National Alliance on Mental Illness

May 9, 2025

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

Re: Arizona Section 1115 Waiver Amendment Request: AHCCCS Works

Dear Secretary Kennedy:

NAMI appreciates the opportunity to submit comments regarding the Arizona Section 1115 Waiver Amendment Request ("AHCCS Works"). NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization and is dedicated to building better lives for people affected by mental illness.

We believe that all people with mental health conditions deserve accessible, affordable and comprehensive health care, which is essential for successfully managing mental health conditions. We believe that the proposed work requirements, lifetime coverage limit, and cost sharing requirements will impede, rather than promote, the objectives of the Medicaid program and the goals of the waiver amendment and therefore should not be approved. Such unnecessary barriers to enrollment and access to care will only worsen health outcomes and economic stability for Medicaid beneficiaries with mental illness. Given Medicaid's important role in paying for mental health care in Arizona, we oppose the Section 1115 Waiver Amendment Request. We urge CMS to reject this request. We offer the following comments.

Medicaid is Essential for Mental Health Care

Medicaid is a lifeline for many Americans as the nation's largest payer of mental health (MH) and substance use disorder (SUD) services[i], and nearly 40 percent of nonelderly adults covered by Medicaid have a mental health condition or SUD[ii]. Medicaid pays for vital services that people with mental health conditions rely on such as medications, case management, therapy, peer supports, and crisis care during mental health emergencies. In Arizona, more than 1.3 million adults live with mental illness[iii]. Arizona's Medicaid expansion has removed barriers for many residents with mental illness by allowing people to qualify based on income rather than a disability determination. This helps people get the mental health services they need to stay healthy and avoid disability. In 2023, nearly 36 percent of adults in the state reported

symptoms of anxiety and/or depressive disorder, compared to 32.3 percent of adults in the U.S[iv]. These figures underscore the need to continue maintaining and expanding Arizona's access to affordable, appropriate, and what are often life-saving services.

Work Reporting Requirements

Under the proposal, the state will require all "able-bodied" members who are 19-55 years old and are not otherwise exempt to verify monthly compliance with the following activities: employment, actively seeking employment, attending school, or partaking in Employment Support and Development (ESD). Beneficiaries who do not comply with the new requirements after an initial grace period will have coverage suspended for two months, at which point the state requests authority to disenroll individuals and prohibit them from re-enrolling in coverage. NAMI opposes proposals to take Medicaid coverage away from people who do not meet a work reporting requirement[v] and urges CMS to reject this proposal for the following reasons:

Work Reporting Requirements Do Not Promote the Objectives of Medicaid

This demonstration waiver proposal conflicts with the core objective of the Medicaid program. Section 1115 of the Social Security Act allows the Secretary to approve demonstrations only to the extent that they are "likely to assist in promoting the objectives of" Title XIX of the Social Security Act, the title that governs Medicaid. The structure and purpose of Title XIX makes clear, and federal courts have confirmed, that the core objective of Medicaid is furnishing medical assistance, rehabilitation, and other services to eligible people. Therefore, Section 1115 demonstrations that impose work reporting requirements as a condition of Medicaid eligibility or continued enrollment are in conflict with the core objective of the Medicaid program and should not be approved.

Additionally, Medicaid waiver demonstrations should be replicated only if they demonstrate promise in strengthening coverage or health outcomes for individuals with low incomes. This is not the case with work reporting requirements, as results from states that have implemented these policies demonstrate that they do not result in increased employment[vi]. Specifically, there was no associated increase in employment or other community engagement activities among low-income individuals subject to the Arkansas requirement either in the first year when the policy was still in effect or nine months after the policy was blocked[vii].

Most people on Medicaid who can work already do so. According to the Kaiser Family Foundation, more than 90 percent of adults with Medicaid coverage are either workers, caregivers, students, or unable to work due to illness. Moreover, research shows that most beneficiaries agree that being enrolled in Medicaid makes it easier to work or look for work. Through Medicaid coverage, enrollees are better able to get treatment for previously untreated health conditions, which makes finding work easier[viii].

