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December 6, 2015

**VIA ELECTRONIC SUBMISSION**

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The Honorable Sylvia Mathews Burwell, Secretary  
U.S. Department of Health & Human Services  
200 Independence Avenue SW  
Washington DC

**RE: Comments on Arizona's New 1115 Demonstration  
Proposal for the Arizona Health Care Cost Containment  
System (AHCCCS)**

Dear Secretary Burwell,

We appreciate the opportunity to comment on Arizona's proposal for a new comprehensive Medicaid 1115 demonstration, including controversial changes for adults with incomes below 138% FPL. Founded in 1969, The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. NHeLP advocates, educates and litigates at the federal and state level.

We fully support Arizona's decision to continue to accept federal funding to cover adults with incomes below 138% FPL. This successful expansion has boosted enrollment by nearly 450,000 since December 2013.<sup>1</sup> In addition to vastly improving access to care for new enrollees, the expansion has substantially reduced hospital uncompensated care costs and increased jobs across the healthcare sector.<sup>2</sup> However, the State's new application proposes burdensome and unnecessary changes that would undermine the objectives of the Medicaid program by reducing access to care and enrollment for low-income adults. We oppose these counterproductive policy changes, including premiums, excessive and unnecessary copays, work requirements, lockouts for nonpayment of premiums, and a five year cumulative time limit on Medicaid eligibility. We also have questions about the legality of a

<sup>1</sup> Ctrs. for Medicare & Medicaid Servs. ("CMS"), *Medicaid & CHIP: September 2015 Monthly Applications, Eligibility Determinations and Enrollment Report*, 7 (Nov. 30, 2015).

<sup>2</sup> State hospitals reported a 38% reduction in uncompensated care after expansion was implemented in January 2014. Ariz. Hosp. & Healthcare Assoc., *Issue Paper: The State Budget and AHCCCS*, 3 (Feb. 2015), <http://www.azhha.org/wp-content/uploads/2015/02/2015-state-budget-issue-paper.pdf>.

number of aspects of the proposed waivers, and more fundamentally, we believe Arizona must explain why additional demonstrations are warranted after already having conducted years of “demonstrations,” often without sufficient (or any) evaluation of the value of those demonstrations. In short, we ask CMS to stop allowing Arizona to use the § 1115 statute as a cloak for deviating from implementing the objectives of the Medicaid program.

### **Public Process: Incomplete Demonstration Proposal**

Before addressing the content of Arizona’s proposal, we would like to discuss serious legal problems with the public stakeholder process of this proposal. HHS should not have accepted this proposal as a complete application for the following reasons:

1. The State has not met the conditions for CMS’s new streamlined “fast track” application process because its proposal includes major new changes *and* the State has not adequately evaluated (or even developed an evaluation plan for) its current demonstration.<sup>3</sup>
2. The proposal does not fulfill the public process requirements listed under 42 C.F.R. § 431.412(a), including that the State explain the demonstration purpose for requested waivers, identify research hypotheses related to the proposed changes, and describe its plans to test those hypotheses;
3. Once again, in this request, the State requests continuing waivers without providing an interim evaluation of their effectiveness or justification for their ongoing demonstration value.
4. The proposal is vague, incomplete and even contradictory to the point where it renders meaningful public comment on many components virtually impossible.

Arizona’s application, characterized by the State as a “new demonstration,” is missing whole components that Medicaid regulations require for any new demonstration application. The State includes no clear discussion of the demonstration purpose for most of the specific requested waivers and no discussion at all of how it plans to test and evaluate its demonstration hypotheses, as required under 42 C.F.R. § 431.412(a)(vii). CMS should be long past the days of approving 1115 demonstrations without robust, well-designed and publicly vetted evaluation plans. Even accepting such a demonstration proposal as “complete” represents a major step backwards for transparency in that it signals to other states they can elide key details during the stakeholder process and sort them out behind closed doors in negotiations with CMS, or even after approval has been obtained. This undermines the whole purpose of the recent 1115 transparency regulations, which sought to bring the demonstration approval

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<sup>3</sup> Vikki Wachino, Ctrs for Medicaid & CHIP Servs., *Informational Bulletin: Implementation of a “Fast Track” Federal Review Process for Section 1115 Medicaid and CHIP Demonstration Extensions*, 1 (July 24, 2015.)

process out of the shadows, allow the public to provide meaningful feedback on concrete, specific proposals, and hold state officials accountable for their decisions.

