February 5, 2018

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Arizona Section 1115 Waiver Amendment—AHCCCS Works

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and under-served people. We appreciate the opportunity to provide these comments on the proposed AHCCCS Works Waiver Amendment. NHeLP asks the Department of Health & Human Services (HHS) to reject Arizona's request. It does not comply with the requirements of § 1115 of the Social Security Act, and it will restrict low-income individuals' access to vital health care services.

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I. HHS Authority and § 1115

To be approved pursuant to § 1115, Kansas's application must:

- propose an "experiment[], pilot or demonstration,"
- waive compliance only with requirements in 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.[1]

The purpose of Medicaid is to enable states to furnish medical assistance to individuals whose income is too low to meet the costs of necessary medical care and to furnish rehabilitation and other services to help these individuals attain or retain the capacity for independence and self-care.[2] Arizona's proposal is inconsistent with the provisions of § 1115.

Work Requirements

Arizona has requested permission to require individuals in the Medicaid "Group VIII" expansion population to complete at least 20 hours of work or other approved activities each week. After an initial grace period of six months, individuals who do not meet the requirement and do not fall within a specified exemption will be terminated from Medicaid. Individuals will only be able to regain eligibility by meeting the requirement for a 30-day period.[3] The State estimates that nearly 400,000 residents will be affected by these work requirements—they will be required to work or to demonstrate they qualify for an exemption.

Although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide medical assistance to all individuals who meet the eligibility criteria established in the federal law. Multiple courts have held that additional eligibility requirements are illegal.[4] Work requirements are not

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[1] 42 U.S.C. § 1315(a).
[2] 42 U.S.C. § 1396-1.
[3] Arizona Section 1115 Waiver Amendment Request: AHCCCS Works Waiver Application (Request) at 4.
[4] *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 were not getting immunizations or check-ups or were missing school because regulation was inconsistent with Medicaid and TANF statutes).

included in the Medicaid eligibility criteria enumerated in federal law. The Medicaid Act does not authorize work requirements.

Section 1115 of the Social Security Act cannot be used to make an end-run around the Medicaid Act's eligibility provisions because there is no basis for finding that work requirements are likely to assist in promoting the objectives of the Medicaid Act.[5] 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.[6] Unlike some other Social Security Act programs, Medicaid is not a work program. Medicaid is a medical assistance program.

The Dear State Medicaid Director (DSMD) Letter that you issued on January 11, 2018 seeks to justify use of § 1115 to condition Medicaid coverage on mandatory work. We raised concerns about the DSMD in a letter to you on January 11, 2018 (incorporated by reference and attached hereto as Ex. A).[7] As that letter and the incorporated Statement of Review explain, the research cited in DSMD Letter does not support the conclusion that mandatory work will make people healthy.

Similarly, Arizona cites four articles as documenting the association between unemployment and poor health in an attempt to support the punitive work requirement.[8] However, Arizona oversimplifies the complex and nuanced relationship between employment and health that these articles discuss. None of the studies cited suggest that *requiring* work as a condition of Medicaid eligibility is likely to improve health outcomes. In fact, all of the studies find that the quality of employment matters. For example, unemployed individuals who become employed in poor quality (low-wage, low-status) jobs have poorer mental health than unemployed individuals.[9]

The literature cited in the DSMD Letter and in the Arizona Request do not provide evidentiary support for imposing a punitive work requirement on Medicaid enrollees. What studies do establish is that conditioning Medicaid eligibility on completion of work activities gets it exactly backwards. Medicaid coverage allows

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[5] 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.

[6] 42 U.S.C. § 1396-1.

[7] Letter from Jane Perkins, National Health Law Program, to Brian Neale, Director, Centers for Medicare & Medicaid Services (Jan. 11, 2018).

[8] Request at 3.

