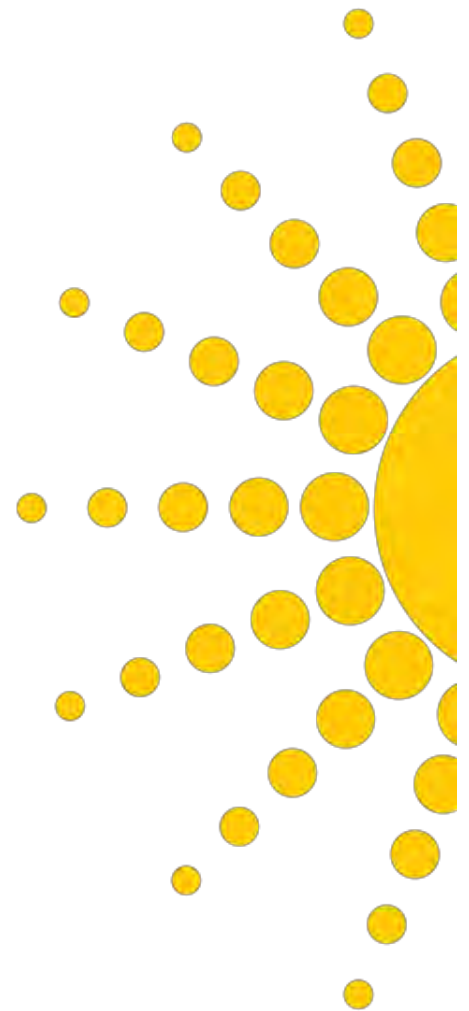




Arizona's Application for a New Section 1115 Demonstration





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Section 1- Governor's Letter



STATE OF ARIZONA
OFFICE OF THE GOVERNOR

DOUGLAS A. DUCEY
GOVERNOR

EXECUTIVE OFFICE

September 30, 2015

Secretary Sylvia Mathews Burwell
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Arizona's Section 1115 Waiver

Dear Secretary Burwell:

On behalf of over 1.8 million Arizonans, I submit this formal request to apply for a new Section 1115 Research and Demonstration Waiver (the "Waiver") that will build upon past successes of the Arizona Health Care Cost Containment System (AHCCCS) and employ new strategies for member engagement. This new Waiver application covers the period of October 1, 2016 through September 30, 2021.

The State's proposal reflects the changing face of Medicaid. Traditionally, Medicaid was designed to serve children, pregnant women, the elderly and individuals with disabilities. Today, Medicaid in Arizona serves nearly as many adults as it does Arizonans enrolled in the traditional eligibility categories. Though we have developed strategies around member engagement, wellness, disease management, supported employment and housing and other opportunities for traditional eligibility categories, the same cannot be said for adults. Accordingly, new strategies must be deployed to engage the adult membership.

I know this is a goal you share. Recently, you launched the "Healthy Self" initiative to engage adults in taking a more active role in their own health and wellness. The Healthy Self initiative addresses the concern that, for a variety of reasons, adults often bypass their checkups and screenings and miss opportunities to take better control of their own health. The goal to "promote a better, smarter and healthier health care system with engaged, educated and empowered people at the center of it" is one that Arizona shares.¹ This shared goal of an engaged, educated and empowered citizenry is at the heart of Arizona's new Waiver.

¹ See <http://www.hhs.gov/blog/2015/06/11/invest-your-healthy-self.html> last accessed September 24, 2015.

The AHCCCS CARE program is designed to reach that adult population², provide them with tools to better manage their health and prepare them for the transition out of Medicaid. AHCCCS CARE is a fresh take on conventional approaches.

1. Giving Meaning to Personal Responsibility.

- *Strategic Copays.* This new look at copayments is designed to direct care to the right setting at the right time. Copayments will not be collected at the point of service, but instead will be billed retrospectively.
 - No Copay. Accordingly, members who access care through their primary care physician (PCP) are not assessed a copayment, whether visiting the doctor for a well check or sick care. The purpose is to emphasize that there is an open door to a member's PCP no matter what the need. Similarly, because the OB-GYN serves as a PCP for many women, there is no copay assessed for those visits. We also want it to be clear that there is no copay for behavioral health services. Behavioral health providers are a critical part of a member's care team. We want to ensure that same open door approach for behavioral health as we have established for physical health. Additionally, if a member needs specialty care, there is no copay as long as a PCP provides a referral, emphasizing the medical home model. Finally, there is no copayment for prescriptions (with two exceptions below) to ensure members have the tools they need to manage chronic disease.
 - Copays Required. Copays for prescriptions only apply to access opioids (unless you have cancer or a terminal illness) and brand name drugs where a generic is available (unless a physician determines the generic is not efficacious). The copay on brand name drugs includes brand name biologics when a biosimilar is available. We recognize that opioid use is sometimes necessary for pain management, but we must take action against opioid abuse that has become a leading public health concern and often results in abuse of illicit drugs. Arizona was pleased to attend your recent 50-state summit to discuss strategies to address this epidemic. We agree that this epidemic is multifaceted and support your efforts. Requiring a copay for opioids is one of Arizona's strategies. Copayments will also be assessed for non-emergency use of the emergency department, missed appointments and specialist care without a PCP referral. Certainly, members cannot always make an appointment, but taking the step to call and cancel obviates the need to pay the copayment.
- *Putting Premiums to Work.* The Arizona Legislature passed a bill to require premiums for the adult population not to exceed 2% of annual household income (SB 1475). I support that measure of personal responsibility and, in my AHCCCS CARE program, added an opportunity to allow members to use their premium dollars for non-covered services like dental and vision care. This way we combine personal responsibility with purpose. To make sure the premium component is not overly burdensome, the AHCCCS CARE

² The New Adult Group would be required to enroll in the AHCCCS CARE program. The New Adult Group in Arizona includes the Prop. 204 eligible childless adults 0-100% of the federal poverty level (FPL) and the expansion adults 100-133% FPL. The AHCCCS CARE program is optional for the TANF parent population, American Indians in the New Adult Group, and adult members that have a serious mental illness. In addition, adults considered medically frail (to be defined) could be excluded from AHCCCS CARE participation until they are able.

program has a ceiling, so members will either pay 2% of their annual household income or \$25 per month, whichever is lesser.

2. **The AHCCCS CARE Account.** Members will receive a quarterly invoice that shows how much they owe for copayments and premiums. Members make monthly payments into their AHCCCS CARE account. Copayments are used to offset program costs. Premium payments are monies that can be withdrawn by members for non-covered services. As long as members are timely with their payments, meet one Healthy Arizona target, and participate in AHCCCS works, they can withdraw funds from their AHCCCS CARE account. The AHCCCS CARE program also offers a new opportunity to engage the business sector. Many employers rely on Medicaid as the source of their employees' health insurance. The AHCCCS CARE account provides those employers with an opportunity to more directly invest in the health of their workforce. Arizona is committed to encouraging business contributions into their employees' AHCCCS CARE accounts. Supporting a healthy workforce requires these types of partnerships. In addition, the AHCCCS CARE account is portable. When AHCCCS members move on from AHCCCS, they can take their AHCCCS CARE account with them.
3. **Healthy Arizona.** Healthy Arizona is simple. The primary goal is to educate members about proactive measures they can take to stay healthy. Meeting the Healthy Arizona target can be as simple as getting your flu shot or mammogram. But we want to also set higher goals and engage employers and the philanthropic community to partner with the State. We all share similar goals to achieve a healthier citizenry. For members who meet tobacco cessation goals, for instance, we want to create opportunities for additional support to be provided into members' AHCCCS CARE accounts by charitable organizations who share that goal.
4. **AHCCCS Works.** The Arizona Legislature passed legislation (SB 1092) to condition Medicaid eligibility upon acquiring work. I supported their legislation because I believe in promoting work and support a national dialogue around how to better engage Medicaid members in work opportunities. The AHCCCS Works program taps into the spirit of SB 1092 by taking that first step – connecting Medicaid members to work opportunities. Participation in AHCCCS Works is not a condition of Medicaid eligibility, nor is there a requirement that the member actually find employment. Rather, participating in AHCCCS Works is a connection to employment supports. It can be as simple as signing up for job seekers assistance through the Arizona Department of Economic Security (DES), attending a job fair, or taking a class. We have a robust program at DES with a dedicated staff that is committed to helping Arizonans find work. All that AHCCCS Works does is extend that opportunity to a ready group – adult members on AHCCCS.

The AHCCCS CARE goal is simple: partnering with the private sector to educate Arizonans about ways to manage their health, take advantage of preventive services, build up a savings account that they can use to reinvest in their own health and connect people to employment. These strategies will also benefit members once they move on from Medicaid enrollment where they will have to manage premiums and copayments in the Marketplace or through their employer's insurance. A member who is better prepared for this transition is more likely to maintain their commercial coverage.

Arizona's Waiver is the right home for AHCCCS CARE. As you know, the AHCCCS program has operated under the flexibility of the Waiver since its inception in 1982. Through that flexibility, Arizona

has built a program that mainstreams its members, allowing individuals the choice to seek their health care from private providers and sit alongside commercially insured Arizonans, rather than being directed to government-operated Medicaid mills. Arizona's Waiver has also served as the foundation for a competitive bidding process among health plans, drawing top quality and driving down costs. Perhaps more importantly, Arizona's Waiver has allowed the program to evolve over time.

While there are still those who maintain an antiquated view of what Medicaid managed care is, today's AHCCCS has grown well beyond simply paying claims and managing prior authorizations. Today's Medicaid managed care program in Arizona: uses sophisticated data analytics tools for assessing risk and developing care management protocols; promotes value based purchasing arrangements that drive quality over quantity; manages oversight of health plans in a manner that is data informed, not needlessly bureaucratic; collaborates with the broader community, extending beyond health care to support population health; and continually seeks opportunities to streamline and integrate the health care system making access to care easier for members. All of these types of initiatives and more are made possible through Arizona's Waiver, which is a living document.

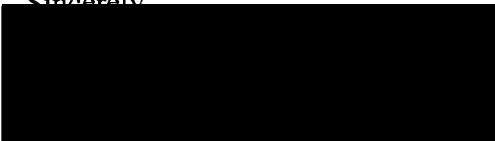
The fact that Arizona's Waiver is an evolving document is critical. Health care is changing at a rate that far outpaces government's ability to keep up through statutes and regulations. The Waiver affords a tool through which states can more nimbly support innovations like AHCCCS CARE to better serve members and their families and allow decision-making at the local level.

The AHCCCS CARE program is only one component of this new Waiver generation. This application includes: proposals for system reform through the Delivery System Reform Incentive Payment (DSRIP) program; uncompensated care payments for Indian Health Services and tribally operated 638 facilities; supporting a medical home model that includes traditional healing practices for our American Indian/Alaska Native members; transition to the new Home and Community Based Services settings standards; phasing out of the Safety Net Care Pool to smarter and more sustainable models that support Phoenix Children's Hospital; and changes that reflect recent transitions within Arizona's Medicaid system. All of these are explained in more detail in the attached document.

