

February 3, 2021

Acting Secretary Norris Cochran
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Proposed Extension of Arizona Health Care Cost Containment Section 1115 Demonstration Project

Dear Secretary Cochran:

The undersigned organizations appreciate the opportunity to comment on Arizona's request to extend the Arizona Health Care Cost Containment (AHCCCS) section 1115 demonstration project from September 30, 2021 to September 30, 2026. The state is asking to continue many of its existing authorities, including the authority to take coverage away from people for not meeting work requirements and to stop providing retroactive coverage to Medicaid beneficiaries who incur medical costs up to three months before they apply.

As explained below, we support parts of Arizona's proposal that promote coverage, but we urge you to reject the state's requests to take coverage away from people for not meeting work requirements and to waive retroactive coverage. These proposals do not further the objectives of the Medicaid program as they create barriers to coverage and expose beneficiaries to medical debt.

Arizona's Work Requirement Will Lead to Thousands Losing Coverage and Should Not be Extended

Arizona's work requirement was approved in January 2019, with an implementation date no sooner than January 1, 2020, but the state suspended implementation in October 2019, citing pending litigation in other states. Arizona is now asking for continuation of the authority to implement a work requirement in its extension request. That request should be denied.

Work requirements do not further the purposes of the Medicaid program and inevitably lead to unacceptable coverage losses. In Arkansas, over 18,000 beneficiaries, or about a quarter of those subject to the work requirement, lost coverage over the first seven months of implementation.¹ In New Hampshire, almost 17,000 beneficiaries, or about 40 percent of those subject to the work requirement, were set to lose Medicaid before the state suspended the requirement.² In Michigan, some 80,000 beneficiaries, or about one-third of those subject to the work requirement, were set to lose coverage before a federal court vacated the state's work requirement policy.³ These coverage

¹ Arkansas Department of Human Services, "Arkansas Works Program: December 2018," January 15, 2019, https://humanservices.arkansas.gov/images/uploads/011519_AWRReport.pdf.

² New Hampshire Department of Health and Human Services, "DHHS Community Engagement Report: June 2019," July 8, 2019, <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf>.

³ Robin Erb, "Gretchen Whitmer Asks to Stop Michigan Medicaid Rules; 80,000 At Risk," *Bridge Michigan*, February 25, 2020, <https://www.bridgemi.com/michigan-health-watch/gretchen-whitmer-asks-stop-michigan-medicaid-work-rules-80000-risk>.

losses are even higher than the 6 to 17 percent coverage loss that Kaiser Family Foundation researchers forecasted could result from implementing work requirements nationwide.⁴

In all three of these states, evidence suggests that people who were working and people with serious health needs who should have been eligible for exemptions lost coverage or were at risk of losing coverage due to red tape. Large numbers of enrollees in Arkansas and New Hampshire reported that they didn't know about the work requirement or whether it applied to them.⁵

Nearly half of working low-income adults wouldn't be able to meet an 80-hour work requirement, like the requirement Arizona seeks to impose, each month. Even among those working 1,000 hours over the course of a year—about 80 hours per month—1 in 4 would be at risk of losing coverage because they wouldn't meet the 80-hour requirement in every month, research shows.⁶

Moreover, there's no evidence that employment of Medicaid enrollees increased due to work requirements implemented in Arkansas. To the contrary, employment rates for low-income Arkansas residents aged 30 to 49 (those potentially subject to work requirements) did not meaningfully increase after the policy took effect, nor did they increase relative to employment rates for older low-income Arkansas residents or low-income younger people in neighboring states, according to Harvard researchers.⁷

Most people who lose coverage due to a work requirement will become uninsured, losing access to medications and other needed care. They will also face financial hardship. Half of people who lost Medicaid in Arkansas reported serious problems paying off medical debt, 56 percent delayed care because of cost, and 64 percent delayed taking medications because of cost.⁸

⁴ Rachel Garfield, Robin Rudowitz, and MaryBeth Musumeci, "Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses," Kaiser Family Foundation, June 27, 2018, <https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/>.

⁵ Benjamin Sommers *et al.*, "Medicaid Work Requirements — Results from the First Year in Arkansas," *New England Journal of Medicine*, June 2019, <https://www.nejm.org/doi/full/10.1056/NEJMSr1901772>; Dave Solomon, "Spreading the word on Medicaid work requirement proves challenging," *Union Leader*, June 16, 2019, https://www.unionleader.com/news/health/spreading-the-word-on-medicaid-work-requirement-proves-challenging/article_740b99e7-9f48-52d4-b2d8-030167e66af8.html; Jason Moon, "Confusing Letters, Frustrated Members: N.H.'s Medicaid Work Requirement Takes Effect," New Hampshire Public Radio, June 18, 2019, <https://www.nhpr.org/post/confusing-letters-frustrated-members-nhs-medicaid-work-requirement-takes-effect#stream/0>.

⁶ Aviva Aron-Dine, Raheem Chaudhry, and Matt Broaddus, "Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements," Center on Budget and Policy Priorities, April 11, 2018, <https://www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements>.

