

# William E. Morris Institute for Justice

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December 10, 2014

VIA EMAIL:

Cynthia Mann  
Director  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P. O. Box 8016  
Baltimore, Maryland 21244-8016

Re: Objections to Arizona's Section 1115  
Waiver Amendment Request for Cost  
Sharing for Arizona's Expansion  
Population

Dear Director Mann:

The Center for Medicare and Medicaid Services ("CMS") posted on its website a January 2014 "Arizona 1115 Waiver Amendment Request – Mandatory Cost Sharing for Expansion Populations" for comment. The proposal was submitted by the Arizona Health Care Cost Containment System ("AHCCCS"). The comment period ends December 18, 2014. The William E. Morris Institute for Justice ("Institute") is a non-profit program that works on issues of importance to low-income Arizonans. Cost sharing in the State Medicaid program is such an issue. The National Health Law Program ("NHeLP") is a program dedicated to protecting the health care rights for those in need, with a focus on Medicaid. For the reasons below, the Institute and NHeLP request that CMS not approve the cost-sharing waiver amendment.

## **I. Federal Requirements for a Demonstration Waiver Under 42 U.S.C. § 1315**

The Social Security Act grants the Secretary of the United States Department of Health and Human Services limited authority to waive the requirements of the Medicaid Act. The Social Security Act allows the Secretary grant a "[w]aiver of State plan

requirements” in 42 U.S.C. § 1396a in the case of an “experimental, pilot, or demonstration project.” 42 U.S.C. § 1315(a) (“section 1115 or 1315”). The Secretary may only approve a project which is “likely to assist in promoting the objectives” of the Title XIX and may only “waive compliance with any of the requirements [of the act] ... to the extent and for the period necessary” for the state to carry out the project. *Id.*<sup>1</sup>

Legislative history confirms that Congress meant for section 1315 projects to test experimental ideas. According to Congress, section 1315 was intended to allow only for “experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients” that are “to be selectively approved,” “designed to improve the techniques of administering assistance and related rehabilitative services,” and “usually cannot be statewide in operation.” S. Rep. No. 87-1589, at 19-20, *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961-62, 1962 WL 4692 (1962). *See also* H. R. Rep. No. 3982, pt. 2 at 307-08 (1981) (“States can apply to HHS for a waiver of existing law in order to test a unique approach to the delivery and financing of services to Medicaid beneficiaries.”).

In addition, the Secretary is bound by the Ninth Circuit’s precedent for any cost sharing requests under 42 U.S.C. § 1315. The Ninth Circuit described section 1315’s application to “experimental, pilot or demonstration” projects as follows:

The statute was not enacted to enable states to save money or to evade federal requirements but to ‘test out new ideas and ways of dealing with the problems of public welfare recipients’. [citation omitted] ... A simple benefits cut, which might save money, but has no research or experimental goal, would not satisfy this requirement.

*Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994). Under *Beno* the record must show the Secretary considered the impact of the cost sharing project on those the Medicaid Act was enacted to protect. *Newton-Nations v. Betlach*, 660 F.3d 370, 380 (9<sup>th</sup> Cir. 2011) (relying upon *Beno*).

As explained below, Arizona’s proposal cannot meet these requirements.

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<sup>1</sup> Cost sharing waivers should not be permitted through section 1115 because there is a specific cost sharing waiver provision in 42 U.S.C. § 1396o(f). *See* section III (B) on pages 5-6.

## **II. The Arizona/AHCCCS Section 1115 Waiver Amendment Request**

Arizona/AHCCCS proposes to impose the following mandatory cost sharing on childless adults with income between 100%-138% of the federal poverty level.

1. A premium of not more than two per cent of the person's household income.
2. A copayment of two hundred dollars for nonemergency use of an emergency room if the person is not admitted to the hospital. The administration shall not impose a copayment on a person who is admitted to the hospital by the emergency department.
3. A copayment of two hundred dollars for nonemergency use of an emergency room if there is a community health center, rural health center or urgent care center within twenty miles of the hospital.

