early education programs, addressing mental health issues for both generations together. When there is a potential mental health issue identified, these mental health consultants would offer services and referrals for needed treatment to both the children and their parents.

Interviewees in several states offered additional suggestions for establishing more formal communication between stakeholders. For instance, a Minnesota interviewee recommended creating a working group specifically focused on addressing maternal depression and its importance to the child care and early education sector. Bringing people from separate agencies and departments together in a formal setting can provide them with the space to create recommendations on how services can be integrated and how resources can be more accessible for families. Others suggested that more coordinated provider training, that spans across sectors, would ensure all providers know about maternal depression, why it is important

to address, and how to make referrals. Still others suggested that states could incentivize collaboration through grant funding initiatives to ensure all of the relevant stakeholders are working together to address maternal depression—a strategy similar to the Ohio and Minnesota initiatives already cited.

Policy Changes in the States

State agencies, advocates, and local innovators also are working to improve Medicaid and related policies to support maternal depression identification and treatment.

Collaboration to Improve Billing Procedures for Dyadic Therapy. In Virginia, stakeholders from the mental health and child care and early education sectors held a meeting with the state's Medicaid office to discuss the possibility of creating billing procedures and the appropriate codes for dyadic therapy—or therapy that includes both the child and the parent(s). Dyadic therapy would allow mothers identified with depression to work on their relationship with their child, since parent-child attachment is so important to the healthy development of a young child. This is an ongoing process in Virginia.

A recent CMS memorandum regarding maternal depression screening and treatment specifically supports the delivery of dyadic therapy through Medicaid and provided guidance to help state Medicaid agencies implement this policy change. Therefore, states wanting to seize this opportunity now have a path for moving this policy forward.

Finding a Way to Extend PostPartum Medicaid Coverage to Provide Continuity of Care. In Minnesota, new mothers were previously covered by Medicaid for a full year postpartum. Over time, this benefit has been reduced, and now, the state only covers mothers for the minimum 60-day postpartum period established through the ACA. A goal among advocates is to extend coverage for these mothers for two years postpartum—while also extending Medicaid coverage to their child for two years—to meet both the mother and child's mental and physical health needs during such a critical time.[35]

Integrating Behavioral and Physical Health Care to Improve Mental Health. Ohio's Medicaid department is in the process of redesigning its community behavioral health benefit to better align services to a person's level of need. Behavioral health care in Ohio is transitioning into the Medicaid MCOs that are currently administering the state's physical health care plans. This transition, which should be complete by the beginning of 2018, will promote stronger coordination, lower cost, and better overall health outcomes. The state is defining what will be covered in a new menu of behavioral health services through Medicaid managed care. There is debate in the health and mental health sectors over whether integrating behavioral and physical health care within MCOs is best. Those operating behavioral health plans often argue that traditional physical health managed care organizations do not have the expertise necessary to better serve patients with mental illness, and proponents of integration believe that the separation of service provision can create barriers to care coordination and information-sharing.[36] Interviewees in Ohio were optimistic about the opportunity the integration afforded the state, and they want to focus on better serving their most vulnerable customers through this change, particularly mothers and children with more intensive care needs, such as cross-systems care needs, and trauma-informed patient care.

Solving Licensing and Reimbursement Barriers. Moving Beyond Depression™ (MBD)[37] is a comprehensive, evidence-based and integrated approach to identifying and treating depression in mothers participating in home visiting programs. It provides a two-generation approach to treating depression in a non-clinical, non-traditional setting. MBD is a systemic program incorporating screening, identification, treatment, and follow-up. It emphasizes collaboration between mental health clinicians and home visitors to optimize both clinical and home visiting outcomes. The key element of MBD is In-Home Cognitive Behavioral Therapy (IH-CBT) developed by Every Child Succeeds® and Cincinnati Children's Hospital Medical Center. It is the only evidence-based treatment program specifically for mothers in home visiting and has been adopted by programs operating in 10 states, including Ohio. MBD has been evaluated and has a proven track record of decreasing depressive symptoms in mothers participating in treatment. Research has found that, after completing IH-CBT, 70 percent of mothers no longer met criteria for major depressive disorder.

Currently, South Carolina, Kentucky, West Virginia, and Massachusetts, are using Medicaid to fund MBD treatment through home visiting programs that contract with or are part of organizations that are already set up to bill Medicaid. Because Medicaid policy varies from state to state, it is more difficult for some states to use Medicaid as a reimbursement mechanism given the nature of the service delivery. Moreover, additional funds are needed to cover the full cost of the program. It is anticipated that MBD will be appealing to MCOs seeking to address maternal depression in high-risk families because of its demonstrated cost-effectiveness, its broad impacts, and the ability for states to leverage of investments made in early childhood home visiting.

Potential Medicaid Support for New Outreach Models. The New Haven Mental Health Outreach for Mothers (MOMS) Partnership is a collaboration of agencies across New Haven, CT, that works to improve the wellbeing of mothers and children. The model includes mothers from the community serving as Community Mental Health Ambassadors who deliver screening, brief intervention, referral, and clinical treatment with clinicians. This has increased utilization and adherence to mental health services dramatically. Medicaid reimbursement for these positions is currently being explored in partnership with Connecticut Department of Social Services. The New Haven MOMS Partnership surveys the mothers to determine what services are needed. In 2015, a survey found that 58 percent reported moderate to high levels of depressive symptoms.[38] Mental health services for maternal depression are provided in non-clinical, de-stigmatizing settings such as in grocery stores and in fully licensed settings that are billable through Medicaid.[39]

Gathering Background Data To Target Services. Minnesota is one of 40 states currently implementing the Pregnancy Risk Assessment Monitoring System (PRAMS) survey tool, through a joint project between the state's Department of Health and the U.S. Centers for Disease Control and Prevention (CDC). In Minnesota, a sample of mothers who have recently given birth to a child, are sent a survey that asks them questions about experiences before, during, and after birth to determine maternal health and behaviors, in addition to infant health. The state samples about 220-250 mothers each month and has chosen to include questions in the survey about maternal depression, anxiety, stressors, and mental health—including treatment, education, or support the mother has received. Results show that 95-97 percent of moms are getting education about maternal depression in the state. Furthermore, Minnesota

uses Medicaid billing data, the PRAMS survey data, and WIC and home visiting data to better understand the prevalence of depression and anxiety. State administrators determined a list of Medicaid billing codes to use inmonitoring and reviewing all instances of maternal depression. States could create similar lists for their own analyses, which could inform decision making on issues like screening, treatment availability, and reimbursements.

Federal Innovations to Inform State Policy. In 2016, the federal government took three significant steps that could galvanize additional state and local activity.

The first one, which affects both Medicaid and private health insurers, is the decision by the U.S, Preventive Services Task Force (USPSTF) that screening for depression in all adults is a preventive service that is well-supported by evidence. This recommendation specifically includes pregnant and postpartum women, and (in a separate opinion) adolescents ages 12-18. When the USPSTF determines that a service has a priority level of A or B (as in this case), insurers are required to cover it free. State Medicaid programs that choose to cover all the A and B level preventative services with no cost-sharing to beneficiaries are eligible for an incentive payment that increases their federal reimbursement level by 1 percent for these services.[40] Currently, 11 states choose to cover all of the A and B services, receiving the incentive payment: California, Colorado, Delaware, Hawaii, Kentucky, New Hampshire, New Jersey, New York, Nevada, Ohio, and Wisconsin. The recommendation highlights the need for effective referral and treatment systems. This is particularly important since there are known effective treatment available. When effectively implemented, this recommendation could result in many fewer women suffering from untreated depression. Since our interviews occurred before this USPSTF decision, we cannot report yet on its impact, but we anticipate it will substantially increase state interest in depression screening and treatment.

The second is a federal policy guidance letter on financing state home visiting initiatives, jointly issued by HRSA—which oversees the other major federal funding stream for home visiting—CMS—which oversees Medicaid. In 2010, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program created the first nationwide home visiting program. MIECHV has supported high-risk families in communities across the country through intensive home visiting services. It supports evidence-based programs that connect families with trained professionals—often nurses, social workers, or parent educators—who help parents acquire the skills they need to promote their children's development. This guidance letter provides states with a step-by-step approach to aligning their Medicaid state plan and their home visiting approach, to draw on Medicaid funding in an appropriate way and achieve their home visiting goals. For example, it suggests approaches to funding case management services as well as direct clinical services offered by home visitors and indicates which federal waiver authorities might be useful. Because home visiting could be a key part of a state's maternal depression plan—to provide screening and referral, treatment, or both—this letter is directly useful to a maternal depression strategy.[41] It also provides a model for future guidance that could help states develop a comprehensive approach to maternal depression. States can consider which of these components may be possible or what state plan changes may be needed to achieve them to best meet the needs of the families in their state.

And finally, CMS issued its first guidance directly related to maternal depression treatment, explaining

how states can fund maternal depression screening and mother-child dyadic treatment based on a child's Medicaid eligibility. The guidance clarifies that states can allow maternal depression screenings to be claimed as a service for the child under Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, because the scientific evidence indicates that maternal depression is a risk factor for the child and that screening for it in a well-child visit is a best practice. Once a state makes that choice, providers such as pediatricians can be reimbursed for conducting the screening. After diagnosis, the guidance also clarifies that treatment services provided to the mother and child together—for example, family or dyadic therapy (but not separate treatment for the mother alone)—can also be claimed as direct services for the child.[42] For mothers who are not eligible for Medicaid themselves and are uninsured, the ability to receive reimbursable treatment when provided jointly with their child opens up new possibilities for treating maternal depression for low-income women.

Next Steps

To build from the individual innovations identified above and move to a future of systemic success in identifying and treating maternal depression will require new and powerful connections across levels of government and across sectors. At minimum, the sectors must include stakeholders from the health, mental health, and child care and early education sectors, but others who are engaged in improving the lives of low-income families and families of color, such as child welfare, should also be considered as partners in this important work. The recommendations below, which draw from both the scan itself and the deliberations of the project's expert advisory board, propose a path forward that combines immediate steps for early successes, the development of infrastructure to sustain the effort, and the creation of a clear policy framework to make it far easier for states to do this work in the future without reinventing the wheel.

<u>For the states:</u>

1. Seize the opportunity of the USPSTF recommendations and the two federal guidance documents (on home visiting and depression screening/ dyadic treatment) as a catalyst for:
    a. outreach and technical assistance from national experts to state leaders and advocates; and
    b. state convenings that bring together stakeholders from all three sectors to learn about the opportunities and consider next steps. These meetings could be ad hoc, or states could invite additional members to join existing entities—such as child care and early education members and local innovators attending a regular Medicaid/ mental health meeting, or Medicaid and mental health state staff going to the early childhood coordinating council.
2. Identify and implement high-priority improvements in Medicaid and related policies to support maternal depression identification and treatment among low-income mothers of young children. The convening just described, along with technical assistance provided with philanthropic support as described below, would likely be very helpful in supporting state leaders, local innovators, and policy advocates in this work.

<u>For philanthropy:</u>

3. Bring together leading state and local innovators along with national experts and federal staff from all the relevant sectors in an intensive experience such as through a roundtable or convening. The goals

should be to broaden the conversation about the most promising next steps—building on the findings of this brief, the new federal opportunities, and the innovations emerging from ground-level—and recruit core partners for the ongoing work needed to better address maternal depression.

4. Support an ongoing learning community that would support regular calls, webinars, and potentially in-person meetings, through support from federal officials and/or philanthropy. The information gathered through this scan suggested substantial interest among states and local jurisdictions, including policymakers and external stakeholders, in such a learning community, to help participants more effectively seize this opportune moment to get started and learn from others engaging in this work.
5. Support the development of a working list of high-priority areas for federal action, including a short list for completion during this administration and a longer list to be incorporated into transition documents and briefings. See inset for examples.

> Creating a list of high priorities for federal action would likely include specific areas of Medicaid policy that need clarification or policy guidance:
>
> - How to reimburse pediatric providers for screening and dyadic treatment through a child's Medicaid coverage;
> - How to incentivize and track effective referral and follow-up for a mother's treatment (that is, going beyond screening);
> - Potential strategies for designing and reimbursing effective benefit packages for maternal depression;
> - Strategies for supporting community outreach and home-based treatment, where appropriate to a state's plans;
> - Strategies for supporting the involvement of non-medical professionals, community health workers, and paraprofessionals (such as early education or home visiting staff) in appropriate roles;
> - Removing obstacles to mental health services in primary care;
> - Promoting quality and accountability in maternal depression treatment, including in managed care contracts;
> - Ensuring smooth integration between Medicaid and the private health care exchanges; and
> - Potential strategies for addressing postpartum coverage gaps under a state's Medicaid plan.

6. Support work towards an overarching state policy framework to improve maternal depression identification and treatment, based on the information gathered from the steps listed above. This policy framework would be developed in partnership with the early adopter states in the learning community and would be a tool other states could use to reform their systems.

<u>For federal agencies:</u>

7. Issue guidance jointly across federal agencies in the high-priority areas identified by states and national partners, building on a number of excellent models. For example, just as HRSA and CMS jointly issued the home visiting guidance, the Administration for Children and Families (ACF), the Substance Abuse and Mental Health Services Administration (SAMHSA), and CMS and other agencies as needed could jointly issue other guidance letters—building on the dyadic treatment letter—that address additional policy questions that come up in using Medicaid to support evidence-based maternal depression treatment.

8. Provide ongoing technical assistance jointly supported by the relevant federal agencies. For example, identify a lead agency with a permanent technical assistance center (such as SAMHSA) to convene other relevant agencies to collaborate and provide the necessary technical assistance to the states.
9. Explore, in collaboration with states, the implications for improved maternal depression policies whenever new regulations or decisions affecting the broader Medicaid context for children and families are implemented. For example, as states implement the new Medicaid managed care rules, they should have access to help thinking through the potential opportunities for improving maternal depression treatment.

Identifying and treating low-income mothers with depression is an important opportunity to take on a major challenge that faces low-income families: promoting children's learning and successful development and families' economic stability. Now is the time, given the reforms to essential state systems—particularly Medicaid and mental health—afforded by the ACA.

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The findings and conclusions of this report are those of the authors alone, and do not necessarily reflect the opinions of our funders.

Appendix I

List of Interviewees, by State

Connecticut

Merrill Gay, Executive Director, Early Childhood Alliance
Lisa Honigfeld, Vice President for Health Initiatives, Child Health and Development Institute of Connecticut
Myra Jones-Taylor, Commissioner, Connecticut Office of Early Childhood
Kimberly Karanda, Regional Manager, Mental Health and Addiction Services
Kate McEvoy, State Medicaid Director, Connecticut Department of Social Services
Judith Meyers, President and CEO, Child Health and Development Institute of Connecticut
Nydia Rios-Benitez, Behavioral Health Clinic Manager, Connecticut Mental Health and Addiction Services
Jessica Sager, Executive Director, All Our Kin
Megan Smith, Assistant Professor of Psychiatry, in the Child Study Center and of Epidemiology (Chronic Diseases); Director, New Haven Mental Health Outreach for MotherS (MOMS) Partnership
Elaine Zimmerman, Executive Director, Connecticut Commission on Children

Minnesota

Mary Jo Banken, Department of Health
Melvin Carter, Executive Director, Minnesota Children's Cabinet
Jennifer DeCubellis, Assistant Commissioner, Minnesota Department of Human Services
Sarah Drake, Pharmacy Program Manager, Minnesota Department of Human Services
Stephanie Hogenson, Research and Policy Director, Children's Defense Fund
Julie Marquardt, Director, Purchasing and Service Delivery, Minnesota Department of Human Services
Julie Pearson, Medicaid Services Policy Supervisor, Minnesota Department of Human Services
Clare Sanford, Director of Government and Community Relations, New Horizon Academy
Tessa Wetjen, Principal Planner of Maternal Depression Screening Program, Minnesota Department of Health
Catherine Wright, Early Childhood Mental Health Coordinator, Minnesota Department of Human Services
Barbara Yates, Executive Director, Resources for Child Caring

Ohio

Avril Albaugh, Project Director, Cleveland Regional Perinatal Network
Robert Ammerman, Scientific Director, Every Child Succeeds
Rebecca Baum, Developmental Behavioral Pediatrician, Nationwide Children's Hospital
Maureen Corcoran, President, Vorys Health Care Advisors
Rebekah Dorman, Director, Invest in Children of Cuyahoga County
Marcia Egbert, Senior Program Officer, The Gund Foundation
Kellee Gauthier, Program Manager, Ohio Chapter, American Academy of Pediatrics
Wendy Grove, Director, Ohio Office of Early Childhood
Sarah Hallsky Lee, Health Promotion Coordinator, Ohio Child Care Resource and Referral Association

Eric Koralak, Executive Director, Action for Children, Ohio
Sandy Oxley, Executive Director, Voices for Ohio's Children
Samuel Rossi, Director of Communications, Ohio Department of Medicaid

Virginia

Suzanne Gore, Deputy Director for Administration, Department of Medical Assistance Services
Jill Hanken, Staff Attorney, Virginia Poverty Law Center
Karen Kimsey, Deputy Director for Complex Care Services, Department of Medical Assistance Services
Tammy Mann, President and CEO, Campagna Center
Saba Masho, Professor, Virginia Commonwealth University Department of Family Medicine and Population Health
Margaret Nimmo-Crowe, Director, Voices for Virginia's Children
Cheryl Roberts, Deputy Director for Programs, Department of Medical Assistance Services

Appendix II

List of Advisory Committee members

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Donna Cohen Ross, Principal, Health Management Associates (and former Senior Policy Advisor/Director of Enrollment Initiatives, Center for Medicaid and CHIP Services)

Megan V. Smith, Assistant Professor of Psychiatry, in the Child Study Center and of Epidemiology (Chronic Diseases); Director, New Haven Mental Health Outreach for MotherS (MOMS) Partnership

Sheila Smith, Director, Early Childhood, National Center for Children in Poverty

Appendix III

Selected State Medicaid Policy Choices

Federal requirements create basic rules for state Medicaid programs, but states still have flexibility in the design of their Medicaid programs around eligibility, enrollment procedures, and benefits. This list is not inclusive of all state options but includes key options with the potential to increase access to and improve the quality of care for pregnant women and young mothers seeking mental health care.

Eligibility Options	
Income eligibility for pregnant women	States have the flexibility to set their Medicaid income eligibility for pregnancy coverage above the federal minimum of 133% FPL. Most states have set their income eligibility at 185% or higher. The higher the income eligibility limit, more pregnant women can benefit from affordable pregnancy-related care.
Income eligibility for adults	The ACA set the minimum Medicaid eligibility for adults at 133% FPL, but this has effectively become a state option due to the Supreme Court's 2012 decision. As a result, adults in non-expansion states may have very limited access to Medicaid and, as a result, fall into the "coverage gap". In non-expansion states eligibility for adults with dependent children varies, but is 67% FPL or lower in 17 states, with two states as low as 18% FPL. In these states, adults who earn more than their state's eligibility limit but less than 100% FPL fall into the coverage gap because they have no affordable health insurance option – they make too much money to qualify for Medicaid but not enough money to receive advanced premium tax credits (APTCs) to purchase insurance through the Marketplace. Adults in non-expansion states without dependent children have even more limited access to Medicaid. Only one state provides Medicaid coverage to these adults. In 18 states, adults without dependent children have zero eligibility for Medicaid. Adults under 100% FPL are therefore not eligible for Medicaid or affordable coverage through the Marketplace, placing them in the coverage gap. Implementing Medicaid expansion is beneficial to maternal and infant health because in expansion states more women have access to affordable health care prior to and after their pregnancy.
Presumptive eligibility for pregnant women	States have an option to adopt presumptive eligibility for pregnant women. Under this option, pregnant women who appear eligible for Medicaid are enrolled immediately while their full application is pending an eligibility determination. This option allows pregnant women to access Medicaid coverage as soon as possible after applying.

Benefits Options	
Pregnancy Coverage	States have the option to provide pregnant women their full Medicaid coverage or only pregnancy-related coverage. When pregnant women receive the full Medicaid benefit package, they have access to mental health services.
Prescription Coverage	All states choose to include prescription coverage in their Medicaid program. However, states can set parameters around brand name versus generic drugs or levels of cost-sharing, potentially impacting the accessibility of certain mental health medications.

Access to Care	
MCO Provider Networks	The majority of states use Managed Care Organizations (MCOs) to provide coverage rather than a fee-for-service model. When negotiating with MCOs, states can set requirements for their provider networks within federal guidelines which have just been updated. Ensuring a robust network across all areas of the state (rural, urban and suburban) will increase access to mental health services.
Reimbursement Rates	States have flexibility to set reimbursement rates for providers. Reimbursement rates can affect the number of providers, including mental health providers, who accept Medicaid.
Cost-Sharing	States have the option to charge premiums to pregnant women over 150% FPL and cost-sharing for non-pregnancy related expenses (such as mental health care). Minimizing cost sharing reduces financial barriers to care.

References

[1] National Research Council and Institute of Medicine (NRC/IOM), *Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention*, 2009.
[2] Tracy Veriker, Jennifer Macomber, and Olivia Golden. *Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Serve*, The Urban Institute, 2010, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412199-Infants-of-Depressed-Mothers-Living-in-Poverty-Opportunities-to-Identify-and-Serve.PDF.
[3] National Research Council and Institute of Medicine, *Depression in Parents.*
[4] National Research Council and Institute of Medicine, *Depression in Parents.*
[5] National Research Council and Institute of Medicine, *Depression in Parents.*
[6] Tracy Veriker, Jennifer Macomber, Olivia Golden, *Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Serve*, The Urban Institute, 2010, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412199-Infants-of-Depressed-Mothers-Living-in-Poverty-Opportunities-to-Identify-and-Serve.PDF.
[7] Marla McDaniel and Christopher Lowenstein, *Depression in Low-Income Mothers of Young Children: Are They Getting the Treatment They Need?*, The Urban Institute, 2013, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412804-Depression-in-Low-Income-Mothers-of-Young-Children-Are-They-Getting-the-Treatment-They-Need-.PDF.
[8] National Research Council and Institute of Medicine, *Depression in Parents.*
[9] McDaniel and Lowenstein, *Depression in Low-Income Mothers of Young Children.*
[10] National Research Council and Institute of Medicine, *Depression in Parents.*
[11] National Scientific Council on the Developing Child and National Forum on Early Childhood Program Evaluation, "Maternal Depression Can Undermine the Development of Young Children," Center on the Developing Child, Harvard University, Working Paper 8, 2009, http://developingchild.harvard.edu/resources/maternal-depression-can-undermine-the-development-of-young-children.
[12] National Scientific Council on the Developing Child and National Forum on Early Childhood Program Evaluation, "Maternal Depression."
[13] Lisa Sontag-Padilla, Dana Schultz, Kerry Reynolds et al., *Maternal Depression: Implications for Systems Serving Mother and Child*, RAND Corporation, 2013, http://www.rand.org/pubs/research_reports/RR404.html; Jean Pierre Lépine and Mike Briley, "The Increasing Burden of Depression" *Neuropsychiatric Disease and Treatment* 7, no. 1 (2011); National Research Council and Institute of Medicine, *Depression in Parents*; Ronald Kessler, Hagop Akiskal, Minnie Ames, et al., "Prevalence and Effects of Mood Disorders on Work Performance in a Nationally Representative Sample of U.S. Workers," *American Journal of Psychiatry* 163, no.9 (2006); Phillip Wang, Amanda Patrick, Jeffery Avorn, et al., "The Costs and Benefits of Enhanced Depression Care to Employers," *Archives of General Psychiatry* 63, no. 12 (2006).
[14] *Making a Difference in the Lives of Children and Families: The Impacts of Early Head Start Programs on Infants and Toddlers and Their Families*, Administration on Children Youth and Families (ACF), U.S. Department of Health and Human Services, 2002.
[15] Mental Health America, "Co-occurring Disorders and Depression" http://www.mentalhealthamerica.net/conditions/co-occurring-disorders-and-depression; and National Institute of Mental Health, "Alliance for Research Progress," 2007, http://www.nimh.nih.gov/outreach/alliance/alliance-report-july-2007_34025.pdf.
[16] Lynne Lamberg, "Treating Depression in Medical Conditions May Improve Quality of Life" *The Journal of the American Medical Association*, (1996), http://jama.jamanetwork.com/article.aspx?articleid=407850.
[17] United States Government Accountability Office, *Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States*, Report to Congressional Requesters, 2015, http://www.gao.gov/assets/680/670894.pdf. Note: Three of the four states that were interviewed for this project have taken up expansion.
[18] Families USA, "A 50 State Look at Medicaid Expansion," updated February 2016, http://familiesusa.org/product/50-state-look-medicaid-expansion.
[19] HealthCare.gov, "Mental Health and Substance Abuse Coverage," U.S. Department of Health and Human Services, https://www.healthcare.gov/coverage/mental-health-substance-abuse-coverage/; and MentalHealth.gov, "Health Insurance and Mental Health Services," U.S. Department of Health and Human Services, http://www.mentalhealth.gov/get-help/health-insurance.
[20] Public Law 111–148 of March 23, 2010, ''Patient Protection

and Affordable Care Act," 124 Stat. 119, https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf; and The Henry J. Kaiser Family Foundation, "Preventive Services Covered by Private Health Plans under the Affordable Care Act," 2015, http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/.

[21] The Henry J. Kaiser Family Foundation, "Coverage of Preventive Services for Adults in Medicaid," 2014, http://kff.org/report-section/coverage-of-preventive-services-for-adults-in-medicaid-appendices/.

[22] Jurgen Unutzer, Henry Harbin, Michael Schoenbaum, et al., *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes*, Medicaid.gov, 2013, https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf.

[23] National Scientific Council on the Developing Child, "Mental health problems in early childhood can impair learning and behavior for life," Center on the Developing Child, Harvard University, Working Paper 6, 2009.

[24] Priya Wickramaratne, Marc Gameroff, Daniel Pilowsky, et al. "Children of Depressed Mothers 1 Year After Remission of Maternal Depression: Findings from the STAR*D-child Study," *The American Journal of Psychiatry* 168, no. 6 (2011).

[25] Robert Whitaker, Brandon Becker, Allison Herman, et al., "The Physical and Mental Health of Head Start Staff: The Pennsylvania Head Start Staff Wellness Survey," 2012, *Preventing Chronic Disease* 10, E181, 2013, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3816599/. Elles J de Schipper, J. Marianne Riksen-Walraven, Sabine A.E. Geurts, et al., "Cortisol levels of caregivers in child care centers as related to the quality of their caregiving," *Early Childhood Research Quarterly* 24, (2009). ; Marleen Groeneveld, H. J Vermeer, Marinus van IJzendoorn, et al., "Stress, cortisol and wellbeing of caregivers and children in home-based child care: A case for differential susceptibility," *Child Care, Health and Development* 38 (2012), http://www.ncbi.nlm.nih.gov/pubmed/21166835; Groeneveld, M. G., Vermeer, H. J., van IJzendoorn, M. H., et al., "Caregivers' cortisol levels and perceived stress in home-based and center-based childcare," *Early Childhood Research Quarterly* 27, (2012), http://www.sciencedirect.com/science/article/pii/S0885200611000378; and Lieny Jeon, Cynthia Buettner, Anastascia Snyder, "Pathways from teacher depression and child-care quality to child behavioral problems," *Journal of Consulting and Clinical Psychology* 82 (2014).

For instance, according to 2013 Bureau of Labor Statistics' data, the mean annual salary of child care workers was just $21,490, and the actual mean hourly wage for the same year was just $10.33. One study of early childhood teaching staff found that the majority of the staff were women, and two-thirds had dependent children at home.

[26] Marcy Whitebrook, Deborah Phillips, Carollee Howees, *Worthy Work, STILL Unlivable Wages: The Early Childhood Workforce 25 Years After the National Child Care Staffing Study*, 2014, Center for the Study of Child Care Employment, http://www.irle.berkeley.edu/cscce/wp-content/uploads/2014/11/ReportFINAL.pdf.

[27] Center for Medicaid & CHIP Services, "Coverage of Maternal, Infant, and Early Childhood Home Visiting Services," March 2, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/cib-03-02-16.pdf.

[28] U.S. Census Bureau, American Community Survey, Table S0901.

[29] CLASP calculations of American Community Survey data, Table B17024, http://www.census.gov/acs.

[30] Families USA, "50 State Look."

[31] Medicaid income eligibility levels can be found on each state's Medicaid homepage: Connecticut: https://www.medicaid.gov/medicaid-chip-program-information/by-state/connecticut.html; Minnesota: https://www.medicaid.gov/medicaid-chip-program-information/by-state/minnesota.html; Ohio: https://www.medicaid.gov/medicaid-chip-program-information/by-state/ohio.html; Virginia: https://www.medicaid.gov/medicaid-chip-program-information/by-state/virginia.html.

[32] Medicaid income eligibility levels can be found on each state's Medicaid homepage: Connecticut: https://www.medicaid.gov/medicaid-chip-program-information/by-state/connecticut.html; Minnesota: https://www.medicaid.gov/medicaid-chip-program-information/by-state/minnesota.html; Ohio: https://www.medicaid.gov/medicaid-chip-program-information/by-state/ohio.html; Virginia: https://www.medicaid.gov/medicaid-chip-program-information/by-state/virginia.html.

[33] Smith, S., Granja, M., Ekono, M., et al, "Medicaid coverage for early childhood mental health services and maternal depression screening: Results of a 50-state survey," (forthcoming) New York: National Center for Children in Poverty, Mailman School of Public Health, Columbia University.

[34] Erum Nadeem, Jane M. Lange, Dawn Edge, et al, "Does stigma keep poor young immigrant and US-born black and Latina women from seeking mental health care?," *Psychiatric Services*, 2007; and Erum Nadeem, Jane M. Lange, and Jeanne Miranda. "Perceived need for care among low-income immigrant and US-born black and Latina women with depression." *Journal of Women's Health* 18, (2009).

[35] Children's Defense Fund – Minnesota, *Zero to Three Research to Policy Project: Maternal Depression and Early Childhood*, 2011, http://cascw.umn.edu/wp-content/uploads/2011/06/CDF-MaternalDepressionReport.pdf.

[36]Deborah Bacharch, Stephanie Anthony, Andrew Detty, *State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment*, 2014, http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=hndJWfFaoRw%3D&tabid=122.

[37] For more information see: http://www.movingbeyonddepression.org.
[38] The New Haven MOMS Partnership, *The MOMS Partnership 2015 Data Report on Mothers in New Haven*, Yale University, 2015 https://medicine.yale.edu/psychiatry/moms/research/MOMS_Partnership_2015_Data_Report_225158_284_18354.pdf.
[39] Personal Communication with Megan Smith, March 2016.
[40] Center for Medicaid and CHIP Services, "RE: Affordable Care Act Section 4106 (Preventive Services)," February 1, 2013, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-002.pdf.
[41] Center for Medicaid and CHIP Services, " Coverage of Maternal, Infant, and Early Childhood Home Visiting Services," March 2, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf.
[42] Center for Medicaid and CHIP Services, " Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children," May 11, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf.

NATIONAL SCIENTIFIC COUNCIL ON THE DEVELOPING CHILD
NATIONAL FORUM ON EARLY CHILDHOOD PROGRAM EVALUATION

Maternal Depression Can Undermine the Development of Young Children

WORKING PAPER 8

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The Issue

SERIOUS DEPRESSION IN PARENTS AND CAREGIVERS CAN AFFECT FAR MORE THAN THE ADULTS WHO are ill. It also influences the well-being of the children in their care. Because chronic and severe maternal depression has potentially far-reaching harmful effects on families and children, its widespread occurrence can undermine the future prosperity and well-being of society as a whole. When children grow up in an environment of mental illness, the development of their brains may be seriously weakened, with implications for their ability to learn as well as for their own later physical and mental health. When interventions are not available to ensure mothers' well-being and children's healthy development, the missed opportunities can be substantial.

Healthy development depends on the interactive influences of genes and experiences, which shape the architecture of the developing brain. The active ingredient of those experiences can be described as mutual responsiveness or the "serve and return" of young children's interactions with adult caregivers.[1] For example, when an infant babbles and an adult responds appropriately with attention, gestures, or speech, this builds and strengthens connections in the child's brain that support the development of communication and social skills. When caregivers are sensitive and responsive to a young child's signals, they provide an environment rich in serve and return experiences, like a good game of tennis or Ping-Pong. However, if depression interferes with the caregiver's ability to regularly provide such experiences, these connections in the child's brain may not form as they should. The difference between a child who grows up in a responsive environment and one who does not can be the difference between the development of strong or weak brain architecture, which serves as a foundation for the learning, behavior, and health that follow.

Maternal depression is particularly worrisome because of its prevalence. An estimated 10 to 20 percent of mothers will be depressed at some time during their lives.[2,3,4,5] About one in eleven infants will experience their mothers' major depression in their first year of life, and the rates are even higher for mothers with previous histories of depression or those experiencing other stressors, such as financial hardship or social isolation.[6,7] Depression and depressive symptoms are particularly common in disadvantaged populations. Recent data indicate that, in households below the federal poverty threshold, one in four mothers of infants is experiencing moderate-to-severe levels of depressive symptoms. (See graph, page 2.)

Because chronic and severe maternal depression has potentially far-reaching harmful effects on families and children, its widespread occurrence can undermine the future prosperity and well-being of society as a whole.

Although it is all the same underlying disorder, mothers' *experiences* of depression may differ in timing, severity, and duration.[8,9] For a substantial proportion of mothers, depression comes in spells that may last just a few months; but, for others, depression is more chronic.[9,10,11] Some mothers may experience depression primarily during their children's infant and toddler years; others endure depression that is prolonged or recurs over many years of a child's life.[10,12,13] Although the greatest cause for concern arises when depression begins early and is long-lasting and severe, poor developmental outcomes have

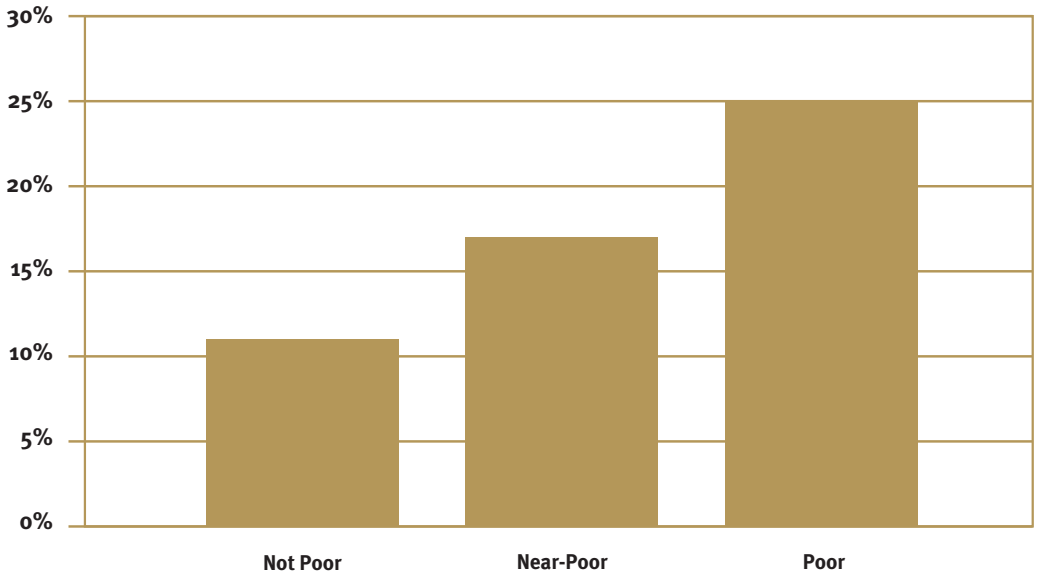
Despite the frequency of depression among new mothers, large numbers of affected individuals may not be identified as having a treatable condition, and only 15 percent obtain professional care.

been documented for children of mothers with declining or low levels of depression, as well.[12,14]

Despite the frequency of depression among new mothers, large numbers of affected individuals may not be identified as having a treatable condition, and only 15 percent obtain professional care.[15] Just as it is essential to treat children's emotional and behavioral problems within the context of their families,[16] it is equally essential for treatments and programs aimed at improving maternal depression and depressive symptoms to consider, treat, and measure their impact on the children. Although depression in fathers or other important caregivers (such as grandparents) also deserves further attention, the effects on children's development are rarely studied, and the research is far less conclusive.[4]

It is not normal for women to suffer major depression after having a baby. Major depression is very different from (but sometimes confused with) the emotional swings experienced by many mothers shortly after childbirth.[17] Characterized by a low mood and loss of interest in usually enjoyable activities, depressive symptoms include difficulty sleeping and

Maternal Depression Affects Children in Low-Income Families Disproportionately



Percent of mothers with a 9-month-old infant who are moderately or severely depressed

Source: Calculations based on analyses of the Early Childhood Longitudinal Study, Birth Cohort 9-month restricted-use data (NCES 2006-044) by Danielle Crosby, PhD, University of North Carolina Greensboro. Maternal Depression is measured by the 12-item version of the Center for Epidemiological Studies' Depression Scale (CES-D). Elevated symptoms of moderate to severe depression are identified by scores of 10 points or higher on a scale that ranges from 0-36. Analytic weights (W1R0) were applied to ensure data were nationally representative of mothers with 9-month-old infants born in 2001. Poor refers to family income less than or equal to 100% Federal Poverty Threshold (FPT). Near poor refers to family income greater than 100% of FPT but less than 200% of FPT. Not poor refers to income greater than 200% of FPT.

concentrating, loss of appetite, feelings of worthlessness or guilt, and low energy. In the face of major clinical depression, the drive, energy, and enjoyment needed to build and maintain positive family relationships recedes.[4] Especially when combined with other, related adversities, deep depression is debilitating, making it difficult for mothers to effectively carry out requisite caregiving tasks and responsibilities and to build and maintain nurturing relationships with their children. This may explain why, when raised by a chronically depressed mother, children perform lower, on average, on cognitive, emotional, and behavioral assessments than children of nondepressed caregivers, and they are at risk for later mental health problems, social adjustment difficulties, and difficulties in school.[18] Such patterns may also forecast difficulties in adult life across a variety of important domains, including employment and health.

As the magnitude and societal consequences of this problem have become better understood, increasing numbers of clinicians and policymakers have begun to realize that it is unacceptable to ignore what science tells us and have made the prevention and treatment of maternal depression an important goal. In order to maximize the impact of such investments on the well-being of children as well as mothers, it's important for policymakers to start from a common understanding of what we know—and what we don't know—about the effects of maternal depression on children as well as the effectiveness of programs designed to treat or prevent this serious condition.

Children who experience maternal depression early in life may suffer lasting effects on their brain architecture and persistent disruptions of their stress response systems.

What Neuroscience and Developmental Research Tell Us

Chronic depression can manifest itself in two types of problematic parenting patterns that disrupt the "serve and return" interaction that is essential for healthy brain development: hostile or intrusive, and disengaged or withdrawn.[19] When parents are hostile and/or intrusive, it is as if the parent is "serving" the ball in ways that make it difficult for the child to "return." Conversely, if a parent is withdrawn or disengaged, the child may serve the ball, but the parent doesn't return it. In both cases, depressed mothers are less likely to respond to their infants' cues (i.e., vocalizations and actions) or to engage with their infants and young children in positive, harmonious interactions.[20,21] When caregivers are hostile or withdrawn for prolonged periods of time, the game of serve and return falls apart, and the architecture of the developing brain may be affected adversely. Such patterns are particularly worrisome because, once negative parent-child interactions are established, they may persist even after a mother's depression has improved and may make the child more likely to have negative interactions with other important adults, as well.[22,23] When infants and young children interact with a hostile, irritable caregiver, this creates feelings of fear and anxiety in the child, which may result in the increased production of potentially harmful stress chemicals.[24] Such a recurring physiological reaction can affect brain development, interfere with young children's ability to learn, and increase the risk of emotional disorders.[25]

Children who experience maternal depression early in life may experience lasting effects on their brain architecture and persistent disruptions of their stress response systems. Studies of children of depressed mothers show patterns of brain activity (as observed on an electroencephalogram, or EEG) that are similar to those found in adults with depression.[26] These patterns are more pervasive when the mother is both depressed and withdrawn from her infant[27]

and when deep depression occurs during the child's second and third year, the time at which the brain systems that generate the depression-associated pattern of brain waves are developing rapidly.[24] Living with a depressed mother may also shape the development of a child's stress biology.[28] Indeed, there is increasing evidence that effects on stress response systems are one mechanism linking maternal depression to the child's own risk of developing depression and other emotional disorders.[29,30] When mothers are depressed, both early in a child's life and later, their children tend to produce higher and more fluctuating levels of stress chemicals such as cortisol.[31,32] Chronic maternal depression over many years of a child's life also predicts cardiovascular patterns suggestive of emergent hypertension in childhood and abnormal stress chemical patterns in response to laboratory testing.[29]

Depressed women produce higher levels of stress chemicals during pregnancy, which reduce fetal growth and are associated with an increased risk for premature labor.

Maternal depression may begin to affect brain development in the fetus before birth. Depressed women produce higher levels of stress chemicals during pregnancy, which reduce fetal growth and are associated with an increased risk for premature labor.[33] Depressive symptoms in an expectant mother also have been shown to be associated with altered immune functioning in her baby after birth.[34] Even more striking, recent research has found that prenatal depression can be linked to the silencing of a gene that controls the over-production of stress chemicals.[35] Thus, by the time of birth, the infant of a seriously depressed mother may have sustained effects on his or her stress response and immune systems that make the child even more vulnerable than average to irritable, intrusive, or withdrawn maternal care.

Depression often occurs in the context of other family adversities, which makes it challenging to treat successfully. When mothers have good social supports, adequate income, and environments free of stress and conflict, they are better able to provide the developmentally appropriate interactions that their children need. However, depression often coincides with a constellation of other adversities that may further undermine child development. For example, mothers experiencing depression are often also young, socially isolated, economically or educationally disadvantaged, and burdened by more family conflict and stressful life events than mothers who are not depressed.[11,36] Mothers who experience deep or chronic depression are also more likely to have experienced intimate partner violence,[37] to be in poorer health, and to have problems with anxiety or substance abuse.[4] Indeed, evidence suggests that 75 percent of adults diagnosed with major depression have at least one other mental health diagnosis.[38] When maternal depression co-occurs with other serious adversities, not only are standard treatments less likely to be successful in reducing depressive symptoms, but the children are at even greater risk for poor outcomes, as these related risk factors also reduce the likelihood that they will experience environments that foster healthy development.[4,39]

What Program Evaluation Research Tells Us

GIVEN THE POTENTIAL NEGATIVE CONSEQUENCES of depression for both mothers and their children, a variety of interventions has been designed to prevent and treat it as well as to buffer children from its harmful effects. By intervening early, before these effects can accrue, we increase the likelihood that children of depressed mothers will grow into healthy, capable, fully contributing members of society.

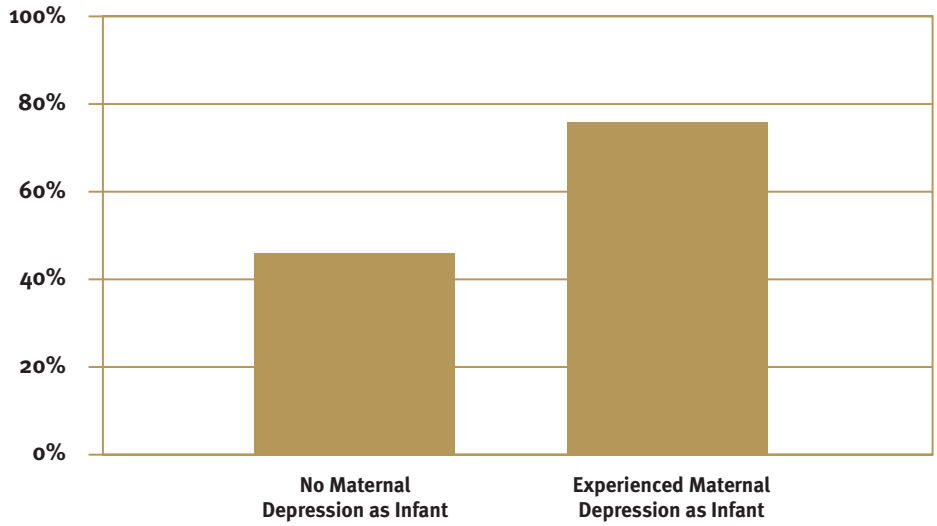
Although a few studies address the more general treatment of maternal depression, much of the research on prevention is focused on the

specific condition of postpartum depression (PPD). Interventions that have been employed differ as to whether they take a biological approach, such as the prescription of antidepressant medications, or a psychosocial approach grounded in therapeutic and psycho-educational strategies. In cases of PPD, the use of medication for preventive purposes has been limited because of concerns about the potentially harmful effects of antidepressants that can pass directly into the fetus through the placenta or into the infant through breast milk.[40] Alternatively, the range of psychosocial interventions that have been employed includes strategies directed either solely to mothers or to the mother-child dyad.

Intensive intervention efforts that focus specifically on mother-child interactions have shown promising results in several recent studies. One program of weekly toddler-parent psychotherapy that lasted over a year produced improved cognitive development among children of depressed mothers.[46] Another successful intervention targeted young, economically disadvantaged mothers of infants and provided a comprehensive set of daily supports, including education opportunities for the mothers, massage therapy for both mothers and infants, and mother-infant interaction coaching.[47] Several recent studies have shown improvements in important dimensions of mother-child

By intervening early, we increase the likelihood that children of depressed mothers will grow into healthy, capable, fully contributing members of society.

Exposure to Maternal Depression in Infancy Causes Stress Hormone Levels to Become More Extreme in Adolescence



Source: Halligan, Herbert, Goodyer, and Murray (2004).

interaction.[40,48] Collectively, these examples demonstrate that intensive, well-designed interventions for depressed mothers and their children can improve both parenting behaviors in the mothers and developmental outcomes in the children. What these studies cannot tease apart, however, is whether the key ingredient in the program's success was its focus on the mother-child dyad or the intensity of the treatment. Nevertheless, interventions with families and older children also provide suggestive evidence that programs that explicitly promote positive parenting practices among depressed parents may have benefits for children and families.[4,49] Yet, the high cost of intensive interventions and the fact that most studies have been conducted on relatively small samples present serious challenges to the task of replicating successful models and taking them to scale.

Interventions with families and older children also provide suggestive evidence that programs that explicitly promote positive parenting practices among depressed parents may have benefits for children and families.

Research indicates that various combinations of psychotherapy and educational treatments that are focused exclusively on adults can be effective in reducing depressive symptoms in mothers but appear to have limited impacts on the development of their young children.[41,42,43,44] A few good studies of therapeutic interventions have demonstrated reductions in maternal depression after treatment, but no differences were documented in long-term child outcomes, such as cognitive functioning and behavior. These findings have led several researchers to argue that therapies should not only treat the mother but should also focus on the mother-child relationship.[45]

Successful efforts to prevent maternal depression before it develops have thus far been more elusive than effective treatments. Several models of educational and psychological interventions to prevent postpartum depression have shown promise.[41,50,51] These programs are diverse in terms of when services are initiated, how and by whom services are delivered, and the likelihood of depression in the population they serve. Most of these prevention programs, however, are short-term, often delivered through a small number of individual or group educational sessions or psychotherapy, midwife care, or home visits. The documented success of a program in which poor women participated in four prenatal sessions of group psychotherapy suggests that preventing PPD may be possible.[52] Yet, the small, voluntary, and select nature of the sample, as well as the lack of child outcome measures, indicate that more research is necessary. Biological approaches to preventing PPD also have been studied, but successful results are rare,[41,53] and, as noted previously, biological prevention approaches are often not well received by mothers because of concerns about the pass-through effects of medication on fetuses or infants. The extent to which maternal depression often coexists with other mental health problems (e.g., anxiety disorders or substance abuse) further complicates the challenge of designing effective prevention programs.

Correcting Common Misconceptions

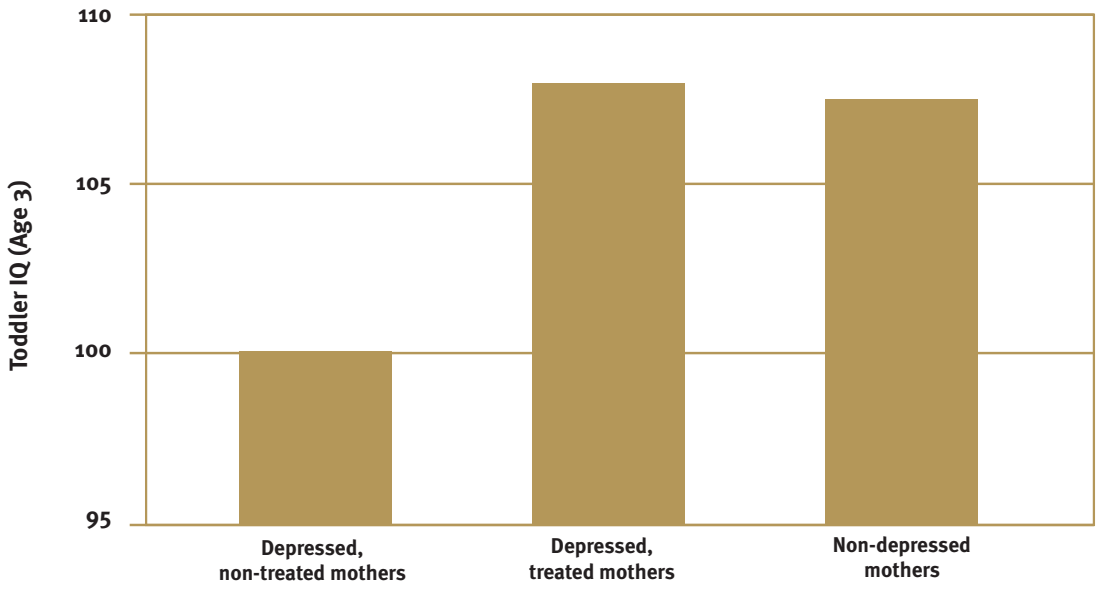
Contrary to popular belief, professional treatment is needed to help mothers overcome major depression. Although many mothers experience emotional adjustments and mood swings in the immediate period following childbirth—sometimes known as the "baby blues"—this is very different from major depression, which is much more severe and can be long-lasting.[17] Major depression should be understood as a serious medical condition that affects brain functioning and typically limits one's ability to carry out everyday activities. Mothers of infants are

more likely than other women to experience such depression, particularly as they experience high caregiving demands, yet they are less likely to get professional help.[15] This is most unfortunate, because there is evidence that a range of treatment approaches may reduce depressive symptoms among these mothers.[54]

It is not commonly understood that even very young children are likely to be affected by their mother's depression and these effects may be lasting. Adverse effects may even begin during pregnancy. As noted earlier, maternal depression in the prenatal period is linked to alterations in the stress response and immune systems of the fetus, which can increase the chance that an infant will be more vulnerable to irritable, intrusive, or withdrawn maternal care than the average baby.[34,35] Moreover, ongoing depression after childbirth is linked to patterns of parenting that may disrupt the normal "serve and return" interactions between an infant and mother, thus potentially harming the child's developing brain architecture and emerging skills.[19] Finally, hostile or withdrawn parenting has been linked to patterns of child brain activity associated with anxious and withdrawn emotions, which may persist over time.[24]

Contrary to what is frequently assumed, reducing mothers' depressive symptoms alone does not necessarily lead to improvements in parenting and children's development. This erroneous assumption has been called into question by treatments that have improved mothers' depressive symptoms but have not had measurable effects on children's development.[42,43,44] Even when successful, short-term treatments that focus only

Toddler-Parent Therapy Improves Cognitive Development



Mothers with a major depressive disorder were randomly selected to participate in Toddler-Parent Psychotherapy as a preventive intervention for their children, age 20 months at entry to program. Children's scores on Bayley Mental Developmenet index did not differ at age of entry, but significant differences appeared in IQ tests given at age 3.

Source: Cicchetti, Rogosch, and Toth (2000).

on reducing mothers' depression may miss the opportunity to also improve their parenting skills and their view of their children.[43] Limited but promising evidence suggests that treatments designed to improve child well-being must attend both to relieving mothers' depression and to focusing on parenting behavior and interactions with the child as central dimensions of the intervention.[9]

The Science-Policy Gap

Postpartum depression has several characteristics that make it a particularly compelling target for preventive intervention, yet little has been done in the U.S. to determine which interventions work. These characteristics include a clear time of onset (childbirth), a distinct risk period (up to six months postdelivery), and an identifiable population of at-risk women (expectant mothers).[51] Despite this striking opportunity, most studies of programs designed to prevent PPD have been conducted outside of the United States, where differences in health service delivery systems may make their findings less applicable to the U.S. context. In view of the fact that maternal depression can set in motion detrimental patterns of parenting and developmental processes that may be difficult to change as time passes, the limited availability of effective prevention programs in the United States represents an important missed opportunity to improve children's development.

Enhanced treatment programs for mental health problems in parents need to address adult behavior toward young children as well as the programs' impacts on children's developmental outcomes. This presents a major challenge, as very few studies to date have measured the impacts of interventions for maternal depression on either mother-child interaction or child well-being. Evidence that depression interferes with a mother's ability to engage in and benefit from a variety of services adds to that challenge, particularly for disadvantaged populations.[4] Several settings have been identified as promising vehicles through which prevention, screening, and treatment services for maternal depression might be embedded, including primary health care, home visiting, and early care and education.[4,55] Each of these types of programs provides an underutilized opportunity to identify and engage depressed mothers, yet they all face distinctive challenges in developing and implementing effective services.[4,56]

Implications for Policy and Programs

Maternal depression matters for children, families, and society. Maternal depression affects a large number of families and can have potentially far-reaching, adverse effects on parenting and the development of children. These consequences have implications for society as a whole, as children who are affected adversely become the next generation of parents and workers. Untreated maternal depression may lead to more hostile or withdrawn parenting, which can, in turn, have harmful effects on young children's developing brains, leaving them at higher risk for later cognitive and socio-emotional problems. Insensitive, hostile, or withdrawn parenting is associated with the development of patterns of brain activity associated with anxious, withdrawn emotions in children and adults. Depressed mothers engage in less stimulation of their children, potentially reducing the strength of brain circuits involved in learning and memory. It is therefore important for the well-being of society to find effective ways to prevent and treat this disorder.

Evidence suggests that intensive therapies that focus on both mothers and their young children together can improve child outcomes. Not only are access and use of mental health services by mothers important, but equally important is the need for policymakers and clinicians to work

together to establish and support a model of care that simultaneously addresses mothers' own mental health needs as well as their caregiving roles and their children's healthy development. Because healthy brain architecture is built by positive interactions with responsive caregivers over time, short-term therapies of low intensity that focus solely on mothers may be effective at reducing their depressive symptoms, but they are unlikely to improve child outcomes. In view of the magnitude of the problem, creative policymaking would be well served by support for promising pilot projects that focus on mothers' interactions with their infants and are linked to strong evaluation designs.

Innovation, evaluation, and continuous improvement are needed to better understand what works for both children and their mothers and to bring such interventions to scale. Findings from program evaluations indicate that the challenge of treating maternal depression is not simply a matter of increased funding. Because there is still much to be learned, two kinds of investments are important for policymakers to consider. The first would focus on replication and expansion of interventions that have been evaluated and shown to have positive effects on young children. The second and equally important kind of investment would provide support for innovative program models that focus on the needs of mothers and their children, guided by advances in neuroscience and developmental research and committed to rigorous evaluations. In short, the prevalence of maternal depression, the growing evidence of its potential adverse impacts on young children, and the lack of interventions that focus on the well-being of the young children of affected mothers all call for increased investment in the design, testing, and continuous improvement of more effective two-generation interventions.

The development and testing of more successful models for prevention of maternal depression, particularly for women who are at increased risk for the disorder, should be an important policy priority. Evaluations of prevention programs for maternal depression thus far have been disappointing. This does not mean that prevention cannot work, but it does indicate that we still have much to learn. The magnitude of risk facing affected mothers and young children from all social classes, particularly those who have low incomes and limited education, underscores the need for policymakers, neuroscientists, doctors, program developers, and evaluation specialists to work together in the search for new and more effective prevention strategies.

The development and testing of more successful models for prevention of maternal depression, particularly for women who are at increased risk for the disorder, should be an important policy priority.

IN SUMMARY, THE PREVALENCE AND MULTIPLE costs of maternal depression and the growing development of conceptual and practical approaches for protecting children whose mothers have the disorder all provide a compelling rationale for testing and evaluating promising practices and new intervention strategies. The continuing failure to address the consequences of depression for large numbers of vulnerable, young children presents a missed opportunity to help families and children in a way that could have far-reaching implications for the productivity, health, and well-being of the next generation.

References

1. National Scientific Council on the Developing Child. (2007). *The science of early childhood development.* Retrieved November 1, 2009, from www.developingchild.harvard.edu.
2. Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., Rush, A. J., Walters, E. E., & Wang, P. S. (2003). The epidemiology of major depressive disorder: Results from the National Comorbidity Survey Replication (NCS-R). *Journal of the American Medical Association, 289*, 3095–3105.
3. Mian, A. I. (2005). Depression in pregnancy and the postpartum period: Balancing adverse effects of untreated illness with treatment risks. *Journal of Psychiatric Practice, 11*(6), 389-396.
4. National Research Council and Institute of Medicine (2009). *Depression in parents, parenting, and children: Opportunities to improve identification, treatment, and prevention*. Committee on Depression, Parenting Practices and the Healthy Development of Children, Board on Children, Youth and Families, Division on Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.
5. O'Hara M. W., & Swain, A. M. (1996). Rates and risk of postpartum depression - a meta-analysis. *International Review of Psychiatry*, *8*, 37-54.
6. Miller, L. J. (2002). Postpartum depression. *Journal of the American Medical Association, 287*, 762-765.
7. Administration for Children and Families. (2002). *Making a difference in the lives of children and families: The impacts of Early Head Start programs on infants and toddlers and their families*. Washington, DC: U.S. Department of Health and Human Services.
8. Cooper, C., Jones, L., Dunn, E., Forty, L., Haque, S., Oyebode, F., Craddock, N., & Jones, I. (2007). Clinical presentation of post-natal and non-postnatal depressive episodes. *Psychological Medicine, 37*, 1273-1280.
9. Whiffen, V. E., & Gotlib, I. H. (1993). Comparison of postpartum and nonpostpartum depression: Clinical presentation, psychiatric history, and psychosocial functioning. *Journal of Consulting and Clinical Psychology*, *61*, 485-494.
10. Campbell, S., Cohn, J. F., & Meyers, T. (1995). Depression in first-time mothers: Mother-infant interaction and depression chronicity. *Developmental Psychology*, *31,* 349-357.
11. Horowitz, S. M., Briggs-Gowan, M. J., Storfer-Isser, A., & Carter, A. (2007). Prevalence, correlates and persistence of maternal depression. *Journal of Women's Health*, 16, 678-691.
12. Ashman, S. B., Dawson, G., & Panatogiotides, H. (2008). Trajectories of maternal depression over seven years: Relations with child psychophysiology and behavior and role of contextual risks. *Development and Psychopathology*, *20*, 55-77.
13. Phillips, J., Sharpe, L., Matthey, S., & Charles, M. (in press). Subtypes of postnatal depression? A comparison of women with recurrent and de novo postnatal depression. *Journal of Affective Disorders.*
14. Campbell, S., Morgan-Lopez, A. A., Cox, M., McLoyd, V. & NICHD ECCRN (2009). A latent class analysis of maternal depressive symptoms over 12 years and offspring adjustment in adolescence. *Journal of Abnormal Psychology*, *3*, 479-493.
15. Vesga-Lopez, O., Blanco,C., Keyes, K., Olfson, M., Grant, B., & Hasin, D. (2008). Psychiatric disorders in pregnant and postpartum women in the United States. *Archives of General Psychiatry*, *65,* 805-815.
16. National Scientific Council on the Developing Child. (2008). *Mental health problems in early childhood can impair learning and behavior for life.* Working Paper No. 6. Retrieved November 1, 2009, from www.developingchild.harvard.edu.
17. Sohr-Preston, S.L., & Scaramella, L. V. (2006). Implications of maternal depressive symptoms for early cognitive language development. *Clinical Child and Family Psychology Review*, *9,* 65-83.
18. Goodman, S. H., & Gotlib, I. H. (1999). Risk for psychopathology in the children of depressed mothers: A developmental model for understanding mechanisms of transmission. *Psychological Review, 106,* 458-490.
19. Lovejoy, M. C., Graczyk, P. A., O'Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. *Clinical Psychology Review, 20*(5), 561-592.
20. Field, T., Pickens, J., Prodromidis, M., Malphurs, J., Fox, N., & Bendell, D. (2000). Targeting adolescent mothers with depressive symptoms for early intervention. *Adolescence, 35,* 381-414.
21. Gladstone, T. R. G., & Beardslee, W. R. (2002). Treatment, intervention and prevention with children of depressed parents: A developmental perspective. In S. H.Goodman & I. H. Gotlib (Eds.). *Children of depressed parents: Mechanisms of risk and implications for treatment* (pp. 277-305). Washington, DC: American Psychological Association.
22. Seifer, R., Dickstein, S., Sameroff, A. J., Magee, K. D., & Hayden, L. C. (2001). Infant mental health and variability of parental depression symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, *40,* 1375–1382.
23. Tronick, E., & Reck, C. (2009). Infants of depressed mothers. *Harvard Review of Psychiatry, 17*, 147-156.
24. Dawson, G., & Ashman, S. (2000). On the origins of a vulnerability to depression: The influence of early social environment on the development of psychobiological systems related to risk for affective disorder. In C. A. Nelson (Ed.), *The effects of early adversity on neurobehavioral development: The Minnesota Symposia on Child Psychology, Vol. 31* (pp. 245-278). New York: Erlbaum & Associates.
25. National Scientific Council on the Developing Child. (2005). *Excessive stress disrupts the architecture of the developing brain.* Working Paper No. 3. Retrieved November 1, 2009, from www.developingchild.harvard.edu
26. Dawson, G., Frey, K., Panagiotides, H., Osterling, J., & Hessl, D. (1997). Infants of depressed mothers exhibit atypical frontal brain activity: A replication and extension of previous findings. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 38*(2), 179-186.
27. Diego, M. A., Field, T., Jones, N. A., & Hernandez-Reif, M. (2006). Withdrawn and intrusive maternal interaction style and infant frontal EEG asymmetry shifts in infants of depressed and non-depressed mothers. *Infant Behavior and Development, 29*, 220-209.

28. Ronsaville, D.S., Municchi, G., Laney, C., Cizza, G., Meyer, S.E. & Haim, A. (2006). Maternal and environmental factors influence the hypothalamic-pituitary-adrenal axis response to corticotropin-releasing hormone infusion in offspring of mothers with or without mood disorders. *Development & Psychopathology, 18*, 173-194.
29. Gump, B. B., Reihman, J., Stewart, P., Lonky, E., Darvill, T., Granger, D. A., & Matthews, K. A. (2009). Trajectories of maternal depressive symptoms over her child's life span: Relation to adrenocortical, cardiovascular, and emotional functioning in children. *Development & Psychopathology, 21*, 207-225.
30. Halligan, S. L., Herbert, J., Goodyer, I., & Murray, L. (2007). Disturbances in morning cortisol excretion in association with maternal postnatal depression predict subsequent depressive symptomatology in adolescents. *Biological Psychiatry, 62*, 40-46.
31. Essex, M. J., Klein, M., Cho, E., & Kalin, N. H. (2002). Maternal stress beginning in infancy may sensitize children to later stress exposure: Effects on cortisol and behavior. *Biological Psychiatry, 52*, 776-784.
32. Halligan, S. L., Herbert, J., Goodyer, I. M., & Murray, L. (2004). Exposure to postnatal depression predicts elevated cortisol in adolescent offspring. *Biological Psychiatry, 55*, 376-381.
33. Diego, M. A., Field, T., Hernandez-Reif, M., Schanberg, S., Kuhn, C., & Gonzalez-Quintero, V. H. (2009). Prenatal depression restricts fetal growth. *Early Human Development, 85*, 65-70.
34. Mattes, E., McCarthy, S., Gong, G., van Eekelen, J. A., Dunstan, J., & Foster, J. (2009). Maternal mood scores in mid-pregnancy are related to aspects of neonatal immune function. *Brain Behavior & Immunity, 23*(3), 380-388.
35. Oberlander, T. F., Weinberg, J., Papsdorf, M., Grunau, R., Misri, S., & Devlin, A. M. (2008). Prenatal exposure to maternal depression, neonatal methylation of human glucocorticoid receptor gene (NR3C1) and infant cortisol stress responses. *Epigenetics, 3*, 97-106.
36. Lorant, V., Deliege, D., Eaton, W., Robert, A., Philippot, P., and Ansseau, M. (2003). Socioeconomic inequalities in depression: A meta-analysis. *American Journal of Epidemiology,157,* 98–112.
37. Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A metaanalysis. *Journal of Family Violence, 14*, 99–132.
38. Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., and Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62,* 593–602.
39. Talati, A., Wickramaratne, P. J., Pilowsky, D. J., Alpert, J. E., Cerda, G., Garber, J., Hughes, C. W., King, C. A., Malloy, E., Sood, A. B., Verdeli, H., Trivedi, M. H. Rush, A. J., & Weissman, M. M. (2007). Remission of maternal depression and child symptoms among single mothers: A STAR*D-Child report. *Social Psychiatry and Psychiatric Epidemiology, 42,* 962-971.
40. Clark, R., Tluczek, A., & Wenzel, A. (2003). Psychotherapy for postpartum depression: A preliminary report. *American Journal of Orthopsychiatry*, *4,* 441-454.
41. Chabrol, H., & Callahan, S. (2007). Prevention and treatment of postnatal depression. *Expert Review of Neurotherapeutics, 7*(5), 557-576.
42. Cooper, P. J., Murray, L., Wilson, A., & Romaniuk, H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of postpartum depression: I. Impact on maternal mood. *British Journal of Psychiatry, 182,* 412-419.
43. Forman, D. R., O'Hara, M. W., Stuart, S., Gorman, L. L., Larsen, K., & Coy, K. C. (2007). Effective treatment for postpartum depression is not sufficient to improve the developing mother-child relationship. *Development and Psychopathology, 19,* 585-602.
44. Murray, L., Cooper, P. J., Wilson, A., & Romaniuk, H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of postpartum depression: II. Impact on the mother-child relationship and child outcome. *British Journal of Psychiatry, 182,* 420-427.
45. Nylen, K. J., Moran, T. E., Franklin, C. L., & O'Hara, M. W. (2006). Maternal depression: A review of relevant treatment approaches for mothers and infants. *Infant Mental Health Journal, 27*(4), 327-343.
46. Cicchetti, D., Rogosch, F. A., & Toth, S.L. (2000). The efficacy of toddler-parent psychotherapy for fostering cognitive development in offspring of depressed mothers. *Journal of Abnormal Psychology, 28*(2), 135-148.
47. Field, T. (2002). Prenatal effects of maternal depression. In S. H.Goodman & I. H. Gotlib (Eds.), *Children of depressed parents: Mechanisms of risk and implications for treatment* (pp. 59-88). Washington, DC: American Psychological Association.
48. Toth, S. L., Rogosch, F. A., Manly, J. T., & Cicchetti, D. (2006). The efficacy of toddler-parent psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: A randomized preventive trial. *Journal of Consulting and Clinical Psychology*, *74*, 1006-1016.
49. Beardslee,W. R., Wright, E. J., Gladstone, T. R. G., & Forbes, P. (2008). Long-term effects from a randomized trial of two public health preventive interventions for parental depression. *Journal of Family Psychology, 21*, 703-713.
50. Dennis, C. (2005). Psychosocial and psychological interventions for prevention of postnatal depression: Systematic review. *British Medical Journal, 331*(7507), 15.
51. Ogrodniczuk, J. S., & Piper, W. E. (2003). Preventing postnatal depression: A review of research findings. *Harvard Review of Psychiatry, 11*(6), 291-307.
52. Zlotnick, C., Johnson, S. L., Miller, I. W., Pearlstein, T., Howard, M. (2001). Postpartum depression in women receiving public assistance: Pilot study of an interpersonal-therapy-oriented group intervention. *American Journal of Psychiatry, 158*, 638-640.
53. Howard, L. M., Hoffbrand, S. Henshaw, C., Boath, L., & Bradley, E. (2005). Antidepressant prevention of postnatal depression. *Cochrane Database of Systematic Reviews, Issue 2.* Article No.: CD004363. DOI: 10.1002/14651858.CD004363.pub2.
54. Dennis, C. L., & Hodnett, E. D. (2009). Psychosocial and psychological interventions for treating postpartum depression (Review). *The Cochrane Library*, 2.
55. Chazen-Cohen, R., Ayoub, C., Pan, B. A., Roggman, L., Raikes, H., McKelvey, L., Whiteside-Mansell, L., & Hart, A. (2007). It takes time: Impacts of Early Head Start that lead to reductions in maternal depression two years later. *Infant and Mental Health Journal*, *28,* 151-170.
56. Tandon, S. D., Parillo, K. M., Jenkins, C., & Duggan, A. K. (2005). Formative evaluation of home visitors' role in addressing poor mental health, domestic violence, and substance abuse among low-income pregnant and parenting women. *Maternal and Child Health Journal*, 9, 273-283.

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Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services

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abstract

BACKGROUND: Since the passage of the Affordable Care Act, Medicaid enrollment has increased by ~17 million adults, including many low-income parents. One potentially important, but little studied, consequence of expanding health insurance for parents is its effect on children's receipt of preventive services.

METHODS: By using state Medicaid eligibility thresholds linked to the 2001–2013 Medical Expenditure Panel Surveys, we assessed the relationship between changes in adult Medicaid eligibility and children's likelihood of receiving annual well-child visits (WCVs). In instrumental variable analyses, we used these changes in Medicaid eligibility to estimate the relationship between parental enrollment in Medicaid and children's receipt of WCVs.

RESULTS: Our analytic sample consisted of 50 622 parent-child dyads in families with incomes <200% of the federal poverty level, surveyed from 2001 to 2013. On average, a 10-point increase in a state's parental Medicaid eligibility (measured relative to the federal poverty level) was associated with a 0.27 percentage point higher probability that a child received an annual WCV (95% confidence interval: 0.058 to 0.48 percentage points, P = .012). Instrumental variable analyses revealed that parental enrollment in Medicaid was associated with a 29 percentage point higher probability that their child received an annual WCV (95% confidence interval: 11 to 47 percentage points, P = .002).

CONCLUSIONS: In our study, we demonstrate that Medicaid expansions targeted at low-income adults are associated with increased receipt of recommended pediatric preventive care for their children. This finding reveals an important spillover effect of parental insurance coverage that should be considered in future policy decisions surrounding adult Medicaid eligibility.

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WHAT'S KNOWN ON THIS SUBJECT: Cross-sectional studies have revealed inconsistent relationships between parental insurance coverage and children's health care use. To our knowledge, no studies have investigated the link between parental insurance and pediatric care by using more robust quasi-experimental methods.

WHAT THIS STUDY ADDS: We found that parental Medicaid enrollment is associated with a 29 percentage point higher probability that low-income children received annual well-child visits, highlighting a link between parents' Medicaid coverage and their children's health care use.

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Since the passage of the Affordable Care Act (ACA), 31 states and the District of Columbia have expanded Medicaid to adults earning <138% of the federal poverty level (FPL).[1] Medicaid expansions have been shown to increase preventive care use, improve health outcomes, and reduce the financial burden of obtaining care.[2–5] The authors of several studies have also identified potential spillover effects in which increases in adult Medicaid coverage indirectly affect health care use in other populations, for example, by increasing insurance enrollment among children and improving family financial standing.[5–7]

One important but understudied effect of expanding access to health insurance for parents is its impact on well-child visit (WCV) use among children. Recommended annually for children 3 years of age and older, and more frequently for infants and toddlers,[8] WCVs serve as the primary platform for growth and developmental screening, vaccination, and provision of anticipatory guidance. Children who receive WCVs are more likely to complete immunization schedules and are less likely to have avoidable hospitalizations.[9,10] WCV use in the United States has been persistently suboptimal, particularly among racial and ethnic minorities and in low-income families.[11]

Although the authors of previous studies have shown that parental health care use is correlated with children's receipt of care,[12–15] evidence regarding the relationship between parental insurance coverage and pediatric care use is mixed. The authors of several cross-sectional studies found a positive correlation between parents' insurance status and children's health care use in primarily low-income families,[16–18] whereas analyses in mixed income populations did not.[14,15] A limitation of cross-sectional analyses is that insured and uninsured adults differ in unobserved ways that may be related to their child's use of care, potentially biasing the estimated relationship between these variables.[19]

To address this bias, we used a quasi-experimental design that leveraged state-level variation in adult Medicaid eligibility over the period from 2001 to 2013 to assess the relationship between parents' Medicaid coverage and children's receipt of annual WCVs. Our findings reveal how changes in federal and state policies that affect Medicaid coverage for adults could indirectly affect low-income children's use of recommended primary care services.

METHODS

Data Sources

We analyzed data from the 2001–2013 Medical Expenditure Panel Surveys (MEPS) linked to state Medicaid eligibility criteria from the Kaiser Family Foundation and county-level characteristics from the Area Health Resources File. The MEPS is a nationally representative survey of the noninstitutionalized US population and includes detailed information about family structure and demographic characteristics, health insurance status, and health care use.[20]

Our analytic sample consisted of children ages 2 through 17 linked to their biological, step, or adoptive parents living in the same household during the calendar year. We first selected children ages 2 through 17 living in the household the entire year. We then linked each child to a parent or guardian (age 20–64) living in the household for the full year. Consistent with previous research, preference was given to the selection of the mother if more than 1 parent in the household was surveyed.[15]

Because Medicaid eligibility rules differ for pregnant women, we excluded children whose mothers met inclusion criteria but were pregnant at any point during the calendar year. Because pregnancy status was not uniformly reported in all years of the MEPS, we identified pregnant women as having either a child born in the same calendar year or by September of the next calendar year, or as having any pregnancy-related inpatient visits over the same period. This measure was highly correlated with pregnancy status for the years in which this variable was included in the MEPS (Supplemental Table 5).

Consistent with the methods in previous studies,[16–18] our primary analyses were focused on low-income families, defined as those with incomes <200% of the FPL.

Measures

Outcome: WCV Use

We assessed whether a child received at least 1 WCV in the calendar year. WCVs were defined as outpatient visits for a "well-child examination," for a "general checkup," or for "immunization or shots" for children <17.[21] We controlled for changes in the recommended WCV schedule over time (such as introduction of annual visit requirements for 7- and 9-year-olds in 2007) by including year fixed effects in regression analyses.[8]

State-Level Medicaid Eligibility for Parents

We obtained state Medicaid eligibility thresholds from 2000 through 2012 from the Kaiser Family Foundation's surveys of state Medicaid programs.[22–32] Because states may change their Medicaid eligibility limits at different points in a year, we used income thresholds from the preceding year in all regression analyses. Thresholds were based on eligibility criteria for unemployed parents with dependent children, reflecting (if applicable) the higher income limits allowed under federal expansion waivers, and were

expressed in percentage points of the FPL.[33] We used linear interpolation to approximate thresholds in years in which data were not reported (2002, 2007, and 2010).

Parental Enrollment in Medicaid

We constructed a binary indicator for whether an adult had Medicaid coverage at any point in the study year.

Covariates

In our primary analyses, we controlled for parental, family, child, and county-level characteristics that are associated with children's health care use.[11,16–18,21] Parental characteristics included age, sex, race, Hispanic ethnicity, comfort speaking English, education, and smoking status. Family level variables were total income, size, and parental structure (mother and father both present in household versus not). We additionally controlled for the child's age and sex, the density of physicians in the patient's county (total active MD physicians divided by the county population), the county-level poverty rate, and an indicator for whether the family lived in an urban area (defined as a Metropolitan Statistical Area).

Statistical Analyses

We first examined the association between the changes in a state's parental Medicaid eligibility thresholds and WCV receipt. Specifically, we estimated a multivariable logistic regression model in which our outcome was the probability that a child received at least 1 WCV during the year by using parental Medicaid eligibility thresholds (lagged by 1 year) as the main independent variable. In this intention-to-treat framework, we used within-state changes in the Medicaid eligibility threshold for parents as the exposure of interest. The models controlled for state and year fixed effects, in addition to the covariates described above. We ran models for our full sample of parent-child dyads (the unit of analysis) and stratified by category of family income (<100% of the FPL and 100% of the FPL to <200% of the FPL). We used these regression analyses to estimate the change in probability of receiving a WCV because of state Medicaid expansions for adults, holding all other covariates at their sample means.

We then examined the relationship between a parent's enrollment in Medicaid and WCV usage by using an instrumental variable (IV) analysis. This approach addresses bias from unmeasured factors that could impact a parent's insurance status and their children's health care use by using within-state changes in Medicaid eligibility for parents as an instrument for parental Medicaid enrollment. We estimated a binary probit model for the probability that a child received a WCV as a function of his/her parent's Medicaid enrollment status, which we instrumented by using within-state changes in Medicaid eligibility thresholds for parents. Our IV models controlled for state fixed effects, year fixed effects, and the covariates described above (see Supplemental Information for details). By using these models, we calculated a predicted change in the probability that a child would receive a WCV if their parent enrolled in Medicaid, holding all covariates at the sample means. The IV models were run on our full sample of families and by stratum of family income.

We performed 4 sensitivity analyses. First, because a child's insurance status may change in response to changes in parental access to insurance[34] (eg, "welcome mat" effects), and because children's insurance status is known to be an independent determinant of health care use,[11,16,18] we ran models additionally controlling for the child's Medicaid or Children's Health Insurance Program (CHIP) status to determine if our findings could be explained by changes in children's health insurance status. Second, because states may also undergo concurrent expansions in children's Medicaid eligibility over time, which could in turn affect child insurance coverage status, we repeated our analyses for a subgroup of 29 large states (with observable state identifiers in the MEPS) whose income thresholds for child Medicaid or CHIP programs were consistently ≥200% of the FPL during the study period. In these states, low-income children in our cohort would have remained consistently eligible for Medicaid, further isolating the impact of parental Medicaid expansions on WCVs.

Third, we limited the study period to 2001 to 2009 to ensure that our results were not driven by the ACA's introduction of regulations requiring insurer coverage of preventive health care services. Fourth, we reestimated our models for families with incomes ≥400% of the FPL. Because we expected parents in these families to be relatively unaffected by Medicaid expansions, this serves as a falsification test (eg, we would not expect to see an impact of increasing parental Medicaid eligibility on children's WCV receipt for this higher income sample).

We used family survey weights provided in the MEPS and variance estimates that accounted for clustering of observations at the state level. This study was approved by the institutional review board of the Johns Hopkins School of Medicine.

RESULTS

Our analytic sample consisted of 50 622 parent-child dyads across the 13 study years, representing 266 557 804 weighted pairs through the study period (Table 1). Slightly less than half of the dyads (44.7%) had incomes <100% of the FPL. The mean age of children was 9.3 years,

and the mean age of linked parents was 35.8 years. The majority of parents were white (72.5%), non-Hispanic (67.4%), and had earned at least a high school diploma or general education diploma (67.0%). The majority of dyads consisted of children linked to mothers (95.4%).

At the beginning of the study period (2001), mean adult Medicaid eligibility (weighted for the population across states in our sample and lagged by 1 year) for unemployed parents was 73.5% of the FPL, and increased to 107.7% of the FPL by 2013 (Supplemental Table 6). The proportion of states with parental Medicaid eligibility limits ≥200% of the FPL increased from 7.8% to 29.4% over the study period (Supplemental Table 6). The percentage of children in our sample receiving an annual WCV increased from 32.7% in 2001 to 47.9% in 2013 (Table 2).

In the intention-to-treat analysis, we found that a 10-point absolute increase in a state's adult Medicaid eligibility threshold (relative to the FPL) was associated with a 0.27 percentage-point increase in the probability that low income children received an annual WCV (95% confidence interval [CI]: 0.058 to 0.48 percentage points, $P = .012$; Table 3). In stratified analyses, changes in adult Medicaid eligibility thresholds were positively associated with WCV use for families with incomes 100% of the FPL to <200% of the FPL (0.38 percentage points, 95% CI: 0.10 to 0.66 percentage points, $P = .008$) and was positively but not significantly related to WCVs in the lowest (<100% of the FPL) income group (0.13 percentage points, 95% CI: −0.11% to 0.36% points, $P = .284$) (Table 3).

