

May 8, 2025

Secretary Robert F. Kennedy, Jr.  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, DC 20201

Re: ARHOME “Pathways to Prosperity” Section 1115 Demonstration Amendment

Dear Secretary Kennedy,

The Center on Budget and Policy Priorities and the Georgetown University Center for Children and Families appreciate the opportunity to comment on Arkansas’ section 1115 demonstration amendment, “Pathways to Prosperity,” to its ARHOME Section 1115 Demonstration Project.<sup>1</sup> The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, CBPP conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America’s children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America’s children and families, particularly those with low and moderate incomes.

Arkansas is seeking to impose work requirements on adults, including parents, in the Medicaid expansion population. The proposal does not further the objectives of Medicaid – to provide health care coverage for low-income Americans – and poses a significant danger to the health and wellbeing of low-income people in Arkansas. In addition, the proposed work requirement would create a high-level of administrative burden for Medicaid enrollees and state staff and would harm vulnerable populations, including parents and people with disabilities. **Arkansas’s proposal does not promote the objectives of the Medicaid program and would take away coverage from low-income Arkansans, as the state’s own analysis concedes. Therefore, we urge you to reject the state’s proposal.**

**ARHOME Pathways to Prosperity will have similar failures to the 2018 ARWorks model.**

Arkansas is proposing an amendment to their “Arkansas Health and Opportunities for Me (ARHOME)” section 1115 demonstration, which the state calls “Pathways to Prosperity.” Under the proposal, the state is seeking to impose a new version of work requirement to all ARHOME adults, including parents, enrolled in Medicaid expansion. Individuals determined to not be “on track” with personal health and economic goals – supposedly identified through data matching and other factors rather than meeting a specified number of work hours per month – would be required to work with a “Success Coach.” Individuals who do not meet the proposed requirements would have Qualified Health Plans (QHP) benefits “suspended,” which appears to mean they lose health coverage without being officially disenrolled from Medicaid. Suspension of benefits *still equates to*

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<sup>1</sup> Arkansas Department of Human Services, “Request to Amend the ARHOME Section 1115 Demonstration Project,” March 26, 2025, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-pa-pathwy-prspty-04102025.pdf>.

*taking coverage away from people.* Even if individuals are still enrolled on the program, they cannot access needed medical care or are exposed to financial risk from any care received during the suspension period.

Under Section 1115 of the Social Security Act, the Secretary has the authority to waive provisions of Section 1902 of the Medicaid statute and to authorize federal matching funds for costs not otherwise matchable under Section 1903 in order to enable a state to conduct a demonstration. Such demonstrations must be “likely to assist in promoting the objectives of” the Medicaid statute. As several recent federal district court decisions have emphasized, the “core objective” of the Medicaid statute is to provide health care coverage for low-income Americans.<sup>2</sup> Health and Human Services’ General Counsel Advisory Opinion 24-01 affirms that the Secretary “lacks authority” to approve Medicaid work or “community engagement” requirements as they “conflict with [the] core objective” of Medicaid to “furnish medical assistance.”<sup>3</sup>

*Arkansas’s proposed demonstration directly conflicts with this objective as an estimated 25% of the individuals assigned to Success Coaches will have their coverage suspended (and some terminated) according to the state’s own analysis.* For the reasons detailed below, the number of people who lose coverage, and become effectively or outright uninsured as a consequence of the demonstration, could be larger. Loss of health coverage would lead to reduced access to medical care, unmet healthcare needs, and greater financial vulnerability for the affected individuals and their families. Health care providers, particularly those in rural areas, would also face an increase in uncompensated care, putting additional financial strain on hospitals and other providers. A recent report found that over 40 percent of rural hospitals in Arkansas are vulnerable to closure;<sup>4</sup> this would likely worsen and/or force hospitals to close if more Arkansans become uninsured from the proposed work requirement. The demonstration as constructed would also undermine the proven benefits of Medicaid coverage that states, including Arkansas, have experienced.<sup>5</sup>

Evidence from the state’s own experience with work requirements under the “ARWorks” demonstration confirms the expected loss of coverage. In 2018, over 18,000 people (twenty-five percent of the individuals subject to the work requirement) lost coverage over the course of just several months, largely due to problems reporting their work status or proving eligibility for an exemption.<sup>6</sup> More recently, Georgia, the second state to attempt work requirements, has had similarly terrible outcomes. As of March 2025, only 7,000 individuals are actively enrolled in Georgia’s “Pathways to Coverage” section 1115 waiver,<sup>7</sup> tens of thousands fewer than the state predicted. In both of these cases, work requirements have led to coverage losses or preventing people from getting coverage they should be eligible for, which does not serve the objectives of the Medicaid program.