[9] Hegenrather K et al., Employment as a Social determinant of Health: A Systematic Review of Longitudinal Studies Exploring the Relationship Between Employment Status and Mental Health, 29 Rehabilitation Research, Policy, and Education 261, 279-80 (2015). Most of the studies cited do not include under-represented populations, and some of them rely on data from countries, such as Germany, with some variation of universal government-funded health care.

people to get access to the care and services that help them to be able to work and maintain employment.[10] 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.[11] Imposing work requirements will reverse this progress and cause individuals to lose coverage.[12]

Moreover, the vast majority of individuals enrolled in Medicaid already work or have good reason for not working.[13] A recent study by the Kaiser Family Foundation found that 61% of non-SSI, nonelderly enrollees work, with 42% working full-time, and 18% maintaining part-time employment.[14] Enrollees who did not have a job were not working because they were dealing with illness or disability (36%); going to school (15%); taking care of their home or family (30%); retired (9%); or unable to find work (6%).[15] Additional data also shows what common sense tells us—that illness and poor health keep individuals from working.[16] These individuals depend on consistent access to care and treatment in order to stay healthy and lead productive lives. The policies contemplated by the Arizona Request will place access to these services in jeopardy,

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[10] Jesse Cross-Call, "More Evidence Medicaid Expansion Boosts Health, Well-Being," Center on Budget and Policy Priorities (Jan. 8, 2018), https://www.cbpp.org/blog/more-evidence-medicaid-expansion-boosts-health-well-being?utm_source=CBPP+Email+Updates&utm_campaign=3434e0fd00-EMAIL_CAMPAIGN_2018_01_12&utm_medium=email&utm_term=0_ee3f6da374-3434e0fd00-111113873; Renuka Tipirneni et al., Institute for Healthcare Policy and Innovation, University of Michigan, *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches*, (2017), available at http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches; Louija Hou et al., "Working Paper No. 22170: The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being," National Bureau of Economic Research, (2016), available at http://nber.org/papers/w22170; Nicole Dissault, Maxim Pinkovskiy, and Basit Zafar, *Is Health Insurance Good for Your Financial Health?* Liberty Street Economics Blog, June 6, 2016 online at http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-yourfinancial-health.html#.V4lHI6It7VJ.

[11] 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. Medicaid expansion also benefits the providers who serve low-income people. Uncompensated care dropped significantly in Arizona as a result of the Medicaid expansion. *See* Arizona Hospitals and Healthcare Association, April 2014 Hospital Financial Results; *see also* Ken Alltucker, *Unpaid Hospital bills drop after Medicaid expansion*, The Arizona Republic, July 13, 2014, http://azcentral.com/story/money/ business/2014/07/13/arizona-medicaid-reduce-unpaid-hospital-bills/12591331.

[12] LaDonna Pavetti, Michelle Derr, and Emily Sama Martin, *Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments*, (2008); Robert Rector, Heritage Foundation, *Work Requirements in Medicaid Won't Work. Here's a Serious Alternative* (2017), available at: http://www.heritage.org/health-care-reform/commentary/work-requirements-medicaid-wont-work-heres-serious-alternative; Hannah Katch, Center on Budget and Policy Priorities, *Medicaid Work Requirements Would Limit Health Care Access Without Significantly Boosting Employment*, (2016), available at: http://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly.

[13] Rachel Garfield, Robin Rudowitz, Anthony Damico, Kaiser Family Foundation, *Understanding the Intersection of Medicaid and Work,* http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work (updated Jan. 2018) (finding that almost 80% of non-SSI, nonelderly adults enrolled in Medicaid live in families with at least one work, and 60% are working themselves).

[14] *Id.*

[15] *Id.*

[16] *Id.* at Table 4b (In Arizona, while 81% of individuals who reported being in "excellent" or "very good" health were working, that number dropped to 66% for individuals in "good" health, and to just 31% for individuals in "fair/poor" health).

worsening health outcomes for those affected and removing any chances of economic mobility.

While Arizona's application indicates that the work requirements will not apply to individuals who are receiving disability benefits, are determined to be medically frail, or have a serious mental illness, the State will not exempt other individuals who are unable to meet the requirements due to a health condition, whether chronic or acute. Evidence from other programs shows that, even when there is an explicit exemption for individuals unable to comply due to health conditions, in practice, individuals with disabilities are not exempted as they should be and are more likely than other individuals to lose benefits.[17] We strongly support efforts to provide resources and accommodations to help people find and maintain jobs, particularly those with health insurance. But a mandatory work requirement will not help accomplish this goal. Numerous redundant and consistent 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.[18]