I am committed to working with you on achieving approval of this proposal. I believe this plan demonstrates the State's commitment to the AHCCCS program so that it continues to serve as a national model of cost-effective, quality care for the State's most vulnerable and continues as a leading example of a successful state-federal partnership. My team stands at the ready to provide you and your staff with whatever additional information you need so that we can have an approved package by October 1, 2016.

Thank you for your consideration and your service to the nation.

Sincerely,



Douglas A. Ducey
Governor
State of Arizona

Section 2- Template



Centers for Medicare & Medicaid Services Office of
Information Services
Information Services Design & Development Group 7500 Security
Blvd
Baltimore, MD 21244-1850

**Section 1115 Demonstration Program
Template**

Section 1115 Demonstration Template for New Demonstrations

Instructions: This template is meant to assist states that are developing an application for a new section 1115 demonstration project; submission of the information provided in this template or the attachments does not guarantee approval of a state's demonstration request. CMS will work with states to identify any additional information necessary to consider demonstration requests. Use of this guide/format is not required; it is a tool that states can use at their option. It was designed to help states ensure the application contains the required elements as provided for under 42 CFR 431.412, as well as promote an efficient review process. It can also be used by states as a template for their application; states can add narrative responses to the information requested in the sections below that are applicable to the state's particular application, and complete the charts and check boxes provided. We will continue to improve this guide based on input from states and expect to have an online section 1115 demonstration application available for use in the future.

Please submit applications electronically to 1115DemoRequests@cms.hhs.gov and mail hard copies to:

Ms. Victoria Wachino
Centers for Medicare & Medicaid Services Children
and Adults Health Programs Group Mail Stop: S2-01-
16
7500 Security Boulevard
Baltimore, MD 21244

Section I - Program Description

This section should contain information describing the goals and objectives of the Demonstration, as well as the hypotheses that the Demonstration will test. In accordance with 42 CFR 431.412(a)(i), (v) and (vii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

- 1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act). (This summary will also be posted on Medicaid.gov after the application is submitted. If additional space is needed, please supplement your answer with a Word attachment);
- 2) Include the rationale for the Demonstration (if additional space is needed, please supplement your answer with a Word attachment);
- 3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them (if additional space is needed, please supplement your answer with a Word attachment);
- 4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the

geographic areas/regions of the State where the Demonstration will operate (if additional space is needed, please supplement your answer with a Word attachment);

- 5) Include the proposed timeframe for the Demonstration (if additional space is needed, please supplement your answer with a Word attachment); and
- 6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems (if additional space is needed, please supplement your answer with a Word attachment).

AZ Response:

See attachment entitled: "Modernizing Arizona Medicaid"

Section II – Demonstration Eligibility

This section should include information on the populations that will participate in the Demonstration, including income level. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

- 1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included). Please refer to Medicaid Eligibility Groups: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf> when describing Medicaid State plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.

AZ Response:

The only population whose eligibility may be affected by the Demonstration are expansion adults 100%-133% FPL in the New Adult Group who fail to make timely payments in the AHCCCS CARE program. See attachment entitled: "Modernizing Arizona Medicaid"

Example Eligibility Chart

Eligibility Group Name	Social Security Act and CFR Citations	Income Level
Transitional Medical Assistance	408(a)(11)(A) 1931(c)(2) 1925 1902(a)(52)	0 – 100% of the FPL
Families who would qualify for cash assistance if the State had expanded its cash assistance program as allowed under federal law (Parent/Caretaker Relatives)	1902(a)(10)(A)(ii)(III) 42 CFR 435.223 1905(a)	100 – 200% of the FPL
Adults without dependent children not otherwise eligible under the State plan	N/A	0-200% of the FPL

- 2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan (if additional space is needed, please supplement your answer with a Word attachment);

AZ Response: N/A

- 3) Specify any enrollment limits that apply for expansion populations under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment);

AZ Response: N/A

- 4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs (if additional space is needed, please supplement your answer with a Word attachment);

AZ Response: The projected number of Medicaid State Plan eligible individuals who would be eligible for the AHCCCS CARE program is:

Newly Eligible Adults	62,763
Prop 204 Restoration	251,987
TANF Adult Parents	256,133
	570,883

- 5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State) (if additional space is needed, please supplement your answer with a Word attachment);

AZ Response: AHCCCS CARE members will receive the same services furnished to all other acute care enrollees. All of the same eligibility procedures will be utilized.

- 6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013) (if additional space is needed, please supplement your answer with a Word attachment); and

AZ Response: N/A

- 7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014 (if additional space is needed, please supplement your answer with a Word attachment).

AZ Response: N/A

Section III – Demonstration Benefits and Cost Sharing Requirements

This section should include information on the benefits provided under the Demonstration as well as any cost sharing requirements. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state’s application in order to be determined complete. Specifically, this section should:

- 1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

Yes No (if no, please skip questions 3 – 7)

- 2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

Yes No (if no, please skip questions 8 - 11)

- 3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided):

AZ Response: There are no changes proposed to the benefits provided under the Demonstration. The benefits chart already in the Demonstration for members enrolled in the Arizona Long Term Care System (ALTCS) is included to reflect the current differences from State Plan services for members at risk of institutionalization. No changes are being proposed to benefits.

Example Benefit Package Chart

Eligibility Group	Benefit Package
Transitional Medical Assistance	Full State Plan
Optional State plan parent/caretaker relatives	Benchmark Equivalent Benefit Package
Expansion Adults	Demonstration-only Benefit Package

AZ Benefit Package Chart

Eligibility Group	Benefit Package
Arizona Long Term Care System (ALTCS)	
	Acute Hospital Admission
	Adult Day Health Services
	Attendant Care
	Behavioral Health Services
	Community Transition Services
	DME / Medical Supplies
	Emergency Alert
	Habilitation
	Home Delivered Meals
	Home Health Agency Services
	Home Modifications
	Home Maker Services
	Hospice Services (HCBS & Institutional)

	ICF / MR
	Medical Care Acute Services
	Nursing Facility Services
	Personal Care
	Respite Care (in home)
	Respite Care (Institutional)
	Therapies
	Transportation
	All Other Medicaid State Plan Services

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

- Federal Employees Health Benefit Package State
- Employee Coverage
- Commercial Health Maintenance Organization
- Secretary Approved

**Please note that, in accordance with section 1937(a)(2)(B) of the Act, the following populations are exempt from benchmark equivalent benefit packages: mandatory pregnant women, blind or disabled individuals, dual eligibles, terminally ill hospice patients, individuals eligible on basis of institutionalization, medically frail and special medical needs individuals, beneficiaries qualifying for long-term care services, children in foster care or receiving adoption assistance, mandatory section 1931 parents, and women in the breast or cervical cancer program. Also, please note that children must be provided full EPSDT benefits in benchmark coverage.

- 5) In addition to the Benefit Specifications and Qualifications form: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf>, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).
AZ Response: N/A. The Demonstration will not provide benefits that differ from the Medicaid/CHIP State Plan other than the HCBS Services identified in the chart under response to #3 above.

Example Benefit Chart

Benefit	Description of Amount, Duration and Scope	Reference
Inpatient Hospital Services	No limitations – coverage is based on State plan	Mandatory 1905(a)(1)
Podiatrist Services	Limited to 12 visits per year	Optional 1905(a)(6)

Benefit Chart

Benefit	Description of Amount, Duration and Scope	Reference

Benefits Not Provided

Benefit	Description of Amount, Duration and Scope	Reference

Please refer to List of Medicaid and CHIP Benefits: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Medicaid-and-CHIP-Benefits.pdf>, when completing this chart.

6) Indicate whether Long Term Services and Supports will be provided.

X Yes (if yes, please check the services that are being offered) No

In addition, please complete the: <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf>, and the: <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf>.

AZ Response: No changes to benefits are being proposed. ALTCS enrolled members receive the full array of HCBS services as under the Demonstration (see #3 above). Acute care enrollees receive the same benefits as under the State Plan and behavioral health benefits as under the State Plan and Demonstration.

- | | |
|---|--|
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Home Health Aide Personal |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Care Services |
| <input type="checkbox"/> Adult Day Health Services Habilitation – | <input type="checkbox"/> Habilitation – Residential Habilitation |
| <input type="checkbox"/> Supported Employment Habilitation – | |
| <input type="checkbox"/> Day Habilitation Habilitation – Other | <input type="checkbox"/> Habilitation – Pre-Vocational |
| <input type="checkbox"/> Habilitative | <input type="checkbox"/> Habilitation – Education (non-IDEA Services) |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Day Treatment (mental health service) |
| <input type="checkbox"/> Psychosocial Rehabilitation | <input type="checkbox"/> Clinic Services |
| <input type="checkbox"/> Environmental Modifications (Home Accessibility Adaptations) | <input type="checkbox"/> Vehicle Modifications |
| <input type="checkbox"/> Non-Medical Transportation | <input type="checkbox"/> Special Medical Equipment (minor assistive devices) |
| <input type="checkbox"/> Home Delivered Meals Personal | <input type="checkbox"/> Assistive Technology |
| <input type="checkbox"/> Emergency Response Community | <input type="checkbox"/> Nursing Services Adult |
| <input type="checkbox"/> Transition Services Day Supports | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> (non-habilitative) Supported Living | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Arrangements Assisted Living | <input type="checkbox"/> Private Duty Nursing Adult |
| <input type="checkbox"/> | <input type="checkbox"/> Companion Services |

- Supports for Consumer Direction/Participant Directed Goods and Services Other
- (please describe)

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

- Yes (if yes, please address the questions below)
- No** (if no, please skip this question)

a) Describe whether the state currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program (if additional space is needed, please supplement your answer with a Word attachment);

- b) Include the minimum employer contribution amount (if additional space is needed, please supplement your answer with a Word attachment);
- c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing (if additional space is needed, please supplement your answer with a Word attachment); and
- d) Indicate how the cost-effectiveness test will be met (if additional space is needed, please supplement your answer with a Word attachment).

8) If different from the State plan, provide the premium amounts by eligibility group and income level (if additional space is needed, please supplement your answer with a Word attachment).

AZ Response: See attachment entitled: **“Modernizing Arizona Medicaid”**

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):

AZ Response: Copayment amounts will follow the State Plan amounts. Arizona has a State Plan Amendment currently pending (See SPA 14-014 – ABP Cost-Sharing at <http://www.azahcccs.gov/reporting/PoliciesPlans/StatePlanAmendments.aspx>). The AHCCCS CARE Demonstration includes exemptions to these amounts. The chart below details copayment amounts that differ from the State Plan pursuant to legislative directives detailed in the narrative “Modernizing Arizona Medicaid.”

