



Administrator
Washington, DC 20201

August 10, 2021

T. Clark Phillip
Interim Director
State of South Carolina, Department of Health & Human Services
1801 Main Street PO Box 8206
Columbia, SC 29201-8206

Dear Mr. Phillip:

On February 12, 2021, the Centers for Medicare & Medicaid Services (CMS) sent you a letter regarding the section 1115 demonstration project entitled “Healthy Connections Works” (Project Number 11-W- 00334/4). The letter advised that CMS would commence a process of determining whether or not to withdraw the authorities previously approved in the Healthy Connections Works demonstration that would permit the state to require community engagement activities as a condition of initial and continued Medicaid eligibility. It explained that in light of the ongoing disruptions caused by the COVID-19 pandemic, South Carolina’s community engagement requirement risks significant coverage losses and harm to beneficiaries. For the reasons discussed below, CMS is now withdrawing approval of the demonstration in whole, which is not currently in effect and which would have expired by its terms on November 30, 2024.

Section 1115 of the Social Security Act (the Act) provides that the Secretary of Health and Human Services (HHS) may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act. In so doing, the Secretary may waive Medicaid program requirements of section 1902 of the Act, and approve federal matching funds per section 1115(a)(2) for state spending on costs not otherwise matchable under section 1903 of the Act, which permits federal matching payments only for “medical assistance” and specified administrative expenses.¹ Under section 1115 authority, the Secretary can allow states to undertake projects to test changes in Medicaid eligibility, benefits, delivery systems, and other areas across their Medicaid programs that the Secretary determines are likely to promote the statutory objectives of Medicaid.

As stated in the above referenced letter sent on February 12, 2021, under section 1115 and its implementing regulations, CMS has the authority and responsibility to maintain continued oversight of demonstration projects in order to ensure that they are currently likely to assist in promoting the objectives of Medicaid. CMS may withdraw waivers or expenditure authorities if it “find[s] that [a] demonstration project is not likely to achieve the statutory purposes.” 42 C.F.R. § 431.420(d); see 42 U.S.C. § 1315(d)(2)(D).

As the February 12, 2021 letter explained, the Healthy Connections Works community engagement requirement is not in effect. Although the demonstration was approved in

¹ 42 U.S.C. § 1315.

December 2019, the Special Terms and Conditions stipulated that the state may not require compliance with the community engagement requirement and may not implement subsequent consequences for failure to meet the requirement sooner than one year after demonstration approval. In the state's draft Implementation Plan submitted to CMS in March 2020, the state indicated a demonstration implementation date of January 1, 2022.² Upon this projected implementation of the community engagement requirement, the compliance requirement would have taken effect. Since the time of submission of the state's draft Implementation Plan, the COVID-19 pandemic and its expected aftermath have made the Healthy Connections Works community engagement requirement infeasible. In addition, implementation of the community engagement requirement to suspend coverage or disenroll beneficiaries who become eligible under the demonstration during the public health emergency for COVID-19 is currently prohibited by the Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127, Div. F, § 6008(a) and (b), 134 Stat. 208 (2020), which conditioned a state's receipt of an increase in federal Medicaid funding during the pandemic on the state's maintenance of certain existing Medicaid parameters. South Carolina has chosen to claim the 6.2 percentage point FFCRA Federal Medical Assistance Percentage (FMAP) increase, and therefore, while it does so, must maintain the enrollment of beneficiaries who were enrolled as of, or after, March 18, 2020.

The February 12, 2021 letter noted that, although the FFCRA's bar on disenrolling such beneficiaries will expire after the COVID-19 public health emergency ends, CMS still has serious concerns about testing policies that create a risk of substantial loss of health care coverage and harm to beneficiaries even after the expiration of the bar on disenrolling beneficiaries. The COVID-19 pandemic has had a significant impact on the health of Medicaid beneficiaries. Uncertainty regarding the current crisis and the pandemic's aftermath, and the potential impact on economic opportunities (including job skills training, work and other activities used to satisfy the community engagement requirement, i.e., work and other similar activities), and access to transportation and affordable child care, have greatly increased the risk that implementation of the community engagement requirement approved in this demonstration will result in substantial coverage loss. In addition, the uncertainty regarding the lingering health consequences of COVID-19 infections further exacerbates the harms of coverage loss for Medicaid beneficiaries.

Accordingly, the February 12, 2021 letter indicated that, taking into account the totality of circumstances, CMS had preliminarily determined that allowing the community engagement requirement to take effect in South Carolina would not promote the objectives of the Medicaid program. Therefore, CMS provided the state notice that we were commencing a process of determining whether to withdraw the authorities approved in the Healthy Connections Works demonstration that permit the state to require work or other community engagement activities as a condition of initial and continued Medicaid eligibility. See Special Terms and Conditions ¶ 10. The letter explained that if CMS ultimately determined to withdraw those authorities, it would "promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date." *Id.* The February 12, 2021 letter indicated that, if the state wished to submit to CMS any additional information that in

² South Carolina Department of Health and Human Services. (2020). Healthy Connections Works Draft Implementation Plan. Submitted March 11, 2020. Under CMS Review.

the state's view may warrant not withdrawing those authorities, such information should be submitted to CMS within 30 days.

On March 11, 2021, South Carolina submitted additional information in response to CMS's February 12, 2021 letter. As further described later in this letter, the additional information that South Carolina submitted did not address the concerns we raised in the February 12, 2021 letter. Specifically, the state did not dispute that the COVID-19 pandemic has had a significant impact on the health of Medicaid beneficiaries, including a discernible uptick in substance use disorder and mental health crises in the state, or that there is uncertainty about the lingering health effects of COVID-19. The state did not provide information to demonstrate how it would minimize coverage losses of at least 7,100 individuals (5,100 for non-completion of required hours of qualifying activities and another 2,000 for lack of timely documentation) by the end of the first full-year of implementation—representing about 35.5 percent of those who would be determined non-exempt from the community engagement requirement based on information available through eligibility and claims data—that it estimated would occur,³ which likely would be further aggravated as a result of the pandemic. The state also did not mitigate concerns of how it would ensure beneficiary awareness and understanding of the community engagement participation requirements, the qualifying exemptions, or the beneficiary reporting obligations.

Additionally, the state did not address how pandemic-related child care shortages in South Carolina could affect individuals' ability to meet the community engagement requirement. Considering the physical, mental, social, and economic toll the public health emergency has taken on individuals, CMS believes it is especially important that the low-income Medicaid beneficiaries in South Carolina be able to access coverage and care, without the initial and continued eligibility obstacle of the community engagement requirement that may be unreasonably difficult or impossible for individuals to meet under the circumstances of COVID-19 and its likely aftermath. Overall, as addressed in detail later, the information available to CMS, including that which was submitted in South Carolina's March 11, 2021 letter, does not provide an adequate basis to resolve the concerns stated in our February 12, 2021 letter.

In light of these concerns, for the reasons set forth below, CMS has determined that, on balance, the authorities that permit South Carolina to require community engagement as a condition of initial and continued eligibility are not likely to promote the objectives of the Medicaid statute. Therefore, we are withdrawing the December 12, 2019 approval of the Healthy Connections Works demonstration as a whole, since this demonstration does not include any authorities besides those that authorize the community engagement requirement.

Background of South Carolina's Demonstration

On December 12, 2019, the Healthy Connections Works demonstration was approved for an initial five-year demonstration period. The demonstration authorized a community engagement requirement as a condition of initial and continued eligibility for parents and caretaker relatives

³ South Carolina Department of Health and Human Services. (2019). Section 1115 Demonstration Application. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-community-engagement-pa.pdf>

(P/CR) and beneficiaries in the Transitional Medical Assistance (TMA) period with incomes up to 62 percent of the federal poverty level (FPL) (effectively 67 percent with a 5 percent income disregard), which are populations covered under the Medicaid state plan.⁴ Under the Healthy Connections Works demonstration, beneficiaries would be required to complete 80 hours of qualifying community engagement activities per month (averaged on a quarterly basis) as a condition of initial and continued Medicaid eligibility.⁵ Beneficiaries would be required to report compliance on an annual basis for those already employed at initial enrollment, and no more frequently than every 90 days for those completing other qualifying community engagement activities or who newly meet the requirement through employment after initial enrollment.⁶

Under the Healthy Connections Works demonstration, if at some point during the benefit year, a beneficiary no longer participated in sufficient qualifying hours of community engagement or qualified for an exemption from the requirement, the beneficiary would have 90 days to report that he or she either had resumed meeting the requirement, qualified for an exemption, or experienced a circumstance that would give rise to a good cause exception. If a beneficiary did not report this information within this 90-day period, he or she would be considered non-compliant and would have coverage suspended until the beneficiary came into compliance. During an eligibility suspension, beneficiaries would be able to reactivate their eligibility in the month following notification to the state that the beneficiary had completed a calendar month of required community engagement hours or qualified for an exemption. If a suspended beneficiary did not complete the one month of community engagement hours to reactivate coverage by his or her redetermination date, and did not qualify for an exemption or for another eligibility category not subject to the requirement, the individual would be disenrolled from Medicaid at that time.

