February 3, 2021

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

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

Dear Acting Secretary Norris Cochran:

Thank you for the opportunity to submit comments on the Proposed Extension of Arizona Health Care Cost Containment Section 1115 Demonstration.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the Department of Health and Human Services (HHS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and our organizations are committed to ensuring that Arizona's Medicaid program provides quality and affordable healthcare coverage. While our organizations support the elimination of the premium and coinsurance program, the proposal also contains policies that would jeopardize patient's access to quality and affordable healthcare. Our organizations offer the following comments on

Arizona's application and ask you not approve the provisions related to work requirements and retroactive coverage.

Work Requirement

On January 11, 2018, The Centers for Medicare and Medicaid Services (CMS) issued a letter to state Medicaid directors inviting states the apply for Section 1115 waivers that condition Medicaid benefits on meeting work and community engagement requirements. Since then, CMS has approved waivers in 12 states that include such requirements.[1] Due to legal challenges and states' decisions to suspend implementation, no states are currently implementing a work requirement policy. While states cannot terminate individuals' coverage for noncompliance with such requirements during the public health emergency (PHE) under the maintenance of effort requirements of the Families First Coronavirus Response Act, the PHE is not indefinite and having this policy in place still jeopardizes healthcare coverage for low-income individuals across the country. On January 8, 2021, many of our organizations wrote to HHS Secretary-Designate Xavier Becerra asking that the department rescind the work requirement guidance to state Medicaid Programs.[2]

As part of Arizona's waiver proposal, individuals between the ages of 19 and 49 are required to prove that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on individuals in the Medicaid program. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. During the first six months of implementation, the state terminated coverage for over 18,000 individuals and locked them out of coverage until January 2019.

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases. If the state finds that individuals have failed to comply with the new requirements, they will lose coverage for the next two months. This coverage includes essential health benefits that patients need, such as preventive services, laboratory tests, and hospitalizations. For example, for patients with acute or chronic conditions, coverage means access to prescription drugs and visits with their doctor, both necessary to stay healthy and avoid a costly visit to the emergency department. A gap in coverage would therefore jeopardize their health.

Our organizations are also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from working. Regardless, even exempt enrollees may have to report their exemption, creating opportunities for administrative error that could jeopardize their coverage. In Arkansas, many individuals were unaware of the new requirements and therefore unaware that they needed to apply for such an exemption.[3] No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

Ultimately, these requirements do not further the goals of the Medicaid program or help low-income individuals find work. Most people on Medicaid who can work already do so.[4] A study published in *JAMA Internal Medicine* looked at the employment status and characteristics of Michigan's Medicaid enrollees.[5] The study found only about a quarter were unemployed (27.6%). Of this 27.6% of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or

physical condition that interfered with their ability to work. Additionally, studies in *The New England Journal of Medicine* and *Health Affairs* have found that Arkansas's work requirement was associated with a significant loss of Medicaid coverage, but no corresponding increase in employment.[6,7]

Continuous Medicaid coverage can actually help people find and sustain employment. In another report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that that being enrolled in Medicaid made it easier to work or look for work (83.5% and 60%, respectively).[8] That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Suspending individuals' Medicaid coverage for non-compliance with these requirements will hurt rather than help people search for and obtain employment.

Our organizations urge you to reject Arizona's request for the authority to impose work requirements on its Medicaid population.

Waiving Retroactive Eligibility

Retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. Arizona's waiver application proposes to limit retroactive eligibility for non-pregnant adults to the first day of the month they apply for coverage in rather than the 90 days before. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. Health systems could also end up providing more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[9] Our organizations urge CMS to reject Arizona's request to limit retroactive eligibility in Medicaid.

Enforceable Premiums

Our organizations applaud Arizona's decision to discontinue enforceable premiums for Medicaid enrollees. Ending patients' coverage for failure to pay a premium can have significant negative consequences for patients and their healthcare coverage. For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of $20 per month, almost half of enrollees lost coverage.[10]

The premium program also included an $8 copay for non-emergent use of the Emergency Department and will also be discontinued. These copays deter patients from seeking care, which can result in negative health outcomes for patients with acute and chronic diseases. For example, a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[11] People should not be financially penalized for seeking lifesaving care for a breathing problem, complications from a cancer treatment or any other

critical health problem that requires immediate care. Our organizations strongly support the state's decision to end this policy and encourage CMS to approve this change.

Our organizations continue to oppose work requirements in the Medicaid program. We urge CMS to reject the state's request for continued authority to impose work and community engagement requirements and to limit retroactive eligibility. We encourage CMS to approve Arizona's proposed changes to premiums and copays.

Thank you for the opportunity to provide comments.

Sincerely,

American Heart Association
The American Liver Foundation
American Lung Association
Arthritis Foundation
Cancer Support Community
Cancer*Care*
Chronic Disease Coalition
Epilepsy Foundation
Hemophilia Federation of America
The Leukemia & Lymphoma Society
March of Dimes
Mended Hearts & Mended Little Hearts
National Alliance on Mental Illness
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute

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[1] Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State. Kaiser Family Foundation. January 26, 2021. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/

[2] Health Partner Letter to Secretary-Designate Becerra re Medicaid Work Requirements. January 8, 2021. Available at: https://www.lung.org/getmedia/5c47aca8-15b1-40bc-ad3a-e67b2d6d210e/ppc-letter-to-transition-team,-supreme-court-and-work-requirements.pdf

[3] Jessica Greene, "Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement," Health Affairs, Sept. 5, 2018. Available at: https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/.

[4] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017. Available at: http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[5] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

[6] Benjamin D. Sommers, MD, et al. "Medicaid Work Requirements—Results from the First Year in Arkansas," *New England Journal of Medicine*. Published online June 18, 2019, https://cdf.nejm.org/register/reg_multistep.aspx?promo=ONFGMM02&cpc=FMAAALLV0818B

[7] Sommers, B., Chen, L., R. Blendon, E. Orav, and A. Epstein. 2020. Medicaid work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care, Health Affairs 39(9): 1522-1530. Accessed at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00538

[8] Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Accessed at: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf.

[9] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. (http://www.modernhealthcare.com/article/20160422/NEWS/160429965)

[10] Id.

[11] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.