



June 24, 2021

Jami Snyder
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, Arizona 85034

Dear Ms. Snyder:

On February 12, 2021, the Centers for Medicare & Medicaid Services (CMS) sent you a letter regarding the January 18, 2019 amendment of the section 1115 demonstration project entitled “Arizona Health Care Cost Containment System (AHCCCS)” (Project Number 11-W-00275/9). The letter advised that CMS would commence a process of determining whether or not to withdraw the authorities previously approved in the AHCCCS demonstration that permit the state to require work and other community engagement activities as a condition of Medicaid eligibility. It explained that in light of the ongoing disruptions caused by the COVID-19 pandemic, Arizona’s community engagement requirement risks significant coverage losses and harm to beneficiaries. For the reasons discussed below, CMS is now withdrawing approval of the community engagement requirement in the January 18, 2019 amended AHCCCS demonstration, which is not currently in effect and which would have expired by its terms on September 30, 2021. Other components of the demonstration will continue to expire on September 30, 2021.

Section 1115 of the Social Security Act (the Act) provides that the Secretary of Health and Human Services (HHS) may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain programs under the Act. In so doing, the Secretary may waive Medicaid program requirements of section 1902 of the Act, and approve federal matching funds per section 1115(a)(2) for state spending on costs not otherwise matchable under section 1903 of the Act, which permits federal matching payments only for “medical assistance” and specified administrative expenses.¹ Under section 1115 authority, the Secretary can allow states to undertake projects to test changes in Medicaid eligibility, benefits, delivery systems, and other areas across their Medicaid programs that the Secretary determines are likely to promote the statutory objectives of Medicaid.

As stated in the above-referenced letter sent on February 12, 2021, under section 1115 and its implementing regulations, CMS has the authority and responsibility to maintain continued oversight of demonstration projects in order to ensure that they are currently likely to assist in promoting the objectives of Medicaid. CMS may withdraw waivers or expenditure authorities if it “find[s] that [a] demonstration project is not likely to achieve the statutory purposes.” 42 C.F.R. § 431.420(d); see 42 U.S.C. § 1315(d)(2)(D).

¹ 42 U.S.C. § 1315.

As the February 12, 2021 letter explained, the AHCCCS community engagement requirement is not in effect. On October 17, 2019, Arizona postponed the implementation of the community engagement program, AHCCCS Works, citing the ongoing litigation concerning Medicaid community engagement requirements. Since that time, the COVID-19 pandemic and its expected aftermath have made the AHCCCS community engagement requirement infeasible. In addition, implementation of the community engagement requirement is currently prohibited by the Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127, Div. F, § 6008(a) and (b), 134 Stat. 208 (2020), which conditioned a state's receipt of an increase in federal Medicaid funding during the pandemic on the state's maintenance of certain existing Medicaid parameters. Arizona has chosen to claim the 6.2 percentage point FFCRA Federal Medical Assistance Percentage (FMAP) increase, and therefore, while it does so, must maintain the enrollment of beneficiaries who were enrolled as of, or after, March 18, 2020.

The February 12, 2021 letter noted that, although the FFCRA's bar on disenrolling such beneficiaries will expire after the COVID-19 public health emergency ends, CMS still has serious concerns about testing policies that create a risk of substantial loss of health care coverage and harm to beneficiaries even after the expiration of the bar on disenrolling beneficiaries. The COVID-19 pandemic has had a significant impact on the health of Medicaid beneficiaries. Uncertainty regarding the current crisis and the pandemic's aftermath, and the potential impact on economic opportunities (including job skills training, work and other activities used to satisfy the community engagement requirement) and access to transportation and affordable child care, have greatly increased the risk that implementation of the community engagement requirement approved in this demonstration will result in substantial coverage loss. In addition, the uncertainty regarding the lingering health consequences of COVID-19 infections further exacerbates the harms of coverage loss for Medicaid beneficiaries.

Accordingly, the February 12, 2021 letter indicated that, taking into account the totality of circumstances, CMS had preliminarily determined that allowing the community engagement requirement to take effect in Arizona would not promote the objectives of the Medicaid program. Therefore, CMS provided the state notice that we were commencing a process of determining whether to withdraw the authorities approved in the AHCCCS demonstration that permit the state to require work or other community engagement activities as a condition of Medicaid eligibility. See Special Terms and Conditions ¶ 11. The letter explained that if CMS ultimately determined to withdraw those authorities, it would "promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date." *Id.* The February 12, 2021 letter indicated that, if the state wished to submit to CMS any additional information that in the state's view may warrant not withdrawing those authorities, such information should be submitted to CMS within 30 days. We have not received any additional information from Arizona in response to the February 12, 2021 letter.

In light of these concerns, for the reasons set forth below, CMS has determined that, on balance, the authorities that permit Arizona to require work and community engagement as a condition of eligibility are not likely to promote the objectives of the Medicaid statute. Therefore, we are withdrawing the community engagement authorities that were added in the January 18, 2019 amendment approval for the AHCCCS demonstration.

Background of Arizona’s Demonstration

The AHCCCS section 1115 demonstration project is a longstanding, comprehensive demonstration that was originally approved in 1982 and has evolved over the subsequent demonstration periods. Currently, Arizona administers the delivery of Medicaid and Children's Health Insurance Program (CHIP) services (including acute care, long term services and supports, home and community-based services, and both mandatory and optional state plan services) through a managed care delivery system to mandatory and optional state plan coverage groups, authorized through the AHCCCS demonstration. Arizona also provides Medicaid coverage to some non-mandatory populations through expenditure authority under the AHCCCS demonstration, such as certain groups of beneficiaries receiving home and community based services. The state also covers some non-mandatory benefits through expenditure authority under the AHCCCS demonstration, including dental for those in the long-term care system. On January 1, 2014, Arizona expanded Medicaid to provide state plan coverage of the new adult group authorized under 1902(a)(10)(a)(i)(VIII) of the Act.

