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February 5, 2017

VIA EMAIL:

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: Comments to AHCCCS Section 1115 Waiver Amendment Request (AHCCCS Works Waiver)

Dear Administrator Verma:

The Arizona Center for Disability Law ("ACDL"), Arizona Center for Law in the Public Interest ("Center") and William E. Morris Institute for Justice ("Institute") submit these comments to Arizona's Section 1115 Waiver Amendment request submitted on December 19, 2017. The ACDL is the protection and advocacy program in Arizona and works on issues concerning access to health care for persons with disabilities. The Center is a public interest law firm that has a major focus on access to health care issues. 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.

As explained below, the ACDL, Center and the Institute request that CMS deny the requested demonstration waiver. The ACDL, Center and Institute strongly supported 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. Approximately 1.9 million persons are on AHCCCS as of January 2018. www.azahcccs.gov/Resources/Downloads/PopulationStatistics/2018/Jan/AHCCCS_Popu-lations_by_Category.pdf. Of this number, 313,000 are the Proposition 204 (0-100% of

federal poverty level) and 80,000 are the adult expansion (100-133% of the federal poverty level). Uncompensated care for hospitals has been substantially reduced.[1] In addition, thousands of health care jobs were created.

On September 30, 2016, the U. S. Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS") approved the Arizona Health Care Cost Containment System's ("AHCCCS") request to extend Arizona's Section 1115 Demonstration Waiver program for five years. The CMS approval is attached as Exhibit A to these comments. The CMS approval specifically denied the following requests:

> … monthly contributions for beneficiaries in the new adult group with incomes up to and including 100 percent of FPL; exclusion from coverage for a period of six months for nonpayment of monthly premium contributions; **a work requirement;** fees for missed appointments; **additional verification requirements; and a time limit on coverag**e. …. (emphasis added).

The reasons for denying these requests were:

> Consistent with Medicaid law, CMS reviews section 1115 demonstration applications to determine whether they further the objectives of the program, such as by strengthening coverage or health outcomes … or increasing access to providers. … CMS is unable to approve the following requests, which could undermine access to care and do not support the objectives of the program. …

Now, only 15 months later, AHCCCS has submitted the same or similar proposals initially denied by CMS in September 2016. The demonstration waiver request if

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[1] 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.

approved, will undo much of the health care gains of the last 5 years. The requests will depress participation, create financial instability, establish high barriers to care and fundamentally change the nature of the Medicaid program in Arizona.

The requested waiver is to allow the following:

1. Require all able-bodied adults (defined as physically and mentally capable of work and not medically frail, who are at least 19 years old who fall within the "Group VIII" population with incomes up to 138% of the federal poverty level and do not fall within another Medicaid category), to verify that they are employed, actively seeking employment as defined under the state's unemployment insurance statute, attending school, or participating in an "Employment Support and Development" ("ESD") activities[2] or any combination of these activities for 20 hours per week. This requirement is referred to as "AHCCCS works activities."
2. Authorize AHCCCS to require able-bodied adults to submit the additional information and deny or discontinue eligibility for those persons who do not provide the information.
3. Require able-bodied adult members to verify on a bi-annual basis compliance with the work requirements and any changes in family income or other eligibility factors and to allow a 3-month redetermination for those individuals who become non-compliant.
4. Authorize AHCCCS to impose a 5-year lifetime coverage limit for all able-bodied adults in paragraph one above during any time they but do not fall within an exception and do not comply with the work requirements effective on the date of CMS approval.

[2] The ESD activities include English as a Second Language courses; parenting classes; disease management education; and courses on health insurance competency, and healthy living classes. In addition, community service hours may count toward the required 20 hours per week for persons leaving the justice system, living in an area of high unemployment, or who otherwise face a significant barrier to employment.

For the reasons below, the ACDL, Center and the Institute request that CMS deny the requested demonstration waiver because the substance of the demonstration waiver has no experimental value related to the Medicaid program, will create barriers to health care and will impede, rather than promote, the objectives of the Medicaid Act.

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

A. Waivers Must Promote the Objectives of the Medicaid Act and Test Experimental Goals

The Social Security Act grants the Secretary of the United States Department of Health and Human Services limited authority to waive the requirements of the Medicaid Act. The Social Security Act allows the Secretary grant a "[w]aiver of State plan requirements" in 42 U.S.C. § 1396a in the case of an "experimental, pilot, or demonstration project." 42 U.S.C. § 1315(a) ("section 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.* This proposed waiver amendment 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.

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:

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[3] Throughout this letter, the undersigned also will refer to the demonstration waiver as "section 1315" as § 1315 is the statutory cite. 42 U.S.C. § 1315.

> 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).

