COMMENTS TO CMS ON PROPOSED ALABAMA MEDICAID WORK REQUIREMENT

By Alabama Arise

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Alabama Arise appreciates the opportunity to comment on Alabama Medicaid's revised 1115 waiver proposal to establish a work requirement for people in the Parents and Other Caretaker Relatives (POCR) eligibility category. We urge CMS to deny waiver approval for the reasons outlined below.

Overall waiver context

Most of Alabama Medicaid's approximately 1 million beneficiaries are children in low-income families. The next largest groups are people with disabilities, low-income seniors, and pregnant women. About 75,000 adults with extremely low incomes qualify for Medicaid coverage as parents and other caretaker relatives (POCR) of Medicaid children. This latter eligibility category – the target of the work requirement waiver proposal – comprises 7.5 percent of the total Medicaid population. By Medicaid's own estimation, most of the POCR group will qualify for exemption, leaving 17,000 individuals – or 1.7 percent of the total Medicaid population – subject to the work requirement. Nearly 90 percent of Alabamians in the POCR category are women. The income limit for Medicaid parents is 18 percent of the federal poverty level ($312 per month for a family of three). Thus, the work requirement waiver creates a barrier to health coverage for the poorest of Alabama's poor. Our concerns about the proposal fall into five broad categories: its rationale, its impact on families, its impact on our state budget, the overall ineffectiveness of mandatory work requirements, and the waiver revisions requested in July by CMS.

Rationale

Section 1115 of the Social Security Act of 1965 authorizes the Secretary of Health and Human Services to waive certain Medicaid requirements for the purpose of allowing a state to pursue an "experimental, pilot, or demonstration project" designed to promote the objectives of Medicaid – namely, providing health coverage for low-income and medically needy individuals. By creating barriers to coverage rather than promoting it, Alabama Medicaid's proposed work requirement fails the most fundamental waiver test.

The dignity of work is a central value in Alabama Arise's policy advocacy. Our mission statement envisions "an Alabama . . . where all people have resources and opportunities to reach their potential to live happy, productive lives." We regard employment as one of many social

determinants of health, along with access to health care services, quality of education, transportation options, safe and affordable housing, nutritious food and others. Accordingly, we support state policies that promote individual employability and workforce development as important elements of a broad strategy to reduce poverty, improve health outcomes and strengthen the state's economy.

Unfortunately, this waiver proposal turns the widely recognized social determinants framework on its head. Instead of acknowledging a range of external contributors to health status, Alabama Medicaid has cherry-picked unemployment as the rationale for a radical policy change premised on punishment rather than support and marked for failure by the very factors it ignores, including the state's coverage gap for low-income workers, lack of affordable quality child care and lack of public transportation.

In its recent guidance on work requirements, CMS cites a purported link between unemployment and negative health outcomes that contradicts prevailing research on the topic. The Kaiser Family Foundation, for example, finds:

> "It is not clear whether tying eligibility to work promotes health. While there is some research showing that increased income or employment is associated with improved health outcomes and mortality, it is difficult to determine the direction of causation – whether income and work lead to better health, or whether better health facilitates income and work. ... There is some evidence of positive effects in programs targeted to people eligible for Medicaid on the basis of a disability, but work is voluntary under those programs, and Medicaid provides a full range of supportive services to enable individuals to continue coverage as income increases." (*Medicaid and Work Requirements: New Guidance, State Waiver Details and Key Issues,* Musumeci, Garfield and Rudowitz, Jan. 16, 2018.)

