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Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Date: November 15, 2012

To: Interested Parties

From: AHCCCS Administration

Re: Referenced Attachments from written comments.

This document includes referenced attachments from correspondence sent to AHCCCS regarding the Childless Adults DRAFT Waiver Amendment and the Future of Arizona's Medicaid Program. The original correspondence can be found on one of the following links:

[Childless Adults](#)

[AZ Future](#)

The referenced attachments include:

- Key findings from a statewide survey of voters in Arizona by the Tarrance Group (Attached to CASE letter 8/31/12)
- Six Exhibits (Attached to William E. Morris Institute letter 10/18/12)
- 128 "I Support AHCCCS Efforts" Petitions (Attached to Crossroads Mission letter 10/18/12)

Key Findings from a statewide survey of voters in Arizona by the Tarrance Group

(Attached to CASE letter 8/31/12)

THE TARRANCE GROUP

TO: THE ARIZONA CHAMBER OF COMMERCE AND INDUSTRY
THE GREATER PHOENIX CHAMBER OF COMMERCE

FROM: BRIAN NIENABER
ED GOEAS

RE: KEY FINDINGS FROM A STATEWIDE SURVEY OF VOTERS IN ARIZONA

METHODOLOGY

The Tarrance Group is pleased to present these key findings from a survey of voters in Arizona. All respondents interviewed in this study were part of a fully representative sample of N=600 registered voters plus an N=150 oversample of registered Republicans to bring the number of Republicans in the sample to N=439. Responses to this survey were gathered December 11-13, 2011. The confidence interval associated with a sample of this type is $\pm 4.1\%$ in 19 of 20 cases for the overall sample and $\pm 4.8\%$ for the N=439 sample of Republicans in 19 of 20 cases.

- On the issue of health insurance exchanges, voters are given a brief explanation about exchanges* and asked their preference -- a state run exchange or a federal run exchange. A majority of all voters (56%) prefer a state run exchange, including 41% of voters who indicate a strong preference for state run exchanges.

** The full language of this question appears in the addendum.*

- Among Republicans, there is an even stronger preference for having the state run these health insurance exchanges. Fully 80% of Republicans prefer a state run exchange. In addition, there is strong support for state run exchanges among key Republican demographic groups like very conservative Republicans (85%) and Republicans who are strong supporters of the Tea Party movement (83%).
- In sum, there is notable opposition to Obamacare among all voters and particularly intense opposition to Obamacare among Republicans. These concerns about federal run solutions for a locally provided and intensely personal service are certainly seen in the clear preference that voters have for state run health insurance exchanges. The state would be well served to create an exchange that both meets the needs of citizens and answers the concerns of voters.

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THE TARRANCE GROUP

Addendum

Full text of the question on health insurance exchanges appears below.

Now, thinking about the issue of health care reform...

As you may already know, the health care reform law passed in 2010 requires health insurance exchanges to be set up in each state by 2014. A state may set up its own exchange. If a state does not set up an exchange, then the federal government will do it.

Exchanges are:

- *Marketplaces created by the state where individuals and small businesses compare, shop, and enroll in a health insurance plan that meets their needs.*
- *Regulated by the state officials if they are set up by a state ,*
- *Offer a website that allows citizens to compare and contrast all aspects of health insurance plans and enroll online, and*
- *The only place where citizens with federal subsidies can use these funds to buy health insurance.*

The state legislature and the Governor are considering two main options for setting up these exchanges. These options are:

- *Setting up an exchange run by the state, OR*
- *Having an exchange set up and run by the federal government?*

Which of these options would you prefer?

Six Exhibits

(Attached to William E. Morris Institute letter 10/18/12)

EXHIBIT 1

TO

**OBJECTIONS TO ARIZONA'S
SECTION 1115 WAIVER AMENDMENT REQUEST
CONTINUING COVERAGE FOR CHILDLESS ADULTS
UNDER THE DEMONSTRATION**

From: Coury, Monica
To: Schubel, Jessica (CMS/CMCS)
Cc: Jensen, Richard (CMS/CMML); Garner, Angela D. (CMS/CMCS); Novo, Don (CMS/CMCHO); Young, Cheryl (CMS/CMCHO); Gonzales, Theresa
Subject: RE: Childless Adult Copays
Date: Wednesday, September 28, 2011 7:17:52 PM

Hello Jessica. Please see the responses regarding copayments for childless adults below. Please let me know if you have any questions or require additional information.

Regards,
Monica

Monica Higuera Coury

Assistant Director
Office of Intergovernmental Relations
AHCCCS
Phone: 602-417-4019
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From: Schubel, Jessica (CMS/CMCS) [mailto:Jessica.Schubel@CMS.hhs.gov]
Sent: Tuesday, September 20, 2011 1:53 PM
To: Coury, Monica
Cc: Jensen, Richard (CMS/CMCS); Garner, Angela D. (CMS/CMCS); Novo, Don (CMS/CMCHO); Young, Cheryl (CMS/CMCHO); Gonzales, Theresa
Subject: Childless Adult Copays

Monica,

I wanted to send you a quick note regarding Arizona's use of mandatory co-payments on the childless adult population. The 9th Circuit held in the Newton-Nations case (McCants) that Demonstration populations are not "eligible" for medical assistance under a State plan. As a result, we continue to think that the 1115 restrictions on waivers of co-payments do not apply to individuals who were not eligible for medical assistance under a State plan. But the Ninth Circuit also concluded that the State needs to justify its request to impose co-payments for the childless adults (the Demonstration population), so I wanted to ask for the following information:

1. What is the State's hypothesis with respect to the co-payments, i.e., what does the State intend to "demonstrate" by imposing mandatory co-payments on the childless adults?

Response: Stated in the simplest terms possible, the State's hypothesis is that the imposition of mandatory copayments on childless adults will permit the State to minimize the number of uninsured in the State to a greater extent than would be financially feasible without mandatory copayments. In addition, the demonstration project will test the hypothesis that the health status of childless adults in Arizona who have access to health care coverage subject to a reasonable but mandatory copayment requirement will be better than childless adults in Arizona that must depend on charity care. Imposition of mandatory copayments permits the State and its Medicaid Managed Care contractors to make corresponding reductions to expenditures for the cost of services (because the provider collects the difference from the

member in the form of the copayment). As a result, the State can use the savings in service costs as part of the overall savings generated by the managed care demonstration project to fund coverage (albeit coverage subject to a copayment) to persons who would otherwise not be entitled to any coverage for care (i.e., Childless Adults). Therefore, the State's hypothesis is that imposing mandatory copayments on childless adults will contribute to the overall objective of the Demonstration Project; that is, to enable the State to expand Medicaid coverage to the greatest extent for persons not otherwise eligible for medical assistance (i.e., non-categorically eligible individuals in the State of Arizona -- i.e. childless adults). In the absence of the financial savings associated with copayments, the State would have to consider alternatives to the proposed Demonstration Project such as coverage of childless adults at a lower percentage of the federal poverty level.

2. Given the research on co-payments and low-income populations, how will the co-payments affect the impacted beneficiaries, particularly with respect to access and health outcomes?

Response: A system that provides the uninsured access to health care subject to mandatory copayments will improve access to care and health outcomes relative to the uninsured who must rely on charity care. While the research may suggest that copayments result in persons forgoing some care, those studies compare utilization for insured persons subject to copayments relative to insured persons not subject to copayments. The State believes that copayments will allow for access to comprehensive coverage for a greater number of individuals and that this access to comprehensive coverage yields better health outcomes than either no coverage or coverage that only provides a basic benefits package. This theory is supported in a study entitled "The Oregon Health Insurance Experiment", which concluded that access to comprehensive Medicaid coverage is better than being uninsured. That study can be viewed at the following link: http://www.nber.org/papers/w17190.pdf?new_window=1 and an article on the same study can be viewed at: <http://economix.blogs.nytimes.com/2011/07/07/how-health-insurance-affects-health/>.

3. How does the State intend to evaluate the demonstration hypothesis with respect to cost sharing? Does the State intend to separately evaluate the mandatory co-payments, or only as part of the larger evaluation of coverage expansion?

Response: The State intends to evaluate the demonstration hypothesis by estimating the number of additional otherwise uninsured persons that the State is able to offer health care due to the savings to the State from the total cost of services. Specifically, the State will measure success by dividing: (1) the State costs avoided due to cost sharing by (2) the per member per month cost for the average childless adult. This will yield the incremental number of uninsured for whom the State was able to offer coverage as the result of cost sharing.

In addition, with respect to your request to impose mandatory co-payments on the State plan populations (kids, pregnant women and TANF parents), how does the State intend to document that it has met the 5 requirements under 1916(f).

We have reviewed 1916(f) and have determined that Congress has established an unattainable standard.

Finally, I'm attaching the Family Planning Extension STCs so you all can begin your review. I'll be happy to discuss further on Wednesday to clarify anything. I look forward to the State's response.

Thanks,

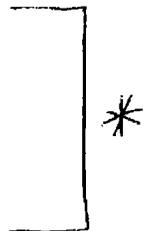


EXHIBIT 2

TO

**OBJECTIONS TO ARIZONA'S
SECTION 1115 WAIVER AMENDMENT REQUEST
CONTINUING COVERAGE FOR CHILDLESS ADULTS
UNDER THE DEMONSTRATION**

1 ELLEN SUE KATZ, AZ Bar. No. 012214
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11 Attorneys for Plaintiffs

12 UNITED STATES DISTRICT COURT
13 DISTRICT OF ARIZONA

15 Sharon Newton-Nations; Manuela
Gonzalez; Cheryl Bilbrey; Donald
16 McCants; Hector Martinez; Anne
Garrison; Dawn House; Dana Franklin;
17 Edward Bonner; D.H.; Jack Baumhardt;
18 Manuel Esparza; and Patricia Jones, on
behalf of themselves and all others
19 similarly situated,

20 Plaintiffs,

21 v.

23 Anthony Rodgers, Director of the Arizona
24 Health Care Cost Containment System;
and Michael O. Leavitt, Secretary of the
25 United States Department of Health and
26 Human Services, in their official
capacities,

27 Defendants.
28

No. CIV 03-2506 PHX EHC

**SECOND DECLARATION OF
LEIGHTON KU, PH.D., M.P.H. IN
SUPPORT OF PLAINTIFFS' MOTION
FOR SUMMARY JUDGMENT**

(Assigned to Hon. Earl H. Carroll)

1 I, Leighton Ku, declare as follows:

2 1. The matters stated in this declaration are given of my own personal
3 knowledge and, if called as a witness, I would truthfully and competently testify
4 consistent with the following.

5 2. I recently joined the faculty of the School of Public Health and Health
6 Services as a Professor of Health Policy at George Washington University in
7 Washington, D.C. My work focuses on conducting and analyzing health research, trends
8 in insurance coverage, health care for immigrants, and federal and state budget concerns
9 and their impact on health care. I have conducted extensive research about the Medicaid
10 program, including state health reforms, Medicaid managed care, and the effects of
11 welfare reform on Medicaid. I am a nationally-recognized expert on cost-sharing and
12 low-income patients and have written research papers and lectured on this topic. I have
13 been invited to speak on this topic in briefings to Congressional staff when they were
14 considering the Deficit Reduction Act, to the National Academy of State Health Policy,
15 to the National Association of State Medicaid Directors, and to the Centers for Medicare
16 and Medicaid Services. I have also taught research methodology and statistics to doctoral
17 students in the public policy and public administration for about 15 years.

18 3. Before this, I was a Senior Fellow at the Center on Budget and Policy
19 Priorities, a nonpartisan policy institute that conducts research and analysis on a range of
20 government policies and programs, with an emphasis on those affecting low- and middle-
21 income people. Before that, I was a principal researcher at the Urban Institute, a
22 nonprofit nonpartisan policy research organization based in Washington, D.C. I authored
23 and directed studies on how welfare reform has affected Medicaid, health care coverage,
24 and health care access for immigrants. Particularly pertinent to this declaration, I was one
25 of the principal evaluators for several states' Medicaid section 1115 demonstration
26 projects, under contract to the Health Care Financing Administration (the prior name of
27 the Centers for Medicare and Medicaid Services) and authored or co-authored of a
28

1 number of reports about section 1115 projects. Thus, I am familiar with both research
2 and policy issues related to these projects.

3 4. At the Urban Institute, I was a founding member of the Institutional Review
4 Board which is responsible for determining whether research studies meet ethical
5 standards for the protection of human subjects in research studies. I reviewed numerous
6 research projects for adherence to these standards. Equally important, as a researcher, I
7 was responsible for ensuring that we maintained ethical safeguards for those who
8 participated in research studies that I conducted. As such, I am familiar with protocols
9 used in research studies that concern voluntary and informed consent in research projects.

10 5. I received a Ph.D. in health policy from Boston University and a Masters in
11 Public Health from the University of California, Berkeley. My curriculum vita is
12 attached as exhibit A, and includes a listing of my publications.

13 6. In preparation for this declaration, I have reviewed the Arizona co-payment
14 regulations at issue in this case, Declarations of Plaintiffs in Support of Plaintiffs' Motion
15 for Preliminary Injunction and Motion for Class Certification, Declarations of Class
16 Members and Other Witnesses in Support of Plaintiffs' Motion for Preliminary
17 Injunction and Motion for Class Certification, Arizona's waiver request the federal
18 approval documents posted at the federal Web site and the exhibits submitted by the
19 federal defendant in a document entitled Certification of Administrative Record.

