DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

August 10, 2021

Maureen Corcoran
Medicaid Director
Ohio Department of Medicaid
50 West Town Street, 4th Floor
Columbus, OH 43215

Dear Ms. Corcoran:

On February 12, 2021, the Centers for Medicare & Medicaid Services (CMS) sent you a letter regarding the March 15, 2019 approval of the section 1115 demonstration project entitled "Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver" (Project Number 11-W-00323/5). The letter advised that CMS would commence a process of determining whether or not to withdraw the authorities previously approved in the Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver demonstration that permit the state to require work and other community engagement activities as a condition of continued Medicaid eligibility. It explained that in light of the ongoing disruptions caused by the COVID-19 pandemic, Ohio'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 February 29, 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).

[1] 42 U.S.C. § 1315.

As the February 12, 2021 letter explained, the Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver community engagement requirement is not in effect. Although the demonstration was approved in March 2019, the state has not implemented the demonstration to date. Since that time, the COVID-19 pandemic and its expected aftermath have made the Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver community engagement requirement infeasible. In addition, implementation of the community engagement requirement 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. Ohio 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), 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 Ohio 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 Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver demonstration that permit the state to require work or other community engagement activities as a condition of Medicaid eligibility. See Special Terms and Conditions ¶ 11. 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 the state's view may warrant not withdrawing those authorities, such information should be submitted to CMS within 30 days.

On March 11, 2021, Ohio submitted additional information in response to CMS's February 12, 2021 letter. As further described later in this letter, the additional information that Ohio submitted did not address the concerns we raised in the February 12, 2021 letter. For example, the state did not dispute that the COVID-19 pandemic has had a significant impact on the health

of Medicaid beneficiaries and that there is uncertainty about the lingering health effects of COVID-19. Nor did the state demonstrate how it would prevent the coverage losses that it had estimated at the time of its demonstration application to CMS, which likely will be further aggravated in the aftermath of the pandemic. The state also did not provide information to indicate how it would ensure beneficiary awareness and understanding of the community engagement participation requirements, the qualifying exemptions, or the beneficiary reporting obligations. We do not have information before us that suggests that the state's employment-related services are likely to reduce the risk that Ohio's demonstration project will result in substantial coverage losses at a time when losing access to health care coverage would cause particularly significant harm to beneficiaries. Overall, as addressed in greater detail below, the information available to CMS, including that which was submitted in Ohio'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 Ohio to require community engagement as a condition of continued eligibility are not likely to promote the objectives of the Medicaid statute. Therefore, we are withdrawing approval of the demonstration as a whole, since this demonstration does not include any features besides those authorities that authorize the community engagement requirement.

Background of Ohio's Demonstration

On March 15, 2019, CMS approved Ohio's request for a new section 1115 demonstration, entitled the "Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver." This demonstration authorizes the state to require all new adult group beneficiaries authorized under section 1902(a)(10)(a)(i)(VIII) of the Act, ages 19 through 49, with certain exemptions, to participate in and timely report 80 hours per month of qualifying community engagement activities, such as employment, education, or job skills training, as a condition of continued Medicaid eligibility.

Upon implementation of the community engagement requirement, after a beneficiary is determined eligible for Medicaid, the state would notify beneficiaries whether they are required to participate in community engagement activities as a condition of continued eligibility or whether the beneficiary is exempt. Non-exempt beneficiaries would have 60 days after that notice to self-attest that they are in compliance with the community engagement requirement or that they meet the criteria for an exemption or good cause exception. Once the beneficiary reports compliance with the requirement (or exemption or good cause exception), no further reporting is required before the beneficiary's next annual redetermination, unless the beneficiary experiences a change in circumstance. If the beneficiary does not report within the initial 60-day period that they meet the community engagement requirement, qualify for an exemption or another Medicaid eligibility group, or have a circumstance giving rise to good cause for non-compliance, the beneficiary would be disenrolled from Medicaid. The individual could re-enroll in Medicaid at any time after disenrollment, and prior noncompliance would not be a factor in any future determination of Medicaid eligibility.

