Date: November 15, 2012

To: Interested Parties

From: AHCCCS Administration

Re: Referenced Attachments from written comments.

This document includes referenced attachments from correspondence sent to AHCCCS regarding the Childless Adults DRAFT Waiver Amendment and the Future of Arizona’s Medicaid Program. The original correspondence can be found on one of the following links:

Childless Adults

AZ Future

The referenced attachments include:

- Key findings from a statewide survey of voters in Arizona by the Tarrance Group (Attached to CASE letter 8/31/12)

- Six Exhibits (Attached to William E. Morris Institute letter 10/18/12)

- 128 “I Support AHCCCS Efforts” Petitions (Attached to Crossroads Mission letter 10/18/12)
Key Findings from a statewide survey of voters in Arizona by the Tarrance Group

(Attached to CASE letter 8/31/12)
THE TARRANCE GROUP

TO: THE ARIZONA CHAMBER OF COMMERCE AND INDUSTRY
    THE GREATER PHOENIX CHAMBER OF COMMERCE

FROM: BRIAN NIENABER
      ED GOEAS

RE: KEY FINDINGS FROM A STATEWIDE SURVEY OF VOTERS IN ARIZONA

METHODOLOGY
The Tarrance Group is pleased to present these key findings from a survey of voters in Arizona. All respondents interviewed in this study were part of a fully representative sample of N=600 registered voters plus an N=130 oversample of registered Republicans to bring the number of Republicans in the sample to N=439. Responses to this survey were gathered December 11-13, 2011. The confidence interval associated with a sample of this type is ± 4.1% in 19 of 20 cases for the overall sample and ± 4.8% for the N=439 sample of Republicans in 19 of 20 cases.

➢ On the issue of health insurance exchanges, voters are given a brief explanation about exchanges* and asked their preference -- a state run exchange or a federal run exchange. A majority of all voters (56%) prefer a state run exchange, including 41% of voters who indicate a strong preference for state run exchanges.

* The full language of this question appears in the addendum.

➢ Among Republicans, there is an even stronger preference for having the state run these health insurance exchanges. Fully 80% of Republicans prefer a state run exchange. In addition, there is strong support for state run exchanges among key Republican demographic groups like very conservative Republicans (85%) and Republicans who are strong supporters of the Tea Party movement (83%).

➢ In sum, there is notable opposition to Obamacare among all voters and particularly intense opposition to Obamacare among Republicans. These concerns about federal run solutions for a locally provided and intensely personal service are certainly seen in the clear preference that voters have for state run health insurance exchanges. The state would be well served to create an exchange that both meets the needs of citizens and answers the concerns of voters.

###
Addendum
Full text of the question on health insurance exchanges appears below.

Now, thinking about the issue of health care reform...

As you may already know, the health care reform law passed in 2010 requires health insurance exchanges to be set up in each state by 2014. A state may set up its own exchange. If a state does not set up an exchange, then the federal government will do it.

Exchanges are:

- Marketplaces created by the state where individuals and small businesses compare, shop, and enroll in a health insurance plan that meets their needs.
- Regulated by the state officials if they are set up by a state,
- Offer a website that allows citizens to compare and contrast all aspects of health insurance plans and enroll online, and
- The only place where citizens with federal subsidies can use these funds to buy health insurance.

The state legislature and the Governor are considering two main options for setting up these exchanges. These options are:

- Setting up an exchange run by the state, OR
- Having an exchange set up and run by the federal government?

Which of these options would you prefer?
Six Exhibits

(Attached to William E. Morris Institute letter 10/18/12)
EXHIBIT 1

TO

OBSJECTIONS TO ARIZONA’S
SECTION 1115 WAIVER AMENDMENT REQUEST
CONTINUING COVERAGE FOR CHILDLESS ADULTS
UNDER THE DEMONSTRATION
Hello Jessica. Please see the responses regarding copayments for childless adults below. Please let me know if you have any questions or require additional information.

Regards,

Monica

Monica Higuera Coury
Assistant Director
Office of Intergovernmental Relations
AHCCCS
Phone: 602-417-4019
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I wanted to send you a quick note regarding Arizona's use of mandatory co-payments on the childless adult population. The 9th Circuit held in the Newton-Nations case (McCants) that Demonstration populations are not "eligible" for medical assistance under a State plan. As a result, we continue to think that the 1115 restrictions on waivers of co-payments do not apply to individuals who were not eligible for medical assistance under a State plan. But the Ninth Circuit also concluded that the State needs to justify its request to impose co-payments for the childless adults (the Demonstration population), so I wanted to ask for the following information:

1. What is the State's hypothesis with respect to the co-payments, i.e., what does the State intend to "demonstrate" by imposing mandatory co-payments on the childless adults?

Response: Stated in the simplest terms possible, the State's hypothesis is that the imposition of mandatory copayments on childless adults will permit the State to minimize the number of uninsured in the State to a greater extent than would be financially feasible without mandatory copayments. In addition, the demonstration project will test the hypothesis that the health status of childless adults in Arizona who have access to health care coverage subject to a reasonable but mandatory copayment requirement will be better than childless adults in Arizona that must depend on charity care. Imposition of mandatory copayments permits the State and its Medicaid Managed Care contractors to make corresponding reductions to expenditures for the cost of services (because the provider collects the difference from the
member in the form of the copayment). As a result, the State can use the savings in service costs as part of the overall savings generated by the managed care demonstration project to fund coverage (albeit coverage subject to a copayment) to persons who would otherwise not be entitled to any coverage for care (i.e., Childless Adults). Therefore, the State's hypothesis is that imposing mandatory copayments on childless adults will contribute to the overall objective of the Demonstration Project; that is, to enable the State to expand Medicaid coverage to the greatest extent for persons not otherwise eligible for medical assistance (i.e., non-categorically eligible individuals in the State of Arizona -- i.e. childless adults). In the absence of the financial savings associated with copayments, the State would have to consider alternatives to the proposed Demonstration Project such as coverage of childless adults at a lower percentage of the federal poverty level.

2. Given the research on co-payments and low-income populations, how will the co-payments affect the impacted beneficiaries, particularly with respect to access and health outcomes?

Response: A system that provides the uninsured access to health care subject to mandatory copayments will improve access to care and health outcomes relative to the uninsured who must rely on charity care. While the research may suggest that copayments result in persons forgoing some care, those studies compare utilization for insured persons subject to copayments relative to insured persons not subject to copayments. The State believes that copayments will allow for access to comprehensive coverage for a greater number of individuals and that this access to comprehensive coverage yields better health outcomes than either no coverage or coverage that only provides a basic benefits package. This theory is supported in a study entitled "The Oregon Health Insurance Experiment", which concluded that access to comprehensive Medicaid coverage is better than being uninsured. That study can be viewed at the following link: http://www.nber.org/papers/w17180.pdf?new_window=1 and an article on the same study can be viewed at: http://economix.blogs.nytimes.com/2011/07/07/how-health-insurance-affects-health/.

3. How does the State intend to evaluate the demonstration hypothesis with respect to cost sharing? Does the State intend to separately evaluate the mandatory co-payments, or only as part of the larger evaluation of coverage expansion?

Response: The State intends to evaluate the demonstration hypothesis by estimating the number of additional otherwise uninsured persons that the State is able to offer health care due to the savings to the State from the total cost of services. Specifically, the State will measure success by dividing: (1) the State costs avoided due to cost sharing by (2) the per member per month cost for the average childless adult. This will yield the incremental number of uninsured for whom the State was able to offer coverage as the result of cost sharing.

In addition, with respect to your request to impose mandatory co-payments on the State plan populations (kids, pregnant women and TANF parents), how does the State intend to document that it has met the 5 requirements under 1916(f).

We have reviewed 1916(f) and have determined that Congress has established an unattainable standard.

Finally, I'm attaching the Family Planning Extension STCs so you all can begin your review. I'll be happy to discuss further on Wednesday to clarify anything. I look forward to the State's response.

Thanks,
EXHIBIT 2

TO

OBJECTIONS TO ARIZONA’S SECTION 1115 WAIVER AMENDMENT REQUEST CONTINUING COVERAGE FOR CHILDLESS ADULTS UNDER THE DEMONSTRATION
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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

Sharon Newton-Nations; Manuela
Gonzalez; Cheryl Bilbrey; Donald
McCants; Hector Martinez; Anne
Garrison; Dawn House; Dana Franklin;
Edward Bonner; D.H.; Jack Baumhardt;
Manuel Esparza; and Patricia Jones, on
behalf of themselves and all others
similarly situated,

Plaintiffs,

v.

Anthony Rodgers, Director of the Arizona
Health Care Cost Containment System;
and Michael O. Leavitt, Secretary of the
United States Department of Health and
Human Services, in their official
capacities,

Defendants.

No. CIV 03-2506 PHX EHC

SECOND DECLARATION OF
LEIGHTON KU, PH.D., M.P.H. IN
SUPPORT OF PLAINTIFFS’ MOTION
FOR SUMMARY JUDGMENT

(Assigned to Hon. Earl H. Carroll)
I, Leighton Ku, declare as follows:

1. The matters stated in this declaration are given of my own personal knowledge and, if called as a witness, I would truthfully and competently testify consistent with the following.

