January 5, 2018

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

Re: North Carolina Amended 1115 Demonstration Application

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and under-served people. We appreciate the opportunity to provide these comments on North Carolina's amended 1115 demonstration application to move the state toward integrated care, including expanding coverage to more North Carolinians.

NHeLP supports North Carolina's efforts to update the previously pending application with additional details and the overall concept of integrating physical and behavioral health and incorporating measures to impact social determinants into the Medicaid program. However, we have concerns about some aspects of the application, including:

- The lack of choice in plans for those served by tailored plans;
- The failure to meet the need for increased state oversight of managed care entities and the ability to compel those entities to make changes;
- The mechanisms by which the state will ensure due process and monitor beneficiary protections throughout the system;
- The failure to include details that ensure an ombudsman program that will be robust, independent, and sufficiently resourced; and
- The state's readiness, especially in terms of technology, to implement integrated health care.

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We raised these issues in our comments to the state of North Carolina that we submitted along with the NC Justice Center, Disability Rights NC, and the Charlotte Center for Legal Advocacy. We incorporate by reference all of the comments submitted by this coalition into these comments.[1] In addition, we provide additional commentary on the IMD exclusion and the Carolina Cares program in these comments. We ask that the state's request for an IMD waiver not be approved as we do not believe it is consistent with the purpose of the Medicaid Act, would not be an experiment for North Carolina, and because North Carolina has the opportunity to expand the use of IMD services through the use of managed care. Also, although we appreciate that the state, pending legislative approval, plans to expand Medicaid to part of the population, we think that this should be a full expansion and, significantly, should in no way include work requirements as a condition of eligibility. Allowing work requirements does not comply with the requirements of § 1115 of the Social Security Act.

I. Carolina Cares

a. HHS authority and § 1115

To be approved pursuant to § 1115, North Carolina'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.[2]

The purpose of Medicaid is to enable states to furnish medical assistance to individuals whose income is too low to meet the costs of necessary medical care and to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care.[3] North Carolina's proposal to impose work requirements cannot be approved because it is inconsistent with the provisions of § 1115.

b. Work Requirements

North Carolina is seeking to impose a work requirement on individuals who are newly eligible under the Medicaid expansion.[4] The application includes only a general statement that "Carolina Cares enrollees would be required to be employed or engaged in activities to promote

[1] We have attached the comments to the State of North Carolina that we incorporate by reference and also submit the comments we, alongside Disability Rights North Carolina, the Charlotte Center for Legal Advocacy, and the North Carolina Justice Center, submitted to the North Carolina Department of Health and Human Services in response to previous invitations regarding the Request for Information on Managed Care Operations (RFI NO. 30-DHB-110217-18-O), the Proposed Concept Paper on Behavioral Health and Intellectual/Developmental Disability Tailored Plans, and the Proposed Program Design for Medicaid Managed Care.
[2] 42 U.S.C. § 1315(a).
[3] See 42 U.S.C. § 1396-1.
[4] 42 U.S.C. § 1396a(a)(10(A)(i)(VIII).

employment" with no additional information as to what this requirement would be.[5] Certain individuals would be exempt from this requirement in limited circumstances.

Under § 1115 and other relevant law, HHS has no authority to approve any waiver permitting North Carolina to condition Medicaid eligibility on compliance with work activities (and, thus, has never done so). Work requirements are an illegal condition of eligibility beyond the Medicaid eligibility criteria clearly enumerated in federal law. Medicaid is a medical assistance program, and although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide medical assistance to all individuals who qualify under federal law. As courts have held, additional eligibility requirements are illegal.[6]

Section 1115 cannot be used to short circuit these Medicaid protections because there is no basis for finding that work requirements are likely to assist in promoting the objectives of the Medicaid Act.[7] The purpose of Medicaid is to enable states to furnish medical assistance to low-income individuals who cannot afford the costs of medically necessary services and to furnish rehabilitation and other services to help such individuals attain or retain capability for independence or self-care.[8] Conditioning Medicaid eligibility on completion of work activities gets it exactly backwards by blocking access to care and services that help individuals be able to work. Research confirms that Medicaid coverage allows individuals to obtain and maintain employment.[9] For example, more than half of individuals enrolled in the Medicaid expansion in Ohio reported that Medicaid coverage has made it easier to continue working. Among enrollees who did not have a job, three-quarters reported that Medicaid coverage made it easier for them to look for one.[10]

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[5] NC Amended 1115 Application 14 (Nov. 20, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-pa2.pdf.

[6] *See, e.g.*, *Camacho v. Texas Workforce Comm'n,* 408 F.3d 229, 235 (5th Cir. 2005) (enjoining Texas regulation that terminated Medicaid coverage of TANF recipients who were substance abusers or whose children were not getting immunizations or check-ups or were missing school because regulation was inconsistent with Medicaid and TANF statutes).

[7] 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.

[8] 42 U.S.C. § 1396-1.

