



December 4th, 2015

The Honorable Sylvia Matthews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted via Medicaid.gov

RE: Arizona's Section 1115 Waiver Amendment, AHCCCS CARE Program

Dear Secretary Burwell,

Thank you for the opportunity to comment on Arizona's Section 1115 waiver amendment request.

Families USA is a national organization representing the interests of health care consumers, with a particular focus on low-income consumers. We are extremely supportive of Arizona's decision to extend Medicaid coverage under the Affordable Care Act through the AHCCCS program. Through the successful expansion of AHCCCS, Arizona has boosted Medicaid enrollment by nearly 450,000 since December 2013.¹ By accepting federal funds to extend coverage, Arizona has ensured these low-income individuals have access to health care when they need it, and the financial security that comes with maintaining insurance.

We appreciate the state's vision of a modernized Medicaid program that focuses on engaging Arizonans and ensuring quality and affordability. However, the incomplete waiver amendment materials submitted raise serious concerns. We believe elements of the state's proposal are inconsistent with the intent of the Medicaid program generally, the ACA's Medicaid expansion in particular and Arizona's stated goals. The state estimates that, if approved, as many as 571,000 current adult Medicaid beneficiaries would be enrolled in the proposed AHCCCS CARES program. We encourage CMS to thoroughly evaluate Arizona's waiver amendment, as it would a new waiver, considering the magnitude of changes being proposed through the AHCCCS CARES program and the size of the population affected.

¹ Ctrs. for Medicare and Medicaid Servs ("CMS"), Medicaid & CHIP: September 2015 Monthly Applications, Eligibility Determinations and Enrollment Report, 7 (Nov. 30, 2015).

We are confident CMS and the state can work together to continue a demonstration consistent with the intent of the Medicaid program and the state's goals of quality care and affordable coverage for enrollees.

Summary

Our principal concerns are summarized below. These, as well as some additional concerns, are discussed in the "comments" section following.

- **The state cannot legally impose a five year time limit on Medicaid coverage and the Secretary must deny such a request.** The Secretary lacks the legal authority to grant Arizona's request for a five year time limit on Medicaid coverage for "able-bodied" adults as proposed in the application. Furthermore, this proposal is in direct conflict with the purposes of the Medicaid Act and serves no demonstration purpose.
- **Requested premium amounts are excessive, particularly for those below 50 percent of poverty.** Arizona's proposed premiums are among the highest of any state Medicaid expansion program and will represent a serious hardship, particularly to those in deep poverty (50 percent of the poverty level or less).
- **Premium penalties, including disenrollment with lock-out, are already being tested in Indiana and should not be approved until evaluation is complete in that state.** We urge CMS not to approve any disenrollment with lock-out penalties until Indiana's demonstration has been thoroughly evaluated for effect on enrollee access to care. Disenrollment penalties generally are inconsistent with the goals of the Medicaid Act, but lock-out periods make this penalty particularly harmful to low-income consumers who have no other option for health insurance coverage.
- **Requested cost-sharing for non-emergency use of the ER is excessive, does not meet the requirements of Section 1916(f) of the Act and should be denied.** The state does not provide sufficient justification for excessive \$25 copays for non-emergency use of the emergency room as required under Sec. 1916(f) of the Social Security Act. The state's request must therefore be denied.
- **CMS has not, and should not, allow participation in work programs to be a feature of the Medicaid program. The states' request for the Arizona Works program to be tied to the AHCCCS CARES Account should be denied.** It is unclear whether the state is asking to waive Sec. 1902(a)(10)(a) requiring the state to provide coverage to all eligible individuals. The request to waive 1902(a) is submitted in the list of waiver authorities, but later the corrected application states that the state is *not* seeking to tie eligibility to participation in the Arizona Works program. In either scenario, the request must be denied. Any link between work status (or work *search* status) to Medicaid benefits, is

impermissible and should be denied as was the case in Pennsylvania and Indiana. The purpose of the Medicaid program is to provide health care to low-income people, and there is an insufficiently close nexus between work and health care to permit work search to be an element of any Medicaid program.