In IV analyses, we found that parental Medicaid enrollment was associated with a 29 percentage-point (95% CI: 11 to 47 percentage points; $P = .002$) increase in the probability that their child would have a WCV (Table 4). This relationship was strongest in families with incomes 100% to <200% of the FPL. For these families, there was a 45 percentage point higher probability that a child would have a WCV if a parent was enrolled in Medicaid compared with the parent not being enrolled (95% CI: 17 to 73 percentage points, $P = .002$). The relationship remained positive, but was not statistically significant, in the <100% of the FPL income group (11 percentage points, 95% CI: −7.4 to 30 percentage points, $P = .237$) (Table 4).

In sensitivity analyses (summarized in Supplemental Table 9), controlling for child Medicaid and/or CHIP enrollment did not significantly affect our results, revealing that parental Medicaid enrollment affects WCV use independently of children's insurance status. Limiting our analysis to large states in which child eligibility for Medicaid and CHIP remained ≥200% through the

TABLE 1 Primary Sample Characteristics

		% of N[a,b]
Child sex		
Male		51.5
Female		48.5
Child age in y (mean)		9.30
Child age in y, categories		
2–6		31.8
7–11		32.9
12–17		35.3
Parent sex		
Male		4.6
Female		95.4
Parent age in y (mean)		35.8
Parental education		
Less than HS		33.0
HS diploma or GED		35.6
Any college		30.5
Not specified		0.9
Parental race		
White		72.5
Black		19.9
Asian or Pacific Islander		4.7
Other		2.9
Parental ethnicity Hispanic		32.6
Parent comfortable with English language		85.3
Parental smoking status		
Nonsmoker		70.0
Current smoker		24.3
Not specified		5.7
Family income (in dollars; mean)	24 593.61	
Family income, percentage of the FPL		
<100%		44.7
100% to <200%		55.3
Family size (no. of members)		
2		6.8
3		15.6
4		27.6
5		24.3
6		13.4
7 or more		12.3
Parental structure		
Single parent		42.5
Two parents		57.5

GED, general education diploma; HS, high school.
[a] $N = 266\,557\,804$ weighted dyads (50 622 unweighted dyads).
[b] Or mean as otherwise specified.

TABLE 2 Proportion of Children Who Received a WCV, Overall and by Year

Year	% Children With WCV[a]	*P*[b]
2001	32.7	<.001
2002	34.3	
2003	34.6	
2004	35.9	
2005	35.8	
2006	33.5	
2007	35.1	
2008	35.8	
2009	39.5	
2010	38.2	
2011	41.1	
2012	40.7	
2013	47.9	
All years	37.5	

[a] Weighted percentage.
[b] Pearson's χ^2 test comparing outcome over years.

TABLE 3 The Adjusted Association Between Changes in a State's Medicaid Eligibility Threshold for Parents and Child's Receipt of a WCV

	Probability (95% CI)[a]	Stratified Analysis by FPL Income Categories	
		<100% Probability (95% CI)[a]	100% to <200% Probability (95% CI)[a]
Parental Medicaid eligibility threshold[b]	0.27 (0.058 to 0.48)	0.13 (−0.11 to 0.36)	0.38 (0.10 to 0.66)

Results represent the change in predicted probability of a WCV for every 10 percentage-point increase in the state parental eligibility threshold. Estimates are from a multivariable logistic regression of WCV receipt on Medicaid eligibility threshold. In addition to state and year fixed effects, covariates in the model included child sex, child age (y), parent sex, parent age (y), parent race, parent ethnicity, parent English-speaking status, parental smoking status, parental education level, parental structure of household, family income, family size, county poverty rate, county physician density, and county Metropolitan Statistical Area Status.
[a] Marginal predicted probability expressed in percentage points, calculated at the means of all other variables in model.
[b] In 10 percentage-point increments of FPL.

TABLE 4 The Adjusted Association of Parental Medicaid Enrollment With Child's Receipt of WCV (IV Analysis): Results Represent the Increased Probability of a WCV for a Child Whose Parent is Enrolled in Medicaid

	Probability (95% CI)[a]	Stratified Analysis by FPL Income Category	
		<100% Probability (95% CI)[a]	100%–<200% Probability (95% CI)[a]
Parental Medicaid enrollment	29 (11 to 47)	11 (−7.4 to 30)	45 (17 to 73)

Results represent the increased probability of a WCV for a child whose parent is enrolled in Medicaid. Estimates are from multivariable probit regression of WCV receipt on instrumental parental Medicaid enrollment. In addition to state and year fixed effects, covariates in the model included child sex, child age (y), parent sex, parent age (y), parent race, parent ethnicity, parent English-speaking status, parental smoking status, parental education level, parental structure of household, family income, family size, county poverty rate, county physician density, and county Metropolitan Statistical Area Status.
[a] Marginal predicted probability expressed in percentage points, calculated at the means of all other variables in model.

study period revealed a positive relationship between parental Medicaid eligibility thresholds and WCVs for our primary analytic sample and a significantly positive relationship for a subset of this sample (families with incomes 125%–200% of the FPL). Limiting our analysis to the pre-ACA period (2001–2008) also did not significantly affect our results. Finally, we did not find a significant association between parental Medicaid eligibility and WCVs in higher-income families (≥400% of the FPL), demonstrating that the effects of changes in Medicaid coverage were concentrated, as expected, among lower-income families.

DISCUSSION

Leveraging 13 years of changes in state Medicaid eligibility for adults and performing an IV analysis, we found that increases in the income threshold for adult Medicaid eligibility were associated with a greater likelihood that children in low-income families received at least 1 annual WCV. With our results, we provide evidence of an independent relationship between parental Medicaid enrollment and children's primary care use in low-income families, and we illustrate the potential for adult Medicaid expansions to have positive spillover effects on children's health care use.

We found the strongest relationship between adult Medicaid eligibility and WCVs in near-poor families (100% to <200% of the FPL). This likely reflects the fact that increases in parental Medicaid eligibility during the 2000s primarily affected families with incomes slightly >100% of the FPL, whereas states with the least generous Medicaid coverage for nonpregnant adults generally did not expand parental eligibility over the study period. Our analyses were therefore less able to detect effects of eligibility changes in the lowest-income families.

Several mechanisms may underlie this spillover effect of parental Medicaid coverage on WCV receipt. One hypothesis, supported by the Behavioral Model of Health Services Use,[35] is that insurance enhances parents' ability to navigate the health care system for themselves and for family members. This may lead to an increase in parental health-seeking behaviors for their children (eg, scheduling WCVs). It may also

function through a welcome mat effect in which eligible but previously uninsured children enroll in Medicaid after their parents gain coverage.[6,7,34] However, because our estimates were substantively unchanged after we controlled for children's Medicaid and/or /State CHIP status, our analyses indicate that such a woodwork effect was not primarily responsible for changes in WCV use.

Another potential mechanism is that parental Medicaid coverage may improve families' financial standing, freeing up resources to provide preventive services for children. Low-income families who enroll in public insurance have decreased out-of-pocket medical spending and a reduced likelihood of bankruptcy.[5,36] Studies have revealed that children's health care use is sensitive to out-of-pocket costs, particularly in low-income families.[37,38]

Our study has several limitations. First, our conclusions are not derived from a randomized controlled trial of Medicaid enrollment; however, we use a quasi-experimental design that leverages plausibly exogenous state-level policy changes to isolate the effect of parental Medicaid enrollment on WCVs from other family and person-level determinants of this relationship. Second, our analyses may not isolate the impact of changes in parental Medicaid eligibility and coverage on WCVs if states contemporaneously expanded Medicaid eligibility or increased coverage generosity for children. To address this concern, we conducted a sensitivity analysis in which we limited our analytic sample to states with CHIP or children's Medicaid eligibility thresholds consistently >200% of the FPL. In this sensitivity analysis, we continued to find a positive relationship between parental eligibility for Medicaid and WCVs, particularly in near-poor families. Third, our study period encompasses several changes in the recommended WCV schedule, the introduction of the ACA's requirement that insurance plans cover preventive services for children, and other efforts to increase pediatric preventive care.[11] We incorporated year fixed effects into our models to control for temporal trends that may have resulted from these changes and verified that our results were unchanged when we limited the study period to years preceding these ACA mandates for pediatric care (2001–2009). Finally, many measures in the MEPS, including insurance status and health care use, are self-reported and subject to recall and social desirability bias. However, respondents are aware that health care providers may be contacted to verify self-reported use, which may mitigate reporting error.[15]

These findings are of great significance given the current uncertainty surrounding the future of the ACA and Medicaid expansions authorized by the law. Our work highlights the potential for Medicaid expansions targeting low-income adults to mitigate disparities in the receipt of WCVs between low- and high-income families. Currently, 19 states have not expanded adult Medicaid coverage to 138% of the FPL under the ACA. According to Current Population Survey data, ~5.5 million children in these 19 states live in families in which a parent would qualify for expanded Medicaid coverage. Our intention-to-treat estimates imply that the spillover effect of Medicaid expansion would result in ~135 000 additional annual WCVs for low-income children in these 19 states (see Supplemental Information for calculation).

Likewise, our results reveal the potential for reductions in adult Medicaid coverage to have unintended spillover effects on children's health care use. Recent proposals to reform the Medicaid program by using block grants or "per-capita caps" on federal financial support have raised the concern that states could curtail Medicaid benefits or eligibility, thereby significantly reducing parental enrollment.[39,40] Given the evidence that increased access to pediatric care early in life is associated with improved health and lower hospital use in adulthood,[41–43] changes in parental coverage may have long-term impacts on children that will be important to consider when modifying the Medicaid program.

CONCLUSIONS

In our study, we demonstrate that parental Medicaid enrollment is associated with increases in pediatric primary care use in low-income families. Given the suboptimal rates of WCV use in low-income families, our findings suggest that efforts to expand Medicaid for parents may help to promote their children's receipt of recommended preventive care.

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ABBREVIATIONS

ACA: Affordable Care Act
CHIP: Children's Health Insurance Program
CI: confidence interval
FPL: federal poverty level
IV: instrumental variable
MEPS: Medical Expenditure Panel Survey
WCV: well-child visit

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REFERENCES

1. Kaiser Family Foundation. Estimates of eligibility for ACA coverage among the uninsured in 2016. 2016. Available at: http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/view/footnotes/. Accessed February 7, 2017
2. Sommers BD, Baicker K, Epstein AM. Mortality and access to care among adults after state Medicaid expansions. *N Engl J Med*. 2012;367(11):1025–1034
3. Sommers BD, Blendon RJ, Orav EJ, Epstein AM. Changes in utilization and health among low-income adults after Medicaid expansion or expanded private insurance. *JAMA Intern Med*. 2016;176(10):1501–1509
4. Gross T, Notowidigdo M. Health insurance and the consumer bankruptcy decision: evidence from expansions of Medicaid. *J Public Econ*. 2011;95(7):767–778
5. Wherry LR, Kenney GM, Sommers BD. The role of public health insurance in reducing child poverty. *Acad Pediatr*. 2016;16(suppl 3):S98–S104
6. Dubay L, Kenney G. Expanding public health insurance to parents: effects on children's coverage under Medicaid. *Health Serv Res*. 2003;38(5):1283–1301
7. DeVoe JE, Tillotson CJ, Angier H, Wallace LS. Predictors of children's health insurance coverage discontinuity in 1998 versus 2009: parental coverage continuity plays a major role. *Matern Child Health J*. 2015;19(4):889–896
8. Hagan J, Shaw J, Duncan P, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008
9. Hakim RB, Bye BV. Effectiveness of compliance with pediatric preventive care guidelines among Medicaid beneficiaries. *Pediatrics*. 2001;108(1):90–97
10. Freed GL, Clark SJ, Pathman DE, Schectman R. Influences on the receipt of well-child visits in the first two years of life. *Pediatrics*. 1999;103(4 pt 2):864–869
11. Abdus S, Selden TM. Adherence with recommended well-child visits has grown, but large gaps persist among various socioeconomic groups. *Health Aff (Millwood)*. 2013;32(3):508–515
12. Bates AS, Fitzgerald JF, Dittus RS, Wolinsky FD. Risk factors for underimmunization in poor urban infants. *JAMA*. 1994;272(14):1105–1110
13. Kogan MD, Alexander GR, Jack BW, Allen MC. The association between adequacy of prenatal care utilization and subsequent pediatric care utilization in the United States. *Pediatrics*. 1998;102(1 pt 1):25–30
14. Hanson KL. Is insurance for children enough? The link between parents' and children's health care use revisited. *Inquiry*. 1998;35(3):294–302
15. Goedken AM, Urmie JM, Polgreen LA. Factors related to receipt of well-child visits in insured children. *Matern Child Health J*. 2014;18(3):744–754
16. Davidoff A, Dubay L, Kenney G, Yemane A. The effect of parents' insurance coverage on access to care for low-income children. *Inquiry*. 2003;40(3):254–268
17. Gifford EJ, Weech-Maldonado R, Short PF. Low-income children's preventive services use: implications of parents' Medicaid status. *Health Care Financ Rev*. 2005;26(4):81–94
18. DeVoe JE, Tillotson CJ, Wallace LS. Children's receipt of health care services and family health insurance patterns. *Ann Fam Med*. 2009;7(5):406–413
19. Wallace J, Sommers BD. Health insurance effects on preventive care and health: a methodologic review. *Am J Prev Med*. 2016;50(5 suppl 1):S27–S33
20. Cohen S. *Sample Design of the 1996 Medical Expenditure Panel Survey Household Component*. Rockville, MD: Agency for Health Care Policy and Research; 1996
21. Selden TM. Compliance with well-child visit recommendations: evidence from the Medical Expenditure Panel Survey, 2000-2002. *Pediatrics*. 2006;118(6). Available at: www.pediatrics.org/cgi/content/full/118/6/e1766
22. Broaddus M, Blaney S, Dude A, Guyer J, Ku L, Peterson J. *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000*. Washington, DC: Center on Budget and Policy Priorities; 2001. Available at: www.cbpp.org/archiveSite/1-2-02health.pdf
23. Kaiser Commission on Medicaid and the Uninsured. Enrolling children and families in health coverage: the promise of doing more. 2002. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2002/05/4046.pdf. Accessed February 7, 2017
24. Kaiser Commission on Medicaid and the Uninsured. Preserving recent progress on health coverage for children and families: new tensions emerge. A 50 state update on eligibility, enrollment, renewal and cost-sharing practices in Medicaid and SCHIP. 2003. Available at: www.cbpp.org/archiveSite/7-30-03health.pdf. Accessed February 7, 2017
25. Kaiser Commission on Medicaid and the Uninsured. Beneath the surface: barriers threaten to slow progress on expanding health coverage of children and families: a 50 state update on eligibility, enrollment, renewal and cost-sharing practices in Medicaid and SCHIP. 2004. Available at: www.cbpp.org/archiveSite/10-4-04health.pdf. Accessed February 7, 2017

26. Kaiser Commission on Medicaid and the Uninsured. In a time of growing need: state choices influence health coverage access for children and families: a 50 state update on eligibility rules, enrollment and renewal procedures, and cost-sharing practices in Medicaid and SCHIP for children and families. 2005. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/in-a-time-of-growing-need-state-choices-influence-health-coverage-access-for-children-and-families-report.pdf. Accessed February 7, 2017

27. Kaiser Commission on Medicaid and the Uninsured. Resuming the path to health coverage for children and parents: a 50 state update on eligibility rules, enrollment and renewal procedures, and cost-sharing practices in Medicaid and SCHIP in 2006. 2007. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7608.pdf. Accessed February 7, 2017

28. Kaiser Commission on Medicaid and the Uninsured. Health coverage for children and families in Medicaid and SCHIP: state efforts face new hurdles a 50-state update on eligibility rules, enrollment and renewal procedures, and cost-sharing practices in Medicaid and SCHIP in 2008. 2008. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7740.pdf. Accessed February 7, 2017

29. Kaiser Commission on Medicaid and the Uninsured. Challenges of providing health coverage for children and parents in a recession: a 50 state update on eligibility rules, enrollment and renewal procedures, and cost-sharing practices in Medicaid and SCHIP in 2009. 2009. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7855.pdf. Accessed February 7, 2017

30. Kaiser Commission on Medicaid and the Uninsured. Holding steady, looking ahead: annual findings of a 50-state survey of eligibility rules, enrollment and renewal procedures, and cost sharing practices in Medicaid and SCHIP, 2010-2011. 2011. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8130.pdf. Accessed February 7, 2017

31. Kaiser Commission on Medicaid and the Uninsured. Performing under pressure: annual findings of a 50-state survey of eligibility, enrollment, renewal and cost-sharing policies in Medicaid and CHIP, 2011-2012. 2012. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8272.pdf. Accessed February 7, 2017

32. Kaiser Commission on Medicaid and the Uninsured. Getting into gear for 2014: findings from a 50-state survey of eligibility, enrollment, renewal and cost-sharing policies in Medicaid and CHIP, 2012-2013. 2013. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf. Accessed February 7, 2017

33. Roberts ET, Gaskin DJ. Projecting primary care use in the Medicaid expansion population: evidence for providers and policy makers. *Med Care Res Rev*. 2015;72(5):515–561

34. DeVoe JE, Marino M, Angier H, et al. Effect of expanding medicaid for parents on children's health insurance coverage: lessons from the Oregon experiment. *JAMA Pediatr*. 2015;169(1):e143145

35. Aday LA, Andersen R. A framework for the study of access to medical care. *Health Serv Res*. 1974;9(3):208–220

36. McMorrow S, Kenney GM, Long SK, Goin DE. Medicaid expansions from 1997 to 2009 increased coverage and improved access and mental health outcomes for low-income parents. *Health Serv Res*. 2016;51(4):1347–1367

37. Children's Health Fund. Unfinished business: more than 20 million children in U.S. still lack sufficient access to essential health care. Available at: https://www.childrenshealthfund.org/wp-content/uploads/2016/11/Unfinished-Business-Final_.pdf. Accessed February 7, 2017

38. Medicaid and CHIP Payment and Access Commission (MACPAC). The effect of premiums and cost-sharing on access and outcomes for low-income children. 2015. Available at: https://www.macpac.gov/wp-content/uploads/2015/07/Effect-of-Cost-Sharing-on-Low-Income-Children.pdf. Accessed February 7, 2017

39. Chatterjee P, Sommers BD. The economics of Medicaid reform and block grants.*JAMA*. 2017;317(10):1007–1008

40. Goodman-Bacon AJ, Nikpay SS. Per capita caps in Medicaid - lessons from the past. *N Engl J Med*. 2017;376(11):1005–1007

41. Currie J, Decker S, Lin W. Has public health insurance for older children reduced disparities in access to care and health outcomes? *J Health Econ*. 2008;27(6):1567–1581

42. Boudreaux MH, Golberstein E, McAlpine DD. The long-term impacts of Medicaid exposure in early childhood: evidence from the program's origin. *J Health Econ*. 2016;45:161–175

43. Miller S, Wherry LR. The long-term effects of early life Medicaid coverage. 2016. Available at: http://dx.doi.org/10.2139/ssrn.2466691. Accessed February 7, 2017

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Updated June 7, 2016

Work Requirements Don't Cut Poverty, Evidence Shows

By LaDonna Pavetti[1]

House Republicans will likely propose work requirements for safety net programs in their plan to address poverty, but the evidence indicates that such requirements do little to reduce poverty, and in some cases, push families deeper into it.

"First we will expect work-capable adults to work or prepare for work in exchange for receiving government benefits," House Ways and Means Committee Chairman Kevin Brady said at a recent Committee meeting.[2] As they unveil their poverty plan tomorrow, Republicans will likely point to the 1996 welfare law, which requires cash assistance recipients to participate in work activities, as a basis for extending similar work requirements to other public benefit programs.

The evidence from an array of rigorous evaluations,[3] however, does not support the view that work requirements are highly effective, as their proponents often claim. Instead, the research shows:

- Employment increases among recipients subject to work requirements were modest and faded over time (for more, see p. 3).
- Stable employment among recipients subject to work requirements proved the exception, not the norm (for more, see p. 5).
- Most recipients with significant barriers to employment never found work even after participating in work programs that were otherwise deemed successful (for more, see p. 7).
- Over the long term, the most successful programs supported efforts to boost the education and skills of those subject to work requirements, rather than simply requiring them to search for work or find a job (for more, see p. 8).

[1] I would like to acknowledge the tremendous effort Katherine Eddins, a former intern, put in to gathering and synthesizing information for this analysis.

[2] Chairman Brady Opening Statement at Markup of Bills to Improve TANF, May 11, 2016, http://waysandmeans.house.gov/chairman-brady-opening-statement-at-markup-of-bills-to-improve-tanf/.

[3] Our analysis primarily draws on 13 random assignment studies that examine the impacts of programs that focus on mandatory work or related activities and are included in a comprehensive analysis of welfare reform by Jeffrey Grogger and Lynn A. Karoly in their book, *Welfare Reform: Effects of a Decade of Change,* Harvard University Press, 2005. A description of these studies and additional sources can be found in Appendix A.

- The large majority of individuals subject to work requirements remained poor, and some became poorer (for more, see p. 9).
- Voluntary employment programs can significantly increase employment without the negative impacts of ending basic assistance for individuals who can't meet mandatory work requirements (for more, see p. 11).

Those who argue that work requirements in the Temporary Assistance for Needy Families (TANF) program have been a major success often cite rigorous, random assignment studies (the gold standard for assessing a program's effectiveness)[4] of mandatory work programs conducted either before TANF's creation in 1996 or during its early years. But these claims usually don't account for these studies' full findings. In this paper, we re-examine the studies of these programs, assessing how individuals subject to work requirements as compared to individuals not subject to the work requirements fared over time, including whether they worked steadily and had incomes that lifted them above the poverty line. We also examine data on how recipients with significant employment barriers, including mental and physical health issues, fared. That's important because these individuals are the least likely to find jobs on their own and have the most to gain from the employment assistance that TANF was supposed to provide. (See Appendix A for a description of the studies that we include in our analysis.)

Work requirements rest on the assumption that disadvantaged individuals will work only if they're forced to do so, despite the intensive efforts that many poor individuals and families put into working at low-wage jobs that offer unpredictable hours and schedules and don't pay enough for them to feed their families and keep a roof over their heads without public assistance of some kind. Too many disadvantaged individuals want to work but can't find jobs for reasons that work requirements don't solve: they lack the skills or work experience that employers want, they lack child care assistance, they lack the social connections that would help them identify job openings and get hired, or they have criminal records or have other personal challenges that keep employers from hiring them. In addition, when parents can't meet work requirements, their children can end up in highly stressful, unstable situations that can negatively affect their health and their prospects for upward mobility and long-term success.

Rather than instituting or expanding work requirements, policymakers should maintain a strong safety net that can help individuals and families weather hard times — and invest more in programs that help public benefit recipients build the skills and acquire the work experience they need to succeed in today's labor market. They also should institute employment policies that open doors for individuals with criminal records or other personal challenges and expand subsidized jobs for the long-term unemployed and those with significant work limitations who otherwise can't secure employment (or can't get a first job through which to acquire skills and experience and show their worth as employees).

[4] The programs cited most often are programs in Riverside, California, and Portland, Oregon, both of which we include in our analysis. These studies, like the others we examine, randomly assigned people to a "program group" that was mandated to participate in a work program or a "control group" that was offered limited employment assistance on a voluntary basis.

Finding #1: Increases in employment among recipients subject to work requirements were modest and faded over time.

Evaluations of programs that imposed work requirements on welfare recipients found modest, statistically significant increases in employment early on among recipients subject to the requirements, but those increases faded over time. Within five years, employment among recipients *not* subject to work requirements was the same as or higher than employment among recipients subject to work requirements in nearly all of the programs evaluated.

In the first two years, the share of recipients subject to work requirements who worked at any point over that period was significantly higher — in nine of the 13 programs included in the analysis — than the share of recipients not subject to the requirements who worked, with the increase in employment ranging from 4.1 to 15.1 percentage points.[5] (See Table 1.) The biggest impacts on employment were found in programs in Riverside, California and Portland, Oregon.

Over time, however, work steadily increased among recipients *not* subject to work requirements, substantially closing the employment gap between the two groups. By the fifth year (the last year any of the studies examined), the impacts of the early years had eroded in each of the programs for which longer-term data are available. In five of the eight programs that initially produced a significant increase in employment rates, by the fifth year the program recipients not subject to the work requirements were just as likely — or more likely— to work than the program recipients subject to work requirements. The net impact fell most in the Riverside LFA (labor force attachment) program,[6] from an increase of 15.1 percentage points in employment rates in the first two years to a gain of just 4.2 percentage points in the fifth year. Similarly, in Portland, the net impact on the employment rate declined from an 11.2 percentage-point increase in the first two years to a barely significant 3.8 percentage-point increase in the fifth year.[7]

The impacts of work requirements were modest in most programs even in the early years, in part because work was far more common among recipients than is generally perceived. Over the five-year period, the vast majority of recipients worked, even if they were *not* subject to work requirements. (See Figure 1 and Appendix Table B-1.) In Portland, which excluded recipients with substantial employment barriers from work requirements, more than 90 percent of recipients worked over the five-year period, regardless of whether or not they were subject to work requirements. In the other sites, employment rates among recipients not subject to work requirements ranged from 74.2 to 91.9 percent. Employment among recipients subject to work requirements ranged from 81.2 to 94.7 percent.[8]

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[5] Jeffrey Grogger *et al.*, "Consequences of Welfare Reform: A Research Synthesis," Rand Corporation, July 2002, http://www.acf.hhs.gov/programs/opre/resource/consequences-of-welfare-reform-a-research-synthesis, Table 5.1.

[6] Labor force attachment programs focus primarily on job search and are also known as "work first" programs.

[7] 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, http://www.mdrc.org/publication/how-effective-are-different-welfare-work-approaches, Appendix Table C-1.

[8] *Ibid.* Appendix Table C.5.

TABLE 1

Employment Increases Among Cash Assistance Recipients Subject to Work Requirements Were Modest and Faded Over Time

	Percentage of recipients who worked					
	Year 1-2			Year 5		
Program Name	Subject to Work Requirements	Not Subject to Work Requirements	Impact	Subject to Work Requirements	Not Subject to Work Requirements	Impact
NEWWS Study Sites						
Atlanta, GA (LFA)	66.1	61.6	4.5***	65.1	63.0	2.1
Atlanta, GA (HCD)	64.4	61.6	2.8**	63.9	63.0	0.6
Columbus, OH (Integrated)	73.9	72.2	1.7	69.1	68.8	0.3
Columbus, OH (Traditional)	73.5	72.2	1.3	69.3	68.8	0.5
Detroit, MI	62.3	58.2	4.1***	68.8	68.8	0.0
Grand Rapids, MI (LFA)	77.7	70.1	7.6***	70.0	73.0	-2.9*
Grand Rapids, MI (HCD)	75.4	70.1	5.3***	70.3	73.0	-2.7*
Oklahoma City, OK	64.1	65.0	-0.9	53.2	54.2	-1.0
Portland, OR	72.1	60.9	11.2***	62.4	58.6	3.8*
Riverside, CA (LFA)	60.1	45.0	15.1***	48.7	44.5	4.2***
Riverside, CA (HCD)	48.2	38.9	9.3***	44.9	39.9	5.0***
Other Study Sites						
IMPACT Basic Track (IN)	45.3	44.6	0.7	NA	NA	NA
Los Angeles, CA Jobs - 1st GAIN	67.2	57.6	9.6***	NA	NA	NA

*, **, and *** denote statistical significance at the .10, .05, and .01 levels, respectively, with .01 being the highest level of significance.

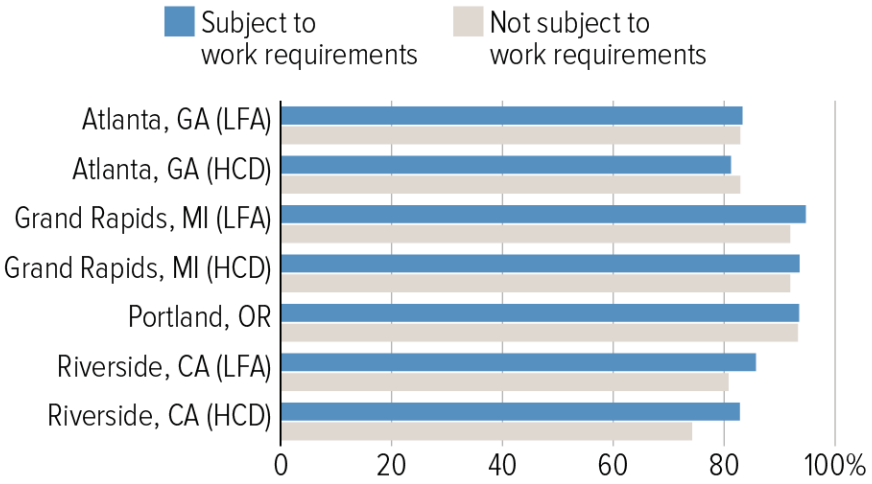
Note: LFA = Labor Force Attachment group (programs that focus primarily on job search, also known as "work first" programs); HCD = Human Capital Development group (programs that also include skills training and education); NEWWS = National Evaluation of Welfare-to-Work Strategies; GAIN = Greater Avenues for Independence; IMPACT = Indiana Manpower Placement and Comprehensive Training Basic Track. The Columbus, Ohio, integrated site featured one worker providing employment case management and eligibility determination, while the traditional site featured two workers: one completing eligibility functions and one providing employment case management.

Source: Jeffrey Grogger and Lynn A. Karoly, *Welfare Reform: Effects of a Decade of Change*, Harvard University Press, 2005.

FIGURE 1

Most Cash Assistance Recipients Worked Regardless of Work Requirements

Percentage of cash assistance recipients who ever worked within a five-year window



Note: LFA = Labor Force Attachment group (primarily job-search focused); HCD = Human Capital Development group (include training and education).

Source: 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

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Finding #2: Stable employment among recipients subject to work requirements proved to be the exception, not the norm.

Work requirements encouraged recipients to enter the labor marker sooner than they would have without them, the evidence from the studies reviewed here suggests. However, this increased employment was often short-lived. Stable employment, defined in these studies as being employed in 75 percent of the calendar quarters in years three through five, was the exception, not the norm. The share of recipients subject to work requirements who worked stably ranged in these programs from a low of 22.1 percent to a high of 40.8 percent. Even when work requirements led to a rise in stable employment, the increases were quite small. In Portland, the site of the largest impact, stable employment rose only from 31.2 to 38.6 percent.[9] (See Table 2.)

[9] Gaye Hamilton *et al.*, December 2001, Table C.6.

TABLE 2

Increases in Stable Employment Due to Work Requirements Were Small

Percentage of cash assistance recipients employed in 75 percent or more of quarters in years 3 to 5

Program Name	Subject to Work Requirements	Not Subject to Work Requirements	Impact
Atlanta, GA (LFA)	37.0	32.5	4.5***
Atlanta, GA (HCD)	35.6	32.5	3.1*
Columbus, OH (Integrated)	43.7	42.4	1.3
Columbus, OH (Traditional)	43.4	42.4	1.0
Detroit, MI	35.9	34.3	1.7
Grand Rapids, MI (LFA)	40.8	38.0	2.9*
Grand Rapids, MI (HCD)	39.8	38.0	1.8
Oklahoma City, OK	22.1	22.8	-0.6
Portland, OR	38.6	31.2	7.5***
Riverside, CA (LFA)	23.7	20.6	3.2***
Riverside, CA (HCD)	20.1	16.2	3.9***

*, **, and *** denote statistical significance at the .10, .05, and .01 levels, respectively, with .01 being the highest level of significance.

Note: GAIN = Greater Avenues for Independence; LFA = Labor Force Attachment group (programs that focus primarily on job search, also known as "work first" programs); HCD = Human Capital Development group (programs that also include skills training and education). The Columbus, Ohio, integrated site featured one worker providing employment case management and eligibility determination, while the traditional site featured two workers: one completing eligibility functions and one providing employment case management.

Source: Jeffrey Grogger and Lynn A. Karoly, *Welfare Reform: Effects of a Decade of Change*, Harvard University Press, 2005.

Two descriptive studies that examine the employment trajectories of recipients who left the welfare rolls arrive at similar conclusions. Researchers studying the employment and earnings trajectories in the late 1990s of parents who left welfare in Wisconsin found that only 19.2 percent were stably employed over a six-year period.[10] In Maryland, researchers examining the employment and earnings paths of recipients who left TANF from December 2001 through March 2009 found that only 21.6 percent of leavers were stably employed over a five-year period.[11]

[10] Chi-Fang Wu, Daniel R. Meyer, and Maria Cancian, "Standing Still or Moving Up? Evidence from Wisconsin on the Long-Term Employment and Earnings of TANF Participants," *Social Work Research*, February, 2008, Vol. 32, No. 2.

[11] Lisa Thiebaud Nicoli, "Climbing the Ladder? Patterns in Employment and Earnings After Leaving Welfare," Family Welfare Research & Training Group, University of Maryland, October 2015, http://www.familywelfare.umaryland.edu/reports1/trajectories.pdf.

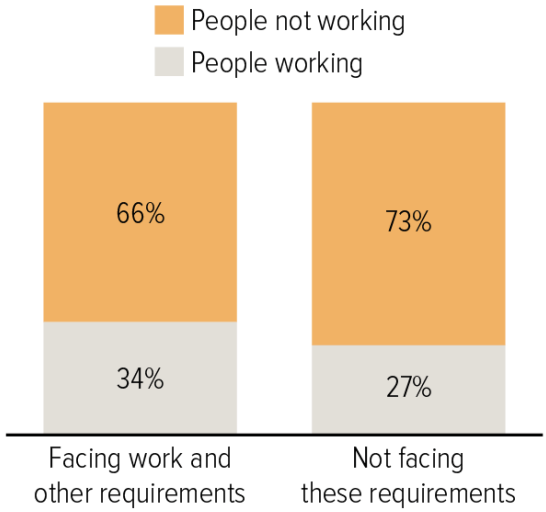
Finding #3: Most recipients who had significant barriers to employment never found employment, even after participating in programs otherwise deemed "successful."

Many recipients turn to public assistance programs because they face significant personal or family challenges that limit their ability to work or reduce their ability to compete for a limited supply of jobs. Physical and mental health conditions that limit an individual's ability to work or limit the amount or kind of work the individual can do are much more common among public benefit recipients than among the general population, research shows.[12] With the right supports and enough time, many of these individuals likely would be able to work, but few welfare employment programs have created alternative pathways to work for them or devised effective assessment procedures that can identify them and ensure that they receive the supports and services they need to find and retain employment.

FIGURE 2

Work and Other Requirements Did Little to Boost Work Among Those With Significant Employment Barriers

Percentage of cash assistance recipients, working and not working, enrolled in a rigorous evaluation of PRIDE program from 2001 to 2002



Note: The personal Roads to Individual Development and Employment (PRIDE) program was a comprehensive assessment and employment program for recipients with significant employment barriers in New York City.

Source: Dan Bloom, Cynthia Miller, and Gilda Azurdia, "Results from the Personal Roads to Individual Development and Employment (PRIDE) Program in New York City," mrdc, July 2007

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Even when special services are provided that successfully increase employment for individuals who face significant employment barriers, the vast majority of recipients participating never find employment, as the one study that explicitly examines the impact of work requirements on this group shows. (See Figure 2.) A rigorous two-year study of the PRIDE (Personal Roads to Individual Development and Employment) program in New York City — a comprehensive mandatory assessment, work experience, and job search program for recipients with significant employment barriers — found that while the program significantly increased employment among program participants relative to what it otherwise would be, the majority still never found jobs.[13] (See Figure 2.) Thirty-four percent of recipients required to participate in the program found jobs,

[12] For example, see: Pamela L. Loprest and Elaine Maag, "Disabilities among TANF Recipients: Evidence from the NHIS," Urban Institute, May 2009, http://www.urban.org/research/publication/disabilities-among-tanf-recipients-evidence-nhis. (This study also includes data on SNAP recipients.)

[13] Dan Bloom, Cynthia Miller, and Gilda Azurdia, "Results from the Personal Roads to Individual Development and Employment (PRIDE) Program in New York City," mrdc, July 2007, http://www.mdrc.org/publication/results-personal-roads-individual-development-and-employment-pride-program-new-york-city.

compared to 27 percent of those who were not required to participate. But even with the intensive services the program provided, two-thirds of the recipients required to participate never found work. In addition, many of the recipients subject to the requirements ended up worse off, because sanctions for not meeting the work requirements took away their only source of cash income. About one-third of those subject to the work requirements were sanctioned compared to only about 8 percent of the group not subject to the requirements.

Finding #4: Over the long term, the most successful programs supported individuals who were subject to the work requirements in efforts to improve their education or build their skills, rather than simply requiring them to work or find a job.

In welfare reform's early years, proponents of a "work first" or labor force attachment approach declared victory over proponents of a "human capital development" approach focused on building education and skills. This declaration in part relied on characterizing two important efforts — in Portland and Riverside LFA — as "work first" programs focused on quick entry into the market, even though both supported individuals' efforts to improve their education or improve their skills. Both programs, which did in fact have the most significant impacts on employment of the programs discussed here, provided job search assistance but also encouraged or supported participation in education and training programs. Portland initially assigned some recipients subject to work requirements to short-term education or training programs, significantly boosting the share of the recipients subject to work requirements who increased their education or training. Although Riverside LFA focused more on getting recipients into the labor market quickly, about 30 percent of the recipients subject to work requirements participated in a post-secondary education or vocational training program.[14]

A study that re-examined the impact over nine years of several programs implemented in California in the early 1990s found that recipients participating in programs that emphasized education and training fared as well as or better than participants in programs that emphasized immediate employment.[15] Employment rates for recipients in work-first programs that focused solely on job search faded over time, while employment for participants in human capital development programs that focused on furthering skills and education increased.

A second study that followed all women who received welfare in Missouri and North Carolina between 1997 and 1999 for 16 quarters found that recipients participating in post-secondary education or training programs fared better than those who participated in assessment or job search

[14] Stephen Freedman *et al.*, "National Evaluation of Welfare-to-Work Strategies: Two-year Impacts for Eleven Programs," Manpower Development Research Corporation, June 2000, http://www.mdrc.org/publication/evaluating-alternative-welfare-work-approaches, Table A-2.

[15] Joseph Hotz, Guido Imbens, and Jacob Klerman, "The Long-Term Gains from GAIN: A Re-Analysis of the Impacts of the California GAIN Program," November 2000, http://www.nber.org/papers/w8007.pdf?new_window=1.

programs.[16] Individuals engaged in post-secondary education or training had lower initial earnings, but their earnings eventually surpassed those of the job-search participants.

More recent studies have added to the evidence that participation in post-secondary education and training programs can significantly improve disadvantaged individuals' long-term employment trajectories. For example, within two years, participants in three sectoral employment programs that prepare recipients for in-demand jobs (such as computer repair or careers in the health industry) that were evaluated as a part of the Sectoral Employment Impact Study[17] earned 29 percent more than the people not randomly selected to participate in the program. Participants in the programs studied also were more likely to be employed, be employed consistently, work in jobs with higher wages, and work in jobs that offered benefits.

Year Up, a one-year training program in information technology or investment operations for young adults, also produced significant impacts on earnings according to a recent random assignment study of the program. In the second year of follow-up, the average participant earned 30 percent more per year than individuals not assigned to participate in the program.[18]

Finding #5: The vast majority of individuals subject to work requirements remained poor, and some became poorer.

Although recipients were more likely to be employed in the first two years after becoming subject to work requirements, their earnings were not sufficient to lift them out of poverty — and in some programs, the share of families living in deep poverty increased.[19] (In these studies, poverty and deep poverty status are based on a measure of income that includes earnings, cash assistance payments, and SNAP benefits.) Regardless of whether recipients were subject to work requirements or not, they were more likely to live in deep poverty than to have incomes above the poverty line, in all but one of the sites. (See Figure 3.) Despite increased earnings, the poverty rate didn't decline, because recipients' earnings gains generally weren't large enough to lift them over the poverty line and were offset in part by reductions in cash assistance payments and SNAP benefits.

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[16] Andrew Dyke *et al.*, "The Effects of Welfare-to-Work Program Activities on Labor Market Outcomes," *Journal of Labor Economics*, Vol 24, No. 3, February 2006: 567-607, http://www.ukcpr.org/sites/www.ukcpr.org/files/files/newsletters/Newsletter-Vol4_2_Article4.pdf.

[17] Carol Clymer *et al.*, "Tuning In to Local Labor Markets: Findings From the Sectoral Employment Impact Study," Public/Private Ventures, July 1, 2010, http://ppv.issuelab.org/resource/tuning_in_to_local_labor_markets_findings_from_the_sectoral_employment_impact_study.

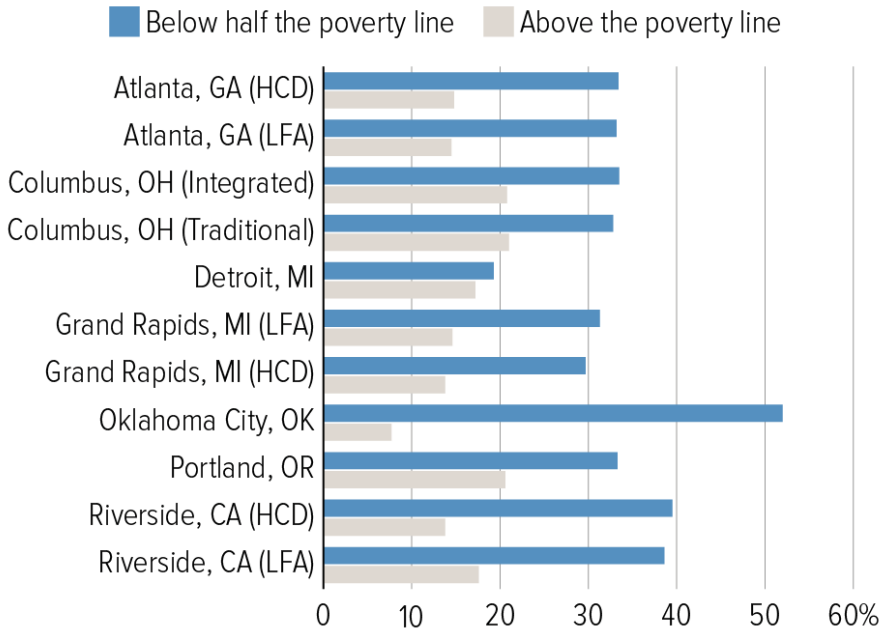
[18] Anne Roder and Mark Elliott, "Sustained Gains: Year–Up's Continued Impact on Young Adults' Earnings," Economic Mobility Corporation, May 2014, http://economicmobilitycorp.org/uploads/sustained-gains-economic-mobility-corp.pdf.

[19] Unless otherwise noted all data in this section are from Freedman *et al.*

FIGURE 3

Cash Assistance Recipients Subject to Work Requirements Likelier to Live in Deep Poverty Than Above Poverty Line

Percentage of cash assistance recipients living above the poverty line and below 50% of poverty line in second year of study follow-up



Note: Deep poverty = below 50 percent of poverty line. Poverty and deep poverty status are based on a measure of income that includes earnings, cash assistance payments, and SNAP benefits as a percentage of the official poverty level for 1992-1994. LFA = Labor Force Attachment group (primarily job-search focused); HCD = Human Capital Development group (include training and education). The Columbus, Ohio integrated site featured one worker providing employment case management and eligibility determination, while the traditional site featured two workers: one completing eligibility functions and one providing employment case management.

Source: Stephen Freedman *et al. "National Evaluation of Welfare-to-Work Strategies: Two-year Impacts for Eleven Programs,"* Manpower Development Research Corporation, June 2000.

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Taking into account the earnings, cash assistance payments, and value of SNAP benefits, poverty rates among recipients subject to work requirements ranged from 71.1 to 92.3 percent in the second year of a two-year follow-up study. Only two programs, Portland and Atlanta HCD, significantly reduced the share of families living in poverty. Even in Portland which had the most significant drop — from 83.4 percent to 79.4 percent — the drop was small. (See Appendix B, Table B-2.) Even when the value of the Earned Income Tax Credit (EITC) is added to income and child care

costs are subtracted from income, only one program, Riverside LFA, showed a significant drop in poverty among families subject to work requirements.[20]

Moreover, not only did the poverty rate remain largely unchanged in nearly all of the sites, but deep poverty increased significantly in six of the 11 sites for which data on deep poverty are available. Deep poverty among program participants ranged from 19.3 percent in Detroit to 52 percent in Oklahoma City. The biggest increase in deep poverty occurred in the Riverside programs, where it rose by 4.9 percentage points in the Riverside LFA program and 6.1 percentage points in the Riverside HCD program.

Contributing to the rise in deep poverty was an increase in the number of recipients subject to work requirements who fell off the welfare rolls even though they had not obtained a job. The share of participants subject to work requirements who had no income from either welfare or work once they left the welfare rolls ranged from 13.1 percent of the participants in Detroit to 39.9 percent in Oklahoma City. In seven of the 11 sites for which we have deep poverty data, the likelihood of a recipient leaving the welfare rolls without work was significantly higher for recipients subject to work requirements than for those not subject to the requirements.

Two other comprehensive studies that followed large numbers of recipients over several years confirmed this finding. A study in Cleveland, Ohio that followed recipients over a four-year period found that the percentage of welfare recipients with neither work nor welfare nearly doubled, from 11 percent in 1998 to 20 percent in 2001.[21] A study in New Jersey tracking former recipients for approximately five years found a steady annual percentage of 25 to 28 percent without either work or welfare. In its examination of this category of welfare leavers, the study found that 40 percent of those who were off welfare and not employed were considered the "least stable" (i.e., they didn't live with an employed spouse or partner and didn't receive income from other programs such as Supplemental Security Income or unemployment insurance). About a third of the "least stable" group left cash assistance due to a sanction, which was often a result of being ruled noncompliant with a work requirement — about twice as high a percentage as among welfare leavers overall.[22]

Finding #6: Voluntary employment programs can significantly increase earnings and employment for very disadvantaged individuals without the negative consequences associated with mandatory work requirements.

The primary downside with imposing work requirements on public benefit recipients is the harm they can cause to the individuals — and their families — who are unable to comply and lose essential assistance as a result. Researchers and practitioners have not devised effective strategies to

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[20] Grogger *et al.*, "Consequences of Welfare Reform: A Research Synthesis," Rand Corporation, July 2002,http://www.acf.hhs.gov/programs/opre/resource/consequences-of-welfare-reform-a-research-synthesis, Table 8.1.

[21] Thomas Brock *et al.,* "Welfare Reform in Cleveland Implementation, Effects, and Experiences of Poor Families and Neighborhoods," Manpower Demonstration Research Corporation, September 2002, http://www.mdrc.org/sites/default/files/full_603.pdf.

[22]Robert G. Wood and Anu Rangarajan,"What's Happening to TANF Leavers Who Are Not Employed?" Mathematica Policy Research, October 2003, http://www.mathematica-mpr.com/~/media/publications/PDFs/tanfleave.pdf.

identify those individuals who will have considerable difficulty complying with the requirements, with the result that some of the neediest individuals with the greatest personal challenges or other barriers to employment can be cut adrift and left with no assistance to meet their basic needs — and with little or no access to the services they need to help them improve their circumstances. The results from a rigorous evaluation of the Jobs-Plus demonstration, an employment program for public housing residents, suggest that *voluntary* work programs can be successful without the harmful consequences that typically accompany work requirements. Unlike most work programs that serve a limited number of people, Jobs-Plus was designed to reach all public housing residents in the public housing developments where it was implemented. In recent years, Congress has recognized the success of Jobs-Plus by providing funds to expand the program to additional locations.

Jobs-Plus is notable for both its scale and its scope. Under the program, public housing residents have access to employment and training services, as well as new rent rules that make low-wage work pay more by allowing residents to keep more of their earnings. In addition, the program takes advantage of its place-based design to develop "community support for work" by involving residents in sharing information about work opportunities. The program targets all working-age, non-disabled residents of the housing developments where it is implemented. Its strategy is to saturate public housing complexes with work-focused encouragement, information, incentives, and employment assistance. The program relies on close coordination and collaboration among local workforce, human service agencies and the public housing authorities.

Jobs-Plus significantly increased earnings for residents in several cities of different sizes and demographics, and increased employment for groups with historically low labor-force participation rates. Although the program was voluntary, about three-quarters of the residents in the four well-implemented sites[23] used its services, rent-based work incentives, or both.[24]

In a long-term follow-up in three well-implemented sites (Dayton, Ohio, Los Angeles, California, and St. Paul, Minnesota), the program produced substantial increases in residents' earnings that were sustained for at least three years after the program ended, researchers found. Earnings for program participants were 14 percent higher, on average, over the last seven years of the nine-year follow-up period, than for the comparison group, which wasn't offered the program services. In contrast to the mandatory work programs where earnings gains declined over time, the earnings gains in these Jobs-Plus sites grew over time.[25] In the final year of follow-up, the earnings gains increased to 20 percent. As a result of Jobs-Plus, some residents who were not employed started working, and others who were already working started working more consistently and at better-paying jobs.

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[23] The Jobs-Plus demonstration project was implemented in six sites. Four of those sites — Dayton, Ohio; Los Angeles, California; St. Paul, Minnesota, and Seattle, Washington — built substantial programs. As would be expected, the program impacts were substantially better in the sites where the program was well-implemented.

[24] Howard Bloom, James. A. Riccio, and Nandita Verma, "Promoting Work in Public Housing: The Effectiveness of Jobs-Plus," Manpower Demonstration Research Corporation, March 2005.

[25] James A. Riccio, "Sustained Earnings Gains for Residents in a Public Housing Jobs Program: Seven-Year Findings from the Jobs-Plus Demonstration," Manpower Demonstration Research Corporation, January 2010, http://www.mdrc.org/publication/sustained-earnings-gains-residents-public-housing-jobs-program.

The Jobs-Plus employment gains also were significant for several groups that historically have had lower-than-average employment rates. For example, employment rates increased by 4.1 percentage points for black, non-Hispanic women in Dayton, 10.8 percentage points for Hispanic men in Los Angeles, and 12.8 percentage points for Southeast Asian women in St. Paul.[26]

[26] *Ibid.*

Appendix A

Studies of 13 programs that used a random-assignment methodology (the gold standard for evaluating social programs) and mandated participation in work-related activities form the core of our analysis. (See Tables A-1 and A-2 for program descriptions.) These studies are included in a comprehensive analysis of the impacts of welfare reform by Jeffrey Grogger of the University of Chicago and Lynn A. Karoly, a Senior Economist of RAND Corporation, two highly regarded researchers.[27] These studies commenced prior to passage of the 1996 welfare law and continued after the law took effect.

People who participated in the studies were randomly assigned to participate in either a program where they were required to work, look for work, or participate in an education or training program and could be sanctioned (i.e., their cash benefits could be terminated or reduced if they were judged not to have met the requirement) or a program where they were not simply referred to an existing workforce or education program in the neighborhood in which they lived. Eleven of the 13 studies were part of the National Evaluation of Welfare-to-Work Strategies, a large random assignment study of mandatory work programs, conducted by mdrc (formerly the Manpower Development Corporation), one of the leading research firms in the country.

Grogger and Karoly included two types of programs in their analysis of mandatory work programs: "work first" programs, also known as labor force attachment (LFA) programs, which focused primarily on job search; and "human capital development" (HCD) programs, which focused on participation in education and training programs.[28] Several study sites operated both types of programs; in those sites, cash assistance recipients were assigned to one of three programs — a LFA program, a HCD program, or a voluntary program that provided minimal assistance with either job search or participation in education or training.

As is true in all random-assignment studies, success is measured by whether the difference in outcomes (e.g., employment, earnings, and poverty) between the "program group" (which was subject to mandatory work requirements) and the "control group" (which didn't participate in the mandatory work program) was statistically significant, meaning that the difference was large enough that it was unlikely due to chance. Because recipients were randomly assigned to one of the groups, the differences in outcomes are not attributable to labor-market conditions or the recipients' personal characteristics, but rather show how effective (or ineffective) the various programs were. Statistical significance levels describe how certain we are that the difference in outcomes of the groups compared did not occur by chance and are defined as: * = 10 percent; ** = 5 percent and

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[27] Jeffrey Grogger and Lynn A. Karoly, *Welfare Reform: Effects of a Decade of Change*, Harvard University Press, 2005 and the initial report on which their book is based, Jeffrey Grogger, Lynn A. Karoly and Jacob Klerman. "Consequences of Welfare Reform: A Research Synthesis." Rand Corporation, July 2002, http://www.acf.hhs.gov/programs/opre/resource/consequences-of-welfare-reform-a-research-synthesis.

[28] Our analysis does not include studies that examined the impact of a "bundle" of reforms, including such policies as cash work incentives and time limits along with work requirements, because it isn't possible to isolate the impacts of work requirements in those studies. Grogger and Karoly include these studies in their analysis but review them separately from those that focus only on mandatory work or related activities.

*** = 1 percent, with 1 percent providing the highest level of confidence that the difference can be attributed to the program.

TABLE A-1

Summary of Mandated Work Program Random-Assignment Methodology

			Sample Sizes		
Program Name	Cases Served	Enrollment Period	Subject to Work Requirements (Program Group)	Not Subject to Work Requirements (Control)	Total
Los Angeles Jobs - 1st GAIN (California)	Single parent recipients and applicants	Apr 96 - Sep 96	11,521	4,162	15,683
Atlanta LFA (Georgia)	Recipients and applicants	Jan 92 - Jan 94	1,141	1,497	2,938
Atlanta HCD (Georgia)	Recipients and applicants	Jan 92 - Jan 94	1,495	1,497	2,992
Grand Rapids LFA (Michigan)	Recipients and applicants	Sep 91 - Jan 94	1,557	1,455	3,012
Grand Rapids HCD (Michigan)	Recipients and applicants	Sep 91 - Jan 95	1,542	1,455	2,997
Riverside LFA (California)	Recipients and applicants	Jun 91 - Jun 93	3,384	3,342	6,726
Riverside HCD (California)	Recipients and applicants, low education	Jun 91 - Jun 93	1,596	3,342	4,938
Portland (Oregon)	Recipients and applicants	Feb 93 - Dec 94	3,529	499	4,028
Columbus Integrated (Ohio)	Recipients and applicants	Sep 92 - Jul 94	2,513	2,159	4,672
Columbus Traditional (Ohio)	Recipients and applicants	Sep 92 - Jul 95	2,570	2,159	4,729
Detroit (Michigan)	Recipients and applicants	May 92 - Jun 94	2,226	2,233	4,459
Oklahoma City (Oklahoma)	Applicants	Sep 91 - May 93	4,309	4,368	8,677
IMPACT Basic Track (Indiana)	Recipients and applicants less job ready	May 95 - Dec 95	3,090	766	3,856

Note: LFA = Labor Force Attachment group (programs that focus primarily on job search, also known as "work first" programs); HCD = Human Capital Development group (programs that also include skills training and education). GAIN = Greater Avenues for Independence; IMPACT = Indiana Manpower Placement and Comprehensive Training Basic Track. The Columbus, Ohio, integrated site featured one worker providing employment case management and eligibility determination, while the traditional site featured two workers: one completing eligibility functions and one providing employment case management.

Source: Jeffrey Grogger and Lynn A. Karoly, *Welfare Reform: Effects of a Decade of Change*, Harvard University Press, 2005

TABLE A-2

Program Descriptions

Program Name	Description
Programs Included in the National Evaluation of Welfare-to-Work Strategies (NEWWS) Evaluation	
Atlanta, GA Labor Force Attachment (LFA)	Beginning in 1992, the program was mandatory for welfare recipients and new applicants with no children under the age of 3. Most people started with job search, but if they could not find jobs after the search, they could participate in short-term adult basic education or vocational training.
Atlanta, GA Human Capital Development (HCD)	The program was mandatory for welfare recipients and new applicants with no children under the age of 3. Adult basic education and vocational training were the most common activities.
Columbus, OH (Integrated)	Beginning in 1992, the program was mandatory for welfare recipients and new applicants with no children under the age of 3. Most people received education and training. Program functions (i.e., eligibility and employment and training case management) previously handled by two workers were integrated and handled by one staff member.
Columbus, OH (Traditional)	The program was mandatory for welfare recipients and applicants with no children under the age of 3. Most people received education and training. Two different staff members handled eligibility and employment and training case management.
Detroit, MI	Beginning in 1992, the program was mandatory for welfare recipients and new applicants with no children under the age of 1. The program did not enforce the mandates as much as other programs making it more like a voluntary program. Long-term education, training, and job search were most common activities.
Grand Rapids, MI Labor Force Attachment (LFA)	Beginning in 1991, the program was mandatory for welfare recipients and applicants with no children under the age of 1. Most people started with job search, but if they could not find jobs after the search, they were placed in a work experience program.
Grand Rapids, MI, Human Capital Development (HCD)	The program was mandatory for welfare recipients and applicants with no children under the age of 1. Adult basic education, vocational training, and post-secondary education were the most common activities among participants.
Oklahoma City, OK	The program was mandatory for new applicants with no children under the age of 3. Case managers emphasized education and training rather than job search.
Portland, OR	Beginning in 1993, the program was mandatory for welfare recipients with no children under the age of

TABLE A-2

Program Descriptions

Program Name	Description
	1. Recipients with significant employment barriers were exempt from participation. Case managers encouraged the less job-ready participants to pursue adult basic education and training. For others, job search for full-time jobs over the minimum wage with fringe benefits were emphasized.
Riverside, CA Labor Force Attachment (LFA)	Beginning in 1991, the program was mandatory for welfare recipients with no children under the age of 3. Most people started with job search, but if they could not find jobs after the search, they could participated in education or vocational training.
Riverside, CA Human Capital Development (HCD)	The program was mandatory for welfare recipients with no children under the age of 3. Only those who needed basic education could enroll. Therefore, adult basic education was the first activity for most people.
Other Programs	
Indiana Manpower Placement and Comprehensive Training (IMPACT) Basic Track	This program was designed for participants who were deemed not job-ready. Education and training activities were most common, with some focus on job search.
Los Angeles, CA Jobs - First GAIN	Beginning in 1996, the program was mandatory for single-parent welfare recipients and applicants with no children under the age of 3. Most people started with a group job search activity (i.e., job club). Financial sanctions were regularly used.

Appendix B

TABLE B-1

Most Recipients Worked Regardless of Work Requirements

Percentage of cash assistance recipients ever employed in years 1 to 5			
Program Name	Subject to Work Requirements (Program Group)	Not Subject to Work Requirements (Control)	Impact
Atlanta, GA (LFA)	83.3	82.9	0.4
Atlanta, GA (HCD)	81.2	82.9	-1.7
Grand Rapids, MI (LFA)	94.7	91.9	2.9*
Grand Rapids, MI (HCD)	93.6	91.9	1.7
Portland, OR	93.5	93.3	0.2
Riverside, CA (LFA)	85.7	80.8	4.9**
Riverside, CA (HCD)	82.8	74.2	8.6***

*, **, and *** denote statistical significance at the .10, .05, and .01 levels, respectively, with .01 being the highest level of significance.

Note: LFA = Labor Force Attachment (programs that focus primarily on job search, also known as "work first" programs); HCD = Human Capital Development (programs that also include skills training and education).

Source: 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, Appendix Table C.5

TABLE B-2

Work Requirements Did Not Reduce Poverty in Most Sites

	Poverty Rate		
Program Name	**Subject to Work Requirements (Program Group)**	**Not Subject to Work Requirements (Control)**	**Impact**
NEWWS Study Sites			
Atlanta, GA (LFA)	85.5	87.1	-1.6
Atlanta, GA (HCD)	85.1	87.1	-2.0*
Columbus, OH (Integrated)	79.3	79.3	0.0
Columbus, OH (Traditional)	79.0	79.3	-0.3
Detroit, MI	82.9	84.1	-1.2
Grand Rapids, MI (LFA)	85.3	86.5	-1.2
Grand Rapids, MI (HCD)	86.2	86.5	-0.3
Oklahoma City, OK	92.3	92.8	-0.5
Portland, OR	79.4	83.4	-4.0***
Riverside, CA (LFA)	82.5	83.5	-1.0
Riverside, CA (HCD)	86.2	86.4	-0.2
Other Study Sites			
IMPACT Basic Track (IN)	88.2	91.2	-3.0
Los Angeles, CA Jobs - 1st GAIN	71.1	75.6	-4.5

*, **, and *** denote statistical significance at the .10, .05, and .01 levels, respectively, with .01 being the highest level of significance.

Note: Poverty status are based on a measure of income that includes earnings, cash assistance payments, and SNAP benefits. LFA = Labor Force Attachment group (programs that focus primarily on job search, also known as "work first" programs); HCD = Human Capital Development group (programs that also include skills training and education). NEWWS = National Evaluation of Welfare-to-Work Strategies; GAIN = Greater Avenues for Independence; IMPACT = Indiana Manpower Placement and Comprehensive Training Basic Track. The Columbus, Ohio, integrated site featured one worker providing employment case management and eligibility determination, while the traditional site featured two workers: one completing eligibility functions and one providing employment case management.

Source: Grogger *et al*, "Consequences of Welfare Reform: A Research Synthesis," Rand Corporation, July 2002, http://www.acf.hhs.gov/programs/opre/resource/consequences-of-welfare-reform-a-research-synthesis, Table 8.1

CLASP
Policy solutions that work for low-income people

Fact Sheet

Updated December 2017 | Jessica Gehr and Suzanne Wikle

The Evidence Builds:

Access to Medicaid Helps People Work

Untreated illness can make it hard to work. Health insurance is a key work support and tool that provides working-age adults with access to care that helps them get and keep a job. Reports from Ohio[1] and Michigan[2] provide compelling new information about the ability of Medicaid expansion enrollees to seek and maintain employment. These reports add to the growing body of research confirming the benefits of Medicaid expansion.[3]

Under the Affordable Care Act (ACA), states are incentivized to expand Medicaid to provide affordable health insurance to people with incomes below 138 percent of poverty ($16,400 for a single person). A geographically diverse mix of 32 red and blue states[4] took advantage of the ACA's provision to expand Medicaid. As a result, millions of low-income adults in those states now have access to affordable care, resulting in better health, greater financial, physical, and mental stability, and fewer deaths.

Most Adult Medicaid Enrollees are Working

Nationwide, the majority of non-disabled working-age adults who are insured through Medicaid are working or living in a family with a worker. In fact, 60 percent of adult recipients are employed and 79 percent live with someone who is working. Furthermore, among Medicaid recipients who are employed, more than half (51 percent) work full-time for the entire year.[5] However, their positions often offer low wages and/or are in small businesses that do not provide health benefits. Only 12 percent of workers earning the lowest wages had employer-provided health insurance in 2016.[6] Medicaid expansion enrollees typically hold physically demanding jobs[7] clustered in employment settings such as restaurants, construction sites, retail stores, and gas stations.[8]

Without the support of Medicaid, health concerns would threaten employment stability.

Key findings from Ohio and Michigan confirm that providing access to affordable health care helps people maintain employment. **More than half of Ohio Medicaid expansion enrollees report that their health coverage has made it easier to continue working.[9] In Michigan, 69 percent of enrollees said that Medicaid helped them do their job better.[10]** Without the support of Medicaid, health concerns would threaten employment stability.

Medicaid Expansion Reduces Barriers to Employment

Disability and illness are among the main reasons why working-age adults may not be employed. An analysis by the Kaiser Family Foundation found that 36 percent of adults enrolled in Medicaid cited illness or

disability as the primary reason for not working.[11] Similarly, a July 2016 report from the American Enterprise Institute found that for working-age adults without children, illness and disability were the primary barriers to employment.[12] The Ohio report confirms that access to Medicaid reduces these barriers to employment. **The majority of unemployed Medicaid enrollees in Ohio (74.8 percent)[13] and Michigan (55 percent)[14] reported that having Medicaid made it easier to look for employment.**

Ohio study participants noted that Medicaid allowed them to get treated for chronic conditions that previously had prohibited them from working. Additionally, about one-third of enrollees screened positive for depression or anxiety disorders, which can limit employment and other routine activities. Enrollees with depression and anxiety reported greater improvement in access to care and prescriptions—key resources needed to stay in the workforce.

Another way Medicaid expansion supports employment is by eliminating the so-called "cliff effect"—the sudden loss of health insurance if earnings exceed Medicaid eligibility limits. For example, prior to Medicaid expansion, a parent with one child who worked 30 hours per week at the minimum wage with annual earnings of $12,000 was eligible for Medicaid in Ohio. But if that parent worked 35 hours per week and earned $14,000, he or she was not eligible.[15] With Medicaid expansion, parents are now incentivized to continue increasing their earnings, because they no longer risk losing their health care due to additional income. Should their income rise above the Medicaid limit, they become eligible for subsidized private health insurance through the ACA's exchange. By contrast, in non-expansion states, parents can still fall into a coverage gap, where they earn too much to qualify for Medicaid but too little for exchange subsidies. Eliminating the cliff effect by expanding Medicaid allows parents to best provide for their families by continuing to improve their employment prospects.

Supporting Work Leads to Better Financial Stability

Prior studies have shown that financial stress is reduced under Medicaid expansion because it provides clear physical and mental health benefits. The Ohio report found that enrollees were more than twice as likely to note improvements in their financial situation. Medicaid enrollment allowed participants to meet other basic needs. More than half of enrollees reported that health coverage made it easier to buy food; about half stated that it was easier to pay their rent or mortgage, and 44 percent said it was easier to pay off other debts.[16] When families are able to meet their basic needs, they can turn their energy to engaging in the workplace.

When families are able to meet their basic needs, they can turn their energy to engaging in the workplace.

Conclusion

The reports from Ohio and Michigan add to the growing body of research showing that Medicaid expansion improves lives by increasing access to health care, reducing financial burden on low-income families, and supporting employment. A recent survey found that 84 percent of Americans support continuing the funding for Medicaid expansion.[17] Congress should avoid any changes that would roll back these gains or undermine the fundamental structure of Medicaid.

Endnotes

[1] The Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," January 2017, **http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.**
[2] Renuka Tipirneni, Jeffrey Kullgren, John Ayanian, Edith Kieffer, Ann-Marie Rosland, Tammy Chang, Adrianne Haggins, Sarah Clark, Sunghee Lee, and Susan Goold, "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches," University of Michigan, June 2017, **http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches.**
[3] Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga, " The Effects of Medicaid Expansion under the ACA: Findings from a Literature Review," Kaiser Family Foundation, June 20, 2016, **http://kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review/.**
[4] Maine adopted the Medicaid expansion through a ballot initiative in November 2017; the ballot measure requires a state plan amendment to be submitted within 90 days and implementation of expansion within 180 days of the effective date. Maine is not included in this count. Maine's Governor has announced his intent to block implementation of expansion.
[5] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, December 2017, **http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/?utm_campaign=KFF-2017-Medicaid&utm_content=46331383&utm_medium=social&utm_source=twitter.**
6 United States Department of Labor,"Table 9.Healthcare Benefits: Access Participation and Take-Up Rates, Civilian Workers," Bureau of Labor Statistics, March 2016, **https://www.bls.gov/ncs/ebs/benefits/2016/ebbl0059.pdf.** Lowest wages is defined as average wage falling in the bottom 10 percent.
[7] Leighton Ku and Erin Brantley, "Myths About The Medicaid Expansion And The 'Able-Bodied'," Health Affairs Blog, March 6, 2017, **http://healthaffairs.org/blog/2017/03/06/myths-about-the-medicaid-expansion-and-the-able-bodied/.**
[8] Dustin Pugel, "Many Kentucky Workers Have Gained Insurance through the Medicaid Expansion and Are Now at Risk," Kentucky Center for Economic Policy, December 8, 2016, **http://kypolicy.org/many-kentucky-workers-gained-insurance-medicaid-expansion-now-risk/.**
[9] The Ohio Department of Medicaid et al.
[10] Tipirneni et al.
[11] Understanding the Intersection of Medicaid and Work.
[12] Angela Rachidi, "America's Work Problem: How Addressing the Reasons People Don't Work Can Reduce Poverty, " American Enterprise Institute, July 2016, **https://www.aei.org/wp-content/uploads/2016/07/Americas-Work-Problem.pdf.**
[13] The Ohio Department of Medicaid et al.
[14] Tipirneni et al.
[15] Policy Matters Ohio, "Ohio Should Say Yes to Medicaid Expansion," September 13, 2012, **http://www.policymattersohio.org/medicaid-sept2012.**
[16]The Ohio Department of Medicaid et al.
[17] Ashley Kirzinger, Elise Sugarman, and Mollyann Brodie, " Kaiser Health Tracking Poll: Future Directions for the ACA and Medicaid," February 24, 2017, Kaiser Family Foundation, **http://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-future-directions-for-the-aca-and-medicaid/.**

Ohio Medicaid Group VIII Assessment:

A Report to the Ohio General Assembly

The Ohio Department of Medicaid

John R. Kasich, Governor Barbara R. Sears, Director

Table of Contents

List of Figures

List of Tables

Executive Summary: The Ohio Medicaid Group VIII Assessment

a. What is the Ohio Medicaid Group VIII Assessment?

House Bill 64 of the 131st General Assembly required the Ohio Department of Medicaid to provide a report evaluating the impact of Ohio's 2014 Medicaid expansion. Guided by the General Assembly's request, the Ohio Medicaid Group VIII Assessment examined how Medicaid expansion has affected new enrollees with respect to access and utilization of health care, physical and mental health status, financial distress/hardship, and employment.

The phrase "Group VIII" refers to the section of the Social Security Act that sets requirements for Medicaid expansion eligibility and allowed most Ohioans age 19 through 64 with incomes at or below 138% of the federal poverty level (FPL) to become eligible for Medicaid. Prior to January 1, 2014, Medicaid eligibility for adults was limited to those with certain qualifying characteristics such as parenthood or disability, and the income limitation for most Medicaid eligibility groups was lower than 90% of the FPL.

b. Who is Included in the Ohio Medicaid Group VIII Assessment Study?

The Ohio Medicaid Group VIII Assessment examined the effects of Ohio's 2014 Medicaid expansion on recipients enrolled through the Group VIII criteria ("Group VIII enrollees"). When appropriate, Group VIII enrollees were compared to those enrolled in Ohio Medicaid under pre-expansion eligibility rules ("pre-expansion enrollees"). Administrative data from the Ohio Department of Medicaid were used to identify eligible persons, and study participants were selected using stratified random sampling techniques. To enable comparison between Group VIII enrollees and the pre-expansion comparison group, the study excluded those enrolled as dual eligible, pregnant, living in institutions, or with less than 11 months continual enrollment (a full list of exclusion criteria is included in the Methodology Report).

c. How was the Ohio Medicaid Group VIII Assessment Conducted?

The Ohio Medicaid Group VIII Assessment is one of the nation's most comprehensive assessments of a state's Medicaid expansion. The assessment used the following methods to collect data:

- A detailed telephone survey of 7,508 Group VIII and pre-expansion enrollees, including questions about access to care, health system utilization, physical and mental health, financial hardship, and employment (cooperation rate of 76.1%).

- A biometric screening of 886 respondents who completed the telephone survey, including both Group VIII and pre-expansion enrollees. The biometric screenings allowed for the systematic collection of comprehensive and verifiable health-related data (screening response rate of 68%).

- A review of the medical records of 430 Group VIII enrollees who completed the telephone survey and biometric screening. Collected records spanned the time periods before and after Medicaid enrollment and enabled an assessment of how health care utilization, health status, and medical treatments changed after enrolling in Medicaid.

- An analysis of Medicaid administrative data for all Group VIII and pre-expansion enrollees eligible for the Group VIII Assessment. The review of administrative data was used to calculate measures of health care utilization, including preventive care and evidence-based care for chronic health conditions.

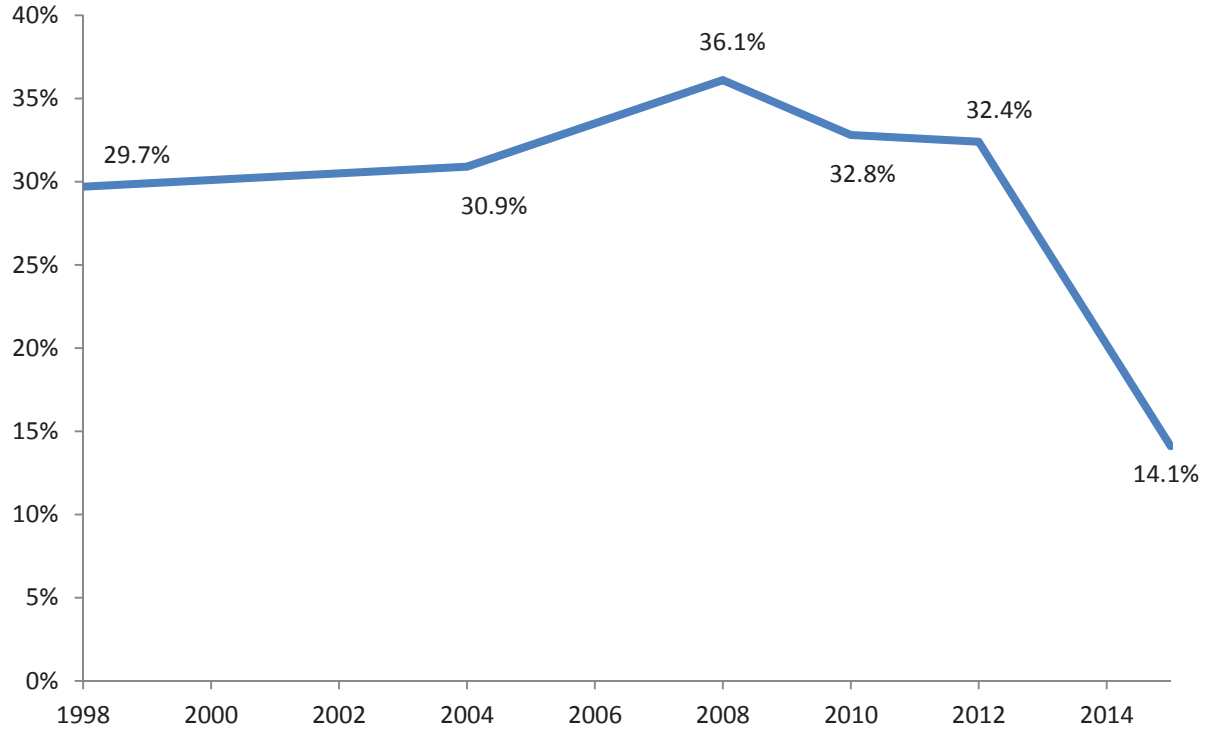
- Focus groups of 27 Group VIII enrollees who participated in the telephone survey at a minimum (some participants completed other components as well). Focus groups were designed to obtain more in-depth and personalized information about survey responses.

- Interviews with 10 Ohio Medicaid service providers and other key stakeholders. These interviews allowed for input from Medicaid stakeholders on the effects of Medicaid expansion.

d. What are the Key Findings of the Ohio Medicaid Group VIII Assessment?

The Group VIII Population (Section II of the Report)

Percentage of Ohioans Age 19-64 with Family Income at or below 138% Federal Poverty Level without Insurance from 1998-2015



Source: Ohio Medicaid Assessment Survey.

1. At the close of sample selection, May 2016, a total of 702,000 individuals were eligible for and received Group VIII Medicaid coverage.[i]

2. Findings from the 2015 Ohio Medicaid Assessment Survey indicate that Medicaid expansion contributed to a large decline in the uninsured rate for low-income non-senior adults in Ohio (≤138% of the FPL) to the lowest rate ever recorded (14.1%).

3. Most Group VIII enrollees were uninsured prior to obtaining Medicaid coverage, either because they had no prior insurance at all (75.1%) or they had lost employer-based insurance (13.9%).

4. Most Group VIII enrollees were white (71.5%), male (55.8%), with a high school degree or less (58.1%), unmarried (83.8%), and without a child in the home (82.1%). Employment rates were similar for Group VIII and pre-expansion enrollees (43.2% versus 41.5%).

5. As a result of being older (51.4% age 45 and older) and more often male than pre-expansion enrollees, Group VIII enrollees had slightly higher rates of health risk indicators—such as high blood pressure

[i] This number includes retroactive and backdated enrollments for May processed through November. See the Methodology Report for details regarding enrollment calculations.

and high cholesterol—and higher rates of chronic disease diagnoses than the younger and more often female pre-expansion enrollees.

Health System Access and Utilization (Section III of the Report)

6. Group VIII enrollees overwhelmingly reported that access to medical care had become easier since enrolling in Medicaid—these gains were largest for those who were previously uninsured.

7. For many Group VIII enrollees, improved access to care was associated with a reduction in unmet medical needs. Nearly half of Group VIII enrollees (43.3%) reported a decline in unmet health care needs, while only 8.3% reported an increase, with the remainder reporting no unmet needs or no change in the level of unmet needs.

8. Emergency department use, which is often a very costly form of care, decreased for Group VIII enrollees. Survey results and medical records analyses showed that Group VIII participants were better integrated into the health care system, increasingly connecting to a usual and appropriate source of health care.

Physical Health (Section IV of the Report)

9. Nearly half of Group VIII enrollees (47.7%) reported improvement in their overall health status since enrolling in Medicaid, compared to 3.5% who said their health had worsened.

10. After obtaining Medicaid coverage, 27.0% of Group VIII enrollees were diagnosed with at least one chronic health condition. These new diagnoses, alongside widespread reports of improved health access, suggest that Group VIII enrollees have become more likely to receive needed appropriate care.

11. According to the medical records case study, the individuals studied had lower levels of high blood pressure or high cholesterol since enrolling in Medicaid.

Mental Health (Section V of the Report)

12. Based on a mental health screening of survey participants, about one-third of Group VIII enrollees (31.9%) and 35.7% of pre-expansion enrollees screened positive for depression or anxiety disorders, with these conditions limiting usual routine activities, including employment.

13. Since enrollment in Medicaid, 44.0% of Group VIII enrollees reported better access to mental health services.

14. Group VIII enrollees with depression and anxiety reported greater improvement in access to care (68.5%) and prescriptions (71.2%) than those without depression or anxiety (62.4% and 62.5%, respectively).

15. For Group VIII enrollees with a clinical diagnosis of depression, most (61.7%) received pharmacotherapy treatment consistent with acute care guidelines established by the National Committee for Quality Assurance that target continuous treatment with antidepressant medication during the first 12 weeks of care.

16. Group VIII participants were as likely as pre-expansion enrollees to be diagnosed with substance abuse or dependence (32.3% versus 33.8%, respectively) and to be diagnosed for opiate abuse and dependence (3.6% for each group). However, Group VIII enrollees were less likely to receive

prescriptions for medications associated with abuse and dependence, such as opioids and benzodiazepines (25.6% versus 32.0% for opioids, 10.4% versus 13.6% for benzodiazepines). This finding is consistent with prior Ohio Department of Medicaid analyses demonstrating reductions in opioid prescribing for pain conditions concurrent with opioid prescribing reform measures.

17. Group VIII enrollees with opioid use disorders reported greater improvement in their access to care than other Group VIII enrollees (75.4% versus 64.0% for overall access to care; 82.7% versus 64.8% for access to prescription medications; and 59.3% versus 32.2% for access to mental health care). Employment and Financial Hardship (Section VI of the Report).

18. Most study participants reported that enrollment in Medicaid made it easier to work and to seek work. Three-quarters of the Group VIII enrollees (74.8%) who were unemployed but looking for work reported that Medicaid enrollment made it easier to seek employment. For those who were currently employed, 52.1% reported that Medicaid enrollment made it easier to continue working.

19. Group VIII enrollees were more than twice as likely to report improvements in their financial situation rather than declines in financial well-being. In particular, Medicaid enrollment enabled participants to meet other basic needs. More than half of Group VIII enrollees (58.6%) reported that it was now easier to buy food, 48.1% stated that it was easier to pay their rent or mortgage, and 43.6% said it was easier to pay off other debts.

20. The percentage of Group VIII enrollees with medical debt fell by nearly half since enrolling in Medicaid (55.8% had debt prior to enrollment, 30.8% had debt at the time of the study).

e. What are the Conclusions about the Impact of Medicaid Expansion in Ohio?

Ohio's Group VIII Medicaid expansion provided coverage to 702,000 low-income Ohioans in May 2016 (the sample date), the vast majority of whom were previously uninsured. Group VIII enrollees reported increased access to usual and appropriate sources of care, better management of chronic diseases and health risk factors, and reductions in emergency department use.

Importantly, many Group VIII enrollees were diagnosed with a previously unknown chronic health condition for which they are now able to seek care. Because they were able to obtain treatment for previously untreated conditions, several of the enrollees stated that they did not think they would be alive today if Medicaid expansion had not occurred. The review of medical records confirmed that many Group VIII enrollees experienced improved chronic disease and health risk factor management for conditions such as heart disease and depression resulting from appropriate access to statin prescriptions, antidepressant medications, and clinical health interventions. The medical records review also revealed an increase in the likelihood of a Group VIII enrollee visiting his or her medical provider at least twice annually.