20 **Review of research concerning copayments for low-income people**

21 7. In the past few years, I have written two reviews of the research literature
22 about the effects of medical cost-sharing for low-income people. On May 7, 2003, the
23 Center on Budget and Policy Priorities published a report that I authored, *Charging the*
24 *Poor More for Health Care: Cost-Sharing in Medicaid (Charging the Poor More)*. On
25 July 7, 2005, the Center released a report that I co-authored with Victoria Wachino, *The*
26 *Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings*. True
27 and correct copies of this report are attached as exhibits B and C.

28

1 8. In these reports, I provided comprehensive analyses of the research to date,
2 assessing the effects of cost sharing on the poor. Cost sharing occurs when insured
3 individuals are required by the insurer to pay for some of their health care coverage, for
4 example, by paying a “copayment” each time a health service is obtained or prescription
5 is filled. (Most of the information described below is documented in the reports, so I do
6 not provide citations in this declaration, since they are available in the reports. In this
7 declaration, I have added some updated information from more recent studies and
8 provide citations for the new evidence.)

9 9. Over the last 35 years, a number of studies have looked at the effects of
10 cost sharing on the poor. Of all forms of cost sharing, copayments are the most heavily
11 studied. Three conclusions can be drawn from this research: first, copayments keep
12 many low-income people from getting needed medical care or medications; second, low-
13 income people cannot always afford these copayments and must choose between them
14 and other basic necessities of life; and third, copayments are not an efficient Medicaid
15 cost saving measure for states.

16 **Negative effect on care needed by low-income people**

17 10. A substantial and rigorous body of research has consistently concluded that
18 low-income individuals—those with income below 100 percent of the federal poverty
19 level—are more vulnerable to the adverse effects of copayments than other groups.
20 Copayment policies that cause only modest reductions in health care use among middle-
21 class individuals can result in more substantial reductions in health care use and lead to
22 significant adverse health consequences among low-income individuals, especially those
23 with chronic health problems. For example, multiple studies have concluded that higher
24 copayments for medical services or prescription drugs cause low-income people to use
25 substantially fewer *essential* and *effective* medical services or medications.

26 11. Copayments have also been shown to lead to poorer health among low-
27 income adults, including worse blood pressure and vision, than among those not subject
28 to copayments. One large, recent study in Quebec found that after copayments for

1 prescription drugs were imposed, poor adults had 88 percent more emergency room visits
2 and experienced a 78 percent increase in medical events like hospitalization or
3 institutionalization as a result of problems experienced when these low-income people
4 went without essential medication. Still other studies have demonstrated the difficulties
5 that Medicaid beneficiaries encounter in accessing medical services when they are being
6 assessed copayments. For example, in a study of Medicaid beneficiaries in Tennessee (in
7 which copayments were elevated under a section 1115 waiver), 20 percent of the patients
8 said they were not able to pay the copayment at the time of a doctor's office visit and 22
9 percent could not pay the prescription drug copayment. Most of those unable to afford
10 the drug copayment went without the medication.

11 12. A very recent study examined the medical consequences that may occur
12 when older adults are unable to fill prescriptions because of cost-related problems. In
13 this study, those who limited their use of medications due cost problems were
14 significantly more likely to experience heart attacks, strokes, angina attacks and to
15 experience a decline in their health status two or three years later, compared to those who
16 did not limit their use of medications because of cost problems. (M. Heiser et al. "The
17 Health Effects of Restricting Medication Use Due to Cost," *Medical Care*, 42(7):626-34,
18 July 2004.)

19 13. Recent studies have also examined the effect of "tiered" copayments, such
20 as those developed in Arizona, in which copayments for certain drugs (e.g., generic
21 medications) are lower than for other drugs (e.g., brand name medications.) A study of
22 privately insured patients found that there was a reduction in some patients' use of
23 medically essential medications as a result of tiered copayments. For example, diabetics
24 reduced their use of anti-diabetes medications, which could lead to progression of their
25 disease and poorer health outcomes (D. Goldman et al., "Pharmacy Benefits and the Use
26 of Drugs by the Chronically Ill," *Journal of the American Medical Association*, 291:
27 2344-50, May 23, 2004). Proponents of tiered copayments argue that copayments
28 provide financial incentives for patients to select lower-cost medications instead of more

1 expensive versions. The problem with this argument is that a physician selects the
2 prescription drug, not the patient, and the physician may not know about the levels of
3 copayments their patients face or may not care; there is no incentive for a physician to
4 prescribe the drug with the lower copayment. In such a situation, the patient may be
5 unable to afford copayment for the medication prescribed, while the physician was
6 unaware that a different medication selection might have had a lower copayment.

7 14. A study conducted at the Hennepin County Medical Center (in
8 Minneapolis) in 2004 found that the enforcement of Medicaid prescription drug
9 copayments (from \$1 to \$3) reduced the access of Medicaid patients to prescription drugs
10 and contributed to adverse medical outcomes, including emergency room visits and
11 hospital admissions, for problems such as strokes, asthma attacks and complications due
12 to diabetes. About half (52%) of those who faced copayments reported being unable to
13 pay for at least one prescription in the past six months after copayments were raised. (M.
14 Mendiola, et al. "Medicaid Patients Perceive Copays as a Barrier to Medication
15 Compliance," Hennepin County Medical Center, Minneapolis, MN, presented at the
16 Society of General Internal Medicine national conference, May 2005 and American
17 College of Physicians Minnesota chapter conference, Nov. 2004.)

18 15. A study that was just published shows that women on Medicare who had to
19 pay higher copayments were less likely to use mammograms, a recommended preventive
20 screening test for breast cancer. (A. Trivedi, et al. "Effect of Cost Sharing on Screening
21 Mammography in Medicare Health Plans," *New England Journal of Medicine*, 358:375-
22 83, Jan. 24, 2008). While the cut-off for heightened copayments in that study was \$10, it
23 is worth noting that only a small share of women in the cost-sharing plans (11 percent) in
24 the study had incomes below the poverty line, whereas all of the women subject to the
25 challenged Arizona have incomes below the poverty line. Because they are poorer, it is
26 reasonable to conclude that these beneficiaries would be deterred from using this
27 screening test even at much lower copayment levels. The cumulative and consistent
28 research concludes that the imposition of heightened copayments on low-income

1 people—particularly those living at or below the poverty line—will likely place the
2 health and well-being of these affected individuals in significant danger.

3 **Low-income people forced to choose between health care and other necessities**

4 16. Cost sharing is on the rise for middle and upper income people with private
5 health insurance coverage. Thus, it is not surprising that states might be interested in
6 mirroring these activities in their Medicaid programs. However, as documented in
7 *Charging the Poor More* and *The Effect of Increased Cost-sharing in Medicaid*, there is
8 an accumulated and consistent body of research concluding that low-income people
9 cannot financially bear copayments as easily as those with higher incomes. This is
10 because low income people are in a different economic position. Data show that
11 Medicaid beneficiaries already have substantial out-of-pocket medical care expenditures.
12 On average, Medicaid beneficiaries pay a larger share of their incomes in out-of-pocket
13 medical expenses than do higher-income individuals with private insurance. Increases in
14 Medicaid copayments would exacerbate their financial burdens.

15 17. Low-income families must also stretch their incomes to meet competing
16 demands for rent, child care, and other expenses. Research indicates that, despite the
17 presence of programs like food stamps, poor families often have difficulties meeting
18 basic needs. In many areas, rising housing costs are claiming an increasing share of poor
19 families' incomes. Studies show that those with incomes below the poverty line already
20 experience hardships, such as running out of food or having difficulty paying rent or
21 utility bills. Elevated copayments for low-income people force many of them to choose
22 between health care and other basic needs.

23 **Medicaid copayments are not an efficient way to reduce state expenditures**

24 18. Instituting or increasing copayments is not an efficient way for states to
25 lower their expenditures for Medicaid because they lose a substantial portion of any
26 savings generated when they institute copayments because this approach reduces federal
27 matching funds. For example, consider a prescription drug that costs \$60. Under
28 Medicaid matching rules, the federal government will pay \$39.72 (or 66.2 percent, the

1 federal Medicaid matching rate for Arizona in 2008), while the state of Arizona pays
2 \$20.18 (33.8 percent of the total). If there is a \$10 copayment, the total cost to Medicaid
3 for the drug is reduced to \$50, so the state share will fall to \$16.90 (33.8 percent of \$50)
4 and the federal government will pay \$33.10. Even though a poor state resident has paid
5 \$10 of his or her limited income for that prescription, the state of Arizona saves only
6 \$3.32 (33.2 percent of \$10), while the great majority of savings accrues to the federal
7 government. That is, the state has imposed a \$10 regressive user fee or tax, which falls
8 only upon low-income state residents, but the state saves only one-third of that amount.
9 From a public finance perspective, this is both regressive and fiscally inefficient. That is,
10 the financial burdens paid by low-income Medicaid recipients are disproportionate
11 relative to the budgetary savings that the state of Arizona accrues. (This example is
12 somewhat simplified, since Arizona does not usually directly pay for prescription drugs
13 on a fee-for-service basis, but pays for these services as part of a larger a capitated
14 amount paid to managed care organizations. But if the managed care organization pays
15 less to pharmacies and reaps savings, these savings will eventually lead to lower
16 capitation rates paid by the state and subject to Medicaid matching rules.)

17 19. The declarations submitted by the plaintiffs and class members in this case
18 are consistent with the findings and conclusions consistently reached in the research
19 literature. Requiring copayments from people with incomes below the federal poverty
20 level, especially copayments that exceed “nominal” levels, in order to receive essential
21 medical care or medications creates a substantial risk of harm to the health of these
22 individuals, as well as creating additional financial burdens upon them. The research
23 shows that copayments lead many patients to forego essential medical care or
24 medications, which can in turn jeopardize their health and lead to worse medical
25 outcomes or require more costly and intensive medical care. If they must pay more for
26 medical care, poor patients are forced to make difficult choices between using their
27 limited incomes to pay for medical services or medications or for other basic needs, such
28 as food or rent. Finally, increasing copayments is an inefficient way to reduce state

1 Medicaid expenditures in which the financial burdens for low-income state residents
2 substantially outweigh the savings for the state of Arizona.

3 **Congress continues to hold that Medicaid beneficiaries with incomes below the**
4 **poverty line should not pay copayments that exceed nominal levels.**

5 20. Since this case was originally filed, two laws have been enacted that
6 modify Medicaid rules regarding copayments: the Deficit Reduction Act of 2005 (Public
7 Law 109-171) and the Tax Relief and Health Care Amendments of 2006 (Public Law
8 109-432). The Centers for Medicare and Medicaid Services, the federal agency that
9 administers Medicaid, recently released a notice of proposed rule-making to implement
10 these provisions, but has not yet issued final regulations. Although these laws offer states
11 new options to increase cost-sharing in Medicaid under certain circumstances, they also
12 make it clear in Section 1916A(a)(2)(A) that individuals with incomes below 100 percent
13 of the federal poverty line should not pay copayments that exceed "nominal" levels of
14 about \$3 per service or medication. Moreover, they also clarify that total aggregate cost-
15 sharing amounts for families with incomes below 100 percent of the poverty line should
16 not exceed 5 percent of family income.

17 **Statement about federal policy regarding cost sharing and waiver projects**

18 21. On page 28 of the Memorandum in Support of Defendant Thompson's first
19 motion for summary judgment, the federal attorneys include a quotation from a report I
20 co-authored with Edwin Park: "States also would have complete flexibility to impose
21 whatever cost-sharing they wish on "expansion" individuals, which could restrict access
22 to necessary services even when the services are covered." (*Administration Medicaid and*
23 *SCHIP Waiver Policy Encourages States to Scale Back Benefits Significantly and*
24 *Increase Cost-Sharing for Low Income Beneficiaries*, Center on Budget and Policy
25 Priorities, August 15, 2001). This quotation is used to imply that it was considered
26 legitimate for the federal government to increase cost sharing in section 1115 waiver
27 projects. However, that quotation was merely a description of the federal policies that
28 had been recently announced (the Health Insurance Flexibility and Accountability or

1 HIFA waiver initiative, which was introduced by the Bush Administration in 2001)
2 toward cost-sharing in section 1115 waivers, not an assessment of whether these policies
3 are appropriate or legal. A true and correct copy of the complete report cited by the
4 federal defendant is attached as exhibit D.

5 22. In a later report, *Charging the Poor More*, I again describe current federal
6 policies regarding cost sharing and waivers, but also note that the federal agency might
7 not be following statutory criteria when it decides to approve waivers: “Under Section
8 1115 waivers, the federal government may permit states to modify these cost-sharing
9 rules. Although these modifications commonly apply to groups that become newly
10 eligible for coverage under the waiver (particularly individuals with incomes above the
11 poverty line), the Centers for Medicare and Medicaid Services (CMS) at the U.S.
12 Department of Health and Human Services (HHS) has been willing to let states modify
13 cost-sharing for those already eligible for benefits, particularly through HIFA waivers
14 which the Bush Administration introduced in 2001. In its HIFA waiver guidance, CMS
15 has not set a limit on total cost-sharing, except for a limit of five percent of family
16 income for children. Federal law establishes criteria concerning when CMS may waive
17 cost-sharing limits in Medicaid, but CMS has not necessarily followed these criteria in
18 approving waivers.”

