NATIONAL WOMEN'S LAW CENTER
Justice for Her. Justice for All.

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
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Submitted electronically

RE: Request to Amend the ARHOME Section 1115 Demonstration Project

The National Women's Law Center (NWLC) writes to comment on Arkansas' § 1115 demonstration application. Since 1972, NWLC has fought for gender justice in the courts, in public policy, and in our society. We have worked to advance the progress of women and their families in core aspects of their lives, including health and reproductive rights, income security, employment, and education, with an emphasis on the needs of people who face multiple and compounding forms of discrimination. Through our work to strengthen and preserve Medicaid programs, we have seen their impact on the health and wellbeing of women and LGBTQI+ people, and we firmly believe in the value of robust Medicaid enrollment and access to services.

We urge the Centers for Medicare and Medicaid Services (CMS) to reject the Arkansas demonstration application as proposed. The project is contrary to the requirements of § 1115 of the Social Security Act and would reduce Medicaid access for eligible individuals, with particular harms for women, women of color, and disabled women.

I. Medicaid coverage is critical for enrollees' health and economic security.

For millions of people, Medicaid is a lifeline, offering access to coverage that they otherwise may not be able to afford. In 2024, over 700,000 living in Arkansas relied on Medicaid coverage for their health care.[1] People of color, women, and disabled people in Arkansas are all more likely to participate in Medicaid, making the program especially crucial for ensuring that these communities can access care and reducing the health disparities they face. In 2021, about half of Medicaid enrollees in Arkansas under the age of 65 were people of color, including nearly a quarter who were Black.[2] Women make up the majority of Medicaid enrollees in Arkansas,[3] with nearly a

[1] Medicaid.gov, *November 2024 Medicaid & CHIP Enrollment Data Highlights* (accessed Apr. 29, 2025), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights.
[2] Kaiser Family Foundation, *Distribution of People Ages 0-64 with Medicaid by Race/Ethnicity* (accessed Apr. 29, 2025), https://www.kff.org/medicaid/state-indicator/medicaid-distribution-people-0-64-by-raceethnicity.
[3] Kaiser Family Foundation, *Distribution of Adults Ages 19-64 with Medicaid by Sex* (accessed Apr. 29, 2025), https://www.kff.org/medicaid/state-indicator/medicaid-distribution-adults-19-64-by-sex.

quarter of nonelderly women enrolled in 2023, or over 200,000.[4] Among Arkansan women with incomes below 200% of the federal poverty line, 46% were enrolled in Medicaid.[5] Women of color make up over four in ten (41%) of women in the Arkansas Medicaid program.[6]

Medicaid coverage has proven to be vital for improving access to care, health outcomes, and economic stability.[7] Without Medicaid coverage, individuals would have to either incur medical expenses beyond their means or forgo critical care. Medicaid expansion in particular—which Arkansas' application would undermine—has undisputedly benefited those who qualify through this pathway. The overwhelming weight of research shows that the expansion program has increased access to and utilization of preventive and primary care; decreased reliance on emergency rooms as a source of low-acuity care; and reduced cases of catastrophic out-of-pocket medical costs.[8] This in turn has improved health outcomes across the spectrum.[9] For example, Medicaid expansion is associated with earlier detection, diagnosis, and treatment of conditions such as breast cancer.[10] And by improving coverage before and after pregnancy, Medicaid expansion has helped combat the existing maternal mortality crisis that disproportionately impacts Black and Indigenous women[11]: Medicaid expansion is associated with lower mortality rates for pregnant women, particularly among Black women.[12]

Stripping enrollees of their access to Medicaid will deny them these lifesaving benefits, threatening their health and financial security. Most people who lose Medicaid coverage do not transition to