In addition to the reduction in unmet medical needs, Group VIII enrollees also reported substantial declines in overall stress and financial hardship. Most Group VIII enrollees reported that Medicaid made it easier to seek employment or remain employed. During the focus group discussions, some participants mentioned that Medicaid allowed them to get treated for chronic conditions that prohibited them from working when they were uninsured.

A small percentage of Group VIII enrollees did report having unmet medical needs or challenges accessing certain services (e.g., dental care). Following up on these reports, when Group VIII researchers asked about access to care, providers and stakeholders confirmed challenges with the low Medicaid payment rates which limited the pool of providers, an issue that predates Group VIII Medicaid expansion. A specific challenge is provider beliefs

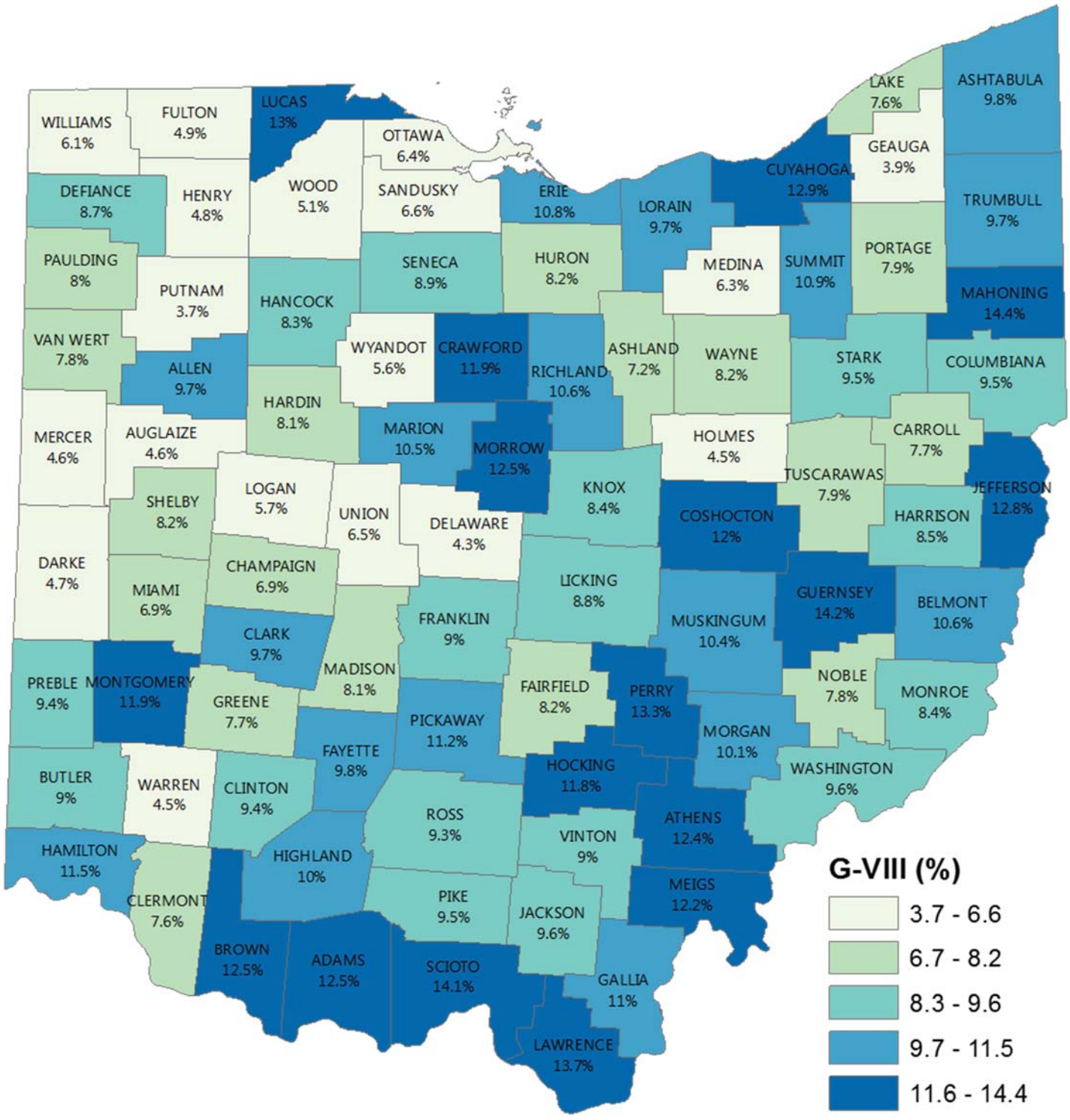
that more financial opportunities exist with other types of insurance reimbursement. These findings may indicate future opportunities for Medicaid to improve access to care for its members.

Generally, however, providers and stakeholders had a positive outlook on Medicaid expansion and reported that it had made access to and use of needed care considerably easier for their patients.

In summary, Medicaid expansion has been beneficial to Ohio Group VIII enrollees in terms of: (1) access to physical and mental health care; (2) health care utilization and reduced emergency department use; (3) detection of unknown or unaddressed prior health conditions (particularly chronic health conditions); (4) security of and opportunities for employment; (5) the lessening of family financial stress; (6) declines in medical debt-holding; and (7) an increase in the ability to pay other nonmedical bills (e.g., household utilities, food, transportation). These results are similar to studies in other states that have found Medicaid expansion to be associated with improved access to and utilization of needed medical care (California, Maine, Massachusetts), increases in general health statuses (Arizona, Maine, Massachusetts, Minnesota), and reduction in stress—including financial stress (Minnesota and Oregon), and more appropriate health care utilization (a review of all expansion states).

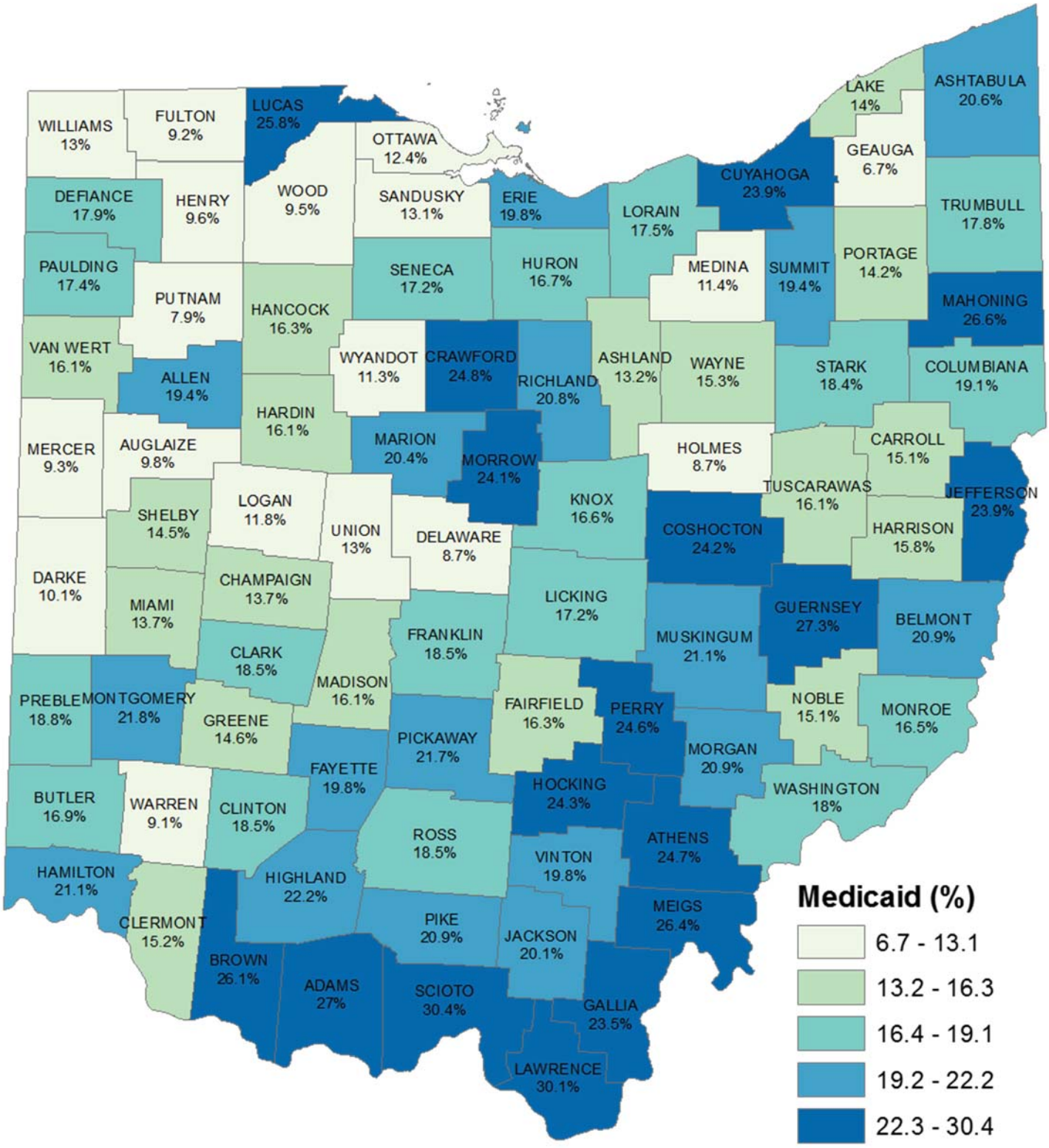
Finally, despite the short time elapsed since Medicaid expansion, Group VIII enrollees reported modest physical and mental health status gains, and most reported an increase in household, employment, and health security. Overwhelmingly, new enrollees reported being grateful for their Medicaid expansion health care coverage and valued having access to Ohio's health care system.

Percentage of All Adults 19-64 Years of Age Enrolled in the Group VIII Expansion, October 2016



Legend is set in quintiles from 0% to 100%; data source is Ohio Department of Medicaid Expenditure and Caseload Report (http://medicaid.ohio.gov/Portals/0/Resources/Research/MedicaidEligExpReports/2016/Med-10.pdf)

Percentage of All Adults 19-64 Years, All Medicaid Enrollment, October 2016



Legend is set in quintiles from 0% to 100%; data source is Ohio Department of Medicaid Expenditure and Caseload Report (http://medicaid.ohio.gov/Portals/0/Resources/Research/MedicaidEligExpReports/2016/Med-10.pdf)

I. Introduction

The Ohio Medicaid Group VIII Assessment report presents results from the first comprehensive study examining the effects of Medicaid expansion in Ohio. To date, no other single state has conducted an evaluation of Medicaid that is as extensive as the Group VIII Assessment.

House Bill 64 of the 131st General Assembly required the Ohio Department of Medicaid (ODM) to provide a report evaluating the effect of Ohio's 2014 Medicaid expansion. Guided by the General Assembly's instruction and at the request of the State Medicaid Director, the Ohio Medicaid Group VIII Assessment examined how Medicaid expansion has affected new enrollees with respect to access and utilization of health care, physical and mental health status, financial distress/hardship, and employment.

The data collected to produce this report included a 7,508-person telephone survey, biometric screenings, medical records reviews, analysis of Medicaid administrative records, and interviews with Medicaid enrollees and stakeholders. All of these data sources consistently demonstrated that Medicaid expansion in Ohio, in addition to providing health insurance coverage to 702,000[ii] low-income Ohioans in May 2016, has had positive effects on new enrollees' access to care, physical and mental health, and financial well-being. In survey responses, participants enrolled through the Medicaid expansion emphasized that Medicaid is critically important to their health status and socioeconomic security, with numerous respondents stating that Medicaid has literally saved their lives because of new access to physicians, dentists, mental health providers, and substance abuse treatment programs. Throughout this report, direct quotes from survey participants are presented in text boxes. These are responses to the survey question, "In your own words, describe in a sentence what getting Medicaid has meant to you."

> "It gives me peace of mind knowing that I don't have to pay for the medical insurance, and it saves me money being able to afford food and utilities and everyday things you need in life."
>
> "It's been a blessing and I thank God that I have Medicaid because I no longer have large payments and I can get my Medicaid medicines."
>
> "More freedom. Less worries. I was an addict for 3 years before getting Medicaid. Because of Medicaid I'm not an addict."
>
> Source: Group VIII Telephone Survey

1. Medicaid Expansion in Ohio and Report Terminology

Beginning January 1, 2014,[iii] many Ohioans age 19 through 64 with incomes at or below 138% of the federal poverty level (FPL) ($16,394 for a single adult in 2016) became eligible for Medicaid benefits under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. Prior to that date, most low-income adults in Ohio were ineligible for Medicaid unless they had an income that was generally below 90% FPL and also possessed certain other qualifying characteristics such as parenthood, disability, or pregnancy.

[ii] This number is unpublished and includes retroactive and backdated enrollments for May processed through November. The source for the estimate is ODM. See the Methodology Report for details regarding enrollment calculations.

[iii] Although the Patient Protection and Affordable Care Act was signed in March 2010, Medicaid expansion in Ohio was initiated statewide as of January 1, 2014.

The population of adults newly eligible for Medicaid in Ohio is referred to in this report as Group VIII (referencing the section of the Social Security Act). The change in policy extending Medicaid eligibility to Group VIII is referred to as "Medicaid expansion."

Those enrolled in Ohio Medicaid through Group VIII are referred to in this report as "Group VIII enrollees." Those enrolled in Ohio Medicaid through other Medicaid programs that existed prior to Medicaid expansion are referred to as "pre-expansion enrollees."[iv] In the figures and charts included in this report, findings for Group VIII enrollees are presented in blue, while findings for pre-expansion enrollees are presented in gray.

2. Statutory Mandate

House Bill 64 of the 131st General Assembly required ODM to provide a report evaluating the effect of Medicaid expansion. Specifically, the statute requires:

> Not later than January 1, 2017, the Ohio Department of Medicaid shall submit to the General Assembly, in accordance with section 101.68 of the Revised Code, a report evaluating the Medicaid program's effect on clinical care and outcomes for the group described in section 1902(a)(10)(A)(i)(VIII) of the "Social Security Act," 42 U.S.C. 1396a(a)(10)(A)(i)(VIII), including the effects on *physical and mental health, health care utilization and access,* and *financial hardship*.

This report and the accompanying Methodology Report and appendices were prepared in fulfillment of ODM's statutory obligations. To assist in preparing this report, ODM contracted with the Ohio Colleges of Medicine Government Resource Center.

3. Literature Review

Recently the Kaiser Family Foundation released a literature review of 22 studies on the impacts of Medicaid expansion that were conducted between January 2014 and May 2016,[1] which assessed the influence of Medicaid expansion on access to care, utilization of services, and health outcomes.

These 22 studies either compared Medicaid expansion states to non-expansion states or examined the experience of one or more states' populations before and after Medicaid expansion. Most of the studies reported statistically significant benefits from Medicaid expansion, although some did not find statistically significant benefits on some or all of the variables they studied. None of the studies found negative health-related outcomes resulting from Medicaid expansion. Studies released since May 2016 have reported similar findings.[2]

Given the relatively short time since Medicaid expansion, studies have not been able to determine whether these effects translate into long-term improvements in health outcomes. Answering this question will require longer-term research and can be examined as a follow-up to this assessment.

Key statistically significant findings from recent studies of Medicaid expansion include the following:

Increased Access to Medical Care, With Some Challenges

- Improvements in measures of access to health care, such as easier access to medications and more low-income individuals with a usual source of care[2,3,4,5,6,7,8,9]
- Fewer people with unmet health needs and fewer people delaying or foregoing needed health care[10,11]
- Increased availability of and access to behavioral health (mental health) services[12,13,14]

[iv] For the purposes of this report, "pre-expansion enrollees" refers to those who enrolled before January 1, 2014.

- Mixed findings on wait times to receive health services with some studies showing increased waiting times at some provider locations because of increased demand for services[15,16] while others show wait times that are similar to pre-expansion Medicaid coverage or to other types of insurance[7,17]

Utilization of Needed Medical Services

- Increased utilization of preventive, dental, and primary care physician services[2,13,18]
- Increases in the percentage of individuals with chronic conditions obtaining regular care[4,7]
- Fewer people skipping medications as prescribed, or non-adherent to prescribed medication regimen (either not filling a prescription or splitting the dose) because of cost[4,6]
- An initial increase in overnight hospital stays[9]
- Mixed findings on emergency department (ED) visits with some finding increases,[19] others finding no significant change,[4,9] and others finding lower use within 2 years of expansion compared to people in non-expansion states[2]
- Some individuals receiving life-saving or life-changing surgeries they could not have received while uninsured[12]

Incremental Improvement in Health Status

- Increased diagnoses of previously unidentified health conditions, such as diabetes, high cholesterol, and cancer[9,20]
- Modest improvements in self-rated health statuses, although some people reported poorer health status upon finding out they had previously unknown health conditions[18]
- Modest decreases in the number of work days missed because of poor health[18]
- Improvement in health and quality of life, with lower levels of stress after expansion (this study included focus groups with Ohioans from Columbus)[11]
- Reported better health from people in expansion states compared to those in non-expansion states by 2 years after expansion[2]

Improvement in Financial Well-Being

- Improvements in financial security, including large declines in trouble paying medical bills[3,4,21]
- Reductions in the amount of unpaid debt sent to collection agencies in zip codes with the highest proportion of low-income residents[21]

Studies on Medicaid expansion have employed a variety of research approaches, including surveys, focus groups, claims and utilization data analysis, and stakeholder interviews. No previous study combined all of the strategies into one comprehensive assessment. The Ohio Medicaid Group VIII Assessment, compared to other studies on Medicaid expansion, uses all of these research methods, along with medical records reviews and biometric screenings, to allow for a more comprehensive assessment of Medicaid expansion's impact on Ohioans.

4. Group VIII Study Design

The general goals of the Ohio Medicaid Group VIII Assessment were to determine whether gaining Medicaid coverage impacted the health and social circumstances of Group VIII enrollees and to understand how those who gained coverage were utilizing Medicaid coverage.

Using Medicaid administrative data, it was possible to identify everyone who had gained coverage through Medicaid expansion. This identification enabled the research team to draw a base sample of respondents from the latest enrolled Medicaid population.

After reviewing data collection possibilities, the Ohio Medicaid Group VIII Assessment research team decided on a staged approach to this assessment using multiple data collection modes. The main topic areas for measurement were: (1) access to health care services; (2) utilization of health care services, particularly for appropriate primary and preventive care; (3) financial distress associated with using health care services—particularly for the uninsured and underinsured; (4) current and future employment; (5) family financial security; (6) changes in health status; and (7) open-ended evaluations of what Medicaid expansion has meant to Group VIII enrollees.

The study design used five data collection modules (see Figure 1 below), with some Medicaid enrollees participating in multiple modules depending on random selection or voluntary consent as described below. When collected, these data were aggregated into a master data file with data linked at the respondent level, with the exception of the qualitative interviews.

The first module was a survey of Group VIII and pre-expansion enrollees that addressed health care access, use, and benefits through survey responses. Survey data were weighted and set to represent the total Group VIII and pre-expansion enrolled populations.

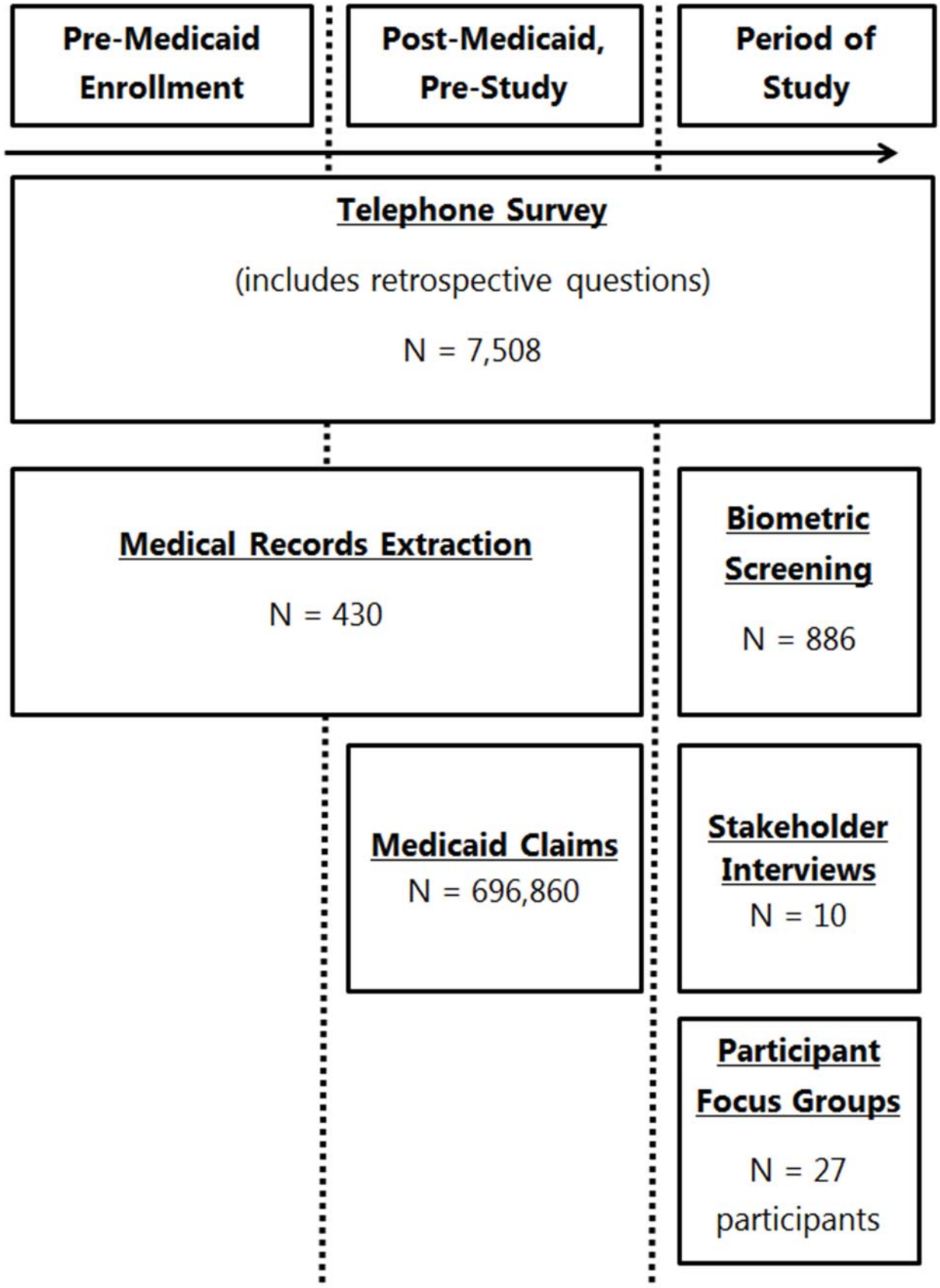
The second study module was a biometric screening of a random selection of Group VIII enrollees who completed the Group VIII Survey. The function of the biometric screening was to supplement the self-reported health status survey data with clinical information. During the biometric screening, permission was requested for researchers to examine medical records.

Medical records collection was the third module and was designed to compare the participant's health diagnoses, conditions, and health system use, pre- and post-Medicaid enrollment. The function of the medical records abstraction module was to identify trends in Group VIII enrollee health system use and health conditions via clinical information.

To serve as a baseline verification of the Ohio Medicaid Group VIII Assessment Survey biometric and medical records abstraction modules, the research team performed a comprehensive study of Ohio Medicaid administrative data for the entire study-eligible universe of Group VIII and pre-expansion Medicaid enrollees using analysis parameters from the Healthcare Effectiveness Data and Information Set (HEDIS) standards. These measurements examined various health conditions, health care system utilization (including preventive care), and rates of evidence-based care for select chronic conditions.

To capture qualitative measures about the value of Group VIII Medicaid enrollment for participants, the last module consisted of group interviews with select Group VIII enrollees and with Medicaid stakeholders, including representatives of provider groups. The questions asked in these interviews addressed topics that were determined to be substantial in the Group VIII Survey and biometric screenings. These interviews were transcribed into text and coded in relation to the prior modules' findings.

Figure 1. Study Design and Data Structure for Group VIII Assessment



Once all data collection was completed, analyses were performed on each independent module and comparatively between modules, when appropriate. These data provide the majority of results contained within the Ohio Medicaid Group VIII Assessment and within the companion Methodology Report. The following subsection descriptions provide more specific details on each of the data sources used for this assessment.

5. Data Sources

The primary data sources for this report include the following:

1. **Telephone Survey:** A total of 7,508 Medicaid enrollees participated in a detailed telephone survey, including 5,111 Group VIII enrollees and 2,397 pre-expansion enrollees. The sample was drawn using a stratified random selection of current Medicaid enrollees from both pre-expansion and Group VIII eligibility groupings, excluding the categories determined to be ineligible for the study (see Methodology Report). The cooperation rate of 76.1% for the telephone survey was stronger than expected, and the response rate of 24.1% is similar to other surveys of low-income populations.[22,23,24,25,26] The telephone survey included both closed- and open-ended questions. Data from the survey allowed for (a) identification of changes experienced by Group VIII enrollees since enrolling in Medicaid, and (b) comparisons between Group VIII and pre-expansion enrollees.

2. **Biometric Screening:** A random subset of telephone survey respondents from 22 counties were invited to participate in a biometric screening. Respondents met in person with a nurse who checked and recorded their blood pressure, heart rate, cholesterol levels, hemoglobin A1c, height, and weight. These counties, which represent over 70% of Ohio's total Medicaid enrollment, were selected with the goal of obtaining a representative number of biometric screenings in urban, rural, and suburban county types. A total of 886 respondents participated in the biometric screening, including 599 Group VIII enrollees and 287 pre-expansion enrollees. The show rate for respondents who agreed to participate in the biometric screening was 68%, which was expected.[27,28] The biometric screening allowed for verification and expansion of survey responses.

3. **Medical Records Examination:** Group VIII enrollees who completed the biometric screening were asked to provide voluntary access to their medical records. Approximately 92% of biometric screening participants signed authorization forms to allow access to their medical records from health care providers who served as their usual source of care in 2013 and for the period covering 2015-2016. These enrollees were associated with 430 eligible medical provider groups, 89% of which provided medical records for at least one of their patients for these time periods. Medical records covering the complete time period of pre- and post-expansion were obtained for 174 respondents, as many of the participants were previously uninsured and had no available medical records prior to enrollment in Medicaid. All medical records were reviewed for information on health status, chronic disease diagnoses, preventive screenings, and medical treatments/prescriptions.

4. **Medicaid Claims and Administrative Data:** Medicaid claims data were analyzed for participants who were enrolled in Medicaid for at least 11 months in 2015. This included 219,342 Group VIII enrollees and 477,518 pre-expansion enrollees. Sub-analyses were conducted for those who participated in the telephone survey and biometric screening. Analyses used well-established measures from HEDIS. Review of Medicaid claims enabled confirmation that the telephone survey sample was representative of the broader Medicaid population. In addition, claims data were used to (1) calculate measures of health care utilization, including preventive care and evidence-based care for chronic health conditions; (2) compare the health-related characteristics of Group VIII and pre-expansion enrollees; and (3) analyze changes in health status during the study period.

5. **Focus Groups and Qualitative Interviews:** Two types of qualitative studies were conducted. First, focus group sessions (with 27 total participants) were held in Cuyahoga, Muskingum/Licking (combined), and Montgomery counties. These sessions were conducted with individuals who participated in one or more of the following: telephone survey, biometric screening, and medical records examination. Second, qualitative interviews were conducted with a total of 10 invited Medicaid program stakeholders, including health care provider associations. These qualitative studies were designed to obtain more in-depth information about survey responses and to examine the perspectives of Medicaid stakeholders on the effects of Medicaid expansion.

6. **Ohio Medicaid Assessment Survey:** The 2015 Ohio Medicaid Assessment Survey (OMAS) is a telephone survey that samples both landline and cell phones of Ohio residents. The survey examines insurance status, access to the health system, health statuses, demographics and other characteristics of Ohio's Medicaid, Medicaid eligible, and non-Medicaid populations. In 2015, researchers completed 42,876 interviews with adults and 10,122 proxy interviews of children. The 2015 OMAS is the sixth iteration of the survey (previously known as Ohio Family Health Survey). Analyses from the 2015 OMAS addressed baseline information of prior insurance status, unmet health care needs, and family socioeconomic distress for the totality of Ohio and the Medicaid population from a population health point of view. For details, please see the 2015 OMAS Methodology Report.[29]

More detail on all of these data collection methods is given in the Methodology Report accompanying this report.

6. Group VIII Assessment Sections

Responding to the statutory mandate, this report examines the impact of Medicaid expansion on Group VIII enrollees as follows:

- Access to and utilization of heath care (Section III)
- Changes in physical health, with a focus on chronic disease diagnoses and risk factors (Section IV)
- Changes in mental and behavioral health (Section V)
- Financial well-being and employment (Section VI)

Although long-term changes in health cannot yet be assessed, to date Medicaid expansion has been strongly beneficial to Group VIII enrollees in all of these areas. This conclusion is confirmed by the multiple data sources used to prepare this assessment.

II. Population Characteristics of Group VIII Enrollees

This section presents information about the population that has enrolled in Ohio Medicaid through Group VIII eligibility. Medicaid expansion has produced a significant increase in health care coverage—and a corresponding decrease in Ohio's uninsured rate—as the majority of Group VIII enrollees were previously uninsured.

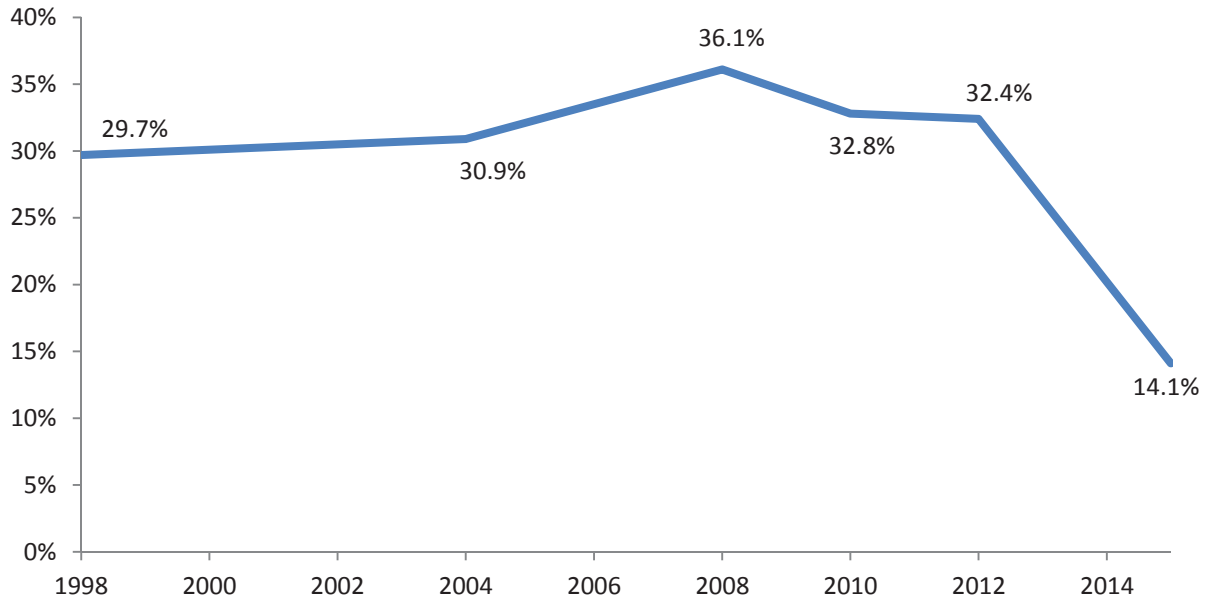
Group VIII enrollees demonstrated high levels of both physical and mental health needs, which the Medicaid program is helping them to address. Because of demographic differences (age, sex, and race), Group VIII enrollees had slightly higher rates of chronic diseases, particularly cardiovascular disease, than pre-expansion enrollees. In particular, males 45-64 years of age had elevated rates of physical health conditions compared to other enrollees.

1. Insurance Characteristics

As of May 2016, more than 702,000[v] Ohioans were enrolled in Medicaid through the Group VIII expansion. In part, resulting from Medicaid expansion, Ohio recorded its lowest adult uninsured rate ever in 2015, at 8.7% for all adults 19-64 years of age. In 2012, the adult uninsured rate was 17.3% (OMAS).

The decline in the uninsured rate was particularly notable for low-income Ohioans. For adults with family incomes under 138% of the FPL, the uninsured rate declined from 32.4% in 2012 to 14.1% in 2015 (Figure 2), the lowest rate ever recorded (OMAS). This precipitous decline was almost entirely the result of Medicaid expansion.

Figure 2. Percentage of Ohioans age 19-64 With Family Income at or Below 138% of the Federal Poverty Level Without Insurance From 1998 to 2015



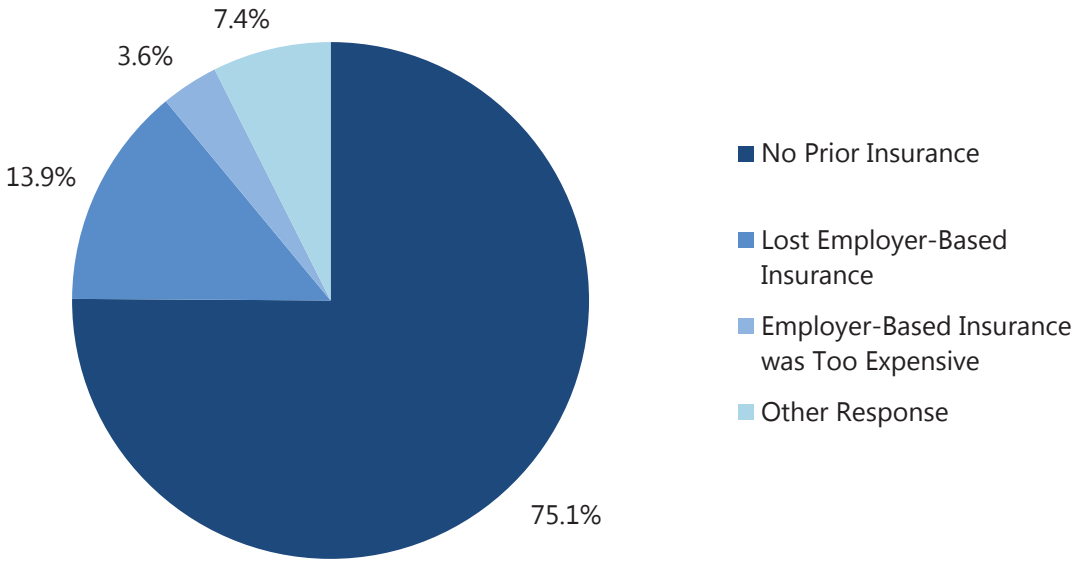
Source: Ohio Medicaid Assessment Survey.

A question regarding Medicaid expansion is whether it attracted people who were currently uninsured or brought people who were otherwise covered into public insurance. According to the Group VIII Survey, 89.0% of Group VIII enrollees were uninsured just prior to Medicaid expansion, including 75.1% who had no prior insurance and 13.9% who had recently lost their employer-based coverage (Figure 3). The remaining 11.0% had some other form of coverage, with 3.6% stating that their employer-based insurance was too expensive to keep (the

[v] This number is unpublished and includes retroactive and backdated enrollments for May processed through November. The source for the estimate is ODM. See the Methodology Report for details regarding enrollment calculations.

insurance substitution rate). Looking specifically at the 24.9% of Group VIII enrollees who had prior insurance within the year before enrollment, 55.8% transitioned to Medicaid because they lost employer-sponsored insurance, and an additional 14.5% transitioned to Medicaid because their employer-sponsored insurance was too expensive.[30,31] These numbers are similar to trends for pre-expansion enrollees over the past decade.

Figure 3. Insurance Status Prior to Enrollment Among Group VIII Enrollees and Reasons for Enrolling in Medicaid Expansion



Source: Group VIII Telephone Survey.

2. Demographic Characteristics

Compared to pre-expansion enrollees, Group VIII enrollees who completed the telephone survey were more likely to be unmarried, male, older (45-64 years), and without children in the household (Table 1). The racial/ethnic background and educational attainment of Group VIII and pre-expansion enrollees were similar, although Group VIII enrollees were somewhat more likely to be white, to have college degrees, and to be employed. These demographic differences are largely the result of the different eligibility criteria for Group VIII enrollment compared to pre-expansion eligibility criteria. Before the 2014 expansion, the largest group of adults enrolled in Ohio Medicaid was women with children in the household (Ohio Medicaid Data, Ohio Medicaid Assessment Survey).

Table 1. Demographic Characteristics of Group VIII Enrollees and Pre-Expansion Enrollees

	Group VIII		Pre-Expansion	
	Weighted Average	Unweighted N	Weighted Average	Unweighted N
Male	55.8%	2,502	30.2%	762
Age				
19-44 years	49.6%	1,992	76.3%	1,484
45-64 years	50.4%	3,119	23.7%	913
Race				
White	71.5%	3,944	67.5%	1,759
Black	24.8%	997	28.0%	541
Other	3.7%	170	4.5%	97
Ethnicity				
Hispanic	3.6%	159	5.0%	104
Education				
High School or Less	58.1%	3,031	62.2%	1,512
Some College	28.3%	1,431	30.4%	704
4-Year Degree or More	13.1%	628	6.8%	167
Marital Status				
Married	15.6%	875	26.8%	648
Divorced	26.0%	1,518	24.4%	692
Widowed	3.8%	247	2.1%	60
Never Married	48.3%	2,174	39.9%	842
Domestic Partner	5.7%	266	6.2%	138
Children in the Household	17.9%	836	75.4%	1,688
Currently Employed	43.2%	2,138	41.5%	921

Source: Group VIII Telephone Survey.

3. Physical and Mental Health Characteristics

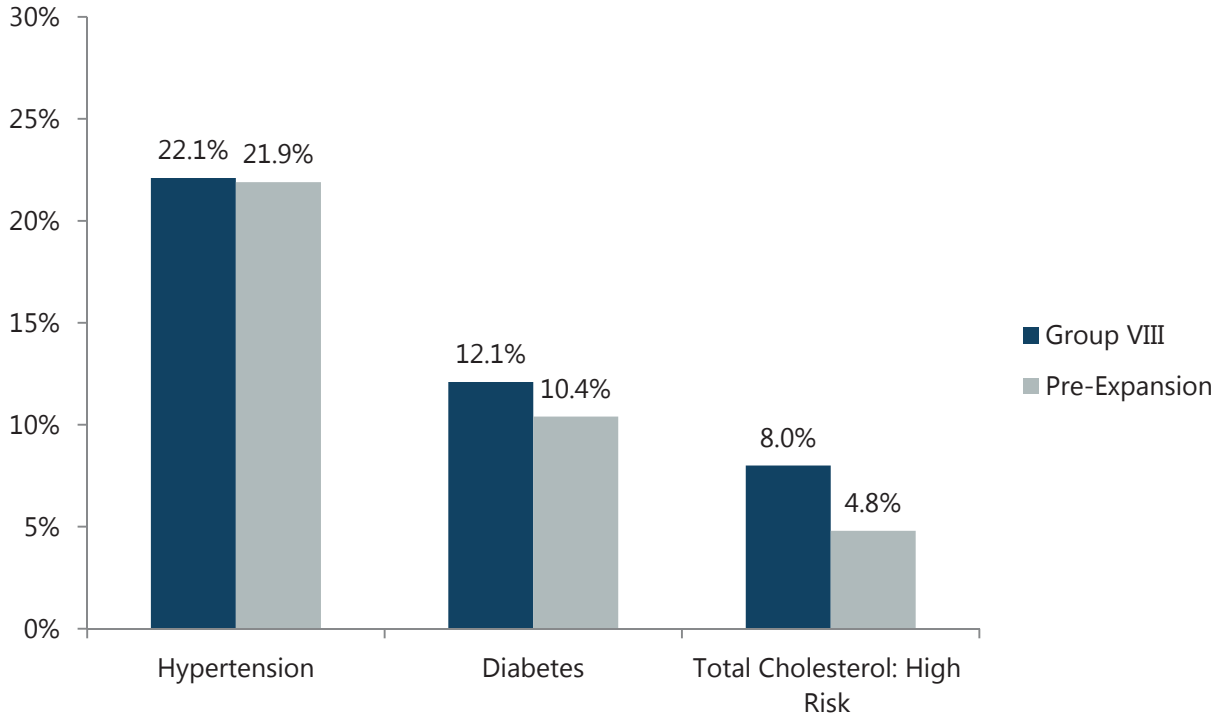
Because the Group VIII enrollees are, on average, older and more likely to be male than pre-expansion enrollees, they face some different health challenges. For example, among those who participated in the biometric screening, members of the Group VIII population were more likely to have at-risk levels of blood pressure, hemoglobin A1c (blood sugar) levels consistent with diabetes, and high cholesterol than pre-expansion enrollees (Figure 4). However, these differences were primarily the result of differences in demographic characteristics. In a series of statistical models with demographic controls, differences between pre-expansion and Group VIII enrollees in terms of hypertension (high blood pressure), blood sugar levels, and cholesterol were not statistically significant (appendix Figure 4). The detailed results from these statistical models are available in the Methodology Report.[vi]

Using the biometric data, Group VIII enrollees were identified as having higher levels of cardiovascular risk than pre-expansion enrollees. This was based on a validated risk score that combined a number of factors (detailed in the Methodology Report) to estimate the likelihood of developing cardiovascular disease. The higher

[vi] Note that the biometric screenings measured markers of health at a single point in time. These results cannot be used to make assumptions or comparisons about the health of these populations at any earlier points in time. Additionally, the biometric screening does not identify people who may have had health risk markers in the past but who have received effective treatment.

cardiovascular risk for the Group VIII population was expected, given that age and sex are two important factors in determining cardiovascular risk, and the Group VIII population is older with a higher proportion of males.

Figure 4. Prevalence of Health Risk Markers



Individuals with the above diseases who were treated to levels below diagnostic levels are not accounted for in this analysis. More information on the risk level definitions is available in the Methodology Report. Source: Group VIII Biometric Screening.

Key Findings

Medicaid expansion resulted in new health insurance coverage for 702,000 Ohioans in May 2016, the vast majority of whom were previously uninsured.

In comparison to pre-expansion enrollees, Group VIII enrollees are more likely to be male, older (45-64 years), and without children.

As a result of demographic differences, Group VIII enrollees had higher rates of cardiovascular risk factors such as hypertension and high cholesterol than pre-expansion enrollees.

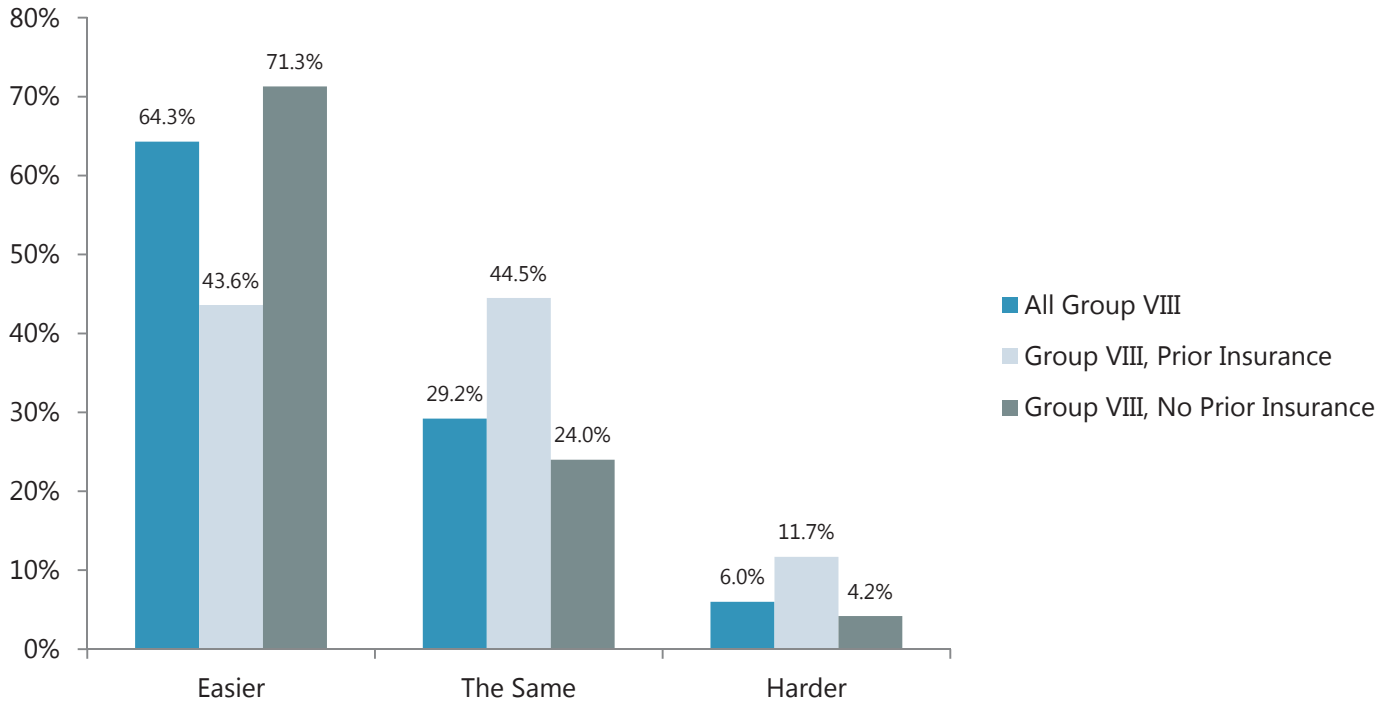
Studies from other states that have expanded Medicaid have similarly found large increases in Medicaid enrollment, primarily because of the enrollment of adults who were previously uninsured.[1]

III. Health System Access and Utilization

A key goal of providing health care coverage is for people to better integrate into the health care system. Past reports show that the uninsured are less likely to have a usual source of care and more likely to use of the ED as a usual source of care. Additionally, the uninsured demonstrate lower utilization of preventive care and higher levels of unmet health needs.[32,33,34,35] This combination of experiences creates a lack of continuity to care and delays in seeking needed care that can often result in later diagnosis of health conditions, use of higher cost sources of care, lower levels of appropriate care being received, and poorer overall health outcomes.

Group VIII enrollees overwhelmingly reported that access to medical care has become easier since enrolling in Medicaid (Figure 5), which has reduced their unmet medical needs. Enrollment in Medicaid has enabled Group VIII enrollees to obtain a usual and appropriate source of care that, in turn, has likely contributed to decreased use of ED care and better management of chronic health conditions.

Figure 5. Changes in Ease of Access to Care Since Enrolling in Medicaid



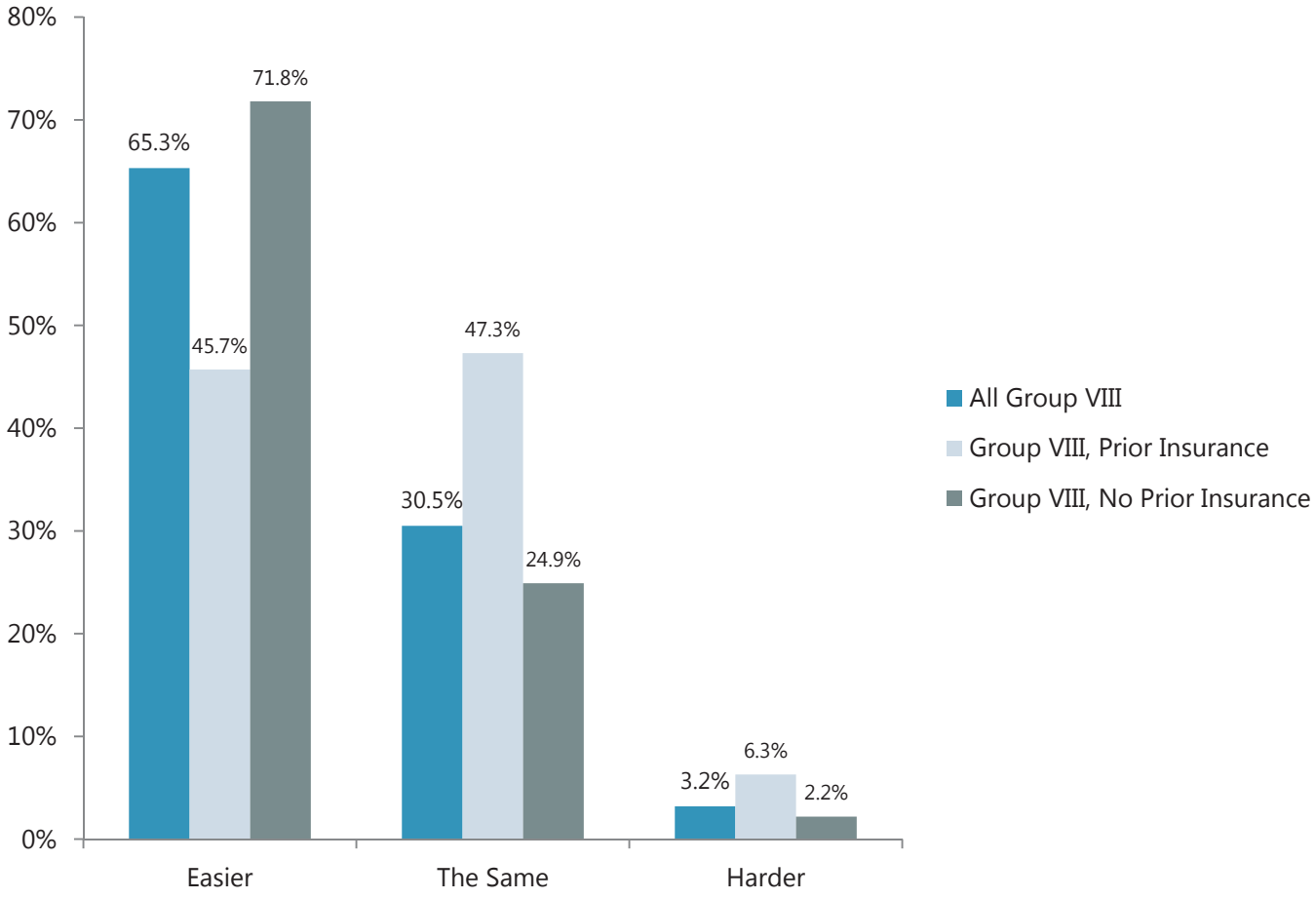
Source: Group VIII Telephone Survey.

1. Access to Care

A majority of Group VIII enrollees reported improved access to care since enrolling in Medicaid; 64.3% stated that accessing care had become easier, 6.0% stated that it had become harder, and 29.2% stated that ease of access remained the same. Getting care became easier for a substantial percentage of Group VIII enrollees with prior insurance (43.6%), indicating that improved access to care was not limited to Group VIII enrollees who were previously uninsured.

Large percentages of Group VIII enrollees reported better access to a variety of health services, including dental care, vision care, and mental health services. Two-thirds of Group VIII enrollees (65.3%) stated that filling prescriptions had become easier, and only 3.2% reported that filling prescriptions had become more difficult (Figure 6).

Figure 6. Changes in Ease of Filling Prescriptions Since Enrolling in Medicaid



Source: Group VIII Telephone Survey.

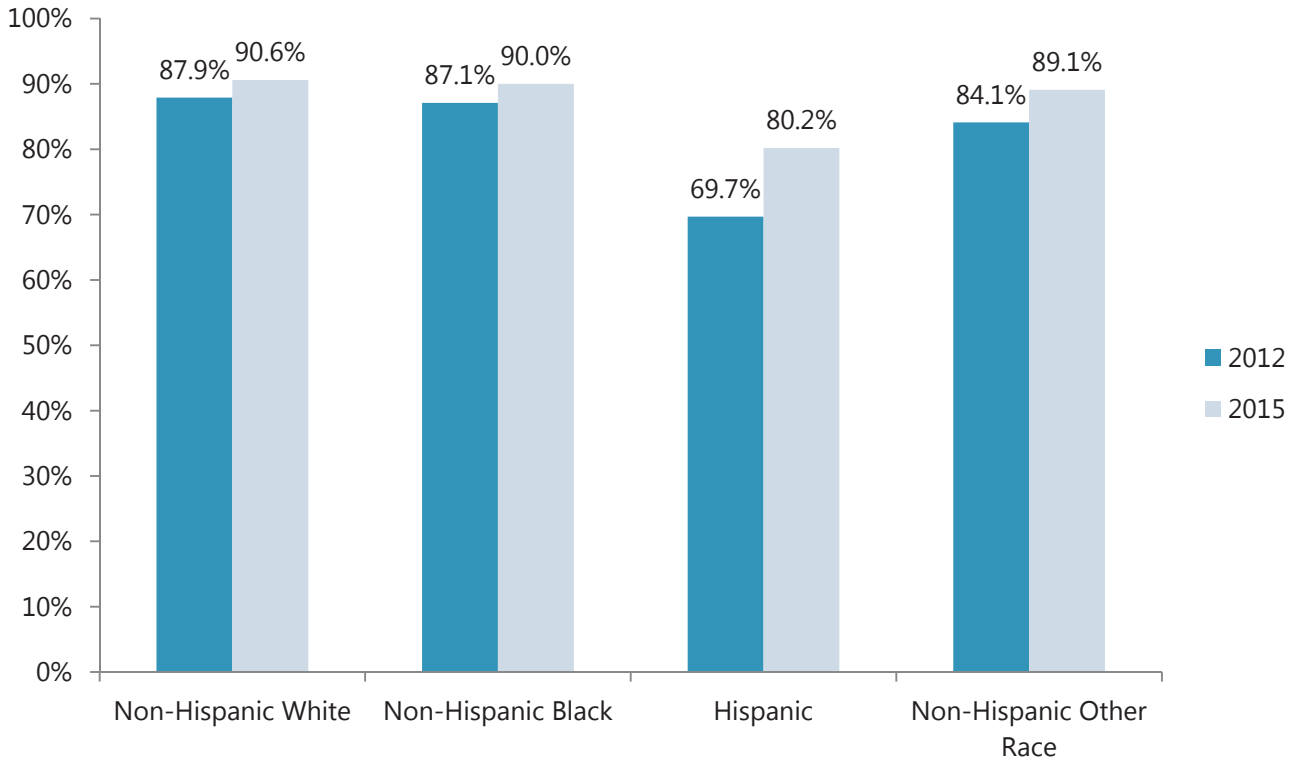
2. Usual Source of Care

A usual source of health care is defined as a particular medical professional or health center where a person would usually go when in need of health care advice or health care services. The main reasons for not having a usual source of care besides seldom getting sick are prohibitive cost for securing health care, being uninsured, and a lack of knowledge concerning when and how to secure health care services.[36] A significant percentage of Group VIII enrollees (32.2%) reported that before they obtained Medicaid coverage they did not have a usual health care provider. This included 21.0% of enrollees with prior insurance and 36.0% of enrollees who were previously uninsured.

For Group VIII enrollees who did not have a usual source of care prior to enrolling in Medicaid, a majority (58.4%) reported having a usual source of care (other than emergency department) at the time they were surveyed. Even among Group VIII enrollees with prior insurance and no usual source of care prior to enrolling in Medicaid, a majority (51.8%) reported having a usual source of care at the time of the study.

Additionally, Medicaid expansion has narrowed the racial and ethnic disparities in access to usual sources of care. Among low-income Ohioans (≤138% FPL), those identifying as Hispanic showed the largest percentage increase in connecting to a usual source of care between 2012 and 2015. However, the percentage of low-income Hispanic Ohioans with a usual source of care (80.2%) still lags behind the comparable percentage for low-income White (90.6%) and Black (90.0%) Ohioans (Figure 7).

Figure 7. Percentage of Ohioans With Income at or Below 138% FPL With a Usual Source of Care by Race, 2012-2015



Source: Ohio Medicaid Assessment Survey.

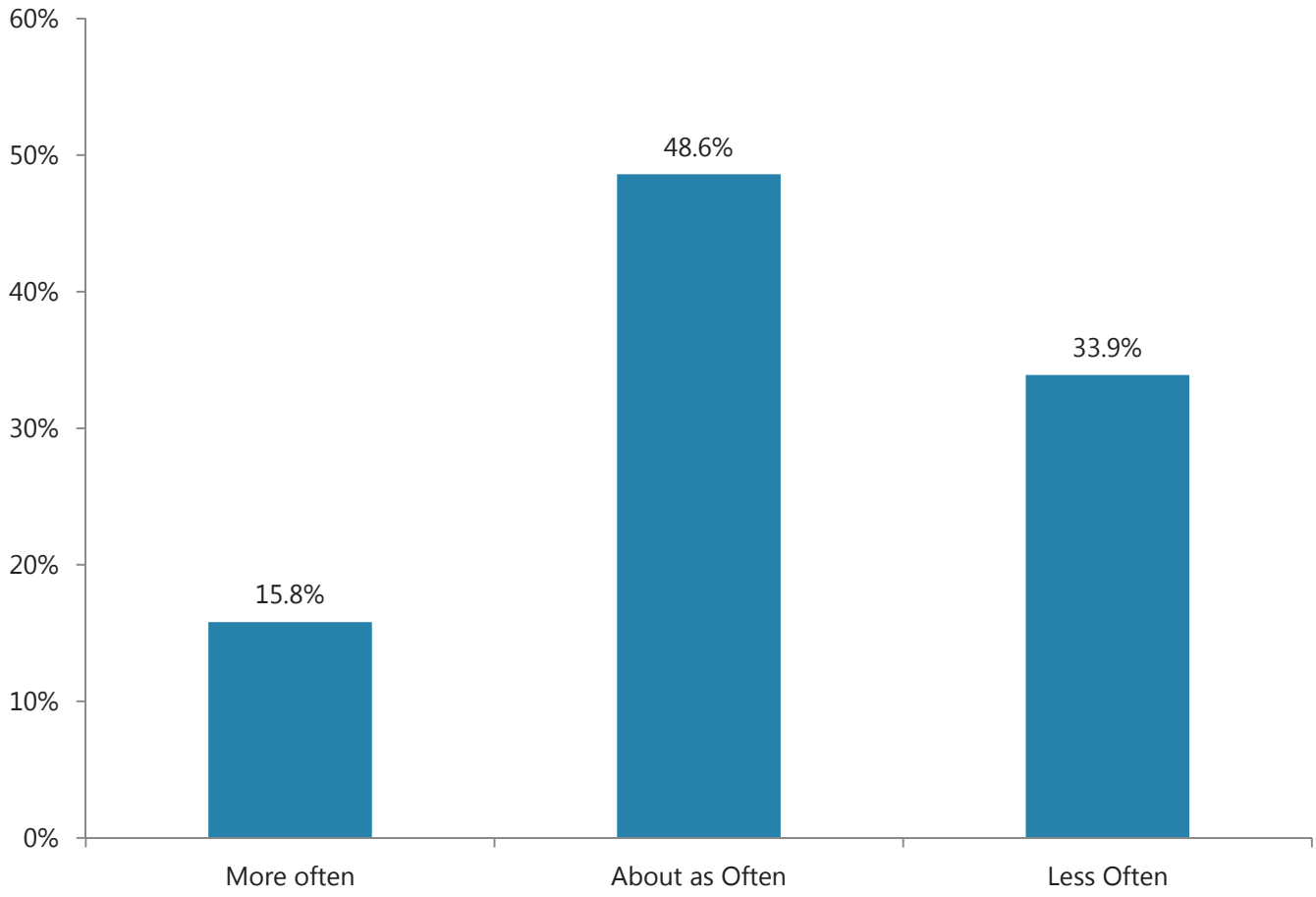
A review of the medical records for Group VIII enrollees with visits to their usual source of care both prior and subsequent to the Medicaid expansions revealed an increase in the likelihood of having two or more visits in a given year since enrollment. This finding supports the telephone survey results that Group VIII enrollees are accessing needed preventive and primary health care.

The medical records review was carried out for a total of 430 Group VIII enrollees. Of these enrollees, 301 reported in the biometric screening having the same usual source of care in 2013, before expansion, as in 2015–2016, after expansion. Of these 301 Group VIII enrollees, 174 medical records were obtained and abstracted for both time periods (pre- and post-expansion). The two main reasons for this were: (1) there being no observable visits on the medical records with their usual source of care in 2013; and (2) health care provider nonresponse. For the subset of Group VIII enrollees with abstracted medical records who identified the same specific provider (as opposed to a group practice) for both time periods, it was determined that a minority sought care with their usual source of care provider during the post-expansion period. These results are indicative of a substantial increase in access to care for Group VIII enrollees—most of who were uninsured and indicated no change in their usual source of care between 2013 and 2016.

3. Emergency Department Use

After Medicaid expansion, emergency department (ED) use tended to decline among Group VIII enrollees. About a third of Group VIII enrollees (33.9%) reported fewer trips to an ED since enrollment, while 15.8% reported an increase and 48.6% reported that use remained the same (Figure 8). The decline in utilization rates was similar for Group VIII enrollees with and without prior insurance.

Figure 8. Changes in Frequency of Emergency Department Use Since Enrolling in Medicaid



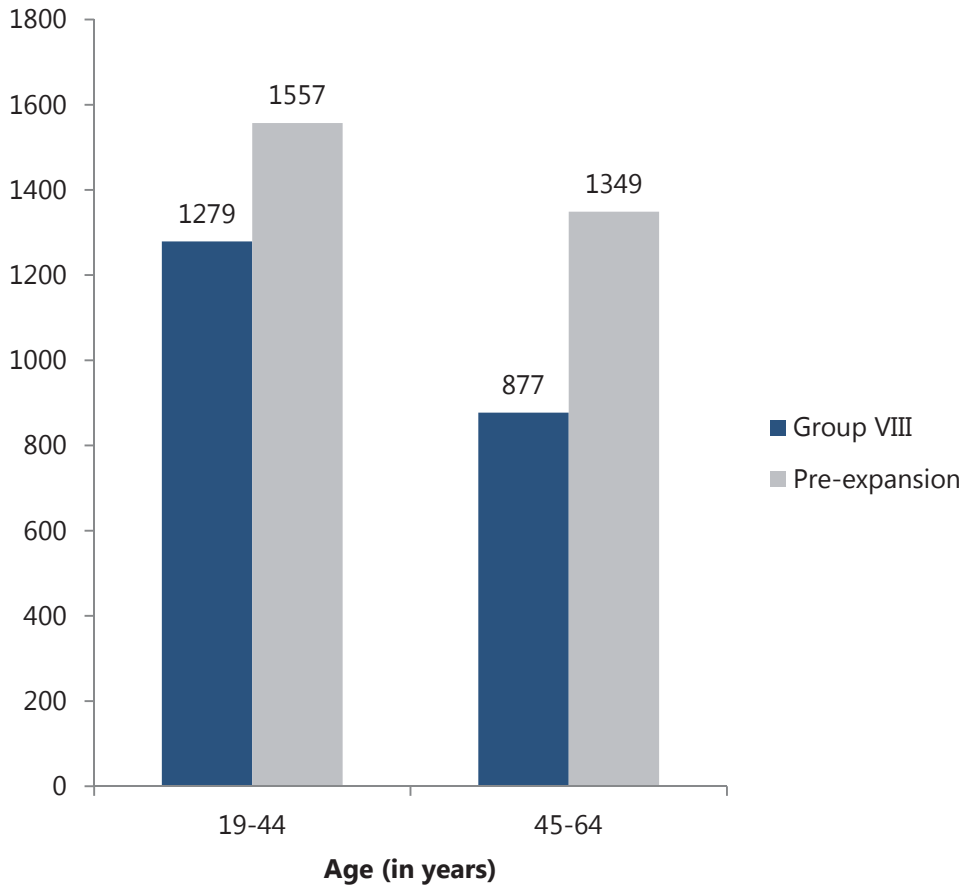
Source: Group VIII Telephone Survey.

Medicaid claims data also demonstrated that Group VIII enrollees were less likely than pre-expansion enrollees to visit the ED. When they did visit an ED, it was more likely to be for a medical condition typically best treated in the ED, such as myocardial infarction (heart attack), acute respiratory failure, or a traumatic brain injury. In particular, Group VIII enrollees aged 45-64 had substantially fewer visits to the ED than pre-expansion enrollees in the same age range (Figure 9). Additional analyses of Medicaid claims revealed that Group VIII enrollees were less likely to use an ED than pre-expansion enrollees for visits in which no immediate care was needed (23.1% versus 26.3% of total visits) and for which care was needed but could have been provided by a primary care provider (21.7% versus 23.0%). Because the ED is an expensive setting in which to deliver care, reducing ED visits for non-emergent care has the potential to lower overall health care costs for the Group VIII population.[37]

When asked what getting Medicaid meant to them, 31.3% of respondents specifically mentioned improved access to care, with many mentioning reduced use of the ED.

> "I'm happy that I can make appointments without going to the emergency room."
>
> "It brought some comfort to know if I was to get sick I can go to a hospital and get treatment and not have to get emergency room care."
>
> "It has helped me a lot. When I didn't have Medicaid I wouldn't go to doctor or hospital. I would use the hospital emergency room as a clinic."
>
> Source: Group VIII Telephone Survey.

Figure 9. Number of Emergency Department Visits per 1,000 Member-Years in 2015



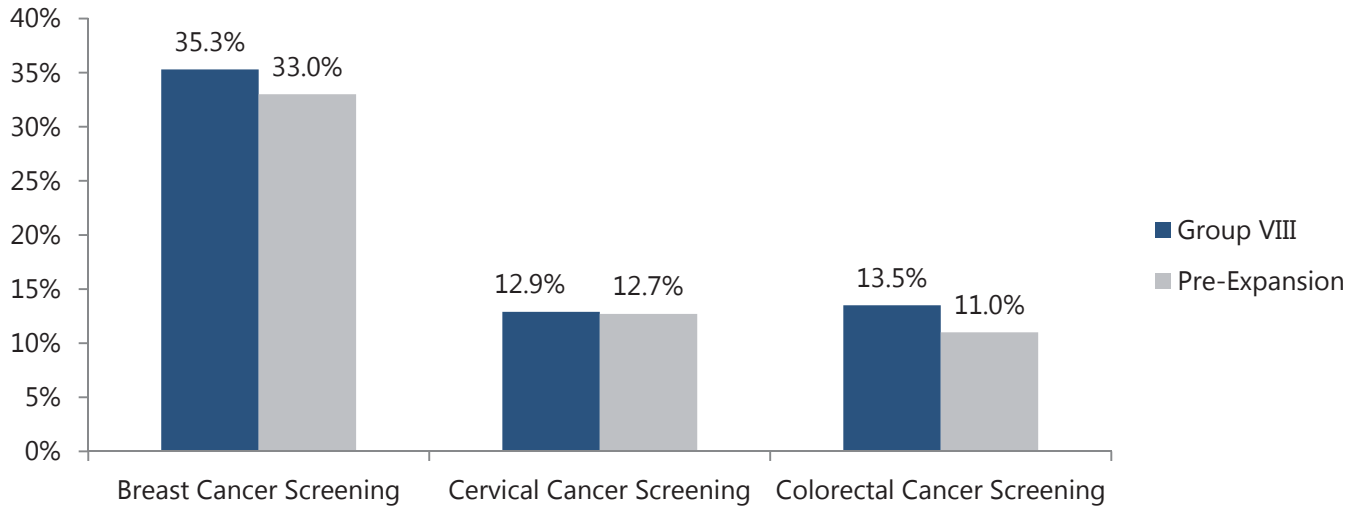
Source: Medicaid Administrative Data.

4. Access to Preventive Care

Medicaid expansion was, in part, intended to facilitate access to preventive services that could help avoid the onset of costly and debilitating diseases. Decades of research suggest that evidence-based clinical preventive services are cost-effective and can be cost-saving.[38]

Medicaid claims data suggest that Group VIII enrollees are obtaining clinical preventive services at rates comparable to those of pre-expansion enrollees (Figure 10). For example, in 2015, 35.3% of Group VIII female enrollees over the age of 50 obtained breast cancer screenings, compared to 33.0% of pre-expansion enrollees. These data are limited to Group VIII enrollees and pre-expansion enrollees who were eligible for these screening procedures.

Figure 10. Percentage of Group VIII and Pre-Expansion Enrollees Who Qualified for and Received Health Screenings in 2015[vii]



Source: Medicaid Administrative Data.

5. Appropriate Care for Chronic Conditions

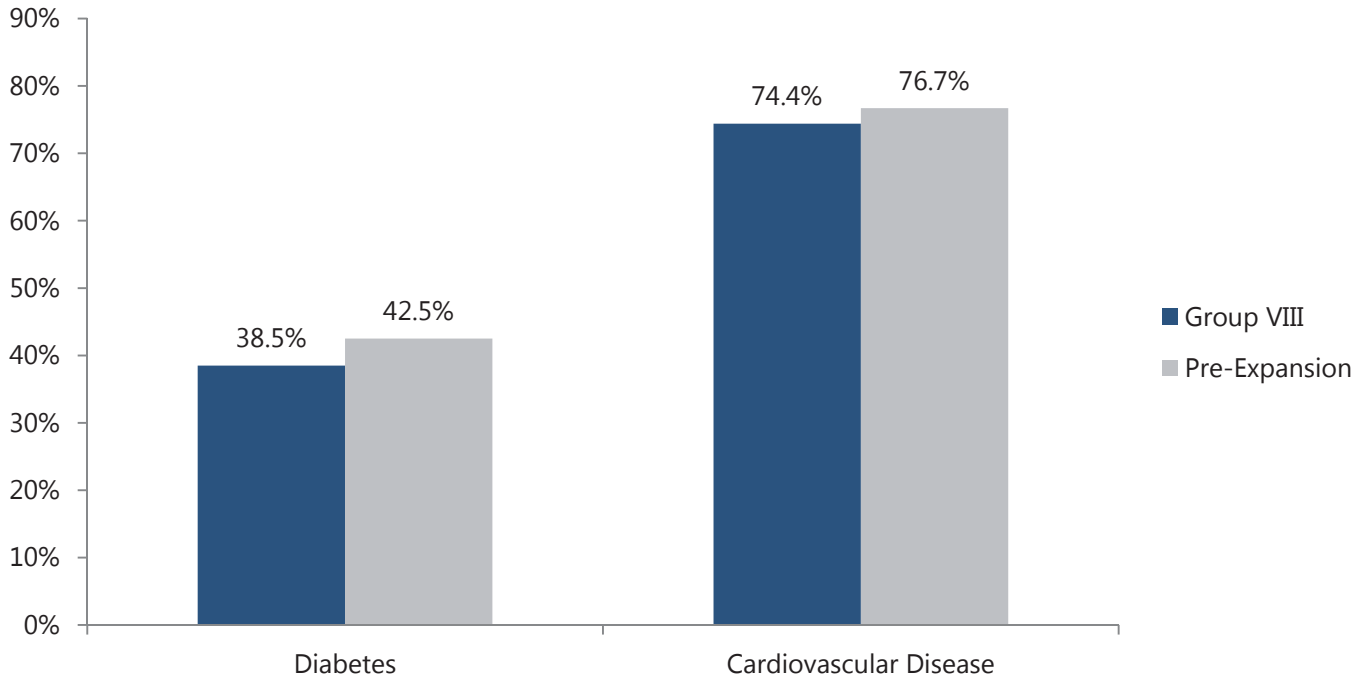
An important function of primary care providers is the treatment of chronic conditions. According to Medicaid administrative data, a large percentage of Group VIII enrollees with chronic condition diagnoses were receiving appropriate care from a clinician based on evidence-based clinical guidelines.

For patients with Type 2 diabetes or cardiovascular disease, statin therapy is a widely used evidence-based treatment.[39,40] Similar percentages of Group VIII enrollees and pre-expansion enrollees with diabetes received statin therapy (38.5% versus 42.5%); likewise, the percentage of patients with cardiovascular disease receiving statins was comparable (74.4% of Group VIII enrollees versus 76.7% of pre-expansion enrollees) (Figure 11). (Statin use for treatment of cardiovascular disease in both the Group VIII and pre-expansion populations exceeded the U.S. average of 58.1% in 2013.[41])

Analyses of Medicaid administrative data indicated that a large majority of Group VIII enrollees with hypertension also had well-controlled blood pressure. Because the care experience and treatment regimens for patients with hypertension and diabetes and those with hypertension but without diabetes are different, the results for these two groups are reported separately. Among Group VIII enrollees with hypertension and diabetes, 79.6% had well-controlled blood pressure, compared to 80.5% for pre-expansion enrollees (Figure 12). Hypertensive Group VIII enrollees without diabetes were less likely to have well-controlled blood pressure (68.1%, compared to 70.6% for pre-expansion enrollees). These results exceed the Healthy People 2020 objective of 61.2%.[42]

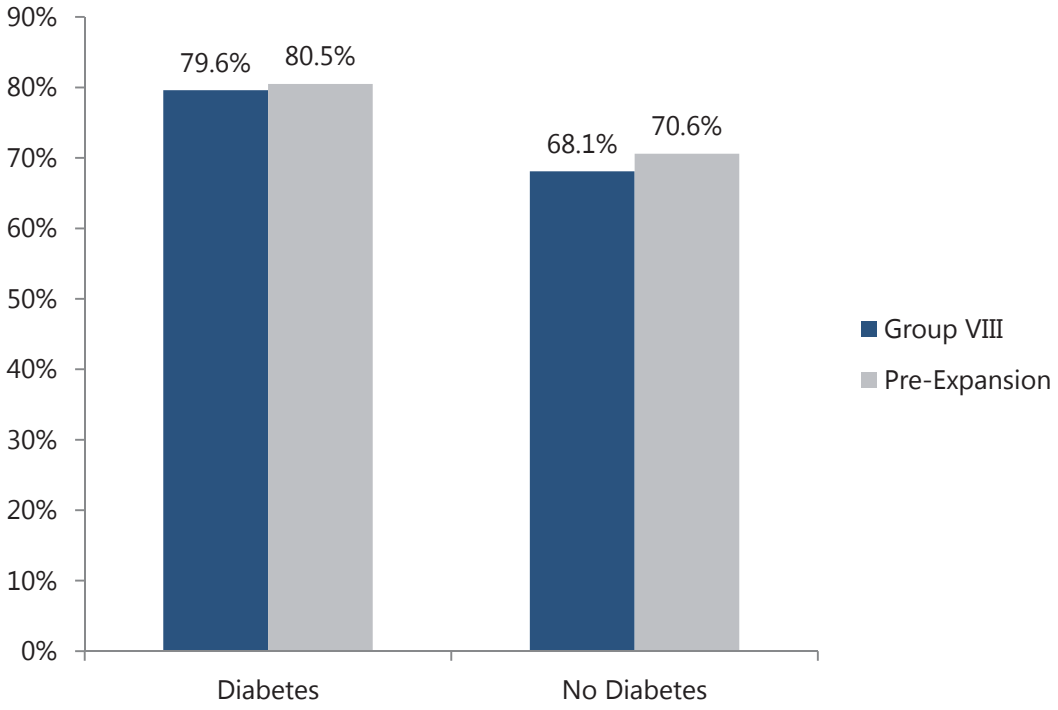
[vii] Not all screenings are performed annually. According to the United States Preventive Services Task Force, the recommended period between screenings is every other year for breast cancer screening (mammography) at age 50, 3 to 5 years for cervical cancer, and yearly to every 10 years for colorectal cancer depending on screening modality, starting at age 50.

Figure 11. Percentage of Group VIII and Pre-Expansion Enrollees With Diabetes or Cardiovascular Disease Diagnoses Who Received Statin Therapy



Source: Medicaid Administrative Data.

Figure 12. Percentage of Group VIII and Pre-Expansion Enrollees With Hypertension Diagnoses Who Have Well-Controlled Blood Pressure by Diabetes Status



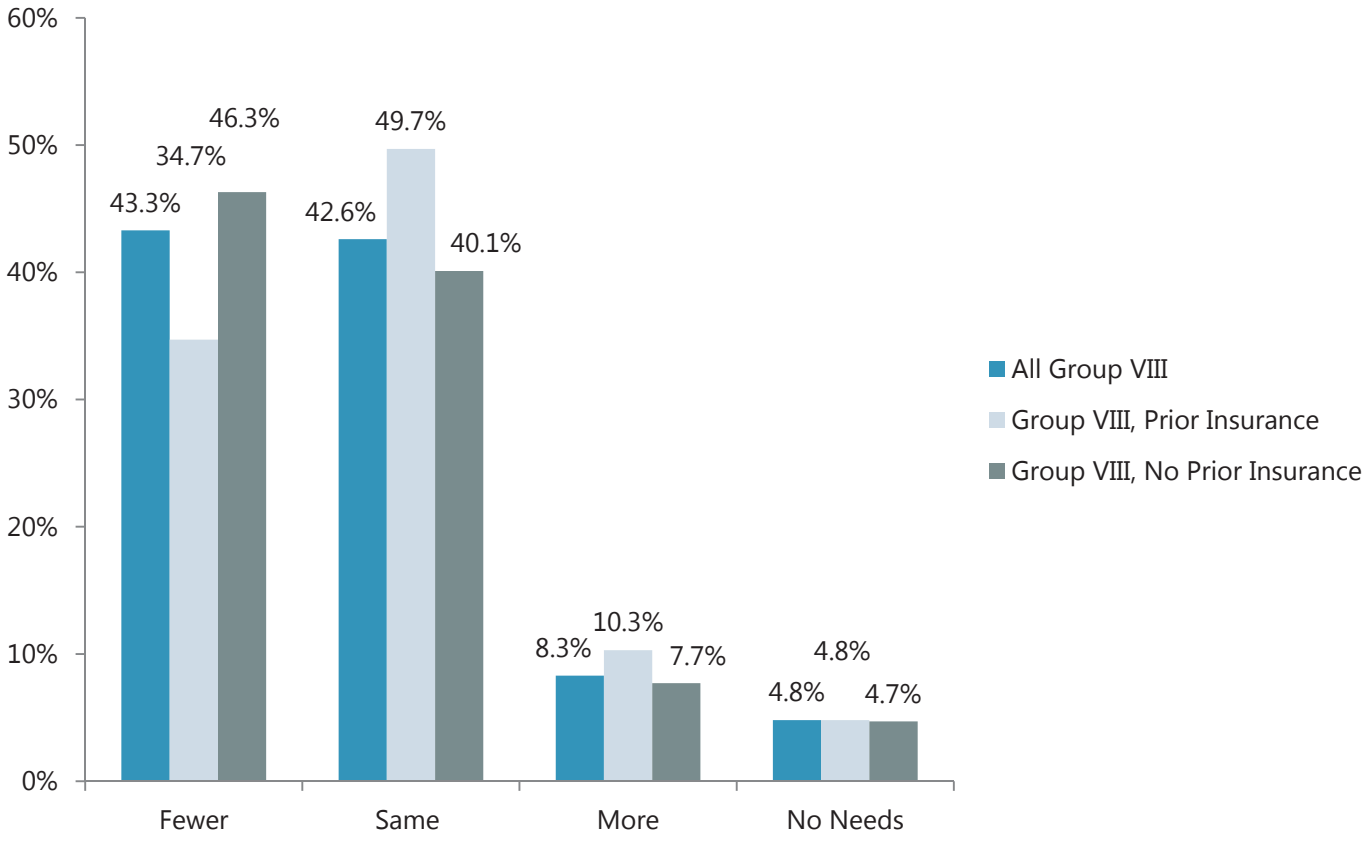
Source: Medicaid Administrative Data.

6. Unmet Health Care Needs

An unmet health care need indicates a physical or mental health condition that is not being addressed. Causes of unmet needs can be classified as barriers to availability, accessibility, and acceptability of services. Problems of *availability* include too-lengthy wait times, services not available when required, and services not available in a geographic area. Problems of *accessibility* include reasons related to cost and transportation. Problems of *acceptability* of available service usually relate to personal preferences or individual circumstances. Unmet needs were examined in the Ohio Medicaid Group VIII Survey for general health, dental health, and mental health.

Overall, Group VIII enrollees reported widespread declines in unmet health care needs (Figure 13). Forty-three percent of Group VIII enrollees reported fewer unmet needs, compared to 8.3% who reported greater needs. Reductions in unmet health care needs were detected for both those who had insurance and those who were uninsured prior to G-VIII enrollment.

Figure 13. Percentage of Group VIII Enrollees Who Have Fewer, More, or the Same Level of Unmet Health Care Needs Since Enrolling in Medicaid



Source: Group VIII Telephone Survey.