Example Copayment Chart

Eligibility Group	Benefit	Copayment Amount
Childless Adults	Podiatrist Services	\$3 per visit

AZ Copayment Chart

Eligibility Group	Benefit	Copayment Amount
New Adult Group (Childless Adults) 0-100% FPL	Non-emergency use of ER if not admitted (1st time)	\$8.00/visit
New Adult Group (Childless Adults)	Non-emergency use of ER if	\$25.00/visit

0-100% FPL	not admitted (after 1st time)	
New Adult Group (Childless Adults) 0-100% FPL	Non-emergency use of ER if CHC/RHC/UCC w/in 20 miles	\$25.00/visit
New Adult Group (Expansion Adults) 100-133% FPL	Non-emergency use of ER if not admitted (1st time and any time thereafter)	\$25.00/visit
New Adult Group (Expansion Adults) 100-133% FPL	Non-emergency use of ER if CHC/RHC/UCC w/in 20 miles	\$25.00/visit
New Adult Group 0-133%	Missed Appointments	Copay amount member would have otherwise paid for the service

If the state is proposing to impose cost sharing in the nature of deductions, copayments or similar charges beyond what is permitted under the law, the state should also address in its application, in accordance with section 1916(f) of the Act, that its waiver request:

- a) will test a unique and previously untested use of copayments;
- b) is limited to a period of not more than two years;
- c) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients;
- d) 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; and
- e) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

AZ Response: See attachment entitled: “Modernizing Arizona Medicaid”

Please refer to Information on Cost Sharing <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Information-on-Cost-Sharing-Requirements.pdf> requirements for further information on statutory exemptions and limitations applicable to certain populations and services.

10) Indicate if there are any exemptions from the proposed cost sharing (if additional space is needed, please supplement your answer with a Word attachment).

AZ Response: The State is seeking exemptions to State Plan copayment requirements for PCP and OB-GYN visits, persons with Serious Mental Illness and treatment of chronic illness, in addition to preventive and wellness services. (See attachment entitled: “Modernizing Arizona Medicaid.”)

Section IV – Delivery System and Payment Rates for Services

This section should include information on the means by which benefits will be provided to Demonstration participants. In accordance with 42 CFR 431.412(a)(ii), a description of the proposed healthcare delivery system must be included in a state’s application in order to be determined complete. Specifically, this section should:

- 1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

X Yes

- No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

- 2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration’s expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms (if additional space is needed, please supplement your answer with a Word attachment);

AZ Response: Arizona’s Demonstration operates a mandatory managed care system. Thus, all participants, except American Indian/Alaska Natives (AI/AN), receive services through a delivery model authorized under the Demonstration. The only proposed delivery system reform is the State’s DSRIP proposal. (See attachment entitled: “Modernizing Arizona Medicaid.”) However, even under the DSRIP, these system reforms will still occur within the broader managed care structure. The improvements to quality, access and cost related to the State’s DSRIP proposal will stem from improved care coordination and better communication between providers. For fee-for-Service enrolled AI/AN members, the State’s Medical Home proposal aims to accomplish some of the same care coordination and managed care initiatives that are in place for managed care enrollees. The goal is to address health care disparities for AI/AN members by linking Indian Health Service and Tribal facilities to other providers to strengthen care coordination and build supports for a medical home model.

- 3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

X Managed care

X Managed Care Organization (MCO),

Prepaid Inpatient Health Plans (PIHP)

Prepaid Ambulatory Health Plans (PAHP)

Fee-for-service (including Integrated Care Models)

X Primary Care Case Management (PCCM) – paid on

**PMPM basis for IHS and Tribal 638 facilities
qualifying as Medical Homes for AI/AN fee-for-
service members**

- Health Homes
- Other (please describe)

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:

AZ Response: Arizona has a small fee-for-service system through which approximately 75% of its AI/AN population are serviced. AI/AN members span all eligibility categories.

Example Delivery System Chart

Eligibility Group	Delivery System	Authority
Transitional Medical Assistance	Fee-for-service	State plan
Optional State plan parent/caretaker relatives	Managed Care – MCO	Section 1915(b) waiver
Childless Adults	Managed Care – MCO	1115

Delivery System Chart

Eligibility Group	Delivery System	Authority

5) If the Demonstration will utilize a managed care delivery system:

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations (if additional space is needed, please supplement your answer with a Word attachment)?

AZ Response: Enrollment utilizes a mandatory managed care delivery system. There are exemptions for American Indians, who can choose to receive services through Fee-For-Service or Managed Care. Individuals who receive services through the Federal Emergency Services receive such services on a Fee-For-Service basis.

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state (if additional space is needed, please supplement your answer with a Word attachment);

AZ Response: Managed care is operated statewide.

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state. If additional space is needed, please supplement your answer with a Word attachment);

AZ Response: N/A

- d) Describe how will the state assure choice of MCOs, access to care and provider network adequacy (if additional space is needed, please supplement your answer with a Word attachment); and

AZ Response: The contracts between AHCCCS and the MCOs require that contractors have a sufficient network to provide covered services within designated time and distance limits. AHCCCS monitors each contractor's compliance with network standards through quarterly and annual deliverables and annual network plans submitted by each contractor as well as during regular operational and financial reviews. Contractors are required to monitor their networks to ensure provider appointment availability standards for primary care and dental, specialty, and maternity care services are met. AHCCCS also tracks the number of providers who leave a contractor's network due to dissatisfaction with rates.

- e) Describe how the managed care providers will be selected/procured (if additional space is needed, please supplement your answer with a Word attachment).

AZ Response: AHCCCS utilizes a highly competitive request for proposal (RFP) process to select contracted managed care organizations (MCOs). This process is documents on the AHCCCS website and includes data, information on open and closed solicitations, bidder's library, contract extensions and other information: <http://www.azahcccs.gov/commercial/Purchasing/purchasing.aspx> .

- 6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion (if additional space is needed, please supplement your answer with a Word attachment);

AZ Response: N/A

- 7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment).

Yes

No

AZ Response: This response reflects the current ALTCS structure that allows for multiple models, including Self Directed Attendant Care, Agency with Choice and a Traditional agency model.

- 8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology (if additional space is needed, please supplement your answer with a Word attachment);

AZ Response: N/A

- 9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438 (if additional space is needed, please supplement your answer with a Word attachment); and

AZ Response: AHCCCS develops capitation rates using generally accepted actuarial principles and practices considered to be actuarially sound as certified by an Actuary. Capitation rates are developed in compliance with CMS requirements in accordance with applicable laws and regulations, appropriate for the Medicaid populations covered under the contracts with the MCOs. In setting these rates, AHCCCS uses historical encounter data to set capitation rates and rate ranges. When setting the Acute Care capitation rate ranges, AHCCCS adjusts the base data when appropriate for reasons including, but not limited to, the following:

- Completion factors
- Seasonality factors
- True-up factors
- Historical program and fee schedule changes
- Trends

Program changes are also considered when reviewing the encounter and financial statement information. Actuarial certifications and other information can be found on the AHCCCS website:

<http://www.azahcccs.gov/commercial/ContractorResources/capitation/capitationrates.aspx>

- 10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected (if additional space is needed, please supplement your answer with a Word attachment).

AZ Response: AHCCCS is proposing a DSRIP program that may allow for quality-based supplemental payments to providers. Metrics and methodologies are still under development through a stakeholder process.

Section V – Implementation of Demonstration

This section should include the anticipated implementation date, as well as the approach that the State will use to implement the Demonstration. Specifically, this section should:

- 1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone (if additional space is needed, please supplement your answer with a Word attachment);

AZ Response: Assuming CMS approval by the October 1, 2016, the current Demonstration expiration date, the State would implement the AHCCCS CARE program upon completion of a contract award for the third party administrator and other time as necessary for the vendor to be ready to launch.

- 2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration (if additional space is needed, please supplement your answer with a Word attachment); and

AZ Response:

- **AHCCCS will mail letters to existing members transitioning to the AHCCCS CARE program. The letter will contain extensive education on AHCCCS CARE, including a description of the member's rights and responsibilities and instruction on how to pay premium and copay amounts due.**
 - **The AHCCCS website (www.azahcccs.gov) will be updated to include information about AHCCCS CARE including eligibility, cost sharing obligations, and how to apply for the program. Information on AHCCCS CARE will also be posted on the managed care plans' websites and in their member newsletters.**
 - **The State will organize public forums to engage and educate members and their families, providers, and advocates about the AHCCCS CARE program.**
 - **It is desired that the vendor administering the AHCCCS CARE program will also possess the capability to allow members to establish an online account from which members can receive messages electronically, by email or text. The vendor would also be able to provide counseling services regarding options and benefits within the AHCCCS CARE program.**
- 3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action (if additional space is needed, please supplement your answer with a Word attachment).

AZ Response: AHCCCS will work with its current contracted managed care organizations which already provide benefits to this population. No procurements for the managed care system are needed at this time. AHCCCS will need to conduct a procurement action to engage a third party administrator to manage the AHCCCS CARE accounts.

Section VI – Demonstration Financing and Budget Neutrality

This section should include a narrative of how the Demonstration will be financed as well as the expenditure data that accompanies this application. The State must include 5 years of historical data, as well as projections on member month enrollment. In accordance with 42 CFR 431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before the application can be acted upon.

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf> includes a set of standard financing questions typically raised in new section 1115 demonstrations; not all will be applicable to every demonstration application. The Budget Neutrality form and spreadsheet: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf> includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

AZ Response: See attached Budget Neutrality Schedule

Section VII – List of Proposed Waivers and Expenditure Authorities

This section should include a preliminary list of waivers and expenditures authorities related to title XIX and XXI authority that the State believes it will need to operate its Demonstration. In accordance with 42 CFR 431.412(a)(vi), this section must be included in a state's application in order to be determined complete. Specifically, this section should:

- 1) Provide a list of proposed waivers and expenditure authorities; and
- 2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Please refer to the list of title XIX and XXI waivers and expenditure authorities: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Waivers-and-Expenditure-Authorities.pdf> that the state can reference to help complete this section. CMS will work with the State during the review process to determine the appropriate waivers and expenditures needed to ensure proper administration of the Demonstration.

AZ Response: See attached Waiver and Expenditure Authority table

Section VIII – Public Notice

This section should include information on how the state solicited public comment during the development of the application in accordance with the requirements under 42 CFR 431.408. For specific information regarding the provision of state public notice and comment process, please click on the following link to view the section 1115 Transparency final rule and corresponding State Health Official Letter:

<http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>

AZ Response: See Attached Public Notice Write Up and referenced attachments for updated response.

Please include the following elements as provided for in 42 CFR 431.408 when developing this section:

- 1) Start and end dates of the state’s public comment period (if additional space is needed, please supplement your answer with a Word attachment);
AZ Response: The Public Comment period will begin with Community Forums held throughout the State during the month of August. The first forum begins August 18, 2015. The draft application and attachments will be posted to the AHCCCS website at that time. The public comment period will close September 25, 2015. See the following link for more information on dates and locations:
<http://www.azahcccs.gov/publicnotices/Downloads/WaiverForumFlyer.pdf>
* See Attached Public Notice Write Up and referenced attachments for updated response.
- 2) Certification that the state provided public notice of the application, along with a link to the state’s web site and a notice in the state’s Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS (if additional space is needed, please supplement your answer with a Word attachment);
AZ Response: The DRAFT Waiver application will be published on the AHCCCS Website August 18, 2015 at the link below. The presentation reviewed during the forums will also be posted to the AHCCCS website. Information about the State’s application, forums schedule and email address for submitting public comment was published in an article in *The Arizona Republic* on August 17, 2015. AHCCCS will also publish a notice in *The Arizona Republic*, the newspaper of widest circulation, 30 days prior to submittal.
<http://www.azahcccs.gov/shared/FiveYear.aspx>
* See Attached Public Notice Write Up and referenced attachments for updated response.
- 3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted (if additional space is needed, please supplement your answer with a Word attachment);
AZ Response: See Response to #1 above. AHCCCS will also present the application to the State Medicaid Advisory Committee on August 19, 2015. Currently five (5) community forums and one (1) tribal consultation are scheduled across the State, with one of these forums including conference line capabilities.
* See Attached Public Notice Write Up and referenced attachments for updated response.
- 4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used. If additional space is needed, please supplement your answer with a Word attachment);
AZ Response: The DRAFT Waiver proposal will be published on the AHCCCS Website at the link below. Once the draft application is posted, the link will be sent to an electronic list serve that includes major associations, the State Medicaid Advisory Council, the Office of Individual and Family Affairs, and others. AHCCCS will also publish information on the

newspaper of widest circulation.