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<sup>2</sup> Philbrick v. Azar, Civil Action 19-773 (JEB), [https://ecf.dcd.uscourts.gov/cgi-bin/show\\_public\\_doc?2019cv0773-47](https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv0773-47).

<sup>3</sup> Department of Health and Human Services, “Advisory Opinion on Medicaid Section 1115 Demonstrations Imposing Work Requirements,” December 2024, <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/advisory-opinion-24-01.pdf>.

<sup>4</sup> Chartis, “2025 rural health state of the state,” [CCRH WP - 2025 Rural health state of the state\\_021125.pdf](https://www.chartis.com/2025-rural-health-state-of-the-state-021125.pdf).

<sup>5</sup> Madeline Guth, Rachel Garfield, and Robin Rudowitz, “The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020,” KFF, March 17, 2020, <https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report>.

<sup>6</sup> Elizabeth Hinton and Robin Rudowitz, “5 Key Facts About Medicaid Work Requirements,” KFF, February 2025, <https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements/#:~:text=3,in%20care%2C%20and%20medical%20debt>.

<sup>7</sup> Pathways to Coverage Monitoring Project (accessed April 25, 2025), <https://www.georgiapathways.org/data-tracker>.

Although Arkansas purports to have learned from the failures of its ARWorks demonstration, it repeats the same basic flaws: the state would not be able to identify individuals who meet exemption criteria and would not be able to communicate regularly with enrollees.<sup>8</sup> The new proposal would also establish work reporting hurdles for a broader group of people than the ARWorks waiver did. The previous demonstration exempted people who were living with a minor dependent child under the age of 18 but the new proposal adds parents with dependent children to the new reporting scheme and expands the reach from adults under age 50 to those under age 64. In addition, the administrative capacity problems Arkansas experienced in its ARWorks demonstration would be dwarfed by the massive bureaucratic effort that would be needed to hire, train, and oversee Success Coaches tasked with intensive monthly communications with tens of thousands of enrollees.

The state would use income, duration of time enrolled in Medicaid, and “engagement” as proxies for a “work requirement.” By doing so, the state is resurrecting its attempt to punish people with low-incomes who face myriad barriers to employment, including the lack of affordable child care, labor market imbalances, opioid use recovery, and transportation challenges that may make it harder for people to obtain or maintain employment. In this new version of a work requirement, individuals would also be penalized for not earning enough to avoid having to meet the additional criteria set out in the state’s proposal. Moreover, the state’s proposal would disadvantage people in larger families, who would have to earn even more to avoid the most onerous elements of the new proposal. The state has not learned from the failures of its previous experience and instead is doubling down on its efforts to disrupt health coverage for people that the state has decided are not worthy.

In order to achieve Arkansas’s goal of supporting work consistent with coverage, the legal purpose of the Medicaid program, we recommend that Arkansas build a system of voluntary supports rather than imposing harmful work requirements that don’t actually support work.<sup>9</sup> **We urge CMS to deny the state’s application and instead encourage the state to establish voluntary employment supports.**

**The Pathways to Prosperity proposal creates unnecessary barriers to accessing coverage.**

Research has consistently shown that work requirements fail to promote employment.<sup>10</sup> In fact, access to Medicaid coverage is supportive of finding and maintaining employment. Surveys of Medicaid expansion enrollees in Michigan, for example, show that coverage has made it easier for people who are unemployed to find work, and for people who have a job to maintain their employment. A study examining the impact of Michigan’s Medicaid expansion found that 69 percent of enrollees said having health insurance through Medicaid helped them do a better job at work and the majority of those who were out of work reported that having Medicaid made them better able to

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<sup>8</sup> MaryBeth Musumeci, “Disability and Technical Issues Were Key Barriers to Meeting Arkansas’ Medicaid Work and Reporting Requirements in 2018,” KFF, June 11, 2019, <https://www.kff.org/medicaid/issue-brief/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018>.