Results from the 2015 OMAS indicate that 37.7% of Group VIII enrollees reported general unmet health care needs, 21.0% reported unmet dental needs, 15.0% reported unmet vision needs, 6.9% reported unmet mental health care needs, and 11.2% reported unmet health care supplies needs.

Key Findings

Nearly two-thirds of Group VIII enrollees (64.3%) reported that Medicaid improved their access to general health care. Similar improvements were reported for access to care in the areas of pharmacy, vision, and dental.

Medicaid has enabled most new enrollees who previously lacked a usual source of care to obtain one.

Access to care through Medicaid has reduced unmet medical needs and likely contributed to many individuals reporting less ED use.

These results are consistent with research from other states demonstrating that Medicaid expansion has resulted in improved access to care and medications, increased likelihood of having a usual source of care, and reduced unmet needs. Previous studies have reached inconsistent results about whether Medicaid expansion increases or decreases ED use.[1] The findings from this study suggest that Ohio Medicaid expansion has, on balance, reduced ED use by Group VIII Medicaid enrollees.

IV. Changes in Physical Health

Better integration into the health care system should result in better physical health. However, measuring physical health improvement in the short run is challenging. Although Medicaid expansion is in its third year, this assessment focuses on people who had received coverage for between 12 and 24 months at the time they were studied.

This assessment was able to examine numerous sources that suggest possible impacts on the physical health of Group VIII enrollees. First, survey data were used to determine how many new enrollees were diagnosed with previously undetected chronic health conditions. Preferably, these diagnoses would occur at earlier stages of the disease, soon after enrollees had obtained Medicaid coverage, which has been Ohio Medicaid's experience with those on pre-expansion Medicaid. Second, survey data were combined with Medicaid administrative data and medical records from a subset of participants to examine whether Group VIII enrollees were better able to manage their chronic health conditions. Effective management of chronic conditions is vital to Medicaid given that enrollees with chronic conditions account for 70% to 80% of total Medicaid spending. Finally, individual self-reports of changes in health status served as an additional measure for assessing Medicaid expansion's impact on health.

Because of the short amount of time that has transpired since Medicaid expansion, dramatic improvements in physical health among Group VIII enrollees were not expected. Since enrollment, Group VIII enrollees have (1) been connected to usual health care (as discussed in Section III); (2) obtained diagnoses for preexisting chronic conditions; and (3) accessed appropriate health care for the treatment and management of those conditions.

> "[Medicaid is] a life saver. It's got my blood pressure back down to almost normal. I'm just grateful for the coverage because I wouldn't get this care without it because I know it isn't cheap."
>
> "I can go to the doctor for my bronchitis and asthma and can get care. I'm able to be healthier and be more functional at work and able not to miss work because I can get health care that I can afford."
>
> "It means that I am healthier, I have asthma and before I couldn't afford my inhaler. It's been a lifesaver."
>
> Source: Group VIII Telephone Survey.

1. Chronic Disease Diagnoses

When assessing health status, data collection for this assessment focused on issues relating to key chronic diseases. The analyses of the Group VIII enrollees showed that selected chronic disease diagnoses are prevalent in this population. The costs associated with chronic disease treatment are a source of tremendous financial disruption and family stress. They have significant impacts on morbidity and mortality for Medicaid recipients and represent many of the leading causes of death.

Many Group VIII enrollees (38.8%) reported having been diagnosed with at least one chronic condition prior to obtaining Medicaid coverage, indicating that many in the Group VIII population had serious preexisting health needs. Since enrolling in Medicaid, more than one-quarter of Group VIII enrollees (27.0%) have been newly diagnosed with at least one chronic condition (Group VIII Telephone Survey). The most common new diagnoses are shown in Figure 14. A review of medical records of Group VIII enrollees who visited their usual source of care

in both 2013 and 2015-2016 also identified increases in chronic disease diagnoses. For example, more than twice as many Group VIII enrollees who participated in the medical records case study were diagnosed as having diabetes in 2016 compared to 2013 (21%, up from 10%), and the percentage diagnosed with depression increased from 13% to 22%.

These new diagnoses make it difficult to assess changes in health status for Group VIII enrollees before and after Medicaid enrollment. The new diagnoses could superficially—and incorrectly—be read to suggest that some Group VIII enrollees have experienced worsened health since enrolling on Medicaid. It is far more likely, however, that these new diagnoses represent conditions that were previously undiagnosed. Thus, enrollment in Medicaid has enabled enrollees to better understand their current health status and to seek treatment for existing—and potentially life-threatening—risk factors and chronic diseases.

Enrollment in Medicaid was instrumental in both identifying previously undiagnosed health conditions and increasing the likelihood of appropriate care for such conditions. In response to the question about what getting Medicaid has meant to respondents, some mentioned having a better understanding of their health or a health condition.

When asked what getting Medicaid meant to them, 31.3% of respondents specifically mentioned improved access to care, with many mentioning reduced use of the emergency department.

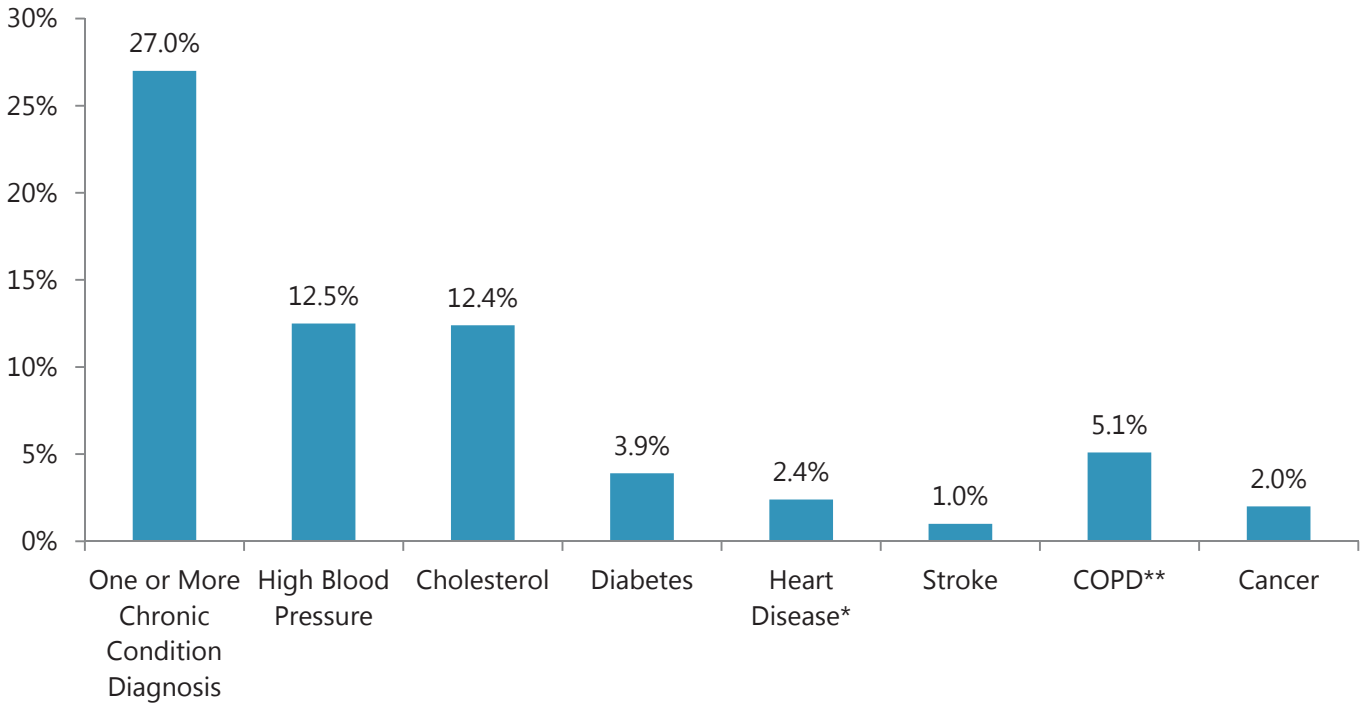
"I'm happy that I can make appointments without going to the emergency room."

"It brought some comfort to know if I was to get sick I can go to a hospital and get treatment and not have to get emergency room care."

"It has helped me a lot. When I didn't have Medicaid I wouldn't go to doctor or hospital. I would use the hospital emergency room as a clinic."

Source: Group VIII Telephone Survey.

Figure 14. Percentage of Group VIII Enrollees Who Reported Receiving a Chronic Condition Diagnosis Since Enrollment



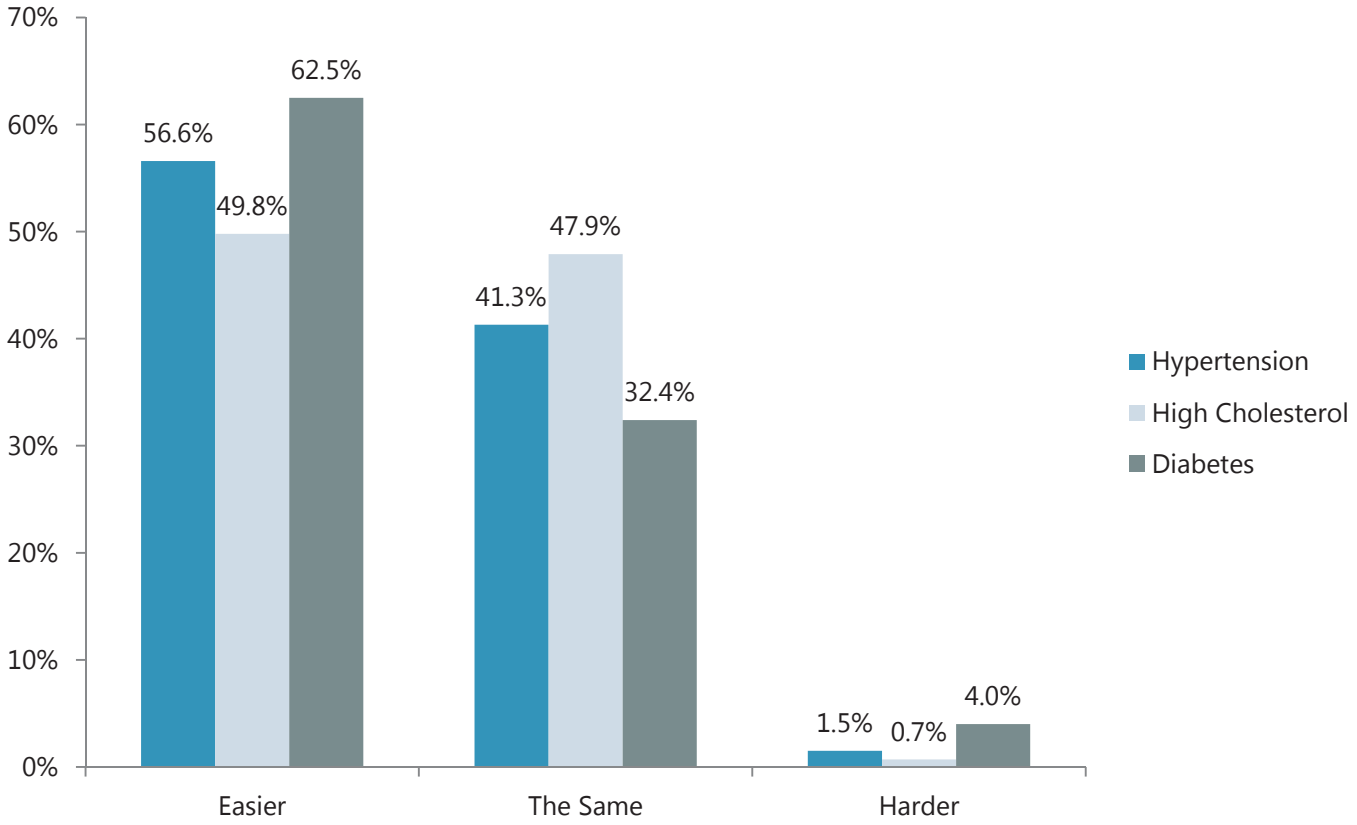
*Coronary Heart Disease, Heart Attack, or Congestive Heart Failure.
**Emphysema, Chronic Obstructive Pulmonary Disease, or Chronic Bronchitis.
Source: Group VIII Telephone Survey.

2. Management of Chronic Conditions

As noted, many Group VIII enrollees (38.8%) had been diagnosed with a chronic condition prior to obtaining Medicaid coverage. However, prior to Medicaid expansion, many of these people were unable to obtain or afford appropriate medical treatment for these conditions.

After Medicaid expansion, as access to care improved and many Group VIII enrollees acquired a usual source of care, large percentages of Group VIII enrollees with preexisting chronic conditions reported that managing their conditions had become easier. Overall, 59.1% of individuals with a chronic condition reported that their condition was easier to manage after enrolling in Medicaid. Changes in ability to manage preexisting hypertension, high cholesterol, and diabetes are reported in Figure 15. As can be seen, more than half of Group VIII enrollees with these conditions reported that their condition had become easier to manage since enrolling in Medicaid, and very few people stated that managing their condition had become harder.

Figure 15. Changes in Ability to Manage Preexisting Chronic Conditions



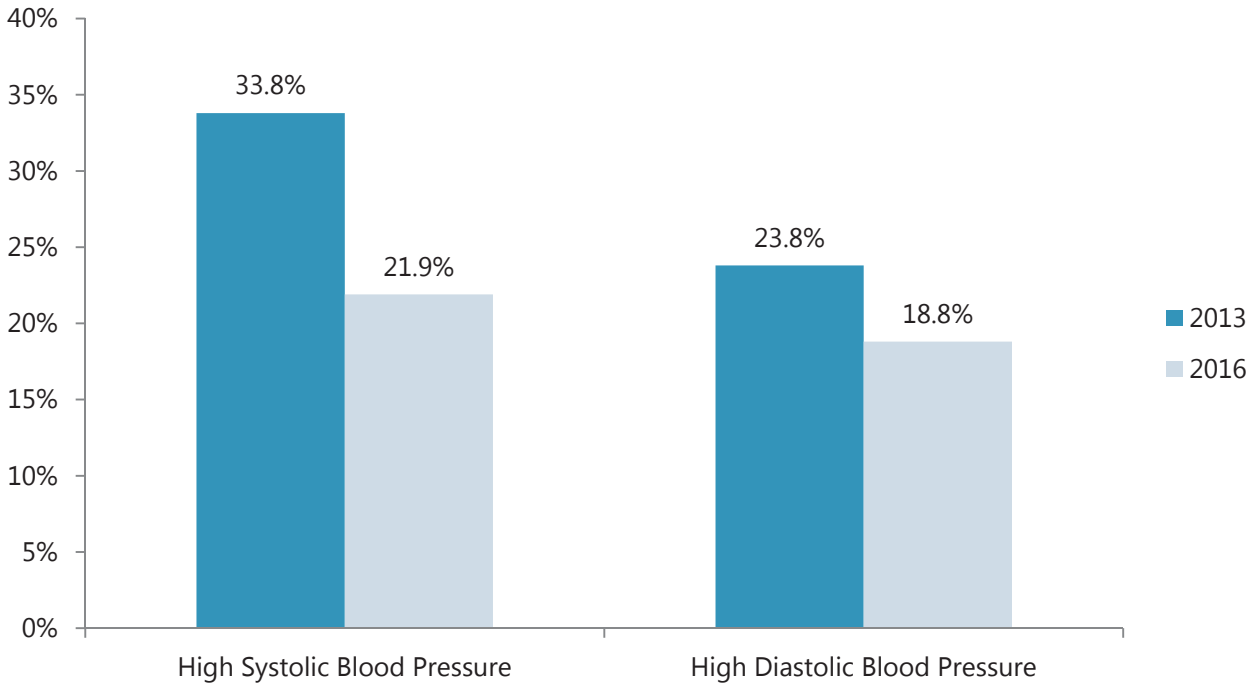
Source: Group VIII Telephone Survey.

Group VIII enrollees who participated in the medical records review were more likely to have appropriate care for their chronic conditions after enrolling in Medicaid. For example, among Group VIII adults aged 40 to 64 years with Type 2 diabetes who visited their usual source of care in both 2013 and 2015-2016, there was nearly a 50% relative increase for statin treatment between the two time periods (29%, up from 21%). Similarly, a substantially greater percentage of Group VIII enrollees diagnosed with depression were receiving antidepressant medications in 2016 (61%), compared to 2013 (48%).

In Medicaid claims data analyses, HEDIS-derived measures were used to assess whether Group VIII enrollees were receiving appropriate clinical care for their chronic conditions, and whether diagnosed risk factors were being effectively treated. As detailed in the Methodology Report, these analyses demonstrated that Group VIII enrollees are making progress in controlling chronic conditions and that Group VIII enrollees were receiving evidence-based treatments at roughly equivalent rates to pre-expansion enrollees. For instance, 79.6% of Group VIII enrollees with diabetes and high blood pressure had their blood pressure under control, compared to 80.5% of pre-expansion enrollees—blood pressure was analyzed because hypertension is a leading risk factor for cardiovascular disease.

Although Group VIII participants had only been enrolled in Medicaid for no more than 2 years, some improvements in physical health were detectable. For example, the medical records review found that, among participants with medical records from both 2013 and 2015-2016, the percentage of patients with high-risk levels of blood pressure (systolic readings of 140 mmHG or above) decreased from 33.8% to 21.9% (Figure 16). Similarly, the percentage of these Group VIII enrollees with a BMI of 40 or greater (very severe obesity) decreased from 17.9% to 16.3%, and the percentage with high-risk levels of cholesterol (240 mg/dL and above) decreased from 10.0% to 3.3%.

Figure 16. Percentage of Group VIII Enrollees in the Medical Records Case Study with High Blood Pressure



Source: Medical Records Case Study.

3. Self-Rated Health Statuses

Group VIII enrollees have experienced improvements in self-rated health statuses (general, dental, vision and mental health). Literature indicates that survey respondents' self-rated health status is a better predictor of overall and general health than many clinical observations.[43,44,45,46] Since Medicaid enrollment, nearly half of Group VIII enrollees (47.7%) reported improvements in their general health status. Only 3.5% stated that their health had gotten worse, while 48.4% stated that their health remained the same. Sixty percent of those who received evidence-based treatment for their chronic conditions[viii] reported improved health status, compared to 46.9% of those who did not receive evidence-based care. Of those reporting a usual source of care, 57.5% reported improved health status, versus 45.5% of people without a usual source of care.[ix]

Compared to Group VIII enrollees, pre-expansion enrollees were less likely to report improvements in their general health status in the past 2 years. Pre-expansion enrollees were about as likely to report that their health had declined as improved, although a majority (65.8%) reported that their health stayed the same (Figure 17). This suggests that enrollment in Medicaid produces a short-term increase in self-rated health status, because people are able to obtain treatment for preexisting conditions (whether previously diagnosed or undiagnosed). As these conditions are managed, Medicaid enrollees—like the general population—are then less likely to report significant improvements in their health from year to year.

Many individuals reported, in response to the question about what getting Medicaid had meant to them, that their physical health, mental health, or quality of life had improved.

[viii] HEDIS-derived measures, Statin Therapy for Patients with Diabetes and Statin Therapy for Patients with Cardiovascular Disease.

[ix] Differences significant at $p < 0.001$.

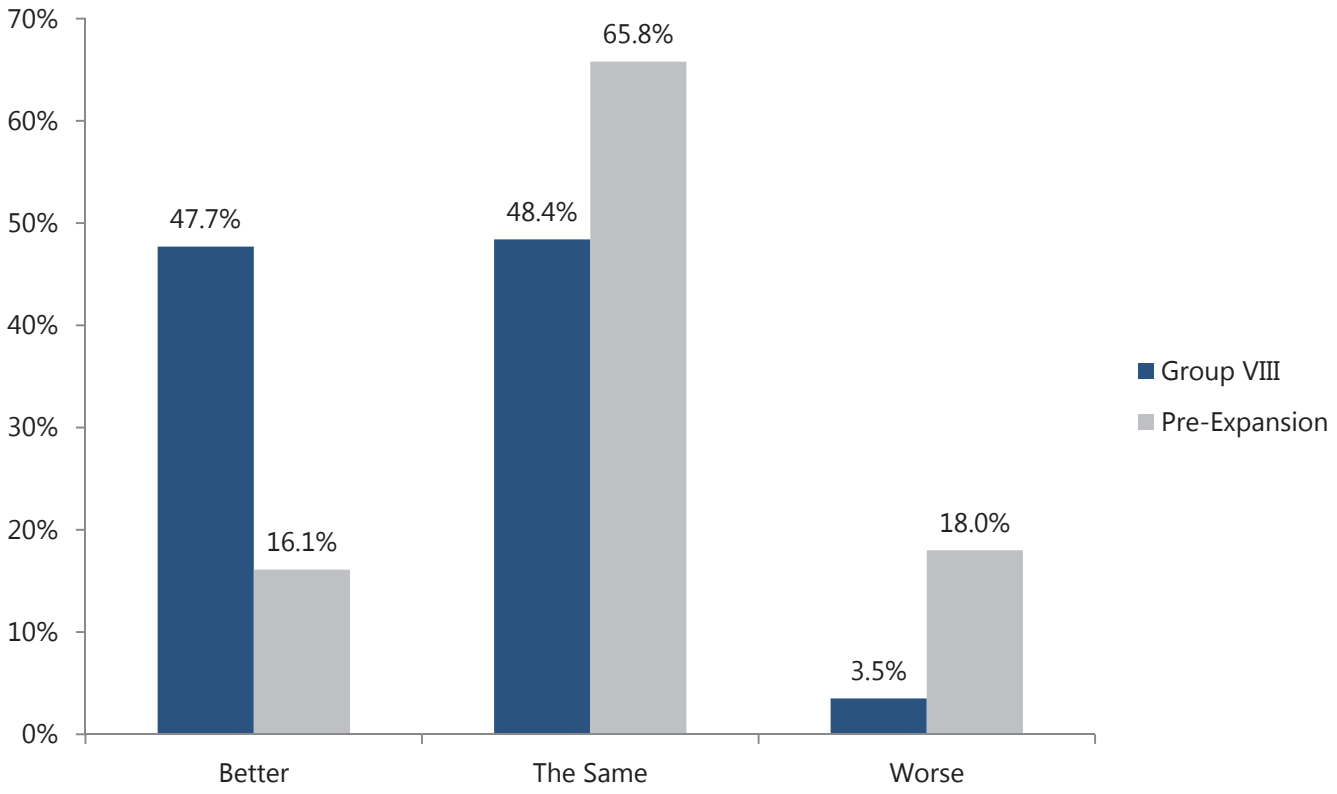
"It's meant that I can treat my Type 2 diabetes correctly, have it under control, which allows me to feel better, and work, and all around my quality of life has improved."

"[Medicaid has] been a godsend. I was diagnose[d] with diabetes and high blood pressure which I did not know I had, and I'm now on medication to take care of those two situation[s]."

"It has saved my life. I have severe mental issues and I have depression and bipolar insanity ADD (Attention Deficit Disorder) and I am on several medications and I would not be able to take care of me if I didn't have Medicaid."

Source: Group VIII Telephone Survey.

Figure 17. Changes in Self-Reported Health Since Enrolling in Medicaid (Group VIII Enrollees) or During the Past Two Years (Pre-Expansion Enrollees)



Source: Group VIII Telephone Survey.

Key Findings

More than one-quarter of Group VIII enrollees were diagnosed with a chronic condition after enrolling in Medicaid, suggesting a high level of unmet medical needs.

Medicaid has enabled those with chronic conditions to obtain evidence-based care. Medical records and Medicaid administrative data demonstrate that Group VIII enrollees are obtaining needed care for their chronic conditions.

Despite the limited time that has passed since Medicaid expansion, Group VIII enrollees are showing improvements in the management of their chronic conditions, including reductions in high-risk levels of blood pressure and cholesterol.

Self-rated health improved for Group VIII enrollees in Ohio; nearly half of all Group VIII survey participants reported that their health is now better than when they enrolled in Medicaid, compared to very few (4%) who reported that their health is worse.

Similar to this study, previous research examining Medicaid expansion has found that enrollment in Medicaid improves self-rated health and enables adults with chronic conditions to receive regular care for those conditions.[1]

V. Changes in Mental Health

Individuals with mental illness historically have higher rates of chronic disease[47] and incur health care costs that are 2-3 times greater than individuals without these conditions.[48] This section identifies the incidence of these complex conditions for Group VIII enrollees and discusses whether they can effectively access treatment with their Medicaid coverage.

Data from this assessment confirmed that Group VIII enrollees with symptoms of mental illness had higher rates of chronic disease – there is evidence that these Group VIII participants are integrating into the health care system at rates comparable to or exceeding those of other Group VIII enrollees. Interviews with Medicaid providers suggest Medicaid expansion has greatly improved access to behavioral health care, but that limited numbers of available providers may pose a challenge in the future.

Several survey respondents mentioned access to mental health and behavioral health care when asked what Medicaid has meant to them.

> "It's helped my mental health and I feel better about myself because I can get the care I need."
>
> "It's meant I've been able to get treated for depression, get prescriptions, go to the doctor and get annual checkups. And dental and vision as well, I couldn't afford health care before."
>
> "Medicaid has meant a great deal. It has enabled me to see my psychiatrist and family doctor. I'm grateful I have Medicaid."
>
> "It has helped me get through the tough times I'm in, as far as getting help with alcohol addiction and mental health care."
>
> Source: Group VIII Telephone Survey

1. Prevalence of Anxiety or Depression

Compared to pre-expansion enrollees, Group VIII enrollees had modestly lower rates of anxiety and depression. Over one-third of pre-expansion enrollees (35.7%) met survey screening criteria[x] for depression, anxiety or both conditions compared to 31.9% of Group VIII enrollees. However, mental health conditions remain a barrier for employment within the Group VIII population, with 17.5% of Group VIII enrollees, compared to 22.5% of pre-expansion enrollees, reporting that a mental health condition kept them from work or other usual activities for 7 days or more in the last month. Overall, Group VIII enrollees meeting the screening criteria for mental illness had an employment rate that was half that of Group VIII enrollees without evidence of mental illness (28.8% versus 51.0%, respectively).

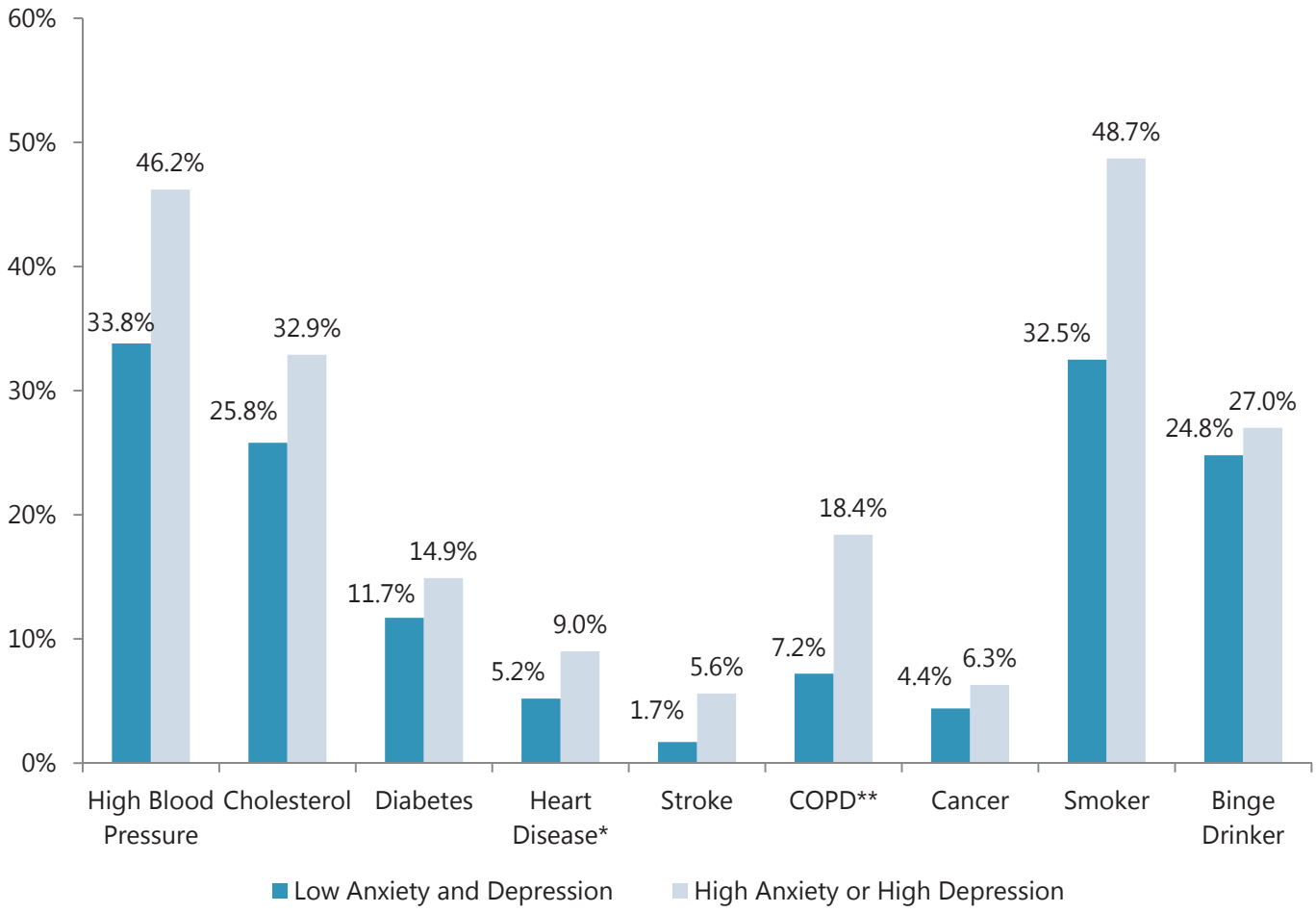
2. Mental Health and Chronic Disease Diagnoses

Consistent with prior analyses from the research team, Ohio Medicaid Group VIII Assessment findings suggest that Group VIII enrollees who met screening criteria for depression and anxiety had higher rates of chronic

[x] A brief screening questionnaire on the PHQ4 standardized screening measure (Kroenke et al., 2010) was used to assess symptoms of depression and anxiety. High scores on this scale suggest that an individual is likely to meet the diagnostic criteria for depression or anxiety.

disease and risk behavior. Comparatively, Medicaid enrollees with a positive depression or anxiety screen were more likely to have a diagnosis for one or more of the following: high blood pressure, high cholesterol, diabetes, heart disease, stroke, chronic obstructive pulmonary disease, and cancer (Figure 18).

Figure 18. Percentage of Group VIII Enrollees With Chronic Condition Diagnoses by Mental Health Screening Status



*Coronary Heart Disease, Heart Attack, or Congestive Heart Failure.

**Emphysema, Chronic Obstructive Pulmonary Disease, or Chronic Bronchitis.

Source: Group VIII Telephone Survey.

3. Access and Utilization of Mental Health Treatment

The survey findings suggest that since Medicaid expansion, Group VIII enrollees with mental illness are making progress in obtaining needed mental health care. Close to half of Group VIII enrollees (44.0%) who met mental health screening criteria reported that access to mental health treatment had become easier, compared to 5.0% who indicated that access had become harder and 43.0% who indicated that it was the same.

Pharmacotherapy treatment for Group VIII enrollees met quality guidelines established by the National Committee for Quality Assurance for 61.7% of enrollees with a clinical diagnosis of depression during the acute phase of their illness, and for 50.9% during their continuation phase. Additionally, 29.4% used psychosocial treatments such as counseling, case management, care coordination, psychotherapy, or relapse prevention in the past year compared to 28.7% for pre-expansion enrollees (psychosocial treatment indicates assistance to psychological development in interaction with an individual's social environment).

4. Access and Utilization of Physical Health Care for Individuals with Mental Health Conditions

Since Medicaid expansion, Group VIII enrollees with mental illness are making progress toward obtaining needed medical care. As mentioned in Section III, 32.2% of Group VIII enrollees reported not having a usual source of care prior to Medicaid expansion. Group VIII enrollees who screened positive for anxiety or depression were more likely to obtain a usual source of care than those who did not screen positive (60.6% versus 57.3%). Those with evidence of a mental health condition also showed greater improvements in access to health care (68.5% versus 62.4%) and access to needed prescriptions (71.2% versus 62.5%).

Despite these results, many Group VIII enrollees who screened for anxiety or depression were more likely than other Group VIII enrollees to report going to the ED more often since enrolling in Medicaid (20.9% versus 13.4%).

5. Substance Use and Misuse

Considering substance use, Group VIII enrollees reported lower tobacco use than pre-expansion enrollees (37.9% versus 39.6%) but higher rates of binge drinking[xi] (25.5% versus 20.5%). However, claims data showed equivalent rates of clinically diagnosed substance abuse or dependence (32.3% for Group VIII enrollees versus 33.8% for pre-expansion enrollees),[xii] and equal rates of diagnosed opiate abuse and dependence (3.6% for each group).[xiii] However, Group VIII enrollees were less likely than pre-expansion enrollees to receive prescriptions for medications associated with abuse and dependence, such as opioids and benzodiazepines (25.6% versus 32.0% for opioids, 10.4% versus 13.6% for benzodiazepines). (Literature and Ohio-specific studies indicate that opioid prescription reforms for pain conditions have lessened the prevalence of prescribing opioids.)

Those with substance use disorders were more likely to report improvement in overall access to care (72.1% versus 60.9%), access to prescription medication (74.4% versus 61.2%), and access to mental health care (44.7% versus 27.7%) than enrollees without substance use disorders. This improvement was even more evident for Group VIII enrollees with an opioid use disorder (75.4% versus 64.0% for overall access to care; 82.7% versus 64.8% for access to prescription medications; and 59.3% versus 32.2% for access to mental health care). This improvement in access to care since enrollment in Medicaid is consistent with research indicating improved access to treatment for opioid and other substance use disorders because of changes in state and federal health policies.[49,50,51,52,53]

These findings suggest that many enrollees with substance use disorder do not receive substance abuse treatment. Only 29.9% for Group VIII enrollees and 28.8% for pre-expansion enrollees with substance use disorders receive psychosocial treatment for substance abuse and, based on pharmacy claims, only 17.9% for Group VIII enrollees and 21.0% for pre-expansion enrollees with opioid use disorders receive Medication Assisted Treatment.

[xi] Binge drinking was defined as having more than four (for women) or five (for men) drinks on one occasion within the past 30 days.

[xii] Including alcohol, cannabis, opioids, sedatives, hypnotics, anxiolytics, cocaine, stimulants, hallucinogens, inhalants, and other psychoactive substances.

[xiii] This finding is based on diagnosed opioid use disorder, which is likely to be an underestimate of the actual prevalence of opioid use disorder.

6. Impact of Medicaid Expansion on the Mental Health and Substance Abuse Treatment System

Stakeholder interviews with behavioral health provider groups found a uniformly positive view of the Medicaid expansion, but stakeholders expressed concern about meeting the increased demand for services, including behavioral health services (particularly substance abuse treatment). In the past, there were not many options for low-income individuals to have coverage for substance abuse treatment. Enrollees with behavioral health issues are now able to get care for their chronic diseases, which are prevalent in this population. Additionally, Medicaid assists individuals with mental illnesses with obtaining housing and employment. Often, these social services contribute to recovery and improvement of mental illness.

Although demand on providers has increased, the supply of providers has remained stagnant. In some public settings, the number of providers has actually decreased because counselors now have more, higher paying options in the private sector.

Key Findings

Compared to pre-expansion enrollees, the Group VIII Telephone Survey screening questions indicated that Group VIII enrollees had modestly lower rates of anxiety and depression, but mental health conditions remain a barrier for employment within the Group VIII population.

Of Group VIII enrollees with positive screens for anxiety or depression, 44.0% reported that access to mental health treatment had become easier since enrolling in Medicaid, while 5.0% indicated that it had become harder.

Group VIII enrollees with evidence of mental illness were more likely to have chronic health conditions, but were integrating into the health care system as levels comparable to or exceeding those of other Group VIII enrollees.

Research from other states has similarly found that Medicaid expansion has increased access to mental health services.[1]

VI. Changes in Financial Hardship and Employment

A goal of all health insurance is to assist in the reduction of family financial stress by providing people with a measure of financial security in the face of medical bills. Prior studies on Medicaid expansion have shown reduction of financial stress to be a key benefit of Medicaid expansion.[1] Research shows that reducing financial stress provides clear physical and mental health benefits.[54,55,56] In addition, reduction of financial stress is associated with lower levels of child and domestic abuse, which reduces health care utilization, and people with less experience of trauma have lower levels of future chronic disease.[57]

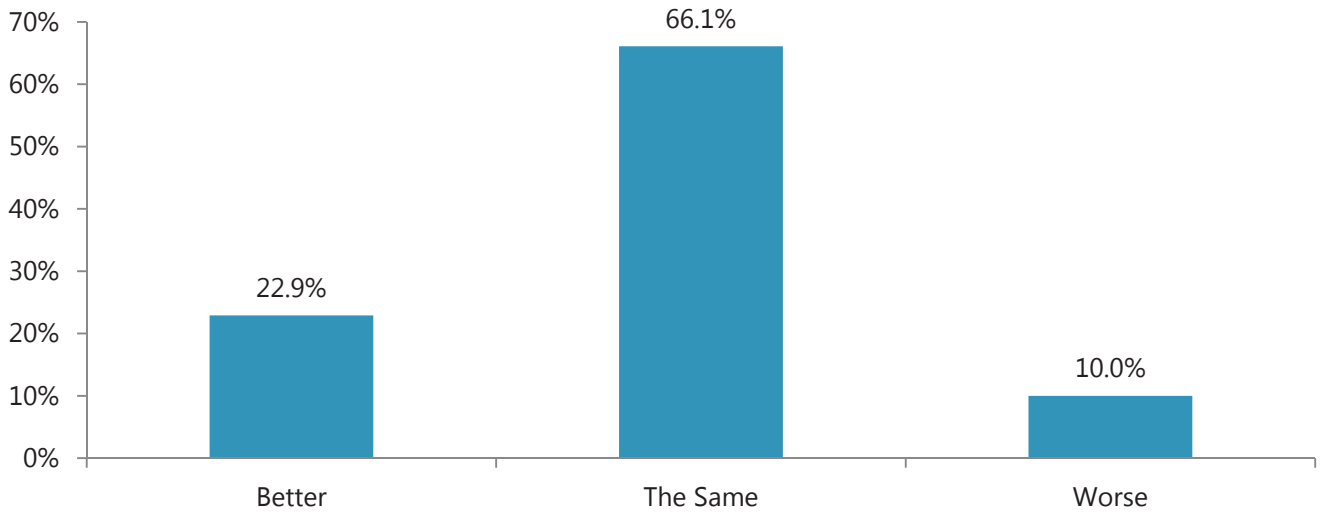
Medicaid reduces financial risks for recipients because it covers most medical costs. This can make household budgeting easier and less stressful because health care utilization and medical expenses are often unpredictable. Group VIII enrollees reported that Medicaid enrollment has enabled them to purchase basic necessities and pay down debt, supported their ability to seek employment, and reduced anxieties about seeking medical care.

1. Changes in Family Finances

Given that for many families health care costs are a major factor that influences household finances, Medicaid has the potential to reduce financial strain by facilitating access to needed care without large out-of-pocket costs.

Among Group VIII enrollees, 22.9% reported an improvement in their financial situation, 10.0% reported worsening finances, and 66.1% reported no change in financial position since enrolling in Medicaid (Figure 19). In other words, Group VIII enrollees, a financially distressed population, were nearly twice as likely to report that their finances were improving instead of worsening since obtaining Medicaid, although the degree to which this result is attributable to Medicaid (as opposed to other changes in a family's financial situation) is unknown. Group VIII enrollees who met screening criteria for depression and anxiety and those who were unemployed were the most likely to report that their financial situation had worsened since joining Medicaid.

Figure 19. Percentage of Group VIII Enrollees Reporting That Their Financial Situation is Better, Worse or the Same Since Enrollment



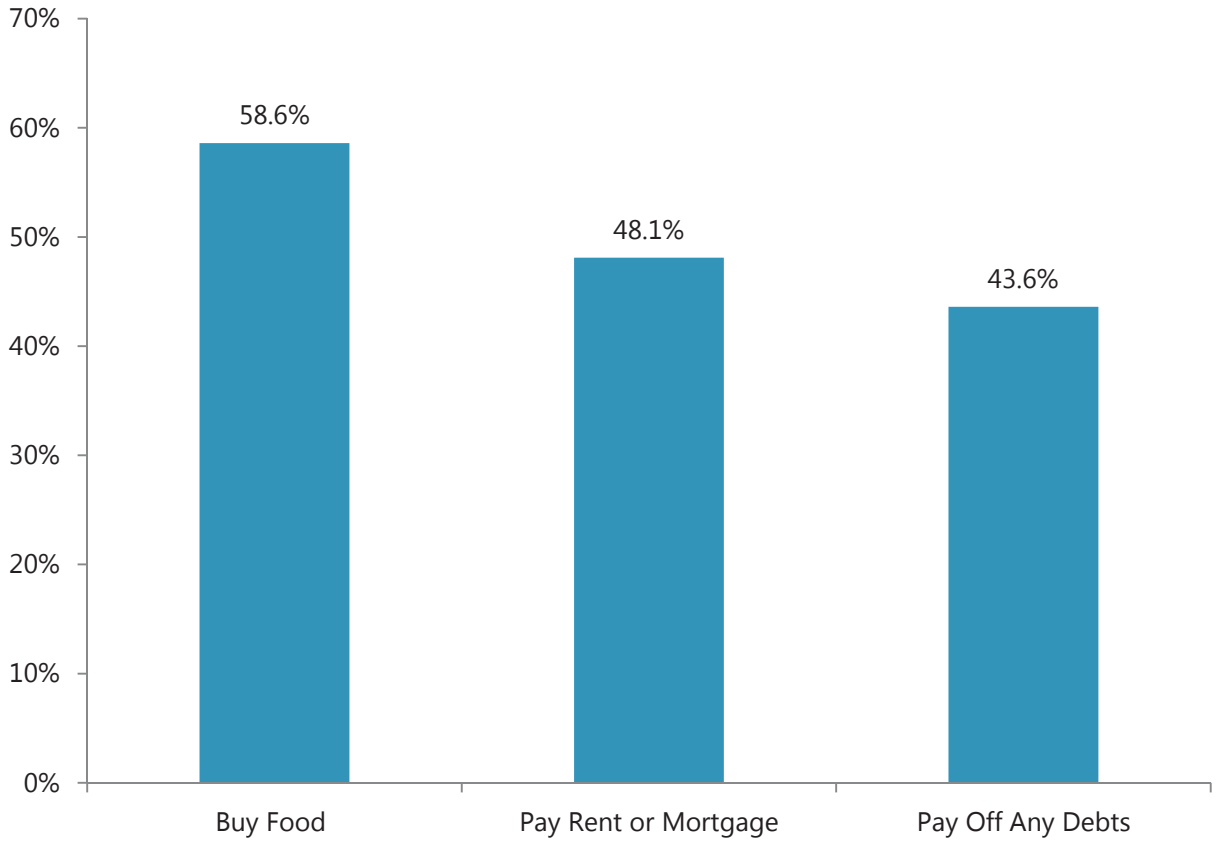
Source: Group VIII Telephone Survey.

One of the ways that Medicaid can promote financial well-being is by freeing up space in the family budget for other necessities, such as food or housing. A majority of Group VIII enrollees (58.6%) reported that it is easier to pay for groceries since getting Medicaid. Close to half of Group VIII enrollees (48.1%) also reported that since getting Medicaid it is easier to remain current on their rent or mortgage and pay off debt (43.6%) (Figure 20).

When asked what getting Medicaid meant to them, nearly one-quarter of Group VIII enrollees mentioned some sort of financial improvement in their household.

> "It has meant me being able to afford food, and paying my rent, and me not worrying about paying for a doctor's visit."
>
> "It has greatly helped me out financially and helped me put food on my table and survive."
>
> "It has given us the freedom to see doctors now to be treated for medical reasons. It also has opened up that now we have more money left for our other expenses like food and such."
>
> Source: Group VIII Telephone Survey.

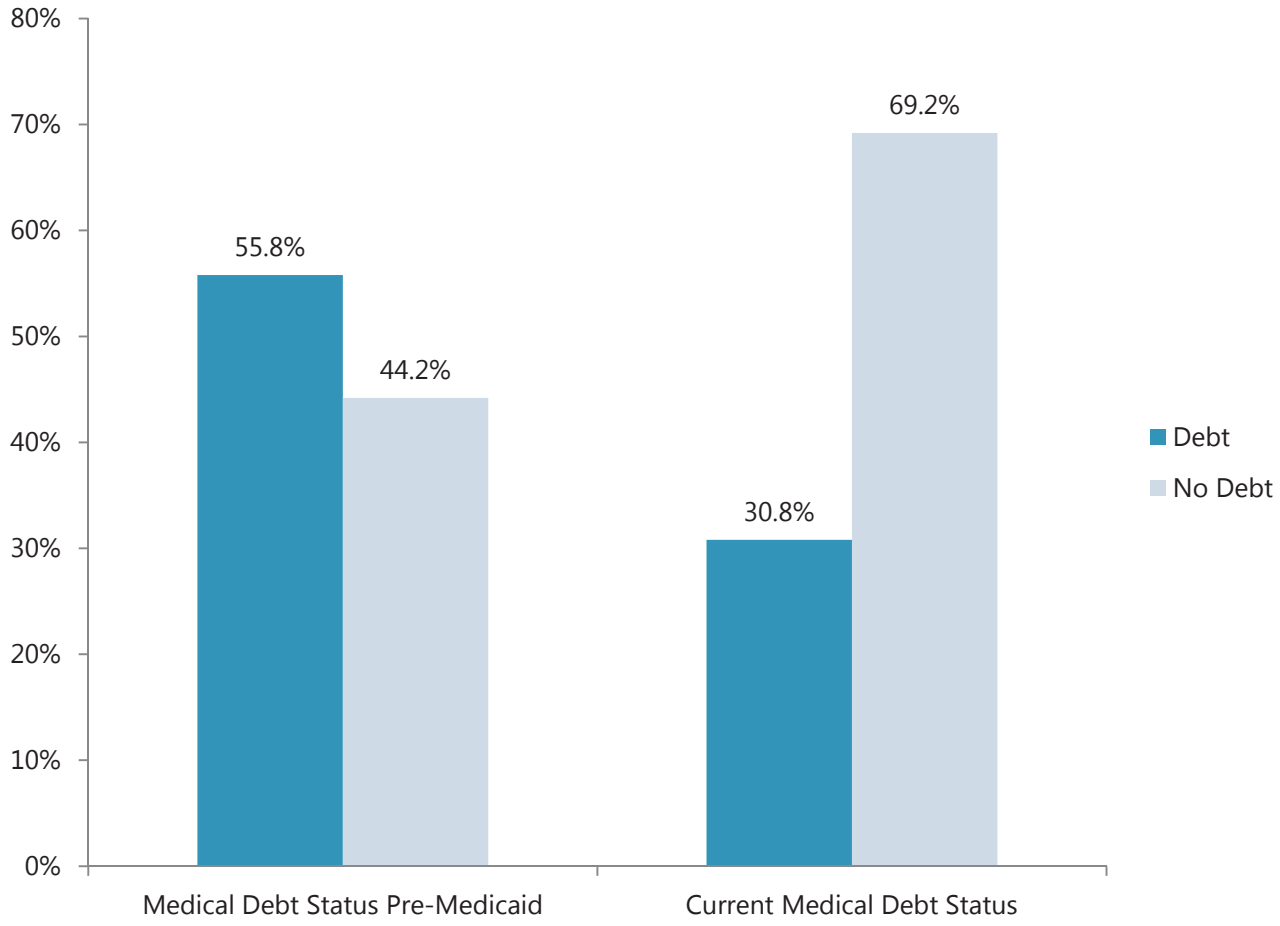
Figure 20. Group VIII Enrollees Reporting That it is Easier to Buy Food, Pay for Housing, and Pay off Debt Since Getting Medicaid Coverage



Source: Group VIII Telephone Survey.

Among the 55.8% of Group VIII enrollees who had medical debt prior to enrollment, 68.0% reported that these debts led them to fall behind on paying bills (Figure 21). At the time of the study, only 30.8% of Group VIII enrollees reported having any medical debt, a 44.8% reduction.

Figure 21. Percentage of Group VIII Enrollees With and Without Medical Debt Before and After Enrolling in Medicaid



Source: Group VIII Telephone Survey.

2. Employment

An additional question about Medicaid expansion is what, if any, influence it has on employment. Studies to date on employment and Medicaid expansion have not reached consensus concerning employment changes or reductions directly related to Medicaid coverage.[58, 59] The Group VIII telephone survey collected information from enrollees on whether having Medicaid assisted in finding work or in maintaining existing work.

A majority of Group VIII enrollees reported that Medicaid has made it easier to secure and maintain employment. Among Group VIII enrollees who are currently employed, 52.1% reported that having Medicaid makes it easier to continue working (Figure 22). Among unemployed Group VIII enrollees looking for work, 74.8% reported that Medicaid makes it easier to look for work. For instance, one focus group respondent mentioned that she had a severe hernia and could not even get out of bed to go to work. After she enrolled in Medicaid, she had the needed surgery and could move around again. She was back to work and feeling much better. When asked what getting Medicaid meant, multiple survey respondents mentioned an improved ability to work when discussing their financial situation.

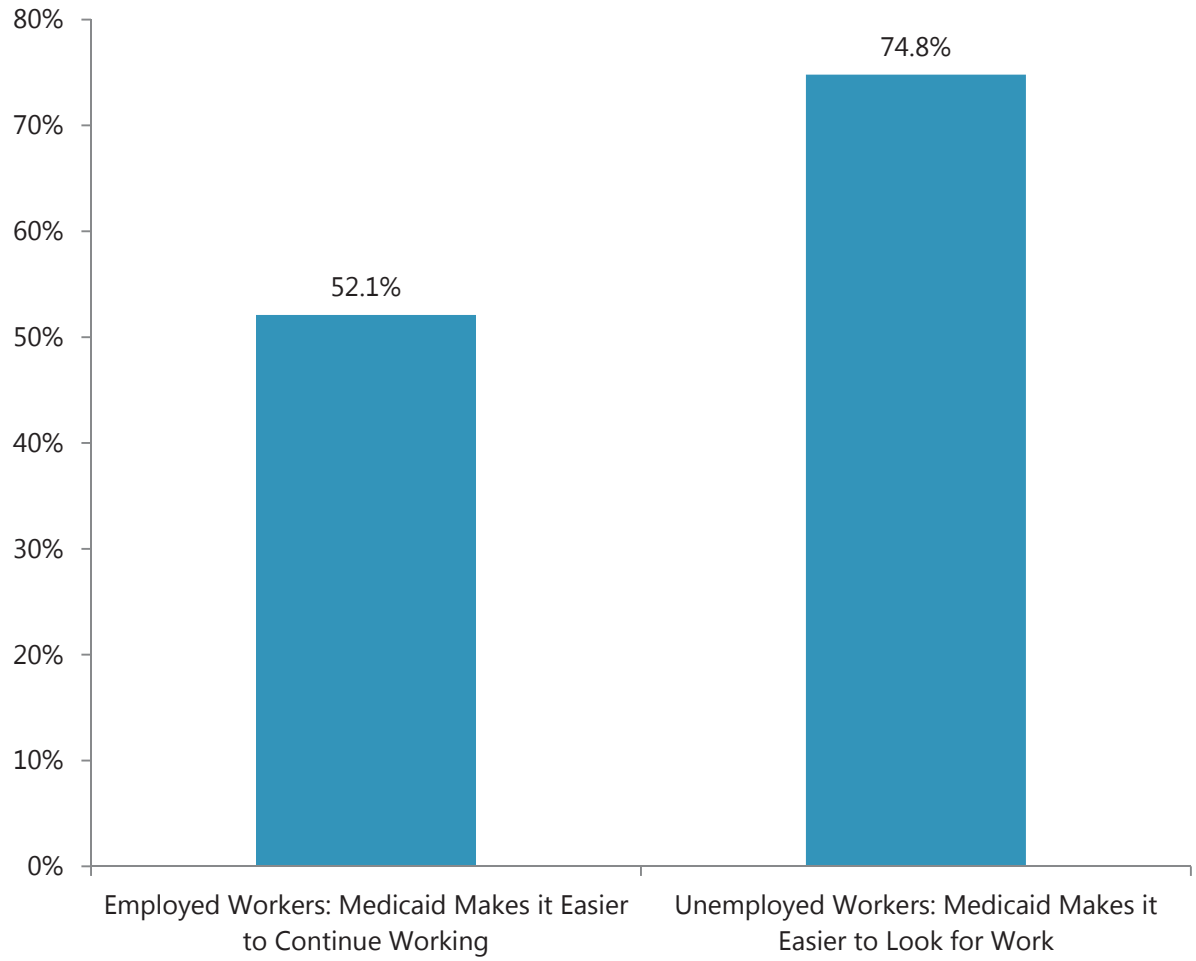
"I had a lot of health problems before but a lot had changed in my life. Now I am able to work more."

"I am finally getting everything that was wrong with me fixed so that I can go back to work. It's a great help."

"Give me the ability to seek employment without worrying about my health."

Source: Group VIII Telephone Survey.

Figure 22. The Effects of Medicaid Enrollment on Employment for Group VIII Enrollees

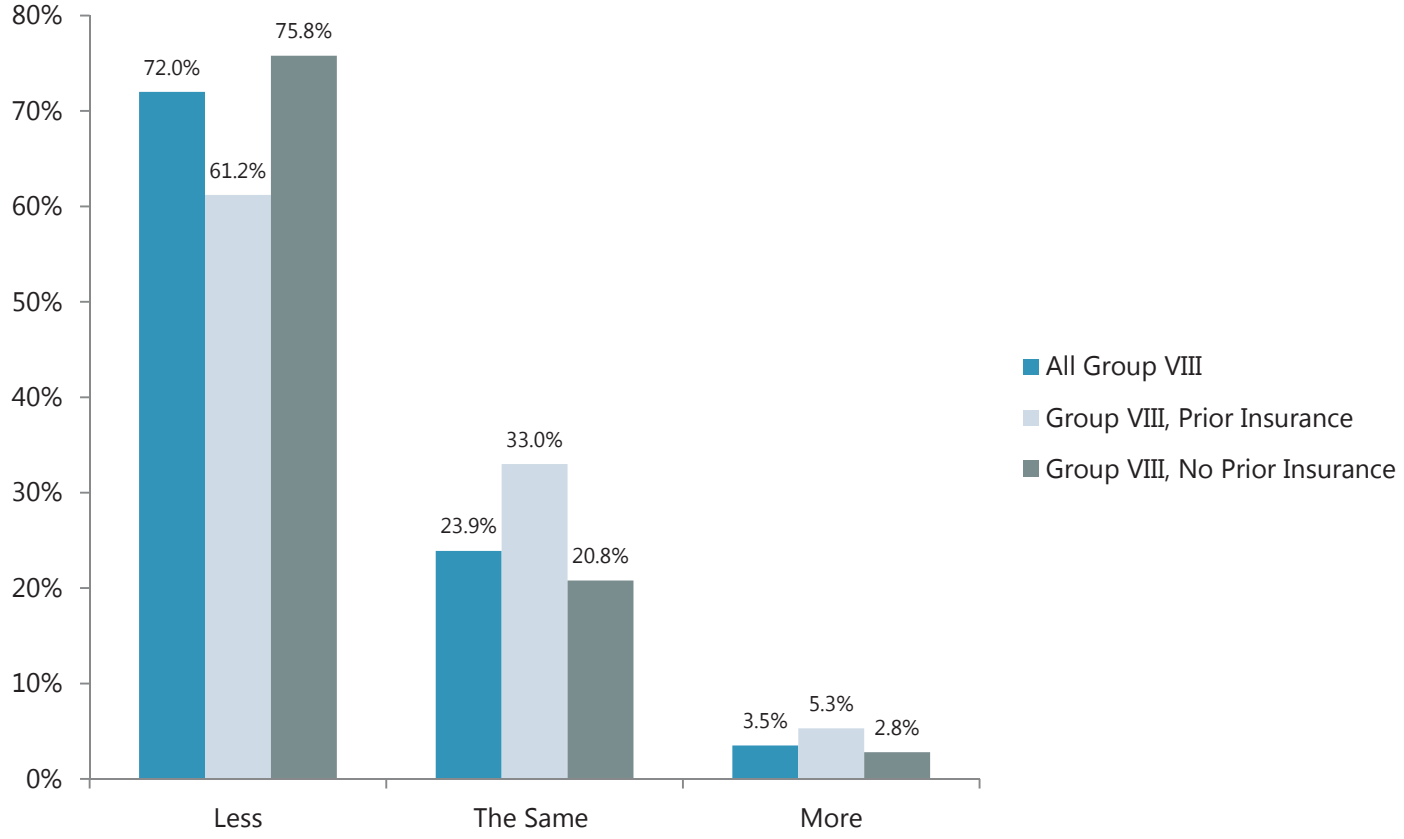


Source: Group VIII Telephone Survey.

3. Worry about Illness, Injury, and Medical Bills

By reducing concern about unaffordable medical costs, enrollment on Medicaid relieves anxiety about becoming ill or injured. Nearly three-fourths of Group VIII enrollees (72.0%) reported having less anxiety about becoming ill and having to go to a doctor since enrolling in Medicaid (Figure 23). Similarly, more than two-thirds of Group VIII enrollees (68.8%) reported less anxiety about getting injured and having to seek medical care.

Figure 23. Group VIII Enrollees' Worry About Getting Sick and Going to Doctor Since Getting Medicaid Coverage

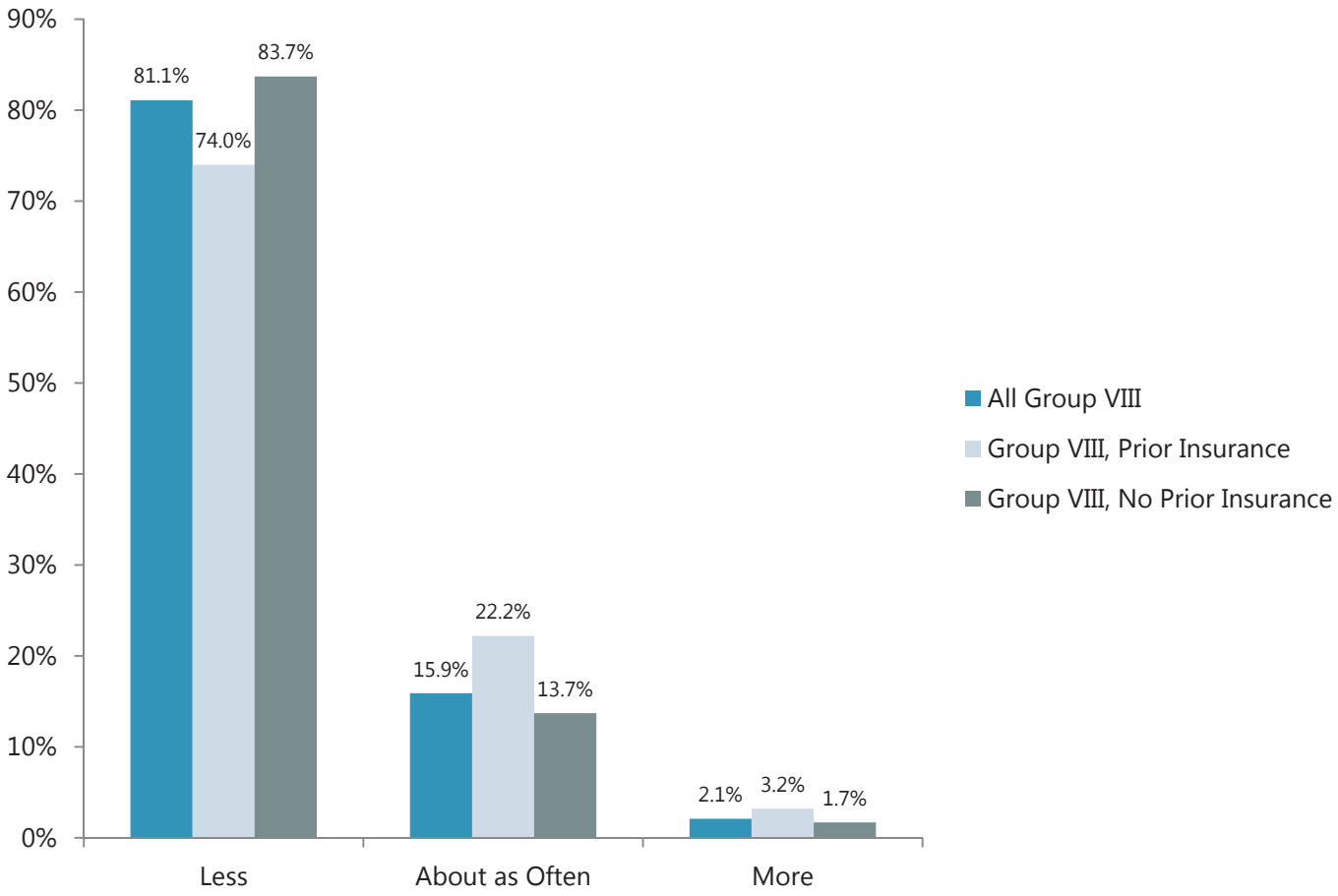


Source: Group VIII Telephone Survey.

Likewise, a large majority of Group VIII enrollees (81.1%) reported that their worry about medical bills has declined since they obtained Medicaid eligibility (Figure 24). Even enrollees who had health insurance in the past reported less worry about medical bills. Over one-quarter of respondents (27.9%) mentioned "relief" in their response to the question about what getting Medicaid meant. Many of these individuals linked relief to less worry about bills.

> "It seems like less stress knowing when having an emergency you don't have to worry about not affording it or been refused services from a hospital."
>
> "[Medicaid] allows me to go to the doctor when I need to instead of not going. It's less worrying about it. It helped me with my mental health."
>
> "It has been a blessing, without it I would be so far in debt from my cancer treatment and medical bills that I incurred. It's been fantastic."
>
> Source: Group VIII Telephone Survey.

Figure 24. Worry About Medical Bills Since Medicaid Eligibility



Source: Group VIII Telephone Survey.

Key Findings

Participation in Medicaid has made it easier for Group VIII enrollees to pay for basic necessities including food and housing.

Medicaid coverage has enabled currently employed Group VIII enrollees to maintain their positions, and it has helped enrollees without jobs to seek employment.

The protection that Medicaid provides against unexpected and unaffordable medical costs significantly reduces enrollees' anxiety about becoming ill or injured.

These findings align with previous research from other states concluding that Medicaid expansion stabilizes participants' household finances, reduces unpaid medical bills and unpaid debt, and reduces stress associated with health care costs.[1] Reduction in stress is associated with improvements in self-rated health. [18, 60, 61]

Prior research comparing expansion and non-expansion states have not found Medicaid expansion to have any significant effects on labor force participation.[59] Group VIII Medicaid enrollees in Ohio, however, believe that Medicaid enrollment has meaningfully enhanced their ability to find and maintain employment.

VII. Conclusions

Ohio's 2014 Medicaid expansion extended health care coverage to more than 702,000 low-income Ohioans as of May 2016. For Group VIII enrollees, access to Medicaid has facilitated access to care, reduced emergency department utilization, improved self-reported health, and supported employment and job-seeking.

In response to the General Assembly's request, this assessment has comprehensively reviewed the effects of Ohio's Medicaid expansion on Group VIII enrollees. This assessment drew on a wide range of data sources including a telephone survey of Medicaid participants, biometric screenings, medical records examinations, Medicaid claims and administrative data, and qualitative interviews. Detailed information about the methodology is included in the Ohio Medicaid Group VIII Assessment Methodology Report.

Key conclusions include the following:

1. Group VIII Participants

Prior to enrolling on Medicaid, most Group VIII enrollees (89.0%) had no health insurance coverage. Medicaid expansion has contributed to the lowest uninsured rate for low-income Ohioans ever recorded. In comparison to pre-expansion enrollees, Group VIII enrollees are more likely to be white, male, with a high school degree or less, and unmarried. They are also more likely to have been diagnosed with a chronic disease and to have at-risk levels of various health indicators.

2. Access and Utilization of Care

Medicaid has improved access to care. Large majorities of Group VIII enrollees report that obtaining care and filling prescriptions has become easier. Additionally inappropriate health system use patterns have shifted, with Group VIII enrollees reducing their use of EDs and connecting instead to usual and appropriate sources of health care.

The reviews of medical records and Medicaid administrative data confirmed that Group VIII participants were increasingly connecting to usual and appropriate sources of care, reducing ED utilization, and obtaining access to evidence-based treatments.

3. Physical Health

Nearly half of Group VIII participants (47.7%) reported that their health has improved since enrolling in Medicaid, compared to only 3.5% reporting worsening health. Those who allowed access to their medical records showed improvements in the treatment of chronic diseases and health risk factors. Since Medicaid enrollment, more than one-quarter of Group VIII participants (27.0%) have been diagnosed with at least one chronic health condition. Many of these chronic conditions would likely have remained undiagnosed and untreated without Medicaid expansion.

4. Mental Health

Approximately one-third of Group VIII enrollees met screening criteria for depression or anxiety disorders, which was slightly lower than the percentage of pre-expansion enrollees with anxiety or depression. These Medicaid participants reported higher levels of improvement in access to care than those without depression and anxiety, and they were more likely to connect to usual and appropriate sources of care after enrolling on Medicaid.

5. Financial and Employment

Enrollment on Medicaid has allowed Group VIII participants to pay for basic necessities such as food and housing, and to pay off medical debt. For example, 58.6% reported that enrollment in Medicaid has made buying food easier.

Group VIII enrollees overwhelmingly reported that having Medicaid coverage made it easier to look for work or to remain employed.

In survey responses, Group VIII enrollees stressed the importance of Medicaid enrollment to their health and their financial situation.

6. Providers and Stakeholders

Providers and stakeholders also discussed the positive impacts of Medicaid expansion and the role it had played in expanding access to health care for low-income Ohioans. Some providers and stakeholders did, however, object to the reimbursement rates provided by Medicaid—an issue that predates Medicaid expansion and is beyond the scope of this assessment.

Many reported that the access to care facilitated by Medicaid allowed enrollees to learn about and seek treatment for previously undiagnosed—and sometimes life-threatening—medical conditions.

7. Final Conclusion

In summary, the consensus of data collected in the Ohio Medicaid Group VIII Assessment is that Ohio's Medicaid expansion has been beneficial to Ohio's Group VIII enrollees in terms of the following:

- Expanding access to care
- Facilitating more appropriate forms of health care utilization
- Detecting previously undiagnosed health conditions
- Supporting employment and job-seeking
- Reducing financial hardship and medical debt

These results suggest that Medicaid expansion has and will continue to improve the health of low-income Ohioans enrolled in Medicaid expansion.

Note: The Ohio Medicaid Group VIII Assessment project was conducted by a partnership of the Ohio Colleges of Medicine Government Resource Center, The Ohio State University College of Public Health, Ohio University, and RTI International for submission to the Director of the Ohio Department of Medicaid. The content of this report is the responsibility of this partnership.

VIII. References

[1] Antonisse, L., Garfield, R., Rudowitz, R., & Artiga, S. (2016). *The effects of Medicaid Expansion under the ACA: Findings from a literature review*. Kaiser Family Foundation. Available at http://kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review/

[2] Sommers, B. D., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2016). Changes in utilization and health among low-income adults after Medicaid expansion or expanded private insurance. *JAMA Internal Medicine*, *176*(10), 1501-1509.

[3] Shartzer, A., Long, S. K., & Anderson, N. (2015). Access to care and affordability have improved following Affordable Care Act implementation; problems remain. *Health Affairs*, 10-1377.

[4] Sommers, B. D., Blendon, R. J., & Orav, E. J. (2016). Both the 'private option' and traditional Medicaid expansions improved access to care for low-income adults. *Health Affairs*, *35*(1), 96-105.

[5] Sommers, B. D., Gunja, M. Z., Finegold, K., & Musco, T. (2015). Changes in self-reported insurance coverage, access to care, and health under the Affordable Care Act. *JAMA*, *314*(4), 366-374.

[6] Aitken, M., Kleinrock, M., Lyle, J., Nass, D., & Caskey, L. (2015). Medicines use and spending shifts. A review of the use of medicines in the US in 2014. IMS Institute for Healthcare Informatics, NJ. Available at www.imshealth.com/en.

[7] Gray, J., Zink, A. & Dreyfus, T. (2016). *Effects of the Affordable Care Act through 2015*. athenaResearch and Robert Wood Johnson Foundation ACA View Report. Available at http://www.athenahealth.com/~/media/athenaweb/files/pdf/acaview_tracking_the_impact_of_health_care_reform.

[8] Gray, J., Sung, I., & Richardson, S. (2015). *Observations on the Affordable Care Act: 2014*. athenaResearch and Robert Wood Johnson Foundation ACA View Report. Available at http://www.athenahealth.com/~/media/athenaweb/files/pdf/acaview_year_end_2014.pdf.

[9] Wherry, L. R., & Miller, S. (2016). Early coverage, access, utilization, and health effects associated with the Affordable Care Act Medicaid expansions: A quasi-experimental study. *Annals of Internal Medicine*, *164*(12), 795-803.

[10] Benitez, J. A., & Creel, L. (2016). Kentucky's Medicaid expansion showing early promise on coverage and access to care. *Health Affairs*, *35*(3), 528-534.

[11] Artiga, S., & Rudowitz, R. (2015). *How have state Medicaid expansion decisions affected the experiences of low-income adults?* Perspectives from Ohio, Arkansas, and Missouri. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Available at http://kff.org/medicaid/issue-brief/how-have-state-medicaid-expansion-decisions-affected-the-experiences-of-low-income-adults-perspectives-from-ohio-arkansas-and-missouri/.

[12] DiPietro, B., Artiga, S., & Gates, A. (2014). *Early impacts of the Medicaid expansion for the homeless population*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Available at http://kff.org/uninsured/issue-brief/early-impacts-of-the-medicaid-expansion-for-the-homeless-population/.

[13] Deloitte Development LLC. (2015). *Commonwealth of Kentucky Medicaid expansion report*. Deloitte Development LLC. Available at http://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf.

[14] Government Accountability Office. (2015). *Behavioral health: Options for low-income adults to receive treatment in selected states*. Washington, DC: Government Accountability Office. Available at http://www.gao.gov/assets/680/670894.pdf.

[15] Artiga S., Tolbert J., & Rudowitz R. (2015). *Year two of the ACA coverage expansions: On-the-ground experiences from five states*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Available at http://kff.org/health-reform/issue-brief/year-two-of-the-aca-coverage-expansions-on-the-ground-experiences-from-five-states/.

[16] Shin, P., Sharac, J., Zur, J., Rosenbaum, S., & Paradise, J. (2015). Health center patient trends, enrollment activities, and service capacity: Recent experience in Medicaid expansion and non-expansion states. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Available at http://kff.org/medicaid/issue-brief/health-center-patient-trends-enrollment-activities-and-service-capacity-recent-experience-in-medicaid-expansion-and-non-expansion-states/.

[17] Tipirneni, R., Rhodes, K. V., Hayward, R. A., Lichtenstein, R. L., Reamer, E. N., & Davis, M. M. (2015). Primary care appointment availability for new Medicaid patients increased after Medicaid expansion in Michigan. *Health Affairs*, *10*-1377.

[18] Simon, K., Soni, A., & Cawley, J. (2016). The impact of health insurance on preventive care and health behaviors: Evidence from the 2014 ACA Medicaid expansions (No. w22265). National Bureau of Economic Research.

[19] Arkansas Health Reform Legislative Task Force. (2015). *Health Care Task Force preliminary report*. Arkansas Health Reform Legislative Task Force. Available at http://www.arkleg.state.ar.us/assembly/2015/Meeting%20Attachments/836/I14218/Task%20Force%20report%2012-17-15%20sent%20to%20Jill.pdf.

[20] Kaufman, H. W., Chen, Z., Fonseca, V. A., & McPhaul, M. J. (2015). Surge in newly identified diabetes among Medicaid patients in 2014 within Medicaid expansion states under the Affordable Care Act. *Diabetes Care*, *38*(5), 833-837.

[21] Hu, L., Kaestner, R., Mazumder, B., Miller, S., & Wong, A. (2016). *The effect of the Patient Protection and Affordable Care Act Medicaid expansions on financial well-being* (No. w22170). National Bureau of Economic Research.

[22] Pottick, K. J., & Lerman, P. (1991). Maximizing survey response rates for hard-to-reach inner-city populations. *Social Science Quarterly*, *72*(1), 172-180.

[23] Helakorpi, S., Mäkelä, P., Holstila, A., Uutela, A., & Vartiainen, E. (2015). Can the accuracy of health behaviour surveys be improved by non-response follow-ups? *The European Journal of Public Health*, *25*(3), 487-490.

[24] Blair, J., Czaja, R. F., & Blair, E. A. (2013). *Designing surveys: A guide to decisions and procedures*. Sage Publications.

[25] McLeod, C. C., Klabunde, C. N., Willis, G. B., & Stark, D. (2013). Health care provider surveys in the United States, 2000–2010 a review. *Evaluation & the Health Professions*, *36*(1), 106-126.

[26] Gundersen, D. A., ZuWallack, R. S., Dayton, J., Echeverría, S. E., & Delnevo, C. D. (2013). Assessing the feasibility and sample quality of a national random-digit dialing cellular phone survey of young adults. *American Journal of Epidemiology*, kwt226.

[27] Norman, G. J., Heltemes, K. J., & Drew, J. (2014). Examining incentive design strategies for worksite wellness program engagement. *Population Health Management*, *17*(6), 324-331.

[28] Allen, H. (2015). Moving forward on the Medicaid debate: Lessons from the Oregon experiment. *Health & Social Work*, *40*(1), 3-9.

[29] RTI International. (2015). *2015 Ohio Medicaid Assessment Survey methodology report*. Available at http://grc.osu.edu/sites/default/files/inline-files/12015OMASMethReptFinal121115psg.pdf.

[30] Seiber, E. E., & Sahr, T. R. (2011). Public–private substitution among Medicaid adults: Evidence from Ohio. *Medicare & Medicaid Research Review*, *1*(1).

[31] Seiber, E. E., & Sahr, T. R. (2015). *Update on public-private substitution among Medicaid adults in Ohio*. Available at http://grc.osu.edu/sites/default/files/inline-files/OMASBriefPublicPrivateSub031416FINAL_0.pdf.

[32] Ayanian, J. Z., Weissman, J. S., Schneider, E. C., Ginsburg, J. A., & Zaslavsky, A. M. (2000). Unmet health needs of uninsured adults in the United States. *JAMA*, *284*(16), 2061-2069.

[33] Davis, K. (2007). Uninsured in America: Problems and possible solutions. *British Medical Journal*, *334*(7589), 346-348.

[34] Wilper, A. P., Woolhandler, S., Lasser, K. E., McCormick, D., Bor, D. H., & Himmelstein, D. U. (2008). A national study of chronic disease prevalence and access to care in uninsured US adults. *Annals of Internal Medicine*, *149*(3), 170-176.

[35] LaCalle, E., & Rabin, E. (2010). Frequent users of emergency departments: The myths, the data, and the policy implications. *Annals of Emergency Medicine*, *56*(1), 42-48.

[36] Kirby, J. B. (2010). *Main reason for not having a usual source of care: Differences by race, ethnicity, income, and insurance status*. Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey Statistical Brief 308, 1-5. Available at https://meps.ahrq.gov/data_files/publications/st308/stat308.pdf.

[37] Billings, J., Parikh, N., & Mijanovich, T. (2000). Emergency department use in New York City: A substitute for primary care? *Issue Brief (Commonwealth Fund)*, (433), 1-5.

[38] National Prevention Council. (2011). *National Prevention Strategy*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General.

[39] American Association of Clinical Endocrinologists (www.aace.com).

[40] American College of Cardiology (www.acc.org).

[41] Salami, J. A., Warraich, H., Valero-Elizondo, J., Spatz, E. S., Desai, N. R., Rana, J. S., & Blumenthal, R. S. (2016). National trends in statin use and expenditures in the US adult population from 2002 to 2013: Insights from the Medical Expenditure Panel Survey. *JAMA Cardiology*. doi:10.1001/jamacardio.2016.4700

[42] Healthy Families 2020 Blood Pressure Control (HDS-12) Target (www.healthypeople.gov).

[43] Idler, E. L., & Benyamini, Y. (1997). Self-rated health and mortality: A review of twenty-seven community studies. *Journal of Health and Social Behavior*, *38*(1), 21-37.

[44] Meurer, L. N., Layde, P. M., & Guse, C. E. (2001). Self-rated health status: A new vital sign for primary care? *Wisconsin Medical Journal*, *100*(7), 35-39.

[45] Miilunpalo, S., Vuori, I., Oja, P., Pasanen, M., & Urponen, H. (1997). Self-rated health status as a health measure: The predictive value of self-reported health status on the use of physician services and on mortality in the working-age population. *Journal of Clinical Epidemiology*, *50*(5), 517-528.

[46] Lopez, R. (2004). Income inequality and self-rated health in US metropolitan areas: A multi-level analysis. *Social Science & Medicine*, *59*(12), 2409-2419.

[47] Parks, J., Svendsen, D., Singer, P., Foti, M. E., & Mauer, B. (2006). *Morbidity and mortality in people with serious mental illness*. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, 25.

[48] Melek, S. P., Norris, D. T., & Paulus, J. (2014). *Economic impact of integrated medical-behavioral healthcare*. Milliman American Psychiatric Association Report.

[49] Knudsen, H. K., Lofwall, M. R., Havens, J. R., & Walsh, S. L. (2015). State's implementation of the Affordable Care Act and the supply of physicians waivered to prescribe buprenorphine for opioid dependence. *Drug and Alcohol Dependence*, *157*(1), 36-43.

[50] Dick, A. W., Pacula, R. L., Gordon, A. J., Sorbero, M., Burns, R. M., Leslie, D. L., & Stein, B. D. (2015). Increasing potential access to opioid agonist treatment in U.S. treatment shortage areas. *Health Affairs*, *34*(6), 1028-1034.

[51] Burns, R. M., Pacula, R. L., Bauhoff, S., Gordon, A. J., Hendrikson, H., Leslie, D. L., & Stein, B. D. (2016). Policies related to opioid agonist therapy for opioid use disorders: The evolution of state policies from 2004 to 2013. *Substance Abuse*, *37*(1), 63-69.

[52] Ducharme, L. J., & Abraham, A. J. (2008). State policy influence on the early diffusion of buprenorphine in community treatment programs. *Substance Abuse Treatment, Prevention, and Policy*, *3*(1), 1.

[53] Baxter, J. D., Clark, R. E., Samnaliev, M., Leung, G. Y., & Hashemi, L. (2011). Factors associated with Medicaid patients' access to buprenorphine treatment. *Journal of Substance Abuse Treatment*, *41*(1), 88-96.

[54] Sweet, E., Nandi, A., Adam, E. K., & McDade, T. W. (2013). The high price of debt: Household financial debt and its impact on mental and physical health. *Social Science & Medicine*, *91*, 94-100.

[55] Price, S. J., Price, C. A., & McKenry, P. C. (Eds.). (2010). *Families & change: Coping with stressful events and transitions*. Sage.

[56] Choi, L. (2009). Financial stress and its physical effects on individuals and communities. *Community Development Investment Review*, *5*(3), 120-122.

[57] Steinman, K. (2010). *Family violence in Ohio: Statewide assessment report*. Available at http://grc.osu.edu/sites/default/files/inline-files/Family_Violence_in_Ohio_Statewide_Assessment_Report%5B1%5D.pdf.

[58] Leung, P., & Mas, A. (2016). *Employment effects of the ACA Medicaid expansions*. Princeton University, Department of Economics, Industrial Relations Section.

