

November 24, 2020

Ms. Jamie Snyder, Director of AHCCCS
801 E. Jefferson St. MD 4100
Phoenix, AZ 85034

publicinput@azahcccs.gov

Dear Director Snyder:

On behalf of the Arizona Peer and Family Coalition we would appreciate the opportunity to comment on the current Medicaid Section 1115 waiver. AHCCCS has done some admirable work in this community and we would like to see this continue.

We oppose the policy of requiring able-bodied adults to verify on a monthly basis compliance with the work requirements. We also oppose the policy that would ban an eligible person from enrollment for one year if the eligible person knowingly failed to report a change in family income or made a false statement regarding compliance with the work requirements.

We find this requirement to be burdensome and an administrative burden to both the claimant and AHCCCS. We know that 79% of adult and child Medicaid enrollees in Arizona are in families with at least one worker. For parents struggling to make ends meet in low-paying jobs, imposing a monthly reporting requirement with the penalty of a year lock out period only makes the goal of climbing out of poverty that much more difficult. Many people are able to work because of the AHCCCS coverage that keeps their chronic and mental health conditions under control. While AHCCCS has identified a variety of situations where the work requirement would not be imposed, the reality of many households on “the edge” status will change month to month making it difficult and even confusing to know if this member qualifies for the exemption. This approach also is further compounded by the phased nature of the program. Members are not necessarily static and residing in only one community over their enrollment in the AHCCCS program. It is a confusing and burdensome requirement without any clearly identified improvement in the well-being of AHCCCS members.

We oppose the proposed lifetime coverage limit of five years for able bodied employees. Individuals who experience poverty are at significantly greater risk of mental illness and individuals experiencing a mental illness often experience periods of wellness, interrupted by periods of severe illness. Imposing a five-year lifetime limit on AHCCCS eligibility contradicts what is known about disability, chronic disease and mental illness, and jeopardizes progress already gained by those covered by AHCCCS. This requirement while mandated by state law, in our opinion, is a poor public health policy. Again, we see a huge administrative burden imposed on AHCCCS to track the months that would be counted and confusing during our current health pandemic we are not disenrolling members. Thank you for the opportunity to comment.

Sincerely,
The Arizona Peer and Family Coalition



Date

Director Jami Snyder
AHCCCS

Re: Comments on Draft 1115 Waiver

To Whom It May Concern:

Thank you for the opportunity to comment on the Draft 1115 Waiver to be submitted to CMS. As you know, the Arizona Council of Human Service Providers is a membership-based advocacy network of behavioral health and child welfare providers throughout the state. Our 100+ members operate over 700 facilities, employ over 30,000 staff, and serve over 1 million children, adults, and families every year.

The comments below are reflective of two different workgroups, where we compiled information from provider agencies, as well as from other organizations and individuals focused on public policy. We have highlighted areas that we support, as well as those we oppose.

SUPPORT

NEW WAIVER REQUESTS:

Overwhelmingly, we support the four proposed new waiver requests:

- Verbal consent in lieu of written signatures for ALTCS members
- Traditional healing services for American Indian and Native Alaskan members
- Dental benefits for tribal members
- Extension and Expansion of the Targeted Investment Program

VERBAL CONSENT:

While we support this waiver requests for ALTCS members, we believe they should be applied more broadly. For instance, the flexibility offered during the pandemic public health emergency for verbal consent for services has been extremely beneficial to allow providers to continue to provide needed mental health and substance use disorder treatment using teleservices (telephonically and via telehealth video services). Providers would like to continue to offer a full spectrum of services which includes; in person, telehealth, and telephonic, based on the assessed needs of clients and



resources available to each client. We understand there are services, conditions, and certain medications for which in-person services, and the opportunity for a “wet signature”, are most appropriate.

The lack of access to broadband internet services with video capacity is a barrier to providing traditional telehealth services in both rural and urban Arizona. However, clients can access care because we have the option of providing services telephonically. Our members report:

- Significant reductions in “no show” rates because of access to teleservices
- No reduction in completion of service plan measures
- Increase in clients who prefer teleservices because they do not have use public transportation or arrange child care to attend their behavioral health appointments

Continuation and expansion of verbal consent for all Medicaid services with expansion of use of electronic signatures makes sense for all AHCCCS members.

TRADITIONAL HEALING:

We support traditional healing opportunities for tribal members. We also urge consideration of other forms of complementary medicine for all AHCCCS members. We know that chiropractic treatments, acupuncture, and massage can work in tandem with medical interventions to address chronic pain issues and reduce the use of opioid medications. Expansion of complementary medicine interventions to address the underlying medical condition may also help to reduce the use of addictive medications.

PREVENTATIVE DENTAL COVERAGE:

We support expansion of the preventative dental benefit for adult tribal members. Providers would also like to see preventative dental coverage for all AHCCCS members. Access to preventive care and early intervention, when oral health issues are identified, reduces the need for emergency care and the likelihood of other chronic physical health conditions, including infection, cardiac and vascular problems, and pregnancy complications. Expanding coverage for preventive oral health care will help reduce overall health care costs and improve the quality of life for AHCCCS members. We suggest further investigation into not only the cost of expanding the dental benefits, but also the cost savings of preventative dental care across the life span.

TARGETED INVESTMENT PROGRAM:

We strongly support extension and expansion of the Targeted Investment Program (TIP). TIP funding has allowed innovation in service delivery and movement towards integrated physical and behavioral health care. Breaking



down the traditional silos of care will take much more time and the continued support for building relationships between physical and behavioral health providers. Outcomes from the TIP projects have been overwhelmingly positive. Funding for this project has been critical to allowing providers to move forward towards true integrated care practices. Shifting from silo-ed health care delivery systems to integrated, whole person care will take time and continuous investment. Furthermore, many providers that did not engage in TIP the first time around, are eager to be involved in expansion efforts. We look forward to a time when we have a health care system built on partnerships formed by physical and behavioral health providers focused on the whole person (Mind, Body, Spirit), not simply payer integration.

ONGOING WAIVER REQUESTS:

For the most part, we support continuation of existing waiver requests, particularly: continuation of eligibility for coverage for children, families, pregnant women, childless adults, ALTCS members, and the Medicaid expansion population, as well as the efficient administration of Medicaid funding. Freedom of choice of health plan and providers is very important to Medicaid members and should be continued. Continuation of the disregard of interest and excess resources for specific populations is important to continue, as well as the ability to pay for Medicare Part B premiums for ALTCS members.

HCBS AND BHRF:

We have questions about the changes related to those in the Home and Community Based Service (HCBS) program through ALTCS. We understand the underlying philosophy of HCBS and the change to federal regulations related to Behavioral Health Residential Facility (BHRF) participation. The overall concern is there may be ALTCS members in BHRF settings because that is the level of care they require—not as a long-term solution, but as a short-term intervention. Where will those currently in BHRF settings be placed? How will BHRF placements be funded for those on ALTCS who need this level of care? Who will coordinate those placements? And how do we ensure they continue to well enough to continue in HCBS settings?

OPPOSE

AHCCCS WORKS:

We have consistently opposed the AHCCCS Works program and continue to question the cost effectiveness of implementing this program. Most adults on AHCCCS are already employed—as many as 80% are employed full or part time; however, they are often employed in low wage jobs without employer health coverage, which makes them AHCCCS-eligible. When you eliminate those excluded from participation in the AHCCCS Works program, you are left



with a very small number of participants qualified for required participation. Tracking eligibility for services to ensure that the AHCCCS member they serve is eligible for Medicaid services this month will be extremely problematic for physical and behavioral health providers and will place an undue burden on AHCCCS members, administration, and contractors.

We question the decision of including Yuma County in Phase One of implementation because this is an area with high unemployment, seasonal job opportunities, and a lack of living wage employment opportunities. It is also a community with a large minority population with deep roots in the area, so being forced to move to access new employment opportunities could be highly disruptive to the mental wellbeing of community members. Additionally, both Maricopa and Pima counties have large areas that are rural, lacking public transportation, and few local employment opportunities. As a result of the COVID-19 pandemic and increased unemployment, implementation of the AHCCCS Works program appears to be a poor public health policy idea.

While we understand this request is required by state law, states that have implemented work reporting requirements have found them to be administratively burdensome and costly. Additionally, states with work reporting requirements have incurred higher overall health care costs because participants are not able to access preventative and ongoing health care. We believe there are better ways to address the issue of employment for AHCCCS members, such as addressing the Social Determinants of Health via the Whole Person Care Initiative, or expanding access to living wage jobs with employer-sponsored health care coverage.

PRIOR QUARTER COVERAGE:

Providers would like to see the return to prior quarter coverage for all AHCCCS members. Our members consistently see uninsured individuals in need of care and seek to enroll them in Medicaid or Marketplace plans. Providing enrollment assistance requires additional staff time and resources, which may not be reimbursable through other sources. At present, our members are seeing a significant increase in uninsured children and families. Without insurance, they are often unable to access preventative health care, care for ongoing health needs, and often become sicker faster and require high-cost hospital care. Reinstating the prior quarter coverage waiver for all AHCCCS participants would allow providers to be reimbursed for care that is currently uncompensated and to identify health issues sooner, before they become emergent.



ITEMS NOT INCLUDED, BUT NOTEWORTHY

SCHOOL BASED SERVICES:

Providers currently have a place of service code for behavioral health services provided in schools. Providers would like to see school-based billing for all AHCCCS services. This would allow the inclusion of integrated physical and behavioral health services in low-income, Title I schools with large AHCCCS populations. This would allow children in these schools to receive preventative health care services at school with parental permission. Prevention services and early intervention services work hand in hand to improve overall health and reduce health care costs.

WHOLE PERSON CARE INITIATIVE:

There is concern that the AHCCCS Whole Person Care Initiative was not included in the 1115 Waiver. The ability to address social determinants of health is critical to promoting long-term health and reducing health care costs. Addressing AHCCCS members' needs for healthy food, safe and affordable housing, quality childcare, transportation, job training, and living wage employment will benefit their physical and mental health and lead to long-term health gains. Access to not only health care, but education, safe communities, and economic stability will help AHCCCS members lead healthy and fulfilling lives. Including the Whole Person Care Initiative in the 1115 Waiver would mean that providers could more fully and creatively address the Social Determinants of Health even if the state experiences a budget shortfall. Again, addressing these needs will result in health care cost savings.

HIFA COVERAGE:

During the Great Recession, HIFA (Health Insurance for Parents of Children on Kids Care) was eliminated. This program provided health insurance for adults with children whose income was between 100% and 200% of the Federal Poverty Level. Some of these parents can now be covered as part of the Medicaid Expansion population, but many low-income parents are not eligible. We are requesting that AHCCCS and CMS consider ways to provide access to health coverage for this population. When parents' health care needs are addressed early and efficiently, they are better able to meet the needs, including the health care needs, of their children. And ultimately, early intervention is far less expensive than waiting for more costly and higher levels of care.

LIFETIME CAP:

We appreciate that the 5-year lifetime cap on AHCCCS eligibility was excluded in this waiver request. We consistently opposed the state law mandate to seek a 5-year lifetime cap on eligibility for Medicaid. Access to healthcare is



important for all Arizona children, adults, and families. When Arizonans have access to prevention and early intervention health care services, they are better able to learn in school, be prepared for meaningful employment, and function as active, involved citizens and, we save money in the long run by addressing health care needs early to prevent things like diabetes, heart disease, and early identification of cancer. Like the AHCCCS Works program, we believe the Lifetime Cap is poor public health policy.

Thank you again for the opportunity to comment on the AHCCCS 1115 Waiver Request. We look forward to continuing to work in partnership with AHCCCS and the provider community to ensure quality, integrated care for low-income children, adults, and families. We are available to answer any questions you might have about our comments.

In partnership,

Bahney Dedolph
Deputy Director

Candy Espino
President and CEO



Jami Snyder
Director
State of Arizona, Arizona Health Care Cost Containment System
801 East Jefferson, MD 4100
Phoenix, AZ 85034

Dear Ms. Snyder:

The National Organization for Rare Disorders (NORD) appreciates the opportunity to submit comments on the draft proposal for the five-year renewal of Arizona's Demonstration project under Section 1115 of the Social Security Act. NORD is a unique federation of voluntary health organizations dedicated to helping the 25-30 million Americans living with a rare disease. We believe that all patients should have access to quality, accessible, and affordable health coverage that is best suited to their medical needs.

Medicaid is a lifeline to many rare disease patients, providing critical health care coverage for low-income individuals and families. NORD does support the state's decision to discontinue enforceable premiums for Medicaid enrollees in the proposed waiver application. This is a positive change that furthers the core objective of the Medicaid program, which is to provide health care coverage to low income Americans. However, many sections of this draft 1115 waiver do not promote patient care, and indeed may cause harm to the patients that we represent. We urge the state to revise this proposal to eliminate the proposed work requirements and to reinstate retroactive eligibility before the waiver is submitted to the Centers for Medicare and Medicaid Services (CMS).

Waiving Retroactive Eligibility

Retroactive eligibility prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual was eligible for Medicaid coverage during that timeframe. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. This is especially common in the rare disease community, as many rare disease patients face long diagnostic journeys and are not diagnosed until later in life. Therefore, retroactive eligibility allows patients who have been diagnosed with a serious illness, such as a rare disease, to begin treatment without being burdened by medical debt prior to their official eligibility determination.

Furthermore, 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. When Ohio was considering a similar provision in 2016, one estimate predicted that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver. An increase in the volume of uncompensated care would add to the financial challenges hospitals are facing as a result of the ongoing COVID-19 pandemic.

NORD would oppose this proposal under any circumstances, but it is especially dangerous to continue this policy during a widespread public health emergency. If someone without health care coverage is exposed to COVID-19, they are less likely to seek testing or treatment due to fears about the cost of care. This puts all Arizonans, but especially rare disease patients who may have compromised immune systems, at greater risk.

Work Requirements

As part of this 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. This proposal would again increase the administrative burden on Medicaid beneficiaries, and will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not.

Failing to navigate these burdensome administrative requirements could have serious consequences for people living with a rare disease. If the state finds that an individual has failed to comply with the new requirements, they will lose coverage for the next two months. People living with rare diseases often depend on regular visits with providers and specialists or must take daily medications to manage their conditions. A sudden interruption in care can be devastating for these patients.

Furthermore, NORD is concerned that the current exemption criteria may not capture all individuals with rare 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. For example, when Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked, many individuals were unaware of the new requirements and therefore unaware that they needed to apply for an exemption.¹ No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

¹ Jessica Greene, "Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement," Health Affairs, Sept. 5, 2018. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20180904.979085/full/>.

Conclusion

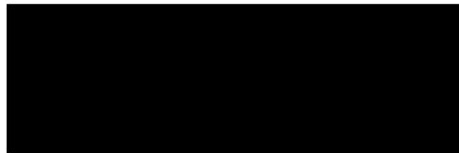
Affordable health care coverage is critical to ensuring that rare diseases patients, and others with serious and chronic conditions, can access needed health care services. Unfortunately, this 1115 waiver extension would continue policies that place unacceptable administrative and financial barriers on health coverage by withholding retroactive eligibility and imposing ineffective work requirements, the results of which can lead to significant financial and health challenges for beneficiaries. Therefore, NORD urges its revision to exclude these harmful policies prior to the submission of this waiver extension to CMS for approval.

Thank you again for the opportunity to submit comments. For questions regarding NORD or the above comments please contact Corinne Alberts at calberts@raredisease.org.

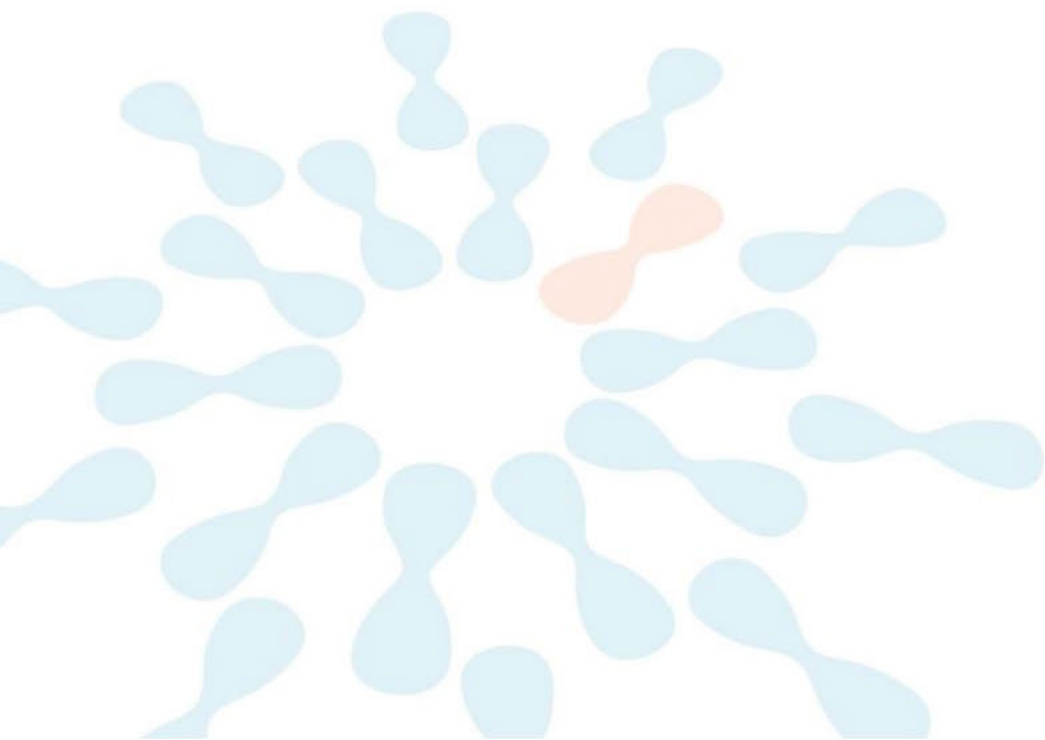
Sincerely,



Heidi Ross, MPH
Director of Policy
National Organization for Rare Disorders



Melinda Burnworth
Volunteer State Ambassador
Arizona Rare Action Network



Submitted via Electronic Mail

November 16, 2020

Ms. Jami Snyder
Director, AHCCCS
c/o Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Director Snyder,

On behalf of the Arizona Association of Providers for People with Disabilities (AAPPD), I am writing to support the Arizona Health Care Cost Containment System's (AHCCCS) 1115 waiver draft renewal application.

The 115 members of AAPPD provide services to individuals with intellectual or developmental disabilities (I/DD) that qualify for the Arizona Long Term Care System (ALTCS), providing care and supports to approximately 70% of the individuals in the ALTCS I/DD system.

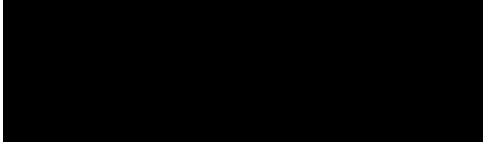
The services provided in the ALTCS system for individuals with an I/DD are not just healthcare services, they are home and community based services that help individuals live their most independent and least restrictive lives possible. The home and community based system of care has shown that you can provide quality services to support individuals in non-institutional settings while at the same time being cost effective. We support AHCCCS' request to continue home and community based services (HCBS) as part of the 1115 waiver demonstration renewal application.

In addition, AAPPD believes that the current managed care model for the ALTCS members with developmental disabilities works well. Having one state-wide managed care entity for long term care services and supports (Division of Developmental Disabilities), provides statewide oversight of the system, allowing choice of managed care plans for physical and behavioral health services as well as choice in the HCBS provided for long term services and supports by community service providers.

AAPPD is also supportive of AHCCCS' request to continue a COVID-19 emergency authority to use verbal consent in lieu of written signature for person-centered service plans for ALTCS members. This flexibility has reduced delays for individuals to receive services and should continue.

AAPPD appreciates the opportunity to comment on the draft 1115 waiver application. We look forward to a continued partnership with AHCCCS to provide members with intellectual and developmental disabilities high quality services so that they may be as independent as possible.

Sincerely,



Wendy Shaw
Chair, AAPPD



November 30, 2020

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

Submitted via email: waiverpublicinput@azahcccs.gov

To Whom it May Concern:

On behalf of Vitalyst Health Foundation, thank you for the opportunity to provide comments on AHCCCS' draft 1115 waiver proposal for 2021-2026. Given Medicaid's reach and impact across Arizona, we are committed to working with the AHCCCS team and community stakeholders to ensure that all Arizonans have access to quality, affordable coverage and care.

Vitalyst Health Foundation commends the AHCCCS team for the work they have undertaken to improve care coordination, reduce costs and ensure the managed care system operates in an efficient manner. The program's recent efforts to address the non-clinical and social risk factors that undergird health provide further evidence of AHCCCS' innovation and status as a national leader among state Medicaid programs. We're confident this 1115 waiver has the potential to continue building on AHCCCS' historical successes while providing new opportunities to advance the program.

Among the many policy proposals in the draft waiver, Vitalyst Health Foundation is most supportive of the following provisions:

Extending the Targeted Investment Program to Addressing Non-Clinical/Social Risk Factors

The proposed "extension" of the Targeted Investment (TI) program in TI 2.0 is a creative and welcomed innovation. Leveraging the success of TI by adding incentives for providers to work with community-based organizations will help advance Arizona's health care system in its journey toward becoming a truly comprehensive health system. In the absence of resources to fully finance the Whole Person Care Initiative (WPCI), this is a promising next step in AHCCCS' efforts to integrate the social determinants of health. As noted in our comments below, Vitalyst still believes it's important to include WPCI in this waiver proposal, but we look forward to learning more about TI 2.0 and we are happy to offer our support.

Discontinuing the AHCCCS CARE Program

Vitalyst has previously stated our concerns with this program, as it threatens to increase administrative burdens for members and would cause eligible members to lose coverage. Discontinuing the CARE program will allow AHCCCS to redirect its energy and resources toward more effective and efficient operations.

Expanding Tribal Dental Benefits

The current \$1,000 cap on emergency dental benefits for American Indian members is helpful but fails to promote comprehensive oral health and prevention. By covering eligible dental services at

A CATALYST FOR COMMUNITY HEALTH

100% of the Federal Medical Assistance Percentage (FMAP), AHCCCS will help to mitigate the oral health disparities we see among Tribal nations in Arizona.

Covering Traditional Healing Services

Traditional healing services have been provided to American Indians by American Indians long before Medicaid existed. By providing reimbursement for such services, AHCCCS acknowledges the sovereignty and knowledge of Tribal nations, and provides a bridge for integration of cultural health practices.

Excluding the 5-Year Lifetime Limit

We support the exclusion of the 5-year lifetime limit that was originally associated with AHCCCS Works. Vitalyst has long expressed our opposition to this statutory obligation. The limit is arbitrary and capricious, and would place undue risk on Arizona's most vulnerable populations at a time when the degree of need for government support has never been greater.

While the provisions above show promise, there are aspects of the draft waiver that are of concern and/or should be enhanced. Prior to submitting the final waiver proposal to the Centers for Medicare and Medicaid Services (CMS), we urge AHCCCS to consider the following changes:

Suspend the Prior Quarter Coverage Waiver and Expedite its Evaluation

Prior to implementation of the PQC waiver, Vitalyst expressed concern that waiving PQC presented health and financial risks to AHCCCS-eligible members. To date, Health Services Advisory Group's (HSAG) evaluation of the PQC waiver is incomplete and cannot answer whether its implementation has had any adverse impacts on members. To avoid furthering any harm that may be occurring, we suggest suspending the PQC waiver until all hypotheses articulated in HSAG's evaluation have been evaluated.

Expand Verbal Consent Permissions to Additional AHCCCS Populations

The 1135 waiver's provision to authorize verbal consent for members in the Arizona Long Term Care System (ALTCS) is a critical advancement. As health care continues to grow its use of telecommunications (i.e., telehealth/telemedicine), the imperative for patients to offer verbal consent, rather than written, becomes clear. We are encouraged to see that AHCCCS intends to make this feature permanently available to ALTCS members, and we ask that AHCCCS consider broadening this permission to other populations as appropriate.

Eliminate AHCCCS Works

Vitalyst has long expressed concern with AHCCCS Works, as it has the potential to create administrative barriers that cause eligible members to lose coverage. While we appreciate the due diligence undertaken by AHCCCS leadership and staff to operationalize the concept of this program, its implementation has proven cost-prohibitive and its legal standing is highly questionable. Given the adverse programmatic outcomes and legal rulings in other states, we urge AHCCCS and the Arizona legislature to repeal this statutory obligation.

Include the Whole Person Care Initiative

The Whole Person Care Initiative, as originally announced, presents a monumental step toward healthier and more prosperous communities in Arizona. When this waiver begins, the wake of the COVID-19 pandemic will further emphasize the importance of programs like WPCI in connecting health care and social services. We believe WPCI has the potential to mark a new era in AHCCCS – one that keeps Arizona at the forefront of Medicaid innovation – and we urge AHCCCS to include WPCI in its 1115 waiver request. Vitalyst is sensitive to the fact that WPCI requires significant

public investment at a time when public funding is unpredictable; however, recent projections from the Joint Legislative Budget Committee suggest the pandemic's fiscal impact to the State will not be as dire as originally predicted. Should budget concerns present constraints, incremental steps (such as piloting WPCI with specific populations (e.g., American Indians)) could be negotiated with CMS.

Leverage Housing Investments to Attract Federal Funds

AHCCCS is a national leader in its pursuit of housing supports for Medicaid members, and this waiver may provide an opportunity to enhance the program's commitment to housing. Therefore, we encourage AHCCCS to explore additional ways it can leverage current housing investments (e.g., funds that house members with Severe Mental Illness) to attract additional federal investment for housing. We also encourage further collaboration with other state agencies and local jurisdictions to maximize the cross-sector services that are being implemented by other organizations.

AHCCCS has a long history of providing care to millions of individuals and families across Arizona, and it has built a reputation within Arizona and the nation as a mature managed care program that delivers high value care at a relatively low cost. We thank you for the opportunity to offer comment on the draft 1115 waiver, and we are proud to offer our support in moving Arizona's health system forward.

Sincerely,



Suzanne Pfister
President and CEO
Vitalyst Health Foundation



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Terry Speth
Region 1

Citadel Post Acute
Bandera Healthcare

David Starrett
Region 1

Plaza Healthcare

Kristopher Woolley
Region 1

Avista Senior Living

John Checkett
AHCA General Counsel
Checkett Law Offices

David A. Voepel
Chief Executive Officer



October 15, 2020

Jami Snyder
AHCCCS
801 E Jefferson Street
Phoenix, AZ 85034

Dear Director Snyder,

Thank you for this opportunity for public comment on the submission of the five-year renewal proposal for the CMS 1115 Demonstration Waiver. I would like to add the Arizona Health Care Association's (AHCA) unequivocal support for your effort. The key components of the 1115 waiver have served Arizona well over the past decades and AHCA supports its continuation. As a pioneering state in long term care managed care, Arizona has successfully implemented a program that is responsive to both members and providers. I have appreciated the opportunity to collaborate on many fronts and the essential access to decision makers in the AHCCCS/ALTCS program is unparalleled, in my experience.

I would like to acknowledge and commend the transparency in your state plan amendment process. All related information is available on the AHCCCS website in a timely manner and the opportunity for public comment is the norm. This is extremely helpful in implementing long term care policy and serving our long term care providers. Also, the AHCCCS Skilled Nursing and Assisted Living Workgroup is an important forum that has been created for dialogue to address ongoing MCO partnership issues and industry trends. We greatly appreciate this opportunity for high level conversation to improve care and service delivery.

Lastly, I would like to thank you for your responsiveness to the needs of long term care providers during the COVID-19 pandemic. We have faced unprecedented financial challenges that have significant consequences in the provision of quality care. We have appreciated the receptiveness of AHCCCS to our urgent plea for financial support in the last few months. Please know that we remain in the eye of the storm. Our vulnerable residents are at risk. This support from AHCCCS *must continue to ensure continuity of care* and we believe that you have set a strong precedent to help us survive the next stage of this devastating pandemic.

Your prioritization of long term care in the AHCCCS program under the 1115 Demonstration Waiver is truly valued. Thank you for the continued collaboration!

David A. Voepel
CEO



November 27, 2020

Jami Snyder, Director
Arizona Health Care Cost Containment System
Attn: Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

ELECTRONIC SUBMISSION

Dear Director Snyder,

The Arizona Alliance for Community Health Centers appreciates the opportunity to comment on the Administration's 1115 Demonstration Waiver renewal application, and offers the following comments on several specific proposals described in the application.

Extending authority to implement

- Payments to providers participating in the Targeted Investments Program

AACHC: Qualified Support

The Alliance is supportive of renewing the Targeted Investments Program and believes that attainment of the program goals would be enhanced by extending eligibility to provider types currently excluded. The Alliance shares the Administration's understanding of the benefits of integrated care and believes Federally Qualified Health Centers are uniquely positioned to lead and succeed in the area of integrating acute medical and behavioral health services.

Renewal of the TI program presents the Administration with an opportunity to reconsider its position that the "federally-mandated reimbursement mechanism" for FQHCs disqualifies those providers from participation in incentive programs. The federally mandated reimbursement mechanism guarantees the FQHC its cost of providing health care to Medicaid members. The purpose in that reimbursement mechanism is to ensure that Section 330 grant funds are used only for their legislative purpose and not used to subsidize Medicaid. The public policy priorities evident in that framework should not be the basis for excluding FQHCs from participation in programs available to other providers, especially where the stated aims of the program are beneficial outcomes which do not similarly discriminate.

Nor can it be said that the federally mandated reimbursement mechanism resulted in "significant increases for FQHCs since 2009", where the key driver of those increases was the Administration's own alternative payment methodology. Having since adopted a new APM, which lacks the feature at the root of significant rate increases, the Administration should now reconsider the value in incentivizing activities toward integration by FQHCs.

In renewing the TI program, the Administration should seek to maximize the program's potential by offering incentives to all provider types capable of furthering the program goals.

- AHCCCS Works

AACHC: Opposed

The Alliance does not support continued authority for the AHCCCS Works community engagement requirement. Its stated goal of increasing “employment, employment opportunities, and . . . financial independence” is admirable and best addressed by public policy outside of the Medicaid program, whose principal objective is to provide health care coverage to those in need.

Given that most adult Medicaid members who are able to work are already doing so, the impact that AHCCCS Works might have on employment would likely be negligible. At the same time, those unable to meet the reporting requirements may experience intermittent periods of ineligibility for coverage. To the extent that the interruption in coverage may cause members to delay or forgo health care, the additional stated goal of “improving health outcomes” presents an internal contradiction. In the alternative, interruptions in coverage may simply shift the cost of care for those members to providers who are legally obligated to provide the care regardless of ability to pay, such as FQHCs and hospital emergency rooms.

AHCCCS Works holds little or no potential to yield positive results in terms of the stated program goals, but holds clear potential for detrimental results in terms of health outcomes for some members and uncompensated cost increases for some providers.

- Waiver of Prior Quarter Coverage for specific populations

AACHC: Opposed

The Alliance does not support continued authority to waive Prior Quarter Coverage for the identified populations. In aiming to evaluate “whether waiving retroactive coverage for certain groups of Medicaid members encourages them to obtain and maintain health coverage” the Alliance believes this project theorizes an unrealistic level of understanding by the population at large of AHCCCS eligibility policy and process. In addition, it rests on an assumption of unwillingness rather than inability in all cases of delayed application for coverage.

Waiving PQC threatens to create a financial burden for members seeking services toward the end of a month while unable to apply for coverage until the beginning of the next month. This scenario could be expected to have a disproportionate impact on members living in rural areas of the state, as well as members experiencing the often cumbersome process of seeking appropriate placement.

This proposal raises some of the same concerns invited by the AHCCCS Works program, specifically: potential for interruptions in coverage, delayed or forgone health care, and cost shifting from Medicaid to health care providers.

While the proposed limitation on PQC would likely yield cost savings for the AHCCCS program, those savings would potentially come at the expense of positive health outcomes for some AHCCCS members and at the expense of the providers to whom the costs would be shifted.

Seeking new authority to implement

- Authority to reimburse traditional healing services provided . . . by the Indian Health Service (IHS), a tribe or tribal organization, or an Urban Indian health program.

AACHC: Supportive

The Alliance supports the addition of coverage for traditional healing services, and appreciates the Administration’s perseverance in its work with tribal providers and CMS to make this important initiative a reality.

The proposal appropriately aligns the Medicaid program with the Indian Health Care Improvement Act in its recognition of the role that traditional healing practices can play in promoting and maintaining patient wellness. It is a welcome enhancement of the Administration’s commitment to supporting culturally competent health care methods and delivery.

The Alliance agrees that placing reimbursement for traditional healing services on par with other outpatient services at the outpatient All-Inclusive Rate is entirely appropriate.

- Authority to reimburse Indian Health Services and Tribal 638 facilities . . . in excess of the \$1,000 emergency dental limit for adult members.

AACHC: Qualified Support

The Alliance supports waiver of the \$1,000 emergency dental limit for IHS and Tribal 638 providers, and believes the waiver should extend also to Urban Indian Health Programs.

