

HHS Approves Harmful Section 1115 Waiver Project in Arkansas – Including Work Requirements with Lockouts

By [David Machledt](#)

The U.S. Department of Health and Human Services (HHS) [approved](#) in March a damaging new Section 1115 waiver project called “Arkansas Works.”¹ This approval adds new waivers that will dramatically worsen access to care. The approved waiver also allows Arkansas to continue to ignore numerous critical and long-standing Medicaid protections for eligible Arkansans.

The now approved project doubles down on existing provisions that discourage enrollment, like premiums, and then adds even more red tape, including conditioning health coverage on fulfilling a work requirement. All told, hundreds of thousands of Arkansans with low incomes and few resources will be hurt by the changes in this 1115 project, and tens of thousands may lose coverage.

Under the law, HHS is only allowed to approve section 1115 demonstration programs that are experimental and likely to promote the objective of Medicaid — which is to help *furnish* health services to enrollees.² HHS’s approval raises a number of legal questions involving not only the purported demonstration quality of the project but also whether the harm that the project will cause – reducing access to coverage and care for low-income Arkansans – reflects Medicaid’s objectives.

Among the worst **new** features of the approved Arkansas project are:

Work requirements. Arkansas received approval to require individuals aged 19 to 49 to complete at least 80 hours of qualifying activities (e.g. employment, education, community service) every month. Individuals subject to this requirement who do not fulfill the 80 hours for 3 months in any calendar year may be terminated from Medicaid and not allowed to reapply until the following year. Some exemptions for caretaking, health status, and life circumstances apply.

- Work requirements like these are not permitted by the Medicaid Act and do not meet the Sec. 1115 standards. In late 2016, HHS reviewed the possibility of work requirements and concluded the agency lacks the legal authority to allow states to implement them.³
- Most Medicaid enrollees live in working households. The vast majority of those who are not working have a disabling condition or are retired, in school, or caretakers. Other Medicaid enrollees who are not working simply cannot find a job.⁴
- Work requirements harm all Medicaid enrollees in the waiver program, *including workers*. All enrollees in Arkansas Works will need to prove they are working or meet

one of the exemptions. Enrollees who do not verify work activities or qualify for an exemption will be disenrolled and locked out. This reporting requirement makes it harder to stay covered. Moreover, the state requires people to verify hours or exemptions online. Individuals with limited internet access may face significant barriers just to report their hours every month or verify their exemption.

- Arkansas claims that it will exempt medically frail enrollees from work requirements. However, the state's current system has only flagged about [7.5 percent of applicants](#) as medically frail. This number falls far short of other states' enrollment estimates for Medicaid expansion enrollees with disabilities and serious chronic conditions. For example, Indiana classifies nearly [20 percent](#) as medically frail. Ohio estimates almost [21 percent](#) of expansion enrollees have significant disabilities (and are not currently working) while about [a third](#) report depression or anxiety disorders that limited routine activities, including employment. Arkansas's gross undercount suggests the state's work requirements may fail to exempt tens of thousands of enrollees with disabilities who face substantial barriers to work force participation.⁵
- Arkansas has not provided estimates of how many enrollees may lose coverage due to the work requirement. But Indiana projects its work requirement will cause 25,000 Hoosiers to lose coverage when fully implemented.⁶ Notably, those estimates do not include thousands more already working or exempt enrollees who will lose coverage due to added red tape to verify their work hours or exemptions.
- Studies show that mandatory work requirements do not effectively improve long-term secure employment. In Wisconsin's food support program that conditions benefits on employment, for every person that gained employment, more than three people lost access to food support.⁷
- Unlike Arkansas' mandatory work requirement, voluntary employment support programs have proven highly effective [if-and-when](#) properly resourced.⁸ In this case, Arkansas has added a bundle of red-tape mandates, but this approval offers no added resources to create new employment opportunities or increase support for job training, education, or affordable childcare. This mandate for work is punishment, not progress.
- There is no evidence that mandatory work programs make people healthier. In contrast, evidence does show that health coverage helps people gain and maintain employment.⁹ As a policy to promote work, mandatory work requirements are counterproductive.

Coverage lock-outs. Medicaid law allows eligible individuals to apply and (if they ever lose coverage) re-apply at any time. Despite the legal requirement, Arkansas will lock people out of coverage (i.e., bar them from re-applying) for the remainder of the coverage year if they do not meet the work requirement. Many people will be unaware of these requirements or unable to submit documentation on time because they have a low-wage job that is paid in cash, have moved, or do not have a steady address to receive mail.