Any waiver request by Arizona must meet these requirements. AHCCCS's request fails to establish any demonstration value and contains requests that would ultimately limit enrollment through work-related requirements, massive new reporting requirements and unprecedented cumulative time limits. Significantly, the request cites to no hypotheses to be tested that relate to the health care of the Medicaid beneficiaries or to the medical services they receive. To the extent the demonstration waiver has any listed objectives and hypotheses, they are solely related to employment. Finally, the request fails to even claim that any of the waiver requests would further the objectives of the Medicaid Act. Instead, in the cover letter AHCCCS states:

> Arizona has long demonstrated its commitment to innovation in Medicaid. Building on that history and experience, **this waiver is designed to provide low-income, able-bodied adults with the tools needed to gain and maintain meaningful employment.** For able-bodied adults, **Medicaid** is an important solution. for temporary life circumstances, but **should not be a long-term substitute for private health insurance.**
>
> **Medicaid coverage for non-categorical adults is a concept supported by Arizona voters for almost two decades. With almost 400,000 qualifying individuals enrolled**, it is important that Medicaid evolve to meet the needs of this population and give them the tools necessary to obtain gainful employment when a path to such employment exists. In support of these efforts, and consistent with requirements in Arizona statute, **Arizona is proposing to establish a program that incentivizes employment, job training and education**. (emphasis added).

Thus, as explained below, the waiver request does not satisfy the § 1315 requirements.[4]

II. The Demonstration Waiver Requests Serve No Experimental Purpose, Create Barriers to Health Care and Will Impede, Not Further, the Objectives of the Medicaid Act

AHCCCS' waiver requests 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, moreover, represent bad policy for low-income Arizonans, those with chronic medical conditions and working Arizonans with disabilities who need coverage. The requests certainly will increase administration complexity, reduce access to care, increase the number of uninsured and lead to worse health outcomes. In addition, these requests undermine core elements of the Medicaid program and some have never been approved by CMS.

As part of our comments, we incorporate the comments submitted by George Washington University, Department of Health Policy and Management to AHCCCS during the public comment period last year that the lifetime limits and work requirements are contrary to Medicaid's objectives; the proposed eligibility restrictions would create serious harm; it is unlikely the state has the capacity to administer such a system; and there are concerns about budget neutrality. Those comments are attached as exhibit B.

Moreover, research has shown that Medicaid coverage makes it easier for working poor adults to work. Two examples are cited. In Indiana researchers found that low-income workers in a Medicaid expansion state had not experienced greater job loss, more frequent job switching, or more switching from full-time to part-time work than low-income workers in non-expansion states. http://content.healthaffairs.org/content/35/1/111.abstract "Medicaid Expansion Did Not Result In Significant Employment Changes Or Job Reductions In 2014." In Ohio, the state found that among those who were unemployed or looking for a job when they gained coverage under the Medicaid expansion, 75% stated that having medical coverage made the task easier. "Ohio Medicaid Group VIII Assessment," Report to the Oho General Assembly by the Ohio Department of Medicaid. www.medicaid.ohio.gov/Portals/0/Resources/Annual/Group-VIII-Assessment.pdf. This evidence further shows that this waiver should not be approved.

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[4] AHCCCS states that the demonstration waiver is budget neutral for the Group VIII members. While we have concerns about the accuracy of that statement, the proposal lacks sufficient information to evaluate that statement.

AHCCCS cites four studies documenting the association between unemployment and poor health in an apparent attempt to justify the punitive work requirements. However, Arizona oversimplifies the complex and nuanced relationship between employment and health. None of the studies cited suggest that *requiring* work or work related activities as a condition of Medicaid eligibility is likely to improve health outcomes. In fact, the studies show that the quality of employment matters. For example, unemployed individuals who become employed in poor quality (low-wage, low-status) jobs have poorer mental health than unemployed individuals.[5]

Moreover, the vast majority of individuals enrolled in Medicaid already work or have good reason for not working.[6] A recent study by the Kaiser Family Foundation found that adult Medicaid enrollees who were not receiving disability benefits and did not have a job were not working because they were: going to school (18%); taking care of their home or family (28%); retired (8%); unable to find work (8%); or dealing with illness or disability (35%).[7] Further data suggests that illness and poor health keep individuals from working.[8]

Similar waiver requests were denied in September 2016, 15 months ago and as explained below, this waiver request should be denied.

A. Lifetime Limit on Enrollment

AHCCCS again proposes a 5-year lifetime limit on the enrollment of "able-bodied" persons, for any month when the person does not fall within an exception to the work activities and they are not in compliance with the reporting and work requirements

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[5] Hegenrather K et al., *Employment as a Social Determinant of Health: A Systematic Review of Longitudinal Studies Exploring the Relationship Between Employment Status and Mental Health*, 29 Rehabilitation Research, Policy, and Education 261, 279-80 (2015).