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[4] Kaiser Family Foundation, *Women's Health Insurance Coverage* (Dec. 12, 2024), https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage.
[5] *Id*.
[6] NWLC calculations based on U.S. Census Bureau, 2023 American Community Survey (ACS), 1-year estimate, using *IPUMS USA, University of Minnesota, www.ipums.org*. ACS survey respondents self-identify their sex, race, and whether they are of Hispanic, Latino, or Spanish origin. Women of color are all those who did not self-identify as white, non-Hispanic.
[7] Gideon Lukens & Elizabeth Zhang, *Medicaid Work Requirements Could Put 36 Million People at Risk of Losing Health Coverage* (Feb. 5, 2025), https://www.cbpp.org/sites/default/files/1-16-25health.pdf.
[8] Madeline Guth & Meghana Ammula, *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021* (May 6, 2021), https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021; Madeline Guth et al., *The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020* (Mar. 17, 2020), https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review.
[9] *Id.*; Kevin N. Griffith & Jacob H. Bor, *Changes in Health Care Access, Behaviors, and Self-Reported Health Among Low-income US Adults Through the Fourth Year of the Affordable Care Act*, 38 MEDICAL CARE 574 (Jun. 2020), https://doi.org/10.1097/MLR.0000000000001321.
[10] Justin M. Le Blanc et al., *Association of Medicaid Expansion Under the Affordable Care Act with Breast Cancer Stage at Diagnosis*, 155 JAMA SURGERY 752 (Jul. 1, 2020), http://doi.org/10.1001/jamasurg.2020.1495.
[11] Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them* (Oct. 25, 2024), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them.
[12] Erica L. Eliason, *Adoption of Medicaid Expansion is Associated with Lower Maternal Mortality*, 20 WOMEN'S HEALTH ISSUES 1049, 1049 (Feb. 25, 2020), https://doi.org/10.1016/j.whi.2020.01.005; Adam Searing & Donna Cohen Ross, *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies* 7 (May 2019), https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf.

private insurance: Rather, many will end up uninsured or experience gaps in coverage.[13] The consequences of losing insurance are multifold. Numerous studies have demonstrated that uninsured individuals are less likely to receive preventive care or access services for major health conditions and chronic diseases.[14] Uninsured women—disproportionately Black, Latina, and Indigenous women—are less likely to have a regular doctor and to receive services like mammograms, Pap tests, and blood pressure checks.[15] They also get less adequate and lower quality care.[16] As a result, uninsured women are more likely to have unmet medical needs and worse health outcomes, from higher rates of maternal mortality, especially among Black women,[17] to later-stage cancer diagnoses.[18]

Uninsured adults broadly are more likely to forgo needed care than those who are insured: In 2023, nearly half (47%) of uninsured people aged 18 to 64 reported that they had not seen a health care professional in the previous year, approximately three times the rate among insured people.[19] Uninsured people are consequently more likely to be hospitalized for avoidable health problems.[20] And when they are hospitalized, they receive fewer medical tests and services and suffer from higher mortality rates than those with insurance.[21] The health impacts are further compounded by financial ones: 62% of uninsured adults report health care debt,[22] which itself leads to wide-ranging impacts on health and wellbeing.[23]

II. Arkansas' application contravenes the Medicaid statute.

Arkansas' application must be rejected as contrary to the Medicaid statute. The purpose of Medicaid is to enable states to furnish medical assistance to individuals who are unable to meet the costs of necessary medical care and to help these individuals attain or retain the capacity for independence and self-care.[24] Although § 1115 of the Social Security Act allows states to apply for waivers of Medicaid's statutory requirements, such waivers 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

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[13] Bradley Corallo et al., *What Happens After People Lose Medicaid Coverage?* (Jan. 25, 2023), https://www.kff.org/medicaid/issue-brief/what-happens-after-people-lose-medicaid-coverage.
[14] Jennifer Tolbert et al., *Key Facts About the Uninsured Population* (Dec. 18, 2024), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population.
[15] Kaiser Family Foundation, *supra* note 4.
[16] *Id*.
[17] Judith Solomon, *Closing the Coverage Gap Would Improve Black Maternal Health* (Jul. 26, 2021), https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health.
[18] Gerard A. Silvestri et al., *Cancer Outcomes Among Medicare Beneficiaries and Their Younger Uninsured Counterparts*, 40 HEALTH AFFAIRS 754 (May 2021), https://doi.org/10.1377/hlthaff.2020.01839.
[19] Tolbert et al., *supra* note 14.
[20] *Id*.
[21] *Id*.
[22] *Id*.
[23] Lunna Lopes et al., *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills* (Jun. 16, 2022), https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings.
[24] 42 U.S.C. § 1396a-1.

- be approved only "to the extent and for the period necessary" to carry out the experiment.[25]

Arkansas' § 1115 waiver application is inconsistent with the objectives of the Medicaid statute. Rather than providing medical assistance to those who need it, the application serves to undermine access to coverage, making it more difficult for individuals who achieve independence and self-care. As discussed in greater detail below, the proposed policy will lead to widespread disenrollment without increasing employment. Additionally, the statute does not condition receipt of Medicaid benefits on any qualifications beyond those that serve to show that an individual is in need of assistance obtaining health care coverage and services. Arkansas' application, by contrast, imposes unwarranted eligibility restrictions. Because the application is contrary to the statute and does not further its objectives, CMS does not have the authority to approve it.