Arizona has run its entire Medicaid program as an 1115 demonstration since the 1980s. This application seeks to continue many of the previously granted waivers *without any justification, evaluation, or even discussion of the beneficial or harmful effect these waivers have had during previous demonstration periods.*<sup>4</sup> Some of these waivers, like the request to restrict when enrollees can disenroll from a plan with and without cause, should not be renewed prior to a careful evaluation of their impact in the current demonstration and their ongoing demonstration purpose. Arizona’s application includes a narrative section entitled “Building upon Arizona’s Past Successes,” but does not discuss the existing waivers beyond claiming they have “served the state well.”<sup>5</sup> The waiver request chart includes brief explanations for some current waivers, but no justification for others.<sup>6</sup> Ultimately, under the statutory framework designed by Congress, § 1115 demonstration authority is not a proper basis for a State to run normal Medicaid operations in perpetuity. At least one Arizona federal district court judge—Judge Carroll during the *Newton-Nations v. Betlach* case—has already questioned this notion of a perpetual experiment. Arizona’s demonstration must have an end date, at which point it should transition to run through the normal state plan approach. Indeed, that end date probably passed years ago – as Arizona’s managed care delivery model is now the norm. CMS should implement the words of 1115; it should not allow Arizona to perpetuate a non-experimental Medicaid program through the 1115 authority simply

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<sup>4</sup> CMS has alternatively referred to this application as an “amendment” (in its letter accepting Arizona’s application as complete) and as an “extension” (on its public comment input web page). Given the demonstration expires in just 10 months—not nearly enough time to conduct a valid experiment—it should not be considered merely an “amendment.” If it is an “extension,” regulations require the State to include with its application an interim evaluation with current findings and future evaluation plans, which Arizona has not done. 42 C.F.R. § 431.412(c)(2)(vi). If it is a “new” demonstration, then every waiver request should be treated as a *new* waiver request and must be justified with a demonstration purpose and evaluation plan.

<sup>5</sup> *Ariz. Health Care Cost Containment System (“AHCCCS”), Arizona’s Application for a New Section 1115 Demonstration*, at 56 of pdf (Sept. 30, 2015), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa2.pdf>. (Hereinafter “AHCCCS application”).

<sup>6</sup> These justifications do not all comport with 1115 demonstration requirements. For example, the restriction on disenrollment without cause is justified because such disenrollments are “costly and require more administrative resources.” AHCCCS application, at 28 of pdf. This suggests the purpose of this waiver is to reduce the State’s budget at the expense of a beneficiary protection, which courts have maintained is not a valid justification for an 1115 demonstration. As stated by one court, § 1115

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).

because it is convenient or would be “a hassle” to require the state to transition Medicaid into a state plan program as called for by Congress.

In addition to largely ignoring the existing managed care related waivers, Arizona’s proposal for consequential new waivers – such as charging heightened cost sharing and premiums to low-income adults, imposing eligibility lock outs for nonpayment of premiums, and adding work requirements and time limits to Medicaid – are vague and in parts outright contradictory. For example, the narrative description of AHCCCS Care requests a six-month lockout for individuals over 100% FPL who miss payments (with no description of a grace period).<sup>7</sup> An attached AHCCCS powerpoint claims that individuals disenrolled for nonpayment would not be reenrolled until they repay all their outstanding debts.<sup>8</sup> Finally, the chart describing Arizona’s actual waiver requests makes no mention of either waiver request.<sup>9</sup> In other areas, key details, such as how the State would define “actively seeking work” and “able-bodied,” who would be exempt from the NEMT waiver and the 5 year eligibility limit, are brushed aside to be determined *after* CMS approves the waivers.<sup>10</sup> This ambiguity and lack of detail make it virtually impossible to meaningfully comment on the proposal except in the most general terms.