By this waiver proposal, it appears evident that the Administration recognizes the inadequacy of the \$1,000 limit. The Alliance is hopeful that adoption of a remedy only where it does not involve cost to the state is merely a first step toward eliminating the limit for all providers.

The \$1,000 emergency dental cap is a budget-driven device that impedes access to dental care. Its waiver for this select population of providers is a positive development.

With appreciation for the Administration’s tireless service to the residents of Arizona,



Victoria Burns, MBA
Senior Director, Regulatory Affairs & Reimbursement
Arizona Alliance for Community Health Centers
(480) 750-9033 | victoriab@aachc.org



November 25, 2020

Via email: waiverpublicinput@azahcccs.gov

Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

To Whom it May Concern:

I write in support of the 1115 Waiver renewal advanced by the Arizona Health Care Cost Containment System (AHCCCS). Arizona joined the Medicaid program in 1982 and since then has been operating under the authority of an 1115 Waiver. This tool is what has allowed Arizona to become one of the best Medicaid programs in the country. The 1115 waiver supports the state's ability to fulfill the mission of government by leveraging the business expertise of private sector companies. The result: more than two million Arizonans have access to high-quality, cost-efficient health care.

Built upon a solid foundation, Arizona's Medicaid system has withstood the strains of the current COVID-19 pandemic. Even in the midst of this challenge, Arizona continues to pursue innovation through programs like the Targeted Investments Program (TIP), which has positioned health care providers for integrated care. Arizona's 1115 Waiver renewal seeks to continue this program for an additional five years, which we appreciate and support.

As a provider of services to adults experiencing homelessness, I write to ask for consideration of expanded support of housing by AHCCCS. Unsheltered homelessness increased significantly in Maricopa County alone over the last five years. With the COVID-19 pandemic and looming evictions, our homeless crisis response network is preparing for an onslaught of demand for our services. And our services often require assistance with housing, permanent supportive housing, rapid rehousing and affordable housing. Arizona must be positioned to draw down additional federal match dollars as they become available to assist with the affordable housing crisis.

I support the renewal of Arizona's 1115 waiver for another five years with the inclusion of expanded opportunities to support housing.

Yours in partnership,



Amy Schwab

Executive Director



November 24, 2020

Via email: waiverpublicinput@azahcccs.gov

Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

To Whom It May Concern:

I write on behalf of the Foundation for Senior Living (FSL) in support of the 1115 Waiver renewal advanced by the Arizona Health Care Cost Containment System (AHCCCS). Arizona joined the Medicaid program in 1982 and since then has been operating under the authority of an 1115 Waiver. This tool is what has allowed Arizona to become one of the best Medicaid programs in the country. The 1115 waiver supports the state's ability to fulfill the mission of government by leveraging the business expertise of private sector companies. The result: more than two million Arizonans have access to high-quality, cost-efficient health care.

Built upon a solid foundation, Arizona's Medicaid system has withstood the strains of the current COVID-19 pandemic. Even in the midst of this challenge, Arizona continues to pursue innovation. With a focus on person centered care, social determinants of health and supportive housing, the Arizona Medicaid system continues to pave innovative solutions that reduce costs, improve health outcomes and enhance the quality of life for people across Arizona.

We acknowledge there are multiple methods through which states can achieve certain flexibilities and we support having a menu of options available for the states from which to choose. For Arizona, our success has come through the 1115 waiver. The 1115 authority is what has allowed us to embed the Medicaid program into the state's overall health care system and ensure one standard of care for all Arizonans regardless of payor type.

For these reasons and more, we respectfully request your consideration to renew Arizona's 1115 waiver for another five years.

Sincerely,


Tom Egan
President



Arizona
Dental
Association

3193 N Drinkwater
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Scottsdale, AZ 85251

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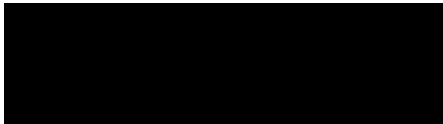
AHCCCS Division of Community Advocacy
& Intergovernmental Relations
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034
waiverpublicinput@azahcccs.gov

Re: Comments to Arizona's Section 1115 Waiver Renewal Request (2021-2026)

The Arizona Dental Association (AzDA) offers the following letter of support to the Arizona Health Care Cost Containment System's (AHCCCS) five-year renewal of Arizona's Demonstration project under Section 1115 of the Social Security Act. The Centers for Medicare and Medicaid Services' (CMS) approval of Arizona's renewal application will continue the success of Arizona's unique Medicaid program and statewide managed care model. The renewal request grants Arizona the authority to implement and continue programs that include: mandatory managed care, home and community-based services for individuals in the Arizona Long Term Care System (ALTCS), administrative simplifications that reduce inefficiencies in eligibility determination, integrated health plans for AHCCCS members, payments to providers participating in the Targeted Investments Program, AHCCCS Works, and waiver of prior quarter coverage for specific populations.

In addition to renewing the current Section 1115 waiver and expenditure authorities, the new waiver requests authority from CMS to reimburse Indian Health Service (IHS) or a Tribal 638 facility to cover the cost of adult dental services that are eligible for 100% federal financial participation. We would like to commend the work of State Representative T.J. Shope for bringing this issue forward in the 2020 legislative session with HB 2244 (AHCCCS; dental services; Native Americans), the Arizona Legislature for passing the bill with nearly unanimous support, and Governor Ducey for signing the legislation into law. Representative Shope's HB 2244 granted AHCCCS the authority to request CMS to cover the costs of adult dental services that are eligible for 100% federal financial participation that are in excess of the \$1,000 emergency dental limit for adult members in Arizona's State Plan and \$1,000 dental limit to individuals age 21 and older enrolled in the ALTCS program.

With zero impact to Arizona's budget, AzDA was delighted to support Arizona's tribal communities in the passage of this important legislation to request additional federal funding for those services that may go beyond the current limitations for reimbursement. Drawing down additional federal monies to provide these services will help increase access to oral health care, especially in areas of Arizona where it is needed the most. AzDA is encouraged by the inclusion of these additional requests and lends our support to AHCCCS' renewal.



Sean Murphy, JD
Executive Director & General Counsel



Jami Snyder
Director
State of Arizona, Arizona Health Care Cost Containment System
801 East Jefferson, MD 4100
Phoenix, AZ 85034

Dear Ms. Snyder:

The National Multiple Sclerosis Society (Society) appreciates the opportunity to provide comments on the *Draft Arizona Demonstration Renewal Proposal*.

Nearly one million people are living with multiple sclerosis (MS) in the United States, more than twice the original estimate. MS is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms vary from person to person and range from numbness and tingling, to walking difficulties, fatigue, dizziness, pain, depression, blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and the National MS Society is committed to ensuring that Medicaid provides adequate, affordable and accessible healthcare coverage. Unfortunately, the *draft Arizona Renewal Proposal* contains policies that would jeopardize patient's access to quality and affordable healthcare. The Society provides the following comments and asks the state to modify the waiver and remove these provisions before submitting to the Centers for Medicare and Medicaid Services (CMS) for approval.

Work Requirement

As part of this draft 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 2019.¹ The U.S. Court of Appeals for the District of Columbia recently reaffirmed that the purpose of the Medicaid program is to provide healthcare coverage and that Arkansas' restrictive waiver, including the work requirement policy, did not meet that objective.²

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. Medicaid is a critical safety net program that provides an array of benefits and services for individuals living with MS such as access to rehabilitative services and durable medical equipment



(including wheelchairs), which allow people with MS to maintain their health and well-being. Medicaid also provides essential prescription drug access. Studies show that early and ongoing treatment with a disease-modifying therapy is the best way to modify the course of the disease, slow the accumulation of disability and protect the brain from damage due to MS. Adherence to medication is a key element of treatment effectiveness. Medicaid is our country's primary payer for long-term services and supports, including home- and community-based services that allow people with MS to remain independent and avoid premature admission to costlier facilities such as nursing homes.

The Society is 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. The National MS Society urges you to remove the work requirement policy from the waiver application.

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. The proposed 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, such as multiple sclerosis, 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 The Society urges you to remove the policy of limiting retroactive coverage from the waiver application.

Enforceable Premiums

The National Multiple Sclerosis Society applauds the decision to discontinue enforceable premiums for Medicaid enrollees in the proposed waiver application. Ending patients' coverage for failure to pay a premium can have significant negative consequences for patients. 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. The Society was concerned that those premiums could deter patients from accessing needed care, resulting in more health complications and more expensive medical bills. The Society supports removing the enforceable premiums for the Medicaid population.

The National Multiple Sclerosis Society encourages Arizona to revise the waiver as outlined above before the waiver is submitted to CMS. Thank you for the opportunity to submit comments.

Sincerely,

Karen LaPolice Cummins, President (Arizona)
National Multiple Sclerosis Society

¹ Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: <https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/>; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

² US Court of Appeals for the District of Columbia Circuit, *Gresham v. Azar*, Feb. 14, 2020. Available at: <https://healthlaw.org/wp-content/uploads/2020/02/Gresham-v.-Azar-DC-Circuit-Ruling-Feb-14.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/doi/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.



Jami Snyder
Director
State of Arizona, Arizona Health Care Cost Containment System
801 East Jefferson, MD 4100
Phoenix, AZ 85034

Dear Ms. Snyder:

The American Lung Association in Arizona appreciates the opportunity to provide comments on the *Draft Arizona Demonstration Renewal Proposal*.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the more than 36 million Americans living with lung diseases including asthma, lung cancer and COPD, including more than 903,000 Arizonians. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and the American Lung Association are committed to ensuring that Medicaid provides adequate, affordable and accessible healthcare coverage. Unfortunately, the *Draft Arizona Renewal Proposal* contains policies that would jeopardize patient's access to quality and affordable healthcare. The Lung Association provides the following comments and asks the state to modify the waiver and remove these provisions before submitting to the Centers for Medicare and Medicaid Services (CMS) for approval.

Work Requirement

As part of this draft 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 2019.¹ The U.S. Court of Appeals for the District of Columbia recently reaffirmed that the purpose of the Medicaid program is to provide healthcare coverage and that Arkansas' restrictive waiver, including the work requirement policy, did not meet that objective.²

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 lung disease patients need, such as preventive services, laboratory tests, and hospitalizations. For example, for patients with asthma, 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.

The American Lung Association in Arizona is 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.

The American Lung Association in Arizona urges you to remove the work requirement policy from the waiver application.

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. The proposed 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, such as lung disease, 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 The Lung Association urges you to remove the policy of limiting retroactive coverage from the waiver application.


Enforceable Premiums

The American Lung Association applauds the decision to discontinue enforceable premiums for Medicaid enrollees in the proposed waiver application. 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 lung disease patients. 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. The Lung Association strongly supports the state's decision to end this policy.

The American Lung Association encourages Arizona to revise the waiver as outlined above before the waiver is submitted to CMS. Thank you for the opportunity to submit comments.

Sincerely,


JoAnna Strother
Senior Director, Advocacy
American Lung Association in Arizona

¹ Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: <https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/>; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/01f519_AWRReport.pdf

² US Court of Appeals for the District of Columbia Circuit, *Gresham v. Azar*, Feb. 14, 2020. Available at: <https://healthlaw.org/wp-content/uploads/2020/02/Gresham-v-Azar-DC-Circuit-Ruling-Feb-14.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/doi/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.



VIA EMAIL

waiverpublicinput@azahcccs.gov

Jami Snyder, Director
Arizona Health Care Cost Containment System (AHCCCS)
801 East Jefferson, MD 4100
Phoenix, AZ 85034

Dear Ms. Snyder:

On behalf of Arizona Bleeding Disorders (ABD), I am writing to submit the following comments on the *Draft Arizona Demonstration Renewal Proposal*.

ABD is a statewide non-profit organization representing families, healthcare workers, educators, policymakers, and the community regarding issues uniquely important to Arizonans affected by bleeding disorders. Our mission is to ensure that persons with inherited bleeding disorders such as hemophilia have timely access to quality medical care, therapies, and services, regardless of their financial circumstances or place of residence.

Since the purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, ABD is committed to ensuring that Medicaid provides adequate, affordable and accessible coverage to those with bleeding disorders. Unfortunately, the *draft Arizona Renewal Proposal* includes policies that greatly jeopardize access to quality and affordable healthcare for persons with bleeding disorders. As a result, ABD asks AHCCCS to modify or remove these provisions before submitting the draft waiver to the Centers for Medicare and Medicaid Services (CMS) for approval.

Work Requirement

As part of this draft 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.ⁱ The U.S. Court of Appeals for the District of Columbia recently reaffirmed that the purpose of the Medicaid program is to provide healthcare coverage and that Arkansas' restrictive waiver, including the work requirement policy, did not meet that objective.ⁱⁱ

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. For persons with bleeding disorders, such a disruption in care could result in severe damage to joints or organs that can be permanent and life-threatening if they are not able to access the prompt, specialized care during an acute bleeding episode.

ABD is 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.ⁱⁱⁱ 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.^{iv} A study published in *JAMA Internal Medicine* looked at the employment status and characteristics of Michigan's Medicaid enrollees.^v 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.^{vi,vii}

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).^{viii} 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. As a result, ABD urges AHCCCS to remove the work requirement policy from the waiver application.

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. The proposed 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, such as hemophilia, 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.^{ix} As result, ABD urges AHCCCS to remove the policy of limiting retroactive coverage from the waiver application.

Enforceable Premiums

ABD applauds AHCCCS to discontinue enforceable premiums for Medicaid enrollees in the proposed waiver application. Ending patients' coverage for failure to pay a premium can have significant negative consequences for patients. 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.^x The premium program also included an \$8 copay for non-emergent use of the Emergency Department and will also be discontinued.



ABD encourages AHCCCS to revise the draft waiver proposal as outlined above before it is submitted to CMS. Should you have any questions or need to further information, please feel free to contact me as listed below.

Sincerely,


Chastity Fermoile
Executive Director
Chastity@arizonahemophilia.org
Cell: 602.550.0112

ⁱ Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: <https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/>; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlkh6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

ⁱⁱ US Court of Appeals for the District of Columbia Circuit, Gresham v. Azar, Feb. 14, 2020. Available at: <https://healthlaw.org/wp-content/uploads/2020/02/Gresham-v.-Azar-DC-Circuit-Ruling-Feb-14.pdf>.

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

^{iv} 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/>.

^v 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

^{vi} 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.neim.org/register/reg_multistep.aspx?promo=ONFGMM02&cpc=FMAAALLV0818B

^{vii} 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>

^{viii} 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>.

^{ix} Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion", *Modern Healthcare*, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)

^x Id.

Arizona Section 1115 Waiver Renewal Request, 2021-2026

Public Comment, 11/30/2020

Growing evidence indicates the need to do much more outside clinical settings, in order to prevent widespread, lifelong, expensive health conditions caused by unhealthy behavior, particularly by [inactivity](#) and [unhealthy nutrition](#) starting in childhood. Countywide, statewide and nationwide indicators show continually worsening obesity, diabetes, heart disease and other chronic disease metrics, *including unprecedented early onset and early extreme severity levels*. Medical professionals' recommendations to patients to "change lifestyles" and clinical programs are not making an adequate dent in our harmful health trajectory, in either childhood or adulthood.

While there is growing interest in addressing "social determinants of health" (SDOH), this has not yet been done in a way that is bending the chronic curve on a broad scale. Instead, the health sector has often focused SDOH efforts on small narrowly-defined subpopulations of very high cost enrollees, rather than the vast majority of enrollees—in spite of very widespread chronic health risks.

Serious Chronic Disease Trends from Childhood

According to the CDC, [60% of adults have chronic disease](#) (heading rapidly toward 2 out of 3), 42% with two or more conditions. The respected *New England Journal of Medicine* recently [projected nearly 1 in 4 adults](#) with severe obesity by 2030, in the US and in Arizona—"with high predictive accuracy." By 2030, according to *NEJM*, more than half of adult Arizonans will have obesity. Lower-income populations, including those enrolled in AHCCCS/Medicaid, tend to have even higher rates of these conditions.

In addition, few realize that [10% of US teens are severely obese](#) (about 75 lbs. or more overweight) and [18% of adolescents have prediabetes](#). Rates are much higher than this in lower-income populations and communities of color. These children are [almost pre-destined for early diabetes](#), then [dying 15+ years prematurely](#)—*the ultimate inequity*. Thanks to lifelong inactivity and unhealthy nutrition, these conditions are starting much earlier in life and are becoming much more severe than in the past.

Meanwhile, Arizona demographics have changed rapidly, with [over half of K-12 students now being Latinx, Native-American or African-American](#). In addition, the [majority of Arizona schools are Title 1](#), with significant poverty.

Our health destiny clock is ticking. Inactive and overweight children are very likely to become teenagers with obesity, who increasingly become young and middle-age adults with chronic disease. Moreover, most children have unhealthy habits (i.e., high amounts of sedentary time along with significant intake of high-sodium, high-fat and sugary foods and beverages), and more than [80% of them](#) become unhealthy adults.

Clearly, our health issues need to be addressed on a more comprehensive, timely, preventative, and truly "whole-population" scale.

Bending The Chronic Curve Down

There is a promising precedent: the 50+ year [antitobacco campaign](#) has demonstrated the power of long-term systemic prevention—reducing smoking [by over 2/3](#) (and by even more among [youth](#) and [communities of color](#)), and [slashing hundreds of billions of dollars](#) in health costs. Schools have been a key contributor to this success.

While our extensive work to slash smoking has been rewarded, by comparison, we have [attempted and achieved very little to reduce inactivity and unhealthy nutrition](#)—in spite of decades of increasing

“diabesity.” Indeed, Mayo Clinic has referred to “[sitting as the new smoking](#),” while a recent Cleveland Clinic study indicates that [unfitness may present an even higher mortality risk than smoking](#). The silver lining on this dark cloud: studies have shown a strong association between youth fitness and much lower rates of middle-age [diabetes](#) and [heart disease](#). Physical activity has also been shown to [reduce child ADHD by 1/3](#) and to [mitigate depression](#).

Healthy Future US has assembled evidence from peer-reviewed journals and government reports, showing that child and teen chronic health issues are already prevalent and expensive. However, physical activity can help [reduce these costs by at least \\$30-75/student/year](#)—even when programs are delivered to the entire student body, not just to those with diagnosed conditions. Given how [high inactivity and poor nutrition levels are among Title 1 students](#), and given high AHCCCS enrollment at these schools: it makes medical and ethical sense to “treat”, i.e., preventively educate, all students—most of whom are already or will soon become at-risk.

Moreover, physical activity also [helps to improve academic achievement](#), and academic performance can be maintained even when [up to 60 minutes of the school day are devoted to activity](#).

Whole-Population Health Improvements, Savings & ROI

The longer term cost savings potential is even more compelling. For example, the lifetime cost of diabetes onset at age 40 has been estimated at over [\\$200,000 per adult, about \\$3,700/year more](#) than similar men without diabetes. Projections which include [estimated undiagnosed early diabetes](#) imply that over 10% of *young* adults enrolled in Medicaid could have diabetes by 2030. Epidemic child obesity and teen prediabetes also implies that up to [1 in 3 adult Medicaid enrollees](#) could have diabetes by 2050. This long-term prognosis, combined with the [difficulty of changing habits in adulthood](#) particularly [in Latinx populations](#), further supports the need for major investments in childhood—and justifies much greater expenditure by AHCCCS/Medicaid in K-12 schools, on a net present value return on investment (ROI) basis.

In our current state political climate, there does not yet appear to be an appetite for policies such as soda taxes or junk food label warnings or unhealthy food advertising restrictions. But there is a broad bipartisan proven interest in [school recess mandates](#), in reforming the [state’s school accountability A-F grading system](#) to include physical and health education (which superintendents have widely stated would increase their incentive from the state to restore school time and resources to these neglected areas), and in [value/performance-based health strategies involving schools](#).

School-based approaches, which are scalable, replicable and cost-effective, and based on valid and reliable evidence, can move the needle for the entire state. Their return on investment can justify very large spending, on the scale needed to address epidemic chronic health issues.

[Proven models exist](#) to increase physical activity and healthy nutrition cost-effectively throughout K-12: with an integrated combination of wellness policy plans, community partnerships, quality physical and health education, recess, classroom activity breaks, and related evidence-based programs and practices. In just three years, one such comprehensive integrated approach [implemented by the University of Arizona, across Sunnyside USD](#), a 20-school Title 1 K-12 district with a predominantly Latinx and Native-American population in high-poverty southern Tucson, increased the percentage of fit students [from 18% to 78%](#) of all students and reduced child obesity.

Potential 1115 Waiver Opportunities

Arizona’s 1115 waiver should provide opportunities for health, education, public, private, nonprofit and other organizations in the state to work and co-invest together, and be reimbursed including by CMS and the state of Arizona for their investments, in order to sustainably increase activity levels and healthy

nutrition and thus to also improve mental health, which are all such major causes of increasing Medicaid and overall health costs.

Examples of waiver opportunities include but should not be limited to:

- **Sustainably funding investments through schools:** Allow AHCCCS health plans and their ecosystems to invest in school-based strategies and then to keep the related health cost savings, and to reinvest those savings in sustainably funding effective school-based strategies in future years. This includes a range of possible strategies and approaches.
- **Reimbursing Pay For Success projects:** There is broad interest in Arizona including within the AHCCCS ecosystem in “[Pay For Success](#)” (PFS) projects—performance-based programs sometimes referred to as “Social Impact Bonds.” One of the global nonprofit leaders in developing and funding PFS “social impact funding,” [Social Finance](#), has stated that it can assemble funding for a PFS project in Arizona based on the Plan-Develop-Assess (P-D-A) model, which in turn is based on [University of Arizona’s successful Partners for Healthy Promises project](#) in Sunnyside USD. United Healthcare’s US headquarters-based social impact group has also expressed interest in helping to fund this, as have senior leaders at AHCCCS plans.

Social impact funders invest monies upfront, with no risk to plans or AHCCCS/Medicaid. Those social impact funders are only paid back, if/when the health cost savings meet or exceed targets agreed with plans, and only when adequate results are confirmed by a third-party evaluator agreed to in advance by all parties.

Pay For Success projects should be listed in the waiver as a reimbursable item. AHCCCS and its plans should be allowed to retain the PFS savings to be used for the performance-based payouts to third-party and other funders.
- **Additional school staff and/or time:** Many Title 1 schools have high numbers of AHCCCS enrollees but very limited financial resources, especially those without [bonds and/or overrides](#) and/or with particularly high at-risk populations. AHCCCS plans should be allowed to invest in expanding school resources in a targeted accountable manner in Title 1 schools where th, including adding adequate quality physical and health education and recess time. This includes generating [National Academy of Sciences-recommended](#) levels of moderate-to-vigorous physical activity (MVPA) among students during physical education, as well as creating [other activity opportunities throughout the school day](#).

Appropriate results should be tracked to demonstrate adequate progress in improving activity etc., related health cost savings, and likely ROI cost-benefits. Plans would track outcomes to show sufficient evidence of impact including on health-related costs, and then be allowed to keep the related health cost savings, and to reinvest those savings in sustainably funding effective school-based strategies in future years.
- **Proving outcomes & savings:** Expanded investments in school activity and healthy nutrition must be accountably measured to demonstrate health outcomes improvements and related adequate combined short-term and long-term medical cost savings. This should include reimbursing plans or designated third-parties for developing and funding information systems and providing access to needed student health and medical data, with appropriate safeguards, under the waiver.
- **Valid & reliable school-based assessments:** Medicaid monies should be permitted to be invested in assessment systems, which can validly and reliably track improvements in key health-related indicators on a school, school district, county and statewide scale. This should include measuring physical activity levels, fitness levels, nutrition behavior and other areas to be determined. This investment will also help finalize assessment systems needed for final approval

of [health-related A-F school accountability metrics by the State Board of Education](#). Once the state awards points for higher quality physical and health education to count toward improving a school's state-calculated A-B-C-D-F grade, superintendents have stated they will reallocate/restore significant resources including school time to these neglected subjects.

This should be done in an efficient as well as valid and reliable manner, maximizing the use of technology and requiring little school time for assessments. Healthy Future US has been making progress with a broad range of stakeholders including physical and health educators and others to determine how this can be done, in a manner which could in the future be approved by the State Board of Education, while meeting teacher and health sector needs.

It should also be noted that such investments in Arizona can have widespread applicability and upside for all 50 states and their K-12 and Medicaid systems.

- **Factoring in long-term savings:** Health plans should also be measured in such a way that they are incentivized to invest in approaches, which credibly demonstrate the potential to save significant health costs long-term, even when short-term cost savings do not cover the full costs of those approaches. This is already done with injected vaccines—we also now need it for preventive education “vaccination.” Long-term savings can be achieved, for example, by increasing activity and healthy nutrition throughout childhood, *in order to postpone the onset and reduce the severity of chronic conditions in youth and adulthood*. Cost savings can be estimated based on projected health cost trajectories and sensitivity analyses for earlier vs. later chronic condition onset and lower vs. higher condition severity—or even complete prevention in some cases.

For example, as noted above, the lifetime cost of diabetes onset at age 40 has been estimated at over [\\$200,000 per adult, about \\$3,700/year more](#) than similar men without diabetes. Since projections which include [estimated undiagnosed early diabetes](#) imply that over 10% of young adults enrolled in Medicaid could have diabetes by 2030, and up to [1 in 3 adult Medicaid enrollees](#) could have diabetes by 2050, major investments in childhood including through K-12 schools can be justified on a net present value ROI basis.

So CMS under this waiver should accept evidence-based projected cost-benefits, not just immediate medical cost savings, as justifying plan spending and long-term cost savings retention under the waiver, as it does with vaccines and other reimbursed practices, conditioned upon appropriate tracking, projections and other supportive data.

- **Payments to schools & others:** Allow schools and their vendors to be paid with Medicaid monies for their part in accountably improving health outcomes, including the work mentioned here, as well as other evidence-based cost-saving approaches such as quality school-based health clinics.
- **New other third-parties as payees:** Allowing third-parties not currently in the AHCCCS payment ecosystem to be accountably paid for services that demonstrably add value toward improving health and reducing health costs, under agreements with and the oversight of AHCCCS and/or plans.

In brief, it is critical to start making progress on this Medicaid K-12 preventive education funding now, for the following reasons:

1) Arizona has a rapidly increasing, young, low-income population with fast-growing chronic health issues;

2) There are currently few, if any, other realistic strategy options for sustainable large-scale whole-population health improvements, which can be started in childhood and then reinforced and built upon effectively in adulthood, with both immediate impact and lasting impact for decades;

3) AHCCCS is a capitated payment system in a state reluctant to spend state monies on Medicaid, whereas school-based approaches which include “traditional” subjects such as physical and nutrition education and recess have bipartisan support;

4) in future years, state health spending (“medication”, as referred to at the legislature) risks increasingly crowding out already low current state K-12 “education” spending, thereby further endangering already-slashed health-related school spending such as physical & health education, nursing and counseling.

In other words, child and whole-population health will continue to worsen, unless we make a much more ambitious, intentional, proactive, evidence-based, and sustained effort, starting in schools.

We need more than a sense of urgency, *we need a sense of emergency.*

We strongly urge AHCCCS to move aggressively to request much greater flexibility in this area in the upcoming waiver application. We would be pleased to work with AHCCCS as it develops the application.

Thank you very much.

Scott Turner, PhD, CEO, [Healthy Future US](#)

Professor Hans van der Mars, [Mary Lou Fulton Teachers College, ASU](#)

Christine Davis, Founder, [Arizonans for Recess & School Wellness](#)

Trisha Bautista, Co-Lead, Advocacy Team, [Arizona School Health & Wellness Coalition](#)

Please contact Scott Turner at:

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www.HealthyFutureUS.org



November 22, 2020

AHCCCS
c/o Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Submitted via e-mail to waiverpublicinput@azahcccs.gov

Re: Draft Arizona Demonstration Renewal Proposal (2021-2026)

Dear AHCCCS:

I am writing today on behalf of the seniors in homelessness who need additional support. We are opposed to the proposals to renew the waiver of the federal protection that provides up to three months of retroactive Medicaid coverage for Arizona Health Care Cost Containment System (AHCCCS) members and the authority to implement AHCCCS Works.

Retroactive Coverage Is Vital to Many Arizonans.

Since July 1, 2019, AHCCCS has been limiting retroactive coverage to the month of application for nearly all adult AHCCCS members, including older adults needing long-term care. AHCCCS is proposing to continue limiting retroactive coverage for an additional 5 years, through 2026, despite not having evaluated the impact of the current waiver on beneficiaries.

Health care needs can be unpredictable. No one can predict a stroke, a car accident, or a fall leading to a broken hip. Once a person finds herself in a hospital or nursing home, she may not be healthy enough to file a Medicaid application, or may not understand that a Medicaid application should be filed. Furthermore, the process of preparing a Medicaid application may require many weeks—for example, an application for Medicaid nursing home coverage may require submitting five years of bank statements.

Because of our unique role working with the elderly in homelessness, there are a number of other barriers: loss of id, no bank accounts, no historical records, no phone, no address, etc. While on the street, this could be life or death. Justa Center receives calls weekly from rehabilitation hospitals and hospital social workers looking for short-term housing options while their patient waits on funding.

To protect consumers in situations such as these, federal Medicaid law requires that Medicaid coverage be retroactive up to three months prior to the application month, if the applicant met Medicaid eligibility standards for the month(s) in question. This protection ensures that persons are not saddled with uncovered medical bills just because they received care close to the end of a month, and/or they were not able, due to medical condition or otherwise, to promptly file a Medicaid application.

AHCCCS's decision to eliminate retroactive coverage also means that older Arizonans could be denied access to a nursing home care when they need it if they cannot pay on their own. Nursing facilities and other providers may be unwilling to admit a resident until their Medicaid application has been approved, knowing that Medicaid will no longer cover prior months' care and that preparing Medicaid applications can take weeks or months.

1001 W Jefferson St | Phoenix, AZ 85007-2913 |602.254.6524

The draft proposal states that the reason for the extension is “to fully evaluate the Demonstration’s progress toward achieving the goals of continuity of care and personal responsibility, and to assess the impact to individuals and providers.”¹ However, it is premature to extend this waiver for 5 years without this full evaluation. While AHCCCS has gathered some limited data on years prior to implementation of the waiver, it has not yet evaluated the waiver’s impact. Critically, AHCCCS has not evaluated the most important factor—the impact of eliminating retroactive coverage on individuals’ access to care or finances. In fact, the proposed evaluation does not include measures to specifically assess impact on access to nursing home care. This is a glaring omission given the unique requirements for long-term care applications, which routinely take weeks or months to complete. Not only do individuals who need nursing home care have to meet financial eligibility criteria, which can require gathering years of bank statements and other records that are often not readily available, they must also meet the functional criteria. This means instantaneous application is impossible.

Finally, waiving retroactive coverage does not promote Medicaid’s objective of providing health coverage to those who cannot afford it. In fact, it does the opposite. AHCCCS’s stated objectives for this “demonstration” are to encourage individuals to obtain and maintain health coverage even when healthy, apply for Medicaid expeditiously, increase continuity of care, and facilitate receipt of preventive services. Regardless of whether these goals are met, the waiver cuts coverage in violation of Medicaid’s primary objective and is therefore not allowable under federal Medicaid law. Moreover, AHCCCS’s objectives are either inapplicable or impossible to meet for Arizonans who need long-term care.

AHCCCS has not considered the effect the COVID-19 pandemic is having on Arizonans’ need and ability to apply for Medicaid as soon as they are eligible. The pandemic is most harshly impacting the communities who are also most likely to need retroactive Medicaid coverage—that is people of color who have limited income and wealth, are more likely to be uninsured and have medical debt, and who are most at risk of contracting and becoming seriously ill from COVID-19. Waivers should be used to improve coverage, not to leave Medicaid-eligible individuals without coverage when they have health care needs, especially when those needs are unpredictable during a global pandemic.

Conclusion

Thank you for considering these comments. We strongly urge AHCCCS not to extend the waiver of retroactive coverage and work requirements because doing so would harm the low-income Arizonans that the Medicaid program should be protecting.

Sincerely,



Wendy Johnson
Executive Director

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(602) 254.6524 x300

¹ AHCCCS, Draft Arizona Demonstration Renewal Proposal (2021-2026), at 18, https://www.azahcccs.gov/Resources/Downloads/1115Waiver/1115WaiverRenewalPacket_DRAFT.pdf.



November 29, 2020

Via email: waiverpublicinput@azahcccs.gov

Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

To Whom it May Concern:

On behalf of the Arizona Housing Coalition Board of Directors, staff, and our over 200+ organizational members and stakeholders, we are writing in support of the 1115 Waiver renewal advanced by the Arizona Health Care Cost Containment System (AHCCCS). Arizona joined the Medicaid program in 1982 and since then has been operating under the authority of an 1115 Waiver. This tool has allowed Arizona to become one of the best - and most responsive - Medicaid programs in the country.

The Arizona Housing Coalition is a statewide collaborative association working to end homelessness by advocating for affordable homes for all Arizonans. We monitor legislative and regulatory policies being adopted at the federal, state, and local level. As such, we appreciate the opportunity to provide public comments to AHCCCS for possible inclusion to the waiver request.