Per the demonstration's Special Terms and Conditions, beneficiaries who would engage in extra hours of qualifying activities above what would be required in a month, could apply the extra hours to other months within a quarter, but could not apply those extra hours to another quarter. That is, beneficiaries could distribute the required 80 hours per month in any manner throughout the quarter, but no hours would be allowed to carry over from one quarter to the next. Individuals who would be exempt from satisfying the community engagement qualifying activities requirement included: individuals receiving Supplemental Security Income (SSI); primary caregivers of a child, up to age 18 and/or of a disabled adult; individuals identified as

⁴ CMS. (2019). Healthy Connections Works Section 1115 Demonstration Approval. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-healthy-connections-works-ca.pdf>; and State Health Facts. (2021). Kaiser Family Foundation. Retrieved from <https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁵ CMS. (2019). Healthy Connections Works Section 1115 Demonstration Approval. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-healthy-connections-works-ca.pdf>
<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-healthy-connections-works-ca.pdf>

⁶ South Carolina Department of Health and Human Services. (2019). Section 1115 Demonstration Waiver Application. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-community-engagement-pa.pdf>

medically frail; members of federally recognized tribes; individuals diagnosed with an acute medical condition that would prevent them from complying with the requirements; individuals who are exempt from Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) employment requirements; and individuals who are pregnant through 365 days postpartum.⁷

The state's demonstration application also requested to expand Medicaid coverage to individuals who meet the criteria of the P/CR group with incomes above the Medicaid standard of 62 percent of the FPL up to and including 95 percent FPL (effectively 100 percent with the five percent disregard) who were not otherwise eligible for full Medicaid coverage, with a community engagement requirement for initial and continued eligibility. Additionally, the state requested authority to expand coverage to a Targeted Adult Group of beneficiaries who would not otherwise be eligible for Medicaid and who meet specific criteria, such as being chronically homeless, being justice involved and in need of substance use or mental health treatment, or being solely in need of substance use disorder treatment. CMS approved authorities to cover most of these populations separately, under the "Palmetto Pathways to Independence" demonstration.⁸

As stated above, the Healthy Connections Works demonstration was approved in December 2019, with implementation anticipated to occur beginning January 1, 2022. Therefore, the community engagement requirement in the Healthy Connections Works demonstration has not been implemented and no penalties have taken effect.

Early Experience from the Implementation of Community Engagement Requirements through Medicaid Section 1115 Demonstrations in Other States

Since the Healthy Connections Works demonstration has not been implemented, there is no direct evidence illustrating how the demonstration would affect the intended beneficiaries of this demonstration. The state did provide in its demonstration application estimates of how many beneficiaries would be impacted by the community engagement requirement.⁹ Specifically, the state estimated that after the first full year of implementation of the community engagement requirement, 16 percent of the state's Medicaid population, i.e., approximately 188,000 beneficiaries, would be subject to a community engagement requirement.¹⁰ However, of those

⁷ CMS. (2019). Healthy Connections Works Section 1115 Demonstration Approval. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-healthy-connections-works-ca.pdf>

⁸ The population requested in the state's application is slightly different than the population approved under the Palmetto Pathways to Independence demonstration. Specifically, the application requested to extend coverage beyond the postpartum period to women who had been eligible for Medicaid based on pregnancy. The approved Targeted Adult Group allows women up to twelve months postpartum to gain eligibility based on their need for SUD treatment, limited to a certain number of beneficiaries.

⁹ South Carolina Department of Health and Human Services. (2019). Section 1115 Demonstration Application. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-community-engagement-pa.pdf>

¹⁰ South Carolina Department of Health and Human Services. (2019). Section 1115 Demonstration Application. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-community-engagement-pa.pdf>

potential and current beneficiaries, the state projected that 168,000 (90 percent) would qualify for an exemption from completing the minimum 80-hours per month (averaged quarterly) of community engagement activities. Of the remaining 20,000 beneficiaries who would be subject to satisfying the community engagement requirement, the state estimated that 70 percent (14,000 individuals) were already working, and projected that 900 individuals would newly engage in a qualifying activity. Therefore, the state estimated that the remaining 5,100 individuals would be unable to access Medicaid coverage and/or would risk suspension from coverage and eventual disenrollment due to non-completion of required hours of qualifying activities by the end of the first year of implementation of the community engagement requirement.¹¹ In addition, the state acknowledged that at least 10 percent of the 20,000 beneficiaries would risk losing coverage due to lack of, or not timely submitting, documentation. As discussed further below, community engagement requirements can cause beneficiaries to lose coverage not only where beneficiaries do not satisfy the required hours of participation or qualify for an exemption, but also because they are not aware of the requirements, do not understand reporting requirements, or are otherwise unable to complete timely reporting, including for qualifying exemptions and good cause exceptions.¹² The Kaiser Family Foundation estimated that with nationwide implementation of a community engagement requirement, 77–83 percent of the total Medicaid disenrollments due to such a requirement would be for non-reporting of qualifying activities or exemptions, with the remainder of the disenrolled beneficiaries losing coverage for not participating in sufficient hours of qualifying activities to meet work or community engagement requirements.¹³ Thus, while the state’s projections of about 2,000 beneficiaries losing coverage due to non-reporting could be conservative, even by these projections, overall at least 7,100 of the 20,000 beneficiaries not initially determined exempt from the community engagement requirement based on information available through eligibility and claims data could potentially lose coverage just in the first year of the demonstration’s implementation.

An independent study from the Georgetown University Health Policy Institute—leveraging the Kaiser Family Foundation estimates of potential nationwide coverage losses resulting from community engagement requirements¹⁴—estimated that between 5,000 and 14,000 South Carolina parents would lose Medicaid coverage as a result of a community engagement requirement in the first year, and total coverage losses could reach up to 26,000 parents in the

¹¹ South Carolina Department of Health and Human Services. (2019). Section 1115 Demonstration Application. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-community-engagement-pa.pdf>

¹² Solomon, J. (2019). Medicaid Work Requirements Can’t Be Fixed: Unintended Consequences are Inevitable Result. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed>

¹³ Garfield, R., Rudowitz, R., & Musumeci, M. (2018). Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses. Kaiser Family Foundation. Retrieved from <https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/>

¹⁴ Garfield, R., Rudowitz, R., & Musumeci, M. (2018). Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses. Kaiser Family Foundation. Retrieved from <https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/>

fifth year of implementation.¹⁵ These estimates only included parents who would be subject to the community engagement requirement. Furthermore, the study projected that the community engagement requirements in South Carolina would disproportionately affect very low-income mothers, Black populations, and those in small towns and rural communities, where families are more likely to have Medicaid coverage and employment is more difficult to find. Specifically, of the parents who would be subject to the state's community engagement requirements, 86 percent are mothers and 51 percent are Black (compared to 28 percent of the statewide population who is Black).¹⁶

Data also suggest that there is a relatively small minority of beneficiaries who could potentially benefit from targeted employment gain with the implementation of the community engagement requirement in South Carolina through the Healthy Connections Works demonstration. Based on estimates from the state,¹⁷ 97 percent of beneficiaries subject to the community engagement requirement in South Carolina already met the requirement or would be exempt from it, so there would be little margin for the program to increase work or community engagement among beneficiaries. In fact, the state estimated that only 900 individuals would newly participate in qualifying community engagement activities.¹⁸ All this is consistent with research indicating more generally that most Medicaid beneficiaries are already working or are likely to be exempt from a potential community engagement requirement.^{19,20,21,22} For example, the study from the Kaiser Family Foundation cited above found that nationally, 81 percent of adults with Medicaid coverage live in families with a working adult, and 6 in 10 are working themselves.²³ Similarly,

¹⁵ Georgetown University Health Policy Institute. (2019). Low-Income Families with Children Will Be Harmed by South Carolina's Proposed Medicaid Work Reporting Requirement. Retrieved from https://ccf.georgetown.edu/wp-content/uploads/2019/01/SC-work-requirement-update_FINAL.pdf

¹⁶ Georgetown University Health Policy Institute. (2019). Low-Income Families with Children Will Be Harmed by South Carolina's Proposed Medicaid Work Reporting Requirement. Retrieved from https://ccf.georgetown.edu/wp-content/uploads/2019/01/SC-work-requirement-update_FINAL.pdf

¹⁷ South Carolina (2019). Section 1115 Demonstration Application. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-community-engagement-pa.pdf>

¹⁸ South Carolina Department of Health and Human Services. (2019). Section 1115 Demonstration Application. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-community-engagement-pa.pdf>

¹⁹ Garfield, R., Rudowitz, R., Guth, M., Orgera, K., & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from <https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/>

²⁰ Huberfeld, N. (2018). Can work be required in the Medicaid program? *N Engl J Med*;378:788-791. DOI: 10.1056/NEJMp1800549

²¹ Goldman, A.L., Woolhandler, S., Himmelstein, D.U., Bor, D.H. & McCormick, D. (2018). Analysis of work requirement exemptions and Medicaid spending. *JAMA Intern Med*, 178:1549-1552. DOI:10.1001/jamainternmed.2018.4194

²² Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center of Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed>

²³ Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from <https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/>

a study published in 2017 found that, out of the 22 million adults covered by Medicaid nationwide who could be subject to a community engagement requirement designed like the one in the Healthy Connections Works demonstration (representing 58 percent of all adults on Medicaid), 50 percent were already working, 14 percent were looking for work, and 36 percent were neither working nor looking for work.²⁴ Of those beneficiaries not working or looking for work, 29 percent indicated that they were caring for a family member, 17 percent were in school, and 33 percent noted that they could not work because of a disability (despite excluding from analysis those qualifying for Medicaid on the basis of disability, highlighting the difficulty with disability determination), with the remainder citing layoff, retirement, or a temporary health problem.

