September 24, 2015

Thomas J. Betlach, Director
AHCCCS
801 E. Jefferson St., MD 4100
Phoenix, AZ 85034

RE: Section 1115 Waiver Renewal

Dear Director Betlach:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA), we want to express our appreciation for the effort the Governor's Office and AHCCCS Administration have put into developing the waiver proposal. We also thank you for the opportunity to offer our comments. AzHHA is a statewide association of 71 hospitals, affiliated healthcare systems, and other healthcare organizations across Arizona. Our members are committed to working collectively to improve the quality of healthcare and the health of all Arizonans. We believe the Medicaid program can be an effective agent for advancing these goals.

Over the past few months, we have convened a Medicaid Futures Task Force comprised of AzHHA members and community partners. The primary charge of the Task Force is to provide AzHHA guidance on Medicaid reform opportunities the state can and should take advantage of to advance the Triple Aim, while also ensuring the state maintains adequate access to healthcare coverage. Our comments incorporate input we have received on the waiver from the Task Force members and our general membership.

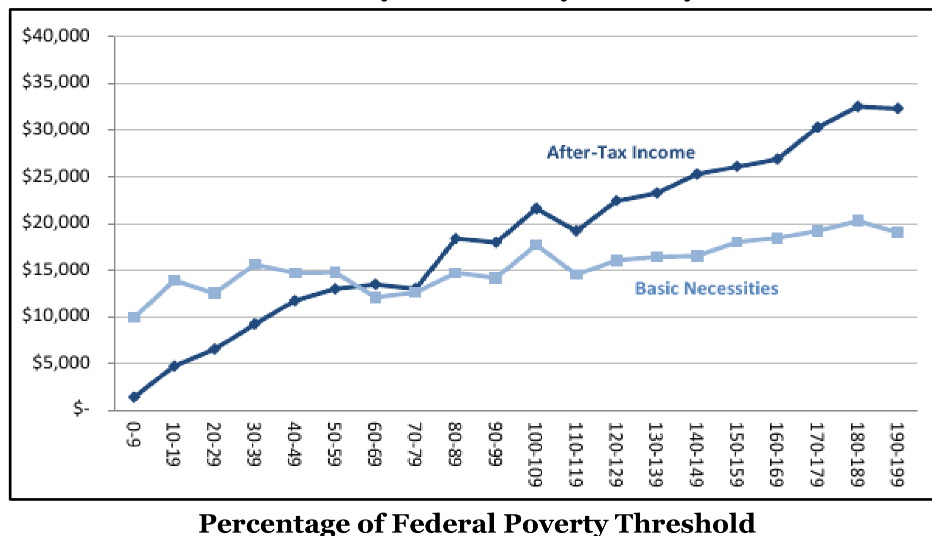
The proposed waiver, in conjunction with the crucial policy step taken in 2013 to restore and expand coverage for 350,000 Arizonans, offers great promise for the future of the Medicaid program. We share several principles embodied in the waiver proposal—incentivizing improved outcomes and quality of care; engaging patients in their healthcare; and the aspiration that Medicaid can be a bridge to independence for many, while acknowledging that this will not always be the case. These principles and an additional principle—ensuring patients have access to the most appropriate, cost effective services—anchor our comments. When possible, we have relied on evidence-based research to guide us.

AHCCCS CARE Cost Sharing

We agree with the premise that financially investing consumers/patients in their healthcare through cost sharing influences their personal healthcare decisions and can shift their utilization patterns. This has been well documented.[1] However, because Medicaid recipients have significantly fewer financial resources than the typical commercially insured patient, implementing cost sharing around premium and copayment requirements presents challenges with this population.

A recent issue brief from the Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, demonstrates this.[2] The brief analyzes and compares the financial condition and healthcare burdens of people living in poverty. As depicted in the graph below, spending on basic necessities (food, clothing, housing and utilities, exclusive of healthcare, transportation, child care and education) exceeds or approximates after-tax income (including SNAP and tax credits) for those living under 80 percent of the federal poverty (FPL) level. While we agree that "having skin in the game" creates a greater sense of personal responsibility for one's decisions, it is important that Medicaid cost sharing requirements take recipients' financial constraints into account. Access to basic necessities, such as housing and nutritious food, can be as important to healthy outcomes as is access to appropriate medical services.

