

William E. Morris Institute for Justice

3707 North Seventh Street, Suite 220, Phoenix, AZ 85014-5095

Phone 602-252-3432

Fax 602-257-8138

December 4, 2015

Sylvia Mathews Burwell
Secretary
Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

E-mailed to: eliot.fishman@cms.hhs.gov
Submitted online at Medicaid.gov

Re: Comments to Arizona's Medicaid
Section 1315 Demonstration Waiver
Request

Dear Secretary Burwell:

The William E. Morris Institute for Justice (“Institute”), the Arizona Center for Law in the Public Interest (“Center”) and the Arizona Center for Disability Law (“ACDL”) submit these comments to the Arizona Health Care Cost Containment System (“AHCCCS”) demonstration waiver request submitted September 30, 2015 and updated November 6, 2015 for the 5 year period beginning on October 1, 2016.¹ The Institute is a non-profit program that advocates on behalf of low-income Arizonans. As part of our work, we focus on public benefit programs, such as Medicaid. The Center is a public interest law firm that has a major focus on access to health care issues. The ACDL is the protection and advocacy program in Arizona and works on issues concerning access to health care for persons with disabilities.

On October 14, 2015, the Centers for Medicare and Medicaid Services (“CMS”), Division of Medical Expansion Demonstrations found Arizona’s application “complete.”

¹ We submitted detailed comments to the AHCCCS draft waiver proposal on September 9, 2015, which are part of the administrative record.

We were surprised by this finding because of the lack of detail in many areas of the proposal and the total failure to satisfy the requirements in 42 U.S.C. § 1315 that each waiver request further the objectives of the Medicaid Act, have an experimental component and test out hypotheses on medical care delivery.

The Institute, Center and ACDL strongly support Arizona's decision to restore Medicaid services to the Proposition 204 adults and to expand Medicaid to all persons with incomes up to 138% of the federal poverty level, with income disregard of 5%. Arizona's restoration and expansion have been highly successful. Over 300,000 persons have been added to the program. Approximately 1.833 million persons are on AHCCCS as of November 2015. www.AHCCCS_Population_by_Category.pdf. Uncompensated care for hospitals has been substantially reduced.² In addition, thousands of health care jobs were created.

Unfortunately the demonstration waiver proposal contains requests that, if approved, will undo much of the health care gains of the last 2 years. The requests will depress participation, create financial instability, create high barriers to care and fundamentally change the nature of the Medicaid program in Arizona, and impede, rather than promote, the objectives of the Medicaid Act.

For the reasons stated below, the Institute, Center and ACDL request that CMS not approve Arizona's waiver requests.

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

A. Waiver Requests Must Show that they Promote the Objectives of the Medicaid Act, Test Experimental Goals and Are Proposed to Save Money

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

² A June 2014 survey of 75% of the state's hospitals by the Arizona Hospital and Healthcare Association found that uncompensated care had dropped significantly as a result of the Medicaid expansion and restoration to \$170 million through the first four months of 2014. During the same period in 2013, uncompensated care was reported to be at \$246 million. *See Arizona Hospitals and Healthcare Association, April 2014 Hospital Financial Results; see also Ken Alltucker, Unpaid Hospital bills drop after Medicaid expansion, THE ARIZONA REPUBLIC, July 13, 2014, <http://azcentral.com/story/money/business/2014/07/13/arizona-medicaid-reduce-unpaid-hospital-bills/12591331>.*

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 1315”).³ 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.*⁴ This proposed waiver, even in its current skeletal form, clearly includes policies that would impede rather than promote the objectives of the Medicaid program by creating unnecessary barriers to enrollment and access to care.

³ Throughout this letter, the undersigned will refer to the demonstration waiver as “section 1315” not “section 1115” as § 1315 is the statutory cite. 42 U.S.C. § 1315.

⁴ Cost sharing waivers should not be permitted through section 1315 because they are not located in 42 U.S.C. § 1396a and section 1315 demonstrations can only waive provisions in § 1396a. Moreover, a waiver of cost sharing is not permissible under any authority unless it specifically complies with the requirements established in 42 U.S.C. § 1396o(f).

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.

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 waiver 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 demonstration project on those the Medicaid Act was enacted to protect. *Newton-Nations v. Betlach*, 660 F.3d 370, 380 (9th Cir. 2011) (relying upon *Beno*).

Arizona’s waiver request must meet these requirements. The State’s proposal fails to establish any demonstration value and instead seems oriented around proposals that would ultimately limit enrollment through premiums and unprecedented cumulative time limits, while substantially raising beneficiary costs to access needed medical care. Premiums in Medicaid and the Children’s Health Insurance Program have proven time and time again to be barriers to Medicaid enrollment. *See, e.g.*, Laura Snyder & Robin Rudowitz, Premiums and Cost-Sharing in Medicaid: A Review of Research Findings (Kaiser Family Foundation) (2013). <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417.pdf>.; Jill Boylston Herndon et al., *The Effect of Premium Changes on SCHIP Enrollment Duration*, 43 Health Services Research 458-77 (2008). Research has shown that higher copayments lead low-income persons to cut back on essential health care due to the cost. Significantly, the proposal cites to no hypotheses to be tested. Finally, the proposal fails to even claim that any of the waiver requests would further the

objectives of the Medicaid Act. Thus, as explained below, the waiver request does not satisfy the § 1315 requirements.