[9] Renuka Tipirneni et al., Institute for Healthcare Policy and Innovation, University of Michigan, *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches*, (2017), available at http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches; Louija Hou et al., "Working Paper No. 22170: The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being," National Bureau of Economic Research, (2016), available at http://nber.org/papers/w22170; Nicole Dissault, Maxim Pinkovskiy, and Basit Zafar, *Is Health Insurance Good for Your Financial Health?* Liberty Street Economics Blog, June 6, 2016 online at http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-yourfinancial-health.html#.V4lHI6It7VJ.

[10] Ohio Dep't of Medicaid, *Ohio Medicaid Group VII Assessment: A Report to the Ohio General Assembly*, (2017), http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

Imposing work requirements will reverse this progress and cause individuals to lose coverage.[11]

Moreover, the vast majority of individuals enrolled in Medicaid already work or have good reason for not working.[12] A recent study by the Kaiser Family Foundation found that adult Medicaid enrollees who were not receiving disability benefits and did not have a job were not working because they were: going to school (18%); taking care of their home or family (28%); retired (8%); unable to find work (8%); or dealing with illness or disability (35%).[13] In North Carolina, most of the people who are uninsured and may be covered by Carolina Cares are working with only 14 percent being unemployed.[14]

The work requirements will also pose a barrier to coverage even for individuals who are working.[15] Data shows that most low-income workers have jobs with variable and unpredictable schedules, for instance in construction, retail, or food service, which can make it difficult to comply with the state's weekly-hours requirements.[16] Moreover, even individuals who do comply with the weekly-hours requirements will have to verify their hours every month to maintain their eligibility. This administrative burden will likely be difficult for individuals to meet and may result in terminations of needed health care even when the individual has met the requirements.

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[11] LaDonna Pavetti, Michelle Derr, and Emily Sama Martin, *Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments*, (2008); Robert Rector, Heritage Foundation, *Work Requirements in Medicaid Won't Work. Here's a Serious Alternative* (2017), available at: http://www.heritage.org/health-care-reform/commentary/work-requirements-medicaid-wont-work-heres-serious-alternative; Hannah Katch, Ctr on Budget & Pol'y Priorities, *Medicaid Work Requirements Would Limit Health Care Access Without Significantly Boosting Employment*, (2016), available at: http://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly.

[12] Rachel Garfield, Kaiser Family Found., *Understanding the Intersection of Medicaid and Work* (2017), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work (finding that almost 80% of adults who are enrolled in Medicaid, but do not receive SSI, live in families with at least one worker, and almost 60% are working themselves).

[13] *Id*.

[14] N.C. State Center for Health Statistics, N.C Dep't Public Health, BRFSS Report: Medicaid, Final 2016, http://www.schs.state.nc.us/data/brfss/medicaid/docs/Medicaid_2016_tables.pdf.

[15] *See e.g.*, Julia B. Isaacs, Michael Katz, and David Kassabian, *Changing Policies to Streamline Access to Medicaid, SNAP, and Child Care Assistance*, Urban Institute, March 2016, http://www.urban.org/sites/default/files/publication/78846/2000668-Changing-Policies-to-Streamline-Access-to-Medicaid-SNAP-and-Child-Care-Assistance-Findings-from-the-Work-Support-Strategies-Evaluation.pdf

[16] Susan J. Lambert, Peter J. Fugiel and Julia R. Henly, *Precarious Work Schedules among Early-Career Employees in the US: A National Snapshot*, University of Chicago, (2014) available at https://ssascholars.uchicago.edu/sites/default/files/work-scheduling-study/files/lambert.fugiel.henly_.precarious_work_schedules.august2014_0.pdf; Stephanie Luce, Sasha Hammad and Darrah Sipe, Retail Action Project, *Short Shifted,* September 2014, http://retailactionproject.org/wp-content/uploads/2014/09/ShortShifted_report_FINAL.pdf; Liz Ben-Ishai, CLASP, *Volatile Job Schedules and Access to Public Benefits*, September 2015, http://www.clasp.org/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf

Interventions that are punitive and force individuals off benefits are more likely to harm the health and wellbeing of individuals than they are to help them.[17] Non-punitive programs that provide work supports, such as education, training, childcare, and other services may be effective in helping increase employment rates, but that is not what North Carolina is proposing to do. The work requirement proposed also fail to recognize that the type of employment matters not only for the health of the employees, but also for their families. Working in poor-quality, low-wage jobs with lower degrees of job security are associated with poor health outcomes.[18] In a demonstration program designed to include social determinants of health, value-based care, and other changes designed around evidence-based practices, work requirements are a strong pull in the opposite direction and are archaic rather than innovative as numerous forms of research show that such requirements are not beneficial. For example, multiple studies from TANF show that punitive work requirements do not have lasting effects on income and can actually increase severe poverty.[19]

Many North Carolinians who would be eligible for Carolina Cares are already working but cannot access affordable coverage. Working is not a way to move away from Medicaid and to other forms of health care coverage, such as employer sponsored coverage. One-third of workers in North Carolina earn below a poverty level wage.[20] North Carolina not only has high percentage of workers who earn below a poverty level wage, but the state has seen a 21 percent increase in workers who earn poverty wages since 2009. This is the second highest increase in South and the sixth highest in the nation, with the number of working poor in North Carolina growing at a rate nearly three times the national average. Low paying jobs are rising at a faster rate than other jobs in North Carolina, with most of the job growth occurring in the more urban counties.[21] Even for those

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[17] Gordon Waddell and A Kim Burton, *Is Work Good For Your Health and Well-Being?* The Stationary Office, London 30 (2006), available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf; *see also, e.g.* R. Dorsett et al., *Leaving Incapacity Benefit. Department of Social Security Research Report No. 86*, The Stationery Office, London (1998) (as summarized in Waddell and Burton).