Evidence from the Supplemental Nutrition Assistance Program (SNAP) also already demonstrates the outcomes of work requirements. Researchers have expressed concern that states regularly fail to exempt from work requirements many of the nearly 20% of all SNAP participants who have a disability but receive no disability benefits.[19] One study from Franklin County, Ohio found that one-third of individuals required to participate in a SNAP employment and training program to keep their benefits reported a physical or mental limitation. Additionally, almost 20% of the individuals had filed for SSI or SSDI within the previous two years.[20] In another example, when Georgia reinstated the SNAP work requirement and time limits for "able-bodied adults without dependents" in 2016, the State found that 62% of nearly 12,000 individuals subject to the requirement were disenrolled after only three months.[21] State

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[17] *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).

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

[19] *See* 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).

[20] Ohio Association of Foodbanks, *Comprehensive Report: Able-Bodied Adults Without Dependents* (2015), http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_204-2015-v3.pdf.

[21] *Correction: Benefits Dropped Story*, U.S. News & World Report, (May 26, 2017), https://www.usnews.com/news/best-states/georgia/articles/2017-05-25/work-requirements-drop-thousands-in-georgia-from-food-stamps.

officials acknowledged that hundreds of enrollees had been wrongly classified as "able-bodied" when they were actually unable to work.[22]

Because conditioning Medicaid eligibility on completion of the work requirement will disproportionately harm 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.[23] These laws make it illegal for states to take actions that have a discriminatory impact on people with disabilities, and they cannot be waived under § 1115 or under any other authority of the Secretary.[24]

Evidence also shows that work requirements may exacerbate health disparities for people of color. In one study based on experimental survey and actual case data, researchers found that African American individuals were more likely to be sanctioned for noncompliance than white individuals, raising concerns that Arizona's proposal will increase racial disparities in the state.[25]

The work requirements will also pose a barrier to coverage even for individuals who are working.[26] Data shows that most low-income workers have jobs with variable and unpredictable schedules, for instance in construction, retail, or food service, which can make it difficult to comply with the State's weekly-hours requirements.[27] Moreover, even individuals who do comply with the weekly-hours requirements will have to verify their hours to maintain their eligibility. The verification requirements have no relationship to private insurance policies and will inevitably lead to increased disenrollment solely for failure to complete paperwork.[28]

The work requirements will particularly affect children of parents and caretakers who are eligible as a result of Group VIII expansion coverage. The unstable childcare arrangements that many families rely on when they have low-wage work with uncertain

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[22] *Id*.
[23] 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).
[24] See *Burns-Vidlak v. Chandler*, 939 F. Supp. 765, 772 (D. Haw. 1996).

[26] *See e.g.*, Julia B. Isaacs, Michael Katz, and David Kassabian, *Changing Policies to Streamline Access to Medicaid, SNAP, and Child Care Assistance*, Urban Institute, March 2016, http://www.urban.org/sites/default/files/publication/78846/2000668-Changing-Policies-to-Streamline-Access-to-Medicaid-SNAP-and-Child-Care-Assistance-Findings-from-the-Work-Support-Strategies-Evaluation.pdf
[27] Susan J. Lambert, Peter J. Fugiel and Julia R. Henly, *Precarious Work Schedules among Early-Career Employees in the US: A National Snapshot*, University of Chicago, (2014) available at https://ssascholars.uchicago.edu/sites/default/files/work-scheduling-study/files/lambert.fugiel.henly_.precarious_work_schedules.august2014_0.pdf; Stephanie Luce, Sasha Hammad and Darrah Sipe, Retail Action Project, *Short Shifted,* September 2014, http://retailactionproject.org/wp-content/uploads/2014/09/ShortShifted_report_FINAL.pdf; Liz Ben-Ishai, CLASP, *Volatile Job Schedules and Access to Public Benefits*, September 2015, http://www.clasp.org/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf
[28] Margot Sanger-Katz, "Hate Paperwork? Medicaid Recipients Will Be Drowning In It," N.Y. Times (Jan. 18, 2018) https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html?nytapp=true&_r=0; Tazra Mitchell and LaDonna Pavetti, *Life After TANF in Kansas: For Most, Unsteady Work and Earnings Below Half the Poverty Line*, Center on Budget and Policy Priorities (Jan. 23, 2018).