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

The Special Terms and Conditions governing Ohio's demonstration state an intention to begin implementing the community engagement requirement on January 1, 2021; however, the state has not implemented the requirement due to the ongoing COVID-19 pandemic. Ohio indicated in its most recently submitted quarterly monitoring report to CMS that the demonstration's implementation has tentatively been delayed to the first day of the month following the quarter in which the COVID-19 public health emergency ends.[2]

Although Ohio's demonstration has not been implemented, the Commonwealth Fund estimated that Medicaid coverage losses could be between 121,000 and 163,000 beneficiaries within the first 12 months of full implementation of the community engagement requirement in Ohio, representing a coverage loss of 26–35 percent out of the estimated total population of 466,000 beneficiaries who could be subject to the requirement in the state.[3] The study based those estimates on the following: (1) Commonwealth Fund projected coverage losses that would have happened in Arkansas within 12 months of its implementation of the community engagement demonstration, based on early actual coverage loss data from Arkansas;[4] (2) author analysis of caseload losses that happened within a year after Supplemental Nutrition Assistance Program (SNAP) work requirements were implemented in Ohio (see Table 3 of the Methods Appendix[5]), and (3) certain demonstration design features as would be pertinent for Ohio's community engagement requirement.[6,7] The state itself estimated that the implementation of the community engagement requirement would require 36,036 Medicaid expansion beneficiaries to start working or newly enroll in job training, education, or start participating in other qualifying community engagement activities, for a total of at least 20 hours per week (80 hours averaged

[2] The state's demonstration year 2 quarter 3 monitoring report submitted to CMS in February 2021, which is under review.

[3] Ku, L. & Brantley, E. (2019). Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults to Lose Medicaid Coverage. The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-coverage

[4] Ku, L. & Brantley, E. (2018). Arkansas's Early Experience with Work Requirements Signals Larger Losses to Come. The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/blog/2018/arkansas-early-experience-work-requirements

[5] Ku, L. & Brantley, E. (2019). Methods Appendix: Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults to Lose Medicaid Coverage. The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/sites/default/files/2019-06/Ku_methods_appendix_06-21-2019.pdf

[6] Ku, L. & Brantley, E. (2019). Methods Appendix: Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults to Lose Medicaid Coverage. The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/sites/default/files/2019-06/Ku_methods_appendix_06-21-2019.pdf

[7] The study accounted for the following dimensions of demonstration features in its coverage loss estimates: (a) the target population ages and status; (b) specific type of exemptions for parents and caretakers; (c) required hours of work and community engagement activities; (d) the timing of when coverage ends if not compliant, and (e) the process to regain coverage.

monthly), to avoid being disenrolled from Medicaid.[8 9,10] Of these 36,036 beneficiaries, the state estimated that half – over 18,000 beneficiaries – would ultimately lose their Medicaid coverage due to noncompliance with the community engagement requirement.[11] While lower by an order of magnitude than the Commonwealth Fund's estimate of potential coverage loss in Ohio, the state's own estimate nevertheless starkly reflects the potential for significant coverage losses. It is plausible that the actual coverage losses would have fallen somewhere in between these two projections from the Commonwealth Fund and the state, since some Medicaid beneficiaries that Ohio estimated would be exempt from the requirement would nevertheless lose coverage for failure to report their exemption to the state. After all, 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] This potential effect would be consistent with research by the Kaiser Family Foundation, which estimated that if community engagement requirements were implemented nationwide, coverage losses 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 not participating in sufficient hours of qualifying activities to meet work or community engagement requirements.[13]

Furthermore, Ohio projected that the vast majority of its new adult group Medicaid beneficiaries would be employed or exempt from the community engagement requirement.[14] Indeed, data suggest that there is a relatively small minority of beneficiaries whom the community engagement requirement is intended to target. According to research from the Kaiser Family Foundation using the Current Population Survey (CPS) data,[15] in Ohio, 68 percent (63 percent

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[8] Ohio Department of Medicaid. (2018). Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver Application. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/oh-work-requirement-community-engagement-pa.pdf