B. State Requests for Waivers Must Have a Transparent and Meaningful Public Notice and Comment Process

In the Patient Protection and Affordable Care Act (“PPACA” or “Affordable Care Act”), Congress recognized the importance of meaningful public participation in the design of section 1315 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 demonstration 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.

Under the regulations, transparency and meaningful public input at the state level require three major components. First, there must be public notice including public hearings, 42 C.F.R. § 431.400(a)(8)(i). Public notice is defined as a notice that contains sufficient detail to notify the public of a proposed action and must be consistent with Section 408 of the regulation. 42 C.F.R. § 431.404. The state agency must provide sufficient detail to allow the public to understand the proposed demonstration 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 and include a summary of the response to the comments when it submits its proposal to CMS. 42 C.F.R. § 431.412(c)(2)(vii).

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.

As explained below, AHCCCS failed to comply with the regulations.

II. The AHCCCS Process Did Not Provide for the Transparent and Meaningful Public Input Required by Federal Law Because AHCCCS Failed to Provide the Public with a Precise and Comprehensive Waiver Proposal

On August 3, 2015, AHCCCS posted on its website a general outline of "Arizona's Section 1115 Waiver Process" concerning "Governor Ducey's Plan to Modernize Arizona's Medicaid Program." Initially, AHCCCS posted on its website a 2 page overview of the changes Arizona sought to make to the Medicaid Program. Also attached was a list of "public forums" AHCCCS had scheduled for August and a very short video by the Governor. On August 17, 2015, AHCCCS posted on its website the CMS "Section 1115 Demonstration Program Template." On August 18, 2015, AHCCCS posted "Arizona's Application for a New Section 1115 Demonstration." AHCCCS also posted a PowerPoint presentation entitled "Modernizing Arizona Medicaid." Although

repackaged, the State's waiver request was hard to follow and understand. There was no self-contained document where the public could find for each request; what is the current federal requirement: what does AHCCCS propose to change; who will be affected by the change; the reasons for the proposed change; what hypotheses will be tested by the change; the plan to test the hypotheses; how the proposed change furthers the objectives of the Medicaid Act, and other information required to be made public. Nor was any required evaluation design submitted. *See* 42 C.F.R. § 431.408(a)(1)(i)D. There were inconsistencies within the documents and vague statements. The application read as a policy statement for the State and not as an application intended to comply with the requirements of 42 U.S.C. § 1315(d). The failure to provide the federally required information should have been fatal to the proposal.

All these inadequacies were explained in detail in our comments to AHCCCS dated September 9, 2015. Despite these significant deficiencies, the AHCCCS final proposal changed little and the above inadequacies remain in the waiver request submitted to CMS. CMS should not have overlooked these deficiencies. The waiver requests amount to an effort to make major revisions to the state Medicaid program. Several of the waiver requests may impact over 570,000 persons. Template, page 3.

AHCCCS' application to CMS contains a cover letter from Governor Ducey and the CMS Demonstration Program template with several questions unanswered or with only a reference to the "Modernizing Arizona Medicaid" Narrative. Several pages of the template are not numbered. In addition, the application has an incomplete and vague list of waivers. The template, narrative and incomplete waiver list are the documents the undersigned will refer to in these comments.

III. The AHCCCS Proposal Contains Requests that Create Barriers to Health Care, Will Impede, Not Further, the Objectives of the Medicaid Act and Serve No Experimental Purpose

AHCCCS seeks substantive waiver components that will create barriers to enrollment and access to care and, thus, do not further the objectives of the Medicaid Act. These waiver requests do not serve any valid experimental purpose and no experiment is proposed. Moreover, these requests represent bad policy for low-income Arizonans who need coverage. They are likely to increase administration complexity, reduce access to care, increase the number of uninsured and lead to worse health outcomes. In addition, some of these proposals undermine core elements of the Medicaid program and have never been approved by CMS. At least one waiver request Arizona proposed before and withdrew from consideration. In addition, AHCCCS appears to propose waiver requests

similar to those made by other states that CMS denied. In each of these matters, CMS should deny the waiver request.

A. Lifetime Limit on Enrollment

AHCCCS proposes a 5 year lifetime limit on enrollment for “able-bodied” persons. Waiver list, page 9; verbatim recitation of Senate Bill 1092, Narrative, page 7. The Institute is not aware of any state that has proposed a lifetime limit on enrollment. The only reason to suggest a lifetime limit is to save money, which is not a valid reason for a Section 1315 waiver. *See Beno*, 30 F.3d at 1069. Also, such a limit only creates a barrier to access to care and does not promote the objectives of the Medicaid Act.