- **Insufficient detail is included around the structure of the Healthy Arizona program.** There is no evidence that wellness programs, like the Healthy Arizona program, improve health, increase enrollee engagement or reduce cost. And the state provides no hypothesis to be tested with the Healthy Arizona program. The proposed wellness program in the state’s amendment application lacks critical detail and should be denied until the state supplies a more substantive description of how the wellness program will function and the hypothesis it will test.

Comments

I. Lifetime limit on Enrollment

Arizona has requested in its amendment application that “able-bodied” enrollees be ineligible for Medicaid coverage after five cumulative years on the AHCCCS CARE program. This request is outside the scope of the Secretary’s authority to approve and should be denied.

- a. The Secretary does not have the authority to approve Arizona’s request for a five year maximum lifetime limit on Medicaid eligibility and this request should be denied.***

In its waiver request list, the state has requested waiver of Sec. 1902(a)(10)(A) of the Act in order to terminate Medicaid benefits for still otherwise eligible enrollees after five cumulative years on the program.

Although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide assistance to all individuals who qualify under federal law. And although Medicaid expansion is optional for states, once a state has made the choice to expand, in order to receive the enhanced federal match, it must cover the expansion population consistent with the requirements of Section 1905(y) of the Social Security Act. Section 1115 of the Social Security Act does not give the Secretary authority to waive any of the requirements of Section 1905, which requires that a state cover all newly eligible individuals outlined in Section 1902(a)(10)(A)(i)(VII).

Furthermore, a five year time limit would represent a fundamental change to the Medicaid program which cannot be undertaken at the Administrative level.

b. The state's proposal represents a partial expansion, and per Congressional direction CMS cannot approve partial expansions

As CMS has stated in clarifying guidance, Congress directed that the enhanced matching rate be used to expand coverage to *all* persons under 133 percent of the federal poverty level.² If an individual meets income and citizenship requirements, in a state that has accepted federal funds to expand Medicaid, that individual is eligible for Medicaid for as long as income eligibility and residency status are maintained. To terminate benefits after 60 months of coverage would carve out an otherwise eligible group of beneficiaries, creating a partial rather than full expansion of Medicaid under the ACA. If a state chooses to extend Medicaid to some but not all non-disabled adults under 133 percent FPL, all new-adult enrollees become ineligible for the enhanced federal matching rate provided by Congress for states that expand Medicaid under the ACA.³

II. Premiums and Cost Sharing

a. Charging premiums and maximum nominal co-pays to expansion enrollees at all levels of poverty serves no demonstration purpose and is incompatible with the goals of the Medicaid program

Arizona's waiver seeks to impose a 2 percent premium on ALL enrollees coupled with maximum out of pocket cost-sharing applied "strategically". Such cost-sharing will represent a serious financial hardship for Medicaid enrollees, and is not in keeping with the purposes of the Medicaid program to provide insurance and access to health care for low-income people.

b. The imposition of premiums, coupled with disenrollment penalties and lock-outs, serves no demonstration purpose and is not in keeping with the goals of the Medicaid program.

As we have noted in our comments on 1115 waivers in Montana, Iowa, Arkansas, Michigan, Pennsylvania and Indiana, premiums do not serve a demonstration purpose. The impact of premium on low-income people is well documented. Disenrollment penalties with lock-out periods are un-necessarily punitive and particularly harmful. Even assuming there is a

² CMS, Frequently Asked Questions on Exchanges, Market Reforms and Medicaid (December 10, 2012) <https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf> ;

Tim Jost, Implementing Health Reform: No Partial Expansion with 100 Percent Federal Match and Other Answers, Health Affairs (December 11, 2012) <http://healthaffairs.org/blog/2012/12/11/implementing-health-reform-no-partial-medicaid-expansion-with-100-percent-federal-match-and-other-answers/>

³ For example, the state of Wisconsin chose to change eligibility to cover all adults under 100% FPL in their Medicaid, but has been ineligible for the enhanced FMAP for this new adult population because they have refused to cover people 100% to 138% FPL. Like Wisconsin, Arizona's proposal would create a group of people eligible for expanded Medicaid under the ACA, but unable to enroll due to state policy.

hypothesis and demonstration purpose behind assessing premiums and disenrollment penalties on Medicaid expansion enrollees, this hypothesis is already being tested in several states, most notably Indiana, and is not novel.