2. I recently joined the faculty of the School of Public Health and Health Services as a Professor of Health Policy at George Washington University in Washington, D.C. My work focuses on conducting and analyzing health research, trends in insurance coverage, health care for immigrants, and federal and state budget concerns and their impact on health care. I have conducted extensive research about the Medicaid program, including state health reforms, Medicaid managed care, and the effects of welfare reform on Medicaid. I am a nationally-recognized expert on cost-sharing and low-income patients and have written research papers and lectured on this topic. I have been invited to speak on this topic in briefings to Congressional staff when they were considering the Deficit Reduction Act, to the National Academy of State Health Policy, to the National Association of State Medicaid Directors, and to the Centers for Medicare and Medicaid Services. I have also taught research methodology and statistics to doctoral students in the public policy and public administration for about 15 years.

3. Before this, I was a Senior Fellow at the Center on Budget and Policy Priorities, a nonpartisan policy institute that conducts research and analysis on a range of government policies and programs, with an emphasis on those affecting low- and middle-income people. Before that, I was a principal researcher at the Urban Institute, a nonprofit nonpartisan policy research organization based in Washington, D.C. I authored and directed studies on how welfare reform has affected Medicaid, health care coverage, and health care access for immigrants. Particularly pertinent to this declaration, I was one of the principal evaluators for several states' Medicaid section 1115 demonstration projects, under contract to the Health Care Financing Administration (the prior name of the Centers for Medicare and Medicaid Services) and authored or co-authored of a
number of reports about section 1115 projects. Thus, I am familiar with both research
and policy issues related to these projects.

4. At the Urban Institute, I was a founding member of the Institutional Review
Board which is responsible for determining whether research studies meet ethical
standards for the protection of human subjects in research studies. I reviewed numerous
research projects for adherence to these standards. Equally important, as a researcher, I
was responsible for ensuring that we maintained ethical safeguards for those who
participated in research studies that I conducted. As such, I am familiar with protocols
used in research studies that concern voluntary and informed consent in research projects.

5. I received a Ph.D. in health policy from Boston University and a Masters in
Public Health from the University of California, Berkeley. My curriculum vita is
attached as exhibit A, and includes a listing of my publications.

6. In preparation for this declaration, I have reviewed the Arizona co-payment
regulations at issue in this case, Declarations of Plaintiffs in Support of Plaintiffs’ Motion
for Preliminary Injunction and Motion for Class Certification, Declarations of Class
Members and Other Witnesses in Support of Plaintiffs’ Motion for Preliminary
Injunction and Motion for Class Certification, Arizona’s waiver request the federal
approval documents posted at the federal Web site and the exhibits submitted by the
federal defendant in a document entitled Certification of Administrative Record.

Review of research concerning copayments for low-income people

7. In the past few years, I have written two reviews of the research literature
about the effects of medical cost-sharing for low-income people. On May 7, 2003, the
Center on Budget and Policy Priorities published a report that I authored, Charging the
Poor More for Health Care: Cost-Sharing in Medicaid (Charging the Poor More). On
July 7, 2005, the Center released a report that I co-authored with Victoria Wachino, The
Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings. True
and correct copies of this report are attached as exhibits B and C.
8. In these reports, I provided comprehensive analyses of the research to date, assessing the effects of cost sharing on the poor. Cost sharing occurs when insured individuals are required by the insurer to pay for some of their health care coverage, for example, by paying a “copayment” each time a health service is obtained or prescription is filled. (Most of the information described below is documented in the reports, so I do not provide citations in this declaration, since they are available in the reports. In this declaration, I have added some updated information from more recent studies and provide citations for the new evidence.)

9. Over the last 35 years, a number of studies have looked at the effects of cost sharing on the poor. Of all forms of cost sharing, copayments are the most heavily studied. Three conclusions can be drawn from this research: first, copayments keep many low-income people from getting needed medical care or medications; second, low-income people cannot always afford these copayments and must choose between them and other basic necessities of life; and third, copayments are not an efficient Medicaid cost saving measure for states.

**Negative effect on care needed by low-income people**

10. A substantial and rigorous body of research has consistently concluded that low-income individuals—those with income below 100 percent of the federal poverty level—are more vulnerable to the adverse effects of copayments than other groups. Copayment policies that cause only modest reductions in health care use among middle-class individuals can result in more substantial reductions in health care use and lead to significant adverse health consequences among low-income individuals, especially those with chronic health problems. For example, multiple studies have concluded that higher copayments for medical services or prescription drugs cause low-income people to use substantially fewer essential and effective medical services or medications.

11. Copayments have also been shown to lead to poorer health among low-income adults, including worse blood pressure and vision, than among those not subject to copayments. One large, recent study in Quebec found that after copayments for
prescription drugs were imposed, poor adults had 88 percent more emergency room visits
and experienced a 78 percent increase in medical events like hospitalization or
institutionalization as a result of problems experienced when these low-income people
went without essential medication. Still other studies have demonstrated the difficulties
that Medicaid beneficiaries encounter in accessing medical services when they are being
assessed copayments. For example, in a study of Medicaid beneficiaries in Tennessee (in
which copayments were elevated under a section 1115 waiver), 20 percent of the patients
said they were not able to pay the copayment at the time of a doctor’s office visit and 22
percent could not pay the prescription drug copayment. Most of those unable to afford
the drug copayment went without the medication.

12. A very recent study examined the medical consequences that may occur
when older adults are unable to fill prescriptions because of cost-related problems. In
this study, those who limited their use of medications due cost problems were
significantly more likely to experience heart attacks, strokes, angina attacks and to
experience a decline in their health status two or three years later, compared to those who
did not limit their use of medications because of cost problems. (M. Heiser et al. “The
Health Effects of Restricting Medication Use Due to Cost,” Medical Care, 42(7):626-34,
July 2004.)

13. Recent studies have also examined the effect of “tiered” copayments, such
as those developed in Arizona, in which copayments for certain drugs (e.g., generic
medications) are lower than for other drugs (e.g., brand name medications.) A study of
privately insured patients found that there was a reduction in some patients’ use of
medically essential medications as a result of tiered copayments. For example, diabetics
reduced their use of anti-diabetes medications, which could lead to progression of their
disease and poorer health outcomes (D. Goldman et al., “Pharmacy Benefits and the Use
of Drugs by the Chronically Ill,” Journal of the American Medical Association, 291:
2344-50, May 23, 2004). Proponents of tiered copayments argue that copayments
provide financial incentives for patients to select lower-cost medications instead of more
expensive versions. The problem with this argument is that a physician selects the
prescription drug, not the patient, and the physician may not know about the levels of
copayments their patients face or may not care; there is no incentive for a physician to
prescribe the drug with the lower copayment. In such a situation, the patient may be
unable to afford copayment for the medication prescribed, while the physician was
unaware that a different medication selection might have had a lower copayment.

14. A study conducted at the Hennepin County Medical Center (in
Minneapolis) in 2004 found that the enforcement of Medicaid prescription drug
copayments (from $1 to $3) reduced the access of Medicaid patients to prescription drugs
and contributed to adverse medical outcomes, including emergency room visits and
hospital admissions, for problems such as strokes, asthma attacks and complications due
to diabetes. About half (52%) of those who faced copayments reported being unable to
pay for at least one prescription in the past six months after copayments were raised. (M.
Mendiola, et al. “Medicaid Patients Perceive Copays as a Barrier to Medication
Compliance,” Hennepin County Medical Center, Minneapolis, MN, presented at the
Society of General Internal Medicine national conference, May 2005 and American
College of Physicians Minnesota chapter conference, Nov. 2004.)

15. A study that was just published shows that women on Medicare who had to
pay higher copayments were less likely to use mammograms, a recommended preventive
Mammography in Medicare Health Plans,” New England Journal of Medicine, 358:375-83, Jan. 24, 2008). While the cut-off for heightened copayments in that study was $10, it
is worth noting that only a small share of women in the cost-sharing plans (11 percent) in
the study had incomes below the poverty line, whereas all of the women subject to the
challenged Arizona have incomes below the poverty line. Because they are poorer, it is
reasonable to conclude that these beneficiaries would be deterred from using this
screening test even at much lower copayment levels. The cumulative and consistent
research concludes that the imposition of heightened copayments on low-income
people—particularly those living at or below the poverty line—will likely place the health and well-being of these affected individuals in significant danger.

**Low-income people forced to choose between health care and other necessit**ies

16. Cost sharing is on the rise for middle and upper income people with private health insurance coverage. Thus, it is not surprising that states might be interested in mirroring these activities in their Medicaid programs. However, as documented in *Charging the Poor More and The Effect of Increased Cost-sharing in Medicaid*, there is an accumulated and consistent body of research concluding that low-income people cannot financially bear copayments as easily as those with higher incomes. This is because low income people are in a different economic position. Data show that Medicaid beneficiaries already have substantial out-of-pocket medical care expenditures. On average, Medicaid beneficiaries pay a larger share of their incomes in out-of-pocket medical expenses than do higher-income individuals with private insurance. Increases in Medicaid copayments would exacerbate their financial burdens.

17. Low-income families must also stretch their incomes to meet competing demands for rent, child care, and other expenses. Research indicates that, despite the presence of programs like food stamps, poor families often have difficulties meeting basic needs. In many areas, rising housing costs are claiming an increasing share of poor families’ incomes. Studies show that those with incomes below the poverty line already experience hardships, such as running out of food or having difficulty paying rent or utility bills. Elevated copayments for low-income people force many of them to choose between health care and other basic needs.