If Alabama is seeking to address unemployment among adult Medicaid beneficiaries who could work with the right supports, why not seek a waiver to offer work supports on a voluntary basis, without the threat of losing health coverage and incurring all the family risks that loss entails? There is evidence that voluntary work programs are more likely to increase participants' income, and to maintain that increase, than mandatory work programs. An evaluation of the Jobs-Plus demonstration project found that about 75 percent of public housing recipients in four sites voluntarily participated in the program. Earnings of program participants were 14 percent higher than those of non-participants, and the gains actually increased over the nine-year evaluation period. These stable earnings increases are in marked contrast to the decline in earnings found in evaluations of mandatory programs. *(Bloom, Miller & Azurdia, "Results from the Personal Roads to Individual Development and Employment [PRIDE] Program in New York City" Manpower Demonstration Research Corporation, July 2007.)*

Contrary to the waiver rationale, a growing body of research highlights the role of Medicaid coverage in helping people find and keep jobs. This supportive effect is evident in states that have expanded Medicaid to cover low-income workers. For example, in Michigan, 55 percent of Medicaid expansion enrollees who were out of work reported that health coverage helped them look for a job, while 69 percent of those who were already working reported that Medicaid coverage made it easier for them to stay employed. In Ohio, almost 75 percent of Medicaid enrollees stated that having Medicaid coverage made it easier for them to look for a job and become employed because they were better able to manage chronic conditions and get needed medications while looking for work. *(Gehr & Wikle, "The Evidence Builds: Access to Medicaid Helps People Work," CLASP, Dec. 2017.)* Unlike the current proposal, a Medicaid waiver aimed at promoting a healthier workforce would recognize that untreated illness is a barrier to both seeking and maintaining employment.

A work requirement for extremely low-income parents and other caretakers receiving Medicaid ignores several additional key points:

- Medicaid beneficiaries in the POCR category are, by definition, working at home to care for one or more dependent children. By limiting adult coverage to caretakers, Alabama Medicaid has already ensured that beneficiaries are engaged in the meaningful work of child-rearing.
- The proposal implicitly attributes the significant growth in the POCR population since 2013 to the group's over-reliance on Medicaid eligibility. It makes no mention of the fact that the Affordable Care Act's introduction of the Modified Adjusted Gross Income (MAGI) eligibility standard extended Medicaid eligibility to some parents who were formerly excluded because their child support payments put them above the income limit. It also fails to acknowledge the "welcome mat" (or "woodwork") effect of ACA Marketplace enrollment efforts, which turned up people who did not realize they were already eligible for Medicaid. Enrollment growth for these two reasons is a fulfillment of Medicaid's purpose, not an encumbrance to it.
- By excluding child support payments from income calculations, the MAGI eligibility standard allows custodial parents to stay at home with young children – a choice that many families with more adequate income value highly.
- Many low-wage jobs are seasonal or irregular and unpredictable in scheduling, which makes them incompatible with the requirement that participants log a set number of work hours each week.

Impact on families

It is important to recognize that the people who will be affected by this proposed policy are exclusively the parents or guardians of children, often very young children. Nearly 90 percent of them are women. They are among the poorest people in Alabama, with an average monthly income of less than $400 for a family of three. Health coverage is one of the few protections they have.

Loss of health coverage. Under Alabama Medicaid's current eligibility rules, a mother of two children earns too much to remain eligible once she works as much as 10 hours per week at minimum wage. But the waiver would require a mom of two children age 6 or older to work 35 hours per week. It takes 55 hours per week at minimum wage to reach the poverty level, where she could qualify for a Marketplace health plan, and 75 hours per week to reach 138 percent of the poverty level, where she could afford a plan. To be clear: *If this new policy "succeeds," and a mother gets a job with the required 20- or 35-hour workweek, she will lose her Medicaid coverage and likely not have access to either employer-provided coverage or an affordable private plan.* She will be caught in the same predicament as someone who did not comply with the work requirement. This *work penalty,* a catch-22 that forces people into the coverage gap, is perhaps the most troubling aspect of the waiver proposal. In the low-wage sectors where participants would be most likely to find employment, the proposed 18-month transitional medical assistance period simply delays the inevitable pain of losing health coverage.

