March 20, 2025

Arizona Health Care Cost Containment System
C/O OOD-Division of Public Policy and Strategic Planning
801 E. Jefferson Street, MD 4200, Phoenix, AZ 85034
waiverpublicinput@azahcccs.gov

Dear AHCCCS:

The Arizona Hospital and Healthcare Association (AzHHA), the Health System Alliance of Arizona (The Alliance), the Arizona Medical Association (ArMA), the Arizona Alliance for Community Health Centers (AACHC), the Arizona Council of Human Services Providers (The Council), and the Arizona Academy of Family Physicians (AAFP) thank you for the opportunity to comment on the AHCCCS Administration's proposed AHCCCS Works Waiver Amendment that would implement a work requirement and a lifetime limit as required by Laws 2015, Ch. 7 (S.B. 1092). We understand that this is a very similar waiver proposal to the AHCCCS Works proposal AHCCCS submitted in 2017, which was approved by CMS in 2019 but later rescinded by the Biden Administration.

In this proposed waiver amendment, the Administration is requesting CMS approval to implement the following:

- The requirement for able-bodied adults between the ages of 19 and 55 in the Group VIII expansion population to be employed, to actively seek employment, to attend school, or to partake in Employment Support and Development activities for at least 20 hours per week, unless an exemption applies.
- The authority for AHCCCS to suspend such a beneficiary from enrollment for two months if the beneficiary fails to comply with the AHCCCS Works requirements, cannot show that a good cause exemption applies and does not initiate an appeal of the suspension.
- The authority for AHCCCS to ban such a beneficiary from Medicaid enrollment for one year if the beneficiary knowingly failed to report a change in family income or made a false statement regarding compliance with the work requirements.
- The authority for AHCCCS to limit lifetime coverage to five years for such beneficiaries accrued during the time they are subject to the work requirements and are non-compliant.
- The authority for AHCCCS to implement cost-sharing for non-emergency use of the Emergency Department and ambulance transport.

We appreciate the Administration's thoughtful approach to developing policies that are fair to the Medicaid population, stakeholders, and providers. However, we would like to express some concerns regarding the proposed work requirements and the five-year lifetime limit. We believe these aspects may not align with the core purpose of the Medicaid program, which is to serve as a safety net for individuals who may not otherwise have access to healthcare.

Additionally, we have some questions about the proposed policy requiring beneficiaries to pay cost-sharing for non-emergency use of the emergency department. Evidence from other states suggests that similar cost-sharing measures do not significantly reduce emergency department visits or lead to substantial cost savings, and we worry they may inadvertently have negative health implications.

Thank you for considering our input.

Work-Related Requirements

We support the Administration's pursuit of assisting members in finding employment. There is undoubtedly a link between health and employment status, in addition to an array of other health determinants. However, we have significant concerns regarding the proposed work requirements. The introduction of a policy requiring members to obtain work assumes that the approximately 500,000 beneficiaries who comprise the Group VIII population[1] electively abstain from work. Evidence from other states demonstrates that work requirements do not increase employment but instead lead to massive Medicaid disenrollment due to administrative complexities. In Arkansas, for example, over 18,000 Medicaid beneficiaries lost coverage within months of implementation—not because they were unwilling to work but due to reporting failures and systemic barriers.

It is important to consider that the relatively small percentage of the AHCCCS population subject to these requirements, along with the even smaller number of beneficiaries successfully securing employment, may not yield sufficient results to justify the program's implementation costs. Furthermore, if non-compliant, able-bodied adults face a two-month suspension, we may see an increase in emergency department visits due to their inability to afford care in other settings. This situation could lead to negative health outcomes and, ultimately, more expensive care. We hope for a collaborative approach to finding solutions that support both employment and healthcare access.

Work Requirement Exemptions

The proposed exemptions, which we agree are necessary, will significantly reduce the percentage of the AHCCCS population that will be subject to this proposal. We are concerned that the small percentage of AHCCCS beneficiaries subject to these requirements, and even fewer who find work, may not justify the program's administrative costs.