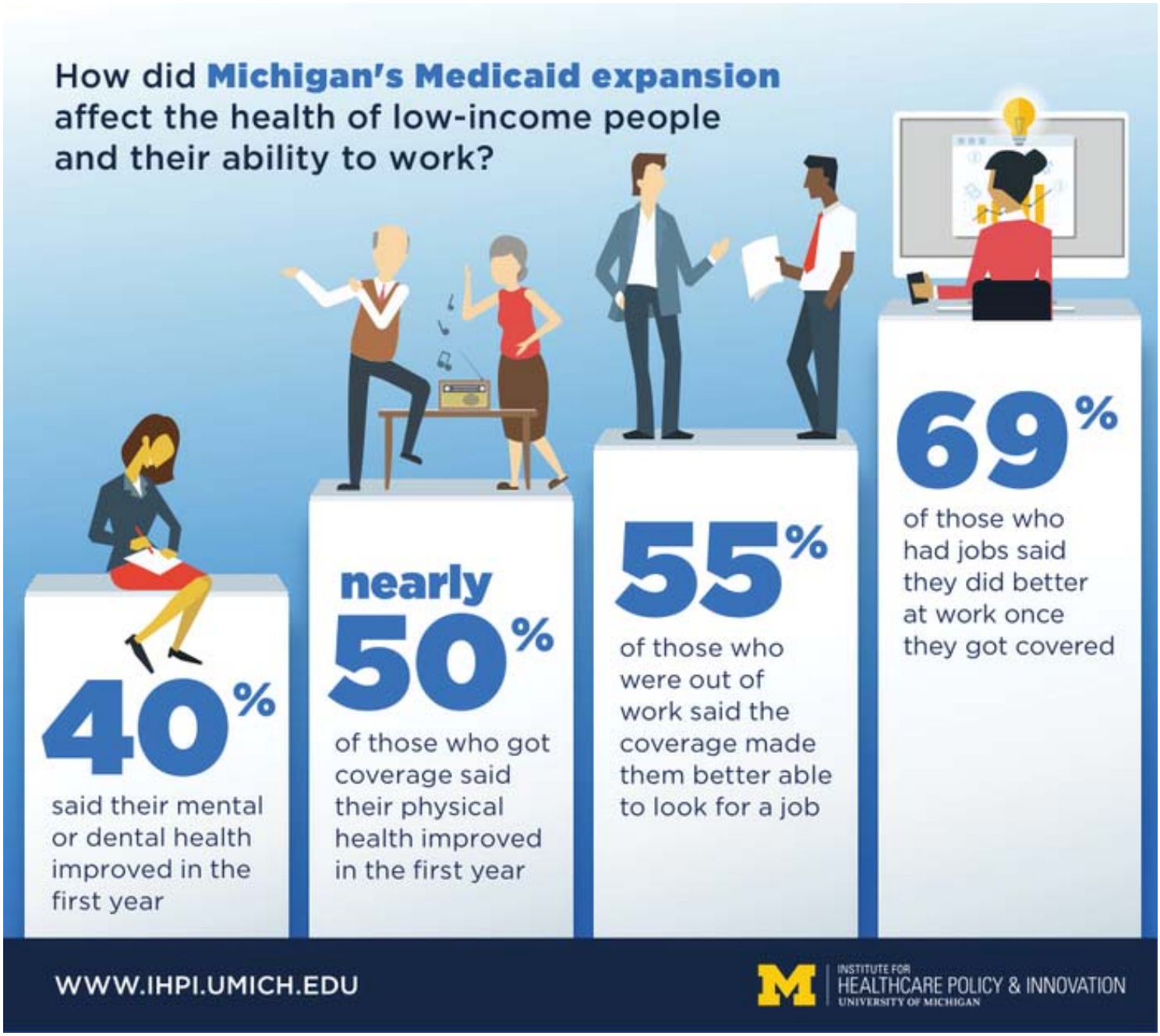
[59] Gooptu, A., Moriya, A. S., Simon, K. I., & Sommers, B. D. (2016). Medicaid expansion did not result in significant employment changes or job reductions in 2014. *Health Affairs*, *35*(1), 111-118.

[60] Adler, N. E., & Newman, K. (2002). Socioeconomic disparities in health: Pathways and policies. *Health Affairs*, *21*(2), 60-76.

[61] Moor, I., Spallek, J., & Richter, M. (2016). Explaining socioeconomic inequalities in self-rated health: A systematic review of the relative contribution of material, psychosocial and behavioural factors. *Journal of Epidemiology and Community Health*, 1-11. doi:jech-2016-207589

JUNE 27, 2017

Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches



NEW ORLEANS – Most low-income Michigan residents who signed up for the state's expanded Medicaid program say their new health insurance helped them do a better job at work, or made it easier for them to seek a new or better job, in the first year after they enrolled, according to a new study.

That's on top of the positive health effects that many said their new coverage brought them, University of Michigan researchers report at the annual research meeting of the AcademyHealth research organization.

In all, 69 percent of those who had jobs said they did better at work once they had health insurance under the Healthy Michigan Plan, the name of Michigan's Medicaid expansion under the Affordable Care Act.

And 55 percent of those who were out of work said the coverage made them better able to look for a job. Eighty percent of the 4,090 people surveyed had incomes below the federal poverty level, and 28 percent were out of work.

Better health through coverage

In all, nearly half of the newly covered Michiganders said their physical health improved in the first year of coverage, and nearly 40 percent said their mental or dental health got better.

Those who said their health improved also had the most chance of experiencing an effect on their work life. As a group, they were four times more likely to say that getting Medicaid coverage helped them do a better job at work. And those who felt their health had improved, but were out of work, were three times as likely to say that their coverage helped them look for a job.

Lead researcher Renuka Tipirneni, M.D., M.Sc., says that she and her colleagues at the U-M Institute for Healthcare Policy and Innovation were surprised at how many reported better health after a short period of coverage. Studies in other expansion states have not shown overall improvement so soon.

Renuka Tipirneni, M.D., M.Sc.

But the impact on employment was even more surprising, she says, and has implications for current debates in state and federal public policy, including proposals to require Medicaid enrollees to work or actively seek work.

"Having health insurance, and being able to take care of one's health as a result, has a large positive impact on a person's ability to do a better job at work or seek employment," she says. "Given that a large portion of those with chronic illness or

poor health are already working, this has many implications for the way we structure Medicaid programs."

How the study was done

Tipirneni and her colleagues performed the survey of a representative sample of Healthy Michigan Plan enrollees, and detailed structured interviews with 67 participants, in 2015 and 2016 as part of the official federally mandated evaluation of the program. They communicated with participants in their choice of English, Spanish or Arabic.

IHPI holds a contract with the Michigan Department of Health and Human Services to carry out that evaluation, and the new data are also described in a report that will be made available on the website of the federal Medicare/Medicaid agency. In all, 672,576 Michigan residents are covered by the plan.

At the AcademyHealth meeting, Tipirneni laid out the findings of the survey, including new data about what Healthy Michigan plan enrollees say about their own health.

Impact of coverage on work

Working-class Michiganders with chronic health conditions made up more than two-thirds of all those surveyed and nearly half of those who were working. They reported a significant increase in their ability to do a good job at work in their first year of coverage.

One-third of the participants who said they were in fair or poor health held down jobs nonetheless – and a slightly smaller percentage of this group said they were out of work.

"Our findings show that many people in the Healthy Michigan Plan who aren't healthy overall are working nonetheless, and so are many people with chronic conditions," says Tipirneni. "We intend to study these participants in future work, to understand what factors influence their ability to hold or seek employment."

The remaining third of those who said their health was fair or poor said they weren't working because illness, disability or other issues made them unable to. The

researchers did not ask about caregiving responsibilities that might have accounted for some people's inability to work.

The in-depth, structured interviews with selected participants revealed some of the personal stories behind the numbers. For instance, they described how receiving mental health care had made them more able to work, or how having dental work done under the plan's coverage had allowed them to feel more professional when looking for jobs.

The Healthy Michigan Plan coverage is open to any Michigan resident making less than 133 percent of the federal poverty level. A person working a full-time job at Michigan's 2016 minimum wage of $8.50 per hour would make just over that threshold if they lived alone, but would be eligible for Healthy Michigan Plan coverage if they support a child or another adult who doesn't or can't work.

More information about the Healthy Michigan Plan evaluation, and other Medicaid-related research being conducted by IHPI members based at the University of Michigan, is available at http://ihpi.umich.edu/initiatives/healthy-michigan-plan (http://ihpi.umich.edu/initiatives/healthy-michigan-plan)

Tipirneni's co-authors on the study are IHPI members and U-M faculty Jeffrey Kullgren, John Ayanian, Edith Kieffer, Ann-Marie Rosland, Tammy Chang, Adrianne Haggins, Sarah Clark, Sunghee Lee, and Susan Goold, and research staff Erica Solway, Erin Beathard, Christina Mrukowicz and Matthias Kirch. Other IHPI evaluation team members that contributed to this study include Erin Sears, Lisa Szymecko, Tolu Olorode, Cengiz Salman, Zachary Rowe, and Community Advisory Board members.

The team is also presenting other findings about Michigan's Medicaid expansion in research posters at the AcademyHealth meeting, including:

- Survey results (https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/16329) and structured interview results (https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/16388) suggesting that Healthy Michigan Plan enrollees reduced their reliance on

urgent care clinics and emergency departments, and increased their use of primary care, after enrolling.

- Data showing (https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/18196) that enrollees who had mental health or substance use issues had better access to care and better mental health after enrolling
- Findings (https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/16388) about the impact of the Michigan plan's dental care provisions, showing that it improved the health of their teeth and gums but that many enrollees were not aware of the benefit.
- An evaluation (https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/16388) of the early impact of the Michigan plan's cost-sharing features, which were intended to encourage enrollees to be cost-conscious about their care.
- An exploration (https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/16237) of the program's impact on enrollees who have chronic health conditions, or were found to have them after seeking medical care with their new coverage.
- A report (https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/16391) on how low-income Michiganders would want to allocate coverage if they were designing a plan for people like themselves, given a set amount of resources, including the cost and access tradeoffs they would be willing to make.

Featured IHPI Members

Renuka Tipirneni, M.D., M.Sc. (/our-experts/rtipirne),
John Ayanian, M.D., M.P.P. (/our-experts/ayanian),
Jeffrey Kullgren, M.D., M.S., M.P.H. (/our-experts/jkullgre),
Susan Goold, M.D., M.H.S.A., M.A. (/our-experts/sgoold),
Edith Kieffer, Ph.D., M.P.H. (/our-experts/ekieffer),
Ann-Marie Rosland, M.D., M.S. (/our-experts/arosland),
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Adrianne Haggins , M.D., M.S. (/our-experts/ahaggins),
Sarah Clark , M.P.H. (/our-experts/saclark),
Sunghee Lee , Ph.D., M.S. (/our-experts/sungheel)

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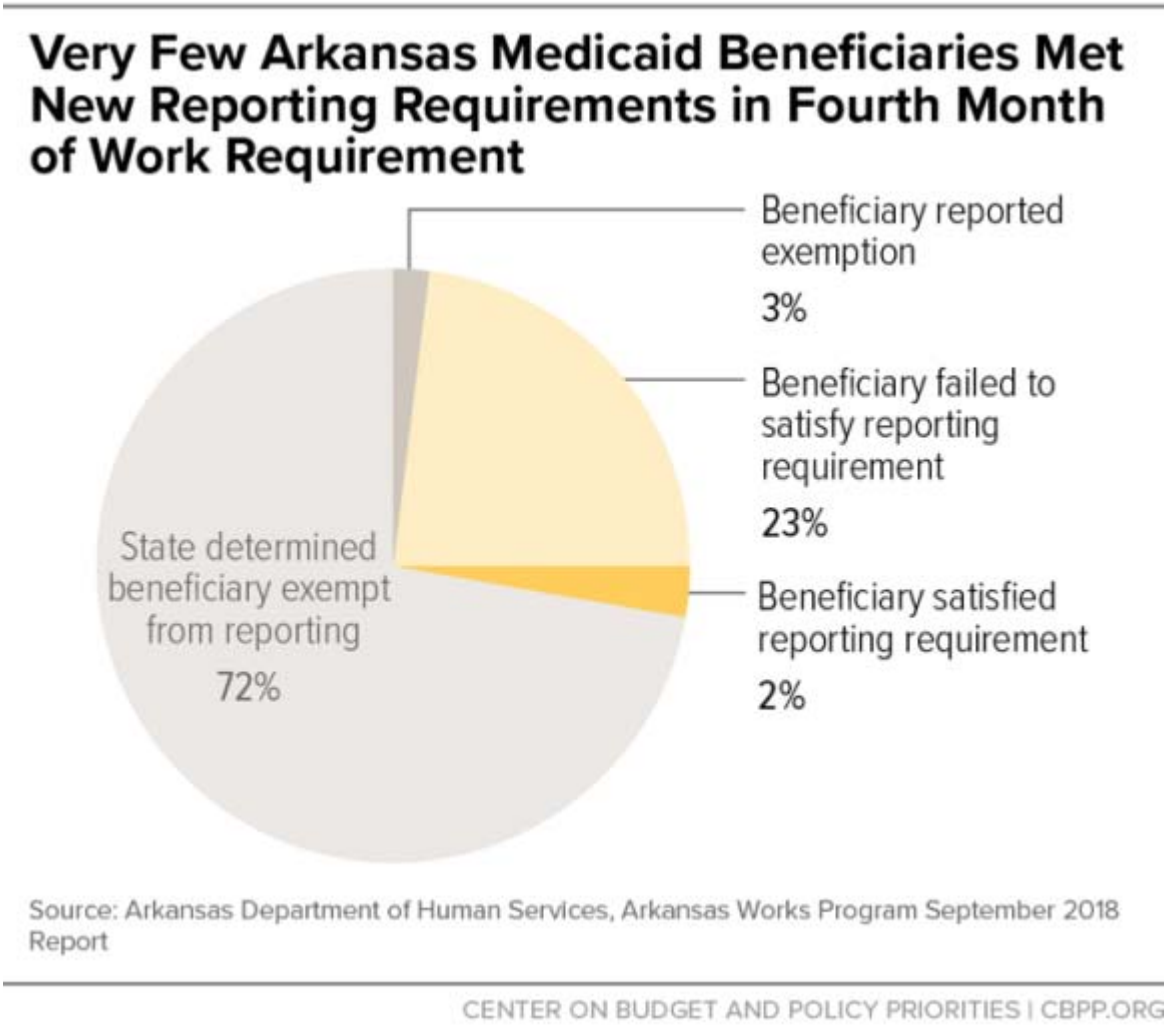
Center on Budget and Policy Priorities

4,109 More Arkansans Lost Medicaid in October for Not Meeting Rigid Work Requirements

BLOG POST | OCTOBER 16, 2018 AT 10:45 AM | BY JENNIFER WAGNER

Some 4,109 Arkansas Medicaid beneficiaries lost coverage on October 1 for not reporting at least 80 hours of work or work-related activities for three months, the state reports. That brings the total to 8,462 beneficiaries who have lost coverage since the state implemented its rigid work requirement. These individuals are locked out of Medicaid for the rest of 2018 even if they report 80 hours of work or work-related activities in future months or become exempt from the requirement due to illness or other reasons.

Over 16,000 beneficiaries (23 percent of those subject to the work requirement) didn't report sufficient work hours in September (see chart). Almost 5,000 beneficiaries now have two months of non-compliance with the work requirement and will lose coverage if they don't report 80 hours of work or work-related activities for another month this year. And another 7,500 have one month of non-compliance and will lose coverage if they have two more non-compliance months. Thousands of them will likely lose coverage in the coming months.



Good cause exemptions, which are available for beneficiaries who can't comply or report compliance due to circumstances beyond their control, don't appear to be protecting vulnerable beneficiaries. In September, Arkansas' Medicaid agency granted only 140 good cause exemptions for August — though over 16,000 beneficiaries didn't comply with the reporting requirement that month. Good cause exemptions were available for beneficiaries who couldn't report due to a statewide computer outage that affected the online reporting portal on the last day to report compliance in September, but few beneficiaries apparently knew it was available. Like other provisions of the work requirement, beneficiaries bear the burden to know the exemption exists, understand that they qualify, and email a request to the agency, which may be hard for beneficiaries with limited Internet and email access.

A new Kaiser Family Foundation brief, based on interviews with state officials, health plans, providers, and beneficiary advocates, details some of the factors that are likely leading eligible Medicaid beneficiaries to slip through the cracks and lose coverage in Arkansas:

- **Many beneficiaries are likely unaware that they face a work requirement.** The state and health plans have conducted much of their outreach through phone calls, but the state has no phone numbers, or incorrect numbers, for many beneficiaries. Other outreach through social media or online videos didn't likely reach beneficiaries without Internet access. Finally, the state's notices contain incomplete information and aren't available in Spanish.

- **Many enrollees have trouble using the online portal to report exemption and compliance activities.** Even if beneficiaries have Internet access and sufficient computer literacy — which many don't — setting up an online account and reporting work hours requires multiple steps. And although the state has authorized "registered reporters" to log hours for beneficiaries, many beneficiaries aren't using them because they don't know about the service or may not understand the new work requirements.

- **Beneficiaries are likely struggling to meet the rigid work requirements.** Transportation is a major barrier to work, and there are few jobs in the state's rural areas and for workers with low education levels. Medicaid funds can't be used for work supports, which are key to overcoming barriers to work, and the number of beneficiaries seeking assistance from the Department of Workforce Services will likely strain the Department's resources because the state hasn't boosted its funding to meet this need. Further, although beneficiaries can comply with the work requirement by volunteering, that may not be practical for those with limited information about available opportunities and limited transportation options to do so.

As we've explained, research suggests that only a small minority of Medicaid beneficiaries potentially subject to the state's work requirement aren't already working and wouldn't qualify for an exemption. The Arkansas experience thus far shows that many eligible beneficiaries who are working or qualify for an exemption are nevertheless getting caught up in the complex policy and restrictive reporting requirements and losing coverage.

TOPICS: Health, Medicaid and CHIP

Center on Budget and Policy Priorities

Over 4,300 Arkansas Beneficiaries Lost Medicaid This Month for Not Meeting Rigid Work Requirements

BLOG POST | SEPTEMBER 13, 2018 AT 4:45 PM | BY JENNIFER WAGNER

Over 4,300 Arkansas Medicaid beneficiaries lost their coverage on September 1, likely becoming uninsured, because they didn't report at least 80 hours of work or work-related activities for June, July, and August, the state reports. These people, the first Medicaid beneficiaries in any state to lose coverage because they couldn't comply with complex work requirements, represent about 17 percent of the first cohort subject to Arkansas' requirement. They're locked out of Medicaid for the rest of 2018 even if they report 80 hours of work or work-related activities in future months or become exempt from the requirement due to illness or other reasons.

Roughly 5,000 other beneficiaries now have two months of non-compliance with the work requirement and will lose coverage if they don't report that they've complied for another month this year. And over 6,100 have one month of non-compliance and will lose coverage if they have two more. Thousands of these beneficiaries are likely to lose coverage in the coming months.

Many of these beneficiaries likely complied with the requirement or qualified for an exemption but struggled with the problem-ridden online portal — the only way that Arkansas lets beneficiaries report. Adding to the portal-related challenges, the state acknowledged that it experienced a computer problem that may have limited access to the website during the crucial reporting window and is extending the reporting deadline for one month for those affected if they request a "good cause" exemption due to the computer issues. As with other good cause exemptions, however, beneficiaries have the burden of knowing the exemption exists and emailing a request to the agency, which may prove hard for beneficiaries with limited Internet and email access.

The good cause exemptions, intended to protect beneficiaries who can't comply with the requirements due to life events such as hospitalization, serious illness, or domestic violence, have proven ineffective at protecting vulnerable beneficiaries. The state granted only 45 good cause exemptions for July even though almost 12,000 beneficiaries didn't comply with the reporting requirement that month.

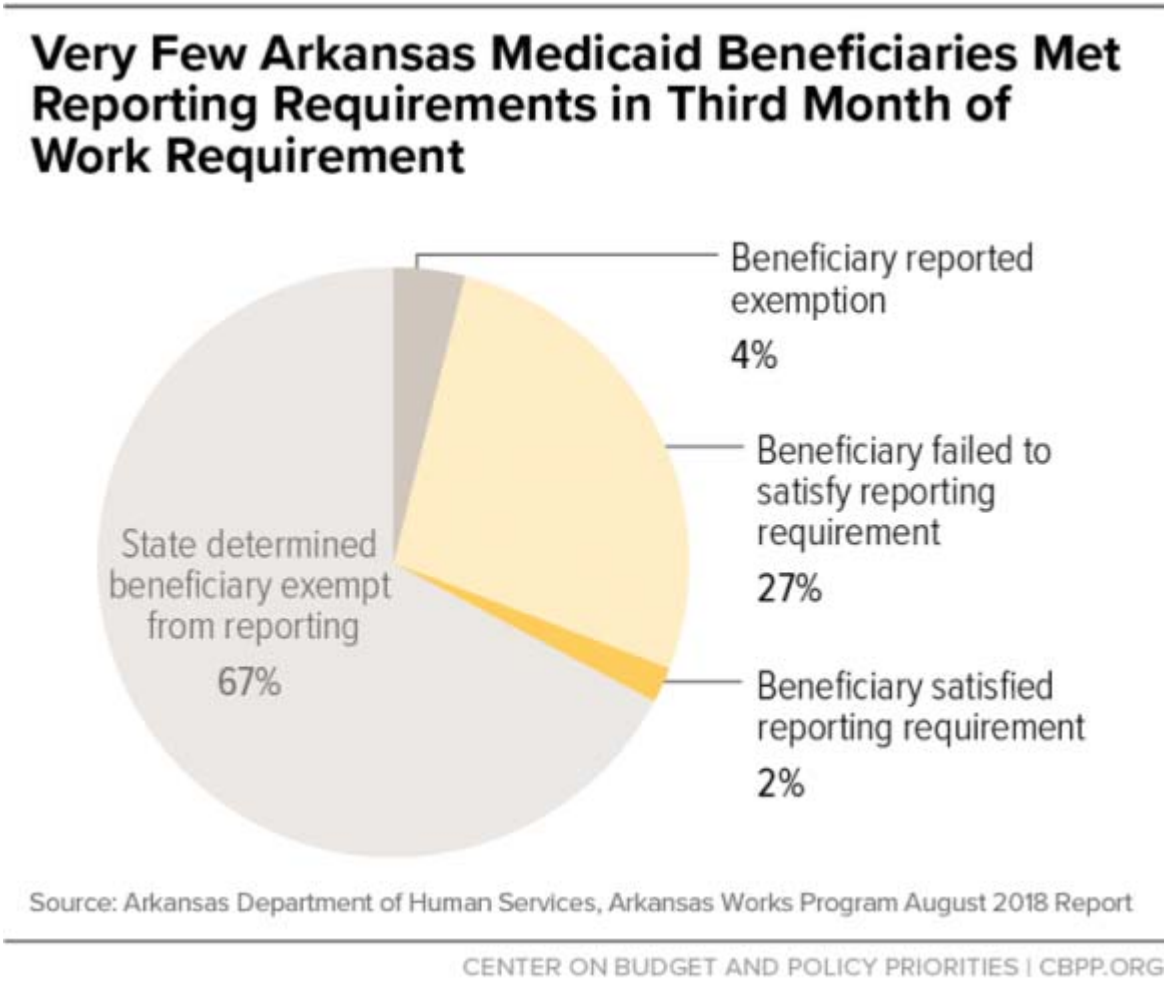
As we've explained, research suggests that only a small minority of Medicaid beneficiaries potentially subject to the state's work requirement aren't already working and wouldn't qualify for an exemption. Yet a much larger number of beneficiaries are accruing months of non-compliance and losing coverage, which suggests that the complex policy and reporting requirements are tripping up many eligible beneficiaries. Recent interviews with 18 Arkansas Medicaid beneficiaries support this conclusion:

- Twelve of the 18 weren't aware of the new work requirement.
- Most of the interviewees who, based on their age, should have received a letter from the state letting them know they were subject to the work requirement weren't sure they received one. And those who did were confused or overwhelmed by the new requirements.
- Many reported the online portal would be a challenge for them or their family members to use because they lacked a smartphone or Internet access.

- Most importantly, *none* of the interviewees reported that the policy had led them — or would lead them — to change their work-related activities, as most of them were already working, actively seeking work, or exempt.

Governor Asa Hutchinson claimed yesterday that more than 1,000 beneficiaries have found work since the work requirements took effect in June, but there's no evidence that that occurred due to the work requirement. Some beneficiaries start new jobs every month regardless of the threat of losing coverage. The state's data show that in August, almost 2,000 beneficiaries in the state's Medicaid expansion population — most of whom aren't yet subject to the requirement — left Medicaid because their incomes rose above program limits.

Even if some beneficiaries sought help finding a job due to the work requirement, that impact must be balanced against the fact that 4,300 beneficiaries lost coverage — many of whom likely are working or qualify for an exemption. A far better approach for Arkansas would be to implement a robust voluntary workforce program, which would provide job training and other services to the small group of beneficiaries who aren't working and can work *without* causing thousands to lose health insurance.



TOPICS: Health, Medicaid and CHIP

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July 30, 2018

Commentary: As Predicted, Eligible Arkansas Medicaid Beneficiaries Struggling to Meet Rigid Work Requirements

By Jennifer Wagner

Nearly 8,000 Arkansas Medicaid beneficiaries had to report compliance with the state's rigid new work requirement or risk losing coverage by July 5. Of that group, only 445[1] — less than 6 percent of those who had to report — successfully navigated the complex requirements and reporting structure to log their hours. Over 7,000 others now have one month of non-compliance with the new requirement and will lose coverage if they have two more. This group is just the first of three cohorts that will become subject to work requirements this summer, and Arkansas is planning to extend its policy to more Medicaid beneficiaries next year.

As we and others have explained,[2] state Medicaid waivers that take coverage away from people who don't work or engage in work-like activities for a set number of hours each month will lead to large coverage losses — including among those who comply with the requirements or should be exempt from them.[3] Arkansas is making the barriers to maintaining enrollment particularly high by requiring beneficiaries — many of whom lack internet access — to use a problem-riddled online portal to report exemptions and log hours.[4]

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[1] Max Brantley, "Work Rule 'works' in first month report; 26 percent flunk," *Arkansas Times*, July 13, 2018, https://www.arktimes.com/ArkansasBlog/archives/2018/07/13/work-rule-works-in-first-month-report-26-percent-flunk.

[2] MaryBeth Musumeci, Rachel Garfield, and Robin Rudowitz, "Medicaid and Work Requirements: New Guidance, State Waiver Details and Key Issues," Kaiser Family Foundation, https://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements-new-guidance-state-waiver-details-and-key-issues/, Hannah Katch, Jennifer Wagner, and Aviva Aron-Dine, "Medicaid Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes," Center on Budget and Policy Priorities, February 8, 2018, https://www.cbpp.org/research/health/medicaid-work-requirements-will-reduce-low-income-families-access-to-care-and-worsen.

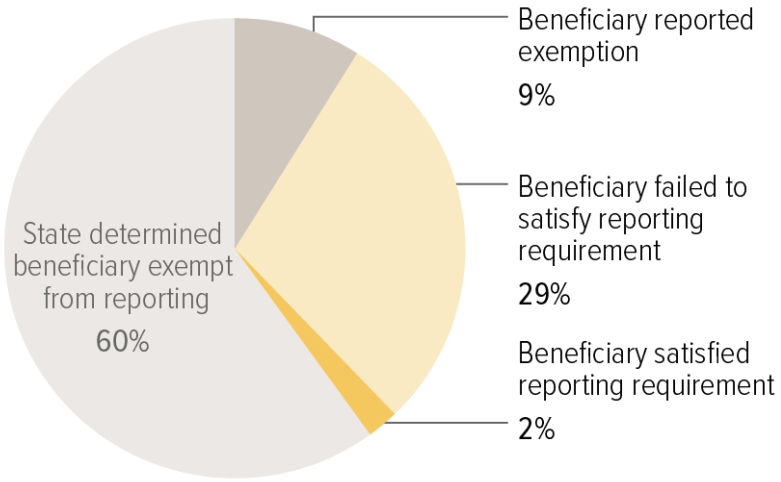
[3] Jennifer Wagner and Judith Solomon, "States' Complex Medicaid Waivers Will Create Costly Bureaucracy and Harm Eligible Beneficiaries," Center on Budget and Policy Priorities, May 23, 2018, https://www.cbpp.org/research/health/states-complex-medicaid-waivers-will-create-costly-bureaucracy-and-harm-eligible.

[4] Jennifer Wagner, "Arkansas Medicaid Waiver Will Mean More Enrollees Lose Coverage," Center on Budget and Policy Priorities, updated June 14, 2018, https://www.cbpp.org/blog/arkansas-medicaid-waiver-will-mean-more-enrollees-lose-coverage.

Arkansas instituted its work requirement policy for the first cohort of almost 26,000 Medicaid beneficiaries June 1. The state deemed more than 15,000 of those beneficiaries to be exempt or meeting the requirement based on information already available to its Medicaid agency, such as the fact that they had a dependent child in their home. Another 2,395 reported exemptions after the state notified them that they were subject to the new requirement. That left nearly 8,000 beneficiaries needing to complete 80 hours per month of work or work-like activities and report it through the online portal. Just 445 successfully navigated the portal and reported sufficient hours. (See Figure 1.)

FIGURE 1

Very Few Arkansas Medicaid Beneficiaries Met New Reporting Requirements in June



Note: Under Arkansas' Medicaid waiver, beneficiaries must complete 80 hours per month of work or work-like activities (known as community engagement hours) and report them through the state's online portal.

Source: Arkansas Department of Human Services, Arkansas Works Program June 2018 Report

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Many of the more than 7,000 beneficiaries who did not report hours — 29 percent of the first group subject to Arkansas's work requirement — likely were already working or should be exempt from the requirement. Research analyzing which Medicaid beneficiaries are already working or qualify for an exemption suggests that only a small minority of Medicaid beneficiaries potentially subject to the state's work requirement aren't already working and wouldn't qualify for an exemption.[5]

A substantial majority of those who lose coverage due to work requirements will be working beneficiaries and beneficiaries with health challenges or caregiving responsibilities that should qualify

[5] Anuj Gangopadhyaya *et al.,* "Medicaid Work Requirements in Arkansas," Urban Institute, May 24, 2018, https://www.urban.org/research/publication/medicaid-work-requirements-arkansas/view/full_report.

them for exemptions, but who get tripped up by red tape, Kaiser Family Foundation researchers recently estimated.[6] Based on past experience with Medicaid eligibility restrictions, the Kaiser researchers projected that 5 to 15 percent of people in these two groups will lose coverage, an estimate they describe as conservative.

The initial data from Arkansas suggest the share of eligible beneficiaries at risk could be higher than the Kaiser projection, at least initially. Many of those who have failed to report likely didn't understand the reporting requirements, lacked internet access or couldn't access the reporting portal through their mobile device, couldn't establish an account and login, or struggled to use the portal due to a disability. Of the beneficiaries losing coverage who weren't already working and didn't qualify for an exemption, many likely couldn't comply because they faced serious barriers to work, including low levels of education and lack of access to transportation.

Most of those who did report compliance with the requirement did so by satisfying exemptions or work requirements for SNAP (formerly known as food stamps). Only 94 beneficiaries reported at least 80 hours of work, education and training, or other allowable activities. Even if none of these beneficiaries were already working — which is unlikely — that would imply that the work requirement influenced *just 94 beneficiaries out of about 26,000* to participate in work or work-like activities for 80 hours in June. In contrast, over 7,000 Arkansas Medicaid beneficiaries — likely including many who would qualify for an exemption or are already working and complying with the requirement — will lose Medicaid coverage if they fail to report or otherwise struggle to meet these requirements for two more months before the end of the year.

The number of Arkansas beneficiaries at risk of losing coverage will almost certainly rise as Arkansas phases in the work requirements for additional groups of Medicaid beneficiaries over the coming months. And more eligible beneficiaries may lose coverage in other states with approved work requirements. Kentucky and New Hampshire will suspend Medicaid benefits after just one month of non-compliance (compared to three in Arkansas), and Kentucky, New Hampshire, and Indiana will apply the work requirement to a larger share of Medicaid beneficiaries, including some low-income parents. Moreover, Arkansas is deeming many workers as in compliance and therefore exempt from reporting requirements due to reported monthly earnings equal to the minimum wage times 80 hours, something the other states may not do. These factors are likely to lead to more eligible beneficiaries losing coverage for failing to report their exemption or compliance in these other states.

Arkansas' experience shows how rigid work requirements put working families and beneficiaries who qualify for exemptions at risk of losing coverage for failing to navigate complex bureaucracy. Despite Arkansas Governor Asa Hutchinson's claim that "The first report is encouraging,"[7] these numbers show that work requirements don't work.

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

[7] Associated Press, "7,000 People Fail to Meet Arkansas Medicaid Work Requirement," *New York Times*, July 13, 2018, https://www.nytimes.com/aponline/2018/07/13/us/ap-us-medicaid-arkansas.html.

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policy solutions that work for low-income people

Volatile Job Schedules and Access to Public Benefits

September 16, 2015

Liz Ben-Ishai

Introduction

For many low-wage workers, Monday-through-Friday, nine-to-five jobs are a thing of the past. Instead, volatile schedules are the norm, especially in retail, restaurant, and other service jobs. Among early career workers (ages 26 to 32) in hourly jobs, more than 40 percent receive one week or less advance notice of their job schedules.[1] Half of these workers have no input into their schedules and three-quarters experience fluctuations in the number of hours they work, with hours varying by more than eight hours per week on average. Many workers receive less than three days' notice.[2]

These schedules make it difficult for workers to secure child care, hold a second job, or attend job training. *Scheduling* instability also leads to *income* instability. When workers do not know whether they will work 10 hours or 40 hours in a given week, it is nearly impossible for them to budget and to make ends meet. A recent study found that nearly one-third of Americans experience considerable fluctuations in their income; of these individuals, more than 40 percent attribute the ups and downs to irregular work schedules.[3]

When combined with low wages and low income, workers with volatile schedules often find themselves in need of income support from public benefits programs, such as cash assistance under Temporary Assistance for Needy Families (TANF) and nutritional assistance under the Supplemental Nutrition Assistance Program (SNAP). These safety net programs are crucial to reducing poverty. One recent estimate found that government tax and transfer policies reduced the share of people who were poor by almost half (from 29 percent to 16 percent) in 2012.[4] Safety net programs also support work, especially for low-income parents, providing crucial stability that helps them advance in their jobs and ensures their children's healthy development. For millions, the safety net has made work pay and lifted families out of poverty.[5]

Ironically, the very job scheduling issues that contribute to many workers' financial insecurity and consequent need for public benefits often create obstacles to *accessing* these benefits.[6] Some of these programs require recipients to work a certain number of hours. As a result, when workers are scheduled for fewer hours, their wages *and* their public benefits go down.[7] Temporary increases in work hours can also be cause for concern. Workers who fail to report increased earnings—even if temporary—can be denied benefits or even charged with fraud. Workers who report increased earnings may have their benefits cut or become ineligible. This is often referred to as the "benefits cliff." Yet many workers whose income increases as a result of additional hours may quickly lose those hours, making them eligible for benefits once again. The reapplication process can

be cumbersome and time consuming, contributing to a process known as "churn" that is as costly for administrative agencies as it is a hardship for families.

Volatile job schedules also exacerbate logistical problems that hinder benefits access. From trying to schedule an appointment with a caseworker to attempting to project one's income to calculate benefits, workers with volatile job schedules find that the path to benefit eligibility is anything but straightforward. Rules related to quitting one's job and technological flaws in the system used to verify income may also present challenges for these workers.

Despite playing an essential role in lifting American workers out of poverty when their employers fail to pay them adequately and treat them fairly, the social safety net needs to be updated to keep up with the changing nature of work. In particular, states' rules and practices are in need of revisions. Workers and advocates can help drive this change; already, their advocacy for stronger workplace protections and collective bargaining rights has effectively increased public support for state and local policy solutions to volatile scheduling. Further advocacy can also drive change at the level of public benefits rules.

This brief examines the ways that volatile schedules complicate and constrain access to public benefits, including those provided under TANF, SNAP, the Child Care Development Fund (CCDF), and Medicaid.[8] (See Appendix A for brief descriptions of each program.) Many of these programs vary considerably across states—both in law and in practice. Because no source tracks state choices in all of these areas, the brief does not offer a comprehensive, state-by-state analysis. Instead, after providing overviews of how scheduling issues may affect benefit access within the context of several categories of rules, requirements, and circumstances, we pose a series of questions to help advocates, policymakers, and researchers assess the effects of their state's practices on recipients and applicants employed in jobs with volatile schedules. We also offer some broad best practices to consider across program areas.

Volatile Schedules: Background

Common scheduling challenges include: little advance notice of shifts; fluctuations in shifts from day to day or week to week; highly variable hours per week; being sent home from work early or called in at the last moment; split shifts (nonconsecutive hours); working late-night closing shifts followed by early morning opening shifts ("clopening"); and inadequate hours. These practices are symptomatic of the "just-in-time" approach to scheduling. Under this model, employers modify employee schedules in response to even small changes in sales and demand without regard for the impact on workers, often using scheduling systems that automatically limit hours. However, scheduling software itself is not inherently unfair to workers; when combined with human intervention, it can improve business success *and* worker wellbeing.[9] There is evidence that this collaborative approach is more profitable for businesses than scheduling practices that don't take workers' needs into account.[10]

New and emerging research demonstrates that volatile schedules are remarkably common. According to an analysis of the National Longitudinal Study of Youth, more than 40 percent of early career hourly-workers (ages 26 to 32) receive one week or less advance notice of their job schedules. Half of these workers have no input into their schedules and three-quarters experience fluctuations in the number of hours they work, with hours varying by more than eight hours per week on average.[11] According to a study of workers of all ages, about 17 percent of the workforce experiences unstable work shift schedules, which includes irregular, on-call, split, and rotating shifts.[12] Parents of young children—the primary recipients of a number of benefits programs—are among those most likely to experience volatile job schedules. Nearly 70 percent of mothers and 80 percent of fathers of children 12 or younger who work in hourly jobs receive hours that fluctuate by up to 40 percent.[13]

Erratic schedules have severe effects on workers' lives. Workers struggle to arrange child care, transportation, medical appointments, and higher education; they experience fatigue and stress that affects family life and health outcomes; and they struggle to stay afloat financially.[14] To curb these devastating effects, a growing movement of workers and advocates across the country is fighting to pass new labor standards that would require employers to improve scheduling practices. At the federal level, the Schedules that Work Act (S. 1772/H.R. 3071) would give all employees at firms with more than 15 people the right to request scheduling accommodations; it would also provide employees in certain categories a right to *receive* those accommodations unless employers have bona fide business reasons to refuse. For workers at firms with more than 15 people in the retail, restaurant, and building cleaning industries, the bill includes additional provisions that require advance notice of schedules and compensation for last-minute changes, on-call work, and split shifts, as well as minimum pay for showing up to work (even if they are sent home early).[15] Legislation to address schedule volatility has also been introduced in 12 states, as well as several local jurisdictions, over the past year. In 2015,

San Francisco passed the Retail Workers Bill of Rights, which will improve scheduling for workers employed by large chain retailers in the City and County of San Francisco.[16]

Low-wage Workers and Public Benefits

About 4 in 10 children (more than 31 million) are poor or near poor, with racial and ethnic minorities disproportionately affected.[17] These children live in families that have difficulty paying the rent or mortgage and keeping food on the table.[18] Yet more than half of poor and near-poor children live with a full-time, year-round worker.[19] Despite the many challenges they face, three-quarters of poor and near-poor single mothers with very young children are participants in the labor force.[20] Among those who work less than full time, more than 6.5 million people would like more hours but aren't able to get them.[21] An additional 1.9 million people are working two part-time jobs.[22] Despite a lot of hard work, many low-wage workers simply can't make ends meet.

Safety net programs, particularly SNAP, Medicaid, and refundable tax credits, have come to play a critical role in filling the gap between what low-wage jobs provide and what families need to get by. In 2013, Medicaid served 57.4 million individuals[23] and SNAP supported 47.6 million individuals.[24] The Earned Income Tax Credit (EITC) benefitted 28 million individuals.[25] Programs with capped funding reached smaller shares of needy families. TANF served 1.75 million families, while child care subsidies through the Child Care and Development Fund reached 1.46 million children.[26] Overall, government tax and transfer policies reduced the share of people who were poor by almost half in 2012. [27]

Many of those who benefit from these programs are in working families. In some cases, such as the EITC or child care, eligibility is directly linked to employment. Most parents receiving child care subsidies are working; 94 percent are either employed or in education or training programs.[28] But even in other programs, participants have significant work attachment. For example, among all SNAP households with at least one working-age adult not receiving disability benefits, more than half have a member who works while receiving SNAP. Additionally, more than 80 percent work either in the year prior to or in the year following SNAP receipt. The rates are even higher for SNAP households with children.[29] These figures reflect deliberate actions by federal and states governments over the past two decades to increase support for low-income working families who are unable to make ends meet based on wages and benefits earned.

Public Benefits Challenges for Workers with Volatile Job Schedules

Although the programs covered in this brief vary widely along legal, policy, and practice lines, a common set of challenges related to volatile job schedules emerges for affected applicants and recipients. Below, we consider how certain broad requirements or rules affect each program's capacity to serve workers with volatile schedules. Since these programs are administered by states, with the exception of certain federally mandated requirements, policies and practices may vary widely depending on geographic location. The specifics of how states apply these requirements will shape workers' experiences.

Work requirements

Since workers with volatile schedules experience instability and unpredictability in their hours, programs that impose work hour requirements pose a particular challenge. Work requirements vary significantly between programs.

- States must engage a specified share of TANF recipients in a limited set of countable activities for a minimum number of hours per week. To be counted toward the federal work participation rate (WPR), recipients must participate a minimum of 20 to 35 hours per week depending on family composition.[30] States have the option of setting their work requirements higher; some have elected to do so, partly because they anticipate variation in weekly hours among recipients. There is no partial credit for recipients who fall just short of the federal standard; consequently, states want a cushion to increase the likelihood of receiving credit.

- SNAP recipients who are not working 30 hours per week (or are otherwise exempt due to age, caregiving responsibilities, disability, or student status) may be required to participate in employment and training activities.[31] (Earning a weekly average of 30 hours per week times the minimum wage is deemed equivalent to working 30 hours.) So-called "able-bodied adults without dependents" ("ABAWDS") can only access SNAP for three months out of a three year-period *unless* they are working or participating in a qualified work activity for a minimum of 20 hours per week.[32] SNAP regulations specify that recipients who are subject to this time limit must report any instances in which their work hours fall below 20 hours per week, averaged across a month, even if they would otherwise not need to report fluctuations in income.[33]

- To qualify for child care assistance under CCDF, parents must participate in a work or education activity or have a child in need of protective services. States each establish their own policies defining acceptable work activities for the purposes of eligibility. Those activities may include employment, job search, job training, or educational programs. The federal child care assistance law prescribes no

minimum work requirement. Nearly half of states have policies requiring parents to work a minimum number of hours.[34] Of those that have set such a minimum, more than half require 20 hours of work or more per week for assistance with full-time care; some require 30 hours of work. States with these higher minimums for full-time care sometimes also establish a lower minimum threshold for part-time care.[35] However, within the context of federal parameters, states have the freedom to modify their rules to ensure that programs meant to support work are in sync with the challenges of today's low-wage labor market.

As Susan Lambert and Julia Henly note in their study of early career workers, work-hour requirements are based on an assumption that workers have control over how many hours they work (meaning those that work less are doing so because of a preference or personal barriers).[36] Yet existing data and workers' stories show this is far from true. While eligibility rules for TANF do not require recipients to find jobs that pay a certain wage or offer specific benefits, they do require a minimum number of hours. This requirement does not reflect the realities of low-wage work.[37]

During the Great Recession, high unemployment meant that most states became eligible for—and took up—state-wide waivers for the ABAWD time limit. Unemployed individuals in these states were not automatically cut off from SNAP if they reached their 3-month time limit and were unable to obtain 20 hours a week of employment or training. However, with the economic recovery, many states are no longer eligible for—or are no longer taking up—the state-wide waivers, despite the ongoing struggles many recipients face in finding sufficient hours of work. In 2015, 31 of the 37 states eligible for state-wide waivers took them up. [38] According to an analysis by the Center on Budget and Policy Priorities, roughly one million people are likely to lose SNAP benefits in 2016 as state-wide waivers expire.[39] While the population expected to lose benefits is often completely unemployed, it will also include those who are underemployed (either on an ongoing basis or as a result of volatile scheduling practices that cause hours to fluctuate).

Work requirements may also present unique challenges for recipients who have part-time jobs or jobs with fluctuating schedules. For example, TANF recipients with part-time jobs may not be offered enough hours of work to meet their state's participation requirements. To meet the requirement, they may be assigned to "job club" (a formal job search group). However, these assignments may not account for workers' job schedules, especially those that fluctuate. In some cases, recipients may need to choose between missing work and attending their mandated "work activities."[40]

The reasons for and ways in which workers *leave* jobs may also affect their eligibility for benefits. Workers who "voluntarily quit" their jobs are typically disqualified from receiving certain benefits, including SNAP and TANF.[41] Yet "quitting" may be the only option for workers with erratic schedules that cause untenable conflicts between their work obligations and their family, school, and health obligations. Some states may have

exceptions for quits deemed to be motivated by "good cause," but TANF rules vary from state to state. For SNAP, by statute, good cause for leaving employment may include discrimination by an employer, unreasonable work conditions (such as working without pay), or acceptance or enrollment in a recognized education or training program on at least half-time basis.[42]

Fluctuating benefit amounts

Means-tested programs are designed to provide more support to those with the greatest need; therefore, they adjust benefit levels in response to changes in recipients' earnings or other income. However, when benefits are adjusted in response to even small or temporary changes in income, the resulting fluctuations in benefit levels—on top of fluctuating earnings—can make it difficult for workers and their families to maintain stability in all aspects of their lives. It may be particularly challenging for families that experience a lag between when earnings change and when they are reflected in benefit amounts. High earnings one month may result in lower benefits the following month. Meanwhile, workers' earnings may well drop and return to previous levels, leaving them struggling to make ends meet on the lower benefits. This can have severe, potentially long-lasting consequences. One report found that in families who experienced decreases in SNAP benefits, children were 70 percent more likely to experience developmental delays; 55 percent more likely to be food insecure; 36 percent more likely to be in poor health; and 12 percent more likely to be hospitalized.[43]

As with work requirements, state policies and practices are critical in determining how volatile schedules will affect benefit levels. States and programs use different methods to calculate benefit amounts; some project earnings in advance of work (prospective budgeting), while some use actual earnings information to budget (retrospective budgeting). States also vary in their requirements regarding how frequently recipients must report income changes or what level of change warrants reporting (see the eligibility verification section below).

Many states now require SNAP recipients to report on their income and household circumstances only at defined intervals—typically every three to six months—unless household income rises above a threshold level. (Recipients who lose income may choose to report it sooner in order to have their benefits adjusted up.) However, other states require monthly reporting. [44] In addition, individuals subject to the SNAP time limits must report reductions in work hours below the 20-hour-per-week threshold.

In recent years, nearly all states have adopted "simplified reporting" processes for SNAP; these require recipients to submit information every six months. Under this system, households must only immediately report changes that push their income over 130 percent of the federal poverty level (FPL).

State policies regarding child care assistance sometimes require care hours to closely match parents' work hours; as a result, children experience instability in their care arrangements as parents' hours fluctuate.[45] Researchers have found that such instability is harmful to children's development. In addition, parents in these

circumstances may find it difficult to identify quality child care providers that will accept their children. This is because in the unsubsidized child care market, families typically pay for care regardless of whether their children are present on a given day. (This is necessary for providers to maintain financial stability.) Even working parents who receive child care subsidies may have difficulty finding quality care. Their struggles with unstable, unpredictable schedules may discourage providers from accepting their children.

There are no federal rules mandating that states impose such requirements on work and care hours. The federal Office of Child Care has clarified that states need not authorize care based on the work, training, or educational schedule of parents. Furthermore, the recently reauthorized child care law specifically encourages states to support fixed costs of care and to use generally accepted payment practices in compensating care providers. Colorado provides one example of a state that does not impose restrictions on child care hours by tying them to parents' work hours. In 2014, it passed legislation prohibiting such rules.[46]

Historically, the need to report changes in employment or other family statuses and to regularly recertify has led to fluctuations in benefit amounts and barriers to maintaining subsidies. In the past, many states required parents to report any changes to income and work schedules to state agencies as they occurred, both for the purposes of maintaining eligibility and to adjust required parent co-payments. For workers with variable schedules, frequent reporting requirements can be burdensome. These restrictive policies, imposed by states, are not federal requirements. States can minimize the changes that must be reported, simplify reporting, and minimize how often they act upon reported changes. State implementation of the new Child Care and Development Block Grant (CCDBG) law, which requires 12-month eligibility unless family income goes over the federal eligibility level (85 percent of state median income), is likely to reduce the burden of reporting requirements for families during their eligibility period.

The new CCDBG law also includes several other provisions that should limit benefit fluctuations and increase child care stability. These include a requirement that states not terminate child care assistance based on parental job loss or cessation of education and training unless they continue assistance for a period of at least three months, in order to provide time for job search. States are also required to demonstrate how they will take irregular fluctuations in parents' earnings into account when determining and redetermining eligibility.[47]

Utah's Approach to Benefits for Workers with Volatile Schedules and Incomes

Utah takes a common-sense approach to calculating income and eligibility for workers with volatile schedules who receive public benefits. Many of the state's policies are designed to reduce barriers for these workers. Nevertheless, continued training and policy refinements are needed to ensure adequate access.

Utah's eligibility workers are trained to estimate recipients' prospective income for cash assistance, SNAP, and child care programs by averaging, anticipating, and/or annualizing income. While check stubs continue to be the gold standard for documenting income, they are not always indicative of expected earnings for the prospective eligibility period (typically 6 or 12 months). Agencies can use other methods to obtain income information, such as documents, collateral contacts, electronic data interface, and the professional judgment approach.[48]

Agency staff may call an employer to inquire about a recipient's expected hours and potential for overtime. The professional-judgment approach allows an eligibility worker to estimate income in cases without check stubs and when collateral contact information may be minimal or unattainable. This subjective area, meant to allow for flexibility, highlights the importance of comprehensive agency training. Income estimates must be carefully narrated in the case file for case reviewers and auditing purposes.[49]

Utah has increasingly relied on electronic data sources to obtain information pertinent to a recipient household's case. This serves several purposes, including: reducing the verification burden for families, who are focused on finding and maintaining jobs; streamlining eligibility processes for agency staff; and improving case accuracy. A customized system called eFind pulls data from dozens of state and federal databases, including motor vehicles, new hire registry, social security, and wage match information.[50] As part of the eligibility determination process, agencies use this data to verify customer-provided information or to access newly reported information. When information from the data is straightforward and clear, eligibility workers can take action on a case, with appropriate notice requirements (typically 1 day or 10 days) for negative actions, such as benefit decreases and case closures. Workers are, however, encouraged to follow up on information that is inconsistent or does not provide a clear picture their particular situation (e.g., wage data from several quarters ago).

Another component of Utah's technologically advanced eligibility process is myCase, which is a customer-friendly website where basic case information can be accessed, including EBT balances, application or review status, and outstanding information needed. Recipients can report changes and complete applications and reviews online, as well as opt in to receive all notices electronically. This allows recipients to access information 24/7 and provides a modern channel through which to communicate with eligibility workers.[51]

Utah has developed technological systems to streamline eligibility processes, enabling recipients to reduce their verification burden when information can be obtained through data interfaces. While these systems are generally a good thing, there are still potential pitfalls to this approach. Eligibility workers should continue to be trained and encouraged to apply common sense and good judgment to estimate prospective income. This includes considering job scheduling fluctuations in the context of the current labor market, characterized by volatile jobs; engaging with employers to approximate expected work hours; and ensuring transparency with recipients regarding how income was calculated so that discrepancies or inconsistencies can be properly communicated and addressed.

Benefit Cliffs

Most means-tested programs are designed to gradually phase out benefits as income increases. TANF programs typically allow recipients to keep all of their initial earnings and phase out benefits over time. With SNAP, an additional dollar of earnings typically results in a loss of 24 to 36 cents worth of benefits.[52] However, some

programs have "benefit cliffs," meaning a small change in income can lead to a large decline in benefits or even lost eligibility. In these instances, recipients may end up *worse off* when they work more hours or earn additional income. That's fundamentally unfair to people working hard to get ahead.

One benefit cliff that low-wage workers with volatile schedules may encounter is the "gross income limit" under SNAP. Under SNAP eligibility rules, households without an elderly or disabled member typically must have gross or total income below 130 percent of FPL. However, benefits are based on net income after taking into account deductions such as child care and other work-related expenses or excessive housing costs. This means that small increases in earnings that push a household over the gross income limit may result in a significant loss of benefits. (States can keep SNAP cases open for a month with zero benefits in order to avoid churn, but if income remains above the gross income limit for a longer period, the case must be closed.)

However, states have the flexibility to raise the gross income limit income limit through a policy called "broad-based categorical eligibility." As of April 2015, 27 states and the District of Columbia had used this option to raise the gross income limit up to as much as 200 percent of FPL. for at least some SNAP recipients.[53] In these states, SNAP benefits will phase out gradually with increased income, without a sharp "benefits cliff."

In its recent reauthorization of the federal child care assistance program, Congress required all states to adopt policies that transition families off child care assistance when they are no longer eligible and provide children with stable care as families' earnings fluctuate (a common occurrence among low-wage workers). First, states are now required to offer 12 months of continuous coverage to children receiving child care assistance, as long as their income stays below the federal cap of 85 percent of state median income—a relatively high threshold. Second, at the end of the 12-month eligibility period, states must have provisions in place to ease families who are no longer income eligible under state eligibility rules off subsidies over some period of time. Combined, these two policy changes could help workers with volatile schedules. However, they may come with additional costs—and most states do not have new money available to cover them. Without significant federal investment, states may choose to reduce the number of families served.

In the 30 states that have adopted the Medicaid expansion under the Affordable Care Act (ACA), one of the most damaging cliffs is gone. Parents no longer have to take the enormous risk of going without health insurance if they add hours to a low-wage job and exceed a pre-ACA Medicaid eligibility ceiling that, in many states, was far below the poverty level. Under ACA, working parents have access to Medicaid coverage at the lowest income levels and, as their income rises, subsidized coverage on a sliding scale through the health insurance exchange. However, in states that have not expanded their Medicaid eligibility to 138 percent of FPL, there is still a steep benefit cliff. Adults in these states will experience a benefit cliff when their income exceeds the state's income eligibility level and they do not earn enough to receive APTCs (Advance Premium Tax Credits) through the Marketplace (see Appendix B for a description of APTCs). For example, in Kansas, the Medicaid eligibility limit for parents with dependent children is 38 percent of FPL (adults without dependent

children are not eligible at all). Therefore, if a parent in Kansas receives her health care through Medicaid and her income rises above 38 percent, she will not have access to affordable health insurance until her income reaches at least 100 percent of FPL, making her eligible for APTCs through the Marketplace. Children have higher eligibility and do not experience a benefit cliff between Medicaid and APTC eligibility.

Eligibility Verification and Program Churn

Recipients of public assistance must verify their eligibility at designated time intervals; if they no longer meet eligibility requirements, they will lose their benefits. In addition, whether or not they are *actually ineligible*, if they fail to provide adequate documentation of their eligibility, they may also lose their benefits. Many recipients who are denied benefits at redetermination due to lack of documentation later reapply and resume receiving benefits. This cycle of losing and then regaining eligibility is called "churn." In addition to creating turmoil and instability in the lives of recipients and their families, churn leads to increased costs and administrative burdens for states. Logistical challenges related to unstable work schedules make it difficult for workers to meet (often burdensome) administrative requirements. Requalifying for benefits after a loss of eligibility is also difficult and involves lengthy waiting periods that delay access to critical services.[54]

A study by the U.S. Department of Agriculture (USDA) found that the rate of churn for SNAP is between 17 and 28 percent. The vast majority of those who leave and then return to the program are gone for less than one month.[55] Churn can result from procedural complications or increased income, both likely scenarios for workers with volatile schedules.[56]

Provisions in the newly reauthorized CCDBG law will reduce the frequency of eligibility redetermination for child care assistance, which has contributed to churn in the past. When families were unable to meet the requirements for eligibility redetermination—because it interfered with employment or because they were unable to gather the required information —they often lost their child care assistance, even if they were still technically eligible.

Prior to reauthorization, churn was common in child care subsidy programs, and it may continue to be an issue until states have fully implemented the eligibility provisions of the new law. One study from 2002 found that 35-58 percent of families returned to the program within one year.[57] Loss of child care assistance is particularly devastating because child care subsidies are not guaranteed to all eligible families. Each state serves only a small fraction of eligible families because of limited funding. At present, 18 states have waiting lists or have frozen intake for child care assistance.[58] This means that losing eligibility temporarily due to administrative challenges may ultimately lead to a lengthy wait before regaining access. Families may spend anywhere from a week to over a year on states' child care assistance waiting lists. Even when families who lose and regain benefits are not placed at the bottom of the waiting list, their child care providers may not be able to hold their

spot without compensation. This forces parents to seek out a new provider, creating instability for children. Further, parents may have difficulty identifying a new provider that can accommodate their volatile job schedules.

While churning at the point of redetermination has been a consistent struggle for Medicaid programs, new options provided by the Affordable Care Act are beginning to contribute to improvements. States are now required to use existing data sources to automate renewals (known as "ex parte renewals") when possible and provide enrollees with prepopulated renewal forms when ex parte renewals are not possible. States also have the option to implement 12-month continuous eligibility, an ideal approach that ensures recipients will not have to report income fluctuations and other work changes for an entire year once approved for Medicaid. States have had this option for children since 1997; those that have exercised it have experienced reduced churn. In states that have not opted for 12-month continuous eligibility, recipients must report income changes throughout the year, potentially causing them to churn on and off Medicaid if their income fluctuates above and below the eligibility threshold.

Missed appointments can also lead to churn. Workers with volatile job schedules may have as little as one day's notice of their work hours, making it difficult to arrange and keep appointments. Even phone interviews can be difficult to schedule. While they reduce the need for travel, workers with inflexible jobs may not have enough break time to take calls related to benefits. Some states issue sanctions to workers who miss appointments, potentially leading to case closure. Other states are more accommodating of workers' job schedules. Some allow phone appointments (which are only helpful to some), weekend or evening in-person meetings, or other concessions that acknowledge the severe challenges recipients face when trying to arrange meetings.
One strategy that can be particularly useful for workers with volatile schedules is "on-demand interviews," where instead of assigning a client a specific time for an interview, the state provides clients with a several-day window during which they may call in at times of their own choosing and be connected with a caseworker who will conduct the interview. Implementing on-demand interviews for SNAP requires a waiver from the USDA's Food and Nutrition Service, which will monitor states to ensure clients' calls are being answered and processed in a timely manner.[59]

The new CCDBG law attempts to explicitly address barriers that workers may encounter as they juggle work and benefit access. It requires states to describe how their redetermination procedures and policies will ensure working parents, particularly those enrolled in TANF, are able to comply without disrupting their employment.[60]

Addressing Logistical Barriers to Benefit Access: A Legislative Approach

A bill recently proposed in the California State Assembly (AB 357) takes an innovative approach to addressing the logistical hurdles many workers with volatile job schedules face when they seek out benefits.[61] In addition to requiring employers to provide more notice to workers and accommodate scheduling needs, the proposed legislation sought to make broad changes to labor standards. It included the following provisions:

- Employers cannot take adverse actions against an employee who takes an unscheduled absence to attend an appointment with a county human services agency, provided the employee provides documentation.
- Welfare agencies cannot sanction employees who refuse employment or requirements related to employment if the employer is not complying with fair scheduling rules proposed under the same law.

Many states use electronic verification systems to track workers' income and verify reports from employees and employers. Electronic verifications can reduce the burden on recipients when they are used to automatically redetermine eligibility and to substitute for paperwork. However, such verifications can be burdensome and counterproductive when recipients are forced to explain and document even minor discrepancies between clients' self-reported income and income reported electronically.

Best Practices [62]

For many of the programs discussed above, states have considerable leeway in adopting practices that could make their safety net more accommodating to workers with volatile schedules. The following recommendations apply to most programs and are in effect in some states already:

Work requirements

- Use the maximum flexibility allowed under federal law to project work hours or average hours over time.
- TANF allows documented hours of work to be projected forward for 6 months.
- States may request a waiver to average hours of work across a month for students (who are subject to restrictions on SNAP eligibility unless they work at least 20 hours per week).[63]
- Provide recipients with flexible "add-on activities," such as online education programs, self-directed job search, or self-organized community service that can be fit around fluctuating work hours, rather than requiring them to attend programs at fixed hours.[64]

- Consider allowing TANF recipients to participate for less than the minimum hours needed to count toward the federal work participation requirement if staying in the same job is a wise decision for their long-term economic prospects. For example, workers may wish to stay in a job that offers fewer hours now but will later give them the seniority to get better shifts/hours.
- Do not tie child care subsidies tightly to actual hours of work.
- Implement new CCDBG rules that allow children to retain subsidies while parents are searching for work after unemployment.
- Treat highly volatile scheduling practices as "good cause" for voluntarily quitting a job, particularly when child care is not available.

Variable benefit amounts

- Allow for variation of income and work hours within a reasonable range without requiring reporting, and/or
- Allow for income calculations that take into account income fluctuations by averaging income over a period of time or incorporating anticipated changes into calculations.
- Disregard temporary increases in earnings that are not expected to last.
- Raise asset limits that restrict the amount of assets, including emergency savings, that benefit recipients can save.[65]

Eligibility cliffs

- Implement new CCDBG rules that provide 12 months of continuous eligibility.
- Offer transitional benefits for recipients that exceed income thresholds for benefit access.
- Adopt eligibility rules that minimize cliff effects, including Medicaid expansion and raising the gross income limit under SNAP.

Verification/churn

- Lengthen recertification periods and assess income eligibility less frequently.
- Minimize the need for face-to-face appointments with caseworkers.
- Allow on-demand interviews, which enable recipients to determine the best time for phone interviews.
- Use electronic verifications to substitute for paperwork and streamline redetermination processes. Develop systems that disregard minor discrepancies and that do not generate constant verification notices for workers with variable schedules.

Conclusion

As workers struggle with employer scheduling practices that leave them with little stability, predictability, and flexibility, many must turn to the safety net for support. While some aspects of public benefits programs are adapting to the realities of the labor market, others are premised on an assumption that recipients can find full-time, standard-hour, predictable employment when desired. This is clearly not the reality for most recipients of income support. Further, some states administering public benefit programs ignore the many logistical challenges created by volatile job scheduling. Keeping an appointment or taking a phone call may be out of reach for a worker who receives little notice of her schedule or faces the constant threat of losing much-needed hours at work.

Across the country, workers' rights advocates are making a strong case for labor standards that create a floor for fair scheduling. But as the scheduling fight proceeds on the labor front, it is also critical that public benefits advocates work to ensure program rules and state policies and practices accommodate workers with volatile schedules. Advocates from each field should collaborate to encourage states to adopt the changes workers need and that are often allowed under federal law. CLASP looks forward to working with partners engaged on both issues to improve the lives of low-income families.

Appendix A: Key Public Benefits Programs

In this brief, we focus on four means-tested public benefit programs where workers who experience volatile schedules may have challenges accessing and sustaining eligibility. While schedule volatility may affect access to other programs as well, these programs illustrate the range of challenges that workers may face. Brief descriptions of each program covered in this paper follow.

Temporary Assistance for Needy Families (TANF)

TANF is a federally funded block grant that state use to provide cash assistance and other benefits and services to poor families with children. States have full flexibility to determine benefit levels and eligibility rules. A key feature of TANF is its emphasis on work for families receiving benefits; states require most adult TANF recipients of cash assistance to be employed or participate in specified "work activities." If adults fail to comply with work requirements, families receive penalties ranging from removing the adult from the case (resulting in a lower benefit) to termination of the entire family's benefit. Federal work participation rates require states to engage half of families receiving TANF in a countable work activity for a minimum of 35 hours per week (for 2-parent families), 30 hours a week (for single parents of children over 6), or 20 hours per week (for single parents with children 6 and under).[66] There is no partial credit for hours worked below these thresholds; consequently, a single parent who works 19 hours per week counts towards the federal rates the same as one who does not have any work at all.

Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps, is the nation's largest and one of the most important anti-hunger programs, providing nutrition assistance to over 46.5 million people in low-income households in 2014.[67] SNAP benefits are fully federally funded, and the federal government sets the benefit levels and eligibility rules, although applications and eligibility determinations are conducted by the states. SNAP is responsive to the needs of individuals and households, expanding to serve more people during economic decline and retracting once the economy recovers. It is a critical part of the nation's safety net. And unlike most other means-tested programs, which are often restricted to particular categories of low-income individuals, SNAP is available to all who are eligible.

Child Care and Development Fund (CCDF)[68]

The Child Care and Development Fund (CCDF) provides child care assistance to low-income families who are employed or enrolled in education or training programs. In 2014, CCDF served over 1.4 million children.[69] The federal law allows states to establish their programs within broad parameters that allow for considerable discretion. States determine what activities count as work or education; whether recipients must work a minimum number of hours to be eligible; procedures for verifying working hours; and procedures related to reporting changes to schedules and work hours. In 2014, CCDF was reauthorized by Congress. The updated law

includes provisions that are meant to make access to the program less burdensome for families and improve children's continuity of care; several of these provisions are particularly important for parents with volatile work schedules. If implemented as intended, they could considerably improve access to and retention of child care assistance among families struggling with scheduling challenges.

Medicaid

Medicaid is a joint program between the federal government and states that provides health care to low-income individuals and families. Eligibility and exact medical benefits vary across states, with some states offering more robust health care access than others. There are multiple eligibility categories for Medicaid, including low-income seniors, persons with disabilities, pregnant women, and general income eligibility. Information included in this paper refers only to the general income eligibility population. One intent of the Affordable Care Act (ACA) was to create a uniform minimum income eligibility standard of 138 percent of the Federal Poverty Level (FPL) for Medicaid across all states. However, the 2012 Supreme Court ruling on the ACA gave states the option of whether or not to expand their Medicaid eligibility to 138 percent. Thirty-one states (including the District of Columbia) have chosen to expand Medicaid eligibility to 138 percent eligibility, while 19 states have not expanded eligibility. One state is still considering whether to expand.[70] In the states without Medicaid expansion, income eligibility ranges from zero eligibility for adults with no dependent children to 148 percent of FPL for parents with dependent children. In the majority of non-expansion states, there is no Medicaid eligibility for adults without dependent children and an eligibility limit below 67 percent of FPL for adults with dependent children.[71] Eligibility for children is consistently higher than that for adults and is less affected by fluctuating income.

Appendix B: Programs not covered in this report

Earned Income Tax Credits (EITCs)

The EITC program is a refundable tax credit granted to families who, despite working, earn a low or moderate income. Eligibility and benefit amount depend on the size of families and earnings of working family members.[72] Families receive the EITC in a lump sum when they file their taxes annually; it is based on annual income for the previous calendar year. We do not discuss the EITC in this report because while many families receiving this benefit are affected by volatile work schedules and income, annual income-based calculations mean EITC access is not affected by this volatility. Rather, the EITC acts as a cushion for many families, providing support to help alleviate the effects of income volatility.[73]

Advance Premium Tax Credits (APTCs)

APTCs are subsidies provided through the tax system to individuals and families who enroll in health insurance through the Marketplace (federal or state-based). While exact eligibility requirements can be complicated,

people generally qualify for APTCs if their household income is between 100 percent and 400 percent of FPL and they do not have another source of affordable health insurance, such as through an employer or Medicaid. In 2015, approximately 84 percent of all persons receiving insurance through the Marketplace are receiving APTCs, totaling 8.3 million enrollees.[74] Like EITC, APTCs are calculated on the basis of annual income. However, because credits are paid to insurance companies during the year, recipients must estimate or project their income for the remainder of the year in order to determine their subsidy. Therefore, if they have schedules changes that significantly affect their annual incomes, they should report their income changes to the Marketplace in order for APTCs to be adjusted accordingly.

Workers with volatile incomes, including those with erratic schedules, may find it difficult to project income. They may either overestimate or underestimate their income. If income is overestimated, they may not receive the full amount of APTCs for which they qualify, increasing their monthly out-of-pocket expense for health insurance. Though they will receive a tax refund for the additional APTC amount they should have received, many workers may be unable to wait until tax time to receive such support and may drop their coverage. If a worker underestimates her income, she may receive more ATPCs than she is eligible for and be required to pay back some or all of the difference when filing taxes, potentially imposing a significant and unexpected burden at tax time.[75]

Unemployment Insurance (UI)

UI provides an important safety net for jobless workers, including workers with volatile schedules who must quit their jobs or are fired due to conflicts created by such scheduling practices. The program also offers support ("partial UI") to workers whose hours are significantly cut. We explore the implications of volatile scheduling for access to UI in another publication, *Out of Sync: How Unemployment Insurance Rules Fail Workers with Volatile Job Schedule.*[76]

Appendix C: Questions for Advocates to Ask

With so much state variation in practices regarding public benefits access, advocates concerned with the intersection of volatile scheduling practices and benefits access must look closely at their local requirements. Following are a series of questions that advocates may want to consider as they evaluate the types of changes and improvements that are needed in their states to ensure workers with volatile schedules can access the income supports they need.

Work requirements

- *What is the minimum number of hours of work required to receive benefits?*
- *Does the state allow for variation in work hours within a certain range?*

- *How frequently must the recipient report on work hours?*
- *What amount of change in work hours is considered large enough to warrant reporting the change to the agency?*
- *Are benefits available to workers employed in part-time jobs? What is considered part time? Full time?*
- *What are the consequences for workers who fail to report changes in hours or who inaccurately estimate their work hours?*
- *Is the change reporting process user-friendly?*

Benefit fluctuations

- *Does the state use a prospective or retrospective budgeting system for each benefit program?*
- *In prospective systems, what are the consequences for recipients who inaccurately estimate their work hours?*
- *How often to do recipients have to recertify their eligibility/report changes in their schedules or work hours?*
- *Does the state impose restrictions or requirements that cause benefits to fluctuate and are* not *required by federal law?*

Eligibility verification and churn

- *How often is eligibility assessed?*
- *Has the state adopted 12-month continuous eligibility for any/all of its programs?*
- *How user-friendly is the eligibility assessment process?*
- *How burdensome is the process of reapplying for benefits when hours are reduced?*
- *Are there waiting lists for programs? What is the waiting list policy for recently ineligible recipients who are reapplying for benefits?*
- *Does the state collect data on churn?*
- *Do programs share information when conducting redeterminations? Are redetermination processes for various states coordinated with one another to reduce burden on recipients?*

Benefit cliffs

- *Does the state have "transitional benefits" for workers that have earned enough to become ineligible, so that they do not face a steep "cliff?"*
- *Has the state expanded Medicaid for adults to 138 percent of FPL?*
- *Is funding available to enact policy changes that would ease cliffs?*

Other issues

- *Does the state have a policy regarding sanctions for missed or rescheduled appointments? Does the policy take into account recipients' job schedules?*
- *Does the state take into account workers' job schedules when assigning them to "job club" or other activities?*
- *Are evening, weekend, or phone appointments available to help accommodate workers' schedules?*
- *How does the state treat voluntary quits? Are scheduling challenges considered "good cause" to quit?*
- *What electronic verification systems are in use? Have there been reports of mistakes, particularly for workers with volatiles schedules?*

Endnotes:

[1] Susan J. Lambert, Peter J. Fugiel, and Julia R. Henly, *Schedule Unpredictability among Early Career Workers in the US Labor Market: A National Snapshot*, EINet, July 17, 2014, https://ssascholars.uchicago.edu/sites/default/files/einet/files/lambert.fugiel.henly_.executive_summary.b_0.pdf.
[2] For example, according to a study of D.C. low-wage workers, one third receive less than three days' notice. Ari Schwartz, Michael Wasser, Merrit Gillard, Michael Paarlberg, *Unpredictable, Unsustainable: The Impact of Employers' Scheduling Practices in D.C.*, D.C. Jobs with Justice, Jobs with Justice Education Fund, DC Fiscal Policy Institute, and Georgetown University Kalmanovitz Initiative for Labor and the Working Poor, June 2015, http://www.dcjwj.org/wp-content/uploads/2015/06/DCJWJ_Scheduling_Report_2015.pdf.
[3] Board of Governors of the Federal Reserve System, *Report on the Economic Well-Being of U.S. Households in 2013*, United States Federal Reserve, July 2014, http://www.federalreserve.gov/econresdata/2013-report-economic-well-being-us-households-201407.pdf.
[4] Christopher Wimer, Liana Fox, Irv Garfinkel, Neeraj Kaushal, Jane Waldfogel, *Trends in Poverty with an Anchored Supplemental Poverty Measure*, Columbia Population Research Center (CPRC), Columbia University School of Social Work, December 5, 2013, http://socialwork.columbia.edu/sites/default/files/file_manager/pdfs/News/Anchored%20SPM.December7.pdf.
[5] Olivia Golden, CLASP, "Testimony on Work Incentives and the Safety Net: A Joint Hearing of the House Committee on Ways and Means, Human Resources Subcommittee and the House Committee on Agriculture, Nutrition Subcommittee," June 25, 2015, http://www.clasp.org/resources-and-publications/publication-1/June-2015-Olivia-Golden-testimony-final.pdf.
[6] There is a growing recognition of the effects of income and schedule volatility on access to public benefits. See for example, Susan J Lambert and Julia R. Henly, "Double Jeopardy: The misfit between welfare-to-work requirements and job realities." *Work and the Welfare State: The Politics and Management of Policy Change*, 2013; Virginia Anderson, Sarah Austin, Joel Doucette, Ann Drazkowski, and Scott Wood, *Addressing Income Volatility of Low Income Population*, Robert M. La Follette School of Public Affairs and The Financial Clinic, May 2015, http://www.lafollette.wisc.edu/images/publications/workshops/2015-income.pdf; Nancy K. Cauthen, *Scheduling Hourly Workers: How Last Minute, "Just-In-Time" Scheduling Practices Are Bad for Workers, Families and Business*, Demos, March 2014, http://www.demos.org/sites/default/files/publications/Scheduling_Hourly_Workers_Demos.pdf.
[7] Lambert and Henly, "Double Jeopardy."
[8] See Liz Ben-Ishai, Rick McHugh and Claire McKenna, *Out of Sync: How Unemployment Insurance Rules Fail Workers with Volatile Job Schedules*, Center for Law and Social Policy and National Employment Law Project, August 2015, http://www.clasp.org/resources-and-publications/publication-1/Out-of-Sync-Report.pdf.
[9] Ethan Bernstein, "Work Schedules: The False Tradeoff Between Fair and Productive," *Roll Call*, July 22, 2015, http://blogs.rollcall.com/beltway-insiders/work-schedules-the-false-tradeoff-between-fair-and-productive-commentary/?dcz=.
[10] Liz Ben-Ishai, *Job Schedules that Work for Businesses*, Center for Law and Social Policy, November 26, 2014, http://www.clasp.org/resources-and-publications/publication-1/Job-Schedules-that-Work-for-Businesses.pdf.
[11] Susan J. Lambert, Peter J. Fugiel, and Julia R. Henly, *Schedule Unpredictability among Early Career Workers in the US Labor Market: A National Snapshot*, EINet, July 17, 2014, https://ssascholars.uchicago.edu/sites/default/files/einet/files/lambert.fugiel.henly_.executive_summary.b_0.pdf.
[12] Lonnie Golden, *Irregular Work Scheduling and Its Consequences*, Economic Policy Institute, April 9, 2015, http://www.epi.org/publication/irregular-work-scheduling-and-its-consequences/. The author believes this is likely a low estimate.
[13] Lambert et al., *Schedule Unpredictability*
[14] Liz Ben-Ishai, Sasha Hammad, and Christina Warden, *Tackling Unstable and Unpredictable Work Schedules: A Policy Brief on Guranteed Minimum Hours and Reporting Pay Policies*, Center for Law and Social Policy, Retail Action Project, and Women Employed, March 7, 2014, http://www.clasp.org/resources-and-publications/publication-1/Tackling-Unstable-and-Unpredictable-Work-Schedules-3-7-2014-FINAL-1.pdf.
[15] Schedules that Work Act,", July 22, 2014, H.R. 5159, http://democrats.edworkforce.house.gov/sites/democrats.edworkforce.house.gov/files/documents/7.22.14-SchedulesThatWorkAct-BillText.pdf.
[16] "Retail Workers Bill of Rights", Jobs for Justice San Francisco, http://retailworkerrights.com/get-the-facts/.
For information on the movement and latest legislative developments, visit CLASP's National Repository of Resources on Job Scheduling Policy:
CLASP, "A National Repository of Resources on Job Scheduling Policy," http://www.clasp.org/issues/work-life-and-job-quality/scheduling-resources.
[17] *New Census Data Tell Us That Poverty Fell in 2013*, Center for Law and Social Policy, September 16, 2014, http://www.clasp.org/resources-and-publications/publication-1/2014.09.16-Census-Bureau-Poverty-Data-Report-FINAL.pdf.
[18] "Current Population Survey, Annual Social Economic Supplement," U.S. Census Bureau, September 2014, http://www.census.gov/cps/data/.
[19] *New Census Data Tell Us That Poverty Fell in 2013*, CLASP, September 16, 2014, http://www.clasp.org/resources-and-publications/publication-1/2014.09.16-Census-Bureau-Poverty-Data-Report-FINAL.pdf,

[20] Bureau of Labor Statistics, "Employment Characteristics of Families Summary --2014," U.S. Department of Labor, April 23, 2015, http://www.bls.gov/news.release/famee.nr0.htm.
[21] Bureau of Labor Statistics, "(Seas) Employment Level - Part-Time for Economic Reasons, All Industries", U.S. Department of Labor, June 2015, http://data.bls.gov/timeseries/LNS12032194.
[22] Bureau of Labor Statistics, "Table A-16. Persons not in the labor force and multiple jobholders by sex, not seasonally adjusted", U.S. Department of Labor, June 2015, http://www.bls.gov/news.release/empsit.t16.htm.
[23] Centers for Medicare and Medicaid Services, "Table I.16 Medicaid and CHIP Enrollment", 2013 CMS Statistics, U.S. Department of Health and Human Services, 2013, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2013_final.pdf.
[24] Food and Nutrition Service, "Supplemental Nutrition Assistance Program Participation and Costs," U.S. Department of Agriculture, June 5, 2015, http://www.fns.usda.gov/sites/default/files/pd/SNAPsummary.pdf.
[25] Olivia Golden, CLASP, "Testimony on Work Incentives and the Safety Net: A Joint Hearing of the House Committee on Ways and Means, Human Resources Subcommittee and the House Committee on Agriculture, Nutrition Subcommittee," June 25, 2015, http://www.clasp.org/resources-and-publications/publication-1/June-2015-Olivia-Golden-testimony-final.pdf.
[26] Congressional Budget Office, *Growth in Means-Tested Programs and Tax Credits for Low-Income Households*, 2013, https://www.cbo.gov/publication/43934; Office of Family Assistance, Administration for Children & Families, U.S. Department of Health & Human Services, "2013 TANF Caseload Data," November 2014, http://www.acf.hhs.gov/programs/ofa/resource/caseload-data-2013; and Office of Child Care, Administration for Children and Families, U.S. Department of Health & Human Services, *Characteristics of Families Served by Child Care and Development Fund (CCDF) Based on Preliminary FY 2013 Data*, 2014, http://www.acf.hhs.gov/programs/occ/resource/characteristics-of-families-served-by-child-care-and-development-fund-ccdf.
[27] Christopher Wimer, Liana Fox and Irv Garfinkel, *Trends in Poverty with an Anchored Supplemental Poverty Measure*, Columbia Population Research Center (CPRC), Columbia University School of Social Work, December 5, 2013, http://socialwork.columbia.edu/sites/default/files/file_manager/pdfs/News/Anchored%20SPM.December7.pdf.
[28] Office of Child Care, "FFY 2013 CCDF Data Tables (Preliminary Estimates)," U.S. Department of Health and Human Services, October 8, 2014, http://www.acf.hhs.gov/programs/occ/resource/fy-2013-ccdf-data-tables-preliminary.
[29] Dottie Rosenbaum, *The Relationship Between SNAP and Work Among Low-Income Households*, Center on Budget and Policy Priorities, January 29, 2013, http://www.cbpp.org/cms/?fa=view&id=3894.
[30] Elizabeth Lower-Basch, *Work Participation Rate: Temporary Assistance for Needy Families*, Center for Law and Social Policy, May 2015, http://www.clasp.org/resources-and-publications/publication-1/TANF-101-Work-Participation-Rate.pdf.
[31] Elizabeth Lower-Basch, *SNAP E&T*, Center for Law and Social Policy, March 2014, http://www.clasp.org/resources-and-publications/publication-1/SNAP-ET-Overview.pdf.
[32] Helly Lee, *SNAP Policy Brief*, Center for Law and Social Policy, June 2013, http://www.clasp.org/resources-and-publications/files/SNAP-Work-Requirements-and-Time-Limits-ABAWD.pdf.
[33] *Guide to Serving ABAWDs Subject to Time-limited Participation: A Guide on Serving Able-Bodied Adults without Dependents*, United States Department of Agriculture, 2015, http://www.fns.usda.gov/sites/default/files/Guide_to_Serving_ABAWDs_Subject_to_Time_Limit.pdf.
[34] Christine Johnson-Staub, Hannah Matthews, and Gina Adams, *Job Hours and Schedules: Implications for State Child Care and Development Fund Policies*, Center for Law and Social Policy and Urban Institute, April 2015, http://www.clasp.org/resources-and-publications/publication-1/Job-Hours-and-Schedules.pdf, citing: Sarah Minton, Christin Durham, Erika Huber, and Linda Giannarelli, *The CCDF Policies Database Book of Tables: Key Cross State Variations in CCDF Policies as of October 1, 2013*, 2014, OPRE Report 2014-72, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services (Table 2., page 28), http://www.urban.org/UploadedPDF/2000021-The-CCDF-Policies-Database-Book-of-Tables.pdf. According to the source, this information "…shows a minimum work hour requirement only when the State/Territory has an explicit policy requiring parents to engage in an approved activity for a minimum number of hours." Even if a program has no explicit minimum work hour policy, the number of work hours generally affects the number of hours approved for subsidized child care, as noted in the section on fluctuating benefits.
[35]Gina Adams and Hannah Matthews, *Confronting the Child Care Eligibility Maze: Simplifying and Aligning with Other Work Supports*, The Urban Institute and the Center for Law and Social Policy, December 2013, http://www.clasp.org/resources-and-publications/publication-1/WSS-CC-Paper.pdf.
[36] Lambert, Susan J., and Julia R. Henly. "Double Jeopardy: The misfit between welfare-to-work requirements and job realities." *Work and the Welfare State: The Politics and Management of Policy Change* (2013): p. 70.
[37] Ibid, 73.
[38] "Status of State Able-bodied Adult without Dependents (ABAWD) Time Limit Waivers in Fiscal Year (FY) 2015*", United States Department of Agriculture, April 10, 2015, http://www.fns.usda.gov/sites/default/files/snap/FY_2015_ABAWD_Waiver_Status.pdf.