On January 18, 2019, CMS approved Arizona’s request to amend the AHCCCS demonstration to implement a community engagement requirement, called AHCCCS Works, requiring beneficiaries in the new adult group, ages 19 through 49, with certain exceptions, to participate in and timely report 80 hours per month of community engagement activities, such as employment, education, job skills training, or community service, as a condition of continued Medicaid eligibility. If a beneficiary fails to report compliance with the community engagement requirement for any month after a three-month grace period, the beneficiary’s eligibility would be suspended for two months. Beneficiaries with suspended eligibility would have their eligibility reactivated immediately after the end of the two-month suspension as long as they continued to meet all other eligibility criteria. Beneficiaries in a suspension status could have their eligibility reinstated earlier if the beneficiary qualified for another category of Medicaid eligibility that was not subject to the community engagement requirement or becomes exempt from the requirement. The demonstration’s Special Terms and Conditions specified that the state would implement the AHCCCS Works requirement no sooner than January 1, 2020.

Early Experience from the Implementation of Community Engagement Requirements through Medicaid Section 1115 Demonstrations in Other States

Arizona never implemented the community engagement requirement under the AHCCCS demonstration. In September 2019, Arizona announced that the community engagement requirement would initially only be implemented in urban areas of the state in the fall of 2020.^{2,3} In October 2019, Arizona sent a letter to CMS informing us of its decision to indefinitely postpone the implementation of the requirement due to “the evolving national landscape

² Norris L. (2019). Arizona and the ACA’s Medicaid expansion. Healthinsurance.org. Retrieved from <https://www.healthinsurance.org/medicaid/arizona/>

³ The state submitted a draft Community Engagement Implementation Plan to CMS on July 1, 2019 describing that the AHCCCS Works program would be implemented geographically, in three phases, starting with the most urbanized counties (counties with less than 20% rural population) in 2020-2021; and subsequently, in 2021-2022 in the semi-urbanized counties (counties with 40-50% moderate rural population), and finally, in 2022-2023 in the least urbanized counties (counties with greater than 40% rural population) of the state.

concerning Medicaid community engagement programs” and the litigation surrounding such requirements in other states.⁴

Although the demonstration’s community engagement requirement was never implemented, the Commonwealth Fund estimated that between 76,000 and 103,000 beneficiaries could lose coverage within the first 12 months of full implementation of AHCCCS Works in Arizona, representing loss of coverage for 26–35 percent of the estimated total population of 293,000 beneficiaries who could be subject to the requirement in the state.^{5,6,7,8}

Data also suggest that there is a relatively small minority of beneficiaries who could potentially benefit from targeted employment gain with the implementation of the community engagement requirement. According to research from the Kaiser Family Foundation using the Current Population Survey (CPS) data,⁹ in Arizona, 61 percent (63 percent nationally) of Medicaid beneficiaries aged 19 to 64 without Supplemental Security Income (SSI) in 2019 were working. Of those who were not working in Arizona, 28 percent (27 percent nationally) indicated that their reason for not working was due to illness or disability, while another 46 percent (51 percent nationally) cited that they were caretaking or attending school. Under Arizona’s community engagement requirement, illness, disability, full time enrollment in educational activities, and caregiving are qualifying exemptions, and educational activities less than full time are a qualifying activity. Accordingly, these data suggest that the majority of beneficiaries who could be subject to Arizona’s community engagement requirement but were not working would have been otherwise exempt from or meeting the requirement.¹⁰ Thus, if implemented, there would be little margin for the program to increase work or community engagement in Arizona.

⁴ Arizona Health Care Cost Containment System (AHCCCS). (2019). Arizona Works Implementation Postponement Letter. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-postponement-ltr-ahcccs-works-10172019.pdf>

⁵ Ku, L. & Brantley, E. (2019). Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults to Lose Medicaid Coverage. The Commonwealth Fund. Retrieved from <https://www.commonwealthfund.org/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-coverage>

⁶ Ku, L. & Brantley, E. (2019). Methods Appendix: Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults to Lose Medicaid Coverage. The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/sites/default/files/2019-06/Ku_methods_appendix_06-21-2019.pdf

⁷ The Commonwealth Fund estimated that in Arizona 293,000 individuals could be subject to the community engagement requirement; this estimate, however, differs from other estimates on the size of the target population, for example, see Brady M. (2019). Arizona Gives Up on Controversial Medicaid Work Requirement. Modern Healthcare. Retrieved from <https://www.modernhealthcare.com/medicaid/arizona-gives-up-controversial-medicaid-work-requirement>

⁸ The study accounted for the following dimensions of demonstration features in its coverage loss estimates: (a) the target population ages and status; (b) specific type of exemptions for parents and caretakers; (c) required hours of work and community engagement activities; (d) the timing of when coverage ends if not compliant, and (e) the process to regain coverage.

⁹ Garfield, R., Rudowitz, R., Guth, M. Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from <https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/>

¹⁰ Lieberman G. (2019). ASU researchers call Arizona Medicaid work requirements ‘unnecessary’. The State Press. Retrieved from <https://www.statepress.com/article/2019/11/spbiztech-asu-researchers-say-work-requirements-are-unnecessary>

This is consistent with research indicating more generally that most Medicaid beneficiaries are already working or are likely to be exempt from a potential community engagement requirement.^{11,12,13,14} For example, the Kaiser Family Foundation found that 81 percent of adults with Medicaid coverage live in families with a working adult, and 6 in 10 are working themselves.¹⁵ Similarly, a study published in 2017 reported that, out of the 22 million adults covered by Medicaid nationwide (representing 58 percent of all adults on Medicaid) who could be subject to a community engagement requirement designed like that in AHCCCS Works, 50 percent were already working, 14 percent were looking for work, and 36 percent were neither working nor looking for work.¹⁶ For those beneficiaries not working or looking for work, 29 percent indicated that they were caring for a family member, 17 percent were in school, and 33 percent noted that they could not work because of a disability (despite excluding from analysis those qualifying for Medicaid on the basis of disability, highlighting the difficulty with disability determination), with the remainder citing layoff, retirement, or a temporary health problem.

Thus, overall, prior to the pandemic, the available data indicated that the substantial majority of the population that would be targeted by a community engagement requirement in Arizona's demonstration were already meeting the terms of the community engagement requirement or would qualify for an exemption from it. This makes it challenging for community engagement requirements to produce any meaningful impact on employment outcomes by incentivizing behavioral changes in a small fraction of beneficiaries, all the while risking substantial coverage losses among those subject to the requirements.