We also have concerns about specific populations that are subject to the work requirements. **Some of the exemptions are undefined or narrowly defined**. Consequently, they would not capture some individuals with chronic conditions, individuals with mental health conditions, seasonal workers, and caregivers of needy family members. Our concerns regarding undefined or narrowly defined exemptions include:

- **Understanding the definition of "medically frail."** Does medically frail cover beneficiaries such as organ transplant recipients and those who have life-threatening diseases such as HIV or cancer who depend on their Medicaid coverage for access to life-saving medication and treatment? Without assurance of this coverage, these vulnerable populations will potentially suffer adverse health outcomes, poor quality of life, or even death.
- **Mental health conditions.** Individuals with mental health conditions separate and apart from substance use disorders often struggle with employment stability.
- **Rural Arizona.** We are also concerned about beneficiaries working in rural communities and seasonal industries. Fluctuating job availability means that some individuals may work overtime during some months of the year but fewer than 20 hours at other times. We encourage AHCCCS to look to Arkansas's experience. Arkansas was the first state to implement Medicaid

[1] See https://www.azahcccs.gov/Resources/Downloads/PopulationStatistics/2025/Feb/PopulationbyCategory02182025.pdf.

work requirements in 2018, mandating certain low-income adults to work or engage in community activities for at least 80 hours per month to maintain coverage. Over 18,000 individuals lost their Medicaid coverage, many from rural areas with limited job opportunities and poor internet access. Rural hospitals faced increased uncompensated care costs as patients delayed seeking care or turned to emergency services without insurance, straining their finances.

- **Able-bodied definition**. We also believe the age range included in the definition of "able-bodied" should be changed from 19-56 to 19-49 because individuals 50 years and older are more likely to suffer from chronic health conditions. These individuals need continued access to healthcare coverage to manage these conditions, remain healthy, and obtain healthcare services in lower-cost and acuity settings.
- **Parents, caretaker relatives, foster parents, and legal guardians**. We are concerned about the lack of a definition for the exemption for "parents, caretaker relatives, foster parents, and legal guardians." S.B. 1092 only exempts sole caregivers of a family member under five years of age. Is this what the waiver contemplates, or does the exemption apply to caregivers of a child up to the age of 18? If a caregiver of a child who is five years old is required to work, the income generated could be insufficient to cover the cost of childcare. In some areas of the state, childcare may not even be accessible. We urge AHCCCS to consider the implications of how this exemption is defined should the program be approved.

  We are concerned that the exemption for family caregivers is limited to those enrolled in ALTCS. Many individuals may not qualify for ALTCS but still require substantial home care. For instance, those who can perform most Activities of Daily Living (ADLs) but are at risk of falling need caregiver assistance. Similarly, individuals with serious mental illnesses may need support to manage daily activities and treatment, while those with dementia may require reminders for medications and assistance with daily tasks. Additionally, individuals who qualify for long-term care under a private health plan may still need caregiving, regardless of their ALTCS status.

While we support incentivizing employment and creating a path forward for individuals to exit the Medicaid system, we are very concerned that this proposal provides a great disservice to vulnerable individuals in need of health care who are not included in the current list of exemptions. Also, some employers do not offer comprehensive healthcare coverage to their employees. Without Medicaid coverage, these working individuals who also lack employer coverage will likely defer seeking care and suffer adverse health consequences.

Five-Year Lifetime Limit

We believe a five-year life limit on benefits is not only arbitrary and unfair to beneficiaries but also completely contrary to the purpose of the Medicaid program, which is to provide a healthcare safety net for Americans. A lifetime limit would disproportionately affect older beneficiaries, who are more likely to need health care services for chronic conditions. It would also jeopardize health outcomes and drive up uncompensated care and overall health-related expenditures.

