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Executive Committee

December 6, 2015

The Honorable Sylvia Mathews Burwell, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Dear Secretary Burwell,

The National Alliance of State and Territorial AIDS Directors (NASTAD) appreciates the opportunity to submit comments on the Arizona proposed Section 1115 Medicaid demonstration, the Arizona Health Care Cost Containment System (AHCCCS) Care program. NASTAD is the organization which represents public health officials who administer state and territorial HIV and hepatitis prevention and care programs nationwide.

Arizona is the first state to request a waiver to alter implementation of its Medicaid expansion after initially expanding through a state plan amendment. Arizona's uninsured rate has dropped from 20.4 to 14.5% since health reform's coverage provisions took effect in 2014,<sup>1</sup> and these gains are due in large part to the state's decision to expand Medicaid. The state estimates that, if approved, as many as 571,000 current adult Medicaid beneficiaries would be impacted by these changes and be subject to its premium and co-pay obligations, work requirement, and five-year lifetime limit on coverage.

As with all 1115 waivers, states must articulate a sound hypothesis tied to a purpose that would promote the objectives of the Medicaid program. Changes to a state's program should not be approved if the waiver would make it harder for the expansion's target population of non-disabled adults to enroll in and maintain coverage, and obtain critical health services. Put another way, *CMS should reject a proposal that would leave Medicaid expansion beneficiaries worse off than they are in the absence of the requested changes.*

- Cost Requirements
- Protecting the Medically Frail
- Work Requirements
- Lifetime Limits on Coverage

### **Premiums and co-pays for adult Medicaid beneficiaries**

We strongly urge CMS to prohibit Arizona from enacting onerous premium and cost sharing requirements for beneficiaries. Numerous studies have demonstrated the

<sup>1</sup> Dan Witters, "In U.S., Uninsured Rates Continue to Drop in Most States," *Gallup*, August 10, 2015, <http://www.gallup.com/poll/184514/uninsured-rates-continue-drop-states.aspx>.

detrimental effect of premiums and cost-sharing requirements on consumer access to care. Individuals with HIV are particularly vulnerable to cost-sharing requirements, as they tend to need more services and require more medications than other populations. Increased cost sharing results in decreased medical adherence and increased use of the medical system. Moreover, discouraging individuals living with HIV from seeking treatment will ultimately result in much higher health care costs in the long-term due to the development of more complicated and costly health problems that could have been prevented by early interventions and consistent access to care. If people living with HIV or hepatitis fall out of coverage due to cost sharing barriers, they will ultimately rely on public hospitals for health care, simply shifting and increasing medical costs.

The proposal is vague about what happens to people who miss their premium payments. For those with incomes above the poverty line, the state is proposing to lock them out of coverage for six months, and it appears this lockout would continue for the full time period – even if the person makes their back payments. Locking individuals living with HIV and other chronic, infectious diseases out of coverage will threaten both individual and public health, and we strongly urge CMS to reject this proposal. Furthermore, Indiana was granted authority to test a similar six-month lockout on beneficiaries above the poverty line so there is no reason to allow another state to test the same structure until information from Indiana is gathered and evaluated.

For people with incomes below the poverty line, unpaid premiums would not result in disenrollment, but would be treated as a debt owed to the state. More information is needed on how beneficiaries both above and below the poverty line would be treated if they miss a premium payment since the state only says that its Department of Revenue will determine "how to best operationalize the program" (page 4 of section 3 of the proposal).

NASTAD is concerned about the lack of clarity included in the proposal about cost sharing. It is also unclear how co-pays would be paired with the premium obligations. The proposal says the state would charge copays "up to three percent of annual household income," and premiums "up to two percent of annual household income" (page 2 of section 3 of the proposal). In his cover letter to the application, Governor Ducey states co-pays will be "strategic" and will be collected if a person visits an emergency room for a non-emergent reason, visits a specialist without getting a referral from a primary care physician, or misses an appointment. Yet the state has also said it intends to charge co-pays "to the maximum extent allowed under federal law" as directed by the legislature," including a \$25 co-pay for non-emergency use of the emergency room that the state seeks under the authority of section 1916(f) of the Social Security Act. A more precise request is needed. Moreover, the state must demonstrate that charging co-payments for particular visits will advance the goals of the Medicaid program. We believe that such a co-payment structure will deter access to medically necessary care and treatment.

### **Protecting the Medically Frail**

NASTAD urges CMS to closely monitor Arizona's implementation of federal protections for "Medically Frail," particularly in light of recent federal clarifications to this standard. The federal definition constitutes the floor of who must be considered to be medically frail (and eligible for the traditional Medicaid benefits package), and CMS must ensure that Arizona's definition adequately protects people living with HIV and other chronic, complex conditions. We support the use of Medicaid Health Home eligibility criteria as a federal floor for the definition of medically frail. At a minimum, anyone living with HIV should

automatically qualify as medically frail. CMS should require detailed information about state processes to identify and educate the medically frail to ensure that all medically frail enrollees are enrolled in the coverage that best meets their medical needs.

### **Work Requirements**

While “ArizonaWorks” does not require employment for enrollment, it does require “all able-bodied adults” to work, be engaged in a job search, or attend school or a job training program. Work requirements have never been part of Medicaid and will only serve to enact additional barriers to coverage for low-income populations, particularly for individuals living with HIV and other chronic conditions who may be less likely to be able to participate in any kind of work incentive program due to illness.

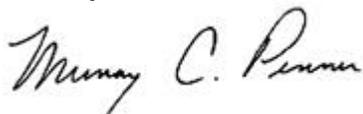
### **Lifetime limit for Medicaid eligibility**

The state proposes to impose a five-year lifetime limit on Medicaid eligibility for “able-bodied” adults. Medicaid is a critical part of health reform’s continuum of coverage, which assures non-elderly adults access to coverage even if their income fluctuates or their job status changes over time. Moreover, many low-income adults eligible under the Medicaid expansion are working, but don’t have access to job-based coverage. This could be especially damaging to people living with long-term, chronic diseases, such as HIV or hepatitis, who could be determined to be “able-bodied,” but also need long term care. A time limit on coverage in Medicaid has never been allowed, and Arizona’s proposal to terminate coverage after five years should be rejected.

In addition, NASTAD is concerned that section 1115 waivers are being used to erode benefits in expansion states. In order to waive federal Medicaid law, the proposed demonstrations set forth in a section 1115 waiver must be consistent with Medicaid objectives, in particular, to extend coverage to low-income and vulnerable populations. Unfortunately, some demonstration proposals seek to change Medicaid guidelines in ways that reduce coverage or restrict eligibility. Specifically, imposing substantial conditions on eligibility like work requirements and higher premiums and co-pays that are not characteristically applied to a low-income population. These type of conditions will shrink the scope of Medicaid expansion under the Affordable Care Act. Furthermore, section 1115 demonstrations are supposed to test innovations that are followed by research and study, but in many states 1115 waivers are seen as a political neutral alternative pathway to federal Medicaid funding. While we understand that section 1115 waivers have enabled states to grow and expand the scope their Medicaid programs, it is essential that HHS do robust evaluation to ensure that the policy outcomes of the waivers are increasing access and assuring quality while not eroding benefits.

NASTAD sincerely appreciates the opportunity to provide comments on the proposed 340B guidance. Should you have any questions, please do not hesitate to contact me.

Sincerely,



Murray C. Penner  
Executive Director