schedules can harm a child's health development.[29] Numerous studies find a relationship between childcare stability, attachment, and child outcomes including effects on social competence, behavior outcomes, cognitive outcomes, language development, school adjustment, and overall child well-being.[30] The effect of parental low wage jobs and childcare instability may particularly impact children living in poverty.[31] Notably, Arizona's proposal is completely silent on increasing resources for affordable, quality childcare. To implement work requirements in Medicaid despite evidence that such requirements would likely cause harm to children and their development would be contrary to purpose of the Medicaid Act.

As this evidence demonstrates, imposing work requirements would inevitably lead to a large number of individuals, including those who are already working or exempt, losing Medicaid coverage.[32] This outcome is directly at odds with the objectives of the Medicaid Act. Furthermore, it is well-documented that gaps in coverage substantially worsen health outcomes[33] and increase medical debt and financial insecurity.[34]

In addition to the dramatic harms work requirements would cause, extensive research reveals that a mandatory work requirement does little or nothing to increase stable, long-term employment and does not decrease poverty.[35] In fact, work requirements have had the reverse effect, leading to an increase in extreme poverty in

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[29] Gina Adams and Monica Rohacek, Urban Inst, *Child Care Instability: Definitions, Context, and Policy Implications* (Oct. 2010), https://www.urban.org/sites/default/files/publication/29446/412278-Child-Care-Instability-Definitions-Context-and-Policy-Implications.PDF.
[30] *Id.* at 7.
[31] *Id.* at 8.
[32] Leighton Ku and Erin Brantley, *Medicaid Work Requirements: Who's At Risk?* Health Affairs Blog, Apr. 12, 2017, http://healthaffairs.org/blog/2017/04/12/medicaid-work-requirements-whos-at-risk/)
[33] Benjamin D. Sommers, Atul A. Gawande, and Katherine Baicker, *Health Insurance Coverage and Health — What the Recent Evidence Tells Us*, 377 New England Journal of Medicine 586 (2017), available at http://www.nejm.org/doi/full/10.1056/NEJMsb1706645; A.G. Hall, J.S. Harman, and J. Zhang, *Lapses in Medicaid coverage: impact on cost and utilization among individuals with diabetes enrolled in Medicaid*, 48 Medical Care 1219 (2008), available at https://www.ncbi.nlm.nih.gov/pubmed/19300311?dopt=Abstract; Andrew Bindman, Amitabha Chattopadhyay, and G. M. Auerback, *Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions*, 149 Annals of Internal Medicine 854 (2008), available at https://www.ncbi.nlm.nih.gov/pubmed/19075204?dopt=Abstract.
[34] Georgetown University Health Policy Institute, Center for Children and Families, "Medicaid: How Does it Provide Economic Security for Families," (Mar. 2017) http://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-and-Economic-Security.pdf.
[35] 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); Gayle Hamilton et al., *National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to- Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs*, Manpower Demonstration Research Corporation (2001).

some areas of the country, as individuals who do not secure employment also lose their eligibility for cash assistance.[36]

Finally, we note that Arizona makes it clear that it cannot adequately implement the work requirement without additional resources for scaling up of the necessary employment and training programs, and AHCCCS wants to "leverage Medicaid funding to support these enhancements."[37] We oppose any request by AHCCCS to use Medicaid funding for a scaling up of the state's employment programs. Arizona should not be allowed to divert critically needed funds for *medical care and services* to employment and training programs.

A far more productive (and permissible) approach would be to connect enrollees to properly resourced voluntary employment programs and supports, an activity that requires no waiver at all. 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.[38] The State also has the option to offer supportive employment services under §§ 1915(c) and (i) of the Social Security Act.

Lifetime Limits

Arizona has requested permission to place a five-year lifetime limit on Medicaid coverage. Each month that an individual is enrolled in Medicaid, is subject to the work requirement, and does not meet the work requirement will count toward that limit.[39] The time limit would most certainly disproportionately impact individuals who, when they become older, will not quality for coverage because they hit the limit earlier in their lives.