**Medicaid copayments are not an efficient way to reduce state expenditures**

18. Instituting or increasing copayments is not an efficient way for states to lower their expenditures for Medicaid because they lose a substantial portion of any savings generated when they institute copayments because this approach reduces federal matching funds. For example, consider a prescription drug that costs $60. Under Medicaid matching rules, the federal government will pay $39.72 (or 66.2 percent, the
federal Medicaid matching rate for Arizona in 2008), while the state of Arizona pays $20.18 (33.8 percent of the total). If there is a $10 copayment, the total cost to Medicaid for the drug is reduced to $50, so the state share will fall to $16.90 (33.8 percent of $50) and the federal government will pay $33.10. Even though a poor state resident has paid $10 of his or her limited income for that prescription, the state of Arizona saves only $3.32 (33.2 percent of $10), while the great majority of savings accrues to the federal government. That is, the state has imposed a $10 regressive user fee or tax, which falls only upon low-income state residents, but the state saves only one-third of that amount. From a public finance perspective, this is both regressive and fiscally inefficient. That is, the financial burdens paid by low-income Medicaid recipients are disproportionate relative to the budgetary savings that the state of Arizona accrues. (This example is somewhat simplified, since Arizona does not usually directly pay for prescription drugs on a fee-for-service basis, but pays for these services as part of a larger a capitated amount paid to managed care organizations. But if the managed care organization pays less to pharmacies and reaps savings, these savings will eventually lead to lower capitation rates paid by the state and subject to Medicaid matching rules.)

19. The declarations submitted by the plaintiffs and class members in this case are consistent with the findings and conclusions consistently reached in the research literature. Requiring copayments from people with incomes below the federal poverty level, especially copayments that exceed “nominal” levels, in order to receive essential medical care or medications creates a substantial risk of harm to the health of these individuals, as well as creating additional financial burdens upon them. The research shows that copayments lead many patients to forego essential medical care or medications, which can in turn jeopardize their health and lead to worse medical outcomes or require more costly and intensive medical care. If they must pay more for medical care, poor patients are forced to make difficult choices between using their limited incomes to pay for medical services or medications or for other basic needs, such as food or rent. Finally, increasing copayments is an inefficient way to reduce state
Medicaid expenditures in which the financial burdens for low-income state residents substantially outweigh the savings for the state of Arizona.

Congress continues to hold that Medicaid beneficiaries with incomes below the poverty line should not pay copayments that exceed nominal levels.

20. Since this case was originally filed, two laws have been enacted that modify Medicaid rules regarding copayments: the Deficit Reduction Act of 2005 (Public Law 109-171) and the Tax Relief and Health Care Amendments of 2006 (Public Law 109-432). The Centers for Medicare and Medicaid Services, the federal agency that administers Medicaid, recently released a notice of proposed rule-making to implement these provisions, but has not yet issued final regulations. Although these laws offer states new options to increase cost-sharing in Medicaid under certain circumstances, they also make it clear in Section 1916A(a)(2)(A) that individuals with incomes below 100 percent of the federal poverty line should not pay copayments that exceed “nominal” levels of about $3 per service or medication. Moreover, they also clarify that total aggregate cost-sharing amounts for families with incomes below 100 percent of the poverty line should not exceed 5 percent of family income.

Statement about federal policy regarding cost sharing and waiver projects

21. On page 28 of the Memorandum in Support of Defendant Thompson’s first motion for summary judgment, the federal attorneys include a quotation from a report co-authored with Edwin Park: “States also would have complete flexibility to impose whatever cost-sharing they wish on "expansion" individuals, which could restrict access to necessary services even when the services are covered.” (Administration Medicaid and SCHIP Waiver Policy Encourages States to Scale Back Benefits Significantly and Increase Cost-Sharing for Low Income Beneficiaries, Center on Budget and Policy Priorities, August 15, 2001). This quotation is used to imply that it was considered legitimate for the federal government to increase cost sharing in section 1115 waiver projects. However, that quotation was merely a description of the federal policies that had been recently announced (the Health Insurance Flexibility and Accountability or
HIFA waiver initiative, which was introduced by the Bush Administration in 2001) toward cost-sharing in section 1115 waivers, not an assessment of whether these policies are appropriate or legal. A true and correct copy of the complete report cited by the federal defendant is attached as exhibit D.

22. In a later report, Charging the Poor More, I again describe current federal policies regarding cost sharing and waivers, but also note that the federal agency might not be following statutory criteria when it decides to approve waivers: “Under Section 1115 waivers, the federal government may permit states to modify these cost-sharing rules. Although these modifications commonly apply to groups that become newly eligible for coverage under the waiver (particularly individuals with incomes above the poverty line), the Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health and Human Services (HHS) has been willing to let states modify cost-sharing for those already eligible for benefits, particularly through HIFA waivers which the Bush Administration introduced in 2001. In its HIFA waiver guidance, CMS has not set a limit on total cost-sharing, except for a limit of five percent of family income for children. Federal law establishes criteria concerning when CMS may waive cost-sharing limits in Medicaid, but CMS has not necessarily followed these criteria in approving waivers.”

Arizona's waiver will not provide meaningful research or demonstration findings about copayments

23. Central to the concept of section 1115 projects is that they are research and demonstration projects that should serve a scientific purpose in testing the effects of a new method of delivering benefits. Under this aegis, the Secretary of Health and Human Services may waive certain federal rules that would otherwise pertain. Section 1115 projects are not intended to simply serve as a mechanism to waive or “get around” federal rules for the convenience of either the state or the federal government. Despite this underlying purpose of the section 1115 projects, my assessment is that neither the State
of Arizona nor the Centers for Medicare and Medicaid Services planned to make any serious attempt to assess or research the effects of copayments under this project.

24. The research expectations that relate to waiving Medicaid cost sharing rules are specified in the Medicaid statute. Under 42 USC §1396o(f), there are a number of criteria that the Secretary of Health and Human Services must consider in advance to determine whether to grant a waiver of cost-sharing rules that otherwise apply. The purpose of these criteria is to ensure that cost sharing rules are waived only under circumstances that would provide useful and scientifically sound research findings, which are appropriate in the context of section 1115 research and demonstration projects. One of the key criteria is that the Secretary determine that the project “test a unique and previously untested use of copayments.” As this declaration indicates, there has been ample research about the effects of copayments in Medicaid. The research predominantly shows that copayments generally reduce the utilization of essential health care services and of medications by low-income people. Some of the studies demonstrate that there were adverse health consequences for those who were required to make copayments. I am not aware of any “unique or untested” aspect of cost-sharing or copayments that would be examined under this project; other states have imposed copayments of a similar nature for the same services (prescription drugs, physician office visits, non-emergency use of emergency rooms). Neither Arizona’s waiver application nor the federal approval letter delineates any unique or untested uses of copayments in this section 1115 project.

25. Similarly, 42 USC §1396o(f) also specifies that a waiver of cost sharing rules should be granted only if the demonstration project is “based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area.” To an experienced researcher and one who teaches public policy research methodology at the graduate level, it is clear that neither the state nor the Centers for Medicare and Medicaid Services laid out a reasonable hypothesis or a sound
methodological plan to assess the effects of cost sharing in this project. They did not
establish a "control group," that is, a group of similar people who would not be required
to make copayments, whose health care utilization or health status could be compared to
those required to make copayments. There is no evidence in the relevant federal or state
documents that any research design was planned, much less a methodologically sound
research design.

26. An additional requirement of 42 USC §1396o(f) is that the project must be
determined to be "voluntary or makes provision for assumption of liability for
preventable damage to the health of recipients of medical assistance resulting from
involuntary participation." As I understand it, AHCCCS beneficiaries were not asked to
volunteer for copayments, not asked for informed consent and not given any protections
with respect to the assumption of liability for preventable damage in the event of
involuntary participation. I suppose that one might argue that AHCCCS is voluntary and
that no one is forced to join the program, but that once enrolled, a beneficiary must abide
by program rules including copayments. But such an argument would be flawed. Based
on the declarations of the plaintiffs in this case that I read, it appears that applicants were
not asked to voluntarily participate in a copayment project. My experience with the
Urban Institute's Institutional Review Board concerning ethical standards that apply to
research involving human subjects indicates that standards for voluntary and informed
consent cannot be met when the incentive for consenting to a research project or the
penalty for not consenting to it is so great that there is no reasonable alternative but to
consent. While people were not forced to join AHCCCS and abide by its copayment
policies, the penalty for not consenting would be to go without health insurance coverage.
Even if applicants knew about copayments in advance, they had no reasonable choice but
to accept the imposition of copayments as a condition of gaining health insurance
coverage; thus, they lacked a credible voluntary choice in this matter.

27. For the work I have performed on this case to date, I have requested no fee.
I declare, pursuant to 28 U.S.C. § 1746, and under the penalty of perjury, that the
foregoing is true and correct.

Executed this 6th day of March 2008.

[Signature]

Leighton Ku, Ph.D., M.P.H.
ORIGINAL of the foregoing electronically filed with the Clerk of the Court this 10th day of March 2008.