<sup>9</sup> Benjamin D. Sommers, et. al., “Medicaid Work Requirements In Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care,” *Health Affairs*, Vol. 39(9), September 2020, <https://doi.org/10.1377/hlthaff.2020.00538>; Cornelia Hall and Elizabeth Hinton, “Supporting Work without the Requirement: State Managed Care Initiatives,” KFF, December 2019, <https://www.kff.org/medicaid/issue-brief/supporting-work-without-the-requirement-state-and-managed-care-initiatives/#:~:text=While%20most%20Medicaid%20adults%20are,eligibility%20on%20having%20a%20job>.

<sup>10</sup> LaDonna Pavetti, “TANF Studies Show Work Requirements Proposals for Other Programs Would Harm Millions, Do Little to Increase Work,” Center on Budget and Policy Priorities, November 2018, <https://www.cbpp.org/sites/default/files/atoms/files/11-13-18tanf.pdf>; Benjamin Sommers, et al., “Medicaid Work Requirements In Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care”

look for a job.<sup>11</sup> Another Michigan study shows that expansion particularly benefits people with chronic health conditions — finding that 76 percent of survey respondents with a behavioral health condition who were employed reported that having Medicaid coverage improved their ability to perform well at work.<sup>12</sup> And studies have found that Medicaid expansion is a powerful anti-poverty tool as it reduced medical debt by \$1,140 per person among those who gained Medicaid coverage and reduced evictions among low-income renters.<sup>13</sup> Some of the state’s goals can thus be achieved simply by assuring that the state’s Medicaid enrollees can access the care they need.

Work requirements create red tape barriers to accessing and maintaining health care coverage, resulting in more low-income individuals going uninsured. The state’s proposal begins by suggesting the state learned lessons from its prior work requirement demonstration by “discontinuing the previous monthly reporting requirement.” However, the state acknowledges the limitations of data matching and would ultimately rely on “personal communication between the Medicaid enrollee and the coaching resource [to] fill in any missing information.” The state does not describe significant new resources for data matching or communications, so the past failures are certain to repeat themselves.

Coverage loss from not meeting the proposed work requirement would result in “churn” - where individuals lose coverage and later reenroll - among individuals whose coverage is suspended or terminated. Multiple studies suggest that churn is associated with increases in emergency room visits, higher levels of unmet health care needs during periods of uninsurance, more frequent use of costly treatments for conditions that could have been prevented through early detection and care, and significantly higher administrative costs.<sup>14</sup>

### **The “Success Coach” model would be burdensome and harmful.**

We are concerned about the proposal’s “Success Coach” component for many reasons, including lack of training, criteria, and dedicated resources.

Research shows that states that created similarly complex incentives programs designed to elicit behavioral changes had trouble identifying and engaging Medicaid enrollees to participate due to inaccurate contact information, changes in enrollees’ eligibility or health status, and difficulties

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<sup>11</sup> Tipirneni, R. et al. “Changes in Health and Ability to Work Among Medicaid Expansion Enrollees: A Mixed Methods Study” *Journal of General Internal Medicine*, December 5th, 2018.

<sup>12</sup> Tipirneni, R. et al., “Association of Expanded Medicaid Coverage with Health and Job-Related Outcomes Among Enrollees with Behavioral Health Disorders,” *Psychiatric Services*, September 25, 2019, <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900179>.

<sup>13</sup> Luoia Hu, et al., “The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing,” *Journal of Public Economics*, May 2018, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6208351>; Heidi Allen, et al., “Can Medicaid Expansion Prevent Housing Evictions?,” *Health Affairs*, September 2019, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05071>.