After Tax Incomes and Expenditures on Basic Necessities For Non-Elderly Families by Poverty Status



Percentage of Federal Poverty Threshold

Source: HHS-ASPE tabulation from the 2011 Panel Study of Income Dynamics

[1] RAND's Health Insurance Experiment conducted from 1971 to 1986 remains the seminal study on this issue. The study showed that higher rates of coinsurance led to declines in medical care utilization. However, the decline resulted from a failure to initiate care. Once patients sought care, the intensity of services and resulting cost was largely unaffected.

[2] Financial Condition and Health Care Burdens of People In Deep Poverty. ASPE Issue Brief. July 16. 2015. See http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty.

Under the AHCCCS CARE proposal, a third party administrator would be responsible for collecting premiums and copayments after services are rendered and potentially administering the AHCCCS CARE accounts. A question has arisen regarding how this process will work with "unbanked" enrollees, those who do not have a bank account. Will these individuals be required to open a bank account to make premium payments and copayments to the third party administrator? Will the state facilitate this process? If cash payments are acceptable, will the administrator have branch offices in rural areas where deposits can be made?

We also seek clarification on how the cost sharing requirements apply to TANF parents. The Waiver Narrative states, "Arizona's proposal seeks to *require* participation in AHCCCS CARE for persons in the New Adult Group as well as TANF Parents."[3] In informal discussions, we have been told a single TANF parent who has one or more children under 6 years of age will be exempt (similar to the work requirement exemption in SB 1092). The separate CMS Demonstration Template projects 256,133 TANF parents are *eligible* for the AHCCCS Care program (emphasis added). We are unsure whether all TANF parents are required to make premiums and copayments under the AHCCCS Care program, or if some are exempt. If there is an exemption for single caregivers of children under six, we urge the Administration to consider expanding this exemption to caregivers of older children who are disabled or who are caring for dependent relatives receiving home and community based services. In addition, we urge the Administration to consider a case-by-case exemption for all adults whose illness makes them unable to work or look for work.

Copayments

We welcome the strategic approach the Administration is taking to direct copayments in a way that addresses inefficient or inappropriate utilization patterns. And, we support the copayment exemptions laid out in the Waiver Narrative.[4] We further recommend the Administration include for exemption purposes behavioral health practitioners under the definition of primary care provider for patients who have a behavioral health diagnosis.

The AHCCCS CARE proposal seeks to minimize the burden on healthcare providers by having a third party administrator bill patients for copayments retroactively after services have been received, and the state would retain the copayments. We very much appreciate and support the Administration's efforts to reduce provider burden in this regard. However, since copayments are typically considered part of the provider's reimbursement, we want to ensure that this process will not result in diminished

[3] See pages 1 -2 of *Arizona's Application for a New Section 1115 Demonstration Section 1 – Program Description. (Emphasis added)*

[4] See Page 2 of *Arizona's Application for a New Section 1115 Demonstration Section 1 – Program Description*. It is also our understanding that the serious mentally ill and the categorical groups of pregnant women and SSI will be exempt, which we support.

provider payments. As you well know, provider payments have been reduced significantly in recent years, and our members tell us the network is extremely fragile—especially in rural areas. We want to ensure that the copayment proposal will not further reduce provider payments, which could negatively impact the network.

We offer the following comments on the specific copayment proposals:

1. *Non-Emergency Use of the Emergency Department (ED)*
   The ED is an expensive place to treat patients because of its high overhead and fixed costs, including the requirement that it be open 24 hours a day. It is understandable that state Medicaid programs would want to discourage enrollees' use of the ED for non-emergent conditions. Many states have implemented frequent user diversion programs. And, about half the states have implemented copayments as a way to dissuade "unnecessary" ED visits.[5] We understand the attractiveness of using copayments for this purpose; however, we have some reservations. First, recent studies have cast doubt on whether these targeted copayments result in reduced utilization and cost savings.[6] One reason might be their previous unenforceability, which would be addressed under the AHCCCS Administration's proposal. But significant medical costs due to triage and EMTALA screening requirements would remain. ED physicians and hospitals must perform medical screenings, including diagnostic procedures, to rule out an emergency medical condition before copayments could be assessed. The system would still have to absorb these costs, regardless of whether the ultimate diagnosis is emergent or non-emergent.