<http://www.azahcccs.gov/shared/FiveYear.aspx>

* See Attached Public Notice Write Up and referenced attachments for updated response.

- 5) Comments received by the state during the 30-day public notice period (if additional space is needed, please supplement your answer with a Word attachment);
AZ Response: The agency will post comments received and provide summary responses to key issues or concerns raised. The agency will also post summaries of comments and questions raised during the Community Forums, as well as summary responses.
* See Attached Public Notice Write Up and referenced attachments for updated response.
- 6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application (if additional space is needed, please supplement your answer with a Word attachment); and
AZ Response: Forthcoming to be included on the agency's website.
* See Attached Public Notice Write Up and referenced attachments for updated response.
- 7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation (if additional space is needed, please supplement your answer with a Word attachment).
AZ Response: Tribal Consultation will be held on August 21, 2015. Summary will be posted on the agency's tribal consultation page here:
<http://www.azahcccs.gov/tribal/consultations/meetings.aspx>. Additional tribal consultation sessions will be held as needed or as requested. The State has pre-scheduled tribal consultation meetings quarterly.
* See Attached Public Notice Write Up and referenced attachments for updated response.

If this application is an emergency application in which a public health emergency or a natural disaster has been declared, the State may be exempt from public comment and tribal consultation requirements as outlined in 42 CFR 431.416(g). If this situation is applicable, please explain the basis for the proposed emergency classification and public comment/tribal consultation exemption (if additional space is needed, please supplement your answer with a Word attachment).

Section IX – Demonstration Administration

Please provide the contact information for the state’s point of contact for the Demonstration application.

Name and Title:

Monica Coury
Assistant Director
Office of Intergovernmental Relations

Telephone Number:

602-417-4000

Email Address:

publicinput@azahcccs.gov

Arizona Waiver and Expenditure Authorities
 Current Demonstration Approval Period: 10/1/2011-9/30/2016
 Proposed for: 10/1/2016 – 9/30/2021

Waiver/ CNOM #	Title	Brief Description	Renew	Notes
Waiver Authorities				
1	Proper and Efficient Administration	a) Limit choice of managed care entities for enrollees in foster care or who are in need of treatment for developmental disabilities, behavioral health issues, or conditions covered by the State's Children's Rehabilitative Services Program to a single MCO b) Auto enroll members who lose eligibility w/in 90 days to same PIHP previously enrolled c) restrict disenrollment w/out cause after 30 days d) restrict disenrollment for cause	Y	Allows the State to only offer one MCO where the Medicaid Act requires enrollees be provided a choice of MCO's. Ensures effective and efficient functions And guarantees continuity of care. The ability to disenroll without cause is costly and requires more administrative resources. Less than 3% of members choose to switch their plans during annual enrollment choice. Waiver Authority Requested: Section 1902(a)(4) (42 CFR 438.52, 438.56)
2	Eligibility Based on Institutional Status	Allows AZ to exclude hospitalized individuals and others in medical institutions for more than 30 days from automatically becoming eligible for LTC services if they do not meet the level of care standard for LTC service.	Y	Arizona would otherwise be required to provide LTC services to acute care individuals with income up to 300% who may not be at risk of institutionalization but are in the hospital for more than 30 days. Waiver Authority Requested: Section 1902(a)(10)(A)(ii)(V) (42 CFR 435.217 and 435.236)
3	Amount, Duration and Scope of	Allows AZ to offer different/additional services based on different care arrangements for members receiving	Y	To limit the number of hours of attendant care that can be provided for members

Arizona Waiver and Expenditure Authorities
Current Demonstration Approval Period: 10/1/2011-9/30/2016
Proposed for: 10/1/2016 – 9/30/2021

Waiver/ CNOM #	Title	Brief Description	Renew	Notes
	Services	spousal caregiver services. Allows MCOs and PIHPs to provide additional or different benefits.		receiving spousal caregiver services. Waiver Authority Requested: Section 1902(a)(10)(B) (42 CFR 440.240 and 440.230)
5	DSH Requirements	Relieves AZ from making payments for inpatient hospital services that take into account disproportionate share of low income patients	Y	Allows flexibility to operate AZ's DSH program under the waiver vs. the State Plan Waiver Authority Requested: Section 1902(a)(13) insofar as it incorporates section 1923
6	Cost Sharing	Allows AZ to charge premiums to parents of ALTCS disabled children <18 from household with income 400%-500% FPL	N	ARS 36-2929 has been revised since CMS authority was approved. Waiver Authority Requested: Section 1902(a)(14) insofar as it incorporates 1916 (42 CFR 447.51 and 447.52)
7	Estate Recovery	Relieves AHCCCS from creating an estate recovery program for acute care enrollees 55 and older who receive LTC services.	Y	Resources for this population are limited and few have lienable/recoverable assets Start up and ongoing costs for initiating the program would outweigh any recovery efforts based on the population and their resources. Waiver Authority Requested: Section 1902(a)(18) (42 CFR 433.36)
8	Freedom of Choice	Restricts freedom of choice of providers by furnishing benefits through MCOs and PIHPs that don't meet the requirements of Section 1932	Y	Allows for the statewide mandatory managed care system to enroll members into health plans which reduces risk to health plans, thus lowering capitation which is key to AHCCCS demonstrative success.

Arizona Waiver and Expenditure Authorities
 Current Demonstration Approval Period: 10/1/2011-9/30/2016
 Proposed for: 10/1/2016 – 9/30/2021

Waiver/ CNOM #	Title	Brief Description	Renew	Notes
				AHCCCS members are able to choose from at least two physicians within their health care plan. Other protections are in place to assure quality and continuity of care through policy, contract and standards. Waiver Authority Requested: Section 1902(a)(23)(A) (42 CFR 431.51)
9	Drug Utilization Review	Exempts AHCCCS from drug use review requirements of 1927(g)	Y	Allows AHCCCS to not be required to utilize drug use review requirements. Waiver Authority Requested: Section 1902(a) (54) insofar as it incorporates section 1927(g) (42 CFR 456.700 through 456.725)
Expenditure Authorities				
Administrative Simplification and Delivery Systems				
1	MCO Requirements (Companion to Waiver #1)	Allows MCOs who do not meet requirements of 1932(a)(3) (freedom of choice of MCOs) to operate one MCO in urban areas for: a) Individuals with SMI b) ALTCS and CMDP	Y	See #1 above CNOM Authority Requested: Section 1932(a)(3) (42 CFR 438.52(a))
2	MCO Requirements (Companion to Waiver #1)	Allows AHCCCS to: a) Restrict enrollees from disenrolling from their health plan without cause beyond 30 days b) Automatically reenroll member into same health plan as was previously enrolled if the member lost eligibility within 90 days (vs. 60 day standard)	Y	See #1 above CNOM Authority Requested: Section 1903(m)(2)(A) to the extent it requires compliance with section 1932(a)(4) and 42 CFR 438.56(c); and section 1903(m)(2)(H) and 42 CFR 438.56(g)

Arizona Waiver and Expenditure Authorities
Current Demonstration Approval Period: 10/1/2011-9/30/2016
Proposed for: 10/1/2016 – 9/30/2021

Waiver/ CNOM #	Title	Brief Description	Renew	Notes
3	MCO Requirements	MCOs do not have to pay Indian Health care providers (IHCPs) when the State pays them for covered services for members enrolled in managed care plans	Y	Allows IHCPs to receive the All Inclusive Rate claiming 100% FMAP and not be required to bill multiple entities for American Indians who receive services through fee-for-service. CNOM Authority Requested: Section 1903(m)(2)(A) to the extent it requires compliance with Section 1932(h)
4	MCO Requirements	Allows the state to make payments for services provided by Indian health care providers to members enrolled in managed care, when those payments are offset from the managed care capitation payment.	Y	See CNOM #3 above
5	MEQC Findings	Enables AHCCCS to use an MEQC process that is different than what is required under 1903(u).	Y	AHCCCS can target specific problem areas rather than random sampling as otherwise required CNOM Authority Requested: Section 1903(u) (42 CFR 431.865)
6	Outpatient Drugs (Companion to waiver #9)	FFP for outpatient drug costs	Y	See Waiver #9 above CNOM Authority Requested: Section 1903(i)(10)
8	Direct payments to CAH	Allows for direct payments to CAH for services provided to enrollees.	Y	CNOM Authority Requested: 42 CFR 438.60
9	FFS UPL	Allows the state to claim capitation for the costs of institutional care provided through managed care regardless of whether aggregate payments exceed upper payment limitations in the regulations listed	Y	Without the waiver, AHCCCS would be required to make various annual assurances and findings and file a DSH State Plan rather than Operational Protocol. Also, a UPL methodology would be required for FFS and prepaid captivated drugs, outpatient hospitals and clinics and for non-risk contracts CNOM Authority Requested: Section 1902(a)(30)

Arizona Waiver and Expenditure Authorities
 Current Demonstration Approval Period: 10/1/2011-9/30/2016
 Proposed for: 10/1/2016 – 9/30/2021

Waiver/ CNOM #	Title	Brief Description	Renew	Notes
				(42 CFR 447.250-.280; 447.300-.334)
10	DSH Payments (Companion to waiver #5)	Expenditures for supplemental payments for inpatient hospital services notwithstanding non-compliance section 1902(a)(13)(A)(iv) to the extent it requires compliance with section 1923 regarding hospitals serving a disproportionate share of low income patients	Y	See Waiver #5 above CNOM Authority Requested: Section 1902(a)(13)(A)
11	HCBS	Expenditures for HCBS through ALTCS for those over 18 who reside on Alternative Residential Settings classified as residential Behavioral Health facilities.	Y	Allows the State to claim the cost of the HCBS services listed in the STC's even though the services are not described in section 1905 and to do so without a separate waiver under section 1915.
Eligibility Simplification				
12a	ALTCS income disregard	Expenditures for the cost of institutional care and HCBS provided to persons whose eligibility is determined based on SSI income standards notwithstanding non-compliance with 42 CFR 435.725 and 726 to the extent that those regulations require payments for those services be reduced by the patient cost of care based on a calculation that begins with total income (include amounts disregarded); rather the State is requesting authority to reduce total income by the disregards in 1612(b) when calculating the patient cost of care (and the commensurate reduction in payments for the patient's care).	Y	Without, AHCCCS would need to set up two different tests for income disregards depending whether the person is applying under 300% of SSI or 100% of SSI. Will also have an impact on post eligibility treatment of income
12b	300% FBR	Applies the PAS to determine ALTCS eligibility for those at 300% FBR regardless of institutionalize 30 day requirement.	Y	Reduces FFS exposure under prior period coverage. Federal law requires applicants to be hospitalized 30 consecutive days before approving eligibility at 300% of SSI. When the person is determined eligible, eligibility is retroactive to the first day of the month of application. With this waiver, persons can be enrolled with a Program Contractor earlier.