The policy will also disproportionately harm individuals who have serious or chronic health challenges that impede their ability to work. Medicaid offers dependable and affordable coverage that supports their ability to generate income (full-time or part-time) and may prevent them from otherwise becoming fully destitute. Because conditioning eligibility on an arbitrary time limit would likely disproportionately impact

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[36] 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); Dorothy Rosenbaum & Ed Bolen, Ctr. On Budget & Policy Priorities, *SNAP Reports Present Misleading Findings on Impact of Three-Month Time Limit* (2016), https://www.cbpp.org/sites/default/files/atoms/files/12-14-16fa.pdf; Stephen Freedman et al., "National Evaluation of Welfare-to-Work Strategies: Two-year Impacts for Eleven Programs," Manpower Development Research Corporation, June 2000, http://www.mdrc.org/publication/evaluatingalternative-welfare-work-approaches.

[37] Request at 4.

[38] 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.

[39] Request at 4.

such individuals, the policy may violate the Americans with Disabilities Act and § 504 of the Rehabilitation Act – provisions that the Secretary cannot waive.

Placing a time limit on Medicaid coverage is contrary to the objectives of the Medicaid Act. CMS acknowledged this in 2016, flatly rejecting Arizona's request to impose a lifetime limit because it "could undermine access to care" and does "not support the objectives of the program."[40] Congress did not intend to limit Medicaid to temporary health care coverage. Instead, Congress designed Medicaid to furnish medical assistance to low-income individuals who cannot afford the costs of necessary medical care when and for as long as they have a medical necessity for such assistance. Indeed, Medicaid covers long-term care services – services that become more and more critical as people age or if they have a disabling or chronic condition. The Secretary may not now use § 1115 to allow Arizona to transform the basic purpose of its Medicaid program in a way that arbitrarily restricts access to coverage and services.

This proposal could also have harmful spillover effects for children whose parents or caretakers lose coverage under the lifetime limits. A recent study, using quasi-experimental data, shows that expanding coverage to parents and caretakers is associated with increased receipt of recommended pediatric preventive care for their children.[41] That study noted an "independent relationship between parental Medicaid enrollment and children's primary care use in low-income families" and cautions that "our results reveal the potential for reductions in adult Medicaid coverage to have unintended spillover effects on children's health care use."[42]

Finally, there is no experiment here. The outcome is predictable – individuals will lose access to affordable health insurance coverage and to medically necessary services and will experience harms to their financial and physical/mental well-being. The time limit will also harm Arizona's provider infrastructure, as some providers will still have to treat uninsured patients without compensation.

Eligibility Redetermination

Current law requires enrollees in the Group VIII expansion population to renew eligibility no more frequently than once a year but to report changes in circumstances that may affect their eligibility.[43] Yet, the Arizona Request seeks to redetermine Medicaid eligibility every six months for this group and also to "redetermine eligibility

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[40] *See* Letter from Andrew M. Slavitt, Acting Admin., Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs. to Mr. Thomas Betlach, Dir. Az. Health Care Cost Containment Sys. 3 (Sept. 30, 2016).
[41] Maya Venkataramani, Craig Evan Pollack, Eric T. Roberts, *Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services*, 140 Pediatrics 1 (Dec. 2017), http://pediatrics.aappublications.org/content/140/6/e20170953.
[42] *Id.*
[43] 42 C.F.R. § 435.916.

within a three-month time frame for individuals who have a change in circumstance that results in non-compliance with AHCCCS Works requirements…."[44] When Washington State made changes that included requiring children to renew eligibility every six months, the number of children participating in Medicaid fell by 30,000 over the next two years. When the State returned to the annual redetermination process, enrollment of children rose back by 30,000 within a year.[45] In other words, the six month renewal was a benefit cut. There is no experiment at work in the Arizona Request, nor is it consistent with Medicaid's purpose of providing medical assistance to individuals whose income cannot cover the cost of medically necessary care.

