August 10, 2017

VIA ELECTRONIC SUBMISSION

The Honorable Thomas Price, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Amendment to Arkansas Works 1115 Demonstration

Dear Secretary Price:

The National Health Law Program (NHeLP) protects and advances the health rights of low-income and underserved individuals. We appreciate the opportunity to comment on Arkansas' request to amend its Arkansas Works Demonstration Project. We support Arkansas' decision to accept federal funds to cover low-income adults through Medicaid. However, NHeLP recommends that HHS not approve several of the Arkansas Works amendments. The amendment application is fundamentally flawed and would be harmful to low-income people who need Medicaid coverage to obtain health care.

Procedural Issues

Arkansas submitted an incomplete extension application that consists of: a red-lined version of the State's currently approved Terms & Conditions; appendices with two notices of public hearings; and a summary of state-level public comments. The document provides no accompanying justification for the proposed changes and lacks sufficient detail on the purpose, hypotheses to be tested, or evaluation design to permit informed public comments on these provisions. It is also difficult to understand what exactly the State wants to change when presented in this format.

Federal regulations require that extension applications include a number of components that the State are missing from this application, including:

- a historical narrative summary of the demonstration project, including the initial objectives and evidence of progress toward meeting those objectives;
- a narrative of the requested changes;
- summaries of documentation of the quality of and access to care provided under the current demonstration;
- an evaluation report of the current demonstration; and an evaluation design for addressing proposed revisions.[1]

CMS should not certify extension applications as complete without these important components. They are crucial to helping the public understand the goals and justifications for the State's demonstration initiatives and, thus, its ability to participate meaningfully during the comment period.

We would also like to point out that the PDF posted on CMS's waiver website is not searchable, meaning that it is not accessible for individuals with disabilities who rely on screen readers to access documents electronically. This does not comply with § 508 of the Rehabilitation Act regarding accessibility of electronic documents for public comment.

Constraints to HHS Authority to Approve § 1115 Demonstrations

To be approved pursuant to § 1115, Arkansas' extension must:

- propose an "experiment[], pilot or demonstration;"
- waive only provisions of 42 U.S.C. § 1396a;
- be likely to promote the objectives of the Medicaid Act; and
- be approved only "to the extent and for the period necessary" to carry out the experiment.[2]

The purpose of Medicaid is to enable states to furnish medical assistance to individuals who are too poor to meet the costs of necessary medical care and to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care.[3] As explained below, Arkansas' proposals to phase down to a partial expansion, establish work requirements with a lockout for non-compliance, eliminate retroactive eligibility, and avoid ex parte review of certain beneficiaries before they are disenrolled cannot be approved because, separately and together, they are inconsistent with the provisions of § 1115.

Phasing down Expansion Eligibility to 100% FPL

Arkansas requests a waiver to phase down its adult eligibility limit from 133% FPL to 100% FPL while continuing to qualify for enhanced federal match. This proposal fails to meet § 1115 approval requirements on several levels: it serves no experimental purpose; it likely increases costs to the federal government; and it would also cut benefits and protections

[1] 42 C.F.R. § 431.412(c)(2).
[2] 42 U.S.C. § 1315(a).
[3] 42 U.S.C. § 1396.

for many low-income Arkansans, counter to the purpose of the Medicaid Act. Beneficiaries disenrolled from Medicaid would lose access to wraparound services, such as non-emergency medical transportation and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for enrollees under 21, as well as some Medicaid cost-sharing protections, such as a 5% aggregate cap on quarterly out-of-pocket expenses. Those individuals would also lose access to important due process protections, such as a right to a fair hearing, associated with the Medicaid program.