[6] Rachel Garfield, Kaiser Family Found., *Understanding the Intersection of Medicaid and Work* (2017), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work (finding that almost 80% of adults who are enrolled in Medicaid, but do not receive SSI, live in families with at least one worker, and almost 60% are working themselves).

[7] *Id.*

[8] *Id*. at Table 4b (In Arizona, while 81% of individuals who reported being in "excellent" or "very good" health were working, that number dropped to 66% for individuals in "good" health, and to just 31% for individuals in "fair/poor" health.).

of the AHCCCS works program described in section B below. [9] AHCCCS defines "able-bodied" as "an individual who is physically and mentally capable of working," and is "not medically frail." AHCCCS concedes it has no definition for this new concept but does give some examples of those who it concludes fall within the category.

We are not aware of any state that has proposed a lifetime limit on enrollment and 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. Last year, the Medicaid program turned 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. Nor is there any reason to believe that CMS should suddenly consider such an extreme departure from established Medicaid law. 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.

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 a § 1315

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[9] The AHCCCS works program has numerous exceptions: "Individuals who are at least 55 years old; American Indians; Women up to the end of the month in which the 90th day of post-pregnancy occurs (footnote omitted); Former Arizona foster youths up to age 26; Individuals determined to have a serious mental illness (SMI); Individuals currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government; Individuals who are determined to be medically frail; Full-time high school students who are older than 18 years old; Full-time college or graduate students (Defined as 12 hours/week for undergraduate programs, 9 hours/week for graduate programs); Victims of domestic violence; Individuals who are homeless; Individuals who have recently been directly impacted by a catastrophic event such as a natural disaster or the death of a family member living in the same household; Parents, caretaker relatives, and foster parents; or Caregivers of a family member who is enrolled in the Arizona Long Term Care System."

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. Also, many persons with disabilities who depend on the home and community- based services provided by AHCCCS programs to avoid institutionalization are also employed. Although such persons can maintain employment through the provision of reasonable accommodations by their employer and are at risk of institutionalization without AHCCCS coverage, complicated questions of whether the persons are "able-bodied" because of their ability to work with reasonable accommodations will arise. Thus, these individuals will be subject to a substantial risk of serious harm to their health and a substantial risk of death.

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 the Secretary is not authorized to waive as part of a § 1315 experiment. It also will disproportionately impact older persons who may have hit the 5-year limit earlier in their lives and now have limited income. 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.

B. Mandatory Work-Related Requirements ("AHCCCS Works")

AHCCCS requests the imposition of mandatory work-related requirements. In general, the mandatory work-related requirements are that "able-bodied" adults work; actively seek work; attend school; or participate in "employment support or development" activities or some combination of these activities for at least 20 hours per week; and verify compliance bi-annually.[10]

[10] The January 11, 2018 Dear State Medicaid Director letter concerning "Opportunities to Promote Work and Community Engagement Among Medicaid

For 50 years the Medicaid program has determined eligibility based on income. This request would add work-related criteria. The proposed hypotheses for the work-related requirements have no reference to health care. Rather they are whether the implementation of the work requirements will increase the rate of able-bodied adults that are employed, actively seeking employment, engaged in training or educational activities for the 20 hours per week or that the average household income of able-bodied adults that are employed will increase. The performance measures are the number and percentage of persons who become employed, actively seek employment or engage in the employment and training programs or have increased household income during the demonstration period. [11] Significantly omitted is any reference to providing health care services to beneficiaries and evaluating their health.

Here as well, there is no explanation of how the mandatory work-related requirements would increase access to healthcare, test an experiment related to the Medicaid program or further the objectives of the Medicaid Act. The proposed requirements obviously do none of these. 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.

Moreover, the undersigned are aware that other states have proposed mandatory work-related requirements and until recently, CMS has denied those requests. Recently, CMS approved the Kentucky waiver that has work requirements. While we disagree with CMS' decision to approve the Kentucky work requirements, until CMS has had sufficient time to evaluate the Kentucky waiver, no other demonstration waivers for work requirements should be approved. For all these reasons, this request should be denied.

Beneficiaries" does no change our analysis of this waiver request. Moreover, the research cited in the letter does not support the conclusion that mandatory work will makes persons healthy.