Given all these shortcomings, the approval of any demonstration based on this application raises serious concerns with the Administrative Procedures Act – concerns in addition to potential violations of Medicaid law. Given the unusual and even radical nature of some of these proposals, the missing details reflect, at best, a rushed and ill-considered plan. At worst, the State may have omitted further details because there is no credible evidence or policy rationale available to support the requested waivers. Despite our serious concerns with process, we address below the content of Arizona’s demonstration proposal and the reasons why the State’s Medicaid expansion program should not be approved under the conditions of § 1115 authority.

## Proposal Content

The following details describe components of Arizona’s demonstration proposal that NHeLP believes are illegal and/or bad Medicaid policy likely to undermine, rather than fulfill, the objectives of the Medicaid program. We fully support Arizona’s successful adult Medicaid expansion, but we believe these changes would lead to poorer participation, additional barriers to needed care, and burdensome costs on individuals and families already living paycheck-to-paycheck.

### **1. Time limits have never been allowed and are contrary to the purpose of the Medicaid program.**

HHS should not grant any waiver to allow a time limit on Medicaid eligibility. As a matter of law, the Medicaid Act does not authorize time limits in Medicaid, and numerous

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<sup>7</sup> AHCCCS application, at 40 of pdf.

<sup>8</sup> *Id.*, at 446 of pdf.

<sup>9</sup> *Id.*, at 35-37 of pdf.

<sup>10</sup> *Id.*, at 475, 477, 480 of pdf.

provisions of the Act explicitly prohibit them. Nothing related to the Affordable Care Act or Medicaid expansion changed the law in that regard. The ACA was enacted, in part, to make sure of just the opposite – that people do not lose their health insurance coverage.

The proposed five year cumulative time limit goes far beyond HHS’s demonstration authority. To our knowledge, HHS has never approved a Medicaid program to implement time limits on an eligibility category in the half-century of Medicaid’s existence. The Medicaid Act requires states to provide assistance to all individuals who qualify under federal law.<sup>11</sup> We cannot imagine any way to construe a time limit as a feature that would “promote the objectives of the Medicaid Act” as is required for a § 1115 demonstration. Barring individuals from enrolling (or arbitrarily cutting them off) does not help furnish medical assistance to enrollees. It does the opposite. It also fails to serve any legitimate *demonstration* purpose as the only results of this policy are harmful and predictable: in five years, many enrollees will lose their Medicaid coverage. Notably, the State in its proposal has not even attempted to describe an experimental purpose, let alone a viable one. Nor does the State offer any policy-based evidence to justify imposing any time limit at all, let alone this specific time limit (5 years) and income range (0–138% FPL.) Lacking any insight from Arizona, we are left to guess.

HHS should not consider any proposed demonstration waiving a core Medicaid provision like § 1902(a)(10)(A), the mandatory eligibility categories, or introducing a fundamental change like a time limit. The mandatory eligibility categories are a bedrock requirement for the Medicaid program. Using demonstration authority to waive such an essential feature of the Medicaid provision to establish time limited conditions on eligibility would be wholly contrary to the program’s intended objectives as stated in the statute and its legislative history. Approval of this request would also set a dangerous precedent encouraging states to seek time-limits for other mandatory eligibility groups, such as children, parents and caretakers, or the aged, blind and disabled. In the context of states trying to control Medicaid costs, such a policy could quickly become a cost-control mechanism proposed as a “demonstration,” and as you know, numerous federal courts have found cost-driven policies cloaked as “demonstrations” to be illegal.

Moreover, time limits applied to health coverage are by nature arbitrary and capricious. For many individuals who face serious or chronic health challenges that impede their ability to work, even if they may not technically qualify as disabled or medically frail, Medicaid offers dependable and affordable coverage that supports their ability to generate income (full-time or part time) and may prevent them from otherwise becoming fully destitute.<sup>12</sup> Such individuals are also more likely to have lower incomes over an extended period of time (and thus be impacted by this proposed policy). Conditioning eligibility on an arbitrary cumulative time limit would likely have a disproportionate impact on such individuals and, as a result, may violate the Americans with Disabilities

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<sup>11</sup> 42 U.S.C. § 1396a(a)(10)(A).

<sup>12</sup> Moreover, the State has offered no evidence to merit confidence in the efficacy of its medically frail screening process.

Act and section 504 of the Rehabilitation Act—provisions that the Secretary is not authorized to waive as part of a § 1115 experiment.

