



May 9, 2025

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

Dear Secretary Kennedy,

The Bazelon Center for Mental Health Law submits these comments in response to Arkansas's Request to Amend the ARHOME Section 1115 Demonstration Project. The Bazelon Center is a national non-profit legal advocacy organization that promotes equal opportunity for individuals with mental disabilities in all aspects of life, including health care, community living, housing, education, employment, voting, and other areas.

The ARHOME Program is Arkansas's Medicaid expansion, and it has been tremendously successful. By Arkansas's own account, ARHOME currently provides health care coverage to more than 220,000 adults ages 19-64 with income at or below 138% of the federal poverty level.¹ It has also significantly reduced the uninsured rate of working-age adults in the state. Between 2014 and 2023, the percentage of adults ages 19-64 who were uninsured dropped from 17.7% to 12.5%.²

Granting the proposed amendment would undermine that success and would likely be unlawful. Work requirements imposed on ARHOME beneficiaries are likely to deter, rather than promote, access to health care and lead to significant numbers of people inappropriately losing needed coverage, not because they are failing to work or look for work, but because they are caught in bureaucratic red tape with respect to the requirements. State commenters highlighted this reality in their opposition to the proposal, citing concerns regarding Arkansas's prior attempt at work requirements, administrative barriers to coverage, lack of clarity around implementation, and misalignment with the goals of Medicaid.³ Despite these concerns, Arkansas declined to provide greater clarity and stated that "the state is not proposing any policy changes to the amendment based on public comment."⁴

We urge CMS to reject Arkansas's proposal because it does not promote the objectives of the Medicaid program; is not an experimental, pilot, or demonstration of the sort contemplated by the Medicaid statute; and would be particularly harmful for beneficiaries with disabilities.

¹ State of Arkansas, Arkansas Department of Human Services, Request to Amend the ARHOME Section 1115 Demonstration Project 5 (Mar. 26, 2025) [hereinafter Arkansas Application].

² *Id.* at 14.

³ *Id.* at 28-32.

⁴ *Id.* at 28.

1. The Department of Health and Human Services (HHS) does not have the authority to grant Arkansas’s request.

HHS lacks authority to approve the proposal to condition health care coverage for ARHOME beneficiaries on these individuals engaging in work, work-related activities, learning activities, or service activities. Section 1115 waivers may only be approved for “any experimental, pilot, or demonstration project which, in the judgment of the secretary, is likely to assist in promoting the objectives of the Medicaid program.”⁵ Arkansas’s proposal is not a demonstration pilot and would not promote the objectives of Medicaid.

A. Arkansas’ proposed work requirements do not promote the objectives of Medicaid.

The statutory objectives of the Medicaid program are to furnish (1) “medical assistance” to people with disabilities, seniors, and families with dependent children, whose income and resources are insufficient to secure needed medical services, and (2) services to help such individuals and families attain or retain independence and self-care.⁶ As the D.C. Circuit held in affirming the suspension of Arkansas’s prior work requirements, “the intent of Congress is clear that Medicaid’s objective is to provide health care coverage, and, as a result, the Secretary ‘must give effect to [that] unambiguously expressed intent of Congress.’”⁷ Further, “[t]he Secretary’s discretion in approving or denying demonstrations is guided by the statutory directive that the demonstration must be ‘likely to assist in promoting the objectives’ of Medicaid.”⁸ HHS should reject Arkansas’s proposal because, like Arkansas’ prior work requirements, it would not further the statutory goal of providing health care coverage.

Past experience with Medicaid work requirements has consistently shown that these requirements do not assist individuals in obtaining employment and independence, and that they do the opposite of furthering Medicaid’s goal of furnishing health care coverage: they cause widespread loss of health care coverage due to misunderstandings about or failure to correctly adhere to opaque and confusing requirements to report work or job searches.⁹ As we explain below, the current proposal can be expected to have the same outcomes.

⁵ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *About Section 1115 Demonstrations*, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations>.

⁶ 42 U.S.C. 1396-1.

⁷ *Gresham v. Azar*, 950 F.3d 93, 100 (D.C. Cir. 2020) (citation omitted).

⁸ *Id.* at 99.

