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October 18, 2012

Attn: Office of Intergovernmental Relations
Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034-2217

ChildlessAdults@AHCCCS.gov

Re: Arizona's Section 1115 Waiver Amendment Request Continuing Coverage for Childless Adults Under the Demonstration

Dear Office of Intergovernmental Relations:

The William E. Morris Institute for Justice ("Institute"), the Arizona Center for Disability Law ("Center"), Community Legal Services ("CLS"), and the National Health Law Program ("NHelp") submit these objections and comments to the proposed "Arizona's 1115 Waiver Amendment Request Continuing Coverage for Childless Adults under the Demonstration" for the period January 1, 2014, through September 30, 2016, posted on the Arizona Health Care Cost Containment System ("AHCCCS") website on September 18, 2012. AHCCCS is the state Medicaid program. 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 the protection and advocacy program in Arizona and works on issues concerning access to health care for persons with disabilities. CLS is the federally funded legal services program in Arizona and represents low-income Arizonans on many civil issues including health care. NHelp is a national program whose mission is to secure health rights for those in need.

On October 21, 2011, the federal government approved Arizona's Section 1115 Demonstration Project until September 30, 2016. The approval contains Special Terms and Conditions ("STCs") for the demonstration project. In order for Arizona to become compliant with the Affordable Care Act ("ACA"), the STCs require that AHCCCS submit a transition plan by July 1, 2012. The transition plan requires that AHCCCS must

transition childless adults into a coverage category in the state plan pursuant to 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) by January 1, 2014. (Paragraph 36(a)(i), page 30). One part of the transition plan is a "cost-sharing transition" that requires AHCCCS to develop a plan that:

> must include the State's process to come into compliance with all applicable Federal cost-sharing requirements, including the section 1916(f) requirements that apply to the adults without dependent children population when it becomes a mandatory State plan population on January 1, 2014.

Paragraph 36(b), page 31.

Despite these requirements, on September 18, 2012, AHCCCS posted on its website a draft "Arizona 1115 Waiver Amendment Request Continuing Coverage for Childless Adults under the Demonstration" with an executive summary. AHCCCS proposes to request approval from the federal government to continue to provide medical assistance to childless adults as a demonstration project and to be allowed to continue the heightened and mandatory cost-sharing for childless adults, including copayments for office visits, prescription medications and non-emergency transportation and the missed appointment penalty. In addition, although AHCCCS does not propose to expand AHCCCS to 133% of the federal poverty level or to include the childless adults in the state plan, AHCCCS proposes to seek the enhanced federal medical assistance percentage ("FMAP") reimbursement for the medical costs for childless adults as if they were state plan enrollees under the ACA beginning January 1, 2014.

As fully explained in this letter, the Institute, the Center, CLS and NHelp object to the proposal concerning childless adults in its entirety and to AHCCCS' apparent intent to not expand medical coverage to all persons with incomes up to 133% of the federal poverty level. Full ACA expansion will help Arizona's economy and save lives. The proposal is an effort to circumvent the ACA and a continuation of the state's failure to comply with Proposition 204, the Arizona voter initiative Arizonans overwhelmingly approved to mandate AHCCCS coverage for persons with incomes up to 100% of the federal poverty level. A.R.S. § 36-2901.01. We also are concerned that AHCCCS is not providing for meaningful input concerning the request as required by federal law. Finally, AHCCCS' proposed continuation of the childless adult demonstration project and its mandatory and heightened copayments fails to meet federal requirements for demonstration projects under federal law. For all these reasons, the proposal should not

be submitted and, instead, AHCCCS should proceed with the transition plan and expand AHCCCS coverage to 133% of the federal poverty level.

A. The Supreme Court's Decision in *National Federation of Independent Business* Provides No Support for the Amended Request

The ACA requires that all states provide Medicaid coverage to "all individuals" with incomes up to 133% of the federal poverty level. 42 U.S.C. § 1396a(a)(10)(A)(i)(VII).[1] The remedy in the ACA if a state failed to expand Medicaid coverage to 133%, was that the federal government could withhold all of the state's Medicaid funding, even for persons covered before the ACA was enacted. 42 U.S.C. § 1396c.

AHCCCS relies upon *National Federation of Independent Business v. Sebelius*, __U.S.__, 132 S.Ct. 2556 (2012) ("NFIB") for support of its claim that childless adults are not a mandatory state population. In that case, the Supreme Court held that the federal government could not withhold all Medicaid funding if a state did not expand its Medicaid program to persons with incomes up to 133% of the federal poverty level. *Id*. at 2606-07. AHCCCS claims that the Court held that the expansion was "optional" and that the ruling "creat[ed] new coverage opportunities for states." Executive Summary, page 1, Draft Amendment Request, page 1. A close reading of the decision shows that AHCCCS is incorrect.

State participation in Medicaid always has been voluntary. Every state has determined it is in their citizens' best interests to participate. In holding that the federal government could not withhold all Medicaid funds to a state if the state did not provide Medicaid coverage up to 133% of the federal poverty level, the Court was careful to explain that states who participate in Medicaid must comply with the Medicaid Act requirements:

> Nothing in our opinion precludes Congress from offering funds under the ACA to expand the availability of health care, and requiring that states accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in the new program by taking away their *existing* Medicaid funding.

[1] Although 42 U.S.C. § 1396a(a)(10)(A)(i)(VII) refers to persons whose income does not exceed 133% of the federal poverty level, because 5% of income is deducted from gross income, the actual income limit is 138%. *See* 42 U.S.C. § 1396a(e)(14)(I).