19 **Arizona’s waiver will not provide meaningful research or**
20 **demonstration findings about copayments**

21 23. Central to the concept of section 1115 projects is that they are research and
22 demonstration projects that should serve a scientific purpose in testing the effects of a
23 new method of delivering benefits. Under this aegis, the Secretary of Health and Human
24 Services may waive certain federal rules that would otherwise pertain. Section 1115
25 projects are not intended to simply serve as a mechanism to waive or “get around” federal
26 rules for the convenience of either the state or the federal government. Despite this
27 underlying purpose of the section 1115 projects, my assessment is that neither the State
28

1 of Arizona nor the Centers for Medicare and Medicaid Services planned to make any
2 serious attempt to assess or research the effects of copayments under this project.

3 24. The research expectations that relate to waiving Medicaid cost sharing rules
4 are specified in the Medicaid statute. Under 42 USC §1396o(f), there are a number of
5 criteria that the Secretary of Health and Human Services must consider *in advance* to
6 determine whether to grant a waiver of cost-sharing rules that otherwise apply. The
7 purpose of these criteria is to ensure that cost sharing rules are waived only under
8 circumstances that would provide useful and scientifically sound research findings, which
9 are appropriate in the context of section 1115 research and demonstration projects. One
10 of the key criteria is that the Secretary determine that the project “test a unique and
11 previously untested use of copayments.” As this declaration indicates, there has been
12 ample research about the effects of copayments in Medicaid. The research
13 predominantly shows that copayments generally reduce the utilization of essential health
14 care services and of medications by low-income people. Some of the studies demonstrate
15 that there were adverse health consequences for those who were required to make
16 copayments. I am not aware of any “unique or untested” aspect of cost-sharing or
17 copayments that would be examined under this project; other states have imposed
18 copayments of a similar nature for the same services (prescription drugs, physician office
19 visits, non-emergency use of emergency rooms). Neither Arizona’s waiver application
20 nor the federal approval letter delineates any unique or untested uses of copayments in
21 this section 1115 project.

22 25. Similarly, 42 USC §1396o(f) also specifies that a waiver of cost sharing
23 rules should be granted only if the demonstration project is “based on a reasonable
24 hypothesis which the demonstration is designed to test in a methodologically sound
25 manner, including the use of control groups of similar recipients of medical assistance in
26 the area.” To an experienced researcher and one who teaches public policy research
27 methodology at the graduate level, it is clear that neither the state nor the Centers for
28 Medicare and Medicaid Services laid out a reasonable hypothesis or a sound

1 methodological plan to assess the effects of cost sharing in this project. They did not
2 establish a “control group,” that is, a group of similar people who would not be required
3 to make copayments, whose health care utilization or health status could be compared to
4 those required to make copayments. There is no evidence in the relevant federal or state
5 documents that any research design was planned, much less a methodologically sound
6 research design.

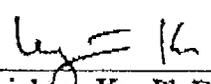
7 26. An additional requirement of 42 USC §1396o(f) is that the project must be
8 determined to be “voluntary or makes provision for assumption of liability for
9 preventable damage to the health of recipients of medical assistance resulting from
10 involuntary participation.” As I understand it, AHCCCS beneficiaries were not asked to
11 volunteer for copayments, not asked for informed consent and not given any protections
12 with respect to the assumption of liability for preventable damage in the event of
13 involuntary participation. I suppose that one might argue that AHCCCS is voluntary and
14 that no one is forced to join the program, but that once enrolled, a beneficiary must abide
15 by program rules including copayments. But such an argument would be flawed. Based
16 on the declarations of the plaintiffs in this case that I read, it appears that applicants were
17 not asked to voluntarily participate in a copayment project. My experience with the
18 Urban Institute’s Institutional Review Board concerning ethnical standards that apply to
19 research involving human subjects indicates that standards for voluntary and informed
20 consent *cannot* be met when the incentive for consenting to a research project or the
21 penalty for not consenting to it is so great that there is no reasonable alternative but to
22 consent. While people were not forced to join AHCCCS and abide by its copayment
23 policies, the penalty for not consenting would be to go without health insurance coverage.
24 Even if applicants knew about copayments in advance, they had no reasonable choice but
25 to accept the imposition of copayments as a condition of gaining health insurance
26 coverage; thus, they lacked a credible voluntary choice in this matter.

27 27. For the work I have performed on this case to date, I have requested no fee.
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I declare, pursuant to 28 U.S.C. § 1746, and under the penalty of perjury, that the foregoing is true and correct.

Executed this 6th day of March 2008.



Leighton Ku, Ph.D., M.P.H.

1 ORIGINAL of the foregoing electronically
2 filed with the Clerk of the Court this
3 10th day of March 2008.

4 COPY of the foregoing emailed via
5 Electronic Case Filing System this 10th
6 day of March 2008 to:

7 Logan Johnston
8 Johnston Law Office PLC
9 One North First Street, Suite 250
10 Phoenix, Arizona 85004-2359
11 Attorney for Defendant Rodgers

12 COPY of the foregoing mailed this
13 10th day of March 2008, to:

14 Vesper Mei
15 U. S. Department of Justice
16 Federal Programs Branch
17 Civil Division – Room 7316
18 20 Massachusetts Avenue, N.W.
19 Washington, D.C. 20001
20 Attorney for Defendant Leavitt

21 COPY of the foregoing mailed this 10th
22 day of March 2008, to:

23 Honorable Earl H. Carroll
24 United States Senior District Judge
25 United States District Court
26 District of Arizona
27 Sandra Day O'Connor U. S. Courthouse
28 401 West Washington Street, SPC 56, Suite 621
Phoenix, Arizona 85003-2156

By /s/ Gaynell Carpenter

EXHIBIT 3

TO

**OBJECTIONS TO ARIZONA'S
SECTION 1115 WAIVER AMENDMENT REQUEST
CONTINUING COVERAGE FOR CHILDLESS ADULTS
UNDER THE DEMONSTRATION**

EXHIBIT A
TO
SUPPLEMENTAL DECLARATION OF
DR. LEIGHTON KU
IN SUPPORT OF PLAINTIFFS'
MOTION FOR PRELIMINARY INJUNCTION

CURRICULUM VITAE

LEIGHTON KU

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Education

- 1990 Ph.D., Health Policy, Boston University (Pew Health Policy Fellow in a joint program of Boston University and Brandeis University)
- 1979 M.P.H., Public Health, University of California, Berkeley
- 1979 M.S., Nutritional Sciences, University of California, Berkeley
- 1975 A.B. (honors), Biochemistry, Harvard College

Professional Background

- 2008 - present Director, Center for Health Policy Research, The George Washington University
- 2008 - present Professor of Health Policy (with tenure), Department of Health Policy, School of Public Health and Health Services, The George Washington University
- 2000 - 2008 Senior Fellow, Center on Budget and Policy Priorities
- 1992 - present Adjunct Professor in Public Policy and Public Administration, Trachtenberg School of Public Policy and Administration, The George Washington University. Began as Associate Professorial Lecturer.
- 1990 - 2000 Principal Research Associate/Senior Research Associate/ Research Associate I, The Urban Institute.
- 1989 - 1990 Research Manager, SysteMetrics/McGraw-Hill
- 1987 - 1989 Pew Health Policy Fellow, Health Policy Institute, Boston University and the Heller School, Brandeis University
- 1980 - 1987 Program Analyst, Office of Analysis and Evaluation and Supplemental Food Programs Division, Food and Nutrition Service, U.S. Dept. of Agriculture

1975 - 1976 Registered Emergency Medical Technician, Dept. of Health and Hospitals,
Boston, MA

Selected Honors

Member, Executive Board, District of Columbia Health Benefits Exchange (2012) (The board will govern the new health insurance exchange for the District of Columbia, based on the Patient Protection and Affordable Care Act. This is based on nomination by the Mayor and approval by the City Council).

Commonwealth Fund, top ten most frequently downloaded reports (2006) .

Award for promoting racial and economic justice, Mississippi Center for Justice, 2005

Choice (the magazine of the American Library Association for academic publications), top ten academic books of the year (1994)

Pew Health Policy Fellow, Boston University and Brandeis University, 1987-1990.

Scholarly Publications

Publications Authored or Co-authored in Peer-Reviewed Journals

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Other Papers, Reports and Publications

Health Policy

[Note: All reports released by the Geiger Gibson/RCHN Community Health Foundation are available at www.gwumc.edu/sphhs/departments/healthpolicy. Reports noted with a [PR] went through a peer-review process prior to release.]

Ku, L., Regenstein, M., Shin, P., Mead, H., Levy, A., Buchanan, K., Byrne, F. "Coordinating and Integrating Care for Safety Net Patients: Lessons from Six Communities." George Washington University Dept. of Health Policy, May 21, 2012.

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Ku, L. "The Potential Impact of Health Reform on CDC's Cancer Screening Programs: Preliminary Results," Presented to NBCCEDP Federal Advisory Committee Meeting, Atlanta, GA, Jun. 17, 2011. (Similar presentations to the American Cancer Society, Sept. 2011.)

Ku, L. "Crystal Balls and Safety Nets: What Happens After Health Reform?" Presented at AcademyHealth, Seattle, WA, June 2011.

Ku, L. "'Strengthening Primary Care to Bend the Cost Curve: Using Research to Inform U.S. Policy," International Community Health Center Conference, Toronto, Canada, June 2011

Ku, L. "Integrating/Coordinating Care for Safety Net Providers: Issues and Local Examples," International Community Health Center Conference, Toronto, Canada, June 2011.

Ku, L. "Health Reform: Federal Implementation and More Unanswered Questions" Presented at American Society of Public Administration, Baltimore, MD, Mar. 14, 2011.

Ku, L. "Key Issues in the Confusing World of Health Reform," Presented to Industrial College of the Armed Forces, National Defense University, Washington, DC, Feb. 25, 2011.

Ku, L. "Reducing Disparities and Public Policy Conflicts," Institute of Medicine Workshop on Reducing Disparities in Life Expectancy, Washington, DC, Feb. 24, 2011.

Ku, L. "Primary Care, Hospitalizations and Health Reform," American Enterprise Institute Workshop, Washington, DC, Feb. 17, 2011.

Bruen, B., Ku, L., Buntin, M. and Burke, M. "Physicians' Eligibility for and Potential Use of Federal Incentive Payments for Electronic Health Records." WHITE Conference, First Annual Conference on HIT and Economics, Washington, DC. Oct. 8, 2010.

Ku, L. "The Promise and Perils of Health Policy for Asians in the United States," Invited keynote talk at 4th International Asian Health and Wellbeing Conference, Univ. of Auckland, New Zealand, NZ, July 6, 2010. Similar talk at symposium sponsored by the New Zealand Office of Ethnic Affairs, Wellington, NZ, July 8, 2010.

Ku, L., "Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform," Briefing for Senate and House staff and media, convened by Sen. Bernie Sanders (VT), Russell Senate Office Building, June 30, 2010.

Ku, L. "Ready, Set, Plan, Implement. Executing Medicaid's Expansion," *Health Affairs* Conference on

Health Reform, Washington, DC, June 8, 2010.

Ku, L. "Coordinating Care Among Safety Net Providers," Primary Care Forum, National Academy of State Health Policy, Alexandria, VA, June 2, 2010.

Ku, L. "Title VI: The Role of Culturally Competent Communication in Reducing Ethnic and Racial Health Care Disparities", National Minority AIDS Education and Training Center Spring Symposium, Howard Univ. May 29, 2010.

Ku, L. "American Health Reform as Massive Incrementalism," American Association for Budget and Program Analysis, Nov. 24, 2009.

Ku, L. "The Health Care Safety Net and Health Reform," National Academy of Public Administration, Conference on Health Care for the Future," Nov. 22, 2009.

Ku, L. "The Health of Latino Children," National Council of La Raza Symposium on Latino Children and Youth, Oct. 22, 2009.

Ku, L. "What the Obama Administration Will Mean for Child Health", AcademyHealth preconference session on Child Health, Chicago, IL June 2009.

Ku, L. "Immigrants and health reform," 6th Annual Immigration and Law Conference, Georgetown Univ. Law School, Migration Policy Institute and Catholic Legal Immigration Network, Washington, DC, June 24, 2009.

Ku, L. "From the Politics of No! to the Potential for Progress," invited keynote talk about immigrant policy and research to Society for Research in Child Development, Denver, CO, April 1, 2009.

Ku, L. "Strengthening the Primary Care Safety Net," National Association of Community Health Centers, Policy and Issues Conference, March 26, 2009.

Ku, L. "The Dial and the Dashboard: Assessing the Child Well-Being Index," Presentation to the Board of the Foundation for Child Development, March 3, 2009.

Ku, L. "Key Data Concerning Health Coverage for Legal Immigrant Children and Pregnant Women," invited presentation to Senate staff, Jan. 13, 2009.

Ku, L. "Comparing the Obama and McCain Health Plans," George Washington Univ. Medical School Alumni Conference, Sept. 27, 2008.

Ku, L. "The Future of Medicaid," Medicaid Congress, sponsored by Avalere Health and Health Affairs, Washington, DC, June 5, 2008.

Ku, L. "A Brief Appreciation of Health Advocates: Progress Made, Some Setbacks, Challenges Ahead," Public Interest Law Center of Philadelphia Conference, Philadelphia, PA, May 14, 2008.

Ku, L. "Financing Health Care Reform in New Jersey: Making Down Payments on Reform," Rutgers-AARP Conference, New Brunswick, NJ. Mar. 18, 2008

Ku, L., Perez, T. and Lillie-Blanton, M. "Immigration and Health Care-What Are the Issues," Kaiser Family Foundation HealthCast, webcast interview March 12, 2008.