Arizona Waiver and Expenditure Authorities
Current Demonstration Approval Period: 10/1/2011-9/30/2016
Proposed for: 10/1/2016 – 9/30/2021

Waiver/ CNOM #	Title	Brief Description	Renew	Notes
12c	Children/ Spouses in Separation	Allows a dependent child/institutionalized spouse to qualify for ALTCS a month earlier by disregarding income of parents and spouses in month of separation.	Y	Without, would require staff to verify income and resources of parents and spouses in the month of separation.
12d	QMB, SLMB, QI-1, SSI MAO, ISM income disregard	Expenditures for medical assistance furnished to persons who would be eligible under section 1902(a)(10)(E) as QMB, SLMB, QI-1 and SSI-MAO if in kind support and maintenance described in section 1612 were disregarded.	Y	Admin simplification
12e	SSI-MAO (1924)	Alternate budget process for ALTCS and SSI-MAO applicants/recipients when there is a spouse or if the applicant/recipient is living w/ a minor dependent child.	Y	Admin simplification Allows for the same budgeting process to apply to these situations. CNOM Authority Requested: 1924
12f	Disregard of interest	Disregards excess interest and dividends from resources for the Pickle category disabled adult children, disabled children, widows and widowers.	Y	Admin simplification CNOM Authority Requested: 42 CFR 435.135 1634(c) 1902(a)(10)(A)(i)(II) 1634(d)
12g	Post-eligibility	Disregards interest and dividend from post-eligibility calculations.	Y	Admin simplification CNOM Authority Requested: 1902(a)(10)(A)(ii)(V)
12h	Disregard of excess resources	Disregards excess resources under Pickle Amendment, disabled adult children and disabled widows and widowers	Y	Admin simplification. CNOM Authority Requested: Section 503 of Public Law 94-566; section 1634(c) of the Act (disabled adult children); or section 1634(b) of the Act (disabled widows and widowers).
12i	\$20 Quarterly	Disregards quarterly income that is less than \$20 in	Y	Admin simplification. AHCCCS rarely

Arizona Waiver and Expenditure Authorities
Current Demonstration Approval Period: 10/1/2011-9/30/2016
Proposed for: 10/1/2016 – 9/30/2021

Waiver/ CNOM #	Title	Brief Description	Renew	Notes
	income	the post-eligibility determination process for the ALTCS program.		encounters quarterly payments of \$20 or less (if so, it's interest from bank accounts). The administrative cost to process is more than the estimated cost adjustment.
13	SSI	Extends eligibility beyond those specified in 42 CFR 435.1003 for those who lose SSI eligibility for a period of up to 2 months from the SSI termination effective date	Y	Admin Simplification CNOM Authority Requested: 42 CFR §435.1003
14	Part B Premiums	Pays for Part B premiums for those in ALTCS with income up to 300% FBR also eligible for Medicare but who do not qualify as QMB, SLMB, or QI1; are eligible for Medicaid under T.19 group for the aged, blind or disabled; are eligible for continued coverage; or are in the guaranteed enrolment period	Y	CNOM Authority Requested: 42 CFR 435.1003 and .212
15	ALTCS PAS	Extends ALTCS eligibility to individuals under 65 using the PAS as a substitute disability standard.	Y	Admin Simplification. Without, would require staff to complete disability determination paperwork for individuals under 65, causing a huge increase in workload. CNOM Authority Requested:
16	HCBS	Authorizes HCBS under ALTCS (including Transitional program)	Y	Allows AHCCCS to pay health plans for home and community based services vs more costly nursing home services. CNOM Authority Requested:
17	Spouses as Paid Caregivers	FFP to reimburse spouses as paid caregivers	Y	Supports and allows members to remain in their homes to receive Home and Community Based Services. CNOM Authority Requested:
Costs Not Otherwise Matchable				
18	SNCP	Expenditures for SNCP PCH through 12/31/2015	N	Expires 12/31/2015; but see Building on AZ's Past Successes #3 below

Arizona Waiver and Expenditure Authorities
 Current Demonstration Approval Period: 10/1/2011-9/30/2016
 Proposed for: 10/1/2016 – 9/30/2021

Waiver/ CNOM #	Title	Brief Description	Renew	Notes
				CNOM Authority Requested: 1905(a) 1923
19	HPE for Pregnant Women	Expenditures for all State Plan Medicaid services not otherwise allowed under sections 1902(a)(47) and 1920 during HPE for pregnant women through 9/30/2016	Y	Without the waiver, pregnant women who receive HPE would not be eligible for all State Plan services. Expires 9/30/2016 CNOM Authority Requested: 42 CFR § 435.1103(a)
20	I.H.S./638 Uncompensated Care	Expenditures to I.H.S. and 638s for uncompensated care through 9/30/2015	Y	Expires 9/30/2016 CNOM Authority Requested:
New Waivers to be Requested				
Governor Ducey's Package to Modernize Medicaid				
1	AHCCCS CARE Program	Provides authority to implement the AHCCCS CARE program- a vision to modernize Medicaid by building upon past successes and implementing opportunities for member engagement, system reform and long-term sustainability, including strategic copays that would include exemptions for certain services and populations.	N/A	Waiver Authority Requested: 1902(a)(14); 42 CFR 447.50-.56
Legislative Directions				
1	Cost Sharing (premiums, copays)	Adds cost sharing requirements in the form of premiums and copays	N/A	See Senate Bill 1475 and 1092 Waiver Authority Requested: 1902(a)(14) and 1916; 42 CFR 447.50-.56 1916(f): cost sharing for non ER use of the ER
2	Eliminate NEMT	Eliminations non-emergency medical transportation as a benefit	N/A	Waiver Authority Requested: 1902(a)(4); 42 CFR 431.53 (assurance of transportation)

Arizona Waiver and Expenditure Authorities
 Current Demonstration Approval Period: 10/1/2011-9/30/2016
 Proposed for: 10/1/2016 – 9/30/2021

Waiver/ CNOM #	Title	Brief Description	Renew	Notes
				1902(a)(10)(B) OR 1902(a)(17); 42 CFR 440.240 and .230 (comparability)
3	Work Requirements	Requires all able-bodied adults to become employed or actively seeking employment or attend school or a job training program	N/A	See Senate Bill 1092 Waiver Authority Requested: 1902(a)(10)(A) (eligibility for expanded pop; waiver from federal law that requires states to provide coverage to all eligible individuals)
4	Monthly income and work requirement verification	Requires members to verify on a monthly basis compliance with the work requirements and any changes in family income	N/A	See Senate Bill 1092 Waiver Authority Requested: see above re eligibility
5	Enrollee Disenrollment	Allows AHCCCS to ban an eligible person from enrollment for one year if the eligible person knowingly failed to report a change in family income or made a false statement regarding compliance with the work requirements	N/A	See Senate Bill 1092 Waiver Authority Requested: see above re eligibility
6	5 year limit	Places all able-bodied adults on a lifetime limit of five years with exceptions for certain circumstances.	N/A	See Senate Bill 1092 Waiver Authority Requested: see above re eligibility
Delivery System Reform Incentive Payment				
1	DSRIP	Build on the current structure for provider network accountability to reform Arizona's delivery and payment systems.	N/A	CNOM Authority Requested:
HCBS Settings				
1	HCBS Final Rule	Arizona's Assessment and Transition Plan as required by the HCBS final rules	N/A	See: http://www.azahcccs.gov/hcbs/default.aspx . Waiver Authority Requested: N/A
American Indian Medical Home				
1	A/I Medical Home	Establishes Medical Homes for American Indians who receive services through the Indian Health Services.	N/A	This request is pending with CMS and has been revised since initially submitted Waiver Authority Requested:

Arizona Waiver and Expenditure Authorities
 Current Demonstration Approval Period: 10/1/2011-9/30/2016
 Proposed for: 10/1/2016 – 9/30/2021

Waiver/ CNOM #	Title	Brief Description	Renew	Notes
				1902(a)(B) and 42 CFR 440.240 (comparability)
Building on AZ's Past Successes				
1	AHCCCS and BHS Integration	Technical amendment to revise Waiver language to reflect the merger of the Division of Behavioral Health Services and AHCCCS	N/A	Waiver Authority Requested: N/A
2	Dual Eligibles Alignment	Technical amendment to revise Waiver language to reflect that dual eligible members choice of health plans for their full benefit package, including behavioral health	N/A	Waiver Authority Requested: N/A
3	Safety Net Care Pool and Phoenix Children's Hospital	Proposes a five-year phase down period per the submitted Transition Plan	N/A	Waiver Authority Requested: N/A
Benefits				
1	Traditional Practitioner Services	Authorizes payment for credentialed Traditional Practitioner services provided through a Regional Behavioral Health Authority integrated plan	N/A	Waiver Authority Requested: 1902(a)(B) and 42 CFR 440.240 (comparability)

Section 3- Narrative (Updated)

Modernizing Arizona Medicaid

Arizona's application for a new demonstration includes multiple components. The application reflects Arizona Governor Doug Ducey's vision for a modernized Medicaid program that does more than simply try to adapt to changing times in health care. This proposal is designed to build upon past successes and recognize new opportunities for member engagement, system reform, and long-term sustainability.

PART I

AHCCCS CARE: Choice, Accountability, Responsibility, Engagement

Today's climate presents unique opportunities to further innovation and change within the existing Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS). Because AHCCCS is rooted in a public/private partnership, mainstreams its members, and touches so many lives, changes within the AHCCCS program can also have a positive and transformative effect across Arizona's entire health care system and its citizenry.

Key to transforming health care in Arizona is the ability to move away from federal prescriptions that hamper private sector innovation. Historically, Arizona has been able to achieve this flexibility through its Section 1115 Research and Demonstration Waiver (the "Waiver"). Building upon this platform is the right approach from which to launch a new version of Medicaid for Arizona.

Some people still have an antiquated view of what Medicaid is and who the Medicaid member is. Today's Medicaid program in Arizona engages private health plans that use sophisticated technology and data analytics tools to assess members' health needs and develop person-centered approaches to manage chronic illness and promote prevention and wellness. The face of Medicaid has also changed, serving nearly as many adults as children and persons with disabilities. Accordingly, Medicaid has a far greater responsibility for impacting population health. Even though a snap shot of today's AHCCCS enrollment shows over 1.87 million members, the AHCCCS program served approximately 2 million unique Arizonans at some point in time during the course of a year.