Id. at 2607 (emphasis added). The Court did not hold that the expansion of Medicaid to 133% of poverty was not mandatory. Rather the Court disallowed the remedy for noncompliance with the ACA of total with-holding of all Medicaid funds even for groups covered by the states prior to the ACA enactment. If a state decides to participate in the "new program" under the ACA, such as pursuing the enhanced federal match for childless adults, then the full expansion for childless adults is a mandatory component of that participation. In addition, the Court treated the ACA expansion as one program and did not bifurcate the expansion into two subsets, those under 100% of poverty and those between 100-133% of poverty. "The Medicaid provisions of the Affordable Care Act … require States to expand their Medicaid programs by 2014 to cover *all* individuals under the age of 65 with incomes below 133% of the federal poverty line." *Id*. at 2601. (emphasis in original).

While there may be unresolved questions, one thing is clear: persons up to 133% of poverty are no longer expansion populations covered by the demonstration authority in 42 U.S.C. § 1315 (the statutory cite that AHCCCS refers to as "1115"). Under the ACA they are mandatory state plan populations. There has not been any guidance from the federal government that undercuts this analysis. The May 22, 2012, CMS "Medicaid/CHIP Affordable Care Act Implementation" sheet specifically noted that demonstrations will not continue beyond December 31, 2013, for childless adults because "States that have utilized demonstrations to expand eligibility to the childless adult population will no longer need the expenditure authority because this population will become a mandatory State plan population under the Affordable Care Act's Medicaid eligibility expansion." http://www.Medicaid.gov/ State-Resource-Center /Frequently-Asked-Questions/Downloads/Coordination-FAQs.pdf. There is nothing in the NFIB's decision to the contrary. Even if a court were to hold that under the ACA the childless adults are an optional population that would not support AHCCCS' proposal. Demonstration projects are not intended to provide coverage to optional populations, but rather expansion populations. *See Spry v. Thompson*, 487 F.3d 1272, 1274 (9th Cir. 2007). Finally, we are not aware of any federal guidance that acknowledges that a state under the ACA could choose to implement a partial Medicaid expansion such as only covering persons up to 100% of the poverty level.

B. AHCCCS Should Comply with Current Demonstration Project Requirements and Transition Childless Adults into the State Plan by January 1, 2014

As noted in the introduction, the Special Terms and Conditions in the current demonstration project provide for a transition plan for AHCCCS to include childless adults with incomes up to 100% of the federal poverty level into the state plan and to be charged the nominal, non-mandatory copayments for state plan participants in the Medicaid Act pursuant to 42 U.S.C. §§ 1396o and 1396o-1. There is nothing in the AHCCCS proposal that explains why this transition should not occur. This is especially true since the state seeks the federal reimbursement rate that applies for childless adults who are state plan enrollees under the ACA.

In the proposal, there are references to "flexibility," keeping options open and the need to obtain the enhanced federal match for childless adults but there is no explanation why the transition plan does not satisfy these purported needs. We request that AHCCCS comply with the transition plan for persons up to 100% of the federal poverty level and include them in the state plan and comply with the Medicaid cost-sharing restrictions in the Act for these persons.

C. The State Should Expand AHCCCS to Include All Persons Up to 133% of the Federal Poverty Level Because the Increased Federal Reimbursement Makes this an Option the State Should Not Decline

The apparent premise of the "amended request" is that the state has no other option except to request a continuation of the demonstration project for childless adults. AHCCCS concedes that stakeholders want AHCCCS to continue to cover childless adults after December 31, 2013. This should not come as a surprise since the citizens of Arizona voted 12 years ago to mandate that AHCCCS cover all persons up to 100% of the federal poverty level. AHCCCS claims one of the Governor's principles is to "recognize the will of Arizona voters regarding AHCCCS coverage for Childless Adults as expressed through the passage of Prop. 204." The will of the citizens of Arizona 12 years ago was full coverage of AHCCCS to 100% of poverty. We believe if the full ACA expansion was put to a vote, Arizonans would overwhelmingly support it.

We do not understand AHCCCS' apparent decision at this point to not include all persons up to 133% of the federal poverty level in the state plan by January 1, 2014. Under the ACA, Arizona's federal reimbursement for childless adults in the state plan will at least be the following:

Year	FMAP for newly eligible expansion adults (100-133% FPL)	FMAP for adults already eligible (below 100% FPL)[2]
2014	**100%**	65.68[3]+ (0.5(100-65.68)=**82.84%**
2015	**100**	65.68+(0.6(100-65.68))=**86.27%**
2016	**100**	65.68+(0.7(100-65.68)=**89.70**
2017	**95**	65.68+(0.8(94-65.68))=**88.33**
2018	**94**	65.68+(0.9(94-65.68))=**91.17**
2019	**93**	65.68+(1(93-65.68)=**93**
2020	**90**	**90**
2021+	**90**	**90**

AHCCCS does not provide any rationale for not covering all persons including childless adults up to 133% of the poverty level beginning in 2014. For the years 2014 through 2016 the federal reimbursement rate for persons between 100-133% of poverty is 100%. After 2016, the rate drops slowly to 90% by 2020 and 2021. Thus, over the eight year period, the lowest reimbursement rate for the 100-133% population is 90%. For every one dollar the state spends, the federal government will reimburse the state at least $9.

For childless adults with incomes up to 100% in the state plan, the reimbursement rate increases by at least 50% from the current reimbursement rate and continues to increase up to 93% in 2019. For 2020 and 2021, it is 90%. Again the receipt of at least $9 for every one dollar in state expenditures is significant.