Ku, L. "How Research Might Affect SCHIP Reauthorization," Child Health Services Research Meeting at AcademyHealth, Orlando, FL, June 2, 2007.

Ku, L. "Immigrant Children and SCHIP Reauthorization," Capital Hill Briefing conducted by the Population Resource Center, April 20, 2007.

Ku, L. "Health Policy and Think Tanks," Robert Wood Johnson Health Policy Fellows, Institute of Medicine, June 2006. Similar talk in other years.

Ku, L. "Medicaid Reform and Mental Health," National Alliance for the Mentally Ill, Annual Conference, Austin, TX, June 20, 2005.

Ku, L. "Cost-sharing in Medicaid and SCHIP: Research and Issues," National Association of State Medicaid Directors, Washington, DC, Nov. 18, 2004. Similar talk given to National Academy of State Health Policy, St. Louis, MO, Aug. 2, 2004.

Ku, L. "Coverage of Poverty-Level Aged and Disabled in Mississippi's Medicaid Program," Testimony to Mississippi Senate Public Health and Welfare Committee, Aug. 24, 2004

Ku, L. "Medicaid Managed Care Issues," Testimony to Georgia House of Representatives Appropriations Committee, March 2, 2004.

Ku, L. "Medi-Cal Budget Issues," Testimony to Joint Hearing of California Senate Budget and Health and Human Services Committees, Feb. 26, 2003.

Ku, L. "New Opportunities to Improve Health Care Access and Coverage," American College of Emergency Physicians, May 1, 2001.

Ku, L., "Medicaid DSH and UPL: Perplexing Issues," National Association of Public Hospitals Health Policy Fellows Conference, Washington, DC, Mar. 20, 2001.

Ku, L., "Insurance Coverage and Health Care Access for Immigrant Families," Testimony Before the U.S. Senate Finance Committee, Washington, DC, March 13, 2001.

Ku, L. "Increasing Health Insurance Coverage for Low-Income Families and Children," Insuring the Uninsured Project Conference, Sacramento, CA, Feb. 13, 2001.

Ku, L., "Concerning the Healthy Families Program Parent Expansion Proposal," Testimony Before a Joint Hearing of the California Senate Health and Human Services and Insurance Committees and Budget and Fiscal Review Subcommittee # 3, Sacramento, CA, January 30, 2001.

Ku, L., "Insurance Trends and Strategies for Covering the Uninsured," National Health Law Program Conference, Washington, DC, Dec. 3, 2000.

Ku, L., "Improving Health Care Access and Coverage: New Opportunities for States in 2001," Midwest Leadership Conference, Council of State Governments, Minneapolis, MN, August 6, 2000.

Ku, L., "Health Care for Immigrants: Recent Trends and Policy Issues," Alliance for Health Reform, Washington, DC, August 2, 2000. Similar talks in Miami at Florida Governor's Health Care Summit and in San Diego at California Program on Access to Care conference.

Ku, L. and Matani, S., "Immigrants' Access to Health Care and Insurance on the Cusp of Welfare Reform," presented at Association for Health Services Research Conference, Los Angeles, CA, June 25, 2000.

Ku, L. and Matani, S. "Immigrants and Health Care: Recent Trends and Issues," presented to the Association of Maternal and Child Health Programs meeting, Washington, DC, March 7, 2000.

Ku, L., Ellwood, M., Hoag, S., Ormond, B. and Wooldridge, J. "Building a Newer Mousetrap: the Evolution of Medicaid Managed Care Systems and Eligibility Expansions in Section 1115 Projects", presented at American Public Health Association meeting, Chicago, IL, Nov. 10, 1999.

Ku, L. "Young Men's Reproductive Health: Risk Behaviors and Medical Care", presented at D.C. Campaign to Prevent Teen Pregnancy Meeting, Washington, DC, Oct. 19, 1999.

Ku, L., "Medicaid and Welfare Reform: Recent Data," presented at Getting Kids Covered Conference, sponsored by National Institute for Health Care Management and Health Resources and Services Administration, Washington, DC, Oct. 6, 1999.

Ku, L. and Garrett, B., "How Welfare Reform and Economic Factors Affected Medicaid Participation," presented at Association for Health Services Research meeting, Chicago, IL, June 29, 1999.

"Recent Factors Affecting Young Men's Condom Use", presented to conference sponsored by National Campaign to Prevent Teen Pregnancy and Advocates for Youth, Washington, DC, February 1999.

"Medicaid, Welfare Reform and CHIP: The Growing Gulf of Eligibility Between Children and Adults", presented to National Association of Public Hospitals and Health Systems, Washington, DC, and to Generations United, Washington, DC, September 1998.

"Sliding Scale Premiums and Cost-Sharing: What the Research Shows" presented at workshop on CHIP: Implementing Effective Programs and Understanding Their Impacts, Agency for Health Care Policy and Research User Liaison Program, Sanibel Island, FL, June 30, 1998.

Ku, L., Sonenstein, F., Boggess, S., and Pleck, J. "Understanding Changes in Teenage Men's Sexual Activity: 1979 to 1995", presented at 1998 Population Association of America Meetings, Chicago, IL, April 4, 1998.

"Welfare Reform, Immigrants and Medicaid" presented at Annual Meeting of the Association of Maternal and Child Health Programs, Washington, DC, March 9, 1998. Similar talk presented at Association for Health Services Research Meeting, Washington, DC, June 23, 1998.

"Medicaid Policy and Data Issues: An Overview" presented to National Committee on Vital and Health Statistics, DHHS, September 29, 1997.

"How Welfare Reform Will Affect Medicaid Coverage" presented to National Ryan White Title IV Program Conference, Washington, DC, November 8, 1996.

Ku, L., Rajan, S., Wooldridge, J., Ellwood, M., Coughlin, T., and Dubay, L. "Using Section 1115 Demonstration Projects to Expand Medicaid Managed Care in Tennessee, Hawaii and Rhode Island", presented at Association of Public Policy and Management, Pittsburgh, Nov. 1, 1996.

"The Federal-State Partnership in Medicaid: Is Divorce Inevitable or Would Therapy Be Enough?" presented to Council of State Governments Conference on Managing the New Fiscal Federalism, Lexington, KY, May 10, 1996.

"The Male Role in the Prevention of Teen Pregnancy", presented to the Human Services Committee, National Council of State Legislatures, Washington, DC, May 9, 1996

"Implications of Converting Medicaid to a Block Grant with Budget Caps", presented to American Medical Association State Legislation Meeting, Aventura, FL, Jan. 1996 and to the American Psychiatric Association Public Policy Institute, Ft. Lauderdale, FL, March 1996.

"Medicaid: Program Under Reconstruction", presented at Speaker's Forum at New York City Council, September 12, 1995.

"State Health Reform Through Medicaid Section 1115 Waivers", presented at Pew Health Policy Conference, Chicago, IL, June 3, 1995.

"Setting Premiums for Participants in Subsidized Insurance Programs", presented at Conference on the Federal-State Partnership for State Health Reform, sponsored by HCFA, the National Academy of State Health Policy and RTI, March 15, 1995.

"Medicaid Disproportionate Share and Related Programs: A Fiscal Dilemma for the Federal Government and the States," with Teresa Coughlin, presented to the Kaiser Commission on the Future of Medicaid, November 13, 1994.

"Full Funding for WIC: A Policy Review," with Barbara Cohen and Nancy Pindus, presented at Dirksen Senate Office Building, Washington, DC, in a panel hosted by the Center on Budget and Policy Priorities, Bread for the World, the Food Research and Action Center and the National Association of WIC Directors, May 5, 1994.

"The Financing of Family Planning Services in the U.S.," presented at the Institute of Medicine, National Academy of Sciences on February 15, 1994 and at the American Public Health Association meeting, San Francisco, CA, October 25, 1993.

"Using SUDAAN to Adjust for Complex Survey Design in the National Survey of Adolescent Males," with John Marcotte and Karol Krotki, briefing at National Institute of Child Health and Human Development, Rockville, MD, April 2, 1992.

"The Association of HIV/AIDS Education with Sexual Behavior and Condom Use Among Teenage Men in the United States" with Freya Sonenstein and Joseph Pleck, presented at the Seventh International Conference on AIDS, Florence, Italy, June 1991.

"Patterns of HIV-Related Risk and Preventive Behaviors Among Teenage Men in the United States," with Freya Sonenstein and Joseph Pleck, paper presented at the Sixth International Conference on AIDS, San Francisco, CA, June 23, 1990.

"Trends in Teenage Childbearing, Pregnancy and Sexual Behavior," paper presented at the American Sociological Association Meeting, Washington, D.C., August 15, 1990.

"Research Designs to Assess the Effect of WIC Participation by Pregnant Women on Reducing Neonatal Medicaid Costs," briefing to Congressional staff, February 1987.

Testimony about the Special Supplemental Food Program for Women, Infants and Children (WIC), with Frank Sasinowski, presented to House Education and Labor Committee on behalf of the American Public Health Association, March 1983.

Media

Leighton Ku has extensive experience with electronic and print media. He has appeared on ABC, National Public Radio, CNN, PBS, Bloomberg TV, BBC and other television or radio news broadcasts and webcasts. He has been quoted in the *New York Times*, *Los Angeles Times*, *Washington Post*, *Wall Street Journal*, *USA Today*, *Christian Science Monitor*, *Politico*, trade publications (such as *Modern Health Care*, *Nation's Health* or *CQ HealthBeat*), etc. He has been an online contributor to the *Washington Post*. He has been a regular panelist on a radio talk show about health policy, broadcast on WMAL in the Washington DC region.

Other Service and Honors

National Institutes of Health, member of various grant review study sections (1996-1999, 2012).

Invited reviewer. Committee on National Statistics. National Academy of Sciences. Databases for Estimating Health Insurance Coverage for Children. 2010-1.

Grant reviewer. Robert Wood Johnson Public Health and Law program. 2010.

Invited reviewer, Institute of Medicine report on family planning services in the U.S., 2009.

External reviewer for faculty promotion and tenure for Univ. of California at Los Angeles, Portland State Univ., Baruch College, etc., 2008-present.

Commonwealth Fund, top ten most frequently downloaded reports (2006) for a report I co-authored with Donna Cohen Ross.

Award for promoting racial and economic justice, Mississippi Center for Justice, 2005

Submitted expert affidavits in federal, state and local lawsuits including: *Lozano v. City of Hazleton* (immigrant rights), *Spry, et al., v. Thompson* (Medicaid cost-sharing), *Dahl v. Goodno* (Medicaid cost-sharing), *Newton-Nations, et al., v. Rogers* (Medicaid cost-sharing) and *Alford v. County of San Diego* (cost-sharing for a local health program)

Board Member and Treasurer, Alliance for Fairness in Reforms to Medicaid (2002-2008)

Service award from the National WIC Directors Association (2002).

Urban Institute, founding member, Institutional Review Board (1997-2000)

National Health Research Institute (Taiwan's NIH) grant reviewer (1999).

Urban Institute, member, Diversity Task Force (1995)

Choice (the magazine of the American Library Association for academic publications), top ten academic books of the year (1994) for a book I co-authored with Teresa Coughlin and John Holahan.

Pew Health Policy Fellow, Boston University and Brandeis University, 1987-1990.

Professional Society Memberships and Service

AcademyHealth (formerly Association for Health Services Research)
American Public Health Association
Association of Public Policy and Management
Association for Public Policy Analysis and Management and AcademyHealth, Program Selection Committees (many years)

Editorial Peer Review Service

Associate editor, *BMC Health Services Research*, 2009 - present.

Reviewer for numerous journals, including *Health Affairs*, *New England Journal of Medicine*, *Inquiry*, *Medical Care*, *Journal of the American Medical Association*, *Pediatrics*, *American Journal of Public Health*, *HSR*, *Medicare and Medicaid Research Review*, *Family Planning Perspectives*, etc. (1990 to now)

Public Health Practice Portfolio

Member, Executive Board, District of Columbia Health Benefits Exchange (2012). The board governs the new health insurance exchange for the District. (Nominated by the Mayor and appointed by the City Council).

Member, Technical Advisory Group for the Design of the Evaluation of the Medicaid Expansion Under the ACA, sponsored by ASPE.

Member, National Workgroup on Integrating the Safety Net, National Academy of State Health Policy, July 2011 – now.

Member, National Advisory group for Iowa Safety Net Integration project, 2011-now.

Foundation for Child Development, Selection Committee, Young Scholars Program, 2008-present.

Foundation for Child Development, Advisory Committee, Child Well-Being Index, 2008-present

Member, National Advisory Board, Center on Social Disparities on Health, University of California at San Francisco, 2005-2008.

National Campaign to Prevent Teen Pregnancy, Member, Effective Programs and Research Task Force (2000)

EXHIBIT 4

TO

**OBJECTIONS TO ARIZONA'S
SECTION 1115 WAIVER AMENDMENT REQUEST
CONTINUING COVERAGE FOR CHILDLESS ADULTS
UNDER THE DEMONSTRATION**

1 ELLEN SUE KATZ, AZ Bar. No. 012214
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8
9 Attorneys for Plaintiffs

10 UNITED STATES DISTRICT COURT
11 DISTRICT OF ARIZONA

12 Flint Wood; Phonesagnam Silivongxay;)
13 Cynthia Roberts; and Flisha Mumaw, on)
behalf of themselves and all others)
14 similarly situated,)

15 Plaintiffs,

16 v.)