The only reason for this request is that the legislature passed legislation in 2013 as part of the budget that required AHCCCS, in general, to "pursue cost sharing requirements ... to the maximum extent allowed under the law" and specifically these provisions. For the rationale for the cost sharing, AHCCCS states:

Arizona is seeking to impose these requirements in order to include a measure of personal responsibility and encourage appropriate use of the emergency department. Arizona expects to see cost savings through the improved control of non-emergent use of the emergency department by re-directing people to more appropriate settings for care.

AHCCCS fails to explain how the Medicaid allowed copayments are not adequate to "include a measure of personal responsibility and encourage appropriate use of the emergency room." In addition, as explained above, cost savings cannot be a basis for a demonstration.

Having failed to explain the need for these copayments, for the evaluation design, AHCCCS simply claims it "will incorporate the effectiveness of imposing cost sharing on the expansion population in a similar manner as required for cost sharing approved on October 22, 2011." Premiums and \$200 copayments were not studied in the prior

evaluation design. The Institute has not seen the results of any study of the enhanced and mandatory copayments approved in October 2011. Regardless, AHCCCS fails to provide sufficient information for a waiver request. AHCCCS provides no other justification for the enhanced cost sharing or explanation of what would be studied and why such a study is needed.

For public participation AHCCCS claims the public could have made comments when the cost sharing was added to the budget bill last year. This argument has no merit. First, the cost sharing was added to the budget bill at the last minute. Significantly, it was part of a multi-page budget bill that most of the public did not know about. AHCCCS also claims that the legislation was discussed on one page of a PowerPoint presentation at a State Medicaid Advisory Meeting in July 2013. As discussed below, this is not meaningful participation as required by federal law.

### **III. The Federal Limitations on Cost Sharing Under the Affordable Care Act**

#### **A. Premiums**

The federal regulations under the Patient Protection and Affordable Care Act (“PPACA”) provide for premiums only for persons whose income is above 150% of the federal poverty level. 42 C.F.R. § 447.55(a). As explained above, to qualify for a waiver under 42 U.S.C. § 1315, a project must be experimental and test a novel idea. There is nothing novel or experimental about charging premiums on low-income persons.<sup>2</sup>

Research from other states shows that premiums significantly depress enrollment in Medicaid. As an example, Oregon increased sliding scale premiums and raised cost sharing on certain adults in its Medicaid program. In the 12 months after implementation, enrollment for the affected population dropped 45%. Samantha Artiga & Molly O’Malley, Kaiser Fam. Found., *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (2005); Leighton Ku & Victoria Wachino, Center on Budget & Policy Priorities, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings* (2005). Other states that implemented premiums or enrollment fees on lower-income persons on Medicaid or the Children’s Health Insurance Program also experienced substantial disenrollment in their programs.

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<sup>2</sup> For a more in-depth discussion of the consistent, redundant research, which finds the negative effects of cost sharing on low-income persons, see David Machledt and Jane Perkins, National Health Law Program, *Medicaid Premiums and Cost Sharing* (March 26, 2014), <http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing#U2Eos1d7R51>.

Samantha Artiga & Molly O'Malley, Kaiser Fam. Found., *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (2005).

In one study, the authors compared premiums for low to moderate income individuals in state public insurance programs. Their study estimated that charges of just 1% of family income reduce participation by approximately 15%. Premiums set at 3% of family income reduce total enrollment by roughly 50%. Leighton Ku & Teresa Coughlin, *Sliding Premium Health Insurance Programs: Four States' Experiences*, 36 *Inquiry* 471 (1999/2000). These analyses together represent direct evidence that high out-of-pocket Medicaid expenses, such as premiums, lead to adverse outcomes such as qualified people avoiding or leaving the program.

All this proposal would do is either take away the limited funds from some of our most vulnerable persons that they need for rent, utilities, clothing, transportation and other necessities of life or lead to disenrollment. These are both unacceptable results and totally unjustified. This part of the request should be denied.