We recommend that CMS allow for a full and complete assessment of Indiana's premium and penalty program before allowing other states to experiment with disenrollment penalties and lock-outs, which can have serious and lasting impacts on enrollees' ability to access care, not to mention strain the provider infrastructure (who must care for uninsured patients locked-out of coverage). Arizona proposes disenrollment after missed premium payment(s) and a lock out period of six months for individuals over the poverty line. Individuals who are locked out of Medicaid coverage have NO option for affordable health coverage. They are not eligible for subsidies on the Marketplace and generally cannot afford employer based coverage, assuming their employer even offers such coverage.

CMS' approval of the Indiana HIP 2.0 plan was unique and predicated on the existence of an already operational 1115 demonstration with program elements that included lock-out and disenrollment.⁴ We are confident that Indiana's HIP 2.0 will bear out what we know anecdotally from HIP 1.0- that lock outs pose considerable hardship to enrollees.

c. Arizona's proposed out of pocket expenses are higher than what has been approved in other states, particularly for people below 50 percent of poverty.

In Iowa and Arkansas, a \$5 monthly contribution was approved for people between 50 percent and 100 percent of poverty. In Montana, enrollees above 50 percent of poverty were charged a premium of two percent of monthly household income. In Indiana, individual down to 0 percent of poverty may pay a monthly premium of two percent, but they are given the option of enrolling in a zero premium plan. In Arizona, the state seeks to charge premiums of two percent down to 0 percent of poverty AND maximum nominal co-pays (see discussion below for comments on the strategic co-pay structure) to individuals down to 0 percent of poverty. If the state's intent is to continue a formula set by the Marketplace wherein premium amounts are based on income, the percentage of premiums charged would continue to diminish to 1 percent for people between 50 percent and 100 of poverty and 0 percent for people below 50 percent of poverty. There is no justification for charging individuals below 50 percent of poverty premiums, and CMS should continue to keep such elements out of all expansion programs.

Additionally, the state seeks to calculate the 5 percent out of pocket maximum annually rather than monthly or quarterly. This has not been approved in any state and to do so would expose chronically ill, low-income enrollees to high out-of-pocket costs and seriously impact their

⁴ It should be noted, evidence from Indiana's first demonstration, HIP 1.0, showed that failure to pay premiums was the second most common cause for disenrollment from the plan. Almost half of all closed HIP member accounts between 2008 and 2012 were closed for failure to make a premium payment (POWER Account contribution). These individuals were then locked out of coverage for one year. Healthy Indiana Plan Demonstration, Section 1115 Annual Report http://www.in.gov/fssa/hip/files/2012_HIP_Annual_Report.pdf

ability to afford necessary care. The state of Iowa similarly requested the five percent cap be calculated annually, and CMS denied the state's request. A shorter time period for calculating the five percent aggregate out of pocket cap is important, because most medical expenses tend to be clustered in a single month or quarter.⁵ Furthermore, the state's request implicates a waiver of Section 1916(f), for which the state provides no detail (see discussion below) and which cannot, therefore, legally be granted.

d. *High out-of-pocket costs for those below poverty, especially below 50 percent of poverty, will pose a significant hardship to AHCCCS CARE enrollees.*

A recent ASPE report showed that people living in poverty, particularly those in deep poverty (below 50 percent FPL) tend to be less healthy and need more medical care than people with higher incomes.⁶ Arizona's proposed premium structure would directly impact those in deep poverty. The report states

“When subject to copayments and premiums, low-income individuals must decide whether to go to the doctor, fulfill prescriptions or pay for other basic needs like child care and transportation. As a result of these daily tradeoffs, low-income individuals are especially sensitive to modest and even nominal increases in medical out-of-pocket costs.” (p.5)

Furthermore, such a proposal would be especially harmful in Arizona where low-income residents already pay a disproportionate amount of their income in fees to the government. Adding premiums and co-pays will push them further into poverty rather than help them attain self-sufficiency. Because Arizona governmental entities rely heavily on sales tax for almost 50 percent of their budgets, people with lower incomes are disproportionately affected because “they pay more of their income in taxes on what they purchase.”⁷ According to the Institute on Taxation and Economic Policy, the poorest 20 percent of Arizonans pay 12.5 percent of their limited income in taxes. Adding copayments and premiums for Medicaid will only drive low-income Arizonans into deeper poverty.