⁹ Jennifer Wagner and Jessica Schubel, Center on Budget and Policy Priorities, *States’ Experiences Confirm Harmful Effects of Medicaid Work Requirements* (Nov. 2020), <https://www.cbpp.org/sites/default/files/atoms/files/12-18-18health.pdf> (due to complex rules, insufficient and ineffective outreach, complex reporting systems, and a lack of staff support, in Arkansas, Michigan, and New Hampshire “people who were working and people with serious health needs who should have been eligible for [work requirement] exemptions lost coverage or were at risk of losing coverage due to red tape”); Michael Karpman et al., The Urban Institute and the Robert Wood Johnson Foundation, *Assessing Potential Coverage Losses among Medicaid Expansion Adults under a Federal Medicaid Work Requirement* (Mar. 2025), <https://www.urban.org/sites/default/files/2025-03/AssessingPotential-Coverage-Losses-among-Medicaid-Expansion-Adults-under-a-Federal-Medicaid-WorkRequirement.pdf> (Study of Arkansas, the only state to fully implement Medicaid work requirements, and New Hampshire, which made significant progress toward implementation, showed that despite nearly all those subject to the requirements either working or qualifying for an

The failure of work requirements to advance the goals of Medicaid has already been clearly demonstrated in Arkansas. In 2018, Arkansas became the only state to fully implement a work requirement in its Medicaid program.¹⁰ In just seven months, before a federal court suspended the requirement,¹¹ 25% of recipients who were subject to it—18,000 people—lost their coverage.¹² Those who lost coverage did not fail to work or qualify for an exemption. Instead, red tape, paperwork, and a lack of clear communication resulted in widespread confusion and thousands of inappropriate terminations.¹³ Among other issues, outreach efforts proved largely ineffective.¹⁴ Nearly half of those subject to the requirement were unsure whether it applied to them, and another third reported hearing nothing about it.¹⁵ As of late 2019, several months after a court had suspended the program, 70% of Arkansas residents were unsure whether it was still in effect.¹⁶ Ultimately, the state spent \$26.1 million on implementing the requirement,¹⁷ and subsequent analysis determined that employment did not increase.¹⁸ Indeed, the lack of any impact on employment is consistent with the fact that nearly two-thirds of working-age Medicaid enrollees nationally are already working and nearly all of the rest would be eligible for an exemption because of caregiving responsibilities, illness or disability, or school attendance.¹⁹

Other states that imposed Medicaid work requirements similarly faced significant loss of health care coverage. Work requirements in New Hampshire were suspended one month after implementation, once it became clear that 40% of those subject to the requirement were on track to lose coverage, even though all but a small minority of those subject to the requirement were already working or qualified for an exemption.²⁰ In Michigan, where the state spent \$28 million on outreach,²¹ the work requirements program was suspended two months into implementation

exemption, “enrollees faced a range of barriers to compliance with the new requirements, including low awareness or understanding of the policy, confusion related to state notices, and difficulties accessing or using online portals or other reporting systems.”).

¹⁰ *Assessing Potential Coverage Losses*, *supra* note 9.

¹¹ *Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019).

¹² Sophia Tripoli et al., Families USA, *Medicaid Work Reporting Requirements: Bureaucratic Burdens That Threaten Working Families, Providers and Local Economies* (Mar. 2025),

<https://familiesusa.org/wpcontent/uploads/2025/03/Medicaid-Work-Reporting-Requirements-Fact-Sheet.pdf>.

¹³ *States’ Experiences Confirm Harmful Effects of Medicaid Work Requirements*, *supra* note 9.

¹⁴ *Gresham v. Azar*, 363 F. Supp. 3d 165, 184 (D.D.C. 2019) (“It bears mentioning here, however, that the State’s outreach efforts may well be falling severely short.”).

¹⁵ *States’ Experiences Confirm Harmful Effects of Medicaid Work Requirements*, *supra* note 9.

¹⁶ *Id.*

¹⁷ MaryBeth Musemeci et al., KFF, *Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees* (Dec. 2020), <https://www.kff.org/medicaid/issue-brief/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees/>.

¹⁸ Benjamin D. Sommers et al., *Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, and Affordability of Care*, 39 *Health Affairs* 1522 (2020), <https://doi.org/10.1377/hlthaff.2020.00538>

¹⁹ Jennifer Tolbert et al., KFF, *Understanding the Intersection of Medicaid and Work: An Update* (Feb. 4, 2025), <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicare-and-work-an-update/>.

