May 9, 2025

The Honorable Robert F. Kennedy
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Re: Arizona Section 1115 Waiver Amendment Request: AHCCCS Works

Dear Secretary Kennedy:

Thank you for the opportunity to submit comments on the Arizona Section 1115 Waiver Amendment Request.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. The diversity of our organizations and the populations we

serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the Centers for Medicare and Medicaid Services (CMS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Arizona's Medicaid program provides quality and affordable healthcare coverage. Our organizations are strongly opposed to Arizona's proposal to implement work reporting requirements, time limits and emergency department and ambulance transport copays for Medicaid beneficiaries. These requirements will lead thousands of people to lose coverage and jeopardize the health of people with serious and chronic conditions in Arizona. Our organizations urge CMS to reject this request and offer the following comments on the AHCCCS Works Demonstration:

Work Reporting Requirements

Work reporting requirements will result in significant coverage losses, which is in direct opposition of the purpose of the Medicaid program – to furnish healthcare services. Under Arizona's proposal, adults under 55 must demonstrate that they meet the work reporting requirements or are exempt. When Arkansas implemented a similar policy requiring Medicaid enrollees to report their hours worked or their exemption, the state terminated coverage for over 18,000 individuals before a federal court halted the policy.[1] Similarly, Georgia's Pathways to Coverage Program, which includes work reporting requirements, enrolled less than 5,000 individuals in its first year, instead of the projected 31,000-100,000 beneficiaries originally estimated to be eligible.[2] Arizona estimates that 190,000 beneficiaries will be subject to work reporting requirements. For patients with serious or chronic conditions, a gap in healthcare coverage can disrupt access to regular care and medications needed to manage their condition, leading to exacerbations that require emergency department visits at a higher cost to both the patient and the state. This proposal contradicts the goals of the Medicaid program and jeopardizes access to care for thousands of Arizonans.

If the state does not think individuals have met the new requirements after an initial grace period, the state will suspend their coverage for two months, at which point the state requests authority to disenroll individuals and prohibit them from re-enrolling in coverage. This would lock patients out of accessing coverage, creating gaps in care and disrupting access to critical and often lifesaving services. Again, coverage lockouts contradict the objectives of the Medicaid program and lead to loss of coverage.

Our organizations are deeply concerned that the proposal may negatively impact eligibility for individuals with, at risk of, or in the process of being diagnosed with, serious and chronic health conditions that prevent them from working. The application states that the definition of medically frail will be developed in the future, making it hard to comment on this aspect of the application at this time. Regardless, any reporting process for exempt enrollees and those with good cause circumstances will create opportunities for administrative error that could jeopardize people's coverage. This is exactly what happened in Arkansas – as one study found, "more than 95% of persons who were targeted by the policy already met the requirement or should have been exempt. Many Medicaid beneficiaries were unaware of the policy or were confused about how to report their status to the state, which suggests that bureaucratic obstacles played a large role in coverage losses under the policy."[3] No criteria can circumvent these problems and the serious risk to the health of people with chronic and serious health conditions.

The waiver is unclear on the reporting process for these requirements. The state does not have a clear process for how and how often individuals will need report their activities, nor does it clarify if compliance will be solely determined with data matching. If the state intends to rely on data matching, there will undoubtedly be individuals whose data is incomplete, outdated, or not accurately captured by the systems in use. For example, data on disability status does not always provide a complete picture of whether individuals with chronic conditions are able to work. Additionally, because of lags in claims data, it is unlikely that information for those with recent diagnoses that prevent them from working would be accurately captured by data matching. Furthermore, while the proposal states that individuals who are suspended from coverage may be reinstated if the state can verify that they had good cause circumstances, the reporting process for this is also unclear. And finally, there is no clearly defined appeals process for individuals who are wrongfully suspended or disenrolled from coverage. Navigating an appeals process can be time-consuming and burdensome. Patients may not have the time or resources to complete a lengthy eligibility appeal, leading to loss of coverage. Our organizations are opposed to the administrative burden that this proposal will place on the patients and the program.

Overall, a major consequence of this proposal will be to increase the administrative burden and overall churn within Medicaid program as beneficiaries are disenrolled as a result of red tape and attempt to reenroll in coverage. The administrative cost of churn is estimated to be between $400 and $600 per person.[4] Arizona's Medicaid program is likely unprepared for the additional administrative burden that the work reporting requirements will generate.

Our organizations are concerned by the cost to implement this waiver. There will likely be large administrative costs to the state to implement data matching and to put a system in place to identify and track exemptions. For example, a GAO study of work reporting requirements estimated that the administrative costs could be up to $272 million.[5] In Georgia, the state spent over $86 million within a year of implementing the Georgia Pathways to Coverage Program, despite the low enrollment, and it is estimated that three quarters of this was for administrative and consulting costs.[6] Taxpayer dollars should focus on providing quality, affordable healthcare coverage, not cutting it.