According to research from the Kaiser Family Foundation using the Current Population Survey (CPS) data,²⁵ in South Carolina, 48 percent (63 percent nationally) of Medicaid beneficiaries aged 19 to 64 without Supplemental Security Income (SSI) in 2019 were working. Of those in South Carolina who were not working, 27 percent (32 percent nationally) cited that they were caretaking. Thus, overall, prior to the pandemic, the available data indicated that the substantial majority of the population that would be targeted by a community engagement requirement like in South Carolina's demonstration would be already meeting the terms of such a requirement or would qualify for an exemption from it. This makes it challenging for community engagement requirements to produce any meaningful impact on employment outcomes by incentivizing behavioral changes in a small fraction of beneficiaries, all the while risking substantial coverage losses among those subject to the requirements. This is illustrated pointedly by South Carolina's projection that its community engagement requirement would likely result in only 900 beneficiaries newly participating in the required hours of qualifying community engagement activities, whereas the state projected that at least 7,100 otherwise eligible individuals would be prevented from initially enrolling in, or would be suspended and eventually disenrolled from, coverage.

Some early data on potential enrollment impacts of a community engagement requirement as a condition of Medicaid eligibility are available for Arkansas, Michigan and New Hampshire.^{26,27}

²⁴ Leighton Ku, L & Brantley, E. (2017). Medicaid Work Requirements: Who's At Risk? Health Affairs Blog. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20170412.059575/full/>

²⁵ Garfield, R., Rudowitz, R., Guth, M. Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from <https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/>

²⁶ Utah and Indiana each also briefly implemented a section 1115 community engagement requirement demonstration, but these states did not impose any non-compliance penalties because beneficiaries were not late in meeting their respective reporting requirements. In Indiana, while the state suspended the community engagement requirement in October 2019, a beneficiary could report compliance or exemption status any time until the last day of the calendar year 2019. In Utah, beneficiaries were required to report compliance, or eligibility for a qualifying exemption or a good cause exception, within three months after receiving the notice to comply. Since Utah suspended the requirement right after the third month of its implementation, no beneficiaries experienced a non-compliance penalty for the community engagement requirement.

²⁷ Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC. (2021). Issue Brief No. HP-2021-03, Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence. Retrieved from <https://aspe.hhs.gov/system/files/pdf/265161/medicaid-waiver-evidence-review.pdf>

Experience from these states indicates that large portions of the beneficiaries subject to these states' community engagement requirements failed to comply with the community engagement reporting requirements or became disenrolled once the requirements were implemented. In Arkansas, for instance, before the U.S. District Court for the District of Columbia halted the community engagement requirement, the state reported that from August 2018 through December 2018, more than 18,000 individuals were disenrolled from coverage for "noncompliance with the work requirement."²⁸ During these five months, the monthly rate of coverage loss, as a percentage of those who were required to report work and community engagement activities, fluctuated between 20 and 47 percent.²⁹ In New Hampshire, almost 17,000 beneficiaries (about 40 percent of those subject to the requirement) were set to be suspended for non-compliance with the requirement and lose Medicaid coverage within the span of just over a month when that state's community engagement requirement was in effect.^{30,31,32} Based on those early data, another study projected that between 30 and 45 percent of New Hampshire beneficiaries subject to the community engagement requirement would have been disenrolled within the first year of implementation.³³ And in Michigan, before the policy was vacated by the courts, 80,000 beneficiaries—representing nearly 33 percent of individuals subject to the community engagement requirement—were at risk of loss of coverage for failing to report compliance with the community engagement requirement.³⁴

Notwithstanding state assurances in the demonstration's Special Terms and Conditions that South Carolina would provide the necessary outreach to Medicaid beneficiaries, evidence shows that lack of awareness of and administrative barriers associated with a community engagement requirement can create serious challenges for beneficiaries, which could result in significant

²⁸ Arkansas Department of Human Services (DHS). (2018 & 2019). Arkansas Works Section 1115 Demonstration Annual Reports. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-annl-rpt-jan-dec-2018.pdf>; <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-annl-rpt-jan-dec-2019.pdf>

²⁹ Arkansas Department of Human Services (DHS). (2018). Arkansas Works Section 1115 Demonstration Annual Report: January 1, 2018 – December 31, 2018. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-annl-rpt-jan-dec-2018.pdf>

³⁰ Wagner, J., & Schubel, J. (2020). States' experiences confirming harmful effects of Medicaid work requirements. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements>

³¹ New Hampshire Department of Health and Human Services. (2019). DHHS Community Engagement Report: June 2019. Retrieved from <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf>

³² Hill, I., Burroughs, E., & Adams, G. (2020). New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results. Urban Institute. Retrieved from <https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results>

³³ The Commonwealth Fund Blog. (2019). New Hampshire's Medicaid Work Requirements Could Cause More Than 15,000 to Lose Coverage. Retrieved from <https://www.commonwealthfund.org/blog/2019/new-hampshires-medicaid-work-requirements-could-cause-coverage-loss>

³⁴ Wagner, J., & Schubel, J. (2020). States' Experiences Confirm Harmful Effects of Medicaid Work Requirements. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements>

coverage losses.³⁵ Early experiences in other states implementing their community engagement requirements were characterized by evidence of widespread confusion and lack of awareness among demonstration beneficiaries regarding the requirements.³⁶ For example, many beneficiaries in New Hampshire reportedly did not know about the community engagement reporting requirement or received confusing and often contradictory notices about whether they were subject to the requirement.^{37,38} Moreover, in Arkansas, Michigan, and New Hampshire, evidence suggests that even individuals who were working or those who had serious health needs, and therefore should have been eligible for exemptions, lost coverage or were at risk of losing coverage because of complicated administrative and paperwork requirements.³⁹ Beneficiaries also reported barriers to obtaining exemptions from the community engagement requirement. For example, beneficiaries with physical and behavioral health conditions reported that their providers were resistant to signing forms needed to establish that the beneficiary was unable to work so that the beneficiary could qualify for an exemption.⁴⁰

There is overwhelming evidence that any impediment to coverage, including eligibility suspensions or disenrollments, could be detrimental to the health of beneficiaries. For example, one study found that low-income individuals without insurance coverage were more likely to avoid or delay needed care, which can lead to greater risk of avoidable illnesses or even death.⁴¹ Further, disenrollment and coverage gaps have been associated with increased barriers to care, lower quality care, and greater medical debt among beneficiaries disenrolled from Medicaid, even after their coverage resumed.⁴² Another study using data from Arkansas found that adults ages 30–49 who had lost Medicaid or Marketplace coverage in the prior year experienced

³⁵ Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed>

³⁶ Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC. (2021). Issue Brief No. HP-2021-03, Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence. Retrieved from <https://aspe.hhs.gov/pdf-report/medicaid-demonstrations-and-impacts>.

³⁷ Solomon, D. (2019). Spreading the Word on Medicaid Work Requirement Proves Challenging. Union Leader. Retrieved from https://www.unionleader.com/news/health/spreading-the-word-on-medicaid-work-requirement-proves-challenging/article_740b99e7-9f48-52d4-b2d8-030167e66af8.html

³⁸ Moon, J. (2019). Confusing Letters, Frustrated Members: N.H.'s Medicaid Work Requirement Takes Effect. New Hampshire Public Radio. Retrieved from <https://www.nhpr.org/post/confusing-letters-frustrated-members-nhs-medicaid-work-requirement-takes-effect#stream/0>

³⁹ Wagner, J., & Schubel, J. (2020). States' Experiences Confirm Harmful Effects of Medicaid Work Requirements. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements>

⁴⁰ Hill, I., Burroughs, E., & Adams, G. (2020). New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results. Urban Institute. Retrieved from <https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results>

⁴¹ Ku, L. & Ross, D.C. (2002). Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families. The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_fund_report_2002_dec_staying_covered_the_importance_of_retaining_health_insurance_for_low_income_families_ku_stayingcovered_586.pdf.pdf

⁴² University of Wisconsin-Madison Institute for Research on Poverty. (2019). Evaluation of Wisconsin's BadgerCare Plus Health Coverage for Parents & Caretaker Adults and for Childless Adults 2014 Waiver Provisions. Retrieved from <https://www.irp.wisc.edu/wp/wp-content/uploads/2019/11/BC-2014-Waiver-Provisions-Final-Report-08302019.pdf>

significantly higher medical debt and financial barriers to care, compared to similar Arkansans who maintained coverage.⁴³ Specifically, 50 percent of Arkansans affected by disenrollment in that age group reported serious problems paying off medical bills; 56 percent delayed seeking health care and 64 percent delayed taking medications because of cost considerations.⁴⁴ These rates were all significantly higher than among individuals who retained coverage in Medicaid or Marketplace all year. Evidence also indicates that those with chronic conditions were more likely to lose coverage,⁴⁵ which could lead to worse health outcomes in the future.