## **B. Emergency Room Cost-Sharing**

The federal regulations provide that the cost-sharing for the non-emergency use of the emergency room is limited to \$8.00 for persons under 150% of the federal poverty level. 42 C.F.R. § 447.54. With no justification, AHCCCS proposes to impose a penalty, not cost sharing, of \$200 that is **25 times the federal limit!** For a person whose income is at 125% of the federal poverty level, less than \$1,200, the \$200 penalty would represent approximately 16% of their monthly income.

Initially, the Institute notes that for cost sharing waivers, the State and CMS must follow the requirements in 42 U.S.C. § 1396o(f). In § 1396o, Congress approved two ways for states to charge copayments that are not nominal. First, the Act provides that:

cost sharing . . . of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services . . . and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

42 U.S.C. §§ 1396o(a)(3) and 1396o(b)(3). Second, in 42 U.S.C. § 1396o(f), Congress establishes strict requirements under which CMS may waive nominal copayments:

No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary, except as provided in subsections (a)(3) and (b)(3) of this section and section 1396o-1 of this title, unless such waiver is for a demonstration project which the Secretary finds after public notice and opportunity for comment—

- (1) will test a unique and previously untested use of copayments,
- (2) is limited to a period of not more than two years,
- (3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,
- (4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and
- (5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

The waiver request by the State does not even purport to meet these strict requirements. For that reason the request should be denied.

Even if CMS reviews the request under section 1115, it still should deny the request. First, there is no evidence submitted that there is any inappropriate use of the emergency room in Arizona. This is not surprising because AHCCCS was required to report to the legislature on the use of the emergency room for non-emergency purposes and concluded based on a very general classification system that approximately 6% of the emergency rooms visits may be for non-emergencies and that “members have a relatively low rate of non-emergency ED utilization particularly when compared to national averages” *See* Arizona State Senate Fact Sheet for Senate Bill 1298 in the 2014 legislative session at [www.azleg.gov](http://www.azleg.gov). Thus, there is no emergency room problem in Arizona that needs to be addressed.

In addition, this extremely harsh penalty would not improve the techniques of health care administration. Nor is it a new idea that any reasonable person would want to

test out. There has been adequate research on the use of copayments for the non-emergency use of the emergency room. *See, e.g.*, the multi-state, multi-year study by K. Mortensen, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments*, *Health Affairs*, 29(9): 1643-50, September 2010, and the study by David Becker, *Copayments and the Use of the Emergency Department Services in the Children's Health Insurance Program*, presented at the Academy Health Annual Research Meeting, June 14, 2013, finding similar results to the Mortensen study. No doubt the Secretary's familiarity with the research is one of the reasons why the \$8.00 copayment amount was selected.

The second part of this proposal concerning use of the emergency room would impose a **second \$200 penalty** on the non-emergency use of the emergency room if there was a "community health center, rural health center or urgent care center" within 20 miles of the hospital. There are a multitude of reasons why a hospital was selected over the other medical care facilities. This is a second extremely harsh penalty that is 25 times the federal limit on cost sharing. If the two penalties were imposed on one hospital visit, a low-income person would have over 30% of his or her monthly income taken away and the penalty would be **50 times** the limit allowed in the federal regulation. Imposition of these penalties would lead to financial disaster in no time.

Finally, Arizona proposes to define a non-emergency visit by whether the person is admitted to the hospital and/or whether another facility was within 20 miles of the hospital. These differentiations clearly violate the prudent layperson standard in the Medicaid regulations. 42 C.F.R. § 438.114. There is no way a person could know beforehand that his or her condition would require hospitalization. Also, the arbitrary distance of another facility from the hospital fails to focus on the prudent layperson standard. Significantly, there is no requirement that the facility actually be available and accessible to the person. The facility might be closed at that time or not accepting walk-ins.