[11] Mandatory work requirements are ineffective in fostering long term secure employment. In a study of Wisconsin's food stamp program that has a work requirement, data showed that for every one person who gained employment more than three persons lost their food benefits. *FoodShare Employment and Training (FSET) Program Cumulative Data*, Wisc. Dep't of Health Servs. (May 5, 2017), https:www.dhs.wisconsin.gov/inititives/fset-cumulative.htm. In contrast, voluntary employment support programs have proven successful and occur without any loss of benefits. Howard Bloom, et al, MDRC, *Promoting Work in Public Housing: The Effectiveness of Jobs-Plus* (2005), https:www.doleta.gov/research/pdf/jobs_plus_3.pdf; James A Riccio, MRDC, *Sustained Earnings Gains for Residents in a Public Housing Job Program:Seven-Year Findings from the Jobs-Plus Demonstration* (2010), http://files.eric.ed.gov/fulltext/ED514703.pdf.

C. Massive New Bi-Annual Reporting Requirements

The waiver request requires participants to verify on a bi-annual basis their compliance with the work-related requirements and their family income. This request fundamentally changes the Medicaid application and renewal process. Beneficiaries will have to provide massive new amounts of information to show whether they meet an exception and if they are in compliance with the works requirements. The range of this information includes whether someone is "medically frail," a victim of domestic violence, homeless, a foster parent, a caregiver or has experienced a catastrophic event or has engaged in the activities under the works requirement for the requisite numbers of hours *each* week. These activities include community service. This is all information that is not collected now. Once submitted, AHCCCS will need to track the information over several decades.

Federal regulations concerning applications and renewals are intended to facilitate not to impede continuous coverage. The proposed process will lead to persons losing their benefits. Increased paperwork and renewals will increase the number of times that persons will not get their renewal forms or not return the forms timely because of family and medical emergencies. Many persons will not have the needed documentation or it will be an unreasonable burden for them to obtain it and provide it. Others will not have access to places where activities can occur. As an example, 13 of the 16 counties in Arizona are still exempt from the time limit and work requirements in the food stamp program because of the counties' high rates of unemployment. The rural counties also lack the public transportation infrastructure that is needed to get Medicaid beneficiaries to employment, job training and educational opportunities. Yet, under this demonstration waiver, these persons are still subject to the work activities requirements and will be forced to comply or lose their coverage. Moreover, Arizona is in the midst of an opioid epidemic and it can be expected that many of the persons who suffer from opioid addiction will not be able to meet the work requirements and will lose coverage when they most need it for their treatment. The challenge to the on-the ground practicalities of the waiver request are huge and there is nothing in the proposal that addresses these concerns.

AHCCCS wants to massively increase reporting requirements and do bi-annual reviews. Requiring bi-annual reporting of this massive amount of information will simply increase the number of times each year that a person may not respond to the reporting request and then lose their coverage, although there has been no change in their circumstances. This proposal is unduly burdensome for all beneficiaries but can be expected to disproportionately fall on persons with chronic medical conditions and disabilities who AHCCCS has not determined fall within one of the exception categories

and are subject to the work requirements because it is more difficult for persons with chronic medical conditions and disabilities to promptly respond to requests for information. To increase reporting requirements, both as to what must be provided and how often, will cause many persons with chronic medical conditions and disabilities to fail to meet the reporting requirements and lose their essential health care coverage.

D. Administrative Burdens and Request to Siphon Medicaid Funds to Support the State's Employment Program and Computer Changes

Not only will this process be an unreasonable burden to recipients, it can be expected that there will be a huge administrative burden on AHCCCS. First, AHCCCS will need to have a process where it stores the eligibility information for 36 years, from when persons are 19 to 55 years of age. Second, AHCCCS concedes that it does not collect any of this data now. Under the needed administrative changes AHCCCS glosses over the magnitude of the changes that will be required to be made to its computer system, Healthe-Arizona Plus ("HEAPlus"). Currently, HEAPlus is not able to make determinations for the food stamp and cash assistance programs that have far less reporting requirements than those proposed under the waiver request. The reason is that after 4 years, HEAPlus has not been able to be programmed to make food stamps and cash assistance determinations. AHCCCS concedes that it will have to electronically capture "job search activities" that currently it does not do. These activities are collected *weekly* for unemployment insurance claims.

In this proposal, AHCCCS wants to collect eligibility information currently collected by unemployment insurance program, the Social Security Administration, the food stamp program and the cash assistance program with no current computer system capacity to do any of this data gathering. Moreover, there is no discussion about the additional staff that will be needed to send out the various notices, interview the beneficiaries, review the documents and information produced, issue decisions and otherwise track compliance.

In addition, AHCCCS also concedes that this waiver will require an investment to scale existing work programs and to enhance infrastructure. AHCCCS fails to state how much additional resources will be needed. Crucially, AHCCCS fails to inform CMS that Arizona has a very minimal and limited employment and training program for persons who received cash assistance and food stamps administered by the Arizona Department of Economic Security. How these programs would provide services to even 50,000 additional persons, let alone the projected 250,000 persons is a glaring omission.

