Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

August 18, 2018

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

Dear Secretary Azar,

Thank you for the opportunity to comment on the revised Section 1115 Medicaid demonstration submitted by the state of Mississippi on January 16, 2018 known as the "Medicaid Workforce Training Initiative". Mississippi is seeking permission to impose a work/community engagement requirement on two mandatory categories of Medicaid beneficiaries; parents and caretaker relatives who have incomes below 27 percent of the poverty line ($468 per month for a family of 3), and parents and caretaker relatives who qualify for Transitional Medical Assistance (TMA) because their earned income has increased.

Summary

With respect to the state's revised proposal, we again urge you to deny the state's request. By its own estimates, the state's proposal will result in thousands of parents in deep poverty losing Medicaid coverage over the five-year duration of the waiver – with approximately 5,000 slated to become uninsured in the first year alone. The vast majority of these parents are likely to become uninsured. When parents lose Medicaid coverage, their children are at risk for losing it as well.[1] Children also stand to be negatively affected as parents lose coverage by the heightened economic insecurity caused by any member of the family being uninsured and because a healthy parent/caregiver is important for children's optimal development.

By putting families in deep poverty at risk of losing their health coverage and piling up medical debt, this proposal cannot be compatible with the objectives of the Medicaid program. We would like to draw your attention to research we conducted about which families in Mississippi would be affected by the state's plan. The full report is attached for your consideration. In short, *families headed by women, families living in rural areas and small towns, and especially African-American families will be disproportionately harmed by this proposal.*

A related concern is that maternal mortality is considerably higher in the Mississippi Delta region as compared to the rest of the country.[2] While we are aware that pregnant women are exempt

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[1] Karpman, M. and G. Kenney. "Health Insurance Coverage for Children and Parents: Changes Between 2013 and 2017" (Washington: Urban Institute, September 7, 2017) available at http://hrms.urban.org/quicktakes/health-insurance-coverage-children-parents-march-2017.html.

[2] Barbara L. Smith et al., "Maternal Mortality in the Delta Region of the United States", 44(1) *Journal of Obstetric, Gynecologic & Neonatal Nursing* Volume 44, Supplement 1, June 2015.

from this proposal, this does not provide us with much comfort as adding bureaucratic hurdles to Medicaid coverage for women of reproductive age such as the state proposes increase the likelihood that women will face significant delays in obtaining early preventive care. Moreover, access to health care *before* a woman gets pregnant, according to guidelines issued by the American College of Obstetricians and Gynecologist, is important to optimize maternal and fetal outcomes.[3] Mississippi's proposal is likely to promote periods of uninsurance which will have negative health effects on women and their babies – especially women of color.

There can be no justification for approving the state's request as *the state's plan creates a fundamental contradiction that has the practical effect of eliminating Medicaid coverage for many of these parents.* It is worth noting here that parents affected by the proposal are a **mandatory coverage group** in the Medicaid statute at §1902(a)(10)(A)(i)(1). Because Mississippi's income eligibility threshold for parents/caretaker relatives is so low (27 percent of the poverty line for a family of three), parents who comply with the new work requirement and work 20 hours a week at minimum wage will earn too much to remain eligible. And those who do not meet the required work/community engagement hours will also lose their Medicaid for noncompliance. This creates a "Catch-22 situation" which is indefensible, unjust, counterproductive and unlawful.

The state's proposed revisions do nothing to change these fundamental features of the proposal, they merely delay the inevitable for a very small group of families. We again urge you to reject this request.

Some additional comments on the revised proposal follow:

Mississippi has still not provided a legitimate hypothesis for the proposed demonstration, and the demonstration is unlikely to meet the objectives the state has provided.

In our previous comments with the Center on Budget et al.[4], we noted that Mississippi's application explicitly stated that the driving force behind the state's proposal was to cut costs because the state "continue(s) to see an increase in expenditures" in its Medicaid budget. We commented then that saving money is not an acceptable basis for a Section 1115 demonstration. While the state has deleted much of the language we referenced in our previous comments, we remain convinced that cost savings achieved by reducing the number of very poor parents and their children remains a key driver of the state's proposal. This objective remains unacceptable and incompatible with the purposes of Medicaid.

