Congress of the United States
Washington, DC 20515

May 4, 2011

Ms. Cindy Mann, Director
Center for Medicaid and State Operations
Centers for Medicare and Medicaid Services
United States Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Mann:

Please accept our comments regarding Arizona's proposed Medicaid changes. We hope that we may have a lengthy and healthy dialogue regarding these concerns before any final decisions are made that will impact our constituents.

Medicaid is not only a program that provides health care to low-income Americans, but one that allows our country to prosper by meeting basic human needs to allow people to be productive members of society. The objective of the Medicaid program is to provide medical services to persons: "whose income and resources are insufficient to meet the costs of necessary medical services." To slash this vital program in times of economic challenges would be irresponsible as it will further devastate our economy and could create a public health crisis. The decisions made now will set precedent for Medicaid programs across our nation. Thus, it must be made clear that the intent of Congress will be carried out and that the objectives of the Medicaid program will be upheld.

The Arizona proposal submitted March 31, 2011 titled "an amended request for a new Section 1115 Research and Demonstration Waiver for the period October 1, 2011 through September 30, 2016" should be rejected for numerous reasons. Below are particular items of concern:

Elimination of Current Childless Adult Program
The state of Arizona is requesting a Maintenance of Effort (MOE) waiver from P.L. 111-148 to terminate coverage for childless adults with incomes up to 100 percent of the federal poverty level (FPL). Additionally, the state is seeking the authority for a "new" childless adult program that freezes the enrollment at the July 1, 2011 level, with the specific authority for the state to "manage the population depending on available funds." This is a thinly veiled request that will undoubtedly result in the full termination of the program, including for those who survive the enrollment freeze under the continued auspice of budgetary constraints. This is potentially the most devastating section of the state's request, resulting in hundreds of thousands of people losing their medical coverage, hospitals and health centers overwhelmed with uncompensated care, and health care providers unable to find work.

Approximately 70,000 people come on and off AHCCCS every month, with the childless adult population facing the highest churn rate. Freezing enrollment could result in tens of thousands of people losing their coverage every month. Allowing the state to freeze enrollment, and providing them with the explicit authority to manage enrollment in perpetuity and without CMS oversight will have longstanding impact on the health of the people and the economy of Arizona. This would result in weaker economic growth, loss of federal matching funds and the loss of the thousands of jobs. The state tax package that was financed at this population's expense will have a substantially lower "bang-for-the-buck" than the Medicaid spending.

This waiver should be rejected on the basis that it will violate Congressional intent of P.L. 111-148. Additionally, federal law allows a waiver *only* to facilitate experimental, pilot or demonstration projects that are found to promote the objectives of Medicaid. This proposal contradicts the objectives of the Medicaid Act and Section 1115 of the Social Security Act.

Enrollment Freeze for Parents between 75 percent – 100 percent of FPL

The state of Arizona is requesting a MOE waiver from PL. 111-148 to implement an enrollment freeze for parents between 75 percent and 100 percent of the FPL. Our objections to the request in implementing the enrollment freeze for parents between 75 percent and 100 percent of the FPL are the same as for the childless adult population. This would result in weaker economic growth, loss of federal matching funds and the loss of the thousands of jobs. The state tax package that was financed at this population's expense will have a substantially lower "bang-for-the-buck" than the Medicaid spending.

This waiver should be rejected on the basis that it will violate Congressional intent of P.L. 111-148. Additionally, federal law allows a waiver *only* to facilitate experimental, pilot or demonstration projects that are found to promote the objectives of Medicaid. This proposal contradicts the objectives of the Medicaid Act and Section 1115 of the Social Security Act.

Required 6 Month Determinations

The state of Arizona is requesting a MOE waiver from P.L. 111-148 to conduct program eligibility redeterminations every six months, ostensibly for "program integrity" and ensure only those who meet income eligibility retain their benefits. This plan is ambiguous in several key areas, such as whether or not a one-time or a one-month increase in income will render them ineligible and therefore unable to reenroll because of the enrollment freeze.

The MOE provision requires states to maintain both their current eligibility standards *and* their current application and renewal procedures. This language was included because burdensome paperwork and reporting requirements create significant barriers to health care. For example, in 2003 Washington State began requiring families to renew their children's Medicaid eligibility every six months instead of every 12 months – this resulted in 30,000 children losing their coverage within two years. As noted above, approximately 70,000 people come off and on the AHCCCS program every month. Increasing the burden of eligibility redetermination coupled with the enrollment freeze will have devastating effects on the countless families who rely on AHCCCS for their medical care. In Arizona this proposal could be particularly devastating for our tribal populations.