Time limits have never been allowed in the history of the Medicaid program. As a matter of law, the Medicaid Act does not allow time limits in Medicaid, and numerous provisions of the Act explicitly prohibit them. Nothing related to the Affordable Care Act or Medicaid expansion changed the law in that regard.

Time limits also are far beyond CMS’ demonstration authority. This year, the Medicaid program turns 50 years old. To our knowledge, in that entire half-century, CMS has never approved any Medicaid program to implement time limits on an eligibility category. Although states have some flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide assistance to all individuals who qualify under federal law.

More specifically, CMS does not have the authority to use § 1315 to invent new Medicaid law. There is no way to construe time limits as a feature that would “promote the objectives of the Medicaid Act” as is required under the law for § 1315 demonstration. Moreover, 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.

Time limits applied to health coverage are by nature arbitrary and capricious, and in this case would likely lead to individuals with chronic conditions and people with disabilities (who are more likely to have lower incomes over an extended period of time) to be put in a situation where they would be subject to higher premiums and cost sharing. For such individuals, who may not qualify as disabled or medically frail but still face serious or chronic health challenges that impede their ability to work, 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. Conditioning eligibility or raising coverage costs based on an arbitrary cumulative time

limit would most certainly have a disproportionate impact on qualified individuals with a disability, and, as a result, may violate the Americans with Disabilities Act and section 504 of the Rehabilitation Act – provisions which the Secretary is not authorized to waive as part of a § 1315 experiment.

In addition, AHCCCS offers no evidence or support to justify imposing any time limit at all, let alone a specific time limit of 60 months. Finally, this waiver request could never have any evidentiary or experimental basis and should not be approved.

B. Mandatory Work-Related Requirements

AHCCCS proposes the mandatory work-related requirements passed last legislative session. Narrative, page 5; Waiver List, page 9. For this waiver request, AHCCCS simply recites Senate Bill 1092. In general, the mandatory work-related requirements are that “able-bodied” adults work; actively seek work; or attend school or job training program, or both, for at least 20 hours per week; and verify compliance monthly.

For 50 years the Medicaid program has determined eligibility based on income. There is no explanation of what would be tested by the work-related requirements or how the mandatory work-related requirements further the objectives of the Medicaid Act. The proposed requirements obviously do not further the objectives of the Medicaid Act. Rather, they defeat those objectives.

Moreover, the undersigned are aware that other states have proposed mandatory work-related requirements and CMS has denied those requests. One example is Pennsylvania. This type of request does not promote the objectives of the Medicaid Act and it is only proposed to create a barrier to access to care and to make persons ineligible for AHCCCS. For these reasons, CMS should deny this request.

1. Mandatory Monthly Reporting and 12 Month Ban on Participation

Not only are the mandatory work-related requirements contrary to the objectives of the Medicaid Act, but AHCCCS proposes further to impose mandatory monthly reporting requirements for the work-related activities and income on recipients and then ban a person from medical coverage for one year if the person knowingly fails to report an income change or makes a false statement about the work-related requirements. Narrative, page 7, verbatim reference to Senate Bill 1092. There is no explanation of how this request furthers the objectives of the Medicaid Act or has any experimental

value. This is another proposal whose only purpose is to create barriers to health care and restrict participation in the Medicaid program. CMS should reject this compounding of ways to make low-income persons ineligible for health care.

2. Work Incentives

In addition to the mandatory work requirements, the State proposes a vaguely described “AHCCCS works” that it claims complements the work requirements. Narrative, page 5. While the State claims this is a voluntary program and is supposed to connect Medicaid recipients to “work opportunities,” Governor Letter, page 3, in the Narrative, page 5, this is listed as “work incentives” that have specific “requirements.” Whether mandatory or voluntary, there is no reason for this program to be part of the waiver request. If the State wants to assist the unemployed to find work, it should do so away from the Medicaid program. CMS should abstain or refuse to sanction such a program. As with all the other requests, there is no explanation how this request furthers the objectives of the Medicaid Act or has any experimental value.

C. Prohibited Premiums

AHCCCS proposes a premium of 2% of household income or \$25.00, whichever is less on certain persons. Narrative, page 2; Waiver list, page 8 (just refers to premiums with no specifics). The undersigned cannot tell whether the affected group is every adult or only certain adults. This lack of adequate explanation highlights the deficiencies of the proposal.

In 2014, AHCCCS proposed a similar premium on persons with income between 100-138% of the federal poverty level. That request also was required by state legislation. In a letter dated December 15, 2014, CMS acknowledged that AHCCCS had withdrawn the request for premiums. The undersigned doubt if CMS had indicated it was prepared to approve the request, that AHCCCS would have withdrawn it. Finally, as explained below, federal law prohibits premiums for persons under 150% of the federal poverty level. In addition, there is no experimental project proposed and no explanation of how this request is consistent with the objectives of the Medicaid Act.