Lack of work supports. While the waiver request says that participants will be referred to supportive services, there is no reason to expect they will be able to receive these services. Subsidized child care, for example, is a necessity for a parent who works. In Alabama, however, most child care subsidies serve the highest priority categories, including foster children, children receiving protective services, and children who are in families that receive Temporary Assistance for Needy Families (TANF). In August 2018, Alabama had a waiting list of more than 1,300 children and significantly more pent-up need for subsidized day care.

The same could be said for other support services, including job training and public transportation, which are essential job supports. Alabama has no state-funded public transportation, and local transit options vary widely, with many rural counties lacking dependable service. These deficiencies are ones that the Alabama Department of Human Resources (DHR) has struggled with over the last several years as it reinstated its SNAP work requirements for Able-Bodied Adults Without Dependents (ABAWD).

An analysis by the Georgetown Center for Children and Families (GCCF) finds that families in rural areas and small towns in Alabama are disproportionately at risk for being sanctioned and losing coverage under the work requirement, because they are more likely to have Medicaid

than those in metro areas. Thus, rural residence places families in double jeopardy, since rural counties often have higher unemployment and less adequate transportation than urban ones. *(GCCF, "The Impact of Alabama's Proposed Medicaid Work Requirements on Low-Income Families with Children," Policy Brief, March 2018.)*

Confusion about exemptions and compliance. The proposal cites "a number of exceptions to employment requirements which must be verified periodically." The list includes several categories for which periodic verification – however vaguely defined – could be relatively easy, such as people receiving Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI), pregnant mothers, people age 60 or older, and people enrolled in the TANF JOBS (Job Opportunities and Basic Skills) program. Medicaid also proposes to exempt those who are exempt from the TANF JOBS program because of significant barriers to work. Verification of those barriers, however, has been extremely challenging, requiring multiple revisions of forms and notices, and resulting, in some cases, in benefit loss among otherwise eligible recipients – costly complications that the waiver proposal fails to acknowledge.

Verification of Medicaid's other proposed exceptions also will be difficult. For example, how and how often will Medicaid evaluate the required "validation" by medical professionals of beneficiaries' disability, medical frailty or medical impediment to work? What happens to people with these conditions who lack adequate validation? How and how often will Medicaid verify beneficiaries' exemption for being "required to care for a disabled child or adult"? What happens to caregivers who can't meet the standard of verification? How and how often will Medicaid verify beneficiaries' exemption for "participating in an intensive, authorized medical treatment program for alcohol or substance abuse or addiction (including opioid addiction)"? Other states' recent experiences raise red flags. The approved Arkansas waiver has only one way for Arkansans to verify an exemption or prove they worked – a portal on the state's website – and response rates have been alarmingly low. Many low-income Alabamians, especially those in rural areas, lack internet access. What happens when the system experiences bugs and outages? Kentucky's switch to a new online eligibility system (prior to their waiver approval) resulted in loss of coverage for thousands of otherwise eligible individuals. These are high-stakes questions that put the health coverage of thousands of Alabamians in jeopardy.

The waiver request also says that people who can't find services like transportation or child care will be exempt. But the way this section is written is particularly unclear. The waiver request says people "compliant with JOBS are exempt." And it says that anyone exempt or deferred from JOBS will not be required to engage in work activities. To be either participating or exempt from JOBS, though, one must be receiving TANF. Alabama has around 4,000 adults

receiving TANF and 75,000 people in the POCR Medicaid category. The actual language of the waiver request is silent on whether any of the other 71,000 participants not receiving TANF will be deferred if they don't have child care or transportation.

The waiver request says that "Alabama Medicaid plans to address exemptions based on economic conditions related to unemployment rates by county as currently done in the TANF JOBS program." This is particularly confusing because TANF does not waive participation in the JOBS program for people who live in counties with high unemployment rates. In previous years, Alabama (and most other states) waived ABAWD SNAP work requirements in areas of the state with very high unemployment rates. (CMS already requires that Medicaid apply SNAP exemptions to any Medicaid recipient also receiving SNAP.) But the waiver request also says that "Alabama Medicaid will not be modeling the program after its SNAP work program, because the SNAP mandatory work program is not applicable for parents and caretakers of dependent children." We are therefore at a loss as to what would be the model, or the policy details, for a Medicaid work exemption based on economic conditions.