COPY of the foregoing emailed via Electronic Case Filing System this 10th day of March 2008 to:

Logan Johnston
Johnston Law Office PLC
One North First Street, Suite 250
Phoenix, Arizona 85004-2359
Attorney for Defendant Rodgers

COPY of the foregoing mailed this 10th day of March 2008, to:

Vesper Mei
U. S. Department of Justice
Federal Programs Branch
Civil Division – Room 7316
20 Massachusetts Avenue, N.W.
Washington, D.C. 20001
Attorney for Defendant Leavitt

COPY of the foregoing mailed this 10th day of March 2008, to:

Honorable Earl H. Carroll
United States Senior District Judge
United States District Court
District of Arizona
Sandra Day O’Connor U. S. Courthouse
401 West Washington Street, SPC 56, Suite 621
Phoenix, Arizona 85003-2156

By /s/ Gaynell Carpenter
EXHIBIT 3

TO

OBJECTIONS TO ARIZONA'S
SECTION 1115 WAIVER AMENDMENT REQUEST
CONTINUING COVERAGE FOR CHILDLESS ADULTS
UNDER THE DEMONSTRATION
EXHIBIT A

TO

SUPPLEMENTAL DECLARATION OF

DR. LEIGHTON KU

IN SUPPORT OF PLAINTIFFS’

MOTION FOR PRELIMINARY INJUNCTION
CURRICULUM VITAE

LEIGHTON KU

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Education

1990  Ph.D., Health Policy, Boston University (Pew Health Policy Fellow in a joint program of Boston University and Brandeis University)

1979  M.P.H., Public Health, University of California, Berkeley

1979  M.S., Nutritional Sciences, University of California, Berkeley

1975  A.B. (honors), Biochemistry, Harvard College

Professional Background

2008 - present  Director, Center for Health Policy Research, The George Washington University

2008 - present  Professor of Health Policy (with tenure), Department of Health Policy, School of Public Health and Health Services, The George Washington University

2000 - 2008  Senior Fellow, Center on Budget and Policy Priorities

1992 - present  Adjunct Professor in Public Policy and Public Administration, Trachtenberg School of Public Policy and Administration, The George Washington University. Began as Associate Professorial Lecturer.

1990 - 2000  Principal Research Associate/Senior Research Associate/ Research Associate I, The Urban Institute.


1987 - 1989  Pew Health Policy Fellow, Health Policy Institute, Boston University and the Heller School, Brandeis University

1975 - 1976 Registered Emergency Medical Technician, Dept. of Health and Hospitals, Boston, MA

**Selected Honors**

Member, Executive Board, District of Columbia Health Benefits Exchange (2012) (The board will govern the new health insurance exchange for the District of Columbia, based on the Patient Protection and Affordable Care Act. This is based on nomination by the Mayor and approval by the City Council).

Commonwealth Fund, top ten most frequently downloaded reports (2006).

Award for promoting racial and economic justice, Mississippi Center for Justice, 2005

*Choice* (the magazine of the American Library Association for academic publications), top ten academic books of the year (1994)

Pew Health Policy Fellow, Boston University and Brandeis University, 1987-1990.

**Scholarly Publications**

**Publications Authored or Co-authored in Peer-Reviewed Journals**


[Note between 2000 and 2008, I was working at the Center on Budget and Policy Priorities and was not principally working on refereed publications.]


Books Authored or Co-authored


Ku, L. and Nimalendran, S. Improving Children’s Health: A Chartbook About the Roles of Medicaid and SCHIP, Center on Budget and Policy Priorities, Jan. 15, 2004


Articles or Chapters in Books (Refereed)


Other Papers, Reports and Publications

Health Policy

[Note: All reports released by the Geiger Gibson/RCHN Community Health Foundation are available at www.gwumc.edu/sphls/departments/healthpolicy. Reports noted with a [PR] went through a peer-review process prior to release.]


http://healthaffairs.org/blog/2010/03/16/can-health-care-investments-stimulate-the-economy/


Ku, L., MacTaggart, P., Pervez, F. and Rosenbaum. S. “Improving Medicaid’s Continuity and Quality of Care,” Association for Community Affiliated Plans, July 2009. [PR]


[Note: All the reports released by the Center on Budget and Policy Priorities can be found at www.cbpp.org.]


L. Ku, “‘Crowd-Out’ Is Not the Same as Voluntarily Dropping Private Health Insurance for Public Program Coverage,” Center on Budget and Policy Priorities, Sept. 27, 2007


Ku, L. Cohen Ross, D. and Broaddus, M. “Survey Indicates Deficit Reduction Act Jeopardizes Medicaid


Ku, L. And Wachino, V. “Medicaid Commission Named By Secretary Leavitt Lacks Balance,” Center on Budget and Policy Priorities, July 10, 2005


Park, E. and Ku, L., “Temporary Medicaid Improvements As Part of a Stimulus Package,” Center on


**HIV/AIDS and Adolescent Risk Behaviors**


Food and Nutrition Policy


Ku, L., "Nutritional Research Relating to Infant Feeding in the WIC Program," Report to the Assistant Secretary for Food and Consumer Services, June 1986.*


* These reports were issued as official Agency or Department reports with no listed authors. In addition, Leighton Ku wrote numerous proposed and final regulations and legislative and budget reports while on the staff of the Food and Nutrition Service. In many cases, these were published in the Federal Register, Congressional Record and related Federal series.

Scholarly Talks and Testimony


Ku, L. “Ready, Set, Plan, Implement. Executing Medicaid’s Expansion,” Health Affairs Conference on
Health Reform, Washington, DC, June 8, 2010.


Ku, L., Perez, T. and Lillie-Blanton, M. "Immigration and Health Care—What Are the Issues," Kaiser
Family Foundation HealthCast, webcast interview March 12, 2008.

Ku, L. "How Research Might Affect SCHIP Reauthorization," Child Health Services Research Meeting at

Ku, L. “Immigrant Children and SCHIP Reauthorization,” Capital Hill Briefing conducted by the

Ku, L. “Health Policy and Think Tanks,” Robert Wood Johnson Health Policy Fellows, Institute of
Medicine, June 2006. Similar talk in other years.

Ku, L. “Medicaid Reform and Mental Health,” National Alliance for the Mentally Ill, Annual Conference,
Austin, TX, June 20, 2005.

Ku, L. “Cost-sharing in Medicaid and SCHIP: Research and Issues,” National Association of State
Medicaid Directors, Washington, DC, Nov. 18, 2004. Similar talk given to National Academy of State

Ku, L. “Coverage of Poverty-Level Aged and Disabled in Mississippi’s Medicaid Program,” Testimony
to Mississippi Senate Public Health and Welfare Committee, Aug. 24, 2004

Ku, L. “Medicaid Managed Care Issues,” Testimony to Georgia House of Representatives Appropriations

Ku, L. “Medi-Cal Budget Issues,” Testimony to Joint Hearing of California Senate Budget and Health

Ku, L. “New Opportunities to Improve Health Care Access and Coverage,” American College of


Ku, L., “Insurance Coverage and Health Care Access for Immigrant Families,” Testimony Before the

Ku, L. “Increasing Health Insurance Coverage for Low-Income Families and Children,” Insuring the

Ku, L., “Concerning the Healthy Families Program Parent Expansion Proposal,” Testimony
Before a Joint Hearing of the California Senate Health and Human Services and Insurance Committees


Ku, L., Rajan, S., Wooldridge, J., Ellwood, M., Coughlin, T., and Dubay, L. "Using Section 1115 Demonstration Projects to Expand Medicaid Managed Care in Tennessee, Hawaii and Rhode Island", presented at Association of Public Policy and Management, Pittsburgh, Nov. 1, 1996.


Testimony about the Special Supplemental Food Program for Women, Infants and Children (WIC), with Frank Sasinowski, presented to House Education and Labor Committee on behalf of the American Public Health Association, March 1983.

**Media**

Leighton Ku has extensive experience with electronic and print media. He has appeared on ABC, National Public Radio, CNN, PBS, Bloomberg TV, BBC and other television or radio news broadcasts and webcasts. He has been quoted in the *New York Times*, *Los Angeles Times*, *Washington Post*, *Wall Street Journal*, *USA Today*, *Christian Science Monitor*, *Politico*, trade publications (such as *Modern Health Care*, *Nation's Health* or *CQ HealthBeat*), etc. He has been an online contributor to the *Washington Post*. He has been a regular panelist on a radio talk show about health policy, broadcast on WMAL in the Washington DC region.

**Other Service and Honors**


Invited reviewer, Institute of Medicine report on family planning services in the U.S., 2009.

External reviewer for faculty promotion and tenure for Univ. of California at Los Angeles, Portland State Univ., Baruch College, etc., 2008-present.

Commonwealth Fund, top ten most frequently downloaded reports (2006) for a report I co-authored with Donna Cohen Ross.

Award for promoting racial and economic justice, Mississippi Center for Justice, 2005.


Board Member and Treasurer, Alliance for Fairness in Reforms to Medicaid (2002-2008)

Service award from the National WIC Directors Association (2002).


National Health Research Institute (Taiwan’s NIH) grant reviewer (1999).
Urban Institute, member, Diversity Task Force (1995)

*Choice* (the magazine of the American Library Association for academic publications), top ten academic books of the year (1994) for a book I co-authored with Teresa Coughlin and John Holahan.

Pew Health Policy Fellow, Boston University and Brandeis University, 1987-1990.

**Professional Society Memberships and Service**

AcademyHealth (formerly Association for Health Services Research)
American Public Health Association
Association of Public Policy and Management
Association for Public Policy Analysis and Management and AcademyHealth, Program Selection Committees (many years)

**Editorial Peer Review Service**

Associate editor, *BMC Health Services Research*, 2009 - present.


**Public Health Practice Portfolio**

Member, Executive Board, District of Columbia Health Benefits Exchange (2012). The board governs the new health insurance exchange for the District. (Nominated by the Mayor and appointed by the City Council).

Member, Technical Advisory Group for the Design of the Evaluation of the Medicaid Expansion Under the ACA, sponsored by ASPE.