Finally, we note that there is no corollary for time-limiting medical coverage in the Marketplace or in commercial health insurance, which both serve a higher income population with fewer health needs. Imposing any time limit would contradict HHS' stated rationale for approving premiums in Medicaid above 100% FPL – comparability with Marketplace policy. Section 1902(a)(10)(A) should not be waived for this purpose, and HHS should set no precedent for time limits in Medicaid.

## **2. Unlawful premiums and cost sharing for Medicaid-eligible adults should not be granted**

Arizona's proposal seeks to impose excessive cost sharing and premiums on low-income adults that run contrary to the objectives of the Medicaid Act. These proposals include:

- Premiums equivalent to 2% of household income (up to \$25/month) for enrollees below 138% FPL;
- An annual, rather than monthly or quarterly, 5% aggregate cap on household out-of-pocket expenses (which is not included in the waiver requests);<sup>13</sup>
- ED copays that would far exceed Medicaid limits for the vast number of enrollees, and that improperly define “nonemergency use;” and
- An unspecified copay for missed appointments that does not align with Medicaid cost sharing law and has previously proven unworkable in the state.

These requests are not legally approvable for numerous reasons. Specifically, the proposal violates three core requirements for § 1115 demonstrations. First, § 1115 explicitly circumscribes waiver authority in Title XIX to requirements contained in § 1902 of the Social Security Act.<sup>14</sup> Anything outside of § 1902 is not waivable through the § 1115 demonstration process. Arizona attempts to impose premiums and cost-sharing by requesting waiver of § 1902(a)(14). However, §§ 1916 and 1916A prohibit any premiums under 150% of the Federal Poverty Level (FPL) and set clear limits on cost-sharing.<sup>15</sup> These are substantive requirements that rest outside of § 1902 and independently require state compliance. Any reference to the (a)(14) provision in § 1902, which could be waived, does not and cannot also waive the independent, freestanding requirements of §§ 1916 and 1916A.

Second, a § 1115 demonstration is precisely that, a *demonstration*. Arizona's request for § 1115 authority regarding premiums is not approvable because it will not test anything novel. Premiums and heightened cost-sharing for low-income enrollees have

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<sup>13</sup> AHCCCS application, at 40, 445 of pdf.

<sup>14</sup> 42 U.S.C. § 1315(a)(1).

<sup>15</sup> See SSA §§ 1916(c), 1916A(b)(1)(A). There are very limited exceptions to this rule, for certain populations, that are not broadly applicable to the Medicaid expansion population. See, e.g., § 1916(d).

already been tested repeatedly and consistently shown to depress enrollment and access to needed care – including for the very population of adults that is the focus of the State’s proposal.<sup>16</sup>

Third, § 1115 demonstrations must be “likely to assist in promoting the objectives” of the Medicaid Act.<sup>17</sup> The objective of Medicaid is to *furnish* health care to low-income individuals.<sup>18</sup> Arizona describes the purpose of its premium and cost sharing waivers to help Medicaid enrollees “more strategically direct care to the right settings and offer tools to support AHCCCS members’ ability to manage their own health.”<sup>19</sup> However, this ignores the fact that Medicaid’s legal cost-sharing system *already* provides generous flexibility for states to create strong incentives for enrollees to avoid unnecessary care. Yet Arizona seeks to bypass these options to implement policies that research has already established to be harmful to low-income people – policies that will clearly result in interrupted care, lost opportunities, and churning. The proposed premiums and cost sharing waivers in Arizona’s proposal cannot be approved because they would *reduce* access to care, especially for individuals at the lowest income levels.<sup>20</sup>

The cost-sharing specific waivers raise additional legal concerns. Although the waiver list chart appears to request a waiver of § 1916(f), the Secretary has no legal authority to waive Medicaid cost sharing requirements unless the State meets each condition of that provision, which Arizona’s proposal fails to detail and which would create significant additional requirements for the State.<sup>21</sup> The annual 5% aggregate cap and the proposal for \$25 ED copays would clearly trigger the requirements of § 1916(f) if implemented as written. The proposal also offers a muddled picture of who would be subject to its “strategic copays” and appears to violate the required exemptions from cost sharing listed in federal regulations, which would require an additional 1916(f) test.<sup>22</sup>