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[2] Formula is: Base FMAP + Percentage of Transition FMAP (NewlyEligibleFMAP-BaseFMAP)). 42 U.S.C. 1396d(z)(2)(B)(ii). Further information available at: http://www.medicaid.gov/State-Resource-Center/downloads/FMAP_for_Newly_Eligible_Mandatory_ Individuals_and_Expansion_States.pdf

[3] Arizona Base FMAP is from 2013, found at http://www.statehealthfacts.org.

The AHCCCS proposal makes no mention of the option to expand AHCCCS to persons whose incomes are 100-133% of poverty and we interpret the proposal to mean that AHCCCS does not intend to expand its program to cover these persons in the state plan or at all. Full ACA expansion guarantees compliance with Proposition 204, ensures the enhanced federal reimbursement and appears to cost the state over 1.3 billion dollars *less* than coverage of childless adults under the current FMAP during the period 2014 through 2017. *See* AHCCCS Medicaid Expansion Cost Analysis.

In addition, using AHCCCS' Medicaid Expansion Cost Analysis, shows that comparing a full ACA expansion (option 1) with AHCCCS' proposal of covering childless adults up to 100% with the enhanced FMAP (option 3), option 1 would only cost the state 12 million dollars for the period 2014 through 2017. *Yet this modest sum would leverage more than 1.4 billion federal dollars.* We do not understand this short-sided approach. We object to the state's apparent decision to not fully implement the ACA and to not obtain these additional federal funds. If AHCCCS fails to implement the full expansion, the citizens of Arizona as well as the state economy will suffer.

1. There Are Significant Economic Benefits to the State for Full ACA Expansion

As noted above, AHCCCS' cost analysis shows the huge infusion of federal funds to the state if the state expands to 133% of poverty. The Grand Canyon Institute recently published an analysis of the economic benefits of the ACA for Arizona. "Arizona's Medicaid Options under the Affordable Care Act: Fiscal and Economic Consequences" September 26, 2012. http://grandcanyoninstitute. The policy paper was prepared by Dave Wells, Ph.D. The analysis looks at three options: (1) keep the freeze on enrollment for childless adults but add coverage for children 6-18 years old to 133%; (2) full compliance with Proposition 204 requirements for mandatory coverage of childless adults with incomes up to 100% of the federal poverty level and increased coverage for children 6-18 years old to 133%; and (3) full compliance with the ACA – coverage up to 133% of the federal poverty level for all persons.

The analysis assumed that if AHCCCS did not fully expand coverage to 133% of poverty that the federal reimbursement rate for childless adults would remain at the current level, approximately 66%. Page 7. This assumption is implicit in the AHCCCS proposal. The analysis found that for every federal funding dollar, the state's economy grew by 1.85 dollars and for every new job created by the initial inflow of federal funds, the multiplier effect resulted in nearly one additional job for a total of 1.97 jobs. Page 2.

The author concludes that by expanding AHCCCS to 133% of poverty, Arizona will create 21,000 jobs and save 1.2 billion dollars. He estimates that the state's economy will grow by 2.776 billion dollars and the unemployment rate will be reduced by .07%. Table 2, and page 3. The author concludes that full implementation of the ACA is "the clear preferred pathway for Arizona." Page 20.

In addition, the ACA provides incentives so that states will be able to shift state and locally funded mental health programs to Medicaid and receive the federal match. Thus, any assessment of the cost of the expansion must also consider the savings that will occur with full expansion. As an example, the ACA requires that newly eligible persons receive mental health and substance abuse services at parity with other benefits. *See* 42 U.S.C. § 1396u-7(b)(6). It is our understanding that much of the current funding for the state's Seriously Mentally Ill ("SMI") program will be covered by the ACA. There are numerous other provisions in the ACA that allow the state to shift what are typically state costs to the Medicaid program. *See, e.g.,* 42 U.S.C. 1396n (community based services that may include housing and other supportive services).

Finally, regardless whether Arizona expands to full ACA compliance, the state is going to lose funding for uncompensated care under the ACA. 42 U.S.C. § 1396r-4(f)(7)(B). The ACA dramatically reduces the Medicaid Disproportionate Share Hospital ("DSH") programs because it is expected that full ACA implementation will result in fewer persons receiving uncompensated care. If Arizona does not implement the full ACA expansion, the number of persons seeking uncompensated care will remain high yet the DSH payments will decrease. For Arizona to lose both the higher FMAP and DSH payments would severely reduce federal dollars that are an integral support for our state Medicaid providers/system. There are many analyses of the ACA and its impact on state budgets. *See, e.g.,* Center for Budget Reform and Policy Priorities "How Health Reform's Medicaid Expansion Will Impact State Budgets," July 25, 2012 at http://www.cbpp.org/cms/index.cfm?fa=view8id=3801; National Health Law Program or Medicaid Expansion Toolbox at www.healthlaw.org.; "50 Reasons Medicaid Expansion is Good for Your State," Jane Perkins, August 2, 2012 at www.healthlaw.org. The state should proceed with full ACA expansion.

2. Full ACA Expansion Will Save Lives and Improve Health

Not only are there significant economic benefits to the state if there is full ACA expansion, but there also are documented improvements in health for those covered by Medicaid. The main benefit of healthcare is that it saves lives. The New England Journal of Medicine on September 13, 2012, published a research paper on this issue.

"Mortality and Access to Care Among Adults After State Medicaid Expansions," Sommers *et al.* at www.nejm.org.doi/full/10.1056/NEJMsa1202099. This study looked at the medical effects of expansion of Medicaid in three states, Arizona, Maine and New York, compared to neighboring states without expansions. Medicaid expansion showed a significant reduction in mortality with the greatest reductions for older adults, non-whites and residents of poorer counties. Improved access to care, decreased rates of delayed care because of cost and increased rates of self-reported health status were also found. Results and Tables 1-4.