Member, National Workgroup on Integrating the Safety Net, National Academy of State Health Policy, July 2011 – now.

Member, National Advisory group for Iowa Safety Net Integration project, 2011-now.

Foundation for Child Development, Selection Committee, Young Scholars Program, 2008-present.

Foundation for Child Development, Advisory Committee, Child Well-Being Index, 2008-present

Member, National Advisory Board, Center on Social Disparities on Health, University of California at San Francisco, 2005-2008.

National Campaign to Prevent Teen Pregnancy, Member, Effective Programs and Research Task Force (2000)
EXHIBIT 4

TO

OBJECTIONS TO ARIZONA’S
SECTION 1115 WAIVER AMENDMENT REQUEST
CONTINUING COVERAGE FOR CHILDLESS ADULTS
UNDER THE DEMONSTRATION
Flint Wood; Phonesagnam Silivongxay; Cynthia Roberts; and Flisha Mumaw, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

Thomas Betlach, Director of the Arizona Health Care Cost Containment System; and Kathleen Sebelius, Secretary of the United States Department of Health and Human Services, in their official capacities,

Defendants.

I, Leighton Ku, declare as follows:

1. The matters stated in this declaration are given of my own personal knowledge and, if called as a witness, I would truthfully and competently testify consistent with the following.

2. I am a tenured Professor of Health Policy at the School of Public Health and Health Services at George Washington University in Washington, D.C. I am also the
Director of the Center for Health Policy Research at the University, which includes more than 50 researchers examining social, economic, legal and policy issues that affect medical care and public health. My personal research focuses on assessment of public policies on health care access and cost, trends in insurance coverage, health care for immigrants, and federal and state budget concerns and their impact on health care. I have conducted extensive research about the Medicaid program, including national and state health reforms, Medicaid waivers, and the effects of welfare reform on Medicaid.

3. I am a nationally-recognized expert on cost-sharing and low-income patients and have written research papers and lectured on this topic. I have been invited to speak as an expert on this topic in briefings for Congressional staff, to the National Academy of State Health Policy, to the National Association of State Medicaid Directors, and to the Centers for Medicare and Medicaid Services. I have also taught research methodology and statistics to graduate students for more than 20 years.

4. Before becoming a professor at George Washington University, I was a Senior Fellow at the Center on Budget and Policy Priorities, a nonpartisan policy institute that conducts research and analysis on a range of government policies and programs, with an emphasis on those affecting low- and middle- income people. Before that, I was a principal researcher at the Urban Institute, a nonprofit nonpartisan policy research organization based in Washington, D.C. I authored and directed studies on how welfare reform has affected Medicaid, health care coverage, and health care access for immigrants. Particularly pertinent to this declaration, I was one of the principal evaluators for several states’ Medicaid section 1115 demonstration projects, under contract to the Health Care Financing Administration (the prior name of the Centers for Medicare and Medicaid Services) and authored or co-authored of a number of reports about section 1115 projects. Thus, I am familiar with both research and policy issues related to these projects.

5. I am also familiar with the implementation of health care policies and health reform. In recognition of my expertise in health policy issues, I have been
appointed a founding member of the Executive Board of the District of Columbia's Health Benefit Exchange, the governing board for the health insurance exchange.

6. I received a Ph.D. in health policy from Boston University and a Masters in Public Health from the University of California, Berkeley. My curriculum vitae is attached as exhibit A, and includes a listing of my publications.

7. In March 2008 and August 2004, I authored affidavits related to research about cost-sharing under Medicaid in the state of Arizona for the case Newton-Nations v. Rodgers, which later became McCants v. Betlach. Portions of this affidavit reiterate and update points made in earlier declarations. In this affidavit I particularly focus on the approval of the waiver by the Centers for Medicare and Medicaid Services, their terms and conditions for the waiver and the draft waiver evaluation plan that has been submitted by the state.

**Review of research concerning copayments for low-income people**

8. I have written two reviews of the research literature about the effects of medical cost-sharing for low-income people. On May 7, 2003, the Center on Budget and Policy Priorities published a report that I authored, *Charging the Poor More for Health Care: Cost-Sharing in Medicaid* (Charging the Poor More). On July 7, 2005, the Center released a report that I co-authored with Victoria Wachino, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings* (in the administrative record at pages 5914-24). A true and correct copy of the first report is attached as exhibit B.

9. I also recently completed new research about the effects of cost-sharing on the use of preventive services for children and have included a copy of the manuscript at exhibit C. This paper was presented at a professional conference, the Annual Research Meeting of AcademyHealth on June 24, 2012 and has been submitted for publication in *Pediatrics*, the peer-reviewed journal of the American Academy of Pediatrics.

10. In the two review papers, I provided comprehensive analyses of the research to date, assessing the effects of cost sharing on low-income and poor populations. Cost sharing occurs when insured individuals are required by the insurer to
pay for some of their health care coverage, for example, by paying a “copayment” each time a health service is obtained or prescription is filled. (Most of the information described below is documented in the reports, so I do not provide citations in this declaration, since they are available in the reports.) In this declaration, I have added some updated information from more recent studies and provide citations for the new evidence.

11. Over the last 40 years, a number of studies have looked at the effects of cost sharing on the poor, including the classic RAND Health Insurance Experiment, considered one of the most important and rigorous studies to examine the effects of cost-sharing. Of all forms of cost sharing, copayments are the most heavily studied. Three conclusions can be drawn from this research: first, copayments keep many low-income people from getting needed medical care or medications; second, low-income people cannot always afford these copayments and must choose between them and other basic necessities of life; and third, copayments are not an efficient Medicaid cost saving measure for states.

12. These general observations are widely held in the field. For example, a recent synthesis of research by Katherine Swartz, a professor at the Harvard School of Public Health, also concluded: “Caution should be used when increasing cost-sharing for low-income populations. Not only are low-income populations disproportionately affected by increased cost-sharing, but they are more price sensitive than higher-income groups. Unless the cost-sharing increases are concentrated on services that are ineffective or unnecessary, low-income people may avoid necessary medical care and that in turn could lead to greater spending on hospital care. In addition, as others have noted, higher cost-sharing may lead to worse health outcomes for low-income people and could increase disparities in health by income.” (Swartz, Katherine. “Cost-sharing: Effects on Spending and Outcomes,” Robert Wood Johnson Foundation Synthesis Report No. 20, Dec. 2010).

The negative effects of copayments have been well-documented
in previous research.

13. A substantial and rigorous body of research has consistently concluded that low-income individuals are more vulnerable to the adverse effects of copayments than other groups. Copayment policies that cause only modest reductions in health care use among middle-class individuals can result in more substantial reductions in health care use and lead to significant adverse health consequences among low-income individuals, especially those with chronic health problems. For example, multiple studies have concluded that higher copayments for medical services, including physician office visits, or for prescription drugs cause low-income people to use substantially fewer essential and effective medical services or medications.

14. Copayments have also been shown to lead to poorer health among low-income adults, including worse blood pressure and vision, than among those not subject to copayments. One large, recent study in Quebec found that after copayments for prescription drugs were imposed, poor adults had 88 percent more emergency room visits and experienced a 78 percent increase in medical events like hospitalization or institutionalization as a result of problems experienced when these low-income people went without essential medication. Still other studies have demonstrated the difficulties that Medicaid beneficiaries encounter in accessing medical services when they are being assessed copayments. For example, in a study of Medicaid beneficiaries in Tennessee (in which copayments were elevated under a section 1115 waiver), 20 percent of the patients said they were not able to pay the copayment at the time of a doctor’s office visit and 22 percent could not pay the prescription drug copayment. Most of those unable to afford the drug copayment went without the medication.

15. A particularly important (and methodologically rigorous) study examined the effects of copayments for low-income Medicaid adult beneficiaries participating in a Medicaid Section 1115 waiver program in Oregon, which included copayments of $5 for physician services, $2 to $15 for prescription drugs in 2003, $5 to $20 for hospital outpatient services, etc. It compared the experiences of Medicaid beneficiaries eligible
under the waiver program with those eligible under traditional welfare-related (Temporary Assistance to Needy Families or TANF) criteria. The researchers found that the copayments led to reductions in prescription drug and office-based physician care, but increases in outpatient and inpatient hospital care. That is, higher copayments under the waiver led patients to reduce their use of routine medication and medical care use, but this ultimately led to greater use of more expensive hospital services instead. The net effect was that Medicaid expenditures appeared to increase, although the increase was not statistically significant. (Wallace, N., McConnell, K.J., Gallia, C, Smith, J. “How Effective Are Copayments in Reduction Expenditures for Low-income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan,” HSR: Health Services Research, 43(2): 515-30, April 2008.) It is worth noting that most of the adults affected by the copayments were childless adults: 79 percent were single adults and 21 percent were couples (some of whom may have been couples without children). (Wallace, N., McConnell, K.J., Gallia, C, Edlund, T. “Benefit Policy and Disenrollment of Adult Medicaid Beneficiaries from the Oregon Health Plan,” Journal of Health Care for the Poor and Underserved, 21: 1382-94, 2010 and personal communication from Prof. Neal Wallace of Portland State University, October 21, 2011.)