The waiver request also says the Medicaid work program itself would be "modeled" on the JOBS program. And the proposed memorandum of understanding with DHR seems to indicate that non-deferred POCR individuals will actually be enrolled in the JOBS program or another program administered by DHR that is very similar to JOBS. A critical element of the JOBS program is access to emergency and job support services, including auto repair, emergency housing assistance, transportation assistance, uniforms and other needs. One of the most important supports in the JOBS program is priority access to subsidized child care without having to be placed on a waiting list.

Will POCR recipients also become eligible for these TANF/JOBS-funded services? And if so, would those auxiliary services be paid for with the already inadequate TANF block grant? If so, this waiver proposes to try to expand services now covering 3,700 people to an estimated additional 17,000 individuals, further stressing an already underfunded JOBS program and reducing assistance now reserved for TANF participants mandated to participate in JOBS.

The waiver request says "each adult in the household" would be required to participate. If this is the case, is the plan to terminate the Medicaid of a compliant or exempt Medicaid recipient if a non-recipient who lives in the same household doesn't participate? Besides the deep unfairness of punishing the Medicaid recipient for the behavior of another household member, this policy empowers the non-recipient to use the threat of the loss of insurance to abuse and control the Medicaid recipient.

The proposal includes "volunteer work activities or community service" under qualifying employment-related activities. Yet the vagueness of this reference seems to invite worker exploitation by unscrupulous employers. What safeguards will Medicaid put in place to make sure unpaid work performed by POCR beneficiaries meets fair labor standards?

Harm to children. The clear intent of this proposal is to take health insurance away from targeted women who are unable, for whatever reason, to comply with employment and training activities. The request speaks to the benefits of work for children and families, and we certainly agree that, with the right supports, families are better off when there is earned income. But we cannot see how the loss of parental health insurance can possibly benefit children. If Mom cannot afford her asthma medicine or her insulin because her Medicaid has been discontinued, then she gets sick and can't work, or ends up in the hospital, or doesn't buy the food, clothing or other necessities for her children in order to buy the medicine she needs. Lack of parental coverage puts families at higher risk of medical debt and bankruptcy. When parents lose their insurance, children are less likely to have regular doctor visits. An Urban Institute study finds that, while it is almost never the case that an insured parent has an uninsured child, there is a correlation between uninsured parents and uninsured children. *(Karpman & Kenney, "Health Insurance Coverage for Children and Parents: Changes Between 2013 and 2017," Urban Institute, Sept. 7, 2017.)* The waiver proposal does not indicate whether Medicaid assumes any loss of children's coverage in its budget neutrality estimates. Given Alabama's strong record of support for children's health insurance, how will the state mitigate the harm that befalls children when parents lose coverage?

Ultimately, the work requirement waiver request raises more questions about its impact on beneficiaries and their families than it answers. Many of the answers apparently will be found in the yet-unspecified MOUs with DHR and the Department of Labor – MOUs that may not be available to the public before they are implemented.

Impact on state budgets

As the previous sections have demonstrated, this waiver request is as troubling for the matters it ignores as for those it addresses. State lawmakers who undertook their own unsuccessful effort to impose Medicaid work requirements in the Legislature's 2018 regular session may be interested to note that the proposal offers no estimate of state dollars associated with implementation of the requirement, which would likely be formidable. Interestingly, the document even fails to identify the multiple provisions that will incur those undetermined costs.

Cost savings appear to be the driving concern of this waiver. The proposal anticipates two sources of those savings: (1) termination of Medicaid coverage for beneficiaries whose income

rises past the eligibility limit; and (2) termination of coverage for non-compliant beneficiaries. The considerable – but unaccounted – cost to the state and to families stemming from the adverse health effects of coverage loss is a sobering subtext of this proposal.