⁵ Thomas M. Selden et. al. *Cost-Sharing in Medicaid and CHIP: How Does It Affect Out-of-Pocket Spending?* 28 Health Affairs W607, W614 (2009) <http://content.healthaffairs.org/content/28/4/w607.abstract>

⁶ Office of the Assistant Secretary for Planning and Evaluation, “Financial Condition and Health Care Burdens of People in Deep Poverty,” July 16, 2015, <http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty>

⁷ Howard Fischer, “Report Finds Arizona’s Tax Among Nation’s Least Fair” Arizona Daily Sun (Sept. 22, 2015) available online at http://azdailysun.com/news/local/report-finds-arizona-tax-among-nation-s-least-fair/article_0ed62a3e-8277-5060-a528-e32cc9df0fa1.html

e. The state's request to charge \$25 ED copays is incomplete, excessive, being tested in another state, and should be denied.

Although the waiver list chart appears to request a waiver of § 1916(f), the Secretary has no legal authority to waive those cost sharing requirements unless the state meets each condition of that provision, which Arizona's proposal fails to detail and which would create significant additional requirements for the state.⁸

The state already has the ability to charge higher (\$8 copays) for non-emergency use of the ED. An even higher \$25 copay for non-emergency use of the ED is already being tested in Indiana and any hypothesis put forward by the state cannot be considered unique.

Furthermore, Arizona's request is particularly inappropriate given a growing body of literature that suggests that nonemergency ED copays are not an effective means to reduce ED utilization in Medicaid.⁹ AHCCCS's own 2013 report to the state legislature found only 6% of Medicaid ED visits were classified as non-emergent, concluding that "members have a relatively low rate of non-emergency ED utilization, particularly when compared to national averages."¹⁰ The state seeks to fix a problem that doesn't exist with a poorly designed solution.

f. Co-pays, even those designed strategically, still impeded access to care for very low income people. More detail is needed on the design of the strategic co-pay structure.

We oppose charging very low-income individuals copays, even those strategically designed. Voluminous literature, including a recent survey by Health and Human Services ASPE documents this.¹¹ However, if the state is going to embark upon a "strategic copay" structure, more detail is necessary in order for meaningful comment.

From the sparse detail the state provides, we wish to offer our support for \$0 co-pay services for primary care visits, generic drugs and specialists with a PCP referral. However, we strongly oppose the state's request for a missed appointment fee. Previously, CMS allowed AHCCCS to impose a missed appointment fee on enrollees but it was not popular among providers and never implemented.¹² The state shows no evidence of a problem with missed appointments to substantiate this proposal or evidence that this second iteration of a failed experiment will go any differently.

⁸ 42 USC 1396o(f). See AHCCCS application, at 35 of PDF

⁹ Karoline Mortenson, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of the Emergency Departments*, 29 HEALTH AFFAIRS 1643 (2010); David J. Becker et al., *Co-payments and Use of Emergency Department Services in the Children's Health Insurance Program*, 70 MED. CARE RES. REV. 514 (2013).

¹⁰ Ariz. State Senate Fact Sheet for S.B. 1298, 1 (51st Legislature, 2014 2nd regular session), available online at <http://www.azleg.gov/legtext/51leg/2r/summary/s.1298hhs.pdf>

¹¹ *Supra* at Note 4

¹² See Comments to AHCCCS Draft Section 1115 (13'5) Demonstration Waiver Request, The William E. Morris Institute for Justice (September 9, 2015)

Finally, it is irresponsible for the state to simultaneously request a waiver of non-emergency transportation and then propose to charge enrollees for missed appointments if they cannot afford or secure transportation to their appointment.

- g. The final waiver should include a hardship exemption for individuals unable to pay their premiums and cost-sharing.*

If the state is intent on charging premiums and co-pays, an easy to access hardship waiver should be available to all persons, although particularly those below 100 percent FPL. Families and individuals below the poverty line are, by definition, already living in economic hardship. If they are unable to pay premiums, they should have the opportunity to attest to that hardship and have premiums waived. Furthermore, there is precedent for hardship waivers in other states. Iowa provides a broad exemption, under which each monthly invoice sent to a beneficiary includes the opportunity to attest to financial hardship.¹³ We recommend shaping an exemption application similar to Iowa's program; namely a simple application and monthly invoice to attest hardship. This allows for minimum administrative costs and resources and provides an easy to use and understand process for consumers.