Ultimately, these requirements do not further the goals of the Medicaid program or help low-income individuals find work. Most people on Medicaid who can work already do so. According to KFF, 92% of adults with Medicaid coverage under age 65 who do not receive Social Security disability benefits are either workers, caregivers, students, or unable to work due to illness.[7] And continuous Medicaid coverage can actually help people find and sustain employment. In a report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that being enrolled in Medicaid made it easier to work or look for work (83.5% and 60%, respectively).[8] That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Additionally, a study in *The New England Journal of Medicine* found that Arkansas's work reporting requirement was associated with a significant loss of Medicaid coverage, but no corresponding increase in employment.[9] Terminating individuals' Medicaid coverage for non-compliance with these requirements will hurt rather than help Arizonans search for and obtain employment. Our organizations urge CMS to reject this request for work reporting requirements.

Time Limits

Our organizations strongly oppose time limits on Medicaid coverage. The state's proposed five-year time limit on how long someone can maintain Medicaid coverage does not promote the objectives of Medicaid. It is an arbitrary, harmful policy and could limit patients' access to critical treatment when

they need it most. The federal government did not approve a nearly identical version of this policy proposed by Arizona in 2019,[10] and we urge CMS to reject this proposal.

People, regardless of income, need access to healthcare throughout their lives. Individuals with lifelong chronic condition who are denied Medicaid coverage because of the coverage limit could be unable to get the medication or treatment they need to manage their condition. For example, cancer treatment is a long process, and numerous cancers, including childhood cancer, lung, brain, and pancreatic cancer have higher chances of recurrence.[11,12] If a cancer or chronic disease patient's coverage ends as a result of a lifetime coverage limit, they could be left without access to lifesaving treatment.

This policy runs counter to both the objectives of Medicaid and the demonstration's stated objectives of supporting Arizonans in gaining the "fulfillment that comes with employment." In Arizona, minimum wage is $14.70, meaning that a family of three where one parent is working full-time at minimum wage would make $2,352 each month, still falling well under 138% of the federal poverty limit ($3,064 per month). Under the proposed time limit, working families with stable incomes would lose coverage despite complying with all other Medicaid eligibility requirements. Additionally, families and individuals in Arizona should not be penalized for having previously relied upon public benefits programs, including before this proposal goes into effect. Our organizations urge CMS to reject the proposed time limit for Medicaid coverage.

Copayments for Non-Emergency Use of Ambulance Transport and Emergency Department
Our organizations strongly oppose the proposed copay for non-emergent use of ambulance transport or the emergency department. These copays deter patients from seeking care, which can result in negative health outcomes for patients with acute and chronic diseases. For example, a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[13] People should not be financially penalized for seeking lifesaving care or transportation for a breathing problem, complications from a cancer treatment or any other critical health problem that requires immediate care. Lay people do not have the knowledge to distinguish a medical emergency, like a heart attack, from other similar non-life-threatening pain. Our organizations urge CMS to reject this policy.

Lack of Detail
Arizona's proposal lacks key details that prevents commenters from providing meaningful input on the proposed changes and is not a complete proposal. The demonstration fails to clarify how and how often individuals will report work activities, if or when the state will terminate an individual's coverage, or if the state will prohibit re-enrollment for noncompliance. Furthermore, the demonstration fails to provide estimates of the impact of this waiver on enrollees, including the number of people who will lose coverage under the new requirements, the number of applicants who will be denied enrollment due to the new requirements, and the number of individuals who are expected to lose coverage as a result of the proposed five-year time limit. This information is crucial to evaluate the waiver, including estimating the cost of the waiver and its budget neutrality. Our organizations urge CMS to clarify these points with the state and reissue the proposal for another comment period of at least 30 days.

Conclusion
Our organizations remain strongly opposed to work reporting requirements, time limits, and emergency department and ambulance transport copays, and we urge CMS to reject this proposal in order to

protect access to quality and affordable healthcare in Arizona. These requirements do not promote the objectives of Medicaid and will take away healthcare coverage from thousands of Arizonans.

Thank you for the opportunity to provide comments.

Sincerely,

AiArthritis
American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Autoimmune Association
Cancer*Care*
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Immune Deficiency Foundation
Lutheran Services in America
National Bleeding Disorders Foundation
National Coalition for Cancer Survivorship
National Health Council
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Sickle Cell Disease Association of America, Inc.
Susan G. Komen
The AIDS Institute
The Coalition for Hemophilia B
The Leukemia & Lymphoma Society
WomenHeart: The National Coalition for Women with Heart Disease

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