By Medicaid's own estimates, some 57,000 people in the POCR caseload will be exempted from work requirements. But the administrative cost of making that determination will add significantly to our famously low-overhead Medicaid budget. It won't be so low-overhead anymore. While CMS does not require states to include administrative cost estimates in their waiver budget neutrality calculations, such information is of utmost interest to taxpayers and their elected representatives. Any public consideration of the waiver proposal is incomplete without projections of the total cost – including administrative costs.

Ineffectiveness of other mandatory work requirements

Research on mandatory work requirements in other means-tested programs has found that these programs rarely move recipients out of poverty. An early 2000s study of TANF work requirements found that, while participants' incomes rose when they engaged in work activities, the increase was not enough to raise them above the poverty level. It also found that the employment that recipients obtained was unstable and that recipients' incomes declined over time. *(Grogger & Karoly,* Welfare Reform: Effects of a Decade of Change, *Harvard University Press, 2005.)*

Studies also show that SNAP work requirements were particularly ineffective for participants with significant employment barriers. A study of Ohio SNAP ABAWD recipients found that nearly a third reported physical or mental health problems and another 13 percent were caregivers for a child or frail adult. Thirty percent of participants had not finished high school or obtained a GED, and 35 percent had a criminal history. For these recipients, work requirements without significant health care, education and job training assistance ended in benefit loss without increased earned income. *(Ohio Association of Foodbanks,* Comprehensive Report on Able-Bodied Adults Without Dependents, *2015.)*

While the proposed waiver provides for exemptions from work requirements if an individual faces significant barriers, the experience of SNAP and TANF recipients has illustrated how difficult it can be to obtain exemptions for which the recipient should qualify. A 2006 review of compliance with SNAP ABAWD exemption requirements found that states failed to comply with the exemption requirements and, instead, terminated food assistance for people who should have been eligible. *(U.S. Department of Agriculture, Office of the Inspector General, "FNS Controls Over SNAP Benefits for Able-Bodied Adults Without Dependents," Sept. 29, 2016.)* A literature review of sanctions in the TANF program found that recipients sanctioned for failing

to comply with work requirements were disproportionately more likely to have dependent care problems, domestic violence, health problems or other barriers to compliance that should have entitled the recipient to an exemption. *(Pavetti, Derr & Hesketh, "Review of Sanction Policies and Research Studies: Final Literature Review," Mathematica Policy Research, Inc., March 10, 2003.)*

Compounding the ineffectiveness of TANF and SNAP work requirements is the reduction of benefits that occurs as participants' incomes increase. Studies have found that welfare-to-work recipients actually did work more hours and had higher gross incomes than did control groups. But studies also found that family net income changed little because, as gross income increased, SNAP and TANF benefits declined, leaving families little better off. *(Hamilton* et al*., "National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs," Manpower Demonstration Research Corporation, December 2001.)* This "cliff effect" is a particular concern in Alabama, both in TANF and in the Medicaid POCR category. Because the income ceiling for both programs is so low (at approximately 18 percent of the federal poverty level), working recipients very quickly hit the ceiling and become ineligible for cash or medical assistance. The loss of Alabama's very low TANF benefit may be more than offset by increased earned income. But the same cannot be said for the loss of health insurance, because the very high cost of health care for an uninsured individual could more than exceed any increase in earned income.

Revision-related concerns

During the first state-level comment period, the waiver proposal drew some 800 comments, 90 percent of them opposed to the waiver (a fact that the revised proposal ignores). In response, Alabama Medicaid made two changes, neither of which addresses the following core concerns: 1) the *work penalty* awaiting compliant Medicaid beneficiaries in a non-expansion state when their transitional medical assistance expires; 2) the lack of available work supports, including public transportation and subsidized child care; 3) the lack of safeguards to prevent burdensome documentation requirements for both compliance and exclusion from resulting in inadvertent termination; 4) the omission of projected budget impact; 5) the omission of projected coverage loss; and 6) the waiver's violation of Medicaid's statutory mission to provide health coverage for low-income and medically needy individuals.