[18] Waddell and Burton, *supra* note 17, at 29.

[19] LaDonna Pavetti, Ctr. on Budget & Pol'y Priorities, *Work Requirements Don't Cut Poverty, Evidence Shows* (2016); Sandra K. Danziger et al., *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 J. POL'Y ANALYSIS & MANAGEMENT 231, 234 (2016); 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 (2001); Stephen Freedman et al., *National Evaluation of Welfare-to-Work Strategies: Two-year Impacts for Eleven Programs*, Manpower Development Research Corporation, (2000), http://www.mdrc.org/publication/evaluatingalternative-welfare-work-approaches.

[20] Tazra Mitchell, N.C. Justice Ctr: Budget & Tax Ctr., *Prosperity Watch Issue 64, No. 1: Number of North Carolinians on SNAP Falling Quickly*, Sept. 13, 2016, http://www.ncjustice.org/?q=budget-and-tax/prosperity-watch-issue-65-no-1-working-poor-make-one-third-north-carolina-workforce.

[21] Rural areas are losing labor force while growth is occurring mainly in the urban areas. For example, Halifax County has lost 15.1 percent of its labor force since 2007 and has an unemployment rate of 6.7 percent while the urban counties are gaining labor force. Rural parts of the state—especially in the mountains and in the East—face high unemployment rates. William Munn, N.C. Justice Ctr.: Budget & Tax Ctr., *Prosperity Watch Issue 80, No. 1: Uneven recovery highlights pockets of economic distress in Eastern NC*, November 2017. http://www.ncjustice.org/?q=budget-and-tax/prosperity-watch-issue-80-no-1-uneven-recovery-highlights-pockets-economic-distress.

looking for work, many North Carolina counties have more jobless workers than job openings.[22] North Carolina's job market has not kept pace with our population growth. North Carolina's the population growth has been more than twice the job growth. Therefore, there should be about 375,000 more jobs than currently exist if the job offerings had kept pace with population growth.[23]

We also have concerns that the harms from work requirements will fall disproportionately on individuals with chronic health conditions. While North Carolina's amended application indicates that the work requirement will not apply to individuals who are "caring for a dependent minor child, and adult disabled child or a disabled parent; receiving active treatment of substance sue disorder; or medically frail," it is not clear how an individual will qualify for this exemption. There is simply not sufficient information to understand the program being proposed, how it will affect those who should be covered, and how people may be excluded from the program. The lack of information means that the public cannot meaningfully provide input on what the state has proposed.

Evidence from other programs with similar exemptions shows that, in practice, individuals with disabilities are not exempted as they should be – often due to strenuous verification requirements – and are more likely than other individuals to lose benefits.[24] Even though an individual may not have a disability such that they would be exempt, they may still have difficulty understanding and meeting the requirements and be terminated. In addition, people with disabilities may also have more difficulty in finding and maintaining employment to meet the requirements, particularly in areas with high unemployment rates. People with disabilities have low employment and wage levels and experience discrimination at various stages of employment, including at hiring when employees with disabilities that would not affect their job performance are 26% less likely to be considered for employment.[25] In addition, people with disabilities are also nearly twice as likely to be employed part time because they cannot find a job with more hours or their hours have been cut back as compared to people without a disability.[26] Numerous studies of state Temporary Assistance for Needy Families (TANF) programs have found that participants with physical and mental health issues are disproportionately likely to be sanctioned for not completing the work

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[22] In 2015, 80 of North Carolina's 100 counties had more jobless workers than job openings. Tazra Mitchell, N.C. Justice Ctr.: Budget & Tax Ctr., *SNAP Policy: The Return of the Harsh Three-Month Time Limit for Childless, Non-Disabled Adults,* November 2015, http://www.ncjustice.org/sites/default/files/BTC%20Policy%20Basic--SNAP%20Time%20Limit_0.pdf

[23] Patrick McHugh, NC Justice Ctr., *Prosperity Watch: The slowest recovery in a generation,* Dec. 18, 2017, http://www.ncjustice.org/?q=budget-and-tax/prosperity-watch-issue-81-no-3-slowest-recovery-generation.

[24] *See, e.g.*, Andrew J. Cherlin et. al., *Operating within the Rules: Welfare Recipients' Experiences with Sanctions and Case Closings*, 76 SOC. SERV. REV. 387, 398 (finding that individuals in "poor" or "fair" health were more likely to lose TANF benefits than those in "good," "very good," or "excellent health"); Vicki Lens, *Welfare and Work Sanctions: Examining Discretion on the Front Lines*, 82 SOC. SERV. REVIEW 199 (2008).