17 Thomas Betlach, Director of the Arizona)
Health Care Cost Containment System;)
18 and Kathleen Sebelius, Secretary of the)
United States Department of Health and)
19 Human Services, in their official)
capacities,)

20 Defendants.)
21)
22)

No. CIV 12-08098 PCT DGC

**SUPPLEMENTAL DECLARATION
OF DR. LEIGHTON KU IN SUPPORT
OF PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION**

23 I, Leighton Ku, declare as follows:

24 1. The matters stated in this declaration are given of my own personal
25 knowledge and, if called as a witness, I would truthfully and competently testify
26 consistent with the following.

27 2. I am a tenured Professor of Health Policy at the School of Public Health
28 and Health Services at George Washington University in Washington, D.C. I am also the

1 Director of the Center for Health Policy Research at the University, which includes more
2 than 50 researchers examining social, economic, legal and policy issues that affect
3 medical care and public health. My personal research focuses on assessment of public
4 policies on health care access and cost, trends in insurance coverage, health care for
5 immigrants, and federal and state budget concerns and their impact on health care. I have
6 conducted extensive research about the Medicaid program, including national and state
7 health reforms, Medicaid waivers, and the effects of welfare reform on Medicaid.

8 3. I am a nationally-recognized expert on cost-sharing and low-income
9 patients and have written research papers and lectured on this topic. I have been invited
10 to speak as an expert on this topic in briefings for Congressional staff, to the National
11 Academy of State Health Policy, to the National Association of State Medicaid Directors,
12 and to the Centers for Medicare and Medicaid Services. I have also taught research
13 methodology and statistics to graduate students for more than 20 years.

14 4. Before becoming a professor at George Washington University, I was a
15 Senior Fellow at the Center on Budget and Policy Priorities, a nonpartisan policy institute
16 that conducts research and analysis on a range of government policies and programs, with
17 an emphasis on those affecting low- and middle- income people. Before that, I was a
18 principal researcher at the Urban Institute, a nonprofit nonpartisan policy research
19 organization based in Washington, D.C. I authored and directed studies on how welfare
20 reform has affected Medicaid, health care coverage, and health care access for
21 immigrants. Particularly pertinent to this declaration, I was one of the principal evaluators
22 for several states' Medicaid section 1115 demonstration projects, under contract to the
23 Health Care Financing Administration (the prior name of the Centers for Medicare and
24 Medicaid Services) and authored or co-authored of a number of reports about section
25 1115 projects. Thus, I am familiar with both research and policy issues related to these
26 projects.

27 5. I am also familiar with the implementation of health care policies and
28 health reform. In recognition of my expertise in health policy issues, I have been

1 appointed a founding member of the Executive Board of the District of Columbia's
2 Health Benefit Exchange, the governing board for the health insurance exchange.

3 6. I received a Ph.D. in health policy from Boston University and a Masters in
4 Public Health from the University of California, Berkeley. My curriculum vitae is
5 attached as exhibit A, and includes a listing of my publications.

6 7. In March 2008 and August 2004, I authored affidavits related to research
7 about cost-sharing under Medicaid in the state of Arizona for the case *Newton-Nations v.*
8 *Rodgers*, which later became *McCants v. Betlach*. Portions of this affidavit reiterate and
9 update points made in earlier declarations. In this affidavit I particularly focus on the
10 approval of the waiver by the Centers for Medicare and Medicaid Services, their terms
11 and conditions for the waiver and the draft waiver evaluation plan that has been
12 submitted by the state.

13 **Review of research concerning copayments for low-income people**

14 8. I have written two reviews of the research literature about the effects of
15 medical cost-sharing for low-income people. On May 7, 2003, the Center on Budget and
16 Policy Priorities published a report that I authored, *Charging the Poor More for Health*
17 *Care: Cost-Sharing in Medicaid (Charging the Poor More)*. On July 7, 2005, the Center
18 released a report that I co-authored with Victoria Wachino, *The Effect of Increased Cost-*
19 *Sharing in Medicaid: A Summary of Research Findings* (in the administrative record at
20 pages 5914-24). A true and correct copy of the first report is attached as exhibit B.

21 9. I also recently completed new research about the effects of cost-sharing on
22 the use of preventive services for children and have included a copy of the manuscript at
23 exhibit C. This paper was presented at a professional conference, the Annual Research
24 Meeting of AcademyHealth on June 24, 2012 and has been submitted for publication in
25 *Pediatrics*, the peer-reviewed journal of the American Academy of Pediatrics.

26 10. In the two review papers, I provided comprehensive analyses of the
27 research to date, assessing the effects of cost sharing on low-income and poor
28 populations. Cost sharing occurs when insured individuals are required by the insurer to

1 pay for some of their health care coverage, for example, by paying a “copayment” each
2 time a health service is obtained or prescription is filled. (Most of the information
3 described below is documented in the reports, so I do not provide citations in this
4 declaration, since they are available in the reports.) In this declaration, I have added
5 some updated information from more recent studies and provide citations for the new
6 evidence.

7 11. Over the last 40 years, a number of studies have looked at the effects of
8 cost sharing on the poor, including the classic RAND Health Insurance Experiment,
9 considered one of the most important and rigorous studies to examine the effects of cost-
10 sharing. Of all forms of cost sharing, copayments are the most heavily studied. Three
11 conclusions can be drawn from this research: first, copayments keep many low-income
12 people from getting needed medical care or medications; second, low-income people
13 cannot always afford these copayments and must choose between them and other basic
14 necessities of life; and third, copayments are not an efficient Medicaid cost saving
15 measure for states.

16 12. These general observations are widely held in the field. For example, a
17 recent synthesis of research by Katherine Swartz, a professor at the Harvard School of
18 Public Health, also concluded: “Caution should be used when increasing cost-sharing for
19 low-income populations. Not only are low-income populations disproportionately
20 affected by increased cost-sharing, but they are more price sensitive than higher-income
21 groups. Unless the cost-sharing increases are concentrated on services that are ineffective
22 or unnecessary, low-income people may avoid necessary medical care and that in turn
23 could lead to greater spending on hospital care. In addition, as others have noted, higher
24 cost-sharing may lead to worse health outcomes for low-income people and could
25 increase disparities in health by income.” (Swartz, Katherine. “Cost-sharing: Effects on
26 Spending and Outcomes,” Robert Wood Johnson Foundation Synthesis Report No. 20,
27 Dec. 2010).

28 **The negative effects of copayments have been well-documented**

1 **in previous research.**

2 13. A substantial and rigorous body of research has consistently concluded that
3 low-income individuals are more vulnerable to the adverse effects of copayments than
4 other groups. Copayment policies that cause only modest reductions in health care use
5 among middle-class individuals can result in more substantial reductions in health care
6 use and lead to significant adverse health consequences among low-income individuals,
7 especially those with chronic health problems. For example, multiple studies have
8 concluded that higher copayments for medical services, including physician office visits,
9 or for prescription drugs cause low-income people to use substantially fewer essential and
10 effective medical services or medications.

11 14. Copayments have also been shown to lead to poorer health among low-
12 income adults, including worse blood pressure and vision, than among those not subject
13 to copayments. One large, recent study in Quebec found that after copayments for
14 prescription drugs were imposed, poor adults had 88 percent more emergency room visits
15 and experienced a 78 percent increase in medical events like hospitalization or
16 institutionalization as a result of problems experienced when these low-income people
17 went without essential medication. Still other studies have demonstrated the difficulties
18 that Medicaid beneficiaries encounter in accessing medical services when they are being
19 assessed copayments. For example, in a study of Medicaid beneficiaries in Tennessee (in
20 which copayments were elevated under a section 1115 waiver), 20 percent of the patients
21 said they were not able to pay the copayment at the time of a doctor's office visit and 22
22 percent could not pay the prescription drug copayment. Most of those unable to afford
23 the drug copayment went without the medication.

24 15. A particularly important (and methodologically rigorous) study examined
25 the effects of copayments for low-income Medicaid adult beneficiaries participating in a
26 Medicaid Section 1115 waiver program in Oregon, which included copayments of \$5 for
27 physician services, \$2 to \$15 for prescription drugs in 2003, \$5 to \$20 for hospital
28 outpatient services, etc. It compared the experiences of Medicaid beneficiaries eligible

1 under the waiver program with those eligible under traditional welfare-related
2 (Temporary Assistance to Needy Families or TANF) criteria. The researchers found that
3 the copayments led to reductions in prescription drug and office-based physician care, but
4 increases in outpatient and inpatient hospital care. That is, higher copayments under the
5 waiver led patients to reduce their use of routine medication and medical care use, but
6 this ultimately led to greater use of more expensive hospital services instead. The net
7 effect was that Medicaid expenditures appeared to increase, although the increase was not
8 statistically significant. (Wallace, N., McConnell, K.J., Gallia, C, Smith, J. "How
9 Effective Are Copayments in Reduction Expenditures for Low-income Adult Medicaid
10 Beneficiaries? Experience from the Oregon Health Plan," HSR: Health Services
11 Research, 43(2): 515-30, April 2008.) It is worth noting that most of the adults affected
12 by the copayments were childless adults: 79 percent were single adults and 21 percent
13 were couples (some of whom may have been couples without children). (Wallace, N.,
14 McConnell, K.J., Gallia, C, Edlund, T. "Benefit Policy and Disenrollment of Adult
15 Medicaid Beneficiaries from the Oregon Health Plan," Journal of Health Care for the
16 Poor and Underserved, 21: 1382-94, 2010 and personal communication from Prof. Neal
17 Wallace of Portland State University, October 21, 2011.)

18 16. The effects can be even more profound when low-income beneficiaries
19 have severe diseases. A new study examined the consequences of copayments for
20 Medicaid patients who had cancer. It compared adult patients in Georgia, which
21 instituted Medicaid copayments in 2003, versus similar patients in South Carolina and
22 Texas, which lacked copayments. After copayments were raised, Georgia cancer
23 patients' use of prescription drugs went down, but their emergency room visits increased
24 and total Medicaid expenditures in the six months after cancer diagnosis rose by more
25 than \$5,000, substantially more than in the two states without controls. Copayments
26 reduced patients' ability to afford medications, which led to medical complications and
27 higher expenditures. (Subramanian, S. "Impact of Medicaid Copayments on Patients
28

1 with Cancer: Lessons for Medicaid Expansion Under Health Reform,” Medical Care,
2 49(9):842-7, Sept. 2011).

3 17. The declarations filed by Flint Wood, Phonesagnam Silivongxay, Cynthia
4 Roberts and Flisha Mumaw all demonstrate the health-threatening hardships imposed by
5 copayments under the Arizona Health Care Cost Containment System on adults with
6 serious chronic diseases.

7 18. Another study examined whether copayments reduce Medicaid
8 beneficiaries’ use of care at emergency departments (EDs) for non-emergency conditions
9 (e.g., care that could be provided on a non-emergency basis in a setting like a doctor’s
10 office, as opposed to the ED). This study compared non-emergency use at EDs by
11 Medicaid patients in states that assessed copayments for non-emergency use with those in
12 states without such copayments. It examined data from 2001-2006 from the nationally
13 representative Medical Expenditure Panel Survey. Briefly, the study found that the
14 copayments had no statistically significant effect on the level of non-emergency ED
15 visits, on emergency ED visits or on ED visits in general. That is, the copayments failed
16 to reduce non-emergency use of EDs and had no discernible impact on ED use in general.
17 (Mortensen, K. “Copayments Did Not Reduce Medicaid Enrollees’ Nonemergency Use
18 of Emergency Departments, Health Affairs, 29(9): 1643-50, Sept. 2010.) A likely
19 explanation for this lies in understanding the difference between what physicians
20 consider an emergency and a patient considers an emergency.

21 19. A more rigorous study of the effects of ED copayments for “unnecessary
22 care” was presented last month at the Annual Research Meeting of Academy Health by
23 Dr. David Becker of the University of Alabama at Birmingham. The study used
24 clinically defined measures of the severity of conditions receiving treatment in EDs and
25 concluded that “Overall, [there is] no evidence that co-pays lead to more efficient use of
26 ED care.” They found very small declines in overall ED use following a co-payment
27 increase, but those reductions were similar for the least severe to the most severe
28 conditions, indicating that at least some people with very severe health problems avoided

1 EDs when copays rose. That is, imposing higher copayments for “unnecessary ED use”
2 also adversely affected those with very severe needs for emergency care. (Becker, D.,
3 Blackburn, J., et al. “Copayments and the Use of Emergency Department Services in the
4 Children’s Health Insurance Program,” presented at Academy Health Annual Research
5 Meeting, June 24, 2012.)

6 **Low-income people forced to choose between health care and other necessities.**

7 20. As documented in Charging the Poor More and The Effect of Increased
8 Cost-sharing in Medicaid, there is an accumulated and consistent body of research
9 concluding that low-income people cannot financially bear copayments as easily as those
10 with higher incomes. This is because low income people are in a different economic
11 position. Data show that Medicaid beneficiaries already have substantial out-of-pocket
12 medical care expenditures. On average, Medicaid beneficiaries pay a larger share of their
13 incomes in out-of-pocket medical expenses than do higher-income individuals with
14 private insurance. Increases in Medicaid copayments would exacerbate their financial
15 burdens.