Imposing a strict five-year cap on Medicaid eligibility ignores the dynamic health and economic realities that individuals encounter throughout their lives. We are deeply concerned that Arizonans who exhaust their five years of Medicaid in their youth may find themselves without essential coverage during critical times later on. As people age, their likelihood of requiring care for chronic health conditions increases, yet they may be ineligible for Medicare. Also deeply concerning is the scenario in which an individual becomes disabled after reaching their lifetime limit and would find themselves without a safety net. Furthermore, during economic downturns, when job losses rise, even more Arizonans will seek AHCCCS coverage, only to be denied healthcare options after exhausting their five years. This lifetime limit unnecessarily restricts access to vital medical services right when individuals need them most.

More generally, a lifetime limit would undoubtedly jeopardize health outcomes for all beneficiaries who lose AHCCCS coverage. Experience has shown that when individuals lose access to care, they delay treatment, which leads to worsened health conditions. There is value in preventative care and care management that contribute toward improved health outcomes for individuals who would otherwise be deemed "super-utilizers" in our healthcare system. For example, we know that those with hypertension and diabetes who go without access to ongoing care are more likely to be without life-supporting medication and suffer adverse health outcomes. Rather than promoting self-sufficiency, this policy will create unnecessary barriers to maintaining good health and preventing existing health issues from becoming more serious and potentially fatal.

In addition to the adverse impact on Arizona's patients, the state's healthcare providers will experience increased financial strain. The proposed lifetime limit will only compound the financial strain providers experience today. We are certain that providers, hospitals in particular, will see an increased reliance on costly emergency services, significantly inflating the burden of uncompensated care. Additionally, there will be greater reliance on Community Health Centers, who, while they serve everyone regardless of ability to pay, will have limited capacity to do so if inundated with a significant increase of uninsured patients. This financial strain on Arizona's already stressed primary care network will result in reduced access to care for all Arizonans, including Medicaid beneficiaries, causing additional financial. Ultimately, all providers in the state will be affected.

Lastly, we are concerned that this policy's unintended consequence will increase healthcare costs for Arizona taxpayers and decrease access to care for everyone.

Administrative Burdens and Implementation Challenges

We have many questions and concerns regarding aspects of the program's implementation that could affect its cost, success, and fairness to beneficiaries and providers. Following are questions and concerns we urge AHCCCS to consider:

- **Will the Administration assume that all able-bodied adults are compliant at the end of the initial 6-month grace period**, or will beneficiaries have to prove compliance or an exemption beforehand?
- **If a beneficiary falls into an exempt category, how will the beneficiary prove this to AHCCCS?** Beneficiary compliance reporting will be especially problematic for individuals living in rural areas with transportation and broadband barriers, for housing-insecure individuals, and for those working low-wage, unstable, or seasonal jobs who lack consistent internet access or paid time off to meet documentation requirements.
- **Will the Administration require ongoing monthly submissions by able-bodied adults to prove their compliance?** We understand that an able-bodied adult will lose coverage for two months if they fail to comply with the requirements, cannot show a good cause exemption, and do not appeal the suspension. Will AHCCCS require monthly submissions proving compliance, or will AHCCCS assume compliance and conduct randomized checks on the population to test for compliance and determine if an exemption applies?
- **In implementing the one-year suspension, how will AHCCCS determine if an individual has intentionally or unintentionally made a false statement regarding compliance or failed to report income changes?** The waiver proposal fails to explain how program administrators will differentiate between those who knowingly or unintentionally provide inaccurate information regarding compliance or income changes. We are concerned that, despite the stated intent, if a beneficiary accidentally misses the deadline to report a change in income or prove compliance, they may be inadvertently penalized and suffer from a lack of insurance for an entire year. At a minimum, if the program is implemented, AHCCCS should implement grace periods and re-enrollment assistance for individuals at risk of losing coverage due to administrative issues.
- **The program will cause excessive administrative burden for providers by straining the workforce and reducing the dollars available for patient care**. We are concerned that implementing the required two-month suspensions, one-year suspensions, and lifetime limits will impose significant administrative challenges on providers, creating an unnecessary burden on an already strained workforce. Tracking compliance will add a complex and resource-intensive data collection process for hospitals, community health centers, and other safety-net providers, diverting funds away from essential healthcare services and into administrative overhead. Increasing administrative expenses in this way ultimately reduces the dollars available for direct patient care, undermining the efficiency and effectiveness of the Medicaid program.