Alabama Arise applauds the decision by CMS to return Alabama Medicaid's waiver proposal for further revision and an additional state-level comment period. We agree with CMS that the original proposal lacked sufficient conceptual rigor and descriptive detail in its proposed evaluation methodology. Unfortunately, the revised request failed to remedy this defect. The second state-level comment period drew more than 500 comments, the vast majority of them

negative, and again Alabama Medicaid ignored commenters' concerns.

According to the Hypotheses and Evaluation Parameters section of the proposal, "the overall goal of the demonstration is to improve health outcomes, both of parents and children, by assisting the POCR eligibility group in finding and preparing for full employment." Yet only one of the five proposed hypotheses addresses health at all – and that one only indirectly, in terms of health coverage. There is no attempt to measure the core aim of better health outcomes.

Alabama Medicaid's sole health-related hypothesis posits that "providing workforce opportunities will result in transition to other health insurance." Any suggestion that this hypothesis relates to the overall goal implies that private coverage results in better health outcomes than public coverage, an assertion for which the proposal offers no supporting evidence. The methodology described under this hypothesis raises a number of concerns: It seems unlikely that insurers will provide a monthly listing of all new members, so what data will Medicaid provide to the insurer to identify a new member as coming from Medicaid? Who will pay the insurers' costs associated with writing reports to identify affected members and transferring the data? Will Medicaid be responsible for receiving multiple data feeds from all private insurers on a monthly basis? What process will Medicaid follow in receiving, loading and analyzing the data? What will be the administrative costs to Medicaid for these added functions?

Both the first and second hypotheses refer to the work requirement as "providing workforce opportunities." Arise is concerned that couching a mandatory, penalty-driven condition as an "opportunity" distorts both the rationale and the evaluation of the waiver. We would heartily support the introduction of workforce opportunities in the form of work supports made available on a voluntary basis, without penalty of coverage loss for non-participation. Further, the methodology for the second hypothesis is flawed in at least two ways: 1) the Alabama Department of Labor does not track pre-employment "workforce activities" outside the Employment Service, which applies primarily to workers drawing unemployment compensation; and 2) references to "eligibility system data" here and elsewhere in the proposal are vague to the point of uselessness. Medicaid offers no substantive explanation of how it will obtain and evaluate employment-related data for this initiative.

The third hypothesis predicts that "over the five-year demonstration, the number of POCR individuals with earned income will increase for Medicaid parents and caretaker relatives who are or were covered by this demonstration." In the absence of Medicaid expansion, this assertion simply acknowledges that a growing number of POCR beneficiaries will lose health coverage by virtue of income that exceeds the eligibility limit. Proof of this hypothesis would, in effect, be antithetical to the stated goal of improving health outcomes.

The fourth hypothesis posits that "more parents and caretaker relatives will receive transitional Medicaid in the short-term, due to increased income and the change in the transition period." As formulated, this hypothesis amounts to a tautology, since the change in the transition period could account for both continued enrollment and re-enrollment of previously disenrolled POCR beneficiaries beyond the current 12-month period but still within the new 18 months. Further, growth in transitional Medicaid enrollment only means more beneficiaries on the path to losing coverage when the work penalty commences at 18 months.

The fifth hypothesis asserts that "fewer parents and caretaker relatives will need to rely on Medicaid, and thus the POCR eligibility group will decrease in size, due to increased income." The verb *rely* in this sentence is deceptive. Medicaid could legitimately assert that beneficiaries who move to employer-based coverage no longer "rely" on Medicaid, but that is only a subset (likely a small one) of those who will leave the Medicaid rolls because of the work requirement. The majority will be beneficiaries who *lose* their Medicaid eligibility because of new earnings or non-compliance with the requirement – with no other coverage on which to rely. Further, in ongoing data collection and analysis, how will Medicaid account for individuals who otherwise would have qualified for POCR coverage but choose not to apply because of the work requirement?