The ED copay proposal would effectively impose a \$25 copay for virtually *all* Medicaid expansion adults for virtually *all* visits to the ED. That amounts to an over 300% increase in the maximum allowable Medicaid limit. The proposal applies a \$25 copay for any visit to an ED within 20 miles of an urgent care clinic, community health center, or rural health center (regardless of actual availability of said clinic). Nearly every hospital ED in the state fits that description, meaning that under this proposal nearly every ED visit would require a \$25 copay. The state statute would also apply an inappropriate and overly

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<sup>16</sup> David Machledt and Jane Perkins, *Medicaid Cost-Sharing and Premiums* (March 2014), <http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing#.UzneLoX3IX5>.

<sup>17</sup> 42 U.S.C. § 1315(a).

<sup>18</sup> See 42 U.S.C. § 1396.

<sup>19</sup> AHCCCS application at 40 of pdf.

<sup>20</sup> For example, in 2003, Oregon experimented with charging sliding scale premiums (\$6-\$20) and higher copays on some groups in an already existing § 1115 demonstration for families and childless adults below poverty. Nearly *half* the affected demonstration enrollees dropped out within the first nine months after the changes. Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 Health Affairs 1106, 1110 (2005).

<sup>21</sup> 42 USC 1396o(f). See AHCCCS application, at 35 of pdf.

<sup>22</sup> 42 C.F.R. § 447.56(a).

restrictive definition of nonemergency use of the ED, imposing the copay on anyone who is not directly admitted to the hospital. Only one in 9 ED visits results in a hospital admission.<sup>23</sup> The State therefore intends to penalize enrollees under a standard of “nonemergency ED use” that does not comport with Medicaid’s definition of “emergency services,” and which implies that over 88% of ED visits are inappropriate. This definition of emergency use clearly violates the prudent layperson standard for emergency visits as required under Medicaid law, because an individual would have no way of knowing ahead of time whether he would be admitted.<sup>24</sup>

Such harsh and ill-conceived policies would not selectively reduce inappropriate use of the ED, but rather would erect a substantial barrier to *appropriate* use of the ED, which Medicaid law expressly forbids. Imposing an excessive copay without the required beneficiary protections would certainly not further the objectives of the Medicaid Act and so should never be approved under a § 1115 demonstration, especially in absence of an explicit plan to comply with the stricter requirements of § 1916(f). Moreover, a growing body of literature suggests that nonemergency ED copays, when implemented, have not effectively reduced ED utilization in Medicaid.<sup>25</sup> And AHCCCS’s own 2013 report to the state legislature found only 6% of Medicaid ED visits were classified as non-emergent, concluding that “members have a relatively low rate of non-emergency ED utilization particularly when compared to national averages.”<sup>26</sup> In short, this appears to be a poorly designed solution to a nonexistent problem.

We also suggest that any CMS approval of Arizona’s demonstration should include clear assurances that the State will comply with all the statutory and regulatory provisions of §§ 1916, 1916A, and 42 CFR §447.51-57, including the 5% monthly or quarterly aggregate cap on household out-of-pocket expenses and the required exemptions for certain groups and services. To our knowledge, HHS has *never* approved a waiver of the aggregate out-of-pocket limit, though a number of states have proposed annual rather than quarterly limits only to remove them at later stages prior to approval. The quarterly cap, when properly applied, is an important Medicaid protection, particularly because health expenses typically cluster into a single month or quarter.<sup>27</sup> It is difficult to imagine any circumstance under which exposing very limited income Medicaid enrollees to a substantially higher financial risk, or to cost sharing that from which they should be exempt, could be construed as promoting the objectives program.

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<sup>23</sup> Ctrs. for Disease Control & Prevention, *Emergency Department Visits*, <http://www.cdc.gov/nchs/fastats/emergency-department.htm> (last visited Dec. 1, 2015.)

<sup>24</sup> 42 C.F.R. §§ 438.114, 447.54.

<sup>25</sup> Karoline Mortenson, *Copayments Did Not Reduce Medicaid Enrollees’ Nonemergency Use of Emergency Departments*, 29 HEALTH AFFAIRS 1643 (2010); David J. Becker et al., *Co-payments and the Use of Emergency Department Services in the Children’s Health Insurance Program*, 70 MED. CARE RES. REV. 514 (2013).