It is well documented in the research that persons without health care coverage forego preventative and necessary care. *See, e.g., Kaiser Commission on Medicaid and the Uninsured, Pub. No. 7451-05, The Uninsured: A Primer* (2009) at page 7. Persons with chronic conditions such as diabetes, asthma and cancer, require on-going treatment and monitoring. The research conclusively shows the shortsightedness of not providing health care for these persons. As an example, individuals with diabetes can face life-threatening complications if the disease is not treated on a regular basis. Persons without health care coverage who postpone care due to a lack of access have a much higher risk of developing complications. Diabetics who cannot acquire needed medication, are substantially more likely to require hospitalization. Diabetes is the leading cause of new cases of blindness, end-stage chronic irreversible kidney disease, and lower-extremity amputations not related to injury. *Centers for Disease Control and Prevention, Diabetes: Successes and Opportunities for Population-Based Prevention and Control, At-a-Glance 2010* (2010). These are all conditions which result in a loss of health that cannot be remedied by emergency treatment.

Without AHCCCS, persons with chronic medical conditions will face a cycle of emergency treatment, stabilization, discharge, deterioration, and renewed emergency treatment. Moreover, without access to medical care, the costs in the AHCCCS program will shift to emergency care, a more costly medical service. *See* discussion in Section G below.

Finally, the AHCCCS executive summary alludes to the fact that persons with incomes above 100% can apply for the insurance exchange. Persons with incomes less than 133% of the federal poverty level are expected to be state plan enrollees and do not have adequate incomes to participate in the exchanges. *See* http://www.cbo.gov/sites/default/ files/cbofiles/attachments/43472-07-024-2012-CoverageEstimates.pdf. If they cannot afford the exchange coverage these persons will increase the uncompensated care costs and potentially be subject to penalties. The fact

that these persons hypothetically could go into the exchange is not a reason to not fully implement the ACA.

3. AHCCCS' Proposal to Limit the Childless Adult Coverage to "Available Resources" Cannot Be Justified When the High FMAP Is Available

With the passage of the ACA and its expected implementation on January 1, 2014, the state should take full advantage of the significantly increased FMAP. To continue to insist that AHCCCS intends to provide coverage to childless adults with "available resources" when the FMAP is so high, is not justifiable. It is not just state funding, but also the federal government's funding that must be considered. As noted above, AHCCCS's Medicaid Expansion Cost Analysis shows that if the state expands to 133% of poverty, it only costs the state 12 million dollars more than expanding the childless adults to 100% of poverty with the enhanced FMAP *but the federal government's reimbursement goes up 1.4 billion dollars.* AHCCCS' analysis also shows that the full ACA expansion costs 1.3 billion dollars less in state funds than coverage for childless adults under the current FMAP. These huge sums of federal funds are available to the state and must be secured.

Any effort to continue the freeze on enrollment for childless adults also is not justifiable and violates the will of the people. In the last year, over 100,000 persons have fallen off the childless adult program. These are our most vulnerable citizens. They are the homeless, persons with mental impairments, those without stable residences and those who find it difficult to navigate the state system and submit documentation to state agencies. If the freeze continues, there will be more preventable hardship.

D. AHCCCS Failed to Provide for Meaningful Public Input

The process AHCCCS has instituted for the request does not provide for meaningful public input as required by federal law. In the news announcement, AHCCCS stated that "[t]o begin the dialogue with the federal government on this matter, AHCCCS has submitted a waiver amendment." Having already submitted the waiver amendment, AHCCCS subsequently set a 30-day public comment period for the waiver amendment request dated September 18, 2012. Although AHCCCS states it will consider the public comments, it is clear AHCCCS already has made up its mind to proceed with the request. On the AHCCCS website, AHCCCS states that "[o]nce the comment period is closed … AHCCCS will formally submit the waiver amendment request to the Centers for Medicare and Medicaid Services ("CMS")." www.azahcccs.gov/reporting/federal/

waiver.aspx.?ID=Pending*. In addition, there is no statement that AHCCCS will consider public comments and two of the three public meetings will occur on October 17 and 18, just 1 and 2 days, respectively, before the end of the comment period.

In the ACA, Congress recognized the importance of meaningful public participation in the design of Section 1115 demonstration waivers. 42 U.S.C. § 1315(d)(1). The ACA required the Secretary of the Department of Health and Human Services ("HHS") to promulgate regulations for transparency and public notice and comment procedures to ensure a meaningful level of public input for applications and renewals of projects that impact eligibility, enrollment, benefits, cost-sharing or financing. 42 U.S.C. § 1315(d)(1) and (2). CMS proposed regulations to implement 42 U.S.C. § 1315(d) and the final regulations were effective April 27, 2012. 42 C.F.R. §§ 431.400-427. The introduction to the proposed regulations outlines the historical lack of public input for demonstration projects. The federal government has made a broad commitment to transparency and meaningful public input for demonstration waivers and these regulations are intended to implement that commitment.

The process AHCCCS is utilizing does not provide the transparency and meaningful public input intended by 42 U.S.C. § 1315(d) and the federal regulations. Under the federal regulations, transparency and meaningful public input at the state level require three major components. First, there must be public notice of the proposed demonstration waiver with sufficient detail to allow the public to understand the proposed 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. 42 C.F.R. § 431.412(c)(2)(vii).