Instead, the proposed waiver imposes administrative barriers that would result in a drastic loss in coverage, creating gaps in care for people and disrupting access to critical and often lifesaving services. We know all too well that when people do not have access to care, their mental health conditions can deteriorate, and people rely more heavily on expensive emergency department visits or can become justice-involved.

Work Reporting Requirements are Costly

We are concerned about the cost implications this waiver proposal would have for the state and federal government. Implementing work requirements as with other types of beneficiary requirements can involve an array of administrative activities by states, including developing or adapting eligibility and enrollment systems, educating beneficiaries, and training staff. These administrative activities have proven to be costly, and we are concerned that the state has not yet developed cost estimates for the implementation of this waiver. A report by the Government Accountability Office (GAO) found states' estimates of the administrative costs to implement work requirements varied from under $10 million to over $250 million[ix].

Rather than spending scarce state and federal dollars on imposing work requirements, we urge the state to invest in robust, evidence-based supported employment programs specifically which help people with mental illness get and keep competitive employment. Research shows that supported employment programs can help people with mental illness find competitive employment, put in more time on the job, and earn higher wages[x]. These programs address health and employment simultaneously to meet the unique needs of a person with mental illness.

Work Reporting Requirements Create Unnecessary Administrative Hurdles

Medicaid work reporting requirements create unnecessary administrative hurdles for working people and families that jeopardize access to needed mental health care and their ability to manage mental health conditions. Work reporting requirements do not account for the realities faced by low-income populations, including unstable job schedules, caregiving responsibilities, and chronic health conditions.

The waiver is unclear on the reporting process for these requirements, nor does it clarify if compliance will be solely determined with data matching. If the state intends to rely on data matching, there inevitably will be individuals whose data is incomplete, outdated, or not accurately captured by the systems in use. Navigating an appeals process can be time-consuming and burdensome. For people in active treatment for a mental health condition or substance use disorder, a challenging and time-consuming appeals process could impact access to lifesaving treatment or lead to loss of coverage.

Lastly, we are also concerned that the waiver proposal does not offer a detailed process for notifying people on Medicaid of changes to eligibility requirements. When Arkansas implemented a Medicaid work reporting requirement in 2018, more than 70 percent of

Arkansans were unsure whether the policy was in effect[xi]. Similarly, early evidence from Georgia's Pathways to Coverage program, suggests that the complex enrollment process and ongoing verification requirements have significantly limited participation, even among those who meet the eligibility criteria. These examples demonstrate how program design can result in bureaucratic obstacles, rather than workforce engagement, determining access to Medicaid coverage.

Exemptions Will Never Protect All People Who Can't Work due to the Seriousness of their Mental Illness

The state's proposed exemptions for people with serious mental illness (SMI) illustrates a fundamental recognition that work reporting requirements are not appropriate for certain people, specifically some people more seriously impacted by their mental health conditions. Yet, we are concerned that the state's exemption will not go far enough to protect the population intended. Specifically, we are concerned that the exemption may be difficult to implement and is not sufficiently inclusive to all people who might not be able to comply with these requirements due to their mental health conditions.

Given the data system limitations outlined above, we are concerned that the data are not comprehensive and accurate enough to identify individuals who would meet this exemption, particularly for young adults experiencing first episodes of psychosis, which often occur in early adulthood. Moreover, it is unlikely that information for those with recent or upcoming serious diagnoses that prevent them from working would be accurately captured by data matching. With the right – and timely - mental health treatment and social supports, young adults experiencing first episode psychosis can lead full, long, and productive lives. Without appropriate resources provided quickly during this critical time, however, they may experience a lifetime of significant health and socioeconomic challenges[xii]. These are the exact people that states should want to support with Medicaid services and supports so that they can avoid deterioration to the point where they qualify for Medicaid based on a disability in the future. Delayed or incorrect treatment takes a heavy toll on individuals and their loved ones, with costly consequences. Schizophrenia alone costs the U.S. economy an estimated $343 billion a year in direct health care costs, unemployment, and lost productivity for caregivers[xiii]. Unfortunately, there is no way to create an exemption process that ensures that these individuals can continue to access needed services and ward off disability.