²⁰ *States’ Experiences Confirm Harmful Effects of Medicaid Work Requirements*, *supra* note 9; Rachel Garfield et al., KFF, *Understanding the Intersection of Medicaid and Work: What Does the Data Say?* (Aug. 2019), <https://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicare-and-Work-What-Does-the-Data-Say>.

²¹ *States’ Experiences Confirm Harmful Effects of Medicaid Work Requirements*, *supra* note 9.

because one-third of recipients subject to the requirement failed to report and were about to lose coverage.²²

Similarly, experience with work requirements in the Temporary Assistance for Needy Families (TANF) program has shown that: (1) stable employment among recipients subject to work requirements was the exception rather than the norm, and (2) most recipients who had significant barriers to employment never found employment.²³ Indeed, within five years, “employment among recipients not subject to work requirements was the same as or higher than employment among recipients subject to work requirements in nearly all of the programs evaluated.”²⁴

While Arkansas says its proposal reflects lessons learned from its prior attempt at work requirements,²⁵ the proposal provides no clarity on how it will prevent the same outcomes when it has many of the same limitations.

Arkansas proposes to establish work and community engagement requirements for the Medicaid expansion population.²⁶ The state proposes to deem people “on track” or “not on track” through data matching.²⁷ To be “on track,” a person must be employed or “engaged in qualifying advancement, learning, or service activities.”²⁸ A person will be deemed “not on track” if they do not meet these requirements, or if they are identified by the state as “most at risk for poor health outcomes due to long-term dependency”²⁹ because they have been enrolled in Medicaid expansion for two years or more or based on other factors such as income level, employment history, educational status, and whether a dependent child is in the household.³⁰ Those who are identified as “not on track” will be offered care coordination called “Success Coaching” to “improve their health, employment, advancement, learning, and community engagement,” including a Personal Development Plan (PDP).³¹ The state says these services will help an individual increase their income, use health care coverage, and address their health related social needs.³²

However, Arkansas fails to provide any clarity on how it could ensure that it has accurate data to identify people as “not on track” based on current employment status or past employment

²² *Id.*; Robin Erb, Bridge Michigan, *Gretchen Whitmer Asks to Stop Michigan Medicaid Rules; 80,000 At Risk* (Feb. 25, 2020), <https://www.bridgemi.com/michigan-health-watch/gretchen-whitmer-asks-stopmichigan-medicaid-work-rules-80000-risk>.

²³ See, e.g., LaDonna Pavetti, Center on Budget and Policy Priorities, *Work Requirements Don't Cut Poverty, Evidence Shows* (June 2016), <https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows>. See also Ladonna Pavetti, Center on Budget and Policy Priorities, *Work Requirements Don't Work* (Jan. 10, 2018), <https://www.cbpp.org/blog/work-requirements-dont-work>; Marybeth Musumeci, KFF, *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (Aug. 18, 2017), <https://www.kff.org/medicaid/issuebrief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/>.

²⁴ *Id.*

²⁵ Arkansas Application 25, 31.

²⁶ Arkansas Application 3.

²⁷ *Id.* at 4.

²⁸ *Id.*

²⁹ *Id.* at 10.

³⁰ *Id.* at 28.

³¹ *Id.* at 4, 11.

³² *Id.* at 21.

history, income level, or educational status. Nor does it provide clarity on how it could ensure effective communication with enrollees who are deemed “not on track” about why they have been so deemed, how they can challenge that determination if it is based on inaccurate information, what would happen to their benefits if they wish to challenge that determination, what suffices to convey agreement to participate in the Success Coaching program, and what the participants of that program must report. Given the difficulty of gathering accurate data on the factors cited by the state as well as the enormous problems with outreach and effective communication during the state’s prior work requirements program, it is virtually certain that Arkansas’ current proposal will be plagued by similar problems as its last effort.