In all states, consistent and stable employment is often out of reach for beneficiaries who might be subject to a community engagement requirement. Many low-income beneficiaries face a challenging job market, which often offers only unstable or low-paying jobs with unpredictable or irregular hours, sometimes resulting in spells of unemployment, particularly in seasonal work.^{46,47,48,49} For example, one study found that among Medicaid beneficiaries likely to be subject to a community engagement requirement who did not always work 20 hours per week, about half reported not working or not working more hours for reasons related to the labor market or the nature of their employment, such as difficulty finding work, employer restrictions on their work schedule, employment in temporary positions, or reduced hours because business was slow.⁵⁰ Given the range of labor market and employment barriers facing Medicaid beneficiaries who could be subjected to the community engagement requirement, South

⁴³ Sommers, B.D., Chen, L., Blendon, R.J., Orav, E.J., & Epstein, A.M. (2020). Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. *Health Affairs*, 39(9), 1522-1530. Retrieved from <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00538>

⁴⁴ Sommers, B.D., Chen, L., Blendon, R.J., Orav, E.J., & Epstein, A.M. (2020). Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. *Health Affairs*, 39(9), 1522-1530. Retrieved from <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00538>

⁴⁵ Chen, L. & Sommers, B.D. (2020). Work Requirements and Medicaid Disenrollment in Arkansas, Kentucky, Louisiana, and Texas, 2018. *American Journal of Public Health*, 110, 1208-1210. DOI <https://doi.org/10.2105/AJPH.2020.305697>

⁴⁶ Butcher, K. & Schanzenbach, D. (2018). Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/poverty-and-inequality/most-workers-in-low-wage-labor-market-work-substantial-hours-in>

⁴⁷ Center on Budget and Policy Priorities. (2020). Taking Away Medicaid for Not Meeting Work Requirements Harms Low-Wage Workers. Retrieved from <https://www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-low-wage-workers>

⁴⁸ Gangopadhyaya, A., Johnston, E., Kenney, G. & Zuckerman, S. (2018). Kentucky Medicaid Work Requirements: What Are the Coverage Risks for Working Enrollees? Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/98893/2001948_kentucky-medicaid-work-requirements-what-are-the-coverage-risks-for-working-enrollees.pdf

⁴⁹ New Hampshire Fiscal Policy Institute. (2019). Medicaid Work Requirements and Coverage Losses. Retrieved from <https://nhfpi.org/resource/medicaid-work-requirements-and-coverage-losses/>

⁵⁰ Karpman, M. (2019). Many Adults Targeted by Medicaid Work Requirements Face Barriers to Sustained Employment. The Urban Institute. Retrieved from <http://hrms.urban.org/briefs/hrms-medicaid-work-requirements-2019.pdf>

Carolina's demonstration requirement for satisfying an average of 80 hours per month (averaged quarterly) is a concern even for low-income adults who are working.^{51,52}

To compound the challenges in accessing coverage, the administrative aspect of the requirement can be onerous for beneficiaries.⁵³ In addition to the challenges associated with learning about the community engagement participation requirement; the nuances of the exemptions, good cause exceptions, qualifying activities; and the reporting obligations, the community engagement requirement could be difficult to comply with in terms of documenting employment or exemption status, filling out forms, and understanding and appropriately responding to notices. All of these can potentially limit access to health coverage and care.⁵⁴ Furthermore, such a requirement is likely to aggravate the psychological costs, including the stigma, stress, frustration, anxiety, and loss of autonomy, which can arise from interacting with administratively burdensome public programs, potentially adversely impacting beneficiary health.⁵⁵ Moreover, the mental stress and negative health implications of administratively burdensome programs may be more pronounced among beneficiary populations of racial minorities.⁵⁶

Furthermore, research examining the outcomes of statutorily authorized work requirements in other public assistance programs, such as TANF and SNAP, indicates that such requirements generally have only modest and temporary effects on employment, failing to increase long-term employment or reduce poverty.^{57,58,59,60} Additionally, studies have found that imposing work requirements in the SNAP program led to substantial reductions in enrollment, even after

⁵¹ Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center of Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed>

⁵² Aron-Dine, A., Chaudhry, R. & Broaddus, M. (2018). Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements. Retrieved from <https://www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements>

⁵³ Herd P. & Moynihan, D. (2020). How Administrative Burdens Can Harm Health. Health Affairs: Health Policy Brief. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hpb20200904.405159/full/>

⁵⁴ Herd P. & Moynihan, D. (2020). How Administrative Burdens Can Harm Health. Health Affairs: Health Policy Brief. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hpb20200904.405159/full/>

⁵⁵ Herd P. & Moynihan, D. (2020). How Administrative Burdens Can Harm Health. Health Affairs: Health Policy Brief. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hpb20200904.405159/full/>

⁵⁶ Schram, S., Soss, J., Fording, R., & Houser, L. (2009). Deciding to Discipline: Race, Choice, and Punishment at the Frontlines of Welfare Reform. *American Sociological Review*, 74(3): 398-422. Retrieved from <https://journals.sagepub.com/doi/pdf/10.1177/000312240907400304>

⁵⁷ Katch, H., Wagner, J. & Aron-Dine, A. (2018). 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. Retrieved from <https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce>

⁵⁸ Danziger, S.K., Danziger, S., Seefeldt, K.S. & Shaefer, H.L. (2016). From Welfare to a Work-Based Safety Net: An Incomplete Transition. *Journal of Policy Analysis & Management*, 35(1), 231-238. DOI: <https://doi.org/10.1002/pam.21880>

⁵⁹ Pavetti, L. (2016). Work Requirements Don't Cut Poverty, Evidence Shows. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows>

⁶⁰ Gray, C., Leive, A., Prager, E., Pukelis, K.B. & Zaki, M. (2021). Employed in a SNAP? The Impact of Work Requirements on Program Participation and Labor Supply. National Bureau of Economic Research, Working Paper 28877. Retrieved from <https://www.nber.org/papers/w28877>

controlling for changes in unemployment and poverty levels.⁶¹ In fact, evidence suggests that there were large and rapid caseload losses in selected areas after SNAP work requirements went into effect, similar to what early data from Arkansas show, and what appeared likely to happen in New Hampshire and Michigan, had those states' community engagement requirements been implemented long enough to begin suspending or disenrolling beneficiaries.

Therefore, existing evidence from states that have implemented community engagement requirements through Medicaid demonstrations, evidence from other public programs with work requirements, and the overall work patterns and job market opportunities for the low-income adults who would be subject to such requirements all highlight the potential ineffectiveness of community engagement requirements at impacting employment outcomes for the target population. And while there are variations in the design and implementation of community engagement requirements in each state that has implemented such a requirement, as well as differences in employment and economic opportunities, findings from the states that implemented community engagement requirements point in the general direction of challenges with beneficiary outreach efforts to ensure understanding of program requirements, various hurdles in complying with reporting requirements, and subsequent coverage losses among individuals subject to such requirements.

As further described later, CMS does not expect that the community engagement requirement as a condition of initial and eligibility in the Healthy Connections Works demonstration would have a different outcome than what was observed during the initial implementation of such a requirement in other states. In effect, the narrow pool of beneficiaries who could be potentially targeted by the demonstration, and the inherent complexity and resulting adverse effects of executing a program like community engagement requirement make it challenging to realize the state's goals of the program. Furthermore, there is irrefutable risk that South Carolina's Healthy Connections Works community engagement requirement will lead to substantial coverage losses, a risk that is exacerbated by the ongoing COVID-19 public health emergency and its likely aftermath.

Impact of COVID-19 and its Aftermath

The COVID-19 pandemic and the uncertainty surrounding the long-term effects on economic activity and opportunities across the nation exacerbate the risks associated with tying a community engagement requirement to Medicaid eligibility, making the Healthy Connections Works community engagement requirement infeasible under the current circumstances. These COVID-related complications may be exacerbated in South Carolina, where COVID-19 rates and deaths remain higher than the national average⁶² and vaccination rates are slightly lower than

⁶¹ Ku, L., Brantley, E. & Pillai, D. (2019). The Effects of SNAP Work Requirements in Reducing Participation and Benefits From 2013 to 2017. *American Journal of Public Health* 109(10), 1446-1451. DOI: <https://doi.org/10.2105/AJPH.2019.305232>. Retrieved from <https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305232>

⁶² Worldometer. (2021). United States Coronavirus Cases. Retrieved on June 16, 2021 from <https://www.worldometers.info/coronavirus/country/us/>

the national average.⁶³ There is a substantial risk that the COVID-19 pandemic and its aftermath will have a negative impact on economic opportunities for Medicaid beneficiaries. If employment opportunities are limited, Medicaid beneficiaries may find it difficult to obtain paid work in the aftermath of the pandemic.^{64,65}

As discussed above, prior to the pandemic, most adult Medicaid beneficiaries who did not face a barrier to work were already working full or part-time.⁶⁶ However, one in three working adult Medicaid beneficiaries was doing only part-time work prior to the COVID-19 public health emergency, often due to fewer opportunities for full-time employment. The pandemic is expected to exacerbate the challenges of finding not only full-time employment, but may create additional obstacles to securing even part-time work, due to shifting caregiving responsibilities and increased transportation barriers.⁶⁷