<sup>14</sup> Leighton Ku and Erika Steinmetz, “Bridging the Gap: Continuity and Quality of Coverage in Medicaid,” George Washington University, Association for Community Affiliated Plans, September 2013, <http://www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%20%209-10-13.pdf>; Carol Irvin et al. “Discontinuous Coverage in Medicaid and Implications for 12-Month Continuous Coverage,” *Mathematica Policy Research*, October 2001, <https://mathematica.org/~media/publications/PDFs/discontinuous.pdf>; Matthew J. Carlson et al., “Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results from a Prospective Cohort Study of the Oregon Health Plan,” *Annals of Family Medicine* 4(5) (September 2006), <https://pmc.ncbi.nlm.nih.gov/articles/PMC1578659/>; Jennifer Wagner and Judith Solomon, “Continuous Eligibility Keeps People Insured and Reduces Costs,” CBPP, May 4, 2021, <https://www.cbpp.org/research/health/continuous-eligibility-keeps-people-insured-and-reduces-costs>.

identifying eligible individuals.<sup>15</sup> Although the application indicates that the state would use data matching to avoid new reporting burdens, the proposal merely shifts the reporting burden from monthly reporting of work hours with DHS to many enrollees now being required to have a “monthly contact” with their coaches (presumably during business hours) and report activities to their coaches. By design, the proposal would (after some time) require this administrative hassle for even full-time workers, on a permanent and on-going basis. It would be inappropriate for enrollees to suffer penalties for missing meetings or required reports, particularly if there are no accommodations for people who cannot meet during business hours. We are also concerned that Success Coaches would be poorly trained and use subjective criteria to determine engagement, which could unfairly disadvantage enrollees that have less in common with the Coach. For example, enrollees with limited English proficiency or who are from different cultural, racial, or ethnic backgrounds. Finally, we are concerned that the state’s proposal does not include – or signal any intent to develop – the necessary investments in training and supporting Success Coaches.

As with Arkansas’s prior failed experiment with work reporting requirements, awareness of the Pathways to Prosperity initiative would likely remain poor. This would affect individuals’ ability to meet the work requirement and mean that people suffer consequences for not complying with a program they may not even realize applies to them. Researchers studying the ARWorks waiver found that many impacted enrollees were not aware of the requirements, which impacted reporting and people’s ability to comply.<sup>16</sup> Similar findings occurred in New Hampshire when the state sought to implement its work requirement. New Hampshire had to delay implementation of its work requirement due to the Medicaid agency having difficulty reaching individuals about the requirements.<sup>17</sup> Despite attempts to conduct a “more robust” outreach campaign than Arkansas, many individuals subject to New Hampshire’s requirement reported confusion and/or difficulties understanding whether they were exempt.<sup>18</sup> The same phenomenon would be likely here.

We know from the ARWorks experience that publicizing new requirements would at a minimum require significant investments in outreach and communications materials to ensure that people are aware of new requirements and their new responsibilities, and it is not clear that outreach could successfully inform such a large population of such a complex administrative process. Lack of

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<sup>15</sup> Hannah Katch and Judith Solomon, “Restrictions on Access to Care Don’t Improve Medicaid Beneficiaries’ Health: Incentives for Healthy Behaviors Have Mixed Results,” CBPP, December 11, 2018, <https://www.cbpp.org/research/health/restrictions-on-access-to-care-dont-improve-medicaid-beneficiaries-health>; Melinda Buntin, John Graves, and Nikki Viverette, “Cost Sharing, Payment Enforcement, and Healthy Behavior Programs in Medicaid: Lessons from Pioneering States,” Vanderbilt University, June 2017

<sup>16</sup> For example, data for the month of February 2019 — shortly before the approval of Arkansas’ work requirement policy was vacated — showed that 87 percent of those subject to the work requirements were exempt from reporting. Of the remaining share required to demonstrate compliance, nearly 9 in 10 did not report any work activities — for example, by not creating online accounts or navigating the online portal — likely reflecting widespread lack of awareness and complex and burdensome reporting requirements. Robin Rudowitz et al., “February State Data for Medicaid Work Requirements in Arkansas,” KFF, March 25, 2019, <https://files.kff.org/attachment/State-Data-for-Medicaid-WorkRequirements-in-Arkansas>; MaryBeth Musumeci et al., “An Early Look at Implementation of Medicaid Work Requirements in Arkansas,” KFF, October 8, 2018, <https://www.kff.org/report-section/an-early-look-atimplementation-of-medicaid-work-requirements-in-arkansas-key-findings-9243>.

<sup>17</sup> Letter from New Hampshire DHHS Commissioner Jeffery Meyers to CMCS on Temporary Delay in Work Requirement Implementation, July 9, 2019, [nh-granite-advantage-health-care-program-temp-delay-20190709.pdf](https://www.nh.gov/Portals/0/Granite-Advantage-Health-Care-Program-Temp-Delay-20190709.pdf).

