William E. Morris Institute for Justice

3707 North Seventh Street, Suite 300, Phoenix, AZ 85014-5014

Phone 602-252-3432 **Fax 602-257-8138**

May 21, 2018

VIA EMAIL:

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

Re: Comments to Arizona's Section 1115 Waiver Amendment Request to Eliminate Prior Quarter Coverage

Dear Administrator Verma:

The Arizona Center for Disability Law ("ACDL"), Arizona Center for Law in the Public Interest ("Center") and the William E. Morris Institute for Justice ("Institute") submit these comments to Arizona's Section 1115 Waiver Amendment Request submitted to the Centers for Medicare and Medicaid Services ("CMS") on April 6, 2018 to waive prior quarter (retroactive) coverage. 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 Institute request that CMS deny the requested waiver. The ADCL, 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 1.85 million persons are on Arizona Health Care Cost Containment System ("AHCCCS")

as of May 2018. www.azahcccs.gov/Re-sources/Downloads/PopulationStatistics/2018/May/AHCCCS_Populations_by_Category.pdf. Of this number, 305,466 are the Proposition 204 population (0-100% of federal poverty level) and 76,228 are the adult expansion (100-133% of the federal poverty level).

AHCCCS now proposes to be allowed to waive prior quarter coverage required by 42 U.S.C. § 1396a(a)(34) and 42 C.F.R. § 435.915. Prior quarter coverage starts with the date of application and goes back three months as long as the person would have been eligible for coverage. AHCCCS claims the proposal promotes the objectives of the Medicaid program by:

> (1) Encouraging members to obtain and continuously maintain health coverage, even when healthy; (2) encouraging members to apply to Medicaid without delays to promote continuity of eligibility and enrollment for improved health status; and (3) containing Medicaid costs. These objectives support the sustainability of the Medicaid program and more efficiently focus resources on providing accessible and high quality health care while limiting the resource-intensive process associated with prior quarter coverage eligibility. Arizona will educate the community regarding this change.

Overview, page 1.[1]

For the reasons below, the ACDL, Center and the Institute request that CMS deny the waiver amendment request because the substance of the amended demonstration

[1] When AHCCCS initially posted the waiver request for comments, it claimed the waiver would "better align Medicaid policies with commercial health insurance coverage." This rationale made little sense, given the substantial differences between Medicaid and commercial insurance. The principal difference is the fact that commercial insurance relies on premium payments, while Medicaid coverage is based upon a determination that a person has limited financial resources and thus cannot afford private coverage. Retroactive coverage is not allowed in commercial insurance because the program's financing relies on premium payments in advance, before a person knows the medical services that he or she may require in any particular month. The same is not true in Medicaid, which does not require premiums from its low-income beneficiaries. Because this rational made little sense, AHCCCS abandoned it.

waiver proposal 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: 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). 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 1115 projects to test experimental ideas. According to Congress, section 1115 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 1115'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). The analysis is whether the project is likely (1) to yield useful information or demonstrate a novel approach to program administration, (2) to further the objectives of the Medicaid Act and (3) is limited to the extent and period necessary. *Beno*, 30 F.3d at 1069-70.

Arizona's waiver request must meet these requirements. As explained below, AHCCCS's request fails to establish any demonstration value, does not further the objectives of the Medicaid Act and instead is a cost saving proposal only.

II. Purpose of Retroactive or Prior Quarter Coverage

When the Medicaid retroactive coverage guarantee was established in 1972, the Senate Finance Committee noted that the purpose of the provision was to "protect[] persons who are eligible for [M]edicaid but do not apply for assistance until after they have received care, either because they did not know about the [M]edicaid eligibility requirements or because the sudden nature of their illness prevented their applying."[2] This statement is just as true now as it was 46 years ago. A person in need of health care cannot be expected to make instantaneous applications for Medicaid coverage. She may be hospitalized after an accident or unforeseen medical emergency. She may also be unfamiliar with Medicaid, or unsure about when her declining financial resources might fall within the Medicaid eligibility threshold. Elimination of the retroactive coverage also will disproportionately and negatively impact persons with disabilities. For example, someone could experience serious impairment as a result of a traumatic brain injury or mental illness that limits their ability to promptly apply for benefits. The three-month retroactivity window is a rational and humane response to these concerns. Retroactive eligibility is only available to persons who meet Medicaid eligibility standards for the month[s] in question.

Because all the affected persons are low-income and Medicaid eligible, elimination of the prior quarter coverage will simply shift the cost of medical care to medical facilities who with reduced funding for uncompensated care, may not be able to obtain reimbursement. With the expansion of Medicaid coverage to more persons, the

---

[2] Senate Report No. 92-1230 at 209 (Discussing Section 255 of H.R. 1) (Sept. 26, 1972). https://archive.org/details/provisonsrelati00unit_0djvu.txt. *See also* H.Rep.No. 92-231, 92d Cong., 2d Sess., *reprinted in* 1972 U.S. Code Cong. & Ad. News 4989, 5099.