During the pandemic, the different sectors of the economy have seen disparate levels of disruption, which has affected labor market outcomes for certain populations more than the others. While the national employment rate⁶⁸ declined by 2.1 percent from January 2020 to May 2021, employment rates for workers in the bottom wage quartile decreased by 21.4 percent while employment rates for workers in the highest wage quartile increased 7.4 percent across that time period.⁶⁹ In South Carolina, employment rates for low-wage earners (i.e., annual wages under \$27,000) decreased by 11.9 percent, compared to a 19.8-percent increase in employment rates for high-wage earners (i.e., wages over \$60,000 per year) from January 2020 to May 2021.⁷⁰

Further, declines in employment have been much higher for Black and Hispanic women and for workers in several low-wage service sectors, such as hospitality and leisure, while workers in

⁶³ The Mayo Clinic. (2021). U.S. COVID-19 vaccine tracker: See your state's progress. Retrieved on June 16, 2021 from <https://www.mayoclinic.org/coronavirus-covid-19/vaccine-tracker>

⁶⁴ Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from <https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/>

⁶⁵ Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

⁶⁶ Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from <https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/>

⁶⁷ Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from <https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/>

⁶⁸ Not seasonally adjusted.

⁶⁹ Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved on July 8, 2021 from www.tracktherecovery.org

⁷⁰ Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved on July 8, 2021 from www.tracktherecovery.org

other sectors, such as financial services, have seen virtually no change.⁷¹ In April 2020, the estimated unemployment rates (including individuals who were employed but absent from work and those not in the workforce but who wanted employment) for the Black and Hispanic populations were as high as 32 and 31 percent, respectively, compared to 24 percent for the White population.⁷² Hispanic populations specifically are more likely to be affected due to their disproportionate representation in industries such as hospitality and construction, which have been most affected by the pandemic-related layoffs.^{73,74,75}

Moreover, pandemic-related national job and income losses have also been more acute among the low-income population—those with the least wherewithal to withstand economic shocks, and who are disproportionately enrolled in Medicaid.⁷⁶ In fact, 52 percent of lower income (annual income below \$37,500) adults nationwide live in households where someone has lost a job or taken a pay cut due to the pandemic.⁷⁷ Understandably, households with a job or income loss were two-to-three times more likely to experience economic hardship than those who did not experience such a loss.^{78,79} Fifty-nine percent of lower-income adults in the country said they worry every day or almost every day about paying their bills.⁸⁰ There are also racial and ethnic disparities in the likelihood of reporting hardships; for example, compared to White households, Black households reported significantly higher chances of putting off filling prescriptions and

⁷¹ Rouse, C. (2021). The Employment Situation in February. The White House Briefing Room. Retrieved from <https://www.whitehouse.gov/briefing-room/blog/2021/03/05/the-employment-situation-in-february/>

⁷² Fairlie, R., Couch, K. & Xu, H. (2020). The Impacts of COVID-19 on Minority Unemployment: First Evidence from April 2020 CPS Microdata. National Bureau of Economic Research. Retrieved from https://www.nber.org/system/files/working_papers/w27246/w27246.pdf

⁷³ Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from <https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/>

⁷⁴ Industries like health care and transportation have been less affected by the pandemic, and that has provided some cushion for Black workers. See Despard et al. (2020).

⁷⁵ Krogstad, J.M., Gonzalez-Barrera, A. & Noe-Bustamante, L. (2020). U.S. Latinos among hardest hit by pay cuts, job losses due to coronavirus. Pew Research Center. Retrieved from <https://www.pewresearch.org/fact-tank/2020/04/03/u-s-latinos-among-hardest-hit-by-pay-cuts-job-losses-due-to-coronavirus/>

⁷⁶ Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from <https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/>

⁷⁷ Parker, K., Horowitz, J.M., & Brown, A. (2020). About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19. Pew Research Center. Retrieved from <https://www.pewresearch.org/social-trends/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/>

⁷⁸ Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from <https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/>

⁷⁹ Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

⁸⁰ Parker, K., Horowitz, J.M., & Brown, A. (2020). About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19. Pew Research Center. Retrieved from <https://www.pewresearch.org/social-trends/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/>

difficulties making housing and other bill payments. Also, Hispanic households were more likely to experience food insecurity compared to White households.^{81,82}

Existing disparities in access to computers and reliable internet may also exacerbate issues in finding and maintaining employment during the pandemic. For example, 29 percent of adults in households with annual incomes below \$30,000 did not own a smartphone, and 44 percent did not have home broadband services in 2019.⁸³ Moreover, fewer than 8 percent of Americans with earnings below the 25th percentile have the capabilities to work remotely.⁸⁴ In South Carolina, there is an unequal distribution of the availability in latest internet technologies, as not all residents have equal access to high-speed, affordable internet, and 171,000 individuals had no access to a wired connection as of April 2021.⁸⁵ These disparities will result in fewer opportunities for beneficiaries to satisfy a community engagement requirement, particularly as more jobs have shifted to telework or “work from home” during the public health emergency. Therefore, implementation of the community engagement requirement approved in this demonstration increases the risk of coverage loss for these low-income individuals.^{86,87}

In addition to the challenges that the COVID-19 pandemic has presented for the labor market, it likely has also exacerbated the difficulty of participating in community or public service and volunteering activities that beneficiaries could use to meet the community engagement requirement instead of (or in combination with) paid work.⁸⁸ Many community or public service opportunities require individuals to help in-person, and oftentimes these activities involve working with the elderly, individuals with disabilities, or other vulnerable populations. Social distancing requirements, restrictions on visiting elderly individuals, and limited access to physical locations where many such activities take place, all have potentially either reduced the

⁸¹ Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from <https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/>

⁸² Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

⁸³ Anderson, M. & Kumar, M. (2019). Digital Divide Persists Even as Lower-Income Americans Make Gains in Tech Adoption. Pew Research Center. Retrieved from <https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/>

⁸⁴ Maani, N., Galea, S. (2020). COVID-19 and Underinvestment in the Health of the US Population. The Milbank Quarterly. Retrieved from <https://www.milbank.org/quarterly/articles/covid-19-and-underinvestment-in-the-health-of-the-us-population/>

⁸⁵ BroadBand Now. (2021). Internet Service in South Carolina. Retrieved on June 24, 2021 from <https://broadbandnow.com/South-Carolina>

⁸⁶ Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from <https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/>

⁸⁷ Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

⁸⁸ Fidelity Charitable. (2020). The Role of Volunteering in Philanthropy. Retrieved from <https://www.fidelitycharitable.org/content/dam/fc-public/docs/resources/the-role-of-volunteering-in-philanthropy.pdf>

number of available community or public service opportunities or made engaging in community or public service more challenging.

The pandemic also has disproportionately impacted the physical and mental health of racial and ethnic minority groups, who already experience disparities in health outcomes. Racial minorities and people living in low-income households are more likely to work in industries that are considered “essential services,” which have remained open during the pandemic.⁸⁹ Additionally, occupations with more frequent exposure to COVID-19 infections, and that require close proximity to others (such as personal care aides and bus drivers) employ Black individuals at higher rates than White individuals.⁹⁰ As a result, Black people may be at higher risk of contracting COVID-19 through their employment. The pandemic’s mental health impact also has been pronounced among populations experiencing disproportionately high rates of COVID-19 cases and deaths. Specifically, Black and Hispanic adults have been more likely than White adults to report symptoms of anxiety and/or depressive disorder during the pandemic.⁹¹

Further a recent study found that low-wage work is associated with the spread of COVID-19.⁹² Therefore, low-wage workers, such as those who would be subject to the community engagement requirement, are potentially at higher risk of COVID-19 morbidity and mortality, particularly since low-wage workers also have higher prevalence of preexisting conditions like diabetes, asthma, and heart disease, which can increase the likelihood of serious illness from COVID-19.⁹³ Additionally, those infected may continue to experience prolonged adverse health effects, since according to recent research, as many as 30 percent of COVID-19 survivors still experience symptoms at least six months after their infections.^{94,95}

⁸⁹ Raifman, M.A., & Raifman, J.R. (2020). Disparities in the Population at Risk of Severe Illness From COVID-19 by Race/Ethnicity and Income. *American Journal of Preventive Medicine*, 59(1), 137–139.