Budget Neutrality

When the narrative supporting the Arizona Request is paired with the budget neutrality statement, the submission precludes meaningful public comment. Arizona does not include any estimates for how the waiver will affect enrollment. These estimates are essential for making valid budget neutrality conclusions. They are also required by federal regulations.[46] Arizona does not estimate *any* changes in expenditures for the Group VIII expansion population. This cannot be accurate. Arizona increases the PMPM for Group VIII population from $603.75 in 2016 (actual) to $719.12 for 2017. The sudden spike when moving from actual to estimated costs is questionable—keeping in mind that, nationwide, the costs for expansion adults are expected to decline through 2018 (then gradually increase but generally stay below the cost of traditionally eligible nondisabled adults).

Conclusion

The AHCCCS Works Waiver will operate as a simply benefit cut. NHeLP asks the Secretary to reject the proposal. We appreciate your consideration of our comments. If you have questions, please contact me.

Respectfully submitted,

Jane Perkins
Legal Director
perkins@healthlaw.org

[44] Request at 7.
[45] Georgetown Center for Children and Families, *Program Design Snapshot; 12-Month Continuous Eligibility*" (Mar. 2009), http://ccf.georgetown.edu/wp-content/uploads/2012/03/CE-program-snapshot.pdf.
[46] 42 C.F.R. § 431.408(a)(1)(i)(C)(requiring "An estimate of the expected increase or decrease in annual enrollment").

NHeLP
NATIONAL HEALTH LAW PROGRAM

EXHIBIT
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January 11, 2018

VIA U.S. MAIL AND ELECTRONIC SUBMISSION

Brian Neale, Director
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: State Medicaid Director Letter, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries"

Dear Director Neale:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people.

Earlier today, the Centers for Medicare & Medicaid Services (CMS) sent a letter to State Medicaid Directors titled "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," which purports to justify imposing punitive work requirements on Medicaid beneficiaries to achieve better health outcomes. The letter suggests that the Secretary would deem such a requirement likely to promote the objectives of the Medicaid Act.

We have grave concerns, both procedural and substantive, regarding this letter. It not only reverses current agency policy that consistently and adamantly rejects work requirements, but it does so without soliciting public comment or feedback. While members of the public have commented on the work requirements proposed by several states in pending section 1115 waiver applications, as advocates, we had no opportunity to respond to the various, specific issues raised in CMS's letter. As a result, these state-specific comments fall far short of the type of public notice and comment that typically attaches to such a significant about face.

Moreover, CMS's novel proposition that work requirements are consistent with the objectives of the Medicaid Act comes only after the state and federal comment periods have closed on at least seven state

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proposals that contain work requirements. The timing of CMS's letter has precluded any opportunity to comment on how or whether various states' waiver applications address specific requirements and policy issues the letter identifies, such as exception processes, budget neutrality, and evaluation design. By waiting to issue this substantive letter for so long, CMS has effectively undermined stakeholders' ability to comment meaningfully during these prior comment periods.

Equally troubling, CMS's rationale in the letter entirely ignores the wealth of literature regarding the negative health consequences of work requirements, which was repeatedly cited by NHeLP and others in those state-specific comments. It appears that CMS has decided on a policy position first and then cherry-picked a small number of studies in an effort to justify this drastic shift in agency policy. However, as the attached and incorporated by reference Statement of Review from LaDonna Pavetti, an expert on work requirements, explains, the studies that CMS cites do not support its conclusion that punitive work requirements are likely to improve health outcomes.

Accordingly, NHeLP urges CMS to re-open or extend the public comment periods for all pending section 1115 waiver applications that seek to impose work requirements as a condition of eligibility, including Arizona, Arkansas, Indiana, Kansas, Kentucky, Maine, New Hampshire, North Carolina, Utah, and Wisconsin. A re-opened comment period will allow all stakeholders a meaningful opportunity to provide input to CMS's newly announced policy.

Thank you for your consideration.

Sincerely,

Jane Perkins
Legal Director
perkins@healthlaw.org

Statement of Review

My name is LaDonna Pavetti. I am Vice President for Family Income Support at the Center on Budget and Policy Priorities where I lead our work on the Temporary Assistance for Needy Families (TANF) program and our analysis of poverty trends. I have been doing work on the implementation and effectiveness of TANF since it was created in 1996. Prior to coming to the Center, I worked as a Senior Fellow at Mathematica Policy Research, Inc., one of the nation's top program evaluation firms that has conducted numerous rigorous evaluations of social programs, including TANF. I hold a Ph.D. in public policy from the Kennedy School of Government at Harvard University where I conducted research on movement on and off the Aid to Families with Dependent Children (AFDC) program, which was the precursor to TANF.