[25] Ameri, Mason and Schur, Lisa and Adya, Meera and Bentley, Scott and McKay, Patrick and Kruse, Douglas L., *The Disability Employment Puzzle: A Field Experiment on Employer Hiring Behavior* (September 2015), *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2663198.

[26] U.S. Bureau of Labor Statistics, Persons with a Disability: Labor Force Characteristics—2016 (June 21, 2017), https://www.bls.gov/news.release/pdf/disabl.pdf.

requirement.[27]

Evidence from the Supplemental Nutrition Assistance Program (SNAP) demonstrates similar outcomes. Researchers have expressed concern that states might incorrectly determine that many of the nearly 20% of all SNAP participants who have a disability, but do not receive disability benefits, are subject to the work requirement.[28] One study from Franklin County, Ohio found that one-third of individuals referred to a SNAP employment and training program in order to keep their benefits reported a physical or mental limitation, and 25% of these individuals indicated that the condition limited their daily activities. Additionally, almost 20% of the individuals had filed for SSI or SSDI within the previous two years.[29] In another example, when Georgia reinstated the SNAP work requirement and time limits for "able-bodied adults without dependents" in 2016, the State found that 62% of nearly 12,000 individuals subject to the requirement were disenrolled after only three months.[30] State officials acknowledged that hundreds of enrollees had been wrongly classified as "able-bodied" when they were actually unable to work.[31]

North Carolina has already experimented with the impact of work requirements on benefits and proven that such requirements cause people to lose benefits. In January 2016, 23 North Carolina counties reinstated federal time limits on SNAP eligibility for unemployed childless adults ages 18-49 who do not have a disability. Regardless of the labor/economic conditions in their communities, these North Carolinians were required to be engaged in a job, job-training program, or volunteer opportunity for 20 hours per week, or they would be terminated from SNAP after three months. The number of participants fell by 35,000 people from January to April, the largest drop during this period in a decade.[32] Assistance dropped more sharply in counties that re-imposed the time limit.[33] The largest decline during the time period was in rural Alexander County, one of the 23 counties that reinstated the time limit, where there are 2.5 times as many job seekers than jobs available.[34] Job seekers outnumbering job openings is a problem in 80 of North Carolina's 100 counties.[35] In addition, the areas with job growth are urban as opposed to rural, with the rural areas

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[27] *See, e.g.*, Yeheskel Hasenfeld et al., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* Departmental Paper, University of Pennsylvania School of Social Policy and Practice (2004), http://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers.
[28] *See* Michael Morris et al., Burton Blatt Inst. at Syracuse Univ., *Impact of the Work Requirement in Supplemental Nutrition Assistance (SNAP) on Low-Income Working-Age People with Disabilities,* 4, 14 (2014).
[29] Ohio Association of Foodbanks, *Comprehensive Report: Able-Bodied Adults Without Dependents* (2015), http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_204-2015-v3.pdf.
[30] *Correction: Benefits Dropped Story*, U.S. News & World Report, (May 26, 2017), https://www.usnews.com/news/best-states/georgia/articles/2017-05-25/work-requirements-drop-thousands-in-georgia-from-food-stamps.
[31] *Id*.
[32] Mitchell, *supra* note 20.
[33] N.C. Dep't Health & Hum. Servs. N.C. State Ctr. for Health Statistics, Health Atlas, Behavioral Risk Factor Surveillance System, http://www.schs.state.nc.us/data/hsa/brfss.htm (maps on disability and chronic conditions).
[34] Mitchell, *supra* note 20.
[35] Tazra Mitchell, N.C. Justice Ctr.: Budget & Tax Ctr., *SNAP Policy: The Return of the Harsh Three-Month Time Limit for Childless, Non-Disabled Adults*, November 2015, http://www.ncjustice.org/sites/default/files/BTC%20Policy%20Basic--SNAP%20Time%20Limit_0.pdf

of North Carolina struggling to come back from the Great Recession and just nine urban counties accounting for 46.3% of the state's labor force.[36] Requiring work where there is little or none to be had, especially without employment supports, has already been proven to cause people to lose benefits and disproportionately affect rural areas. The effect of imposing a work requirement on Medicaid will be the same: people losing benefits that are important to obtaining and gaining effective, stable employment.

Because conditioning Medicaid eligibility on completion of the work requirement will disproportionately harm individuals with chronic and disabling conditions, the requirement implicates the civil rights protections contained in the Americans with Disabilities Act (ADA), § 504 of the Rehabilitation Act, and § 1557 of the Affordable Care Act.[37] These laws make it illegal for states to take actions that have a discriminatory impact on people with disabilities, and they cannot be waived under § 1115 or under any other authority of the Secretary.[38]

Furthermore, evidence shows that in other public benefits programs, states disproportionately impose sanctions for failure to comply with program rules on African American individuals. In one study based on experimental survey and actual case data, researchers found that African American beneficiaries were more likely to be sanctioned for noncompliance than white beneficiaries,[39] raising concerns that North Carolina's proposal will increase racial disparities in the state.