<https://doi.org/10.1016/j.amepre.2020.04.003>

⁹⁰ Hawkins, D. (2020). Differential Occupational Risk for COVID-19 and Other Infection Exposure According to Race and Ethnicity. *American Journal of Industrial Medicine*, 63(9):817-820. Retrieved from

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7323065/>

⁹¹ Panchal, N., Kamal, R., Cox, C. & Garfield, R. (2021). The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation. Retrieved from <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>

⁹² Padilla, A. & Orozco, E. (2020). Hidden Threat: California COVID-19 Surges and Worker Distress. Community and Labor Center at the University of California Merced. Retrieved from

<https://news.ucmerced.edu/news/2020/low-wage-work-linked-spread-covid-19-study-finds>

⁹³ 165 Koma, W., Artiga, S., Neuman, T., Claxton, G., Rae, M., Kates, J. & Michaud, J. (2020). Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus. Kaiser Family Foundation. Retrieved from <https://www.kff.org/coronavirus-covid-19/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/>

⁹⁴ Logue, J.K., Franko, N.M., McCulloch, D.J., McDonald, D., Magedson, A. Wolf, C.R. & Chu, H.Y. (2021). Sequelae in Adults at 6 Months After COVID-19 Infection. *JAMA Network*;4(2).

doi:10.1001/jamanetworkopen.2021.0830. Retrieved from

<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776560>

⁹⁵ del Rio C., Collins L.F. & Malani P. (2020). Long-term Health Consequences of COVID-19. *JAMA*, 324(17):1723–1724. doi:10.1001/jama.2020.19719. retrieved from

<https://jamanetwork.com/journals/jama/fullarticle/2771581>

Since the start of the pandemic, individuals have delayed or postponed seeking care, either due to concerns with out-of-pocket expenses or to avoid risk of contact with infected individuals in health care settings. For example, one study showed that screenings for breast, colon, prostate, and lung cancers were between 56 and 85 percent lower in April 2020 than in the previous year.⁹⁶ Results of another survey-based study show that 40 percent of respondents canceled upcoming health care appointments due to the pandemic, and another 12 percent reported they needed care but did not schedule or receive services.⁹⁷ These unmet health care needs may lead to substantial increases in subsequent mortality and morbidity.⁹⁸ With the estimated calendar year 2020 age-adjusted death rates increasing for the first time since 2017,^{99,100} evidence also shows that Black, American Indian, and Hispanic individuals disproportionately experienced higher COVID-19-related mortality rates and deaths at younger ages than White individuals.¹⁰¹ In addition to the health and mortality consequences associated with delaying care, pandemic-related delays in seeking care are estimated to increase annual health care costs nationwide by a range of \$30 to \$65 billion.¹⁰²

The impact of the COVID-19 public health emergency on the economy has been significant, and, importantly, experience with previous recessions suggests the impact is likely to persist for an extended period of time. The unemployment rate went up from 3.5 percent in February 2020, prior to when the pandemic hit, to 14.8 percent in April 2020, and has subsequently fallen to 5.8 percent in May 2021.¹⁰³ The labor force participation rate (i.e., the percentage of the civilian non-institutional population age 16 or older who are working or actively seeking work during the prior month) likewise dipped from 63.3 percent in February 2020 to 60.2 percent in April 2020

⁹⁶ Patt, D., Gordan, L., Diaz, M., Okon, T., Grady, L., Harmison, M., Markward, N., Sullivan, M., Peng, J., Zhau, A. (2020). Impact of COVID-19 on Cancer Care: How the Pandemic Is Delaying Cancer Diagnosis and Treatment for American Seniors. *JCO Clinical Cancer Informatics*, 4, 1059-1071. DOI: 10.1200/CCI.20.00134. Retrieved from <https://ascopubs.org/doi/full/10.1200/CCI.20.00134>

⁹⁷ McKinsey & Company (2020). Understanding the Hidden Costs of COVID-19's Potential on U.S. Healthcare. Retrieved from <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/understanding-the-hidden-costs-of-covid-19s-potential-impact-on-us-healthcare#>

⁹⁸ Chen, J. & McGeorge, R. (2020). Spillover Effects Of The COVID-19 Pandemic Could Drive Long-Term Health Consequences For Non-COVID-19 Patients. *Health Affairs Blog*, DOI: 10.1377/hblog20201020.566558. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20201020.566558/full/>

⁹⁹ During January–December 2020, the estimated 2020 age-adjusted death rate increased for the first time since 2017, with an increase of 15.9 percent compared with 2019, with 113.5 more deaths per 100,000 population (from 715.2 in 2019 to 828.7 in 2020). COVID-19 was the underlying or a contributing cause of 377,883 deaths (91.5 deaths per 100,000). See Ahmad F.B. et al. (2021).

¹⁰⁰ Ahmad F.B., Cisewski J.A., Miniño A. & Anderson R.N. (2021). Provisional Mortality Data — United States, 2020. *MMWR and Morbidity and Mortality Weekly Report* 2021;70:519–522. DOI: <http://dx.doi.org/10.15585/mmwr.mm7014e1>

¹⁰¹ Alsan, M., Chandra, A. & Simon, K. (2021). The Great Unequalizer: Initial Health Effects of COVID-19 in the United States. National Bureau of Economic Research. Retrieved from <http://www.nber.org/papers/w28958>

¹⁰² McKinsey & Company (2020). Understanding the Hidden Costs of COVID-19's Potential on U.S. Healthcare. Retrieved from <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/understanding-the-hidden-costs-of-covid-19s-potential-impact-on-us-healthcare#>

¹⁰³ U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from <https://www.bls.gov/cps/>

only to recover somewhat to 61.6 percent in May 2021.^{104,105} Compared to pre-pandemic conditions, these data suggest that the labor force is still down in May 2021 by approximately 3.6 million individuals.^{106,107} State-level data for these labor market indicators are available most recently for March 2021, and in South Carolina, the unemployment rate increased from 2.6 percent to 5.1 percent from January 2020 to March 2021, while the labor force in the state is still 36,742 individuals less over the same period.¹⁰⁸

Evidence shows that losing a job can have significant long-term effects on an individual's future earnings. Studies have found that workers who lose their jobs in mass layoffs still earn 20 percent less than similar workers who kept their jobs, 15 to 20 years after the layoff, and the impacts are greater for individuals who lose their jobs during a recession. On average, men lost 2.8 years of pre-layoff earnings when the mass layoff occurred in a time when the unemployment rate was above eight percent.¹⁰⁹ Further, workers who enter the labor market during a recession also face long-term consequences for their earnings.¹¹⁰ Additionally, non-White individuals and individuals with lower educational attainment have experienced larger and more persistent earning losses than other groups who enter the labor market during recessions.¹¹¹

¹⁰⁴ The numerator of the labor force participation rate, i.e., the total labor force, consists of those employed and unemployed, where the unemployed are individuals without a job but actively looking for work during the past month. The labor force does not include individuals who would like to and are available for work but may have given up looking for work altogether (known as discouraged workers, or more broadly as, marginally attached workers), usually because they believe that there are no jobs available for them or there are none for which they would qualify. Recessions, such as the one that resulted as a consequence of the COVID-19 pandemic, often lead to a sharp rise in the number of discouraged workers, and therefore, the size of the labor force shrinks resulting in a sharp decline in labor force participation rates. These individuals who leave the labor force *discouraged* are not represented either in the employment or unemployment rates. Therefore, in addition to the employment and unemployment rates, the labor force participation rate is another important measure of the labor market, particularly during times of economic shocks. For more information, for example, see: <https://fred.stlouisfed.org/series/LNU05026645>, <https://www.bls.gov/charts/employment-situation/civilian-labor-force-participation-rate.htm>, and <https://www.bls.gov/opub/btn/archive/ranks-of-discouraged-workers-and-others-marginally-attached-to-the-labor-force-rise-during-recession.pdf>.

¹⁰⁵ U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from <https://www.bls.gov/cps/> and <https://www.bls.gov/charts/employment-situation/civilian-labor-force-participation-rate.htm>

¹⁰⁶ For May 2021 seasonally adjusted labor force data, see: U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved on June 10, 2021 from <https://www.bls.gov/web/empsit/cpseea08b.pdf>

¹⁰⁷ For February 2020 seasonally adjusted labor force data, see: U.S. Bureau of Labor Statistics. (March, 2020). The Employment Situation – February 2020. News Release.

Table A-1. Retrieved from https://www.bls.gov/news.release/archives/empsit_03062020.pdf

¹⁰⁸ U.S. Bureau of Labor Statistics. Databases, Tables & Calculators by Subject. Retrieved on June 23, 2021 from https://data.bls.gov/timeseries/LASST4500000000000006?amp%253bdata_tool=XGtable&output_view=data&include_graphs=true

¹⁰⁹ Davis, S.J. & von Wachter, T. (2011). Recessions and the Costs of Job Loss. Brookings Papers on Economic Activity. Retrieved from https://www.brookings.edu/wp-content/uploads/2011/09/2011b_bpea_davis.pdf

¹¹⁰ Schwandt, H. & von Wachter, T.M. (2018). Unlucky Cohorts: Estimating the Long-term Effects of Entering the Labor Market in a Recession in Large Cross-sectional Data Sets. NBER Working Paper 25141. Retrieved from <https://www.nber.org/papers/w25141>

¹¹¹ Schwandt, H. & von Wachter, T.M. (2018). Unlucky Cohorts: Estimating the Long-term Effects of Entering the Labor Market in a Recession in Large Cross-sectional Data Sets. NBER Working Paper 25141. Retrieved from <https://www.nber.org/papers/w25141>

Layoffs can also impact an individual's mortality and morbidity risks.¹¹² For example, one study found that male workers experienced mortality rates that were 50-100 percent higher than expected in the year after a layoff occurred, and 20 years later, mortality rates remained 10-15 percent higher for these individuals.¹¹³ Furthermore, workers experiencing layoff have reductions in health care utilization, especially among those who lose coverage, which suggests that access to coverage, and continuity of care, could be important in alleviating the long-term ill effects of layoffs on mortality.¹¹⁴

In summary, the short-to-long-term adverse implications of the COVID-19 pandemic on the economic opportunities for Medicaid beneficiaries, which have been aggravated further by challenges around shifting childcare and caregiving responsibilities as well as constraints on public transportation during the pandemic, heightens the risks of attaching a community engagement requirement to eligibility for coverage. In addition, the uncertainty regarding the lingering health complications of COVID-19 infections exacerbates the risk of potential coverage losses for Medicaid beneficiaries. The likely ramifications of losing timely access to necessary health care also can be long lasting. As such, CMS believes that the potential for coverage loss among Medicaid beneficiaries—especially from a requirement that is difficult for beneficiaries to understand and administratively complex for states to implement—would be particularly harmful in the aftermath of the pandemic, and makes the community engagement requirement under the Healthy Connections Works demonstration impracticable.