Further, the state fails to explain how care coordination would be implemented and meaningfully provided. The state offers only the vague and speculative assurance that “currently assessing public and private sector options for acquiring talent to fulfill these functions,” as well as intending to leverage existing state resources and community partners “already engaged in education and training, workforce support, and care coordination.”³³ It offers no concrete plans to ensure such a comprehensive service is available for so many people. Those details, it claims, “will be developed in future actions.”³⁴

The proposal would allow the state to terminate enrollees’ coverage for nebulous reasons with no clear explanation of how care coordination will enable them to regain coverage. For example, an individual who engages in Success Coaching but is deemed by the state as failing to cooperate can lose their health care coverage.³⁵ An individual who engages in Success Coaching but fails to get “on track” within three months will lose their health care coverage.³⁶ By its own estimate, Arkansas anticipates 25% of those subject to Success Coaching will have their health coverage suspended.³⁷ With little explanation or analysis, the state speculates that half of those who lose coverage will regain coverage after cooperating.³⁸ When state commenters pointed to the lack of key details regarding suspension, qualifications and services of Success Coaching, and criteria or standards for the personal development plan, Arkansas had no response other than to say that it would address such details through implementation and monitoring.³⁹

A demonstration that cuts off large numbers of people from coverage under the guise of failing to comply with an opaque and undeveloped system of support services does not further Medicaid’s primary goal of providing health care coverage. The proposal simply fails to provide any assurance that the services it describes will be available or sufficient to provide everyone the support they need to comply with the requirement and be deemed “on track.”

Even if Arkansas were to provide robust care coordination to people it flags as off track, its proposal would almost certainly lead to many people losing coverage not because they were unemployed, but because they were mistakenly deemed “not on track” and unable to cut through the red tape to get coverage back. Arkansas plans to “use data-matching to identify individuals

³³ *Id.* at 11, 33.

³⁴ *Id.* at 33.

³⁵ *Id.* at 18.

³⁶ *Id.* at 19.

³⁷ *Id.* at 25-26

³⁸ *Id.*

³⁹ *Id.* at 29.

who could benefit from extra support to reach health and economic goals,”⁴⁰ but acknowledges that its prior experience with work requirements demonstrated “the limitation of data matching,” and that many enrollees fell through the cracks.⁴¹ While the state says it “will not rely solely on data matching to assess individuals’ needs for support,”⁴² it fails to identify any additional sources it will rely on.

Those individuals who are designated via potentially incomplete or inaccurate data to be “not on track” and in need of Success Coaching will find themselves navigating just the sort of bureaucratic barriers that have historically resulted in inappropriate loss of coverage. Although the proposal claims to have no reporting requirement, that is untrue for those marked for coaching. At a minimum, the care coordination process requires reporting to a Success Coaching entity at least once a month, participating in any identified services, and being tracked and monitored for progress.⁴³ As discussed above, if a beneficiary is deemed to have failed to cooperate fully with Success Coaching or make sufficient progress, they will lose their coverage, regardless of whether the person is even aware they have been deemed “not on track” or understands their obligations.⁴⁴

Past Medicaid work requirements programs in Arkansas and elsewhere clearly show widespread lack of understanding or awareness among beneficiaries as to whether they are subject to the requirement and how to report if it is required, resulting in inappropriate terminations.⁴⁵ Robust outreach campaigns prior to and during implementation of these programs made little difference.⁴⁶ While Arkansas says it has learned “the importance of providing clear communications through multiple means, simplicity in design, and the need for personal interaction rather than over-reliance on technology,”⁴⁷ it provides no information about how it will communicate the new requirements or ensure personal interaction. It says “personal communication between the Medicaid enrollee and the coaching resource” is a cure for gaps in data matching,⁴⁸ but provides no information on how it will ensure an enrollee is reached and personal communication happens.

A further concern is the lack of clarity about whether the three-month period of offering coaching services⁴⁹ begins with attempted or actual contact with a beneficiary. If the former, Arkansas could suspend coverage for many who simply did not realize they had been identified.

⁴⁰ Arkansas Application at 3.

⁴¹ *Id.* at 10, 28.

⁴² *Id.* at 10.

⁴³ *Id.* at 17-18.

⁴⁴ *Id.* at 11, 18-19.

⁴⁵ *States’ Experiences Confirm Harmful Effects of Work Requirements*, *supra* note 9.

⁴⁶ *Id.*

⁴⁷ Arkansas Application 3.

⁴⁸ *Id.* at 28.

⁴⁹ *Id.*

B. *Arkansas’s proposed work requirements are not an experiment, pilot, or demonstration of the sort contemplated by the Medicaid statute.*

The waiver proposal has no experimental value and should be rejected. 1115 Waiver and Demonstration programs are intended to contain clearly defined goals, identify a specific problem that is being addressed, have a reasonable basis to believe that the demonstration is likely to address the problem effectively and without harm, and put measures in place to ensure that individuals are not harmed.