Being responsive to the changing healthcare needs of Arizonans, including in the midst of a global pandemic, is a signature benefit of Medicaid programs operating under Section 1115 waivers. Yet key to the evolving needs of people in our state is the importance that housing plays in response to not only social determinants of health, the response to the COVID-19 pandemic, but also in response to the racial reckoning that our country is in the midst of. Research demonstrates that access to stable housing may improve health outcomes and decrease health care costs. Without housing, it can be difficult to maintain a healthy lifestyle, let alone manage behavioral health and chronic conditions. Affordable housing is also part of the equation. If people spend a large portion of their income on housing, less of their budget is available for health care expenses. Additionally, various physical hazards -such as the presence of lead, poor air quality, or extreme low or high temperatures—can lead to higher rates of chronic conditions or injury.

Therefore, we respectfully request that AHCCCS prioritize housing supports in the next draft waiver to CMS. We recognize that AHCCCS has been a leader in the whole health of an individual and has dedicated staff and significant resources to address housing. However, our affordable housing crisis is crippling our most vulnerable citizens in our state and we must leverage every resource we can. Therefore, we ask that AHCCCS consider the following inclusions in the next waiver:



- Supportive housing services (table source: Corporation for Supportive Housing)

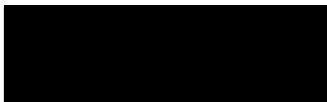
TABLE 5: Supportive Housing Services

TENANCY SUPPORTS	HOUSING CASE MANAGEMENT
Outreach and engagement	Service plan development
Housing search assistance	Coordination with primary care and health homes
Collecting documents to apply for housing	Coordination with substance use treatment providers
Completing housing applications	Coordination with mental health providers
Subsidy applications and recertifications	Coordination of vision and dental providers
Advocacy with landlords to rent units	Coordination with hospitals/emergency departments
Master-lease negotiations	Crisis interventions and Critical Time Intervention
Acquiring furnishings	Motivational interviewing
Purchasing cleaning supplies, dishes, linens, etc.	Trauma Informed Care
Moving assistance if first or second housing situation does not work out	Transportation to appointments
Tenancy rights and responsibilities education	Entitlement assistance
Eviction prevention (paying rent on time)	Independent living skills coaching
Eviction prevention (conflict resolution)	Individual counseling and de-escalation
Eviction prevention (lease behavior requirements)	Linkages to education, job skills training, and employment
Eviction prevention (utilities management)	Support groups
Landlord relationship maintenance	End-of-life planning
Subsidy provider relationship maintenance	Re-engagement

We recognize that Medicaid does not provide funding for room and board, except in limited cases, however CMS’s 2015 Informational Bulletin clarifies that circumstances that Medicaid programs reimburses for certain housing-related activities, with the goal of promoting community integration for individuals with disabilities, older adults needing long-term services and supports, and those experiencing chronic homelessness. And early signals from the incoming Biden Administration indicate there may be expanded opportunities for AHCCCS to support housing—drawing down as much as \$70 million in additional federal match. We believe this starts with AHCCCS positioned properly by including the importance of housing in the Section 1115 Waiver to CMS.

Thank you for the opportunity to comment.

Sincerely,



Joan Serviss, Executive Director
Arizona Housing Coalition



UnitedHealthcare Community Plan welcomes the opportunity to provide comments in support of the 1115 Waiver renewal advanced by the Arizona Health Care Cost Containment System (AHCCCS). We have been a committed partner to the AHCCCS since 1982, and we are proud to serve over 445,000 Arizonans through the AHCCCS Complete Care, Arizona Long Term Care System (ALTCS), and Developmental Disabilities (DD) programs. We have highlighted three key areas for which we would like to provide supportive comments.

Targeted Investments Program Renewal Request (TI Program 2.0)

Arizona's Targeted Investments (TI) Program has positioned health care providers for integrated care. We look forward to continuing to provide support to the expansion cohort for TI Program 2.0 and working with AHCCCS to develop sustainable models beyond the end of the program.

We commend AHCCCS for incorporating community-based organizations (CBOs) into the TI Program 2.0 and look forward to supporting AHCCCS as they develop the details of this program. In doing so, we encourage AHCCCS to ensure that participating CBOs have the infrastructure and capacity to participate in the program by seeking expenditure authority through the 1115 waiver as was done in North Carolina. This approach will ensure the CBOs have funds to pay for infrastructure and services that have not traditionally been reimbursed by Medicaid for members who meet certain clinical and social barrier criteria.

Access to Safe and Stable Housing

Housing is a basic human need and a critical social determinant of health that has been shown to have a significant effect on wellness and quality of life.

- Several studies have demonstrated the connection between access to affordable, supportive housing and improved mental and physical health and reduced active substance use.
- Further, access to safe housing reduces ED utilization and inpatient hospitalizations among high utilizers of health services and reduces the extent to which individuals or families are involved in the criminal justice or child welfare systems.

UHCCP of Arizona proudly served as one of the original pilot markets for UnitedHealthcare's work in affordable housing. As of 2020, UnitedHealthcare has invested over \$500M nationwide, including a \$100M Housing & Health Fund launch in March. This fund solely invests in housing that has some integration with health care. Our programs acknowledge the importance of safe and affordable housing and respond with Housing First models that offer low-barrier entry into supportive housing without the typical requirements of transitional housing programs, which often require participants to be abstinent from substances, receive behavioral health or medical services, and be employed.

For individuals with complex medical and social needs, safe and stable housing is often the critical factor that allows them to then engage in integrated behavioral and physical health care. Permanent housing affords individuals consistent access to electricity, refrigeration for nutritious foods and medications, and the security of being able to lock their doors—reducing anxiety and improving their wellbeing.

We applaud AHCCCS's recognition that housing integrated with coordinated wrap-around services is critical for its members, especially those determined to have serious mental health needs, and the allocation of approximately \$30 million annually to provide permanent supportive housing units for over 3,000 of its members. UnitedHealthcare is proud to participate in the Home Matters Arizona Fund through initial



financing and collaboration with other stakeholders. The Fund, first discussed during a work group meeting of Governor Ducey's Goal Council to Reduce Homelessness, addresses Arizona's rising affordability crisis and highlights the need for housing justice for underrepresented families and communities. With the changing Federal administration and the Governor's ongoing focus on access to housing, we encourage AHCCCS to continue building on prior investments by seeking expenditure authority through the 1115 waiver to leverage renewed interest, partnership opportunities and funding from federal stakeholders.

Verbal Consent in Lieu of Written Signature

UnitedHealthcare supports allowing the State permanent authority to accept verbal consent in lieu of written signature for up to 30 days for all care and treatment documentation for ALTCS members when included in the member's record and when identity can be reliably established. This flexibility is instrumental in allowing us to continue care for our most vulnerable ALTCS members during the Federal Public Health Emergency.

We welcome the opportunity to collaborate with the AHCCCS to achieve improved outcomes for high-risk Medicaid members. Should you have any questions or require further information, please do not hesitate to contact me by phone at (602) 255-8457 or by email at jean_kalbacher@uhc.com.



Jean Kalbacher
Chief Executive Officer
UnitedHealthcare Community Plan of Arizona



Arizona Association of Health Plans
2375 East Camelback Road, Suite 600
Phoenix, AZ 85016
602-680-7680

November 17, 2020

Via email: waiverpublicinput@azahcccs.gov

Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

To Whom it May Concern:

I write on behalf of the member companies of the Arizona Association of Health Plans (AZAHP) in support of the 1115 Waiver renewal advanced by the Arizona Health Care Cost Containment System (AHCCCS). Arizona joined the Medicaid program in 1982 and since then has been operating under the authority of an 1115 Waiver. This tool is what has allowed Arizona to become one of the best Medicaid programs in the country. The 1115 waiver supports the state's ability to fulfill the mission of government by leveraging the business expertise of private sector companies. The result: more than two million Arizonans have access to high-quality, cost-efficient health care.

The member companies of the AzAHP contract with AHCCCS to serve as the private half of a public-private model that makes the AHCCCS program work. This private business model has enabled Arizona to create a better, responsible, and cost-effective way to serve the health care needs of our most vulnerable citizens. In every part of Arizona, the AzAHP health plans serve women and children, seniors, people with disabilities, and others who rely on AHCCCS for essential care. We help prevent disease, treat chronic ailments, and improve physical and mental health. Arizona's health plans also build programs and interventions to support justice-involved individuals achieve successful community re-entry, as well as engage homeless populations, invest in housing and help members address employment and food insecurity.

Built upon a solid foundation, Arizona's Medicaid system has withstood the strains of the current COVID-19 pandemic. Even in the midst of this challenge, Arizona continues to pursue innovation through programs like the Targeted Investments Program (TIP), which has positioned health care providers for integrated care. Arizona's 1115 Waiver renewal seeks to continue this program for an additional five years, which we appreciate and support.

Through education and capacity building, the Targeted Investments Program is directly contributing to the transformation of clinical practices, a necessary step for achieving the quadruple aim of improved quality of care, better patient experience, lower cost, and higher provider satisfaction. The program is grounded in accountability by directly tying incentive

payments to attainment of specific measurable clinical outcomes. The AzAHP and all the health plans provide significant supplemental support to this initiative through our own value-based purchasing initiatives, data sharing, care coordination, and collaborative efforts because we believe in achieving shared successes across the system. We will continue to provide this support for the duration of the initiative, and work to develop sustainable models beyond the end of the program.

We also applaud the changes AHCCCS seeks to support the State's American Indians, represented by 22 federally recognized tribes. These are common sense changes that received overwhelming bi-partisan support when considered by the elected leaders who serve in Arizona's legislature:

- Authority to reimburse traditional healing services provided in, at, or as part of services offered by facilities and clinics operated by the Indian Health Service (IHS), a tribe or tribal organization, or an Urban Indian health program.
- Authority to reimburse Indian Health Services and Tribal 638 facilities to cover the cost of adult dental services that are eligible for 100 percent FFP, that are in excess of the \$1,000 emergency dental limit for adult members in Arizona's State Plan and \$1,000 dental limit for individuals age 21 or older enrolled in the ALTCS program.

Finally, the AzAHP also supports giving the state the permanent authority to allow for verbal consent in lieu of written signature for up to 30 days for all care and treatment documentation for ALTCS members when included in the member's record and when identity can be reliably established. This flexibility has proven invaluable as we have cared for our most vulnerable members during the pandemic.

We acknowledge there are multiple methods through which states can achieve certain flexibilities and we support having a menu of options available for the states from which to choose. For Arizona, our success has come through the 1115 waiver. The 1115 authority is what has allowed us to embed the Medicaid program into the state's overall health care system and ensure one standard of care for all Arizonans regardless of payor type.

For these reasons and more, we respectfully request your consideration to renew Arizona's 1115 waiver for another five years.

Yours in partnership,



Deb Gullett
Executive Director
Arizona Association of Health Plans



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November 16th, 2020

Arizona Health Care Cost Containment System
Attn: Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

FOR ELECTRONIC SUBMISSION

To whom it may concern:

I am writing on behalf of Children's Action Alliance (CAA) in response to AHCCCS' draft Section 1115 waiver proposal for the years 2021-2026. Through research, publications, media campaigns, and advocacy, CAA seeks to influence policies and decisions affecting the lives of Arizona children and their families on issues related to health, child abuse and neglect, early care and education, budget and taxes, juvenile justice, children and immigration, and working families. As advocates for children's health and health equity in Arizona, CAA supports key aspects of the draft Section 1115 waiver and oppose others.

Children's Action Alliance is supportive of many of the requests in the draft waiver, particularly those pertaining to the American Indian population. Specifically, we support the following provisions:

- **Reimbursement for traditional healing services provided to American Indian Tribal members at 100% of the Federal Medical Assistance Percentage (FMAP).** We believe this will further promote integration of cultural health practices. Recognizing the importance of traditional healing services is a first step toward promoting health equity for Tribal members.
- **Reimbursement for adult dental care for American Indian Tribal members at 100% FMAP.** Oral health inequities persist for American Indian Tribal members. Reimbursement for services provided to American Indian AHCCCS participants is critical to reducing rates of oral disease and decay and is in line with fulfillment of our country's treaty promise to provide health care at no cost to members of sovereign Tribal nations.
- **Discontinuation of the AHCCCS Care program demonstration.** This program would have posed an administrative burden on both AHCCCS participants and the agency, and we believe it would have disincentivized enrollment in health care and increased the rate of enrollment churn.
- **Exclusion of the 5-year lifetime limit provision associated with the AHCCCS Works program.** Though we recognize that state statute requires AHCCCS to request the lifetime limit, we remain opposed to this statutory obligation and do believe that limiting access to health care in the current public health climate is neither wise nor ethical.
- **Disregard of interest and excess income for children and adults with disabilities.** This is a critical step to help keep children and families with disabilities connected to a reliable source of health coverage, even when their financial circumstances may be in flux.
- **IHS / 638 uncompensated care continuation.** Continuation of this provision provides a level of protection to tribal members in case optional benefits are limited. Children's Action Alliance supports the Arizona Advisory Council on Indian Health Care's advocacy efforts for adequate rate payments and supportive methodology for these services.

- **Expansion and extension of the Targeted Investment Program.** We support AHCCCS' efforts to integrate behavioral and physical health care and look forward to seeing the results of this investment. Participation in TIP by an Indian Health Service (IHS) or other Tribal providers should also be considered.

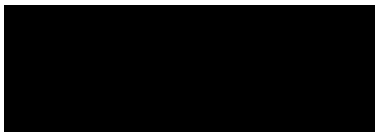
Each of these provisions have the potential to promote health equity in Arizona, and CAA commends the agency's inclusion of these requests in the draft Section 1115 waiver.

We do see several areas for improvement in the waiver request, and ask that AHCCCS consider the following modifications before submitting the Section 1115 waiver to the Centers for Medicaid and Medicare Services:

- **Prior quarter coverage should be reinstated for all AHCCCS populations.** Retroactive eligibility provided critical relief to uninsured low-income Arizonans and the providers that serve them. Information should be made available regarding the impact on out-of-pocket costs for populations who were previously eligible for prior quarter coverage, as well as the cost of uncompensated care for providers since its discontinuation. Indian Health Services and other Tribal health care facilities noted that their facilities were able to make improvements to their health care systems and facilities when they were assured that services provided to eligible beneficiaries during the prior quarter would be reimbursed. When prior quarter coverage was discontinued, they noted a significant decline in revenue.
- **We remain concerned about AHCCCS Works and the additional administrative burden of this program.** Though we understand the agency is under a statutory obligation to request work reporting requirements in its Section 1115 waiver, which also provided exemptions, we would like to take this opportunity to express our continued objections to work reporting requirements for Medicaid. Now is not the time to waste limited state dollars on implementing a program that is likely to be tied up in litigation for years. Instead, we request that the Arizona legislature repeal this requirement and redirect limited state resources to promote child and family health. Restricted access to preventive care and treatment for chronic health issues limits the productivity of working people and is not an incentive to employment.
- **We believe that verbal consent for ALTCS person-centered care plans is a great first step** and ask that AHCCCS consider expanding its request to allow verbal consent in lieu of written signature authorization for all AHCCCS populations.
- **Though we understand the financial and administrative strain AHCCCS is facing during the pandemic, we hope to see substantive efforts made toward implementing the Whole Person Care Initiative,** and ask that the agency consider piloting this program with American Indian members. This would come at no cost to the state and would provide valuable data on the efficacy of the initiative.
- **Lastly, we were disappointed that school-based Medicaid billing was not included in the draft Section 1115 waiver** but look forward to partnering with AHCCCS and other stakeholders in health and education to advance this initiative via State Plan Amendment in 2021.

Thank you for taking these comments into consideration. We appreciate the opportunity to provide feedback on the draft Section 1115 waiver.

Sincerely,



Siman Qaasim
Chief Executive Officer
Children's Action Alliance



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November 24, 2020

Arizona Health Care Cost Containment System
Attn: Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

FOR ELECTRONIC SUBMISSION

To whom it may concern:

I am writing on behalf of Children's Action Alliance (CAA) in response to AHCCCS' draft Section 1115 waiver proposal for the years 2021-2026. For over 30 years, CAA has been an independent voice for Arizona children and families at the state capitol and in the community. As a result of extensive stakeholder input from uninsured community members and the health professionals that serve them, and in addition to the comments previously filed by CAA on November 16th, 2020, we request that AHCCCS amend its draft Section 1115 waiver and that the agency submit an emergency Section 1135 waiver to better meet the needs of Arizona's uninsured population during the current public health crisis.

We urge AHCCCS to request permission from the Centers for Medicare and Medicaid Services (CMS) via both its 2021-2026 Section 1115 waiver and an emergency Section 1135 waiver to re-implement the previously CMS-authorized uninsured eligibility category in response to a recent surge in COVID-19 cases.

Additionally, we ask that AHCCCS clarify that emergency Medicaid billing codes may be used to cover the cost of COVID-19 related treatment, regardless of where care is delivered.

The novel coronavirus does not discriminate, nor should our response. Children's Action Alliance believes that immigrant children and families would benefit from enhanced access to health care reimbursed through Medicaid. The current pandemic poses an urgent threat to individual and public health; thus, care provided to any uninsured individual with a confirmed case of COVID-19, regardless of immigration status or place of service delivery, should be billable through emergency Medicaid.

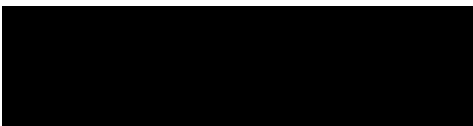
Children and families can better maintain their health and seek early care and treatment for COVID-19 if they are able to quickly access affordable care when needed, and from a provider they trust. While Arizona health care providers are currently billing the Health Resources and Services Administration (HRSA) fund for care provided to uninsured and/or undocumented individuals, this funding is finite and may not support a prolonged response to the pandemic.

One in four Arizona children has at least one immigrant parent. Immigrants play a vital role in Arizona's economy and community. In our state, one in six essential workers is an immigrant; these individuals are on the front lines of this pandemic, risking their lives daily to provide the health care, grocery and retail, shipping and transportation, and child care services we need to fight the pandemic. Longstanding evidence suggests that increasing access to affordable health care can help mitigate the spread of infectious disease; therefore, any effective public health response must be inclusive of all individuals, regardless of documentation status.

Not having access to affordable health care may result in more people seeking non-emergent care at hospitals. Allowing FQHCs and other non-hospital, community-based providers to bill Emergency Medicaid for COVID-19-related treatment would help to secure more cost-effective care options for immigrant families, reduce the burden of uncompensated care, and help our health care system to preserve precious emergency care resources.

Thank you for your consideration of these comments.

Sincerely,



Siman Qasim
President and CEO
Children's Action Alliance



November 30, 2020

Ms. Jami Snyder
Director, Arizona Health Care Cost Containment System
801 East Jefferson, MD 4100
Phoenix, AZ 85034

Sent electronically to: waiverpublicinput@azahcccs.gov
RE: Draft Arizona 1115 Waiver Demonstration Renewal Proposal

Dear Ms. Snyder,

Thank you for the opportunity to comment on the *Draft Arizona Demonstration Renewal Proposal*. On behalf of people with cystic fibrosis (CF) living in Arizona, we write to express our serious concerns with this waiver application. While we support Arizona's request to discontinue the AHCCCS Choice, Accountability, Responsivity, and Engagement (CARE) program, we oppose the state's proposed work and community engagement requirements and continuation of the elimination of retroactive eligibility for most Medicaid beneficiaries. We fear these policies will jeopardize patient access to quality and affordable healthcare at a time when they can least afford it, and ask that the state modify the waiver and remove these harmful provisions before submitting its request to the Centers for Medicare and Medicaid Services (CMS).

Cystic fibrosis is a life-threatening genetic disease that affects more than 30,000 people in the United States, including over 550 in Arizona. Roughly a quarter of adults living with CF in the state rely on Medicaid for some or all of their health care coverage. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications. If left untreated, infections and exacerbations caused by CF can result in irreversible lung damage and the associated symptoms of CF lead to early death, usually by respiratory failure.

The CF Foundation offers the following comments on the demonstration request:

Work and Community Engagement Requirements

The Cystic Fibrosis Foundation opposes Arizona's proposed community engagement requirements, as they threaten access to high-quality, specialized CF care for people with cystic fibrosis. If Medicaid enrollees are unable to satisfy the work requirements imposed by this waiver, they will lose coverage for the next two months and may only reapply after fulfilling the requirements or meeting exemption criteria. The ability of people with CF to work can vary with changes in health status and such penalties for noncompliance put Arizona Medicaid enrollees with CF at risk of experiencing unacceptable gaps in care and jeopardize their access to the care and treatments they need to stay healthy. Declines in health status due to pulmonary exacerbations, infections, and other events are common and can take someone out of the workforce for significant periods of time. CF patients bear a significant treatment burden on a

daily basis, amounting to hours of chest physiotherapy, delivery of nebulized treatments, administration of intravenous antibiotics, and/or other activities required to maintain or improve their health. Maintaining sustained employment may not be possible due to the time required to undergo necessary treatment, which includes an intense and time-consuming daily regimen.

While the Cystic Fibrosis Foundation appreciates Arizona’s decision to exempt from community engagement and work requirements individuals who are medically frail or have an acute medical condition, we still have serious concerns about the administrative challenges someone with CF could face in understanding and navigating these requirements and the exemption process. Arkansas’ program is a prime example of how administrative burdens can jeopardize coverage. The November 2018 Arkansas Works program report shows an overwhelming majority – nearly 80 percent – of those required to log-in and report compliance with the work requirements or request an exemption failed to do so, putting these individuals at risk for loss of coverage.¹ In total, 18,000 people in Arkansas lost Medicaid coverage as a result of the state’s work and community engagement requirements.²

Furthermore, while this proposal is concerning until normal conditions, the state’s decision to move forward with this request during the current public health emergency further threatens access to care and financial stability for Arizonans when they can least afford it. We urge the state to remove the work requirements policy from this waiver application.

Waiver of Retroactive Eligibility

We are concerned with this waiver’s request to extend the elimination of retroactive coverage for all non-pregnant adults and believe the state should complete its evaluation of the impacts of eliminating this policy before requesting an extension. Retroactive eligibility helps ensure continuous coverage for people with CF who experience changes in insurance status and become Medicaid eligible. There are many reasons why Arizonans, including people with CF, may not be able to submit a timely Medicaid application when they become eligible. Someone with CF may be consumed by a complicated medical situation—such as an extended hospitalization—that can make it difficult to complete an application. Applications can be burdensome and confusing and people may not realize their coverage has lapsed until they seek care.

Retroactive eligibility helps adults living with CF in Arizona who rely on Medicaid avoid gaps in coverage and costly medical bills, and is an especially important safeguard for those who have lost their job or are experiencing changes in their insurance status as a result of the COVID-19 pandemic. Without it, people with CF may face significant out-of-pocket costs. Cystic fibrosis care and treatments are costly, even with coverage. According to a survey conducted by George Washington University of 2,500 people living with CF, 45 percent of this patient population spent \$5,000 or more annually in out-of-pocket costs for copayments, coinsurance, and noncovered services.

Cost-Sharing Requirements

The CF Foundation applauds the state’s decision to discontinue its AHCCCS Choice, Accountability, Responsivity, and Engagement (CARE) program, which would have required individuals with incomes above 100 percent of the federal poverty level to pay monthly premiums and coinsurance for select services, including non-emergency use of the emergency department.

¹ https://humanservices.arkansas.gov/images/uploads/newsroom/181217_AWreport.pdf

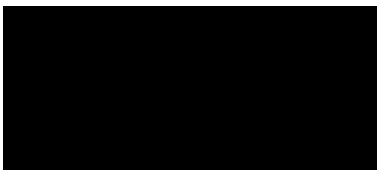
² <https://khn.org/news/study-arkansas-medicaid-work-requirements-hit-those-already-employed/>

Under this program, an individual's failure to pay their monthly premiums would have resulted in disenrollment. This policy would likely increase the number of enrollees who lose Medicaid coverage, as nominal premiums are often unaffordable for low-income beneficiaries and the process of making a premium payment can create barriers to care for a population that may not have bank accounts or credit cards. 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.³ An analysis of Indiana's Medicaid program also found that nearly 30 percent of enrollees either never enrolled in coverage or were disenrolled from coverage because they failed to make premium payments. The analysis found 22 percent of individuals who never enrolled because they did not make the first month's payment cited affordability concerns, and 22 percent said they were confused about the payment process.⁴

Research has also shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.⁵ The CARE program's coinsurance requirement for low-income beneficiaries would also have been a significant financial burden for patients. People with CF bear a significant cost burden and out-of-pocket costs can present a barrier to care. The aforementioned GW survey found that while 98 percent of people with CF have some type of health insurance coverage, 58 percent have postponed or skipped necessary medical care or treatments due to cost concerns. Such actions seriously jeopardize the health of people with CF and can lead to costly hospitalizations and fatal lung infections.

We appreciate the opportunity to submit comments on the *Draft Arizona Demonstration Renewal Request* and urge the state to remove the work and community engagement requirements and retroactive eligibility waiver from this request. The Cystic Fibrosis Foundation appreciates your attention to these important issues. Please consider us a resource moving forward.

Sincerely,



Mary B. Dwight
Chief Policy & Advocacy Officer
Senior Vice President of Policy & Advocacy

³ Id.

⁴ Lewin Group. Healthy Indiana Plan 2.0: POWER Account Contribution Assessment. March 31, 2017. Retrieved from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf>

⁵ Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>.

William E. Morris Institute for Justice

3707 North Seventh Street, Suite 300, Phoenix, Arizona 85014

November 30, 2020

VIA EMAIL:

waiverpublicinput@azahcccs.gov

Attn: Division of Community Advocacy and Intergovernmental Relations

Arizona Health Care Cost
Containment System
801 East Jefferson Street
Mail Drop 4200
Phoenix, Arizona 85034

Re: Comments to AHCCCS Proposed
Renewal Request for Section 1115
Demonstration Waiver for 2021-26

Dear Division of Community Advocacy and Intergovernmental Relations:

The Arizona Center for Disability Law (“ACDL”), Arizona Center for Law in the Public Interest (“Center”), and William E. Morris Institute for Justice (“Institute”) submit these comments to Arizona’s proposed renewal request for Section 1115 Demonstration Waiver for the years 2021-2026. The ACDL is the protection and advocacy program in Arizona and its service priorities include providing legal representation to promote 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.

Background

The ACDL, Center and Institute strongly supported Arizona’s decision to restore Medicaid services to the Proposition 204 adults and to expand Medicaid to all persons with incomes up to 138% of the federal poverty level, with income disregard of 5 percent. Arizona’s restoration and expansion have been extraordinarily successful.

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Approximately 2.1 million persons are on AHCCCS as of November 2020. www.azahcccs.gov/Re-sources/Downloads/PopulationStatistics/2020/Nov/AHCCCS_Populations_by_Category.pdf. Of this number, approximately 384,000 are the Proposition 204 group whose coverage is required by the voter initiative (0-100 percent of federal poverty level) and 123,000 are the adult expansion group (101-133 percent of the federal poverty level). Uncompensated care for hospitals has been substantially reduced.¹ In addition, thousands of health care jobs were created.

On September 30, 2016, the U. S. Department of Health and Human Services (“HHS”), Centers for Medicare and Medicaid Services (“CMS”) approved the Arizona Health Care Cost Containment System’s (“AHCCCS”) request to extend Arizona’s Section 1115 Demonstration Waiver program for another five years. At that time, CMS specifically denied a work requirement and additional verification requirements. The reasons for denying these requests and others were because

Consistent with Medicaid law, CMS reviews section 1115 demonstration applications to determine whether they further the objectives of the program . . . CMS is unable to approve the following requests, which could undermine access to care and do not support the objectives of the program....

Subsequently, AHCCCS submitted waiver amendments to include the work requirements and to eliminate prior quarter coverage. On October 17, 2019, CMS approved “AHCCCS Works” which is a work-related requirement for able-bodied adults

¹ A June 2014 survey of 75 percent of the state’s hospitals by the Arizona Hospital and Healthcare Association found that uncompensated care had dropped significantly as a result of the Medicaid expansion and restoration to \$170 million through the first four months of 2014. During the same period in 2013, uncompensated care was reported to be at \$246 million. *See* Arizona Hospitals and Healthcare Association, April 2014 Hospital Financial Results; *see also* Ken Alltucker, *Unpaid Hospital bills drop after Medicaid expansion*, THE ARIZONA REPUBLIC, July 13, 2014, <http://azcentral.com/story/money/business/2014/07/13/arizona-medicaid-reduce-unpaid-hospital-bills/12591331>. The reduction in uncompensated care continued. Between 2013-2017, Arizona hospitals experienced a 58 percent reduction in uncompensated care expenses. Matt Broaddus, *Uncompensated Care Costs Well Down in ACA Medicaid States*, Center on Budget and Policy Priorities, Oct. 21, 2020, <https://www.cbpp.org/blog/uncompensated-care-costs-well-down-in-aca-medicaid-expansion-states>.

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who are eligible under § 1902(a)(10)(A)(i)VIII), referred to as the Group VIII population with income at or below 133 percent of the federal poverty level who do not qualify for Medicaid in any other group. The objective of the program was to “increase employment, employment opportunities, and activities that enhance employability, increase financial independence and improving health outcomes of AHCCCS members.” Although approved, AHCCCS did not implement the works program.

On January 18, 2019, CMS approved Arizona’s request to limit retroactive coverage to a few categories of persons. AHCCCS implemented that waiver on July 1, 2019.

In the proposed five-year AHCCCS demonstration waiver renewal that is posted for public comment, AHCCCS includes both the AHCCCS works program and the elimination of the prior quarter coverage for specific populations.² For the reasons below, the ACDL, Center and the Institute request that AHCCCS not proceed with the proposed renewal requests for the demonstration waiver for AHCCCS works and waiver of prior quarter coverage. Each request 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 to grant a “[w]aiver of State plan requirements” in 42 U.S.C. § 1396a in the case of an “experimental, pilot, or demonstration project.” 42 U.S.C. § 1315(a) (“section 1315”).³ The Secretary may only approve a project which is “likely to assist in promoting the objectives” of 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

² AHCCCS does not pursue the monthly premiums and cost-sharing under the AHCCCS CARE program that were never implemented. Pages 22, 39-40. We support this discontinuation.

³ Throughout this letter, the undersigned will refer to the demonstration waiver as “section 1315” not “section 1115” as § 1315 is the statutory cite. 42 U.S.C. § 1315.

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waiver amendment clearly includes policies that would impede rather than promote the objectives of the Medicaid program by creating unnecessary barriers to enrollment and access to care.

Legislative history confirms that Congress meant for section 1315 projects to test experimental ideas. According to Congress, section 1315 was intended to allow only for “experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients” that are “to be selectively approved,” “designed to improve the techniques of administering assistance and related rehabilitative services,” and “usually cannot be statewide in operation.” S. Rep. No. 87-1589, at 19-20, *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961-62, 1962 WL 4692 (1962). *See also* H. R. Rep. No. 3982, pt. 2 at 307-08 (1981) (“States can apply to HHS for a waiver of existing law in order to test a unique approach to the delivery and financing of services to Medicaid beneficiaries.”).

In addition, the Secretary is bound by the Ninth Circuit’s precedent for any waiver requests under 42 U.S.C. § 1315. The Ninth Circuit described section 1315’s application to “experimental, pilot or demonstration” projects as follows:

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). Under *Beno* the record must show the Secretary considered the impact of the demonstration project on those the Medicaid Act was enacted to protect. *Newton-Nations v. Betlach*, 660 F.3d 370, 380 (9th Cir. 2011) (relying upon *Beno*). Finally, several circuit courts have held that the objective of the Medicaid Act is to provide medical assistance to those who cannot afford it. *Gresham v. Azar*, 950 F.3d 93, 99-100 (D.C. Cir. 2020) (collecting cases).

Any waiver request by Arizona must meet these requirements. The AHCCCS Works proposal fails to establish any demonstration value and instead is oriented around proposals that would ultimately limit enrollment through work-related requirements. Thus, as explained below, these proposals do not satisfy the § 1315 requirements.

II. The AHCCCS Works Program Serves No Experimental Purpose, Creates Barriers to Health Care and Will Impede, Not Further, the Objectives of the Medicaid Act

AHCCCS again intends to submit substantive waiver components that will create barriers to enrollment and access to care and, thus, do not further the objectives of the Medicaid Act. These waiver requests do not appear to serve any valid experimental purpose and, moreover, represent bad policy for low-income Arizonans. They are likely to increase administration complexity, reduce access to health care and increase the number of uninsured.