III. Individual Account (AHCCCS CARE Account)

The state has requested that enrollee premiums and copays be paid into an individual account, the AHCCCS CARE Account, which enrollees can then use to buy supplemental, non-covered health care services and products like vision care, dental care and sunscreen. The concept behind AHCCCS CARES is not unreasonable. However, the implementation presents multiple concerns. If enrollees make all account payments (premiums and retrospectively billed co-pays), participate in Healthy Arizona and the AHCCCS Works program, they can access the funds paid into the account to buy non-covered health care, or roll over the balance of their account towards payment of a private plan premium.

The waiver application includes scant detail about the Healthy Arizona wellness program or the AHCCCS Works work incentive program. From the information given, we believe these programs will adversely impact enrollees who are sick, parents of dependent children and caretaker relatives. We suggest the wellness program be more fully developed before approved and refrain from including any health based measures, while the AHCCCS works program should be denied outright.

We support that the state is allowing for optional partition in AHCCCS CARE for caregivers of elderly or disabled individuals pursuant to public comment. We would also suggest that, if implemented, those with dependent children be exempted from participation in the AHCCCS CARE program.

¹³ Iowa Health and Wellness Plan p. 41

a. More detail is needed on the Healthy Arizona Program.

The lack of detail regarding the Healthy Arizona program is deeply concerning, and we are unable to comment fully on the proposal without more specificity. The application vaguely refers to wellness targets such as “wellness exams, flu shots, glucose screening, mammograms, tobacco cessation and chronic disease management for diabetes substance use disorders and asthma.” There is no evidence to date showing wellness programs improve enrollee health, promote engagement or save money. We suggest this element of the proposal be denied as requested.

If, however, the state is determined to move forward with a wellness program element, we strongly suggest it that Healthy Arizona be based on completing healthy activities- such as getting a health screening- rather than on health outcomes- such as whether an individual quits smoking or loses weight.¹⁴

b. CMS should deny the state’s request to tie participation in the AHCCCS Works program to the AHCCCS CARE Account.

While the state revised its initial application to explicitly state that participation in AHCCCS Works is not tied to program eligibility, we still believe the AHCCCS Works program in its current form is not approvable.

The purpose of the Medicaid program, according to the Medicaid Act itself, is to “furnish medical assistance on behalf of eligible populations.”¹⁵ Medicaid dollars cannot be used for other purposes. More specifically, section 1115 authority, which sets “promoting the objectives” of the Medicaid Act as a prerequisite for approval, clearly cannot be used to authorize a work incentive scheme.

Arizona does not even attempt to provide evidence of a causal connection between work and health care. Such an argument was made by the state of Pennsylvania, and its request for a work incentive program tied to premium amounts was appropriately denied by CMS. We urge CMS to likewise deny Arizona’s request.

Not only would a work incentive program be an impermissible use of Medicaid money and contrary to federal Medicaid law, the policy raises serious implementation problems that would implicate the Americans with Disabilities Act and state anti-discrimination laws. It would be difficult, if not impossible, for the state of Arizona to implement such a program in a way that did not discriminate against people who cannot work or engage in work search activities

¹⁴ Lydia Mitts, *Designing Consumer Friendly Wellness Programs in Medicaid*, Families USA (Jan. 2014) http://familiesusa.org/sites/default/files/product_documents/Medicaid_Designing%20Wellness%20Programs%20Brief_web.pdf

¹⁵ Social Security Act § 1901

because of their chronic or temporary health status. By penalizing individuals who are unable to work, the state and HHS open themselves to legal liability associated with discrimination on the basis of health condition, health status or disability by allowing such a provision to go into effect.¹⁶

We appreciate that Arizona is concerned about the employment opportunities available to low-income people. We fully support states' efforts to create *independent* (from Medicaid) and *voluntary* employment supports for lower income individuals. From a practical standpoint, work requirements applied to health coverage get it exactly backwards. The majority of Medicaid expansion enrollees are employed, and individual needs to be healthy in order to obtain and maintain employment. A work requirement can prevent an individual from getting the health care they need to be able to work.