Other low-income working Arkansans may lose access to affordable coverage altogether if they have access to employer-sponsored insurance (ESI). The affordability threshold for ESI is 9.69% of household income in 2017. As long as the employee's share of premiums is below that threshold, she would not qualify for Marketplace tax credits or cost sharing reductions. If her ESI offer is also available to family members, they could not receive tax credits and CSRs either. ESI typically includes much higher cost sharing as well. That means that ESI, even if offered, will often be far too expensive for low-income working individuals and their spouses. For comparison, premiums for such households covered by Medicaid would not exceed 2% of household income under Arkansas' current demonstration and cost sharing is relatively low. Under this proposal, many low-income working adults would likely end up uninsured. The State does not acknowledge – let alone estimate – how many low-income working Arkansans will lose access to affordable coverage due to this proposed phase-out.

This eligibility cut is a mechanism to shift state costs to the federal government. Currently, the state pays a nominal state match – 6% in 2018 going to 10% in 2020 – for newly enrolled expansion adults enrolled in Marketplace through its premium assistance program. The partial expansion proposal would shift these state expenditures to the federal government, because the federal government would bear the full cost of covering the population that transitions from Medicaid to the Marketplace through premium tax credits and cost sharing reductions. HHS has previously made it clear that any proposal to implement partial expansion after 2016 would have to maintain the "same level of coverage, affordability and comprehensive coverage at no additional cost to the federal government."[4] This proposal will reduce coverage and shift costs onto the federal government.

Moreover, granting a partial expansion waiver would set a very dangerous precedent for other states that would subsequently seek to shift their costs to the federal government. Wisconsin, for example, has already received approval for a partial expansion to 100% FPL, but HHS rejected the State's request for enhanced match. Nothing has changed in the statutory structure since HHS established that precedent. Approving an enhanced match for Arkansas would likely trigger a flood of similar proposals from other states looking to save money by shifting costs to the federal government.

[4] CMS envisioned that any successful partial expansion proposal must require a 1332/1115 waiver that considers projected federal costs and coverage estimates for Medicaid and the Marketplace together. CMS, *Medicaid/CHIP Affordable Care Act Frequently Asked Questions: Exchanges, Market Reforms, and Medicaid*, 11 (Dec. 2012).

Premiums for Arkansas Works enrollees with incomes above 100% FPL

Strong evidence from relevant literature demonstrates that premiums reduce participation and access to care for low-income populations.[5] Nonetheless, in December 2016 Arkansas received approval to implement required premiums on expansion enrollees with incomes above 100% FPL. Nonpayment results in the accumulation of a debt to the state.

In this case, premiums serve no apparent policy purpose other than adding additional financial burdens to low-income enrollees, which does not promote the objectives of the program. Based on available evidence and voluminous past research, CMS should not allow premiums for Medicaid expansion enrollees.

Deletion of ex parte review requirement for phased out Medicaid enrollees

In addition to phasing out Medicaid expansion enrollees, the State deletes language from the current Terms and Conditions requiring the Medicaid agency to conduct administrative reviews for any affected enrollee in the event of a full or partial phase-down of the demonstration.[6] Grounded in core principles of due process, this type of "ex parte review" obligates the state to identify whether an affected individual might be eligible for Medicaid in another category before determining her ineligible.[7] As with the partial expansion, the proposal appears solely designed to cut costs.

Some individuals currently enrolled through the Medicaid expansion will be eligible through another category and would clearly benefit from staying in the Medicaid program. One example is pregnant women. Pregnant women would actually be exempt from premiums and cost sharing by shifting to the pregnancy category, while other people with disabilities may qualify for different services if they have not been previously identified. Others may have had an unreported change in income that puts them below the Federal Poverty Level, thus keeping them in the Medicaid premium assistance program. When Rhode Island terminated Medicaid coverage for parents over 138% of FPL in 2014, roughly one in four of the 6,574 affected parents remained eligible for Medicaid after their ex parte review.[8]

The Medicaid agency has a responsibility to ensure that its enrollees understand all their options and end up in the best coverage program to suit their needs. The ex parte

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[5] Samantha Artiga et al., KAISER FAM. FOUND., *The Effects of Premiums and Cost Sharing on Low-Income Populuations: Updated Review of Research Findings* (June 1, 2017), http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[6] STATE OF ARK., *Arkansas Works Extension Application*, 10 (June 30, 2017), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-pa2.pdf.