A. The AHCCCS Works Program Requirements

AHCCCS requests that CMS approve the AHCCCS Works program that requires able-bodied adults between the ages of 19-49 who do not qualify for an exemption to meet the following activities or a combination of the activities for at least 80 hours per month: Be employed, actively seeking employment, attending school (less than full time) participate in other employment readiness activities (such as job skills training, life skills training and health education), and /or community service. Page 18. AHCCCS has exempted the following groups of persons from the program requirements:

- Individuals under age 19 and above age 49
- Pregnant women and women up to the end of the month in which the 60th day of post-pregnancy occurs
- Former foster care youth up to age 26
- Individuals who are members of a federally recognized tribe
- Individuals with a SMI designation
- Individuals currently receiving temporary or permanent long-term disability benefits from a private insurer or from the state or federal government, including workers compensation benefits
- Individuals who are medically frail
- Individuals who are in active treatment with respect to a substance use disorder (SUD)
- Full time high school, trade school, college or graduate students
- Survivors of domestic violence

- Individuals who are homeless
- Designated caretakers of a child under 18 years of age
- Caregivers who are responsible for the care of an individual with a disability
- Individuals who have an acute medical condition
- Individuals who are receiving Supplemental Nutrition Assistance Program (SNAP), Cash Assistance, or Unemployment Insurance income benefits
- Individuals participating in other AHCCCS approved work programs
- Individuals not mentioned above who have a disability as defined by federal disabilities rights laws (ADA, Section 504, and Section 1557) who are unable to participate in AHCCCS Works Requirements for disability-related reasons

AHCCCS estimates that approximately 119,532 persons will be subject to the requirements. Page 19.

The general parameters of the program are the following: There is a three month “orientation” period for persons to become familiar with the program. After the orientation period ends, for each subsequent month, the person must engage in required activities for at least 80 hours per month and report their activities by the 10th day of the following month. If the beneficiary fails to report qualifying activities for a month, their medical benefits will be suspended for two months starting the next month unless the recipient raises a good cause exemption or files an appeal. At the end of the two-month suspension, the person’s benefits will be automatically reinstated. Page 19. AHCCCS Works will be implemented by geographic area in three phases. Page 20. AHCCCS states the phased-in implementation will give the State:

time to assess the availability of community engagement resources in rural areas and address gaps. Counties with a higher percentage of urban populations are likely to have sufficient community engagement resources compared to counties with a higher percentage of rural populations.

Furthermore, the State will assess areas that have high rates of unemployment, areas with limited economies and/or educational opportunities, and areas that lack public

transportation to determine whether further exemptions from the AHCCCS Works requirements and/or additional mitigation strategies are needed to alleviate unreasonable burden on members.

Id.

B. The Goals and Objectives of the Renewal Proposal Do Not Further the Objectives of the Medicaid Act

Under the “Goals and Objectives of the Proposed Demonstration Renewal,” AHCCCS proposes the following research and initial design approach. The proposed objectives of AHCCCS Works are:

The AHCCCS Works program will increase employment, employment opportunities, and activities to enhance employability, increase financial independence, and improve health outcomes of AHCCCS members.

Page 32. The proposed hypotheses are:

The AHCCCS Works Program will increase the rate of “able bodied adults” that are employed.

The AHCCCS Works program will increase the rate of “able bodied adults” that are actively seeking employment.

The AHCCCS Works Program will increase the rate of “able bodied adults” that are engaged in training or educational activities.

Current and former AHCCCS members subject to the community engagement requirement will have better health outcomes than members not subject to the requirements.

The AHCCCS Works program will increase the average household income of “able bodied adults” that are employed.

1. Federal courts have uniformly found CMS approved mandatory work-related requirements invalid

As a preliminary matter, while the above objectives for AHCCCS Works may be appropriate for a work program, they are not relevant to a health care program. Moreover, testing whether work-related requirements will increase the employment rate for beneficiaries is not a proper experimental waiver for the Medicaid program. Nor do these requirements further the objectives of the Medicaid Act, which does not have as one of its purposes, moving beneficiaries into work-related activities.

CMS approved mandatory work-related requirements in other states and uniformly the federal courts have found them invalid. *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020). The *Gresham* decision reviewed the Arkansas work-related requirements also euphemistically referred to as “community engagement.” Judge Sentelle recognized that it “is indisputably correct that the principal objective of Medicaid is providing health care coverage.” *Id.* at 99. Thus, the inquiry is whether AHCCCS’ proposal promotes the objective of providing health care coverage.

The *Gresham* court looked at other public benefits programs, such as food stamps, 7 U.S.C. § 2015(d)(1) and TANF, 42 U.S.C. §§ 601(a)(2), 607(c), whose statutes expressly condition eligibility upon completion of a certain number of hours per week to support the objectives of the laws. The court noted the contrast with the Medicaid Act that does not condition the receipt of benefits on fulfilling work requirements. *Gresham*, 950 F.3d at 101.

Any assessment of the renewal proposal must consider whether beneficiaries will lose coverage. *Gresham*, 950 F.3d at 231. Numerous studies predict massive coverage loss due to work requirements.⁴ Work requirements have resulted in loss of coverage in

⁴ See Jennifer Wagner & Jessica Schubel, Center on Budget and Policy Priorities, *States’ Experiences Confirming Harmful Effects of Medicaid Work Requirements* (updated Oct. 22, 2019), <https://www.cbpp.org/health/states-experiences-confirming-harmful-effects-of-medicaid-work-requirements>; Benjamin Sommers et al., *Medicaid Work Requirements: Results from the First Year in Arkansas*, 381 N. Eng. J. Med. 1073 (Sept. 2019), <https://www.nejm.org/doi/pdf/10.1056/NEJMSr1901772?articleTools=true>; and Leighton Ku & Erin Brantley, *The Commonwealth Fund, Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults to Lose Medicaid Coverage* (June 21, 2019), <https://www.commonwealthfund.org/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-coverage>.

every other state where work requirements were imposed and there is nothing in this proposal that rebuts this expectation.

2. Going on and off medical coverage does not distinguish the AHCCCS Works Program from invalid work requirements in other states

We understand that AHCCCS' proposal of having beneficiaries go on and off medical coverage is something that AHCCCS thinks distinguishes it from other work-related programs that the federal courts have struck down. We disagree. The three-month orientation period only pushes back the loss of coverage; it will not eliminate it. Moreover, the complicated two-month suspensions and automatic reinstatements will be confusing to beneficiaries, will be disruptive to health care coverage and will lead to "churning." This occurs when a beneficiary fails to do an action required and is terminated from the program until they take the action. In Arkansas, nearly a quarter of the persons subject to the work requirement lost coverage in the first few months.⁵

The reasons for the churning are many. Many enrollees will fail to receive adequate notice of or simply will not understand the requirements, and as a result, will not comply.⁶ In-depth interviews with 18 adult Medicaid enrollees in Arkansas in September 2019 revealed "a profound lack of awareness" about the work requirements,

⁵ Wagner & Schubel, *States' Experiences Confirming Harmful Effects of Medicaid Work Requirements*.

⁶ See, e.g., See Mary Beth Musumeci et al., Kaiser Family Foundation, *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana* (Jan. 31, 2017), <http://files.kff.org/attachment/Issue-Brief-An-Early-Look-at-Medicaid-Expansion-Waiv-er-Implementation-in-Michigan-and-Indiana> (describing confusion about content of notices sent in Michigan and confusion among beneficiaries, advocates, and providers over Indiana's POWER accounts, how premiums were calculated, and other program features); See also Leighton Ku et al., *Improving Medicaid's Continuity of Coverage and Quality of Care* at 3, https://publichealth.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhpPublications (noting that "families often do not know when their Medicaid certification periods expire, may be dropped without knowing it, and do not know why they lost coverage. Those who have been disenrolled typically say they wanted to retain their insurance coverage, but did not know how to do so.").

with two thirds of the enrollees having not even heard of them.⁷ Later focus groups conducted with 31 Medicaid enrollees in Arkansas showed many were still unaware of or confused by the new requirements in November 2019, a full six months after they went into effect.⁸ And the recent study done by Harvard researchers confirmed that 44 percent of people subject to the work requirements in Arkansas had not heard of them.⁹

Early evidence from New Hampshire revealed similar problems. There, the State reported that it had been unable to contact 20,000 of the approximately 50,000 people subject to the work requirements – notwithstanding mailing notices to all beneficiaries, holding public information sessions, and making tens of thousands of phone calls.¹⁰ Although New Hampshire claimed that its outreach and reporting would differ from the approach in Arkansas, the result of the work requirements was very similar.¹¹

AHCCCS' proposal will substantially increase reporting requirements. Nor is there any explanation of the projected cost and where the money will come from to administer the increase in reporting requirements on over 119,000 persons each month.

⁷ Jessica Greene, *Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement*, HEALTH AFFAIRS BLOG, Sept. 5, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180904.979085/full/>.

⁸ MaryBeth Musumeci et al., Kaiser Family Foundation, *Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees* (December 2018), <http://files.kff.org/attachment/Issue-Brief-Medicaid-Work-Requirements-in-Arkansas-Experience-and-Perspectives-of-Enrollees> [hereinafter Musumeci, *Medicaid Work Requirements in Arkansas*].

⁹ Sommers et al., *Medicaid Work Requirements – Results from the First Year in Arkansas*, at 1077.

¹⁰ Ethan DeWitt, “New Hampshire Medicaid work requirement faces crucial test,” CONCORD MONITOR (July 6, 2019), <https://www.concordmonitor.com/New-Hampshire-Medicaid-work-requirement-faces-crucial-test-26791579/>; Gary Rayno, “Progress Made on NH Medicaid work requirement deal,” EAGLE TRIBUNE (Jun. 18, 2019), https://www.eagletribune.com/news/progress-made-on-nh-medicaid-work-requirement-deal/article_fd8bc5df-4375-5e2d-a694-a3dc6c2b73f9.html.

¹¹ Jason Moon, “N.H. Said Its Medicaid Work Requirement Would Be Different, Early Numbers Suggest Otherwise,” N.H. PUBLIC RADIO (July 9, 2019), <https://www.nhpr.org/post/nh-said-its-medicaid-work-requirement-would-be-different-early-numbers-suggest-otherwise#stream/0>.

Requiring monthly reporting will simply increase the number of times each year that a person may not respond to the reporting request and then lose their coverage for two months, although there has been no change in their circumstances. Research in Arkansas supports this concern.¹²

Evidence shows that churn on and off Medicaid increases both administrative and medical costs. Because the work requirements will result in increased churning between enrollment, suspension, and reinstatement, Arizona will incur substantially higher administrative costs per-beneficiary than continuous enrollment.¹³ Studies show that enrollment costs can be hundreds of dollars per person enrolled in a program, and those costs—both expenses and time—increase with documentation requirements.¹⁴ These estimates do not take into account the increased uncompensated care costs that hospitals and community health centers will face when individuals who do not comply with the work requirement lose coverage.¹⁵

¹² Nia Johnson, et al., *Did Medicaid Work Requirements Achieve Their Goals in Arkansas?*, The Commonwealth Fund (Sept. 15, 2020) at 1-2, <https://www.commonwealthfund.org/blog/2020/did-medicaid-work-requirements-achieve-their-goals-arkansas>. (Compared to individuals in states without work requirements – work requirements did not increase employment for 30-49-year-old Arkansans (the age group targeted by the policy) but did result in significant coverage losses while the requirements were in effect in 2018).

¹³ Ku et al., *Improving Medicaid's Continuity of Coverage*, at 1.

¹⁴ See Gerry Fairbrother et al., *Costs of Enrolling Children in Medicaid and SCHIP* 23 HEALTH AFFAIRS 237 (2004) <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.23.1.237> (administrative costs equal \$280 per child enrolled in New York's Medicaid program); Gerry Fairbrother, *How Much Does Churning in Medi-Cal Cost?*, 6-7 (2005), <https://www.issuelab.org/resources/9743/9743.pdf> (estimating \$180 in administrative costs to re-enroll a child in California's Medicaid program).

¹⁵ See, e.g., Jessica Sharac et al., The George Washington Univ., *How Would Medicaid Losses in Approved Section 1115 Medicaid Work Experiment States Affect Community Health Centers?* (June 2019), <https://www.rchnfoundation.org/wp-content/uploads/2019/06/Draft-GG-IB-59-6.19-FINAL.pdf>; Randy Haught et al., The Commonwealth Fund, *How Will Medicaid Work Requirements Affect Hospitals' Finances?*, (Mar. 14, 2019), <https://www.commonwealthfund.org/publications/issue-briefs/2019/mar/how-will-medicaid-work-requirements-affect-hospitals-finances>; Jessica Schubel & Matt Broaddus, Center on Budget & Policy Priorities, *Uncompensated Care*

3. Spending significantly more money on administrative costs for the AHCCCS Work Program is not supported by studies that the vast majority of individuals enrolled in Medicaid already work or have good cause not to work

Notably, Arizona is requesting to incur these expenses to target a very small portion of individuals. A recent study by the Kaiser Family Foundation confirms that the vast majority of individuals enrolled in Medicaid already work or have good reason for not working.¹⁶ Spending significantly more money on work requirements in hopes of changing behavior for the small remaining fraction of Medicaid enrollees is not in line with the objectives of the Medicaid program.

Moreover, many low-wage workers struggle for consistent hours every month due to the volatile nature of the low-wage labor market. Between 2002 and 2017, the ten most common jobs among Medicaid and SNAP recipients were: nursing aides, orderlies, and attendants; cashiers; cooks; truck, delivery, and tractor drivers; retail sales clerks; janitors; laborers outside construction; waiter/waitresses; supervisors and proprietors of sales jobs; and housekeepers, maids, butlers, and stewards. Approximately one third of SNAP and Medicaid recipients worked in one of these occupations.¹⁷ These jobs do not provide consistent, predictable hours each month. They have variable schedules, often set

Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect: Medicaid Waivers That Create Barriers to Coverage Jeopardize Gains (2018), <https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage>.

¹⁶ Garfield et al., *Understanding the Intersection of Medicaid and Work* (finding that of adults who are enrolled in Medicaid but do not receive SSI, almost 80% live in families with at least one worker, and over six-in-ten are working themselves).

¹⁷ See Kristin F. Butcher & Diane Whitmore Schanzenbach, Ctr. on Budget & Pol. Priorities, *Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs*, figure 6 (2018), <https://www.cbpp.org/sites/default/files/atoms/files/7-24-18pov.pdf> (adding percentages in figure 6 for a total of 32.9 percent) [hereinafter Butcher & Whitmore Schanzenbach]; see also Josh Bivens & Shawn Fremstad, Economic Pol. Inst., *Why Punitive Work-Hours Tests in SNAP and Medicaid Would Harm Workers and Do Nothing to Raise Employment* (July 26, 2018), <https://www.epi.org/publication/why-punitive-work-hours-tests-in-snap-and-medicaid-would-harm-workers-and-do-nothing-to-raise-employment/> (reporting data from 2016 listing the most common occupations for workers receiving SNAP or Medicaid) [hereinafter Bivens & Fremstad].

by employers with no possibility for changes, making it difficult (or impossible) for individuals to make up for a loss of hours in a given month.¹⁸ In total, 83 percent of part-time workers report having unstable work schedules, and 41 percent of hourly workers between ages 26 and 32 receive one week or less notice of their schedules.¹⁹

Moreover, these occupations experience high rates of *involuntary* part-time employment—meaning workers wanted full-time hours but were only offered part-time hours—with the retail, trade, and leisure and hospitality industries ranking highest.²⁰ Thus, even when workers do work a substantial number of hours throughout the year, they are likely to experience periods with less or no work.²¹ As a result of the churn and volatility in the low-wage labor market, almost half of low-income workers would fail a work-hours test in at least one month over the course of the year.²²

¹⁸ Susan J. Lambert et al., *Precarious Work Schedules among Early-Career Employees in the US: A National Snapshot* (2014) (attached); Stephanie Luce et al., City Univ. of N.Y. and Retail Action Project, *Short Shifted*, (2014) http://retailactionproject.org/wp-content/uploads/2014/09/ShortShifted_report_FINAL.pdf; Liz Ben-Ishai, CLASP, *Volatile Job Schedules and Access to Public Benefits* (2015), <https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf>; Bivens & Fremstad; Tanya L. Goldman et al., Ctr. for Law & Social Pol., *The Struggles of Low Wage Work* (2018), https://www.clasp.org/sites/default/files/publications/2018/05/2018_lowwagework.pdf [hereinafter Goldman, *The Struggles of Low Wage Work*]; Michael Karpman et al., *Precarious Work Schedules Could Jeopardize Access to Safety Net Programs Targeted by Work Requirements*, Urban Inst. (2019), https://www.urban.org/sites/default/files/publication/100352/precarius_work_schedules_could jeopardize_access_to_safety_net_programs.pdf.

¹⁹ Goldman, *The Struggles of Low Wage Work*.

²⁰ Bivens & Fremstad; Goldman, *The Struggles of Low Wage Work*.

²¹ Kaiser Family Foundation, *What Do Different Data Sources Tell Us about Medicaid and Work?* (2018), <https://www.kff.org/medicaid/fact-sheet/what-do-different-data-sources-tell-us-about-medicaid-and-work/>.

²² Aviva Aron-Dine et al., Center On Budget & Policy Priorities, *Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements* (2018), <https://www.cbpp.org/sites/default/files/atoms/files/4-11-18health.pdf>.

Nor will volunteering or other un-paid activities be a viable solution for Medicaid enrollees. Many individuals whose hours fluctuate regularly will struggle to complete other activities at the last minute in a month when their work hours fall short. Thus, the variation and volatility of the low-wage market will make it difficult for individuals to complete any of the non-work activities. In addition, obstacles that prevent people from finding and maintaining work, such as lack of internet access and lack of transportation, will prevent people from completing volunteer activities. Nationwide, half of households with incomes under \$25,000 have either no computer or no broadband at home.²³ Further, low-income people are less likely to own a car than their middle- or upper-income peers, and many low-income families do not have access to affordable transportation, particularly in rural areas.²⁴

Moreover, conditioning Medicaid on unpaid work could run afoul of other laws the Secretary is not permitted to waive, such as the Fair Labor Standards Act (“FLSA”), which requires that all individuals be compensated in an amount equal to at least the minimum wage in exchange for hours they work.²⁵ FLSA concerns will also limit the number of recurring, stable volunteer opportunities that are available to Arizona beneficiaries.²⁶

²³ Camille Ryan & Jamie Lewis, American Community Survey Reports, *Computer and Internet Use in the United States: 2015*, at 9 (2017), <https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-37.pdf>; Rachel Garfield et al., Kaiser Family Foundation, *Implications of Work Requirements in Medicaid: What Does the Data Say?* (Jun. 12, 2018), <http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say> [hereinafter Garfield et al., *Implications of Work Requirements in Medicaid: What Does the Data Say?*].

²⁴ Federal Highway Admin., *National Household Travel Survey Brief: Mobility Challenges for Households in Poverty* (2014), <https://nhts.ornl.gov/briefs/PovertyBrief.pdf>; Samina T. Syed, Ben S. Gerber & Lisa K. Sharp, *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38 J. COMMUNITY HEALTH 976 (2013)..

²⁵ See 29 U.S.C. § 206(a)(1)(C); Dep’t of Labor, *How Workplace Laws Apply to Welfare Recipients 2* (1997), <http://nclej.org/wp-content/uploads/2015/11/Labor-ProtectionsAndWelfareReform.pdf>.

²⁶ See e.g., Dep’t of Labor, Wage and Hour Division, *Fact Sheet #14A: Non-Profit Organizations and the Fair Labor Standards Act 2* (2015), <https://www.dol.gov/whd/regs/compliance/whdfs14a.pdf>.

Research has shown that Medicaid coverage makes it easier for working poor adults to work. There is abundant evidence that denying health coverage to people significantly decreases their ability to seek, find, and retain employment. A paper published by Antoinette and Garfield for the Kaiser Family Foundation summarizes research supporting the idea that maintaining or obtaining health insurance coverage increases the chances of finding and retaining employment.

For example, in an analysis of Medicaid expansion in Ohio, most expansion enrollees who were unemployed but looking for work reported that Medicaid enrollment made it easier to seek employment, and over half of employed expansion enrollees reported that Medicaid enrollment made it easier to continue working. Similarly, a study on Medicaid expansion in Michigan found that 69% of enrollees who were working said they performed better at work once they got coverage, and 55% of enrollees who were out of work said the coverage made them better able to look for a job. A study on Montana's Medicaid expansion found a substantial increase of 6 percentage points in labor force participation among low-income, non-disabled Montanans ages 18-64 following expansion, compared to a decline in labor force participation among higher-income Montanans. National research found increases in the share of individuals with disabilities reporting employment and decreases in the share reporting not working due to a disability in Medicaid expansion states following expansion implementation, with no corresponding trends observed in non-expansion states.²⁷

Similarly, the Kaiser Family Foundation's research paper shows that providing health coverage also increases the likelihood of volunteerism. "Additional literature suggests that access to health insurance and care promotes volunteerism, finding that the expansion of Medicaid under the ACA was significantly associated with increased volunteerism among low-income adults." *Id.*

²⁷ KFF, *The Relationship Between Health and Work: Findings from a Literature Review* (August 2018), available at <https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/> (footnotes omitted) (last visited November 29, 2020).

In 2017, the Kaiser Family Foundation found that a Medicaid enrollee's health is the leading factor determining an enrollee's likelihood to be working. According to that study, the category of Medicaid enrollees most likely to be affected by work requirements (non-SSI, non-elderly adults) are 30% more likely to be employed if they are in good health.²⁸ State-specific studies further support this finding. In Indiana researchers found that low-income workers in a Medicaid expansion state had not experienced greater job loss, more frequent job switching, or more switching from full-time to part-time work than low-income workers in non-expansion states.²⁹ In Ohio, the state found that among those who were unemployed or looking for a job when they gained coverage under the Medicaid expansion, 75 percent stated that having medical coverage made the task easier.³⁰ This evidence further shows that this waiver proposal should not be submitted.

Here as well, there is no explanation of how the mandatory work-related requirements would increase access to health care, test an experiment related to the Medicaid program or further the objectives of the Medicaid Act. The proposed requirements obviously do none of these. This type of request does not promote the objectives of the Medicaid Act and it is only proposed to create a barrier to access to care and to make persons ineligible for AHCCCS. Finally, this is not the time to waste limited resources that should be better targeted to promote child and family health. Restricted access to preventative care and the treatment for chronic health issues and limits the productivity of working persons and is not an incentive for employment.

For all these reasons, AHCCCS should not proceed with the AHCCCS Works program proposal.

²⁸ Rachel Garfield, et al., Kaiser Family Foundation, *Understanding the Intersection of Medicaid and Work: What Does the Data Say?*, Aug. 2019, <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work-What-Does-the-Data-Say>.

²⁹ “Medicaid Expansion Did Not Result In Significant Employment Changes Or Job Reductions In 2014.” <http://content.healthaffairs.org/content/35/1/111.abstract>.

³⁰ “Ohio Medicaid Group VII Assessment,” Report to the Ohio General Assembly by the Ohio Department of Medicaid. www.medicaid.ohio.gov/Portals/0/Resources/Annual/Group-VII-Assessment.pdf.

C. The Disability-Related Exemption Is Too Vague to Evaluate and Will Likely Lead to Loss of Coverage

Even if the goals and objectives of the AHCCCS Works program furthered the purposes of the Medicaid Act, which they do not, AHCCCS Works requirements disadvantage people with disabilities.

The criteria for a disability-related exemption—has a disability as defined by federal disabilities rights laws (ADA, Section 504, and Section 1557) who are unable to participate in AHCCCS Works Requirements for disability-related reasons—is not sufficiently defined to ascertain whether any particular person with a health or disability issue will be exempt. When is a person with a disability “unable to participate in the AHCCCS Works Requirement”? Many people with health conditions can do work at some pace and at some level but cannot produce results at an economically viable level. Employment requires more than the ability to work. It requires attention to task, the ability to cooperate with coworkers, to follow instructions, to achieve a particular level of productivity, to attend regularly and punctually. Health conditions can make a person’s attendance unpredictable and their output highly variable. The ability to work and the ability to sustain employment for a specified number of hours per week is different. Individual determinations of the ability to participate in AHCCCS Work Requirements will likely prove to be a resource intensive process. Based on the vague, subjective standard, decisions are likely to be arbitrary.

A recent Kaiser Family Foundation study similarly found that despite the purported exemptions and safeguards in some states, significant numbers of individuals with a disability still lost coverage. The study found that safeguards were complex and difficult to navigate and so exempted very few enrollees.³¹ Massive coverage losses occurred despite in Arkansas where the State used “existing data sources when possible” to confirm disability status.³²

³¹ MaryBeth Musumeci, Kaiser Family Foundation, *Disability and Technical Issues Were Key Barriers to Meeting Arkansas’ Medicaid Work and Reporting Requirements in 2018* (Jun. 11, 2019), <https://www.kff.org/medicaid/issue-brief/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018/>.

³² Sommers et al., *Medicaid Work Requirements – Results from First Year in Arkansas*, at 8.

The State's 1115 Waiver fails to describe in any detail how it will make reporting mechanisms, including requests for exemptions, accessible for people with disabilities who require accommodations.

III. Elimination of the Prior Quarter Coverage Serves No Experimental Purpose, Creates Barriers to Health Care and Will Impede, Not Further, the Objectives of the Medicaid Act

AHCCCS proposes to be allowed to continue to waive prior quarter coverage required by 42 U.S.C. § 1396a(a)(34) and 42 C.F.R. § 435.915 for certain populations. 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.³³ AHCCCS proposes to continue to limit prior quarter coverage to the first day of the month of application for all Medicaid members, "except for pregnant women, women who are 60 days or less postpartum, and children under 19 years of age. Pregnant women, women who are 60 days or less postpartum, and children under the age of 19 are eligible for Medicaid coverage up to three months prior to the month in which their application was submitted." Page 18.

Although AHCCCS eliminated the retroactive coverage in July 2019, it has not evaluated the program. This failure to evaluate the current waiver should preclude any continuation of the waiver. Regardless, as with the AHCCCS works program, AHCCCS' objective and hypotheses are not appropriate for a demonstration waiver.

For the Waiver of Prior Quarter coverage, the objectives are:

The waiver of Prior Quarter Coverage will encourage members to obtain and continuously maintain/retain health coverage.

Page 37. This is the same objective for the elimination of the prior quarter coverage the Secretary relied upon to approve the Arkansas waiver that was found invalid in *Gresham*,

³³ When AHCCCS initially proposed this waiver in 2019, it claimed the waiver would "better align Medicaid policies with commercial health insurance coverage." It is not an objective of the Medicaid Act to prepare persons for commercial medical insurance and even if it were, persons on Medicaid are familiar with private health insurance.

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950 F.3d at 97. Thus, the focus in the proposal is incorrectly not on the statutory objective of providing coverage but rather a non-statutory objective.

The proposed hypotheses are:

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

The implementation of the proposal will not reduce member satisfaction.

The implementation of the proposal will not adversely affect health outcomes.

Page 37. Elimination of prior quarter coverage eliminates health care coverage, and is contrary to the objectives of Medicaid. Thus, in *Gresham*, the Secretary's approval of this waiver was found to be arbitrary and capricious. *Id.* at 104.

For the reasons below, the ACDL, Center and the Institute request that AHCCCS not proceed with the proposed waiver renewal request because the substance of the demonstration 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. 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.³⁴

This waiver proposal has no evidentiary or experimental basis and will impede not further access to care and the objectives of the Medicaid Act. Therefore, the proposed waiver should not be submitted.

³⁴ Previously, when AHCCCS proposed to limit prior quarter coverage it was solely to save money. AHCCCS delineated the prior quarter coverage historical expenditures for 2014-2018 and stated that the proposal to waive prior quarter coverage will save Arizona \$39,431,100 in state fiscal year 2019. 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.

IV. The Waiver Proposal Should Include School-Based Medicaid Billing

The draft proposal should include a provision to expand the Medicaid school-based claiming program in Arizona to allow direct billing by school districts and to broaden scope beyond students with a service documented in the Individual Education Plan (“IEP”).

Currently, for services provided by a public school or charter school to be reimbursable under the Arizona Medicaid program, the need for the service(s) must be documented in the student’s IEP. We support expanding School-Based Medicaid billing to broaden the program and to provide services for students that may not be associated with an IEP. Specifically, the program should be expanded to allow services to be covered if they are part of a section 504 plan, an individual health care plan (“IHCP”), an individualized family service plan (IFSP), an individual service plan (“ISP”), any state-mandated screenings, and some services deemed medically appropriate. Such an expansion would broaden access to reimbursement significantly to include nutritionists, school psychologists, respiratory therapists, dental hygienists, and other health care professionals working through educational institutions. The pools of services acceptable under the expansion should include medical services, therapy services, behavioral/mental health services, and administrative services.

AHCCCS is the agency that develops the policies and administers the Medicaid School-Based Claiming program through a third-party administrator (currently, the Public Consulting Group or PCG) and in collaboration with the Arizona Department of Education. AHCCCS is the only entity that may submit claims to CMS to receive federal financial reimbursement for allowable Medicaid costs. We support an expansion of the program to allow for Direct Service Claiming (“DSC”), which provides a channel through which LEA’s can seek federal reimbursement for Medicaid provided services delivered in their schools. The type of direct medical services include services, such as physical and occupational therapies, speech therapies, counseling of a psychological nature, audiology services, skilled nursing, personal care services, and therapy services considered to be in the arena of Applied Behavior Analysis (“ABA”). Allowing schools to direct bill for Medicaid services would promote expansion of school-based health services.

According to the Community Preventive Services Task Force (“CPSTF”), the implementation and maintenance of school-based health centers (“SBHCs”) in low-income communities is recommended, based on sufficient evidence of effectiveness in

improving educational and health outcomes.³⁵ Findings from the CPSTF include: improved educational outcomes include school performance, grade promotion, and high school completion; and improved health outcomes such as the delivery of vaccinations and other recommended preventive services, asthma morbidity, emergency department and hospital admissions, prenatal care and birth weight, and other health risk behaviors. *Id.* The CPSTF also found that SBHCs result in net savings to SBHC users and the Medicaid program. *Id.* If targeted to low-income communities, SBHCs are likely to reduce educational gaps and advance health equity. *Id.*

V. Key Positive Proposed Waiver Sections

As advocates for healthcare access and health equity in Arizona, the ACDL, the Center and the Institute support key aspects of the AHCCCS's proposed Section 1315 waiver. We support the following requests in the waiver:

- **Reimbursement for traditional healing services provided to American Indian tribal members at 100% of the Federal Medical Assistance Percentage (“FMAP”).** We believe this will further promote integration of cultural health practices and that recognizing the importance of traditional healing services is one way to promote health equity for tribal members.
- **Oral health inequities persist for American Indian tribal members.** Reimbursement for services provided to American Indian AHCCCS participants is critical to reducing rates of oral disease and decay and is in line with fulfillment of our country's treaty promise to provide health care at no cost to members of sovereign tribal nations.
- **Disregard of interest and excess income for children and adults with disabilities.** We feel this is a critical step to help keep children and families with disabilities connected to a reliable source of health coverage, even when their financial circumstances may be in flux. -IHS / 638 uncompensated care - provides a level of protection to tribal members in case optional benefits are limited. Our agencies will continue to advocate for adequate rate payments / methodology for these services.

³⁵ See Community Preventive Services Task Force, *Promoting Health Equity Through Education Policies: School Based Health Centers* at 2 (last updated April 1, 2016), available at https://www.thecommunityguide.org/sites/default/files/assets/Health-Equity-School-Based-Health-Centers_1.pdf (last visited November 29, 2020).

Attn: Division of Community Advocacy and Intergovernmental Relations
Arizona Health Care Cost Containment System
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- **Expansion and extension of the Targeted Investment Program (“TIP”).** We support AHCCCS’ efforts to integrate behavioral and physical health care and look forward to seeing the results of this investment. The participation of an Indian Health Service (“HIS”) Tribal provider in TIP should be considered.

Each of these provisions holds promise to promote healthcare access and health equity in Arizona, and we commend the agency’s inclusion of these requests in the draft Section 1315 waiver.

We also request that AHCCCS consider the following additional changes before submitting the Section 1315 waiver to the Centers for Medicaid and Medicare Services:

Verbal consent for ALTCS person-centered care plans is a great first step and ask that AHCCCS consider expanding its request to allow verbal consent in lieu of written signature authorization for all AHCCCS populations.

Substantive efforts toward implementing the Whole Person Care Initiative and consider piloting this program with American Indian members. This would come at no cost to the state and would provide valuable data on the efficacy of the initiative.

Conclusion

For all the above reasons, AHCCCS should not submit the renewal waiver proposal with the requests for AHCCCS Works and elimination of the prior quarter coverage. As explained above, AHCCCS failed to show that these requests comply with federal requirements that they be experimental and test something experimental related to the Medicaid program and further the objectives of the Medicaid Act. Moreover, work requirements pose significant disadvantages to persons with disabilities and exemptions prove difficult to implement without massive coverage losses.

We are disappointed that Arizona’s proposal did not include expansion of Medicaid funding through Direct School Billing and look forward to it being added to this proposal or as an addendum in 2021.

Finally, if any of the above requests are currently being imposed in other states, then the undersigned do not think AHCCCS’ requests satisfy the novel or experimental prong of the waiver statute. In those situations, AHCCCS should wait to see what the results are of the testing in the other states before proceeding with the requests.

Attn: Division of Community Advocacy and Intergovernmental Relations
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Thank you for the opportunity to comment on the draft proposal. 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, Legal Director, Arizona Center for Disability Law at 520-327-9547, ext. 323.