[39]Ed Bolen, *Approximately 1 Million Unemployed Childless Adults Will Lost SNAP Benefits in 2016 as State Waivers Expire*, Center on Budget and Policy Priorities, January 5, 2015, http://www.cbpp.org/research/food-assistance/approximately-1-million-unemployed-childless-adults-will-lose-snap-benefits.
[40] Linda L. Shaw, John Horton, and Manual H. Moreno, "Sanctions as Everyday Resistance to Welfare Reform," *Social Justice Journal*, 35:4(2008-9), http://www.socialjusticejournal.org/archive/114_35_4/114_07Horton.pdf.
[41] This is a major issue for access to Unemployment Insurance benefits. See: Liz Ben-Ishai, Rick McHugh and Claire McKenna, *Out of Sync: How Unemployment Insurance Rules Fail Workers with Volatile Job Schedules,"* Center for Law and Social Policy and National Employment Law Project, August 2015, http://www.clasp.org/resources-and-publications/publication-1/Out-of-Sync-Report.pdf.
[42] 7 Code of Federal Regulations, §273.7(i)
[43]*The Unintended Consequences of Cutting SNAP Benefits*, Children's HealthWatch, December 2013, http://www.centerforhungerfreecommunities.org/sites/default/files/pdfs/cliff%20effect%20report%20single%20pages%5B1%5D.pdf.
[44] *State Options Report: Supplemental Nutrition Assistance Program*, United States Department of Agriculture, Food and Nutrition Service, Program Development Division, September 2013, http://www.fns.usda.gov/sites/default/files/snap/11-State_Options.pdf.
[45] Christine Johnson-Staub, Hannah Matthews and Gina Adams, *Job Hours and Schedules: Implications for State Child Care and Development Fund Policies*, Center for Law and Social Policy and Urban Institute, April 2015, http://www.clasp.org/resources-and-publications/publication-1/Job-Hours-and-Schedules.pdf.
[46] Child Care Assistance Authorization Period of March 2014, Colorado House of Representatives, 14-1022, http://www.leg.state.co.us/clics/clics2014a/csl.nsf/fsbillcont3/8E32BC5A5F81453F87257C30000603B5?Open&file=1022_enr.pdf.
[47] Hannah Matthews, Karen Shulman, Julie Vogtman, Christine Johnson-Staub, and Helen Blank, "Family Friendly Policies." *Implementing the Child Care and Development Block Grant Reauthorization: A Guide for States*, 2015, http://www.clasp.org/issues/child-care-and-early-education/pages/body/Chapter4_CCDBGGuide.pdf.
[48] "451 Methods Of Determining The Best Estimate Of Income," DWS Financial/Food Stamp/Child Care Eligibility Manual, Utah Department of Workforce Services, http://jobs.utah.gov/Infosource/eligibilitymanual/400_Income_Standards/451_Methods_of_Determining_the_Best_Estimate_of_Income.htm.
[49] "720-4 Methods of Verification," DWS Financial/Food Stamp/Child Care Eligibility Manual, Utah Department of Workforce Services, http://jobs.utah.gov/Infosource/eligibilitymanual/700_Eligibility_Process_and_Case_Maintenance/720-4_Methods_of_Verification.htm.
[50] "myCase," Utah Department of Workforce Services, https://www.statereforum.org/system/files/efind_and_mycase.pdf.
[51] ibid
[52] *Effective Marginal Tax Rates for Low- and Moderate – Income Workers*, Congressional Budget Office, November 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/MarginalTaxRates_one%20column.pdf.
[53] http://www.fns.usda.gov/sites/default/files/snap/BBCE.pdf
[54] Dottie Rosenbaum, *Lessons Churned: Measuring the Impact of Churn in Health and Human Services Programs on Participants and State and Local Agents*, The Center on Budget and Policy Priorities, March 20, 2015, http://www.cbpp.org/research/lessons-churned-measuring-the-impact-of-churn-in-health-and-human-services-programs-on.
[55] *Understanding the Rates, Causes and Costs of Churning in the Supplemental Nutrition Assistance Program (SNAP)*, United States Department of Agriculture, Food and Nutrition Service, Office of Policy Support, November 2014, http://www.fns.usda.gov/sites/default/files/ops/SNAPChurning.pdf.
[56] Ibid
[57] Gina Adams and Hannah Matthews, *Confronting the Child Care Eligibility Maze*, The Urban Institute and the Center for Law and Social Policy, December 2013, http://www.clasp.org/resources-and-publications/publication-1/WSS-CC-Paper.pdf ; Elizabeth Davis, "Subsidies and Continuity: Overview of Findings of Recent Studies," presentation, Child Care Policy Research Consortium Conference, Bethesda, MD, October 23–25, http://www.researchconnections.org/files/meetings/ccprc/2012/B2SubsidiesandContinuity.pdf.
[58] Karen Schulman and Helen Blank, *Turning the Corner: State Child Care Assistance Policies 2014*, National Women's Law Center, October 2014, http://www.nwlc.org/sites/default/files/pdfs/nwlc_2014statechildcareassistancereport-final.pdf.
[59] Supplemental Nutrition Assistance Program, letter to Regional Directors of SNAP, May 13, 2014, http://www.fns.usda.gov/sites/default/files/SNAP%20-%20Guidance%20for%20States%20on%20Novel%20Waivers.pdf
[60] Hannah Matthews, Karen Shulman, Julie Vogtman, Christine Johnson-Staub, and Helen Blank, "Family Friendly Policies." *Implementing the Child Care and Development Block Grant Reauthorization: A Guide for States*, 2015, http://www.clasp.org/issues/child-care-and-early-education/pages/body/Chapter4_CCDBGGuide.pdf.
[61] AB-357 of February 17, 2015, Fair Scheduling Act, http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB357.
[62] See recommendations: Heather D. Hill and Marci A. Ybarra, *Less-educated workers' unstable employment: Can the safety net help?*, Institute for Research and Poverty, March 2014, http://www.irp.wisc.edu/publications/fastfocus/pdfs/FF19-2014.pdf; Lambert and Henly (2013) ; Nancy K.

Cauthen, *Scheduling Hourly Workers: How Last Minute, "Just-In-Time" Scheduling Practices Are Bad for Workers, Families and Business,* Demos, March 2014, http://www.demos.org/sites/default/files/publications/Scheduling_Hourly_Workers_Demos.pdf.

[63] Elizabeth Lower-Basch and Helly Lee, *SNAP Policy Brief: College Student Eligibility*, Center for Law and Social Policy, June 2014, http://www.clasp.org/resources-and-publications/publication-1/SNAP-Policy-Brief_College-Student-Eligibility-Update.pdf.

[64] See, for example, the discussion of the use of online learning modules at http://www.dhs.state.or.us/caf/ss/tanf/docs/program_reports/elearning.pdf

[65] See further, Virginia Anderson, Sarah Austin, Joel Doucette, Ann Drazkowski, and Scott Wood, *Addressing Income Volatility of Low Income Population*, Robert M. La Follette School of Public Affairs and The Financial Clinic, May 2015, http://www.lafollette.wisc.edu/images/publications/workshops/2015-income.pdf.

[66] Elizabeth Lower-Basch, *Work Participation Rate: Temporary Assistance for Needy Families*, Center for Law and Social Policy, May 2015, http://www.clasp.org/resources-and-publications/publication-1/TANF-101-Work-Participation-Rate.pdf.

[67] Food and Nutrition Service, United States Department of Agriculture, "Supplemental Nutrition Assistance Program Participation and Costs," August 7, 2015, United States Department of Agriculture, http://www.fns.usda.gov/sites/default/files/pd/SNAPsummary.pdf.

[68] For more on volatile schedules and child care assistance, see Christine Johnson-Staub, Hannah Matthews and Gina Adams, *Job Hours and Schedules: Implications for State Child Care and Development Fund Policies*, Center for Law and Social Policy and Urban Institute, April 2015, http://www.clasp.org/resources-and-publications/publication-1/Job-Hours-and-Schedules.pdf and Liz Ben-Ishai, Hannah Matthews, and Jodie Levin-Epstein, *Scrambling for Stability: The Challenges of Job Schedules Volatility and Child Care*, Center for Law and Social Policy, March 2014, http://www.clasp.org/resources-and-publications/publication-1/2014-03-27-Scrambling-for-Stability-The-Challenges-of-Job-Schedule-Volat-.pdf.

[69] Office of the Administration for Children and Families, Office of Child Care, "FY 2014 Preliminary Data Table 1- Average Monthly Adjusted Number of Families and Children Served," May 2015, http://www.acf.hhs.gov/programs/occ/resource/fy-2014-preliminary-data-table-1.

[70] "The Henry J. Kaiser Family Foundation, "Current Status of State Medicaid Expansion Decisions," September 2015, http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/.

[71] "The Henry J. Kaiser Family Foundation, "Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level," April 2015, http://kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/.

[72] *Policy Basics: The Earned Income Tax Credit*, Center on Budget and Policy Priorities, January 20, 2015, http://www.cbpp.org/research/policy-basics-the-earned-income-tax-credit.

[73] Kathy Edin, *It's Not Like I'm Poor*, 2015.

[74] Centers for Medicare and Medicaid Services, "Effectuated Enrollment Snapshot," June 30, 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html.

[75] *Health Reform: Beyond the Basics*, Center for Budget and Policy Priorities, August 2013, http://www.healthreformbeyondthebasics.org/premium-tax-credits-answers-to-frequently-asked-questions/.

[76] Liz Ben-Ishai, Rick McHugh and Claire McKenna, *Out of Sync: How Unemployment Insurance Rules Fail Workers with Volatile Job Schedules,"* Center for Law and Social Policy and National Employment Law Project, August 2015, http://www.clasp.org/resources-and-publications/publication-1/Out-of-Sync-Report.pdf.

THE HENRY J. KAISER FAMILY FOUNDATION

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November 2017 | Fact Sheet

Key Facts about the Uninsured Population

The Affordable Care Act (ACA) led to historic gains in health insurance coverage by extending Medicaid coverage to many low-income individuals and providing Marketplace subsidies for individuals below 400% of poverty. Under the law, the number of uninsured nonelderly Americans decreased from 44 million in 2013 (the year before the major coverage provisions went into effect) to less than 28 million as of the end of 2016. Recent efforts to alter the ACA or fundamentally change the structure of Medicaid may pose a challenge to further reducing the number of uninsured and may threaten coverage gains seen in recent years. This fact sheet describes how coverage has changed under the ACA, examines the characteristics of the uninsured population, and summarizes the access and financial implications of not having coverage.

Summary: Key Facts about the Uninsured Population

How has the number of uninsured changed under the ACA?

In the past, gaps in the public insurance system and lack of access to affordable private coverage left millions without health insurance. Beginning in 2014, the ACA expanded coverage to millions of previously uninsured people through the expansion of Medicaid and the establishment of Health Insurance Marketplaces. Data show substantial gains in public and private insurance coverage and historic decreases in uninsured rates under the ACA. Coverage gains were particularly large among low-income people living in states that expanded Medicaid. Still, millions of people—27.6 million in 2016— remain uninsured.

Why do people remain uninsured?

Even under the ACA, many uninsured people cite the high cost of insurance as the main reason they lack coverage. In 2016, 45% of uninsured adults said that they remained uninsured because the cost of coverage was too high. Many people do not have access to coverage through a job, and some people, particularly poor adults in states that did not expand Medicaid, remain ineligible for financial assistance for coverage. Some people who are eligible for financial assistance under the ACA may not know they can get help, and undocumented immigrants are ineligible for Medicaid or Marketplace coverage.

Who remains uninsured?

Most uninsured people are in low-income families and have at least one worker in the family. Reflecting the more limited availability of public coverage in some states, adults are more likely to be uninsured than children. People of color are at higher risk of being uninsured than non-Hispanic Whites.

How does the lack of insurance affect access to health care?

People without insurance coverage have worse access to care than people who are insured. One in five uninsured adults in 2016 went without needed medical care due to cost. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.

What are the financial implications of lacking coverage?

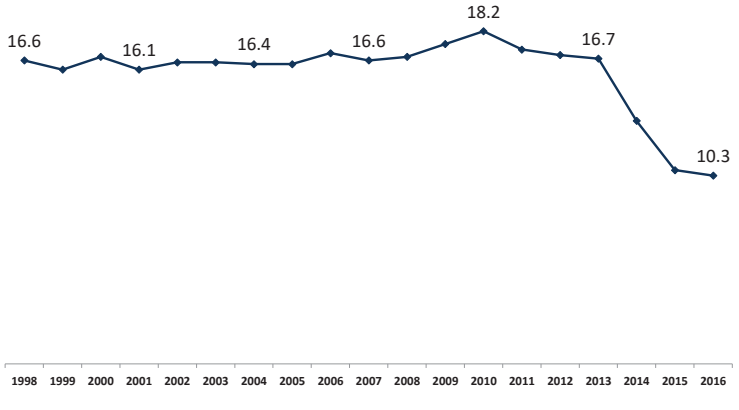
The uninsured often face unaffordable medical bills when they do seek care. In 2016, uninsured nonelderly adults were over twice as likely than their insured counterparts to have had problems paying medical bills in the past 12 months. These bills can quickly translate into medical debt since most of the uninsured have low or moderate incomes and have little, if any, savings.

How has the number of uninsured changed under the ACA?

In the past, gaps in the public insurance system and lack of access to affordable private coverage left millions without health insurance, and the number of uninsured Americans grew over time, particularly during periods of economic downturns. By 2013, more than 44 million people lacked coverage. Under the ACA, as of 2014, Medicaid coverage has been expanded to nearly all adults with incomes at or below 138% of poverty in states that have expanded their programs, and tax credits are available for people who purchase coverage through a health insurance marketplace. Millions of people have enrolled in these new coverage options, and the uninsured rate has dropped to a historic low. Coverage gains were particularly large among low-income adults living in states that expanded Medicaid. Still, millions of people—27.6 million nonelderly individuals in 2016—remain without coverage.[1]

Figure 1

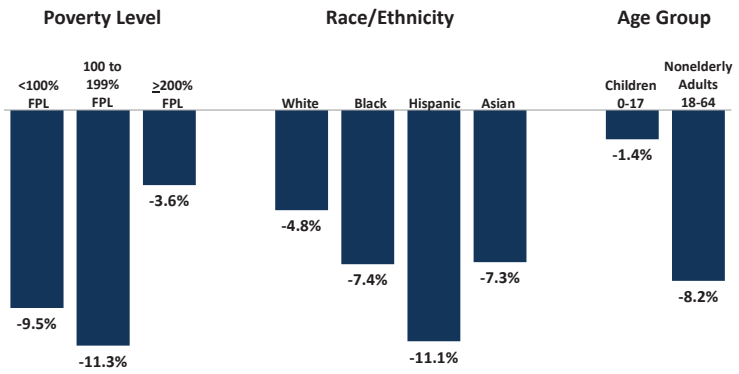
Uninsured Rate Among the Nonelderly Population, 1998-2016



NOTES: Includes nonelderly individuals ages 0-64.
SOURCE: Kaiser Family Foundation analysis of the 2016 National Health Interview Survey.

Figure 2

Percentage Point Change in Uninsured Rate among the Nonelderly Population by Selected Characteristics, 2013-2016



NOTES: Includes nonelderly individuals ages 0-64.
SOURCE: Kaiser Family Foundation analysis of the 2013 and 2016 National Health Interview Survey.

Key Details:

- The share of the nonelderly population that was uninsured hovered around 16% between 1998 and 2007, then peaked during the ensuing economic recession (Figure 1). As early provisions of the ACA went into effect in 2010, and as the economy improved, the uninsured rate began to drop. When the major ACA coverage provisions went into effect in 2014, the uninsured rate dropped dramatically and continued to fall in subsequent years. In 2016, the nonelderly uninsured rate was 10.3%, the lowest in decades.
- Coverage gains from 2013 to 2016 were particularly large among groups targeted by the ACA, including adults and poor and low-income individuals. The uninsured rate among nonelderly adults, who are more likely than children to be uninsured, dropped from 20.5% in 2013 to 12.2% in 2016, a 40% decline. In addition, between 2013 and 2016, the uninsured rate declined substantially for poor and near-poor nonelderly individuals (Figure 2). People of color, who had higher uninsured rates than non-Hispanic Whites prior to 2014, had larger coverage gains than non-Hispanic Whites. Though uninsured rates dropped across all states, they dropped more in states that chose to expand Medicaid, decreasing by 7.1 percentage points compared to 3.7 points in non-expansion states.[2] (See Appendix A for state-by-state data on changes in the uninsured rate).
- Coverage gains were seen in new ACA coverage options. As of February 2017, over 10 million people were enrolled in state or federal Marketplace plans,[3] and as of June 2017, Medicaid enrollment had grown by over 17 million (29%) since the period before open enrollment (which started in October 2013).[4]

Why do people remain uninsured?

Most of the nonelderly in the United States obtain health insurance through an employer, but not all workers are offered employer-sponsored coverage or, if offered, can afford their share of the premiums. Medicaid covers many low-income individuals, and financial assistance for Marketplace coverage is available for many moderate-income people. However, Medicaid eligibility for adults remains limited in some states, and few people can afford to purchase coverage without financial assistance. Some people who are eligible for coverage under the ACA may not know they can get help, and others may still find the cost of coverage prohibitive.

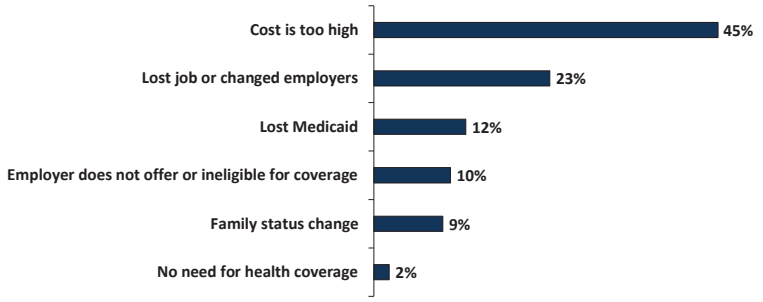
Key Details:

- Cost still poses a major barrier to coverage for the uninsured. In 2016, 45% of uninsured nonelderly adults said they were uninsured because the cost is too high, making it the most common reason cited for being uninsured (Figure 3). Though financial assistance is available to many of the remaining uninsured under the ACA,[5] not everyone who is uninsured is eligible for free or subsidized coverage. In addition, some uninsured who are eligible for help may not be aware of coverage options or may face barriers to enrollment.[6] Outreach and enrollment assistance was key to facilitating both initial and ongoing enrollment in ACA coverage, but these programs face challenges due to funding cuts and high demand.[7]

Figure 3

Reasons for Being Uninsured Among Uninsured Nonelderly Adults, 2016

Share who say they are uninsured because:



NOTES: Includes nonelderly adults ages 18-64. Respondents can select multiple reasons. Status change includes marital status change, death of spouse or parent, or ineligible due to age or leaving school.
SOURCE: Kaiser Family Foundation analysis of the 2016 National Health Interview Survey.

- Access to health coverage changes as a person's situation changes. In 2016, 23% of uninsured nonelderly adults said they were uninsured because the person who carried the health coverage in their family lost their job or changed employers (Figure 3). Nearly one in ten was uninsured because of a marital status change, the death of a spouse or parent, or loss of eligibility due to age or leaving school (9%), and some lost Medicaid because of a new job/increase in income or the plan stopping after pregnancy (12%).
- As indicated above, not all workers have access to coverage through their job. In 2016, 74% of nonelderly uninsured workers worked for an employer that did not offer health benefits to the worker.[8] Moreover, nine out of ten uninsured workers who do not take up an offer of employer-sponsored coverage report cost as the main reason for declining (90%).[9] From 2006 to 2016, total premiums for family coverage increased by 58%, and the worker's share increased by 78%, outpacing wage growth.[10]
- Medicaid and CHIP are available for low-income children, but eligibility for adults is more limited. As of January 2017, 31 states plus DC had expanded Medicaid eligibility for adults under the ACA.[11] However, in states that have not expanded Medicaid, eligibility for adults remains limited, with median eligibility level for parents at just 44% of poverty and adults without dependent children ineligible in most cases.[12] Millions of poor uninsured adults fall in a "coverage gap" because they earn too much to qualify for Medicaid but not enough to qualify for Marketplace premium tax credits.[13]
- Undocumented immigrants are ineligible for Medicaid or Marketplace coverage.[14] While lawfully-present immigrants under 400% of poverty are eligible for Marketplace tax credits, only those who have passed a five-year waiting period after receiving qualified immigration status can qualify for Medicaid.

Who remains uninsured?

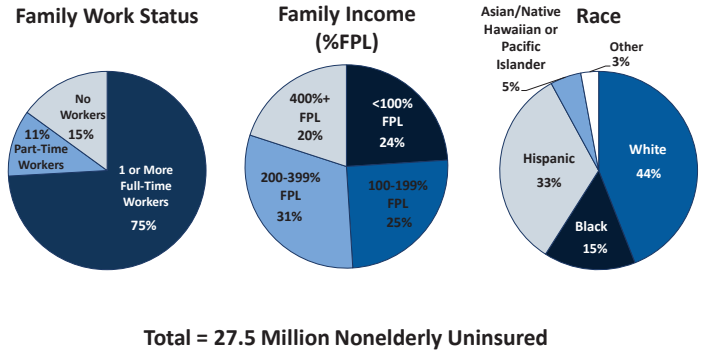
Most remaining uninsured people are in working families, are in families with low incomes, and are nonelderly adults.[15] Reflecting income and the availability of public coverage, people who live in the South or West are more likely to be uninsured. Most who remain uninsured have been without coverage for long periods of time.

Key Details:

- In 2016, three quarters of the uninsured (75%) had at least one full-time worker in their family, and an additional 11% had a part-time worker in their family (Figure 4).
- Individuals below poverty[16] are at the highest risk of being uninsured. In total, eight in ten of the uninsured were in families with incomes below 400% of poverty in 2016 (Figure 4).
- While a plurality (44%) of the uninsured are non-Hispanic Whites, people of color are at higher risk of being uninsured than Whites. People of color make up 42% of the nonelderly U.S. population but account for over half of the total nonelderly uninsured population (Figure 4). Hispanics and Blacks have significantly higher uninsured rates (16.9% and 11.7%, respectively) than Whites (7.6%).[17]
- Most (85%) of the uninsured are nonelderly adults. The uninsured rate among children was just 5% in 2016, less than half the rate among nonelderly adults (12%),[18] largely due to broader availability of Medicaid/CHIP for children than for adults.
- Most of the uninsured (78%) are U.S. citizens, and 22% are non-citizens.[19] Uninsured non-citizens include both lawfully present and undocumented immigrants. Undocumented immigrants are ineligible for federally funded health coverage, but legal immigrants can qualify for subsidies in the Marketplaces and those who have been in the country for more than five years are eligible for Medicaid.[20]
- Uninsured rates vary by state and by region, with individuals living in the South and West the most likely to be uninsured. The eight out of the twelve states with the highest uninsured rates in 2016 were in the South (Figure 5 and Appendix A). This variation reflects different economic conditions, state expansion status, availability of employer-based coverage, and demographics.
- Over two-thirds (67%) of the remaining uninsured in 2016 have been without coverage for more than a year.[21] People who have been without coverage for long periods may be particularly hard to reach in outreach and enrollment efforts.

Figure 4

Characteristics of the Nonelderly Uninsured, 2016

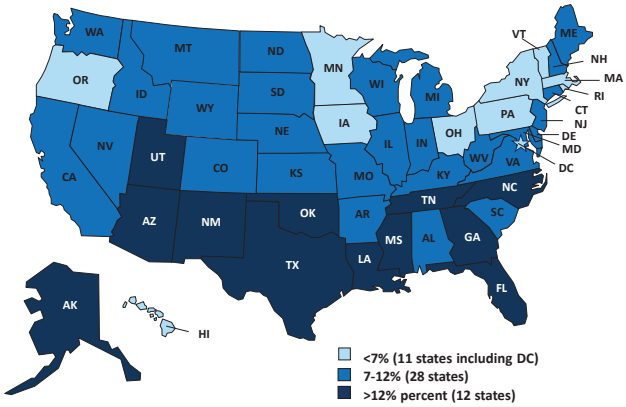


Total = 27.5 Million Nonelderly Uninsured

NOTES: Includes nonelderly individuals ages 0-64. The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $19,318 in 2016. Data may not total 100% due to rounding. Persons of Hispanic origin may be of any race; all other race/ethnicity groups are non-Hispanic.
SOURCE: Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.

Figure 5

Uninsured Rates Among the Nonelderly by State, 2016



NOTES: Includes nonelderly individuals ages 0-64.
SOURCE: Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.

How does the lack of insurance affect access to health care?

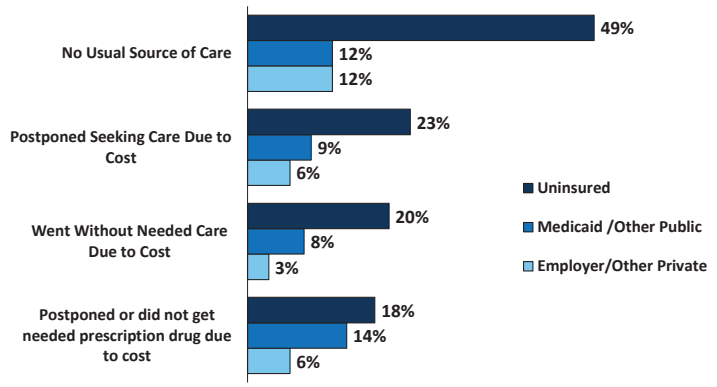
Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured adults are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.

Key Details:

- Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.[22, 23] One in five (20%) nonelderly adults without coverage say that they went without care in the past year because of cost compared to 3% of adults with private coverage and 8% of adults with public coverage. Part of the reason for poor access among the uninsured is that many (49%) do not have a regular place to go when they are sick or need medical advice (Figure 6).

Figure 6

Barriers to Health Care Among Nonelderly Adults by Insurance Status, 2016



NOTE: Includes nonelderly adults ages 18-64. Includes barriers experienced in past 12 months. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All differences between uninsured and insurance groups are statistically significant ($p < 0.05$).
SOURCE: Kaiser Family Foundation analysis of the 2016 National Health Interview Survey.

- Because of the cost of care, many uninsured people do not obtain the treatments their health care providers recommend for them. In 2016, uninsured nonelderly adults were three times as likely as adults with private coverage to say that they postponed or did not get a needed prescription drug due to cost (18% vs. 6%).[24] And while insured and uninsured people who are injured or newly diagnosed with a chronic condition receive similar plans for follow-up care, people without health coverage are less likely than those with coverage to obtain all the recommended services.[25]
- Because people without health coverage are less likely than those with insurance to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health. When they are hospitalized, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.[26,27,28,29]
- Research demonstrates that gaining health insurance improves access to health care considerably and diminishes the adverse effects of having been uninsured. A seminal study of a Medicaid expansion in Oregon found that uninsured adults who gained Medicaid coverage were more likely to receive care than their counterparts who did not gain coverage.[30] A comprehensive review of research on the effects of the ACA Medicaid expansion finds that expansion led to positive effects on access to care, utilization of services, the affordability of care, and financial security among the low-income population.[31]
- Public hospitals, community clinics and health centers, and local providers that serve disadvantaged communities provide a crucial health care safety net for uninsured people. However, safety net providers have limited resources and service capacity, and not all uninsured people have geographic access to a safety net provider.[32,33]

What are the financial implications of lack of coverage?

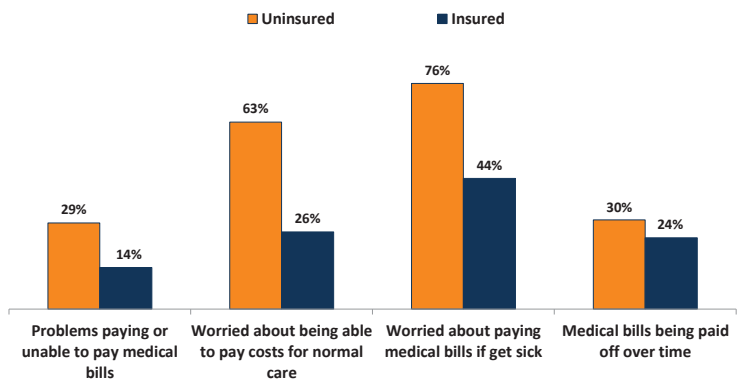
The uninsured often face unaffordable medical bills when they do seek care. These bills can quickly translate into medical debt since most of the uninsured have low or moderate incomes and have little, if any, savings.[34]

Key Details:

- Those without insurance for an entire year pay for one-fifth of their care out-of-pocket.[35] In addition, hospitals frequently charge uninsured patients much higher rates than those paid by private health insurers and public programs.[36,37]
- Medical bills can put great strain on the uninsured and threaten their financial well-being. In 2016, nonelderly uninsured adults were over twice as likely as those with insurance to have problems paying medical bills (29% vs. 14%; Figure 7) with two thirds of uninsured who had medical bill problems unable to pay their medical bills at all (67%).[38] Uninsured adults are also more likely to face negative consequences due to medical bills, such as using up savings, having difficulty paying for necessities, borrowing money, or having medical bills sent to collection.[39]

Figure 7

Problems Paying Medical Bills by Insurance Status, 2016



NOTE: Includes nonelderly adults ages 18-64. All differences between uninsured and insured groups are statistically significant ($p < 0.05$).
SOURCE: Kaiser Family Foundation analysis of the 2016 National Health Interview Survey.

- Uninsured nonelderly adults are also much more likely than their insured counterparts to lack confidence in their ability to afford usual medical costs and major medical expenses or emergencies. Uninsured nonelderly adults are over twice as likely as insured adults to worry about being able to pay costs for normal health care (63% vs. 26%; Figure 7). Furthermore, over three quarters of uninsured nonelderly adults (76%) say they are very or somewhat worried about paying medical bills if they get sick or have an accident, compared to 44% of insured adults.
- Lacking insurance coverage puts people at risk of medical debt. In 2016, three in ten (30%) of uninsured nonelderly adults said they were paying off least one medical bill over time (Figure 7). Medical debts contribute to over half (52%) of debt collections actions that appear on consumer credit reports in the United States[40] and contribute to almost half of all bankruptcies in the United States.[41] Uninsured people are more at risk of falling into medical bankruptcy than people with insurance.[42]
- Though the uninsured are typically billed for medical services they use, when they cannot pay these bills, the costs may become bad debt or uncompensated care for providers. State, federal, and private funds defray some but not all of these costs. With the expansion of coverage under the ACA, providers are seeing reductions in uncompensated care costs, particularly in states that expanded Medicaid.[43]
- Research suggests that gaining health coverage improves the affordability of care and financial security among the low-income population. Multiple studies of the ACA have found larger declines in trouble paying medical bills in expansion states relative to non-expansion states. A separate study found that, among those residing in areas with high shares of low-income, uninsured individuals, Medicaid expansion significantly reduced the number of unpaid bills and the amount of debt sent to third-party collection agencies.[44]

Conclusion

Millions of people have gained coverage under the ACA provisions that went into effect in 2014, and current debate over rolling back ACA coverage threaten these gains in coverage and make it difficult to reach the 27.6 million who remain without coverage. Proposed policies to change the structure of the Medicaid program or cut back subsidies for Marketplace coverage may lead to even more uninsured individuals. On the other hand, if additional states opt to expand Medicaid as allowed under the ACA, there may be additional coverage gains as low-income individuals gain access to affordable coverage. Going without coverage can have serious health consequences for the uninsured because they receive less preventive care, and delayed care often results in serious illness or other health problems. Being uninsured also can have serious financial consequences. The outcome of current debate over health coverage policy in the United States has substantial implications for people's coverage, access, and overall health and well-being.

Appendix A: Uninsured Rate Among the Nonelderly by State, 2013-2016				
	2013 Uninsured Rate	2016 Uninsured Rate	Change in Uninsured Rate	Change in Number of Uninsured
Expansion States	**13.6%**	**8.1%**	**-5.5%**	**-9,110,784**
Alaska	15.8%	15.2%	-0.5%	-4,605
Arizona	21.2%	14.0%	-7.1%	-383,719
Arkansas	17.8%	9.1%	-8.7%	-206,013
California	16.4%	8.7%	-7.6%	-2,526,529
Colorado	13.8%	10.8%	-3.1%	-139,372
Connecticut	11.8%	7.2%	-4.6%	-145,215
Delaware	8.3%	10.6%	2.3%	20,756
District of Columbia	8.9%	5.9%	-2.9%	-15,885
Hawaii	5.7%	6.3%	0.6%	7,414
Illinois	11.9%	8.6%	-3.3%	-403,107
Indiana	14.6%	7.6%	-7.0%	-382,508
Iowa	9.5%	6.2%	-3.3%	-87,375
Kentucky	16.3%	7.2%	-9.1%	-351,749
Louisiana	16.4%	12.1%	-4.3%	-158,238
Maryland	13.3%	7.2%	-6.0%	-309,202
Massachusetts	3.6%	6.4%	2.7%	161,492
Michigan	12.1%	7.4%	-4.8%	-412,911
Minnesota	7.9%	6.9%	-1.0%	-52,380
Montana	19.0%	8.5%	-10.4%	-85,493
Nevada	22.0%	10.2%	-11.8%	-270,526
New Hampshire	13.2%	7.6%	-5.6%	-65,367
New Jersey	13.4%	9.0%	-4.4%	-339,457
New Mexico	19.5%	13.0%	-6.5%	-112,780
New York	11.1%	6.6%	-4.5%	-775,319
North Dakota	12.1%	8.9%	-3.2%	-19,617
Ohio	13.9%	6.5%	-7.4%	-708,788
Oregon	14.2%	6.2%	-8.0%	-257,142
Pennsylvania	11.6%	5.7%	-5.9%	-647,343
Rhode Island	10.7%	5.8%	-5.0%	-43,871
Vermont	9.1%	6.5%	-2.6%	-13,549
Washington	13.4%	8.1%	-5.4%	-299,746
West Virginia	14.2%	8.8%	-5.4%	-82,642
Non-Expansion States	**18.1%**	**13.3%**	**-4.8%**	**-4,575,853**
Alabama	17.8%	10.1%	-7.7%	-305,483
Florida	22.0%	14.6%	-7.5%	-1,128,462
Georgia	18.5%	13.7%	-4.7%	-334,624
Idaho	16.8%	10.2%	-6.6%	-87,058
Kansas	11.5%	9.8%	-1.7%	-41,999
Maine	11.3%	8.7%	-2.6%	-30,792
Mississippi	16.4%	13.9%	-2.6%	-63,174
Missouri	13.1%	9.8%	-3.2%	-168,358
Nebraska	10.6%	8.2%	-2.4%	-38,713
North Carolina	17.3%	12.4%	-5.0%	-377,650
Oklahoma	18.1%	12.4%	-5.7%	-163,857
South Carolina	18.9%	10.8%	-8.1%	-297,343
South Dakota	11.6%	9.4%	-2.2%	-15,268
Tennessee	15.2%	13.2%	-2.0%	-90,107
Texas	22.8%	17.1%	-5.7%	-1,191,130
Utah	13.7%	13.5%	-0.2%	16,342
Virginia	13.1%	11.5%	-1.7%	-125,841
Wisconsin	10.4%	8.3%	-2.2%	-98,298
Wyoming	17.5%	11.2%	-6.3%	-34,040

SOURCE: Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.

Appendix Table B: Characteristics of the Nonelderly Uninsured, 2016					
	Nonelderly (millions)	Percent of Nonelderly	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
Total Nonelderly	271.1	100.0%	27.5	100.0%	10.1%
Age					
Children - Total	78.2	28.8%	4.2	15.3%	5.4%
Nonelderly Adults - Total	192.9	71.2%	23.3	84.7%	12.1%
Adults 19 - 25	29.8	11.0%	3.9	14.2%	13.1%
Adults 26 - 34	39.7	14.7%	6.2	22.7%	15.7%
Adults 35 - 44	40.0	14.8%	5.3	19.1%	13.1%
Adults 45 - 54	42.0	15.5%	4.3	15.8%	10.3%
Adults 55 - 64	41.3	15.2%	3.5	12.8%	8.5%
Annual Family Income					
<$20,000	35.9	13.3%	6.7	24.3%	18.6%
$20,000 - <$40,000	43.1	15.9%	6.8	24.9%	15.9%
$40,000 +	192.1	70.8%	13.9	50.8%	7.3%
Family Poverty Level					
<100%	36.5	13.5%	6.5	23.6%	17.7%
100% - <200%	44.2	16.3%	6.8	24.7%	15.3%
200% - <400%	78.8	29.1%	8.6	31.4%	10.9%
400%+	111.6	41.2%	5.6	20.4%	5.0%
Household Type					
Single Adults Living Alone	45.0	16.6%	6.7	24.5%	15.0%
Single Adults Living Together	35.7	13.2%	4.9	17.7%	13.6%
Married Adults	37.1	13.7%	3.2	11.5%	8.5%
1 Parent with Children	23.4	8.6%	2.2	8.1%	9.5%
2 Parents with Children	83.4	30.7%	5.5	19.9%	6.6%
Multigenerational	14.2	5.2%	1.6	5.9%	11.4%
Other with Children	32.3	11.9%	3.4	12.4%	10.5%
Family Work Status					
2+ Full-time	93.4	34.4%	6.8	24.8%	7.3%
1 Full-time	131.1	48.4%	13.7	49.9%	10.4%
Only Part-time	19.4	7.2%	2.9	10.7%	15.1%
Non-Workers	27.2	10.0%	4.0	14.6%	14.7%
Race/Ethnicity					
White	157.5	58.1%	12.0	43.9%	7.6%
Black	34.9	12.9%	4.1	14.9%	11.7%
Hispanic	53.6	19.8%	9.1	33.0%	16.9%
Asian/N. Hawaiian and Pacific Islander	17.1	6.3%	1.4	5.2%	8.3%
American Indian/Alaska Native	2.1	0.8%	0.4	1.5%	18.9%
Two or More Races	5.8	2.1%	0.4	1.6%	7.4%
Citizenship					
U.S. Citizen - Native	233.7	86.2%	19.8	72.3%	8.5%
U.S. Citizen - Naturalized	15.7	5.8%	1.6	6.0%	10.4%
Non-U.S. Citizen, Resident for <5 Years	5.9	2.2%	1.4	5.0%	23.2%
Non-U.S. Citizen, Resident for 5+ Years	15.8	5.8%	4.6	16.7%	29.0%
Health Status					
Excellent/Very Good	186.8	68.9%	16.9	61.5%	9.0%
Good	61.9	22.8%	8.0	29.0%	12.9%
Fair/Poor	22.4	8.3%	2.6	9.5%	11.7%

NOTES: Includes nonelderly individuals ages 0-64. The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $19,318 in 2016. Parent includes any person with a dependent child. Multigenerational/other families with children include families with at least three generations in a household, plus families in which adults are caring for children other than their own. Part-time workers were defined as working <35 hours per week. Respondents who identify as mixed race who do not also identify as Hispanic fall into the "Two or More Races" category. All individuals who identify as Hispanic ethnicity fall into the Hispanic category regardless of race.
SOURCE: Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.

Endnotes

[1] Kaiser Family Foundation analysis of the 2016 National Health Interview Survey

[2] Robin A. Cohen, Michael E. Martinez, and Emily P. Zammitti, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January – March 2017* (Hyattsville, MD: National Center for Health Statistics, August 2017), https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201708.pdf

[3] State Health Facts. "Total Marketplace Enrollment and Financial Assistance, February 2017." Kaiser Family Foundation, 2017, http://kff.org/health-reform/state-indicator/total-marketplace-enrollment-and-financial-assistance/

[4] State Health Facts. "Total Monthly Medicaid and CHIP Enrollment." Kaiser Family Foundation, June 2017, http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/.

[5] Rachel Garfield, Anthony Damico, Cynthia Cox, Gary Claxton, and Larry Levitt, *New Estimates of Eligibility for ACA Coverage among the Uninsured* (Washington, DC: Kaiser Family Foundation, Jan 2016), http://kff.org/health-reform/issue-brief/new-estimates-of-eligibility-for-aca-coverage-among-the-uninsured/

[6] Bianca DiJulio, Jamie Firth, and Mollyann Brodi, *Kaiser Health Tracking Poll: December 2015*, (Washington, D.C.: Kaiser Family Foundation, Dec 2015), http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-december-2015/

[7] Karen Pollitz, Jennifer Tolbert, and Ashley Semanskee. *2016 Survey of Health Insurance Marketplace Assister Programs and Brokers* (Washington, DC: Kaiser Family Foundation, June 2016), http://www.kff.org/health-reform/report/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers/

[8] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement

[9] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement

[10] Kaiser Family Foundation. *2016 Employer Health Benefits Survey* (Washington, DC: Kaiser Family Foundation, September 2016), http://kff.org/report-section/ehbs-2016-summary-of-findings/

[11] State Health Facts. "Status of State Action on the Medicaid Expansion Decision." Kaiser Family Foundation, 2017, http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

[12] Tricia Brooks, Karina Wagnerman, Samantha Artiga, Elizabeth Cornachione, and Petry Ubri, *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey* (Washington, DC: Kaiser Family Foundation, January 2017), http://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-findings-from-a-50-state-survey/

[13] Rachel Garfield and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update* (Washington, DC: Kaiser Family Foundation, January 2016), http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/

[14] Samantha Artiga and Anthony Damico, *Health Coverage and Care for Immigrants* (Washington, DC: Kaiser Family Foundation, July 2017), http://www.kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-immigrants/

[15] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement

[16] $19,318 for a family of three in 2016

[17] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement

[18] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement

[19] Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement

[20] Samantha Artiga and Anthony Damico, *Health Coverage and Care for Immigrants* (Washington, DC: Kaiser Family Foundation, July 2017), http://www.kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-immigrants/

[21] Kaiser Family Foundation analysis of the 2016 National Health Interview Survey

[22] Jack Hadley, "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition." *JAMA* 297, no. 10 (March 2007):1073-84.

[23] Stacey McMorrow, Genevieve M. Kenney, and Dana Goin,"Determinants of Receipt of Recommended Preventive Services: Implications for the Affordable Care Act," *American Journal of Public Health* 104, no. 12 (Dec 2014): 2392-9.

[24] Kaiser Family Foundation analysis of the 2016 National Health Interview Survey

[25] Jack Hadley, "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition," *JAMA* 297, no. 10 (March 2007): 1073-84.

[26] Fizan Abdullah, et al., "Analysis of 23 Million US Hospitalizations: Uninsured Children Have Higher All-Cause In-Hospital Mortality," *Journal of Public Health* 32, no. 2 (June 2010): 236-44.

[27] Andrew Wilper, et al., "Health Insurance and Mortality in US Adults," *American Journal of Public Health* 99, no. 12 (December 2009): 2289-2295.

[28] Wendy Greene, et. al., "Insurance Status is a Potent Predictor of Outcomes in Both Blunt and Penetrating Trauma." *American Journal of Surgery* 199, no. 4 (April 2010): 554-7.

[29] Sarah Lyon, "The Effect of Insurance Status on Mortality and Procedural Use in Critically Ill Patients," *American Journal of Critical Care Medicine* 184, no. 7 (October 2011): 809-15.

[30] Amy Finkelstein, et. al, "The Oregon Health Insurance Experiment: Evidence from the First Year" (National Bureau of Economic Research, July 2011), http://www.nber.org/papers/w17190

[31] Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga, *The Effects of Medicaid Expansion on the ACA: Findings From a Literature Review* (Washington, D.C.: Kaiser Family Foundation, Jun 2016), http://kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review/

[32] Mark Hall, "Rethinking Safety Net Access for the Uninsured," *New England Journal of Medicine 364 (January 2011):7-9.*

[33] John Holahan and Brenda Spillman, *Health Care Access for Uninsured Adults: A Strong Safety Net is not the Same as Insurance* (Washington, DC: The Urban Institute, January 2002), http://www.urban.org/research/publication/health-care-access-uninsured-adults

[34] Sherry Glied and Richard Kronick, *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills* (Washington, DC: Office of Assistant Secretary for Planning and Evaluation, HHS, May 2011), http://aspe.hhs.gov/health/reports/2011/ValueofInsurance/rb.pdf

[35] The Kaiser Commission on Medicaid and the Uninsured, *Uncompensated Care for the Uninsured in 2013: A Detailed Examination*, (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8596-uncompensated-care-for-the-uninsured-in-2013.pdf

[36] Glenn Melnick, "Fair Pricing Law Prompts Most California Hospitals to Adopt Policies to Protect Uninsured Patients from High Charges," *Health Affairs* 32, no. 6 (Jun 2013); 1101-8.

[37] Stacie Dusetzina, Ethan Basch, and Nancy Keating, "For Uninsured Cancer Patients, Outpatient Charges Can Be Costly, Putting Treatments out of Reach," *Health Affairs* 34, no. 4 (April 2015): 584-591, http://content.healthaffairs.org/content/34/4/584.abstract

[38] Kaiser Family Foundation analysis of the 2016 National Health Interview Survey

[39] Liz Hamel, Mira Norton, Karen Pollitz, Larry Levitt, Gary Claxton, and Mollyann Brodie, *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey,* (Washington, D.C.: Kaiser Family Foundation, Jan 2016), http://kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/

[40] Consumer Financial Protection Bureau, "Consumer Credit Reports: A Study of Medical and Non-Medical Collections." (Consumer Financial Protection Bureau: December 2014), http://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf

[41] David U. Himmelstein, Deborah Thorne, Elizabeth Warren, Steffie Woolhandler, "Medical Bankruptcy in the United States, 2007: Results of a National Study." *The American Journal of Med*icine, 122, no. 8 (2009): 741-6, http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf

[42] Ibid.

[43] Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga, *The Effects of Medicaid Expansion on the ACA: Findings From a Literature Review* (Washington, D.C.: Kaiser Family Foundation, Jun 2016), http://kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review-issue-brief/

[44] Ibid.

kaiser commission on medicaid and the uninsured

Is Lack of Coverage a Short- or Long-term Condition?

Prepared by
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June 2003

THE HENRY J. KAISER FAMILY FOUNDATION

kaiser commission on medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of The Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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INTRODUCTION

Despite widespread discussion of the problems of being uninsured, there is still disagreement regarding the nature of the condition. Is it a problem of brief duration or a problem that persists over longer periods of time? The answer to this question could shape the types of policies that might be considered. If people who become uninsured remain so for very short periods of time, then policies designed to plug gaps in coverage (e.g., subsidies that would make COBRA coverage affordable to more people) might seem sensible. However, if people tend to be without coverage for longer periods of time, then policies aimed at making structural changes in health insurance that would enhance accessibility and affordability over the long run (e.g., permanent tax credits, insurance market reforms and/or expansions of public coverage beyond low income groups) might be needed.

A major reason that the nature of the problem remains unsettled is that the survey data that have been used to study the uninsured vary with respect to the reference periods for which insurance coverage is measured (Lewis, Ellwood, and Czajka 1998; Short 2001; Department of Health and Human Services 2002). For example, the Current Population Survey (CPS) – the most widely cited estimate of the number of uninsured – collects data that literally implies that its estimate refers to people who are uninsured for a full year. However, some analysts believe respondents report data about coverage at the time of the survey rather than throughout the prior year (Lewis, Ellwood, and Czajka 1998*)*. Alternatively, other surveys focus on people uninsured at the time of the survey (e.g., the National Health Interview Survey [NHIS] and Community Tracking Study [CTS]), while others can produce multiple estimates because they track people over time (e.g., the Medical Expenditure Panel Survey [MEPS] and Survey of Income and Program Participation [SIPP]). Although a careful interpretation of these data suggests that lack of coverage has been wrongly depicted as a temporary problem (Swartz 1994), this has not expunged the notion from the policy debate (National Association of Health Underwriters [NAHU] 2000).[1]

This paper produces alternative estimates of the numbers of uninsured within the context of a single survey and explores the distribution of the duration of uninsured spells for people who lacked coverage at some time during a 12-month period. We consider uninsured spells overall and for a variety of socioeconomic and demographic subgroups. Estimates are presented for the share of the population uninsured for short time periods as well as for the share uninsured for at least one year. We focus on people who lacked coverage at some time during a 12-month period instead of the narrower group that is uninsured at a point in time, because the 12-month period allows us to capture all uninsured spells that occurred during that year. To show the potential consequences of short and long spells without health coverage, we also examine the relationship between length of time without coverage and health care access and utilization. This paper uses the 1999 National Survey of America's Families (NSAF), a survey of nonelderly adults and children in over 42,000 households, which contains information on insurance coverage at the time of the survey and in the prior 12 months.

Based on NSAF, 36 million nonelderly individuals were uninsured at the time of the survey. A much larger number – 49 million – were uninsured at the time of the survey or at some point during the 12 months prior to the survey. Of these 49 million, 22 million

experienced short-term uninsured spells (i.e., were uninsured for less than a full year), while 27 million were uninsured for a year or more, indicating that a large share of the uninsured are experiencing long spells without coverage. The Congressional Budget Office (CBO, 2003) used data from the 1998 SIPP and MEPS to estimate that almost 60 million nonelderly people were uninsured at some time during the year. Another recent study estimated that 75 million nonelderly Americans were uninsured for at least one month over a recent two-year period (Families USA 2003). These estimates are substantially larger than the estimate based on NSAF for a number of methodological reasons related to differences in estimates of the number of people uninsured at the time of the survey, differences between the surveys with respect to how they measure changes in insurance coverage over time, and the timeframe of the estimates. These issues are discussed in more detail in the Discussion section of this paper.

BACKGROUND

There are excellent reviews of the surveys that are commonly used to produce estimates of the uninsured and how the differences between the surveys may yield different estimates (Short 2001; Fronstin 2000; Lewis, Ellwood and Czajka 1998). These studies typically address issues related to the design of the questionnaire, the time frame covered by the survey, the primary reason for conducting the survey, the sample frame and how the survey was administered. The timeframe referenced in the uninsured estimates has a direct effect on the number of uninsured. Estimates of those uninsured at the time of the survey (or on an average day) are larger than estimates of the numbers of full-year uninsured, but are not as large as the estimate of those uninsured at some time during, say, a one- or two-year period. Although these differences are not always apparent looking at estimates across surveys, they are displayed in the context of the MEPS (Rhoades, et al., 2002). The MEPS study showed that uninsured rates can vary up to twofold depending on the reference period for the estimates.

The most relevant research related to the present study comes from a series of analyses that used data from the SIPP. These studies (e.g., CBO 2003; Swartz and McBride 1990; Swartz, Marcotte, and McBride 1993; Nelson and Short 1990) showed that the majority of new uninsured spells (i.e., those that began within a specified time frame) end within 9 months and that the median spell length is 6 months. However, McBride (1994) showed that, although nearly 70 percent of all new spells ended in less than 9 months, over 50 percent of the people who were uninsured at a point in time had been without coverage for more than 2 years. In fact, the recent CBO report contains a detailed technical appendix that explains how three apparently different SIPP estimates of the distribution of uninsured spells are all consistent with one another. CBO shows that 29 percent of new uninsured spells last more than a year, 59 percent of people uninsured at some time during a year lack coverage for more than a year and 78 percent of people uninsured in a given month have been uninsured for at least a year.

As both McBride (1994) and Swartz (1994) point out, their findings were misinterpreted to conclude that the majority of *ongoing* uninsured spells are short and that, as a result, the severity of the problem was being overstated (e.g., *Wall Street Journal* 1993; Reynolds 1993; Council for Affordable Health Insurance 1993; Crane 1993). As recent evidence suggests, the notion still persists that a large share of the uninsured would be helped if policymakers developed approaches that carried people through their short periods without coverage (NAHU

2000). In part, this appears to be the motivation behind the tax credits provided in the Trade Adjustment Assistance Act of 2002.

In this paper, we reexamine the distribution of uninsured spells using data from 1999. In addition to focusing on many demographic and economic subgroups, we pay particular attention to differences across states and, for adults, differences related to eligibility for public coverage. Given that states have the primary responsibility for developing policies and approaches for covering the uninsured (e.g., through Medicaid, the State Children's Health Insurance Program [S-CHIP] or state programs), it is important to understand if the short- or long-term nature of the problem is fundamentally different across states and if eligibility for public coverage affects how long people are uninsured.

DATA AND METHODS

National Survey of America's Families

This analysis uses the 1999 National Survey of America's Families (NSAF), conducted by the Urban Institute as part of its *Assessing the New Federalism* (ANF) project. NSAF is a nationally representative survey of nonelderly adults and children in over 42,000 households that represents the non-institutionalized civilian population under age 65. It over-samples the low-income population (those with family incomes below 200 percent of the federal poverty level [FPL]) and populations in 13 states.[2] The survey contains detailed information on health insurance coverage, access, and utilization for up to two sampled children (one age 5 or under and one between ages 6 and 17) and one sampled adult in each household. The sample was weighted to population totals, and weights adjust for the design features of the sample, including over-sampling low-income households and those in the 13 study states, as well as non-response and under-coverage.

Measurement of Health Insurance Coverage

Respondents were asked about selected family members' health insurance coverage, including a question that confirmed lack of coverage for those not originally identified as having any type of coverage (Rajan, Zuckerman, and Brennan 2001). The health insurance coverage sequence allows for assessment of coverage both at the time of the survey and in the 12 months prior to the survey.

Individuals identified as having no health insurance coverage at the time of the survey are classified as being uninsured at a point in time. Those uninsured either at the time of the survey or at any time in the prior 12 months are classified as having been uninsured during the previous 12 months. Among those without coverage at some time during the 12-month period, a long-term spell was defined as being uninsured for a full year or more (that is, at the time of the survey and for all of the prior 12 months); individuals uninsured for less than 12 months are divided into two groups of short-term uninsured: those uninsured for 1 to 5 months and those uninsured for 6 to 11 months.

Measurement of Eligibility for Public Coverage

Adults and children were further classified according to whether or not they appeared to be eligible for public health insurance coverage (Medicaid or S-CHIP for children and Medicaid or other state programs for adults). The determination of eligibility mimics the eligibility determination process faced by families by comparing information collected in the survey on family structure, work status, income, and assets to the various state standards and eligibility thresholds in place at the time of the survey. Further information about these measures is available elsewhere (Dubay, Haley, and Kenney 2002; Davidoff et al. forthcoming).

Analyses Conducted

In this paper, we conduct bivariate analysis examining uninsured rates and length of uninsured spells by a variety of socioeconomic status and demographic characteristics, including the family's poverty level, highest education level among adults in the family, health status, age, race/ethnicity, citizenship status, state of residence, community type (inside or outside a metropolitan area), and whether or not individuals are eligible for public insurance coverage (the eligibility results are only presented for adults). Additional results about variations in health care access and utilization by length of time without coverage are based on regression-adjusted means derived from a two-step process. First, we estimated logistic regression models that control for differences in socioeconomic status, demographic characteristics and insurance status. Then, we predicted values of the access and utilization variables for each uninsured group using the full-year insured as a comparison group. Variances of estimates for both the bivariate and multivariate analysis were adjusted to account for the survey's complex sample design.

Limitations to the Data

While NSAF is a useful survey for examining insurance status over the course of a year, there are some limitations to using the data in this way. First, while many analyses of insurance coverage use longitudinal data, NSAF collects information on coverage during a 12-month period at a single point in time. Because information on past year coverage is retrospective, some respondents may forget about conditions in the past or report those conditions erroneously. In addition, for cases with between 2 and 11 months without coverage, the survey does not collect information about transitions between statuses – i.e., whether the person experienced one uninsured spell or intermittent periods without coverage. Finally, some characteristics examined in this report may not reflect the conditions during the time the person was uninsured. For instance, the family income measure reflects conditions during the entire calendar year prior to the survey and may not necessarily represent conditions during an uninsured spell.

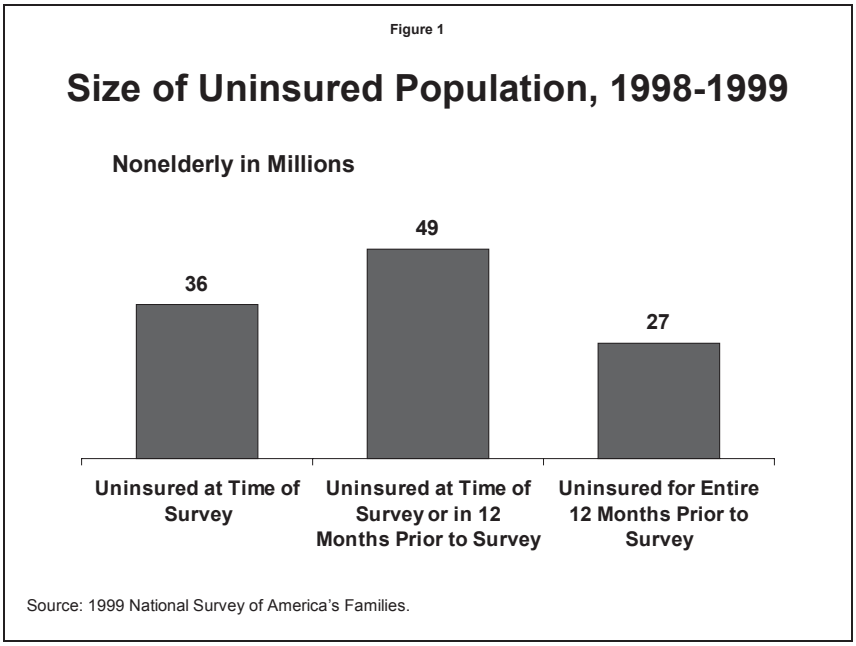
RESULTS

Estimates of the Uninsured

Figure 1 presents the number of nonelderly uninsured in NSAF using three different time frames. Thirty-six million people were uninsured at the time of the survey (a single point in time). An additional 13 million were uninsured during at least one of the 12 months prior to the survey but received coverage by the time of the survey. Combining these two groups, 49 million people were uninsured at the time of the survey or at some point in the 12 months prior to the

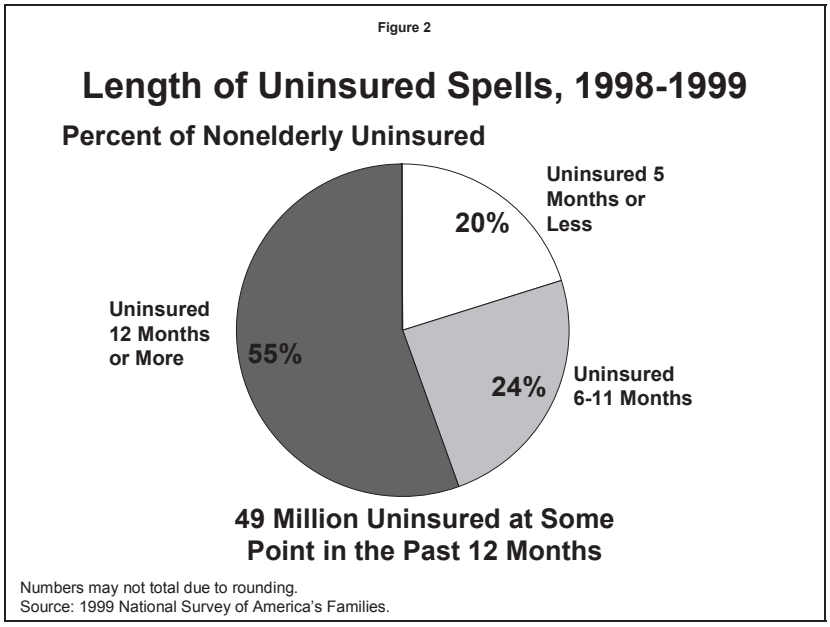
survey. Of those 49 million people, over half—27 million—were uninsured for the entire 12 months. As these estimates show, the size of the uninsured population varies considerably by time frame, even within a single survey.

Figure 1



For the 49 million people who were uninsured at some point during the year, Figure 2 shows the number of months they spent without coverage. About 20 percent (10 million) were uninsured for five months or less, and 24 percent (12 million) were uninsured for more than five months but less than a year. Thus, 44 percent (22 million) were uninsured for part of the year and are defined in this study as the short-term uninsured, while 55 percent (27 million) lacked coverage for at least a full year, and are classified as long-term uninsured. (See Appendix A for a detailed comparison between this distribution of uninsured spells and the distribution presented in the recent CBO report.)

Figure 2



Variation in Uninsured Spells Across Subgroups

Health insurance coverage varies by several social and economic factors, as well as by state. We find that the share who are long-term uninsured varies more than the share who are short-term uninsured across subgroups and states, and, in fact, that the differences in long periods without coverage largely explain the disparities across groups in lacking coverage at all. Tables 1-4 present the share of the total population and selected subgroups that were uninsured at any point in the year and, of those, the share uninsured for various lengths of time.

Differences by Income, Education, Health Status, and Age

The first panel in Table 1 shows that the likelihood of being uninsured at some time during the year varied greatly with family income. Over 40 percent of people living in families with incomes below poverty experienced an uninsured spell, compared with just 9 percent of people in families with incomes greater than three times the poverty level. Although there were significant differences across income groups with respect to the probability of having a short episode without coverage, the most dramatic differences occurred among those lacking coverage for a year or more. The likelihood of a person in the highest income group being uninsured for a long spell was about 4 percent compared to 25 percent for people living in poverty. Looking just at the uninsured, about 40 percent of the uninsured in the highest income group were uninsured for a year or more, compared to over 60 percent of the poor uninsured.

The overall uninsured rates, as well as long-term uninsured rates, varied dramatically by education as well. Only 14 percent of those in families with the highest education experienced a spell without coverage, compared with almost half of those in families with no high school graduates. While both short- and long-term uninsured rates were higher among those with less education than among the more highly educated, the differences in long-term uninsured rates were larger. As a result, the share of the uninsured who were long-term uninsured was under half in the highest education group but nearly three-quarters in the lowest education group.

The differences in health coverage by health status were also large, with higher uninsured rates among those in fair or poor health status than among those in good health or better. The differences in short-term uninsured rates were small, but there was a twofold difference in the long-term uninsured rate (10 percent for those in excellent, very good, or good health, compared with 21 percent for those in fair or poor health).

There were interesting differences in the uninsured rates and length of time without coverage for different age groups. Overall, children had low uninsured rates of about 17-19 percent, young adults (ages 19 to 34) had the highest rate (about 30 percent), the rate of 35 to 54 year olds was about that of children, and the near elderly (ages 55 to 64) had the lowest rate of about 13 percent. However, these differences were due to several different underlying factors. The higher likelihood of being uninsured among young adults compared to children was due to a larger share of young adults with both short- and long-term spells without coverage, but particularly due to their higher frequencies of long-term spells. For example, 19 to 34 year olds had over twice the long-term uninsured rate of young children. While the overall uninsured rate for adults ages 35 to 54 was similar to the rate for children, adults in this age group were *less* likely to have short-term uninsured spells but *more* likely to have long-term uninsured spells than

young children. Finally, the near elderly (ages 55-64) were less likely than young children to go without coverage overall, particularly for short spells, but they had higher long-term uninsured rates. Interestingly, the near elderly had the *lowest* overall uninsured rate among the age subgroups (13 percent) but the *highest* long-term uninsured rate among those who lacked coverage (69 percent).

Table 1
Duration of Uninsured Spells: Rates by Family Income, Education, Health Status, and Age, Nonelderly Population, 1998-1999

	Number in Group (Millions)	Percent Ever Uninsured During Previous 12 Months	Length of Uninsured Spells			Ratio of Full-Year Uninsured to Ever Uninsured
			≤ 5 Months	6-11 Months	≥ 12 Months	
Total Nonelderly Population	238.6	20.5 %	4.1 %	5.0 %	11.4 %	0.56
Poverty Level						
<100% FPL	31.7	40.8 ***	6.3 ***	9.6 ***	25.0 ***	0.61
100-200% FPL	43.3	35.9 ***	6.1 ***	7.7 ***	22.1 ***	0.62
200-300% FPL	41.9	21.8 ***	4.7 ***	5.5 ***	11.6 ***	0.53
>300% FPL	*121.7*	*9.3*	*2.7*	*2.7*	*3.9*	*0.42*
Education^						
Less than High School	23.0	47.3 ***	5.4 ***	6.9 ***	34.9 ***	0.74
High School Degree or GED	65.3	25.4 ***	5.0 ***	6.4 ***	13.9 ***	0.55
Attended College	*148.0*	*14.0*	*3.6*	*4.1*	*6.4*	*0.46*
Health Status						
Excellent/Very Good/Good	*215.1*	*19.2*	*4.1*	*4.8*	*10.3*	*0.54*
Fair/Poor	23.5	32.2 ***	4.0	7.3 ***	20.8 ***	0.65
Age						
0-5	*23.6*	*17.2*	*5.2*	*5.1*	*7.0*	*0.41*
6-12	28.6	18.6 *	4.3	5.0	9.3 ***	0.50
13-18	24.1	18.1	3.4 ***	4.1 *	10.6 ***	0.59
19-34	59.8	31.4 ***	6.7 ***	8.8 ***	15.9 ***	0.51
35-54	79.5	17.0	2.7 ***	3.3 ***	11.0 ***	0.65
55-64	23.0	12.5 ***	1.7 ***	2.3 ***	8.6 **	0.69

Source: 1999 National Survey of America's Families (NSAF).
Notes: Italics indicate reference category for tests of statistical significance.
*** indicates group is significantly different from the reference category at the 0.01 level.
** indicates group is significantly different from the reference category at the 0.05 level.
* indicates group is significantly different from the reference category at the 0.10 level.
^ Education indicates the highest level of education among adults in the family.

Differences by Race/Ethnicity and Citizenship Status

As seen in Table 2, overall uninsured rates differed by race/ethnicity. Black non-Hispanics, Hispanics, and Native Americans were more likely to experience an uninsured episode than white non-Hispanics. There were statistically significant, but small, variations in the share of each of these groups without coverage for short periods and much larger disparities in long-term uninsured. For example, Hispanics were only slightly more likely than whites to be uninsured for a short period of time, but they were over three times as likely to be uninsured for a full year or more. As a result, just half of uninsured white non-Hispanics were long-term uninsured, while this is the case for nearly 70 percent of uninsured Hispanics.

The differences by citizenship status were also considerable – over half of non-citizens were uninsured during a 12-month period, compared with less than a fifth of citizens. Short-term uninsured rates were only slightly higher for non-citizens, but long-term uninsured rates were very different; less than 10 percent of citizens were uninsured for a year or more, compared to nearly 40 percent of noncitizens. Accordingly, just half of uninsured citizens were long-term uninsured, compared with over three-quarters of uninsured non-citizens.

Table 2
Duration of Uninsured Spells: Rates by Race/Ethnicity and Citizenship Status, Nonelderly Population, 1989-1999

	Number in Group (Millions)	Percent Ever Uninsured During Previous 12 Months	Length of Uninsured Spell			Ratio of Full-Year Uninsured to Ever Uninsured
			≤ 5 Months	6-11 Months	≥ 12 Months	
Total Nonelderly Population	238.6	20.5 %	4.1 %	5.0 %	11.4 %	0.56
Race/Ethnicity						
White, non-Hispanic	*167.0*	*16.2*	*3.7*	*4.3*	*8.2*	*0.51*
Black, non-Hispanic	30.9	26.3 ***	6.0 ***	6.7 ***	13.7 ***	0.52
Hispanic	29.1	39.1 ***	4.6 **	7.5 ***	27.1 ***	0.69
Native American	2.2	42.4 ***	6.4 **	9.3 ***	26.8 ***	0.63
Asian American	9.3	14.7	4.3	3.3	7.1	0.48
Citizenship Status						
US-Born or Naturalized Citizen	*224.2*	*18.5*	*4.1*	*4.9*	*9.6*	*0.52*
Non-Citizen	14.4	51.7 ***	5.3 **	7.2 ***	39.2 ***	0.76

Source: 1999 National Survey of America's Families (NSAF).
Notes: Italics indicate reference category for tests of statistical significance.
*** indicates group is significantly different from the reference category at the 0.01 level.
** indicates group is significantly different from the reference category at the 0.05 level.
* indicates group is significantly different from the reference category at the 0.10 level.

Differences by State and Residential Location

Table 3 presents the various uninsured rates by state and community type. We see that there is much less variation across states in short-term uninsured rates than in long-term uninsured rates. For example, in only 6 of the 13 NSAF states is the share of the population uninsured for 1 to 5 months significantly different from the national average of 4 percent. In contrast, the long-term uninsured rate in each of the 13 NSAF states is significantly different from the national average rate of 11 percent. Moreover, the range of uninsured rates varies dramatically across states when disaggregated by the amount of time uninsured. The rate of spells that are less than 5 months ranges from 3 to 5 percent, whereas the rate of long-term spells (those at least 12 months long) varies from 4 to 20 percent.

Table 3
Duration of Uninsured Spells: Rates by Geographic Characteristics, Nonelderly Population, 1989-1999

	Number in Group (Millions)	Percent Ever Uninsured During Previous 12 Months	Length of Uninsured Spell			Ratio of Full-Year Uninsured to Ever Uninsured
			≤ 5 Months	6-11 Months	≥ 12 Months	
Total Nonelderly Population	238.6	20.5%	4.1%	5.0%	11.4%	0.56
State of Residence						
Texas	18.2	31.2***	3.9	7.0***	20.3***	0.65
Mississippi	2.5	25.6***	5.0*	6.2**	14.5***	0.57
Florida	12.4	24.6***	4.4	7.3***	13.0*	0.53
California	29.7	23.8***	3.9	5.1	14.8***	0.62
New York	15.9	19.7	5.1**	4.7	10.0**	0.51
Colorado	3.6	19.3	4.9	5.2	9.3***	0.48
Alabama	3.8	18.2**	4.1	4.8	9.3***	0.51
Washington	5.1	16.5***	4.1	4.8	7.5***	0.45
New Jersey	7.2	16.3***	3.3**	3.9***	9.2***	0.56
Michigan	8.7	14.4***	4.0	4.2	6.3***	0.44
Wisconsin	4.6	13.2***	3.2***	3.7***	6.3***	0.48
Massachusetts	5.4	11.1***	3.2**	3.1***	4.9***	0.44
Minnesota	4.2	11.1***	3.4**	4.0***	3.8***	0.34
Community Type						
Metropolitan Area	*190.1*	*19.5*	*4.1*	*4.8*	*10.6*	*0.54*
Non-Metropolitan Area	48.5	24.4***	4.2	5.7**	14.5***	0.59

Source: 1999 National Survey of America's Families (NSAF).
Notes: Italics indicate reference category for tests of statistical significance. For state, the reference category is the national average.
*** indicates group is significantly different from the reference category at the 0.01 level.
** indicates group is significantly different from the reference category at the 0.05 level.
* indicates group is significantly different from the reference category at the 0.10 level.

The four states with the highest probabilities of being uninsured at some time during the year show how much of a role moderate length spells (between 6 and 11 months) and year-long spells play in determining state differences. Although residents of Texas, Mississippi, Florida and California are all significantly more likely to be uninsured at some time during the year, there are virtually no differences in the probability of residents of these state experiencing an uninsured spell of less than 5 months. For these states, differences in overall uninsured rates are the result of differences in moderate length (between 6 and 11 months) and long (at least 12 months) spells. The most extreme example of this occurs in Texas. Thirty-one percent of Texans experienced an uninsured spell during the year and two-thirds of them were uninsured for at least 12 months. For contrast, consider Minnesota – one of the states with the lowest probability of being uninsured. Of the 11 percent of Minnesotans who were uninsured at some time during the year, only about one-third were uninsured for a year or more.

Differences between metropolitan and non-metropolitan communities follow a similar pattern. The rate of being uninsured at some time during the year is significantly higher for people living outside of metropolitan areas, but there is no significant difference in the probability of the shortest spells and a significant, but small, difference in the probability of a moderate spell. Again, most of the difference in uninsured rates between metropolitan and non-metropolitan residents is related to differences in their chances of being long-term uninsured.

Differences Among Adults by Eligibility for Public Coverage

Among low-income adults, Table 4 shows the relationship between eligibility for public coverage and duration of uninsured periods. Overall, low-income adults have one of the highest uninsured rates of the subgroups studied in this paper. However, the data show that poor adults are significantly less likely to be uninsured over the course of the year if they are eligible for some type of public coverage (38 percent for those who are eligible versus 53 percent for those who are ineligible). Virtually all of this difference is due to the fact they are less likely to be uninsured for a long period of time (12 months or longer).

The story is somewhat different among near-poor adults. Although the probability of being uninsured at some time during the year is still lower for eligible adults, the difference between eligibility groups is much smaller than for poor adults. In part, this is due to the higher probability of short-term episodes among the near-poor who are eligible for public programs compared to those not eligible. However, among the near-poor, those eligible for public coverage are still less likely to have a long episode without health coverage.

Table 4
Duration of Uninsured Spells: Rates by Public Program Eligibility Status, Nonelderly Low-Income Adult (Age 19-64) Population, 1998-1999

	Number in Group (Millions)	Percent Ever Uninsured During Previous 12 Months	Length of Uninsured Spell			Ratio of Full-Year Uninsured to Ever Uninsured
			≤ 5 Months	6-11 Months	≥ 12 Months	
Low-Income Adult Population	44.1	40.2	6.4	9.2	24.6	0.61
<100% FPL						
Eligible for Public Coverage	*6.8*	*38.0 %*	*7.5 %*	*10.5%*	*20.0%*	*0.53*
Ineligible for Public Coverage	11.2	53.1 ***	5.2 *	10.0	38.0 ***	0.71
100-200% FPL						
Eligible for Public Coverage	*3.8*	*35.0*	*8.5*	*11.5*	*15.0*	*0.43*
Ineligible for Public Coverage	22.3	40.4 **	5.0 ***	7.3 ***	28.1 ***	0.70

Source: 1999 National Survey of America's Families (NSAF).
Notes: Italics indicate reference category for tests of statistical significance.
*** indicates group is significantly different from the reference category at the 0.01 level.
** indicates group is significantly different from the reference category at the 0.05 level.
* indicates group is significantly different from the reference category at the 0.10 level.
Low-income indicates below 200% of poverty.

Relationships Between Duration of Uninsured Spells and Health Care Access and Utilization

Previous evidence (e.g., Sudano and Baker 2003) suggests that lack of insurance coverage for even short periods of time results in lower rates of preventive service use. In this section, we examine differences in a variety of access and use indicators across individuals with varying lengths of uninsured spells. We use a series of multivariate models to control for the differences in the characteristics of people in the uninsured groups (e.g. health status and income) in order to measure the association between access, use and time without coverage. The results are presented in Table 5 as regression-adjusted means for each uninsured group and for the full-year insured.

All three of the access to care indicators deteriorate significantly if an insured individual becomes uninsured, even for a short period of time. For example, relative to having insurance for the full year, people who are uninsured for less than 6 months are 8 percentage points less likely to have a usual source of care that is not an emergency room, 8 percentage points more likely to lack confidence in their ability to get care and 12 percentage points more likely to have unmet medical or prescription drug needs. The problems associated with lacking insurance get worse with respect to having a usual source of care and lacking confidence in getting access to care as the amount of time without insurance increases.

In contrast, as the length of time without coverage increases, the chances of reporting unmet need decrease—that is, the long term uninsured report fewer unmet needs. This may reflect their increasing disconnection with the health care system, which is evidenced by the health service utilization measures (Table 5), and, consequently, a growing lack of awareness of health care problems. The chances of seeing a physician during the 12 months prior to the survey is 77 percent among those covered for the full year, but only 50 percent for those uninsured for at least a year. Similarly, the probability of seeing a health professional other than a physician (e.g., nurse practitioner or midwife) drops from 31 percent for the full-year insured to 19 percent for the long-term uninsured. Even emergency room use falls; 23 percent of the full-year insured visit an emergency room compared to 17 percent of the long-term uninsured.

Table 5
Patterns of Access to Care and Utilization, by Insurance Status, Nonelderly Population, 1998-1999

	Full-Year Insured	Ever Uninsured During Previous 12 Months: Length of Uninsured Spell		
		≤ 5 Months	6-11 Months	≥ 12 Months
Access to Care				
Has a Usual Source of Care (Other than ER)	90.7 %	82.7 % ***	77.9 % ***	72.0 % ***
Is Not Confident in Access to Care	5.4	12.6 ***	16.8 ***	19.3 ***
Had Unmet Medical and/or Prescription Drug Need in Past Year	6.9	18.7 ***	17.4 ***	14.3 ***
Utilization				
Had a Doctor Visit in Past Year	77.4	72.4 ***	65.1 ***	50.1 ***
Had a Health Professional Visit in Past Year	30.5	31.7	29.2	19.1 ***
Had an Emergency Room Visit in Past Year	22.6	24.0	22.7	16.8 ***

Source: 1999 National Survey of America's Families (NSAF).
Notes: Estimates are regression-adjusted means that control for differences in socioeconomic and demographic characteristics, including race/ethnicity, age, education level, poverty level, gender, citizenship, health status, work status, community type, state of residence, eligibility status, and insurance status.
*** indicates group is significantly different from the full-year insured at the 0.01 level.
** indicates group is significantly different from the full-year insured at the 0.05 level.
* indicates group is significantly different from the full-year insured at the 0.10 level.

DISCUSSION

This study shows that lacking health insurance cannot simply be characterized as a short- or long-term problem. The majority of people (55 percent) who are uninsured at some point during a 12-month period lack coverage for a year or more; a substantial minority (44 percent) was uninsured for less than a year, and only 1 in 5 people (20 percent) experienced an interruption in coverage of less than six months. These data, along with data from other studies (e.g., Rhoades et al., 2002), show that the uninsured are not largely composed of people experiencing short-term gaps in coverage as they move between employers or between public and private coverage.

The persistence of a sizable short-term uninsured population among all the subgroups we examined is largely a byproduct of the existing health insurance system within the United States. This voluntary system of mixed public and private coverage creates many transitions that can result in short-term gaps in coverage. People may experience gaps in private coverage when they or their spouse change jobs, lose a job or get divorced. Although public coverage can fill gaps for most low-income children and some low-income adults, enrolling and staying enrolled in these programs can often be difficult (Ku and Cohen Ross 2002). To the extent that short-term gaps in coverage will persist in this type of system, our findings suggest that it may be difficult to reduce the uninsured rate below the 3 to 6 percent range. This range is based on estimated differences across demographic subgroups and states in the share of the population that experienced gaps in coverage of less than six months.