[7] 42 C.F.R. § 435.916(f).

[8] R.I. HEALTH COVERAGE PROJECT, *Health Coverage: How Did RI Do? What Now?*, 6 (May 20, 2014), http://economicprogressri.org/ndocs/RI%20HCP%20May%2020%202014%20Workshop%20Presentation.pdf. (Panel presentation including powerpoint on Medicaid enrollment from Sharon Kernan, R.I. EXEC. OFF. HEALTH & HUMAN SERVS.)

redetermination process should be maintained because it helps avoid breaks in coverage and the unnecessary administrative costs associated with them.

Work requirements

Arkansas seeks to impose a work requirement on individuals enrolled in Arkansas Works.[9] If an enrollee does not meet or properly document compliance in three cumulative months in a coverage year, the individual will be disenrolled and locked out from coverage for the rest of the coverage year. The demonstration seeks to "incentivize employment and increase the number of employed…beneficiaries."[10] States and CMS have worked in recent years to streamline Medicaid, in part, by making it more consistent with Medicare and other insurance programs, not by making it look like welfare programs such as TANF or SNAP. The proposed work requirement ignores this progress.

Under § 1115 and other relevant law, HHS has no authority to approve any waiver permitting Arkansas to condition Medicaid eligibility on compliance with work activities (and, thus, has never done so). Work requirements are an illegal condition of eligibility beyond the Medicaid eligibility criteria clearly enumerated in federal law. Medicaid is a medical assistance program, and although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide medical assistance to all individuals who qualify under federal law. As courts have held, additional eligibility requirements are illegal.[11]

Moreover, the work search requirements are not likely to assist in promoting the objectives of the Medicaid Act.[12] As noted earlier, the purpose of Medicaid is to enable states to furnish medical assistance to low-income individuals who cannot afford the costs of medically necessary services and to furnish "rehabilitation and other services to help [such individuals] attain or retain capability for independence or self-care.[13] Conditioning Medicaid eligibility on completion of a work requirement gets it exactly backwards by blocking access to the care and services that help individuals attain and retain independence or self-care that then enables them to work. Research confirms that *Medicaid coverage allows*

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[9] STATE OF ARK., *supra* note 6, at 8.
[10] *Id.*, at 6-7.
[11] See, *e.g.*, *Camacho v. Texas Workforce Comm'n,* 408 F.3d 229, 235 (5th Cir. 2005) (enjoining Texas regulation that terminated Medicaid coverage of TANF recipients who were substance abusers or whose children did were not getting immunizations, check-ups, or were missing school because regulation was inconsistent with Medicaid and TANF statutes); *see also Dalton v. Little Rock Family Planning Services*, 516 U.S. 474, 478 (1996) (holding state coverage of abortion services needed to be consistent with federal provisions setting forth the circumstance for that coverage).
[12] By contrast, as far back as the 1970s, states obtained section 1115 waivers to test work requirements in the AFDC program (which, unlike Medicaid, does have work promotion as a purpose of the program). These waivers required states to conduct "rigorous evaluations of the impact," typically requiring the random assignment of one group to a program operating under traditional rules and another to a program using the more restrictive waiver rules. UNITED STATES DEP'T OF HEALTH & HUMAN SERVS., *State Welfare Waivers: An Overview*, http://aspe.hhs.gov.hsp/isp/waiver2/waivers.htm.
[13] 42 U.S.C. § 1396-1.

individuals to obtain and maintain employment. For example, more than half of individuals enrolled in the Medicaid expansion in Ohio reported that Medicaid coverage has made it easier to continue working. Among enrollees who did not have a job, three-quarters reported that Medicaid coverage made it easier for them to look for one.[14]