Moreover, there is nothing in the proposal that is likely to achieve the state's purported goal of "promoting access to workforce training for job readiness" (p. 2) that requires a Section 1115 waiver – other than the unacceptable request to condition parent's eligibility for Medicaid on compliance with a new set of requirements. The state neither brings nor requests any new resources to address affordable child care, inadequate transportation, job training or high rates of unemployment in rural areas – in other words the many serious barriers these low-income families face in securing meaningful employment with an offer of affordable health insurance that would result in them gaining "independence from government assistance" as the State puts it (p. 2).

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[3] *Guidelines for Women's Health Care: A Resource Manual, 4th Edition.* Issued by the American College of Obstetricians and Gynecologists, 2014.
[4] Our previous comments are included in Appendix 1.

An analysis of the state's budget neutrality projections finds that approximately 5,000 persons will lose coverage in the first year, with comparable coverage losses in subsequent years.[5]

The state's budget neutrality spread sheet shows a reduction in member months equivalent to a loss of coverage in the first year for almost 5,000 parents. These coverage losses continue throughout implementation of the waiver with approximately 20,000 losing coverage by the fifth year. It is very unlikely that these parents will find other health insurance as persons under the poverty line are not eligible for federal advanced premium tax credits for use in the marketplace nor do they have the discretionary income to purchase private insurance. Offers of affordable health insurance from employers for low wage and part time workers are very rare in Mississippi and elsewhere. Only 14 percent of nonelderly adults with incomes below the poverty line in Mississippi have employer-sponsored insurance.[6]

New data from Arkansas suggests that Mississippi's coverage losses could be even greater than the budget neutrality numbers suggests.

Arkansas is currently implementing a Medicaid work requirement and coverage lockout under a Secretary-approved demonstration. The state requires individuals to go online and report work hours or an exemption or face losing coverage after three months of noncompliance. Of 15,137 individuals who needed to go online and comply with reporting requirements in the second month of Arkansas's implementation, 12,587—83 percent—did not do so. At the end of this month, 5,426 Arkansans may lose their coverage if they do not comply with the state's reporting requirements.[7] Arkansas will not terminate coverage until beneficiaries are out of compliance for three months. *Unlike Arkansas, Mississippi's proposal contemplates terminating coverage immediately after one month of non-compliance.*

As a result, we can expect that eligibility "churn" will increase and promote periods of uninsurance i.e., when beneficiaries are disenrolled, then reenrolled, even though they continue to be eligible during the period of disenrollment, and regardless of whether they are in a course of treatment or develop a medical condition during disenrollment. Multiple studies suggest that eligibility churn is associated with increases in emergency room visits, higher levels of unmet health care needs during periods of uninsurance, more frequent use of costly treatments for conditions that could have been prevented through early detection and care, and significantly higher administrative costs.[8]

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[5] These projections are calculated from the state budget neutrality submitted in the Initial Complete Application, submitted January 16, 2018. The difference of the with and without-waiver enrollment (in member months) was divided by 12 months to approximate the increase/decrease in the number of beneficiaries enrolled per year. It is possible that more people lose coverage for some period of time, regain coverage, then lose coverage again within a demonstration year.

[6] "Health Insurance Coverage of the Nonelderly (0-64) with Incomes below 100% Federal Poverty Level (FPL)" (Washington: Kaiser Family Foundation, 2016).

[7]Appendix 2 contains our two blog posts analyzing this new data as well as both months of data that Arkansas has released.

[8] L. Ku and E. Steinmetz, "Bridging the Gap: Continuity and Quality of Coverage in Medicaid" (Washington: George Washington University, Association for Community Affiliated Plans, September 10, 2013) available at http://www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%20%209-10-13.pdf.; Irvin, C. et al. "Discontinuous Coverage in Medicaid and Implications for 12-Month Continuous Coverage" (Washington: Mathematica Policy Research, October 24, 2001), available at https://www.mathematica-mpr.com/our-

Periods of uninsurance expose families with children to medical debt and even bankruptcy – a prospect which undermines the financial stability and economic prospects of these families. It is well established in the research literature that Medicaid reduces financial barriers to obtaining needed care and improves a family's economic security.[9]

Children are also at risk of coverage losses should the state's proposal be approved.