16 21. Research by Thomas Selden of the federal Agency for Healthcare Research
17 and Quality found that “Medicaid cost-sharing adds to families’ financial hardship,
18 forcing difficult choices between health care and other basic necessities.” (Selden, T.,
19 Kenney, G. Pantell, M. and Ruther, J. “Cost Sharing in Medicaid and CHIP: How Does
20 It Affect Out of Pocket Spending?” Health Affairs, 28(4): 607-19, June 2009.)

21 22. Low-income families must also stretch their incomes to meet competing
22 demands for rent, child care, and other expenses. Research indicates that, despite the
23 presence of programs like food stamps, poor families often have difficulties meeting
24 basic needs. In many areas, rising housing costs are claiming an increasing share of poor
25 families’ incomes. Studies show that those with incomes below the poverty line already
26 experience hardships, such as running out of food or having difficulty paying rent or
27 utility bills. Elevated copayments for low-income people force many of them to choose
28 between health care and other basic needs.

1 23. Instituting or increasing copayments is not an efficient way for states to
2 lower their expenditures for Medicaid. As noted above, research often shows that,
3 paradoxically, copayments lead to higher Medicaid costs because people skimp on basic,
4 routine medical care like medications or routine medical visits, but end up sicker and
5 incur higher hospital expenditures.

6 **Arizona's waiver will not provide meaningful research or**
7 **demonstration findings about copayments.**

8 24. Central to the concept of Medicaid section 1115 projects is that they are
9 research and demonstration projects that should serve a scientific purpose in testing the
10 effects of a new method of delivering benefits. Under this aegis, the Secretary of Health
11 and Human Services may waive certain federal rules that would otherwise pertain.
12 Section 1115 projects are not intended to simply serve as a mechanism to waive or "get
13 around" federal rules for the convenience of either the state or the federal government.
14 Despite this underlying purpose of the section 1115 projects, my assessment is that
15 neither the State of Arizona nor the Centers for Medicare and Medicaid Services have
16 planned serious attempts to research new or novel approaches to deliver care with respect
17 to cost-sharing that would offer meaningful information about the effects of cost-sharing.

18 25. The opinion from the United States Court of Appeals for the Ninth Circuit
19 regarding *McCants v. Betlach* specified three tests that the Secretary of Health and
20 Human Services must meet in granting Section 1115 demonstration waivers, based on an
21 earlier analysis in the case *Beno v. Shalala*: "First whether the project is an
22 "Experimental, Pilot or Demonstration Project." Second, whether the project is "Likely
23 to Assist in Promoting the Objectives of the Act." Third, "the extent and period" for
24 which she finds the project necessary." This indicates that a valid Section 1115
25 demonstration project should be designed to yield meaningful and valid information that
26 could be used to help improve the Medicaid program on a broader basis; it should be
27 more than information that is "nice to know."

28

1 26. As this declaration indicates, there has been ample research about the
2 effects of copayments in Medicaid. The research overwhelmingly shows that
3 copayments generally reduce the utilization of essential health care services and of
4 medications by low-income people.

5 27. In its approval, dated October 21, 2011, the Centers for Medicare and
6 Medicaid Services approves "Authority to impose co-payments on the childless adult
7 population as permitted under the expiring Demonstration, subject to matters still under
8 discussion and the State's forthcoming evaluation of the Demonstration." This issue has
9 been studied repeatedly over the past 40 years and more recent examples, such as the
10 study in Oregon mentioned in paragraph 15 involved low-income childless adults under
11 circumstances that are directly parallel to those in Arizona. Moreover, the state of
12 Arizona has been imposing copayment for childless adults since October 2010 and could
13 already have evaluated this. There do not appear to be any reasonable research insights
14 that would be gained under this project that have not already been studied elsewhere
15 repeatedly.

16 28. The Centers for Medicare and Medicaid Services also approved a \$4
17 copayment for non-emergency Medicaid transportation. The previous research (and
18 basic logic) would indicate that this would also reduce the use of these important
19 services. For example, a study in Georgia and Kentucky assessed the impact of Medicaid
20 transportation services and found that they were associated with reduced levels of
21 hospital use for children with asthma and for adults with diabetes. (Kim, J., Norton, E.,
22 Stearns, S. "Transportation Brokerage Services and Medicaid Beneficiaries' Access to
23 Care," *HSR: Health Services Research*. 44(1): 145-61, Feb. 2009.)

24 29. I am not aware of any prior research about imposing a fee for missed
25 appointments, so could imagine that a demonstration of this concept may yield useful
26 information, but fail to understand the merits of further testing of the other policies as
27 evidence of an "experimental, pilot or demonstration" project which could be useful for
28 assessment of future Medicaid policies.

1 30. On page 26-27 of the Centers for Medicare and Medicaid Services
2 document entitled “Special Terms and Conditions,” the federal agency lays out a general
3 framework for evaluating the cost-sharing for childless adults. But virtually all of these
4 items have been tested in other circumstances repeatedly. Moreover, given that the state
5 of Arizona was presumably responsible for evaluating cost-sharing under its previous
6 waiver and did very little, it is not clear why the federal agency would approve this in
7 advance. The document refers to quarterly and annual reports about the progress of the
8 evaluation, but does not specify a due date for a report, nor does it explain how it would
9 determine whether to continue to waiver of cost-sharing requirements after a report is
10 submitted.

11 **The state’s actual evaluation plan does not appear to correspond**
12 **to requirements under the Special Terms and Conditions.**

13 31. In the Special Terms and Conditions, CMS specified certain criteria for the
14 evaluations to be conducted by the state of Arizona. Under VII(c) and VII(d) (pages 26
15 and 27), CMS said Arizona must conduct “independent” evaluations. As I examine the
16 draft evaluation plan submitted by the state on June 19, 2012, it is not clear who is
17 conducting the evaluation or whether they are independent. For example, if state staff or
18 the regular data processing contractor for the state are doing the evaluation, I fail to see
19 how the evaluation is “independent.” An independent evaluation would require an
20 evaluator who is free to conclude that the state did or did not meet its objectives.

21 32. Under VII(c)(i) CMS specifies that the state evaluate how “needed
22 preventive, primary care and treatment services will be utilized for childless adults
23 subject to the copayment requirements. Under the state’s evaluation plan (pg. 53), the
24 state proposes to compare pre-copay implementation (Oct. 1, 2008-Sept. 30, 2009)
25 “office visit utilization rates” vs. post-copay (Oct. 1, 2011-Sept. 30, 2012) “office visit
26 utilization rates.” Presumably the state would interpret the difference as the impact of
27 copayments. A basic reading of the CMS requirement would indicate that the
28 independent evaluation would need to assess the effect on “necessary” (as compared to

1 unnecessary) preventive visits, necessary primary care visits and necessary treatment
2 visits. It does not appear that the state's measure of office utilization rates will examine
3 necessary visits (nor how it will evaluate whether a visit is necessary vs. unnecessary,
4 although criteria to separate these are available), nor whether the visits are for preventive,
5 primary care or treatment office-based services. An important conclusion from prior
6 research was that high copays lead to reductions in "necessary" medical care as well as
7 "unnecessary" care, but the state does not appear to be making any such differentiation.

8 33. CMS' criteria in VII(c) also asks the state to examine control of chronic
9 conditions, such as asthma and diabetes. The state's evaluation plan (pg 53 and 54) says
10 it will examine the effect of drug copays on appropriate use of medications for those
11 diagnosed with diabetes by examining hemoglobin A1c (a measure of how well diabetes
12 is being controlled) and LDL (low density lipoprotein cholesterol, a measure of risk of
13 coronary heart disease) before and after the copays were implemented and similarly
14 assess the effects of prescription copays by checking long-term control of asthma for
15 those who are asthmatic. I believe that most medical experts would agree that
16 hypertension (high blood pressure) is a more common chronic disease for adults than
17 asthma that should also be measured and that control of hypertension is also a critical
18 measure of control for diabetics, since hypertension, as well as high cholesterol, are
19 common problems for adult diabetics. In particular, the classic RAND experiment found
20 serious problems in the control of hypertension when copays were required of low-
21 income people.

22 34. Section VII(c)(ii) of the Terms and Conditions requires the state to evaluate
23 the impact of copayments on non-emergent use of emergency departments and
24 appropriate utilization of generic and brand name prescription drugs. The state's
25 evaluation plan simply says it will examine pre-copay vs. post-copay ER utilization rates,
26 but does not differentiate the impact of non-emergent conditions vs. more serious
27 conditions, nor does it specify how it will define non-emergent vs. more serious
28 conditions. Again, the failure of copayments to differentiate between less and more

1 severe conditions has been an important focus of prior research on this topic. The state's
2 evaluation design also does not appear to be able to differentiate the effects of pharmacy
3 copayments vs. ED copayments, since they were imposed at the same time. Equally
4 important, it does not at all address the "appropriate" utilization of generic and brand
5 name prescription drugs and does not propose to analyze the actual use of prescription
6 drugs by Medicaid beneficiaries at all.

7 35. Sections VII(c)(iii) and (iv) of the terms and conditions require the state to
8 evaluate the impact of copayments on state and federal expenditures in the short and long
9 term and on the willingness of physicians to accept appointments from childless adults.
10 As far as I could see, the state evaluation plan did not address these topics.

11 36. Section VII(c) (page 27) require the state to evaluate how the non-
12 emergency transportation copayments affects access for childless adults in Maricopa and
13 Pima Counties vs. all other counties in the state. The state evaluation plan does not
14 address the differential effects across counties and simply says it will compare office visit
15 utilization rates before and after copayments were imposed and does not indicate whether
16 it will examine differential effects across counties nor whether it will examine the rate of
17 use of non-emergency medical transportation at all.

18 37. The one actual area where Arizona is testing a concept for which I am not
19 aware of prior research that corresponds to the criteria established by the statute or by the
20 decision of the Court of Appeals concerns the effect of missed appointment fees. The
21 terms and conditions established by CMS are quite detailed in this area. In addition to
22 requiring an "independent" evaluation, CMS required the state to assess the impact of the
23 missed appointment fees on: "(i) reducing the number of missed appointments, (ii)
24 Beneficiaries seeking more care from walk-in clinics, urgent care centers or emergency
25 rooms and any resulting impact on costs, (iii) denial of service as a result of the fee, (iv)
26 subgroups within the adults without dependent children population, i.e., were there
27 variations by income level, age, gender, etc., (v) program integrity, (vi) compliance with
28 the provisions for missed appointments in STC 17(e), (vii) administrative feasibility and

1 cost to the provider, and (viii) the rate of missed appointment fees by provider type and
2 region of the state.”

3 38. The state’s evaluation plan in this area (pg. 56-58) is astonishingly
4 deficient. It says it will simply examine pre-fee vs. post-fee “ER utilization rate” and
5 “office visit utilization.” It fails to actually measure the level of missed appointments, the
6 extent to which patients may have shifted care to other sorts of settings such as walk-in
7 clinics or urgent care centers, the actual denial of service, subgroups of the population,
8 compliance with the provisions for missed appointments laid out in the special terms and
9 conditions, the administrative feasibility and costs to providers and the actual rate of
10 missed appointment fees assessed or collected by provider type or region.

11 39. Given that this waiver authority expires January 1, 2013 and the state must
12 submit the evaluation before that date, I fail to see how the state can possibly meet these
13 criteria on a timely basis at this point in time, particularly given the time frames needed
14 for CMS review and approval.

15 **Flaws in Arizona’s evaluation plan will render the findings almost useless.**

16 40. The severe deficiencies of the state’s evaluation design become clearer
17 when one realizes that the state claims it can use the same data to evaluate the different
18 effects of three different policies. In order to assess the impact of copays on childless
19 adults, it will compare pre-copay (Oct. 1, 2008-Sept. 30, 2009) to post-copay (Oct. 1,
20 2011- Sept. 30, 2012) office utilization rates. But it also says these same data from the
21 same period will evaluate the effect of non-emergency medical transportation copays. To
22 assess the missed appointment fees, it will also compare office utilization rates from Oct.
23 1, 2008-Sept. 30, 2009) and Oct. 1, 2011-Sept. 30, 2012. Since the same data would be
24 used to test three different hypotheses, the evaluation design would not be able to
25 differentiate between the effect of higher office visit copays, non-emergency medical
26 transportation copays and the missed appointment fees. To the extent that the purpose of
27 the demonstration project and the waiver is to assess the effects of different policies, the
28 evaluation design would be unable to tell which policy affected which outcome,

1 invalidating the purpose of the evaluation. A parallel is to imagine a grocery store that is
2 trying to test, all at the same time, the effects of special sales coupons, changes in
3 shopping cart size and the presence of pleasing background music, on consumers'
4 shopping behaviors simply by looking at changes in average grocery expenditures per
5 customer in Time A vs. Time B. Even if you observed a \$3 difference in average grocery
6 bills, you would not be able to determine whether the change was due to the sales
7 coupons, shopping cart size or background music. The weak evaluation design would not
8 produce useful findings.

9 41. In a similar fashion, the state proposes to compare emergency room
10 utilization rates from Oct. 1, 2008-Sept. 30, 2009 to Oct. 1, 2011-Sept. 30, 2012 to
11 measure the effects of both ER copays and missed appointment fees. The evaluation
12 design would not be able to disentangle the effects of different policies, rendering the
13 information useless.