One of my areas of expertise is the effect of mandatory work requirements as they have been applied in TANF. I have examined the literature assessing the effectiveness of work requirements extensively and have been asked to present testimony to Congress on this topic multiple times. I also served on the advisory group for a comprehensive synthesis of the impacts of welfare reform on families' employment and earnings.

I have read the Dear State Medicaid Director letter re: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, issued by the Department of Health and Human Services Centers for Medicare & Medicaid Services on January 11, 2018. CMS cites seven resources to support of its assertion that punitive work requirements are likely to improve health outcomes. I have reviewed the cited materials. As discussed below, those studies do not support CMS's conclusion.

First, as a general matter, none of the articles that CMS has relied upon suggest that *requiring* work as a condition of eligibility is likely to promote health outcomes. In fact, the 2006 literature review from Waddell and Burton actually reports evidence to the contrary. It cites strong research finding that forcing people off public benefit programs has negative consequences. In its summary of research on people who leave public benefits programs, the review finds that "[t]he net result is that interventions which encourage and support claimants to come off benefits and successfully get them (back) into work are likely to improve their health and well-being; interventions which simply force claimants off benefits are more likely to harm their health and well-being."[1]

Despite these findings from its own cited study, CMS has decided that it will permit punitive work requirements that will force beneficiaries to lose benefits, while at the same time refusing to offer states federal funding for the work supports that this and other studies have found actually improve health outcomes. Absent a major infusion of state dollars to bolster such supports – which no state has proposed to do – any mandatory work requirement cannot realistically expect to increase employment rates. To the contrary, such an approach directly contradicts the evidence before the agency and will inevitably force some people off Medicaid and force others to seek low-wage, temporary employment with erratic work schedules to the detriment of their health and well-being.

Second, CMS has entirely ignored the evidence that the quality of work matters, choosing instead to erroneously assert that any and all work will improve health outcomes. But the evidence cited by CMS once again undercuts its position. Both Waddell and Burton and van der Noordt et al. suggest that work can

[1] Gordon Waddell and A Kim Burton, *Is Work Good For Your Health and Well-Being?*, at 30 (2006). *See also, e.g.* R. Dorsett et al., *Leaving Incapacity Benefit. Department of Social Security Research Report No. 86*. The Stationery Office, London (1998) [summarized in Waddell and Burton]

benefit health, but the quality and sustainability of the job matters.[2] In fact, according to the Waddell and Burton review, individuals who lost social security benefits suffered worse health outcomes partly because they often work in poor-quality, low-wage jobs and have ongoing issues with job security.[3] Decent job options can be scarce for this population and enforcing a work requirement that funnels beneficiaries toward predominantly temporary, dead-end jobs could actually worsen their health outcomes.

Third, CMS failed to even consider or discuss the applicability of basing its policy decisions on studies from the United Kingdom and other European countries that offer universal health coverage. The cited longitudinal analysis involves male workers in England and Wales, and both literature reviews draw heavily on studies from Europe and the UK. Individuals in these countries who lose social security benefits nonetheless maintain their health insurance. The review on which CMS relies to assert that "unemployment is generally harmful to health," therefore, in fact has little bearing on how policies that terminate health coverage will influence health outcomes in the United States. Moreover, it bears repeating that, even in the UK, where individuals do have stable access to health care, "interventions which simply force claimants off benefits are more likely to harm their health and well-being."[4]

Fourth, CMS has failed to acknowledge the important distinction between correlation and causation. For instance, van der Noordt et al. acknowledge that their results could be overstated because they were unable to adequately account for a "healthy worker effect," whereby relatively healthier individuals are also more likely to find a job.[5] Similarly, the letter cites a 2014 Gallup poll, which suggests a correlation between long-term unemployment and depression. But many social determinants correlate with health outcomes and improved mental health. For instance, access to steady housing is associated with improved health outcomes, while homelessness is associated with significantly worse outcomes.[6] Of course, requiring people to have a home to maintain their Medicaid benefits – particularly if a state provided no appreciable extra help – would hardly be expected to improve their health outcomes. It would just kick homeless people off the program and exacerbate their problems.