⁷ Sommers *et al.*, 2019; Benjamin Sommers *et al.*, "Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care," *Health Affairs*, September 2020, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00538>.

⁸ Somers, *et al.*, 2020.

Retroactive Coverage is Crucial for Beneficiaries and Providers

Arizona’s proposal to continue its waiver of retroactive coverage prohibits Medicaid reimbursement for medical costs incurred by most Medicaid beneficiaries for up to three months before they apply. Medicaid payments are normally available for these expenses if the beneficiary was eligible for Medicaid during this period. Retroactive coverage, which has been a feature of Medicaid since 1972, provides financial security to low-income beneficiaries, and helps prevent medical bankruptcy. For example, data from Indiana shows how important retroactive coverage is for low-income parents in the state -- a group that wouldn’t be expected to have large medical costs, but in fact incurred significant medical costs prior to enrollment. Medicaid paid \$1,561 on average on behalf of parents in Indiana who incurred medical costs prior to enrolling in Medicaid.⁹

The greatest impact of waiving retroactive coverage will most likely be felt by seniors and people with disabilities who need long-term services and supports. Eliminating retroactive coverage will make it harder for this vulnerable population to get nursing home care when they need it, because they may delay applying due to a lack of familiarity with Medicaid and its eligibility rules. Eligibility rules for people needing nursing home care are complex, often requiring help from family members to assemble information on assets and income needed for an eligibility determination. Moreover, it’s often not clear when Medicaid eligibility begins, given the need to spend down available assets.

The impact of waiving retroactive coverage on the availability of nursing home care for seniors and people with disabilities is not speculative. Nursing homes in Iowa are already making changes in their admission processes as a result of the retroactive coverage waiver your predecessor approved in the state in 2017. The chief financial officer of an Iowa-based nursing home company wrote to the Centers for Medicare and Medicaid Services (CMS) stating that “with the state requesting elimination of (retroactive payment), our nursing homes will no longer admit any prospective resident who is Medicaid-pending, or will become Medicaid-pending shortly after admission.”¹⁰ Denying nursing home admission at the time it is needed prevents seniors and people with disabilities from getting the care they need, potentially leading to unnecessary and lengthy hospital stays and medical debt.

In addition to helping people get the care they need, retroactive coverage increases the financial stability of hospitals and other safety net providers by allowing them to be reimbursed for care they have provided during the three-month period that would otherwise have gone as uncompensated care. Without retroactive coverage in place, a hospital would no longer get paid for an emergency appendectomy or setting a broken bone for adults who are uninsured but Medicaid-eligible at the time of their accident. In Iowa, rural and urban hospitals alike are being harmed by the state’s retroactive coverage waiver, resulting in a push by the Iowa Hospital Association to get rid of the

⁹ July 29, 2016 letter from the Centers of Medicare and Medicaid Services to the state of Indiana, available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf>.

¹⁰ Clark Kauffman, “Medicaid Cuts to Roughly 40,000 Iowans Approved By the Feds,” *Des Moines Register*, October 31, 2017, <https://www.desmoinesregister.com/story/news/health/2017/10/31/iowa-medicaid-cuts-for-roughly-40000-iowans-approved-by-federal-government/816993001/>

policy.¹¹ Moreover, the Medicaid beneficiary could end up with significant medical debt, undermining his or her family's financial stability.

Providers in Arizona have also expressed concern over the state's request to eliminate retroactive coverage citing its importance in ensuring the financial health of both Medicaid beneficiaries and safety net providers alike. For example, the Arizona Alliance for Community Health Centers expressed concern that continuing to waive retroactive coverage has the "potential for interruptions in coverage, delayed or foregone health care, and cost shifting from Medicaid to health care providers."¹² With the coronavirus pandemic, individuals face greater risk of coverage interruptions and incurring significant medical debt from the limits on retroactive coverage. Beneficiaries may end up responsible for thousands of dollars in COVID-19 treatment and other resultant health care costs.¹³

Integrating Primary and Behavioral Health Care and Improving Connections with CBOs Will Improve Access to Care

Arizona's proposal to *extend* and *expand* its Targeted Investments (TI) Program would improve access to care for Medicaid beneficiaries who often face the greatest barriers to care. People with co-occurring physical and behavioral health conditions often struggle to simultaneously navigate both the physical and behavioral health care systems, leading to gaps in care and contributing to preventable use of expensive emergency systems. Improving coordination between primary care and behavioral health services can enhance access to high-value services, helping to avoid the use of more costly and less effective emergency services.¹⁴ Arizona's TI Program promotes cross-system screening, integrated care plans, integrated electronic health record systems, and other strategies for achieving close collaboration between behavioral and physical health providers. Arizona's proposal to expand the TI Program to include more providers will mean even more beneficiaries will benefit from integrated care.

Arizona's proposal to *extend* its TI Program also shows tremendous promise. In addition to difficulties navigating the health care system, people with complex health needs often face unmet social needs that create additional barriers to health care and wellness.¹⁵ For instance, living in shelters or on the streets makes it extremely difficult to store and manage medications, access

¹¹ Harris Meyer, "New Medicaid barrier: Waivers ending retrospective eligibility shift costs to providers, patients," Modern Healthcare, February 9, 2019, <https://www.healthaffairs.org/doi/10.1377/hblog20200506.111318/full/>.