In summary, Medicaid's hypotheses for this demonstration are deeply flawed. None of the five hypotheses address the stated goal of improving health outcomes. Only one of the five is health-related at all. And the proposed methodologies raise more questions than they answer – relating to inter-agency cooperation, interaction with private entities, underlying data analysis rationale, associated costs and other factors. Arise believes that Alabama Medicaid has not fulfilled its charge from CMS regarding hypotheses and evaluation parameters.

Conclusion

A work requirement for parents and other caretaker relatives in Alabama Medicaid would create unreasonable barriers to health care for some of the state's most vulnerable families. Making Alabama's bare-bones Medicaid even more stringent is the wrong way to promote a healthier workforce. The state's failure to expand Medicaid to cover low-income adults turns the work requirement into a work penalty.

In a state with 18.5 percent of its people in poverty, Medicaid proposes to put about 1.5 percent of Alabamians under a microscope, expecting to find about one-third of 1 percent who can be disenrolled. Many of these parents will likely become and remain uninsured. The huge administrative effort required by this proposal will result at best in a few thousand mothers finding jobs at the price of losing their health coverage.

Rather than create new barriers to health care, as this waiver would do, we urge the state to invest its time and resources in efforts that would achieve the triple aim of better care, better health and lower costs. The forthcoming expansion of health homes for the majority of Medicaid beneficiaries and the creation of an Integrated Care Network for long-term care patients are moves in the right direction. Toward that end, Alabama Arise has developed a set of principles of consumer-centered Medicaid reform *(see appendix)*.

The work requirement waiver proposal suggests that health coverage is a privilege of working people, yet it ignores the lack of coverage available to the new workers it would create. One question overarches all the others raised by the waiver: Why hasn't Alabama expanded Medicaid to cover low-income workers who don't get employer coverage and can't afford private plans? Threatening loss of health care in an attempt to force work efforts, without providing the supports that would make those work attempts successful, is flagrantly cruel and will result in no outcome other than poorer, more desperate and less healthy Alabama families. Instead of imposing an ill-conceived and punitive "work requirement," Alabama could make genuine progress in promoting employment by ending its Medicaid work penalty.

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Appendix

Patients First: Principles of Consumer-Centered Medicaid Reform

Arise Citizens' Policy Project offers the following eight core principles of consumer-centered Medicaid reform, with a focus on Medicaid managed care:

1. **Better health is the bottom line.** Meaningful Medicaid reform will address the central role that Alabamians' poor health outcomes play in the state's escalating health care costs. Increasing access to and utilization of preventive and primary care will reduce delayed interventions, preventable hospitalizations and chronic illness, which in turn will reduce costs. To set budgetary goals apart from defined health outcome goals could lead to cost-cutting that denies access to essential care.

2. **Consumer engagement is essential.** Medicaid reform is more likely to ensure quality services that meet consumer needs if consumers and advocates are involved at all levels of planning and implementation. Meaningful consumer involvement reflects both the broad diversity of the patient population and the multiple stages of decision-making, monitoring and assessment.

3. **Effective consumer outreach includes education and assistance.** Getting patients enrolled in Medicaid coverage is not enough. New enrollees need information, in the language they speak, about how plans work and assistance with navigating the system, as well as means to address consumer problems and resolve disputes. The state should work with trusted consumer and community organizations that know patients' needs to identify and plan these processes and develop the necessary resources.

4. **Successful managed care treats the whole person.** Medicaid reform offers Alabama an unprecedented opportunity to reject the "bare bones" model in favor of more comprehensive services designed to improve the state's health outcomes, not just to meet minimum standards for federal funding. The state should go beyond federally required services to include prescription drugs, long-term care focused on home- and community-based services, behavioral health care, social services and supports, and transportation in a comprehensive plan.