1. Federal Limits on Premiums in the Affordable Care Act

The federal regulations under the 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.⁵

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 month 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 studies are noted on page 4 of this letter. 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. 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.

The above research was referenced in our comments to AHCCCS about the draft waiver published for public comments. AHCCCS failed to rebut this research or show what would be tested by the imposition of the premiums proposed. Rather, 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 proposal should not be pursued.

⁵ 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>.

2. AHCCCS “CARE” Account

The State proposes an AHCCCS Care program. Narrative, page 2. Those persons required to participate are Proposition 204 adults with income up to 100% of the federal poverty level and expansion adults with incomes from 100-133% of the federal poverty level. Persons exempt are persons with serious mental illness, Native Americans, medically frail (not defined) and caregivers to the elderly or disabled (not defined). In the Narrative, page 2, in one sentence, AHCCCS states participation is optional for TANF parents and then in another sentence, that it is required. Since there are over 256,000 TANF parents (Template, page 3) such confusion cannot be allowed.

Participants must pay premiums (and mandatory cost sharing) into what is called an “AHCCCS CARE” Account. Application, page 2. Copays are up to 3% of annual household income and premiums are up to 2% of annual household income with a monthly payment of 2% of income or \$25, whichever is less. Contributions cannot exceed 5% of annual household income. Narrative, page 2. Moreover, given the way the proposal is written, it appears that AHCCCS expects most recipients to meet the 5% cap and is not treating the 5% cap as a rare event. There are no specifics about how this account will work. There is reference that an AHCCCS “CARE Account” is “like” a Health Savings Account, but there is no information provided to substantiate this statement.

In the Narrative, page 3, the State proposes that those over 100% of the federal poverty level will be disenrolled for 6 months if “AHCCCS CARE Payments” are not made. For persons under 100% of the federal poverty level, the failure to make the AHCCCS Care payments will be “counted as a debt” owed to the state. Narrative, page 4. AHCCCS states it will work with the Arizona Department of Revenue on how best to “operationalize” this aspect of the program.

Although the proposal claims the premium payments “stay with the member,” and can be used for certain “non-covered” services, this is only correct if the person is in “good standing” which is defined as making timely payments, meeting the work requirements and meeting the healthy targets. Narrative, page 3. This vague proposal appears both burdensome and difficult to monitor. AHCCCS was required to tell the public now how this program will work, not at some later date. The mechanics of how low-income persons who do not have credit cards or checking or bank accounts will make these required Care payments are totally missing from the proposal. Finally, there is no experimental project proposed nor any explanation of how this request is consistent with the objectives of the Medicaid Act.

This superficial description of proposed fundamental changes to AHCCCS is alarming and violates the public notice requirements in the federal law. Moreover, such drastic measures are the antithesis of the Medicaid program. CMS should deny this request.

a. Termination/Public Debt for Failure to Make Mandatory Cost Sharing and Premium Payments

Despite the fact that monthly premiums are not allowed for the population below 150% of the federal poverty level and AHCCCS seeks new heightened and mandatory cost-sharing on populations not subject to these types of cost sharing. *See, e.g.*, Sections E and F below. AHCCCS proposes to punish participants if they do not make the cost-sharing and premium payments by disenrolling the participants for 6 months or counting the unpaid payments as a debt owed to the state. Narrative, pages 3-4. This huge waiver request does not even make it on to the waiver list. The State seeks to impose medical care payments on low-income persons who cannot afford the payments and then punish the persons further with sanctions when they cannot afford to make the payments. CMS should deny this punishment request. There is nothing experimental noted and no explanation about how this request does anything other than deny low-income Arizonans much needed medical care.

D. Elimination of Non-Emergency Transportation

AHCCCS proposes to eliminate non-emergency transportation for some to all participants. *See* Narrative, page 3; Waiver List, page 8. Here, as well, the public does not know the parameters of who would be impacted by the proposal because no specifics are provided. Senate Bill 1475 concerning the elimination of non-emergency transportation only applies to persons above 100% of the federal poverty level. Yet, AHCCCS' materials repeatedly state this is a benefit that AHCCCS proposes to eliminate. The proposal is found only in the Narrative Section of the Application in the verbatim recitation of Senate Bill 1475, page 7 and in the Waiver List, page 8 where AHCCCS describes the waiver request as "Eliminations [sic] non-emergency medical transportation as a benefit." The State added to its proposal that it "acknowledges and appreciates the concerns raised around ensuring that members have access to needed medical care" but states it will consider exempting only "certain medically frail populations." This minor concession to the harshness of this proposal is of little reassurance. Narrative, page 8.

