August 8, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Palmetto Pathways to Independence Waiver

Dear Administrator Oz:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Community Engagement Section 1115 Demonstration Waiver Application submitted on June 23, 2025. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

While ACS CAN supports South Carolina expanding Medicaid, we oppose the current proposal for a severely limited expansion with work requirements and an enrollment cap. We urge CMS to reject this proposal.

South Carolina proposes a new Section 1115 demonstration called Palmetto Pathways to Independence. The demonstration would be a very limited Medicaid expansion, covering only parents or caretaker relatives from 67% to 100% of FPL who meet a work reporting requirement. The work requirement would apply to individuals aged 19-64, who would be ineligible for and/or terminated from coverage unless working 80 hours per month or meeting qualifying exemptions, including for education, work search, compliance with SNAP work requirements, and a few other select exemptions. The state estimates up to 17,700 people are potentially eligible for coverage, but the state has requested authority to implement an enrollment cap based on available state funding of up to 11,400 members. The state also includes a waiver request to not provide hospital presumptive eligibility in the demonstration.

<u>Medicaid work requirements don't help more people work – they cause people to lose coverage.</u>
ACS CAN opposes tying access to affordable health care for lower income persons to employment or income as a proxy for employment, because cancer patients and survivors – as well as those with other complex chronic conditions – could be unable to comply and find themselves without Medicaid coverage. Many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[1,2,3,4,5] Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.[6,7] Recent cancer survivors often require frequent follow-up visits[8] and suffer from multiple comorbidities linked to their cancer treatments.[9,10] Cancer survivors are often unable to work or are limited in the amount or kind of work they can participate in because of health problems related to their cancer

diagnosis and treatment.[11,12,13,14,15]

If work is required as a condition of eligibility, many newly diagnosed and recent cancer survivors, as well as those with other chronic illnesses could find that they are ineligible for the lifesaving care and treatment services provided through South Carolina's Medicaid program. We also note that imposing work requirements on lower income individuals as a condition of coverage could impede individuals' access to prevention and early detection care, including cancer screenings and diagnostic testing.

For individuals who are fortunate enough to meet requirements and gain coverage through this program, they will always be at risk of losing coverage again if their employment status changes – including due to a new cancer diagnosis. Suspension of benefits and loss of coverage create gaps in care for patients and disrupt access to critical and often lifesaving services. When individuals lose coverage – even if they only lose it for a short time while their paperwork is sorted out – it makes it difficult or impossible for those with cancer to continue treatment. For cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. The loss of coverage can be devastating to cancer patients and their families. Mostly recently, the link between disruptions in Medicaid coverage and worsened health outcomes was established among Medicaid-insured children and adolescents with blood cancers: lack of continuous Medicaid coverage was associated with advanced-stage diagnosis of lymphoma,[16] and poorer survival.[17]

<u>South Carolina's proposal will still leave many uninsured with no access to care.</u>
The proposed demonstration will only reach a small fraction of the estimated 134,000 individuals who could potentially be eligible for coverage under Medicaid expansion.[18] South Carolina's proposed enrollment cap of 11,400 individuals represents less than 18% of the 65,000 uninsured individuals in the state with incomes under 100% of the FPL. ACS CAN and its advocates have strongly urged the state to fully expand Medicaid and ensure access to care for the thousands of South Carolinians who fall into the current coverage gap.

Fully expanding Medicaid in South Carolina without barriers to enrolling in and maintaining Medicaid coverage is a more cost-effective way to ensure that South Carolinians can protect their health and participate productively in the workforce. Palmetto Pathways is modeled off the failed Georgia Pathways partial expansion program, which enrolled only a fraction of those estimated to be eligible and has demonstrated the ineffectiveness of barrier-to-entry work requirement policies in furthering health objectives for cancer patients and for anyone in need of cancer screenings and other preventative care.

The current qualifying criterion for this new category completely omits several critical populations, including individuals with, at risk of, or in the process of being diagnosed with, serious and chronic health conditions that prevent them from working. As already addressed, many people with cancer are unable to work or must reduce their work hours due to symptoms, the time required to go to treatments and side effects of those treatments. Working can become a challenge even before an individual has been diagnosed – as the process of diagnosis of cancer can take months and involve many invasive tests. All these challenges are not accounted for South Carolina's proposal, leaving people with cancer in this group who are unable to work the required hours with no affordable option to get the healthcare they desperately need to treat their cancer. However, even with broader criteria, additional processes to determine patient eligibility and participation in program requirements inherently create opportunities for administrative errors that jeopardize access to

care.

Work requirements are challenging and costly to implement.
The waiver has no clearly defined process for compliance verification, including tracking worked hours or job search activities and handling appeals. The state intends to negotiate data-sharing agreements with other agencies to allow data matching, but there will undoubtedly be individuals whose data is incomplete, outdated, or not accurately captured by the systems in use. For example, during the unwinding of the Medicaid continuous coverage requirements, only 40% of enrollees in South Carolina were automatically re-enrolled, demonstrating the significant gaps in existing data and the increased administrative burden many people will face.[19] Furthermore, the waiver is unclear on how individuals will be able to demonstrate compliance or address inaccuracies if data sources fail to verify their eligibility.

