FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

February 5, 2018

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Azar:

Families USA is national organization that advocates for access to affordable health care for all Americans, with a particular focus on policies that affect low-income individuals. We appreciate the opportunity to comment on Arizona's December 19, 2017 request for an amendment to the Arizona Health Care Cost Containment System (AHCCCS) section 1115 demonstration project that would allow Arizona to implement the AHCCCS Works program. The AHCCCS Works program would condition Medicaid eligibility on compliance with work requirements, impose time limits on Medicaid coverage for Group VIII (Medicaid expansion eligible adults) to a lifetime maximum of 5 years, and increase the frequency of Medicaid eligibility redeterminations.

We urge you to reject Arizona's request. It fails to meet the statutory requirements for a demonstration project under section 1115 of the Social Security Act. In particular, the program proposed would not further the objective of the Medicaid program, which is to enable states to furnish (1) medical assistance and (2) rehabilitation services.[1]

It is clear from the state's proposed goals, hypotheses, and performance measures that the requested changes bear no relation to Medicaid's objectives of providing medical services. All of the hypotheses and performance measures are related to employment and reducing the number of individuals on Medicaid, rather than furthering Medicaid's goals of providing medical assistance. The statute requires that 1115 waivers promote the objectives of Title XIX, Medicaid.[2] Because the goals and objectives of this waiver proposal do not in any way relate to the Medicaid program's objectives, there is no argument that they can further those objectives. Therefore, this waiver request must be denied.

[1] Social Security Act section 1901.
[2] Social Security Act section 1115, Demonstrations.

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Work requirement.

Work requirements are not part of the Medicaid program and are outside of the Secretary's authority to approve through an 1115 waiver.

Program description.

Arizona proposes to require certain adult Medicaid enrollees who do not fall into listed exemptions to meet a 20-hour per week work requirement.[3] The requirement can be met through a minimum number of hours per week of employment, certain educational activities, job search activities, and, for some enrollees who meet specified conditions, volunteer work.[4]

The proposed program includes an initial 6-month grace period followed by disenrollment and program lock-out if the employment requirement is not met. Individuals may reenroll if they can demonstrate that they have met the work requirement for 30 days. Subsequent enrollment periods include 3-month, rather than 6-month, evaluations for compliance with the work requirement.

A work requirement is a radical change to the Medicaid program; approving such a change through an 1115 waiver is an abuse of the Secretary's authority. As we have written in our 1115 comments for Utah's Primary Care Network waiver request, Wisconsin's Badgercare Reform waiver request, Kentucky's Kentucky Health modified waiver request, and Arkansas's Arkansas Works and Kansas's KanCare 2.0 renewal application, work requirements are outside of the Secretary's authority. The fact that work requirements have no place in Medicaid law was recently noted by the Congressional Budget Office in September 2017, in a report in which they stated: "Under current law, states may not condition the receipt of Medicaid on any criteria related to a person's employment status."[5]

Linking Medicaid eligibility to work—whether requiring hours worked or a job search or job training or volunteer work—is adding a whole new aspect to Medicaid eligibility, one that would fundamentally change the program. Such a radical change to the program must be made through the legislative process, not through waivers. Indeed, Congress has recently failed to pass such a change despite recently taking up such a provision in the American Health Care Act and the Better Care Reconciliation Act. The work requirement on the TANF and SNAP programs

[3] Defined for purposes of this application as adults eligible for Medicaid under Social Security Act (SSA) Section 1902(a)(10)(A)(i)(VIII) (henceforth referred to as the "Group VIII" population) and who do not fall under any of the exemptions listed in the waiver application. .

[4] Individuals who are leaving the justice system, live in areas of high unemployment, or "otherwise face significant barriers to work" may substitute community service for employment in order to retain Medicaid coverage.

[5] Congressional Budget Office, "Preliminary Analysis of Legislation That Would Replace Subsidies for Health care With Block Grants," September 25, 2017, https://www.cbo.gov/publication/53126.

were all enacted through Congressional legislation. The Secretary must give effect to Congress's unambiguous intent.[6]

Adding a work-related eligibility requirement to the Medicaid program is beyond the Secretary's authority to approve through a waiver, a change that would be in conflict with Congressional intent. Therefore, the Secretary must deny this request.