Moreover, CMS has publicly acknowledged that such retrospective approaches will not satisfy the prudent layperson standard. In the preamble to the July 15, 2013 Final Eligibility and Enrollment regulations CMS stated:

We agree that it is difficult to implement a system to differentiate non-emergency from emergency services for cost sharing purposes in a way that ensures beneficiary protections consistent with the prudent layperson standard. We continue to believe that the use of diagnosis and procedure codes alone is not an appropriate process for

determining non-emergency services, as doing so would not adequately protect beneficiaries legitimately seeking ED services based on the prudent layperson standard, for whom a CPT code assigned after care is provided may indicate a non-emergency condition. ... We sought comments on feasible methodologies for states and hospitals to make this distinction, but did not receive any recommendations.

78 Fed. Reg. 42278. CMS must not approve the state's request to impose harsh and indiscriminate penalties on legitimate emergency room use. Imagine a Medicaid patient with a history of heart disease who experiences chest pains and puts off calling the ambulance for fear of the \$200 bill they would face if their condition turned out to be merely indigestion or angina. This proposal, if approved, would literally put lives at risk. Hence, the waiver request would hinder the objectives of the Medicaid Act.

Moreover, these types of harsh penalties do not promote the objectives of the Medicaid Act. If AHCCCS wants to further reduce the non-emergency use of the emergency room, more public education or broader primary care networks would be a good start and would not infringe on recipients' access to medical care. There is no evidence that AHCCCS has tried any less drastic measures.

Such a penalty also exceeds the aggregate limits in state and federal regulations. Pursuant to Arizona's Administrative Rule R9-22-711(G), the total aggregate amount for all household copayments and premiums is limited to 5% of the person's income. Similarly, the federal regulation limits the aggregate of all copayments and premiums to 5% of a person's monthly or quarterly income. 42 C.F.R. § 447.56(f). The emergency room penalty would surpass this aggregate by 300% without consideration of any other copayments!

For all these reasons, this part of the request should be denied.

#### **IV. Lack of Meaningful Public Input**

AHCCCS first posted on its website on February 11, 2014, a draft Section 1115 Waiver Amendment Request for Cost Sharing for Arizona's Expansion Population. The time to submit comments ended on March 14, 2014. On February 11, 2014, the first day of the public comment period, AHCCCS submitted its Section 1115 Waiver Amendment

Request by e-mail to several staff at the Centers for Medicare and Medicaid Services (“CMS”) and the request appeared to be under consideration.<sup>3</sup>

Although the State had a public comment period for the waiver request, it is obvious that the comment period was a sham. Prior to the comment period even beginning, AHCCCS sent the draft request to CMS staff. Significantly, prior to the submission there was no public meeting. If the State wanted and valued public input, it would have posted a public notice and requested public comment prior to submission of its proposal.<sup>4</sup>

In the PPACA, Congress recognized the importance of meaningful public participation in the design of section 1115 demonstration waivers. 42 U.S.C. § 1315(d)(1). The PPACA required the Secretary of the Department of Health and Human Services to promulgate regulations for transparency and public notice and comment procedures to ensure a meaningful level of public input for applications and renewals of projects that impact eligibility, enrollment, benefits, cost-sharing or financing. 42 U.S.C. § 1315(d)(1) and (2). The final regulations were effective April 27, 2012. 42 C.F.R. §§ 431.400-427. The introduction to the proposed regulations outlines the historical lack of public input for demonstration projects. The federal government has made a broad commitment to transparency and meaningful public input for demonstration waivers and these regulations are intended to implement that commitment.

The process AHCCCS utilized did not provide the transparency and meaningful public input intended by 42 U.S.C. § 1315(d) and the federal regulations. Under the federal regulations, transparency and meaningful public input at the state level require three major components. First, there must be public notice of the proposed demonstration waiver with sufficient detail to allow the public to understand the proposed changes and respond. 42 C.F.R. § 431.408(a)(1). Second, the state must allow a sufficient time and appropriate forum for the public to comment on the state's proposal with at least a 30-day comment period. *Id.* Third, the state must review and consider the public comments. 42 C.F.R. § 431.412(c)(2)(vii). Finally, the state should have

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<sup>3</sup> The Institute only discovered in late April 2014 that AHCCCS had submitted the request to CMS because of a response to a public records request.