[9] Ohio Medicaid Proposed Work Requirements. (2018). Retrieved from http://www.morrowcountyhealth.org/wp-content/uploads/2018/03/Ohio-Medicaid-Work-Requirements-FINAL-2-16-2018.pdf

[10] Norris, L. (2020). Ohio and the ACA's Medicaid expansion. Health insurance.org. Retrieved from https://www.healthinsurance.org/medicaid/ohio/

[11] Ohio Department of Medicaid. (2018). Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver Application. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/oh/oh-work-requirement-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] The state estimated that, based on State Fiscal Year 2018 data, there would be 709,923 individuals enrolled in Group VIII, and of those, no more than 36,036 individuals would be considered not exempt and not currently working. The state further estimated that all the other Medicaid expansion beneficiaries would be already employed or exempt from the community engagement requirement.

[15] 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

nationally) of Medicaid beneficiaries aged 19 to 64 without Supplemental Security Income (SSI) in 2019 were working. Of those who were not working in Ohio, 41 percent (27 percent nationally) indicated that their reason for not working was due to illness or disability, while another 37 percent (32 percent nationally) cited that they were caring for a child or a family member. The remainder of those not working were either attending school or indicated not working due to other reasons, such as retirement and not finding work. Under Ohio's community engagement requirement, illness and disability could give rise to an exemption or good cause exception, whereas educational activities are qualifying activities, and caregivers are exempt from the requirement. Accordingly, these data suggest that the substantial majority of beneficiaries who could be subject to Ohio's community engagement requirement but were not working would have been otherwise meeting or exempt from the requirement. Thus, if implemented, there would be little margin for the program to increase work or community engagement in Ohio.

In fact, the number of beneficiaries that Ohio's community engagement requirement targets is even smaller than what the Kaiser Family Foundation research suggests. A report published by Ohio that focused specifically on the state's Medicaid expansion found that 93.8 percent of the individuals continuously enrolled in Ohio's Medicaid expansion population "were either employed, in school, taking care of family members, participating in an alcohol and drug treatment program, or dealing with intensive physical health or mental health illness."[16] 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.[17,18,19,20] For example, the Kaiser Family Foundation found that 81 percent of adults with Medicaid coverage live in families with a working adult, and 6 in 10 are working themselves.[21] Similarly, a study published in 2017 reported that, out of the 22 million adults covered by Medicaid nationwide who could be subject to a community engagement requirement designed like that in

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from https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/

[16] 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.

[17] 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/

[18] Huberfeld, N. (2018). Can Work be Required in the Medicaid Program? New England Journal of Medicine. 378:788-791. DOI: 10.1056/NEJMp1800549

[19] 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

[20] 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

[21] 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/

the Ohio's section 1115 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.[22] For 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.

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 in Ohio's demonstration were already meeting the terms of the community engagement 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.

Arkansas, Michigan, and New Hampshire, three states where a community engagement requirement as a condition of Medicaid eligibility was in effect, provide some early evidence on potential enrollment impacts.[23,24] Experience from these states indicates that large portions of the beneficiaries subjected 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 court halted the community engagement requirement, the state reported that from August 2018 through December 2018, 18,164 individuals were disenrolled from coverage for "noncompliance with the work requirement."[25] 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.[26] 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

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[22] Ku, L. & Brantley, E. (2017). Medicaid Work Requirements: Who's At Risk? Health Affairs Blog. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20170412.059575/full/

[23] Utah and Indiana also briefly implemented a community engagement requirement that was part of these states' section 1115 demonstrations, but the program designs in these states did not require beneficiaries subject to the community engagement requirement to comply with reporting minimum hours during the period the requirement was in effect in each state.