A work requirement does not assist in promoting the objectives of the Medicaid Act as required by Section 1115. As stated in statute, the objectives of the Medicaid program are to enable each state "to furnish (1) medical assistance [to eligible individuals] and (2) rehabilitation and other services to help [eligible individuals] attain or retain capability for independence or self-care…." These two purposes reflect Medicaid's role covering medical care and long-term services. "Independence or self-care" in the context of the statute clearly refers to an individual's ability to care for him or herself on a daily basis, related provision of long-term services and supports, i.e., the "rehabilitation and other services," the delivery of which the statue is intended to support.

In contrast, in its application, Arizona states the goal of its proposed program is "to increase employment opportunities and reduce individual reliance on public assistance."[7]

Increasing employment is not an objective of the Medicaid program, nor is reducing enrollment in public assistance. The state does not even attempt to tie its request to Medicaid's statutory objective of furnishing medical services.

Failing to meet that basic requirement to further the objectives of the statute, the request must be denied.

Section 1115 does not give the Secretary authority to add new requirements to Medicaid. A work requirement adds a totally new eligibility requirement unrelated to any other program requirements or the program's purpose and is therefore outside of 1115 authority. Section 1115 gives the Secretary the authority to waive requirements of section 1902 when the request meets conditions set out in the statute. It does not give the Secretary the authority to add new requirements to 1902 Medicaid eligibility. A work requirement would be the addition of a totally new eligibility requirement that is unrelated to Medicaid's objectives and is therefore not the kind of program change supported by 1115 authority. The request must therefore be denied.

The supposed linkage between work and health is a red herring; it is still outside of the Secretary's authority under 1115 to add a work requirement to Medicaid. In its January 11,

[6] *Comacho –v- Texas Workforce Commission,* op cit.
[7] Arizona waiver application page 10.

2018 State Medicaid Director letter, CMS outlined literature on a broad range of issues linked to individuals' health, work being among those.[8] It cited those studies as a basis for supporting the addition of a work requirement in Medicaid programs using 1115 authority.

The objectives of both the Medicaid program and the requirements for 1115 waivers are set out in statute. Regardless of how the agency defines the objectives of 1115 waivers in State Medicaid Director letters, or on the Medicaid.gov website, it is the statute that governs what is and is not within the Secretary's authority.

Based on the statute, whether or not there is a relationship between health and working is irrelevant to the purpose of the Medicaid program which, as we have noted, is to ***furnish*** *medical assistance and rehabilitative services.* It is not to address every possible factor that could relate to individuals' health, whether that be work, housing quality, air quality, water quality, access to healthful food, education, etc. The list of things that impact individual health is nearly endless. However, the objective of the Medicaid program is considerably narrower and does not include requiring work.

Compensating volunteer work with health insurance may violate other federal laws. Arizona states that in certain economically depressed areas, for individuals who have other barriers to work, and for individuals transitioning out of the criminal justice system, it may allow undefined community service hours to count toward the work requirement, i.e., unpaid work. This is no more related to Medicaid's purpose than paid work, and the analysis outlined above applies.

In addition, this is bad economic policy that could drive down wages, further impoverishing the very people this program claims it is designed to help. It has the potential to result in paid employees being laid off in favor of an unpaid workforce, thereby increasing the ranks of the unemployed.

This may also violate other federal laws. In the United States, people are generally paid for work that they do. The Fair Labor Standards Act created a right to a minimum wage.[9] Medicaid coverage is not a substitute for wages. Medicaid pays doctors and other health care providers for services rendered to patients. It does not pay enrollees.

Work requirements seek to solve a problem that does not exist and there is no evidence the requirement will promote employment. Most people on Medicaid who can work, do so. For people who face major obstacles to employment, harsh penalties for not working—such as

[8] Centers for Medicare and Medicaid Services, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries" SMD 18-002, January 11, 2018, https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.

[9] The Fair Labor Standards Act of 1938, 29 U.S.C. sec 203.

taking away the insurance that affords them access to health care—will not help them overcome those barriers to work.

Indeed, the work requirement disenrollment penalty laid out in the AHCCCS Works application is likely to have the opposite effect.[10] An individual needs to be healthy in order to obtain and maintain employment. Arizona's proposed disenrollment penalty and program lock-out will mean that many individuals will not be able to access the health care that could help them retain or regain the physical or mental health that would better enable them to work.[11] All this flies in the face of the state's goals and objectives in requesting the waiver.