Cost-Sharing for Non-Emergency Use of the Emergency Department and Ambulance Transport

Hospital emergency departments (ED) are required to remain open 24 hours a day, seven days a week. They are an expensive place to treat patients because of their high overhead and fixed costs. Understandably, state Medicaid programs want to discourage beneficiaries' use of the ED for non-emergent conditions in order to achieve cost savings. However, we are concerned about the likely effectiveness of this cost-sharing proposal. About half the states have implemented copayments as a way to dissuade "unnecessary" ED visits.2 Several studies indicate that implementing copayments does not consistently lead to a significant reduction in overall ED utilization.3 Of course, this directly impacts the anticipated cost savings of the program. One study indicated that other factors, such as access to primary care, play a much larger role in determining ED utilization.4

Additionally, cost-sharing does not address the significant costs due to triage and EMTALA screening requirements. ED physicians and hospitals must perform medical screenings, including diagnostic procedures, to rule out an emergency medical condition before copayments can be assessed. The system would still have to absorb these costs, regardless of whether the ultimate diagnosis is emergent or non-emergent. These factors will offset any potential savings.

Further complicating the situation is the lack of consensus over what constitutes an inappropriate, non-emergent, or unnecessary ED visit. The RAND Corporation found that no two studies defined non-urgent visits in the same way.5 Additional studies have found that the inconsistency in how "non-emergency" visits are classified contributes to the varied and limited impact of copayments.6 While there are coding strategies that Medicaid programs can use to define a visit as emergent or non-emergent retroactively, these are based on a final diagnosis after diagnostic tests are run, not on the presenting symptoms. A 55-year-old who presents in the ED with chest pain may be discharged with a non-emergent diagnosis of GERD but must first be evaluated for a cardiovascular emergency. A recent study found that only 6.3 percent of ED visits were later determined to have primary care-treatable diagnoses based on ED discharge diagnosis.7 However, in these cases, 89 percent of patients experienced symptoms that mimicked the chief complaints of all ED visits. In short, we are concerned that copayments for "non-emergent" use of the ED may unfairly penalize some patients who are appropriately using the emergency department.

Additionally, we have concerns that this cost-sharing policy will deter patients from seeking necessary care, fearing that their condition will not be deemed sufficiently emergent. As you may know, the landmark RAND Health Insurance Experiment and additional recent studies back up this logic, finding that while co-payments could reduce overall healthcare utilization, they may also discourage necessary

[2] Michael Ollove. States Strive to Keep Medicaid Patients Out of the Emergency Department. The PEW Charitable Trusts. February 24, 2015. See http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/2/24/states-strive-to-keep-medicaid-patients-out-of-the-emergency-department.

[3] "The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005", available at https://pmc.ncbi.nlm.nih.gov/articles/PMC4441261/ . "Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Emergency Medicine An Information Paper," available at https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/medicaid-ed-copayments---effects-on-access-to-emergency-care-and-the-practice-of-emergency-medicine.pdf.

[4] "Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Emergency Medicine An Information Paper," available at https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/medicaid-ed-copayments---effects-on-access-to-emergency-care-and-the-practice-of-emergency-medicine.pdf

[5] Lori Uscher-Pines. Applying What Works to Reduce Non-Urgent Emergency Department Use. RAND Corporation. May 22, 2013.

[6] "The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005," available at https://pmc.ncbi.nlm.nih.gov/articles/PMC4441261/. "Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Emergency Medicine An Information Paper," available at https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/medicaid-ed-copayments---effects-on-access-to-emergency-care-and-the-practice-of-emergency-medicine.pdf.

[7] Maria Raven, M.D, MPH, et al. "Comparison of Presenting Complain vs Discharge Diagnosis for Identifying 'Nonemergency' Emergency Department Visits," *JAMA. March 20, 2013.*

care, potentially leading to negative health outcomes.[8] Since many Medicaid recipients have low incomes, even small co-payments may deter them from seeking necessary care. In these cases, their condition will likely deteriorate, resulting not only in serious health consequences but also in a more costly visit when the beneficiary finally sees no other choice than going to the ED. This will also reduce any savings the Medicaid program might expect from this policy.