Likewise, while the Gallup poll shows a correlation between unemployment and depression, it does not automatically follow that increased employment will reduce or treat depression. In fact, the study expressly notes that "[t]he causal direction of the relationship, though, is not clear from Gallup's data," and one explanation is that depression makes it harder to find and maintain a job.[7] Even setting aside this criticism, terminating Medicaid benefits for failing to meet a mandatory work requirement is likely to leave many individuals suffering from depression without access to non-emergency care or treatment—a concern which CMS did not address in its letter to the states.

Fifth, the letter claims that community engagement is associated with improved health outcomes and can lead to paid employment. CMS first cites a health plan survey that appears to have made no adjustments

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[2] Gordon Waddell and A Kim Burton, *Is Work Good For Your Health and Well-Being?*, at 24 (2006).
[3] Gordon Waddell and A Kim Burton, *Is Work Good For Your Health and Well-Being?*, at 29 (2006).
[4] Gordon Waddell and A Kim Burton, *Is Work Good For Your Health and Well-Being?*, at 30 (2006).
[5] Van der Noordt et al., Health effects of employment: a systematic review of prospective studies, at 735 (2014).
[6] "Homelessness & Health: What's the Connection?" National Health Care for the Homeless Council (June 2011) https://www.nhchc.org/wp-content/uploads/2011/09/Hln_health_factsheet_Jan10.pdf (collecting studies).
[7] Steve Crabtree, "In U.S., Depression Rates Higher for Long-Term Unemployed," Gallup (2014) http://news.gallup.com/poll/171044/depression-rates-higher-among-long-term-unemployed.aspx. *See also*, *e.g.*, C. McLean, *Worklessness and Health: What Do We Know about the Causal Relationship, 1st Edition,* Health Development Agency, London, (2005) [summarized in Waddell and Burton].

at all for relative socioeconomic status, health status, or ability to volunteer among its respondents and thus provides little added value. A second citation, a literature review on the effects of volunteering (defined as an act of free will), "did not find any consistent, significant health benefits arising through volunteering."[8] While the review found limited benefits on well-being and mental health among people who volunteer, it relied mostly on study cohorts that are aged 50 and over and notes that improved outcomes "may be limited to older volunteers" and may also decline as hours of volunteering increase.[9] Importantly, the authors also note that the results of the cohort studies were not confirmed by randomized studies which are the gold standard for determining the effectiveness of an intervention. In short, the evidence cited hardly supports, and more likely undermines, the value of state proposals that would mandate substantial "community engagement" as a mechanism to improve health outcomes.

Finally, CMS cites evidence for the largely uncontroversial point that higher income is associated with longer life expectancy. But the study CMS cites cautions that these relationships "should not be interpreted as causal effects of having more money because income is correlated with other attributes that directly affect health."[10] The very fact that people in poor health tend to make less money could easily explain much of the mortality/income gradient. Moreover, CMS offers no evidence or basis for its belief that imposing work requirements would lead to increased employment or higher income. In fact, repeated studies find that access to Medicaid benefits facilitates employment,[11] while evidence from TANF shows that punitive work requirements have little or no lasting effect on income and can actually increase severe poverty.[12]

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[8] Jenkinson, et al., *Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers* (2013).

[9] Jenkinson, et al.

[10] R. Chetty, M. Stepner, and S. Abraham et al., *The Association Between Income and Life Expectancy in the United States, 2001-2014,* 315 JAMA 1750, 1764 (2016).

[11] Renuka Tipirneni et al., Institute for Healthcare Policy and Innovation, University of Michigan, *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches*, (2017), available at http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches; Louija Hou et al., "Working Paper No. 22170: The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being," National Bureau of Economic Research, (2016), available at http://nber.org/papers/w22170; 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.

[12] 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); Gayle Hamilton et al., *National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs*, Manpower Demonstration Research Corporation (2001); Stephen Freedman et al., *National Evaluation of Welfare-to-Work Strategies: Two-year Impacts for Eleven Programs*, Manpower Development Research Corporation, (2000) http://www.mdrc.org/publication/evaluatingalternative-welfare-work-approaches.