Critical to ensuring meaningful participation is the requirement that the state actually consider and address the matters raised by the public comments. The regulations emphasize that public participation must be meaningful. If a state does not seek or consider public input, meaningful participation cannot occur. The state also is required to include in its request issues raised by the public during the comment period and how the state considered those comments when developing the demonstration extension application. 42 C.F.R. § 431.412(c)(1)(vii).

As explained above, AHCCCS has made up its mind and so public input will not be meaningful. Furthermore, AHCCCS' proposal does not provide the required information. 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 re- quest.
> >
> > (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.

AHCCCS provided only a cursory overview of the information required by paragraph A. AHCCCS also failed to provide the information required in paragraph C. As a preliminary matter, although AHCCCS attaches two cost summaries, it is impossible for the public to understand what assumptions AHCCCS made in reaching these cost summaries. There is no information provided explaining how AHCCCS calculated the

costs. As an example, AHCCCS fails to provide per member per month costs it used in its calculations. Moreover, the summaries fail to segregate out childless adults in each option. In addition, although the summaries show either "total lives" or "increase in covered lives," there is no explanation on how these numbers were derived. Nor is there any indication that AHCCCS considered any savings that the state would achieve from the full ACA expansion including the shift of state and local costs for medical care to the Medicaid program.

In addition, for one of the expansion cost analysis/summary, AHCCCS uses the terms "Transitional match" for option 1 and "Enhanced Transitional match" for option 3 without explaining what the difference is, if any. In the written request the term "enhanced FMAP" is used. Clearly the information required in paragraph C above was not provided. Thus, it is impossible for the public to understand the cost summaries and evaluate whether AHCCCS' financial analyses are correct.

The information requested in paragraph D also is not provided. As an example, for "details," the AHCCCS proposal states: "This amendment seeks to maintain a current program beyond the stated termination date of December 31, 2013. There are no other anticipated changes at this time." For "evaluation design," the proposal only states that "The State proposes to apply the same evaluation criteria to this proposal that it currently applies to this Demonstration population." The inadequacy of the current draft evaluation is discussed in Section H below.

E. The Proposed Section 1115 Childless Adult Amendment Request Fails to Satisfy Federal Requirements for Demonstration Projects

Although we request that AHCCCS expand to cover all persons up to 133% of the federal poverty level as state plan enrollees pursuant to 42 U.S.C. § 1396a(a)(10)(A)(i)(VII), we also address the demonstration extension request. In this and subsequent sections, we explain the reasons why the demonstration extension does not comply with federal law and should be scrapped.

Section 1115 of the Social Security Act, 42 U.S.C. § 1315(a) authorizes the Secretary under certain conditions to approve "experimental, pilot or demonstration projects" that are "likely to assist in promoting the objectives of the Medicaid Act." The hallmark of Section 1115 is its requirement of research or experimentation. Thus, section 1115

> was not enacted to enable states to save money or to evade federal requirements but to 'test out new ideas and ways of dealing with problems of public welfare recipients.' [citation omitted].

Beno v. Shalala, 30 F.3d 1057, 1069 (9th Cir. 1994); *See also, Newton-Nations v. Betlach*, 660 F.3d 370, 380 (9th Cir. 2011). In *Beno*, the Ninth Circuit held Section 1315(a) "plainly obligates the Secretary to evaluate the merits of a proposed state project, including its scope and potential impact" on recipients. *Id.* at 1068. Under *Beno*, there are three main parts to the required analysis. First, the Secretary must determine that the project has research or demonstration value. *Id*. at 1069. Second, the proposed project must assist in promoting the objectives of the Act. *Id.* As part of this assessment, the Secretary must consider the impact the demonstration project has on the persons the Medicaid Act was intended to protect. *Id.* Part of this assessment implies the collection of data. *Id.* at 1070-71 and fn. 30. Finally, the Secretary can only approve Section 1315 projects for the "extent and period" necessary. *Id.* at 1071.

The only rationale AHCCCS provides for the proposed amendment request is to have "flexibility" to provide coverage for childless adults "within available resources." This rationale does not satisfy the statutory requirements for a Section 1115 demonstration project. Moreover, there is nothing experimental, pilot or demonstrational about covering childless adults up to 100% of the poverty level when as of January 1, 2014, all states are required to cover "all" persons up to 133% of the federal poverty level. Many states already have expanded coverage for childless adults under the ACA.

AHCCCS also fails to explain how this proposal promotes the objectives of the Medicaid Act, when the ACA requires coverage of childless adults as state plan participants. AHCCCS totally fails to provide any explanation about how a childless adult demonstration project extension meets the requirements of Section 1115.

F. The Proposed Continuation of the Mandatory and Heightened Copayments Is Inconsistent with the Medicaid Act's Strict Limits on Cost Sharing for Low-Income Persons Below 100% of Poverty

AHCCCS wants to continue the heightened and mandatory copayments for prescriptions, doctor visits, and the non-emergency use of emergency room as well as the missed appointment penalty, and the transportation copayment. AHCCCS does not want to comply with the Medicaid Act cost sharing limits for state plan enrollees. Congress initially refers to cost sharing at 42 U.S.C. § 1396a(a)(14). According to section

1396a(14), the state plan must provide that, if cost sharing is being used, it will be imposed as provided in 42 U.S.C. § 1396o. *See also* Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 133 (adding 42 U.S.C. § 1396o).