III. Arkansas' application would threaten access to Medicaid coverage.

Under Arkansas' application, all individuals enrolled through Medicaid expansion will be subject to an assessment of whether they are "on track" or "not on track" towards "meeting their personal health and economic goals."[26] The focus of this assessment is on individuals' employment status: Those who are not employed "must be engaged in qualifying advancement, learning, or service activities to be considered 'on track.'"[27] Other factors considered include "an individual's income level, employment history, educational status, whether a dependent child is in the household, [and] length of enrollment in ARHOME."[28] Enrollees whom the state deems to be "not on track" will be required to engage with "focused care coordination services," including the "establishment and monitoring of a Personal Development Plan" (PDP).[29] Those who "refuse to cooperate…will have their ARHOME coverage suspended" through the end of the calendar year.[30]

Arkansas' application ultimately amounts to a work requirement that imposes numerous administrative barriers to coverage and will lead to disenrollment, while failing to improve employment outcomes. There is no doubt that holistic supports and services are critical for Medicaid recipients who wish to make use of them. But what Arkansas is proposing stands in sharp contrast to such a policy: It is a mandatory program with vague requirements determined by the state, where "noncompliance" results in the punitive loss of Medicaid benefits.

a. Like Arkansas' previous work requirement, this proposal would lead to widespread disenrollment and administrative burdens.

Arkansas' 2018 attempt at implementing work requirements was a failure. In the seven months the work requirement was in operation before a federal court stopped the program,[31] over 18,000

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[25] 42 U.S.C. § 1315(a).
[26] Arkansas Department of Human Services, *Request to Amend the ARHOME Section 1115 Demonstration Project* 11 (Jan. 28, 2025).
[27] *Id*. at 4.
[28] *Id*. at 11.
[29] *Id*. at 4.
[30] *Id*. at 12.
[31] *See Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019).

people lost coverage—amounting to one in four of those subject to the work requirement.[32] This included many people who were working, qualified for an exemption, or were otherwise eligible.[33] Indeed, most people who lost coverage did not lose it because they failed to work or qualify for an exemption, but rather because of extensive administrative hurdles, red tape, and confusion.[34] Many were unaware of the new reporting requirements until they were disenrolled and seeking care.[35] The impacts on coverage were lasting. The vast majority—89%—of those who lost Medicaid coverage in 2018 did not regain it the following year, leaving many uninsured.[36] Arkansans who lost coverage in this time period faced significant repercussions: 50% reported serious problems paying off medical debt, 56% delayed care because of cost, and 64% delayed taking medication because of cost.[37]

Arkansas now proposes another attempt at implementing work requirements, only by another name. Like the previous work requirements, the current proposal would create confusion and uncertainty among enrollees about how to maintain their Medicaid benefits. This risk is particularly high given the vagueness of the policy: The state agency is given broad discretion to determine whether an individual is "on track" and whether they are "cooperating" with the requirements of their PDP. For example, without a clear threshold for "cooperation," agency officials might determine an enrollee to be noncompliant if they miss a meeting or do not respond to a telephone call. Enrollees who face barriers to such engagements—including unpredictable work schedules, caregiving responsibilities, and a range of disabilities—would be particularly harmed by this subjective standard. This discretion also invites racial and other bias into the assessment of individuals' compliance: Studies of programs such as Temporary Assistance for Needy Families (TANF) have repeatedly found that Black participants are significantly more likely to be deemed not in compliance with work-related requirements and thus lose benefits—a result of the broad discretion caseworkers have rather than differences in actual compliance.[38]

This proposal would impose substantial administrative burdens on Medicaid enrollees, potentially leading to individuals being once again disenrolled because they struggled to navigate unnecessary bureaucratic requirements or obtain documentation. This burden would be particularly significant for enrollees who are required to engage in a PDP; the potentially intensive labor of demonstrating compliance with the PDP may be especially taxing for those whose resources and capacity are already stretched thin.