Work requirements that result in parents seeking low-wage employment, as the labor statistics show will be most likely in North Carolina, will also be detrimental to children in those families. As discussed previously, where jobs are available in North Carolina they are most likely low-wage positions. While parental employment is not necessarily harmful, if only low-wage, stressful jobs are available, working can be costly for family and child wellbeing.[40] Such employment can jeopardize the quality of parenting because of the demands on parents' time, energy, and attention. Studies find that when mothers start a low-wage, repetitive job, the quality of their children's experiences at home begins to deteriorate, becoming less stimulating and nurturing, impacting a child's development and long-term outcomes.[41] In addition, the multiple, unstable childcare arrangements that many families rely on when they have low-wage work with uncertain schedules can harm a child's health development.[42] Numerous studies find a relationship between child care stability, attachment, and child outcomes including effects on social competence, behavior outcomes, cognitive outcomes, language development, school adjustment, and overall

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[36] Munn, *supra* note 21.
[37] 42 U.S.C. § 12312; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (prohibiting recipients of federal funds from discriminating on the basis of disability); 42 U.S.C. § 18116.
[38] See *Burns-Vidlak v. Chandler*, 939 F. Supp. 765, 772 (D. Haw. 1996).
[39] Sanford F. Schram, Joe Soss, Richard C. Fording and Linda Houser, *Deciding to Discipline: Race, Choice, and Punishment at the Frontlines of Welfare Reform*, 74 Am. Soc. Rev. 398 (2009).
[40] Toby Parcel and Elizabeth Menaghan, *Effects of Low-Wage Employment on Family Well-being,* 7(1) WELFARE TO WORK 116 (Spring 1997);
[41] *Id.*
[42] Gina Adams and Monica Rohacek, Urban Inst, *Child Care Instability: Definitions, Context, and Policy Implications* (Oct. 2010), https://www.urban.org/sites/default/files/publication/29446/412278-Child-Care-Instability-Definitions-Context-and-Policy-Implications.PDF.

child well-being.[43] The effect of parental low wage jobs and childcare instability may particularly impact children living in poverty.[44] Medicaid for children, particularly the EPSDT provision, "assure[s] that individual children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible."[45] To implement work requirements in Medicaid in the face of evidence that the effect of such requirements would be to cause harm to children and their development would be contrary to purpose of the Medicaid Act.

As this evidence demonstrates, the inevitable outcome of these work requirements is that large numbers of individuals, including those who are already working, will lose health insurance coverage,[46] an outcome that is directly at odds with the objectives of the Medicaid Act. Furthermore, it is well-documented that gaps in coverage substantially worsen health outcomes.[47]

In addition to the dramatic harms work requirements will cause, extensive research reveals that a mandatory work requirement is also ineffective at increasing self-sufficiency. Studies of cash assistance programs have already established that a work requirement does little to increase stable, long-term employment and does not decrease poverty.[48] In fact, work requirements have had the reverse effect, leading to an increase in extreme poverty in some areas of the country, as individuals who do not secure employment also lose their eligibility for cash assistance.[49]

North Carolina's proposal could also runs afoul of other laws, which the Secretary is not authorized to waive. The broad requirement to "be employed or engaged in activities to promote employment" but such a requirement could mean that individuals are required to provide services to the state, or other public entities, without paying them the minimum wage, which would violate the Fair Labor Standards Act, its implementing regulations, and Department of Labor guidelines.[50]

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[43] *Id.* at 7.
[44] *Id.* at 8.
[45] CMS, COVERAGE IN THE MEDICAID BENEFIT FOR CHILDREN AND ADOLESCENTS 1 (2014), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.
[46] Leighton Ku and Erin Brantley, *Medicaid Work Requirements: Who's At Risk?* Health Affairs Blog, Apr. 12, 2017, http://healthaffairs.org/blog/2017/04/12/medicaid-work-requirements-whos-at-risk/)
[47] Benjamin D. Sommers, Atul A. Gawande, and Katherine Baicker, *Health Insurance Coverage and Health — What the Recent Evidence Tells Us*, 377 New England Journal of Medicine 586 (2017), available at http://www.nejm.org/doi/full/10.1056/NEJMsb1706645; 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*, 48 Medical Care 1219 (2008), available at https://www.ncbi.nlm.nih.gov/pubmed/19300311?dopt=Abstract; Andrew Bindman, Amitabha Chattopadhyay, and G. M. Auerback, *Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions*, 149 Annals of Internal Medicine 854 (2008), available at https://www.ncbi.nlm.nih.gov/pubmed/19075204?dopt=Abstract.
[48] Pavetti, *supra* note 19; Sandra K. Danziger et al., *supra* note 19; Hamilton, *supra* note 19.
[49] Pavetti, *supra* note 19; Sandra K. Danziger et al., *supra* note 19; Dorothy Rosenbaum & Ed Bolen, Ctr. on Budget & Policy Priorities, *SNAP Reports Present Misleading Findings on Impact of Three-Month Time Limit* (2016), https://www.cbpp.org/sites/default/files/atoms/files/12-14-16fa.pdf; 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/evaluatingalternative-welfare-work-approaches.
[50] *See* 29 U.S.C. § 206.