- The lockout period in Arkansas is up to eight months if the person cannot meet the work requirements or provide documentation in the first three months of the coverage year. This will leave many individuals unable to access health care for the majority of the year. Churning in and out of Medicaid, or having extended periods without insurance, is linked with inconsistent treatment for chronic conditions and poorer health outcomes.
- Locking people out of coverage directly contradicts the objective of Medicaid – to furnish health care.

Retroactive coverage shortened from 90 days to 30 days. Many individuals apply for Medicaid *after* a fall, accident, or serious illness that requires urgent treatment. Medicaid law requires states to provide retroactive coverage so treatment received before applying to Medicaid is covered.

- This provision helps protect consumers and also medical providers (such as hospitals) from bankruptcies due to expensive, uninsured care.
- This waiver explicitly reduces coverage for enrollees and directly opposes the objectives of Medicaid to furnish medical assistance to low income individuals.
- The stated justification – that this change will encourage people to sign up before getting sick – assumes that people avoid signing up for Medicaid because they know retroactive eligibility is available. This is a red herring. Few people know before applying for Medicaid that retroactive eligibility exists, so it plays little role in their decision to apply or not.

The approved Sec. 1115 waiver includes **existing** waivers for policies that add roadblocks to coverage and make accessing care more complicated and costly. Though Medicaid law expressly prohibits premiums for individuals under 150 percent of the federal poverty line, the approval allows Arkansas to continue to charge premiums to individuals just above poverty. The state [plans to collect](#) on past due premium debts through garnishing income tax returns. Numerous studies consistently show that imposing premiums on low-income individuals means fewer people will stay on Medicaid. There is nothing experimental about charging premiums, and the known outcome contradicts the objectives of Medicaid.

Finally, Arkansas has a tarnished history of implementing new policies related to Medicaid expansion, yet the state has laid out an extremely aggressive timeline to operationalize work requirements – potentially as soon as June 2018. In prior years, the state abandoned a program to implement health expense accounts for Medicaid enrollees due to massive complexity and administrative costs exceeding [\\$9 million](#) per year. The state also struggled with a persistent and substantial backlog in processing applications and has not implemented a hospital “presumptive eligibility” policy.¹⁰ CMS seems to acknowledge this poor implementation record by requiring the state to develop an eligibility and enrollment monitoring plan, but prior Sec. 1115 approvals also required

remedial actions from the state with mixed results and delays. This history of implementation failures and cost overruns raises serious doubts about the State agency's readiness and how the readiness issues may greatly exacerbate the negative impact of added red tape from work requirements.

¹ Centers for Medicare and Medicaid Services, Arkansas Works Health Approval Letter and Special Terms and Conditions (Mar. 5, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf>.

² See Social Security Act §§ 1115 and 1901.

³ See Centers for Medicare and Medicaid Services, AHCCCS 1115 Demonstration Extension 2 (Sept. 30, 2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-demo-ext-09302016.pdf>; Letter from Vikki Wachino, Director, CMS, to Jeffrey A. Meyers, Comm'r, N.H. Dep't of Health & Human Servs. 1-2 (Nov. 1, 2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-cms-response-110116.pdf>.

⁴ Rachel Garfield, Robin Rudowitz and Anthony Damico, Kaiser Family Foundation, *Understanding the Intersection of Medicaid and Work* at Figures 1 and 6 (Dec. 2017), <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>.

⁵ Some may request a "good cause exemption," but the approval suggests this exemption must be requested monthly, which could prove quite burdensome.

⁶ Indiana's 1115 waiver has higher enrollment, with roughly 400,000 individuals compared to just over 300,000 in Arkansas. Robert M. Damler et al., Milliman, *1115 Waiver – Healthy Indiana Plan*, 4 (May 24, 2017), attached to HIP 2.0 application.

⁷ *FoodShare Employment and Training (FSET) Program Cumulative Data*, Wisc. Dep't of Health Servs. (May 5, 2017), <https://www.dhs.wisconsin.gov/initiatives/fset-cumulative.htm>.

⁸ 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>.

⁹ See Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* 46 (Dec. 2016), <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>; Jean P. Hall, Adele Shartzter, Noelle K. Kurth, Kathleen C. Thomas, *Effect of Medicaid Expansion on Workforce Participation for People With Disabilities*, 107 Am. J. Pub. Health 262-264 (Feb. 1, 2017).

¹⁰ Presumptive eligibility allows hospitals and other providers to provide provisional Medicaid eligibility for uninsured patients who are likely Medicaid eligible to reduce uncompensated care.