Arkansas’s proposed work requirements have no experimental value. Work requirements have been tested repeatedly. They are neither new nor innovative. As discussed above, work requirements through Medicaid programs have already been tested in Arkansas,⁵⁰ as well as frequently through TANF and other programs, and have not been shown to be successful in expanding work and lifting individuals out of poverty.⁵¹ Arkansas acknowledges the failures of its prior work requirements program without indicating this new one will avoid the same results. Although Arkansas’s proposal may have some differences from its prior program, the fundamental challenges presented by the limits of outreach, confusion about compliance and reporting requirements, and barriers to preventing incorrect termination remain the same. If the proposal is implemented, it is virtually certain that large numbers of people will again lose coverage even if they are working or doing other required activities.

2. Arkansas’s proposal will have a harmful impact on people with disabilities

Arkansas’s proposal is particularly troubling for people with disabilities. While the amendment claims to impact only “able-bodied adults,” and implies that those with disabilities are either already enrolled in other, more appropriate, Medicaid programs or could be moved there as a result of “Success Coaching,” it is highly unlikely the requirements will be implemented in a way that protects all people with disabilities that interfere with work and ensures that they do not inappropriately lose coverage. Arkansas’s application to only “able-bodied adults” is especially concerning for those individuals with a mental health disability. Up to 35% of individuals getting care through Medicaid have a mental health condition, with over 20% having a moderate to severe condition.⁵²

The overwhelming majority of people with disabilities want to and can work, but many are not working as a result of attitudinal barriers among employers, the need for reasonable accommodations that have not been provided, the need for supported employment services that are scarcely available, or the lack of reliable, accessible transportation. Because of those barriers, the employment rate of people with disabilities has remained far lower than that of any other group tracked by the Bureau of Labor Statistics. Among working age adults, the employment rate of people with disabilities is half of that for people without disabilities.⁵³ For

⁵⁰ *Medicaid Work Requirements In Arkansas: Two-Year Impact*, *supra* note 18.

⁵¹ *Work Requirements Don’t Work*, *supra* note 24.

⁵² Brit Vanneman, National Health Law Program, *Cuts to Medicaid Expansion Harm People with Mental Health Disabilities* (Apr. 2025), <https://healthlaw.org/resource/cuts-to-medicaid-expansion-harm-people-with-mental-health-disabilities/>.

⁵³ U.S. Department of Labor, Bureau of Labor Statistics, *Persons with a Disability: Labor Force Characteristics* (Feb. 25, 2025), <https://www.bls.gov/news.release/pdf/disabl.pdf> (among persons age 16 to 64, the employment-

people with serious mental illness, the employment rate is even lower; it has been estimated over time at about 22%, with approximately 12% working full-time.⁵⁴ The dramatic gap between the desire of people with serious mental illness to work and their low employment rates is not an inability to work, but rather “attitudinal, service, and system barriers” such as stigma and discrimination, inadequate treatment, and lack of employment services.⁵⁵

Additionally, many people with disabilities who are working may be working part-time schedules of fewer than 80 hours/month as an accommodation, or may have seasonal, temporary, or contractor work, which would potentially lead to loss of coverage between work opportunities or even while working. In other programs that have implemented work requirements, participants with physical and mental health issues were more likely to be sanctioned for not completing the work requirement.⁵⁶ That is a likely outcome here as well. Arkansas not only fails to be explicit in terms of the factors it will use to identify whether someone is “on track,” it also expresses concerns about those beneficiaries who are “underemployed.”⁵⁷ This sort of caveat could easily impact those beneficiaries with disabilities who are working, though perhaps less than Arkansas deems sufficient.

The last time Arkansas implemented work requirements, a study found that “people with disabilities were particularly vulnerable to losing coverage under the Arkansas work and reporting requirements, despite remaining eligible.”⁵⁸ Arkansas acknowledges reports that its prior work requirements program caused widespread uncertainty among enrollees and failed to adequately exempt those with disabilities, but maintains that removing exemptions will “significantly simplify implementation for enrollees.”⁵⁹ The idea that eliminating exemptions entirely will somehow provide greater protection for those with disabilities than exemptions did last time is unfounded and insufficient to justify approval.