If policymakers want to tackle the uninsured problem and the associated health risks, they will need to consider approaches that meet the needs of both the short- and long-term uninsured. Focusing solely on "bridging" policies such as offering subsidies or tax credits that allow more people to purchase COBRA coverage or assuring that more eligible people fill coverage gaps by participating in Transitional Medicaid, regular Medicaid or S-CHIP, will not address the needs of the long-term uninsured. For this latter group, more basic structural reforms are likely to be needed. These reforms might include acceptance of a greater role for publicly subsidized care (through either tax credits or expansions in public programs) or extensive reforms in the insurance marketplace (e.g., broad purchasing cooperatives as a substitute for the non-group market or government reinsurance to ease private insurers' fears of catastrophic costs). When taken together, the policies needed to address both the short- and long-term uninsured may seem daunting. However, when studies show that almost 50 million Americans lack coverage in a given year, and the majority are uninsured for a full year or more—small incremental approaches are likely to leave many people without coverage.

Despite the need for extensive and potentially complex policy changes, reality suggests that efforts to move toward universal coverage are not likely in the near future. If policymakers need to prioritize their actions, the data presented here provide reasonably clear guidance as to which groups are most in need. The long-term uninsured are at a greater disadvantage than those who experience shorter uninsured spells. Those who have low incomes, are less educated, are in fair or poor health, are Hispanic or Native American or are not citizens are more likely to have been uninsured for a year or more. Among low-income adults, those who are not eligible for public coverage also are more likely to be long-term uninsured than those who are eligible. In fact, across the subgroups examined in this paper, it is long-term uninsured rates as opposed to short-term uninsured rates that drive differences in overall uninsured rates. These differences in coverage are also associated with more serious access problems and significantly lower levels of health care utilization among the long-term uninsured.

To the extent that policymakers agree that the most immediate focus should be on the long-term uninsured, these data show that the burden will not be evenly distributed across states. States such as Texas, California and Mississippi have estimated long-term uninsured rates among their non-elderly population that are almost three times the rates estimated for Minnesota and Massachusetts. These differences tend to parallel differences in employer-sponsored insurance (ESI) rates than have been shown to be largely beyond state control (Shen and Zuckerman 2003). In fact, as a result of having a strong base of ESI and broad eligibility for public coverage among

those without ESI (Spillman 2000), a few states face long-term uninsured rates that are comparable to their rates of short-term coverage gaps. However, it may be impractical at this time to expect states, with current levels of federal financial support, to address the needs of the long-term uninsured when these differences are so large.

This analysis indicates that a substantial proportion of the population experienced problems obtaining insurance coverage in 1998-1999: nearly 50 million people were uninsured at some point during the year, and more than half of them were uninsured for a full year or more. Another recent study estimated that over 70 million people were uninsured at some time over the two-year period covering 2001 and 2002 (Families USA 2003). The most direct reason that our estimate is smaller than the estimate from the Families USA study is that we look at health coverage over a shorter period of time. In fact, the recent CBO (2003) estimate of almost 60 million nonelderly persons experiencing some period without coverage during 1998, although greater than the NSAF estimate, is closer to NSAF because both studies focus on a 12-month time frame. The bigger time frame through which coverage is being observed in the Families USA study leads to a greater probability of observing someone without coverage. Nevertheless, the NSAF estimates of the number of uninsured from 1998-1999 are substantial and are likely to understate the current number of uninsured now that economic conditions have worsened. Thus, it is even more important to find solutions to the uninsured problem, both for those experiencing short-term episodes without coverage and for the long-term uninsured.

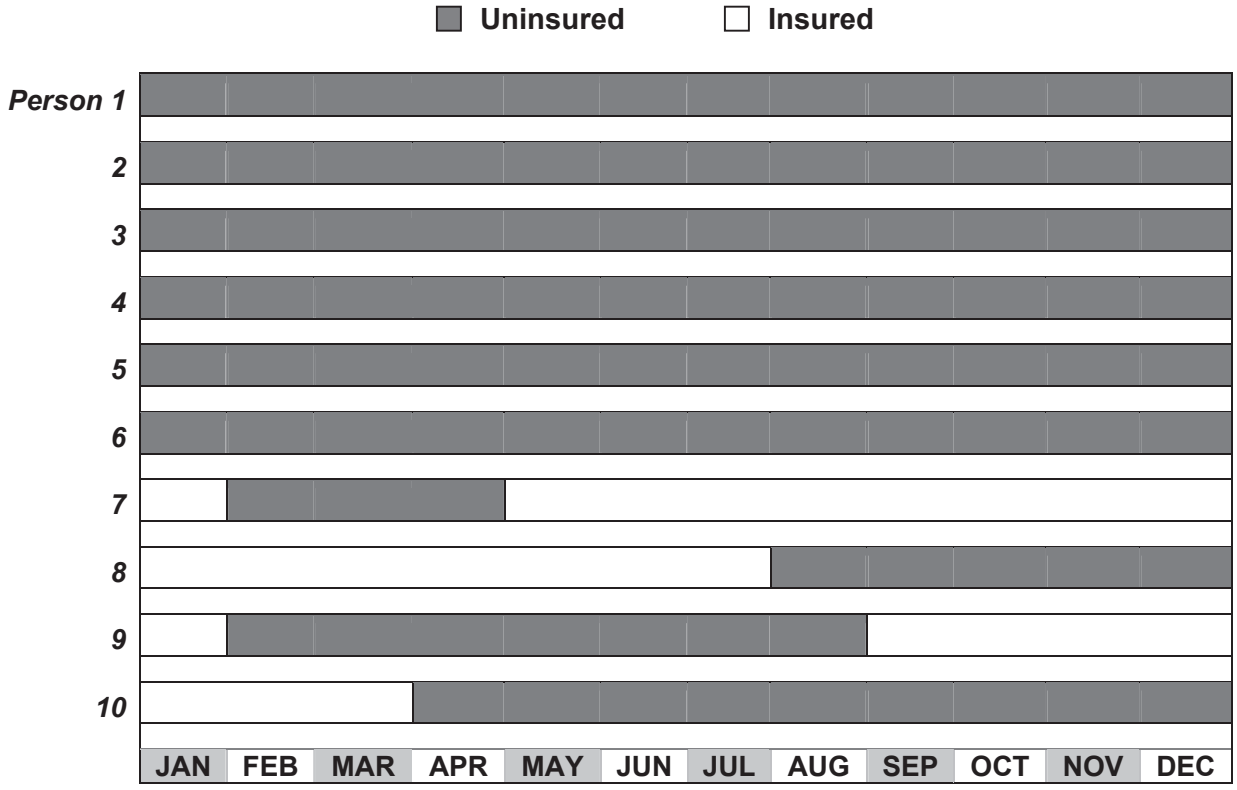
Appendix A
The Distribution of Uninsured Spells in NSAF and SIPP

A recent CBO report (2003) presented SIPP data on the distribution of the length of uninsured spells for three reference periods: (1) spells that began between July 1996 and June 1997; (2) spells in progress during March 1998 (a point-in-time context); (3) spells in progress between June 1997 and July 1998 (a full-year context). In this paper, we use NSAF to focus on the length of uninsured spells in progress at some time during a full year, i.e., mid-1998 through mid-1999. With the exception of the specific time period covered, our reference period corresponds to the concept behind the third of the CBO categories. NSAF can also be used to estimate the length of uninsured spells in progress at the time of the survey (approximately mid-1999), although we did not do that in this paper. Health coverage at the time of the survey is a point-in-time concept comparable to the second of the CBO reference periods. The goal of this Appendix is to compare the estimates of the share of the uninsured who are without coverage for short periods of time across the NSAF and CBO estimates based on SIPP.

Before turning to this comparison, we consider the results presented by CBO on their own. In Figure 2 of the CBO report, there are two pieces of data on short-term uninsured spells that could be compared to each other and could lead to different conclusions about the nature of uninsured spells. Based on SIPP, CBO reports that 45 percent of spells that began between July 1996 and June 1997 ended in 4 months or less. This would imply that a large number of spells end quickly. In fact, we know from other sources that many uninsured spells that begin and end quickly go unobserved in studies that estimate the uninsured during a fixed period of time. The other estimate in Figure 2 of the CBO report establishes this point quite clearly. CBO reports that only 8 percent of spells in progress during March of 1998 were for 4 months or less. This implies that, in any given month, very few uninsured spells are short spells. However, CBO explains in Appendix B of its report that these results are entirely consistent with each other and differ only because they are based on different reference periods and focus on spells in progress versus new spells.

A figure can be useful for explaining the relationship between the distribution of the length of uninsured spells, the nature of spells (new versus in-progress) and the length of the fixed reference period. Assume we observe 10 people who are uninsured at some time during a fixed calendar year. A hypothetical distribution of the length of the uninsured spells is shown in Appendix Figure 1. If we examine the distribution of new uninsured spells, we find four new spells during this hypothetical year, of which half are for 5 months or less and half are between 6 and 11 months.[3] If, instead, we look at the distribution of those uninsured at any time during the reference year, we would find that all ten people were uninsured at some point during the year and estimate that 20 percent were uninsured for 5 months or less, 20 percent were uninsured for between 6 and 11 months, and 60 percent were uninsured for at least the full year. However, if we observe the distribution of uninsured spells at a point in time such as December, we would find eight people were uninsured and that, of those people, 12.5 percent were uninsured for 5 months or less, 12.5 percent were uninsured for between 6 and 11 months, and 75 percent were uninsured for at least the entire year. This comparison shows that moving from the full year as the reference period to a single month of the year increases the share of long-term uninsured and reduces the share of the short-term uninsured.

Appendix Figure 1
Hypothetical Distribution of Uninsured Spells Within a Fixed Calendar Year



In this paper, we estimate that 20 percent of people who were uninsured at some time during the year were uninsured for 5 months or less. The CBO estimate of the share of short spells, either based on new spells or the March 1998 point in time estimate, is much different from our NSAF estimate largely because of differences that stem from the different reference periods. [4] The CBO estimate of the share of short-term spells based on new spells is larger than the NSAF estimate, because it fails to count long-term uninsured who became uninsured before the reference period. However, the NSAF estimate of the share of spells that are short-term is larger than the CBO March 1998 point-in-time estimate. The CBO estimate refers to uninsured spells observed during a single *month*, while the NSAF estimate is based on spells observed during a single *year*. As the reference period shortens, the likelihood of observing short uninsured spells decreases.

Appendix Table A provides a more comprehensive comparison of the CBO/SIPP estimates and those derived from NSAF. For the purpose of this table, we present NSAF estimates of the distribution of the length of uninsured spells for spells in progress at the time of the NSAF survey in addition to spells that occurred at some time during a 12-month period. In light of the differences in the time periods of the surveys, as well as between the definitions of short, moderate and long uninsured spells, we did not expect the results to line up exactly. However, for the two reference periods in which CBO/SIPP and NSAF estimates can be compared, we find that the results are quite similar.

Appendix Table A
Comparison of CBO/SIPP and NSAF Estimates of Distribution of Uninsured Spells

	CBO/SIPP	NSAF
New Spells Beginning During a Fixed Time Period	**July 96-June 97**	
Short	45%	n/a
Moderate	26	n/a
Long	29	n/a
Spells in Progress at a Point in Time	**March 98**	**Mid-Year 99***
Short	8%	13%
Moderate	14	12
Long	78	75
Spells in Progress at Some Time During a Year	**July 97-June 98**	**Mid-Year 98-Mid-Year 99****
Short	22%	20%
Moderate	19	24
Long	59	56

Sources:
CBO/SIPP: Congressional Budget Office. 2003. “How Many People Lack Health Insurance and For How Long?” The Congress of the United States, Washington, DC.
NSAF: 1999 National Survey of America's Families (NSAF).
Notes:
Short: 4 months or less for CBO/SIPP; 5 months or less for NSAF.
Moderate: 5 to 12 months for CBO/SIPP; 6 to 11 months for NSAF.
Long: More than 12 months for CBO/SIPP; 12 or more months for NSAF.
*NSAF's point-in-time estimate is based on the point in time the survey was administered; NSAF was administered between February 1999 and October 1999.
**NSAF's estimate of spells in progress at some time during the year is based on the 12 months prior to the time the survey was administered and approximately represents the period from July 1998-June 1999.

ENDNOTES

[1] Recent legislation that provided tax credits to allow certain displaced workers to purchase coverage through COBRA suggests that Congress and the Administration see the short-term uninsured as worthy of a policy response.
[2] The 13 NSAF states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. The rest of the sample was drawn from the balance of the nation to allow for nationally representative results.
[3] One of the uninsured spells – the one that is 9 months long - is still in progress at the end of this calendar year and could turn out to be a spell of much longer duration.
[4] We defined our short-term uninsured category as including spells of 5 months or less, whereas CBO defined its short-term category as 4 months or less. As a result, for comparable reference periods, one should expect to find fewer short-term uninsured in the CBO estimates than in the NSAF estimates.

REFERENCES

Congressional Budget Office. 2003. "How Many People Lack Health Insurance and For How Long?" The Congress of the United States, Washington, DC.

Council for Affordable Health Insurance. 1993. "Medical Savings Accounts: Questions and Answers." Alexandria, VA.

Crane, Philip. 1993. House Ways and Means Committee Hearing, Washington, DC, November 16.

Davidoff, Amy, Anna Sommers, Alshadye Yemane, and Jennifer Lesko. Forthcoming. "Public Insurance Eligibility and Participation Among Non-Elderly Adults."

Department of Health and Human Services. 2002. "Understanding Estimates of the Uninsured: Putting the Differences in Context." http://aspe.hhs.gov/health/reports/hiestimates.htm. [Accessed 10 December 2002.]

Dubay, Lisa, Jennifer Haley, and Genevieve Kenney. 2002. "Children's Eligibility for Medicaid and SCHIP: A View from 2000." *Assessing the New Federalism* Policy Brief B-41. Washington, D.C.: Urban Institute.

Families USA. 2003. "Going without Health Insurance: Nearly One in Three Nonelderly Americans." Washington, D.C.: Families USA. Publication No. 03-103.

Fronstin, Paul. 2000. Counting the Uninsured: A Comparison of National Surveys. Washington, D.C.: Employee Benefit Research Institute. Brief No. 225.

Ku, Leighton, and Donna Cohen Ross. 2002. "Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families." New York, NY: The Commonwealth Fund. Publication No. 586.

Lewis, Kimball, Marilyn Ellwood, and John L. Czajka. 1998. "Counting the Uninsured: A Review of the Literature." Washington, D.C.: The Urban Institute. Assessing the New Federalism Occasional Paper No. 8.

McBride, Timothy D. 1994. "Estimating the Real Number of Chronically Uninsured." *Journal of American Health Policy* 4(4): 16-20, 22-3.

National Association of Health Underwriters. 2000. "The Problem of the Uninsured." http://www.nahu.org/government/issues/The%20Uninsured/uninsuredfactsheet.pdf. [Accessed 10 December 2002.]

Rajan, Shruti, Stephen Zuckerman, and Niall Brennan. 2000. "Confirming Insurance Coverage in a Telephone Survey: Evidence from the National Survey of America's Families." *Inquiry* 37: 317-327.

Reynolds, Alan. 1992. Another Big Lie. *Forbes,* 22 June.

Rhoades, Jeffrey A., Jessica P. Vistnes, and Joel W. Cohen. 2002. "Chartbook #9: The Uninsured in America: 1996-2000." Agency for Health Care Research and Quality. http://www.meps.ahrq.gov/papers/cb9_02-0027/cb9.htm. [Accessed 30 December 2002.]

Shen, Yu-Chu, and Stephen Zuckerman. 2003. "Why Is There State Variation In Employer-Sponsored Insurance?" *Health Affairs* 22(1): 241-251.

Short, Pamela Farley. 2001. "Counting and Characterizing the Uninsured." Ann Arbor, MI: University of Michigan. Economic Research Initiative on the Uninsured Working Paper No. 2.

Spillman, Brenda. 2000. "Adults without Health Insurance: Do State Policies Matter?" *Health Affairs* 19(4): 178-187.

Sudano, Joseph J., and David W. Baker. 2003. "Intermittent Lack of Health Insurance Coverage and Use of Preventive Services." *American Journal of Public Health* 93(1): 130-137.

Swartz, Katherine. 1994. "Dynamics of People Without Health Insurance: Don't Let the Numbers Fool You." *Journal of the American Medical Association* 271(1): 64-66.

Swartz, Katherine, and Timothy D. McBride. 1990. "Spells Without Health Insurance: Distributions of Durations and Their Link to Post-in-Time Estimates of the Uninsured." *Inquiry*27: 281-288.

Wall Street Journal. 1993. Dissecting the Uninsured, April 15.

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Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results From a Prospective Cohort Study of the Oregon Health Plan

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ABSTRACT

PURPOSE Medicaid programs in all 50 states recently implemented cost-saving strategies, including benefit reductions, cost sharing, and tightened administrative rules. These changes resulted in loss of insurance coverage for thousands of low-income adults nationwide. In this study we assessed the immediate impacts of disrupted and lost Medicaid coverage on adults enrolled in the Oregon Health Plan (OHP) when program changes were implemented.

METHODS Data come from baseline survey results of a prospective cohort study designed to assess the impacts of OHP changes on adult beneficiaries. We used bivariate and multivariate analyses to examine the effects of disrupted and lost insurance coverage on unmet health care needs, utilization, and medical debt occurring in the first 10 months after OHP changes were implemented.

RESULTS After OHP changes were implemented, 31% of enrolled adults reported losing coverage, and another 15% reported disrupted coverage. Controlling for demographic characteristics, income, and health status, those with disrupted coverage were less likely to have a primary care visit (odds ratio [OR] = .66; $P < .05$) and more likely to report unmet health care needs (OR = 1.85; $P < .01$) and medical debt (OR = 1.99; $P < .01$) when compared with those continuously insured. Those who lost coverage were less likely to have a primary care visit (OR = 0.18; $P < .01$) and more likely to report unmet health care needs (OR = 5.55; $P < .01$), unmet medication needs (OR = 2.05; $P < 01$), and medical debt (OR = 3.06; $P < .01$) than those continuously insured.

CONCLUSIONS Medicaid program changes that increase cost sharing and limit enrollment have significant negative impacts on health care access and utilization among Medicaid beneficiaries; these impacts occur rapidly, within the first 10 months after changes.

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INTRODUCTION

Medicaid plays a major role in ensuring access to care for more than 50 million low-income Americans. A growing body of research shows that the expansion of Medicaid programs during the last 2 decades resulted in improved health care access for millions of low-income adults and children.[1-5] During the recent economic downturn, however, all 50 states implemented cost-containment strategies affecting millions of Medicaid beneficiaries nationwide.[6] For example, in 2004, 19 states reduced benefits, including those for vision, dental, and mental health; 21 states restricted eligibility by tightening administrative rules or expanding premiums; and 20 states expanded or added co-payments.[1] Recent

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research examining the impacts of Medicaid changes suggests that several states reported declining enrollment after the implementation of program changes.[7]

Losing public insurance coverage has serious consequences for low-income adults. Most who lose Medicaid coverage do not have access to other health insurance and become uninsured.[1,8-10] Abundant literature shows that uninsured persons, especially those with low incomes, are more likely to have unmet health care needs and poorer health than those with insurance. In contrast, persons with insurance and a usual source of care have better access to care and better overall health outcomes.[9-22]

Most research examining the impact of uninsurance on low-income populations compares uninsured with insured populations or assesses the impact of lost coverage after a 1- to 2-year period.[23,24] There is very little information about the more immediate effects of lost coverage on low-income adults enrolled in Medicaid.

Recent Changes in the Oregon Health Plan

In March 2003, Oregon implemented cost-containment mechanisms in the Oregon Health Plan (OHP). Oregon developed OHP2, which comprised 2 distinct Medicaid benefit packages: OHP Plus and OHP Standard. OHP Plus serves the categorically eligible Medicaid population (families receiving Temporary Assistance for Needy Families and disabled adults) and remained largely unchanged. OHP Standard covers the expanded eligibility population (low-income single adults and couples with no children) and included several changes. First, premiums and co-payments were increased. The amount of sliding-scale premiums remained the same for single persons but doubled for couples, with the new monthly premiums ranging from $6 to $20 per person. Groups with previous premium exemptions, including the homeless and those with no income, were also required to pay premiums. Second, certain benefits, including behavioral health services, dental services, durable medical equipment, and vision services, were eliminated. Finally, a 6-month lockout was instituted for members who missed a monthly premium payment.

To help understand the impact of these changes on OHP beneficiaries, a 3-year cohort study was launched in 2003 with the intention of observing a representative sample of the Oregon Medicaid population for 3 years. The objectives of the ongoing study are to assess the short and long-term impact of policy changes on individuals' insurance coverage, access to and utilization of health care, family finances, and health status.

The findings presented here describe the short-term impacts of lost or disrupted coverage on health care access, utilization, and financial outcomes. Three groups of adults are compared for the 8- to 10-month period immediately after the OHP program changes: persons with stable insurance coverage, those who lost coverage but regained insurance before the end of the study period, and those who lost coverage and remained uninsured.

METHODS

Study Population

The study population included adults aged 19 years and older who were enrolled in the OHP for at least 30 days before program changes were implemented in the OHP Standard population. A stratified random sample of 10,600 potential cohort members was drawn from Medicaid eligibility files, divided evenly between adults in OHP Standard and OHP Plus. Oversampling was used to ensure adequate representation of African American, Native American, and Hispanic adults. After excluding those who had died, had moved out of state, or had no current address, 8,260 persons were eligible for panel recruitment.

We recruited study participants using multiwave mail methods, with reminder cards and a second request sent to nonrespondents. A total of 2,783 adults responded and became part of the panel, for a response rate of 34%. The research protocol was approved by Portland State University's Human Subjects Research Review Committee.

Data Collection

An unique survey instrument was designed to assess insurance status, heath care access, utilization, and financial and health outcomes. The instrument was created using widely accepted data collection tools, including the Consumer Assessment of Health Plans (CAHPS) survey, the Community Tracking Study, and the SF-12 health assessment instrument.[25-27] Cognitive pretesting of the survey instrument was conducted with a small sample of OHP members who agreed to participate in a validation interview. Spanish language survey instruments were translated and then independently back-translated to ensure fidelity. Survey instruments were mailed between November 2003 and January 2004, approximately 8 to 10 months after the policy changes were implemented in March 2003. To minimize recall bias, the survey instrument asked respondents about their experiences in "the last 6 months."

Principal Measures

Coverage Pattern

Based on responses to a set of insurance status questions, respondents were placed into 1 of 3 groups. The stable coverage group comprised those who remained continuously enrolled in OHP after the program rede-

sign and were still enrolled in OHP at the time of the survey. The disrupted coverage group comprised those who left OHP after the redesign, but returned to OHP or found other insurance by the time of the initial survey. The lost coverage group comprised those who left OHP after the redesign and remained uninsured at the time of the survey.

Access to Care

Unmet need was the principal measure of access. Respondents were asked whether, at any time in the past 6 months, they needed care but failed to receive it. Respondents were also asked whether they were unable to afford needed prescription medications at any time in the last 6 months.

Health Care Utilization

Respondents were asked how many times they had a visit with a clinician, excluding hospitals and emergency departments, in the preceding 6 months. They were also asked how many times they had visited a hospital emergency department in the previous 6 months. Responses to each question were collapsed into 2 categories: those with no visits, and those with at least 1 visit.

Financial Impacts

Respondents were asked to estimate how much money they currently owed health care providers, credit cards, or other loan companies for medical expenses. Responses were collapsed into 2 categories: those owing less than $500, and those owing $500 or more in medical debt.

Analyses

Statistical tests were performed using SPSS version 13.0; χ^2 tests of independence were conducted to assess associations between insurance status and access to health care and medications, utilization, and medical debt.

To assess the net effect of insurance status on outcomes, we used multivariate logistic regression to estimate the relative odds of each outcome while controlling for age, sex, race, language, education, income as a percentage of federal poverty level, self-reported health status, and chronic illness. We defined respondents as chronically ill if they reported any of the following conditions: diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease, or hypertension.

RESULTS

Insurance Status

A total of 2,783 adult OHP beneficiaries returned survey instruments (34% response rate). Although demographic characteristics of the study sample were similar to those of the OHP population, respondents were more likely to be female, white, and English-speaking than nonrespondents, as shown in Table 1. Because program changes were implemented only in OHP Standard, analyses are limited to this population. A total of 1,378 OHP Standard enrollees returned baseline survey instruments. Of those responders, 95% (n = 1,300) reported their insurance status and are thus included in the analyses. African Americans, Hispanics, and individuals with less than a high school education were significantly less likely to report insurance information. There were no differences by age, sex, income, or health status.

In the first 10 months after OHP changes were implemented, 55% (n = 712) of OHP Standard cohort members reported maintaining stable coverage, 14% (n = 183) reported disrupted coverage (left OHP, but regained coverage), and 31% (n = 405) reported lost coverage (left OHP and remained uninsured). Demographic characteristics of each group are displayed in Table 2. Those who reported disrupted or lost coverage were younger, more likely to be male, white, and in the highest income group (100% of federal poverty level). Those with stable coverage were more likely to be Native American, have very low or no incomes, and have a chronic illness compared with those who had disrupted or lost coverage.

Access to Health Care and Medications

Lost or disrupted coverage was significantly associated with unmet need. As shown in Figure 1, 67% of those

Table 1. Comparison of Study Respondents with Eligible Sample

Demographic Characteristics	Eligible OHP Sample n = 8,260 %	Study Respondents n = 2,783 %
Sex, female*	60.6	67.3
Race/ethnicity*		
Asian	3.5	2.1
African American	10.0	8.1
Hispanic	14.1	11.4
Native American/ American Indian	9.5	9.3
White	62.8	69.1
Primary language*		
English	87.9	92.1
Spanish	7.6	5.9
Other	4.5	1.7
Eligibility category		
OHP Plus	51.6	50.5
OHP Standard	48.4	49.5

OHP = Oregon Health Plan.

* $P < .05$.

who lost coverage reported unmet health care needs, compared with 40% of those with disrupted coverage and 28% of those with stable coverage. The proportion of respondents reporting unmet medication needs were similar among those with stable and disrupted coverage (46%). Those who lost coverage, however, reported significantly higher rates (61%) of unmet medication needs.

When all respondents were asked to identify why they did not get needed care, the principal access barrier for most was cost: 74% of those with disrupted or lost coverage indicated that cost was the reason, compared with 52% of those with stable coverage (P <.001, analysis not shown).

Table 2. Sample Characteristics by Insurance Status

Demographic Characteristic	Stable Coverage (n = 712) %	Disrupted Coverage (n = 183) %	Lost Coverage (n = 405) %
Mean age, y*	42	38	39
Sex†			
Female	67	58	60
Male	33	42	40
Total	100	100	100
Race/ethnicity*			
White (non-Hispanic)	67	71	72
Black (non-Hispanic)	5	5	7
American Indian/ Alaskan Native (non-Hispanic)	12	9	4
Other (non-Hispanic)	5	3	6
Hispanic	11	12	11
Total	100	100	100
Primary language			
English	92	92	95
Spanish	8	8	5
Total	100	100	100
Education			
> High school	45	54	46
High school/GED	35	29	36
< High school	20	17	18
Total	100	100	100
Income as percentage of FPL*			
100+	8	18	20
26-100	45	55	39
1-25	23	14	20
0	18	10	15
Not reported	6	3	6
Total	100	100	100
Health status			
Very good, excellent	21	28	22
Good	34	37	37
Fair, poor	45	35	41
Total	100	100	100
Any chronic illness†			
No	47	55	55
Yes	53	45	45
Total	100	100	100

GED = general equivalency diploma; FPL = federal poverty level.

* χ^2, P <.01.
† χ^2, P <.05.

Health Care Utilization

Respondents were asked how many times they had a primary care visit in the preceding 6 months. As shown in Figure 2, respondents who lost coverage were significantly less likely than the other groups to have a primary care visit. Only 45% of those who lost coverage had a visit compared with 74% of those with disrupted coverage and 82% of those with stable coverage. Visits to hospital emergency departments were comparable across all 3 coverage groups.

Financial Impacts

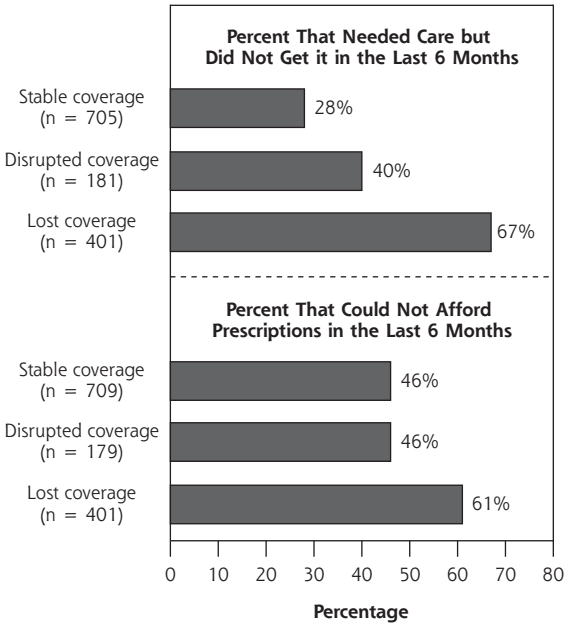
There was also a significant relationship between medical debt and insurance status. Forty percent of those who lost coverage reported owing $500 or more in medical debt compared with 31% of those with disrupted coverage and 20% of those with stable coverage. Those who lost coverage were also significantly more likely to have been denied care because of unpaid medical bills (Figure 3).

Multivariate Analysis

To estimate the net effect of insurance coverage on outcomes, multivariate logistic regression was performed for each of the significant outcome measures: unmet health care and medication needs, primary care utilization, and medical debt. Models were adjusted for age, sex, race, language, education, income as a percentage of the federal poverty level, health status, and chronic illness. Adjusted odds ratios for coverage patterns are displayed in Table 3, and full models are shown in Table 4.

As shown in Table 3, compared with those with stable coverage, respondents with disrupted coverage were significantly more likely to report unmet health care needs, were less likely to have a primary care visit, and were more likely to have medical debt of $500 or more. Also compared with the stably insured, those who lost coverage were significantly more likely to report unmet health care needs and medication needs, were less likely to have a primary care visit, and were more likely to owe $500 or more in medical debt.

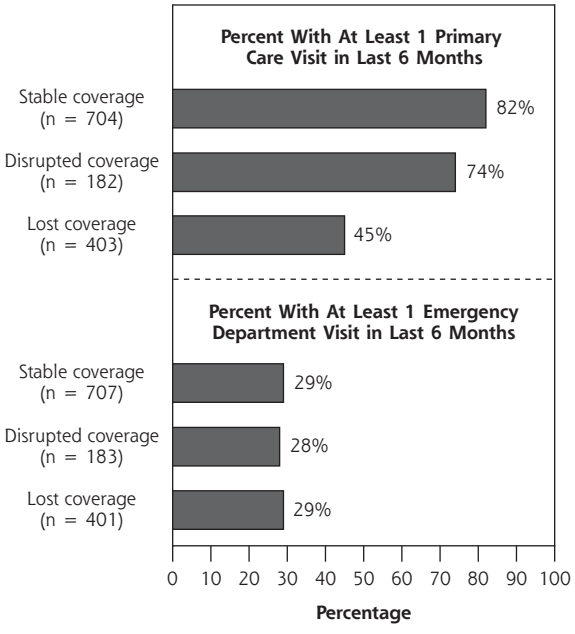
Figure 1. Unmet health care need by insurance status.



Unmet Need: $P = .001$, χ^2 test.

Prescriptions: $P = .001$, χ^2 test.

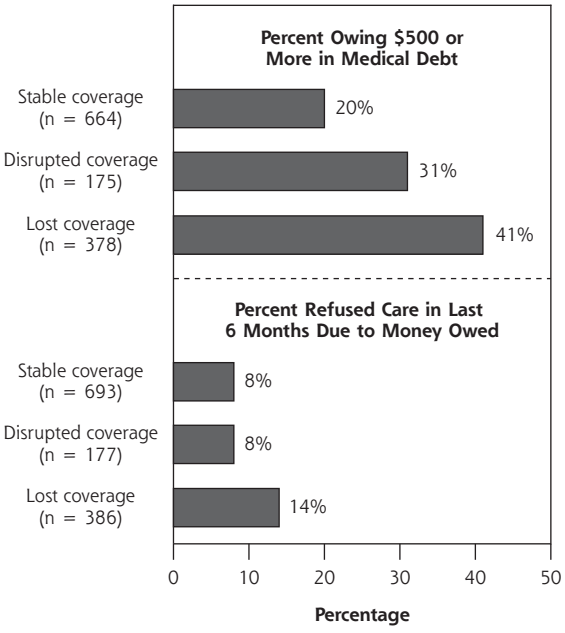
Figure 2. Utilization of health care by insurance status.



Primary care: $P = .001$, χ^2 test.

Emergency department visits: not significant.

Figure 3. Financial outcomes by insurance status.



Medical debt: $P = .001$, χ^2 test.

Refused care: $P = .001$, χ^2 test.

DISCUSSION

Results from the baseline OHP cohort survey indicate that nearly one half (45%) of the OHP Standard population experienced disrupted or lost coverage in the first 10 months after the OHP redesign. This result is consistent with the OHP administrative data, which show a 46% decline, from 88,874 to 47,957 covered lives, between February and December 2003. This decline stands in stark contrast to the same period 1 year before the policy changes, when enrollment among the same population declined by only 3% from 93,722 (February 2002) to 91,174 (December 2002).[28]

OHP program changes were identified by respondents as a primary reason for losing coverage. As reported in earlier research on the same population, nearly one half (44%) of those losing coverage reported that program costs and ineligibility because of a missed premium were the main reasons for losing coverage. Other common reasons for leaving OHP included increased income (31%) and obtaining private insurance coverage (10%).[29]

OHP beneficiaries who lost coverage reported significantly worse health care and medication access and significantly higher medical debt than those with stable coverage. These results are similar to the findings of a study conducted on a clinical sample of California Medicaid enrollees more than 2 decades ago. Lurie et al[9] examined changes in access to care for a 6-month period among 215 Medi-Cal beneficiaries whose benefits were terminated. Among those terminated, 62% reported being unable to obtain needed medical care compared with only 7% of those who remained insured. Moreover, clinically significant increases in uncontrolled hyperten-

Table 3. Adjusted Odds Ratios for Reporting Unmet Health Care Needs, Primary Care Utilization, and Medical Debt in the Past 6 Months

Insurance Status	Odds of Unmet Health Care Needs n = 1,271	Odds of Unmet Medication Needs n = 1,271	Odds of Primary Care Use n = 1,272	Odds of Medical Debt n = 1,239
Stable coverage	1.00	1.00	1.00	1.00
Disrupted coverage	1.85* (1.28-2.67)	1.16 (0.81-1.68)	0.66†(0.44-0.99)	1.99* (1.35-2.93)
Lost coverage	5.55* (4.17-7.38)	2.05* (1.55-2.71)	0.18* (0.13-0.24)	3.06* (2.28-4.12)

Note: Model adjusted for age, sex, race, language, income, education, health status, and chronic disease.

* $P < .01$.
† $P < .05$.

Table 4. Adjusted Odds Ratios for Reporting Unmet Health Care Needs, Primary Care Utilization and Medical Debt in the Past 6 Months—Full Model

Characteristics	Odds of Unmet Health Care Needs n = 1,271	Odds of Unmet Medication Needs n = 1,271	Odds of Primary Care Use n = 1,271	Odds of Medical Debt n = 1,239
Insurance status				
Stable coverage	1.00	1.00	1.00	1.00
Disrupted coverage	1.85*	1.16	0.66†	1.99*
Lost coverage	5.55*	2.05*	0.18*	3.06*
Age	0.98†	0.99	1.00	0.97*
Sex				
Female	1.00	1.00	1.00	1.00
Male	0.95	0.74†	0.52*	1.46†
Race/ethnicity				
White (non-Hispanic)	1.00	1.00	1.00	1.00
Black (non-Hispanic)	1.06	0.99	0.89	1.31
American Indian/Alaskan Native (non-Hispanic)	0.68	0.49†	0.96	0.74
Other (non-Hispanic)	1.21	0.57	0.85	1.05
Hispanic	1.19	1.45	0.82	1.03
Primary language				
English	1.00	1.00	1.00	1.00
Spanish	0.32*	0.16*	0.60	0.41†
Education				
More than high school	1.00	1.00	1.00	1.00
High school/GED	0.61*	1.04	0.67*	0.74
Less than high school	0.74*	1.35	0.62†	1.42
Income as % of FPL				
100%+	1.00	1.00	1.00	1.00
26%-100%	1.15	0.86	0.82	0.64
1%-25%	1.13	0.71	0.79	0.54
0%	0.99	0.61	0.56	0.44
Not reported	0.98	1.01	0.63	1.31
Health status				
Very good/excellent	1.00	1.00	1.00	1.00
Good	1.41†	1.92*	1.01	1.91†
Fair/poor	3.04*	3.76*	1.93†	4.38*
Any chronic illness				
No	1.00	1.00	1.00	1.00
Yes	1.18	2.24*	1.39†	1.33†

GED = general equivalency diploma; FPL = federal poverty level.

* $P < .01$.
† $P < .05$.

sion that were evident among those whose Medi-Cal coverage was terminated did not occur among those who retained insurance. A follow-up study at 1 year conducted on the same population indicated that although access to care among those terminated remained far worse than those with insurance, there was no significant decrease in access to care at 12 months than at 6 months.[10]

In the current study, disruptions in insurance coverage were also associated with an increased likelihood of unmet need and medical debt. These findings are similar to those of previous research conducted with a national sample of low-income adults.[24] In the latter study, respondents who reported at least 1 gap in health insurance over a 2-year period were 2 to 3 times more likely to report unmet health care and medication needs and to have trouble paying medical bills than respondents with continuous insurance.

Interestingly, there was no relationship in the current study between lost or disrupted coverage and emergency department utilization in the 6-month reporting period. It is possible that the reporting period was too brief for declining primary care or medication access to cause increased emergency department use. Another reasonable explanation is that there were financial disincentives for all 3 groups. For those with stable insurance, the imposition of a $50 co-payment may have acted as a disincentive; for the uninsured or unstably insured, fear of receiving medical bills with no insurance coverage may have done so.

Limitations

There were limitations in the current study. First, it relied heavily on self-report, which can be subject to recall bias.[30] To limit this bias, multiple items were used to examine issues such as access to care, all based on well-validated surveys. Additionally, a 6-month recall period was used, rather than a 1-year period, to minimize recall bias.

Self-reported information about health care needs and chronic conditions are subject to bias as well. For example, it is not clear whether those who reported needing health care actually needed it. On the other hand, it is also likely that many of those not reporting health care needs may have actually needed care. Similarly, the measure of chronic illness in this study depends both on having contact with a physician to obtain a diagnosis and accurately recalling that this event occurred.

Finally, our survey response rate was approximately 34%, a rate comparable to those of other studies of Medicaid populations, even those that used telephone follow-up.[31] As in similar studies, questions still arise about nonresponse bias. For example, individuals with no current address were excluded from the study, which likely results in underreporting the experiences of some populations, including the homeless or persons in transitional housing. Additionally, although 95% of respondents reported insurance information, a higher percentage of African Americans, Hispanics, and less-educated respondents did not report this information. It is possible, therefore, that these findings underestimate the extent to which these groups were affected by changes in insurance status. There is also the possibility of unmeasured differences between responders and nonresponders. For example, if those who were more adversely affected by program changes were also more likely to respond to the survey, results presented here may overestimate the impacts of coverage loss or disruptions. On the other hand, the proportion of responders in the survey cohort who reported losing coverage (45%) was very similar to the actual number known to have lost coverage based on Medicaid enrollment data (46%). This similarity provides some measure of confidence for the estimates reported in this analysis.

Policy Implications

As many states continue to struggle with financing their Medicaid programs and as the federal budget proposes deep cuts in Medicaid funding, the findings presented here should give rise to a serious discussion about the potentially negative impacts of policy options that include increasing cost sharing or limiting enrollment.

Early findings from this ongoing cohort study suggest that increased cost sharing and tightened administrative rules in Oregon resulted in immediate loss of coverage, unmet health care needs, and increased debt for a substantial number of low-income adults. Moreover, even relatively brief gaps in coverage can lead to decreased access and increased financial burden. It is reasonable to assume that short-term reductions in access to health care and medications may result in worsening health status with time and may lead to increased risk of emergency department utilization or hospitalization. Although it is too soon to address the long-term impacts of disrupted insurance coverage in Oregon, surveys of subsequent waves of the study cohort will be able to address more fully these important questions.

To read or post commentaries in response to this article, see it online at http://www.annfammed.org/cgi/content/full/4/5/391.

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References

1. Schoen C, Lyons B, Rowland D, Davis K, Puleo E. Insurance matters for low-income adults: results from a five-state survey. *Health Aff (Millwood).* 1997;16:163-171.
2. Haber SG, Khatutsky G, Mitchell JB. Covering uninsured adults through Medicaid: lessons from the Oregon health plan. *Health Care Financ Rev.* 2000;22:119-135.
3. Mitchell JB, Haber SG, Khatutsky G, Donoghue S. Impact of the Oregon Health Plan on access and satisfaction of adults with low income. *Health Serv Res.* 2002;37:11-31.
4. Coughlin TA, Long SK, Shen YC. Assessing access to care under Medicaid: evidence for the nation and thirteen states. *Health Aff (Millwood).* 2005;24:1073-1083.
5. Long SK, Coughlin T, King J. How well does Medicaid work in improving access to care? *Health Serv Res.* 2005;40:39-58.
6. Smith V, Ramesh R, Gifford K, et al. The continuing Medicaid budget challenge: State Medicaid spending growth and cost containment in fiscal years 2004 and 2005. Kaiser Commission on Medicaid and the Uninsured; 2004.
7. Artiga S, O'Malley M. Increasing premiums and cost sharing in Medicaid and SCHIP: Recent state experiences. Washington DC: Kaiser Commission on Medicaid and the Uninsured. 2005.
8. Wright BJ, Carlson MJ, Edlund T, et al. The impact of increased cost sharing on Medicaid enrollees. *Health Aff (Millwood).* 2005;24:1106-1116.
9. Lurie N, Ward NB, Shapiro MF, Brook RH. Termination from Medi-Cal--does it affect health? *N Engl J Med.* 1984;311:480-484.
10. Lurie N, Ward NB, Shapiro MF, et al. Termination of Medi-Cal benefits. A follow-up study one year later. *N Engl J Med.* 1986;314:1266-1268.
11. Strunk BC, Cunningham PJ. Treading water: Americans' access to needed medical care, 1997-2001. *Track Rep.* 2002:1-6.
12. DeVoe JE, Fryer GE, Phillips R, Green L. Receipt of preventive care among adults: insurance status and usual source of care. *Am J Public Health.* 2003;93:786-791.
13. The importance of primary care physicians as the usual source of healthcare in the achievement of prevention goals. *Am Fam Physician.* 2000;62:1968.
14. Bindman AB, Grumbach K, Osmond D, Vranizan K, Stewart AL. Primary care and receipt of preventive services. *J Gen Intern Med.* 1996;11:269-276.
15. Hayward RA, Bernard AM, Freeman HE, Corey CR. Regular source of ambulatory care and access to health services. *Am J Public Health.* 1991;81:434-438.
16. Weissman JS, Stern R, Fielding SL, Epstein AM. Delayed access to health care: risk factors, reasons, and consequences. *Ann Intern Med.* 1991;114:325-331.
17. Gross CP, Mead LA, Ford DE, Klag MJ. Physician, heal Thyself? Regular source of care and use of preventive health services among physicians. *Arch Intern Med.* 2000;160:3209-3214.
18. Ettner SL. The timing of preventive services for women and children: the effect of having a usual source of care. *Am J Public Health.* 1996;86:1748-1754.
19. Ettner SL. The relationship between continuity of care and the health behaviors of patients: does having a usual physician make a difference? *Med Care.* 1999;37:547-555.
20. Yu SM, Bellamy HA, Kogan MD, et al. Factors that influence receipt of recommended preventive pediatric health and dental care. *Pediatrics.* 2002;110:e73.
21. Corbie-Smith G, Flagg EW, Doyle JP, O'Brien MA. Influence of usual source of care on differences by race/ethnicity in receipt of preventive services. *J Gen Intern Med.* 2002;17:458-464.
22. Sudano JJ, Jr., Baker DW. Intermittent lack of health insurance coverage and use of preventive services. *Am J Public Health.* 2003;93:130-137.
23. Kasper JD, Giovannini TA, Hoffman C. Gaining and losing health insurance: strengthening the evidence for effects on access to care and health outcomes. *Med Care Res Rev.* 2000;57:298-318; discussion 319-225.
24. Schoen C, DesRoches C. Uninsured and unstably insured: the importance of continuous insurance coverage. *Health Serv Res.* 2000;35:187-206.
25. CAHPS 2.0 Survey and Reporting Kit. Silver Springs, MD: Agency for Healthcare Research and Quality; 2002.
26. Community Tracking Survey, Household Survey Instrument 2000-2001, Round Three. Washington DC: Center for Studying Health System Change; 2004. Technical Publication #54.
27. Ware J, Kolinski M, Keller S. *How to Score the SF-12 Physical and Mental Health Summaries: A User's Manual.* The Health Institute, New England Centre; 1995.
28. OHP Eligibility Report, Month Ending December 2002. Salem, OR: Oregon Department of Human Services; 2003.
29. Carlson M, Wright B. The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population. Salem, OR: Office for Oregon Health Policy and Research; 2005.
30. Guyatt GH, Feeny DH, Patrick DL. Measuring health-related quality of life. *Ann Intern Med.* 1993;118:622-629.
31. *Annual Report of the National CAHPS Benchmarking Database 2000.* Rockville, MD: U.S. Agency for Healthcare Research and Quality; 2001.

CLASP

Policy solutions that work for low-income people

March 2018

Child Care in the FY 2018 Omnibus Spending Bill

The fiscal year 2018 (FY 2018) omnibus spending bill, passed by the U.S. House of Representatives today, includes the largest-ever single-year increase in federal funding for the Child Care and Development Block Grant (CCDBG). The bill increases CCDBG discretionary funding by $2.4 billion.[1]

This investment will fully fund the 2014 child care reauthorization, according to estimates from the U.S. Department of Health and Human Services (HHS).[2] The reauthorization included provisions to improve the health, safety, and quality of child care and make child care assistance a more stable support for families.[3] The funds will also allow states to expand access to child care assistance—reversing course from years of decline. Over nine years, CCDBG served 21 percent fewer children in an average month—resulting in the smallest number of children served in the program's history in 2015.[4]

CLASP estimates that after funding the reauthorization costs, the increase will provide resources for more than 151,000 additional children to gain child care assistance.[5] The actual number of children served will depend on states' current compliance with the reauthorization as well as state policy choices, including quality initiatives and provider payment rates.

State Impact of $2.37 Billion Increase in CCDBG Funding		
State	**Additional Funding in FY 18[6]**	**Additional Children to Receive CCDBG-funded Child Care**
Alabama	$44,088,000	2,690
Alaska	$4,417,000	388
Arizona	$59,281,000	2,643
Arkansas	$27,862,000	803
California	$252,727,000	11,770
Colorado	$29,321,000	1,833
Connecticut	$15,248,000	923
Delaware	$6,358,000	783
District of Columbia	$3,823,000	161

State	Additional Funding in FY 18[7]	Additional Children to Receive CCDBG-funded Child Care
Florida	$139,521,000	8,906
Georgia	$98,679,000	6,384
Hawaii	$8,496,000	736
Idaho	$13,888,000	723
Illinois	$82,813,000	5,005
Indiana	$53,575,000	3,767
Iowa	$20,369,000	1,787
Kansas	$21,465,000	1,519
Kentucky	$42,802,000	1,097
Louisiana	$41,585,000	1,994
Maine	$7,505,000	301
Maryland	$29,960,000	1,887
Massachusetts	$29,497,000	3,199
Michigan	$69,675,000	3,480
Minnesota	$31,734,000	2,536
Mississippi	$32,679,000	2,222
Missouri	$44,556,000	3,901
Montana	$6,680,000	348
Nebraska	$12,932,000	1,258
Nevada	$21,247,000	609
New Hampshire	$4,930,000	596
New Jersey	$42,478,000	5,199
New Mexico	$20,106,000	1,780
New York	$106,694,000	11,811
North Carolina	$79,943,000	6,946
North Dakota	$3,689,000	241
Ohio	$79,631,000	5,112

State	Additional Funding in FY 18[8]	Additional Children to Receive CCDBG-funded Child Care
Oklahoma	$32,660,000	2,630
Oregon	$26,860,000	1,660
Pennsylvania	$69,759,000	10,131
Rhode Island	$5,467,000	649
South Carolina	$42,045,000	1,171
South Dakota	$5,969,000	442
Tennessee	$55,449,000	2,764
Texas	$242,556,000	12,105
Utah	$27,580,000	1,171
Vermont	$3,064,000	468
Virginia	$45,878,000	2,690
Washington	$40,547,000	4,865
West Virginia	$14,937,000	890
Wisconsin	$35,482,000	3,005
Wyoming	$2,937,000	348
Total	**$2,370,000,000[9]**	**151,370**

Endnotes

[1] The federal government provides states with mandatory funding, or the Child Care Entitlement, authorized in Section 418 of the Social Security Act, and discretionary funding, authorized in the CCDBG Act and appropriated annually by Congress. The increase in discretionary funding would bring total annual federal funding, including mandatory and discretionary funds, for child care assistance to $8.1 billion in FY 2018—an increase of $2.4 billion over FY 2017 funding.

[2] Final Rule of September 30, 2016, Child Care and Development Fund Program, Federal Register, Vol. 81, No. 190 https://www.gpo.gov/fdsys/pkg/FR-2016-09-30/pdf/2016-22986.pdf.

[3] Hannah Matthews, Karen Schulman, Julie Vogtman, Christine Johnson-Staub, Helen Blank, Implementing the Child Care and Development Block Grant Reauthorization: A Guide for States, CLASP, 2017, **https://www.clasp.org/publications/report/brief/implementing-child-care-and-development-block-grantreauthorization-guide**.

[4] Hannah Matthews, Christina Walker, CCDBG Participation Drops to Historic Low, CLASP, 2017, **https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/CCDBGParticipation-2015.pdf**.

[5] CLASP estimated the number of children served based on a per-child cost derived from CCDF expenditures and

participation. We also accounted for the costs of implementing the 2014 child reauthorization as outlined in the CCDF Final Rule and the costs of maintaining current caseloads.

[6] Estimated allocations based on FY 2017 CCDF Allocations, U.S. Department of Health and Human Services, Administration for Children and Families, 2017, **https://www.acf.hhs.gov/occ/resource/fy-2017-ccdf-allocations-including-redistributedfunds**. Actual amounts may differ due to Secretary discretion in set-aside funding.

[7] Estimated allocations based on FY 2017 CCDF Allocations, U.S. Department of Health and Human Services, Administration for Children and Families, 2017, **https://www.acf.hhs.gov/occ/resource/fy-2017-ccdf-allocations-including-redistributedfunds**. Actual amounts may differ due to Secretary discretion in set-aside funding.

[8] Estimated allocations based on FY 2017 CCDF Allocations, U.S. Department of Health and Human Services, Administration for Children and Families, 2017, **https://www.acf.hhs.gov/occ/resource/fy-2017-ccdf-allocations-including-redistributedfunds**. Actual amounts may differ due to Secretary discretion in set-aside funding.

[9] Included in the $2.4 billion is funding for U.S. territories; tribes; technical assistance; research and evaluation; and a national hotline and website.

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Revised January 2018 | Issue Brief

Understanding the Intersection of Medicaid and Work

Rachel Garfield, Robin Rudowitz and Anthony Damico

Medicaid is the nation's public health insurance program for people with low incomes. Overall, the Medicaid program covers one in five Americans, including many with complex and costly needs for care. Historically, nonelderly adults without disabilities accounted for a small share of Medicaid enrollees; however, the Affordable Care Act (ACA) expanded coverage to nonelderly adults with income up to 138% FPL, or $16,642 per year for an individual in 2017. As of December 2017, 32 states have implemented the ACA Medicaid expansion.[1] By design, the expansion extended coverage to the working poor (both parents and childless adults), most of whom do not otherwise have access to affordable coverage. While many have gained coverage under the expansion, the majority of Medicaid enrollees are still the "traditional" populations of children, people with disabilities, and the elderly.

Some states and the Trump administration have stated that the ACA Medicaid expansion targets "able-bodied" adults and seek to make Medicaid eligibility contingent on work. Under current law, states cannot impose a work requirement as a condition of Medicaid eligibility, but some states are seeking waiver authority to do so. These types of waiver requests were denied by the Obama administration, but the Trump administration has indicated a willingness to approve such waivers. This issue brief provides data on the work status of the nearly 25 million non-elderly adults without SSI enrolled in Medicaid (referred to as "Medicaid adults" throughout this brief) to understand the potential implications of work requirement proposals in Medicaid. Key takeaways include the following:

- Among Medicaid adults (including parents and childless adults — the group targeted by the Medicaid expansion), nearly 8 in 10 live in working families, and a majority are working themselves. Nearly half of working Medicaid enrollees are employed by small firms, and many work in industries with low employer-sponsored insurance offer rates.

- Among the adult Medicaid enrollees who were not working, most report major impediments to their ability to work including illness or disability or care-giving responsibilities.

- While proponents of work requirements say such provisions aim to promote work for those who are not working, these policies could have negative implications on many who are working or exempt from the requirements. For example, coverage for working or exempt enrollees may be at risk if enrollees face administrative obstacles in verifying their work status or documenting an exemption.

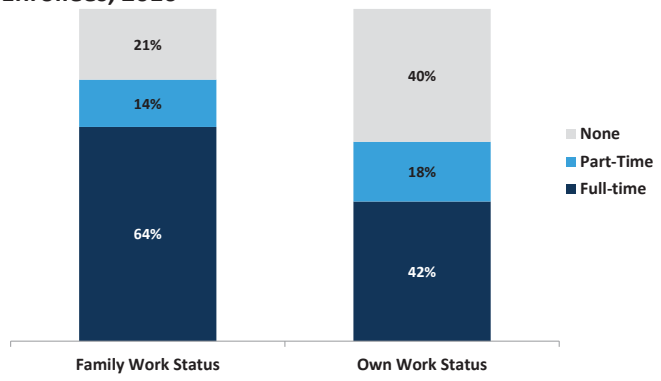
Data Findings

Among nonelderly adults with Medicaid coverage—the group of enrollees most likely to be in the workforce—nearly 8 in 10 live in working families, and a majority are working themselves.

Because policies around work requirements would be intended to apply to primarily to nonelderly adults without disabilities, we focus this analysis on adults whose eligibility is not based on receipt of Supplemental Security Income (SSI, see methods box for more detail). Data show that among the nearly 25 million non-SSI adults (ages 19-64) enrolled in Medicaid in 2016, 6 in 10 (60%) are working themselves (Figure 1). A larger share, nearly 8 in 10 (79%), are in families with at least one worker, with nearly two-thirds (64%) with a full-time worker and another 14% with a part-time worker; one of the adults in such families may not work, often due to caregiving or other responsibilities.

Figure 1

Work Status of Non-SSI, Nonelderly Adult Medicaid Enrollees, 2016



Total = 24.6 Million Non-Elderly Adults without SSI

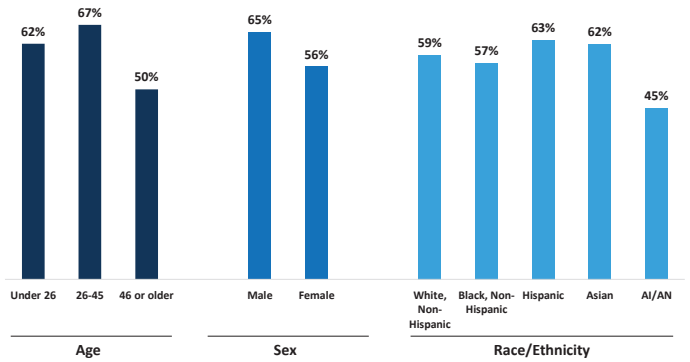
NOTE: Totals may not add due to rounding. Includes nonelderly adults who do not receive Supplemental Security Income (SSI).
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Because states that expanded Medicaid under the ACA cover adults with family incomes at higher levels than those that did not, adults in Medicaid expansion states are more likely to be in working families or working themselves than those in non-expansion states (Table 1). Adults who are younger, male, Hispanic or Asian were more likely to be working than those who are older, female, or White, Black, or American Indian, respectively (Figure 2 and Table 2). Not surprisingly, adults with more education or better health were more likely to work than others (Figure 3 and Table 2). Perhaps reflecting job market conditions, those living in the South were less likely to work than those in other areas, though similar rates of enrollees in urban and rural areas were working (Table 2). For state-level data, see Appendix tables.

Figure 2

Work Status of Non-SSI, Nonelderly Adult Medicaid Enrollees by Key Demographics, 2016

Share who are working themselves:

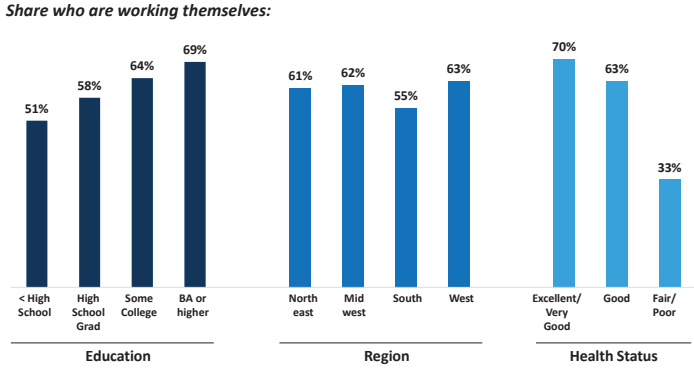


NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI). "Asian" includes Asian, Native Hawaiian, or Pacific Islander. "AI/AN" includes American Indian or Alaska Native.
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Figure 3

Work Status of Non-SSI, Nonelderly Adult Medicaid Enrollees by Key Demographics, 2016

Share who are working themselves:



NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI). "Asian" includes Asian, Native Hawaiian, or Pacific Islander. "AI/AN" includes American Indian or Alaska Native.
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

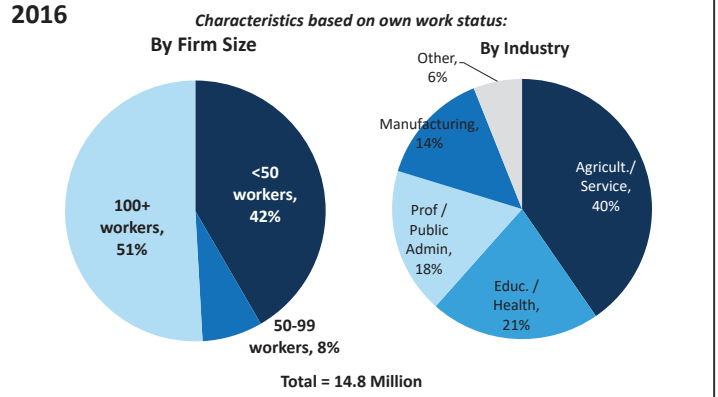
Most Medicaid enrollees who work are working full-time for the full year, but their annual incomes are still low enough to qualify for Medicaid. Among adult Medicaid enrollees who work, the majority (51%) worked full-time (at least 35 hours per week) for the entire year (at least 50 weeks during the year) (Table 3).[2] Most of those who work for only part of the year still work for the majority of the year (26 weeks or more). By definition (that is, in order to meet Medicaid eligibility criteria), these individuals are working low-wage jobs. For example, an individual working full-time (40 hours/week) for the full year (52 weeks) at the federal minimum wage would earn an annual salary of just over $15,000 a year, or about 125% of poverty, below the 138% FPL maximum targeted by the ACA Medicaid expansion.

Many Medicaid enrollees working part-time face impediments to finding full-time work. Among adult Medicaid enrollees who work part-time, many cite economic reasons such as inability to find full-time work (10%) or slack business conditions (11%) as the reason they work part-time versus full-time. Other major reasons are attendance at school (14%) or other family obligations (14%).

Nearly half of working adult Medicaid enrollees are employed by small firms, and many work in industries with low employer-sponsored coverage offer rates. Working Medicaid enrollees work in firms and industries that often have limited employer-based coverage options. More than four in ten adult Medicaid enrollees who work are employed by small firms with fewer than 50 employees that will not be subject to ACA penalties for not offering coverage (Figure 4). Further, many firms do not offer coverage to part-time workers. Four in ten Medicaid adults who work are employed in industries with historically low insurance rates, such as the agriculture and service industries. A closer look by specific industry shows that one-third of working Medicaid enrollees are employed in ten industries, with one in 10 enrollees working in restaurants or food services (Figure 5). The Medicaid expansion was designed to reach low-income adults left out of the employer-based system, so, it is not surprising that among those who work, most are unlikely to have access to health coverage through a job.

Figure 4

Work Characteristics of Working Adult Medicaid Enrollees, 2016



Notes: Data may not sum to 100% due to rounding. Includes nonelderly adults who do not receive Supplemental Security Income (SSI). Industry classifications: Agricult./Service includes agriculture, construction, leisure and hospitality services, wholesale and retail trade. Educ./Health includes education and health services. Prof/Public Admin includes finance, professional and business services, information, and public administration. Manufacturing includes mining, manufacturing, utilities, and transportation.
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Figure 5

Industries with Largest Number of Workers Covered by Medicaid, 2016

Industry	Number of Adult Workers with Medicaid
Restaurant and food services	1,486,000
Construction	974,000
Elementary and secondary schools	461,000
Grocery stores	396,000
Hospitals	354,000
Department stores and discount stores	328,000
Home health care services	311,000
Services to buildings and dwellings	294,000
Nursing care facilities	275,000
Child day care services	274,000
Total for Listed Industries (38% of adult Medicaid enrollees who are workers)	5,153,000

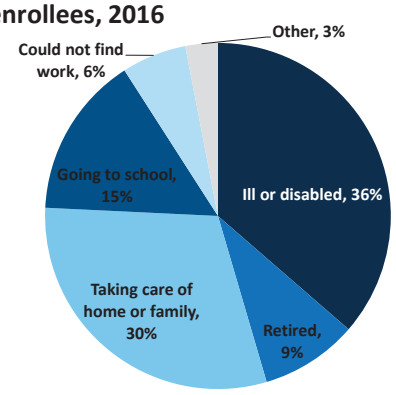
NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI).
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Among the adult Medicaid enrollees who were not working, most report major impediments to their ability to work. Even though individuals qualifying for Medicaid on the basis of a disability through SSI were excluded from this group, more than one-third of those not working reported that illness or disability

was the primary reason for not working. SSI disability criteria are stringent and can take a long time to establish. People can have physical and/or mental health disabilities that interfere with their ability to work, or to work full-time, without those impairments rising to the SSI level of severity. Other analysis indicates that nearly nine in ten (88%) non-SSI Medicaid adults who reports not working due to illness or disability has a functional limitation, and more than two-thirds (67%) have two or more chronic conditions such as arthritis or asthma.[3]

Figure 6

Main reasons for not working among non-SSI, adult Medicaid enrollees, 2016



Total = 9.8 Million

NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI).
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

30% of non-working Medicaid adults reported that they did not work because they were taking care of home or family; 15% were in school; 6% were looking for work and another 9% were retired (Figure 6). Women accounted for 62% of Medicaid enrollees who were not working in 2016, and parents with children under the age of 6 accounted for 17%.

Policy Implications

Under current law, states cannot impose a work requirement as a condition of Medicaid eligibility. As with other core requirements, the Medicaid statute sets minimum eligibility standards, and states are able to expand coverage beyond these minimum levels. Prior to the ACA, individuals had to meet not only income and resource requirements but also categorical requirements to be eligible for the program. These categorical requirements provided coverage pathways for adults who were pregnant women or parents as well as individuals with disabilities, but other adults without dependent children were largely excluded from coverage. The ACA was designed to fill in gaps in coverage and effectively eliminate these categorical eligibility requirements by establishing a uniform income threshold for most adults. States are not allowed to impose other eligibility requirements that are not in the law.

Some states have proposed tying Medicaid eligibility to work requirements using waiver authority that may be approved by the Trump Administration. Under Section 1115 of the Social Security Act, the Secretary of HHS can waive certain provisions of Medicaid as long as the Secretary determines that the initiative is a "research and demonstration project" that "is likely to assist in promoting the objectives" of the program. The Obama administration did not approve waivers that would condition Medicaid eligibility on work on the grounds that they did not meet the waiver test to further the purpose of the program which is to provide health coverage. The Trump Administration has indicated a willingness to approve waivers to require work.

Research shows that Medicaid expansion has not negatively affected labor market participation, and some research indicates that Medicaid coverage supports work. A comprehensive review of research on the ACA Medicaid expansion found that there is no significant negative effect of the ACA Medicaid expansion on employment rates and other measures of employment and employee behavior (such as transitions from employment to non-employment, the rate of job switches, transitions from full- to part-time employment, labor force participation, and usual hours worked per week). In addition, focus

groups, state studies, and anecdotal reports highlight examples of Medicaid coverage supporting work and helping enrollees transition into new careers. For example, individuals have reported that receiving medication for conditions like asthma or rheumatoid arthritis through Medicaid is critical in supporting their ability to work. Addressing barriers to work requires adequate funding and supports. While TANF spending on work activities and supports is critiqued by some as too low, it exceeds estimates of state Medicaid program spending to implement a work requirement.

Implementing work requirements can create administrative complexity and put coverage at risk for eligible enrollees who are working or who may be exempt. States can incur additional costs and demands on staff, and some eligible people could lose coverage. While work requirements are intended to promote work among those not working, coverage for those who are working could be at risk if beneficiaries face administrative obstacles in verifying their work status or documenting an exemption. In addition, some individuals who may be exempt may face challenges in navigating an exemption which could also put coverage at risk.

Methods

This analysis is based on Kaiser Family Foundation analysis of the March 2017 Current Population Survey (CPS), which reflects health insurance coverage in 2016. We included nonelderly adults (age 19-64) who indicated that they had Medicaid at some point during the year. We excluded people who indicated that they received Supplemental Security Income (SSI) during the year, since these individuals likely qualify for Medicaid on the basis of having a disability (and would likely be excluded from work requirements). To match timing of work variables to health insurance coverage, we used measures of work status throughout 2016. Individuals who worked at any point in 2016 were classified as "working."

Rachel Garfield and Robin Rudowitz are with the Kaiser Family Foundation. Anthony Damico is an independent consultant to the Kaiser Family Foundation.

Table 1: Family and Own Work Status of Non-SSI, Nonelderly Adult Medicaid Enrollees, 2016		
State	**Share in Working Family**	**Share Working Themselves**
Expansion states (median)	**79%**	**62%**
Alaska	76%	57%
Arizona	81%	62%
Arkansas	73%	57%
California	84%	62%
Colorado	86%	70%
Connecticut	81%	70%
Delaware	77%	60%
DC	73%	58%
Hawaii	74%	51%
Illinois	81%	64%
Indiana	75%	58%
Iowa	87%	72%
Kentucky	74%	62%
Louisiana	69%	52%
Maryland	87%	66%
Massachusetts	80%	67%
Michigan	75%	60%
Minnesota	84%	66%
Montana	81%	67%
Nevada	78%	65%
New Hampshire	77%	65%
New Jersey	84%	53%
New Mexico	80%	60%
New York	78%	57%
North Dakota	60%	49%
Ohio	72%	61%
Oregon	85%	69%
Pennsylvania	79%	64%
Rhode Island	76%	68%
Vermont	80%	69%
Washington	80%	62%
West Virginia	69%	53%
Non-expansion states (median)	**74%**	**58%**
Alabama	65%	43%
Florida	78%	61%
Georgia	75%	58%
Idaho	80%	59%
Kansas	86%	69%
Maine*	74%	64%
Mississippi	65%	47%
Missouri	71%	60%
Nebraska	81%	59%
North Carolina	76%	57%
Oklahoma	67%	51%
South Carolina	73%	51%
South Dakota	69%	55%
Tennessee	77%	57%
Texas	76%	49%
Utah	81%	63%
Virginia	67%	48%
Wisconsin	74%	62%
Wyoming	74%	62%

Note: * Maine adopted the Medicaid expansion through a ballot initiative in November 2017; due to uncertainty over the exact date of implementation, Maine is still categorized as a non-expansion state in this analysis.
Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Table 2: Own Work Status of Non-SSI, Nonelderly Adult Medicaid Enrollees, 2016				
		Total	Share Who Worked in 2016	Share Who Did Not Work in 2016
Total		24,580,000	**60%**	**40%**
Age	Under 26	5,379,000	62%	38%
	26 - 45	11,449,000	67%	33%
	46 or older	7,751,000	50%	50%
Sex	Male	10,718,000	65%	35%
	Female	13,862,000	56%	44%
Race/Ethnicity	White Non-Hispanic	11,478,000	59%	41%
	Black Non-Hispanic	4,035,000	57%	43%
	Hispanic	6,658,000	63%	37%
	Asian, Native Hawaiian, or Pacific Islander	1,626,000	62%	38%
	American Indian or Alaska Native	320,000	45%	55%
	Multiple Races	463,000	68%	32%
Education	Less than High School	4,488,000	51%	49%
	High School Graduate	9,185,000	58%	42%
	Some College	7,395,000	64%	36%
	Bachelor's Degree or Higher	3,513,000	69%	31%
Geographic Region	Northeast	5,104,000	61%	39%
	Midwest	5,095,000	62%	38%
	South	6,465,000	55%	45%
	West	7,915,000	63%	37%
Metro Status	Non-Metro*	3,720,000	58%	42%
	Metro	20,860,000	61%	39%
Family Type	One Parent with Children	2,336,000	73%	27%
	Two Parents with Children	4,815,000	68%	32%
	Multi-generational	1,824,000	58%	42%
	Married Adults	2,702,000	55%	45%
	Adults Living Together	4,688,000	52%	48%
	Single Person	4,513,000	56%	44%
	Other	3,704,000	62%	38%
Family Work Status	Multiple Full-Time Workers in Family	4,888,000	86%	14%
	One Full-Time Worker in Family	10,947,000	71%	29%
	Only Part-Time Workers in Family	3,519,000	81%	19%
	No Workers in Family	5,226,000	0%	100%
Self-Reported Health	Excellent/Very Good	11,866,000	70%	30%
	Good	7,705,000	63%	37%
	Fair/Poor	5,009,000	33%	67%

* Includes people in not-identified areas
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Table 3: Characteristics of Working Nonelderly Adult (19-64) Medicaid Enrollees, 2016		
Total		**14,802,000**
Work Status	Full-Time*	69%
	Full-Time, Full-Year	51%
	Full-Time, Part-Year	19%
	Part-Time	31%
	Part-Time, Full-Year	16%
	Part-Time, Part-Year	15%
Number of Weeks Worked During the Year	1-12 weeks	8%
	13-25 weeks	8%
	26-38 weeks	9%
	39-51 weeks	12%
	52 weeks	64%
Firm Size	< 50 employees	42%
	50 - 99 employees	8%
	100+ employees	51%

* Full-Time is based on total number of hours worked per week (at least 35 hours). Full-time workers may be simultaneously working more than one-job.
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Endnotes

[1] Maine adopted the Medicaid expansion through a ballot initiative in November 2017; due to uncertainty over the exact date of implementation, Maine is still categorized as a non-expansion state in this analysis.

[2] Full-time workers include people working 35 hours or more, those who worked 1-34 hours for noneconomic reasons (e.g., illness) and usually work full-time, and people "with a job but not at work" who usually work full- time. People working full time may work at more than one job.

[3] Kaiser Family Foundation analysis of 2016 National Health Interview Survey.

Appendix Tables

Appendix Table 1: Family and Own Work Status of Non-SSI, Nonelderly Adult Medicaid Enrollees, 2016							
		Family Work Status			Own Work Status		
	Total # Non-SSI, Nonelderly Adult Medicaid Enrollees	No Worker in Family	Full-Time Worker in Family	Part-Time Worker in Family	Not Working	Working Full-Time	Working Part-Time
US TOTAL	**24,580,000**	**21%**	**64%**	**14%**	**40%**	**42%**	**18%**
ALABAMA	308,000	35%	58%	8%	57%	31%	12%
ALASKA	69,000	24%	61%	15%	43%	39%	19%
ARIZONA	636,000	19%	63%	18%	38%	41%	21%
ARKANSAS	178,000	27%	60%	13%	43%	40%	17%
CALIFORNIA	4,777,000	16%	69%	14%	38%	44%	18%
COLORADO	361,000	14%	73%	13%	30%	54%	16%
CONNECTICUT	337,000	19%	60%	21%	30%	47%	23%
DELAWARE	103,000	23%	67%	9%	40%	43%	17%
DISTRICT OF COLUMBIA	88,000	27%	62%	11%	42%	46%	12%
FLORIDA	1,069,000	22%	67%	12%	39%	44%	18%
GEORGIA	398,000	25%	65%	NA	42%	40%	18%
HAWAII	96,000	26%	57%	18%	49%	32%	19%
IDAHO	87,000	20%	69%	11%	41%	41%	18%
ILLINOIS	1,040,000	19%	68%	13%	36%	46%	19%
INDIANA	541,000	25%	64%	11%	42%	45%	14%
IOWA	245,000	13%	66%	20%	28%	45%	27%
KANSAS	107,000	14%	68%	18%	31%	47%	21%
KENTUCKY	337,000	26%	64%	NA	38%	47%	14%
LOUISIANA	421,000	31%	54%	15%	48%	34%	18%
MAINE	100,000	26%	52%	22%	36%	39%	25%
MARYLAND	390,000	NA	74%	12%	34%	51%	16%
MASSACHUSETTS	776,000	20%	64%	16%	33%	46%	21%
MICHIGAN	967,000	25%	61%	14%	40%	42%	18%
MINNESOTA	354,000	16%	73%	10%	34%	48%	18%
MISSISSIPPI	182,000	35%	57%	9%	53%	35%	12%
MISSOURI	285,000	29%	61%	10%	40%	44%	16%
MONTANA	86,000	19%	64%	16%	33%	46%	21%
NEBRASKA	65,000	19%	65%	16%	41%	40%	NA
NEVADA	216,000	22%	66%	12%	35%	46%	18%
NEW HAMPSHIRE	56,000	23%	66%	NA	35%	41%	24%
NEW JERSEY	639,000	16%	69%	15%	47%	37%	16%
NEW MEXICO	306,000	20%	63%	17%	40%	40%	20%
NEW YORK	2,114,000	22%	66%	13%	43%	39%	18%
NORTH CAROLINA	520,000	24%	60%	16%	43%	39%	18%
NORTH DAKOTA	28,000	40%	47%	12%	51%	33%	16%
OHIO	1,121,000	28%	58%	15%	39%	40%	21%
OKLAHOMA	203,000	33%	53%	NA	49%	35%	16%
OREGON	459,000	15%	74%	11%	31%	53%	16%
PENNSYLVANIA	942,000	21%	60%	19%	36%	41%	23%
RHODE ISLAND	87,000	24%	60%	16%	32%	44%	24%
SOUTH CAROLINA	280,000	27%	63%	NA	49%	41%	11%
SOUTH DAKOTA	38,000	31%	48%	21%	45%	36%	19%
TENNESSEE	482,000	23%	61%	16%	43%	37%	20%
TEXAS	1,016,000	24%	63%	13%	51%	33%	16%
UTAH	97,000	NA	63%	18%	37%	39%	24%
VERMONT	54,000	20%	59%	20%	31%	47%	22%
VIRGINIA	298,000	33%	53%	NA	52%	35%	12%
WASHINGTON	705,000	20%	62%	18%	38%	38%	23%
WEST VIRGINIA	194,000	31%	54%	15%	47%	38%	15%
WISCONSIN	303,000	26%	51%	24%	38%	37%	25%
WYOMING	20,000	26%	59%	15%	38%	38%	24%

Notes: NA= estimate does not meet minimum standard for statistical reliability. Full-Time is based on total number of hours worked per week (at least 35 hours). Full-time workers may be simultaneously working more than one-job. Note that total number of non-elderly, non-SSI adults from survey data may be lower than state administrative data.

Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Appendix Table 2: Reason for Not Working Among Non-SSI, Nonelderly Adult Medicaid Enrollees, 2016				
	Ill or Disabled	Caretaking	Attending School	Other Reason
US TOTAL	**36%**	**30%**	**15%**	**19%**
ALABAMA	41%	23%	14%	22%
ALASKA	26%	26%	NA	21%
ARIZONA	37%	34%	NA	19%
ARKANSAS	53%	27%	NA	14%
CALIFORNIA	28%	36%	18%	17%
COLORADO	36%	30%	NA	NA
CONNECTICUT	35%	30%	22%	NA
DELAWARE	42%	21%	13%	24%
DISTRICT OF COLUMBIA	26%	27%	19%	28%
FLORIDA	36%	29%	14%	21%
GEORGIA	47%	28%	NA	NA
HAWAII	33%	32%	NA	26%
IDAHO	39%	26%	NA	24%
ILLINOIS	36%	26%	14%	24%
INDIANA	47%	26%	NA	23%
IOWA	37%	30%	14%	NA
KANSAS	42%	NA	NA	NA
KENTUCKY	51%	27%	NA	NA
LOUISIANA	29%	27%	23%	21%
MAINE	52%	33%	NA	NA
MARYLAND	39%	NA	17%	NA
MASSACHUSETTS	42%	22%	9%	27%
MICHIGAN	39%	31%	12%	18%
MINNESOTA	35%	NA	NA	33%
MISSISSIPPI	48%	24%	NA	NA
MISSOURI	54%	31%	NA	NA
MONTANA	37%	33%	18%	NA
NEBRASKA	40%	NA	NA	NA
NEVADA	28%	39%	NA	NA
NEW HAMPSHIRE	49%	NA	NA	27%
NEW JERSEY	27%	23%	31%	19%
NEW MEXICO	29%	33%	19%	19%
NEW YORK	26%	28%	24%	22%
NORTH CAROLINA	40%	31%	20%	NA
NORTH DAKOTA	32%	NA	NA	NA
OHIO	58%	30%	NA	NA
OKLAHOMA	29%	40%	NA	18%
OREGON	24%	39%	NA	23%
PENNSYLVANIA	45%	19%	15%	21%
RHODE ISLAND	37%	29%	NA	32%
SOUTH CAROLINA	52%	32%	NA	NA
SOUTH DAKOTA	29%	NA	NA	NA
TENNESSEE	41%	27%	17%	15%
TEXAS	33%	35%	14%	17%
UTAH	39%	36%	NA	NA
VERMONT	56%	29%	NA	NA
VIRGINIA	46%	27%	NA	NA
WASHINGTON	29%	26%	15%	29%
WEST VIRGINIA	41%	34%	12%	14%
WISCONSIN	43%	39%	NA	NA
WYOMING	62%	30%	NA	NA

Notes: NA= estimate does not meet minimum standard for statistical reliability.

Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Appendix Table 3: Characteristics of Working Nonelderly Adult Medicaid Enrollees, 2016								
	Firm Size			Industry				
	<50 Employees	50-99 Employees	100+ Employees	Agricult./ Service	Educ./ Health	Prof/Public Admin	Manufacturing	Top Industry
US TOTAL	**42%**	**8%**	**51%**	**40%**	**21%**	**18%**	**14%**	**Restaurants/Food Service**
ALABAMA	34%	NA	61%	40%	19%	NA	26%	NA
ALASKA	51%	NA	41%	43%	23%	13%	11%	Construction
ARIZONA	44%	6%	50%	44%	16%	24%	13%	Construction
ARKANSAS	45%	NA	48%	26%	30%	22%	13%	NA
CALIFORNIA	47%	8%	45%	42%	17%	19%	15%	Restaurants/Food Service
COLORADO	44%	NA	52%	39%	16%	21%	NA	NA
CONNECTICUT	30%	NA	60%	37%	28%	19%	15%	Construction
DELAWARE	30%	NA	61%	48%	21%	20%	NA	Restaurants/Food Service
DISTRICT OF COLUMBIA	31%	10%	59%	34%	27%	26%	6%	Restaurants/Food Service
FLORIDA	40%	5%	55%	46%	18%	21%	8%	Restaurants/Food Service
GEORGIA	36%	NA	58%	42%	17%	21%	NA	NA
HAWAII	58%	NA	38%	45%	18%	14%	NA	NA
IDAHO	39%	NA	52%	39%	27%	19%	NA	NA
ILLINOIS	37%	9%	54%	40%	20%	16%	18%	Restaurants/Food Service
INDIANA	33%	9%	58%	25%	18%	23%	27%	NA
IOWA	33%	NA	60%	35%	21%	19%	23%	Elementary/Secondary Schools
KANSAS	39%	NA	53%	39%	25%	NA	NA	NA
KENTUCKY	47%	NA	48%	43%	16%	21%	14%	NA
LOUISIANA	37%	9%	53%	44%	24%	14%	11%	Restaurants/Food Service
MAINE	52%	NA	43%	57%	27%	NA	NA	NA
MARYLAND	41%	NA	55%	37%	27%	22%	NA	Restaurants/Food Service
MASSACHUSETTS	39%	10%	51%	40%	26%	18%	10%	Restaurants/Food Service
MICHIGAN	37%	10%	53%	33%	23%	16%	19%	Restaurants/Food Service
MINNESOTA	35%	13%	52%	39%	24%	19%	12%	NA
MISSISSIPPI	42%	NA	55%	52%	17%	12%	11%	Furniture manufacturing
MISSOURI	33%	NA	56%	30%	23%	20%	20%	NA
MONTANA	56%	NA	37%	48%	20%	21%	NA	Construction
NEBRASKA	35%	NA	59%	35%	22%	32%	NA	NA
NEVADA	38%	NA	55%	53%	NA	24%	NA	NA
NEW HAMPSHIRE	38%	NA	55%	47%	24%	NA	NA	NA
NEW JERSEY	46%	10%	43%	36%	26%	13%	14%	NA
NEW MEXICO	45%	8%	47%	50%	20%	16%	7%	Construction
NEW YORK	46%	7%	47%	38%	25%	17%	14%	Restaurants/Food Service
NORTH CAROLINA	44%	NA	53%	42%	17%	19%	18%	Construction
NORTH DAKOTA	43%	NA	44%	44%	NA	NA	NA	NA
OHIO	36%	5%	59%	40%	23%	17%	16%	Restaurants/Food Service
OKLAHOMA	37%	NA	58%	42%	24%	NA	13%	NA
OREGON	53%	6%	41%	40%	21%	19%	14%	Restaurants/Food Service
PENNSYLVANIA	35%	9%	57%	36%	23%	18%	17%	Restaurants/Food Service
RHODE ISLAND	38%	NA	55%	39%	25%	NA	19%	NA
SOUTH CAROLINA	29%	NA	64%	41%	18%	17%	20%	NA
SOUTH DAKOTA	37%	NA	47%	47%	NA	NA	NA	NA
TENNESSEE	42%	NA	53%	34%	19%	16%	26%	Restaurants/Food Service
TEXAS	40%	6%	54%	41%	19%	22%	10%	Restaurants/Food Service
UTAH	36%	0%	64%	44%	NA	21%	NA	NA
VERMONT	58%	NA	38%	36%	26%	18%	NA	NA
VIRGINIA	56%	NA	41%	41%	26%	NA	NA	NA
WASHINGTON	42%	13%	45%	46%	24%	16%	10%	Glass manufacturing
WEST VIRGINIA	39%	10%	51%	38%	21%	15%	21%	Restaurants/Food Service
WISCONSIN	43%	NA	50%	38%	23%	NA	16%	NA
WYOMING	40%	NA	50%	30%	25%	NA	16%	NA

Notes: NA= estimate does not meet minimum standard for statistical reliability.

Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Appendix Table 4a: Share Working among Non-SSI, Nonelderly Adult Medicaid Enrollees by Socio-Demographic Characteristics, 2016									
	Share Working Within Each Age Group			Share Working Within Each Sex		Share Working Within Each Race/Ethnicity Group			
	Age 19-25	Age 26-45	Age 46+	Women	Men	White, Non-Hispanic	Black, Non-Hispanic	Hispanic	Other Non-Hispanic
US TOTAL	**62%**	**67%**	**50%**	**56%**	**65%**	**59%**	**57%**	**63%**	**61%**
ALABAMA	60%	45%	24%	40%	49%	47%	36%	63%	NA
ALASKA	56%	60%	51%	49%	65%	57%	66%	67%	54%
ARIZONA	64%	67%	54%	55%	70%	58%	67%	64%	64%
ARKANSAS	76%	53%	50%	57%	57%	57%	56%	60%	NA
CALIFORNIA	61%	66%	58%	58%	68%	62%	59%	63%	63%
COLORADO	65%	78%	62%	69%	71%	73%	77%	73%	50%
CONNECTICUT	63%	85%	53%	72%	67%	70%	56%	69%	93%
DELAWARE	64%	66%	49%	59%	61%	60%	59%	53%	91%
DISTRICT OF COLUMBIA	46%	67%	46%	54%	63%	94%	48%	72%	67%
FLORIDA	74%	63%	48%	57%	67%	59%	65%	62%	63%
GEORGIA	61%	67%	35%	55%	64%	58%	56%	65%	65%
HAWAII	62%	52%	44%	52%	49%	66%	NA	49%	47%
IDAHO	56%	65%	50%	48%	74%	58%	NA	58%	NA
ILLINOIS	71%	70%	52%	61%	68%	65%	54%	69%	68%
INDIANA	72%	61%	49%	54%	64%	59%	47%	86%	61%
IOWA	71%	88%	46%	66%	80%	71%	81%	89%	48%
KANSAS	82%	82%	NA	62%	83%	75%	NA	48%	64%
KENTUCKY	76%	70%	38%	61%	62%	61%	NA	80%	NA
LOUISIANA	53%	63%	33%	53%	48%	46%	58%	45%	68%
MAINE	67%	70%	53%	57%	75%	60%	NA	NA	92%
MARYLAND	64%	76%	51%	63%	71%	63%	65%	57%	88%
MASSACHUSETTS	85%	70%	57%	67%	67%	65%	76%	72%	52%
MICHIGAN	74%	64%	43%	56%	65%	61%	55%	62%	52%
MINNESOTA	77%	71%	52%	65%	67%	67%	64%	NA	57%
MISSISSIPPI	60%	53%	26%	42%	54%	53%	44%	NA	NA
MISSOURI	74%	64%	39%	55%	71%	60%	56%	69%	59%
MONTANA	68%	76%	53%	61%	75%	70%	NA	NA	48%
NEBRASKA	65%	70%	NA	57%	62%	57%	NA	65%	NA
NEVADA	77%	67%	55%	59%	73%	62%	50%	74%	64%
NEW HAMPSHIRE	69%	84%	39%	66%	62%	62%	NA	NA	86%
NEW JERSEY	31%	72%	49%	48%	60%	53%	53%	54%	49%
NEW MEXICO	64%	67%	48%	57%	64%	60%	88%	61%	55%
NEW YORK	43%	62%	59%	54%	61%	51%	57%	63%	63%
NORTH CAROLINA	54%	67%	46%	50%	68%	58%	56%	70%	43%
NORTH DAKOTA	NA	70%	NA	53%	NA	56%	NA	NA	NA
OHIO	74%	69%	36%	55%	68%	59%	62%	63%	79%
OKLAHOMA	57%	54%	37%	46%	57%	54%	NA	59%	49%
OREGON	74%	76%	55%	59%	79%	68%	85%	76%	64%
PENNSYLVANIA	57%	75%	51%	63%	64%	65%	55%	69%	66%
RHODE ISLAND	88%	73%	53%	65%	72%	70%	67%	58%	NA
SOUTH CAROLINA	56%	55%	44%	48%	57%	49%	49%	85%	NA
SOUTH DAKOTA	51%	63%	43%	47%	71%	65%	NA	NA	NA
TENNESSEE	55%	67%	39%	61%	49%	56%	63%	45%	NA
TEXAS	55%	56%	35%	47%	54%	43%	64%	45%	59%
UTAH	66%	64%	57%	54%	76%	61%	NA	68%	NA
VERMONT	67%	78%	60%	65%	74%	69%	75%	NA	55%
VIRGINIA	60%	53%	36%	48%	46%	37%	54%	56%	65%
WASHINGTON	60%	67%	56%	57%	68%	61%	NA	75%	50%
WEST VIRGINIA	55%	65%	34%	50%	58%	53%	NA	NA	70%
WISCONSIN	NA	74%	44%	64%	59%	61%	72%	66%	47%
WYOMING	63%	66%	52%	62%	62%	63%	NA	59%	NA

Notes: NA= estimate does not meet minimum standard for statistical reliability.

Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Appendix Table 4b: Share Working among Non-SSI, Nonelderly Adult Medicaid Enrollees by Socio-Demographic Characteristics, 2016							
	Share Working Within Each Education Level				Share Working Within Each Health Status Group		
	< High School	High School	Some College	BA or Higher	Fair/Poor	Good	Excellent/ Very Good
US TOTAL	**51%**	**58%**	**64%**	**69%**	**33%**	**63%**	**70%**
ALABAMA	35%	40%	56%	43%	28%	40%	54%
ALASKA	49%	59%	58%	57%	42%	51%	75%
ARIZONA	57%	61%	68%	65%	31%	66%	74%
ARKANSAS	44%	60%	63%	60%	43%	50%	75%
CALIFORNIA	58%	60%	66%	69%	38%	64%	70%
COLORADO	33%	64%	87%	82%	NA	75%	80%
CONNECTICUT	60%	62%	73%	88%	68%	65%	73%
DELAWARE	49%	57%	65%	73%	NA	51%	79%
DISTRICT OF COLUMBIA	54%	49%	65%	69%	25%	65%	62%
FLORIDA	61%	58%	65%	62%	36%	50%	75%
GEORGIA	58%	60%	57%	51%	NA	72%	64%
HAWAII	57%	47%	46%	66%	NA	57%	59%
IDAHO	50%	53%	58%	76%	43%	61%	68%
ILLINOIS	41%	65%	72%	67%	34%	66%	75%
INDIANA	50%	53%	62%	79%	27%	53%	82%
IOWA	37%	77%	73%	78%	42%	85%	76%
KANSAS	NA	79%	70%	57%	38%	62%	81%
KENTUCKY	54%	65%	55%	79%	NA	79%	72%
LOUISIANA	34%	55%	58%	65%	40%	51%	58%
MAINE	NA	64%	67%	66%	21%	66%	79%
MARYLAND	50%	71%	70%	65%	38%	65%	75%
MASSACHUSETTS	47%	69%	67%	75%	35%	68%	79%
MICHIGAN	46%	61%	60%	65%	35%	65%	67%
MINNESOTA	46%	61%	68%	81%	43%	67%	73%
MISSISSIPPI	33%	43%	54%	74%	20%	52%	59%
MISSOURI	38%	69%	57%	72%	NA	55%	83%
MONTANA	53%	64%	65%	83%	41%	65%	77%
NEBRASKA	NA	57%	68%	NA	NA	75%	61%
NEVADA	46%	69%	65%	69%	48%	65%	70%
NEW HAMPSHIRE	65%	64%	58%	85%	34%	78%	79%
NEW JERSEY	41%	63%	42%	55%	30%	61%	56%
NEW MEXICO	46%	60%	64%	72%	38%	57%	72%
NEW YORK	53%	51%	61%	68%	32%	61%	62%
NORTH CAROLINA	51%	53%	63%	61%	33%	58%	71%
NORTH DAKOTA	NA	59%	NA	60%	NA	NA	58%
OHIO	50%	53%	68%	79%	29%	64%	75%
OKLAHOMA	45%	41%	67%	58%	NA	43%	64%
OREGON	72%	68%	63%	79%	35%	77%	79%
PENNSYLVANIA	52%	64%	61%	73%	39%	70%	74%
RHODE ISLAND	45%	68%	79%	73%	39%	62%	88%
SOUTH CAROLINA	30%	58%	54%	63%	NA	51%	71%
SOUTH DAKOTA	NA	55%	68%	74%	NA	59%	64%
TENNESSEE	48%	48%	74%	70%	NA	70%	72%
TEXAS	44%	40%	57%	73%	25%	57%	58%
UTAH	NA	61%	75%	62%	NA	74%	70%
VERMONT	52%	66%	71%	81%	44%	73%	76%
VIRGINIA	NA	45%	83%	NA	34%	46%	58%
WASHINGTON	55%	69%	54%	69%	42%	65%	69%
WEST VIRGINIA	37%	50%	68%	62%	30%	60%	63%
WISCONSIN	51%	55%	73%	75%	31%	77%	73%
WYOMING	67%	55%	68%	59%	NA	75%	75%

Notes: NA= estimate does not meet minimum standard for statistical reliability.

Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

By Aparna Soni, Marguerite E. Burns, Laura Dague, and Kosali I. Simon

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DATAWATCH

Medicaid Expansion And State Trends In Supplemental Security Income Program Participation

The Affordable Care Act made low-income nonelderly adults eligible for Medicaid in 2014 without requiring them to obtain disabled status through the Supplemental Security Income (SSI) program. In states that participated in the Medicaid expansion, we found that SSI participation decreased by about 3 percent after 2014.

The Affordable Care Act (ACA) authorized the largest expansion of Medicaid eligibility for nonelderly, nondisabled childless adults since the program's inception.[1] Before 2014, childless adults were eligible for Medicaid via the Supplemental Security Income (SSI) program but not through traditional Medicaid in most states[2]—and in states where they were eligible through traditional Medicaid, enrollment was typically capped.[3] SSI was also important to parents whose state Medicaid income threshold was lower than the SSI income criteria.[4] After 2014, we would expect to see decreases in SSI participation among populations newly eligible for Medicaid. Indeed, we observed a small (2 percent) decline after 2014 in numbers of SSI participants in expansion states and a small (1 percent) increase in numbers of SSI participants in nonexpansion states, for a net decline of 3 percent in expansion states (Exhibit 1). In the current health policy environment, it is critical to understand Medicaid's potential spillover effects, to assess future changes to the program.

As of January 2017, thirty-two states and the District of Columbia had adopted the ACA Medicaid expansion.[5] In these states, low-income adults may obtain Medicaid benefits without completing the intensive SSI application process.[6] In states that have not expanded Medicaid, nonelderly adults—particularly those without children—continue to have fewer Medicaid coverage options outside of SSI participation.

In addition to cash benefits, SSI typically confers immediate Medicaid eligibility on adults who have a work-limiting disability, low income,

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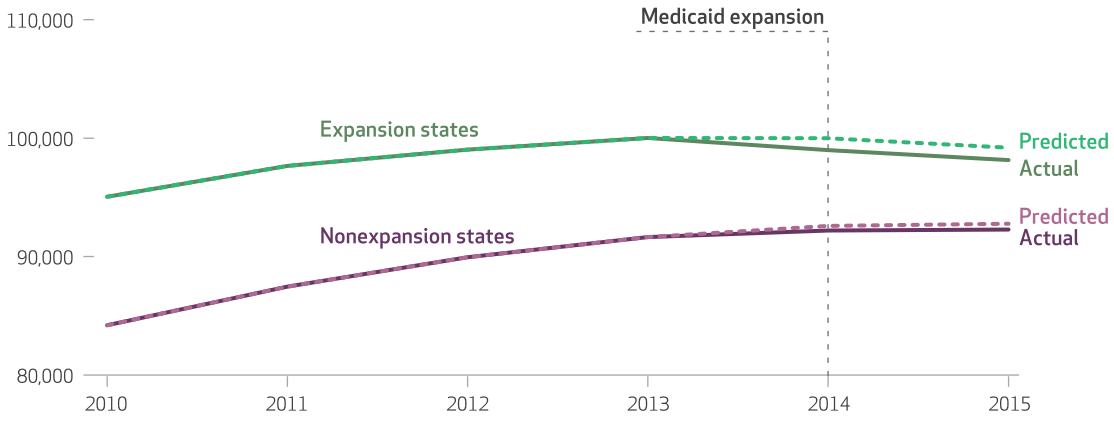
EXHIBIT 1

Average number of people ages 18–64 participating in the Supplemental Security Income program in states that did or did not expand eligibility for Medicaid, 2010–15



SOURCE Authors' analysis of administrative data for 2010–5 from the Social Security Administration. **NOTES** The predicted numbers show the quadratic line of best fit, based on 2010–13 trends. Under a provision of the Affordable Care Act, the state indicated expanded eligibility for Medicaid as of January 1, 2014.

and limited assets. The Medicaid expansion provides services that are comparable to those covered for traditionally eligible populations,[7] but it makes those services available to adults regardless of disability status, allows them to have a higher income than SSI does, and imposes no asset test. This coverage creates an opportunity for low-income adults to increase their earnings and savings beyond SSI limits without jeopardizing their Medicaid benefits.

Although not uniform in their findings, empirical studies that have considered interactions between public health insurance and adult participation in SSI provide support for the possibility that increased access to Medicaid decreases SSI participation.[2,8–11] We tracked the early impact of ACA Medicaid expansions on SSI participation among low-income nonelderly adults overall and on childless adults specifically—a subgroup that may be particularly responsive to the expanded availability of Medicaid coverage. We extend the literature by using recent survey and administrative data to examine changes in SSI participation resulting from these expansions.

Study Data And Methods

We used two data sources for 2010–15: the reports of the Social Security Administration (SSA) on SSI recipients by state, and responses to the American Community Survey (ACS) of the Census Bureau. The SSA data include counts of SSI participants by age group (younger than 18, 18–64, and 65 and older), regardless of income or family type. For each of the three age groups, there were 306 state-year observations. Our outcome variable was the number of SSI participants ages 18–64 in a given state and year.

For the ACS data, we restricted the sample to nonelderly childless adults. Although the expansion made people with incomes of up to 138 percent of the federal poverty level eligible for Medicaid, we limited our sample to adults with incomes below 100 percent of poverty. Adults with incomes of 100–138 percent of poverty in nonexpansion states effectively experienced an expansion in insurance availability because they became eligible for Marketplace subsidies in 2014. Therefore, including this subgroup would have contaminated our control group. Finally, we omitted noncitizens who had lived in the United States for less than five years. This gave us approximately two million observations. Our outcome variable was an indicator for receiving any SSI income in the previous year.[12]

We compared states that expanded Medicaid in 2014 to those that did not expand, before and after the expansion.[13] Our analysis regressed SSI participation on the interaction of Medicaid expansion and the period after 2014, state unemployment rates, and state and year fixed effects using ordinary least squares. For our analysis using data from the ACS, we also included controls for individuals' age, sex, and race/ethnicity. Standard errors are clustered at the state level.

Supplementary analyses—including full results of our ordinary least squares logit models, parallel trends tests, and falsification tests—are available in the online Appendix.[14]

Our study had some limitations. First, we were unable to separate recipients by income level and family type in the SSA data. Thus, in contrast to our analyses using the ACS data, we could not examine the subgroup that might be most affected by the Medicaid expansion (low-income childless adults), given the previous absence of Medicaid coverage for this group in most states. Second, our results can be interpreted causally only to the extent that trends in SSI participation did not influence Medicaid expansion decisions. Further study is warranted to tease out the various factors related to Medicaid that affect SSI participation.

Study Results

DESCRIPTIVE RESULTS SSI participation increased in both expansion and nonexpansion states during 2010–13, the period before the Medicaid expansion (Exhibit 1). During 2014–15, the period after expansion, the average number of SSI recipients continued to rise in nonexpansion states, whereas it declined in expansion states.

Before the expansion, an average Medicaid expansion state had 97,946 SSI participants ages 18-64, whereas an average nonexpansion state had 88,312 (Exhibit 2). After 2014, the average number of SSI participants ages 18–64 rose by 617 in expansion states and by 3,928 in nonexpansion states.

Before 2014, the probability of participating in SSI for people ages 18–64 was 0.109 in expansion states and 0.107 in nonexpansion states. After 2014, the probability rose by 0.004 in expansion states, versus 0.006 in nonexpansion states.

DIFFERENCE-IN-DIFFERENCES REGRESSION RESULTS These findings suggest that SSI participation declined in expansion states compared to nonexpansion states after 2014. We next conducted a regression analysis to control for potential confounding economic and demographic factors and to assess the significance of the results.

The first row of Exhibit 3 displays the impact of Medicaid expansion on SSI participation. Each

subsequent row displays the estimated impact of an economic or demographic covariate in the regression model on SSI participation. On average, Medicaid expansion reduced the number of a state's SSI participants ages 18–64 by 3,593 per year (Exhibit 3). This represents a 3.9 percent decrease from the 2013 average SSI participation level in nonexpansion states.

In our analyses using the ACS data where we further controlled for age, sex, and race/ethnicity, Medicaid expansion reduced the probability of participating in SSI by 0.0035 for nonelderly childless adults (Exhibit 3). This represents a 3.3 percent decrease from the 2013 level in nonexpansion states, which is close to the estimate we obtained from the SSA data.

EXHIBIT 2

Average number of people ages 18–64 participating in SSI and the probability of participating in states that did or did not expand eligibility for Medicaid, before and after 2014

	Average number of SSI participants	Probability of participating in SSI[a]
Expansion states		
Before 2014	97,946.2	0.109
After 2014	98,563.6	0.113
Difference	617.4	0.004***
Nonexpansion states		
Before 2014	88,311.9	0.107
After 2014	92,240.3	0.113
Difference	3,928.4	0.006***
Difference in differences	–3,310.9	–0.002

SOURCE Authors' analysis of data for 2010–15 from the Social Security Administration (for number of Supplemental Security Income [SSI] participants) and from the American Community Survey (for probability of participation). **NOTE** Under a provision of the Affordable Care Act, states could expand eligibility for Medicaid as of January 1, 2014. In column 1, an observation is a state-year. [a]Limited to nonelderly childless adults with incomes below the federal poverty level. ***$p < 0.01$

Discussion

Using data that spanned two full years after the 2014 Medicaid expansions, we analyzed how access to health insurance that is independent of work or disability status affected participation in Supplemental Security Income. The results illustrated here point to a 3.3–3.9 percent decrease in receipt of SSI in states that expanded Medicaid.

Although many studies have quantified the impacts of the Medicaid expansion on coverage and access, effects on cross-program participation are important secondary outcomes. Reduced reliance on SSI could generate savings at the federal and state levels because, for people who are on Medicaid but do not participate in SSI, the government covers only heath care costs and does not have to disburse additional cash benefits. The expected cumulative expenditures for a disabled adult from his or her entering SSI through the first six years of enrollment are about $12,000 in cash benefits and $55,000 in Medicaid spending.[15]

While recent work suggests that the Medicaid

EXHIBIT 3

Regression results: impact of Medicaid expansion on SSI participation by adults ages 18–64

	Average number of SSI participants in state	Probability of participating in SSI
Post X expansion	–3,592.8**	–0.0035*
State unemployment rate	–1,880.8**	–0.0018
Age	—[a]	0.0055***
Male	—[a]	–0.0077***
Race/ethnicity	—[a]	
White, non-Hispanic	—[a]	Omitted
Black, non-Hispanic	—[a]	0.0232***
Asian, non-Hispanic	—[a]	–0.0467***
Other, non-Hispanic	—[a]	0.0117***
Hispanic	—[a]	–0.021***
Number of observations	306	1,989,856
2013 mean	91,647.9	0.107

SOURCE Authors' analysis of data for 2010–15 from the Social Security Administration (for number of Supplemental Security Income [SSI] participants) and from the American Community Survey (for probability of participation). **NOTES** For column 1, the outcome variable is the number of SSI recipients in a state; an observation is a state-year. For column 2, the outcome variable is an indicator for whether the person receives SSI income; the sample is limited to nonelderly childless adults with incomes below the poverty level. The key independent variable, "Post X expansion," is measured as the interaction between an indicator for post-2014 years and expansion states; this term represents the "treatment effect" of Medicaid expansion on SSI outcomes. All models include state and year fixed effects. Standard errors are clustered at the state level. The last row displays the mean of the outcome variable for nonexpansion states before expansion. [a]These variables are not included in the analysis because they are not provided in the data set. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$

expansions did not change employment, on average,[16] our results support previous findings of increased employment among disabled Americans.[17] Since future Medicaid policy may place greater emphasis on cost-cutting features, understanding behavioral responses to the availability of new insurance coverage is essential. ■

NOTES

1 Blum JD, Hethcoat GO II. Medicaid governance in the wake of *National Federation of Independent Business v. Sebelius*: finding federalism's middle pathway, from administrative law to state compacts. John Marshall Law Rev. 2012;45(3):601–34.

2 Henry J. Kaiser Family Foundation. Medicaid income eligibility limits for other non-disabled adults, 2011–2017 [Internet]. Menlo Park (CA): KFF;. c 2017 [cited 2017 Jun 6]. Available from: http://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-other-non-disabled-adults/?currentTimeframe=0&sortModel=%7B"colId":"Location","sort":"asc"%7D

3 Burns M, Dague L. The effect of expanding Medicaid eligibility on Supplemental Security Income program participation. J Public Econ. 2017;149(20–34).

4 Henry J. Kaiser Family Foundation. Medicaid income eligibility limits for parents, 2011–2017 [Internet]. Menlo Park (CA): KFF; c 2017 [cited 2017 Jun 6]. Available from: http://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

5 Henry J. Kaiser Family Foundation. Status of state action on the Medicaid expansion decision [Internet]. Menlo Park (CA): KFF; 2017 Jan 1 [cited 2017 Jun 6]. Available from: http://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

6 Wagner KL. Medicaid expansions for the working age disabled: revisiting the crowd-out effect. J Health Econ. 2015;40:69–82.

7 Rosenbaum S, Mehta D, Dorley M, Hurt C, Rothenberg S, Lopez N, et al. (2015). Medicaid benefit designs for newly eligible adults: state approaches [Internet]. New York (NY): Commonwealth Fund; 2015 May [cited 2017 Jun 6]. Available from: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1815_rosenbaum_medicaid_benefit_designs_newly_eligible_adults.pdf

8 Yelowitz AS. Using the Medicare buy-in program to estimate the effect of Medicaid on SSI participation. Econ Inq. 2000;38(3):419–41.

9 Yelowitz AS. Why did the SSI-Disabled program grow so much? Disentangling the effect of Medicaid. J Health Econ. 1998;17(3):321–49.

10 Maestas N, Mullen KJ, Strand A. Disability insurance and health insurance reform: evidence from Massachusetts. Am Econ Rev. 2014; 104(5):329–35.

11 Baicker K, Finkelstein A, Song J, Taubman S. The impact of Medicaid on labor market activity and program participation: evidence from the Oregon Health Insurance Experiment. Am Econ Rev. 2014; 104(5):322–8.

12 For some observations, the Census Bureau imputes SSI values. We included subjects with self-reported or imputed values of SSI income.

13 Our expansion states were AK*, AZ, AR, CA, CO, CT, DE, DC, HI, IL, IA, IN*, KY, MD, MA, MI*, MN, NV, NH*, NJ, NM, NY, ND, OH, OR, PA*, RI, VT, WA, WV, and WI. Our nonexpansion states were AL, FL, GA, ID, KS, LA*, ME, MS, MO, MT*, NE, NC, OK, SC, SD, TN, TX, UT, VA, and WY. States with an asterisk are those where Medicaid expansion was implemented after January 2014. Because our data extended only through 2015, we categorized states that expanded Medicaid in 2016 (Montana and Louisiana) as nonexpansion states for the purpose of our analysis. Although Wisconsin did not officially participate in the ACA Medicaid expansion, adults with incomes of up to 100 percent of poverty are eligible for its Medicaid program. The Wisconsin adults in our sample would qualify for Medicaid; therefore, we considered it a Medicaid expansion state for the purpose of our analysis.

14 To access the Appendix, click on the Appendix link in the box to the right of the article online.

15 Riley GF, Rupp K. Cumulative expenditures under the DI, SSI, Medicare, and Medicaid programs for a cohort of disabled working-age adults. Health Serv Res. 2015;50(2): 514–36.

16 Gooptu A, Moriya AS, Simon KI, Sommers BD. Medicaid expansion did not result in significant employment changes or job reductions in 2014. Health Aff (Millwood). 2016;35(1):111–8.

17 Hall JP, Shartzer A, Kurth NK, Thomas KC. Effect of Medicaid expansion on workforce participation for people with disabilities. Am J Public Health. 2017;107(2):262–4.

Franklin County

Work Experience Program

Comprehensive Report

Able-Bodied Adults Without Dependents

Work Experience Program
Ohio Association of Foodbanks
101 E. Town St. Ste, 540
Columbus, OH 43215
www.ohiofoodbanks.org
614.221.4336

Table of Contents

Executive Summary

For almost two years, the Ohio Association of Foodbanks has been assisting able-bodied adults without dependents (ABAWDs) receiving Supplemental Nutrition Assistance Program (SNAP) benefits in Franklin County with meeting the federal work requirement to maintain their food assistance as part of an ongoing partnership with the Franklin County Department of Job and Family Services (FCDJFS). The association has been able to grow this Work Experience Program (WEP), offering more services and resources to ABAWDs in need. WEP provides work experience and job training for participants who are currently unemployed or underemployed, as a means to enhance their ability to secure sustainable employment.

Prior to assigning a client in a job placement within our network of partner nonprofit and faith-based organizations, the association meets with each ABAWD to perform an in-depth assessment. To date, we have assessed close to 5,000 individuals. The data we have collected through these assessments continue to reinforce what we have been able to identify as key barriers for many of our clients as they seek gainful employment. Our findings indicate that many of our clients struggle with accessing reliable transportation, unstable living situations, criminal records, education, and both physical and mental health problems. Our deeper understanding of these issues has led us to partner with organizations that can help ABAWDs navigate through many of their challenges, giving our clients a better chance at improving their lives and supporting themselves.

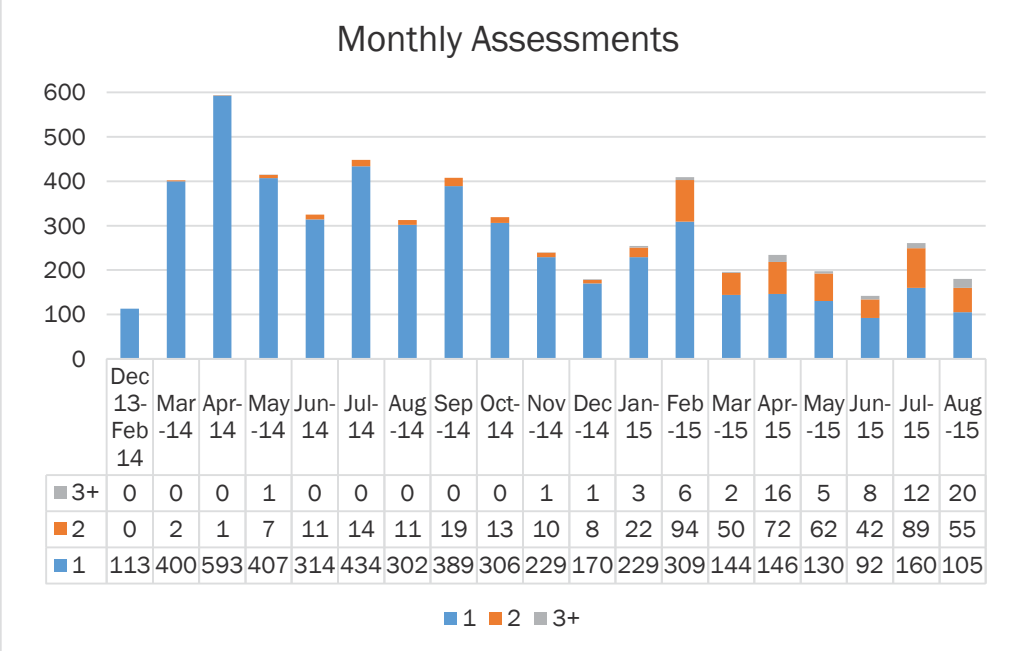
The data has prompted many recommendations to FCDJFS including but not limited to: providing additional funding for programs that support WEP participants and low-income households; expanding enrollment of nationally certified educational programs as well as programs for youth aging out of foster care; and creating an employment pipeline into strategic aspects of the job market.

Assessment of ABAWDs in Franklin County, OH

When Franklin County Department of Job and Family Services (FCDJFS) caseworkers make the determination that a client receiving SNAP benefits meets the criteria to be considered an able-bodied adult without dependents (ABAWD) and is required to work under federal regulations, the client is referred to their local opportunity center to meet with an Ohio Association of Foodbanks Work Experience Program (WEP) assessment specialist. Each specialist completes a comprehensive interview with each client using a series of questions on the Work Experience Assessment Portal. The assessment is designed to determine employability and identify barriers to employment.

The assessment process is part of an ongoing contract targeting clients who are subject to a strict, three-month time limit in every 36-month period for SNAP eligibility. As we approach the second anniversary of this program, we have closely examined the data collected from 4,827 ABAWDs and gathered from 5,434 self-reported employability and skills assessments that took place between December 10, 2013 and September 1, 2015. Over the past two years the information obtained for this ongoing project represents the most comprehensive and up-to-date information collected about this misunderstood population. These findings offer instructive, meaningful insight into who these individuals are and what will be needed to address the barriers and challenges faced by these individuals as they attempt to secure stable employment.

The chart depicts the number of ABAWD assessments performed by association staff for each month. Clients coming in for an initial assessment each month appear in blue, second time visits in any given month appear in orange, and clients who are completing the assessment for the third or more times appear in gray.

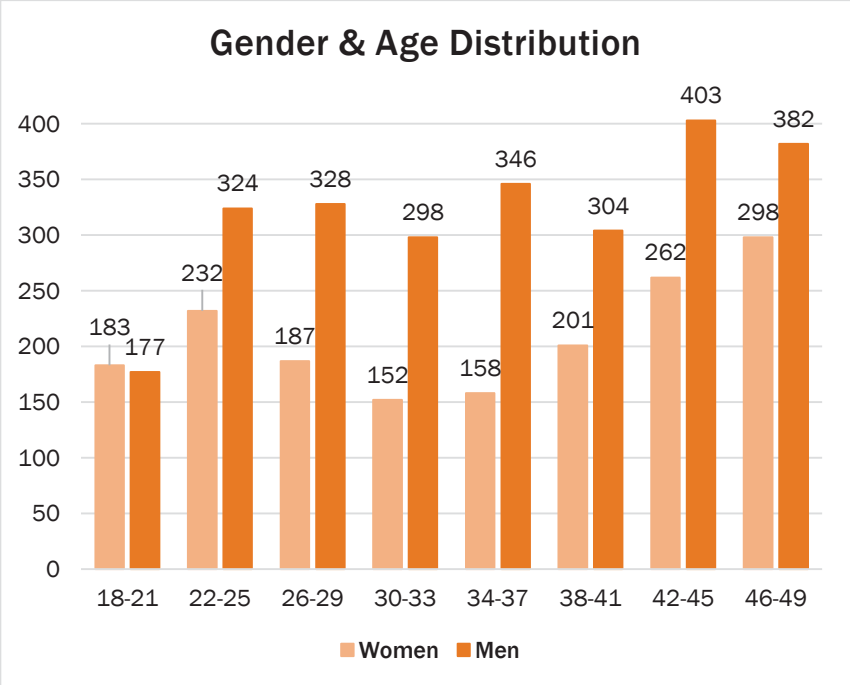


	Dec 13-Feb 14	Mar -14	Apr-14	May -14	Jun-14	Jul-14	Aug -14	Sep -14	Oct-14	Nov -14	Dec -14	Jan-15	Feb -15	Mar -15	Apr-15	May -15	Jun-15	Jul-15	Aug -15
3+	0	0	0	1	0	0	0	0	0	1	1	3	6	2	16	5	8	12	20
2	0	2	1	7	11	14	11	19	13	10	8	22	94	50	72	62	42	89	55
1	113	400	593	407	314	434	302	389	306	229	170	229	309	144	146	130	92	160	105

Age & Gender

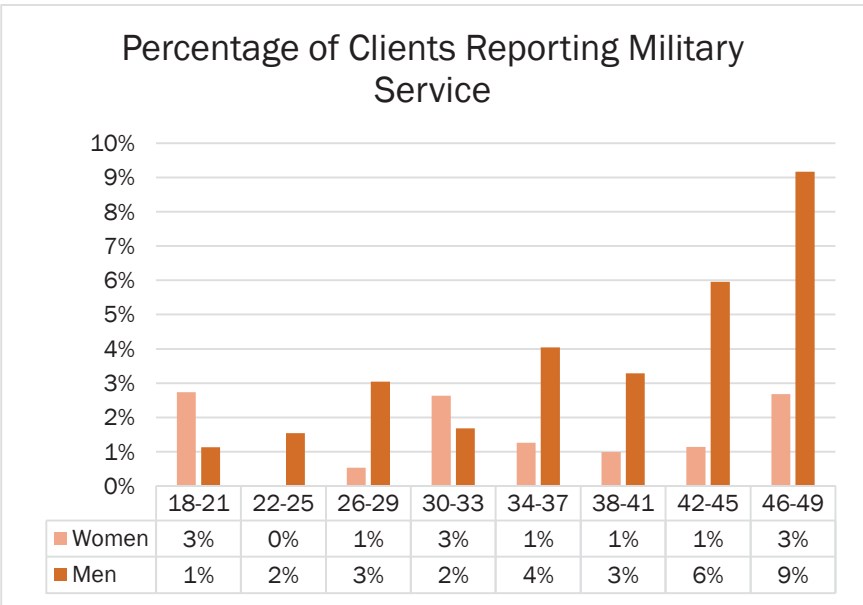
From the total population of 4,827 ABAWDs surveyed, **1,880** clients (**38.9%**) were **female,** and **2,945** clients (**61.0%**) were **male**. Two clients preferred to be identified as **transgender.**

The chart represents a distribution of the ABAWDs based on age and gender. This distribution does not include the 507 clients (176 female and 331 male) for which there was no age listed, nor does it include the 83 clients (31 female and 52 male) who were over 50 at the time of the assessment and therefore exempted from the program.



Veteran Status

Only 156 clients (3.2%) reported that they were **veterans**. While veterans make up a relatively small percentage of all ABAWD clients, they represent a significant portion of the male population over the age of 35 as represented in the chart. As we encounter veterans, we are able to help them find resources designated to assist them with housing, employment, and shelter.



	18-21	22-25	26-29	30-33	34-37	38-41	42-45	46-49
Women	3%	0%	1%	3%	1%	1%	1%	3%
Men	1%	2%	3%	2%	4%	3%	6%	9%

Communication

Communication is critical to clients participating in WEP, and maintaining a reliable form of communication with clients has continued to be a challenge as FCDJFS and the association communicate with clients primarily by mail. Since we started collecting mailing information in April 2014, 65 clients have indicated that they do not have a mailing address, while 31 clients provided a mailing address and identified themselves as homeless. Additionally, 152 clients have provided a mailing address that is known to be a homeless shelter, check-in center, or mental health facility.

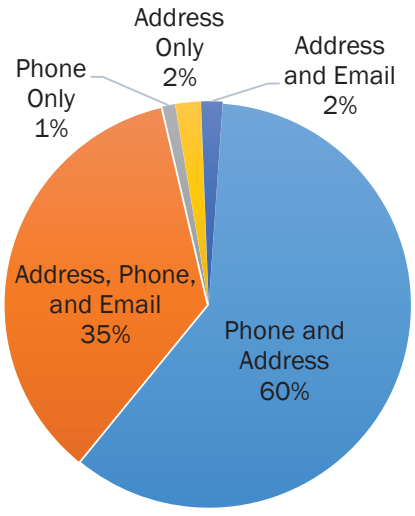
- Faith Mission (245 N Grant Ave) **16** Clients
- Friends of the Homeless (924 E. Main St.) **21** Clients
- Open Shelter (61 E. Mound St.) **24** Clients
- Holy Family Soup Kitchen and Shelter (57 S. Grubb St.) **17** Clients
- Star House (1621 N. 4th) **4** Clients
- YWCA (595 Van Buren) **17** Clients
- YMCA (40 W. Long) **39** Clients
- Southeast Community Mental Health Center (16 W. Long St.) **10** Clients
- North Central Mental Health (1301 N. High St.) **4** Clients

This indicates that at least 248 clients (5.1%) of our ABAWD clients are dealing with housing insecurity. These numbers do not capture the homeless clients who provide the mailing address of a relative or friend, and do not specifically identify that they are homeless.

Types of Communication Reported

- 4,625 clients (95.8%) listed phone numbers
- 1,800 clients (37.3%) listed e-mail addresses
- 4,381 clients (90.8%) listed mailing addresses
- 65 clients (1.3%) reported not having an address
- 380 clients (7.9%) were assessed before address information was asked

Communication Avenues



While 95.8% of clients reported having phone numbers, this does not mean that they have continuous access to a phone. Clients using subsidized government provided cell phones often run out of wireless minutes before the end of the month, or in many other cases their personal phones have been disconnected, or phone numbers are frequently changed due to using prepaid cellular devices. We can only assume that if we are unable to contact clients via phone, potential employers are also unable to reach them.

The association always offers clients the opportunity to register for an e-mail address as a viable, dependable alternative to a phone. Because most major employers require clients to fill out job applications online, having an e-mail address is critical to the application process. We encourage clients to visit their local libraries to check their messages, but find that some clients may not have reliable or readily available community-based access to the Internet. In this process, we also find that many clients struggle with using technology and computers.

Additional information gleaned from the 531 repeat ABAWD clients reinforces our findings, and provides insight into other forms of stable communication for this population. This 11% of ABAWD clients who have taken the assessment more than once shows:

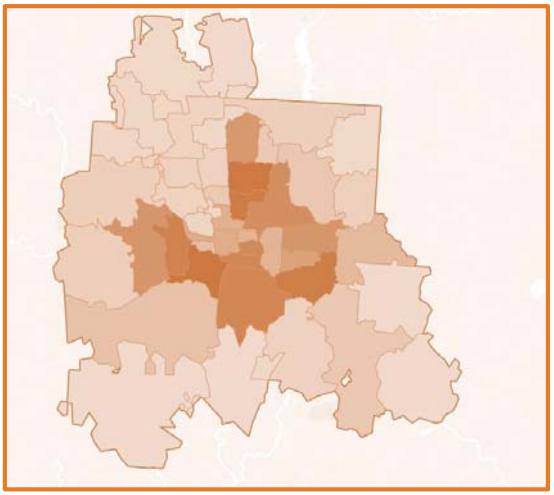
- 47% (253) have changed their phone number between assessments
- 34% (181) have changed their addresses between assessments

This transiency can have real consequences for ABAWD clients who are sanctioned (cut off from their benefits) because they did not receive an appointment or assignment notice from FCDJFS which required action to avoid a disruption in their benefits.

Client Locations

While the clients who have reported addresses represent 58 different zip codes in Franklin County, **over 55% of clients come from 9 zip codes**:

- 43223: 141 clients (7.0%)
- 43224: 140 clients (6.9%)
- 43211: 137 clients (6.8%)
- 43232: 133 clients (6.6%)
- 43204: 123 clients (6.1%)
- 43206: 117 clients (5.8%)
- 43207: 116 clients (5.7%)
- 43205: 112 clients (5.5%)
- 43219: 104 clients (5.1%)

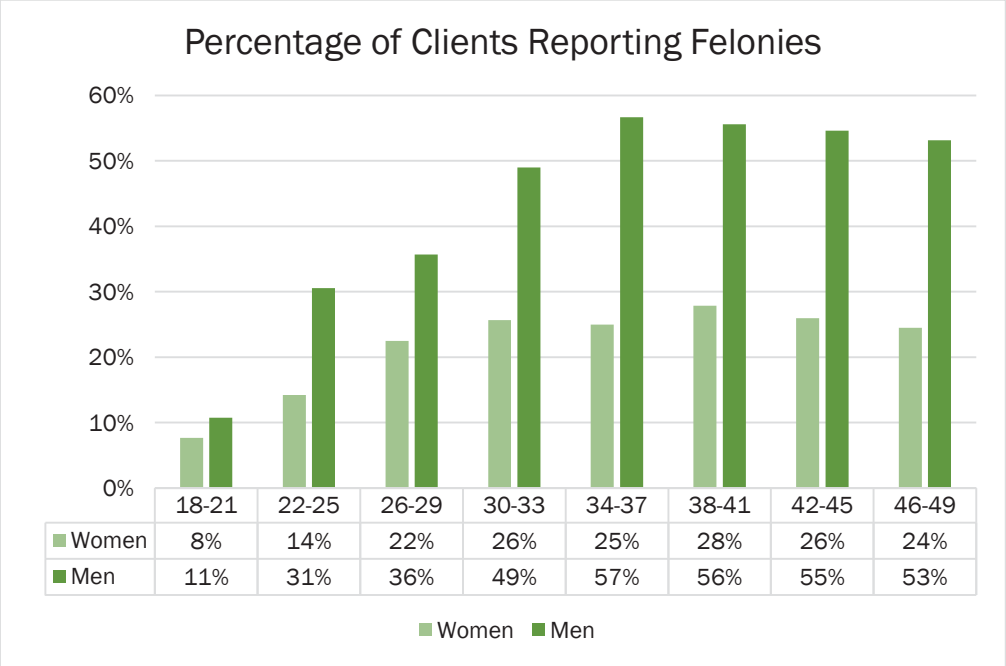


Criminal History

As part of the ABAWD assessment, clients are asked if they are willing to complete an FBI/BCI background check. Over 96% of clients agree to comply with this request.

A history of criminal activity or previous incarceration can have an incredibly damaging impact. The stigma of a felony conviction can follow someone for a lifetime, even if their release is meant to suggest that they have been rehabilitated. These restored citizens miss out on many opportunities, job related or otherwise.

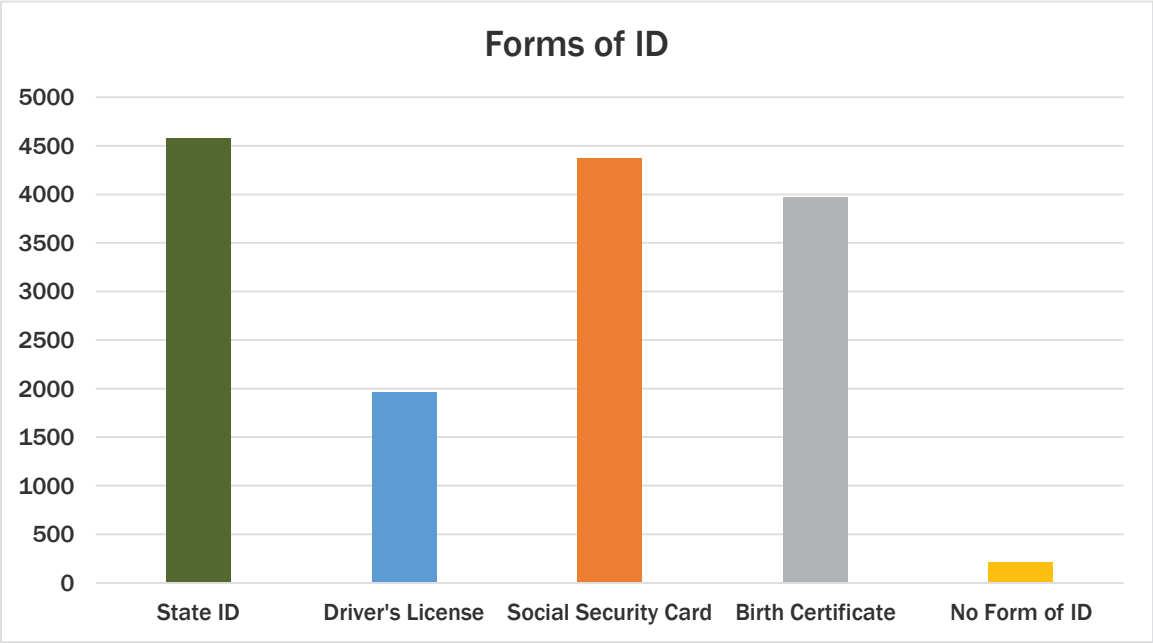
- Over 35.8% of the clients in our program reported having a felony conviction. Some clients have multiple felonies, or a combination of felonies and misdemeanors.
- Close to 12.8% of clients are on probation or parole which means they may not qualify for services offered through legal aid, such as record sealing.
- 541 clients (11.2%) have indicated that they have domestic violence charges.
- 709 clients (14.7%) reported having DUI or OVI violation. These types of violations can severely limit a client's ability to secure employment.



Forms of ID

To apply for jobs, housing, and government benefits, to vote, or to obtain a driver's license, most agencies usually require two forms of Identification (ID). Because the association requires all participants to have an FBI and BCI background check to be placed at one of our host organizations we offer vouchers for clients to receive government issued state IDs when they indicate that they do not already have an ID.

- **4,578** clients (94.8%) have some form of State Identification.
    - 1,963 (40.7%) of clients have indicated that they have a driver's license.
    - 2,615 have indicated that their primary form of identification is a State ID.
    - 206 clients 4.3% indicated that they did not have any form of state identification.
- **4,369** clients (90.5%) reported having access to their Social Security card.
    - 370 clients (7.7%) do not have access to their Social Security card.
- **3,969** clients (82.2%) reported having access to their birth certificate.
    - An additional 752 (15.6%) do not have a birth certificate.



Transportation

To assist with transportation, clients receive a monthly travel stipend from FCDJFS in the form of a $62 check. Many clients report that they have not received the travel stipend. This could be due to an inaccurate mailing address, the inability to contact their caseworker, or a delay in dispersing of funds. Some clients report that the travel stipend is not enough to cover travel to and from work sites. Some clients do not have bank accounts and have to pay a service fee to cash the check they receive from FCDJFS, leaving an insufficient amount to purchase a monthly bus pass which the stipend should cover.

2,749 clients (57.0%) said they have access to reliable transportation, whether it is their own vehicle, the COTA bus system, or a ride from friends and family members. It is important to note that the use of a friend or family member's vehicle may not always be reliable. Owning a vehicle may pose its own challenges for low-income populations, as the car could break down and the client may not have the means to fix it.

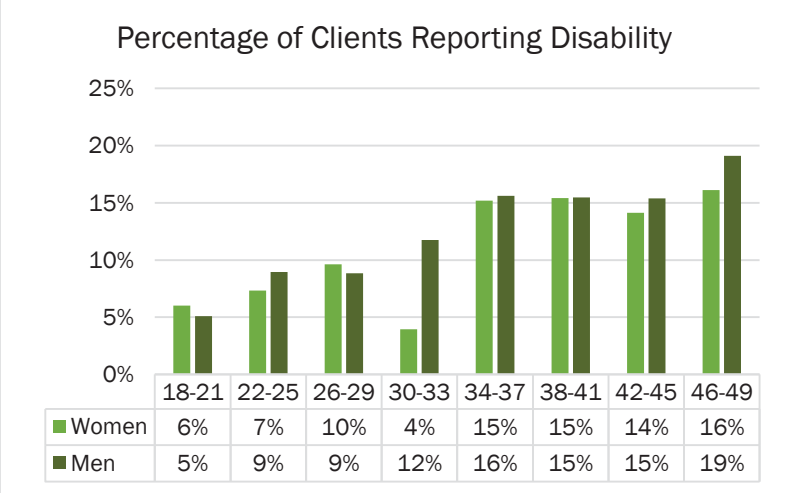
- 40% of clients said they do not have reliable transportation.
- **3,565** clients (73.9%) indicated that they live near a bus stop.
- 610 clients (12.6%) indicated that they did not live near a bus stop.
- Only **40%** of clients indicated that they have a valid driver's license, which indicates that clients are either using public transportation or are driving without a license.
    - Some clients may not be able to obtain a driver's license if they owe child support and have had their driving privileges suspended, or if they have outstanding tickets or unpaid fines which they may be unable to resolve with their limited income.
- **904** clients (18.7%) indicated that they did have car insurance.
    - An additional 3,232 clients (67.0%) indicated that they did not have car insurance, inferring that some are driving without insurance which can be attributed to a variety of factors, including affordability. As it is the law to maintain car insurance for any vehicles owned, some clients could be making the tough choice to pay for utilities, food, or medicine instead of car insurance.

Disabilities and Limitations

"Able-bodied" indicates that clients should not be medically certified and documented as physically or mentally unfit for employment. As part of the assessment, clients are asked to self-report disabilities or limitations, both physical and mental.

- **598** ABAWD clients (12.4%) have self-reported a disability. Of these clients, 261 clients (44%) have indicated that they are not able to work and earn $1010 a month, which could make them eligible for disability benefits.
    - 74 clients (12%) indicated that they are able to work and earn $1,010 per month.

- **1 in 3** ABAWD clients (32.5%) have self-reported some type of physical or mental limitation. Of these clients, 25% (392) have indicated that their condition limits their ability to perform daily activities.
- 70.3% (1,102) indicated some type of physical limitation.
- 30.1% (471) indicated some type of mental limitation.



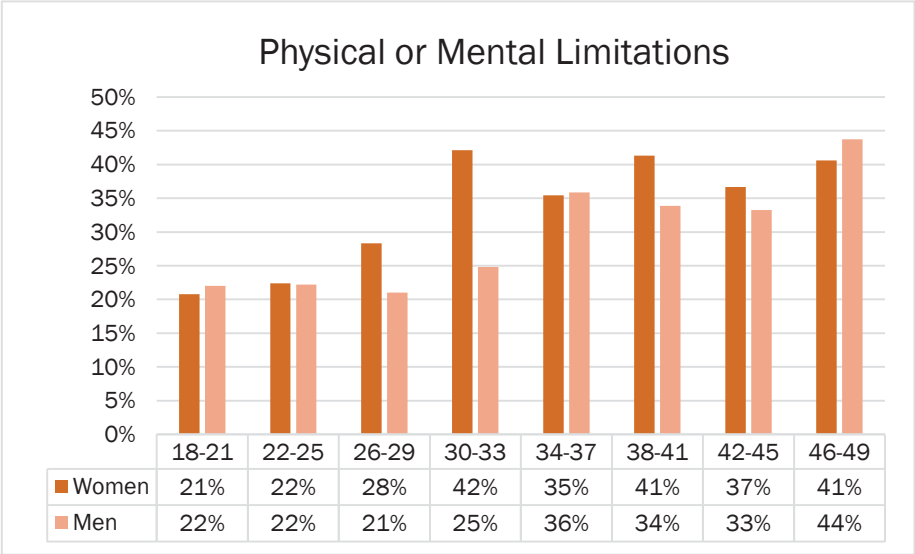
	18-21	22-25	26-29	30-33	34-37	38-41	42-45	46-49
Women	6%	7%	10%	4%	15%	15%	14%	16%
Men	5%	9%	9%	12%	16%	15%	15%	19%

Most Common Types of Physical and Mental Limitations Reported:

- Back Injuries 18.3%
- Respiratory Difficulties 6.0%
- Knee Injuries 5.9%
- Diabetes 3%
- Shoulder Injuries 2.8%
- Arthritis 2.5%
- Heart Conditions 2.3%
- Depression 10.1%
- Bipolar Disorder 9.3%
- Anxiety 8.1%
- Post-Traumatic Stress Disorder 3.1% (PTSD)
- Schizophrenia 1.5%

Additionally, a small percentage of clients reported physical difficulties due to crimes of violence.

- 27 reported physical difficulties as the result of gunshot wounds.
- 4 clients reported physical difficulties as the result of stab wounds.



	18-21	22-25	26-29	30-33	34-37	38-41	42-45	46-49
Women	21%	22%	28%	42%	35%	41%	37%	41%
Men	22%	22%	21%	25%	36%	34%	33%	44%

Social Security and Health Care

1 in 5 ABAWD clients (18.6%) have reported filing for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Of these clients, most have reported filing in the last two years:

- 82 (9%) reported filing in 2015
- 333 (37%) reported filing in 2014
- 155 (17%) reported filing in 2013
- 114 (13%) applied in 2012
- 223 (25%) applied in 2011 or earlier

1 in 4 clients (25.0%) indicated said they were under a doctor's care, and 1,347 clients (27.9%) indicated that they were currently on medications.

Nearly 6 in 10 clients (58.2%) have reported already applying for Medicaid, although all clients may be eligible to receive this expanded necessary health coverage due to their low-income status. 1,950 clients (40.4%) said they had not applied for Medicaid. As part of our outreach process, we invite health care navigators to our monthly WEP events to help clients sign up for health coverage.

Children and Families

According to the USDA definition of an ABAWD, it is assumed that all clients do not have dependents. We found that clients with children, although not in their custody, still spend time parenting their children on a regular basis while the custodial parent works.

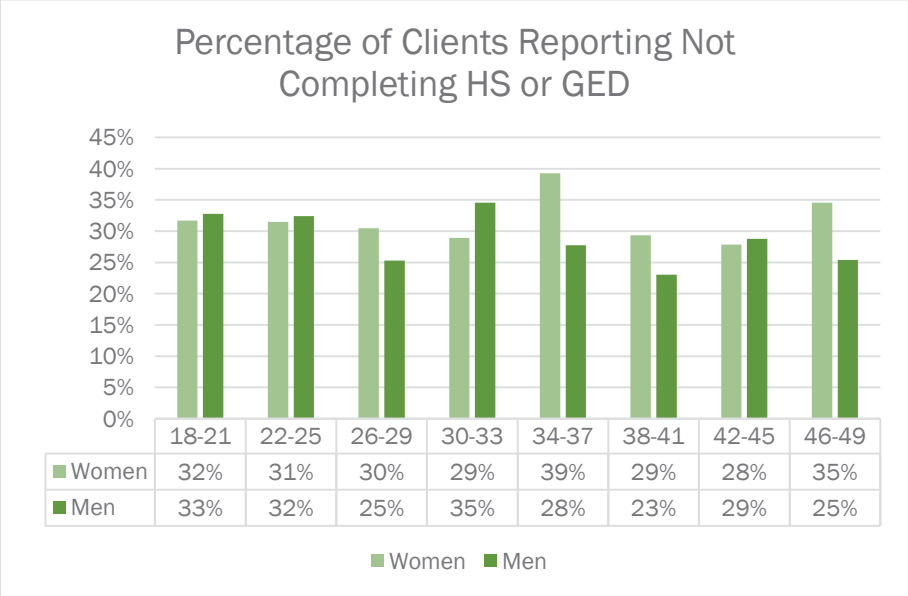
- **1 in 4** clients (**23.5%**) indicated that they had **children not in their custody**.
- **868** clients (**18.0%**) indicated that they **owe child support**.
- **86** clients (**1.8%**) indicated that they **need childcare**.

Having the status of caregiver to a relative should potentially exempt an individual from participating in WEP. Caregivers can often replace the services of a Medicaid or Medicare home-healthcare provider. **618** clients (**12.8%**) indicated that they are caregivers for a parent, friend, or relative.

Education

Many of the clients in this population have not earned a degree or certification to work in industries that pay more than entry level wages.

- **3,342** clients (69.2%) report having earned a high school diploma or GED.
- 1,424 (29.5%) of clients report never having graduated high school.

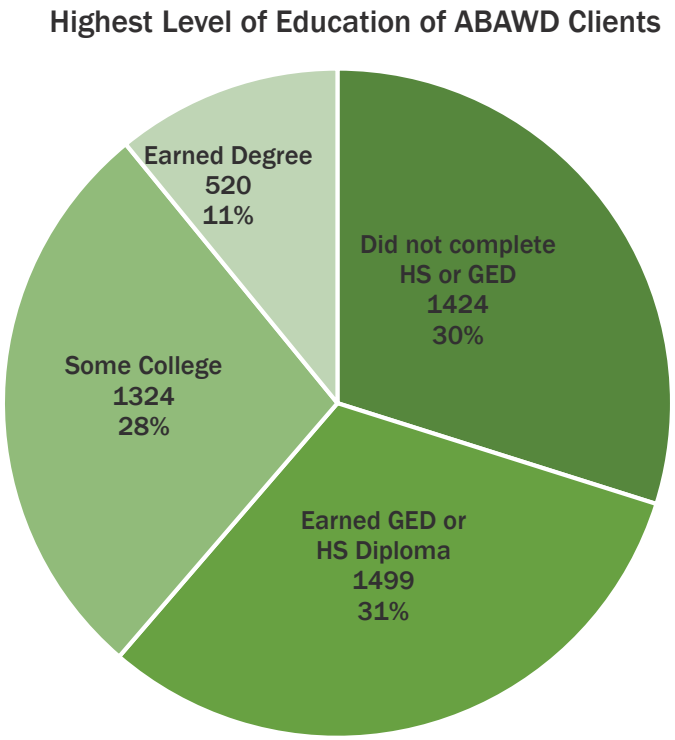


Of those students that did not earn a GED or high school diploma:

- 121 (2.5%) report having attended last in the 12th grade
- 404 (8.4%) report having attended last in the 11th grade
- 316 (6.5%) report having attended last in the 10th grade
- 190 (3.9%) report having attended last in the 9th grade
- 86 (1.8%) report having left school before high school
- 5 clients (0.1%) report never having attended school before

College Education

Of the students who earned either a high school diploma or GED, an additional 1,324 (28%) attended college, and an additional 520 (11%) earned some type of degree or certification.



Employment

Working 20 or more hours of paid employment per week, every week can exempt an ABAWD from participating in WEP.

- **547** clients (11.3%) indicated that they are **currently working**.
    - 16 clients (2.9%) indicate that they are working less than 10 hours per week
    - 62 clients (11.3%) indicate that they are working 10-20 hours per week
    - 75 clients (13.7%) indicate that they are working 20-30 hours per week
    - 34 clients (6.2%) indicate that they are working 30-40 hours per week
    - 23 clients (4.2%) indicate that they are working over 40 hours a week
    - 337 clients (61.1%) did not indicate how many hours they were working

At least 91 clients (**1.9%**) reported that they generally work for **temporary employment agencies** (including day labor and labor pool agencies). These clients may be unable to identify how many hours they work per week due to inconsistent scheduling and availability of consistent job assignments. Because of this, clients may not be able to regularly fulfill the 20 hour work requirement to qualify for an exemption.

Most Common Employment Industry

- Warehouse Work (including pick/pack, forklift)
- Customer Service
- Food Service (including fast food, restaurants, cooking, and food preparation)
- Janitorial and Cleaning
- Construction (including carpentry, masonry, drywall, and electric)

Employment History

Having gaps in a resume can influence an employer's decision in the hiring process, which can negatively impact a client's chances of obtaining employment. Of the 4,284 clients who reported the time since they were last employed, 1,579 (36.8%) reported working last sometime within the current year. An additional 1,216 clients (28.4%) reported working last in the previous year, 665 clients (15.5%) reported working last within the last 2-3 years, 429 (10.1%) reported working last within 4-6 years, 204 (4.8%) reported working last within the last 7-10 years, 109 clients (2.5%) reported working last between 11-15 years, 34 clients (0.7%) reported working last within the last 16-20 years, 12 clients (0.3%) reported working last over 20 years ago, and 36 clients (0.8%) reported having never worked before.

In-Kind Work

Just as traditional employment can exempt a client from participating in WEP, in-kind work may qualify clients from an exemption as well. **402** clients (8.3%) reported **working in-kind** for food or housing.

- 67 clients (16.7%) reported working less than 10 hours per week
- 84 clients (20.9%) reported working 10 to 19 hours per week
- 82 clients (20.4%) reporting working 20 to 29 hours per week
- 21 clients (5.2%) reported working 30 to 39 hours per week
- 28 clients (7.0%) reported working 40 or more hours per week
- 120 clients (29.8%) did not report the number of hours they were working per week

Employment Assistance

The ABAWD assessment screens for additional assistance or equipment clients may need to perform tasks at their worksite.

- **435** clients (9.0%) indicated that they needed **special accommodations** at their worksite in order to do a job. The most commonly requested accommodations were **no heavy lifting** and **no standing or walking** for long periods of time.
- **757** clients (15.7%) indicated that they need **supportive services** to obtain employment. The most commonly requested services were **language interpretation** (especially for Somalian refugees) and help with **transportation**.

Workforce Development

In an effort to offer more job seeking resources to clients, they are referred to Ohio Means Jobs (www.ohiomeansjobs.com). **7 in 10** clients indicated that they were not registered to work through Ohio Means Jobs website. This shows that the outreach for the Ohio Means Jobs website has been ineffective in reaching this population.

We assist clients with creating resumes so they are able to take them to career fairs and apply for jobs that require resumes.

- 2,594 clients (53.8%) indicated that they did not have a current resume.
- **2,183** clients (**45.2%**) indicated that they would like **help to write or update their resume.**
- 2,410 clients (49.9%) indicated that they were not interested in help to write or update their resume.

Unemployment Compensation Benefits

Many job applications ask if applicants have ever been fired or dismissed from a previous position. **1 in 4** clients (24.0%) reported having been previously **fired or dismissed from a job**. When this question appears on a job application it can be a deterrent for employers to hire an applicant.

We inquire if clients have ever received unemployment compensation benefits, as this can qualify them for an exemption in participating in WEP if they are still receiving it. Nearly **8 in 10** clients (**78.3%**) reported that they have **never received unemployment compensation benefits**.

- 886 clients (18.4%) reported that they are receiving or have received unemployment compensation, ranging in time from 1984 to February 2015.

Work Experience Program

Immediate program goals for WEP participants are to actively ensure viable work opportunities for ABAWDs in Franklin County to fulfill the work requirement to maintain their SNAP benefits and prepare ABAWDs for reentry into the workforce. The long-term goals and objectives for WEP participants are focused on decreasing unemployment among Franklin County ABAWDs to break systemic cycles of poverty and hunger and ensure clients can become economically self-sufficient.

Consistent Outreach

During the initial ABAWD assessment at the FCDJFS opportunity centers, clients are given information about job openings and job fairs in Franklin County. When we find that one of the many barriers the assessment is meant to capture is stifling a client in their attempt to secure employment, we refer them to clothing banks, resources for homelessness, mental health facilities, educational opportunities, and food pantries.

Many clients who attend our monthly job and resource fair leave with jobs!

All new clients are required to attend a WEP employment and resource fair their first month in the program. We bring together employers (with assistance from FCDJFS Workforce Development and Franklin County Economic Development), health care navigators and certified application counselors, Legal Aid Society of Columbus lawyers, workforce development agencies, GED and adult education or vocational training organizations, and many more stakeholders to ensure we are able to offer clients a variety of valuable services.

At this event, clients also receive a required background check for their job placements. They participate in hands-on activities and receive assistance with filling out job applications and creating or updating resumes, assistance with using computers, and referrals to obtain suiting for job interviews.

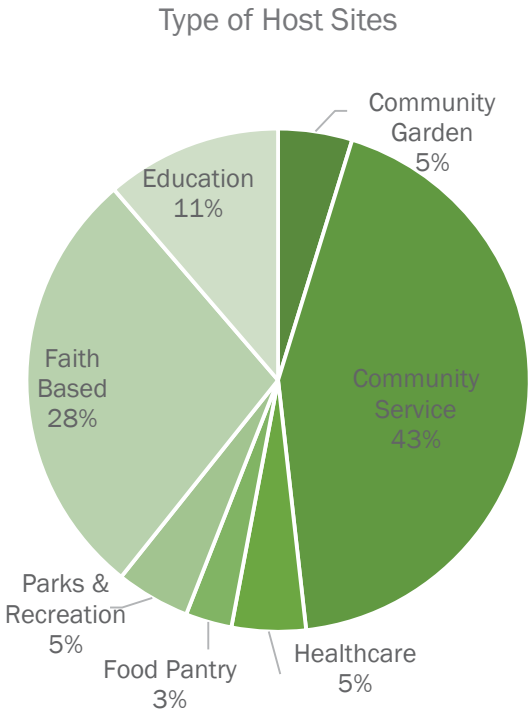
WEP Volunteer Host Sites

The recruitment process for developing new sites involves calling, mailing, e-mailing, and visiting numerous nonprofit and faith-based organizations in Franklin County. Each organization is required to sign a Memorandum of Agreement, establishing a strong partnership that also holds these organizations accountable for reporting hours for clients.

Each volunteer experience through WEP is intended to give participants training, education, or experience that would be beneficial in an ABAWD's search for future employment. Some sites even report hiring WEP workers when they have open positions available.

A list of possible volunteer roles could include but is not limited to:

- Janitorial Work
- Painting
- Grounds Maintenance & Landscaping
- Warehouse Positions
- Office and Clerical Work
- Manual Labor
- Customer Service
- Food Preparation and Service



"One of our WEP clients began working at the Broad Street Food Pantry in October 2014 as part of the Ohio Association of Foodbanks Work Experience Program. From the time she started, she demonstrated excellent work ethics – never missing a day, always working hard and making sure that customers were served efficiently, the shelves kept full, and the pantry kept clean and neat. Last winter when our assistant moved on to another job, our WEP client was one of the first candidates we identified. After a thorough search, we hired her for the permanent position."

-Kathy Kelly-Long, Broad Street Food Pantry Director

WEP participants paint a mural at Fusion Bakery and Cafe

Placements

Our network of nonprofits, workforce development partners, and faith-based organizations make it possible for Franklin County ABAWDs to obtain their required work hours through volunteer service or job readiness activities, while also offering work experience. Placements are made at these organizations after clients have completed a background check at the WEP monthly employment and resource fair.

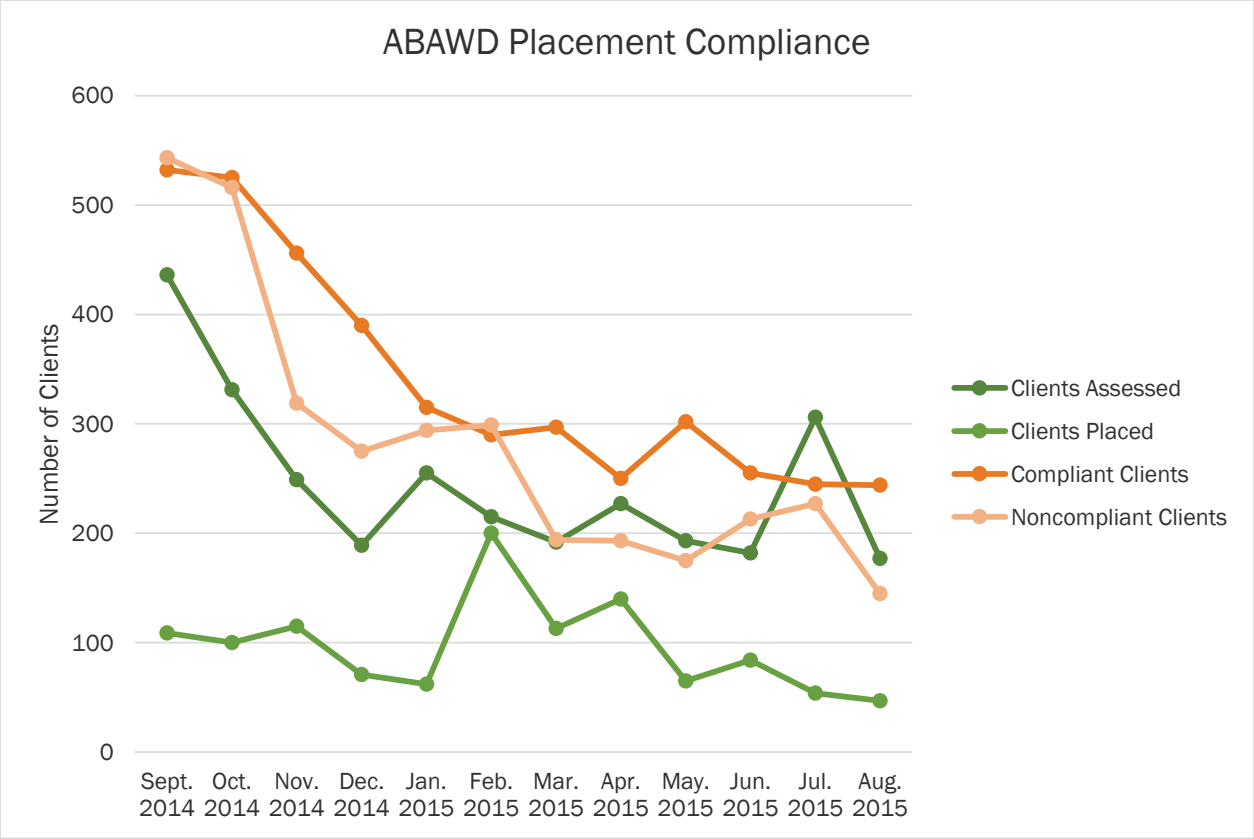
The Ohio Association of Foodbanks requires clients to have a background check to ensure that we are not placing clients in situations that may compromise the integrity of our partners, and to protect their clients and staff in the event of a known conflict of interest. Clients are not eligible to be placed at a volunteer host site until their FBI/BCI background check is received.

Through the assessment process we gather an inventory of job skills from each clients. We are able to determine what jobs would best suit that client, and strategically place them at sites where we believe they will thrive. We do make accommodations for any client that is already volunteering in the community, and make an attempt to bring their volunteer site on as a host organization so that the client can maintain their relationship with that organization.

ABWAD Placement Compliance

At times, it can be very difficult to place clients at a volunteer site. If the host location is not on the bus line or if it is not easily accessible by public transportation, clients can have a hard time getting to their placement. Some host sites even require a college education or degree, which many of our clients do not have. Some sites have a list of restricted felonies which would limit a large portion of our clients from volunteering with those sites. The same is true for workforce development programs. Many clients do not meet the minimum education requirements to enroll in such programs, or struggle with passing an entrance exam.

The Ohio Association of Foodbanks placement specialist makes every effort to place all clients, no matter how limiting their personal situations may be. Even with the best effort to make sure that a client's skills match the site's needs, and that the location is less than an hour bus ride from their address, not all clients report to their assigned placements each month. In order for a client to remain compliant with WEP they must report to their worksite for 23 hours per month. When a client fails their work requirement hours they are sanctioned and at risk of losing their monthly SNAP benefits.



Recommendations

As we bring light to the situations this population faces, we are able to make the following insightful recommendations which are supported by the findings of the WEP assessment data. These recommendations have been presented to FCDJFS after the first analysis of this information. They are meant to encourage other government organizations to consider a further examination of the implication of programs like WEP.

Program Next Steps

The specific program needs of the Ohio Association of Foodbanks will enhance the overall client experience while strengthening relationships with our partners.

- Coordinate with other Departments of Job and Family Services statewide in an effort to replicate the positive results we have seen in Franklin County, to expand this program to other metro and rural areas.

- Increase the efficiency of our program in order to enhance client satisfaction and success while working with very limited resources.

- Coordinate with Franklin County to offer more opportunities for clients to connect with available employment and training.

- Improve quality assurance measures and outcomes as well as communication channels between the Ohio Association of Foodbanks, clients, host sites, and Franklin County Department of Job and Family Services.

Increase Oversight to Improve Effectiveness

- Analyze the expenditures of Workforce Development Programs funded by FCDJFS compared to outcomes. WEP at the Ohio Association of Foodbanks has proven a 24% success rate, compared to a 16% success rate of similar government funded workforce programs in Franklin County.

Provide Additional Funding to Organizations Supporting WEP

- When clients fail a WEP assignment and do not have access to their food stamp benefits, they may begin utilizing the services of their local emergency food programs. This warrants more emergency funding to be provided to Mid-Ohio Foodbank to support the purchase, acquisition, and distribution of additional food for Franklin County food pantries, soup kitchens, shelters, and churches who are feeding the individuals affected.
- Utlize banked months of exemptions (estimated at 405,000) to reenroll participants in the food assistance program while Departments of Job and Family Services work to establish additional work experience program infrastructure.
- Provide additional funding to the Ohio Association of Foodbanks to support the cost of emergency vouchers for transportation, travel vouchers, and basic needs.
- To increase interest in becoming a part of the host site network, there needs to be more incentive for organizations to serve ABAWDs through WEP. By offering operating support to the nonprofit and faith-based organizations that are providing WEP services and slots, we can motivate more sites to partner with the Ohio Association of Foodbanks, while current sites may be able to effectively increase their capacity to serve more ABAWDs.
- Provide supplemental support for the continuation, expansion, and analysis of workforce development programs operated by the Ohio Association of Foodbanks for young adults aging out of the foster care system. All youth who successfully complete these programs either enroll in school or start working, which in many cases exempts them from particpating in WEP as ABAWDs.
- Improve the funding and training of a specialized unit dedicated to the implementation of this work requirement and the ABAWD population's specific needs.

Study the Social and Economic Impact of WEP

- Monitor and report on the impacts to well-being, health, and safety of clients, WEP host site staff/volunteers, and the community at large.
- Conduct an Economic Impact Analysis on the loss of food assistance/SNAP benefit issuance on the Franklin County economy.
- Provide funding for comprehensive case-management, longitudinal tracking of employment, wages, public assistance participation, and well-being of the ABAWD population.

Provide More Work Support Opportunities for ABAWDs

- Expand enrollment, participation, and successful completion of nationally certified programs such as the FastPath program at Columbus State Community College, including ServSafe, customer service, advanced logistics, and STNA.

- Create an employment enterprise or pipeline into strategic aspects of the job market. This will help harder-to-employ individuals find opportunities to gain sustainable employment.

- Prioritize Workforce Investment Act funding to provide education, training, and supportive services to ensure a seamless delivery of services.

- Establish a relationship with the Ohio Department of Rehabilitation and Correction in order to address the specific concerns of the employer community in regard to the future employment of felons.

- Examine opportunities to secure additional USDA/SNAP Employment and Training funds to enhance service delivery.

Examine and Evaluate the Needs of Special Populations

- Provide support and funding for a study on the mental and physical health status and outcomes of the ABAWD population and their utilization of Medicaid.

- Fund person-centered, community-based case management of ABAWDs applying for SSI/SSDI, and supportive services including Legal Aid assistance to non-custodial parents and individuals with criminal charges and felony convictions.

- Convene a study group to examine the impact of temporary and day labor employment services and its effects on this population.

- The Ohio Association of Foodbanks will continue to analyze assessments and data including current and previous encounters with the criminal justice system, community impact, and these associated costs.

Host Site Partner Organizations

Without the support of our wonderful network of nonprofit and faith-based organizations we could not offer so many meaningful volunteer opportunities to ABAWDs in Franklin County. We extend our sincere gratitude to each organization for their continued partnership and dedication to serving the community.

- Agora Ministries
- Authority of the Believers
- Beatty Recreation Center
- Brice UMC
- Bridge Community Center
- Broad Street Food Pantry
- Broad Street UMC
- Calhoun Memorial Temple
- Cat Welfare Association
- Catique
- Center for Family Safety
- Chalmers P Wylie VA Ambulatory Care Center
- Charitable Pharmacy of Central Ohio, Inc.
- Child Development Council of Franklin County
- Christ Harvest Church
- City of Whitehall
- Clintonville Beechwold
- Colony Cats (& dogs)
- Columbus Arts Technology Academy
- Columbus Chosen Generation Ministries
- Columbus Growing Collective
- Columbus Humanities Arts & Technology Academy
- Columbus Urban League
- Community Kitchen, Inc.
- Core Resource Center, Inc.
- East Columbus Development Company
- EL Hardy Center
- Family Missionary Baptist Church
- Franklinton Gardens
- Genesis of Good Samaritans Ministries
- Glory Praise & Help Center
- Greater Ebenezer Cathedral of Praise and Kingdom Kids Daycare
- Habitat for Humanity's ReStore
- Hands On Central Ohio
- Heart Food Pantry
- Heart of Christ Community Church
- Helping Hands Health And Wellness Center, Inc.
- Holy Family Soup Kitchen
- House of Refuge for All People
- HUB Community Development Corporation
- J Ashburn Jr Youth Center
- King Arts Complex MLK
- Kingdom Alive Word Church

- Libraries for Liberia Foundation
- Long Lasting Community Development
- Loving Hands Learning Center
- Lutheran Social Services Ohio Benefit Bank – SOUTH
- Lutheran Social Services Ohio Benefit Bank – WEST
- Magic Johnson Bridgescape Academy - New Beginnings
- Mock Rd University for Children
- National Parkinson Foundation Central & Southeast OH
- New Salem Baptist Church and Community Development
- NNEMAP, Inc.
- Ohio Association of Foodbanks
- Ohio Business Development Center
- Ohio Empowerment Coalition
- Pri-Value Foundation
- Project Redeem
- R F Hairston Early Learning Center
- Reeb-Hossack Community Baptist Church
- Seven Baskets Community Development Corp
- Shiloh Christian Center
- Short North Stage at The Garden Theater
- Society Of St Vincent De Paul
- Soldiers of Life Food Pantry
- Somali Bantu Youth Community of Ohio
- Southeast Friends of the Homeless
- Southeast, Inc.
- St Dominic Roman Catholic Church
- St Marks United Methodist Church
- St Philip Episcopal Church Food Pantry
- St Stephens Community House
- Stoddart Avenue Community Garden
- Temple Israel
- Trinity Assembly
- United House of Prayer
- Unity of Columbus
- Welcome Home Ohio
- Wesley Church of Hope UMC