16. The effects can be even more profound when low-income beneficiaries have severe diseases. A new study examined the consequences of copayments for Medicaid patients who had cancer. It compared adult patients in Georgia, which instituted Medicaid copayments in 2003, versus similar patients in South Carolina and Texas, which lacked copayments. After copayments were raised, Georgia cancer patients’ use of prescription drugs went down, but their emergency room visits increased and total Medicaid expenditures in the six months after cancer diagnosis rose by more than $5,000, substantially more than in the two states without controls. Copayments reduced patients’ ability to afford medications, which led to medical complications and higher expenditures. (Subramanian, S. “Impact of Medicaid Copayments on Patients
with Cancer: Lessons for Medicaid Expansion Under Health Reform,” Medical Care, 49(9):842-7, Sept. 2011).

17. The declarations filed by Flint Wood, Phonesagham Silivongxay, Cynthia Roberts and Flisha Mumaw all demonstrate the health-threatening hardships imposed by copayments under the Arizona Health Care Cost Containment System on adults with serious chronic diseases.

18. Another study examined whether copayments reduce Medicaid beneficiaries’ use of care at emergency departments (EDs) for non-emergency conditions (e.g., care that could be provided on a non-emergency basis in a setting like a doctor’s office, as opposed to the ED). This study compared non-emergency use at EDs by Medicaid patients in states that assessed copayments for non-emergency use with those in states without such copayments. It examined data from 2001-2006 from the nationally representative Medical Expenditure Panel Survey. Briefly, the study found that the copayments had no statistically significant effect on the level of non-emergency ED visits, on emergency ED visits or on ED visits in general. That is, the copayments failed to reduce non-emergency use of EDs and had no discernible impact on ED use in general. (Mortensen, K. “Copayments Did Not Reduce Medicaid Enrollees’ Nonemergency Use of Emergency Departments, Health Affairs, 29(9): 1643-50, Sept. 2010.) A likely explanation for this lies in understanding the difference between what physicians consider an emergency and a patient considers an emergency.

19. A more rigorous study of the effects of ED copayments for “unnecessary care” was presented last month at the Annual Research Meeting of Academy Health by Dr. David Becker of the University of Alabama at Birmingham. The study used clinically defined measures of the severity of conditions receiving treatment in EDs and concluded that “Overall, [there is] no evidence that co-pays lead to more efficient use of ED care.” They found very small declines in overall ED use following a co-payment increase, but those reductions were similar for the least severe to the most severe conditions, indicating that at least some people with very severe health problems avoided
EDs when copays rose. That is, imposing higher copayments for “unnecessary ED use” also adversely affected those with very severe needs for emergency care. (Becker, D., Blackburn, J., et al. “Copayments and the Use of Emergency Department Services in the Children’s Health Insurance Program,” presented at Academy Health Annual Research Meeting, June 24, 2012.)

**Low-income people forced to choose between health care and other necessities.**

20. As documented in Charging the Poor More and The Effect of Increased Cost-sharing in Medicaid, there is an accumulated and consistent body of research concluding that low-income people cannot financially bear copayments as easily as those with higher incomes. This is because low income people are in a different economic position. Data show that Medicaid beneficiaries already have substantial out-of-pocket medical care expenditures. On average, Medicaid beneficiaries pay a larger share of their incomes in out-of-pocket medical expenses than do higher-income individuals with private insurance. Increases in Medicaid copayments would exacerbate their financial burdens.


22. Low-income families must also stretch their incomes to meet competing demands for rent, child care, and other expenses. Research indicates that, despite the presence of programs like food stamps, poor families often have difficulties meeting basic needs. In many areas, rising housing costs are claiming an increasing share of poor families’ incomes. Studies show that those with incomes below the poverty line already experience hardships, such as running out of food or having difficulty paying rent or utility bills. Elevated copayments for low-income people force many of them to choose between health care and other basic needs.
23. Instituting or increasing copayments is not an efficient way for states to lower their expenditures for Medicaid. As noted above, research often shows that, paradoxically, copayments lead to higher Medicaid costs because people skimp on basic, routine medical care like medications or routine medical visits, but end up sicker and incur higher hospital expenditures.

   **Arizona's waiver will not provide meaningful research or demonstration findings about copayments.**

24. Central to the concept of Medicaid section 1115 projects is that they are research and demonstration projects that should serve a scientific purpose in testing the effects of a new method of delivering benefits. Under this aegis, the Secretary of Health and Human Services may waive certain federal rules that would otherwise pertain. Section 1115 projects are not intended to simply serve as a mechanism to waive or “get around” federal rules for the convenience of either the state or the federal government. Despite this underlying purpose of the section 1115 projects, my assessment is that neither the State of Arizona nor the Centers for Medicare and Medicaid Services have planned serious attempts to research new or novel approaches to deliver care with respect to cost-sharing that would offer meaningful information about the effects of cost-sharing.

25. The opinion from the United States Court of Appeals for the Ninth Circuit regarding *McCants v. Betlach* specified three tests that the Secretary of Health and Human Services must meet in granting Section 1115 demonstration waivers, based on an earlier analysis in the case *Beno v. Shalala*: “First whether the project is an "Experimental, Pilot or Demonstration Project.” Second, whether the project is “Likely to Assist in Promoting the Objectives of the Act.” Third, “the extent and period” for which she finds the project necessary.” This indicates that a valid Section 1115 demonstration project should be designed to yield meaningful and valid information that could be used to help improve the Medicaid program on a broader basis; it should be more than information that is “nice to know.”
26. As this declaration indicates, there has been ample research about the effects of copayments in Medicaid. The research overwhelmingly shows that copayments generally reduce the utilization of essential health care services and of medications by low-income people.

27. In its approval, dated October 21, 2011, the Centers for Medicare and Medicaid Services approves “Authority to impose co-payments on the childless adult population as permitted under the expiring Demonstration, subject to matters still under discussion and the State’s forthcoming evaluation of the Demonstration.” This issue has been studied repeatedly over the past 40 years and more recent examples, such as the study in Oregon mentioned in paragraph 15 involved low-income childless adults under circumstances that are directly parallel to those in Arizona. Moreover, the state of Arizona has been imposing copayment for childless adults since October 2010 and could already have evaluated this. There do not appear to be any reasonable research insights that would be gained under this project that have not already been studied elsewhere repeatedly.

28. The Centers for Medicare and Medicaid Services also approved a $4 copayment for non-emergency Medicaid transportation. The previous research (and basic logic) would indicate that this would also reduce the use of these important services. For example, a study in Georgia and Kentucky assessed the impact of Medicaid transportation services and found that they were associated with reduced levels of hospital use for children with asthma and for adults with diabetes. (Kim, J., Norton, E., Stearns, S. “Transportation Brokerage Services and Medicaid Beneficiaries’ Access to Care,” *HSR: Health Services Research*. 44(1): 145-61, Feb. 2009.)

29. I am not aware of any prior research about imposing a fee for missed appointments, so could imagine that a demonstration of this concept may yield useful information, but fail to understand the merits of further testing of the other policies as evidence of an “experimental, pilot or demonstration” project which could be useful for assessment of future Medicaid policies.
30. On page 26-27 of the Centers for Medicare and Medicaid Services document entitled “Special Terms and Conditions,” the federal agency lays out a general framework for evaluating the cost-sharing for childless adults. But virtually all of these items have been tested in other circumstances repeatedly. Moreover, given that the state of Arizona was presumably responsible for evaluating cost-sharing under its previous waiver and did very little, it is not clear why the federal agency would approve this in advance. The document refers to quarterly and annual reports about the progress of the evaluation, but does not specify a due date for a report, nor does it explain how it would determine whether to continue to waiver of cost-sharing requirements after a report is submitted.

**The state's actual evaluation plan does not appear to correspond to requirements under the Special Terms and Conditions.**

31. In the Special Terms and Conditions, CMS specified certain criteria for the evaluations to be conducted by the state of Arizona. Under VII(c) and VII(d) (pages 26 and 27), CMS said Arizona must conduct “independent” evaluations. As I examine the draft evaluation plan submitted by the state on June 19, 2012, it is not clear who is conducting the evaluation or whether they are independent. For example, if state staff or the regular data processing contractor for the state are doing the evaluation, I fail to see how the evaluation is “independent.” An independent evaluation would require an evaluator who is free to conclude that the state did or did not meet its objectives.

32. Under VII(c)(i) CMS specifies that the state evaluate how “needed preventive, primary care and treatment services will be utilized for childless adults subject to the copayment requirements. Under the state’s evaluation plan (pg. 53), the state proposes to compare pre-copay implementation (Oct. 1, 2008-Sept. 30, 2009) “office visit utilization rates” vs. post-copay (Oct. 1, 2011-Sept. 30, 2012) “office visit utilization rates.” Presumably the state would interpret the difference as the impact of copayments. A basic reading of the CMS requirement would indicate that the independent evaluation would need to assess the effect on “necessary” (as compared to
unnecessary) preventive visits, necessary primary care visits and necessary treatment visits. It does not appear that the state’s measure of office utilization rates will examine necessary visits (nor how it will evaluate whether a visit is necessary vs. unnecessary, although criteria to separate these are available), nor whether the visits are for preventive, primary care or treatment office-based services. An important conclusion from prior research was that high copays lead to reductions in “necessary” medical care as well as “unnecessary” care, but the state does not appear to be making any such differentiation.

33. CMS’ criteria in VII(c) also asks the state to examine control of chronic conditions, such as asthma and diabetes. The state’s evaluation plan (pg 53 and 54) says it will examine the effect of drug copays on appropriate use of medications for those diagnosed with diabetes by examining hemoglobin A1c (a measure of how well diabetes is being controlled) and LDL (low density lipoprotein cholesterol, a measure of risk of coronary heart disease) before and after the copays were implemented and similarly assess the effects of prescription copays by checking long-term control of asthma for those who are asthmatic. I believe that most medical experts would agree that hypertension (high blood pressure) is a more common chronic disease for adults than asthma that should also be measured and that control of hypertension is also a critical measure of control for diabetics, since hypertension, as well as high cholesterol, are common problems for adult diabetics. In particular, the classic RAND experiment found serious problems in the control of hypertension when copays were required of low-income people.