Arkansas, Michigan, and New Hampshire, three states where a community engagement requirement as a condition of Medicaid eligibility was in effect, provide some early evidence on

¹¹ Garfield, R., Rudowitz, R., Guth, M. Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from <https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/>

¹² Huberfeld, N. (2018). Can work be required in the Medicaid program? *N Engl J Med*;378:788-791. DOI: 10.1056/NEJMp1800549

¹³ Goldman, A.L., Woolhandler, S, Himmelstein, D.U., Bor, D.H. & McCormick, D. (2018). Analysis of work requirement exemptions and Medicaid spending. *JAMA Intern Med*, 178:1549-1552. DOI:10.1001/jamainternmed.2018.4194

¹⁴ Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed>

¹⁵ Garfield, R., Rudowitz, R., Guth, M. Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Issue Brief. Kaiser Family Foundation. Retrieved from <https://www.kff.org/coronavirus-covid-19/issue-brief/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements/>

¹⁶ Ku, L. & Brantley, E. (2017). Medicaid Work Requirements: Who's At Risk? Health Affairs Blog. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20170412.059575/full/>

potential enrollment impacts.^{17,18} Experience from these states indicates that large portions of the beneficiaries subjected to these states' community engagement requirements failed to comply with the community engagement reporting requirements or became disenrolled once the requirements were implemented. In Arkansas, for instance, before the court halted the community engagement requirement, the state reported that from August 2018 through December 2018, 18,164 individuals were disenrolled from coverage for "noncompliance with the work requirement."¹⁹ During these five months, the monthly rate of coverage loss as a percentage of those who were required to report work and community engagement activities fluctuated between 20 and 47 percent.²⁰ In New Hampshire, almost 17,000 beneficiaries (about 40 percent of those subject to the requirement) were set to be suspended for non-compliance with the requirement and lose Medicaid coverage within the span of just over a month when that state's community engagement requirement was in effect.^{21,22,23} Based on that early data, another study projected that between 30 and 45 percent of New Hampshire beneficiaries subject to the community engagement requirement would have been disenrolled within the first year of implementation.²⁴ And in Michigan, before the policy was vacated by the courts, 80,000 beneficiaries—representing nearly 33 percent of individuals subject to the community engagement requirement—were at risk of loss of coverage for failing to report compliance with the community engagement requirement.²⁵

¹⁷ Utah and Indiana also briefly implemented a community engagement requirement that was part of these states' section 1115 demonstrations, but the program designs in these states did not require beneficiaries subject to the community engagement requirement to comply with reporting minimum hours during the period the requirement was in effect in each state.

¹⁸ Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC. (2021). Issue Brief No. HP-2021-03, Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence. Retrieved from <https://aspe.hhs.gov/pdf-report/medicaid-demonstrations-andimpacts>

¹⁹ Arkansas Department of Human Services (DHS). (2018 & 2019). Arkansas Works Section 1115 Demonstration Annual Reports. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-annl-rpt-jan-dec-2018.pdf>; <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-annl-rpt-jan-dec-2019.pdf>

²⁰ Arkansas Department of Human Services (DHS). (2018). Arkansas Works Section 1115 Demonstration Annual Report: January 1, 2018 – December 31, 2018. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-annl-rpt-jan-dec-2018.pdf>

²¹ Wagner, J., & Schubel, J. (2020). States' experiences confirming harmful effects of Medicaid work requirements. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements>

²² New Hampshire Department of Health and Human Services. (2019). DHHS Community Engagement Report: June 2019. Retrieved from <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf>

²³ Hill, I., Burroughs, E., & Adams, G. (2020). New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results. Urban Institute. Retrieved from <https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results>

²⁴ The Commonwealth Fund Blog. (2019). New Hampshire's Medicaid Work Requirements Could Cause More Than 15,000 to Lose Coverage. Retrieved from <https://www.commonwealthfund.org/blog/2019/new-hampshires-medicaid-work-requirements-could-cause-coverage-loss>

²⁵ Wagner, J., & Schubel, J. (2020). States' Experiences Confirm Harmful Effects of Medicaid Work Requirements. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements>

Despite state assurances in the demonstration's Special Terms and Conditions that Arizona would provide the necessary outreach to Medicaid beneficiaries, experience from other states with similar community engagement requirements shows that notwithstanding similar assurances, lack of awareness of and administrative barriers associated with community engagement requirements create serious challenges for beneficiaries, which could result in significant coverage losses.²⁶ Indeed, research on potential beneficiary coverage loss from community engagement requirements indicates that most of those losing coverage would be individuals who are already working or should be exempt, but would lose coverage because of the inherently complex reporting requirements and the apparent challenges of informing and educating beneficiaries about the requirements in general.^{27,28,29} The Kaiser Family Foundation, for example, estimated that if community engagement requirements were implemented nationwide, coverage losses due to non-reporting of qualifying activities or exemptions would account for 77–83 percent of total Medicaid disenrollments due to such a requirement, with the rest potentially attributable to not participating in sufficient hours of qualifying activities to meet work or community engagement requirements.³⁰ In fact, there was evidence of widespread confusion and lack of awareness among demonstration beneficiaries regarding the community engagement requirements in the states where the requirements were implemented.³¹ For example, many beneficiaries in New Hampshire reportedly did not know about the community engagement reporting requirement or received confusing and often contradictory notices about whether they were subject to the requirement.^{32,33} Moreover, in Arkansas, Michigan, and New Hampshire, evidence suggests that even individuals who were working or those who had serious health needs, and therefore should have been eligible for exemptions, lost coverage or were at

²⁶ Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed>.

²⁷ Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed>

²⁸ Wagner, J., & Schubel, J. (2020). States' experiences confirming harmful effects of Medicaid work requirements. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicicaid-work-requirements>

²⁹ Garfield, R., Rudowitz, R., & Musumeci, M. (2018). Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses. Kaiser Family Foundation. Retrieved from <https://www.kff.org/medicaid/issue-brief/implications-of-a-medicicaid-work-requirement-national-estimates-of-potential-coverage-losses/>

³⁰ Garfield, R., Rudowitz, R., & Musumeci, M. (2018). Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses. Kaiser Family Foundation. Retrieved from <https://www.kff.org/medicaid/issue-brief/implications-of-a-medicicaid-work-requirement-national-estimates-of-potential-coverage-losses/>

³¹ Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC. (2021). Issue Brief No. HP-2021-03, Medicaid Demonstrations and Impacts on Health Coverage: A Review of the Evidence. Retrieved from <https://aspe.hhs.gov/pdf-report/medicaid-demonstrations-andimpacts>.