A state is required to ensure necessary transportation for recipients to and from providers. 42 C.F.R. § 431.53. This requirement is based on the recognition from past

experience that unless needy persons can actually get to and from providers of services, the entire purpose of the Medicaid program is compromised. The requirement to provide transportation also is provided in state law. A.R.S. § 36-2907(A)(11) and (G).

AHCCCS' proposal will deny non-emergency transportation to persons with no other means to get to their medical appointments. They include the homeless, persons with disabilities, the unemployed because of medical conditions, persons who are in the process of applying for Social Security Disability Benefits, the elderly and persons with debilitating medical conditions such as cancer, heart complications, asthma and arthritis. These persons cannot walk miles to their medical providers' offices under normal conditions and certainly not in the Arizona scorching heat. Many recipients may have no access to public transit, or it is too expensive to use to get a provider, or they are in no condition to use public transit because of their medical conditions. Refusing to provide access to transportation for such individuals will mean some of them simply will not get needed care, which can lead to expensive complications and more expensive care down the road. It also represents bad policy and is contrary to the objectives of the Medicaid Act. As shown by all the examples above, low-income Medicaid recipients who cannot get to their doctors will suffer if this request is granted. But these are just some examples. The untold harm will go beyond these examples.

Finally, the only possible reason to eliminate the transportation service is to save money. A cost savings is not an appropriate basis to seek a waiver or to approve a waiver. *Beno*, 30 F.3d at 1069. There is no experimental project proposed nor any explanation of how this request is consistent with the objectives of the Medicaid Act. CMS should deny this request.

1. AHCCCS Has Not Studied the Non-Emergency Transportation Copayments CMS Previously Allowed AHCCCS to Impose

Although the State has not proposed a valid experiment to be tested and the Institute knows of no valid experiment that could be evaluated by denying non-emergency transportation to participants, AHCCCS previously was allowed to experiment with charging copayments for non-emergency transportation. In a letter dated October 21, 2011, CMS allowed AHCCCS to charge certain participants in Pima and Maricopa Counties a copayment for non-emergency taxi transportation. Those copayments were in effect from approximately mid-2012 until the end of 2013. As part of the waiver authority, AHCCCS was required to study the effects of these copayments on access to healthcare. Although the Institute has an on-going public records request to AHCCCS for all documents concerning its copayment evaluation, none has been produced. AHCCCS has not produced an evaluation design or preliminary documents of

any evaluation of the transportation copayments. There is no evaluation of the transportation copayments on the AHCCCS website.

Despite this failure to evaluate the transportation copayments, AHCCCS proposes to now eliminate non-emergency transportation. Before CMS considers such a proposal, it should require AHCCCS to evaluate the non-emergency transportation copayments previously imposed, prepare a written evaluation of the effects of the copayments on access to health care and publish the evaluation for the public's review. Depending on what the evaluation shows, it may not be appropriate for AHCCCS to consider the drastic measure of eliminating non-emergency transportation. For all the reasons stated above, CMS should deny this request.

E. Mandatory Heightened Copayments for the Non-Emergency Use of the Emergency Room

AHCCCS proposes to charge childless adults up to 100% of the federal poverty level an \$8.00 copayment for the first non-emergency use of the emergency room ("ER"), and a heightened \$25.00 copayment for each subsequent non-emergency use of ER. Waiver List, page 8. Non-emergency is defined as the person is not admitted to the hospital. For childless adults under 100% of the federal poverty level, they also will be charged \$25.00 for each non-emergency use of ER, if there is a community health center, rural health center or urgent care within 20 miles of the hospital. *See* pages 8-9 of the template; page 8 of Waiver List; verbatim recitation of Senate Bill 1475, pages 6-7 of Narrative.

For adults between 100-133% of federal poverty level, a heightened \$25.00 copayment would be imposed for each non-emergency use of the ER if the person is not admitted to the hospital or if there is a community health center, rural health center or urgent care center within 20 miles of the hospital. *See* page 9 of the template.

These requests should be denied for several reasons. 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. Thus, there is no emergency room problem in Arizona that needs to be addressed.

Second, there is no showing that the waiver request meets the requirements of 42 U.S.C. § 1396o(f) (*see* footnote 3.). Significantly, AHCCCS fails to set forth an evaluation design, including the use of control groups and state what hypothesis it would test. Instead, AHCCCS refers to the attachment “Modern Arizona Medicaid” which provides no required information, including any hypothesis to be tested. That is no doubt because 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*, 70 MED. CARE RES. REV. (2013) 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 for all individuals under 150% of the federal poverty level. *See* 42 C.F.R. § 447.54(b).