IV. Benefits: Non-Emergency Medical Transportation

Arizona's request to waive Non-Emergency Medical Transportation (NEMT) will present an unnecessary barrier to care and does not advance the purposes of the Medicaid program generally, or the AHCCCS Care program's stated goals.

a. Evidence from Iowa and Indiana shows that lack of NEMT creates unmet need for transportation services that adversely impacts the sickest, highest cost enrollees.

Studies have consistently shown that providing transportation to non-emergency care results in fewer missed appointments, shorter hospital stays, and fewer emergency room visits.¹⁷ Alternatively, poor access to transportation is related to lower use of preventive and primary care and increased use of emergency department services.¹⁸ Data collected by the University of Iowa Public Policy Center to evaluate the waiver of NEMT in that state's Medicaid expansion program demonstrates there is unmet need for transportation that affects the lowest income individuals.¹⁹ Initial evaluations of Iowa's Medicaid expansion NEMT waiver show that, without NEMT, some of the lowest-income enrollees are those most likely to miss necessary appointments. A survey of Iowa's Medicaid expansion enrollees found that twenty percent of new enrollees with incomes below 100 percent of poverty could not get transportation to or from a health care visit.

¹⁶ Americans with *Disabilities Act* (ADA) and Section 504 of the Rehabilitation Act

¹⁷ Transit Cooperative Research Program, *Cost Benefit Analysis of Providing Non-Emergency Medical Transportation*, (Oct., 20015) http://onlinepubs.trb.org/Onlinepubs/tcrp/tcrp_webdoc_29.pdf

¹⁸ *Medicaid Non-Emergency Medical Transportation (NEMT) Saves Lives and Money*, The Non-Emergency Medical Transport Association <http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTpaper.pdf>

¹⁹ Iowa NEMT Waiver Amendment Request (May 29, 2015) <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Market-Place-Choice-Plan/ia-marketplace-choice-plan-pending-app-05292015.pdf>

In Iowa and elsewhere, NEMT is most often used for regularly scheduled, non-emergency medical trips for behavioral health services, substance abuse treatment, and dialysis treatment.²⁰ Without NEMT, patients with these conditions could miss appointments, making treatment less effective. Chronically ill patients could end up sicker and hospitalized or institutionalized, leading to more expensive care.

b. Waiving NEMT does not further the objectives of the Medicaid program and demonstrations evaluating the effect of a waiver of NEMT are already taking place.

NEMT helps ensure that Medicaid can address enrollees' health needs. The Medicaid program is designed to address the unique health care needs of low-income people and improve their access to care. Omitting the NEMT benefit from the program does not further this goal. Iowa, Arkansas and Indiana have all secured waivers of NEMT and, to date, have shown evidence that the absence of NEMT leads to barriers to care.

In rural and frontier areas, there may be no transportation at all. This will especially impact American Indian populations and others living outside of major metropolitan areas.

We fully support the state's decision to continue the Medicaid expansion and, as stated at the outset of our comments, we hope that CMS and Arizona can successfully negotiate a waiver amendment agreement that furthers the purposes of the Medicaid program to deliver health care to eligible populations.

However, as proposed, Arizona's waiver amendment works against the purposes of the Act by tying Medicaid coverage to a work requirement, the imposition a five year bar on enrollment, high premiums and copays for very low income people and the waiver of the important NEMT benefit. The amendment as submitted would place current Arizona Medicaid enrollees in a worse position than they are now, making it more difficult for them to access and afford care, achieve and maintain continuous insurance enrollment. Additionally, the request lacks the detail in many areas needed for complete comments, and the planning and evaluation necessary for full public engagement.

Thank you for the opportunity to comment on this important program. Should you have any questions, please don't hesitate to contact Dee Mahan, Medicaid Program Director dmahan@familiesusa.org or Andrea Callow, Senior Policy Analyst acallow@familiesusa.org .

²⁰ Medicaid Expansion and Premium Assistance: The Importance of Non-Emergency Medical Transportation (NEMT) to Coordinated Care for Chronically Ill Patients, *MJS and Company*, (March 2014) <http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTreportfinal.pdf>

Respectfully submitted,

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