Evidence Submitted by South Carolina

On March 11, 2021, South Carolina submitted a response to CMS's letter of February 12, 2021. As noted above, the February 12, 2021 letter informed South Carolina that CMS preliminarily determined that allowing the community engagement requirement under the Healthy Connections Works demonstration to take effect in South Carolina would not promote the objectives of the Medicaid program. The February 12, 2021 letter explained that the potential impact of the COVID-19 public health emergency on economic opportunities, as well as on access to transportation and affordable child care, has increased the risk that South Carolina's Healthy Connections Works community engagement requirement would result in significant coverage losses at a time when losing access to health care coverage would cause substantial harm to beneficiaries.

South Carolina's response does not resolve the concerns we raised in the February 12, 2021 letter. In its response, the state noted that "incentivizing those who are able to contribute to their

¹¹² Banks, J., Karjalainen, H. & Propper, C. (2020). Recessions and Health: The Long-Term Health Consequences of Responses to the Coronavirus. *Journal of Applied Public Economics*. DOI: 10.1111/1475-5890.12230. Retrieved from <https://onlinelibrary.wiley.com/doi/full/10.1111/1475-5890.12230>

¹¹³ Sullivan, D. & von Wachter, T. (2009). Job Displacement and Mortality: An Analysis Using Administrative Data. *Quarterly Journal of Economics*. Retrieved from http://www.econ.ucla.edu/tvwachter/papers/sullivan_vonwachter_qje.pdf

¹¹⁴ Schaller, J., Stevens, A. (2015). Short-Run Effects of Job Loss on Health Conditions, Health Insurance, and Health Care Utilization. *Journal of Health Economics*, 43, 190-203. DOI: 0.1016/j.jhealeco.2015.07.003. Retrieved from <https://www.sciencedirect.com/science/article/pii/S0167629615000788>

community by participating in a wide variety of activities of their own choosing ... will improve beneficiary health outcomes, increase the financial independence of beneficiaries and strengthen communities across the state.”¹¹⁵ However, there is no evidence offered by the state establishing that the Healthy Connections Works community engagement requirement is likely to lead to greater economic well-being and financial independence, or better health outcomes. There is overwhelming evidence that individuals must be healthy to work, and consistent access to health coverage is vital to being healthy enough to work.^{116,117,118,119} In contrast, there is no evidence of a causal effect of employment on health outcomes, particularly for the population likely to be subject to the community engagement requirement.

In addition, the challenge of finding full-time or even part-time employment has likely become further complicated due to a lack of affordable child care that has only compounded during the pandemic in all states.¹²⁰ Parents and caretaker relatives in South Carolina’s Medicaid population—one of the primary target populations of the Healthy Connections Works demonstration—in particular, may continue to experience substantial obstacles to meeting the community engagement requirement due to shortages in affordable child care centers in the state. A survey from late-2020 found that nearly half of child care centers surveyed had reduced the number of children served to allow for distancing.¹²¹ The study identified staffing challenges, including difficulty hiring new staff, issuing temporary layoffs, or having staff miss work due to COVID-19 exposure.¹²² According to an interactive cost calculator, the costs of center-based child care in the state were estimated to have increased by 13 percent during the pandemic

¹¹⁵ Healthy Connections Medicaid. (2021). Letter Re: Feb, 12, 2021, Healthy Connections Works and Palmetto Pathways to Independence Letters. Retrieved from <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/sc-cms-ltr-from-state-03112021.pdf>

¹¹⁶ Gehr, J. & Wikle, S. (2017). The Evidence Builds: Access to Medicaid Helps People Work. CLASP. Retrieved from <https://www.clasp.org/sites/default/files/publications/2017/04/The-Evidence-Builds-Access-to-Medicaid-Helps-People-Work.pdf>

¹¹⁷ Tipimene R., Ayanian J., Kullgren J., Goold S., Kieffer E., Chang T., Haggins A., Clark S. & Lee S. (2017). Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches. The Institute for Healthcare Policy and Innovation (IHPI). Retrieved from <https://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches>

¹¹⁸ Musumeci M., Rudowitz R. & Lyons B. (2018). Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees. Kaiser Family Foundation. Retrieved from <https://www.kff.org/report-section/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees-issue-brief/>

¹¹⁹ The Ohio Department of Medicaid. (2018). 2018 Ohio Medicaid Group VIII Assessment: A Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment. Retrieved from <https://www.medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf> . Beneficiaries participating in substance use disorder treatment are exempt from the community engagement requirement.

¹²⁰ McGrath, J. (2021). Child Care in Crisis. Third Way. Retrieved from <https://www.thirdway.org/memo/child-care-in-crisis#:~:text=Child%20care%20in%20America%20was,now%20it's%20a%20deep%20crisis.&text=Thirty%2Dfive%20states%20are%20seeing,tune%20of%201.2%20million%20workers>

¹²¹ Carolan, M. (2021). Child Care Staffing a Major Challenge in South Carolina as Providers Do More with Less. Institute for Child Success. Retrieved from <https://www.instituteforchildsuccess.org/child-care-staffing-major-challenge-in-south-carolina/>

¹²² Carolan, M. (2021). Child Care Staffing a Major Challenge in South Carolina as Providers Do More with Less. Institute for Child Success. Retrieved from <https://www.instituteforchildsuccess.org/child-care-staffing-major-challenge-in-south-carolina/>

compared to the pre-pandemic scenario.^{123,124} Additionally, caregivers across the United States have experienced intensified caregiving responsibilities both in terms of the types of care provided and hours spent in caregiving during the pandemic, all of which can affect the physical and mental health of caregivers.¹²⁵ Research has also shown that women in front-line roles in health care and service industries (e.g., grocery store clerks), where telecommuting is not an option, faced difficult decisions choosing between paid employment and caring for children due to the closure of child care centers and schools.¹²⁶ These increased barriers in accessing affordable child care could make it unreasonably difficult for beneficiaries to meet the community engagement requirement.

Research on potential beneficiary coverage loss from community engagement requirements indicates that most of those losing coverage would be individuals who are already working or should be exempt, but who would lose coverage because of challenges around beneficiary understanding and policy awareness as well as the increased administrative and reporting challenges inherent in community engagement requirements.^{127,128,129} The Kaiser Family Foundation, for example, estimated that if community engagement requirements were to be implemented nationwide, coverage loss due to non-reporting of qualifying activities or exemptions would account for 77-83 percent of total Medicaid disenrollments due to such a requirement, with the rest potentially attributable to actually not participating in sufficient hours of qualifying activities to meet work or community engagement requirements.¹³⁰ The challenges of successfully reporting compliance with community engagement requirements estimated and observed in other states that led to coverage losses could also lead to large numbers of low-income South Carolinians losing coverage. The coverage losses for Healthy Connections Works beneficiaries possibly could be by a much larger magnitude than that projected by the state itself,

¹²³ Choi, A. (2021). How Much Child Care Went Up in Your State. Politico Nightly. Retrieved from <https://www.politico.com/newsletters/politico-nightly/2021/05/26/how-much-child-care-went-up-in-your-state-493017>

¹²⁴ Workman, S. & Brady, M. (2020). The Cost of Child Care During the Coronavirus Pandemic. Center for American Progress. Retrieved from <https://www.americanprogress.org/issues/early-childhood/news/2020/09/03/489962/cost-child-care-coronavirus-pandemic/>

¹²⁵ Cohen, S., Kunicki, Z., Drohan, M. & Greaney, M. (2021). Exploring Changes in Caregiver Burden and Caregiving Intensity due to COVID-19. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7919204/>

¹²⁶ Raile, A., Raile, E., Parker, D., Shanahan, E., Haines, P. (2020). Women and the Weight of the Pandemic: A Survey of Four Western US States Early in the Coronavirus Outbreak. Feminist Frontiers.