³² Solomon, D. (2019). Spreading the Word on Medicaid Work Requirement Proves Challenging. Union Leader. Retrieved from https://www.unionleader.com/news/health/spreading-the-word-on-medicicaid-work-requirement-proves-challenging/article_740b99e7-9f48-52d4-b2d8-030167e66af8.html

³³ Moon, J. (2019). Confusing Letters, Frustrated Members: N.H.'s Medicaid Work Requirement Takes Effect. New Hampshire Public Radio. Retrieved from <https://www.nhpr.org/post/confusing-letters-frustrated-members-nhs-medicicaid-work-requirement-takes-effect#stream/0>

risk of losing coverage because of complicated administrative and paperwork requirements.³⁴ Beneficiaries also reported barriers to obtaining exemptions from the community engagement requirement. For example, beneficiaries with physical and behavioral health conditions reported that their providers were resistant to signing forms needed to establish that the beneficiary was unable to work so that the beneficiary could qualify for an exemption.³⁵

Losing health care coverage undoubtedly has negative consequences for affected beneficiaries down the road. For example, one study found that adults in Arkansas ages 30–49 who had lost Medicaid or Marketplace coverage in the prior year experienced significantly higher medical debt and financial barriers to care, compared to similar Arkansans who maintained coverage.³⁶ Specifically, 50 percent of Arkansans affected by disenrollment in that age group reported serious problems paying off medical bills; 56 percent delayed seeking health care and 64 percent delayed taking medications because of cost considerations.³⁷ These rates were all significantly higher than among individuals who retained coverage in Medicaid or Marketplace all year. Evidence also indicates that those with chronic conditions were more likely to lose coverage,³⁸ which could lead to worse health outcomes in the future.

In all states, consistent and stable employment is often out of reach for beneficiaries who might be subject to a community engagement requirement. Many low-income beneficiaries face a challenging job market, which often offers only unstable or low-paying jobs with unpredictable or irregular hours, sometimes resulting in spells of unemployment, particularly in seasonal work.^{39,40,41,42} For example, one study found that among Medicaid beneficiaries likely to be

³⁴ Wagner, J., & Schubel, J. (2020). States' Experiences Confirm Harmful Effects of Medicaid Work Requirements. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/states-experiences-confirm-harmful-effects-of-medicaid-work-requirements>

³⁵ Hill, I., Burroughs, E., & Adams, G. (2020). New Hampshire's Experience with Medicaid Work Requirements: New Strategies, Similar Results. Urban Institute. Retrieved from <https://www.urban.org/research/publication/new-hampshires-experiences-medicaid-work-requirements-new-strategies-similar-results>

³⁶ Sommers, B.D., Chen, L., Blendon, R.J., Orav, E.J., & Epstein, A.M. (2020). Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. *Health Affairs*, 39(9), 1522-1530. Retrieved from <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00538>

³⁷ Sommers, B.D., Chen, L., Blendon, R.J., Orav, E.J., & Epstein, A.M. (2020). Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. *Health Affairs*, 39(9), 1522-1530. Retrieved from <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00538>

³⁸ Chen, L. & Sommers, B.D. (2020). Work Requirements and Medicaid Disenrollment in Arkansas, Kentucky, Louisiana, and Texas, 2018. *American Journal of Public Health*, 110, 1208-1210. DOI <https://doi.org/10.2105/AJPH.2020.305697>

³⁹ Butcher, K. & Schanzenbach, D. (2018). Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/poverty-and-inequality/most-workers-in-low-wage-labor-market-work-substantial-hours-in>

⁴⁰ Center on Budget and Policy Priorities. (2020). Taking Away Medicaid for Not Meeting Work Requirements Harms Low-Wage Workers. Retrieved from <https://www.cbpp.org/research/health/taking-away-medicaid-for-not-meeting-work-requirements-harms-low-wage-workers>

⁴¹ Gangopadhyaya, A., Johnston, E., Kenney, G. & Zuckerman, S. (2018). Kentucky Medicaid Work Requirements: What Are the Coverage Risks for Working Enrollees? Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/98893/2001948_kentucky-medicaid-work-requirements-what-are-the-coverage-risks-for-working-enrollees.pdf

⁴² Karpman, M. (2019). Many Adults Targeted by Medicaid Work Requirements Face Barriers to Sustained Employment. The Urban Institute. Retrieved from <http://hrms.urban.org/briefs/hrms-medicaid-work-requirements-2019.pdf>

subject to a community engagement requirement who did not always work 20 hours per week, about half reported not working or not working more hours for reasons related to the labor market or the nature of their employment, such as difficulty finding work, employer restrictions on their work schedule, employment in temporary positions, or reduced hours because business was slow.⁴³ The AHCCCS demonstration's rigid requirement for reporting 80 or more hours every month is a concern even for low-income adults who are working. For example, 46 percent of this group nationally, as well as 25 percent of those working as many as 1,000 hours during a year (which would be sufficient for meeting the 80-hour monthly requirement) could be at risk of losing coverage for one or more months because they would not meet the 80-hour minimum requirement in every month.^{44,45}

Furthermore, research examining the outcomes of statutorily authorized work requirements in other public assistance programs, such as Temporary Assistance for Needy Families (TANF) and SNAP indicates that such requirements generally have only modest and temporary effects on employment, failing to increase long-term employment or reduce poverty.^{46,47,48} Additionally, studies have found that imposing work requirements in the SNAP program led to substantial reductions in enrollment, even after controlling for changes in unemployment and poverty levels.⁴⁹ In fact, evidence suggests that there were large and rapid caseload losses in selected areas after SNAP work requirements went into effect, similar to what early data from Arkansas show, and what appeared would be likely to happen in New Hampshire and Michigan after these states began implementing community engagement requirements, if those states' community engagement requirements had been implemented long enough to reach the scheduled suspensions or disenrollments.

