



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

February 7, 2018

The Honorable Alex Azar II
Secretary,
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

The undersigned organizational members of the Consortium for Citizens with Disabilities (CCD) and other supporting organizations write to express our strong opposition to the Centers for Medicare and Medicaid Services (CMS) January 11, 2017 guidance authorizing states to implement unprecedented work requirements for the Medicaid program, and its subsequent approval of Kentucky's waiver application seeking to implement work requirements. CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society.

We reject CMS's attempt to establish a false equivalency between work requirements and existing Medicaid supported employment services. Medicaid employment services and supports, where available, have been highly successful at getting people with disabilities into the workforce because they provide additional services tailored to address the unique barriers people with disabilities face.¹ Work requirements, in contrast, are a punitive condition on eligibility that does not accommodate the needs of individual Medicaid beneficiaries, with and without disabilities, and provide few if any additional services or resources to create new job opportunities, improve access to affordable child care, or increase funding for job training, employer accommodations, or other employment supports. CMS has made clear that any added supports will be left entirely to states.² Notably, Kentucky has proposed no additional state resources to address these needs.

¹ See e.g., Mathematica, Matthew Kehn, Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2011: Final Report (May 20, 2013); Tina Marshall, et al., *Supported Employment: Assessing the Evidence*, *Psychiatric Serv.*, Vol. 65 No. 1, 16 (Jan. 2014), <http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201300262>.

² DEPT. OF HEALTH AND HUMAN SERV., CENTERS FOR MEDICARE & MEDICAID SERV., DEAR STATE MEDICAID DIRECTOR, RE: OPPORTUNITIES TO PROMOTE WORK AND COMMUNITY ENGAGEMENT AMONG MEDICAID BENEFICIARIES (Jan. 11, 2018).

We are particularly concerned that CMS is using decades of disability-driven employment policy to justify the imposition of work requirements. People with disabilities face some of the worst employment rates in the United States, often due to a lack of necessary support services. We are proud our collective advocacy has resulted in increased work opportunities for people with disabilities through the supports and services provided via Medicaid Buy-Ins, supported employment services, Money Follows the Person, and other employment-driven policies. Much of that progress remains incomplete and if CMS wishes to boost income and build careers for Medicaid-enrolled adults, CMS should focus on expanding access to Medicaid-covered employment services and supports for people with disabilities and Medicaid Buy-In programs and not on punitive requirements that cut off access to needed health coverage.

We oppose these work requirements because they will result in hundreds of thousands of low-income Americans, including people with disabilities, losing access to Medicaid services. Work requirements create barriers to Medicaid coverage and are justified by using false stereotypes about people who live in poverty. Nearly four in five adults enrolled in Medicaid who are not receiving disability benefits already live in families with at least one worker.³ Those adults not doing paid work are mostly either caregivers, students, or persons with chronic conditions or disabilities (who might either be temporarily unable to work or require supportive services to find and keep a job).⁴ In all fewer than one in ten of this population of adult Medicaid beneficiaries cited some other reason for not working. This small target subgroup hardly justifies the added administrative burdens imposed across all adult Medicaid enrollees enrolled in the waiver. Rather, it suggests that the true goal of the policy may not be to boost employment, but rather to slim the Medicaid rolls by adding more paperwork. The approved Kentucky waiver will also impose premiums, lockouts, waiting periods and other punitive requirements on Medicaid recipients, creating additional barriers to coverage and crucially important health services for people with disabilities and thousands of other low-income individuals. Kentucky's own estimates project over 95,000 adults will lose coverage compared to leaving the current Medicaid expansion in place.⁵

It may seem simple to assert that “people with disabilities will be exempt,” but converting such a statement into an effective policy process is complicated, expensive, and fundamentally flawed. The Social Security definition for disability is quite strict (fewer than 4 in 10 applicants are awarded benefits) and denies thousands of low-income people with seriously compromised health or functional status. Consequently, millions of Americans with disabilities become eligible for Medicaid on a basis other than SSI disability, such as through the adult Medicaid expansion. The Medicaid Expansion is especially crucial for millions of people with behavioral health needs: 28.4% of adults with incomes below the Medicaid expansion threshold are individuals with mental illnesses or substance use disorders.⁶ Additional exemptions and medical frailty screens will not be enough to shield all of them from mandatory work

³ Kaiser Family Foundation, Rachel Garfield, Robin Rudowitz, and Anthony Damico, *Understanding the Intersection of Medicaid and Work* (Jan. 2018).