<https://doi.org/10.1111/gwao.12590>. Retrieved from <https://onlinelibrary.wiley.com/doi/full/10.1111/gwao.12590#gwao12590-bib-0001>

¹²⁷ Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed>

¹²⁸ Wagner, J., & Schubel, J. (2020). States' experiences confirming harmful effects of Medicaid work requirements. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements>

¹²⁹ Garfield, R., Rudowitz, R., & Musumeci, M. (2018). Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses. Kaiser Family Foundation. Retrieved from <https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/>

¹³⁰ Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed>

where the state estimated that 10 percent of the 20,000 beneficiaries who would not be determined exempt based on eligibility and claims information would lose coverage “due to lack of documentation.”¹³¹ Furthermore, there have been pronounced job losses in the state’s public and social benefit nonprofit sector during the pandemic, with a 20.6 percent decrease in full-time employees from March 2020 to March 2021.¹³² This loss in public and social benefit employees could further complicate staffing and other resources available to help beneficiaries apply for and maintain coverage through required reporting of community engagement activities.

While beneficiaries in the Healthy Connections Works demonstration who would meet the requirement through subsidized or unsubsidized employment at application or redetermination would not have to report hours again until it is time for their next annual redetermination, beneficiaries completing other qualifying community engagement activities would be required to report their hours once every 90 days, including if they would meet the requirement through employment at some point after enrollment.¹³³ However, evidence shows that a community engagement requirement can create barriers to coverage not only when current and potential beneficiaries do not satisfy the required hours of participation or qualify for an exemption, but also because they are not aware of the requirement, do not understand the reporting requirements or are otherwise unable to complete timely reporting, including for qualifying exemptions and good cause exceptions.¹³⁴ There is also evidence that such reporting requirements could be burdensome for beneficiaries, who might find it difficult to report work hours due to documentation requirements, such as paystubs and timesheets, possibly from multiple employers, and other bureaucratic hurdles.^{135,136} This would be more challenging for individuals who are self-employed and therefore might not have such documentation readily available.¹³⁷ Furthermore, with increased administrative requirements, and burdens on the state agency, it is

¹³¹ South Carolina Department of Health and Human Services. (2019). Section 1115 Demonstration Application. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-community-engagement-pa.pdf>

¹³² Kahle, R.W. & Roderick, G. (2021). Nonprofit COVID-19 Impact Survey: Top-Line Report. Kahle Strategic Insights. Retrieved from https://assets.noviams.com/novi-file-uploads/tsc/pdfs-and-documents/TSC_Nonprofit_COVID_Impact_March_19_.pdf

¹³³ Per the Special Terms and Conditions, exempt beneficiaries will not be required to regularly report that they continue to be exempt, although they may be required to report whether they qualify for an exemption at eligibility redetermination and will be required to report consistent with 42 CFR 435.916(c) if they experience a change in circumstance that makes them no longer eligible for an exemption.

¹³⁴ Solomon, J. (2019). Medicaid Work Requirements Can’t Be Fixed: Unintended Consequences are Inevitable Result. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed>

¹³⁵ Katch, H., Wagner, J. & Aron-Dine, A. (2018). 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. Retrieved from <https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce>

¹³⁶ Hahn, H., Sullivan, L., Tran, V., Blount, D. & Waxman, E. (2019). SNAP Work Requirements in Arkansas for Adults without Dependents or Disabilities. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101112/snap_work_requirements_in_arkansas_for_adults_with_out_dependents_or_disabilities_5.pdf

¹³⁷ Katch, H., Wagner, J. & Aron-Dine, A. (2018). 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. Retrieved from <https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce>

possible that a backlog in processing paperwork could develop and result in delays or mistakes affecting coverage of individuals subject to the community engagement requirement.¹³⁸

Further, there remains significant uncertainty about the pandemic's aftermath in terms of its lingering economic and health impacts, especially in the context of the newer and more transmissible variants of COVID-19. The state indicated that it would include exemptions for individuals residing in regions that experience an unemployment rate of eight percent or greater, and that only one county was above that threshold at the time of the March 11, 2021 letter. By the state's own estimates, the demonstration was estimated to target only a small percentage of the state's population because the vast majority of beneficiaries subject to the community engagement requirement were already working or would have qualified for an exemption.¹³⁹

While qualifying exemptions are important in the design of the community engagement requirement, they also limit the number of beneficiaries who might newly engage in qualifying activities, including employment, as a result of the requirement. This further underscores one of CMS's main points – that this demonstration, if implemented, has the potential only to influence the behavior of a very small number of individuals, while risking coverage loss for many.

The state has not presented information to suggest that withholding safety net benefits, such as Medicaid coverage, from otherwise eligible beneficiaries has led to increased employment or other positive outcomes for low income and vulnerable individuals. Overall, we do not have information before us that suggests that the design and approach of South Carolina's Healthy Connections Works community engagement requirement are likely to reduce the risks that the state's demonstration project would result in substantial coverage losses at a time when losing access to health care coverage would cause significant harm to beneficiaries. Therefore, given the early experience from states that implemented a community engagement requirement and the health and economic repercussions that are likely to continue from the COVID-19 pandemic, CMS does not believe that the community engagement requirement under Healthy Connections Works would succeed in generating employment and not result in coverage losses.

Withdrawal of the Healthy Connections Works Demonstration

Based on the foregoing, and pursuant to our obligation under section 1115 of the Act to review demonstration projects and ensure they remain likely to promote the objectives of Medicaid, CMS has determined that, on balance, the approval authorizing South Carolina to implement a community engagement requirement as a condition of initial and continued eligibility is not likely to promote the objectives of the Medicaid program. At a minimum, in light of the significant risks and uncertainties described above about the adverse effects of the pandemic and its aftermath, the information available to CMS does not provide an adequate basis to support an affirmative judgment that the community engagement requirement is likely to assist in promoting the objectives of Medicaid.

¹³⁸ Katch, H., Wagner, J. & Aron-Dine, A. (2018). 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. Retrieved from <https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce>

¹³⁹ South Carolina (2019). Section 1115 Demonstration Application. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-community-engagement-pa.pdf>

Accordingly, pursuant to its authority and responsibility under applicable statutes and regulations to maintain ongoing oversight of whether demonstration projects are currently likely to promote those objectives, CMS is hereby withdrawing the December 12, 2019 approval of the Healthy Connections Works demonstration that permits the state to require work and community engagement as a condition of initial and continued eligibility. CMS's December 12, 2019 letter approving the demonstration and the accompanying waivers and Special Terms and Conditions are withdrawn. The withdrawal of these authorities is effective on the date that is thirty days after the date of this letter, unless the state timely appeals, as discussed below.

Procedure to Appeal This Decision

In accordance with Special Terms and Conditions ¶ 10 and 42 C.F.R. § 430.3, the state may request a hearing to challenge CMS's determination prior to the above-referenced effective date by appealing this decision to the Departmental Appeals Board (DAB or Board), following the procedures set forth at 45 C.F.R. part 16. This decision shall be the final decision of the Department unless, within 30 calendar days after the state receives this decision, the state delivers or mails (the state should use registered or certified mail to establish the date) a written notice of appeal to the DAB.

A notice of appeal may be submitted to the DAB by mail, by facsimile (fax) if under 10 pages, or electronically using the DAB's electronic filing system (DAB E-File). Submissions are considered made on the date they are postmarked, sent by certified or registered mail, deposited with a commercial mail delivery service, faxed (where permitted), or successfully submitted via DAB E-File. The Board will notify the state of further procedures. If the state faxes its notice of appeal (permitted only if the notice of appeal is under 10 pages), the state should use the Appellate Division's fax number, (202) 565-0238.

To use DAB E-File to submit your notice of appeal, the state's Medicaid Director or its representative must first become a registered user by clicking "Register" at the bottom of the DAB E-File homepage, <https://dab/efile.hhs.gov/>; entering the information requested on the "Register New Account" form; and clicking the "Register Account" button. Once registered, the state's Medicaid Director or its representative should login to DAB E-File using the e-mail address and password provided during registration; click "File New Appeal" on the menu; click the "Appellate" button; and provide and upload the requested information and documents on the "File New Appeal-Appellate Division" form. Detailed instructions can be found on the DAB E-File homepage.

Due to the COVID-19 public health emergency, the DAB is experiencing delays in processing documents received by mail. To avoid delay, the DAB strongly encourages the filing of materials through the DAB E-File system. However, should the state so choose, written requests for appeal should be delivered or mailed to U.S. Department of Health and Human Services, Departmental Appeals Board MS 6127, Appellate Division, 330 Independence Ave., S.W., Cohen Building Room G-644, Washington, DC 20201. Refer to 45 C.F.R. Part 16 for procedures of the Departmental Appeals Board.

The state must attach to the appeal request, a copy of this decision, note its intention to appeal the decision, a statement that there is no dollar amount in dispute but that the state disputes CMS's withdrawal of certain section 1115 demonstration authorities, and a brief statement of why the decision is wrong. The Board will notify the state of further procedures. If the state chooses to appeal this decision, a copy of the notice of appeal should be mailed or delivered (the state should use registered or certified mail to establish the date) to Judith Cash, Acting Deputy Director, Center for Medicaid and CHIP Services at 7500 Security Blvd, Baltimore, MD 21244.

Medicaid is a federal-state partnership and we look forward to continuing to work together. If you have any questions, please contact Judith Cash at (410) 786-9686.

Sincerely,

A handwritten signature in blue ink, reading "Chiquita Brooks-LaSure". The signature is written in a cursive, flowing style.

Chiquita Brooks-LaSure