It appears from the budget neutrality documents that the declines in enrollment expected by the state are anticipated solely in the affected eligibility groups (i.e. Section 1931 parents and Transitional Medical Assistance (TMA) beneficiaries). However, it is probable that additional coverage losses may occur among children in these families. Research is clear that when parents have health insurance their children are more likely to be insured.[10] Children whose parents are insured are almost always insured themselves, whereas 21.6 percent of children whose parents are uninsured are also uninsured.[11] As this proposal will likely result in more parents becoming uninsured, their children are also at greater risk of becoming uninsured.

Moreover, the provision of Medicaid coverage to low-income parents helps parents afford the health care they need and (among other benefits) improves their economic status — the loss of Medicaid coverage will reverse these gains and keep vulnerable parents from improving their family's economic fortunes, putting them at risk for medical debt and even bankruptcy. Research is very clear on this point as well with one recent study finding that Medicaid is the third-largest anti-poverty program in the United States and kept at least 2.6 million Americans from falling into poverty in 2010.[12] We have attached a copy of our summary of research findings on this point entitled "Medicaid: How Does It Provide Economic Security for Families."

Medicaid Coverage is Critical to the Health of Low-Income Children and Families

Medicaid coverage is extremely important to low-income children and families in Mississippi and elsewhere. The research on this point is clear. Children with Medicaid coverage have better access to needed care than do uninsured children. Compared to uninsured children, children with Medicaid or CHIP are significantly more likely to have a regular source of care and to have a physician visit and dental visit in the last two years.[13] Children with Medicaid or CHIP are also more likely to receive preventive care and have a personal physician or nurse than children who are

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publications-and-findings/publications/discontinuous-coverage-in-medicaid-and-the-implications-of-12month-continuous-coverage-for-children.;

M. Carlson, J. DeVoe, and B. J. Wright, "Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results from a Prospective Cohort Study of the Oregon Health Plan" (2006) Annals of Family Medicine 4(5): 391-398.

[9] For an overview of the research findings, see "Medicaid: How Does It Provide Economic Security for Families?" (Washington: Georgetown University Center for Children and Families, March 2017), available at https://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-and-Economic-Security.pdf.

[10] J.L. Hudson and A.S. Moriya, "Medicaid Expansion for Adults Had Measurable "Welcome Mat" Effects on Their Children," *Health Affairs* 36, no. 9 (September 2017).

[11] M. Karpman and G. Kenney, op cit.

[12] B.D. Sommers and D. Oellrich. "The Poverty Reducing Effect of Medicaid" *Journal of Health Economics* 32, no. 5, (September 2013).

[13] R. Rudowitz, S. Artiga, and R. Arguello, "Children's Health Coverage: Medicaid, CHIP and the ACA" (Washington: Kaiser Family Foundation, March 2014), available at https://www.kff.org/health-reform/issue-brief/childrens-health-coveragemedicaid-chip-and-the-aca.

uninsured.[14] The same study found that children who are uninsured are more likely to have unmet medical and dental needs than children with Medicaid/CHIP coverage.[15] Mothers covered by Medicaid are more likely than uninsured mothers to have a regular source of care, a doctor visit, and to receive preventive care.[16]

Research also underscores the value of Medicaid for the health of parents in many ways – including their mental health. A study that focused on Medicaid eligibility expansions for parents between 1997 and 2009 found improved mental health outcomes for low-income parents.[17] Medicaid coverage may play a particularly important role improving access to mental health care; participants in the Oregon Experiment reported significantly better mental health with no significant changes in physical health one year after gaining coverage.[18]