<sup>4</sup> As noted in footnote three, the Institute only discovered in late April that AHCCCS had submitted the request to CMS because of a response to a public records request. By keeping its submission to CMS a secret, AHCCCS minimizes the chance that advocates will communicate their objections to CMS prior to CMS making a decision on the request.

informed CMS of the comments and AHCCCS' response. None of this happened in this case.

First, AHCCCS' proposal did not provide the required information. The federal regulations require that the public notice "shall include all of the following information." 42 C.F.R. § 431.408(a)(1).

(i) A comprehensive description of the demonstration application or extension to be submitted to CMS that contains a sufficient level of detail to ensure meaningful input from the public, including:

(A) The program description, goals, and objectives to be implemented or extended under the demonstration project, including a description of the current or new beneficiaries who will be impacted by the demonstration.

(B) To the extent applicable, the proposed health care delivery system and the eligibility requirements, benefit coverage and cost sharing (premiums, co-payments, and deductibles) required of individuals that will be impacted by the demonstration, and how such provisions vary from the State's current program features.

(C) An estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the demonstration requested by the State in its extension request.

(D) The hypothesis and evaluation parameters of the demonstration.

(E) The specific waiver and expenditure authorities that the State believes to be necessary to authorize the demonstration.

AHCCCS provided only a cursory overview of the information required by this regulation. Specifically, AHCCCS provided minimal information required by paragraph A and no information required by paragraphs C and D.

Second, AHCCCS submitted the draft section 1115 amendment to CMS the first day of the comment period which shows AHCCCS did not care what the public input was. AHCCCS recognizes that it is not providing for a meaningful public participation and tries to bolster the lack of a public comment period and public meeting by reference to the budget bill and one meeting last summer. Subsequently, the first time the public saw the proposal was the day the demonstration project request was submitted to CMS and posted on the AHCCCS website. No public hearings were held. This is not what is contemplated by the federal regulation as meaningful participation by the public.

Third, critical to ensuring meaningful participation is the requirement that the state actually consider and address the matters raised by the public comments. The regulations emphasize that public participation must be meaningful. If a state does not seek or consider public input, meaningful participation cannot occur. The state also is required to include in its request issues raised by the public during the comment period and how the state considered those comments when developing the demonstration extension application. 42 C.F.R. § 431.412(c)(1)(vii). Since AHCCCS did not seek any public input prior to its submission, it could not consider and address public concerns. By failing to seek and consider public comments, AHCCCS denied the public a transparent process and meaningful public participation before it submitted its proposal to change Arizona's Medicaid program.

Finally, as explained above, AHCCCS made up its mind prior to the comment period and so public input was not meaningful. During the comment period, the Institute submitted detailed objections and comments to the proposed request. After the public comment period closed, AHCCCS failed to post on its website any comments received and failed to prepare a “report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension request.” 42 C.F.R. § 431.412(c)(2)(vii). (AHCCCS website last visited on April 28, 2014). Additionally, AHCCCS failed to supplement its waiver request and report the issues raised by the Institute or explain how AHCCCS considered these comments when submitting and discussing the request.

Therefore, the State totally failed to comply with federal requirements on meaningful public participation and made a sham of this process. For this reason the waiver request should be denied in its totality.

Cynthia Mann  
December 10, 2014  
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**Conclusion**

For all the above reasons, CMS should deny the proposed section 1115 waiver request. If you have any questions concerning this letter, please contact Ellen Katz at (602) 252-3432 or at eskatz@qwestoffice.net.

Sincerely,

/s/ Ellen Sue Katz  
William E. Morris Institute for Justice

/s/ Jane Perkins  
National Health Law Program

ESK