<sup>26</sup> Ariz. State Senate Fact Sheet for S.B. 1298, 1 (51st Legislature, 2014 2nd regular session), available at <http://www.azleg.gov/legtext/51leg/2r/summary/s.1298hhs.pdf>.

<sup>27</sup> Thomas M. Selden et al., *Cost Sharing in Medicaid and CHIP: How Does It Affect Out-of-Pocket Spending?* 28 HEALTH AFFAIRS w607–w619 (2009).

Finally, while we are aware that Arizona has previously received CMS approval for imposing a missed appointment copayment, the State ran into significant logistical problems and never actually implemented those copays. We believe that such a copay falls outside the scope of what the Medicaid statute permits, as it does not relate directly to a reimbursable service actually rendered. CMS considers missed appointments part of a providers' normal cost of doing business, though it acknowledges that an MCO could arrange to directly reimburse its providers for missed appointments.<sup>28</sup> In this proposal, Arizona has provided no evidence of what it would do differently to successfully implement this waiver or how it would evaluate the experiment according to the requirements of 1916(f). The State offers no guardrails around when the charge could be levied, or what would qualify as a reasonable excuse. Nor has it established that missed appointments are even a problem for the Medicaid program. With so little to go on, we find no reason for CMS to authorize copayments for missed appointments at this time.

### **3. Termination and Lockouts for failure to pay premiums or report income changes do not promote the objectives of Medicaid**

Since monthly premiums are not permitted for this population below 150% FPL, *termination* for non-payment of contributions should also never be approved for anyone in this group. Premiums for those living on incomes below 100% FPL are especially concerning, since they contradict the structure of the ACA and numerous Medicaid cost-sharing protections set at 100% FPL. We note that, under the law, premiums are equally impermissible for individuals below 150% FPL whether they are enforceable or not.

Arizona's proposal to disenroll and lock out individuals between 100-138% FPL who fail to pay their premiums is especially inconsistent and unclear. No waiver request specifically addresses a lockout, yet the narrative description clearly requests a 6-month lockout, and at the same time a later powerpoint suggests a requirement that individuals fully repay their outstanding debt prior to reenrollment. The proposal does not suggest what the State would use as a grace period prior to disenrollment, nor does it specify a time limit after which enrollees could reenroll even if they were unable to repay their debts. Without knowing precisely what the State is proposing, we are left to point out simply that there is no plausible argument that delaying enrollment into Medicaid for numerous months helps furnish medical assistance. Furthermore, § 1115 demonstrations must actually *demonstrate* something, and Arizona provides no hypothesis about what this lockout provision might test, nor is any such viable hypothesis imaginable. Arizona's waiver request fails to satisfy multiple legal requirements of § 1115 authority and this waiver should not be approved.

In addition, a lockout would be a bad policy for Arizona Medicaid enrollees. This provision would unnecessarily increase the number of uninsured Arizonans by preventing low-income individuals from re-enrolling in Medicaid. We note that many

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<sup>28</sup> CMS and the Oral Health Technical Advisory Group, *Policy Issues in the Delivery of Dental Services to Medicaid Children and Their Families*, 10 (Sept. 22, 2008), <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/policy-issues-in-the-delivery-of-dental-services.pdf>.

consumers will attempt to re-enroll precisely at critical moments when they need medical care and delays could dramatically worsen health outcomes. Such a policy not only harms consumers, but also costs the entire state health care system as it absorbs the costs of paying for uncompensated care.

The State's application also includes a waiver request to allow the State to ban individuals for one year for failing to report a change of income in a timely fashion.<sup>29</sup> This 12-month ban would also apply to individuals who knowingly reported false statements regarding work requirement activities. To do so, the State requests a waiver of § 1902(a)(10)(A), which describes Medicaid's core mandatory eligibility categories. While the State has not specified a corresponding waiver request for the premium lockout in its application, we believe that HHS should generally not approve requests for waivers of § 1902(a)(10)(A) or § 1902(a)(8), the reasonable promptness protection. Allowing states flexibility not to enroll individuals who are known to be eligible threatens the most basic guarantee of Medicaid. As states face budgetary pressure over the coming decades they will invoke this flexibility as a budgetary control tool and it has the potential to eviscerate the Medicaid entitlement. HHS should not approve this or any other similar waivers of § 1902(a)(8) or § 1902(a)(10)(A).<sup>30</sup>