Therefore, existing evidence from states that have implemented community engagement requirements through Medicaid demonstrations, evidence from other public programs with work

⁴³ Karpman, M. (2019). Many Adults Targeted by Medicaid Work Requirements Face Barriers to Sustained Employment. The Urban Institute. Retrieved from <http://hrms.urban.org/briefs/hrms-medicaid-work-requirements-2019.pdf>

⁴⁴ Solomon, J. (2019). Medicaid Work Requirements Can't Be Fixed: Unintended Consequences are Inevitable Result. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed>

⁴⁵ Aron-Dine, A., Chaudhry, R. & Broaddus, M. (2018). Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements. Retrieved from <https://www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements>

⁴⁶ Katch, H., Wagner, J. & Aron-Dine, A. (2018). Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce>

⁴⁷ Danziger, S.K., Danziger, S., Seefeldt, K.S. & Shaefer, H.L. (2016). From Welfare to a Work-Based Safety Net: An Incomplete Transition. *Journal of Policy Analysis & Management*, 35(1), 231-238. DOI: <https://doi.org/10.1002/pam.21880>

⁴⁸ Pavetti, L. (2016). Work Requirements Don't Cut Poverty, Evidence Shows. Center on Budget and Policy Priorities. Retrieved from <https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows>

⁴⁹ Ku, L., Brantley, E. & Pillai, D. (2019). The Effects of SNAP Work Requirements in Reducing Participation and Benefits From 2013 to 2017. *American Journal of Public Health* 109(10), 1446-1451. DOI: <https://doi.org/10.2105/AJPH.2019.305232>. Retrieved from <https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305232>

requirements, and the overall work patterns and job market opportunities for the low-income adults who would be subject to such requirements all highlight the potential ineffectiveness of community engagement requirements at impacting employment outcomes for the target population. And while there are variations in the design and implementation of community engagement requirements in each state that has implemented such a requirement, as well as differences in employment and economic opportunities, findings from the states that implemented community engagement requirements point in the general direction of challenges with beneficiary outreach efforts to ensure understanding of program requirements, various bottlenecks in complying with reporting requirements, and subsequent coverage losses among individuals subject to such requirements.

CMS is not aware of any reason to expect that the community engagement requirement as a condition of eligibility in Arizona's Medicaid demonstration project would have a different outcome than what was observed during the initial implementation of such a requirement in other states. Accordingly, there is risk that Arizona's AHCCCS Works program, as approved as an amendment to the state's AHCCCS demonstration in January 2019, will lead to substantial coverage losses, a risk that is exacerbated by the ongoing COVID-19 public health emergency and its likely aftermath.

Impact of COVID-19 and its Aftermath

The COVID-19 pandemic and the uncertainty surrounding the long-term effects on economic activity and opportunities across the nation exacerbate the risks associated with tying a community engagement requirement to eligibility, making Arizona's community engagement requirement infeasible under the current circumstances. There is a substantial risk that the COVID-19 pandemic and its aftermath will have a negative impact on economic opportunities for Medicaid beneficiaries. If employment opportunities are limited, Medicaid beneficiaries may find it difficult to obtain paid work in the aftermath of the COVID-19 pandemic.^{50,51}

As discussed above, prior to the pandemic, most adult Medicaid beneficiaries who did not face a barrier to work were working full or part-time.⁵² However, one in three working adult Medicaid beneficiaries was doing only part-time work prior to the COVID-19 public health emergency, often due to fewer opportunities for full-time employment. The pandemic is expected to exacerbate the challenges not only of finding full-time employment, but it also may create additional obstacles to securing even part-time work, due to shifting caregiving responsibilities and increased transportation barriers.⁵³

⁵⁰ Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from <https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/>

⁵¹ Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

⁵² Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from <https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/>

⁵³ Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from

Moreover, during the pandemic, the different sectors of the economy have seen disparate levels of disruption, which has affected labor market outcomes for certain populations more than the others. While the national employment rate⁵⁴ declined by 10.2 percent from January 2020 to January 2021, employment rates for workers in the bottom wage quartile decreased by a larger percentage than for workers in the highest wage quartile across that time period (28.7 percent vs. 1.7 percent).⁵⁵ In Arizona, employment rates for low-wage earners (i.e., annual wages under \$27,000) declined by 23 percent, compared to an 8 percent increase in employment rates for high-wage earners (i.e., wages above \$60,000 per year) from January 2020 to January 2021.⁵⁶

Further, declines in employment have been much higher for black and Hispanic women and for workers in several low-wage service sectors, such as hospitality and leisure, while workers in other sectors, such as financial services, have seen virtually no change.⁵⁷ In April 2020, the estimated unemployment rates (including individuals who were employed but absent from work and those not in the workforce but who wanted employment) for the black and Hispanic populations were as high as 32 and 31 percent, respectively, compared to 24 percent for the white population.⁵⁸ Hispanic populations specifically are more likely to be affected due to their disproportionate representation in industries such as hospitality and construction, which have been most affected by the pandemic-related layoffs.^{59,60,61}

Moreover, pandemic-related job and income losses have also been more acute among the low-income population—those with the least wherewithal to withstand economic shocks, and who are disproportionately enrolled in Medicaid.⁶² In fact, 52 percent of lower income adults (annual income below \$37,500) live in households where someone has lost a job or taken a pay cut due

<https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/>

⁵⁴ Not seasonally adjusted.

⁵⁵ Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved from www.tracktherecovery.org

⁵⁶ Opportunity Insights: Economic Tracker. (2021). Percent Change in Employment. Retrieved from www.tracktherecovery.org

⁵⁷ Rouse, C. (2021). The Employment Situation in February. The White House Briefing Room. Retrieved from <https://www.whitehouse.gov/briefing-room/blog/2021/03/05/the-employment-situation-in-february/>

⁵⁸ Fairlie, R., Couch, K. & Xu, H. (2020). The Impacts of COVID-19 on Minority Unemployment: First Evidence from April 2020 CPS Microdata. National Bureau of Economic Research. Retrieved from https://www.nber.org/system/files/working_papers/w27246/w27246.pdf

⁵⁹ Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from <https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/>

⁶⁰ Industries like health care and transportation have been less affected by the pandemic, and that has provided some cushion for black workers. See Despard et al. (2020).