⁴ *Id.*

⁵ COMMONWEALTH OF KY., *KENTUCKY HEALTH: HELPING TO ENGAGE AND ACHIEVE LONG TERM HEALTH AT ATTACHMENT A 12-13*, (2017) (“Application Modification”).

⁶ U.S. DEPT. OF HEALTH AND HUMAN SERV., ASS. SEC. OF PLANNING AND EVAL., *BENEFITS OF MEDICAID EXPANSION FOR BEHAVIORAL HEALTH 4* (Mar. 28, 2016).

requirements. Asking on an application if someone has a disability misses thousands who may not define themselves as having a disability or may not understand its importance for their eligibility. Checking claims is retrospective and often inadequate. Survey screens face similar challenges and are costly and difficult to design, test and implement.

Kentucky's approval does not include any description of its disability screening process. But whatever the state designs, thousands of Kentuckians with disabilities will now have to make an appointment for a screening, or get a document signed by a doctor, or complete some other verification requirement to maintain their coverage. Others will be subjected to the work requirement, without recognition of their need for employment supports, and will likely have coverage suspended. In other programs that have implemented work requirements, participants with physical and mental health issues were more likely to be sanctioned for not completing the work requirement.⁷ Even when there is an explicit exemption for individuals unable to comply due to health conditions, in practice, those exemption processes have failed, leaving individuals with disabilities more likely than other individuals to lose benefits.⁸ Inevitably, the added verification red tape will lead to coverage losses for individuals with disabilities and their families whose well-being literally depends on steady access to Medicaid supports and services.

Access to health care coverage is a matter of life, death, and independence for millions of Americans with disabilities, and their families and friends. The disability community and bipartisan Administration and Congressional leaders have worked together to ensure that adults and children with disabilities have access to home- and community-based services that allow them to live, work, and receive an education in the community. This new work requirement policy does not improve Medicaid for the millions of Americans, with or without disabilities, who rely on it. We ask CMS to rescind this guidance and instead focus on ensuring that all adults and children with disabilities have access to the healthcare and related employment services and supports they need. If you have any questions please contact Bethany Lilly (bethanyl@bazelon.org), co-chair of the CCD Health Task Force.

Sincerely

American Association on Health and Disability
American Association of People with Disabilities
American Civil Liberties Union
American Occupational Therapy Association, Inc
American Physical Therapy Association
Autistic Self Advocacy Network
Autism Society of America
Bazelon Center for Mental Health Law

⁷ See, e.g., Yeheskel Hasenfeld et al., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* Departmental Paper, University of Pennsylvania School of Social Policy and Practice (2004), . http://repository.upenn.edu/spp_papers/88.

⁸ See, e.g., Andrew J. Cherlin et. al., *Operating within the Rules: Welfare Recipients' Experiences with Sanctions and Case Closings*, 76 Soc. Serv. Rev. 387, 398 (finding that individuals in "poor" or "fair" health were more likely to lose TANF benefits than those in "good," "very good," or "excellent health"); Vicki Lens, *Welfare and Work Sanctions: Examining Discretion on the Front Lines*, 82 Soc. Serv. Review 199 (2008).

Brain Injury Association of America
Center for Public Representation
Christopher & Dana Reeve Foundation
Community Legal Services of Philadelphia
Disability Rights Education and Defense Fund
Epilepsy Foundation
Family Voices
Institute for Educational Leadership
Justice in Aging
Lutheran Services in America-Disability Network
National Academy of Elder Law Attorneys
National Alliance on Mental Illness
National Association of Councils on Developmental Disabilities
National Association of Disability Representatives
National Association of State Head Injury Administrators
National Council for Behavioral Health
National Council on Aging
National Disability Institute
National Disability Rights Network
National Down Syndrome Congress
National Health Law Program
National Organization of Social Security Claimants' Representatives
National Respite Coalition
TASH
The Advocacy Institute
The Arc of the United States
United Spinal Association

Other Supporting Organizations

American Congress of Rehabilitation Medicine
Collaboration to Promote Self-Determination
Disability Power & Pride
Lakeshore Foundation
The Advocrat Group