[24] 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-andimpacts

[25] 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

[26] 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

state's community engagement requirement was in effect.[27,28,29] Based on that 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.[30] 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.[31]

These coverage losses are at least partly attributable to beneficiaries' lack of awareness of and administrative barriers associated with community engagement requirements.[32] Despite Ohio's assurances in the demonstration's Special Terms and Conditions that the state would provide the necessary outreach to Medicaid beneficiaries, Ohio indicated in its monitoring report for demonstration year 2, quarter 2 (June 1, 2020 – August 31, 2020), submitted to CMS in November 2020, that while the state had started preparations for implementation, several design features had not been developed or finalized yet, including outreach and education materials, training materials, self-appraisal forms, and beneficiary notices.[33] That is consistent with other states' early experiences in implementing their community engagement requirements, which were characterized by evidence of widespread confusion and lack of awareness among demonstration beneficiaries regarding the requirements in the states where the requirements were implemented.[34] For example, many beneficiaries in New Hampshire reportedly did not know about the community engagement reporting requirement or received confusing and often

[27] 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

[28] 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

[29] 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

[30] 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

[31] 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

[32] 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

[33] Ohio Department of Medicaid. (2020). Ohio Group VIII Work Requirement and Community Engagement Section 1115 Demonstration Year 2 Quarter 2 Monitoring Report. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/oh-work-requirement-community-engagement-qtrly-rpt-jun-aug-2020.pdf

[34] 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-andimpacts.

contradictory notices about whether they were subject to the requirement.[35,36] 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.[37] 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.[38] In Ohio, there were news reports of possible malfunctions with the computer system used to determine Medicaid eligibility; as a result of these glitches, some beneficiary applications and other documents needed to confirm eligibility were misplaced or eliminated, while in other cases, beneficiaries were assigned incorrect renewal dates.[39] Furthermore, state audits have found serious issues with the state's eligibility determination system and backlog in application processing, including one report indicating that the error rate for determining Medicaid eligibility in the state was 43 percent, more than double the national average.[40,41,42,43] Against the backdrop of these documented challenges to the state's Medicaid eligibility determination system, Ohio may face even greater challenges with preparing clear and effective notices to beneficiaries with accurate information, and even if beneficiaries received, understood, and responded to notices, there could be complications with accurately recording compliance with or exemption or exception from the community engagement requirement.

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[35] 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

[36] 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

[37] 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

[38] 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

[39] Candisky, C. (2020). Ohio Medicaid officials pledge to fix eligibility and backlog problems. The Columbus Dispatch. Retrieved from https://www.dispatch.com/news/20200117/ohio-medicaid-officials-pledge-to-fix-eligibility-and-backlog-problems#:~:text=not%20get%20paid.-,The%20state's%20plan%20comes%20in%20response%20to%20a%20blistering%20federal,error%20rate%20in%20Medicaid%20payments

[40] Candisky, C. (2020). Lawmakers Urge Delay of Ohio's Medicaid Work Requirements. The Columbus Dispatch. Retrieved from https://www.timesreporter.com/news/20200116/lawmakers-urge-delay-of-ohiorsquos-medicaid-work-requirements/2

[41] Ohio Auditor of State, Keith Faber. (2020). Ohio's Medicaid Eligibility Determination Process. Retrieved from https://ohioauditor.gov/auditsearch/Reports/2020/Medicaid_Eligibility_117_Audit_Franklin_2020.pdf

[42] Candisky, C. (2020). Ohio Medicaid officials pledge to fix eligibility and backlog problems. The Columbus Dispatch. Retrieved from https://www.dispatch.com/news/20200117/ohio-medicaid-officials-pledge-to-fix-eligibility-and-backlog-problems#:~:text=not%20get%20paid.-,The%20state's%20plan%20comes%20in%20response%20to%20a%20blistering%20federal,error%20rate%20in%20Medicaid%20payments

[43] Department of Health and Human Services. Office of the Inspector General. (2020). Ohio did not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries. Report in Brief. Retrieved from https://oig.hhs.gov/oas/reports/region5/51800027.pdf

Thus, the introduction of an administratively complex program like the community engagement requirement presents a serious risk of beneficiary disenrollment due to technical errors. While there were reports early in 2020—before the COVID-19 pandemic began—that the state had been working to fix these systemic problems and reduce the state's application backlog, the state expected the process to take "several years."[44]