Affordable Care Act ("ACA") intended to reduce the number of persons who were uninsured. Correspondingly, the ACA also reduced the Disproportionate Share Hospital Program ("DSH") that provided additional funds to hospitals for uncompensated care under Medicaid and Medicare. *See* "Q and A: Disproportionate Share Hospital Payments and the Medicaid Expansion." https://www.healthlaw.org/issues/medicaid/qa-dis-propotionate-share-hospital-payments-and-the-medicaid-expansion. The waiver request conflicts with that intent to provide coverage directly on behalf of the uninsured and, instead, will result in more medical facilities providing uncompensated care with no available federal funds to cover their costs. This will be especially difficult for our rural hospitals in Arizona that are often their community's only trauma facility capable of providing such care.

III. The Waiver Amendment Request Serves No Experimental Purpose and Will Impede, Not Further, the Objectives of the Medicaid Act

This waiver amendment request does not serve any valid experimental purpose and, moreover, represents bad policy for low-income Arizonans and working Arizonans with disabilities who need coverage. Such a limit on access to Medicaid only creates a barrier to access to care and does not promote the objectives of the Medicaid Act.

A. The Waiver Request Is Really an Improper Cost Saving Measure

AHCCCS' real reason for the waiver request is to save money. In fiscal year 2017, AHCCCS states the "total cost" to reimburse medical providers was $21,347,700 for prior quarter coverage. Of this amount it is estimated that only 9% ($1,921,293) came from the state funds because of the high reimbursement rate provided to Arizona by the federal government. AHCCCS delineates the prior quarter coverage historical expenditures for 2014-2018 and states that the proposal to waive prior quarter coverage will save in "total costs" $39,431,100 in state fiscal year 2019.[3] As explained above, a proposal to save money, is not a valid reason for a Section 1315 waiver. *See Beno,* 30 F.3d at 1069.

Moreover, this request is very short-sighted. While in one year, the state may save $1,983,800, it will forgo approximately 20 million dollars in federal Medicaid reimbursement payments that could provide medical care for persons all over the state. To spend one dollar and get nine dollars back is a great return on the use of state funds in general and in this case the funds go to provide much needed medical care for our most

[3] AHCCCS does not explain how it projects the prior quarter coverage costs for 2019 that are almost 50% above the actual costs in fiscal year 2017.

vulnerable Arizonans. As these numbers show, retroactive coverage is truly a win-win situation.

B. The Waiver Request has No Experimental Purpose that Furthers the Objectives of the Medicaid Act

1. The Proposed Hypotheses and Proposed Performance Measures

During the public comment period, we commented that the waiver had no experimental purpose and did not further the objectives of the Medicaid Act. For its formal waiver request, AHCCCS has identified three hypotheses it seeks to test. Taking each hypothesis individually shows that these are not appropriate hypotheses and performance measures.

The first hypothesis is:

1. The implementation of the proposal will not adversely affect access to care.

For the first hypothesis, the performance measures are:

- The number of adults and children who had an annual visit with a primary care physician (PCP) measured during the baseline year and annually thereafter.
- The number and percentage of members utilizing specialty services measured during the baseline year and annually thereafter.
- The number and percentage of members utilizing skilled nursing facilities measured during the baseline year and annually thereafter.

This hypothesis does not test anything experimental and does not further the objectives of the Medicaid Act. A hypothesis that access to care will not be "adversely" affected is not a proper hypothesis. The waiver should test a positive outcome that furthers the objectives of the Medicaid Act. Moreover, the fact that a recipient had an annual visit with a primary physician, utilized specialty services or utilized skilled nursing facilities are "measurements" unrelated to the hypothesis or to retroactive prior quarter coverage.

The second hypothesis is:

2. The implementation of the proposal will not result in reduced member satisfaction.

For the second hypothesis, the performance measure is:

- Members' satisfaction with overall health care experience, getting needed care, and getting care quickly as defined by the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey assessment measured during the baseline year and one year during the demonstration.

Here as well, this hypothesis does not test anything experimental and does not further the objectives of the Medicaid Act. A hypothesis that member satisfaction will not be reduced is not a proper hypothesis. Most recipients will not know about the prior quarter coverage and will not be able to compare that benefit and the loss of it.

The third hypothesis is:

3. The implementation of the proposal will generate cost savings over the term of the waiver.

For the third hypothesis, the performance measure is:

- The number of members who received Prior Quarter Coverage and the total funds expended on Prior Quarter Coverage measured during the baseline year and annually thereafter.

As explained above, this is the real reason for the waiver request and a cost saving measure is unlawful under *Beno.*

Thus, the waiver amendment proposed has no evidentiary or experimental basis and will not further access to care and the objectives of the Medicaid Act. Therefore, CMS should deny the waiver request.

2. Failure to Further Objectives of the Medicaid Act

The legislative history shows that Congress understood that prior quarter coverage promoted the objectives of the Medicaid Act. Nothing in the AHCCCS proposal shows how the objectives of the Medicaid Act will be furthered. Instead, AHCCCS makes the bald claim that elimination of the retroactive coverage will encourage members to obtain and continuously maintain health coverage, even when healthy and to apply to Medicaid without delays to promote continuity of eligibility and enrollment for improved health status. This is simply a claim without any basis in fact.

Finally, it is our understanding that CMS has approved this request in at least four states. While we disagree with CMS' decision to approve those waivers, until CMS has received sufficient documentation and has had sufficient time to evaluate the waivers in those states, no other demonstration waivers for elimination of retroactive coverage should be approved.

Conclusion

For all the above reasons, CMS should deny the waiver amendment request. As explained above, AHCCCS failed to show that the request complies with federal requirements that it 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 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