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. *See* 42 C.F.R. § 447.51, invoking 42 C.F.R. § 438.114. There is no way a person could know beforehand that his or her condition would require hospitalization. Medicaid also requires that individuals be screened, informed that their condition is not emergent, and appropriately referred to a provider with lower (or no) cost sharing *before* any copayment may be assessed. Arizona’s proposal does not appear to meet any of these requirements. Also, the arbitrary distance of another facility from the hospital appears to violate Medicaid statute. Significantly, AHCCCS does not specify that the community health center or urgent care facility actually be available and accessible to the person at the time they visit the ER. The facility might be closed at that time or not accepting walk-ins. Finally, there is no requirement that the facility actually be an appropriate alternative for medical care. By the proposed standard, the overwhelming majority of Arizona Medicaid beneficiaries would be charged \$25 for nearly every visit to the ER, because nearly everyone lives within 20 miles of one of these facilities, and only a very small percentage of ER visits (including emergent visits) actually results in an inpatient admission.

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. AHCCCS' proposal will penalize 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 heightened \$25 copayment 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, 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. For all these reasons, CMS should deny this part of the request.

F. Mandatory Missed Appointment Copayment

AHCCCS proposes to charge the "New Adult Group" between 0-133% of the federal poverty level a missed appointment copayment. This is the charge that would have been imposed if the appointment had been kept. *See* Narrative, page 3. This copayment is not specifically listed in the Waiver List or in the template.

Previously, CMS approved allowing AHCCCS to impose a missed appointment fee but no physicians wanted to charge it and it was never implemented. The State has not cited to any evidence of a problem with missed appointments by Medicaid beneficiaries. The undersigned know of no other state that has imposed a "no-show" fee. Moreover, any such copayment would require AHCCCS to comply with 42 U.S.C. § 1396o(f). *See* footnote 3. No such showing has been made. No information is provided

on the hypothesis to be tested and how the copayment would further the objectives of the Medicaid Act as required by 42 U.S.C. § 1315(d). Nor is there any explanation of an evaluation that meets the requirements of 42 U.S.C. § 1396o(f)(1) with control groups.

A missed appointment fee is contrary to Medicaid policy that: (1) Medicaid sets a reimbursable rate for a service and a missed appointment is part of a provider's overall cost of doing business and is not a distinct reimbursable service; (2) Medicaid regulation 42 C.F.R. § 447.15 provides that as part of participating in the Medicaid program, providers agree to accept as payment in full the amounts paid by the state agency; and (3) a policy allowing missed appointment fees would hinder recipients from seeking needed medical care and would not be in the recipient's best interests. There is no reason to revisit this long-standing policy.

Moreover, this request is fraught with practical problems. What if a patient claims she called and left a voice message that she needed to cancel the appointment? What if a patient uses public transportation and the bus breaks down? What if there is no public or other transportation available? What if the person has debilitating cancer and the taxi does not show up? What about persons with mental impairments? This request coupled with the State's request to eliminate non-emergency transportation are the types of policies that will make it harder for persons to obtain needed care.

Finally, the Institute, Center and ACDL think it is hypocritical and perverse to take away non-emergency transportation and then charge persons when the ride they scrounge up to get to the doctor falls through. For all these reasons, this part of the proposal should be denied.

G. Wellness Targets

While not adequately developed, the proposal refers to wellness targets such as "wellness exams, flu shots, glucose screening, mammograms, tobacco cessation and chronic disease management such as for "diabetes, substance use disorders, asthma." Narrative, page 4. If participants meet their "Healthy Arizona target," they can reduce their required AHCCCS Care Payments or roll over unused funds into the next benefit year. Significantly, participants can only access funds in their account if they meet one healthy target. *See* Narrative, page 3. Although the State claims AHCCCS eligibility is not conditioned upon meeting a healthy target and the "medically frail" (undefined) are exempt, the State intends to impose consequences for failing to comply with the targets. A person can only access their Care account if he or she is in good standing and that includes meeting a target. *See* Narrative, page 3.

Regulations implementing the nondiscrimination provisions of the Health Insurance Portability and Accountability Act (“HIPAA”) make clear that health plans cannot discriminate in eligibility rules, premiums or contributions based on health status. 45 C.F.R. §§ 146.121(b)(1)(i), (c)(1)(i). The regulations provide exceptions for wellness plans designed to promote health or prevent disease that meet specified requirements, 45 C.F.R. §§ 146.121(b)(2)(ii), (c)(3), (f).⁶

The HIPAA regulations make clear that even when it comes to rewarding individuals for wellness behaviors, if the condition for obtaining a reward is based on requiring an individual to satisfy a standard that is related to a health factor, the plan must meet specified requirements, one of which is that “[t]he program must be reasonably designed to promote health or prevent disease.” 45 C.F.R. § 146.121(f)(2)(ii).

In addition, in the waiver request, there is a reference to additional incentives through “corporate and philanthropic” partnerships the State is seeking. There also are references to employers making contributions to AHCCCS Care accounts. The Institute does not understand what is proposed because of the lack of any specificity. AHCCCS should wait until it has a fully developed proposal before it tries to sneak in waivers during negotiations with CMS. AHCCCS has provided inadequate information and we and the public are not able to evaluate this proposal and whether a design (if forthcoming) could satisfy HIPAA. No information is provided on the hypothesis to be tested and how the proposal would further the objectives of the Medicaid Act as required by 42 U.S.C. § 1315(d). Finally, because of the barriers to eligibility, it is unclear how many persons would benefit from the reduction or rollover of Care payments. CMS should deny this request.