Losing health care coverage undoubtedly has negative consequences for affected beneficiaries down the road. For example, one study found that adults in Arkansas ages 30–49 who had lost Medicaid or Marketplace coverage in the prior year experienced significantly higher medical debt and financial barriers to care, compared to similar Arkansans who maintained coverage.[45] 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.[46] 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,[47] 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.[48,49,50,51] For example, one study found that among Medicaid beneficiaries likely to be

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[44] Candisky, C. (2020). Ohio Medicaid officials pledge to fix eligibility and backlog problems. The Columbus Dispatch. Retrieved from https://www.dispatch.com/news/20200117/ohio-medicaid-officials-pledge-to-fix-eligibility-and-backlog-problems#:~:text=not%20get%20paid.-,The%20state's%20plan%20comes%20in%20response%20to%20a%20blistering%20federal,error%20rate%20in%20Medicaid%20payments.

[45] 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

[46] 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

[47] 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

[48] 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

[49] 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

[50] 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

[51] 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

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.[52] Given the range of labor market and employment barriers facing Medicaid beneficiaries who could be subjected to community engagement requirements, Ohio's Group VIII Work Requirement and Community Engagement Section 1115 Demonstration's requirement for satisfying 20 hours per week (80 hours averaged monthly) is a concern even for low-income adults who are working.[53,54]

Furthermore, research examining the outcomes of statutorily authorized work requirements in other public assistance programs, such as Temporary Assistance for Needy Families (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.[55,56,57] Additionally, studies have found that imposing work requirements in the SNAP program led to substantial reductions in enrollment, even after controlling for changes in unemployment and poverty levels.[58] 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 would be likely to happen in New Hampshire and Michigan after these states began implementing community engagement requirements, if those states' community engagement requirements had been implemented long enough to reach the scheduled suspensions or disenrollments.

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

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[52] 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

[53] 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

[54] 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

[55] 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

[56] 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

[57] 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

[58] 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

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 bottlenecks in complying with reporting requirements, and subsequent coverage losses among individuals subject to such requirements.

As further described below, notwithstanding the particular design features of Ohio's community engagement requirement that the state highlights in its March 11, 2021 letter to CMS (e.g., the requirement to only report compliance once a year unless there is a change in circumstances, or the flexibility of self-attesting to meeting hours requirements or exempt status), on the whole, CMS does not expect that implementing the requirement as a condition of continued eligibility in Ohio's Medicaid demonstration would have a different outcome than what was observed during the initial implementation of such a requirement in other states. Considering all available information, there is a substantial risk that the community engagement requirement in Ohio's demonstration project, as approved in March 2019, would 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 eligibility, making Ohio's community engagement requirement infeasible under the current circumstances. 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 COVID-19 pandemic.[59,60]

As discussed above, prior to the pandemic, most adult Medicaid beneficiaries who did not face a barrier to work were working full or part-time.[61] However, one in three working adult Medicaid beneficiaries was doing only part-time work prior to the COVID-19 public health emergency,

[59] 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/

[60] 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

[61] 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/

often due to fewer opportunities for full-time employment. The pandemic is expected to aggravate the challenges not only of finding full-time employment, but it also may create additional obstacles to securing even part-time work, due to shifting family caregiving obligations and increased transportation barriers.[62]

Moreover, 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 rate[63] declined by 10.2 percent from January 2020 to January 2021, employment rates for workers in the bottom wage quartile decreased by a larger percentage than for workers in the highest wage quartile across that time period (28.7 percent vs. 1.7 percent).[64] In Ohio, employment rates for low-wage earners (i.e., annual wages under $27,000) declined by 17 percent, compared to a 2 percent increase in employment rates for high-wage earners (i.e., wages above $60,000 per year) from January 2020 to January 2021.[65]

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 other sectors, such as financial services, have seen virtually no change.[66] 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.[67] 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.[68,69,70]

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[62] 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/

[63] Not seasonally adjusted.

[64] Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved from www.tracktherecovery.org

[65] Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved from www.tracktherecovery.org

[66] 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/

[67] 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

[68] 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/

[69] 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).