The proposed program would add complexity, bureaucracy, administrative cost. Arizona has set forth 14 work requirement exemption categories. A combination of work, school, other education program attendance, job search and possibly volunteer work in areas of high unemployment will be counted toward meeting the required work hours.

This will be very complex to track, requiring added manpower and systems modifications that will increase program costs. Such a complex system will predictably result in individuals being cut from coverage who either fall within exemptions or who meet the work requirement but have difficulty documenting hours worked. Documentation will be particularly challenging for individuals who have multiple employers, who engage in free-lance or contract work, or who, by the very nature of their occupations, have large seasonal variations in work hours.

The costs of this added bureaucracy will be borne by the federal government and Arizona, and ultimately federal and state taxpayers. Adding new, complicated requirements to Medicaid eligibility, particularly where there is no supported benefit to Medicaid consumers, is fiscally irresponsible.

Time limit on eligibility.

Time limits are contrary to Congressional intent, in conflict with the objectives of the Medicaid program, and serve no demonstration purpose.

[10] The Kaiser Family Foundation, *The intersection of Medicaid and Work* (The Kaiser Family Foundation: Washington, DC) Feb, 15, 2017 available online at http://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/

[11] Jessica Gehr, et al, "The Evidence Builds: Access to Medicaid Helps People Work," CLASP, December 2017 online at https://www.clasp.org/sites/default/files/publications/2017/04/The-Evidence-Builds-Access-to-Medicaid-Helps-People-Work.pdf.

Program description.

Arizona requests approval to impose a five-year lifetime eligibility time limit on individuals subject to the work requirement. The time that an individual is enrolled in the program and meeting the work requirement would not count toward that limit.

Imposing a time limit on Medicaid eligibility does not promote the objectives of the Medicaid program; it would change the Medicaid program in a manner far beyond what was ever intended to be within the Secretary's 1115 waiver authority and therefore must be denied. The Social Security Act is direct regarding time limits in the Temporary Assistance for Needy Families program, as is the Food and Nutrition Act regarding time limits in the SNAP program. Title XIX of to the Social Security Act makes no reference to time limits of any kind.

Section 1115 of the Social Security Act gives the Secretary authority to approve pilot, experimental or demonstration projects that he or she believes will "assist in promoting the objectives of" the Medicaid program.[12]

As we noted above, the objective of the Medicaid program, set out in section 1901 of the Social Security Act, is to provide federal funding to enable each state "to furnish (1) medical assistance on behalf of [statutorily eligible individuals], and (2) rehabilitation and other services to help such [individuals] attain or retain capability for independence or self-care….."[13]

Eligibility time limits, no matter how defined or how the time is counted, do not assist in furnishing medical or rehabilitation services. Imposing a limit on the number of months that someone can receive medical assistance—when an individual's need for medical care is unpredictable throughout one's life—does not promote those objectives. It runs contrary to those objectives. The predictable outcome of limiting residents' access to Medicaid coverage would be an increase in the state's uninsured population, thus reducing low-income individuals' access to medical and rehabilitative services.

By hindering, rather than promoting, Medicaid's objectives, the request to add time limits on eligibility is outside of the Secretary's waiver authority and must be denied.

It is Congress's clear intent that there not be time limits in Medicaid. Congress has placed income and other limits on individual eligibility, but in the over 50 years Medicaid has been in operation, it has never placed a limit on the time that otherwise eligible individuals can receive benefits. Limiting time-on-program would be adding a new eligibility requirement that would fundamentally change the program itself.

[12] Social Security Act sec. 1115 [42 U.S.C. 1315(a)].

[13] Social Security Act Sec. 1901. [42 U.S.C. 1396].

It is Congress's unambiguous intent that there should not be time limits on Medicaid eligibility and the Secretary must give effect to Congress's intent.[14] Adding time limits through a waiver request is far beyond the Secretary's waiver authority, would be in conflict with Congressional intent, and therefore, the Secretary must deny this request.

The request to add a time limit serves no demonstration purpose and therefore does not meet the requirements of section 1115 and must be denied. Section 1115 of the Social Security Act is titled: Demonstration Projects. That is because the waivers are, by statute, to serve a demonstration or experimental purpose. Arizona's request to limit individuals' time on Medicaid does not serve any plausible demonstration purpose.