Even more concerning is that for the additional "scaling" up of the employment and training programs, AHCCCS wants to be able to "leverage Medicaid funding to support these enhancements." We oppose any request by AHCCCS to use Medicaid funding for a wholesale scaling up of the state's employment programs. Arizona should not be allowed to divert the critically needed funds for *medical care and services* to employment and training programs that the state has historically under-funded.

AHCCCS also wants to "leverage" Medicaid funding for any needed "enhancements" to its computer system. AHCCCS should not be allowed to use the Medicaid funds to make changes to its computer systems to enable it to collect all the unnecessary and unreasonable data that would be needed to determine compliance with the works programs. This proposed massive transfer of Medicaid funding away from beneficiary medical care to administrative functions for requests that have no experimental value and undercut the objectives of the Medicaid Act should be denied.

E. Increased Redeterminations, Terminations and Re-enrollments

Once the works program is operational, a person is allowed an initial 6-month grace period from compliance with the works requirements. If the person fails to comply with the work requirements after the 6-month grace period, they will be terminated from Medicaid. Re-enrollment is allowed after the person complies with the work requirements for 30 days.

AHCCCS wants to re-determine eligibility bi-annually based on the extensive new information required to be provided. There is a 3-prong process for redeterminations and changes in circumstances that can change the person from compliant to non-compliant. There also are processes for getting back into compliance. As an example, at redetermination, some members will be allowed three additional months to become compliant and others will disenrolled and have to demonstrate compliance for 30 days to obtain coverage again. This process will result in persons going on and off the Medicaid program (the "churn") and will certainly cause harm to persons who have significant on-going medical conditions or have new medical conditions arising.

Second, as explained above, there is no explanation of the projected cost and where the money will come from to administer the increase in reporting requirements on one-fourth of the AHCCCS population.[12]

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[12] If any of the requests are currently being imposed in other states under waiver authority, then the undersigned state that this request does not satisfy the novel or experimental prong of the waiver statute for that reason as well and CMS should wait and

Conclusion

For all the above reasons, CMS should deny the demonstration waiver request. As explained above, AHCCCS failed to show that any of these requests comply with federal requirements that they be experimental and test something experimental related to the Medicaid program and further the objectives of the Medicaid Act.

Thank you for the opportunity to comment on the demonstration waiver request. If you have any questions concerning this letter, please contact Ellen Katz at (602) 252-3432 or at eskatz@qwestoffice.net. or Rose Daly-Rooney at 520-327-9547, ext. 323.

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

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evaluate the results of the testing in the other states before proceeding with AHCCCS' requests.

EXHIBIT A

TO

COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

SEP 30 2016

Mr. Thomas Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, AZ 85034

Dear Mr. Betlach:

The Centers for Medicare & Medicaid Services (CMS) is approving Arizona's request to extend its Medicaid demonstration, entitled "Arizona Health Care Cost Containment System (AHCCCS)" (Project Number 11-W-00275/09). The demonstration is approved for an additional 5 years under the authority of section 1115(a) of the Social Security Act (the Act), effective October 1, 2016 through September 30, 2021.

Arizona's section 1115 demonstration provides authority for the continuation of its Medicaid managed care delivery system for mandatory and optional Medicaid state plan populations and physical and behavioral health integration through regional behavioral health authority (RBHA) and children's rehabilitative services (CRS) plans.

The demonstration advances strategies Arizona proposed to engage newly eligible beneficiaries in Arizona in maintaining and improving their health by providing incentives for beneficiaries to adopt healthy behaviors and receive care in the right setting at the right time.

The new beneficiary engagement initiative, AHCCCS Choice Accountability Responsibility Engagement (CARE), will affect the new adult group population addressed in section 1902(a)(10)(A)(i)(VIII) of the Act who have incomes above 100 percent up to and including 133 percent of the federal poverty level (FPL). Under this initiative, the state will link Medicaid benefits to an AHCCCS CARE program that will test the use of incentives to build health literacy, achieve identified health targets and encourage appropriate care. Under the state's AHCCCS CARE program, the state may require that Medicaid beneficiaries pay monthly contributions in amounts not more than two percent of household income and utilization-based copayment-like charges on a limited set of services, subject to Medicaid's aggregate cap of five percent of household income.

The state's AHCCCS CARE program also includes "Healthy Arizona," a healthy behaviors component to incentivize beneficiaries to engage in managing preventive healthcare and chronic illnesses. Individuals who meet a healthy behaviors target will qualify for elimination of their monthly contribution for six months as well as have access to incentive payments from their AHCCCS CARE account. Incentive expenditures out of the account are not subject to federal match. We look forward to working with the state on an evaluation design that will help CMS

and the state evaluate the link between Medicaid benefits and the state's AHCCCS CARE program.