Increasing access to Medicaid through the Carolina Cares program without eligibility restrictions would help close the coverage gap. Closing this gap could bring as many as 43,000 new jobs, with half of them in the health care sector, as well as increase total business activity by $21 billion and gross state product by $14 billion.[51] These federal dollars would be invested into local communities across the state, including some of our most economically disadvantaged counties, providing a boost to local health care providers and the economy as a whole. The act of increasing access to Medicaid alone—and doing so without restrictive eligibility requirements and administrative barriers to coverage—would do far more to promote employment than a Medicaid work requirement.

A far more productive (and permissible) approach would be to connect enrollees to properly-resourced voluntary employment programs and supports, an activity that does not need waiver approval from CMS. Studies show that these voluntary employment programs increase employment and income among low-income individuals. For example, a rigorous evaluation of Jobs Plus, a voluntary employment program for public housing residents, found that the program produced substantial and sustained gains in earnings when fully implemented.[52] The State also has the option to offer supportive employment services under § 1915(i) of the Social Security Act. The State could target such supportive employment services to specific populations that, based on research and other information, would be the most likely to benefit rather than be harmed by employment activities.

In summary, work requirements stand Medicaid's purpose on its head by creating barriers to coverage and the pathway to health that the coverage represents. The end result of this policy will be fewer people with Medicaid coverage and more uninsured people delaying treatment and later seeking uncompensated care in hospitals and federally qualified health centers. There will be more gaps in coverage, meaning more expensive treatment when eligibility is eventually regained. Hospitals and community health centers will suffer financially as they are expected to treat more people with chronic or acute illness with less funding. Importantly, individuals and families will suffer due to not only poor health outcomes, but other negative effects from compelled employment. For these and other reasons, HHS has consistently denied states' requests to impose a work requirement on individuals who are seeking medical assistance through the Medicaid program.

c. Premiums and Lock-Out Period

North Carolina's proposal to impose premiums on the Carolina Cares population is not a proper use of a § 1115 waiver. For individuals over 50 percent of FPL, North Carolina seeks to impose monthly premiums of 2 percent of their income.[53] Individuals who fail to pay their premiums within

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[51] Center for Health Policy Research, The Economic and Employment Costs of Not Expanding Medicaid in North Carolina: A County-Level Analysis, December 2014. http://www.conehealthfoundation.com/app/files/public/4202/The-Economic-and-Employment-Costs-of-Not-Expanding-Medicaid-in-North-Carolina.pdf

[52] 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, 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.

[53] NC Amended Application, *supra* note 5, at 14.

60 days of their due date would be disenrolled from Medicaid unless they demonstrate an exemption from the premium requirement prior to the end of the 60 day period, with re-enrollment only allowed if back due premiums were repaid.[54] As with the work requirements, North Carolina's proposal exceeds statutory limits on § 1115 waivers, does not promote the objectives of the Medicaid Act, and is not experimental.

As stated above, § 1115 only permits the Secretary to waive compliance with the requirements of 42 U.S.C. § 1396a. But the statutory authorizations for premiums are contained in independent, free-standing requirements set forth at 42 U.S.C. §§ 1396o, 1396o-1. While these statutes provide states with a great deal of flexibility to impose premiums and cost sharing, they prohibit imposing premiums on persons with incomes below 150% FPL. The Secretary should deny this request because he does not have the authority to grant it under § 1115.

The premiums are also not experimental and not likely to advance the objectives of the Medicaid Act. An ample body of research already clearly demonstrates that the imposition of premiums on very low-income populations only reduces access to coverage.[55] This longstanding and redundant research consistently reaches the same conclusion: premiums cause low-income individuals to lose health care coverage, and they increase expenditures when sick but uninsured individuals delay care until they need emergency, urgent, and/or acute care.[56] Most recently, the Kaiser Family Foundation reviewed the research from 65 studies and noted that this research finds that premiums create significant barriers to low-income people obtaining Medicaid coverage, with those living below the poverty level particularly affected because they are most likely to become uninsured and to have great health care needs.[57] Given the numerous and well-established studies on the impact of premiums on low-income people, there is no experimental value to North Carolina's proposal to implement premiums.[58]

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[54] *Id.*

[55] "Research examining the impact of premiums in public programs has found that participation falls off sharply as the premium amount increases" Julie Hudman & Molly O'Malley, Kaiser Comm'n on Medicaid & the Uninsured, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* (Mar. 2003), http://www.academia.edu/6759690/Health_Insurance_Premiums_and_Cost-Sharing_Findings_from_the_Research_on_Low-Income_Populations; *see also* Judith Solomon, Ctr. on Budget & Pol'y Priorities, *Ensuring Affordable Health Insurance Coverage and Health Care Services in an Insurance Exchange* (May 21, 2009), http://www.cbpp.org/sites/default/files/atoms/files/5-21-09health2.pdf (finding that "Research has shown that as premiums rise, fewer low-income people participate in health insurance voluntarily.").