Individuals' losing health insurance would be the predictable outcome of the state's requested time limit policy. It is well documented that lacking or losing health insurance has a negative impact on low-income individuals' ability to access health care services.[15] No further study of the issue could possibly be needed.

Lacking any plausible demonstration purpose, the request must be denied.

Increased frequency of redeterminations

Increased frequency for redeterminations will predictably result in more individuals losing coverage, does not support the objectives of the Medicaid program, serves no demonstration function and, therefore, must be denied.

Program description.

The state is requesting to redetermine Medicaid eligibility every 6 months and for some individuals ("who have had a change in circumstances that result in non-compliance with

[14] See *Comacho –v- Texas Workforce Commission,* 408 F.3rd 209, April 29, 2005, Holding that Texas cannot terminate medical benefits for TANF recipients who do not vaccinate their children, citing *Chevron, U.S.A. Inc. –v- Natural Res. Def. Council, Ins.* 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed.2d 694 noting "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress."

[15] This lists a few of the many studies on this point: National Center for Health Statistics, "Health Insurance and Access to Care," February 2017, at https://www.cdc.gov/nchs/data/factsheets/factsheet_hiac.pdf; Annals of Internal Medicine, "The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?" 2017; 167 (6): 4240431 at http://annals.org/aim/fullarticle/2635326/relationship-health-insurance-mortality-lack-insurance-deadly#; Kaiser Family Foundation, "Key Facts About the Uninsured Population," September 19, 2017, at https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/; Julia Paradise, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence," Kaiser Family Foundation, August 2, 2013, at https://www.kff.org/report-section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/.

AHCCCS Work requirements"), every 3 months. It is unclear how the 3 month redetermination would be operationalized and applied.

This proposal flies directly in the face of decades of statutory change to simplify Medicaid renewals and establish uniform 12 month eligibility periods.

Increasing redeterminations would predictably result in individuals losing Medicaid coverage, running counter to the program's objectives.

Increasing renewal frequency will reduce enrollment and result in more individuals experiencing breaks in health coverage. Those outcomes are inconsistent with Medicaid's objectives and therefore not appropriate for approval under 1115 waiver authority.

The impact of more frequent redeterminations has been documented. In 2003, Washington State made program process changes, including increasing renewal frequency for children from 12 months to 6 months. Over the next two years, Medicaid enrollment fell by more than 30,000. In 2005, the state moved back to 12-month continuous eligibility and enrollment rose by 30,000.[16]

Other studies support continuous coverage, less frequent redetermination, as a way to promote quality care.[17] There is no doubt but that the frequency or redeterminations requested would increase the number of adults dropping coverage, even if meeting all other program requirements. This result in no way furthers the objectives of Medicaid, and should therefore be denied.

This proposal has been reviewed by CMS and denied; CMS's prior denial should stand.
Arizona's prior request to add a work requirement, time limits and additional verification was denied in September 2016 based on CMS's determination that the request did not support Medicaid's objectives.[18] The Medicaid statute's objectives have not changed in the intervening time nor has any other aspect of the statutory requirements for 1115 waiver determinations. Therefore, CMS must again deny the request.

[16] Georgetown Center for Children and Families, "Program Design Snapshot: 12-Month Continuous Eligibility," March 2009, online at http://ccf.georgetown.edu/wp-content/uploads/2012/03/CE-program-snapshot.pdf.
[17] See: Leighton Ku, et al, "Improving Medicaid's Continuity of Coverage and Quality of Care," prepared for the Associationfor Community Affiliated Plans, July 2009 at https://www.communityplans.net/wp-content/uploads/2016/08/ACAP%20MCQA%20Report.pdf.2; MACPAC Report to Congress on Medicaid and CHIP, Chapter 2, March 2014 at https://www.macpac.gov/wp-content/uploads/2015/01/Promoting_Continuity_of_Medicaid_Coverage_among_Adults_under_65.pdf.
[18] CMS letter to the state of Arizona, September 30, 2016, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-demo-ext-09302016.pdf.

Thank you for your consideration of our comments. If you have any questions or would like additional information, please contact Dee Mahan (dmahan@familiesusa.org,) or Andrea Callow (acallow@familiesusa.org). We can both be reached by telephone at (202) 628-3030.

Sincerely,

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