[70] 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/

Moreover, pandemic-related 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.[71] In fact, 52 percent of lower income adults (annual income below $37,500) live in households where someone has lost a job or taken a pay cut due to the pandemic.[72] 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.[73,74] Fifty-nine percent of lower-income adults said they worry every day or almost every day about paying their bills.[75] 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 difficulties making housing and other bill payments. Also, Hispanic households were more likely to experience food insecurity compared to White households.[76,77]

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.[78] Moreover, fewer than 8 percent of Americans with earnings below the 25th percentile have the capabilities to work remotely.[79] 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

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[71] 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/

[72] 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/

[73] 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/

[74] 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

[75] 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/

[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] 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

[78] 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/

[79] 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/

approved in this demonstration increases the risk of coverage loss for these low-income individuals.[80,81]

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 volunteering or similar community service activities that beneficiaries could use to meet the community engagement requirement instead of (or in combination with) paid work.[82] Many community 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 number of available volunteer and community service opportunities or made engaging in volunteering and community 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.[83] 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.[84] As a result, Black people may be at a 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.[85]

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,

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[80] 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/

[81] 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

[82] 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

[83] 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

[84] 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. DOI: 10.1002/ajim.23145

[85] 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/

and lung cancers were between 56 and 85 percent lower in April 2020 than in the previous year.[86] 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.[87] These unmet health care needs may lead to substantial increases in subsequent mortality and morbidity.[88] In addition to the health 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.[89]

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 6.2 percent in February 2021.[90] 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 6.1 percent in April 2021.[91] 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

[86] 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

[87] 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#

[88] 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/do/10.1377/hblog20201020.566558/full/

[89] 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#

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

[91] 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 61.7 percent in April 2021.[92,93] Compared to pre-pandemic conditions, these data suggest that the labor force is still down in April 2021 by approximately 3.6 million individuals.[94,95]

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.[96] Further, workers who enter the labor market during a recession also face long-term consequences for their earnings.[97] 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.[98]

Layoffs can also impact an individual's mortality and morbidity risks.[99] For example, one study found that male workers experienced mortality rates that were 50-100 percent higher than

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[92] 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.

[93] 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

[94] For April 2021 seasonally adjusted labor force data, see: U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved on May 12, 2021 from https://www.bls.gov/web/empsit/cpseea08b.pdf

[95] 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

[96] 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

[97] 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

[98] 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

[99] 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

expected in the year after a layoff occurred, and 20 years later, mortality rates remained 10-15 percent higher for these individuals.[100] 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.[101]

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 and the potential long-term adverse health effects resulting from the economic and non-economic consequences of the pandemic exacerbates the risk of any 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 impracticable.

Evidence Submitted by Ohio

On March 11, 2021, Ohio submitted a response to CMS's letter of February 12, 2021. As noted above, the February 12, 2021 letter informed Ohio that CMS had preliminarily determined that allowing the community engagement requirement to take effect in Ohio would not promote the objectives of the Medicaid program. The February 12, 2021 letter explained that, in light of the COVID-19 public health emergency, Ohio's community engagement requirement risks significant coverage losses at a time when losing access to health care coverage would cause substantial harm to beneficiaries.

Ohio's response does not resolve the concerns we raised in the February 12, 2021 letter. In its response, Ohio argues that the state's community engagement requirement is designed differently than those approved for other states and that it is flexible enough to account for the issues CMS raised. However, although the state describes its community engagement requirement as "tailored to target a narrow subset of individuals within the expansion group," by the state's own estimates, 50 percent of the target population (that is, non-exempt Medicaid expansion beneficiaries not already working or participating in other qualifying community engagement activities for at least 20 hours per week or 80 hours per month) is expected to lose coverage. Those coverage losses alone would be substantial. The actual coverage losses may be greater than Ohio's estimates and would not be limited to the individuals Ohio's community