14 42. A final comment on the evaluation design. As a research methodology
15 expert, the comparison of pre- and post-implementation status proposed by the state is a
16 very weak design. It assumes that the entire difference in utilization between one period
17 and the next is due to the policies that are being tested. As I noted above, since the pre-
18 and post-fee periods and the pre- and post-copay periods are the same and the measures
19 of utilization are the same, the state would not be able to differentiate the effects in any
20 meaningful way. Moreover, it assumes nothing else of any consequence changed from
21 Oct. 2008 to Sept 2009 and Oct. 2011 to Sept. 2012. But we know that is not true. The
22 unemployment rate has been falling in Arizona and the foreclosure rate is also changing.
23 The enactment and subsequent debate about Arizona's SB 1070 legislation appears to
24 have had effects on the behaviors of the Hispanic population in Arizona. These may
25 change the health behavior of low-income Arizonans. A more rigorous researcher would
26 use more sophisticated statistical analysis to control for differences that might be related
27 to race or ethnicity, age of enrollees, income levels and so on. This could lead to more
28 valid estimates of the effects. Going back to the grocery store example in paragraph 40,

1 it is possible that grocery expenditures rose by \$3 between the two periods simply
2 because of inflation, not because of changes in grocery store operations that were tested;
3 a stronger analysis would adjust for inflation. Arizona's evaluation plan does not appear
4 to have more sophisticated elements that would provide more valid findings.

5 43. In conclusion, the evaluation plan that has been submitted by the state does
6 not appear to fulfill the conditions established by the federal government in the terms and
7 conditions. Moreover, and perhaps more important, the weakness in the design and in the
8 measures being proposed by the state would render the information from this evaluation
9 almost inconsequential from the perspective of understanding the effects of copayments
10 or missed appointment fees on the use of health care services by low-income
11 beneficiaries in Arizona. Thus, the evaluation will not provide meaningful understanding
12 of the effects of the policies being tested on the basis of being an "experimental,
13 demonstration or pilot" project which might help understand broader national policies.

14 **Final Attestations**

15 44. For the work I have performed on this case to date, I have requested no fee.
16 I declare, pursuant to 28 U.S.C. § 1746, and under the penalty of perjury, that the
17 foregoing is true and correct.

18 Executed this 11th day of July, 2012, at Washington, D.C.

19
20
21
22 
23 _____
Leighton Ku, Ph.D., M.P.H.

EXHIBIT 5

TO

**OBJECTIONS TO ARIZONA'S
SECTION 1115 WAIVER AMENDMENT REQUEST
CONTINUING COVERAGE FOR CHILDLESS ADULTS
UNDER THE DEMONSTRATION**

1 Logan T. Johnston, Bar No. 009484
JOHNSTON LAW OFFICES, P.L.C.
2 One N. 1st Street, Suite 250
Phoenix, AZ 85004
3 (602) 452-0615
Attorneys for Defendants Rodgers and AHCCCS

4
5 **IN THE UNITED STATES DISTRICT COURT**
6 **FOR THE DISTRICT OF ARIZONA**

7 SHARON NEWTON-NATIONS, MANUELA) No. CV 03-2506 PHX EHC
8 GONZALEZ, CHERYL BILBREY, DONALD)
9 MCCANTS, HECTOR MARTINEZ, ANNE)
10 GARRISON, DAWN HOUSE, DANA)
FRANKLIN, EDWARD BONNER, D.H., JACK)
11 BAUMHARDT, MANUEL ESPARZA, AND)
PATRICIA JONES, on behalf of themselves)
and all others similarly situated,)

**DEFENDANT RODGERS'
ANSWERS TO PLAINTIFF'S
INTERROGATORIES**

12 Plaintiffs,

13 v.

14 ANTHONY RODGERS, Director of the)
Arizona Health Care Cost Containment)
15 System, and TOMMY THOMPSON, Secretary)
of the United States Department of Health)
16 and Human Services, in their official)
capacities,)

17 Defendants.

18
19
20 Pursuant to Federal Rule of Civil Procedure 33, Defendant Anthony Rodgers, by
21 and through the undersigned, provides the following answers to Plaintiff's
22 Interrogatories:

23 Interrogatory No. 1

- 24 I. For each of Plaintiffs' First Set of Non-Uniform Interrogatories, identify each
25 person answering and/or providing information, including all persons

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January 2000 to March 2001
Budget Control Development Specialist III
Division of Business & Finance
701 East Jefferson, Phoenix, Arizona 85034

Dawn Tibbs

April 2001 to Present
Financial Consultant, Division of Health Care Management
701 East Jefferson, Phoenix, Arizona 85034

Jennifer Vehonsky

December 2003 to Present
Administrative Services Officer II, Office of Intergovernmental
Relations
801 East Jefferson, Phoenix, Arizona 85034

Interrogatory No. 2

- 2. Explain each reason that supports Defendant's contention in his Answer to Complaint that the Medicaid notice and hearing rights, set forth in 42 U.S.C. 1396a(a)(3) and 42 C.F.R. §431.200 et seq., do not apply in this case. For each reason, state the following:
 - (a) each fact that supports the reason; and for each fact state the following:
 - (i) identify each person who has knowledge of the fact; and
 - (ii) identify all documents that support the fact.

Answer

Prior to the implementation of the copayments at issue in this case, the AHCCCS Administration provided notice to all eligible persons affected by the implementation. A copy of that notice is provided in response to the request for production of documents. The implementation of the copayments at issue in this case did not give rise to hearing rights because the action taken arose from a change in State law requiring an automatic change affecting some or all recipients. See 42 CFR § 431.220(b).

Interrogatory No. 3

- 3. Please describe the process that AHCCCS adopted and/or implemented for adjusting capitation rates to health plans to reflect the collection of copayments at issue in this case.

Answer

The copayments in question only impacted our Title XIX Waiver Group rates. The language below is from the AHCCCS CYE 04 (Year XXII) Capitation Rate Methodology letter prepared for AHCCCS by Mercer, Government Human Services Consulting. Mercer is an actuarial firm that assists AHCCCS with capitation rate development. The

1 population referred to below is the Title XIX Waiver Group (TWG) and the methodology
2 described resulted in a reduction to the capitation rates.

3 "A recent change will subject this population to greater cost sharing arrangements in
4 CYE04. It is Mercer's understanding that for the TWG population, medically necessary
5 services can be denied for failure to make a co-pay. To account for this, Mercer made
6 adjustments to both the net unit costs for the affected categories of service and the
7 utilization rates for the categories of service impacted by these cost sharing
8 arrangements.

9 Based on a March 2003, Kaiser Commission study on the impact of cost sharing on
10 Medicaid and the uninsured, Mercer assumed lower utilization rates for the services to
11 which co-pays applied, and increased the assumed utilization of inpatient hospital and
12 emergency room services. The Kaiser study, as well as several others, showed that
13 when cost sharing is applied to a population like the TWG, people will tend to forgo
14 seeing their physician and having their prescriptions filled. Use of the hospital and
15 emergency services will increase because the use of preventative services has
16 decreased."

17 Interrogatory No. 4

- 18 4. Please describe how the collection of copayments is accounted for in the
19 AHCCCS budget process. State specifically whether the collection of
20 copayments is reflected as administrative savings to the AHCCCS program.
21 If the answer is other than an unqualified "yes," explain in detail how the
22 copayments are reflected in the program budget.

23 Answer

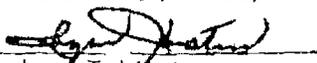
24 The collection of copayments is not accounted for in the AHCCCS budget process.
25 Copayments are reflected as a reduction in the per member capitation rate (CMS
approved per BBA) paid to participating health plans. Additionally, the appropriation
passed by the legislature, identified amounts related to co-payments as an adjustment
to the prior year's appropriated amount for specific programs and line items. An
example is in the Acute Care program, the capitation line item appropriated amount is
based on actuarial assessments by each rate code, of medical services utilization and
costs incurred with adjustments for various items/issues such as enrollment growth
medical inflation and other items including co-payment amounts charged to qualifying
members. Copayment collections are not specifically recorded as an accounting
transaction to reflect savings to the AHCCCS program. However, the FY 2004 JLBC
Appropriations report reflects amounts for specific programs or line items that represent
adjustments to the prior fiscal year appropriation for increasing copayments and/or
increasing or implementing premiums and or enrollment fees.

1 I swear under oath that the answers provided have been reviewed by the persons
2 indicated in the answer to the first interrogatory, and that I have ascertained that the
3 answers provided herein are true and correct.

4 
5 Matthew J. Devlin

6 Dated this 10th day of August, 2004.

7 RESPECTFULLY SUBMITTED this 10 day of August, 2004.

8 JOHNSTON LAW OFFICES, P.L.C.
9 By 
10 Logan T. Johnston
11 One N. 1st Street, Suite 250
12 Phoenix, AZ 85004
13 Attorney for Defendants Rodgers
14 and AHCCCS

15 ORIGINAL mailed this ___
16 day of August, 2004 to:
17 Ellen Sue Katz
18 William E. Morris Institute for Justice
19 202 East McDowell, Suite 257
20 Phoenix, Arizona 85004

21 COPIES mailed this ___
22 day of August, 2004 to:
23 Diane Kelleher
24 U.S. Department of Justice
25 Civil Division
Federal Programs Branch
202 Massachusetts Avenue, NW
Room 7308
Washington, DC 20001

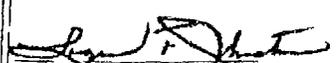
26 
27 vjv/vvvv/interrogatory.doc

EXHIBIT 6

TO

**OBJECTIONS TO ARIZONA'S
SECTION 1115 WAIVER AMENDMENT REQUEST
CONTINUING COVERAGE FOR CHILDLESS ADULTS
UNDER THE DEMONSTRATION**

Lindley, Robert

From: Coury, Monica
Sent: Wednesday, February 21, 2007 9:33 AM
To: Lindley, Robert
Subject: FW: Cost Sharing Proposals

Follow Up Flag: Follow up
Flag Status: Completed

Maybe you should attend...

From: Betlach, Tom
Sent: Wednesday, February 21, 2007 9:23 AM
To: Rodgers, Anthony - AHCCCS Director; Coury, Monica; Hott, Jennifer
Subject: RE: Cost Sharing Proposals

Those are very good arguments - another is that putting the infrastructure in place over all our plans and all the exceptions required by CMS is difficult - if we are forced to do cost sharing the easiest and cheapest method is premiums

From: Rodgers, Anthony - AHCCCS Director
Sent: Wednesday, February 21, 2007 9:18 AM
To: Betlach, Tom; Coury, Monica; Hott, Jennifer
Subject: Cost Sharing Proposals

Regarding legislative proposals on cost sharing (I assume co-payments or coinsurance type cost sharing).

Cost sharing works against the notion of managed care. Cost sharing is imposed to change beneficiary behavior or to make the beneficiary financially responsible for the service choices "they" make (like overuse the emergency room). PPO or open network health plans use cost sharing because they don't medically manage the members. If you are going to put co-payments and co-insurance on AHCCCS MCO members it will work against the health plans medical management programs. The reason that AHCCCS has one of the lowest PMPM of all state Medicaid programs is our managed care model. Health plan manage the utilization of members better than any cost sharing program would do. Cost sharing is for States that don't have Medicaid managed care.

Anthony D. Rodgers
Director
AHCCCS
(602) 417-4711
Anthony.Rodgers@azahcccs.gov
www.ahcccs.state.az.us

128 "I Support AHCCCS Efforts" Petitions
(Attached to Crossroads Mission letter 10/18/12)

URGENT AHCCCS UPDATE

Please restore the Health Care coverage for childless adults. Study show up to 1 quarter of a million adults has or will lose health coverage by January 2014. This is a major Health Crisis. AHCCCS is seeking a waiver from the Federal Government to restore these funds and is asking an increase. I Support AHCCCS' Efforts!

Raelee Cornelius

10/15/12

Staff Member Name

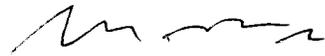
Date



AHCCCS received 128 responses

URGENT AHCCCS UPDATE

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10-17-12

Staff Member Name

Date

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Staff Member Name


Date

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Karn S Bennett

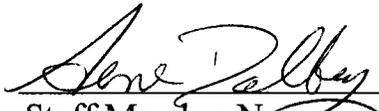
10-17-12

Staff Member Name

Date

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Staff Member Name


Date

URGENT AHCCCS UPDATE

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Glenda Wilson

10-17-12

Staff Member Name

Date

URGENT AHCCCS UPDATE

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Angela Seala

Staff Member Name

Date

10/16/10

URGENT AHCCCS UPDATE

Please restore the Health Care coverage for childless adults. Study show up to 1quarter of a million adults has or will lose health coverage by January 2014. This is a major Health Crisis. AHCCCS is seeking a waiver from the Federal Government to restore these funds and is asking an increase. I Support AHCCCS' Efforts!

Harold Best-Shaw
Staff Member Name

10/16/12
Date

URGENT AHCCCS UPDATE

Please restore the Health Care coverage for childless adults. Study show up to 1quarter of a million adults has or will lose health coverage by January 2014. This is a major Health Crisis. AHCCCS is seeking a waiver from the Federal Government to restore these funds and is asking an increase. I Support AHCCCS' Efforts!