The work requirement will be particularly counterproductive for the many individuals with chronic conditions – including mental illnesses and substance use disorders – that affect their ability work but do not qualify them for disability benefits. A recent study by the Kaiser Family Foundation found that 35% of adult Medicaid enrollees who were not receiving disability benefits and did not have a job reported illness or disability as their primary reason for not working.[15] While the proposal indicates that the work requirement will not apply to beneficiaries who are medically frail or who are physically or mentally unable to work, the State's screening process will be problematic. Evidence from other programs with similar exemptions shows that, in practice, individuals with disabilities are not exempted as they should be – often due to verification requirements – and are more likely than other individuals to lose benefits.[16]

Numerous studies of state Temporary Assistance for Needy Families (TANF) programs have found that participants with physical and mental health issues are disproportionately likely to be sanctioned for not completing the work requirement.[17] Such individuals may not understand what is required of them, or may find it difficult to complete the necessary paperwork or to travel to appointments to be assessed for an exemption.

Evidence from the Supplemental Nutrition Assistance Program (SNAP) suggests that roughly one in five SNAP participants has a disability but does not receive disability benefits, and many of these individuals are not exempted from the SNAP work requirement.[18] One study from Franklin County, Ohio found that one-third of individuals referred to a SNAP employment and training program in order to keep their benefits reported a physical or mental limitation, and 25% of these individuals indicated that the condition limited their daily activities. Additionally, almost 20% of the individuals had filed

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[14] OHIO DEP'T OF MEDICAID, *Ohio Medicaid Group VII Assessment: A Report to the Ohio General Assembly*, (2017), http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[15] Rachel Garfield, KAISER FAMILY FOUND., *Understanding the Intersection of Medicaid and Work* (2017), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

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

[17] *See, e.g.*, Yeheskel Hasenfeld et al., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* (June 2004) (Departmental Paper University of Pennsylvania School of Social Policy and Practice), http://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers.

[18] Michael Morris et al., BURTON BLATT INST. AT SYRACUSE UNIV., *Impact of the Work Requirement in Supplemental Nutrition Assistance (SNAP) on Low-Income Working-Age People with Disabilities,* 4, 14 (2014).

for SSI or SSDI within the previous two years.[19] States are often not prepared to correctly identify and exempt these individuals. For example, when Georgia's SNAP work requirement waiver expired in 2016, the State found that 62% of nearly 12,000 individuals subject to the requirement were disenrolled after just three months.[20] State officials acknowledged that hundreds of enrollees had been wrongly classified as "able-bodied" when they were actually unable to work.[21]

We are extremely concerned that the State's exemption process, whatever it is, will fail to identify all enrollees who should be exempt.[22] Even with an effective screen, the increased burden of verifying and reverifying an exemption will likely increase disenrollment of individuals who may be substantively compliant with work activity requirements or exempt, but encounter difficulties with the administrative process. This will only be made worse by the State's limited approach that would force all enrollees to report compliance with the requirement (or an exemption) through an electronic portal. Providing access to a computer in a county office is an inadequate accommodation for the many individuals who have limited internet access or who may have challenges engaging with the electronic portal for a variety of reasons.[23]

Because conditioning Medicaid eligibility on completion of the work requirement will disqualify individuals with chronic and disabling conditions, the requirement implicates the civil rights protections contained in the Americans with Disabilities Act (ADA) and § 504 of the Rehabilitation Act.[24] These laws make it illegal for states to take actions that have a discriminatory impact on people with disabilities, and they not be waived under § 1115 or under any other authority of the Secretary.[25]

In addition, extensive research reveals that a mandatory work requirement does not effectively increase self-sufficiency. Studies of cash assistance programs have already established that a work requirement does little to increase stable, long-term employment and does not decrease poverty.[26] In fact, work requirements have had the reverse effect for some, leading to an increase in extreme poverty in some areas of the country, as individuals who do not secure employment lose their eligibility for cash assistance.[27]