   Another concern is the lack of consensus over what constitutes an inappropriate, non-emergent or unnecessary ED visit. In a recent review of 26 studies, The RAND Corporation found that no two studies defined non-urgent visits in the same way.[7] While there are coding strategies that Medicaid programs can use to retroactively define a visit as emergent or non-emergent, these are based on a final diagnosis after diagnostic tests are run, not on the presenting symptoms. A 55 year old who presents in the ED with chest pain may be discharged with a non-emergent diagnosis of GERD, but must first be evaluated for a cardiovascular emergency. A recent study found that only 6.3 percent of ED visits were later determined to have primary care-treatable diagnoses based on ED discharge diagnosis. But of these cases, 89 percent of patients experienced symptoms that mimicked the chief complaints of all ED

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

[6] Mona Siddiqui, M.D., et al. "The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reductions Act of 2005," *JAMA Internal Medicine*. March 2015. Karolin Mortensen. "Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments," *Health Affairs*, September 2010.

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

visits.[8] In short, we are concerned that copayments for "non-emergent" use of the ED may unfairly penalize some patients who are appropriately using the emergency department, and may deter patients from seeking necessary care.

Based on the studies we have reviewed, there is no definitive answer as to why patients, including Medicaid recipients, use the ED for primary care treatable conditions. There are many possible explanations, including the inability to timely access primary care services and specialists. With this in mind, we urge the Administration to couple any ED copayment requirements with efforts to expand access to primary care, specialists and ambulatory clinics, and to increase urgent care locations and hours. We acknowledge that this might necessitate additional funding for outpatient services, particularly for physicians who have been reluctant to accept new Medicaid patients because of reduced payments.

Efforts to address frequent ED users through more extensive care coordination and access to wrap around services should also be pursued, and we welcome the opportunity to work with the Administration and health plans on such programs. Finally, in an effort to better understand the impact and value that copayments may bring to ED utilization and over-all system costs, we recommend the AHCCCS Administration and health plans study the impact of such copayments on utilization and health outcomes, pending CMS approval of the proposal.

2. *Use of Opioids*

Given the state of opioid and other prescription pain medication abuse in Arizona[9], we commend the Administration for focusing their attention on this issue. While we are not aware of any studies analyzing the efficacy of using strategic copayments to mitigate prescription drug abuse, this approach may indeed have merit. However, we urge the Administration to broaden the exceptions beyond "persons who have cancer or are diagnosed as terminally ill." Opioids and other prescription pain medications are effective palliative care interventions used with many advanced chronic diseases.[10] Palliative care physicians prescribe opioids and other pain medications to manage pain and other complications associated with illnesses ranging from multiple sclerosis to congestive heart failure to emphysema. Such treatments are often given at the advance stage of an illness, not just at the end of life or in connection with a "terminal" diagnosis. Moreover, palliative care is often given in

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

[9] The Arizona Department of Health Services, Office of Injury Prevention tracks monitors prescription drug abuse. See http://www.azdhs.gov/phs/owch/ipcfr/prescription-drugs.php for additional information.

[10] See for example: Sarah Goodlin. M.M. "Palliative Care in Congestive Heart Failure," *Journal of the American College of Cardiology*. (Vol. 54, Iss.5) July 2009; and *A Palliative Approach into the Management of Chronic, Life-Threatening Diseases: Who, How and When?*. Canadian Hospice Palliative Care Association. 2013

conjunction with curative treatments.[11] It can improve quality of life and reduce expensive inpatient admissions if properly administered.

We support the direction that the Administration is taking with copayments for opioids, but we urge reconsideration of the exemptions to include exceptions for patients receiving palliative care or who are under the supervision of a pain management specialist. AzHHA has convened a committee of palliative care specialists, and we would be happy to offer their expertise on this subject as the Administration moves forward.

3. *Missed Appointments*
A literature review suggests Medicaid recipients have a higher rate of missed appointments than commercially insured patients.[12] As such, it is understandable the Administration would focus on this area to strategically target copayments. The reasons for missing appointments may vary. One review of the literature identifies several possibilities: (1) difficulty with transportation; (2) unsuitable or poorly scheduled appointment times; (3) forgetting the appointment was scheduled; (4) being sick or having a sick child; and (5) lack of child care.[13] We urge the Administration to be mindful of these reasons when implementing a copayment for missed appointment.