#### **4. Work Incentives should be independent of Medicaid**

We appreciate that Arizona is concerned about the employment opportunities available to low income individuals. Most of our low income clients are employed, but those who are not employed repeatedly report difficulties finding employment despite their exhaustive efforts. We therefore fully support States' efforts to create *independent* (from Medicaid) and *voluntary* employment supports for lower income individuals, as accessible employment supports are services that our clients, particularly those with disabilities, have sought and been denied for decades. However, Arizona's demonstration application mentions workforce development in the context of Medicaid, and we are concerned that the State, despite its claim to the contrary, is proposing to condition aspects of Medicaid beneficiaries' eligibility on participation in some kind of work or work search activities.

The State would condition enrollees' access to their health expense accounts on the monthly completion of work search requirements. These accounts are funded with enrollee premium contributions to pay for health services not covered by AHCCCS. As noted above, the proposal does not clearly define what constitutes a "work search activity" nor describe who exactly constitutes "the able-bodied." Thus the vagueness of the policy may mask the real harm it will create. More importantly, there is no evidence describing the scope of the perceived problem, which appears to be based on the false assumption that Medicaid beneficiaries are mostly unemployed and happy to stay that

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<sup>29</sup> AHCCCS Application, at 36 of pdf.

<sup>30</sup> This is especially true in this case, where the State leaves out critical details, such as how big a change of income would trigger a required report, how long the grace period would be or what the notification process would look like. Once again, the State fails to identify a pressing need or a demonstration purpose for this waiver request.

way. In other words, this proposal does not establish a demonstration purpose for the work requirement policy because it does not clearly articulate any problem to solve.

Despite the State's claims to the contrary, this work search "incentive" would amount to an illegal condition on eligibility in excess of the Medicaid eligibility criteria clearly enumerated in Federal law.<sup>31</sup> Medicaid is a medical assistance program, period. Although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide assistance to all individuals who qualify under federal law, and courts have held additional eligibility requirements to be illegal.<sup>32</sup> Section 1115 cannot be used to short circuit these Medicaid protections. Under the law, HHS cannot allow Arizona to implement any kind of work search requirement that is in any way related to Medicaid. This means that HHS cannot approve a waiver allowing a work search requirement *and* that HHS cannot allow Arizona to independently (*i.e.*, without a waiver) implement a work search requirement by altering Medicaid status based on participation, otherwise targeting Medicaid enrollees for state benefits or penalties contingent on participation, or even creating the appearance of Medicaid impacts based on participation.<sup>33</sup>

From a practical standpoint, work requirements applied to health coverage get it exactly backwards. An individual needs to be healthy to work, but a work requirement can prevent an individual from getting the health care they need to be able to work. We note finally that in almost any system in which eligibility is conditioned on or attached to work search, there are likely to be serious violations of nondiscrimination laws, as persons with disabilities may end up with fewer benefits or higher costs due to their condition or the lack of adequate systemic supports to foster their employment. We have similar concerns about Arizona's proposal to link enrollee health account access to achieving wellness goals, such as a flu shot or successful management of a chronic condition.

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<sup>31</sup> See generally 42 U.S.C. § 1396a.

<sup>32</sup> *Id.* §§ 1902(a)(10)(A), (B); *Camacho v. Texas Workforce Comm'n*, 408 F.3d 229, 235 (5th Cir. 2005), *aff'g*, 326 F. Supp. 2d 803 (W.D. Tex. 2004) (finding that Texas could not "add additional requirements for Medicaid eligibility"). See generally *Carleson v. Remillard*, 406 U.S. 598 (1972) (invalidating state law that denied AFDC benefits to children whose fathers were serving in the military where no such bar existed in federal law governing eligibility).

<sup>33</sup> The fact that the State requests a waiver to deny eligibility for one year for any beneficiary who knowingly provides incorrect information in reports of her work search activities demonstrates how easily these "incentives" can be directly linked to eligibility. See AHCCCS application, at 36 of pdf.