Sincerely,

/s/ Ellen Sue Katz
Ellen Sue Katz, on behalf of
Arizona Center for Law in the Public Interest
William E. Morris Institute for Justice

/s/Rose Daly-Rooney
Rose Daly-Rooney, Legal Director
Arizona Center for Disability Law



Jami Snyder
Director
State of Arizona, Arizona Health Care Cost Containment System
801 East Jefferson, MD 4100
Phoenix, AZ 85034

Dear Ms. Snyder:

The Epilepsy Foundation and our local chapter, Epilepsy Foundation Arizona, appreciate the opportunity to provide comments on the *Draft Arizona Demonstration Renewal Proposal*.

The Epilepsy Foundation is the leading national voluntary health organization that speaks on behalf of more than three million Americans with epilepsy and seizures. Together we foster the wellbeing of children and adults affected by seizures through research programs, educational activities, advocacy, and direct services. Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. Approximately 1 in 26 Americans will develop epilepsy at some point in their lifetime.

The purpose of the Medicaid program is to provide healthcare coverage for low-income individuals and families, and the Epilepsy Foundation and Epilepsy Foundation Arizona are committed to ensuring that Medicaid provides adequate, affordable and accessible healthcare coverage. Unfortunately, the *draft Arizona Renewal Proposal* contains policies that would jeopardize access to quality and affordable healthcare for Arizonans with epilepsy. We provide the following comments and asks the state to modify the waiver and remove these provisions before submitting to the Centers for Medicare and Medicaid Services (CMS) for approval.

Work Requirement

As part of this draft 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.ⁱ The U.S. Court of Appeals for the District of Columbia recently reaffirmed that the purpose of the Medicaid program is to provide healthcare coverage and that Arkansas' restrictive waiver, including the work requirement policy, did not meet that objective.ⁱⁱ

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious chronic diseases like epilepsy. If the state finds that individuals have failed to comply with the new requirements, they will lose coverage for the next two months.



For the majority of people living with epilepsy, epilepsy medications are the most common and most cost-effective treatment for controlling and/or reducing seizures. Missing even one dose of anti-seizure medication puts a person with epilepsy at risk for breakthrough seizures and related complications including injury, disability, loss of mobility or employment, and even death. Mortality rates among people with epilepsy are three times higher and sudden death rates are twenty times higher than rates for the general population. Each year, about 1 out of 1,000 adults die from Sudden Unexpected Death in Epilepsy (SUDEP). We are very concerned that this two-month lack of coverage will lead to missed prescription refills, which will cause more seizures, avoidable ER visits, and even deaths.

The Epilepsy Foundation and Epilepsy Foundation Arizona 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. Many people with epilepsy have disabilities that prevent them from working, even if they are not eligible through a disability pathway in Medicaid. 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.ⁱⁱⁱ 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.^{iv} A study published in *JAMA Internal Medicine* looked at the employment status and characteristics of Michigan's Medicaid enrollees.^v 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.^{vi,vii}

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).^{viii} That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. For people with epilepsy, access to health care can help reduce or control seizures, which in turn improves employment opportunities. Suspending individuals' Medicaid coverage for non-compliance with these requirements will hurt rather than help people search for and obtain employment. We urge you to remove the work requirement policy from the waiver application.

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. The proposed 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 like epilepsy to begin treatment without being burdened by medical debt prior to their official eligibility determination.

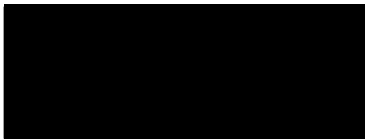
Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, people with epilepsy could 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.^{ix} We urge you to remove the policy of limiting retroactive coverage from the waiver application.

Enforceable Premiums

We applaud the decision to discontinue enforceable premiums for Medicaid enrollees in the proposed waiver application. Ending patients’ coverage for failure to pay a premium can have significant negative consequences for patients. 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.^x The premium program also included an \$8 copay for non-emergent use of the Emergency Department and will also be discontinued. Many people with epilepsy are very low income, and struggle to afford expenses like food and rent. They also must pay for non-health care expenses related to their epilepsy, such as payment for transportation because they cannot drive themselves. Removal of enforceable premiums in Medicaid will help Arizonans with epilepsy continue to access health care.

We urge you to revise the waiver as outlined above before the waiver is submitted to CMS. Thank you for the opportunity to submit comments.

Sincerely,



Suzanne Matsumori
Executive Director
Epilepsy Foundation Arizona



Laura Thrall
President & CEO
Epilepsy Foundation



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- ⁱ Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, “A Look at November State Data for Medicaid Work Requirements in Arkansas,” Kaiser Family Foundation, December 18, 2018. Available at: <https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/>; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf
- ⁱⁱ US Court of Appeals for the District of Columbia Circuit, *Gresham v. Azar*, Feb. 14, 2020. Available at: <https://healthlaw.org/wp-content/uploads/2020/02/Gresham-v.-Azar-DC-Circuit-Ruling-Feb-14.pdf>.
- ⁱⁱⁱ Jessica Greene, “Medicaid Recipients’ Early Experience With the Arkansas Medicaid Work Requirement,” *Health Affairs*, Sept. 5, 2018. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20180904.979085/full/>.
- ^{iv} 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/>.
- ^v 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
- ^{vi} 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
- ^{vii} 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>
- ^{viii} 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>.
- ^{ix} Virgil Dickson, “Ohio Medicaid waiver could cost hospitals \$2.5 billion”, *Modern Healthcare*, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)
- ^x Id. _

Date: Tuesday, November 24, 2020 at 3:01:28 PM UTC-7
 Subject: 1115 Waiver Comments and Suggestions
 To: waiverpublicinput@azahcccs.gov <waiverpublicinput@azahcccs.gov>

Good Afternoon,

I appreciate the opportunity to provide the feedback below on the draft AHCCCS 1115 Waiver:

Section	Page	Description	Recommendation/Suggestion
V. Proposed Changes to the Current Demonstration	22	Verbal consent in lieu of written signatures for ALTCS members	I support this change however it should be applied to Medicaid members not just ALTCS except for high-risk services that required informed consent (e.g. medications, ECT, TMS and inpatient). Signatures are not required by licensing rules and the flexibility offered during the pandemic public health emergency for verbal consent for services has been extremely beneficial to allow providers to continue to provide needed behavioral treatment using teleservices (telephonically and via telehealth video services). There are other ways to document agreement without having to chase down a “wet” signature especially with today’s technology (e.g. electronic signatures). This is a barrier to accessing services in a timely manner and an administrative burden to providers. For example, in the progress note a service provider could simply indicate the change in service(s) were agreed upon, indicate that the assessment was reviewed, and then update the treatment plan - verbal agreement should be acceptable.
V. Proposed Changes to the Current Demonstration	28	Traditional healing services for American Indian and Native Alaskan members	I support this change and recommend AHCCCS consider expanding to include other forms of complementary medicine for all AHCCCS members. Chiropractic treatments, acupuncture, and massage can work in tandem with medical interventions to address chronic pain issues and reduce the use of opioid medications. Expansion of complementary medicine interventions to address the underlying medical condition may also help to reduce the use of addictive medications and improve health outcomes.
		Dental benefits for tribal members	I support this change and recommend AHCCCS consider expanding the preventative dental for all AHCCCS members. Access to preventive care and early intervention, when oral health issues are identified, reduces the need for emergency care and the likelihood of other chronic physical health conditions, including infection, cardiac and vascular problems, and pregnancy complications. This would help reduce overall health care costs and improve the quality of life for members and suggest that AHCCCS further investigation both the cost of expanding the dental benefits and associated cost savings of preventative dental care across the life span.

V. Proposed Changes to the Current Demonstration	23	Extension and Expansion of the Targeted Investment Program	I would also like to see the opportunity for current TIP providers to participate in the expansion category with incentives to add new sites, programs and/or locations. The description in the draft indicates that the expansion cohort for TIP Program 2.0 will include primary care practices, behavioral health providers, and integrated care clinic “with no prior TI participation” . I would also recommend that Peer Run Organizations also be allowed to participate as TIP providers as they have been a key partner in engaging our members in whole health care and providing critical services to support successful re-entry and long-term recovery.
Iv. Current Program Features to Continue Under Demonstration Renewal	16	AHCCCS WORKS	I am concerned with the impact of the AHCCCS Works program on our communities (e.g. inability for people to access lifesaving services in a timely manner). Tracking will also be a huge administrative burden for members, contractors, providers and AHCCCS. Additional research is needed what has been implemented in other states. Addressing SDOH and eliminating barriers to employment services would likely produce better employment outcomes than reducing access to physical and behavioral health services which frequently are the barriers to long-term sustainable employment.
IV. Current Program Features to Continue Under Demonstration Renewal	16	Prior Quarter Coverage	Recommend reinstating prior quarter coverage for all Medicaid members to allow providers to be reimbursed for care that is currently uncompensated, identify health issues sooner before they become emergent, and provide needed services in a timely manner while also reducing enrollment burden to providers.
Additional Considerations		Whole Person Care and Social Determinants of Health (SDOH)	AHCCCS should consider adding into the 1115 Wavier the Whole Person Care Initiative including opportunities to better address SDOH which are critical to improving health outcomes and support of long-term recovery. For example, providers should be reimbursement for non-emergency transportation to access needed SDOH services and support to address them as well include additional non-AHCCCS registered providers location such as probation and parole offices, mental health and drug courts, city and county housing departments, domestic violence services, etc.

Thank you again for the opportunity to comment on the AHCCCS 1115 Waiver Request and please let me know if you have any question on the above suggestions,





Vicki Staples, MEd, CPRP

Director OP Behavioral Health Programs

Valleywise Behavioral Health Center - Phoenix

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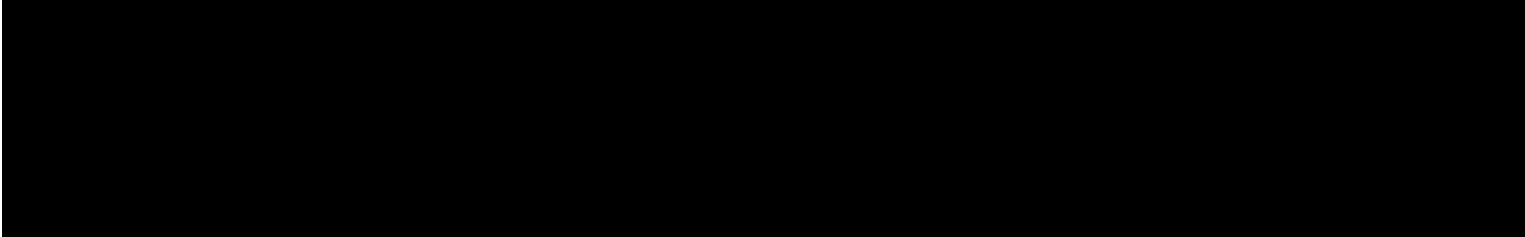
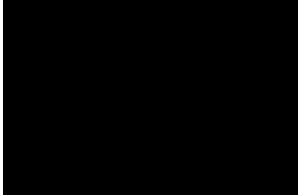
Date: Friday, November 27, 2020
Subject: Comment on the current Medicaid section 1115 waiver.
To: publi...@azahcccs.gov
Cc: Carol McDermott <NUT...@cox.net>

I appreciate the opportunity to comment on the current Medicaid Section 1115 waiver.

The policy of requiring able-bodied adults to verify compliance with the work requirements on a monthly basis would be very difficult for my grandson to understand and to complete and, if he unintentionally failed to do so, the consequences would be destabilizing for him.. He is now 20 years old, has been receiving mental health services through AHCCCS since age 3 and was designated General Mental Health (GMH) category upon turning age 18. He completed his high school diploma after 5 years of attending a special needs placement at the Austin Center for Exceptional Children as specified on his very specific IEP from Glendale Union High School District. His diagnoses include Autism Spectrum Disorder and Bipolar Disorder. He struggled to find employment but has now been employed at Cobblestone Car Wash for one year as a vacuumer and car detailer, He receives treatment through AHCCCS which includes medications and monthly injections. He does not have healthcare options through his employment. His work schedule is full-time, hours varying weekly as the company often changes his work hours and sends workers home early if business is slow. He needs constant reminders to make the appointment for his monthly medication shot and is irregular in taking two other medications, states he forgets. The reporting requirement would be another difficulty. Too many increase his anxiety and depression and his functioning level.

Secondly I oppose the proposed lifetime coverage limitation of 5 years of AHCCCS for able-bodied employees For a young person with a cyclical mental health history and the possibility of 45+ years of work ahead of him this not reasonable nor appropriate. This young man wants to work and makes that effort daily, but may have periods of being unable to work and should have the safety net of AHCCCS services when needed during his lifetime.

Thank you for the opportunity for me to submit these comments.



[REDACTED]
UTC-7

Subject: Comments by Arizona Naturopathic Medical Association in Support of Section 1115 Waiver Renewal
To: waiverpublicinput@azahcccs.gov <waiverpublicinput@azahcccs.gov>

The Arizona Naturopathic Medical Association (AzNMA) is pleased to support the request by the Arizona Health Care Cost Containment System (AHCCCS) for renewal of its five-year Section 1115 Waiver. AzNMA represents licensed naturopathic physicians in Arizona, which is at the forefront among states in offering high quality naturopathic medical services to its residents. Naturopathic physicians in Arizona practice under a comprehensive licensure program (ARS Title 32, Chapter 14) and provide medical services within the scope of licensure at the same level as medical doctors and doctors of osteopathy. AHCCCS has already authorized naturopathic medical services under its EPSTD program. The next step will likely be adoption of a State Plan Amendment to authorize naturopathic medical services for adult AHCCCS members. AzNMA finds nothing in the Section 1115 renewal submission by AHCCCS that would interfere with this process, with much of the submission being beneficial to all AHCCCS members and medical services providers. If any problem should arise in the renewal process that would affect the providing of naturopathic medical services, please promptly notify AzNMA. With that understanding, AzNMA recommends renewal of the Section 1115 Waiver.

For any questions, please contact:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]
Date: Monday, November 30, 2020 at 9:45:56 AM UTC-7

Subject: Ideas for 1115 waiver expansion

To: waiverpublicinput@azahcccs.gov <waiverpublicinput@azahcccs.gov>

To whom it may concern,

At the Arizona Developmental Disabilities Planning Council (ADDPC) we had a few ideas that were around expanding service options. We were looking at what would need to be done to expand transportation options through waivers. We were also looking at therapeutic recreational activities as well. We know the current waiver does not cover them but wondered if it was possible to change that. If we expand the Medicaid waiver to include transportation for employment that would eliminate a major barrier for individuals with disabilities and would vastly improve their ability to achieve employment. Which would increase overall revenue/GDP of Arizona for everyone. Also increasing transportation recreational activities would increase individual's health therefore, decreasing medical expenses for that individual in the future. Which would increase the overall health of Arizonans also decreasing the load on the Arizona healthcare system. As a person with a disability myself I know how eliminating the barriers can improve an individual's income as well as their mental and physical health. Making myself a more productive person and able to contribute to society in a positive way.


Have a great day,

Jason Snead JD.

Research and Communication Specialist

Arizona Developmental Disabilities Planning Council (ADDPC)

[REDACTED]



Date: Wednesday, November 18, 2020 at 12:25:02 PM UTC-7

Subject: Opposed

To: waiverpublicinput@azahcccs.gov <waiverpublicinput@azahcccs.gov>

The draft proposal states that the reason for the extension is “to fully evaluate the Demonstration’s progress toward achieving the goals of continuity of care and personal responsibility, and to assess the impact to individuals and providers.” However, it is premature to extend this waiver for 5 years without this full evaluation. While AHCCCS has gathered some limited data on years prior to implementation of the waiver, it has not yet evaluated the waiver’s impact. Critically, AHCCCS has not evaluated the most important factor—the impact of eliminating retroactive coverage on individuals’ access to care or finances. In fact, the proposed evaluation does not include measures to specifically assess impact on access to nursing home care. This is a glaring omission given the unique requirements for long-term care applications, which routinely take weeks or months to complete. Not only do individuals who need nursing home care have to meet financial eligibility criteria, which can require gathering years of bank statements and other records that are often not readily available, they must also meet the functional criteria. This means instantaneous application is impossible.

AHCCCS’s stated objectives for this “demonstration” are to encourage individuals to obtain and maintain health coverage even when healthy, apply for Medicaid expeditiously, increase continuity of care, and facilitate receipt of preventive services. Regardless of whether these goals are met, the waiver cuts coverage in violation of Medicaid’s primary objective and is therefore not allowable under federal Medicaid law. Moreover, AHCCCS’s objectives are either inapplicable or impossible to meet for Arizonans who need long-term care.

[REDACTED]

Date: Monday, November 30, 2020 at 11:07:25 AM UTC-7

Subject: Public Comment 1115 Waiver

To: waiverpublicinput@azahcccs.gov <waiverpublicinput@azahcccs.gov>

[REDACTED]

Gila River would like to thank AHCCCS for seeking public comment regarding the 1115 Waiver Renewal Request. Regarding the Waiver of Prior Quarter Coverage, Gila River would like to request that the waiver not continue or not apply to Tribal members because we believe they are disproportionately affected. Our concern is in regards to access to care. We think the waiver disproportionately affects our disenfranchised members who may not have easy access to their mail. A good number of our clients utilize a PO Box rather than have mail delivery to their home. Many of our clients do not have reliable transportation and Gila River does not have a public transportation system that would easily allow our clients to get to their mail. Some clients live as much as 10 miles from where their mail is delivered. This means that for some of our clients there can be a significant delay in receiving notifications from DES or AHCCCS when it is time to renew. It also presents challenges to our clients to submit return mail timely (because they can't get back to the post office easily or quickly) thus leading to unnecessary periods of no coverage through no fault of their own. Delays in reapplying due to lack of transportation infrastructure and mail delivery results in periods of not being covered (since coverage does not retroactively extend back to when their coverage ended) which leads to access to care issues. Other tribes have verbally agreed with these access to care concerns. Thank you for your consideration.



Gila River
HEALTH CARE

Rick Poulin

Network Manager, Behavioral Health Services



GRHC.ORG

[REDACTED]

[REDACTED]

[REDACTED]

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CHAIR, BOARD OF TRUSTEES November 30, 2020

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VICE CHAIR, BOARD OF
TRUSTEES

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INITIATIVES

Elizabeth A. Cullen
COUNSEL, HEALTH POLICY

AHCCCS
c/o Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Re: Arizona's Section 1115 Waiver Renewal Request (2021-2026)

Dear Director Snyder:

Thank you for the opportunity to comment on the Arizona Health Care Cost Containment System's ("AHCCCS") proposed request to renew and extend its 1115 Waiver for an additional five-year period ("Renewal Request"). The Jewish Federations of North America (JFNA) joined by the Jewish Federation of Greater Phoenix urges you to reconsider the renewal of two current program features that we believe harm Medicaid beneficiaries and providers by limiting access to care for the most vulnerable: (1) waiver of prior quarter coverage; and (2) AHCCCS works.

With respect to the waiver of prior quarter coverage, AHCCCS seeks feedback on a renewal of its current policy limiting retroactive eligibility for coverage to the month of application (as opposed to the three months prior). As set forth below, JFNA believes that at a time when millions of Americans are at risk of losing health insurance coverage as a result of the COVID-19 pandemic and the resulting economic downturn, continued restrictions on retroactive eligibility run contrary to the core purposes of the Medicaid program.

Arizona's community engagement program, AHCCCS Works, poses separate but related problems. While not yet implemented in Arizona, the experience of other states implementing similar models makes clear that any move to impose a community engagement requirement would be misguided and detrimental to the health and well-being of Arizonans. We discuss both of these issues below.

JFNA represents 146 Jewish federations – including the Jewish Federation of Greater Phoenix -- that support 15 leading academic medical centers/health systems, 95 Jewish nursing homes and aging communities, 125

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Washington, DC 20006

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JewishFederations.org



Jewish family & children's agencies, and 14 group homes providing health and long-term care services and supports. Our network of provider agencies greatly depend on Medicaid to serve the more than one million Jewish and non-Jewish clients who come to our doors seeking care.

Retroactive Coverage Is Critical for Many Medicaid Beneficiaries, Particularly Older Adults and People with Disabilities

JFNA strongly supports retroactive coverage for Medicaid beneficiaries and therefore opposes AHCCCS' proposal to renew its waiver of prior quarter coverage. As evidence shows, retroactive coverage provides vital financial security to vulnerable, low-income beneficiaries who experience unexpected, significant health care events, such as a stroke, a car accident, or a fall leading to a broken hip. Hospitalized patients or those in nursing facilities may not be healthy enough or familiar enough with Medicaid and its eligibility rules, to file a Medicaid application immediately. Further, the process of preparing a Medicaid application may require significant time to locate the required documentation. For example, an application for Medicaid nursing home coverage may require submitting five years of bank statements.

To protect low-income, vulnerable adults in these situations, federal Medicaid law requires retroactive Medicaid coverage for up to three months. Arizona's proposal to renew its current policy limiting retroactive coverage creates a significant barrier to affordable health care and harms Medicaid beneficiaries, particularly older adults and people with disabilities.

AZHCCS' own interim evaluation report should be evidence enough to discontinue this policy. Based on the results presented in Table 9-1 ("PQC Results Baseline Summary), two measures actually worsened under the policy since it was implemented in 2019. The hypotheses posed by the demonstration, including whether eliminating prior quarter coverage will have an adverse financial impact on consumers, are clearly knowable without subjecting thousands of Arizonans to a needless experience. Indeed, we already know that the elimination of retroactive coverage will harm both the pocketbooks and health of Arizonans.

As reiterated recently in *Health Affairs*, the concerns about the elimination of private quarter coverage are particularly acute in light of the COVID-19 pandemic,



with individuals facing job loss, unemployment, and the associated loss of health insurance coverage.¹

In the absence of health insurance coverage, treatment costs for COVID-19 regularly reach into the tens of thousands of dollars even without severe complications that require a stay in intensive care, pushing treatment bills into the six figures. If Arizona moves forward with this renewal request, it will keep in place the inability of individuals to receive the benefits of retroactive coverage in the event illness precedes a Medicaid eligibility determination and enrollment. Moreover, in households with more than one worker, the loss of a single job may not even qualify the newly unemployed and uninsured individual for health insurance coverage until all members of the family are unemployed (and, at this point, any care and treatment sought in the interim would fall outside of the Medicaid benefit).

JFNA believes retroactive eligibility should be an indispensable feature of all state Medicaid programs, and therefore we strongly urge that this feature be reinstated in Arizona given the acute concerns presented during the current health and economic crisis.

AHCCCS Works Should be Removed from Arizona's Renewal Request

Stakeholders, including JFNA, were encouraged by AHCCCS' decision in October 2019 to postpone implementation of AHCCCS Works, which would implement a community engagement requirement for able-bodied adult members in the state. We believe the very clear data emerging from other states that have implemented similar programs counsels in favor of removing and/or further delaying the implementation of this program.

In Arkansas, which implemented a community engagement requirement in the summer of 2018, more than 18,000 people (nearly one in four of those subject to the requirement) lost coverage over the course of just seven months following implementation.² In two other states – New Hampshire and Michigan – thousands of individuals avoided losing coverage solely because of legal injunctions issued

¹ Shafer P, Huberfeld N, Gobersterin E. "Medicaid Retroactive Eligibility Waivers Will Leave Thousands Responsible For Coronavirus Treatment Costs," Health Affairs (May 8, 2020).

² Arkansas Department of Human Services, "Arkansas Works Program: December 2018," January 15, 2019, https://humanservices.arkansas.gov/images/uploads/011519_AWReport.pdf.



against the use of such policies.³ This loss of coverage *was not* due to individuals finding employment and associated health insurance.⁴ Instead, the data from other states clearly shows that a series of complex and confusing rules, as well as persistent barriers to work (including unstable work hours, few employment opportunities, and disabilities) prevent individuals who are not currently employed from joining the work force.⁵

JFNA has a particular concern with community engagement requirements and their impact on the disability community. In Arkansas, for example, the state failed to adequately explain beneficiaries' rights under the Act, and it lacked a comprehensive system for providing reasonable modifications to protect people with disabilities, such as modifying the hourly requirement or providing support to help people meet the reporting requirement.⁶ Individuals with disabilities are particularly vulnerable to coverage interruptions, however brief. Such gaps can lead to increased emergency room visits, hospitalizations, and admissions to mental health facilities.

Given the availability of clear and convincing evidence now emerging from states that have implemented programs comparable to AHCCS Works, JFNA strongly urges you to reconsider including this program in your renewal.

³ 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>. See also 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>.

⁴ 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>

⁵ Wagner J, Shubel J. "States' Experiences Confirm Harmful Effects of Medicaid Work Requirements," Center on Budget and Policy Priorities, November 2020, <https://www.cbpp.org/health/states-experiences-confirming-harmful-effects-of-medicaid-work-requirements>.

⁶ MaryBeth Musumeci, "Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018," Kaiser Family Foundation, June 11, 2019, <https://www.kff.org/medicaid/issue-brief/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018/>.



Conclusions

JFNA appreciates the opportunity to provide comment on Arizona's section 1115 waiver renewal request. As detailed in this comment letter, we urge the agency to reconsider the inclusion of two elements of the renewal: (1) the waiver of prior quarter coverage; and (2) AHCCCS works.

JFNA believes that eliminating the critical protection of retroactive coverage will continue to create a significant barrier to affordable health care and harm Medicaid beneficiaries, particularly for older adults and people with disabilities who depend on long-term services and supports. We also believe that the continued elimination of retroactive coverage will harm safety net hospitals and other safety net providers by increasing uncompensated care costs and jeopardizing safety net providers' financial stability, particularly at a time of global pandemic.

Given the experience of other states in implementing community engagement requirements, we similarly believe any attempt to renew the authority for the AHCCCS Works program is misguided and could place Arizonans, including those with disabilities, at risk of losing vital health coverage.

Thank you for your consideration of our comments.

Sincerely,

Jonathan S. Westin, Senior Director for Health Initiatives, JFNA

Elizabeth A. Cullen, Counsel for Health Policy, JFNA

Marty Haberer, President & Chief Executive Officer
The Jewish Federation of Greater Phoenix



American Cancer Society
Cancer Action Network
www.fightcancer.org/AZ

November 20, 2020

Jami Snyder, Director
Arizona Health Care Cost Containment System (AHCCCS)
c/o Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Re: Arizona 1115 Waiver Renewal Request

Dear Director Snyder:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Arizona's proposal to amend the state's existing 1115 demonstration waiver. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

ACS CAN supports the Arizona Health Care Cost Containment System (AHCCCS) goals of providing quality healthcare to members and ensuring access to care. We commend your decision to discontinue AHCCCS Choice, Accountability, Responsibility, Engagement (CARE) cost sharing provisions. However, the proposed implementation of AHCCCS Works and elimination of retroactive eligibility (waiver of priority quarter coverage) could limit – rather than ensure – access to care for some of the most vulnerable Arizonans, including those with cancer, cancer survivors, and those who will be diagnosed with the disease. Further, we think moving forward with these proposals in the midst of the pandemic and economic recession is especially burdensome and could jeopardize the health and well-being of countless Arizonans. We strongly urge AHCCCS (or “the Department”) to address the concerns that we and other stakeholders have before moving forward with the waiver process.

More than 36,000 Arizona residents are expected to be diagnosed with cancer this year,¹ and there are more than 392,000 cancer survivors in the state² – many of whom rely on the AHCCCS program. ACS CAN wants to ensure that AHCCCS enrollees have adequate access and coverage under the Medicaid program, and that specific requirements do not create barriers to care for cancer patients, survivors, and those who will be diagnosed with cancer.

Following are our specific comments on Arizona's 1115 waiver application:

¹ American Cancer Society. *Cancer Facts & Figures 2020*. Atlanta, GA: American Cancer Society; 2020.

² American Cancer Society. *Cancer Treatment & Survivorship Facts & Figures 2019-2021*. Atlanta, GA: American Cancer Society; 2019.

Community Engagement Activities

ACS CAN opposes tying access to affordable health care for lower income persons to employment or community engagement requirements, because cancer patients and survivors – as well as those with other complex chronic conditions – could be seriously disadvantaged and find themselves without Medicaid coverage because they are physically unable to comply. Many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.^{3,4,5} Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.⁶ Recent cancer survivors often require frequent follow-up visits⁷ and suffer from multiple comorbidities linked to their cancer treatments.^{8,9} Cancer survivors are often unable to work or are limited in the amount or kind of work they can participate in because of health problems related to their cancer diagnosis.^{10,11} If work and community engagement is required as a condition of eligibility, many newly diagnosed and recent cancer survivors, as well as those with other chronic illnesses could find that they are ineligible for the lifesaving care and treatment services provided through the state's Medicaid program. We also note that imposing work or community engagement requirements on lower income individuals as a condition of coverage could impede individuals' access to prevention and early detection care, including cancer screenings and diagnostic testing.

We appreciate the Department's acknowledgement that not all people are able to work and the decision to include several exemption categories from the community engagement/work requirement

³ Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv.* 2016; 10:241. doi: 10.1007/s11764-015-0470-y.

⁴ de Boer AG, Taskila T, Tamminga SJ, et al. Interventions to enhance return to work for cancer patients. *Cochrane Database Syst Rev.* 2011; 16(2): CD007569. doi: 10.1002/14651858.CD007569.pub2.

⁵ Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. *J Cancer Surviv.* 2016; 10:480. doi:10.1007/s11764-015-0492-5.

⁶ Ramsey SD, Blough DK, Kirchhoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy than People Without a Cancer Diagnosis," *Health Affairs*, 32, no. 6, (2013): 1143-1152.

⁷ National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care.* Accessed October 2019. <https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care>.

⁸ Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation.* 2018; 137(7): CIR.0000000000000556.

⁹ Dowling E, Yabroff R, Mariotto A, et al. Burden of illness in adult survivors of childhood cancers: Findings from a population-based national sample. *Cancer.* 2010; 116:3712-21.

¹⁰ Ibid.

¹¹ Guy GP Jr, Berkowitz Z, Ekwueme DU, Rim SH, Yabroff R. Annual economic burden of productivity losses among adult survivors of childhood cancers. *Pediatrics.* 2016; 138(s1):e20154268; Zheng Z, Yabroff KR, Guy GP Jr, et al. Annual medical expenditures and productivity loss among colorectal, female breast, and prostate cancer survivors in the United States. *JNCI J Natl Cancer Inst.* 2016; 108(5):djv382; and Kent EE, Davidoff A, de Moor JS, et al. Impact of sociodemographic characteristics on underemployment in a longitudinal, nationally representative study of cancer survivors: Evidence for the importance of gender and marital status. *J Psychosoc Oncol.* 2018; 36(3):287-303.

and associated lock-out period. However, the waiver still does not go far enough to protect vulnerable individuals, including recent cancer survivors and others living with debilitating side effects as a result of their cancer treatment.^{12,13} Increased administrative reporting requirements for enrollees to attest to their work or exemption status would likely further decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt.^{14,15} While we appreciate the state using as many automated tools as possible to determine compliance with and exemptions from the community engagement/work requirements, the Department cannot ensure that the automated tools will prevent unnecessary disenrollments and coverage losses.

Given the experience with Arkansas' community engagement/work requirement, where uninsured rates were driven up and employment actually declined in the state after the requirement went into effect,¹⁶ Arizona must consider the number of state residents whose health could be negatively impacted, and coverage lost due to this proposal. Additionally, it is clear from the data from Arkansas that the community engagement/work requirements did not meet the state's goal of incentivizing employment and increasing the number of employed Arkansas Works enrollees.¹⁷

We are also concerned with the proposal to phase-in the community engagement requirements, starting with urban counties. Even a phased-in approach will add to enrollee confusion. If an enrollee moves from a Phase I county that has implemented community engagement requirements to a Phase III county that has yet to implement the requirements, it is unclear what mechanisms would be in place for the system to be alerted to the fact that the enrollee is no longer subject to the reporting requirements.

While the waiver does suggest that the State will assess areas with high rates of unemployment to determine whether additional mitigation strategies are needed to alleviate enrollee burden, the economic crisis caused by the pandemic and state's current 6.7 percent unemployment rate should prompt the Department to reconsider seeking reauthorization for AHCCCS Works.¹⁸ We would urge the State to not even consider implementing community engagement requirements until the unemployment rate in any county reverted to rates lower than existed pre-pandemic.

¹² Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

¹³ Dowling E, Yabroff R, Mariotto A, et al. Burden of illness in adult survivors of childhood cancers: Findings from a population-based national sample. *Cancer*. 2010; 116:3712-21.

¹⁴ Garfield R, Rudowitz R, Musumeci M. Implications of a Medicaid work requirements: National estimates of potential coverage losses. Kaiser Family Foundation. Published June 2018. Accessed October 2019. <http://files.kff.org/attachment/Issue-Brief-Implications-of-a-Medicaid-Work-Requirement-National-Estimates-of-Potential-Coverage-Losses>.

¹⁵ Sommers BD, Goldman AL, Blendon RJ, et al. Medicaid work requirements – Results from the first year in Arkansas. *NEJM*. 2019. DOI: 10.1056/NEJMSr1901772.