The reality is that Medicaid helps individuals with SMI address their health needs and get back work. As illustrated by the stories from NAMI advocates:

> "Because of Medicaid I was able to afford my mental health medication when I aged out of my parents' insurance. This allowed me to manage my symptoms and continue to work" - Kate

"Medicaid helped me continue to receive treatments until I was able to get re-employed. Without Medicaid, I would have had to file for disability assistance." – Patricia

"Without Medicaid, I could not have gotten my needed medications. This allowed me time to recover from my latest psychiatric hospitalization and return to work." - Susan

5-Year Lifetime Limit on Medicaid Coverage

The state proposes a five-year maximum lifetime coverage limit for "able-bodied adult" members who are subject to the above requirement and do not fall under one of the exemptions. NAMI opposes the use of lifetime limits in Medicaid and urges CMS to reject the state's proposed 5-year limit.

We believe a five-year life limit on benefits is not only arbitrary and unfair to beneficiaries but also completely contrary to the purpose of the Medicaid program. The mental health needs of beneficiaries will not suddenly disappear after five-years of Medicaid coverage. In fact, beneficiaries with mental health conditions who reach this limit will no doubt still have health care needs and will end up seeking care in hospital emergency departments, which is detrimental for the individuals involved, the hospital, and all other people who need care in an emergency room.

This policy also runs counter to the demonstration's stated objectives of supporting Arizonans in gaining the "fulfillment that comes with employment." In Arizona, minimum wage is $14.70, meaning that a family of three where one parent is working full-time at minimum wage would make $2,352 each month, still falling well under 138 percent of the FPL ($3,064 per month). Therefore, under the proposed time limit, working families with stable, full-time, minimum wage incomes would lose coverage despite complying with all other Medicaid eligibility requirements. Rather than promoting self-sufficiency, this policy will create unnecessary barriers to maintaining good health and preventing existing health issues from becoming more serious and potentially fatal.

Emergency Department Cost-Sharing for Non-Emergency Use

NAMI opposes the proposed copay for non-emergent use of ambulance transport or the Emergency Department (ED) use and urges CMS to reject it. Decades of research shows that copays deter patients from seeking care, which can result in negative health outcomes. There are also particular challenges regarding copays for patients facing mental health emergencies.

There is little consensus over what constitutes an inappropriate, non-emergent, or unnecessary visit, and even ED health care providers may have difficulty determining whether a visit was due to a medical emergency or was nonurgent[xiv]. Copayments for "non-emergent" use of the ED may unfairly penalize some patients who are appropriately using the emergency department or have difficulty distinguishing urgent from nonurgent care. A recent study found that among ED visits later determined to have primary care-treatable diagnoses based on ED discharge diagnosis[xv], 89 percent of patients experienced symptoms that mimicked the chief complaints

of all ED visits. We are concerned that increases in cost-sharing will lead to delayed care for true emergencies and unmet health needs.

Moreover, research indicates that such copays do not work as intended. Individuals seek care for non-emergent conditions for a variety of reasons, including problems accessing services in more appropriate settings and difficulty of determining the urgency of symptoms[xvi]. Indeed, other factors, such as access to primary care, play a much larger role in determining ED utilization[xvii]. Evidence from Indiana's Medicaid waiver found that a high co-payment on non-emergency use of the ED did not reduce such use[xviii], while an earlier study found that co-pays for non-emergency use of the ED didn't increase beneficiaries' use of primary care or outpatient medical providers[xix]. NAMI encourages Arizona to remove this proposal and pursue other non-punitive, evidence-based programs to reduce avoidable ED utilization. For example, diversion programs can help reduce "unnecessary" ED visits by identifying individuals who frequently use EDs for primary care and provide them with targeted interventions, such as care coordination and case management, to address their underlying health and social needs.

Conclusion

Thank you for the opportunity to provide comments on this important issue. We strongly believe that the proposals outlined in this demonstration application will create adverse effects for Arizonans with mental illness that do not further the objectives of the Medicaid program. We urge CMS to reject this waiver. If you have any questions or would like to discuss this issue, please do not hesitate to contact me at hwesolowski@nami.org.

Sincerely,

Hannah Wesolowski
Chief Advocacy Officer
NAMI

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