We have an opportunity and obligation to do more. We have the tools to truly modernize Medicaid. The goal of AHCCCS CARE is to: (1) Engage Arizonans to take charge of their health; (2) Make Medicaid a temporary option; and (3) Promote a quality product at the most affordable price.

The AHCCCS CARE Program: A Bridge to Independence

The AHCCCS CARE program uses personal responsibility not as a penalty, but a tool to build a bridge to independence. Members must contribute financially in order to more actively manage their own health. They also need the right tools that allow individuals to access the health care they need on their own terms. Building a healthy balance between requirements and incentives is the AHCCCS CARE approach. Arizona's proposal seeks to require participation in AHCCCS CARE for persons in the New Adult Group as well as TANF Parents.

Who is Required to Participate in AHCCCS CARE

Participation is required for adults enrolled in the New Adult Group. This includes:

- Prop. 204 eligible childless adults between 0-100% FPL
- Expansion adults between 100-133% FPL

New Adult Group members that are exempted from participation in AHCCCS CARE include:

- Persons with a serious mental illness
- American Indians/Alaska Natives
- Individuals who are medically frail (to be defined through discussion with CMS)
- Members who serve as caregivers to an individual that is elderly or disabled

The State is proposing that participation in AHCCCS CARE be optional for:

- TANF parents

No other eligibility groups are required to participate in AHCCCS CARE. Thus, individuals enrolled in ALTCS, dual eligible, SSI-MAO, children, pregnant women, Freedom to Work, or any other category are exempted from AHCCCS CARE participation.

AHCCCS CARE: Requiring Member Contributions

- Copays: Up to 3% of annual household income. Members will make monthly AHCCCS CARE payments reflecting copays for services already obtained. This also removes the burden of collecting the copay by providers at the point of service. Copayments will serve as a program offset.

Premiums: Up to 2% of annual household income. Included in the monthly AHCCCS CARE payment is a premium requirement set at 2% of income- or \$25 per month, whichever is lesser.

- Member contributions do not exceed 5% of annual household income.
- The AHCCCS CARE program is not designed as a cost savings measure. The goal is to take the directives as set forward by the Arizona Legislature and build upon them to more strategically direct care to the right settings and offer tools to support AHCCCS members' ability to manage their own health. The State is not counting any savings related to copayments and is allowing premium payments to stay with the member.

Employing Strategic Copays

Copays would be strategically implemented to steer members to the right care at the right setting.

- **No Copays:**

- Preventive Services
- Wellness
- Services to manage chronic illness
- Persons with Serious Mental Illness
- Services obtained at your PCP or OB-GYN's office, **whether for a well check or sick visit**
- Services obtained from a specialist, as long as the member has a PCP referral
- Behavioral health services
- Prescription drugs (see exceptions below)

- **Copay Required:**

- Non-Emergency use of the Emergency Department
- Use of opioids except for persons who have cancer or are diagnosed as terminally ill
- Missed Appointments – There is a code for missed appointments, so providers should submit a claim showing a missed appointment. Copayments will be assessed and added to the member's invoice for what they would have paid for that service.
- Accessing specialist services without a referral from your PCP. Once a PCP refers to the specialist, the member can go to follow up appointments as needed without additional referrals.
- Use of brand name drugs when a generic is available, unless the physician has determined that the generic drug is ineffective.

The AHCCCS CARE Account: Giving People Tools to Manage Their Own Health

- The AHCCCS CARE Account is like a Health Savings Account, except that premiums paid into the AHCCCS CARE Account do not fund services that are already covered.
- Contributions for premiums go into the AHCCCS CARE Account,
- A member's premium dollars stay with the member and can be used for the following non-covered services: ~~like~~ dental, vision, ~~or~~ chiropractic services, nutritional counseling, recognized weight loss programs, gym memberships and sunscreen.
- Members still have access to the full array of covered services.
- Members must be in good standing to be eligible for the AHCCCS CARE Account by: making timely payments; participating in AHCCCS Works; and meeting the Healthy Arizona targets.
- Employers and the Philanthropic community can make AHCCCS CARE Account contributions.

Personal Responsibility: Enforcing Member Contribution Requirements

- Over 100% FPL: Members will be disenrolled from the AHCCCS program for a period of six months for failure to make AHCCCS CARE payments.

- Under 100%: Failure to make AHCCCS CARE payments is counted as a debt owed to the State. AHCCCS will work with the Arizona Department of Revenue as to how best to operationalize this aspect of the program.

Healthy Arizona: Promoting Healthy Behaviors

Healthy Arizona is part of the AHCCCS CARE program that sets simple yet important health goals for adult members. Engaging Arizonans in actively managing their health, providing health targets and then affording appropriate and responsible incentives for meeting those targets is a key component to the AHCCCS CARE program.

- Promoting healthy behaviors and proactive measures people can take to better manage their health is part of most corporate wellness programs, but has been missing in Medicaid.
- Healthy Arizona is a set of targets:
 - Promoting wellness: for example, wellness exams, flu shots, glucose screenings, mammograms, and tobacco cessation.
 - Managing Chronic Disease: such as, diabetes, substance use disorders, and asthma.
- If members meet their Healthy Arizona target, they have the choice of either:
 - Reducing their required AHCCCS CARE payments; or
 - Rolling unused AHCCCS CARE Account funds over into the next benefit year.
- Members can only access the funds in their AHCCCS CARE account if they have met at least one of the Healthy Arizona targets.
- Meeting additional targets may unlock added incentives through corporate and philanthropic partnerships the State is seeking.
- The idea is not to make managing a member's health onerous. Rather, Healthy Arizona sets simple and achievable health goals.
- Accordingly, members only need to meet one healthy target. The goal can be met by simply getting a flu shot, for example.
- Education around options and ways to achieve these goals will be provided to members.
- Members that are medically frail and unable to meet a healthy target are exempted.
- AHCCCS eligibility is not conditioned upon meeting a Health Arizona target.
- The goal is to build health literacy around basic health and wellness measures and public health concerns.

The AHCCCS Works Program: Viewing AHCCCS as a Pit Stop

The AHCCCS Works program builds in the needed element of promoting work within Medicaid and building greater partnerships with the businesses and philanthropic communities. We all share in the goal of healthy employees and healthy families. Now, we can take steps to truly make that happen.

AHCCCS Works: Getting Back to Work

- The Requirements: Per legislative directives like SB1092, all able-bodied individuals must be employed, actively seek employment or attend school or a job training program.
- Work Incentives: ~~In addition,~~ AHCCCS Works ~~builds in~~ serves as a complement to the work requirement in SB1092. Thus, AHCCCS Works functions as a Work Incentives.
 - Employers that contribute to their employee's AHCCCS CARE Account can reduce their employee's contribution requirements or that member can use their employer's contribution to build up funds in their AHCCCS CARE Account that can be used for non-covered services.
 - The AHCCCS Works program will also partner with existing employment supports programs, like the program administered by the Arizona Department of Economic Security (DES) to provide members the tools they need to build their skills and find their confidence.
 - The member meets this requirement by simply taking the step to get connected to a program through DES, attend a job fair, enroll in job seeker's assistance, take a class, or other similar goals.
 - Education around opportunities to meet this requirement will be provided to members.
 - Members who are medically frail are not required to meet the AHCCCS Works goals.
 - The purpose of AHCCCS Works is to assist members in achieving maximum independence, recognizing that employment is an important factor in maintaining health and wellness and enjoying greater quality of life.
 - AHCCCS eligibility is not conditioned upon participation in AHCCCS Works.
 - **Once a member's income exceeds AHCCCS eligibility, their AHCCCS CARE Account transfers to a private HSA account or can be maintained through the AHCCCS CARE administrator that they can continue to use.**

Private Sector Partnerships: Engaging the Business and Philanthropic Community

- Employers will be able to make direct contributions into their employees' AHCCCS CARE accounts that their employees can use toward non-covered services.
- Employer contributions are strictly voluntary; the State is not mandating employer participation.
- The Philanthropic community can make contributions for targeted purposes, such as smoking cessation, ~~or~~ managing chronic disease or to support an identified population, such as individuals with bleeding disorders.
- Private sector contributions are tax-deductible.

- This builds upon the AHCCCS public/private model and provides an avenue for employers whose workforce is insured by Medicaid to promote a healthy workforce and allows mission-driven organizations to truly further their goals.

PART II

The Legislative Partnership

The Arizona Legislature is an important partner in the effort to modernize Medicaid. As part of the 2015 legislative session, the Arizona Legislature included a number of initiatives that form part of this application. The relevance of these requests is to engage the federal government and all stakeholders in a broader dialogue about the role of Medicaid and its long-term sustainability. These legislative directives also are designed to engage in a dialogue about aligning programs. As alignment is sought at the federal level between Medicaid, Medicare and the Marketplace, state legislatures are seeking to include issues like personal responsibility and flexibility as part of that effort.

The legislative directives that Arizona is seeking to include in this application are contained in two key pieces of legislation: Senate Bill 1475 and Senate Bill 1092. These bills went through the public process during the 2015 legislative session. These directives are cited below.

Senate Bill 1475:

Sec. 19. AHCCCS; cost sharing requirements; rulemaking exemption

- A. The Arizona health care cost containment system administration shall pursue cost sharing requirements for members to the maximum extent allowed under federal law.
- B. Subject to approval by the centers for medicare and medicaid services, beginning January 1, 2016, the administration shall charge and collect from each person who is enrolled pursuant to section 36-2901.01, Arizona Revised Statutes:
 1. A premium of two percent of the person's household income.
 2. A copayment of eight dollars for nonemergency use of an emergency room for the first incident and twenty-five dollars for each subsequent incident if the person is not admitted to the hospital. The administration may not impose a copayment on a person who is admitted to the hospital by the emergency department.
 3. A copayment of twenty-five dollars for nonemergency use of an emergency room for the first incident and twenty-five dollars for each subsequent incident if there is a community health center, rural health center or urgent care center within twenty miles of the hospital.
- C. Subject to approval by the centers for medicare and medicaid services, beginning January 1, 2016, the administration shall charge and collect from each person who is enrolled pursuant to section 36-2901.07, Arizona Revised Statutes:
 1. A premium of two percent of the person's household income.
 2. A copayment of twenty-five dollars for nonemergency use of an emergency room if the person is not admitted to the hospital. The administration may not impose a copayment on a person who is admitted to the hospital by the emergency department.

3. A copayment of twenty-five dollars for nonemergency use of an emergency room if there is a community health center, rural health center or urgent care center within twenty miles of the hospital.
4. An exemption from providing nonemergency medical transportation services from October 1, 2015 to September 30, 2016.
- D. For the purpose of implementing cost sharing pursuant to this section, the Arizona health care cost containment system administration is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, for one year after the effective date of this act.