⁶¹ Krogstad, J.M., Gonzalez-Barrera, A. & Noe-Bustamante, L. (2020). U.S. Latinos among hardest hit by pay cuts, job losses due to coronavirus. Pew Research Center. Retrieved from <https://www.pewresearch.org/fact-tank/2020/04/03/u-s-latinos-among-hardest-hit-by-pay-cuts-job-losses-due-to-coronavirus/>

⁶² Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from <https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/>

to the pandemic.⁶³ Understandably, households with a job or income loss were two-to-three times more likely to experience economic hardship than those who did not experience such a loss.^{64,65} Fifty-nine percent of lower-income adults said they worry every day or almost every day about paying their bills.⁶⁶ There are also racial and ethnic disparities in the likelihood of reporting hardships; for example, compared to white households, black households reported significantly higher chances of putting off filling prescriptions and difficulties making housing and other bill payments. Also, Hispanic households were more likely to experience food insecurity compared to white households.^{67,68}

Existing disparities in access to computers and reliable internet may also exacerbate issues in finding and maintaining employment during the pandemic. For example, 29 percent of adults in households with annual incomes below \$30,000 did not own a smartphone, and 44 percent did not have home broadband services in 2019.⁶⁹ Moreover, fewer than 8 percent of Americans with earnings below the 25th percentile have the capabilities to work remotely.⁷⁰ These disparities will result in fewer opportunities for beneficiaries to satisfy a community engagement requirement, particularly as more jobs have shifted to telework or “work from home” during the public health emergency. Therefore, implementation of the community engagement requirement approved in this demonstration increases the risk of coverage loss for these low-income individuals.^{71,72}

⁶³ Parker, K., Horowitz, J.M., & Brown, A. (2020). About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19. Pew Research Center. Retrieved from <https://www.pewresearch.org/social-trends/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/>

⁶⁴ Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from <https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/>

⁶⁵ Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

⁶⁶ Parker, K., Horowitz, J.M., & Brown, A. (2020). About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19. Pew Research Center. Retrieved from <https://www.pewresearch.org/social-trends/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/>

⁶⁷ Despard, M., Weiss-Grinstein, M., Chun, Y. & Roll, S. (2020). COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship. Brookings Institution. Retrieved from <https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/>

⁶⁸ Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

⁶⁹ Anderson, M. & Kumar, M. (2019). Digital Divide Persists Even as Lower-Income Americans Make Gains in Tech Adoption. Pew Research Center. Retrieved from <https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/>

⁷⁰ Maani, N., Galea, S. (2020). COVID-19 and Underinvestment in the Health of the US Population. The Milbank Quarterly. Retrieved from <https://www.milbank.org/quarterly/articles/covid-19-and-underinvestment-in-the-health-of-the-us-population/>

⁷¹ Garfield, R., Rudowitz, R., Guth, M., Orgera, K. & Hinton, E. (2021). Work Among Medicaid Adults: Implications of Economic Downturn and Work Requirements. Kaiser Family Foundation. Retrieved from <https://www.kff.org/report-section/work-among-medicaid-adults-implications-of-economic-downturn-and-work-requirements-issue-brief/>

⁷² Gangopadhyaya, A. & Garrett, B. (2020). Unemployment, Health Insurance, and the COVID-19 Recession. Urban Institute. Retrieved from https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf

In addition to the challenges that the COVID-19 pandemic has presented for the labor market, it likely has also exacerbated the difficulty of participating in community service activities that beneficiaries could use to meet the community engagement requirement instead of (or in combination with) paid work.⁷³ Many community service opportunities require individuals to help in-person, and oftentimes these activities involve working with the elderly, individuals with disabilities, or other vulnerable populations. Social distancing requirements, restrictions on visiting elderly individuals, and limited access to physical locations where many such activities take place, all have potentially either reduced the number of available community service opportunities or made engaging in community service more challenging.

The pandemic also has disproportionately impacted the physical and mental health of racial and ethnic minority groups, who already experience disparities in health outcomes. Racial minorities and people living in low-income households are more likely to work in industries that are considered “essential services,” which have remained open during the pandemic.⁷⁴ Additionally, occupations with more frequent exposure to COVID-19 infections, and that require close proximity to others (such as personal care aides and bus drivers) employ black individuals at higher rates than white individuals.⁷⁵ As a result, black individuals may be at a higher risk of contracting COVID-19 through their employment. The pandemic’s mental health impact also has been pronounced among populations experiencing disproportionately high rates of COVID-19 cases and deaths. Specifically, black and Hispanic adults have been more likely than white adults to report symptoms of anxiety and/or depressive disorder during the pandemic.⁷⁶

Since the start of the pandemic, individuals have delayed or postponed seeking care, either due to concerns with out-of-pocket expenses or to avoid risk of contact with infected individuals in health care settings. For example, one study showed that screenings for breast, colon, prostate, and lung cancers were between 56 and 85 percent lower in April 2020 than in the previous year.⁷⁷ Results of another survey-based study show that 40 percent of respondents canceled upcoming health care appointments due to the pandemic, and another 12 percent reported they needed care but did not schedule or receive services.⁷⁸ These unmet health care needs may lead

⁷³ Fidelity Charitable. (2020). The Role of Volunteering in Philanthropy. Retrieved from <https://www.fidelitycharitable.org/content/dam/fc-public/docs/resources/the-role-of-volunteering-in-philanthropy.pdf>

⁷⁴ Raifman, M.A., & Raifman, J.R. (2020). Disparities in the Population at Risk of Severe Illness From COVID-19 by Race/Ethnicity and Income. *American Journal of Preventive Medicine*, 59(1), 137–139. <https://doi.org/10.1016/j.amepre.2020.04.003>

⁷⁵ Hawkins, D. (2020). Differential Occupational Risk for COVID-19 and Other Infection Exposure According to Race and Ethnicity. *American Journal of Industrial Medicine*, 63(9):817-820. DOI: 10.1002/ajim.23145

⁷⁶ Panchal, N., Kamal, R., Cox, C. & Garfield, R. (2021). The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation. Retrieved from <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>

⁷⁷ Patt, D., Gordan, L., Diaz, M., Okon, T., Grady, L., Harmison, M., Markward, N., Sullivan, M., Peng, J., Zhou, A. (2020). Impact of COVID-19 on Cancer Care: How the Pandemic Is Delaying Cancer Diagnosis and Treatment for American Seniors. *JCO Clinical Cancer Informatics*, 4, 1059-1071. DOI: 10.1200/CCI.20.00134. Retrieved from <https://ascopubs.org/doi/full/10.1200/CCI.20.00134>