H. AHCCCS Must Comply with Medicaid Provisions for Medical Services with No Copayment

The Narrative, page 3, lists certain medical services that will not have copayments. *See also* Template, page 9. This list appears more restrictive than required by federal

⁶ *Cf.* Equal Employment Opportunity Commission informal opinion letter (revised), (Match 6, 2009), stating that although medical inquiries are permitted as part of voluntary wellness programs, “a wellness program is voluntary if employees are neither required to participate nor penalized for non-participation,” and expressing the opinion that a county health risk assessment program is not voluntary if employees are required to participate and denied benefits if they do not. *Available at* www.eeoc.gov/foia/2009/ada_disability_medexam_healthrisk.html.

law. 42 C.F.R. § 447.56(a)(2). Services for which no copayments may be imposed for anyone include emergency services, family planning services, preventative services, pregnancy-related services and provider-preventable services. AHCCCS' current regulation sets this out. R9-22-711(B). AHCCCS should be required to exempt all services that the federal law exempts from copayments. If AHCCCS wants to expand the medical services that have no copayments, then that should be explicit as well. The information provided is inadequate and AHCCCS should be required to follow the federal law on the medical services with no copayments.

I. AHCCCS Must Comply with Medicaid Provisions for Persons Exempt from Copayments

The template and narrative do not affirmatively state that AHCCCS will exempt all persons in 42 C.F.R. § 447.56(a)(1) from all cost sharing. Given the way that AHCCCS has set up the proposal with the template referring to the narrative and the list of waivers vague and incomplete, this information needs to be specified. AHCCCS' current regulation sets this out. R9-22-711(C). AHCCCS should be required to exempt all persons who are exempt from copayments as required by federal law.

IV. AHCCCS Should Not Receive Any Cost Sharing, Premium, Reduction in Services or Other Waivers Until It Completes Its Evaluation of the Heightened and Mandatory Copayments Imposed on Childless Adults

On October 21, 2011, AHCCCS obtained a waiver to impose heightened and mandatory copayments on childless adults with income less than 100% of the federal poverty level. AHCCCS was required to study several hypotheses concerning these copayments and to evaluate how the copayments impacted access to health care. Those copays ended December 2013, yet two years later, AHCCCS has not evaluated those copayments and has not published any findings.

The whole purpose of section 1315 waivers is to test experimental ideas. It is not to save the state money or to erect barriers to health care for low-income Arizonans. Before AHCCCS receives any additional cost-sharing, premium or other waivers of the Medicaid requirements, it should complete its evaluation of the heightened and mandatory copayments it imposed on childless adults and publish its findings so that the public can review the impact of the cost sharing on vulnerable participants. AHCCCS should not be rewarded for its failure to study prior waivers. CMS should not allow AHCCCS to continue to seek waivers and then not comply with the evaluation requirements.

As noted above, Arizona's Medicaid expansion and restoration are working. AHCCCS should complete the evaluations on its current and previous waiver requests before embarking on any new waiver requests.

V. AHCCCS Proposes Yearly, Not Monthly or Quarterly Tracking of the 5% CAP on Medical Expenses and Fails to Disclose this is a Major Deviation from Medicaid Requirements

The federal regulation limits the aggregate of all copayments and premiums to 5% of a household's monthly or quarterly household income. 42 C.F.R. § 447.56(f)(1). 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 quarterly income. In addition, AHCCCS is required to track the incurred premiums and cost sharing through an "effective mechanism that does not rely on beneficiary documentation." 42 C.F.R. § 447.56(f)(2). The shorter time period is important because most medical expenses tend to be clustered in a single month or quarter.⁷

In the proposal, AHCCCS seeks to only aggregate medical expenses yearly, not monthly or quarterly. Here is another example of how inadequate the proposal is. There is no mention of the requested waiver in the waiver list and no explanation in the Narrative that this proposal would deviate from federal law. Unless someone knows that the federal requirement is monthly or quarterly tracking of the cap, they will not know that AHCCCS seeks a waiver of the requirement. This is why it is crucial that **every** demonstration waiver request should have been separately listed so the public understands what AHCCCS is seeking as a waiver.

In addition, such a proposal would have to satisfy all the requirements under 42 U.S.C. §1396o(f). Here as well, no such showing is made. Several other states, including Iowa and Indiana, included annual aggregate caps in early versions of their Medicaid expansion proposals but CMS refused to approve any of these requests.

Moreover, the Institute does not think AHCCCS currently tracks the 5% aggregate cap on medical expenses as required by federal law. Previously, the Institute served

⁷ Thomas M. Selden, et al., *Cost Sharing in Medicaid and CHIP: How Does It Affect Out-of-Pocket Spending?* 28 Health Affairs W607, W614 (2009).