The Medicaid Act also concerns the contents of a state plan. 42 U.S.C. § 1396o. This provision allows states to use various types of cost sharing, for example premiums and copayments, and is detailed concerning the copayments allowed. Among other things, it provides that "the state plan shall" impose only "nominal" copayments on individuals who are described in the Medicaid Act's mandatory categorically needy, optional categorically needy and medically needy provisions. *See* 42 U.S.C. § 1396o(a) (regarding categorically needy individuals described in section 1396a(a)(10)(A) or (E)(i)); § 1396o(b) (regarding individuals other than those described in 1396a(a)(10)(A) or (E)).

Although copayments are authorized, they are strictly limited for very low-income persons. 42 U.S.C. §§ 1396o, 1396o-1. This is a safety valve provision because low-income persons have little or no discretionary income. While the Deficit Reduction Act of 2006 gave states additional flexibility for cost sharing, individuals with family income below 100% of the federal poverty level were exempt from this new flexibility. 42 U.S.C. § 1396o-1(a)(2)(A). For mandatory and optional Medicaid categories, only nominal copayments are allowed. 42 U.S.C. § 1396o(a)(3) and (b)(3).

The Medicaid Act refers to the definition of "nominal" contained in duly promulgated regulations in effect on July 1, 1982. *Id.* The federal regulations tie the permissible copayment to the amount the state Medicaid program pays for the service subjected to the copayment. *See* 42 U.S.C. 1396o-1(b); 42 C.F.R. § 447.54(a)(3). These amounts can be adjusted for the medical component of the consumer price index. *Id.* Currently, copayments may range from $.65, when the Medicaid payment for the service is $10.00 or less, up to a maximum of $3.80, when the Medicaid payment for the service is $50.01 or more. CMS Informational Bulletin, September 30, 2011, found at http://downloads.cms.gov/archived-downloads/ CMCSBulletins/downloads/CIB-9-30-2011.pdf. Also, for individuals with family income below 100% of the federal poverty level, the copayments are non-mandatory, meaning that Medicaid providers cannot deny care to an eligible individual because of the inability to pay a copayment. 42 U.S.C. §§ 1396o(e); 1396o-1(a)(2)(A).

There are many categories of persons and services exempt from copayments and others who can only be charged nominal copayments. *See, e.g.*, 42 U.S.C. §§ 1396o(a)(2), (b)(2), (b)(3); §§ 1396o-1(a)(2), (b)(3)(B). In addition, even for higher

income individuals, a state must include a cap on copayments of 5% of income. 42 U.S.C. § 1396o-1(b)(1)(B)(ii). All these protections would be eliminated under the AHCCCS proposal.

As of January 1, 2014, the current Demonstration Project requires AHCCCS to come into compliance with 42 U.S.C. § 1396o for childless adults. Special Terms and Conditions, Paragraph 36(b). Under that provision, the Secretary can only approve non-nominal cost-sharing under the waiver of a demonstration project. In addition, the Secretary must make specific findings "after public notice and the opportunity for comment." 42 U.S.C. § 1396o(f). Those required findings are that the demonstration project:

> (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.

AHCCCS' cost sharing requests does not purport to satisfy the requirements of 42 U.S.C. § 1396o(f). In fact, in an e-mail to the federal government on September 18, 2011, in response to a request concerning how AHCCCS would meet the requirements in section 1396o(f) if AHCCCS was allowed to impose heightened and mandatory copayments on state plan enrollees AHCCCS stated that "Congress has established an unattainable standard" in section 1396o(f). Attached as Exhibit 1.

What this request boils down to is another barrier to the receipt of health care. Certainly there is no factual support for a "unique and previously untested use of copayments, or a study based on a "reasonable hypothesis" to test in a "methodologically sound manner," or the use of control groups. 42 U.S.C. §1396o(f)(4). Nor is there any showing of how this will be voluntary. 42 U.S.C. §1396o(f)(5).

Finally, it is unconscionable that although AHCCCS has not evaluated the mandatory and heightened copayments it has imposed since October 2010 on prescriptions, office visits and the non-emergency use of the emergency room, to see if they hinder the ability of low-income persons to obtain needed medical care, AHCCCS proposes an extension of those copayments. Before AHCCCS considers a proposal to extend the copayments, it must draft a competent study, complete its study, analyze the data and make the results public.

G. The Proposed Continuation of the Mandatory and Heightened Copayments Does Not Satisfy the Requirements for Demonstration Projects Under 42 U.S.C. § 1315

AHCCCS seeks authority to continue the mandatory and heightened copayments for childless adults currently in place to "retain the personal responsibility component." By its own admission, there is nothing experimental, pilot or demonstrational about heightened and mandatory copayments for childless adults. AHCCCS has imposed the heightened and mandatory copayments since October 2010. In the past two years, AHCCCS has failed to conduct any valid experiment or evaluation of the copayments.

Dr. Leighton Ku, a national expert on Medicaid and cost sharing prepared declarations in the *Newton-Nations* and *Wood v. Betlach*, CIV 12-08098 PCT DGC, litigation. In 2008, Dr. Ku submitted a declaration in *Newton-Nations v. Rodgers*, CIV 2003-2506 PHX EHC, in which he stated that "of all forms of cost sharing, copayments are the most heavily studied." Second Declaration of Leighton Ku, ¶ 9, ("Second Ku Dec."), attached as Exhibit 2. Dr. Ku's current resume is attached as Exhibit 3.

Dr. Ku stated that the effects of copayments on the poor have been extensively researched and studied for over 30 years. Second Ku Dec. ¶¶ 9-18. Dr. Ku noted that a "substantial and rigorous body of research has consistently concluded" that individuals with incomes below the federal poverty level are more vulnerable to the adverse effects of copayments than other groups, and copayments cause these individuals "to use substantially fewer *essential* and *effective* medical services or medications." Copayments lead to an increase in emergency room visits and more hospitalizations. Second Ku Dec.