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[32] Laura Harker, *Pain But No Gain: Arkansas' Failed Medicaid Work-Reporting Requirements Should Not Be a Model* (Aug. 8, 2023), https://www.cbpp.org/research/health/pain-but-no-gain-arkansas-failed-medicaid-work-reporting-requirements-should-not-be.
[33] *Id*.
[34] Jennifer Wagner & Jessica Schubel, *States' Experiences Confirm Harmful Effects of Medicaid Work Requirements* (Nov. 18, 2020), https://www.cbpp.org/sites/default/files/atoms/files/12-18-18health.pdf.
[35] Harker, *supra* note 32.
[36] *Id*.
[37] Benjamin D. Sommers et al., *Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care*, 39 HEALTH AFFAIRS 1522 (Sep. 2020), https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2020.00538.
[38] LaDonna Pavetti, *TANF Studies Show Work Requirement Proposals for Other Programs Would Harm Millions, Do Little to Increase Work* (Nov. 13, 2018), https://www.cbpp.org/research/family-income-support/tanf-studies-show-work-requirement-proposals-for-other-programs.

b. This policy lacks justification.

While Arkansas suggests that the program would incentivize employment for Medicaid enrollees, the evidence indicates otherwise. Like its previous attempt at work requirements, which did not result in significant changes to employment,[39] the current proposal is based on inaccurate beliefs about the Medicaid population. It is based on the false premise that Medicaid enrollees choose not to work and are taking advantage of the program's benefits—a narrative that is driven by stereotypes based on race, gender, disability, and class. In fact, about two thirds of Medicaid enrollees ages 19-64 already work; the remaining do not work primarily due to caregiving responsibilities, illness or disability, or school attendance.[40] Threatening enrollees' Medicaid coverage actually makes it *more* difficult for them to sustain employment: Access to Medicaid makes it possible for enrollees to get the care and supports they need to be able to work, particularly for those with health conditions and disabilities.[41] Those who are insured are more likely to become and remain employed.[42]

Arkansas further assumes that when Medicaid enrollees do not work, it is a result of individual choices rather than systemic barriers. The application rests on the belief that increasing employment rates is simply a matter of providing enrollees with the right incentives or connecting them with resources. The reality is that most Medicaid enrollees are highly motivated to work but face a range of hurdles to doing so. For example, women, in particular women of color and disabled women, face substantial barriers to employment, such as high rates of discrimination, harassment, lack of accommodations for pregnancy or disability, and lack of caregiving support.[43] Inadequate access to childcare and other caregiving services represents a particularly significant barrier to employment for women in the Medicaid programs. Among Medicaid enrollees, 19% of women did not work due to caregiving responsibilities, compared to 4% of men.[44] Nearly three in ten (28%) women enrollees with children under the age of 18 were not working due to caregiving responsibilities, seven times the rate among men with children under the age of 18 (4%) .[45] And among those working part time, 27% of women (compared to 12% of men) reported that it was due to problems securing childcare or other family obligations.[46] Given these barriers to employment, it is therefore unsurprising that, nationally, women enrolled in Medicaid are less likely to be working than men.[47] In Arkansas, the gap is especially pronounced among parents of

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[39] Harker, *supra* note 32.
[40] Lukens & Zhang, *supra* note 7.
[41] David Machledt, *How Medicaid Work Requirements Hurt People with Disabilities* (Dec. 16, 2024), https://healthlaw.org/resource/unfit-to-work-how-medicaid-work-requirements-hurt-people-with-disabilities-2.
[42] Larisa Antonisse & Rachel Garfield, *The Relationship Between Work and Health: Findings from a Literature Review* (Aug. 7, 2018), https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review.
[43] *See, e.g.,* Isabela Salas-Betsch, *Ending Discrimination and Harassment at Work* (Mar. 14, 2024), https://www.americanprogress.org/article/playbook-for-the-advancement-of-women-in-the-economy/ending-discrimination-and-harassment-at-work.
[44] Ivette Gomez et al., *Medicaid Work Requirements: Implications for Low Income Women's Coverage* (Apr. 30, 2025), https://www.kff.org/womens-health-policy/issue-brief/medicaid-work-requirements-implications-for-low-income-womens-coverage.
[45] *Id*.
[46] *Id*.
[47] *Id*.

minor children: Among men with children under the age of 18, 82% were working in 2023, compared to only 63% of women.[48]

IV. Conclusion

Arkansas' application fails to meet the statutory requirements for § 1115 waivers and would create unwarranted hardships for Medicaid enrollees, harming communities that already face disparities in access to care. We urge CMS to reject it.

We request that the supporting documentation we have made available through direct links in our citations be considered as part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS does not intend to consider these materials part of the record as requested, we ask that you notify us and provide us with an opportunity to submit copies of the studies and articles into the record.

For further information, please contact us at the email address below.

Sincerely,

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[48] *Id*. Data is among nonelderly Medicaid enrollees who do not receive benefits from Supplemental Security Income or Social Security Disability Insurance programs and are not also covered by Medicare.