Access to non-emergency transportation will be a key factor in ensuring many Medicaid recipients can make their appointments. Expanding office hours and locations may also be beneficial. And, we are optimistic that the electronic and text reminders the Administration is proposing will help. However, there will continue to be a segment of the population, particularly those with general mental illnesses, who will struggle with missed appointments. These patients may require a "high touch" solution, not merely a "high tech" solution. We applaud the Administration's current efforts to integrate behavioral and physical health. We believe more intensive care coordination interventions built upon this integrative approach will be the most effective strategy with this population.

4. *Specialist Services without a PCP Referral*
Arizona is experiencing a physician shortage. Wait times to see some specialists can last two months or more. While we wholeheartedly agree that care should be coordinated at the primary care level, it is important that appropriate specialty care

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[11] Amy S. Kelley, M.D and Diane E. Meier, M.D. "Palliative Care—A Shifting Paradign," The New England Journal of Medicine. August 2010.
[12] See for example B.A. Majeroni et al. "Missed Appointments and Medicaid Managed Care," *Archives of Family Medicine*. Oct. 1996. B.P. Horsley et al. "Appointment Keeping Behavior of Medicaid vs non-Medicaid Orthodontic Patients," *American Journal of Orthodontics and Dentofacial Orthopedics. July 2007. Erik F. Lamberth M.D. et al. "Rates of Missed Appointments Among Pediatric Patients in a Private Practice: Medicaid Compared with Private Insurance," JAMA Pediatrics*. January 2002.
[13] Linda A. Detman and Patricia A. Gorzka. "*A Study of Missed Appointments in a Florida Public Health Department. "1999.*

not be delayed—and we urge the Administration to take this into account when developing the specifics of this copayment proposal. If copayments for specialist services without a PCP referral are implemented, we recommend the Administration carefully track the impact on access to care and resulting outcomes. In addition, we recommend that the referral authority be expanded to include emergency department physicians, hospitalists, and specialists referring to subspecialists.

5. *Brand Name Drugs when the Generic is Available*
   We support this proposal with an exception for cases in which the physician determines that the generic will be ineffective, less effective or otherwise contraindicated for the patient.

Premiums, Cost-Sharing and Failure to Pay

As mentioned previously, we believe Medicaid cost-sharing requirements should be based on a careful consideration of the financial resources of Medicaid recipients, so as not to impede access to care. We appreciate the Administration's proposal not to disenroll Medicaid recipients below 100 percent FPL for non-payment, and to possibly tier copayments. However, we have reservations over the extent to which this group can financially absorb the cost of any premium payment. In addition, we question whether the administrative costs of collecting such a premium outweigh the state's return on investment. This is a question, however, that may only be answered after the program is implemented.

As proposed by the Administration, Medicaid recipients earning between 100 and 133 percent FPL could be disenrolled for non-payment. Those earning less than 100 percent FPL would not be disenrolled, but unpaid cost-sharing amounts would be considered a debt owed to the state. While other states have been granted authority to disenroll recipients earning over 100 percent FPL, we question whether this is the most appropriate policy path—as it runs counter to our stated principle of promoting access to the most appropriate, cost-effective care. While we wholeheartedly share the Administration's principle of engaging Medicaid beneficiaries in their health and advancing responsible decision-making, we remain committed to ensuring access to care. If patients lose coverage, they are likely to seek care in less appropriate, more expensive settings such as EDs. And, as medical conditions deteriorate, we would expect to see an increase in inpatient admissions for chronic conditions that are manageable in an outpatient setting. (An alternative option might be to test a pilot program with a smaller segment of the Medicaid population to assess the impact of the proposal on access to care and health outcomes.)

Should CMS approve the proposal, we would like to ensure there is a clear and efficient process for communicating disenrollment decisions to Medicaid recipients and providers. Recipients should receive a grace period, which providers should be made aware of. Medical care that is provided during this period should be reimbursable.

A more technical issue is whether, and if so, how disenrollment would impact the hospital assessment. The current assessment, which pays for all childless adults and TANF parents, is based on a delicately balanced model designed so that no health system incurs a net loss. This mitigates the need to pass on the cost of the assessment to other payers and patients. A disproportionate reduction in enrollment of the over 100 percent adult group could impact this model. Moving forward, we obviously want to ensure that no health system incurs a net loss under the assessment. Additionally, we would oppose any proposal to use the assessment to pay for administrative costs of the AHCCCS CARE program.