¶¶ 10-17, 19 (emphasis in original). He noted that copayments have been shown to lead to poorer health for low-income persons and that copayments increase the use of emergency rooms when persons go without essential medications. Second Ku Dec. ¶ 11. When persons limit their use of medications because of the inability to pay for copayments, they are significantly more likely to experience heart attacks, strokes, and experience a decline in health. Second Ku Dec. ¶ 12. Dr Ku concludes that he knows of no "unique or untested" aspect of copayments. Second Ku Dec. ¶ 24.

The Institute and the National Health Law Program represent four Plaintiffs in the *Wood et al. v. Betlach et al.* case who challenge the current heightened and mandatory copayments for prescriptions, office visits and the non-emergency use of the emergency room that AHCCCS wants to continue until 2016. . Dr. Ku submitted a supplemental declaration in the *Wood* case in July 2012, in which he summarizes recent research on copayments. Supplemental Declaration of Leighton Ku. ("Supp. Ku Dec."), attached as Exhibit 4. Dr. Ku reiterates that over the last 40 years, the most heavily studied aspect of cost sharing is copayments and his expert opinion that copayments present barriers to low-income persons' receipt of needed medical care and medication. Supp. Ku Dec. ¶11. He cites studies in Tennessee and Oregon concerning access to medical care when copayments were imposed on similar populations to the childless adults in Arizona. Supp. Ku Dec. ¶¶14-15. In Tennessee, those who could not pay the copayments went without medical care. Supp. Ku Dec. ¶ 14. In Oregon the researchers found the copayments led to reductions in prescription drug and office-based physician care, but increases in outpatient and inpatient hospital care. Thus, higher copayments on a population similar to the childless adults led patients to reduce their use of routine medication and medical care use, and this led to greater use of more expensive hospital services. Supp. Ku Dec. ¶ 15.

Dr. Ku cites a study of adult cancer patients in Georgia, where after copayments were raised, use of prescription medications went down, while emergency room visits increased and Medicaid expenditures increased. Supp. Ku Dec. ¶16. He also cites research that looked at whether copayments reduce the use of emergency rooms and found the copayments do not. Supp. Ku Dec. ¶¶18-19.

AHCCCS has known about the effects of copayments on low-income persons for almost a decade. AHCCCS' consultants in 2003-04 reached similar conclusions that mandatory and heightened copayments would reduce utilization of preventative services and increase the use of costly hospital services by the affected persons:

> Based on a March 2003, Kaiser study on the impact of cost sharing on Medicaid and the uninsured, Mercer assumed lower utilization rates for the services to which co-pays applied, and increased the assumed utilization of inpatient hospital and emergency room services. The Kaiser Commission study, as well as several others, showed that when cost sharing is applied to a population like the TWG [with incomes below the poverty level], people will tend to forgo seeing their physician and having their prescriptions filled. Use of the hospital and emergency services will increase because the use of preventative services has decreased.

Defendant Rodgers' Answers to Plaintiffs' Interrogatories, No. 3 in *Newton-Nations* case. Exhibit 5.

The former director of AHCCCS explained in an e-mail to AHCCCS staff dated February 21, 2007, how cost sharing interferes with managed care. He concluded that "Cost sharing works against the notion of managed care." He further explained:

> Cost sharing is imposed to change beneficiary behavior or to make the beneficiary financially responsible for the service choices "they" make… If you are going to put co-payments and co-insurance on AHCCCS MCO [managed care organization] members it will work against the health plans medical management programs. The reason that AHCCCS has one of the lowest PMPM [per member per month payments] of all state Medicaid programs is our managed care model. Health plan[s] manage the utilization of members better than any cost sharing program would do. Cost sharing is for States that do not have Medicaid managed care.

Exhibit 6. The current AHCCCS director agreed. *Id.* We agree with them. AHCCCS' proposal is inconsistent with the managed care model it claims is so successful.

Finally, these mandatory and heightened copayments fall heaviest on those with the most medical needs. Both the *Newton-Nations* and *Wood* cases have numerous declarations from persons adversely affected by the copayments. These are persons who often have applied for disability and have significant and chronic medical conditions.

They cannot afford the copayments and go without needed medical care. Without proper medical care, these persons end up using the most costly medical care in hospitals or emergency rooms.

H. AHCCCS' Current Evaluation Design Is Fundamentally Flawed and Useless and Should Not Be Used

AHCCCS proposes to continue to "apply the same criteria to the proposal that it currently applies to the Demonstration population." Currently, AHCCCS claims it will test four hypotheses. The first hypothesis is: "How will utilization of needed preventive, primary care, and treatment services be affected." The second hypothesis is: "To what extent will the imposition of the pharmacy copayments and copayments related to non-emergent use of emergency rooms ensure appropriate utilization of emergency room care and appropriate utilization of cost and clinically effective generic and brand name drugs." There is absolutely nothing novel, pilot or experimental about these hypotheses. As explained by Dr. Ku and noted by the Ninth Circuit in *Newton-Nations*, these hypotheses have been repeatedly tested by more than the 35 years of research that consistently concludes that the imposition of the challenged copayments on lower income beneficiaries results in these individuals using "substantially fewer *essential* and *effective* medical services or medications" and an increase use of emergency rooms and hospitalizations. *See* Second Ku Decl., Exhibit 2 (emphasis in original). *Newton-Nations*, 660 F.3d at 381.