For very low-income women like those that will be affected by Mississippi's proposed cuts, Medicaid's effectiveness in treating depression is vital, as depression is epidemic among these women. With respect to deeply poor families (those with incomes under half the poverty level), evidence of the high incidence of depression comes from several studies. Disconnected single mothers are those who are neither working nor on cash assistance, live in deep poverty, and average just over $9,000 in annual household income for all family members. These women had high rates of maternal depression that were far greater than those of other impoverished groups.[19] A review of home visiting program reports aimed at poor and high-risk mothers with young children found the rates of maternal depression ranging from 29 percent to 61 percent in each study.[20]

The state's proposed solution to the Catch 22 inherent in the proposal to extend TMA is no solution at all. At best, it offers a temporary delay to the inevitable coverage loss for a very small number of parents.

A close read of Mississippi's revised proposal reveals that this inadequate and temporary fix is no fix at all. Parents are only eligible for additional TMA if they work every month of the 12 months offered. The state projects that only 1,280 parents a year (p. 8) will be able to access the additional TMA coverage. The state provides enrollment data for parents (p. 5) in 2017 (19,123 new

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[14] A.R. Kreidler et al., "Quality of Health Insurance Coverage and Access to Care for Children in Low-Income Families" JAMA Pediatrics 170, no. 1 (January 2016): 43-51, available at https://jamanetwork.com/journals/jamapediatrics/fullarticle/2470859.
[15] Ibid.
[16] S. Long, T. Coughlin, and J. King, "How Well Does Medicaid Work in Improving Access to Care?" Health Services Research 40, no.1 (February 2005): 39-58.
[17] S. McMorrow et al., "Medicaid Expansions from 1997 to 2009 Increased Coverage and Improved Access and Mental Health Outcomes for Low-Income Parents" Health Services Research 51, no. 4 (August 2016): 1347-1367, available at https://onlinelibrary.wiley.com/doi/epdf/10.1111/1475-6773.12432.
[18] K. Baicker et. al., "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes" The New England Journal of Medicine 368, no. 18 (May 2013): 1713-1722, available at https://www.nejm.org/doi/full/10.1056/NEJMsa1212321.
[19] P. Loprest, "Disconnected Families and TANF," Washington: The Urban Institute (May 2012), available at https://www.urban.org/research/publication/disconnected-families-and-tanf.; O. Golden, M. McDaniel, P. Loprest, and A. Stanczyk, "Disconnected Mothers and the Wellbeing of Children: A Research Report," (Washington: The Urban Institute, May 2013), available at https://www.urban.org/research/publication/disconnected-mothers-and-well-being-children-research-report.
[20] R. Ammerman, F. Putnam, N. Bosse, A. Teeters, and J. Van Ginkel, "Maternal Depression in Home Visiting: A Systematic Review." Aggression and Violent Behavior 15, no. 3 (2010): 191–200.

applicants and 37, 254 beneficiaries) ***which means that the "fix" will only temporarily help a mere two percent of parents in Mississippi annually who are receiving Medicaid***.

Earlier this year, we submitted comments to you (dated February 22, 2018) with the Center on Budget and Policy Priorities and 17 additional signatories urging you to reject the state's request. We reaffirm our previous comments, a copy of which is attached in Appendix 1, and request that they be considered by CMS and the Secretary as part of a review of these comments. Furthermore, our comments include numerous references to supporting research. In order to ensure the inclusion of certain evidence in the administrative record and its consideration by CMS and the Secretary, we have submitted two additional appendices. Appendix 2 includes recently released data from the state of Arkansas which is in the process of implementing its Section 1115 Medicaid waiver that bears many similarities to Kentucky's proposal as well as our analyses of this data. Appendix 3 includes the text of research cited that may be difficult to access. For the remainder of the citations we have provided active hyperlinks. We request that the full text of each of the studies for which we have provided active hyperlinks be included in the administrative record and be considered by CMS and Secretary in determining whether or not to approve the State of Mississippi's proposal.

For all of these reasons, we urge you to reject Mississippi's request. Thank you for your consideration of our comments. If you need any additional information, please contact Joan Alker (jca25@georgetown.edu).

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