Ricardo Delgado
Staff Member Name

10/17/2012
Date

URGENT AHCCCS UPDATE

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Bennie Gipson 10-17-12
Staff Member Name Date

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Fred Glass

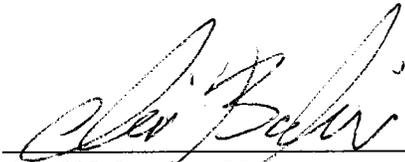
10/17/12

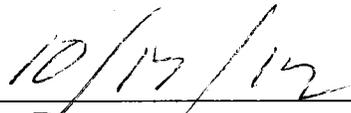
Staff Member Name

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Ulenah Penko 10-17-12
Staff Member Name Date

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DeLarae Oct 17, 2012
Staff Member Name Date

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Karen Inde

Staff Member Name

10/17/2012

Date

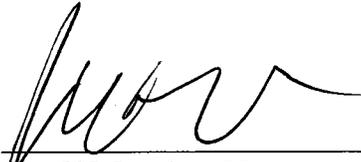
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Meghan Wood 10-17-12
Staff Member Name Date

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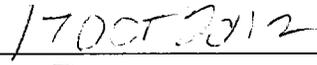
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Lisa Tejada

10.17.12

Staff Member Name

Date

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Miguel Lopez

Staff Member Name

10/17/12

Date

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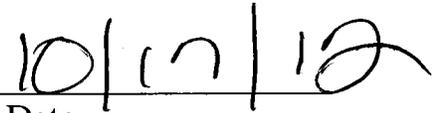
Ann Caracci 10-17-12
Staff Member Name Date

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Melinda Jean 10/17/12
Staff Member Name Date

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Shante Bierbrodt
Staff Member Name

10-17-12
Date

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Phyllis Johnson

Staff Member Name

10/17/12

Date

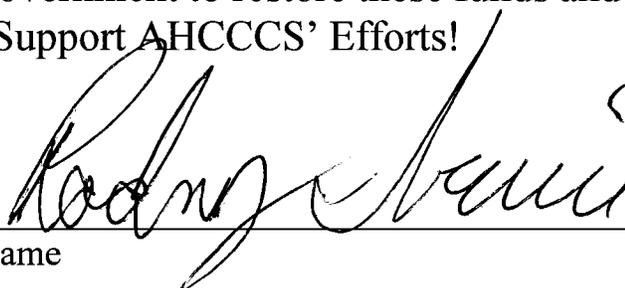
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Lawrence Baker 10-17-12
Staff Member Name Date

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William McPeak

10-17-12

~~_____~~ Member Name

Date

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Jose Fabiani
~~Staff~~ Member Name

10/17/12
Date

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Mike Berg
~~Member Name~~ Member Name

12-7-12
Date

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John McLeod 10-17-12
~~Staff~~ Member Name Date

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Greg Duidott 10.16.12
~~Self~~ Member Name Date

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Antonio Chavez
Staff Member Name

10-17-2012
Date

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Michael V. Hualobos

12-17-12

Staff Member Name

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Roy Grubbs

10/17/12

Staff Member Name

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E. Lou Cavallo

Staff Member Name

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Diana L Klein

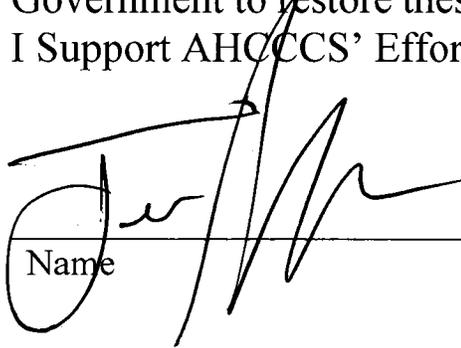
Staff Member Name

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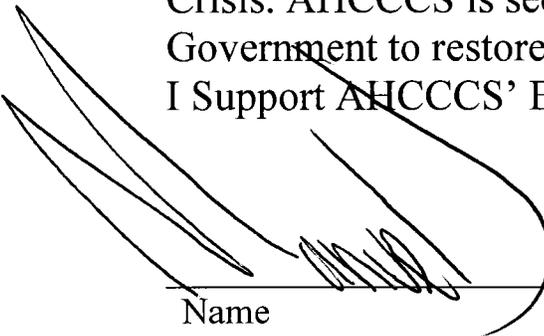
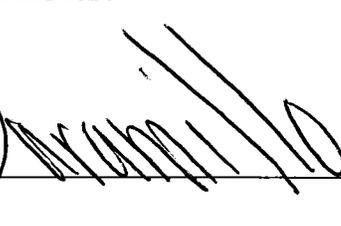
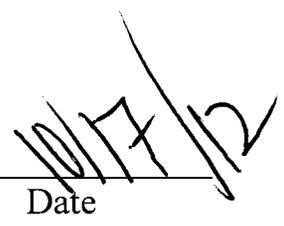
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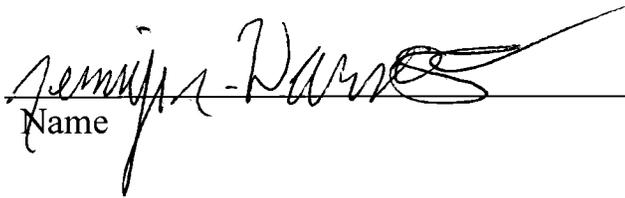
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Margaret Williams
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10-17-12
Date

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(MARIO)

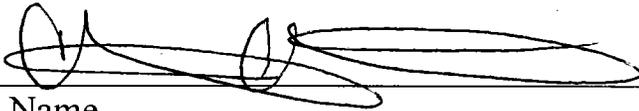
Eulogio Duenas

Name

Date

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A handwritten signature in black ink, consisting of several loops and a long horizontal stroke.

Name

10/17/12

Date

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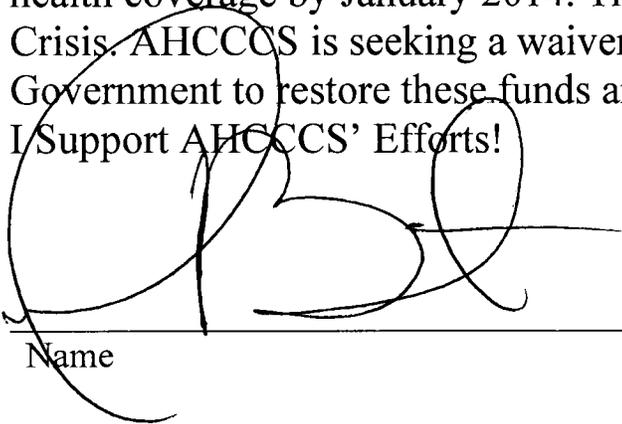
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10/17/2002
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A large, stylized handwritten signature in black ink, appearing to be 'RBE', written over a horizontal line.

10/17/12

Name

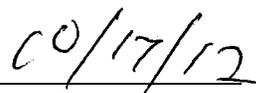
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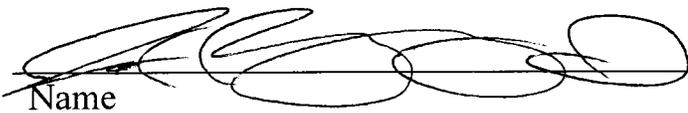
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Joseph Vieira
Staff Member Name

10/17/12
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Francis Garcia 10/17/12
Staff Member Name Date

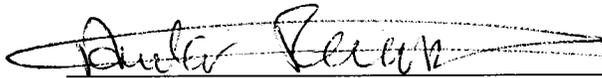
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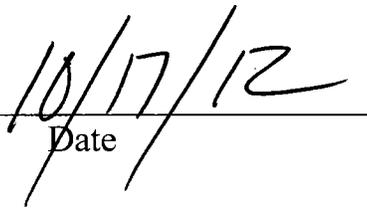
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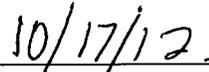

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10-17-2012

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Erik Ramos

Staff Member Name

10-18-12

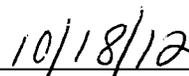
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Robert R. LaMee

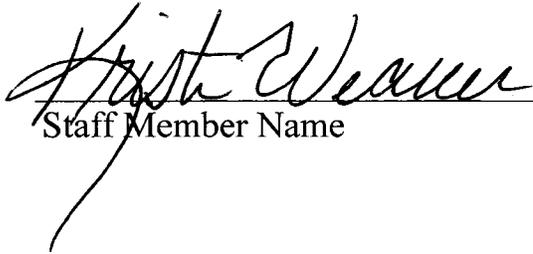
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10/17/12

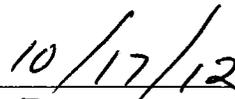
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Eva C Garcia

10-17-12

Staff Member Name

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Kim Ballentine

Name

10-17-12

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JOHNATHAN MARENELLI
Name

10-17-12
Date

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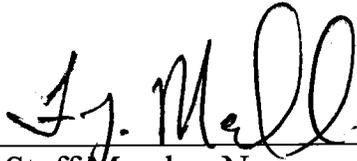
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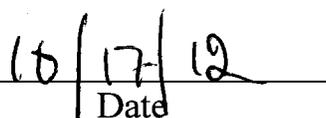
Shannon Barrera
Name

10/17/12
Date

URGENT AHCCCS UPDATE

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Tim Brown 10-17-12
Name Date

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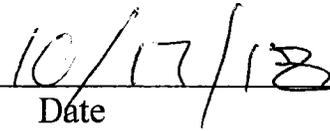
angelica Vargas 10/17/12
Staff Member Name Date

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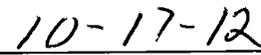

Staff Member Name

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Nicole Stout

Staff Member Name

10/17/12

Date

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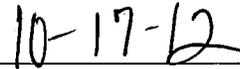
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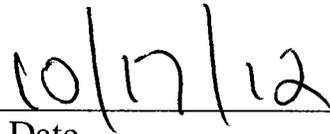
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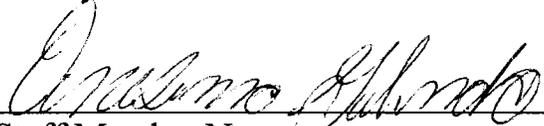
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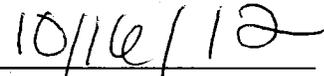

Staff Member Name _____ Date 10-17-12

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Maria Cabrera

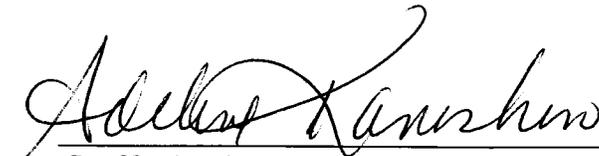
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Wendy Plase
Staff Member Name

10-16-12
Date

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Staff Member Name

10-17-12
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BRYAN MACK

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Robert Toeger

10-16-12

Staff Member Name

Date

MDiv, BHT

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Reggie Assum
Staff Member Name

10/16/12
Date

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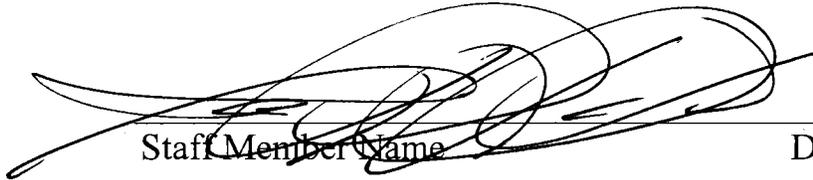
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A large, stylized handwritten signature in black ink, consisting of several overlapping loops and a long horizontal stroke extending to the left.

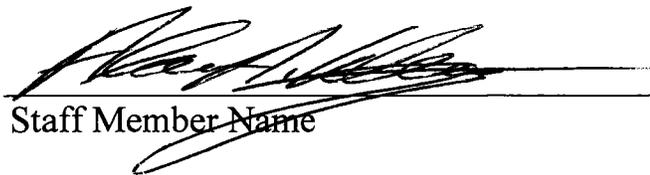
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10/16/2012

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Staff Member Name Date

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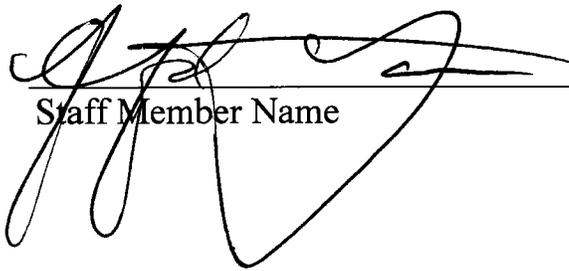
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Bill Clark
Staff Member Name

10/16/12
Date

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Staff Member Name

10-16-12

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CESAR ACOSTA



10/16/12

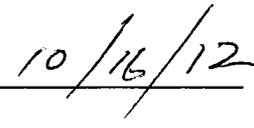
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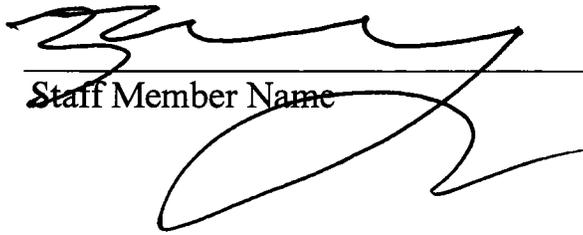
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A large, stylized handwritten signature in black ink, written over a horizontal line. The signature is cursive and somewhat abstract, with a large loop at the bottom.

Staff Member Name

Date

10/16/12

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Busilda M. Baro 10/16/2012
Staff Member Name Date

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Teresa a Gribble

Staff Member Name

10-16-2012

Date

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10-17-12

Name

Date

Theresa Palmer

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Stephanie Hurtado 10.17.12
Name Date

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Ashley Petersa

Name

10-17-12

Date

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ALEX GARZA
Name

10-17-12
Date

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Calvin M. Mccord

Name

Date