34. Section VII(c)(ii) of the Terms and Conditions requires the state to evaluate the impact of copayments on non-emergent use of emergency departments and appropriate utilization of generic and brand name prescription drugs. The state’s evaluation plan simply says it will examine pre-copay vs. post-copay ER utilization rates, but does not differentiate the impact of non-emergent conditions vs. more serious conditions, nor does it specify how it will define non-emergent vs. more serious conditions. Again, the failure of copayments to differentiate between less and more
severe conditions has been an important focus of prior research on this topic. The state’s
evaluation design also does not appear to be able to differentiate the effects of pharmacy
copayments vs. ED copayments, since they were imposed at the same time. Equally
important, it does not at all address the “appropriate” utilization of generic and brand
name prescription drugs and does not propose to analyze the actual use of prescription
drugs by Medicaid beneficiaries at all.

35. Sections VII(c)(iii) and (iv) of the terms and conditions require the state to
evaluate the impact of copayments on state and federal expenditures in the short and long
term and on the willingness of physicians to accept appointments from childless adults.
As far as I could see, the state evaluation plan did not address these topics.

36. Section VII(c) (page 27) require the state to evaluate how the non-
emergency transportation copayments affects access for childless adults in Maricopa and
Pima Counties vs. all other counties in the state. The state evaluation plan does not
address the differential effects across counties and simply says it will compare office visit
utilization rates before and after copayments were imposed and does not indicate whether
it will examine differential effects across counties nor whether it will examine the rate of
use of non-emergency medical transportation at all.

37. The one actual area where Arizona is testing a concept for which I am not
aware of prior research that corresponds to the criteria established by the statute or by the
decision of the Court of Appeals concerns the effect of missed appointment fees. The
terms and conditions established by CMS are quite detailed in this area. In addition to
requiring an “independent” evaluation, CMS required the state to assess the impact of the
missed appointment fees on: “(i) reducing the number of missed appointments, (ii)
Beneficiaries seeking more care from walk-in clinics, urgent care centers or emergency
rooms and any resulting impact on costs, (iii) denial of service as a result of the fee, (iv)
subgroups within the adults without dependent children population, i.e., were there
variations by income level, age, gender, etc., (v) program integrity, (vi) compliance with
the provisions for missed appointments in STC 17(e), (vii) administrative feasibility and
cost to the provider, and (viii) the rate of missed appointment fees by provider type and
region of the state."

38. The state’s evaluation plan in this area (pg. 56-58) is astonishingly
deficient. It says it will simply examine pre-fee vs. post-fee “ER utilization rate” and
“office visit utilization.” It fails to actually measure the level of missed appointments, the
extent to which patients may have shifted care to other sorts of settings such as walk-in
clinics or urgent care centers, the actual denial of service, subgroups of the population,
compliance with the provisions for missed appointments laid out in the special terms and
conditions, the administrative feasibility and costs to providers and the actual rate of
missed appointment fees assessed or collected by provider type or region.

39. Given that this waiver authority expires January 1, 2013 and the state must
submit the evaluation before that date, I fail to see how the state can possibly meet these
criteria on a timely basis at this point in time, particularly given the time frames needed
for CMS review and approval.

**Flaws in Arizona’s evaluation plan will render the findings almost useless.**

40. The severe deficiencies of the state’s evaluation design become clearer
when one realizes that the state claims it can use the same data to evaluate the different
effects of three different policies. In order to assess the impact of copays on childless
adults, it will compare pre-copay (Oct. 1, 2008-Sept. 30, 2009) to post-copay (Oct. 1,
2011- Sept. 30, 2012) office utilization rates. But it also says these same data from the
same period will evaluate the effect of non-emergency medical transportation copays. To
assess the missed appointment fees, it will also compare office utilization rates from Oct.
used to test three different hypotheses, the evaluation design would not be able to
differentiate between the effect of higher office visit copays, non-emergency medical
transportation copays and the missed appointment fees. To the extent that the purpose of
the demonstration project and the waiver is to assess the effects of different policies, the
evaluation design would be unable to tell which policy affected which outcome,
invalidating the purpose of the evaluation. A parallel is to imagine a grocery store that is
trying to test, all at the same time, the effects of special sales coupons, changes in
shopping cart size and the presence of pleasing background music, on consumers’
shopping behaviors simply by looking at changes in average grocery expenditures per
customer in Time A vs. Time B. Even if you observed a $3 difference in average grocery
bills, you would not be able to determine whether the change was due to the sales
coupons, shopping cart size or background music. The weak evaluation design would not
produce useful findings.

41. In a similar fashion, the state proposes to compare emergency room
measure the effects of both ER copays and missed appointment fees. The evaluation
design would not be able to disentangle the effects of different policies, rendering the
information useless.

42. A final comment on the evaluation design. As a research methodology
expert, the comparison of pre- and post-implementation status proposed by the state is a
very weak design. It assumes that the entire difference in utilization between one period
and the next is due to the policies that are being tested. As I noted above, since the pre-
and post-fee periods and the pre- and post-copay periods are the same and the measures
of utilization are the same, the state would not be able to differentiate the effects in any
meaningful way. Moreover, it assumes nothing else of any consequence changed from
unemployment rate has been falling in Arizona and the foreclosure rate is also changing.
The enactment and subsequent debate about Arizona’s SB 1070 legislation appears to
have had effects on the behaviors of the Hispanic population in Arizona. These may
change the health behavior of low-income Arizonans. A more rigorous researcher would
use more sophisticated statistical analysis to control for differences that might be related
to race or ethnicity, age of enrollees, income levels and so on. This could lead to more
valid estimates of the effects. Going back to the grocery store example in paragraph 40,
it is possible that grocery expenditures rose by $3 between the two periods simply because of inflation, not because of changes in grocery store operations that were tested; a stronger analysis would adjust for inflation. Arizona’s evaluation plan does not appear to have more sophisticated elements that would provide more valid findings.

43. In conclusion, the evaluation plan that has been submitted by the state does not appear to fulfill the conditions established by the federal government in the terms and conditions. Moreover, and perhaps more important, the weakness in the design and in the measures being proposed by the state would render the information from this evaluation almost inconsequential from the perspective of understanding the effects of copayments or missed appointment fees on the use of health care services by low-income beneficiaries in Arizona. Thus, the evaluation will not provide meaningful understanding of the effects of the policies being tested on the basis of being an “experimental, demonstration or pilot” project which might help understand broader national policies.

Final Attestations

44. For the work I have performed on this case to date, I have requested no fee.

I declare, pursuant to 28 U.S.C. § 1746, and under the penalty of perjury, that the foregoing is true and correct.

Executed this 11th day of July, 2012, at Washington, D.C.

[Signature]

Leighton Ku, Ph.D., M.P.H.
EXHIBIT 5

TO

OBJECTIONS TO ARIZONA’S
SECTION 1115 WAIVER AMENDMENT REQUEST
CONTINUING COVERAGE FOR CHILDLESS ADULTS
UNDER THE DEMONSTRATION
IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

SHARON NEWTON-NATIONS, MANUELA GONZALEZ, CHERYL BILBREY, DONALD MCCANTS, HECTOR MARTINEZ, ANNE GARRISON, DAWN HOUSE, DANA FRANKLIN, EDWARD BONNER, D.H., JACK BAUMHARDT, MANUEL ESPARZA, AND PATRICIA JONES, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

ANTHONY RODGERS, Director of the Arizona Health Care Cost Containment System, and TOMMY THOMPSON, Secretary of the United States Department of Health and Human Services, in their official capacities,

Defendants.

No. CV 03-2506 PHX EHC

DEFENDANT RODGERS’ ANSWERS TO PLAINFTIHELL’S INTERROGATORIES

Pursuant to Federal Rule of Civil Procedure 33, Defendant Anthony Rodgers, by and through the undersigned, provides the following answers to Plaintiff’s Interrogatories:

Interrogatory No. 1
1. For each of Plaintiffs’ First Set of Non-Uniform Interrogatories, identify each person answering and/or providing information, including all persons
January 2000 to March 2001
Budget Control Development Specialist III
Division of Business & Finance
701 East Jefferson, Phoenix, Arizona 85034

April 2001 to Present
Dawn Tibbs
Financial Consultant, Division of Health Care Management
701 East Jefferson, Phoenix, Arizona 85034

December 2003 to Present
Jennifer Vehonsky
Administrative Services Officer II, Office of Intergovernmental Relations
801 East Jefferson, Phoenix, Arizona 85034

Interrogatory No. 2
2. Explain each reason that supports Defendant's contention in his Answer to Complaint that the Medicaid notice and hearing rights, set forth in 42 U.S.C. 1396a(a)(3) and 42 C.F.R. §431.200 et seq., do not apply in this case. For each reason, state the following:
(a) each fact that supports the reason; and for each fact state the following:
   (i) identify each person who has knowledge of the fact; and
   (ii) identify all documents that support the fact.