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Mandatory Co-payments for Children

The state of Arizona is requesting a waiver in accordance with Section 1916(f) of 42 U.S.C. Federal law requires that any cost-sharing project must, among other criteria, "provide benefits to recipients of medical assistance, which can reasonably be expected to be equivalent to the risks to the recipients" and "is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation." The state proposal does not meet the federal requirements.

Implementation of co-payments have been extensively studied and it has been consistently established that use of copayments on poorer populations lead to delays in seeking primary and preventive health care, worsened health outcomes and increased emergency room visits. This additional cost burden will undoubtedly be shifted onto hospitals and those that have private insurance.

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Elimination of Coverage for Federal Emergency-Services
This is a violation of federal law and will shift costs to hospitals under 42 U.S.C. section 1395dd. Additionally, this provision is unworkable. This request suggests that emergency health providers are going to have to become de facto immigration agents and determine the alien status of a patient before providing emergency care. Health providers are legally and ethically bound to provide health care services, especially in emergency situations. As such, if this exemption is granted all such care will become uncompensated care with the cost burden shifted onto the health facility, taxpayers and private insurance premiums. Not only does this provision not make practical or economic sense, it is also immoral.

Penalties for Missed Appointments
Precedent is clearly established to deny this request. There is a longstanding agency policy against this very request. I ask that CMS continue this policy and reject this request that will only be an added burden on the most vulnerable populations, namely the mentally ill and those suffering from debilitating diseases, such as cancer, that may already have unique barriers to accessing care.

Elimination of Non-Emergency Medical Transportation
Precedent is clearly established to deny this request. A December 17, 2010 CMS letter states that: "CMS has not approved your request to waive the requirement to provide non-emergency medical transportation (NEMT) to childless adults…" Additionally, copayments on NEMT would be subject to the previously stated cost-sharing requirements and therefore the state proposal will not meet the federal requirements. I ask that CMS reject this request that will only be an added burden on the most vulnerable populations, namely the mentally ill and those suffering from debilitating diseases, such as cancer, that may already have unique barriers to accessing care. The compound effect of these requests is to erect barriers to health care, contrary to the objective of the Medicaid Act.

Restoration of Transplant Services
I support the proposed restoration of transplant services that were previously eliminated and am grateful that the negative impact of eliminating a critical service has been realized by the state

Congress included the MOE specifically to prevent states from initiating this type of drastic reduction in their Medicaid plans, both to ensure continuity of coverage for Medicaid enrollees as well as to prevent states from gaming the new increased federal matching funds afforded under the Affordable Care Act for newly eligible individuals. However, the MOE was restricted under section 1902(gg)(3) of P.L. 111-148 in which states have the ability to reduce certain populations above 133% FPL if the states have or are facing a budget deficit. This section was included to provide states with flexibility if they are already covering people above 133% FPL. The inclusion of this section demonstrates the intent of Congress to allow only limited exceptions to the MOE (as defined by this section), but not beyond. Arizona's does not meet this exception because they do not cover these populations.

Because the state is seeking the specific authority to "manage the population depending on available funds" it would provide Arizona with an unprecedented level of authority that could potentially impair future decisions by the Secretary of Health and Human Services. The period of time requested for the amended plan would be in direct conflict with P.L. 111-148 because beginning in 2014 all persons up to 133% FPL must be covered in a state plan. Additionally, the state has refused to consider number viable alternatives that would make this proposal and the reductions in services and eligibility unnecessary. The state's health care community – including providers, hospitals, health systems and the larger business community – approached the state with an assessment plan to generate $465 million and cover the costs to AHCCCS until 2013. This plan was submitted to the governor and the state legislature by the Arizona Hospital and Healthcare Association but has not been given any serious consideration.

And finally, we appreciate your response to the February 25, 2011 letter that requested: 1) a public comment period, 2) a formal fiscal report and 3) a local hearing with CMS officials in my district. We would like to reiterate our support for an open process with public input. We know this is a core belief of CMS, but unfortunately the state did not allow public comment prior to submitting the amended plan. The decisions before CMS have the potential to impact hundreds of thousands of individual's health care, raise cost for everyone who continues to be insured, reduce our workforce, and damage our overall state economy. Thus, we are asking that you consider additional means of requesting and accepting public input at the federal level by considering holding a public hearing in Arizona, at the minimum.

Thank you again for helping us ensure the citizens of Arizona are protected. We look forward to working with you as this proposal moves forward.

Sincerely,

Raul M. Grijalva
Member of Congress

Ed Pastor
Member of Congress

Copied: Kathleen Sebelius, Secretary Health and Human Services