<sup>18</sup> Ian Hill, Emily Burroughs, and Gina Adams, “New Hampshire’s Experience with Medicaid Work Requirements,” Urban Institute, February 2020, [https://www.urban.org/sites/default/files/publication/101657/new\\_hampshires\\_experience\\_with\\_medicaid\\_work\\_requirements\\_v2\\_0\\_7.pdf](https://www.urban.org/sites/default/files/publication/101657/new_hampshires_experience_with_medicaid_work_requirements_v2_0_7.pdf).

awareness would likely mean that people will not satisfy the terms of the new approach.<sup>19</sup> The state's application does not detail any plans for such investments.

**The proposal and its “factors” determining who would be subject to the work requirement are invasive and harmful – particularly for parents, individuals who are pregnant, and people with disabilities.**

We are also deeply concerned by the “factors” the state is proposing to identify who would have to meet its work requirement, such as subjecting people to more coaching, and increasing their chances of losing coverage, because of their “educational status.” Individuals would be subjected to invasive monitoring going well-beyond the parameters of health by a “Coach” that has the power to terminate their health insurance. Health care should not be an excuse for government tracking the life of Arkansans.

It is inappropriate as a matter of law or policy to use “time enrolled” as a factor in review as it effectively will create a time limit on Medicaid coverage for some enrollees. Medicaid is critical to ensuring people are able to receive necessary care regardless of life circumstances, such as losing a job or having a seasonally dependent profession. By penalizing people for length of time enrolled on Medicaid, the proposal would harm Arkansas residents who have do not have access to other affordable insurance options and/or work in sectors where pay is consistently low resulting in household income below 138 period FPL across several years.

*The proposal's lack of explicit exemptions for parents is harmful to both parents and their children.*

Arkansas's proposed demonstration factors would create barriers to maintaining or obtaining coverage for parents and caretakers with dependent children. Unlike almost every other proposal for work requirements in recent years, Arkansas's proposal includes no automatic exemption for parents with dependent children of any age – including for parents of babies and toddlers. While the proposal mentions that “serving” one's community can include caring for a child or a person with a disability, it lacks clear and automatic exemptions for parents and caretakers, instead relying on data matching and case-by-case assessment by “Success Coaches.” Many parents caring for their own children or other caretakers may not be consistently identified and recognized as fulfilling this criterion. Moreover, requiring parents and caretakers to engage in personalized assessments and develop a Personal Development Plan introduces an additional layer of burden for families – and it is unclear what documentation would be possible or sufficient for a parent to demonstrate that caregiving responsibilities toward their own children meet Arkansas's expectations for being “on track.” In Arkansas, over 6% of children are being raised by at least one grandparent, and data has shown low-income children nationally are more likely to be cared for by grandparents.<sup>20</sup>

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<sup>19</sup> See, e.g., Jessica Green, "Medicaid Recipients' Early Experience with the Arkansas Medicaid Work Requirement," Health Affairs Forefront, September 5, 2018, <https://www.healthaffairs.org/doi/10.1377/forefront.20180904.979085/full/>; Ian Hill and Emily Burroughs, "Lessons from Launching Medicaid Work Requirements in Arkansas," Urban Institute, October 2019, [https://www.urban.org/sites/default/files/publication/101113/lessons\\_from\\_launching\\_medicaid\\_work\\_requirements\\_in\\_arkansas.pdf](https://www.urban.org/sites/default/files/publication/101113/lessons_from_launching_medicaid_work_requirements_in_arkansas.pdf).

<sup>20</sup> U.S. Department of Labor, “Grandchildren Being Raised by Grandparents,” 2021 ACS Data, [https://www.dol.gov/agencies/wb/topics/grandparents-raising-grandkids#:~:text=In%202021%2C%202.33%20million%20children,most%20of%20their%20basic%20needs](https://www.dol.gov/agencies/wb/topics/grandparents-raising-grandkids#:~:text=In%202021%2C%202.33%20million%20children,most%20of%20their%20basic%20needs;); Pew Research Center, “Children Living with or Being Cared for by a Grandparent,” September 4, 2013, <https://www.pewresearch.org/social-trends/2013/09/04/children-living-with-or-being-cared-for-by-a-grandparent>.