Finally, we share the Administration's vision that Medicaid can and should be a bridge to independence for many. And, we want to ensure that any Medicaid recipients who incur a debt to the state as a result of unpaid copays or premiums have ample opportunity to reduce or work off the debt through community service or other mechanisms. Debt can be an impediment to obtaining employment and securing housing—both of which are important components of independence.

AHCCCS CARE Accounts and Healthy Arizona Targets

AzHHA applauds the Administration for taking an innovative approach in establishing AHCCCS CARE as a bridge to independence. We believe that setting simple and achievable health goals, as well as providing member-engagement tools, are appropriate and novel strategies to prepare members for the commercial market. While we appreciate the distinctions between the public and private insurance markets, we believe the proposal would benefit from the consideration of existing regulations that govern the commercial market—specifically, 71 FR 75014, which governs the design of corporate wellness programs and may provide guidance to help maximize the effectiveness of AHCCCS CARE.[14]

CARE Account Access & Consequences

The proposed waiver allows qualified members[15] to maintain access to their CARE accounts. In addition, members who meet their healthy Arizona targets can choose between a reduction to their monthly premium or rolling unused CARE account funds into the next benefit year. Of these approaches, we believe the more effective strategy for incentivizing healthy behaviors is aligning health targets with a possible reduction in premium payments. In the private market, it is common for "health-contingent" wellness programs to tie premium payments to the achievement of health targets; however, we are not familiar with any programs that require members to contribute to financial accounts, yet lose access to those funds based on members' health-related

[14] Department of the Treasury. 71 FR 75014. Nondiscrimination and Wellness Programs in Health Coverage in the Group Market. December 13, 2006. Retrieved 8/31/15 from http://www.gpo.gov/fdsys/pkg/FR-2006-12-13/pdf/06-9557.pdf

[15] Qualified members are those who make timely premium payments and copayments, participate in AHCCCS Works, and meet Healthy Arizona targets.

behaviors. Questions have also arisen as to what happens to the fund balance that a member may no longer access. Does the third party administrator retain these funds, or do they roll over to the State? While we believe the creation of savings accounts for accessing non-covered services is a very innovative approach for introducing market-based concepts to the Medicaid population, we have reservations about withholding funds from individuals who have paid into them.

We urge the Administration to consider eliminating the proposal to link CARE account access to the attainment of specified targets, and instead focus on the incentive to reduce premium payments based on meeting health targets. We believe this change better reflects wellness programs in the commercial market, continues to advance personal responsibility, and protects access to care.

Reasonable Alternatives

Regarding the Healthy Arizona targets, the Waiver Narrative states, "[t]he idea is not to make managing a member's health onerous. Rather, Healthy Arizona sets simple and achievable health goals."[16] Examples given related to promoting wellness seem to fit this construct quite well. But because the list of examples is not exhaustive, we want to ensure that health targets are achievable for all. With this in mind, we suggest that AHCCCS consider looking for guidance from regulations governing the commercial market. Federal regulations require small group issuers in the commercial market to offer "reasonable alternative standards" or waivers of health-contingent standards for individuals whom are medically unable to achieve applicable health targets.[14] AzHHA recommends the Administration consider the inclusion of reasonable alternative standards in its proposal to ensure that all beneficiaries, regardless of medical status, are able to obtain rewards for meeting health targets.

CARE Account Qualified Expenses

AzHHA applauds the Administration's commitment to allow CARE account contributions to be applied to non-covered services. We agree that the non-covered services currently listed (dental, vision, chiropractic, nutrition counseling, weight loss programs, gym memberships and sunscreen) are appropriately included, and we recommend the Administration add language to allow for further growth in these services. One solution may be to adopt the definition of "medical care" as described in Section 213(d) of the Internal Revenue Service Tax Code, which governs tax-deductible medical expenses.[17] This inclusion would allow for greater flexibility in CARE account expenses for non-covered services while still preparing consumers for the commercial market.

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[16] See page 3 of the Waiver Narrative.