The following Medicaid enrollees are not required to participate in AHCCCS CARE: individuals with incomes up to and including 100 percent of the FPL, individuals with serious mental illness, individuals who are considered medically frail, and American Indian/Alaska Natives.

In addition, outside this demonstration, the state aims to encourage employment through referrals to a new state-only work search and job training program called AHCCCS Works. This program, which will help connect beneficiaries to employment supports, is available for AHCCCS CARE beneficiaries who choose to participate. Health coverage provided by the Medicaid program and this demonstration will not be affected by this state initiative.

Additionally, for Arizona Long Term Care Services (ALTCS) beneficiaries, CMS is authorizing the state to provide adult dental benefits to up to $1,000 annually, per person. CMS has also revised the special terms and conditions (STCs) and waiver and expenditure authorities to update certain requirements in accordance with CMS policy and to remove authorities that are obsolete or expired, including:

- The authorities that restrict individuals from disenrolling from managed care without cause have been time limited to align with the new managed care regulations. Beginning October 1, 2017, beneficiaries will be allowed 90 days to change managed care plans without cause.
- The expenditure authorities have been updated to reflect continuation of the phase-out of the safety net care pool (SNCP) for Phoenix Children's Hospital. Currently the state is allowed to claim up to $110,000,000 total computable through the end of calendar year 2016. For calendar year 2017, the state is allowed to claim up to $90,000,000 total computable before a complete phase out of the SNCP.
- The waiver of retroactive eligibility under section 1902(a)(34) of the Act that expired on December 31, 2013 has been removed.
- The waiver authority for disproportionate share hospital (DSH) payment requirements is revised to allow a one-year transition period to change its authority for its DSH payments to the Medicaid state plan in accordance with section 1923 of the Act.
- The expenditure authority to relieve the state of disallowances under section 1903(u) of the Act based on Medicaid Eligibility Quality Control (MEQC) findings has been removed because the state will follow current MEQC recoveries processes.
- The expenditure authority for outpatient drugs otherwise not allowable under section 1903(i)(23) of the Act expired November 1, 2012 and has been removed.
- The expenditure authority related to the tribal facility payments has been updated to clarify that the authority is for services to Medicaid eligible individuals.

Consistent with Medicaid law, CMS reviews section 1115 demonstration applications to determine whether they further the objectives of the program, such as by strengthening coverage or health outcomes for low-income individuals in the state or increasing access to providers. After reviewing Arizona's application to determine whether it meets these standards, CMS is unable to approve the following requests, which could undermine access to care and do not

support the objectives of the program: monthly contributions for beneficiaries in the new adult group with incomes up to and including 100 percent of FPL; exclusion from coverage for a period of six months for nonpayment of monthly premium contributions; a work requirement; fees for missed appointments; additional verification requirements; and a time limit on coverage.

Although not included in this approval, CMS will continue to work with Arizona on the important delivery system reforms it has proposed to integrate physical and behavioral health for children and adults and Medicaid beneficiaries leaving the justice system. We will also continue to engage the state on the pending American Indian Medical Home amendment request.

CMS' approval of this extension is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Jessica Woodard. She is available to answer any questions concerning your section 1115 demonstration. Ms. Woodard's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Jessica.Woodard@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Woodard and Ms. Henrietta Sam-Louie, Associate Regional Administrator, in our San Francisco Regional Office. Ms. Sam-Louie's contact information is as follows:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707
Email: Henrietta.Sam-Louie@cms.hhs.gov

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Thank you for all your work with us, as well as stakeholders in Arizona, over the past months on this demonstration extension. Congratulations on its approval.

Sincerely,

Andrew M. Slavitt
Acting Administrator

Enclosures

cc: Henrietta Sam-Louie, Associate Regional Administrator, CMS San Francisco Regional Office

EXHIBIT B

TO

COMMENTS

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Department of Health Policy and Management

February 27, 2017

Arizona Health Care Cost Containment System
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Cc: Jane Perkins, National Health Law Program
Ellen Sue Katz, William Morris Institute for Justice
Judith Solomon, Center on Budget and Policy Priorities

Sent by email to publicinput@azahcccs.gov

Subject: Comments on Section 1115 Waiver Amendment under Senate Bill 1092

Dear Sir or Madam:

We would like to submit public comments concerning the plan to submit a Section 1115 waiver proposal to the Centers for Medicare and Medicaid Services pursuant to Senate Bill 1092 to add work requirements and a five-year lifetime coverage limit for able-bodied adults in Medicaid.[1]