[56] *See*, *e.g.*, Samantha Artiga et al., Kaiser Family Found., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (June 1, 2017), http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/; David Machledt & Jane Perkins, Nat'l.Health Law Program, *Medicaid Premiums & Cost Sharing and Premiums* (March 2014), http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing.

[57] Artiga, Kaiser Fam. Found., *supra* note 56.

[58] In another example, in 2003, Oregon experimented with charging sliding scale premiums ($6-$20) and higher copayments on some groups in an already existing § 1115 demonstration for families and childless adults living below poverty. Nearly *half* the affected demonstration enrollees

Moreover, the lock-out penalty for failure to pay makes North Carolina's proposal even more harmful and illegal. This policy will unnecessarily increase the number of uninsured individuals. It will contradict any effort to promote continuity of care and will harm the provider infrastructure in North Carolina (as providers will continue to treat uninsured patients). Individuals will end up not getting care when it is most appropriate. Individuals will lose coverage, wait until their conditions worsen, then seek care in the Emergency Department or only then get back onto North Carolina Medicaid when their health conditions are more expensive to treat. This policy creates a disincentive to obtaining timely and appropriate care. This proposal is counter-productive to not only North Carolina's strong history of care coordination and case management--and the savings such activities generate--but also to the entirety of North Carolina's program proposal regarding integrated care, care coordination, and social determinants of health. And as discussed above, the Secretary does not have the legal authority to allow North Carolina to implement premiums for individuals below 150% FPL. Given this, the Secretary also lacks the authority to allow termination and lock-out for failure to pay monthly premiums.

II. IMD Exclusion

A broad waiver of the IMD exclusion provision for substance use disorder and mental health treatment is unnecessary and unwise. North Carolina does not need a waiver of the IMD exclusion given that it is moving to integrated managed care and thus there will be access to IMD services through in lieu of services. Using the in lieu of services provision for IMD services will greatly increase access to these services. Accordingly, no additional waiver of the IMD exclusion should be requested or granted until the effect of in lieu of services is understood in North Carolina. North Carolina has a repeated history of overuse of IMD and IMD-like facilities, resulting in lawsuits, settlements, and multiple problematic reform efforts.[59] The state's current system is not prepared for an IMD exclusion and it should not be requested nor granted.

The request for an IMD may be driven by a need for psychiatric beds, but that need largely driven by a lack of community-based services and funding for mental health services. North Carolina is failing at providing community based services, which is driving the pressure for facility-based placements.[60] State officials have recognized that the rise in pressure on emergency rooms for psychiatric treatment and access to bed is because of a lack of community-based resources and

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dropped out within the first nine months after the changes. Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 HEALTH AFFAIRS 1106, 1110 (2005).

[59] From the *Thomas S. v. Flaherty* case to more modern cases such as the settlement with the U.S. Department of Justice (adults with mental health diagnoses) and *Disability Rights NC v. Brajer* (children who are dually diagnosed with mental health and developmental disabilities), along with multiple attempts at reform, including the current transformation, indicate the lack of a system to protect against unnecessary segregation and overuse of IMD and IMD-like facilities.

[60] Taylor Knopf, *For 11-year-old in ER, the wait for a psych bed is 10 days*, North Carolina Health News (Oct. 17, 2017), https://www.northcarolinahealthnews.org/2017/10/17/for-11-year-old-er-wait-for-psych-bed-10-days/ (citing UNC Health Care Spokesman Tom Hughes stating, "behavioral health needs are a growing concern in North Carolina as patients and their families often have no access to community solutions. This can result in large numbers of patients seeking treatment in emergency departments.")

treating clinicians cite the need for community based facilities.[61] The lack of overall spending for behavioral health care is also cited as source of the lack of access to behavioral health care.[62] North Carolina is one of just three states to decrease its spending on behavioral health from 2012 to 2015.[63]

North Carolina's behavioral health system focuses on serving people in mental health crisis as opposed to ensuring access to community-based services that help individuals not get to the point of crisis. Providing access to IMDs focuses on the crisis rather than the cause and diverts resources away from the necessary long-term fixes of appropriate community-based services that help people stay out of crisis.[64] Allowing North Carolina to increase its reliance on institutional placement is harmful to the individuals seeking treatment and the overall system of care in the state. Moreover, such reliance on, and promotion of, institutional placement as opposed to community-based care may be a violation of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Section 1557 of the Affordable Care Act. These violations may be attributable both to the state that is administering the programs and, for the purposes of Sections 504 and 1557, to CMS for encouraging and approving the use of federal funds in this manner.