The proposal may effectively force parents or caretakers to choose between losing their health coverage or finding child care for their children while they pursue work, even if they prefer to care for their children and/or the cost of child care is cost-prohibitive. In Arkansas, the average cost of child care for a school-age child in 2022 (adjusted to 2024 dollars) ranged from \$4,938 to \$6,255 annually (about 19-23% of income for a family of three living at the federal poverty level); parents of younger children in Arkansas can face even higher child care costs, as high as \$8,829 depending on the age of the child and what county they live in.<sup>21</sup> As a practical matter, these child care challenges, among others, would prevent many parents from meeting the work requirement, leaving them uninsured.<sup>22</sup>

Parental coverage loss harms their children as well. For low-income families, one member being uninsured exposes the entire family to grave economic risk due to medical debt and even bankruptcy.<sup>23</sup> Additionally, ample evidence has found that children are more likely to have coverage and better health when their parents are insured.<sup>24</sup> **CMS should require Arkansas to implement an automatic exemption for all parents and caretakers with children under the age of 19 if the agency chooses to approve this highly problematic policy.**

*The proposal could result in coverage loss among individuals who are pregnant and risks disrupting access to prenatal care.*

Arkansas also offers no general exemption for pregnancy. Given that pregnancy is an independent *mandatory* basis of categorical Medicaid eligibility – with income levels that exceed eligibility for the VIII group – no individual who is pregnant should ever face disenrollment (or other penalties or burdens) due to policies for the *Medicaid expansion* population. However, CMS guidance has indicated that states have no obligation to monitor individuals for pregnancy status and individuals who are pregnant are not required to move eligibility categories.<sup>25</sup>

The state indicates that “there are no exemptions to participation” from the proposed work requirement. This means that the policy would apply to someone who is pregnant and is enrolled in the expansion group. In its original ARHOME application, the state indicated approximately 15,000 pregnant women are enrolled in the expansion group each year.<sup>26</sup> While the state’s entire proposal is

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<sup>21</sup> Department of Labor, Women’s Bureau, “The Price of Child Care by County,” Updated March 2025, <https://public.tableau.com/app/profile/women.s.bureau.department.of.labor/viz/CountyFactsheets/Childcareinthecounties>.

<sup>22</sup> Gina Adams, *et al.*, “Child Care Challenges for Medicaid Work Requirements,” Urban Institute, September 2019, available at: Child Care Challenges for Medicaid Work Requirements.

<sup>23</sup> Lunna Lopes *et al.*, “Health Care Dept in the U.S.” The Broad Consequences of Medical and Dental Bills,” KFF, June 2022, <https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings>.

<sup>24</sup> Julie L. Hudson and Asako S. Moriya, “Medicaid Expansion for Adults Had Measurable ‘Welcome Mat’ Effects on Their Children,” *Health Affairs*, Vol. 36(9), September 2017, available at <https://doi.org/10.1377/hlthaff.2017.0347>; Jessica Schubel, “Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children,” Center on Budget and Policy Priorities, October 2020, <https://www.cbpp.org/research/health/expanding-medicaid-for-parents-improves-coverage-and-health-for-both-parents-and>; Rebekah Levine Coley, “Parents’ and Caregivers’ Health Insurance Supports Children’s Healthy Development,” Society for Research in Child Development, June 2019, <https://www.srcd.org/research/parents-and-caregivers-health-insurance-supports-childrens-healthy-development>;

<sup>25</sup> States are required to inform individuals who are pregnant of benefits in the pregnancy eligibility category, including differences in benefits, premiums, and cost-sharing, but are not required to monitor pregnancy status nor move the individuals in the Group VIII population to the pregnancy eligibility group once they become pregnant. Preamble to 42 CFR Parts 431, 435, and 457, pg. 6: [2012-6560.pdf](https://www.federalregister.gov/documents/2012/06/20/2012-6560); Center for Medicaid and CHIP Services, “SHO #21-007 RE: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children’s Health Insurance Program,” December 7, 2021, [sho21007\\_1.pdf](https://www.cms.gov/medicaid-coverage-innovation/2021/12/sho21007-1.pdf).