1. Lifetime Limits and Work Requirements Are Contrary to Medicaid's Objectives

Section 1115 permits research and demonstration waivers if they are "very likely to assist in promoting the objectives of Title ... XIX" of the Social Security Act. There is no statutory objective of Title XIX that includes or is supportive of Medicaid work requirements or lifetime coverage limits. The waiver proposal is contrary to the objectives of the Act; such requirements have not been authorized in the fifty years since Medicaid began. Medicaid has permitted coverage for ongoing treatment needs such as long-term care, care for chronic diseases, and preventive care since its origin; it is inconceivable that lifetime limits are consistent with the objectives of the program. The creation of Section 1931 under the 1996 welfare reform law specifically severed the connection of Medicaid and TANF eligibility to ensure that those losing coverage due to work requirements and lifetimes limits in TANF could still retain health insurance coverage. As the state of Arizona knows, similar waiver proposals have been consistently rejected in the past, establishing a precedent that these policies are contrary to the objectives of Medicaid.

Because of this fundamental conflict with the objectives of the program, the proposed waiver request is unlawful and should not be submitted.

[1] AHCCCS. Arizona Section 1115 Waiver Amendment Request: Senate Bill 1092 Arizona Legislative Directives. Jan. 2017.
https://www.azahcccs.gov/Resources/Federal/sb1092legislativedirectivewaiverproposal.html

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t 202-994-4100

In addition to this fundamental problem with the waiver proposal, we note that there are other serious flaws.

2. The Proposed Eligibility Restrictions Would Create Serious Harm

The proposed five year lifetime limit on Medicaid (AHCCCS) eligibility for those considered "able-bodied" is very harmful. We are unaware of any rationale for the proposed limit. It is a basic fact of life that health needs grow as we age; people in their forties to sixties are more prone to serious chronic diseases like diabetes or coronary artery disease or illnesses like breast or prostate cancer. Effective, life-saving medical therapies are available for these diseases, but long-term treatment is often needed to allow people to maintain their health. If low-income people are ineligible for Medicaid because they used the program for five years while they were impoverished in their twenties, they are likely to be uninsured and unable to get the types of medical care or medications when they most need assistance. It is inconceivable that the objectives of Medicaid are consistent with such a harsh limit on eligibility. Low-income people should not be required to ration an allotment of health insurance over the course of their lifetimes, guessing at when they will urgently need care and leaving themselves exposed to unexpected needs and without preventative care when going uninsured.

The inevitable result of lifetime limits will be increased morbidity and mortality because care will be unavailable when it is most needed. Research has shown that Medicaid expansions can significantly reduce mortality[2] and efforts to cut eligibility can have truly life-threatening results. Some uninsured individuals may still be able to get some services from safety net hospitals and clinics, but this is not a substitute for insurance and would greatly increase the level of uncompensated care these providers must bear. Moreover, these additional burdens placed on the safety net providers will make it harder for them to provide care for others in need.

The work requirements are also inappropriate to Medicaid. Although the proposal would exempt those who are disabled, many adults have physical or mental health problems that require medical care, even though they have not met conditions for disability. We analyzed data from the 2015 National Health Interview Survey about the health status of non-elderly Medicaid enrollees in the Medicaid expansion income range. About one-quarter (26%) of Medicaid expansion enrollees reported SSI or Social Security disability status. But an additional 15% reported functional limitations (i.e., problems that interfere with basic activities of living or working) caused by diseases such as arthritis, cancer, diabetes and mental health problems and another 7% reported being in fair or poor health.[3] Those who report being in fair or poor health are more likely to die.[4] That is, the

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[2] Sommers B, Baicker K, Epstein A. Mortality and Access to Care among Adults after State Medicaid Expansions. New England Journal of Medicine. 2012; 367:1025-1034. Sept. 13, 2012.

[3] GW analyses of the 2015 National Health Interview Survey, conducted by the Centers for Disease Control and Prevention.

[4] Mc Gee, et al. Self-reported Health Status and Mortality in a Multiethnic US Cohort. American Journal of Epidemiology. 1999; 149 (1): 41-46.

number of Medicaid expansion adults with serious health problems but not classified as disabled is almost as high as the number who classified as disabled. The exemptions may miss a very large number of adults with serious health problems, some of which may make it impossible for the person to secure employment.

Getting exemptions for disability will entail substantial delays in coverage. National data indicate that the average time to process a Supplemental Security Income or Social Security Disability claim was 83 to 86 days in 2014.[5] Appeals, which are common and often upheld, typically take years. People with serious problems could be denied eligibility for months or even years while trying to get disability determinations.