[100] 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

[101] 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

engagement requirement purports to target. The Commonwealth Fund estimated that actual coverage losses caused by the community engagement requirement in Ohio would likely be between 121,000 and 163,000 beneficiaries in the first 12 months after implementation.[102] Those estimates are consistent with research by the Kaiser Family Foundation, which 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.[103,104] Whenever the state would not have a record sufficient to determine that a beneficiary qualifies for an exemption or a good cause exception, there is a risk that the beneficiary could lose coverage just for failing to notify the state of his or her exempt or excepted status. Thus, even after taking the particular features of Ohio's community engagement requirement into account, the demonstration would likely result in substantial coverage losses—possibly of a much larger magnitude than that predicted by the state itself—despite the fact that most demonstration beneficiaries are likely already meeting the community engagement requirement or exempt from it.

In addition, the state's response letter does not resolve certain state-identified concerns described in the demonstration's monitoring report (demonstration year 2 quarter 2) that there were several potential barriers and challenges for beneficiaries in securing and maintaining employment or participating in other community engagement activities.[105] For example, the state mentioned challenges around assuring availability of adequate and reliable transportation to support commuting to work and other qualifying activities; adequate communication to beneficiaries and providers about program design, requirements, and supports; and access to adequate employment and other community engagement opportunities. It also noted that the COVID-19 pandemic further complicated those challenges and barriers.[106] The state also noted in its demonstration year 1 annual monitoring report, submitted to CMS on September 2020, that the COVID-19 pandemic emerged as one of the largest challenges/barriers for the implementation of the community engagement requirement, and that the "health and economic consequences [of the

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[102] Ku, L. & Brantley, E. (2019). Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults to Lose Medicaid Coverage. The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-coverage

[103] 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/

[104] 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

[105] Ohio Department of Medicaid. (2020). Ohio Group VIII Work Requirement and Community Engagement Section 1115 Demonstration Year 2 Quarter 2 Monitoring Report. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/oh-work-requirement-community-engagement-qtrly-rpt-jun-aug-2020.pdf

[106] Ohio Department of Medicaid. (2020). Ohio Group VIII Work Requirement and Community Engagement Section 1115 Demonstration Year 2 Quarter 2 Monitoring Report. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/oh-work-requirement-community-engagement-qtrly-rpt-jun-aug-2020.pdf

pandemic] in Ohio are potentially long-term and the full effects remain unknown."[107] The state also recognized that the availability of long-term employment opportunities and work supports may remain a significant barrier even after the public health emergency ends in the state.[108] In its March 11, 2021 letter, the state mentioned that many such obstacles, such as a lack of transportation or limited employment opportunities, could support an exemption or good cause exception from being required to satisfy the minimum-hours requirement. Likewise, the state mentioned that beneficiaries in high unemployment areas would be exempt from satisfying the minimum-hours requirement based on the demonstration's adoption of the SNAP work requirement exemption for counties with high unemployment. But the possibility that more beneficiaries would be eligible for an exemption or good cause exception does not reduce the risk that an estimated half or more of the beneficiaries targeted by the community engagement requirement would lose coverage, or the harm to those beneficiaries resulting from that lost coverage, which is exacerbated by the long-term economic and health effects of the COVID-19 pandemic. Moreover, the fact that there are so many exemptions and good cause exceptions underscores that this demonstration, if implemented, only has the potential to influence the behavior of a very small number of individuals, while risking coverage loss for many.

Ohio notes in its response letter that its community engagement requirement is closely modeled on the state's work requirement for SNAP.[109] Data show that Ohio counties exempt from SNAP work requirements are disproportionately White, and the exemption from work requirements may not be reaching counties where Black households are more likely to experience poverty.[110] With the COVID-19 pandemic potentially exacerbating the racial inequity in both the labor market and healthcare access, the existing racial disparity in county-based SNAP work requirement exemptions may further aggravate the inequities if the demonstration were to be implemented at the end of the public health emergency.

Furthermore, Ohio has not addressed CMS's concerns about the state's infrastructure to administer the community engagement requirement. For example, Ohio has not presented any plan for how it will effectively communicate to beneficiaries and providers about program design, reporting requirements, and the availability of employment supports. Therefore, given Ohio's reported challenges with its Medicaid eligibility determination system and other system infrastructure concerns described earlier, the demonstration—if implemented—threatens substantial coverage losses.