Senate Bill 1092:

36-2903.09. Waivers; annual submittal; definitions

A. On or before March 30 of each year, the director shall apply to the centers for medicare and medicaid services for waivers or amendments to the current section 1115 waiver to allow this state to:

1. Institute a work requirement for all able-bodied adults receiving services pursuant to this article. The work requirement shall:
 - (a) Require an eligible person to either:
 - (i) Become employed.
 - (ii) Actively seek employment, which would be verified by the department.
 - (iii) Attend school or a job training program, or both, at least twenty hours per week.
 - (b) Require an eligible person to verify on a monthly basis compliance with requirements of subdivision (a) of this paragraph and any change in family income.
 - (c) Require the administration to confirm an eligible person's change in family income as reported under subdivision (b) of this paragraph and redetermine the person's eligibility under this article.
 - (d) Allow the administration to ban an eligible person from enrollment for one year if the eligible person knowingly failed to report a change in family income or made a false statement regarding compliance with the requirements of subdivision (a) of this paragraph.
 - (e) Allow for an exemption if a person meets any of the following conditions:
 - (i) Is at least nineteen years of age but is still attending high school as a full-time student.
 - (ii) Is the sole caregiver of a family member who is under six years of age.
 - (iii) Is currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government.
 - (iv) Has been determined to be physically or mentally unfit for employment by a health care professional in accordance with rules adopted by the administration.
2. Place on able-bodied adults a lifetime limit of five years of benefits under this article that begins on the effective date of the waiver or amendment to the current section 1115 waiver and does not include any previous time a person received benefits under this article. The lifetime limit under this paragraph does not include any time during which the person meets any of the following conditions:
 - (a) Is pregnant.
 - (b) Is the sole caregiver of a family member who is under six years of age.
 - (c) Is currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government.

- (d) Is at least nineteen years of age but is still attending high school as a full-time student.
 - (e) Is employed full time but continues to meet the income eligibility requirements under this article.
 - (f) Is enrolled before reaching nineteen years of age.
 - (g) Is an eligible person as defined in section 36-2901, paragraph 6, subdivision (a), item (iii).
3. Develop and impose meaningful cost-sharing requirements to deter both:
- (a) The nonemergency use of emergency departments.
 - (b) The use of Ambulance services for nonemergency transportation or when it is not medically necessary.
- B. In any year, the director shall apply under subsection A of this section for only the waivers or amendments to the current section 1115 waiver that have not been approved and are not in effect.
- C. On or before April 1 of each year, the director shall submit a letter confirming the submission of the waiver requests required under subsection A of this section to the governor, the president of the senate and the speaker of the house of representatives.
- D. For the purposes of this section:
- 1. "Able-bodied" means an individual who is physically and mentally capable of working.
 - 2. "Adult" means an individual who is at least nineteen years of age. END_STATUTE

The State acknowledges and appreciates the concerns raised around ensuring that members have access to needed care and will explore opportunities to exempt certain medically frail populations from the directive to exclude non-emergency medical transportation as a covered service.

PART III

Delivery System Reform Incentive Payment (DSRIP): Arizona's Approach

AHCCCS has initiated significant payment and delivery system reform in recent years. These include payment, administration, and care delivery integration of behavioral health and physical health, alignment and care coordination for dually eligible persons, Children's Rehabilitative Services system simplification, justice system transition of care improvements, and value based purchasing contractual requirements.

With these reform initiatives established, the development of a State Health System Innovation Plan through a State Innovation Model (SIM) Design award, and the findings of the Arizona State Health Improvement Plan, Arizona is positioned to utilize DSRIP to further develop care delivery and payment reform network infrastructure, implement system re-design options identified through the SIM process, establish highly impactful outcome expectations, and strengthen population focused health improvements.

The Arizona DSRIP model will be built on provider network accountability. AHCCCS has a well-established managed care infrastructure. Arizona also has geographically distributed health systems that are well positioned to participate in payment and delivery reform initiatives through the DSRIP. These networks will provide the foundational infrastructure and connectivity to foster provider collaboration and break down persistent silos that limit

progress on outcome improvement and cost reduction. The specific transformation models and arrangements will be established based on the findings of the stakeholder driven State Health System Innovation Plan, developed through the Arizona SIM Model Design award.

Projects and Initiatives

The Arizona DSRIP projects and initiatives will focus on areas including, but not limited to:

- Behavioral Health –Physical Health Care Delivery and Payment Integration
- Chronic diseases associated with persons identified as having High Needs/High Costs
- Primary Care models with accountability for population health outcomes

Results of the State Innovation Plan will inform the selection of additional areas of focus and development of a menu of projects in collaboration with healthcare stakeholders that encompasses the selected focus areas.

Performance Metrics

The choice of performance process and outcome measures will be based on the projects and initiatives identified through the SIM process and selected through the DSRIP planning processes and will include:

- Measures of infrastructure development and participation – such as, membership in the state Health Information Exchange
- System redesign – such as, establishing value based payment arrangements that align to produce desired collaboration and integration
- Clinical outcome improvement – such as, establishing targets for hospital readmission or asthma related hospitalizations
- Population health improvement – such as, percentage of homelessness among persons with serious mental illness

In addition, establishing statewide measures will be considered to support collaborative provider accountability for outcomes, and systemic transformation.

Performance Payments

A DSRIP incentive payment methodology will be established based on the milestones of the projects and initiatives established under the Arizona DSRIP.

- Performance payments will be tied to achievement of project specific measures
- Performance payments will be tied to achievement of statewide measures
- Payment pools available for provider performance payments will tie to savings associated with DSRIP initiatives
- Accountable provider networks will have the ability to allocate performance payments to providers in their respective networks
- Payments to provider networks for infrastructure identified as critical to implementation of SIM and DSRIP initiatives and systems changes

Learning Collaborative

Providers will participate in a learning collaborative related to the DSRIP projects. The learning collaborative will be designed to promote the following objectives:

- Encouraging the principle of continuous quality improvement
- Collaborating based on shared ability and experience
- Sharing DSRIP project development including data, challenges, and best practices

PART IV

Home and Community Based Services (HCBS) Final Rule: Arizona's Assessment and Transition Plan

Arizona's successful Home and Community Based Services program for persons enrolled in the Arizona Long Term Care System (ALTCS) has had a long history as part of the State's 1115 Waiver. To conform with the final rule that defines HCBS qualifying settings, Arizona conducted an assessment of its settings, as well as a draft transition plan. Extensive stakeholder meetings and public forums have already been held to seek input and engage in dialogue around the state's Assessment and Transition Plan.

Due to the length of the Assessment and Transition Plan, it will be incorporated by reference here. All materials, including the Assessment and Transition Plan, the schedule of community forums, the presentation that is being reviewed at the forums and other materials can be found on the AHCCCS website at: <http://www.azahcccs.gov/hcbs/default.aspx>.

PART V

The American Indian Medical Home Supporting Arizona's Commitment to Addressing Health Care Disparities for American Indians/Alaska Natives

Overview

AHCCCS administers Medicaid to over 1.7 million members through a mandatory managed care delivery system. This system operates managed care insurance programs that establish each member with a Primary Care Physician (PCP) upon enrollment. Case management is provided as an administrative service to those members identified by their health plan to require care coordination or assistance in managing a chronic illness. Health plans also offer call lines staffed by medical professionals as an administrative service.

The AHCCCS model requires every Medicaid beneficiary to enroll with a managed care organization (MCO). The only exception to this requirement is for the American Indian/Alaska Native (AI/AN) population, which has the option of enrolling with an MCO or receiving services in the AHCCCS fee-for-service (FFS) program, known as the American Indian Health Program (AIHP). American Indians and Alaska Natives who enroll in the American Indian Health Program receive their care largely through Indian Health Services (IHS) facilities and Tribal facilities operated under Public Law (PL) 93-638. IHS and Tribal facilities do not have the administrative dollars to support case management functions or call lines to assist members in coordinating their care. The clinical leadership of IHS recognizes that fundamental changes in their system are required in this time of fewer resources and health reform.

The IHS Improving Patient Care (IPC) program goal is to engage IHS, Tribal, and Urban Indian health programs to improve the quality of, and access to, care for AI/AN members through the development of a system of care called the Indian Health Medical Home Program (IHMHP). The IPC program is focusing on patient-and-family-centered care while ensuring access to primary care for all AI/AN people. High-quality care will be delivered by health care teams who will be making sustainable and measurable improvements in care. Medicaid is IHS' biggest payor/partner. Therefore, AHCCCS would like to align its efforts in Arizona with the efforts being made by IHS and the federal government to modernize and improve the health care delivery system for the AI/AN population.

The most recent U.S. Census figures state the AI/AN population is approximately 350,000 in Arizona.¹ Almost half of the AI/AN population in Arizona is enrolled in AHCCCS, and approximately 75 percent of AI/AN AHCCCS members are enrolled in the American Indian Health Program. Significant health disparities exist between the AI/AN population and the general population of Arizona, including the average age of death (17.5 years lower for American Indians), and higher death rates from many preventable diseases. AHCCCS proposes an IHMHP that aligns with the IPC program in order to address some of these disparities and to support the ability of IHS, Tribal, and Urban Indian health programs, as well as non-IHS facilities with high AI/AN patient volumes, to better manage the care for American Indians and Alaska Natives enrolled in the American Indian Health Program.

Accordingly, to accomplish these goals AHCCCS seeks the following authority:

- **Comparability** - Waiver from §1902(a)(10)(B) and corresponding regulations at 42 CFR §§440.240, to allow the State to provide services that support a medical home for AI/AN members enrolled in FFS who receive services provided through the IHS and Tribal facilities. These services are Primary Care Case Management, diabetes education, after-hospital care coordination and 24-hour call lines staffed by medical professionals.

¹ Current tribal enrollment numbers collected by survey taken by AHCCCS estimate the AI/AN population in Arizona to be approximately 443,000.

- **Reimbursement CNOM-** Expenditure authority to allow the State to pay for services that support a medical home for AI/AN members enrolled in FFS who receive services provided through the IHS and Tribal facilities. Expenditure authority to allow the State to pay non-IHS/Tribal facilities a shared savings payment to support the Indian Health Medical Home Program.

Developing the American Indian Medical Home through Consultation

Originally, this concept was proposed and brought to AHCCCS by the Tucson Area IHS. Verbal notification on the development of this proposal as well as notification that a future consultation meeting would be held to further discuss this topic was provided at an AHCCCS Consultation Meeting with Tribes and IHS, Tribal, and Urban Indian health programs (I/T/U) on March 31, 2011.

AHCCCS also obtained information related to medical home activities from the Navajo Area IHS, Phoenix Area IHS, Tucson Area IHS, and certain Tribal Facilities. This information was used in the development of the first waiver proposal. AHCCCS formally consulted with tribes and I/T/Us in Arizona on the components of the original waiver proposal in accordance with the AHCCCS Tribal Consultation Policy and Medicaid State Plan on August 4, 2011. The amendment was also placed on the AHCCCS website for public comment around that time.