A particularly unfair paradox inherent in Arizona's proposal is that a person may be unable to even pay to get a doctor's physical or mental evaluation if they are denied Medicaid coverage because they might be "able-bodied." Comprehensive physical examinations are usually more expensive than other types of primary care visits because they take more time. It frequently takes months to get appointments for physicals scheduled. In the meanwhile, people may be unable to get needed medical care or medications.

Arizona's proposal does not include any accommodation for local differences in the availability of work. Arizona employment data indicate that in July 2016 county unemployment rates varied from a low of 5.5% in Vavapai County to a high of 24.5% in Yuma County.[6] In certain areas of the state there are far fewer jobs available than in other areas and residents of those areas are therefore much less likely to find work and will be more often ineligible for health insurance coverage.

Finally, we note that the types of low-wage jobs that Medicaid enrollees are likely to get frequently lack health insurance. For example, in 2015 only 25.5% of workers in Arizona employed in private firms with low average wages (e.g., retail, food service, and agriculture) had health insurance at work, slightly below the national average of 27.5%. Less than half (48%) of Arizona workers in these low-wage firms were even eligible for work-based health insurance, substantially below the national average of 58%.[7] Even when low-wage workers are eligible for insurance, the monthly premiums are often too high to be affordable or the insurance available has such high deductibles (e.g., HSA-compatible plans) that they offer very little real coverage. Thus, many low-income workers will continue to need Medicaid coverage for longer than the proposed 5 year time frame.

3. It Is Unlikely That Arizona Has the Capacity to Administer Such a System

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[5] Office of the Inspector General, Social Security Administration. Disability Determination Services Processing Times (A-07-15-15037) May 8, 2015.

[6] https://laborstats.az.gov/local-area-unemployment-statistics

[7] These data are for firms with the lowest quartile of average wages, as reported by the 2015 Medical Expenditure Panel Survey, Insurance Component, Agency for Healthcare Research and Quality. https://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp

In a public forum, AHCCCS provided a preliminary estimate that 224,000 adult enrollees might be subject to the new requirement. While there are already work requirements, as well as related evaluation, counseling, job search, job training and education and monitoring systems for TANF and SNAP, the scope of the number of new Medicaid enrollees would likely overwhelm the system. Providing sufficient job training and evaluation services, as well as monitoring beneficiaries' compliance with the new requirements, would substantially increase Medicaid administrative costs. These administrative costs only receive a 50% federal match, so the state would bear a substantial increase in state expenses to develop this system and to ensure adequate capacity in all regions of the state.

If the state believes it can administer and finance an adequate system of job support services for all adult enrollees subject to the new requirements, the details should be provided in its Section 1115 waiver request.

4. We Have Concerns about Federal Budget Neutrality

One of the most important elements of any federal Section 1115 waiver proposal is the assessment of federal budget neutrality. As stated above, the administrative costs for this waiver would be substantial. Additionally, the exclusions of Medicaid eligibility will increase federal outlays, such as premium tax credits or disability benefits, creating problems for federal budget neutrality.

Many Arizonans excluded from Medicaid eligibility if this policy is adopted ought to become eligible instead for premium tax credits under the federal health insurance marketplace. Federal tax credit and marketplace eligibility do not include work requirements or lifetime limits. Those excluded from Medicaid will have very low incomes, making them eligible for the largest tax credits and cost-sharing subsidies, incurring additional federal costs. Since Medicaid costs per enrollee are often lower than the maximum tax credits and cost-sharing subsidies, federal costs may actually rise if a large number of individuals are excluded from Medicaid coverage and instead receive federal tax credits and cost-sharing assistance.

Moreover, the work requirements and lifetime limits would likely increase the number of adults who seek and become eligible for Supplemental Security Income or Social Security Disability benefits because this will enable them to get health insurance coverage. This could also increase federal costs.

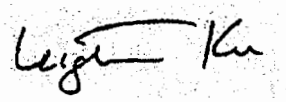
Any assessment of budget neutrality should include assessments of the impact of Arizona's proposed policies on raising costs for these federal programs.

Thank you for consideration of our comments.

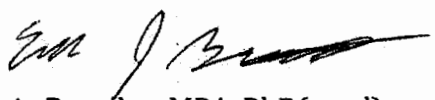
Our qualifications: Leighton Ku is a Professor of Health Policy and Management and Director of the Center for Health Policy Research at George Washington University. He is a nationally-known health policy researcher with strong expertise in issues related to Medicaid and health insurance marketplaces. Erin Brantley is a Senior Research Associate working with Professor Ku and PhD candidate in health policy at the Trachtenberg School

of Public Policy and Public Administration. She has expertise in Medicaid and public health issues.

Yours truly,



Leighton Ku, PhD, MPH
Professor of Health Policy and Management
Director, Center for Health Policy Research



Erin Brantley, MPA, PhD(cand)
Senior Research Associate