¹⁶ Sommers BD, Chen L, Blendon RJ, et al. Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care. *Health Affairs*. 2020. DOI: 10.1377/hlthaff.2020.00538

¹⁷ Ibid.

¹⁸ U.S. Bureau of Labor Statistics. Economy at a Glance: Arizona. Sept. 2020. Available at <https://www.bls.gov/eag/eag.az.htm>.

Penalties for Non-Compliance

We oppose the proposed disenrollment from coverage and two-month penalty for non-compliance with the workforce engagement requirement. The Department offers individuals who have failed to participate in the requirement “good cause” exemptions, but it is unclear if an appeal process would be offered, how long the appeal process could take, and whether the beneficiary would lose health coverage during that process.

Those with acute and chronic health care conditions who apply for an exemption to avoid the disenrollment and one-month penalty period will still have to verify their exemption and undertake a burdensome documentation process. This could lead to instances where those who should be able to maintain coverage are disenrolled, jeopardizing access to life-saving treatment. If individuals are suspended from coverage, they will likely have no access to affordable health care coverage, making it difficult or impossible for a cancer patient or recent survivor to continue treatment or pay for their maintenance medication until they come into compliance with the requirement or they are determined to be exempt. This is particularly problematic for cancer survivors who require frequent follow-up visits and maintenance medications as part of their survivorship care plan to prevent recurrence¹⁹ and who suffer from multiple comorbidities linked to their cancer treatments.²⁰ It may also be a problem for individuals in active cancer treatment who may not realize they are exempt. Being denied access to one’s cancer care team could be a matter of life or death for a cancer patient or survivor and the financial toll that the penalty period would have on individuals and their families could be devastating.

Waiving Retroactive Eligibility

Medicaid currently allows retroactive coverage if: 1) an individual was unaware of his or her eligibility for coverage at the time a service was delivered; or 2) during the period prospective enrollees were preparing the required documentation and Medicaid enrollment application. Policies that would reduce or eliminate retroactive eligibility could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals battling cancer. Therefore, we are concerned about the Department’s request to continue to waive retroactive eligibility, as it applies to non-expansion populations, including women who gain access to Medicaid through the Breast and Cervical Cancer Treatment Program via the state’s Well Woman Health Check Program.

Many uninsured or underinsured individuals who are newly diagnosed with a chronic condition already do not receive recommended services and follow-up care because of cost.^{21,22} In 2017, one in five

¹⁹ National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed October 2019. <https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care>.

²⁰ Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

²¹ Hadley J. Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. *JAMA*. 2007; 297(10): 1073-84.

²² Foutz J, Damico A, Squires E, Garfield R. The uninsured: A primer – Key facts about health insurance and the uninsured under the Affordable Care Act. *The Henry J Kaiser Family Foundation*. Published January 25, 2019. Accessed November 2019. <https://www.kff.org/report-section/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-under-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-health-care/>.

uninsured adults went without care because of cost.²³ Waiving retroactive eligibility could mean even more people are unable to afford care and forgo necessary care due to cost.

Safety net hospitals and providers also rely on retroactive eligibility for reimbursement of provided services, allowing these facilities to keep the doors open. For example, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.²⁴ Retroactive eligibility allows hospitals to be reimbursed if the individual treated is eligible for Medicaid coverage. Likewise, Federally Qualified Health Centers (FQHCs) offer services to all persons, regardless of that person's ability to pay or insurance status.²⁵ Community health centers also play a large role in ensuring low-income individuals receive cancer screenings, helping to save the state of Arizona from the high costs of later stage cancer diagnosis and treatment. Therefore, we urge the Department to consider these providers and their contribution to Arizona's safety net, as well as the patients who rely on Medicaid for health care coverage, before waiving retroactive eligibility for its Medicaid beneficiaries.

Discontinuation of Cost Sharing

ACS CAN commends the Department's decision to discontinue AHCCCS CARE. Cost sharing can create financial burdens for enrollees, and cause significant disruptions in care, especially for cancer patients and survivors. Studies have shown that imposing even modest premiums on low-income individuals is likely to deter enrollment in the Medicaid program.^{26,27,28} Imposing copayments or out-of-pocket costs on low-income populations has been shown to decrease the likelihood that they will seek health care services, including preventive screenings.^{29,30,31} Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.³² Uninsured and underinsured

²³ The Henry J. Kaiser Family Foundation. Key facts about the uninsured population. Updated December 7, 2018. Accessed November 2019. <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

²⁴ Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed October 2019. <https://www.cms.gov/regulations-and-guidance/legislation/emtala/>.

²⁵ National Association of Community Health Centers. Maine health center fact sheet. Published March 2017. Accessed November 2019. http://www.nachc.org/wp-content/uploads/2016/03/ME_17.pdf.

²⁶ Hendryx M, Onizuka R, Wilson V, Ahern M. Effects of a Cost-Sharing Policy on Disenrollment from a State Health Insurance Program. *Soc Work Public Health*. 2012; 27(7): 671-86.

²⁷ Wright BJ, Carlson MJ, Allen H, Holmgren AL, Rustvold DL. Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out. *Health Affairs*. 2010; 29(12):2311-16.

²⁸ Office of the Assistant Secretary for Planning and Evaluation. Financial Condition and Health Care Burdens of People in Deep Poverty. Published July 16, 2015. Accessed April 21, 2016. <http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty>.

²⁹ Solanki G, Schauflier HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research*. 2000; 34: 1331-50.

³⁰ Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. *Med Care*. 2011; 49: 865-71.

³¹ Trivedi AN, Rakowski W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med*. 2008; 358: 375-83.

³² American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2016-2017*. Atlanta: American Cancer Society; 2017.

individuals already have lower cancer screening rates resulting in a greater risk of being diagnosed at a later, more advanced stage of disease.³³

Cancer patients undergoing an active course of treatment for a life-threatening health condition need uninterrupted access to the providers and facilities from whom they receive treatment. Disruptions in primary cancer treatment care, as well as longer-term adjuvant therapy, such as hormone therapy, can result in negative health outcomes. Additionally, recent cancer survivors often require frequent follow-up visits and maintenance medications as part of their survivorship care plan to prevent recurrence,³⁴ and suffer from multiple comorbidities linked to their cancer treatments.³⁵ Ensuring both cancer patients and recent survivors receive the care they need is critical to positive health outcomes.

Conclusion

We appreciate the opportunity to provide comments on the Arizona demonstration waiver update. The preservation of eligibility, coverage, and access to AHCCCS remains critically important for many low-income state residents who depend on the program for cancer and chronic disease prevention, early detection, diagnostic, and treatment services. We ask the Department to weigh the impact of these proposals on low-income Arizonans access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors. We look forward to working with you to ensure that coverage through AHCCCS meets the health care needs of eligible individuals and families and reduces the burden of cancer for lower income Arizonans. If you have any questions, please feel free to contact me at brian.hummell@cancer.org or 602.586.7414.

Sincerely,

Brian Hummell
Arizona Government Relations Director
American Cancer Society Cancer Action Network

³³ Ibid.

³⁴ National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed October 2018. <https://www.cancer.gov/about-cancer/coping/survivorship/follow-up-care>.

³⁵ Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.



November 30, 2020

Via email: waiverpublicinput@azahcccs.gov

Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

To Whom it May Concern:

Mercy Care is a not-for-profit Medicaid managed-care health plan, serving Arizona Health Care Cost Containment System (AHCCCS) members in Arizona since 1985. Mercy Care contracts with AHCCCS for all Medicaid programs in Arizona and in every part of the state Mercy Care serves women and children, seniors, people with disabilities, and others who rely on AHCCCS for essential care. On behalf of Mercy Care, one of the largest AHCCCS plans in Arizona, I write in support of the 1115 Waiver renewal advanced by AHCCCS.

Built upon a solid foundation, Arizona's Medicaid system has withstood the strains of the current COVID-19 pandemic. Even in the midst of this challenge, Arizona continues to pursue innovation through programs like the Targeted Investments Program (TIP), which has positioned health care providers for integrated care. Arizona's 1115 Waiver renewal seeks to continue this program for an additional five years, which we appreciate and support. We also applaud the changes AHCCCS seeks to support the State's American Indians, represented by 22 federally recognized tribes.

Finally, Mercy Care supports giving the state the permanent authority to allow for verbal consent in lieu of written signature for up to 30 days for all care and treatment documentation for ALTCS members when included in the member's record and when identity can be reliably established. This flexibility has proven invaluable as we have cared for our most vulnerable members during the pandemic.

We also encourage AHCCCS to consider expanding their request to include housing support for persons with a serious mental illness. Mercy Care believes that making housing part of health care is essential to the well-being of AHCCCS members. As the Regional Behavioral Health Authority (RBHA), Mercy Care administers housing programs in the largest geographic service

area (GSA) of Arizona. Addressing social determinants of health, such as housing, is one of the most effective ways of removing cost out of the healthcare system. In 2018, NORC of the University of Chicago, conducted an outcomes study of 606 members participating in Mercy Care's 110 Scattered Site program. Scattered Site program members had Medicaid costs of approximately \$20,000 per member per 111 quarter in the period prior to entering the program. This amount is higher than members in Mercy Care's supported 112 housing or Assertive Community Treatment (ACT) programs. The high cost is attributed to high acuity and chronic homelessness of individuals receiving 113 housing subsidies through the Scattered Site program. After 18 months of program operations, findings were:

- 24 percent decrease in total costs per quarter for XXX.
- 20 percent reduction in psychiatric hospitalizations
- Decrease of \$5,002 in the total cost of care
- Decrease of \$5,642 in behavioral health costs

We acknowledge there are multiple methods through which states can achieve certain flexibilities and we support having a menu of options available for the states from which to choose. For Arizona, our success has come through the 1115 waiver. The 1115 authority is what has allowed us to embed the Medicaid program into the state's overall health care system and ensure one standard of care for all Arizonans regardless of payor type.

For these reasons and more, we respectfully request your consideration to renew Arizona's 1115 waiver for another five years.

Thank you,



Lorry Bottrill
Chief Executive Officer
Mercy Care



November 30, 2020

Arizona Health Care Cost Containment System
Attn: Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

FOR ELECTRONIC SUBMISSION

To Whom It May Concern:

On behalf of the Nurse-Family Partnership® National Service Office (NFP NSO), thank you for the opportunity to comment on AHCCCS' draft Section 1115 waiver proposal for the years 2021-2026. Nurse-Family Partnership (NFP) is a national, evidence-based, maternal-infant health community nursing intervention that partners highly skilled registered nurses with first-time expectant mothers (adolescents and adults) to improve pregnancy outcomes, improve child health and development, reduce instances of child maltreatment and neglect, and increase families' economic self-sufficiency.

We are writing in support of key provisions of the 1115 waiver renewal and to increase our collaboration with AHCCCS in prioritizing maternal and child health in implementation of the Whole Person Care Initiative going forward.

NFP draws on more than 40 years of research and implementation experience to demonstrate effectiveness in successful replication of the program. Under normal circumstances, NFP's weekly-to-biweekly, 60- to 75-minute encounters occur in the home (or other location preferred by the client). Participants enroll during pregnancy and receive visits from their personal nurse through their children's second birthday. During the pandemic, NFP nursing has been delivered continuously through the use of telehealth.

NFP currently serves 750 mothers in Maricopa and Pima counties. We are excited about opportunities described in the 1115 waiver renewal to partner with the State to offer NFP nursing services to more AHCCCS members given our shared goal of ensuring optimal outcomes for Arizona's most vulnerable families, including:

- a) reducing disparities in maternal and infant health outcomes,
- b) mitigating the effects of perinatal or postpartum mood and anxiety disorders (PMAD) or perinatal substance misuse,
- c) connecting children with early intervention services, and
- d) increasing children's immunization rates.

In this time of economic uncertainty due to COVID, strategic investments in proven, evidence-based interventions will be crucial to maintaining critical health care services without increasing cost. An independent analysis projects that **for every Arizona mom and baby who receive NFP nursing services, government programs save \$27,688 - 60% of which accrues to Medicaid.**¹

Within the first 12 months that expectant and new mothers participate in the program, ***NFP reduces health care costs by reducing preterm births by 15% and cutting pregnancy-induced hypertension by 33%. The program also reduces costs associated with emergency room utilization through a***

¹ Miller, T.R. (2015). "Projected outcomes of Nurse-Family Partnership home visitation during 1996-2013, USA." *Prevention Science*. 16 (6). 765-777. This fact sheet relies on a state-specific return on investment calculator derived by Dr. Miller from published national estimates to project state-specific outcomes and associated return on investment. The calculator is revised periodically to reflect major research updates (latest revision: 12/22/2018).

projected 34% cut in ER visits or hospitalizations for childhood injuries for infants through age 2. NFP also improves infant health by, among other outcomes, increasing immunizations by a projected 14% for children through age 2.²

The provisions of Arizona's 1115 waiver renewal request that NFP NSO supports are:

1. **Extending integration with current Targeted Investment (TI) Program providers and expanding the cohort of eligible providers under TI 2.0.** We support AHCCCS' efforts to integrate mitigation of social risks by connecting current TI providers with community-based organizations with competency addressing social determinants of health.

While we applaud AHCCCS' intent to expand provider types eligible to receive enhanced payments through TI, **we encourage the State to include non-physician medical professionals who deliver evidence-based maternal, infant and early childhood home visiting services through health departments, community-based organizations and other non-clinical settings** to reflect their contribution to improving AHCCCS members' health and reducing costs of care.

We further encourage the State to prioritize maternal and early child health for TP 2.0. We commend AHCCCS for the strong steps already taken in this direction as evident in robust MCH and EPSDT policies and guidance detailed in Section 400 of the Medicaid Policy Manual. One area for consideration is authorizing non-physician medical professionals, such as registered nurses delivering evidence-based maternal, infant and early childhood home visiting services, to separately bill for developmental screenings, health education, counseling, and anticipatory guidance on what to expect in child development.

We seek to partner with AHCCCS in building on the TP foundation already established by expanding both provider types eligible for TP 2.0 incentive payments and outcomes to include those that indicate improvements in pregnancy, infancy and early childhood development. NFP is well-positioned to support such work, as three agencies that deliver NFP nursing services in Arizona already are TI participants (adult and/or pediatric behavioral health cohorts).³ Moreover, standard NFP nursing practice also includes consistent data collection and reporting using a Web-based platform toward measurable impacts, including:

- Preterm births;
- Child injuries and hospitalizations/emergency department utilization;
- Birth spacing between 1st and 2nd child;
- Developmental screenings; and
- Adherence with immunization, well-child, and postpartum care guidelines.

2. **Verbal consent in lieu of written signatures for person-centered service plans** for ALTCS members. We encourage AHCCCS to consider expanding its request to allow verbal consent in lieu of written signature authorization for all AHCCCS populations. NFP integrated telehealth delivery into our nursing practice in 2017 to augment in-person encounters. This enabled Arizona nurses to seamlessly transition to an all-virtual delivery of NFP nursing services in March 2020 to provide ongoing services to AHCCCS members during COVID.

Given AHCCCS' decision to advance the Whole Person Care Initiative (WPC) outside of this waiver, NFP NSO seeks to partner with the agency to enhance care delivery for mothers, infants and children through this mechanism.

We commend the state's leadership in health care innovation by leveraging the Medicaid delivery and payment system to integrate physical health, behavioral health, and social support services for AHCCCS

² Ibid.

³ Casa de los Ninos, Easterseals Blake Foundation, and Southwest Human Development

members. Though we understand the financial and administrative strain AHCCCS is facing during the pandemic, we hope to see substantive efforts made toward implementing WPC.

As a national service provider, NFP NSO can support AHCCCS in exploring the integration of evidence-based maternal, infant and early childhood community nursing services that address social risk factors into the WPC initiative. NFP:

- Uses specially trained nurses who enroll participants early enough in pregnancy to improve maternal health outcomes during pregnancy and after their children's birth, as determined by the U.S. Administration for Children & Families Home Visiting Evidence of Effectiveness clearinghouse.⁴
- Uses validated nursing assessments, clinically recognized developmental and mental health screening tools (PHQ-9, GAD-7, ASQ3 and others), and continuous data collection to identify and document physical health, behavioral health, and social risks that inform client-centered care plans to address those needs.⁵
- Uses client-centered care plans to deliver care coordination, case management, health education, screenings, assessments, parenting education and anticipatory guidance for both mom and infant through a strengths-based, two-generational, whole-person approach.
- Provides enhanced training, skills and nursing practices to address opioids/substance misuse, disparities in maternal mortality and severe maternal morbidity, and maternal mental health – issues identified by the State.⁶
- Serves ACC, CMDP and RBHA members already identified by the State as likely to benefit from integrated care coordination that incorporates mitigation of social determinants of health. Arizona NFP client demographic data shows moms are likely to have experienced, or be at risk of experiencing:
 - addiction or substance misuse
 - developmental delays
 - high-risk pregnancy
 - homelessness or housing instability
 - intimate partner violence
 - involvement with child welfare or the criminal justice systems
 - lower levels of educational attainment
 - mental or behavioral health needs
 - teen pregnancy
 - trafficking
- Monitors many of the same quality and outcome measures prioritized by the State, such as prenatal and post-partum care; screenings for adverse childhood and community experiences, intimate partner violence, anxiety and depression, childhood developmental delays, and lead exposure; well-child visits in the first 15 months of life; and childhood immunization status.
- Is one of the evidence-based maternal, infant and early childhood home visiting programs authorized by the Arizona Department of Health Services to provide home visiting services through the Strong Families AZ home visiting alliance.

⁴ "Home Visiting Evidence of Effectiveness Outcomes: Maternal Health," U.S. Department of Health & Human Services Administration for Children & Families, accessed Nov. 30, 2020, at <https://homvee.acf.hhs.gov/outcomes/maternal%20health/ln%20Brief>

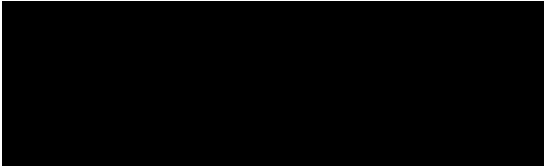
⁵ See addendum: Physical Health, Behavioral Health & Social Risk Factors Assessed and Managed through NFP Nursing Services

⁶ NFP NSO has developed enhanced training for NFP nurses regarding opioid use disorder and neonatal abstinence syndrome for nurses' use with clients experiencing perinatal opioid/substance addiction. Standard NFP nursing practice includes baseline assessment for anxiety and depression during prenatal program enrollment, again before delivery, upon delivery, and regularly during the postpartum period and the duration of program participation up to two years after delivery. In addition, the program has developed a mental health integration recognized by the U.S. Health Resources and Services Administration as meeting standards for certain referred mental health services. Because of NFP nurses' trusted relationship with expectant mothers, they are able to monitor clinical indicators of high-risk pregnancy and birth complications that contribute to disparities in maternal mortality and severe maternal morbidity.

Given the opportunity to comment on extension of the 1115 waiver, we wanted to highlight our desire to partner with the State to better integrate NFP nursing services into maternity and early childhood benefits for AHCCCS members.

Please feel free to contact me for further discussion at Toni.Panetta@NurseFamilyPartnership.org.

Sincerely,



Toni Panetta
 Southwest Regional Government Affairs Manager
 Nurse-Family Partnership National Service Office

**Addendum: Physical Health, Behavioral Health & Social Risk Factors
 Assessed and Managed through NFP Nursing Services**

Domain of NFP Nursing Practice	Factors Assessed
Personal health	<ul style="list-style-type: none"> • substance use • pregnancy complications and/or chronic illness • developmental and intellectual disability • depression, anxiety, and behavioral health issues
Maternal role	<ul style="list-style-type: none"> • caregiving attitudes and behaviors • child health and development • childcare
Life course development	<ul style="list-style-type: none"> • maternal education and work • pregnancy planning • English literacy limitations • criminal justice/involvement in the legal or child welfare system
Family and friends	<ul style="list-style-type: none"> • loneliness and social isolation • intimate partner violence • unsafe family or friend network
Environmental health	<ul style="list-style-type: none"> • economic adversity • homelessness or residential instability • environmental health • home safety
Health and human services system	<ul style="list-style-type: none"> • health services utilization • well-child care • use of other community services

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

November 30, 2020

AHCCCS

c/o Division of Community Advocacy and Intergovernmental Relations

801 E. Jefferson Street, MD 4200

Phoenix, AZ 85034

Submitted via e-mail to waiverpublicinput@azahcccs.gov

Re: Draft Arizona Demonstration Renewal Proposal (2021-2026)

Justice in Aging appreciates the opportunity to comment on the draft demonstration renewal proposal. Our comments focus on our opposition to the proposals to renew the waiver of the federal protection that provides up to three months of retroactive Medicaid coverage for Arizona Health Care Cost Containment System (AHCCCS) members and the authority to implement AHCCCS Works.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older Arizonans and older adults nationwide. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources, particularly populations that have been marginalized and excluded from justice such as women, people of color, LGBTQ individuals, and people with limited English proficiency. We have decades of experience with Medicaid and working with advocates who represent low-income older Arizonans.

[Waiving Retroactive Coverage Deprives Older Arizonans of Necessary Coverage](#)

Since July 1, 2019, AHCCCS has been limiting retroactive coverage to the month of application for nearly all adult AHCCCS members, including older adults needing long-term care. AHCCCS is proposing to continue limiting retroactive coverage for an additional 5 years, through 2026, despite not having evaluated the impact of the current waiver on beneficiaries.

Retroactive coverage is a long-standing safeguard built into the Medicaid program. When Congress established the retroactive coverage guarantee in 1972, the Senate Finance Committee noted that the provision would “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.”¹ This statement is just as true now as it was 45 years ago.

Health care needs can be unpredictable. No one can predict a stroke, a car accident, or a fall leading to a broken hip. Once a person finds herself in a hospital or nursing home, she may not

¹ Senate Report No. 92-1230, at 209 (Sept. 26, 1972) (discussing section 255 of H.R. 1).

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be healthy enough to file a Medicaid application, or may not understand that a Medicaid application should be filed. The impossibility of instantaneous Medicaid applications is always the case for individuals who become eligible for Medicaid based on needing nursing facility care or other long-term services and supports (LTSS). These applications are complex and cannot be completed until after both the functional and financial eligibility criteria are met and documented. It can take weeks, or even months, for an individual and their loved ones to consider how their care will be paid for, and additional weeks or months to prepare a Medicaid application and be approved because the application requires gathering bank records and other information about assets that may not be readily available. For example, in Iowa, the average application for a nursing home resident takes 71 days to assemble, file and be approved.²

The need for Medicaid services may arise unexpectedly and when the person needing care and their families are already experiencing the stress of dealing with either a sudden or a prolonged illness. In some instances, families provide the bulk of needed services at home up until family caregivers are physically, emotionally, and financially exhausted. Alternatively, individuals may be discharged directly to a nursing facility from a hospital after an emergency, such as a stroke or fall or COVID-19 infection. In either situation, the transition to a nursing facility can be a confusing, overwhelming process for both the nursing facility resident and their family. This is especially true for older adults with dementia, a common reason people need nursing facility care.

In addition, many older adults and their families assume nursing facility care will be covered by Medicare.³ They do not realize that Medicare coverage of skilled nursing facilities is restricted to follow-up of hospital admissions of more than three days, and limited to a maximum of 100 days, though often cut off much sooner.⁴

Without the three-month retroactive coverage protection, Arizonans who need nursing home care are at risk of being denied entry. A nursing facility or other provider requires assurance that payment will be made. Absent retroactive coverage, facilities might very well deny care. Delaying nursing facility admission endangers older adults and people with disabilities with

² Harris Meyer, Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers, *Modern Healthcare* (Feb. 9, 2019), www.modernhealthcare.com/article/20190209/NEWS/190209936/new-medicaid-barrier-waivers-ending-retrospective-eligibility-shift-costs-to-providers-patients.

³ See, e.g., T. Thompson et al., Associated Press-NORC Ctr. or Public Affairs Research, *Long Term Care: Perceptions, Experiences, and Attitudes Among Americans 40 or Older 7* (2013) (survey shows Americans “overestimate the long-term care services that Medicare will cover”), available at www.apnorc.org/PDFs/Long%20Term%20Care/AP_NORC_Long%20Term%20Care%20Perception_FINAL%20REPORT.pdf.

⁴ 42 C.F.R. §§ 409.30(a), 409.31(b), 409.32, 409.61(b). In 2016, the average length of stay under Medicare was only 27.6 days. Medicare Payment Advisory Commission (MedPAC), A Data Book: Health Care Spending and the Medicare Program 112, Chart 8-4 (June 2016), available at www.medpac.gov/docs/defaultsource/data-book/june-2016-data-book-health-care-spending-and-the-medicare-program.pdf.

fragile health, and in many cases leads to bloated hospital stays, since the hospital would be unable to find an alternative placement at time of discharge.

The draft proposal states that the reason for the extension is “to fully evaluate the Demonstration’s progress toward achieving the goals of continuity of care and personal responsibility, and to assess the impact to individuals and providers.”⁵ However, it is premature to extend this waiver for 5 years without this full evaluation. While AHCCCS has gathered some limited data on years prior to implementation of the waiver, it has not yet evaluated the waiver’s impact. Critically, AHCCCS has not evaluated the most important factor—the impact of eliminating retroactive coverage on individuals’ access to care or finances. In fact, the proposed evaluation does not include measures to specifically assess impact on access to nursing home care. This is a glaring omission given the unique requirements for long-term care applications, which, as discussed above, routinely take weeks or months to complete.

It is also important to note that waiving retroactive coverage does not promote Medicaid’s objective of providing health coverage to those who cannot afford it. In fact, it does the opposite. AHCCCS’s stated objectives for this “demonstration” are to encourage individuals to obtain and maintain health coverage even when healthy, apply for Medicaid expeditiously, increase continuity of care, and facilitate receipt of preventive services. Regardless of whether these goals are met, the waiver cuts coverage in violation of Medicaid’s primary objective and is therefore not allowable under federal Medicaid law. Moreover, for the reasons previously given, AHCCCS’s objectives are either inapplicable or impossible to meet for Arizonans who need long-term care.

Finally, AHCCCS has not considered the effect the COVID-19 pandemic is having on Arizonans’ need and ability to apply for Medicaid as soon as they are eligible. The pandemic is most harshly impacting the communities who are also most likely to need retroactive Medicaid coverage—that is people of color who have limited income and wealth, who are more likely to be uninsured and have medical debt, and who are most at risk of contracting and becoming seriously ill from COVID-19. In addition, this cut harms providers and the state by increasing the uncompensated care burden, an impossible burden for individuals, hospitals, and the state to bear amid a public health crisis. Waivers should be used to improve coverage, not to leave Medicaid-eligible individuals without coverage when they have health care needs, especially when those needs are unpredictable during a global pandemic.

Work Requirements Would Harm Family Caregivers

We also urge AHCCCS to abandon its plans to implement work requirements on adults under age 50. While older adults themselves would not be subject to these work requirements, their health and wellbeing would be jeopardized by impacting the health and well-being of low-income family members and/or friends who care for them. Many family caregivers, especially

⁵ AHCCCS, Draft Arizona Demonstration Renewal Proposal (2021-2026), at 18, https://www.azahcccs.gov/Resources/Downloads/1115Waiver/1115WaiverRenewalPacket_DRAFT.pdf.

women of color, leave the workforce or reduce their hours to provide informal care to their children, aging parents, other family, friends and neighbors. These caregivers are likely to be Medicaid eligible because they are low-income and unlikely to have access to health insurance through a job or spouse.⁶ In fact, 34% of non-elderly Medicaid enrollees not receiving SSI in Arizona cite caretaking as their reason for not engaging in the type of work activities the state is proposing to require of them.⁷

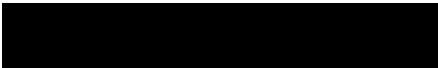
The exemption for “Caregivers who are responsible for the care of an individual with a disability” is vague and likely too narrow to account for intermittent caregiving that many older adults rely on to remain healthy and independent. In other words, requiring family caregivers to work or produce evidence that they meet an exemption does not reflect the reality of nor enormous economic value of family caregiving. Many family caregivers who qualify for Medicaid would be forced to choose between providing care for their loved ones and maintaining their own health.⁸

Conclusion

Thank you for considering our comments. We strongly urge AHCCCS not to move forward with its proposed extension of the waiver of retroactive coverage and work requirements because doing so would harm the low-income Arizonans that the Medicaid program should be protecting.

If any questions arise concerning this submission, please contact Natalie Kean, Senior Staff Attorney, at nkean@justiceinaging.org.

Sincerely,



Jennifer Goldberg
Deputy Director

⁶ Justice in Aging, Medicaid Work Requirements: The Impact on Family Caregivers and Older Adults (Nov. 2018), www.justiceinaging.org/wp-content/uploads/2018/11/JusticeInAging-Medicaid-IssueBrief-November19-11am-2018.pdf.

⁷ Kaiser Family Found., Understanding the Intersection of Medicaid and Work 10 (App. Table 2) (Jan. 2018), <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>.

⁸ Justice in Aging, Medicaid Work Requirements: The Impact on Family Caregivers and Older Adults (Nov. 2018), www.justiceinaging.org/wp-content/uploads/2018/11/JusticeInAging-Medicaid-IssueBrief-November19-11am-2018.pdf.

Nov 25, 2020, 8:06:30 AM
to waiverpublicinput@azahcccs.gov

Thank you for the opportunity to comment on the Draft 1115 Waiver to be submitted to CMS.

I support the following:

Verbal consent in lieu of written signatures for ALTCS members. I would also ask that this be applied more broadly. The flexibility implemented during the public health emergency for verbal consent for services is extremely beneficial as it allows providers to continue provision of needed mental health and substance use disorder treatment utilizing telehealth /telephonic services. The use of telehealth/ telephonic services , when clinically appropriate has proven extremely effective during this time. Continuation and expansion of verbal consent for all Medicaid services with expansion of use of electronic signatures makes sense for all AHCCCS members.

Traditional healing services for American Indian and Native Alaskan members. I also support the addition of other complementary medicine such as acupuncture and therapeutic massage in the treatment of chronic pain.

Dental Benefits for Tribal members. The expansion of dental benefits for adult tribal members and all AHCCCS members would aid in improving the overall health of AHCCCS members.

Extension and expansion of the Targeted Investment Program. I strongly support the extension and expansion of the Targeted Investment Program (TIP). TIP funding has been instrumental in my own agencies integration of physical and behavioral health care. I would like to suggest the addition of Peer Run Agencies to the eligible cohort. They have proven to be invaluable in outreach and engagement for many of our more reluctant members.

I oppose the following:

AHCCCS Works. This program will be difficult to implement and the cost effectiveness is seriously in question. Many of our AHCCCS members are employed but work in jobs that do not provide adequate health insurance and only pay minimum wage. This program will not achieve the outcomes hoped for by its implementation.

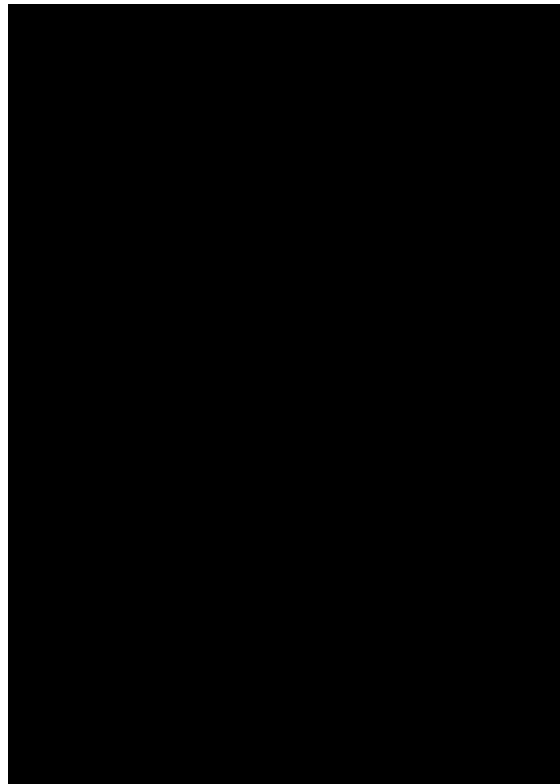
Elimination of Prior Quarter Coverage. I support the return of prior quarter coverage for all AHCCCS members. Prior quarter coverage helps defray that providers incur when they register eligible members in the AHCCCS program as it require additional resources to perform this necessary task.

Reinstating prior quarter coverage for all AHCCCS members will allow providers to be reimbursed for care that is currently uncompensated and allowing the identification of health issues before they become so acute they require emergent intervention.

Thank you for not including the 5- year lifetime cap on AHCCCS eligibility. Access to health care is important for the citizens of Arizona. As with the AHCCCS Works Program I believe that the Lifetime cap is poor public policy.

Thank you again for the opportunity to comment on the AHCCCS 1115 Waiver Request.