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[107] Ohio Department of Medicaid. (2020). Ohio Group VIII Work Requirement and Community Engagement Section 1115 Demonstration Year 1 Monitoring Report. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/oh-work-requirement-community-engagement-dy1-annl-rpt-mar2019-feb2020.pdf

[108] Ohio Department of Medicaid. (2020). Ohio Group VIII Work Requirement and Community Engagement Section 1115 Demonstration Year 1 Monitoring Report. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/oh-work-requirement-community-engagement-dy1-annl-rpt-mar2019-feb2020.pdf

[109] Medicaid beneficiaries in counties that have SNAP work requirement waivers due to high unemployment will be exempt from the community engagement requirement.

[110] White, A. (2018). Who Receives Food Assistance in Ohio? Implications of Work Requirements for SNAP Enrollment across Racial, Ethnic and Geographic Divisions. The Center for Community Solutions. Retrieved from https://www.communitysolutions.com/research/receives-food-assistance-ohio-implications-work-requirements-snap-enrollment-across-racial-ethnic-geographic-divisions/

Ohio stated in its March 11, 2021 letter that its program was designed "to promote and foster independence—and the associated health outcomes—with increased community engagement," and notes an association between economic well-being and health status. However, there is no evidence offered by the state establishing that its community engagement requirement is likely to lead to greater economic well-being and financial independence, or better health outcomes. In fact, the state's comprehensive assessment of Medicaid expansion indicates that the majority of beneficiaries (nearly 84 percent) mentioned that expansion of coverage made it easier for them to continue working, and 60 percent of unemployed beneficiaries said that access to Medicaid made it easier for them to look for work.[111] Individuals must be healthy to work, and consistent access to health coverage is vital to being healthy enough to work.[112] The state's own report on Medicaid expansion shows that taking health coverage away from beneficiaries is likely to make it more difficult for them to find or keep a job.[113]

The state did not dispute that the COVID-19 pandemic has had a significant impact on the health of Medicaid beneficiaries and that there is uncertainty about the lingering health effects of COVID-19. Nor did the state dispute the pandemic's likely impact on economic opportunities for beneficiaries. There is significant uncertainty as to whether there will be sufficient employment or other qualifying community engagement opportunities for those beneficiaries who are not already working or otherwise meeting or exempt from the community engagement requirement, even once the public health emergency has ended.

While Ohio has outlined its planning around programs to support job training and employment connections for the Medicaid expansion group and others in the state, which are currently being implemented or developed separately from the demonstration, the state has not described whether or how these initiatives will lead to employment gains for Ohioans. We do not have information before us that suggests that those programs are likely to reduce the risks that Ohio's demonstration project will result in substantial coverage losses at a time when losing access to health care coverage would cause particularly significant harm to beneficiaries. Nor has the state presented information to suggest that withholding safety net benefits, such as Medicaid coverage, from otherwise eligible beneficiaries is likely to lead to increased employment or other positive outcomes for low income and vulnerable individuals. Thus, the existence of employment support programs in Ohio is not sufficient to demonstrate that allowing Ohio's community engagement requirement to take effect would be likely to promote the objectives of the Medicaid program.

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[111] 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.

[112] Gehr, J. & Wikle, S. (2017). The Evidence Builds: Access to Medicaid Helps People Work. CLASP. Retrieved from http://www.clasp.org/resources-and-publications/publication-1/The-Evidence-Builds-Access-toMedicaid-Helps-People-Work.pdf

[113] 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.

Withdrawal of the Group VIII Work Requirement and Community Engagement 1115 Demonstration Waiver 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 Ohio to implement a community engagement requirement as a condition of 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. 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 March 15, 2019 demonstration approval that permits the state to require work and community engagement as a condition of continued eligibility. CMS's March 15, 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 ¶ 11 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, a note of 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,

[redacted]

Chiquita Brooks-LaSure