Answer
Prior to the implementation of the copayments at issue in this case, the AHCCCS Administration provided notice to all eligible persons affected by the implementation: A copy of that notice is provided in response to the request for production of documents. The implementation of the copayments at issue in this case did not give rise to hearing rights because the action taken arose from a change in State law requiring an automatic change affecting some or all recipients. See 42 CFR § 431.220(b).

Interrogatory No. 3
3. Please describe the process that AHCCCS adopted and/or implemented for adjusting capitation rates to health plans to reflect the collection of copayments at issue in this case.

Answer
The copayments in question only impacted our Title XIX Waiver Group rates. The language below is from the AHCCCS CYE 04 (Year XXII) Capitation Rate Methodology letter prepared for AHCCCS by Mercer, Government Human Services Consulting. Mercer is an actuarial firm that assists AHCCCS with capitation rate development. The
population referred to below is the Title XIX Waiver Group (TWG) and the methodology described resulted in a reduction to the capitation rates.

"A recent change will subject this population to greater cost sharing arrangements in CYE04. It is Mercer's understanding that for the TWG population, medically necessary services can be denied for failure to make a co-pay. To account for this, Mercer made adjustments to both the net unit costs for the affected categories of service and the utilization rates for the categories of service impacted by these cost sharing arrangements.

Based on a March 2003, Kaiser Commission study on the impact of cost sharing on Medicaid and the uninsured, Mercer assumed lower utilization rates for the services to which co-pays applied, and increased the assumed utilization of inpatient hospital and emergency room services. The Kaiser study, as well as several others, showed that when cost sharing is applied to a population like the TWG, people will tend to forget seeing their physician and having their prescriptions filled. Use of the hospital and emergency services will increase because the use of preventative services has decreased."

Interrogatory No. 4

4. Please describe how the collection of copayments is accounted for in the AHCCCS budget process. State specifically whether the collection of copayments is reflected as administrative savings to the AHCCCS program. If the answer is other than an unqualified "yes," explain in detail how the copayments are reflected in the program budget.

Answer

The collection of copayments is not accounted for in the AHCCCS budget process. Copayments are reflected as a reduction in the per member capitation rate (CMS approved per BBA) paid to participating health plans. Additionally, the appropriation passed by the legislature, identified amounts related to co-payments as an adjustment to the prior year's appropriated amount for specific programs and line items. An example is in the Acute Care program, the capitation line item appropriated amount is based on actuarial assessments by each rate code, of medical services utilization and costs incurred with adjustments for various items/issues such as enrollment growth, medical inflation and other items including co-payment amounts charged to qualifying members. Copayment collections are not specifically recorded as an accounting transaction to reflect savings to the AHCCCS program. However, the FY 2004 JLBC Appropriations report reflects amounts for specific programs or line items that represent adjustments to the prior fiscal year appropriation for increasing copayments and/or increasing or implementing premiums and or enrollment fees.
I swear under oath that the answers provided have been reviewed by the persons indicated in the answer to the first interrogatory, and that I have ascertained that the answers provided herein are true and correct.

Matthew J. Devlin

Dated this 1st day of August, 2004.

RESPECTFULLY SUBMITTED this 1st day of August, 2004.

JOHNNSTON LAW OFFICES, P.L.C.

By

Logan T. Johnston
One N. 1st Street, Suite 250
Phoenix, AZ 85004
Attorney for Defendants Rodgers and AHCCCS

ORIGINAL mailed this ___

day of August, 2004 to:

Eileen Sue Katz
William E. Morris Institute for Justice
202 East McDowell, Suite 257
Phoenix, Arizona 85004

COPIES mailed this ___

day of August, 2004 to:

Diana Kelly
U.S. Department of Justice
Civil Division
Federal Programs Branch
202 Massachusetts Avenue, NW
Room 7308
Washington, DC 20001
EXHIBIT 6

TO

OBSJECTIONS TO ARIZONA'S
SECTION 1115 WAIVER AMENDMENT REQUEST
CONTINUING COVERAGE FOR CHILDLESS ADULTS
UNDER THE DEMONSTRATION
Maybe you should attend...

From: Betlach, Tom
Sent: Wednesday, February 21, 2007 9:23 AM
To: Rodgers, Anthony - AHCCCS Director; Coury, Monica; Hott, Jennifer
Subject: RE: Cost Sharing Proposals

Those are very good arguments - another is that putting the infrastructure in place over all our plans and all the exceptions required by CMS is difficult - if we are forced to do cost sharing the easiest and cheapest method is premiums

From: Rodgers, Anthony - AHCCCS Director
Sent: Wednesday, February 21, 2007 9:18 AM
To: Betlach, Tom; Coury, Monica; Hott, Jennifer
Subject: Cost Sharing Proposals

Regarding legislative proposals on cost sharing (I assume co-payments or coinsurance type cost sharing).

Cost sharing works against the notion of managed care. Cost sharing is imposed to change beneficiary behavior or to make the beneficiary financially responsible for the service choices "they" make (like overuse the emergency room). PPO or open network health plans use cost sharing because they don't medically manage the members. If you are going to put co-payments and co-insurance on AHCCCS MCO members it will work against the health plans medical management programs. The reason that AHCCCS has one of the lowest PIMPM of all state Medicaid programs is our managed care model. Health plan manage the utilization of members better than any cost sharing program would do. Cost sharing is for States that don't have Medicaid managed care.

Anthony D. Rodgers
Director
AHCCCS
(602) 417-4711
Anthony.Rodgers@azahcccs.gov
www.ahcccs.state.az.us
128 “I Support AHCCCS Efforts” Petitions

(Attached to Crossroads Mission letter 10/18/12)
URGENT AHCCCS UPDATE

Please restore the Health Care coverage for childless adults. Study show up to 1/quarter of a million adults has or will lose health coverage by January 2014. This is a major Health Crisis. AHCCCS is seeking a waiver from the Federal Government to restore these funds and is asking an increase. I Support AHCCCS’ Efforts!

Raelee Cornelius 10/15/12
Staff Member Name Date

AHCCCS received 185 responses
URGENT AHCCCS UPDATE

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[Signature]

10-17-12

Staff Member Name

Date
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Bill Payne  
Staff Member Name  
10/17/12  
Date
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[Signature]

Staff Member Name

[Date]

18-17-12
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Glena Wilcox 10-17-12
Staff Member Name Date
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Angela Scala 10/16/12
Staff Member Name Date
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[Signature]
Staff Member Name

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[Signature]

Staff Member Name

10/17/2012

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[Signature]
[Date: 10-17-12]
Staff Member Name

Date
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[Signature]
Staff Member: [Name]
Date: 10/17/12
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[Signature]

Staff Member Name  Date

10-17-17
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[Signature]
Oct 17, 2012
Staff Member Name Date
URGENT AHCCCS UPDATE

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[Signature]
Staff Member Name

[Date]

10/17/2013
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(Staff Member Name)  16-17-12

(Date)
URGENT AHCCCS UPDATE

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[Signature]
Staff Member Name

[Signature]
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Lisa Tejeda

Staff Member Name

10.14.12

Date
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[Signature]

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Stephanie A. Hurtado 10-17-12
Staff Member Name Date
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Kassy Shank 10/17/12
Staff Member Name Date
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Phyllis Johnson 10/17/12
Staff Member Name Date
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I Support AHCCCS’ Efforts!

[Signature]
Name

[Signature]
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[Signature]
Staff Member Name

[Signature]
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[Signature]  [0-17-12]
Member Name  Date
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Jose Fabiani  10/17/12
Member Name  Date
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Member Name  Date

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John MCLeod 10-17-12

Member Name Date
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[Signature] 10.16.12

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[Signature]
Michael Dale Simmons
Staff Member Name

Date
Oct. 17, 12
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Antonio Chavez 10-17-2012
Staff Member Name Date
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[Signature]
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Brian Hamley 10-17-12
Staff Member Name Date
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Staff Member Name

[Date]

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Roy Grubler 10/17/12
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Susan D. Norgren 10-17-2012
Staff Member Name Date
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[Signature]

Staff Member Name

[Date] 10-17-12
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[Signature]

Name

[Date] 12.17.12
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[Signature]

Name

Date
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Name

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Robert O’Malley 10-17-12
Name Date
URGENT AHCCCS UPDATE

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Rosalinde Chang 10/17/12
Name Date
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10-12-12
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(Mario)

Eulogio Duena
Name

Date
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Dennis J. Martin 10/17/12
Name Date
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Joseph Vierra 10/17/12
Staff Member Name Date
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Staff Member Name  

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Erik Ramos 10/18/12
Staff Member Name Date
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Robin R. La Nee 10/17/12
Name Date
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Jenny Hilbert
Staff Member Name

10/17/12
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Eval C. Garcia 10-17-12
Staff Member Name Date
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Name: Kim Ballentine   Date: 10-17-12
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Jonathan MacNeil /10-17-12
Name Date
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Robert Lee
Staff Member Name

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Shannon Bareaga 10/17/12
Name Date
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Angelica Vargas
Staff Member Name

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Nicole Stout
Staff Member Name

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Maria Cabrera 10-16-12
Staff Member Name Date
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[Signature]
Staff Member Name

[Date]
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[Signature]
Wendy Place
Staff Member Name

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BRYAN MACK
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Staff Member Name
MDiv, B H
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Thang Chiu 10/16/12
Staff Member Name Date
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June a Gribble 10-16-2012
Staff Member Name Date
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Theresa Palmer

10-17-12
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Stephanie Hurtado 10.17.12

Name Date
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Ashley Peterson  10-17-12
Name  Date
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Mikken Malone 10.17.12
Name Date
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