[17] *See page 882* – Title 26 – Internal Revenue Code. Retrieved 9/3/2015 from http://www.gpo.gov/fdsys/pkg/USCODE-2011-title26/pdf/USCODE-2011-title26-subtitleA-chap1-subchapB-partVII-sec213.pdf

The current AHCCCS CARE proposal affords qualified members the option to roll CARE account funds into the next benefit year to "offset copayment amounts," yet offers no mention of permitting CARE accounts to cover copayments during a member's initial year in the program. We interpret this to mean qualified members are only permitted to apply CARE account funds toward copayments if they elect to do so using annual carry-over funds. In the commercial market, HSA funds (similar to those proposed in AHCCCS CARE accounts) are commonly permitted to be applied to copayments. Should the proposed copayments be approved by CMS, AzHHA encourages the Administration to allow members to apply CARE account funds to copayments from the time of their entry into the program. This, again, would assist in preparing members to transition to the commercial market.

Third-Party Administrator

Whereas AHCCCS CARE will require procurement of a third party administrator to bill members and collect funds, we strongly urge the Administration to consider the impact of seemingly nominal fees on low-income individuals. Most third party administrators of HSAs charge such fees in order to cover those costs of maintaining consumer accounts. AzHHA urges the Administration to ensure that the chosen third party administrator mitigates potentially overly-burdensome financial obligations by assessing minimal fees and charges.

AHCCCS Works

AzHHA supports the Administration's pursuit to assist members in finding employment. There is undoubtedly a link between health and employment status, in addition to an array of other health determinants. However, we have some concerns regarding the work requirements proposed under the legislative directives. The introduction of a policy requiring members to obtain work assumes a preponderance of low-income, able-bodied individuals who are electively abstaining from work. AzHHA has not seen evidence to justify this assumption, although we welcome the opportunity to review such data. Our review of recent research, however, suggests the opposite might be true.[18]

We also have outstanding questions regarding how the program will work. Most significantly—will the Department of Economic Security's employment monitoring system capture all types of employment activity and job searches? We commend the Administration for acting on this complex situation, but until we have a better understanding of the program specifics, we are unable to offer more detailed comments.

If a work requirement is approved, however, we urge the Administration to broadly draft implementing regulations to account for persons who have trouble maintaining

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[18] See for example, Altman, Drew. "Behind the Split over Linking Medicaid Coverage to Work Requirements." May 11, 2015. Retrieved 9/1/2015 from http://blogs.wsj.com/washwire/2015/05/11/behind-the-split-over-linking-medicaid-coverage-to-work-requirements/

work due to their health status. This includes individuals who suffer from general mental health illnesses and chronic diseases, and individuals who are caring for disabled dependents or relatives who may not be able to function independently.

Lifetime Enrollment Limits and Non-Emergency Transportation

The Administration has included a number of legislative proposals in the proposed waiver, including a lifetime limit of five years for Medicaid benefits and an exemption for non-emergency transportation. We have serious concerns with each of these proposals, and do not support them.

Medicaid is a counter cyclical program. When the economy contracts and people lose their jobs, the Medicaid rolls expand. A person may likewise get sick and lose his or her job, becoming eligible for Medicaid. Once recovered and back to work, the individual may no longer be eligible for Medicaid. These cycles can repeat themselves on and off over a person's lifetime. A five year limit on benefits is arbitrary and would needlessly limit a person's access to medical services.

We also do not support the elimination of non-emergency transportation. As mentioned previously, Arizona is experiencing significant healthcare workforce shortages. The federal government has deemed many areas of the state as medically underserved or health professional shortage areas. Access to medical professionals is an on-going concern, which is exacerbated by a relatively weak public transit system in the state's urban hubs and large rural areas spanning the rest of the state.[19] Non-emergency transportation is a critical component of the delivery system for Medicaid recipients who have no other means of transportation.

Delivery System Reform Incentive Payments (DSRIP)

AzHHA enthusiastically supports the Administration's intention to include a DSRIP program in the waiver. As we understand it, the proposal is currently a "placeholder." Considerable work will need to be done to flesh it out, including identifying authorized projects, metrics, financing, and eligible providers/organizations. We look forward to collaborating with the Administration and other stakeholders on the development of the program.

We support the initial direction the Administration is taking by utilizing findings from the State Health Improvement Plan and State Innovation Model grant to inform DSRIP priorities. Over the last 18 months, AzHHA has convened segmented constituencies of behavioral health providers, regional community health systems, post-acute care providers, and small rural hospitals. These constituency groups have identified projects they are working toward to drive delivery system transformation. We believe there is significant synergy between these projects and the goals of a DSRIP program, and we

[19] See St. Luke's Health Initiatives http://slhi.org/health-workforce-healthy-economy-january-2015/
Five Thirty Eight http://fivethirtyeight.com/datalab/how-your-citys-public-transit-stacks-up/

look forward to exploring opportunities for alignment via the stakeholder process outlined in the Waiver Narrative.