Indeed, North Carolina does not have a stable mental health and substance use disorder system that has sufficient community based services, including crisis services, and strong guardrails against institutionalization. Currently, the state is in the process of implementing a settlement with the U.S. Department of Justice regarding the segregation of and lack of appropriate community-based services for people with mental health diagnoses; a settlement that has been extended after the Department of Justice filed a motion to enforce citing a failure to meet deadlines.[65] The move away from segregating people in adult care homes and similar facilities is not complete, much less well established. In 2012, the state underwent a review of these facilities to determine whether any of them met the IMD criteria. The state found two facilities were IMDs and that at least twenty five facilities likely fit the IMD definition.[66] These settings were found to unnecessarily segregate people with mental health diagnoses by the DOJ investigation and have been the subject of numerous reports, some of which found dangerous situations for the

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[61] Richard Crave, *Hospitals see huge uptick in mental health, substance abuse cases,* Winston-Salem Journal (Nov. 29, 2016), http://www.journalnow.com/news/local/hospitals-see-huge-uptick-in-mental-health-substance-abuse-cases/article_93818f5e-da17-5805-a798-6bb57e0e0ca1.html; *see also* Aica Nesper, et al., *Effect of Decreasing County Mental Health Services on the Emergency Department*, 67(4) ANNALS OF EMERGENCY MEDICAID 535-530 (April 2016) (finding that people seeking psychiatric treatment through the ER increased significantly after the closure of community outpatient treatment and elimination of local psychiatric beds).
[62] Crave, *supra* note 61.
[63] *Id.*
[64] Frank Taylor and Michael Gebelein, *Investigation: NC adult Care Homes System Under Fire, with Oversight Inconsistent, Unreliable*, Carolina Public Press (July 27, 2017), https://www.northcarolinahealthnews.org/2017/07/27/21048/ (quoting Jack Register regarding the crisis-based system that lacks a menu of services for people to rely upon on a consistent basis when they're not in crisis).
[65] U.S. Dep't of Justice, Olmstead Enforcement: U.S. v. North Carolina – No. 5:12-cv-557 – (E.D.N.C. 2012), https://www.ada.gov/olmstead/olmstead_cases_list2.htm#NC.
[66] Tiffany Healthcare et al. v. N.C. Dept of Health & Hum. Servs., Petition for Contested Case Hearing (June 13, 2002), https://www.ncala.org/ACH-Petition-Filed-6-13-12.pdf.

residents.[67] An IMD exclusion waiver would open the floodgates for institutional settings as opposed to the community based services the state needs.

Treatment in IMDs is not the best practice for either substance use disorder or mental health diagnoses.[68] The energies and resources that would be used to provide services in IMDs should instead be used to develop community-based providers and settings that meet the needs of the population, such as medically-assisted treatment for substance use disorders. An institutional approach is contrary not only to treatment standards, but also to the integrated care focus of this proposal and community integration requirements of the ADA. In addition, the state's process for monitoring, licensing, and investigating facilities needs to be able to effectively ensure quality care in facilities. However, there is no mention of increasing staffing and resourcing for this department to ensure that any and all facilities meet the licensure standards, provide quality care, and have any allegations of abuse and neglect investigated.[69]

The in lieu of services allowance for IMD services should be more fully explored and understood and efforts made to increase community-based services before an IMD exclusion waiver is used. Finally, providing Medicaid services in IMDs is not consistent with the Medicaid Act as it is explicitly prohibited and would not be an experiment for North Carolina, as the state already has a long history of relying on institutional placements as opposed to community-based services for behavioral health services. Before an IMD exclusion waiver is approved, the State should consult with stakeholders who are knowledgeable about systemic problems in order to set up protections, monitoring, and other guardrails to ensure IMD services are not overused.

Conclusion

NHeLP strongly objects to any efforts to use § 1115 to skirt essential provisions that Congress has placed in the Medicaid Act to protect Medicaid beneficiaries and ensure that the program operates in the best interests of the population groups described in the Act. As demonstrated above, North Carolina's proposal to impose punitive work requirements, require premiums, provide Medicaid-funded IMD services, and other provisions are inconsistent with the standards of § 1115 and with other provisions of law. We appreciate your consideration of our

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[67] U.S DOJ, *supra* note 2; Taylor & Gebelein, *supra* note 64; N.C. Inst. Of Med., *Short- and Long-Term Solutions for Co-Location in Adult and Family Care Homes: a report of the NCIOM Task Force on the Co-Location of Different Populations in Adult Care Homes* (2011), http://nciom.org/wp-content/uploads/2011/01/AdultCareHomes_wcover.pdf; *see also* Frank Taylor and Michael Gebelein, *Questionable Care Series,* available at https://carolinapublicpress.org/27277/forum-on-housing-for-those-with-mental-illness-in-nc/.

[68] Treatment of substance use disorder does not require institutional placement or treatment but instead may occur in a variety of settings, a decision made by the treating clinician based on an array of factors. ASAM, The American Society of Addiction Medicine, ASAM Standards of Care for the Addiction Specialist Physician (2014), https://www.asam.org/docs/default-source/practice-support/quality-improvement/asam-standards-of-care.pdf?sfvrsn=338068c2_10.

[69] The system for investigating and inspecting adult care homes has been identified as inconsistent and dangerous conditions have been found in these facilities. Frank Taylor & Michael Gebelein, *Who's watching: investigation raises doubts about NC inspection system for adult care homes,* Carolina Public Press (July 26, 2017), https://carolinapublicpress.org/27323/whos-watching-doubts-about-inspection-system-adult-care-homes/.

comments. If you have questions about these comments, please contact Elizabeth Edwards (edwards@healthlaw.org) or me.

Respectfully submitted,

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Attachments: Comments submitted to the State of North Carolina