<sup>26</sup> Arkansas Department of Human Services, “Arkansas ARHOME Section 1115 Demonstration Application,” page 4, July 19, 2021, [ar-arhome-pa.pdf](https://www.arhome-pa.pdf).

concerning, the potential harm to pregnant individuals is particularly egregious. Evidence shows that for low-income pregnant patients, disruptions in health insurance coverage are associated with lower levels of recommended pregnancy-related care, increasing the risk of adverse outcomes for both mothers and babies.<sup>27</sup> **CMS should require the state to clarify that no individual who is pregnant would ever have their health coverage suspended or terminated under the work requirement.**

*The proposal falls well short in safeguarding coverage for individuals with disabilities.*

The design and policy flaws in Arkansas’s proposal—including ambiguity in definitions, absence of evaluation criteria, reliance on unfeasible automation processes, and documentation burdens for enrollees—would also *discriminatorily* harm individuals with disabilities. Contrary to the state’s characterization of ARHOME being for “able-bodied,” ARHOME includes many people with a wide range of disabilities and chronic health conditions. In fact, only one-third of Arkansas Medicaid enrollees with a disability receive SSI.<sup>28</sup> Many individuals with disabilities in the remaining two-thirds are in ARHOME. This population is at serious risk, similar to the harm suffered in the first Arkansas work requirement, when “[p]eople with disabilities were particularly vulnerable to losing coverage under the Arkansas work and reporting requirements, despite remaining eligible.”<sup>29</sup>

The state’s purported reliance on data matching would not work for many individuals with disabilities who have a wide range of disabilities. The lack of data sources for some of these health conditions and the incredible variability in these populations mean there is just not enough available information to possibly identify many individuals who have disabling health conditions, meaning individuals would have to self-identify and report. As mentioned, in ARWorks many enrollees didn’t even know about the work requirements. For the ones that do, they won’t know what disability criteria might make them “on track” and able to maintain their health insurance. And even if an enrollee/applicant knows what they need to do, many will struggle to get the necessary documentation to prove their condition. Consider the challenges in collecting and filing documentation for individuals with clinical depression, or a physical impairment, or participating in an opioid use treatment program. It will be deeply harmful to the state and Arkansan families when individuals in the middle of a drug treatment program lose their health insurance—and potentially their treatment program—because they didn’t know what documentation to collect or what to do with it. Uninsured applicants may also struggle to collect documentation precisely because they don’t have access to a provider who can help document their health condition.

Loss of coverage will be deeply harmful to these populations with disabilities. For example, individuals who rely on wheelchairs and are uninsured are less likely to be able to access the home- and community-based services they need to perform basic tasks, such as bathing, preparing meals, or entering or leaving their homes.<sup>30</sup> **CMS should not approve this demonstration. Work**

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<sup>27</sup> Lindsay K. Admon et al., “Insurance Coverage and Perinatal Health Care Use Among Low-Income Women in the US, 2015-2017,” *JAMA Network Open*, Vol. 4(1), January 2021, available at <https://doi.org/10.1001/jamanetworkopen.2020.34549>.

<sup>28</sup> Alice Burns, et al., “5 Key Facts About Medicaid Coverage for People with Disabilities,” KFF, February 7, 2025, <https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-coverage-for-people-with-disabilities>.

<sup>29</sup> MaryBeth Musumeci, “Disability and Technical Issues Were Key Barriers to Meeting Arkansas’ Medicaid Work and Reporting Requirements in 2018,” KFF, June 11, 2019, <https://www.kff.org/medicaid/issue-brief/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018>.

<sup>30</sup> Lisa I Iezzoni et al., “Uninsured persons with disability face substantial barriers to health care services,” *Disability and Health Journal*, Vol. 4(4), September 2011, available at <https://doi.org/10.1016/j.dhjo.2011.06.001>; Rachel Litchman, “I’m disabled. I’m terrified

**requirements inherently create broad harms to people with disabilities and the state would not be able to avoid improper terminations for this population.**

## **Conclusion**

Our comments include numerous citations to supporting research, including direct links to the research, for HHS's benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

Thank you for your willingness to consider our comments. If you need any additional information, please contact Joan Alker ([joan.alker@georgetown.edu](mailto:joan.alker@georgetown.edu)) or Allison Orris ([aorris@cbpp.org](mailto:aorris@cbpp.org)).

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