As the Administration fleshes out its DSRIP proposal we recommend the program have a statewide focus in order to drive improved health for all Arizonans. Collaboration among providers and the development of community partnerships should also be promoted. Finally, we support a model that allows provider led organizations to design and take lead on implementing projects. While there is much variation among providers, many are becoming increasingly adept at managing risk. These organizations will welcome the opportunity to contract directly with AHCCCS.

American Indian Medical Home

AzHHA celebrates the Administration's approach to construct a medical home model for Indian Health Services (IHS) and Tribal 638 facilities. Our membership is comprised of many of the facilities who provide services to the patients who stand to benefit from the proposed medical home model. We offer our support and assistance as this initiative moves forward.

Critical Access Hospital Supplemental Payments

The Demonstration proposal reflects recent legislative changes which seek to invest additional monies into Critical Access Hospitals (CAHs). Whereas AzHHA's membership represents many of the affected facilities, we are encouraged by this opportunity and look forward to working with the Administration to discuss potential strategies to ensure future financial viability of Arizona's CAHs and to improve the health of the patients they serve.

Safety Net Care Pool Transition

AzHHA originally supported implementation of the Safety Net Care Pool (SNCP) as a mechanism for offsetting increases in hospital uncompensated care resulting from the freeze on Prop. 204 enrollment, elimination of the medical expense deduction program, and the state's reduction in support for KidsCare. The SNCP program was originally envisioned as "bridge financing." Beginning in January 2014, more Arizonans gained access to insurance coverage through the Marketplace and Medicaid expansion, uncompensated care was reduced, and the SNCP was phased out. As part of 2013 legislation to restore Prop. 204 and expand Medicaid, the Legislature reauthorized the SNCP program for freestanding children's hospitals through 2017. Phoenix Children's Hospital (PCH) is the only facility to have benefited from this extension for the past two years. The AHCCCS Administration proposes an additional five-year extension of the program for PCH, coupled with a phase out of the program.

AzHHA does not support the continuation of the SNCP program as proposed on pages 17 through 20 of the Waiver Narrative, as it singles out one hospital for benefit. More significant, the proposal seems to run counter to the Administration's desire to move the payment system to a more value-based approach. While we appreciate the plight of

PCH, there are other freestanding children's hospitals operating in the state that are just as vulnerable, as well as other hospitals that have a higher Medicaid payer mix and more significant Medicaid shortfalls. And, as the Waiver Narrative points out, the AHCCCS Administration has designed the new APR-DRG payment methodology to take into account the potentially high cost of certain pediatric cases, by which PCH benefits. In addition, PCH does not incur some of the costs that other hospitals do—such as the hospital assessment, which funds Medicaid expansion.

We urge the Administration to consider the following changes to the SNCP program as currently proposed in the Waiver Narrative:

- Convert the SNCP program to a DSRIP program or DSRIP-like program, in which the recipient organization(s) must meet one or more performance metrics, and/or
- Expand eligibility for the SNCP to include other freestanding children's hospitals and public hospitals with high Medicaid utilization, such as Maricopa Medical Center.[20]

KidsCare

In addition, we ask the Administration to consider reinstating KidsCare as a more comprehensive approach to addressing concerns surrounding access to pediatric services. While this will not provide supplemental payments to PCH or other freestanding children's hospitals, it will expand access to services for many needy children with no or minimal cost to the State. Children will have an opportunity to receive these services in the most appropriate setting, which is often a community physician's office or clinic, and not the hospital. A 2006 study found that KidsCare children who become uninsured are half as likely to visit a doctor's office, four times as likely to visit and ED and eight times as likely to be admitted to a hospital.[21] Based on this analysis, reinstating the program seems to make fiscal sense.

While we recognize that KidsCare operates under a separate funding mechanism, the waiver represents an opportunity for the Administration to propose to CMS how its waiver strategy complements broader efforts to address issues around children's health coverage in Arizona. Should the Administration decide not to reinstate the KidsCare program, we would recommend that it explore alternative coverage options for children, especially those with special healthcare needs, from working low income families who may be caught in the *Affordable Care Act's* "family glitch."