Sincerely

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November 30, 2020

Arizona Health Care Cost Containment System (AHCCCS)
Attn: Division of Community Advocacy and Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

FOR ELECTRONIC SUBMISSION

To whom it may concern:

The Arizona Advisory Council on Indian Health Care (AACIHC) submits these comments in response to AHCCCS' draft Section 1115 waiver proposal for the years 2021-2026. The mission of the AACIHC is to advocate for increasing access to high quality health care programs for all American Indians in Arizona. The AACIHC, utilizing its knowledge of Indian healthcare issues and tribal sovereignty, serves as a resource for Tribal governments and the State of Arizona, and supports prevention, training, education, and policy development as the keys to meeting the unique health care needs of the Arizona Indian population. As advocates for Indian health and health equity in Arizona, AACIHC supports key aspects of the draft Section 1115 waiver and provides recommendations for others.

AACIHC is supportive of many of the requests in the draft waiver, especially those pertaining to the Indian Health system and to American Indian populations. In collaboration with AHCCCS, some of the waiver requests were drafted via workgroups. Each workgroup was facilitated by AHCCCS staff and comprised of various American Indian health system experts, including Traditional Practitioners. These workgroups have demonstrated to be very effective in the formulation of the waivers. Furthermore, AACIHC and Tribes advocated to amend state law that provided AHCCCS authority to move forward with specific provisions of the waivers. Specifically, we support the following provisions:

- **Tribal Dental Benefit (House Bill 2244; ARS 36-2907 and 36-2939).** Oral health inequities and disparities have persisted for American Indians for many years. Reimbursement for services provided to American Indian AHCCCS eligible members beyond the legislatively mandated \$1000 cap for emergency dental and ALTCS members is critical to reducing rates of oral disease and decay. By lifting the cap, tribal and IHS dental clinics can fully be reimbursed for services provided and is in line with fulfillment of our country's treaty promise to provide health care at no cost to Tribal populations while drawing down the 100% FMAP.
- **Exclusion of American Indians from the 5-year lifetime limit provision.** Though we recognize that state statutes require AHCCCS to request the lifetime limit, we remain opposed to this statutory obligation and believe that limiting access to health care in the current public health climate is neither wise nor ethical. In addition, federal law does not put any limitations to the length an individual who is served by a Medicaid program. Furthermore, it limits Tribes' options to provide health care to American Indians as almost half of the American Indian population in Arizona is eligible for AHCCCS.
- **Exclusion of American Indians from the AHCCCS Works program.** As litigation continues in others states as to the implementation of work requirements, we are pleased to see the thoughtful implementation for American Indians to self-identify. Although, there is still concern

for those American Indians that need to provide documentation that they are from a federally recognized Tribe, especially those who do not reside near their tribal enrollment offices, proving it difficult to near impossible to attain the appropriate documentation.

- **Reimbursement for traditional healing services provided at Indian Health Service, Tribal and Urban Indian Programs at 100% of the Federal Medical Assistance Percentage (FMAP).** Recognizing the importance of traditional healing services is a first step toward promoting health equity for Tribal members. The draft waiver language was developed by multiple tribal stakeholders and over multiple years. AACIHC supports that the draft language includes how the qualifying entity will be responsible to define and endorse traditional healers and the services they perform. Plus, the proposed reimbursement methodologies reflect rational approaches. For outpatient services, AHCCCS proposes reimbursement at the all-inclusive rate (AIR) and a traditional healing service provided in an inpatient setting, when provided in conjunction with a separate qualifying Medicaid inpatient stay, would be reimbursed as a professional fee. Although, urban Indian Health Programs do not currently receive the 100% FMAP for services provided to HIS eligible members, it is important to consider options to include them as IHS eligible members receive services across the ITU system. We believe this will further promote integration of cultural health practices.
- AACIHC supports the continuation of eligibility simplification for ALTCs enrollees by disregarding of interest and excess income for children and adults with disabilities. This is a critical step to help keep children and families with disabilities connected to a reliable source of health coverage, even when their financial circumstances may be in flux. AHCCCS also proposes a continuation of the waiver authority in which individuals enrolled in the ALTCs, CMDP and RBHA programs are limited to a single Managed Care Organization. In this regard, the covered services these individuals receive by Indian Health Care Providers should not be considered out-of-network and reimbursed at the AIR outpatient and inpatient rates.
- **Continuation of the IHS / 638 uncompensated care waiver.** Continuation of this provision provides a level of protection to IHS and 638 health care facilities should optional benefits be eliminated. The waiver should also be flexible enough to reimburse HIS and 638 facilities if optional benefits were to be reduced but not entirely eliminated. Most importantly, reimbursement should remain unchanged and ensure that IHS and Tribal facilities continue to receive the All-Inclusive Rate (AIR). If this cannot be achieved, per Tribal consultation, an explanation of a reimbursement rate methodology should strive to be as close as possible to the AIR.
- **Expansion and extension of the Targeted Investment Program (TIP).** We support AHCCCS' efforts to integrate behavioral and physical health care and look forward to seeing the results of this investment. Participation in the TIP expansion cohort by an IHS facility or other Tribal provider should also be considered. Formation of a workgroup can assist in the creation of the waiver.

Each of these provisions has the potential to promote positive Indian health care outcomes. AACIHC commends the agency's inclusion of these requests in the draft Section 1115 waiver and the process by which AHCCCS received input via workgroups and tribal consultations.

Throughout the draft waiver are multiple beneficial provisions, but recommend modifications before submitting the Section 1115 waiver to the Centers for Medicaid and Medicare Services:

- **Waiver of Prior quarter coverage.** Although the draft waiver for prior quarter coverage does not include pregnant women, women who are 60 days or less postpartum, and children under 19 years of age, it should go further and be reinstated for all AHCCCS populations. Retroactive

eligibility provided critical relief to uninsured low-income Arizonans and the providers that serve them. Information should be made available regarding the impact on out-of-pocket costs for populations who were previously eligible for prior quarter coverage, as well as the cost of uncompensated care for providers since its discontinuation. IHS and Tribal health care facilities noted that they were able to make improvements to their health care facilities and service delivery when they were assured that services provided to eligible beneficiaries during the prior quarter would be reimbursed. When prior quarter coverage was discontinued, they noted a significant decline in revenue.

- **Expansion of Verbal Consent.** AHCCCS accepting verbal consent in lieu of written signature authorization for ALTCS person-centered care plans is a great first step. This authority should be expanded across all AHCCCS populations. This is especially important for American Indian and other low income populations that have difficulty to physically come in to AHCCCS offices to provide signatures.

Overall, the draft waiver provides many innovative demonstrations that improve the AHCCCS as a whole and in part. As the state prepares for financial and administrative strain due to the public health emergency, we encourage AHCCCS to continue to make substantive efforts and seek input toward implementing the Whole Person Care Initiative (WPCI). AACIHC and Tribes are looking forward to the upcoming Special Tribal Consultation that seeks input on the WPCI and ask that the agency consider piloting this program with Tribal and IHS facilities. This could come at no cost to the state and would provide valuable data on the efficacy of the initiative.

Lastly, we were disappointed that school-based Medicaid billing was not included in the draft Section 1115 waiver but look forward to partnering with AHCCCS and other stakeholders in health and education to advance this initiative via State Plan Amendment in 2021.

Thank you for taking these comments into consideration. We appreciate the opportunity to provide feedback on the draft Section 1115 waiver.

Sincerely,

Kim Russell
Executive Director
Arizona Advisory Council on Indian Health Care



November 24, 2020

Jami Snyder
Medicaid Director
AHCCCS
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801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034
Via e-mail: waiverpublicinput@azahcccs.gov

Re: Arizona's Section 1115 Waiver Renewal Request (2021-2026)

Dear Director Snyder,

ViiV Healthcare Company (ViiV), wishes to offer the following recommendations on the proposed renewal of the Arizona Health Care Cost Containment System (AHCCCS) from October 1, 2021 through September 30, 2026.¹

ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in human immunodeficiency virus (HIV) treatment and prevention to support the needs of people living with HIV (PLWH). From its inception in 2009, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment.

As an exclusive manufacturer of HIV medicines, ViiV is proud of the scientific advances in the treatment of this disease. These advances have transformed HIV from a terminal illness to a manageable chronic condition. Effective HIV treatment can help PLWH to live longer, healthier lives, and has been shown to reduce HIV-related morbidity and mortality at all stages of HIV infection.^{2,3} Furthermore, effective HIV treatment can also prevent the transmission of the disease.⁴

Ending the HIV Epidemic (EHE)

In 2016, the Arizona Department of Health Services released its "2017 to 2021 Integrated HIV Prevention

¹ The Arizona Health Care Cost Containment System (AHCCCS) "Draft Arizona Demonstration Renewal Proposal (2021-2026)" https://www.azahcccs.gov/Resources/Downloads/1115Waiver/1115WaiverRenewalPacket_DRAFT.pdf

² Severe P, Juste MA, Ambrose A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med.* Jul 15 2010;363(3):257-265. Available at

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=20647201.

³ Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med.* Apr 30 2009;360(18):1815-1826. Available at

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=19339714.

⁴ Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. *The Lancet.* Published Online May 2, 2019 [https://dx.doi.org/10.1016/S0140-6736\(19\)30418-0](https://dx.doi.org/10.1016/S0140-6736(19)30418-0).

and Care Plan for Arizona” aptly subtitled “Arizona’s audacious plan to end the local HIV epidemic.”⁵ The plan was the conclusion of a lengthy community planning process with the HIV community in the state, the HIV Statewide Advisory Group and the Phoenix EMA Ryan White Planning Council.⁶ We applaud the state for their leadership in this area, and note the efforts of these groups to end the HIV epidemic in the state.

As you know, in 2019, the federal Department of Health and Human Services (DHHS) announced a goal to end the HIV epidemic in the U.S. within 10 years and released the “Ending the HIV Epidemic: A Plan for America” (EHE).⁷ This initiative proposes to use scientific advances in antiretroviral therapy (ART) to treat PLWH and expand proven models of effective HIV care and prevention through a focused effort across federal, state, and local health agencies. The EHE is supported by HIV advocacy, and endorsed by the President’s Advisory Council on HIV/AIDS (PACHA).⁸ Seven states and 48 counties with high rates of transmission are targeted by the EHE initiative, including Maricopa county in Arizona.⁹

HIV and Medicaid

Since the earliest days of the epidemic, Medicaid has played a critical role in HIV care. Medicaid is the largest source of coverage for people living with HIV.¹⁰ In fact, more than half of PLWH who are engaged in medical care have incomes at or below the federal poverty level.¹¹ Medicaid is an essential source of access to medical care and ART drug coverage for people living with HIV. This medical care and drug treatment not only preserve the health and wellness of PLWH and improves health outcomes, but it also prevents new HIV transmissions.

In order to promote the goal to end the HIV epidemic, it is imperative that state Medicaid programs align with local and national efforts, and promote policies that contribute to HIV public health goals, such as preserving continuous access to comprehensive health care, including ART.

Given that AHCCCS is seeking renewal of its waiver for 5 years,¹² we wish to provide the following comments about effective management of HIV as a disease state. We hope the state will take these comments into consideration in its proposal to CMS, as well as take specific actions to improve health outcomes for PLWH:

1. Effectively Managing HIV in Medicaid through Un-Interrupted Access to ART

Treatment of HIV is a dynamic area of scientific discovery, and treatment protocols are changed and updated to reflect advances in medical science. The clinical standard for HIV treatment is combination ART, and many regimens are available as a once-per-day single tablet regimen (STR). Prescription drug

⁵ “The 2017 to 2021 Integrated HIV Prevention and Care Plan for Arizona” 2016 <https://hivaz.org/assets/documents/09.30.16AZIntegratedPlan.pdf> (accessed Nov. 14, 2020)

⁶ “The 2017 to 2021 Integrated HIV Prevention and Care Plan for Arizona” 2016 <https://hivaz.org/assets/documents/09.30.16AZIntegratedPlan.pdf> (accessed Nov. 14, 2020)

⁷ HIV.gov “Ending the HIV Epidemic” <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview> Accessed July, 15, 2019.

⁸ Presidential Advisory Council on AIDS (PACHA) Resolution in Support of “Ending the HIV Epidemic: A Plan for America” <https://files.hiv.gov/s3fs-public/PACHA-End-HIV-Elimination-Resolution-passed.pdf>

⁹ Ending the HIV Epidemic Counties and Territories, <https://files.hiv.gov/s3fs-public/Ending-the-HIV-Epidemic-Counties-and-Territories.pdf> Accessed March 12, 2020.

¹⁰ Kaiser Family Foundation. Medicaid and HIV, <http://www.kff.org/hiv/aids/fact-sheet/medicaid-and-hiv/>

¹¹ CDC, Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection—Medical Monitoring Project, United States, <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-hssr-mmp-2014.pdf> 2014 cycle (June 2014-May 2015). Surv report 17

¹² The Arizona Health Care Cost Containment System (AHCCCS) “Draft Arizona Demonstration Renewal Proposal (2021-2026)” https://www.azahcccs.gov/Resources/Downloads/1115Waiver/1115WaiverRenewalPacket_DRAFT.pdf

treatment is essential to PLWH, to effectively manage a deadly virus, to extend health and wellness, and to prevent transmission. However, PLWH often face a variety of medical challenges that impede access to, engagement in, and adherence to HIV care and treatment.

The federal DHHS has laid out clear guidelines for proper management of HIV by covering all FDA approved drugs, including ART for PLWH, without utilization management and facilitating adherence. In its December 1, 2016 Informational Bulletin entitled *Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries*, DHHS states:

Given that adherence to ART is a critical prerequisite to realizing both individual and public health benefits, states are reminded of the statutory requirement to cover all covered outpatient drugs of manufacturers with agreements described in section 1927(b) of the Act, including single tablet ART regimens. States can also, and are strongly encouraged to, go farther to support access and adherence to effective treatments for PLWH. States should design their prescription drug formularies to minimize potential barriers presented by utilization management techniques so that Medicaid and CHIP beneficiaries living with HIV can readily access all regimens described for potential use (including those labeled as “Recommended”, “Alternative”, and “Other”) in the DHHS Guidelines.¹³

Therefore, we wish to offer the following comments on how Arizona AHCCCS can take into account each of those recommendations to provide optimal management for HIV within the Medicaid FFS and Managed Care populations:

a) Open Access in Prescription Drug Formularies

ViiV supports coverage policies that ensure open access to HIV treatment for all PLWH. Therefore, we encourage AHCCCS to ensure open access to life-saving treatment for PLWH, and continued access to prevention medications for at-risk populations in both FFS and Medicaid Managed Care. This would continue to support the work of the EHE and help to align ART coverage across all state programs.

Studies show that restricting access to drugs through closed formularies results in non-adherence or poor adherence to prescribed medication regimens, worsened health outcomes, and higher, long-run costs, both to Medicaid and other state and local programs.^{14, 15}

Health care providers work closely with patients to select HIV treatment options with great specificity for each patient. Effective treatment of HIV is highly individualized and accounts for a patient’s size, gender, treatment history, viral resistance, coexisting illnesses, drug interactions, immune status, and side effects. In fact, the DHHS clinical treatment guidelines¹⁶ state that, “Regimens should be tailored for the individual patient to enhance adherence and support long-term treatment success.” The guidelines also recognize that “[s]election of a regimen should be individualized based on virologic efficacy, potential adverse effects, childbearing potential and use of effective contraception, pill

¹³ Joint HHS, CMCS, HRSA, and CDC Informational Bulletin, *Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries*, p. 12 (December 1, 2016), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib120116.pdf>. Accessed October 13, 2017.

¹⁴ Happe LE, Clark D, Holliday E, Young T. A systematic literature review assessing the directional impact of managed care formulary restrictions on medication adherence, clinical outcomes, economic outcomes, and health care resource utilization. *J Manag Care Spec Pharm*. 2014;20(7):677-84.

¹⁵ Zullig, LL, Bosworth, H, Engaging patients to optimize medication adherence. *NEJM Catalyst*, May 14, 2017.

¹⁶ DHHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines>

burden, dosing frequency, drug-drug interaction potential, comorbid conditions, cost, access, and resistance test results.” Patients often respond differently to the same drug. Drugs in the same class can have different side-effect profiles, with patients often best suited to one particular drug.

Medical challenges for PLWH also include an increased risk for, and prevalence of, comorbidities that require additional drug treatment such as depression and substance use disorders, as well as cardiovascular disease, hepatic and renal disease, osteoporosis, metabolic disorders, and several non–AIDS-defining cancers.^{17,18,19,20} The most common non-infectious co-morbidities of HIV are hypertension, hyperlipidemia, and endocrine disease.²¹

Aging PLWH often experience non-HIV related comorbidities²² that require polypharmacy which creates a higher risk of drug-drug interactions between antiretroviral drugs and concomitant medications. Clinically significant drug interactions have been reported in 27 to 40 percent of HIV patients taking antiretroviral therapy requiring regimen changes or dose modifications.²³

Thus, broad access to the full array of available treatment options is vital in HIV treatment. PLWH must have access to a robust formulary that provides physicians with the ability to prescribe the right treatments at the right time for their patients.

The need for broad access was separately supported by CMS. A 2013 Protected Classes Review Plan convened by CMS to consider antiretroviral medications determined that antiretrovirals met the non-interchangeability criteria.²⁴ CMS also concluded that there is a need to adjust specific combination antiretroviral therapy in real time which is complex and must consider, among other things, viral sensitivity to the drugs, drug interactions and other factors. This conclusion was based on the number of multiple drug combinations and adjunctive therapies involved in treatment, the frequency with which recommended drug protocols change, and the role that changing drug resistance plays in determining the selection of different antiretroviral drugs.²⁵

Accordingly, it is critical that PLWH in Arizona have access to all necessary treatments to optimize their overall health rather than limiting access through a closed formulary.

b) ART Should Not Be Subject to Utilization Management

Due to the individualized nature of HIV treatment, it is important that treatment decisions are not subject to utilization management processes, which run the risk of disrupting established treatment regimens. A review of 29 studies evaluating the impact of non-medical switching (the practice of

¹⁷ CDC. Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection. Medical Monitoring Project United States, 2013 Cycle (June 2013–May 2014). HIV Surveillance Report 16.

¹⁸ Joel Gallant, Priscilla Y Hsue, Sanatan Shrey, Nicole Meyer; Comorbidities Among US Patients With Prevalent HIV Infection—A Trend Analysis, *The Journal of Infectious Diseases*, Volume 216, Issue 12, 19 December 2017, Pages 1525–1533, <https://doi.org/10.1093/infdis/jix518>.

¹⁹ Rodriguez-Penney, Alan T. et al. “Co-Morbidities in Persons Infected with HIV: Increased Burden with Older Age and Negative Effects on Health-Related Quality of Life.” *AIDS Patient Care and STDs* 27.1 (2013): 5–16. PMC. Web. 21 June 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3545369/>.

²⁰ Joint HHS, CMCS, HRSA, and CDC Informational Bulletin, Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries, p. 9 (December 1, 2016), <https://www.medicare.gov/federal-policy-guidance/downloads/cib120116.pdf>. Accessed October 13, 2017.

²¹ Joel Gallant, Priscilla Y Hsue, Sanatan Shrey, Nicole Meyer; Comorbidities Among US Patients With Prevalent HIV Infection—A Trend Analysis, *The Journal of Infectious Diseases*, Volume 216, Issue 12, 19 December 2017, Pages 1525–1533, <https://doi.org/10.1093/infdis/jix518>.

²² Schouten J, et al. *Clin Infect Dis*. 2014 Dec 15;59(12):1787-97.

²³ Evans-Jones JG et al. *Clin Infect Dis* 2010;50:1419–1421; Marzolini C et al. *Antivir Ther* 2010;15:413–423.

²⁴ Center for Medicare: Protected Classes Review Panel, December 2013.

²⁵ Ibid

switching to a chemically distinct but similar medicine for reasons other than lack of clinical efficacy/response) found that among patients with stable, well-controlled disease switching led to poor side effects or nonadherence and was associated with mostly negative outcomes.²⁶

Prior authorization can lead to patients experiencing delays in receiving their medications, which negatively impacts patient adherence – a vital component of effective HIV treatment. In a study, people living with HIV who faced drug benefit design changes were found to be nearly six times more likely to face treatment interruptions than those with more stable coverage, which can increase virologic rebound, drug resistance, and increased morbidity and mortality.²⁷

Utilization management requirements also impact provider efficiency, and increase costs of care.^{28, 29} The historic lack of uniformity between health plans' and insurers' prior authorization processes results in providers spending excessive amounts of time completing prior authorization forms, negotiating administrative systems and spending less time on patient care.³⁰ More importantly, restricting access to HIV treatment for Medicaid beneficiaries may have permanent consequences for future treatment options.

Within the Medicare program HIV is a protected class, and ART drugs are not subject to utilization management. The Medicare Prescription Drug Benefit Manual states: "For HIV/AIDS drugs, utilization management tools such as prior authorization and step therapy are generally not employed in widely used, best practice formulary models."³¹

CMS stated support for applying the Medicare Part D protected classes protection for HIV treatment to the Medicaid program in recent guidance:³²

In addition, to ensure that this demonstration supports CMS's objectives related to the treatment of HIV... CMS expects states to provide coverage of... substantially all antiretroviral drugs (including PrEP) consistent with Medicare Part D coverage...³³

We hope that Arizona will consider this important example, and also apply Medicare Part D-like protections to ART access in AHCCCS and the MMCOs, by prohibiting utilization management, step therapy, or prior authorization for ART. The state has taken a great first step in prohibiting utilization

²⁶ Nguyen E, Weeda E, Sobieraj D, et al. Impact of Non-Medical Switching on Clinical and Economic Outcomes, Resource Utilization and Medication-Taking Behavior: A Systematic Literature Review. *Current Medical Research and Opinion*. 2016;32(7):1281-1290. Accessible at: <https://www.ncbi.nlm.nih.gov/pubmed/27033747>.

²⁷ Das-Douglas, Moupali, et al. "Implementation of the Medicare Part D prescription drug benefit is associated with antiretroviral therapy interruptions." *AIDS and Behavior* 13.1 (2009): 1.

²⁸ Health Affairs "What does it cost physician practices to interact with health insurance plans?" 2009 http://content.healthaffairs.org/content/28/4/w533.abstract?jkey=ab6e6c7d689c5a4949c03fc849458f04aeb59a2d&keytype2=tf_ipsecsha.

²⁹ Oxford Journal of Clinical Infectious Diseases "Uncompensated Medical Provider Costs Associated with Prior Authorization for Prescription Medications in an HIV Clinic" Vol. 51 Issue 6, 2010 <http://cid.oxfordjournals.org/content/51/6/718.abstract>.

³⁰ Health Affairs "US physician practices versus Canadians: spending nearly four times as much money interacting with payers. 2011.

http://content.healthaffairs.org/content/30/8/1443.abstract?ikey=702ae6e197f5830f7a20cd1ac2a80f693306073f&keytype2=tf_ipsecsha.

³¹ CMS.gov "Prescription Drug Benefit Manual" <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals>.

³² Medicaid.gov, SMD# 20-001, Re: Healthy Adult Opportunity SMD, January 30, 2020: <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf>. Accessed July 8, 2020.

³³ Medicaid.gov, SMD# 20-001, Re: Healthy Adult Opportunity SMD, January 30, 2020 (Page 9): <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf>. Accessed July 8, 2020

management for prevention medication, and now it's the chance to do even more for PLWH and their treatment options.

c) Importance of Adherence

ViiV is opposed to any utilization management of ART for PLWH as it can negatively impact adherence and cause viral resistance and lead to loss of effectiveness for an entire therapeutic class to a patient.

Strict adherence to ART – taking HIV medicines every day and exactly as prescribed – is essential to sustained suppression of the virus, reduced risk of drug resistance, and improved overall health.³⁴ The Health Resources and Services Administration (HRSA) states in its *Guide for HIV/AIDS Clinical Care* that “adherence to ART is the major factor in ensuring the virologic success of an initial regimen and is a significant determinant of survival.”³⁵ In fact, the World Health Organization (WHO) recently reported that resistance among people receiving ART ranged from three to 29 percent, while among people with unsuppressed viral load on NNRTI-based first-line ART regimens, dual class resistance ranged from 21 to 91 percent.³⁶ The U.S. Department of Health and Human Services’ (DHHS) Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, referred to as the federal HIV clinical treatment guidelines, also emphasizes the importance of adherence to ensure long-term treatment success.³⁷

For PLWH, un-interrupted adherence to antiretroviral medication is paramount in maintaining their health, maintaining viral suppression, preventing medical complications and co-morbidities, and preventing new transmissions. Uninterrupted access to medical care and drug treatment benefits is directly linked to the health and wellness of PLWH covered by public health programs. For PLWH, adherence to antiretroviral medication is paramount in maintaining their health, avoiding viral resistance, and preventing medical complications and co-morbidities.^{38,39} As previously mentioned, PLWH who face drug benefit design changes are nearly six times more likely to face treatment interruptions than those with more stable coverage, which can increase virologic rebound, drug resistance and increased morbidity and mortality.⁴⁰ To achieve optimal clinical outcomes for PLWH and to realize the potential public health benefit of treatment as prevention, adherence to ART and retention in care are essential. The DHHS HIV Treatment Guidelines state, “... high-quality system processes are vital in promoting rapid linkage and sustained retention in care and adherence to ART.”⁴¹

For one example in applying these concepts to MMCOs, AHCCCS could refer to the Mississippi

³⁴ AIDS info.gov, NIH, Following an HIV Regimen: Steps to Take Before and After Starting HIV Medicines, January 31, 2019 <https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/55/following-an-hiv-regimen---steps-to-take-before-and-after-starting-hiv-medicines>.

³⁵ HRSA, Guide for HIV/AIDS Clinical Care (April 2014), <https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf>. Accessed October 13, 2017.

³⁶ WHO, HIV Drug Resistance Report 2019 <https://www.who.int/hiv/pub/drugresistance/hivdr-report-2019/en/>

³⁷ DHHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines>

³⁸ Chesney MA. The elusive gold standard. Future perspectives for HIV adherence assessment and intervention. J Acquir Immune Defic Syndr. 2006;43 Suppl 1:S149-155, <http://www.ncbi.nlm.nih.gov/pubmed/17133199>.

³⁹ HRSA, Guide for HIV/AIDS Clinical Care (April 2014), <https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf>. Accessed October 13, 2017.

⁴⁰ Das-Douglas, Moupali, et al. "Implementation of the Medicare Part D prescription drug benefit is associated with antiretroviral therapy interruptions." AIDS and Behavior 13.1 (2009): 1.

⁴¹ DHHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV, <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines>

DURB study⁴² as one model for how FFS and MMCOs should look at HIV adherence. CMS could also suggest that states require that MMCOs put an adherence program in place to assist providers who have patients who are under 90 percent adherence.

d) Viral Suppression and HIV Treatment as Prevention

When a PLWH receives and maintains effective HIV treatment and receives quality medical care they can reach viral suppression. Viral suppression means that the virus has been reduced to an undetectable level in the body with standard tests.⁴³ Viral suppression results in reduced mortality and morbidity and leads to fewer costly medical interventions.⁴⁴

Viral suppression also helps to prevent new transmissions of the virus. When successful treatment with an antiretroviral regimen results in virologic suppression, secondary HIV transmission to others is effectively eliminated. In studies sponsored by the National Institutes of Health (NIH), investigators have shown that when treating the HIV-positive partner with antiretroviral therapy, there were no linked infections observed when the HIV+ partner's HIV viral load was below the limit of detection.⁴⁵ The National Institute of Allergy and Infectious Diseases (NIAID) supported research that demonstrated when PLWH achieve and maintain viral suppression, there is no risk scientifically of transmitting HIV to their HIV-negative sexual partner.⁴⁶ Multiple subsequent studies also showed that PLWH on ART who had undetectable HIV levels in their blood, had no risk of passing the virus on to their HIV-negative partners sexually.^{47, 48, 49} As a result, the CDC estimates viral suppression effectiveness in preventing HIV transmission at 100 percent.⁵⁰

The scientific breakthrough that HIV treatment also offers the benefit of prevention of HIV transmission led to the development of a movement called “U=U” or Undetectable = Untransmittable. Multiple studies showed that PLWH on ART who have undetectable HIV levels in their blood, have no risk of passing the virus on to their HIV-negative partners sexually.^{51,52, 53} Backed by this science , U=U reinforces the message that viral suppression can help end the HIV epidemic.⁵⁴

⁴² Antiretroviral adherence in the treatment of HIV” -- Special Analysis Project presented to the Mississippi Division of Medicaid Drug Utilization Review Board, March 19, 2020. <https://medicaid.ms.gov/wp-content/uploads/2020/03/DURAgenda031920.pdf> Accessed on April 8, 2020, page 30.

⁴³ National Institutes of Health (NIH) “Ten things to Know about HIV Suppression” <https://www.niaid.nih.gov/diseases-conditions/10-things-know-about-hiv-suppression>

⁴⁴ “Retention in Care and Adherence to ART are Critical Elements of HIV Care Interventions,” Stricker, et al, AIDS and Behavior, October 2014, Volume 18, Supplement 5, pp 465–47.; <https://link.springer.com/article/10.1007/s10461-013-0598-6>

⁴⁵ Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 [http://dx.doi.org/10.1016/S0140-6736\(19\)30418-0](http://dx.doi.org/10.1016/S0140-6736(19)30418-0) .

⁴⁶ NIAID, <https://www.niaid.nih.gov/news-events/undetectable-equals-untransmittable>. Accessed August 1, 2018.

⁴⁷ Bavinton, et al. The Opposites Attract Study of viral load, HIV treatment and HIV transmission in serodiscordant homosexual male couples: design and methods. *BMC Public Health*. 2014; 14: 917. doi: [10.1186/1471-2458-14-917](https://doi.org/10.1186/1471-2458-14-917).

⁴⁸ Cohen, et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. September 1, 2016. *N Engl J Med* 2016; 375:830-839. DOI: 10.1056/NEJMoa1600693.

⁴⁹ “HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention” National Institute of Allergy and Infectious Diseases <https://www.niaid.nih.gov/diseases-conditions/treatment-prevention>.

⁵⁰ Centers for Disease Control and Prevention (CDC) “Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV” <https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html> Accessed November 23, 2020

⁵¹ Bavinton, et al. The Opposites Attract Study of viral load, HIV treatment and HIV transmission in serodiscordant homosexual male couples: design and methods. *BMC Public Health*. 2014; 14: 917. doi: [10.1186/1471-2458-14-917](https://doi.org/10.1186/1471-2458-14-917)

⁵² Cohen, et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. September 1, 2016. *N Engl J Med* 2016; 375:830-839. DOI: 10.1056/NEJMoa1600693

⁵³ “HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention” National Institute of Allergy and Infectious Diseases <https://www.niaid.nih.gov/diseases-conditions/treatment-prevention>

⁵⁴ NIH.gov “Science Validates Undetectable = Untransmittable HIV Prevention Message” NIAID Now, July 22, 2018 <https://www.niaid.nih.gov/news-events/undetectable-equals-untransmittable>, Accessed 1/14/2020

Today, the NIH, CDC and health authorities in many other countries have endorsed the U=U message.^{55,56} Over twenty states and many more regional health departments have endorsed U=U in a variety of capacities.⁵⁷ We applaud the Arizona Department of Health Services for joining this effort, and spreading the message of U=U within the state.⁵⁸

We urge AHCCCS to partner with the Arizona Department of Health Services (ADHS) to provide information to the MMCOs about U=U, and the ADHS's endorsement of it. Furthermore, we encourage the state to distribute this information to all providers within AHCCCS network, and to require the MMCOs to provide information and resources about U=U to all providers in their networks. Information is available along with materials⁵⁹ on U=U that all Medicaid providers may find useful. This message is an important step in combatting stigma and encouraging PLWH and medical providers to pursue viral suppression as the goal of HIV treatment.

Reduced transmissions not only improve public health, but also save money. Preventing new transmissions offers a substantial fiscal benefit to the state. It is estimated PLWH who are not retained in medical care may transmit the virus to an average of 5.3 additional people per 100-person years.⁶⁰ Other studies estimate that each HIV positive patient may approach \$338,400 in additional costs to the healthcare system over his or her lifetime even if diagnosed early and retained in care.⁶¹ Successful treatment with an antiretroviral regimen results in virologic suppression and virtually eliminates secondary HIV transmission to others. As a result, it is possible to extrapolate that successful HIV treatment and medical care of each infected patient may save the system up to \$1.79 million by preventing⁶² further transmission to others. These savings can only occur, access to medical care, receive treatment, and remain adherent to their prescribed therapy.

ViiV encourages AHCCCS to promote this separate but dual benefit of HIV “treatment as prevention” (TasP)⁶³ to all MMCOs along with the U=U message, and provide education that the fact that achieving and maintaining viral suppression for PLWH can also prevent new infections.

2. Importance of HIV Pre-exposure Prophylaxis (PrEP) Coverage

ViiV applauds ACHHHS for allowing access to PrEP medications without prior authorization. ViiV also supports coverage of pre-exposure prophylaxis (PrEP) to all at-risk populations.

Use of PrEP by at-risk populations is a key part of the EHE. The “Ready, Set, PrEP!” Initiative,⁶⁴ could be further advanced by state Medicaid programs.