AHCCCS with a public records request that requested the documents showing that AHCCCS tracked the 5% cap. No documents were produced.⁸

Finally, as with all the demonstration waiver requests, there is no explanation what this waiver would test or how it would further the objectives of the Medicaid Act. For all these reasons, this part of the demonstration waiver should not be approved.

VI. Use of a Third Party Vendor to Manage and Track the CARE Accounts

Under the proposal, AHCCCS wants to contract with a third party vendor to manage and track the AHCCCS Care Program accounts. *See* Template, page 14. From the cursory explanation, this program is going to have very high administrative costs. The complexities include monitoring when the adults go on and off AHCCCS, their income changes, their exempt status changes, exclusions for exempt services and the calculation of the 5% aggregate cap figured monthly or quarterly. As explained above, the Institute understands that currently AHCCCS does not track the 5% aggregate cap even quarterly. In addition, there is the huge problem of the largely unbanked population making these payments.

Before there is any request for a third party vendor, AHCCCS must monitor the 5% aggregate cap pursuant to federal law for several years. Then there will be a baseline of information to understand the implementation complexities of any proposed program waivers. Until AHCCCS complies with the federal law, there is no reason for CMS to consider and approve a demonstration waiver request to pass this administrative function on to a third party. CMS should deny this request.

VII. The Proposed Delivery System Reform Incentive Payment (“DSRIP”) Is Fatally Vague

As another part of the waiver request, Arizona proposes delivery system reform in Part III of its Narrative, pages 8-10. The state claims it is:

“positioned to utilize DSRIP to further develop care delivery and payment reform network infrastructure, implement system redesign options identified through the SIM process,

⁸ The Institute also has seen documents that show that CMS is aware that AHCCCS was not tracking the cap. This issue came up when AHCCCS proposed its state plan amendment, SPA 14-014, in the fall of 2014.

establish highly impactful outcome expectations, and strengthen population focused health improvements.

Page 8. There is no specific information provided. Instead there are aspirational statements.

The State claims the program “may allow for quarterly-based supplemental payments to providers. Metrics and methodologies are still under development through a stakeholder process.” Template, Section IV, Question 10, page 13. There is no information provided as to who has been “invited” to participate in the stakeholder process. We think it is critical that the stakeholder process be broad and transparent. Consumer advocates must be invited. As currently proposed, there is no adequate proposal for the public to comment on and be engaged in this process. This part of the proposal should be denied and the State should be required to open up the stakeholder process for broader participation, including consumer advocates and seek public input and comments required by § 1315.

VIII. Home and Community Based Services Assessment and Transition Plan

The undersigned submitted separate comments to Arizona’s proposed Home and Community Based Services Assessment and Transition Plan on September 9, 2015. Those comments are in the administrative record. In those comments we noted that Arizona did not intend to comply with the federal regulations until 2021, its public comment process was flawed and substantively the plan was not in compliance with the regulations. AHCCCS made only minor or limited changes and we incorporate our September 2015 comments into this letter.

IX. Federal Approval of Waivers in Other States

Finally, if any of AHCCCS’ requests are currently being imposed and studied in other states, then the undersigned do not think AHCCCS’ requests satisfy the novel or experimental prong of the waiver statute. In those situations, CMS should wait to see what the results are of the testing in the other states before receiving a similar request from AHCCCS.

X. The AHCCCS Program No Longer Should Continue as a Demonstration Project

AHCCCS was initiated in 1982, over 33 years ago. Whatever reasons may have justified it being a demonstration project, those reasons no longer exist. Managed care is

Sylvia Mathews Burwell
December 4, 2015
Page 24

no longer experimental. Rather, as long as AHCCCS continues as a demonstration project, every 5 years, a whole new proposal is required. This process encourages more waiver requests with the public struggling to understand what is being requested.

As explained above, AHCCCS should be required to state that it accepts all federal requirements, except for a specific limited list of items. For the listed items, AHCCCS should clearly disclose to the public: what is the current federal requirement; what does AHCCCS propose to change; what group will be affected by the change; the reasons for the proposed change; what hypotheses will be tested by the change; the plan to test the hypotheses; how the proposed change furthers the objectives of the Medicaid Act, and other required information.

Conclusion

For all the above reasons, CMS should deny the above waiver requests. All the requests fail to meet the Section 1315 requirements. There is no experimental value and no evaluation or testing proposed. The requests hinder rather than further the objectives of the Medicaid Act. In addition, CMS must require AHCCCS to evaluate and publish the evaluation results for any current and previous cost sharing provisions before CMS considers any new waiver requests from Arizona. Until AHCCCS can meet the waiver requirements in federal law, its waiver requests should be denied.

Thank you for the opportunity to comment on the demonstration waiver. 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, on behalf of
Arizona Center for Disability Law
Arizona Center for Law in the Public Interest
William E. Morris Institute for Justice

ESK