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[20] Because the State has reduced the allocation of disproportionate share hospital payments that flow to safety net hospitals and/or redirected these funds to the state general fund via certified public expenditures, public and other safety net hospitals face increased fiscal pressure. This is one reason they find the SNCP attractive. An alternative to extending the SNCP might be to reevaluate recent changes to the DSH program, including the longer term practice of redirecting these funds to the state general fund.

[21] Johnson, Tricia J. et. al., "The Effects of Cost-Shifting in the State Children's Health Insurance Program." *American Journal of Public Health,* 709-715, April 2006.

Value-Based Purchasing Differential

The Administration states that it is considering implementing for FFY 2017 a payment differential for inpatient and outpatient hospital services based on whether a hospital meets performance metrics, which are not yet specified. AzHHA supports the inclusion of value-added components within the Medicaid system. As part of our commitment to the Triple Aim we believe it is essential to begin shifting away from volume-based payments toward models that reward improved healthcare and health outcomes. But, we are wary of how a payment differential will be implemented within the current budget environment. The last publicly released Access to Care report showed AHCCCS paying hospitals about 70 percent of cost.[22] On top of this, the Legislature has greatly reduced disproportionate share hospital payments.[23] While we would like to see additional movement toward value-based arrangements under Medicaid, there needs to be an infusion of funding into the system first or concurrently.

It will be difficult to comment thoroughly on the payment differential until we receive more details on the proposal—such as the specific metric(s); whether it is budget neutral; and how the process will work within a managed care framework.

Member Outreach & Notification

The proposed Demonstration seeks to notify members of forthcoming changes through direct mail, online outreach, public forums and personalized online accounts capable of email or text messaging.[24] AzHHA appreciates the Administration's due diligence in providing a variety of outreach techniques, given that low-income populations may be particularly difficult with which to maintain communication. According to a recent report, only 50 percent of U.S. adults earning less than $30,000 annually own a smartphone, while an average of 75 percent of adults earning above $30,000 are smartphone owners.[25] Another report, however, suggests that a majority of low-income individuals own a basic cell phone capable of sending and receiving text messages.[26] Thus, AzHHA commends the Administration's proposed outreach strategy and recommends emphasizing the use of text messaging to communicate with members. In addition to the proposed outreach strategies, we encourage the Administration to

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[22] A new Access to Care report was conducted this year, but has not yet been released. We expect the cost coverage ratio to be even lower given rate cuts and freezes that hospitals have incurred since the last report.
[23] Under the 2016 budget, $74 million in DSH funds are transferred to the state general fund via certified public expenditures with Maricopa Integrated Health System. MIHS receives $4.2 million. Private hospitals are allowed to share $18 million, if they can secure a local match.
[24] *See page 14* – Section 1115 Demonstration Program Template. Retrieved 9/2/2015 from http://www.azahcccs.gov/shared/Downloads/WaiverTemplateDRAFT8-18-15.pdf
[25] Smith, Aaron. "Chapter One: A Portrait of Smartphone Ownership." April 1, 2015. Retrieved 9/2/2015 from http://www.pewinternet.org/2015/04/01/chapter-one-a-portrait-of-smartphone-ownership/
[26] Gates, A., Stephens, J., Artiga, S. "Profiles of Medicaid Outreach and Enrollment Strategies Using Text Messaging to Reach and Enroll Uninsured Individuals into Medicaid and CHIP." March 7, 2014. Retrieved 8/31 from http://kff.org/medicaid/issue-brief/profiles-of-medicaid-outreach-and-enrollment-strategies-using-text-messaging-to-reach-and-enroll-uninsured-individuals-into-medicaid-and-chip/

communicate through other media outlets (e.g., television and radio) to notify members of program changes.

In closing we would like to thank the Administration again for the effort it has put into the waiver proposal. AzHHA shares in the Administration's ambition and commitment toward creating a more engaging, cost-effective and patient-centered program that stretches beyond the traditional constraints of Medicaid. We believe many of the strategies proposed here will propel Arizonan's toward better health. However, we have reservations that some components of the proposal may prove cost-prohibitive and could reduce access to care. We look forward to working with the Administration on these issues, and are thankful for the opportunity to respond to the waiver proposal. Please do not hesitate to contact me if you have any questions.

Sincerely,

Greg Vigdor
President and Chief Executive Officer