Hypothesis three is: "Will the mandatory co-payments affect State and federal expenditures (per enrollee) in the short and long term." This hypothesis, which is tied to cost expenditures, is not a proper basis for a section 1315 proposal. Rather, the Secretary must look at the impact of the project on those whom the Medicaid Act is intended to serve, namely low income people. *Newton-Nations*, 660 F.3d at 381; *Beno*, 30 F.3d at 1069.

The fourth hypothesis is: Will there be an impact on physician participation, or physician willingness to accept appointments from the adults without dependent children population. In addition to adding nothing to the decades of copayment experimentation, hypothesis (iv) looks at physician participation and similarly fails to focus on the impact of the copayments on the beneficiaries. *Newton-Nations*, 660 F.3d at 381; *Beno*, 30 F.3d at 1069-1070.

In addition to the concerns about what AHCCCS proposes to study, there are concerns about AHCCCS' methodology. Dr. Ku has provided his expert opinion in

Wood v. Betlach, CIV 12-08098 PCT DGC, concerning AHCCCS' draft evaluation plan for the copayments AHCCCS would like to continue beyond December 31, 2013. Suppl. Ku Dec., Exhibit 4. Dr. Ku's expert testimony is that a demonstration project must be designed to yield "meaningful and valid information that could be used to improve the Medicaid program on a broader basis." Suppl. Ku Dec. ¶25. His opinion based on his review of the evaluation plan is that the proposed copayment demonstration project in the *Wood* litigation and the evaluation that AHCCCS proposes to continue will not provide any "reasonable research insights . . . that have not been studied elsewhere repeatedly." Suppl. Ku Dec. ¶24. Dr. Ku's expert opinion is that "neither the State of Arizona not the Centers for Medicare and Medicaid Services have planned serious attempts to research new or novel approaches to deliver care with respect to cost-sharing that would offer meaningful information about the effects of cost-sharing." Suppl. Ku Dec. ¶24.

Dr. Ku also assessed the draft evaluation plan to see if it would yield anything useful. He noted that the plan did not have an independent evaluation and is fatally flawed. *Id.* . Suppl. Ku Dec. ¶¶31-39. The plan purports to test the effect of copayments on medications, office visits, the use of the emergency room and to evaluate the transportation copayment and the missed appointment fee at the same time and on the same persons. Suppl. Ku Dec. ¶¶31-32, 34, 36, 38, 40-42. Dr. Ku concluded the findings will be useless. He likens this study to a study of a grocery store

> that is trying to test, all at the same time, the effects of special sales coupons, changes in shopping cart size and the presence of pleasing background music, on consumers' shopping behaviors simply by looking at changes in the average grocery expenditures per customer in Time A vs Time B. Even if you observed a $3 difference in average grocery bills, you would not be able to determine [the cause]. The weak evaluation design would not produce useful findings.

Suppl. Ku Dec. ¶40.

AHCCCS has imposed the heightened and mandatory copayments since October 2010, and as of the date of this letter has not crafted a competent evaluation plan and thus has not completed an evaluation of the copayments. There is no lawful justification to extend these copayments and AHCCCS should not request the extension.

I. The Missed Appointment Penalty for Childless Adults Should Not Be Extended

The State wants to continue to allow a provider to charge a missed appointment penalty if a childless adult does not attend the scheduled appointment in counties outside Maricopa and Pima Counties. This penalty is allowed in the current STCs, Paragraph 17(e), page 12. The STCs also include a required evaluation component. Paragraph 26(d), page 27. This penalty is set to expire on January 1, 2013, but may be extended upon request to December 31, 2013.

CMS allowed AHCCCS to impose this penalty and AHCCCS began the penalty in April 2012. AHCCCS purportedly is going to study this penalty but as Dr. Ku concluded, AHCCCS' draft evaluation plan is fundamentally flawed and will produce useless information. Suppl. Ku Dec. ¶ 24, Exhibit 4. There is no reasonable justification to continue the penalty and AHCCCS should not request the extension.

J. The Copayment for Non-Emergency Transportation for Childless Adults in Maricopa and Pima Counties Should Not Be Extended

The State seeks to continue the copayment for non-emergency medical transportation for childless adults in Maricopa and Pima counties. The current SCTs allow AHCCCS to impose these copayments and AHCCCS began the copayments in April 2012. These copayments like the ones for medications, doctor visits and the non-emergency use of the emergency room, end with the transition of childless adults to the state plan by December 31, 2013. As explained above, Dr. Ku has concluded that AHCCCS' draft evaluation plan is fundamentally flawed and will produce useless information. Suppl. Ku Dec. ¶ 24, Exhibit 4. There is no reasonable justification to continue these copayments and AHCCCS should not make this request.

K. The State Should Consider a Challenge to the Differential FMAP for Childless Adults for Arizona Under the ACA

The ACA provides for a differential federal reimbursement percentage for childless adults in states depending on whether the state covered expansion populations prior to the ACA. If the state does not think this differential treatment has a rational basis, then it should challenge the reimbursement rate on equal protection grounds or any other basis the state concludes has merit. Of course, to pursue this challenge, the state would have to state its intent to comply with the full ACA expansion.

Conclusion

For all the above reasons, the William E. Morris Institute for Justice, the Arizona Center for Disability Law, Community Legal Services and the National Health Law Program request that AHCCCS not submit or withdraw the amended request and instead, work toward full ACA expansion up to 133% of the poverty level. If you have any questions or need additional information, please contact me at (602) 252-3432.

Sincerely,

/s/

Ellen Sue Katz on behalf of

Arizona Center for Disability Law

Community Legal Services

National Health Law Program

William E. Morris Institute for Justice

ESK
Attachments