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[19] OHIO ASS'N OF FOODBANKS, *Comprehensive Report: Able-Bodied Adults without Dependents* (2015), http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_204-2015-v3.pdf.
[20] *Correction: Benefits Dropped Story*, U.S. NEWS & WORLD REPORT, https://www.usnews.com/news/best-states/georgia/articles/2017-05-25/work-requirements-drop-thousands-in-georgia-from-food-stamps, (May 26,2017).
[21] *Id.*
[22] STATE OF ARK., *supra* note 6, at 23.
[23] *Id.* at 57.
[24] 42 U.S.C. § 12312; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (prohibiting recipients of federal funds from discriminating on the basis of disability).
[25] See *Burns-Vidlak v. Chandler*, 939 F. Supp. 765, 772 (D. Haw. 1996).
[26] LaDonna Pavetti, CTR. ON BUDGET & POL'Y PRIORITIES, *Work Requirements Don't' Cut Poverty, Evidence Shows* (2016); Sandra K. Danziger et al., *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 J. POL'Y ANALYSIS & MANAGEMENT 231, 234 (2016).
[27] *Id. See also*, Pamela Loprest & Austin Nichols, URBAN INSTITUTE, *Dynamics of Being Disconnected from Work and TANF* (2011), http://www.urban.org/research/publication/dynamics-being-disconnected-work-and-tanf; Sandra K. Danziger et al., *supra* note 26.

A far more productive approach would be to connect Arkansas Works enrollees to properly-resourced voluntary employment programs. Studies show that these voluntary employment programs increase employment and income among low-income individuals. For example, a rigorous evaluation of Jobs Plus, a voluntary employment program for public housing residents, found that the program produced substantial and sustained gains in earnings when fully implemented.[28] The key here is that employment programs require significant investments in job training, educational opportunities, child care and other supports that make it possible to realize long-term gains. But the application only suggests that DHS will provide low-touch job search assistance and work with the Department of Workforce Services to facilitate access to training and other resources.

The State provides no indication that it would increase availability of these services once tens of thousands of Medicaid enrollees become subject to a work requirement. Effective employment and training services are expensive. In Arkansas' SNAP Employment and Training program, the State pays $161 just for a basic job search training with a skills assessment.[29] A voucher for workforce training under the Workforce Investment Act averaged more like $3,000 per participant in 2012.[30] Yet, none of that "infrastructure" is proposed here. If Arkansas is serious about improving the employment outcomes for Medicaid enrollees, it would need to substantially increase investments in meaningful training services on a much broader scale. This proposal merely imposes a requirement with no clear strategy for an effective job search program.

In summary, the work requirement stands Medicaid's purpose on its head by creating new barriers to coverage and the pathway to health that the coverage represents. The end result of this policy will likely be fewer people with Medicaid coverage and more uninsured people delaying treatment and later seeking uncompensated care in hospitals and federally qualified health centers. There will be more gaps in coverage, meaning more expensive treatment when eligibility is eventually regained. Hospitals and community health centers will suffer financially as they are expected to treat more people with chronic or acute illness with less funding. The State will have to develop costly and burdensome administrative procedures to track employment and exemptions, a budgetary impact that the proposal needs to quantify. We note that most individuals who will be subject to the requirement are already working and

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[28] Howard Bloom et al., MDRC, *Promoting Work in Public Housing: The Effectiveness of Jobs-Plus* (2005), https://www.doleta.gov/research/pdf/jobs_plus_3.pdf; James A. Riccio, MDRC, *Sustained Earnings Gains for Residents in a Public Housing Jobs Program: Seven-Year Findings from the Jobs-Plus Demonstration* (2010), http://files.eric.ed.gov/fulltext/ED514703.pdf.

[29] ARK. DEPT. WORKFORCE SERVS., *WIOA State Plan for the State of Arkansas*, 355 (Jan. 2017), http://www.arkansas.gov/esd/AWDB/pdfs/stateplan/Approved%20WIOA%20Combined%20State%20Plan%201-18-2017.pdf.