ACS CAN is also concerned by the cost to implement this waiver. There will likely be large administrative costs to the state given the complexity of tracking work activities and having a system in place to identify and track exemptions. For example, a GAO study of work reporting requirements estimated that the administrative costs could be up to $272 million.[20] South Carolina's Medicaid program is unprepared for the cost and administrative disruption of the proposed requirements.

Enrollment caps will leave eligible people uninsured.
ACS CAN is strongly opposed to South Carolina's proposed enrollment cap for the new eligibility group. The state's proposed cap of 11,400 individuals does not promote the objectives of Medicaid. It is an arbitrary, harmful policy that limits coverage based on who hears about the program first and files their application the fastest. The state estimates that there are 17,700 South Carolinians who will potentially qualify for the new eligibility group, meaning thousands of otherwise eligible individuals will be relegated to a waitlist for coverage. Implementing a coverage waitlist would represent a huge step backwards in coverage policy – harkening back to the days of waitlists for insurance through high risk pools prior to the enactment of the Affordable Care Act. This kind of arbitrary cap is especially concerning for cancer patients, who need timely treatment upon diagnosis and cannot wait for their number to be called for coverage.

This policy would also likely contribute to significant churn among the eligible population, where individuals lose coverage due to deemed non-compliance, and then are required to re-apply for coverage, where they are placed on a waiting list of potentially thousands of individuals prior to moving back onto coverage. Given this and that the administrative cost of churn is estimated to be between $400 and $600 per person,[21] this policy would be harmful to both the enrollees and the program. We urge the state to not move ahead with the proposed enrollment cap.

Waiving retroactive eligibility will leave more patients with medical debt and hospitals with uncompensated care.
Policies that reduce or eliminate retroactive eligibility place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals battling cancer. Therefore, we are concerned about the State's request to waive retroactive eligibility for this demonstration.

Many uninsured or underinsured individuals who are newly diagnosed with a chronic condition already do

not receive recommended services and follow-up care because of cost.[1,2] In 2019, three in ten uninsured adults went without care because of cost.[3] Waiving retroactive eligibility could mean even more people are unable to afford care and forgo necessary care due to cost.

Safety net hospitals and providers also rely on retroactive eligibility for reimbursement of provided services, allowing these facilities to keep the doors open. For example, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.[4] Retroactive eligibility allows hospitals to be reimbursed if the individual treated is eligible for Medicaid coverage. Likewise, Federally Qualified Health Centers (FQHCs) offer services to all persons, regardless of that person's ability to pay or insurance status.[5] Community health centers also play a large role in ensuring low-income individuals receive cancer screenings, helping to save South Carolina from the high costs of later stage cancer diagnosis and treatment. For these reasons, we urge the state to remove this waiver request from the application.

Conclusion

Ultimately, work reporting requirements and the other policies highlighted do not further the goals of the Medicaid program or help low-income individuals find work. The vast majority of those with Medicaid who can work already do so; nationally, 92% of individuals with Medicaid coverage under age 65 who do not receive Social Security disability benefits are either workers, caregivers, students, or unable to work due to illness.[22] Continuous Medicaid coverage can actually help people find and sustain employment. In a report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that being enrolled in Medicaid made it easier to work or look for work (83.5 percent and 60 percent, respectively).[23] That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Additionally, a study in The New England Journal of Medicine found that Arkansas's work requirement was associated with a significant loss of Medicaid coverage, but no corresponding increase in employment.[24] Terminating individuals' Medicaid coverage for non-compliance with these requirements will hurt rather than help Utahns search for and obtain employment.

Finally, South Carolina's proposal does not align with the work reporting requirements specified by Public Law 119-21, and the Secretary does not have the authority to waive these specifications. States may only use Section 1115 demonstrations to enact work reporting requirements earlier than 2027 if those demonstrations comply with the provisions of the law. South Carolina's current waiver proposal differs from these

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specifications in numerous ways. For example, federal law exempts parents, guardians, caretaker relatives, or family caregivers of a dependent child age 13 or under, however, South Carolina's proposal explicitly targets parents and caretakers and does not offer any exemptions for those caring for young children. As identified above, the proposal neglects several other exemption groups identified in P.L. 119-21, including individuals with mental and physical disabilities and inmates exiting incarceration. In addition, the law requires states to use available data to evaluate compliance with a work reporting requirement, including using wage data as a proxy to verify compliance. However, South Carolina's proposal has no clearly defined process for compliance verification and is unclear on how individuals will be able to demonstrate compliance or address inaccuracies if data sources fail to verify their eligibility. If the state wants to implement work reporting requirements before the statutory effective date of January 1, 2027, the Secretary should require that the state revise its amendment to comply with P.L. 119-21 and seek comment on the revised application at the state level (consistent with 42 C.F.R. 431.408) prior to resubmitting to CMS.

The goal of the Medicaid program is to provide health coverage and access to care for people who need it. We do not believe this proposal meets this goal, and we urge CMS to reject it. If you have any questions, please feel free to contact Jennifer Hoque at jennifer.hoque@cancer.org.

Sincerely,

Kirsten Sloan
Managing Director, Public Policy
American Cancer Society Cancer Action Network

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