Arkansas appears to suggest that those with disabilities either already participate in another Medicaid program developed for individuals with serious mental illness or who are “medically frail,” or that they will be moved to such a program as a result of Success Coaching. Either suggestion ignores the reality that nearly three-fifths of all non-elderly adult Medicaid enrollees with disabilities do not receive their benefits through Medicaid’s Supplemental Security Income

population ration in 2024 for people with disabilities was 37.4 percent, in contrast to 74.9 percent for people without disabilities).

⁵⁴ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, *Federal Financing of Supported Employment and Customized Employment for People with Mental Illness: Final Report* vii (Feb. 1, 2011) <http://aspe.hhs.gov/daltcp/reports/2011/supempFR.pdf>.

⁵⁵ Written Testimony of Dr. Gary Bond, *U.S. Equal Employment Opportunity Commission public meeting on Employment of People with Mental Disabilities* (March 15, 2011), <https://www.eeoc.gov/eeoc/meetings/3-15-11/bond.cfm>.

⁵⁶ 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/spp_papers/88.

⁵⁷ Arkansas Application 31-32.

⁵⁸ 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/issuebrief/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018/>.

⁵⁹ Arkansas Application 10, 28-29.

(SSI) program.⁶⁰ In fact, 47% of working-age adults enrolled in a non-disability category of Medicaid qualify for benefits based on disability.⁶¹ Therefore, it is likely that many with disabilities are enrolled in expansion programs like the ARHOME program and cannot simply be moved to another model of care through the coaching process. This is especially true for individuals with mental health conditions, many of whom lack the resources, documentation, or history of consistent care necessary to obtain a formal disability determination, may be navigating emerging mental health disabilities, or may be relying on the expansion program while they await a disability determination.⁶²

The work requirements also fail to ensure that beneficiaries who come into compliance after coverage is suspended will regain access to care. The proposal states that “benefits are restored after the individual contacts DHS with agreement to cooperate with their PDP,”⁶³ and that if a suspension is approved by a three-person DHS panel, “the individual will receive a written notice of the action with a right to appeal,”⁶⁴ but offers no additional information on the appeal and re-enrollment process, including a likely timeline. Any coverage interruptions, even brief, may have severe consequences for many beneficiaries, particularly those with disabilities.⁶⁵

While we agree with the goals of increasing employment and encouraging involvement in the community, the proposed work requirements are not a credible means to achieve those goals and their primary result would be the widespread inappropriate loss of needed health coverage. Losing health care will make it harder, not easier, for people, especially those with mental health needs, who are unemployed and facing challenges securing work to get and keep a job. The proposal, which lacks any evidence to the contrary, should be rejected.

We appreciate the opportunity to provide comments on the Arkansas Application. Our comments include citations to supporting research including direct links for the benefit of HHS in reviewing our comments. We direct HHS to 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 the purposes of the Administrative Procedure Act.

⁶⁰ Center on Budget Policy and Priorities, Taking Away Medicaid for Not Meeting Work Requirements Harms People With Disabilities (Mar. 2020), <https://www.cbpp.org/sites/default/files/atoms/files/1-26-18health.pdf>.

⁶¹ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid enrollees who qualify for benefits based on disability*, <https://data.medicaid.gov/dataset/b12e390f-1721-47c0-bb38-b0b1805e0446#data-table>

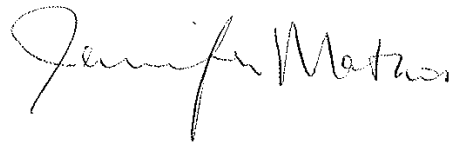
⁶² *Cuts to Medicaid Expansion Harm People with Mental Health Disabilities*, *supra* note 68.

⁶³ Arkansas Application 19-20.

⁶⁴ *Id.* at 18.

⁶⁵ Anna Bailey and Judith Soloman, Center on Budget and Policy Priorities, *Medicaid Work Requirements Don't Protect People with Disabilities* (Nov. 14, 2018), <https://www.cbpp.org/research/health/medicaid-work-requirements-dont-protect-people-with-disabilities>.

Respectfully submitted,

A handwritten signature in black ink that reads "Jennifer Mathis". The signature is written in a cursive, flowing style.

Jennifer Mathis
Deputy Director
jenniferm@bazelon.org

Claire Shennan
David & Mickey Bazelon Fellow
claires@bazelon.org