While we understand the attractiveness of using copayments to deter unnecessary ED utilization, we have reservations about the policy's effectiveness and are providing recommendations for AHCCCS' consideration.

- **We urge the Administration to couple any ED copayment requirements with efforts to expand access to primary care, specialists, and ambulatory clinics, as well as to increase urgent care locations and hours**. This policy attempts to reduce non-emergent visits to the ED by imposing a penalty without addressing the underlying reasons for this behavior and how it can be deterred. One reason patients use the ED for primary care treatable conditions is the inability to access primary care services and specialists in a timely manner. We acknowledge that increasing access to primary care, specialists, ambulatory clinics, and urgent care centers might necessitate additional funding for outpatient services, particularly for physicians who have been reluctant to accept new Medicaid patients because of poor reimbursement.
- **We recommend exploring frequent user diversion programs to help reduce "unnecessary" ED visits.** These initiatives identify individuals who frequently use EDs for primary care and provide them with targeted interventions, such as care coordination and case management, to address their underlying health and social needs.
- **We propose that AHCCCS consider implementing Primary Care Case Management Programs.** Some states have used Primary Care Case Management (PCCM) Programs, in which Medicaid beneficiaries are assigned to primary care providers, including Community Health Centers, who coordinate their healthcare services. We understand these programs exist largely in states without fully managed care, unlike Arizona. Still, there may be ways to incorporate the principles of PCCM through AHCCCS MCOs or other approaches to emphasize continuous primary care and address health issues promptly, which would reduce unnecessary ED visits.

We welcome the opportunity to collaborate with AHCCCS and health plans on such programs to better understand the impact and value that copayments may have on ED utilization and overall system costs.

[8] https://www.rand.org/health-care/projects/hie.html, https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/medicaid-ed-copayments---effects-on-access-to-emergency-care-and-the-practice-of-emergency-medicine.pdf

Conclusion

We appreciate the intent behind the AHCCCS Works waiver request to enhance cost-effectiveness and assist beneficiaries with gaining employment. While we understand the objectives behind the proposed work requirements, lifetime coverage limit, and cost-sharing measures, we are concerned about the possibility of significant coverage losses and adverse health outcomes that could arise from these changes.

In addition to the concerns discussed in this letter, we would like to call attention to the timing of the program's introduction of work requirements. As you may be aware, Congress is currently discussing a budget resolution that includes potential significant reductions in federal Medicaid funding. If any funding cuts are incorporated into the reconciliation bill, it may prompt AHCCCS and the state to make difficult programmatic adjustments. We believe that implementing the AHCCCS Works program during this uncertain period could present additional challenges for AHCCCS, its beneficiaries, and healthcare providers, possibly leading to confusion within Arizona's healthcare system. Therefore, we suggest that the implementation of this program, pending CMS approval, be postponed until we have a clearer picture regarding Medicaid program changes.

If approved, the AHCCCS Works program will be complex, and determining the best approach to implementing it will require considerable time and collaboration. We encourage the Administration to involve external stakeholders in discussions that can assist in operationalizing the program effectively and minimizing any potential negative impacts on the system, providers, and, most importantly, Medicaid beneficiaries.

We wish to ensure that the AHCCCS program continues to serve its crucial purpose without adversely affecting low-income individuals, chronically ill patients, and rural communities. If the AHCCCS Works initiative moves forward, we urge AHCCCS to prioritize access to care by exploring opportunities to expand exemptions, reconsider the lifetime limit, reduce administrative hurdles, and revisit cost-sharing policies. We are committed to collaborating on solutions that support workforce participation while safeguarding the health and stability of Arizona's most vulnerable populations.

Thank you for the opportunity to share our thoughts on the proposed AHCCCS Works waiver amendment. Please feel free to reach out if you have any questions or need further clarification.

Respectfully,

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