[30] Sheena McConnell et al., MATHEMATICA, *Providing Public Workforce Services to Job Seekers: 15-Month Impact Findings on the WIA Adult and Dislocated Worker Programs,* 59 (May 2016), https://www.mathematica-mpr.com/our-publications-and-findings/publications/providing-public-workforce-services-to-job-seekers-15-month-impact-findings-on-the-wia-adult. For participants enrolled in WIA services from November 2011 through April 2013, the median Individual Training Account, which provided vouchers to attend approved training programs, was $3,000.

do not need additional "encouragement" to obtain or maintain employment.[31] For them, this proposal will only add red tape and increase administrative burden.

For these and other reasons, HHS has consistently denied other states' requests to impose a work requirement on individuals who are seeking medical assistance through the Medicaid program. The Secretary should continue to honor that precedent in this case.

Along with the work requirement, Arkansas has proposed a lock out on enrollees who fail to properly complete or document their compliance with the work requirement. This lockout, which extends to the end of an individual's plan year, could last as long as 9 months. Among other things, disenrollment with lockouts will increase churn and cut thousands of Arkansans off from Medicaid coverage. Indiana's recent evaluation of the Healthy Indiana Program (HIP) showed that individual's locked out from Medicaid were likely to remain uninsured and reported substantially higher barriers accessing needed care.[32]

The Secretary should set an extremely high bar for states that want to *prohibit* individuals from obtaining health insurance coverage that they will need for medically necessary, often unpredictable, health care. This proposal does not come close to meeting the requirements for a section 1115 waiver.

Retroactive Eligibility

Medicaid requires states to provide retroactive coverage for enrollees.[33] Arkansas has requested § 1115 demonstration authority to waive this requirement. In its application and response to public comments objecting to this provision, Arkansas argues that retroactive coverage affects relatively few individuals, but this unsupported claim is not nearly enough to justify waiving this important Medicaid requirement.[34]

This waiver is not limited to enrollees in the Arkansas Works demonstration, but would also apply to individuals excluded from the demonstration after being determined medically frail. We strongly support CMS's recent rejection of Arizona's request to reapprove a retroactive eligibility waiver in its last approval of that state's comprehensive waiver, and we urge CMS to deny this waiver as well. This important Medicaid protection shields Medicaid-eligible individuals from financially devastating medical debts and improves provider's financial stability (and willingness to participate in Medicaid) by reducing uncompensated care claims.

Moreover, there is no demonstration value to the State's request to waive this provision. The entirely predictable result will be: (1) more low-income individuals experiencing medical debt collections and bankruptcy; (2) more providers – especially safety net hospitals –

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

[32] LEWIN GROUP, *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment*, 22 (Mar. 31, 2017).

[33] 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.915.

[34] STATE OF ARK., *supra* note 5, at 55.

incurring losses; and (3) more individuals experiencing gaps in coverage when some providers refuse to treat them because the providers know they will not be paid retroactively by Medicaid. This policy promises very concrete harms, particularly since the State proposes to apply this provision to medically frail individuals who may have already required hospital or nursing home care prior to applying.

We also note that Arkansas' previous approval was conditioned on the State completing its Backlog Mitigation plan and implementing presumptive eligibility for hospitals to minimize the potential harms to enrollees and providers from a retroactive eligibility waiver. It has provided no evidence that it lived up to these promises, and now, the State has removed this requirement from its proposal as well as any indication that it will monitor or evaluate the effects of the waiver on access to care and provider solvency and participation. Aside from the questionable legality, the State should not be allowed to implement a critical cutback in Medicaid coverage when it did not comply with the previous requirements for the waiver.

Conclusion

Thank you for consideration of our comments. If you have any questions, please contact David Machledt, Sr. Policy Analyst (machledt@healthlaw.org) or Jane Perkins, Legal Director (perkins@healthlaw.org).

Sincerely,

Jane Perkins
Legal Director