⁷⁸ McKinsey & Company (2020). Understanding the Hidden Costs of COVID-19’s Potential on U.S. Healthcare. Retrieved from <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/understanding-the-hidden-costs-of-covid-19s-potential-impact-on-us-healthcare#>

to substantial increases in subsequent mortality and morbidity.⁷⁹ In addition to the health consequences associated with delaying care, pandemic-related delays in seeking care are estimated to increase annual health care costs nationwide by a range of \$30 to \$65 billion.⁸⁰

The impact of the COVID-19 public health emergency on the economy has been significant, and, importantly, experience with previous recessions suggests the impact is likely to persist for an extended period of time. The unemployment rate went up from 3.5 percent in February 2020, prior to when the pandemic hit, to 14.8 percent in April 2020, and has subsequently fallen to 6.1 percent in April 2021.⁸¹ The labor force participation rate (i.e., the percentage of the civilian non-institutional population age 16 or older who are working or actively seeking work during the prior month) likewise dipped from 63.3 percent in February 2020 to 60.2 percent in April 2020 only to recover somewhat to 61.7 percent in April 2021.^{82,83} Compared to pre-pandemic conditions, these data suggest that the labor force is still down in April 2021 by approximately 3.6 million individuals.^{84,85}

Evidence shows that losing a job can have significant long term effects on an individual's future earnings. Studies have found that workers who lose their jobs in mass layoffs still earn 20 percent less than similar workers who kept their jobs, 15 to 20 years after the layoff, and the impacts are greater for individuals who lose their jobs during a recession. On average, men lost 2.8 years of pre-layoff earnings when the mass layoff occurred in a time when the unemployment

⁷⁹ Chen, J. & McGeorge, R. (2020). Spillover Effects Of The COVID-19 Pandemic Could Drive Long-Term Health Consequences For Non-COVID-19 Patients. Health Affairs Blog, DOI: 10.1377/hblog20201020.566558. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20201020.566558/full/>

⁸⁰ McKinsey & Company (2020). Understanding the Hidden Costs of COVID-19's Potential on U.S. Healthcare. Retrieved from <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/understanding-the-hidden-costs-of-covid-19s-potential-impact-on-us-healthcare#>

⁸¹ U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from <https://www.bls.gov/cps/>

⁸² The numerator of the labor force participation rate, i.e., the total labor force, consists of those employed and unemployed, where the unemployed are individuals without a job but actively looking for work during the past month. The labor force does not include individuals who would like to and are available for work but may have given up looking for work altogether (known as discouraged workers, or more broadly as, marginally attached workers), usually because they believe that there are no jobs available for them or there are none for which they would qualify. Recessions, such as the one that resulted as a consequence of the COVID-19 pandemic, often lead to a sharp rise in the number of discouraged workers, and therefore, the size of the labor force shrinks resulting in a sharp decline in labor force participation rates. These individuals who leave the labor force *discouraged* are not represented either in the employment or unemployment rates. Therefore, in addition to the employment and unemployment rates, the labor force participation rate is another important measure of the labor market, particularly during times of economic shocks. For more information, for example, see:

<https://fred.stlouisfed.org/series/LNU05026645>, <https://www.bls.gov/charts/employment-situation/civilian-labor-force-participation-rate.htm>, and <https://www.bls.gov/opub/btn/archive/ranks-of-discouraged-workers-and-others-marginally-attached-to-the-labor-force-rise-during-recession.pdf>.

⁸³ U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved from <https://www.bls.gov/cps/> and <https://www.bls.gov/charts/employment-situation/civilian-labor-force-participation-rate.htm>

⁸⁴ For April 2021 seasonally adjusted labor force data, see: U.S. Bureau of Labor Statistics. (2021). Labor Force Statistics from the Current Population Survey. Retrieved on May 12, 2021 from <https://www.bls.gov/web/empsit/cpseea08b.pdf>

⁸⁵ For February 2020 seasonally adjusted labor force data, see: U.S. Bureau of Labor Statistics. (March, 2020). The Employment Situation – February 2020. News Release. Table A-1. Retrieved from https://www.bls.gov/news.release/archives/empsit_03062020.pdf

rate was above eight percent.⁸⁶ Further, workers who enter the labor market during a recession also face long-term consequences for their earnings.⁸⁷ Additionally, non-white individuals and individuals with lower educational attainment have experienced larger and more persistent earning losses than other groups who enter the labor market during recessions.⁸⁸ Layoffs can also impact an individual's mortality and morbidity risks.⁸⁹ For example, one study found that male workers experienced mortality rates that were 50-100 percent higher than expected in the year after a layoff occurred, and 20 years later, mortality rates remained 10-15 percent higher for these individuals.⁹⁰ Furthermore, workers experiencing layoff have reductions in health care utilization, especially among those who lose coverage, which suggests that access to coverage, and continuity of care, could be important in alleviating the long-term ill effects of layoffs on mortality.⁹¹

In summary, the short-to-long-term adverse implications of the COVID-19 pandemic on the economic opportunities for Medicaid beneficiaries, which have been aggravated further by challenges around shifting childcare and caregiving responsibilities as well as constraints on public transportation during the pandemic, heightens the risks of attaching a community engagement requirement to eligibility for coverage. In addition, the uncertainty regarding the lingering health complications of COVID-19 infections exacerbates the risk of potential coverage losses for Medicaid beneficiaries. The likely ramifications of losing timely access to necessary health care also can be long lasting. As such, CMS believes that the potential for coverage loss among Medicaid beneficiaries—especially from a requirement that is difficult for beneficiaries to understand and administratively complex for states to implement—would be particularly harmful in the aftermath of the pandemic, and makes the community engagement requirement impracticable.