⁵⁵ “Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV,” CDC, <https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html>

⁵⁶ “For HIV, Treatment is Prevention” Dr. Francis Collins, NIH Director’s Blog, posted January 22nd, 2019 <https://directorsblog.nih.gov/2019/01/22/for-hiv-treatment-is-prevention/>

⁵⁷ “UNDETECTABLE = UNTRANSMITTABLE: HEALTH DEPARTMENT ENGAGEMENT MAP” NASTAD, <https://www.nastad.org/maps/undetectable-untransmittable-health-department-engagement-map>

⁵⁸ Arizona Department of Health Services “World AIDS Day Recognizes Progress Made to End the Epidemic,” <https://directorsblog.health.azdhs.gov/world-aids-day-recognizes-progress-made-to-end-the-epidemic/>

⁵⁹ Prevention Access Campaign, “Resources for Providers” <https://www.preventionaccess.org/providers>

⁶⁰ Skarbinski, et al. Human immunodeficiency virus transmission at each step of the care continuum in the United States. *JAMA Intern Med.* 2015;175(4):588-596.

⁶¹ Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. *Medical care.* 2015;53(4):293–301, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/>

⁶² Schackman BR, Fleishman JA, Su AE, Berkowitz BK, Moore RD, Walensky RP, et al. The lifetime medical cost savings from preventing HIV in the United States. *Medical care.* 2015;53(4):293–301, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4359630/>

⁶³ HIV.gov, For HIV, Treatment is Prevention, <https://www.hiv.gov/blog/hiv-treatment-prevention>

⁶⁴ “Ready, Set, PrEP” HIV.gov, <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/prep-program>

Additionally, the US Preventive Services Taskforce (USPSTF) recently issued a “Grade A” rating of HIV PrEP treatment.⁶⁵ The new USPSTF recommendation means that Medicaid programs that cover PrEP without cost-sharing along with other preventive services can receive an FMAP increase under the ACA, similar to coverage of HIV testing.

3. Incorporate Future Scientific Innovations: Long-Acting Provider-Administered HIV Treatments and Preventions

ViiV encourages the state to also consider how AHCCCS and MMCOs in the state will incorporate innovative HIV preventive therapies in the future, especially those that are administered by physicians or other health care professionals.

The first ever long-acting antiretroviral HIV treatments will become available to patients in the coming years, and their arrival will require new considerations by coverage providers and care programs. A series of reports by the organization AmFAR details these innovative treatments and also the consideration for policy makers and coverage providers.⁶⁶ Additional information about long-acting HIV medications can be found on HIV.gov website.⁶⁷ Some of these long acting treatment options will be provider-administered, which the state should take into consideration and planning for future coverage considerations.

Furthermore, some of these long acting treatment options may then be followed by indications for HIV prevention.^{68, 69} Because of the possibility these new modalities may offer, we urge the state to consider how such future prevention innovations might be made similarly accessible to the populations that could benefit from them once available.

4. Designate PLWH as “Medically Frail” for Exemption Purposes

ViiV urges Arizona to ensure PLWH have unfettered access to necessary medical care and treatment by specifically designating PLWH as a medically frail population in the AHCCCS program. This designation will allow PLWH to be exempted from demonstrations which could cause potential disruptions to treatment adherence, and would also allow PLWH to make a choice between an alternative benefit plan (ABP) or the traditional state plan benefit package. We applaud the state of Arizona for specifically listing HIV as a population that would be considered medically frail and therefore exempted in its 2017 waiver.⁷⁰ We encourage AHCCCS ensure that designation remains in place, and ensure that PLWH are ensured this protection in all state Medicaid programs and demonstrations.

Medically frailty as defined in federal regulation 42 CFR 440.315 says, “... *the State’s definition of individuals who are medically frail or otherwise have special medical needs must at least include those ... with serious and complex medical conditions...*”⁷¹ According to one analysis, this means that CMS has

⁶⁵ US Preventive Services Task Force Final Recommendation Statement, “Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis,” June 11, 2019 <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis#:~:text=The%20USPSTF%20recommends%20that%20clinicians,selection%20of%20effective%20antiretroviral%20therapies>

⁶⁶ AmfAR “Long-Acting HIV Treatment and Prevention Are Coming” <https://www.amfar.org/long-acting-arv/>

⁶⁷ HIV.gov “Long-Acting HIV Prevention Tools” <https://www.hiv.gov/hiv-basics/hiv-prevention/potential-future-options/long-acting-prep>

⁶⁸ AmfAR “Long-Acting HIV Treatment and Prevention Are Coming” <https://www.amfar.org/long-acting-arv/>

⁶⁹ AmfAR “Long-Acting HIV Treatment and Prevention Are Coming: Preparing for Potential Game Changers” July 2018 https://www.amfar.org/uploadedFiles/amfarorg/Articles/On_The_Hill/2018/chart.pdf Accessed Nov 12, 2020

⁷⁰ Arizona Section 1115 Waiver Amendment Request: AHCCCS Works Waiver, 2017

<https://www.azahcccs.gov/shared/Downloads/News/AHCCCSWorks1115WaiverAmendmentRequest.pdf> (Accessed Nov 18, 2020)

⁷¹ Government Publishing Office, “42 CFR § 440.315 - Exempt individuals,” <https://www.govinfo.gov/content/pkg/CFR-2013-title42-vol4/pdf/CFR-2013-title42-vol4-sec440-315.pdf>.

left it up to the states to establish their own definition.⁷² CMS also took further steps to ensure medically frail populations would be exempted from Medicaid initiatives that might cause disruptions to enrollment or accessing necessary medical care in their 2018 guidance to state Medicaid programs, which required that medically frail populations be exempted from disenrollment penalties.⁷³

Many states have defined populations that should be protected within Medicaid due to their health and medical needs in their definition of "medical frailty" including Kentucky,⁷⁴ Virginia,⁷⁵ and Indiana.⁷⁶

In a best practice example, in 2018 the State of Michigan submitted a Medicaid demonstration waiver (Healthy Michigan Plan §1115 Demonstration Waiver Extension Application / Project No. 11-W-00245/5)⁷⁷ to CMS, implementing a work requirement for the Michigan Medicaid expansion program. The State of Michigan took a commendable step in responding to the concerns of patient advocates to ensure that PLWH were able to maintain access to vital health benefits while the state pursued its new program goals. In the proposal submitted to CMS,⁷⁸ the state exempted medically frail individuals from the demonstration, including PLWH through the use self-attestation and/or using claim analysis codes specific to HIV. This process is notable because most PLWH are "automatically" exempted without need for further action on their part.

We encourage Arizona to ensure that it specifically designates PLWH as a medically frail population within all aspects of the AHCCCS program, and exempt PLWH from any demonstrations that might cause loss of enrolment, or access to care and uninterrupted ART. Doing so will help to facilitate the goals of the EHE and ensure PLWH in Arizona have access to the coverage option most likely to facilitate their medical needs.

5. Work Requirement

Although Arizona was one of many states to request and receive approval of a work requirement (or community engagement requirement) from CMS in recent years, we would like to encourage the state to bring an end to that policy by formally withdrawing its request for approval as part of this extension request.

Work requirements in Medicaid, while popular during the last four years, have been largely unsuccessful policies thus far. As of October 2020, four states have had work requirement waivers set aside by the courts.⁷⁹ To date, Arkansas is the only state to have implemented a waiver that conditioned Medicaid

⁷² Mosbach, Peter and Campanelli, Sherry J., "State Differences in the Application of Medical Frailty Under the Affordable Care Act: 2017 Update" (2017). Commonwealth Medicine Publications. 40. https://escholarship.umassmed.edu/commed_pubs/40.

⁷³ CMS, SMD: 18-002, "RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," January 11, 2018 <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18002.pdf> Accessed April 6, 2020.

⁷⁴ "Kentucky Medically Frail Medical Condition Guide v5," 2018 <https://passporthealthplan.com/wp-content/uploads/2018/06/PROV02104-Kentucky-Medically-Frail-Medical-Condition-Guide-Provider-v5.pdf> Accessed 4/14/2020

⁷⁵ "Medicaid Expansion Overview - Virginia Department of Health," PDF, Sep 19, 2018 http://www.vdh.virginia.gov/content/uploads/sites/10/2018/09/For-Posting_Medicaid-Expansion-Overview_KAS_092618.pdf Accessed 4/14/2020

⁷⁶ Indiana.gov, Family and Social Services Division, "Conditions that may qualify you as medically frail," <https://www.in.gov/fssa/hip/2465.htm>, Accessed March 10, 2020.

⁷⁷Section 1115 Demonstration Extension Application, Healthy Michigan Plan Project No. 11-W-00245/5, AMENDED: September 10, 2018 <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf>.

⁷⁸Section 1115 Demonstration Extension Application, Healthy Michigan Plan Project No. 11-W-00245/5, AMENDED: September 10, 2018 <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf>.

⁷⁹ Kaiser Family Foundation, The Landscape of Medicaid Demonstration Waivers Ahead of the 2020 Election, Guth et, al. Oct 30, 2020, <https://www.kff.org/medicaid/issue-brief/the-landscape-of-medicaid-demonstration-waivers-ahead-of-the-2020-election/>

eligibility on meeting a work and reporting requirement, which resulted in over 18,000 people losing coverage before the waiver approval was set aside by the court.⁸⁰

While eight states currently still have approved waivers with work requirements, and seven have such waiver requests pending, no states are currently implementing those work requirements.⁸¹

Although the state could not have known in advance, ViiV notes the unfortunate timing of the many work requirement proposals. The COVID 19 pandemic has resulted in millions of individuals losing jobs, and with it, their employer-based insurance. An analysis published by Health Management Associates estimated how the economic downturn primarily driven by the COVID-19 pandemic could impact enrollment in Medicaid and found that the number of people receiving coverage from an employer could decline by 12 to 35 million, including both workers and family members. It also found that Medicaid enrollment could increase from 71 million to 82-94 million (by 11 to 23 million across all states) this year.⁸²

Medicaid is intended to provide health coverage for low-income individuals including the unemployed, especially in times of economic downturn. It is for this reason that the Families First Coronavirus Response Act (FFCRA) conditioned enhanced FMAP funding on a “maintenance of effort” requirement for all state Medicaid programs as a condition of receiving support to uphold coverage amidst the COVID-19 pandemic.⁸³

Given the change in economic and public health circumstances for Arizona, and the entire U.S., ViiV urges the state to consider whether renewing a policy that conditions Medicaid access on employment is feasible or appropriate. The COVID-19 pandemic is an unfortunate realization of the concerns that advocates have raised for years about restrictions on the Medicaid program. With the economic downturn that has been created by the COVID-19 pandemic,⁸⁴ it may be very difficult for individuals to obtain employment in the coming years.

The draft waiver renewal notes that, “[o]n October 17, 2019, AHCCCS informed CMS of Arizona’s decision to postpone implementation of AHCCCS Works until further notice. This decision was informed by the evolving national landscape concerning Medicaid community engagement programs and ongoing related litigation.”⁸⁵

We urge the state to consider formally eliminating the AHCCCS Works policy permanently, as part of its waiver renewal request to CMS.

HIV Quality Measures

The CDC states that 60 percent of PLWH in America are virally suppressed, and the national goal is 80

⁸⁰ Kaiser Family Foundation, The Landscape of Medicaid Demonstration Waivers Ahead of the 2020 Election, Guth et, al. Oct 30, 2020, <https://www.kff.org/medicaid/issue-brief/the-landscape-of-medicaid-demonstration-waivers-ahead-of-the-2020-election/>

⁸¹ Kaiser Family Foundation, The Landscape of Medicaid Demonstration Waivers Ahead of the 2020 Election, Guth et, al. Oct 30, 2020, <https://www.kff.org/medicaid/issue-brief/the-landscape-of-medicaid-demonstration-waivers-ahead-of-the-2020-election/>

⁸² Health Management Associates (HMA), “COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State,” published April 2020 <https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf> Accessed April 7, 2020.

⁸³Kaiser Family Foundation, “Medicaid Maintenance of Eligibility (MOE) Requirements: Issues to Watch When They End” Dolan, et al. Sep 22, 2020 <https://www.kff.org/medicaid/issue-brief/medicaid-maintenance-of-eligibility-requirements-issues-to-watch-when-they-end/>

⁸⁴ Health Management Associates (HMA), “COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State,” published April 2020 <https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf> Accessed April 7, 2020.

⁸⁵ The Arizona Health Care Cost Containment System (AHCCCS) “Draft Arizona Demonstration Renewal Proposal (2021-2026)” https://www.azahcccs.gov/Resources/Downloads/1115Waiver/1115WaiverRenewalPacket_DRAFT.pdf

percent.⁸⁶

The measure “HIV Viral Load Suppression (VLS)”⁸⁷ is the quality measure associated with achievement of viral suppression in people living with HIV PLWH. Reaching and maintaining viral suppression is the goal of HIV treatment, as it is a key factor in improving overall health for people living with HIV (PLWH), and a factor that determines long term survival.⁸⁸ Viral suppression also prevents sexual transmission of HIV to others.^{89,90,91}

This builds a strong case for implementing HIV-focused process and outcome quality measures to encourage testing, linkage to care, and ongoing treatment so PLWH can achieve viral suppression and ultimately improve their health outcomes.

Several HIV quality measures used in federal programs are endorsed by the National Quality Forum (NQF). NQF endorsement demonstrates that the measures have been rigorously tested and are evidence-based, useful, and can drive quality improvement. The NQF uses the following criteria in their evaluation of measures: importance to measure and report, scientific acceptability of measure properties, feasibility, usability and use, and harmonization with or superiority to existing measures.⁹²

The Centers for Medicare and Medicaid Services (CMS), and Health Resources and Services Administration (HRSA) have all included NQF-endorsed HIV measures in their quality programs or core measure sets.^{93,94,95,96} The CMS 2020 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) includes the HIV measure of HIV Viral Load Suppression (HVL-AD).⁹⁷ The Adult Core Set represents the health care quality measures that indicate the access to—and quality of—the health care adult Medicaid beneficiaries receive.⁹⁸

Medicaid uses quality measures to assess care quality, assign provider accountability, and support performance improvement. Tracking and reporting HIV measures in the Medicaid Adult Core Set will help to ensure their future inclusion on the Centers for Medicare and Medicaid Services’ (CMS) Medicaid Scorecard.^{99, 100} The Scorecard compares outcome measures that are reported by at least twenty-five

⁸⁶ CDC.gov

“Understanding the HIV Care Continuum” <https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf> JULY 2019

⁸⁷HIV/AIDS Bureau Performance Measures, “HIV Viral Load Suppression,” <https://hab.hrsa.gov/sites/default/files/hab/About/clinical-quality-management/coremeasures.pdf> Accessed May 15, 2020

⁸⁸ HRSA, Guide for HIV/AIDS Clinical Care (April 2014), <https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf>. Accessed October 13, 2017.

⁸⁹ NIAID, <https://www.niaid.nih.gov/news-events/undetectable-equals-untransmittable>. Accessed August 1, 2018.

⁹⁰ Cohen, et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission; N Engl J Med 2016; 375:830-839 DOI: 10.1056/NEJMoa1600693

⁹¹ Centers for Disease Control and Prevention (CDC) “Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV” <https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html> Accessed September 20, 2019.

⁹² NQF, “Measure Evaluation Criteria,”

http://www.qualityforum.org/Measuring_Performance/Submitting_Standards/Measure_Evaluation_Criteria.aspx

⁹³ America’s Health Insurance Plans Consensus Core Set: HIV / Hep C Core Measures https://www.ahip.org/wp-content/uploads/2016/02/Public_Consensus-HIV-Hep-C-Measure-List_FINAL.pdf.

⁹⁴ CMS (2020). Core Measures. https://cmit.cms.gov/CMIT_public/ListMeasures

⁹⁵ PQA. PQA’s Specialty Core Measure Set. Retrieved from <https://www.pqaalliance.org/specialty-core-measure-set>

⁹⁶ HRSA. Performance Measure Portfolio. Retrieved from <https://hab.hrsa.gov/clinical-quality-management/performance-measure-portfolio>

⁹⁷ Medicaid.gov “2020 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set),”

<https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-core-set.pdf>

⁹⁸ Mathematica, “Annual Review of the Child and Adult Core Sets of Quality Measures for Medicaid and CHIP,”

<https://www.mathematica.org/features/maccoresetreview>

⁹⁹ Medicaid. Adult Health Care Quality Measures. Retrieved from <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set/index.html>

¹⁰⁰ Medicaid. Medicaid & CHIP Scorecard. Retrieved from <https://www.medicaid.gov/state-overviews/scorecard/index.html>

states. In the most current CMS data for FY 2019, seven states reported HIV VLS measures – including California, Delaware, Louisiana, Mississippi, New York, Rhode Island, and Texas.¹⁰¹

We are pleased to report that additional Medicaid managed care plans will be required to report on the viral load suppression measure in Oklahoma (10/1/2021)¹⁰² and Ohio (1/5/2022).¹⁰³

Arizona has been working to adopt the CMS Child and Adult Core Set gradually. We hope the state will see this as a call to action to report on HIV VLS immediately.

More and more, states are using contracts between Medicaid agencies and Medicaid managed care organizations (MMCOs) to deliver health benefits and services to beneficiaries while reducing care costs and utilization.¹⁰⁴ Several state Medicaid programs have linked HIV quality measures to MMCO performance, thus incentivizing achievement of viral suppression for their PLWH. For example, New York State's Ending the Epidemic Plan recommends that HIV providers, facilities, and managed care plans report and monitor viral suppression rates and provide financial incentives for performance.¹⁰⁵ Consequently, New York State's Department of Health requires that MMCOs report HIV-specific measures, including Viral Load Suppression (VLS), and awards financial incentives based on performance on these HIV metrics.¹⁰⁶ New York MMCO's efforts have significantly improved rates of viral suppression among Medicaid beneficiaries; by linking many PLWH to care the MMCOs report that more than 40 percent of their Medicaid beneficiaries have achieved viral suppression.¹⁰⁷

Louisiana's Medicaid managed care program, Bayou Health, has included the VLS outcome measure in its contracts with MMCOs. To further drive improvement the MMCOs have incorporated resources from the Louisiana Office of Public Health's (OPH) STD/HIV Program into disease management programs after the state added measures to their contracts. This participation by the MMCOs in supporting HIV care and treatment programs has achieved 79 percent viral suppression among PLWH engaged in medical care in Louisiana.¹⁰⁸

Optimal outcomes for PLWH can only occur if systems are measured and are able to benchmark their performance against the current standard of care in the HIV care continuum. The use of HIV-related quality measures will promote standards of health care coverage that support adherence to current HIV clinical and federal guidelines.¹⁰⁹

Conclusion

Thank you for your consideration of these comments related to the effective management of HIV care,

¹⁰¹ Medicaid.gov <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-chart-pack.pdf>

¹⁰² SoonerSelect RFP 8070001240 (Updated 11/13/2020)

<http://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=25354&libID=24340> Accessed November 18, 2020

¹⁰³ Ohio Medicaid Managed Care Organizations, RFA Number: ODMR-2021-0024, Issued: September 30, 2020; "Attachment A," page 232: <https://procure.ohio.gov/PDF/ODMR202100249302020115355ODMR20210024.pdf>

¹⁰⁴ Medicaid. Managed Care. Retrieved from <https://www.medicaid.gov/medicaid/managed-care/index.html>

¹⁰⁵ New York State Department of Health. 2015 Blueprint. Retrieved from https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf

¹⁰⁶ NASHP. December 2017. Prioritizing Care: Partnering with Providers and Managed Care Organizations to Improve Health Outcomes of People Living with HIV. Retrieved from <https://nashp.org/wp-content/uploads/2017/09/HIV-Affinity-Provider-MCO-Engagement-Brief.pdf>

¹⁰⁷ New York State Department of Health. Ending the Epidemic Progress Report: March 2018. Retrieved from https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/Executive_Summary_2018_.pdf

¹⁰⁸ Louisiana HIV/AIDS Strategy 2017-2021, published by the Louisiana HIV Planning Group; August, 2016. Accessed at <https://www.louisianahealthhub.org/wp-content/uploads/2018/10/LouisianaHIVAIDSStrategy.pdf>

¹⁰⁹ HIV Medicine Association. Tools for Monitoring HIV Care: HIV Clinical Quality Measures (Updated) February 2015. Available at: http://paetc.org/wp-content/uploads/2015/04/Tools_for_Monitoring_Issue_Brief_update-April-2015.pdf. Accessed April, 14, 2020.

including treatment and prevention, under the AHCCCS system.

We hope that as the state moves to reauthorize this program for the next five years, you will consider the needs of PLWH, and ensure open access to all HIV treatments without barriers, prioritize adherence, and ensure access to new HIV treatment innovations as specified in the DHHS Guidelines. We also encourage the state to ensure that populations at high risk for HIV have access to PrEP for prevention. Further, we request the state bring an end to the work requirements proposal in the state and to exempt PLWH from the work requirements through designation as a medical frail population. We also urge the state to move towards reporting of the VLS quality metric, in order to ensure high quality care for PLWH.

Please feel free to contact me at kristen.x.tjaden@viivhealthcare.com with any questions.

Sincerely,



Kristen Tjaden
Government Relations Director
ViiV Healthcare



Health System Alliance of Arizona

November 30, 2020

Director Jami Snyder
AHCCCS
801 E. Jefferson
Phoenix, Arizona 85034

Dear Director Snyder:

On behalf of the Health System Alliance of Arizona (Alliance), we appreciate the opportunity to provide comment on the AHCCCS Section 1115 Waiver Renewal.

To begin, we acknowledge the strong partnership between AHCCCS and the healthcare industry in service to Medicaid patients and their families across Arizona. This partnership has been critical throughout the COVID-19 pandemic. The Agency has exercised tremendous leadership over the past year, providing critical support to providers and hospitals as they respond to the crisis. To this end, AHCCCS received emergency authority from CMS to obtain verbal rather than written consent from members of the Arizona Long-Term Care System (ALTCS) for person-centered service plans. This flexibility is critical to ensure the provision of timely care for vulnerable patients. The Alliance recognizes the value in continuing this authority and supports its inclusion in AHCCCS's renewed 1115 Waiver.

Over the past five years, AHCCCS has acted as a leader in driving advancements in quality across the healthcare industry. Specifically, the Agency has incentivized medical providers to invest in the social determinants of health and coordinate with social service providers to ensure that Medicaid patients have access to not only quality medical care, but also housing, food, and transportation. To that end, access to affordable housing continues to be a critical issue in Arizona, particularly for our vulnerable and at-risk populations. For this reason, we would request that this application include a request for additional resources to expand housing for individuals who are diagnosed with a serious mental illness.

The Alliance continues to support AHCCCS's goal to integrate the delivery system so that patients have access to medical and behavioral health services in a single health plan. We support the Agency's request to continue this effort through the extension and expansion of the Targeted Investments Program, which will continue to incentivize providers to integrate behavioral and medical services into a "patient-centered" delivery of care, while also leveraging the electronic medical record, which may be utilized to share patient data and further promote the integration of care delivery across the state.

The Alliance supports AHCCCS's request for the authority to provide reimbursement for preventative dental services to the American Indian population in Arizona. Members of the tribal

populations in Arizona have limited access to care in comparison to the rest of the state. Indian Health Service and Section 638 Tribal Facilities provide critical resources to tribes whose members reside in the most remote parts of Arizona. Providing AHCCCS with the authority to reimburse these facilities to provide dental care to tribal members will provide a critical point of care for individuals who otherwise would be more likely to suffer from more acute and expensive dental infections.

The Alliance also supports reimbursement for traditional healing services to individuals enrolled in the American Indian Health Program (AIHP). Traditional healing is a practice that has cultural and historical significance within the American Indian community. By incorporating traditional healing practices into the AIHP service array, AHCCCS is promoting the integration of spiritual and physical wellness into the American Indian community in a manner that is most culturally appropriate to the population.

The Alliance supports the Agency's proposals to advance and continue to integrate care for patients in Arizona and appreciates its continued partnership in the face of the global pandemic. However, AHCCCS is seeking authorization to continue two Waiver authorities that the Alliance cannot support, authority to implement the AHCCCS Works Program and continued authority to limit AHCCCS enrollment to the first day of the month of application.

In October 2019, AHCCCS postponed its planned implementation of the AHCCCS Works program, citing outstanding litigation and uncertainty in the outcomes of similar proposals in other states. The Alliance is on record with its opposition to the AHCCCS Works program, citing concerns about poor patient outcomes, limited access to alternate forms of healthcare coverage and increased uncompensated care. We reiterate our opposition to this proposal and caution that, even with the exclusion of at-risk populations outlined in the Waiver authority, the limitation of healthcare coverage to any population will result in reduced access to care, coupled with a corresponding increase in otherwise preventable and costly emergency room visits and hospitalizations.

Finally, this Waiver renewal application also seeks to extend the current authority to limit retroactive coverage to the first day of the month in which an individual applied for Medicaid, rather than the first day of the quarter in which the application was completed. At the time of the application for this authority, AHCCCS estimated that the state would save approximately \$40 million a year by limiting the number of months an individual would be eligible to enroll. In reality, this application represented a cost-shift of this savings onto hospitals who have been burdened with increased uncompensated care costs from patients who have been uninsured and unable to consistently remain enrolled in the Medicaid program due to part-time or seasonal employment. There has been some reprieve to "churn" during the federal emergency due to the federal maintenance of effort requirements, but it is anticipated that this trend will resume once the pandemic concludes and Medicaid members are able to roll on and off the program as before.

Once again, we appreciate our partnership with AHCCCS and the opportunity to provide comment on the Waiver Renewal Application. I am happy to answer any questions or provide additional information.

Respectfully,



Jennifer A. Carusetta
Executive Director
Health System Alliance of Arizona

November 24, 2020

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

FOR ELECTRONIC SUBMISSION

Re: Arizona's Section 1115 Waiver Renewal Request (2021-2026)

To whom it may concern:

On behalf of *Wildfire: Igniting Community Action to End Poverty in Arizona*, I am writing in response to AHCCCS' draft Section 1115 waiver proposal for the years 2021-2026. Wildfire is a statewide anti-poverty organization and Arizona's State Community Action Association. For over half a century, Wildfire has worked to alleviate the impact of poverty in Arizona. We advocate for fair practices, collaborate on policy issues, and support community action programs and agencies. Beyond easing the effects of poverty, we hope to ignite lasting change, to "stop poverty before it starts."

Wildfire is committed to creating an Arizona where all may thrive by connecting families to services that help them make it through another day. This includes ArizonaSelfHelp.org, a free and easy way for families to get help from 40 different health and human services programs, including our state Medicaid programs. Wildfire believes meaningful access to quality affordable health care is a human right. We believe in universal coverage for all community members, which includes affordable prescription drugs, reductions in geographic and categorical barriers to access, and provision of mental health services. All members of our community deserve a health care system that allows them to live healthy lives while pursuing their goals.

As advocates for health and health equity in Arizona, Wildfire supports key aspects of the draft Section 1115 waiver, provides recommendations for other aspects, and also requests an emergency Section 1135 waiver to re-implement the previously authorized uninsured eligibility category in response to the recent surge in COVID-19 cases throughout Arizona.

We are very supportive of many of the requests in the draft waiver, including:

- Reimbursement for traditional healing services provided to American Indian tribal members at 100% of the Federal Medical Assistance Percentage (FMAP). We believe this will further promote integration of cultural health practices and that recognizing the importance of traditional healing services is one way to promote health equity for tribal members.
- Reimbursement for adult dental care for American Indian tribal members at 100% FMAP. Oral health inequities persist for American Indian tribal members. Reimbursement for services provided to American Indian AHCCCS participants is critical to reducing rates of oral disease and decay and is in line with fulfillment of our country's treaty promise to provide health care at no cost to members of sovereign tribal nations.

- Discontinuation of the AHCCCS Care program demonstration. This program would have posed an administrative burden on both AHCCCS participants and the agency, and we believe it would have disincentivized enrollment in health care and increased the rate of enrollment churn.
- Exclusion of the 5-year lifetime limit provision associated with the AHCCCS Works program; though we recognize that state statute requires AHCCCS to request the lifetime limit, we remain opposed to this statutory obligation and do not believe that limiting access to health care is wise or ethical.
- Disregard of interest and excess income for children and adults with disabilities. We feel this is a critical step to help keep children and families with disabilities connected to a reliable source of health coverage, even when their financial circumstances may be in flux. -IHS / 638 uncompensated care - provides a level of protection to tribal members in case optional benefits are limited.
- Expansion and extension of the Targeted Investment Program. We support AHCCCS' efforts to integrate behavioral and physical health care and look forward to seeing the results of this investment.

Each of the provisions mentioned above have the potential to promote health equity in Arizona, and we commend the agency's inclusion of these requests in the draft Section 1115 waiver.

We do see several areas for improvement in the waiver request, and ask that AHCCCS consider the following modifications before submitting the Section 1115 waiver to the Centers for Medicaid and Medicare Services:

- Though we are fortunate that the agency has requested a continuation of its request for prior quarter coverage for pregnant women and children, we feel that three-month retroactive eligibility should be reinstated for all populations.
- We remain concerned about AHCCCS Works and the additional administrative burden of this program. Though we understand the agency is under a statutory obligation to request work reporting requirements in its Section 1115 waiver, we would like to take this opportunity to express our continued objections to work reporting requirements for Medicaid. Now is not the time to waste limited state dollars on implementing a program that is likely to be tied up in litigation for years; instead, we request that the Arizona legislature repeal this requirement and redirect limited state resources so that AHCCCS may have the ability to offer housing support programs for their members. Restricted access to preventive care and treatment for chronic health issues limits the productivity of working people and is not an incentive to employment.
- We believe that verbal consent for ALTCS person-centered care plans is a great first step and ask that AHCCCS consider expanding its request to allow verbal consent in lieu of written signature authorization for all AHCCCS populations.
- Though we understand the financial and administrative strain AHCCCS is facing during the pandemic, we hope to see substantive efforts made toward implementing the Whole Person Care Initiative, and ask that the agency consider piloting this program with American Indian members. This would come at no cost to the state and would provide valuable data on the efficacy of the initiative.
- We were disappointed that school-based Medicaid billing was not included in the draft Section 1115 waiver but look forward to partnering with AHCCCS and other stakeholders in health and education to advance this initiative via State Plan Amendment in 2021.
- Finally, we are supportive of AHCCCS exploring future opportunities that assist their members in finding adequate and affordable housing. Safe, affordable, and stable housing is the bedrock of improving health outcomes for low income families. We are hopeful that future opportunities to draw down as much as \$70 million in additional federal matching funds will allow AHCCCS to provide housing support programs to their members.

Wildfire urges AHCCCS to request permission from the Centers for Medicare and Medicaid Services (CMS) for an emergency Section 1135 waiver to re-implement the previously authorized uninsured eligibility category in response to a recent surge in COVID-19 cases.

Additionally, Wildfire asks that AHCCCS clarify that emergency Medicaid billing codes may be used to cover the cost of COVID-19 related treatment, regardless of where care is delivered.

The COVID-19 does not discriminate, nor should our response. Wildfire believes that immigrant families would benefit from enhanced access to health care reimbursed through Medicaid. The current pandemic poses an urgent threat to individual and public health; thus, care provided to any uninsured individual with a confirmed case of COVID-19, regardless of immigration status or place of service delivery, should be billable through emergency Medicaid.

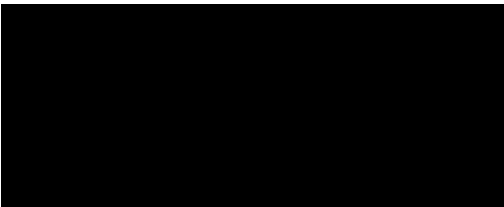
Families can better maintain their health and seek early care and treatment for COVID-19 if they are able to quickly access affordable care when needed, and from a provider they trust. While Arizona health care providers are currently billing the Health Resources and Services Administration (HRSA) fund for care provided to uninsured and/or undocumented individuals, this funding is finite and may not support a prolonged response to the pandemic.

Immigrants play a vital role in Arizona's economy and community. Our community has always been strengthened and become more prosperous by the addition of diverse voices and experiences from all over the globe. In our state, one in six essential workers is an immigrant; these individuals are on the front lines of this pandemic, risking their lives daily to provide the health care, grocery and retail, shipping and transportation, and child care services we need to fight the pandemic. Longstanding evidence suggests that increasing access to affordable health care can help mitigate the spread of infectious disease; therefore, any effective public health response must be inclusive of all individuals, regardless of documentation status.

Not having access to affordable health care may result in more people seeking non-emergent care at hospitals. Allowing FQHCs and other non-hospital, community-based providers to bill Emergency Medicaid for COVID-19-related treatment would help to secure more cost-effective care options for immigrant families, reduce the burden of uncompensated care, and help our health care system to preserve precious emergency care resources.

Thank you for taking these comments into consideration. We appreciate the opportunity to provide feedback on the draft Section 1115 waiver. We are also hopeful CMS will grant an emergency Section 1135 waiver to re-implement the previously authorized uninsured eligibility category in response to a recent surge in COVID-19 cases.

Sincerely,



Cynthia Zwick
Executive Director