5. **Special needs require special accommodation.** Managed care that is well-suited to the average patient may not be adequate for individuals with complex health profiles, such as children with special health care needs, people with disabilities, frail elders, people with HIV/AIDS, and people with mental illness. Often, these individuals rely on particular care providers capable of delivering the full range of appropriate services (from weighing a patient in a wheelchair to intervening when the patient becomes ill), as well as complex drug regimens. Where the state has already demonstrated its ability to provide services in appropriate community-based settings (e.g., to persons with mental illness and intellectual disabilities), those supports should be strengthened and refined. Where the

state has not provided appropriate community-based services (e.g., to prevent unnecessary nursing home admissions), supports must be created and expanded. Alabama should adopt a clear definition of Medical Necessity that promotes individualized services to help people with special needs achieve, as closely as possible, their own goals of inclusion, independence and productivity. Participation by such individuals in managed care should reflect risk-adjusted capitation rates and should be strictly voluntary until Medicaid demonstrates the system's capacity to meet their needs. Once enrolled, these patients must have the right to opt out if their plan fails to provide the necessary supports.

Expanding home- and community-based long-term care can improve outcomes and save money. Managed care for individuals who depend on long-term services should employ proven care models based on consumer choice and self-direction. Program planning should allow time for consultation with stakeholders (including consumers, providers, suppliers and managed care organizations), for collaboration among state agencies in program design, and for working with CMS to obtain approval. Ultimately, the success of these efforts will depend on the availability of affordable accessible housing and qualified caregivers, which will require innovative coordination among public and private entities. Whenever possible, Medicaid should contract with community-based support services (e.g., those funded by the Ryan White Care Act for people living with HIV/AIDS). The Affordable Care Act offers strong incentives to expand home- and community-based care – for example, by combining "rebalancing" initiatives with the health home model that brings a 90 percent federal match.

7. **Accessible managed care requires a robust provider network.** To comply with federal law, Alabama should set standards for access ensuring that patients have a choice of providers (including those who speak their language and understand their cultural beliefs) and do not have to wait long or travel far for necessary care. Alabama should expand efforts to address our chronic health care provider shortage, particularly in rural areas. Low payments to providers are another obstacle to maintaining robust networks. Primary care provider payments should be as close to Medicare rates as possible (higher than Medicare for specialists) and adjusted for patient age and health status. Managed care plans should aggressively recruit into their provider networks all qualified practitioners and suppliers who currently serve Medicaid disability and high-risk populations.

8. **Quality and accountability bring Medicaid reform full circle.** To ensure that managed care in Alabama achieves the dual goals of improving health outcomes and lowering health care costs, the state must employ aggressive quality and accountability safeguards, such as the following:

   - full use of oversight authority under federal and state law;
   - full compliance with the Americans with Disabilities Act, the Rehabilitation Act of 1973, and the Olmstead decision;
   - full compliance with federal and state sunshine and disclosure laws;
   - financial incentives to reduce harmful or unnecessary care;
   - independent ombudsman to maintain consumer hotline, address consumer complaints, identify

systemic problems and propose solutions to the state, and issue a public report annually on the type and number of complaints;

- a robust appeals process that links consumers directly to Medicaid review staff;
- cultural competency training for all Medicaid and plan staff in contact with the public;
- clear strategies to assess and improve quality of managed care, including annual reporting of quality outcomes by race, ethnicity, gender and primary language;
- clear strategies to monitor and reduce multidimensional health disparities;
- smart, consumer-friendly cost containment strategies that do not cut eligibility, benefits or provider fees (options include reducing payment for preventable complications and readmissions, and expanding use of generic drugs);
- penalties for plans that skimp on services; and
- per-patient payment rates that adequately reflect the cost of providing comprehensive care to the population served, which will be higher for people with complex health needs.