## 5. Nonemergency Medical Transportation (NEMT) is a critical service that should not be waived

Arizona requests a waiver of critical NEMT service that helps enrollees with limited resources and transportation options to get to the care they need. NEMT has been shown to be a cost-effective service that can help reduce hospitalizations and ED visits due to delayed care and poor chronic disease management for low-income individuals.<sup>34</sup> Yet again, the State provides no demonstration purpose for waiving this key service nor evidence to suggest cutting it would not harm enrollees. On the contrary, a recent surge in complaints led the State to fine one of its health plans for inadequate coverage of NEMT, which only highlights the access barriers transportation can pose for Arizona enrollees. We are left to assume that the primary reason to waive NEMT is to reduce the budget, which courts have found is not a valid justification for waivers under § 1115 demonstration authority.<sup>35</sup> Finally, while the State suggests in the proposal that it would include exemptions to certain individuals in the 100-138% FPL group, such harm mitigation exemptions would not cure the underlying illegality of the waiver request.

## 6. Harm mitigation

As you know, we have included harm mitigation suggestions in our comments regarding other states' Medicaid expansion waivers. However, we are not doing so here. We do not believe that HHS has the authority to approve the waivers discussed above. We do not believe that Arizona's track record with monitoring and reporting on previous awards of demonstration authority (e.g., its failure to report adequately – or in some instances at all – on the results of its “experiment” to impose heightened and mandatory copayments) justifies an award that would allow the state to implement the types of restrictions it is now seeking to impose on low-income Arizonans.

## 7. DSRIP

Arizona's proposal for a DSRIP comprises two pages of impossibly vague quality platitudes, such as “network accountability.” It hints at general areas of focus and provides a list of general pay for performance approaches, but leaves all details to be worked out later and informed by the State Health System Innovation Plan design process. In December 2014, Arizona received a \$2.5 million grant to develop this plan to set goals and priorities for delivery system reform.<sup>36</sup> That final plan will not be complete before March 2016.<sup>37</sup> This DSRIP proposal is clearly not ripe for review. CMS

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<sup>34</sup> P. Hughes-Cromwick et al., ALTAREM INST., *Cost Benefit Analysis of Providing Non-Emergency Medical Transportation* (2005), <http://www.trb.org/Main/Blurbs/156625.aspx>; Richard Wallace et al., *Cost-Effectiveness of Access to Nonemergency Medical Transportation*, 1956 TRANSPORTATION RES. RECORD 86 (2006).

<sup>35</sup> *Beno v. Shalala*, *supra* note 6.

<sup>36</sup> AHCCCS, *Contractor Update: SIM Grant Update, March 2015*, 15 (Mar. 18, 2015), [www.azahcccs.gov/commercial/Purchasing/RFPInfo/SIMGrant.pptx](http://www.azahcccs.gov/commercial/Purchasing/RFPInfo/SIMGrant.pptx).

<sup>37</sup> *Id.*

should not approve any DSRIP waiver for the State until the Health System Innovation Plan stakeholder process has completed its work and the State can produce a proposal with enough specific detail to allow for meaningful feedback from the public.

## **Conclusion**

We fully support Arizona's Medicaid expansion as currently implemented, and we see no compelling evidence from the State to justify the proposed changes. We suggest that CMS require the State to thoroughly evaluate its current demonstration, including the cost sharing provisions applied prior to 2014, and apply those lessons learned before even considering any new experiments with premiums and cost-sharing.

The Medicaid expansion provisions in the State's current proposal, ambiguous though they may be, are almost uniformly contrary to the objectives of the Medicaid Act, and we urge CMS to reject them. Other elements, such as the DSRIP program, are potentially positive but are too vague to evaluate. Certainly, prior to approving any new Arizona 1115 demonstration, HHS should require the State to develop and clarify any hypotheses it is testing and design a robust evaluation plan with clear timelines to properly test the hypotheses in accordance with the law.

If you have any questions or need any further information, please contact David Machledt ([machledt@healthlaw.org](mailto:machledt@healthlaw.org); 202-384-1271), Policy Analyst, or Jane Perkins ([perkins@healthlaw.org](mailto:perkins@healthlaw.org)), Legal Director, at the National Health Law Program.

Sincerely,

Jane Perkins,  
Legal Director