Withdrawal of Community Engagement Requirement in the January 18, 2019 Amendment of the AHCCCS Demonstration

Based on the foregoing, and pursuant to our obligation under section 1115 of the Act to review demonstration projects and ensure they remain likely to promote the objectives of Medicaid, CMS has determined that, on balance, the amendment approval authorizing Arizona to implement a community engagement requirement as a condition of eligibility is not likely to

⁸⁶ Davis, S.J. & von Wachter, T. (2011). Recessions and the Costs of Job Loss. Brookings Papers on Economic Activity. Retrieved from https://www.brookings.edu/wp-content/uploads/2011/09/2011b_bpea_davis.pdf

⁸⁷ Schwandt, H. & von Wachter, T.M. (2018). Unlucky Cohorts: Estimating the Long-term Effects of Entering the Labor Market in a Recession in Large Cross-sectional Data Sets. NBER Working Paper 25141. Retrieved from <https://www.nber.org/papers/w25141>

⁸⁸ Schwandt, H. & von Wachter, T.M. (2018). Unlucky Cohorts: Estimating the Long-term Effects of Entering the Labor Market in a Recession in Large Cross-sectional Data Sets. NBER Working Paper 25141. Retrieved from <https://www.nber.org/papers/w25141>

⁸⁹ Banks, J., Karjalainen, H. & Propper, C. (2020). Recessions and Health: The Long-Term Health Consequences of Responses to the Coronavirus. Journal of Applied Public Economics. DOI: 10.1111/1475-5890.12230. Retrieved from <https://onlinelibrary.wiley.com/doi/full/10.1111/1475-5890.12230>

⁹⁰ Sullivan, D. & von Wachter, T. (2009). Job Displacement and Mortality: An Analysis Using Administrative Data. Quarterly Journal of Economics. Retrieved from <https://academic.oup.com/qje/article-abstract/124/3/1265/1905153?redirectedFrom=fulltext>

⁹¹ Schaller, J., Stevens, A. (2015). Short-Run Effects of Job Loss on Health Conditions, Health Insurance, and Health Care Utilization. Journal of Health Economics, 43, 190-203. DOI: 0.1016/j.jhealeco.2015.07.003. Retrieved from <https://www.sciencedirect.com/science/article/pii/S0167629615000788>

promote the objectives of the Medicaid program. At a minimum, in light of the significant risks and uncertainties described above about the adverse effects of the pandemic and its aftermath, the information available to CMS does not provide an adequate basis to support an affirmative judgment that the community engagement requirement is likely to assist in promoting the objectives of Medicaid. Accordingly, pursuant to its authority and responsibility under applicable statutes and regulations to maintain ongoing oversight of whether demonstration projects are currently likely to promote those objectives, CMS is hereby withdrawing its approval of that portion of the January 18, 2019 amendment that permits the state to require work and community engagement as a condition of eligibility under the AHCCCS demonstration. The provisions of CMS's letter approving the January 18, 2019 amendment and the corresponding provisions of the waivers and Special Terms and Conditions that authorize the community engagement requirement are withdrawn.

The withdrawal of these authorities is effective on the date that is thirty days after the date of this letter, unless the state timely appeals, as discussed below. The waivers, expenditure authorities, and Special Terms and Conditions reflecting this change are attached to this letter and will govern the AHCCCS demonstration from the effective date of the withdrawal of the community engagement authorities until the demonstration expires on September 30, 2021.

As indicated in CMS's February 12, 2021 letter, CMS is also reviewing the other authorities that CMS previously approved in the AHCCCS demonstration. That review remains ongoing. The state and CMS will work together to update the evaluation design, as needed, to reflect all the key policies that are implemented during the approval period. The current established timeline for the quarterly and annual monitoring reports as well as the interim and summative evaluation reports will remain in effect. CMS looks forward to continuing to work with the state on the evaluation design, interim and summative evaluation reports.

Procedure to Appeal This Decision

In accordance with Special Terms and Conditions ¶ 11 and 42 C.F.R. § 430.3, the state may request a hearing to challenge CMS's determination prior to the above-referenced effective date by appealing this decision to the Departmental Appeals Board (DAB or Board), following the procedures set forth at 45 C.F.R. part 16. This decision shall be the final decision of the Department unless, within 30 calendar days after the state receives this decision, the state delivers or mails (the state should use registered or certified mail to establish the date) a written notice of appeal to the DAB.

A notice of appeal may be submitted to the DAB by mail, by facsimile (fax) if under 10 pages, or electronically using the DAB's electronic filing system (DAB E-File). Submissions are considered made on the date they are postmarked, sent by certified or registered mail, deposited with a commercial mail delivery service, faxed (where permitted), or successfully submitted via DAB E-File. The Board will notify the state of further procedures. If the state faxes its notice of appeal (permitted only if the notice of appeal is under 10 pages), the state should use the Appellate Division's fax number, (202) 565-0238.

To use DAB E-File to submit your notice of appeal, the state's Medicaid Director or its representative must first become a registered user by clicking "Register" at the bottom of the DAB E-File homepage, <https://dab/efile.hhs.gov/>; entering the information requested on the "Register New Account" form; and clicking the "Register Account" button. Once registered, the state's Medicaid Director or its representative should login to DAB E-File using the e-mail address and password provided during registration; click "File New Appeal" on the menu; click the "Appellate" button; and provide and upload the requested information and documents on the "File New Appeal-Appellate Division" form. Detailed instructions can be found on the DAB E-File homepage.

Due to the COVID-19 public health emergency, the DAB is experiencing delays in processing documents received by mail. To avoid delay, the DAB strongly encourages the filing of materials through the DAB E-File system. However, should the state so choose, written requests for appeal should be delivered or mailed to U.S. Department of Health and Human Services, Departmental Appeals Board MS 6127, Appellate Division, 330 Independence Ave., S.W., Cohen Building Room G-644, Washington, DC 20201. Refer to 45 C.F.R. Part 16 for procedures of the Departmental Appeals Board.

The state must attach to the appeal request, a copy of this decision, a note of its intention to appeal the decision, a statement that there is no dollar amount in dispute but that the state disputes CMS's withdrawal of certain section 1115 demonstration authorities, and a brief statement of why the decision is wrong. The Board will notify the state of further procedures. If the state chooses to appeal this decision, a copy of the notice of appeal should be mailed or delivered (the state should use registered or certified mail to establish the date) to Judith Cash, Acting Deputy Director, Center for Medicaid and CHIP Services at 7500 Security Blvd, Baltimore, MD 21244.

Medicaid is a federal-state partnership and we look forward to continuing to work together. If you have any questions, please contact Judith Cash at (410) 786-9686.

Sincerely,



Chiquita Brooks-LaSure