¹² Arizona Alliance for Community Health Centers Comment Letter to AHCCCS, November 27, 2020, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa8.pdf>.

¹³ Paul Shafter, Nicole Huberfeld, and Ezra Golberstein, "Medicaid Retroactive Eligibility Waivers Will Leave Thousands Responsible For Treatment Costs," Health Affairs, May 8, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20200506.111318/full/>.

¹⁴ Hannah Katch, "States are Using Flexibility to Create Successful, Innovative Medicaid Programs" Center on Budget and Policy Priorities, June 2016, <https://www.cbpp.org/research/health/states-are-using-flexibility-to-create-successful-innovative-medicaid-programs>.

¹⁵ Peggy Bailey, "Housing and Health Partners Can Work Together to Close the Housing Affordability Gap," Center on Budget and Policy Priorities, January 2020, <https://www.cbpp.org/research/housing/housing-and-health-partners-can-work-together-to-close-the-housing-affordability>.

transportation to medical appointments, or consistently eat nutritious foods. Under the proposal, providers already participating in the TI Program would extend their integration efforts to include coordination with community-based organizations (CBOs) that provide key social services. By connecting beneficiaries with social services — including affordable housing, food assistance, and child care — participating providers will help remove barriers to care and support better health outcomes.¹⁶

However, many of the people who would benefit most from integrated care are likely also those most at risk of losing coverage under Arizona’s work requirement policy and incurring higher medical debt from the lack of retroactive coverage.¹⁷ Similarly, the safety net clinics participating in the TI Program would face greater unreimbursed care costs from both Arizona’s work requirement and retroactive coverage policies, undermining their efforts to integrate care and connect beneficiaries to social services.

Arizona’s Requests to Reimburse for Traditional Healing Services and Adult Dental Services Provided at Indian Health Service, Tribal 638 Facilities, and Urban Indian Health Programs Should be Approved

Arizona is requesting the ability to reimburse for the provision of an array of practices provided by traditional healers to patients of Indian Health Service, Tribal 638, or Urban Indian Health (I/T/U) facilities. These traditional healing practices would be complementary to, not in lieu of, allopathic medicine services. As the state’s request explains, tribes believe that traditional health practices “help patients achieve wellness and healing for a specific physical or mental ailment or affliction and to restore emotional balance and one’s relationship to the environment.” Arizona is asking permission to evaluate whether making traditional healing services available to Medicaid patients of I/T/U facilities will improve the health outcomes of American Indian beneficiaries. Given the health disparities faced by American Indians and Alaska Natives, this is an important hypothesis that deserves to be tested.

Arizona is also requesting that it be allowed to reimburse I/T/U facilities for the costs of adult dental services furnished to their Medicaid patients in excess of the limits that would otherwise apply to Medicaid beneficiaries in Arizona. Currently, the state imposes a \$1,000 per year limit on payment for emergency dental services for adult members enrolled in the AHCCCS program and a \$1,000 limit on dental services for individuals age 21 or older enrolled in the ALTCS program. The state is requesting the ability to waive these limits as they apply to patients of I/T/U facilities.

As the state’s application recognizes, “Oral health care is essential to a person’s overall health and quality of life. A growing body of evidence has linked oral health, particularly periodontal (gum) disease, to several chronic diseases, including diabetes, heart disease, and stroke.” This is true for all Medicaid beneficiaries, not just American Indians, and we believe that the state should eliminate these cost limits for all of its adult Medicaid beneficiaries. However, the evidence presented by the

¹⁶ Hannah Katch, “Medicaid can Partner with Housing Providers to Address Enrollee’s Social Needs,” Center on Budget and Policy Priorities, January 2020, <https://www.cbpp.org/research/health/medicaid-can-partner-with-housing-providers-and-others-to-address-enrollees-social>.

¹⁷ Anna Bailey & Judith Solomon, “Medicaid Work Requirements Don’t Protect People with Disabilities,” Center on Budget and Policy Priorities, November 2018, <https://www.cbpp.org/research/health/medicaid-work-requirements-dont-protect-people-with-disabilities>.

state makes clear that the oral health of American Indians and Alaska Natives (AI/ANs) is worse than that of Whites. Eliminating the payment limits for patients at I/T/Us will improve the ability of those facilities to recruit and retain dental professionals, thereby improving access for adults and children alike. We therefore support the state's proposal to reduce oral health disparities among its American Indian Medicaid beneficiaries.

Conclusion

Our comments include numerous citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

Thank you for your willingness to consider our comments. While we recommend renewing Arizona's section 1115 demonstration project, we urge you to reject the state's request to continue its work requirement policy and retroactive coverage waiver and protect Arizonans who rely on Medicaid. If you need additional information, please contact Judith Solomon (Solomon@cbpp.org) or Joan Alker (jca25@georgetown.edu).

Center for Medicare Advocacy
Center on Budget and Policy Priorities
Epilepsy Foundation
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