Since then, AHCCCS has embarked upon a Tribal Care Coordination effort of its own. AHCCCS revised this proposal to align this amendment with the IPC and AHCCCS Tribal Care Coordination efforts. The AHCCCS Tribal Care Coordination initiative strives to improve the quality of care for its members by increasing the efficiency of the multiple systems of care in which members can access services. While there are various care coordination models being implemented across the nation, as well as here in Arizona, AHCCCS adopted the Indian Health Service's IPC Care Model to avoid creating duplication in the system and confusion amongst the various efforts being implemented to improve the care for AI/AN members. Furthermore, the Agency recognizes the importance of promoting a shared message in working toward a common goal — improve the quality, connectivity, and accessibility of care in the American Indian healthcare delivery system. AHCCCS works toward that goal in its role as a facilitator of data exchange to inform providers of utilization trends among members empaneled to them. As a major payor, AHCCCS provides this data so that the medical home can develop interventions that will assist patients empaneled to them to better manage their health. I/T/Us, however, need additional tools to build their capacity to act as medical homes that can be held accountable for reducing emergency department utilization, admissions or readmissions, and improve outcomes.

Anticipated updates to the draft proposal were presented verbally at tribal consultation on August 15, 2013. AHCCCS has also posted the revision to its website for public comment. The revised amendment was also presented to the State Medicaid Advisory Committee on April 9, 2014. Subsequently, representatives from the three IHS Area offices made

revisions to the proposal for consideration requiring additional review. These revisions have been incorporated here and will be presented for comment at the tribal consultation in August 21, 2015.

Arizona expects that the oversight and payment for IHMHP service delivery will necessitate close working relationships between the State and the IHS, Tribal, Urban Indian health program, and non-IHS facilities with AI/AN patient volumes greater than 30%, and that this process will enhance collaboration toward similar goals of reducing health disparities and delivering cost-effective care.

Provider Payments

The American Indian Health Program has worked in conjunction with tribes and IHS facilities to determine the cost of delivering an IHMHP, which would reimburse for Primary Care Case Management, a 24-hour call line and care coordination. In order to simplify claiming and payment, AHCCCS has elected not to offer a tiered payment structure, but to combine requirements and payment into one flat rate. The American Indian Health Program cost data from IHS and tribal facilities in Arizona were evaluated to determine a PMPM payment of \$7.11 with an annual increase of 4.6%, which is based upon the average annual increase of the outpatient all-inclusive rate over the past ten years. For approved medical homes providing diabetes education pursuant to guidelines established within that model and herein, an additional \$2.00 PMPM will be available.

The medical home services for which AHCCCS proposes to reimburse are currently not reimbursed through the all-inclusive rate and will therefore be billable by IHS and Tribal facilities only on a monthly basis to AHCCCS. PMPM payments will be made with 100% FFS dollars and will only be available for IHS and tribally operated 638 facilities for FFS members in order to avoid duplicative payment. Facilities will be required to submit an IHMHP claim for each member that is empanelled in their medical home on a monthly basis. Empanelment will be determined by AHCCCS based on the criteria discussed below.

Overview Development of Medical Home Criteria

IHS and Tribal facilities may choose whether or not to provide an Indian Health Medical Home Program (IHMHP) for their members. In order to receive reimbursement for services provided by their IHMHP, facilities must present their proposal to AHCCCS for review every three years or sooner if their program structure changes. This proposal should detail the mechanisms in place to meet the criteria outlined in the definition of an IHMHP below. For example, when the IHMHP requires that each member be empanelled to a personal Primary Care Provider (PCP), the facility should describe how they empanel patients, what their empanelment rate is, and what type of providers they employ as PCPs. When approved as medical home providers, IHS and Tribal facilities should have a goal of 100% empanelment of their FFS AHCCCS members. However, FFS AHCCCS members will have the option to not be empaneled so as not to restrict choice; reimbursement will be based upon only those members that are formally part of the

medical home. To ensure there is choice given, the AHCCCS FFS member must sign a form at the facility stating they are agreeing to be empaneled to that particular facility.

AHCCCS recognizes the importance of prior research and development in the area of medical homes. The AHCCCS criteria for medical home designation are based upon the following Joint Principles of the Patient Centered Medical Home as presented in February 2007 by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, combined with AHCCCS Tribal Care Coordination and IPC principles.

- **Personal physician** – Each patient has an ongoing relationship with a personal, licensed primary care provider trained to provide first contact, continuous and comprehensive care.
- **Physician directed medical practice** – The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** – The personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; behavioral health; chronic care; preventive services; and end of life care.
- **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- **Quality and safety** are hallmarks of the medical home.
- **Enhanced access** to care is available through systems, such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- **Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

With these guidelines in mind and in conjunction with the IHS, tribally operated 638 programs and the American Indian Health Program, AHCCCS has developed the following mandatory criteria for IHMHP designation when provided by IHS and tribally owned or operated 638 facilities in Arizona.

Medical Home Program Mandatory Criteria:

1. Assigns the member to a primary care team led by a primary care physician, nurse practitioner or physician’s assistant. When staffing limitations prevent direct patient empanelment to a primary care physician, a primary care physician must be available for consultation and advisement as needed. The primary care team may consist of, but

- is not limited to, a combination of the following professionals: physician's assistants, nurse practitioners, registered nurses, licensed practical nurses, pharmacists, social workers, case managers, community health representatives (CHRs), diabetes health educators, behavioral health professionals, and medical assistants.
2. Provides or coordinates medically necessary primary and preventive services.
 3. Organizes clinical data in an electronic format as a patient-specific charting system for individual patients.
 4. Reviews all medications a patient is taking including prescriptions and maintains the patient's medication list in the chart.
 5. Maintains a system to track tests and provide follow-up on test results.
 6. Maintains a system to track referrals including referral plan and patient report on self-referrals.
 7. Provides Care Coordination and Continuity of Care to the member, especially following hospital discharge, and supports family participation in coordinating care. Agrees to provide follow-up with the member within five days of hospital discharge. Provides various administrative functions including but not limited to securing referrals for specialty care and prior authorizations, including referrals for behavioral health treatment.
 8. Provides patient education and support as needed.
 9. Provides 24/7 voice to voice telephone call-line coverage with immediate availability of an on-call medical professional.
 10. Uses mental health and substance abuse screening and referral procedures.
 11. Agrees to follow and report to AHCCCS on an annual basis the following measures:
 - a. Hospital readmissions within 30 days of discharge;
 - b. Number of hospital readmissions within 30 days of discharge with a behavioral health diagnosis;
 - c. Average number of ED visits per empanelled patient per year;
 - d. GPRA measure: Childhood immunizations; and
 - e. Additional GPRA measures will be added following two years of successful implementation of these criteria.

Patient Empanelment

While an AHCCCS member retains the right to seek care from any AHCCCS registered provider, AHCCCS may only pay for one medical home per member. In order to avoid reimbursement to two different IHMHPs for the same member, AHCCCS will recognize patient empanelment to a specific IHMHP by the receipt of claims for at least three distinct dates of services within a six month time period within the member's service area. An IHMHP will not be able to be reimbursed for PMPM claims until the empanelment process has been completed

After a facility is approved as a medical home by AHCCCS, the facility must submit to AHCCCS Division of Fee-for-Service Management (DFSM) a file of empaneled members. Members submitted that already have been empaneled in a medical home will be rejected back to the facility; in this case, the facility or member can request a transfer through the transfer process.

All empanelment files and transfers must be submitted to AHCCCS by the 22nd of the month for the facility to be able to submit a claim for the following month. Information received after the 22nd of the month will not be able to be claimed until the following month.

The AHCCCS transfer process can be utilized when a member is empaneled with another facility. In this case, the facility that would like the member to be transferred must complete the AHCCCS approved transfer form. This form must be signed by the requesting facility, the currently empaneled facility and the member.

Diabetes Education Mandatory Criteria

IHMHPs providing diabetes education must provide an evidence-based curriculum designed to enhance regular treatment and disease-specific education, such as diabetes instruction. The Diabetes Education Program provides individuals with the skill sets necessary to coordinate all the things needed to manage their health, which is particularly helpful for individuals with more than one chronic condition. Subjects covered by an IHMPP Diabetes Education Program must include:

1. Education on techniques to deal with problems such as frustration, fatigue, pain and isolation
2. Education on appropriate exercise for maintaining and improving strength, flexibility, and endurance
3. Education on the appropriate use of medications and medication compliance
4. Education on how to communicate effectively with family, friends, and health professionals
5. Nutrition Education
6. Education on decision making
7. Education on how to evaluate new treatments

IHMHPs using a diabetes education curriculum and receiving an additional PMPM for these services must separately report the following:

- Hospital readmissions within 30 days of discharge with a diabetes diagnosis
- Number of ED visits with a diabetes diagnosis

Non-IHS/Tribal facilities: Supporting the IHS Indian Health Medical Home Model

American Indian members are not limited to using only IHS/Tribal facilities. They access care from non-IHS/Tribal facilities particularly in areas where a non-IHS/638 facility is more readily available than an IHS/Tribal facility. Additionally, AI/AN members often access non-IHS/638 facilities and providers for specialty care that may not be accessible at an IHS/Tribal facility. As a result, there are a number of non-IHS/Tribal facilities with high AI/AN patient volumes that can help support the IHMHP. These facilities are grappling with issues of care coordination, hospital readmissions and non-emergent use of the emergency department related to the AI/AN population.

Facilities with high AI/AN inpatient enrollment in AIHP, specialty care (e.g., OB/GYN) or emergency department patient volumes can help support the IHMHP model by allowing an IHS/Tribal facility to embed an IHS/Tribal care coordinator within their facility. Non-IHS/Tribal facilities that exceed 30% AI/AN patient volumes are eligible to receive shared savings payments through structured arrangements with AHCCCS that, among other measures: reduce emergency department use; reduce readmissions, coordinate with behavioral health; and share data with AHCCCS. These initiatives will be arranged on a case-by-case basis depending on the specialty of the provider type.

By supporting the model in this way, the non-IHS/Tribal facilities will be partnering with the IHMHP to connect AIHP enrolled members with the services necessary to address the health disparities that exist within the population, thereby, reducing the rate of hospital readmissions and non-emergent use of the emergency department. These facilities should be rewarded for the improvements in care delivery and in savings achieved for their efforts in supporting this model. Addressing healthcare disparities for the AI/AN population is not possible without the participation of non-IHS/Tribal facilities.

Arizona is proposing to offer services that support an Indian Health Medical Home Program – Primary Care Case Management, 24-hour call line, diabetes education and care coordination – to its acute care FFS Population. IHMHPs will be charged with addressing health disparities between American Indians and other populations in Arizona, specifically by enhancing case management and care coordination. In tracking the successes of IHMHPs across the state, Arizona expects to see trends indicating cost savings through the prevention of hospital readmissions and improved control of non-emergent use of the emergency department. Non-IHS/Tribal facilities will also share in those savings as critical players in addressing healthcare disparities for the AI/AN population.

PART VI

Building upon Arizona's Past Successes

While Arizona has had a longstanding 1115 Waiver through which the State has operated its Medicaid program, the demonstration has not remained stagnant. In fact, through over 33 years of Medicaid managed care experience, the State of Arizona has learned that Medicaid managed care is an evolutionary process. Existing demonstrations are modified, adjustments are continually made, and the program is further refined, modernized and streamlined. The result is a Medicaid managed care operation that is continually seeking opportunities to improve and build upon past successes to achieve greater health outcomes for its members and long-term sustainability for the program.

As part of this refinement, this new demonstration will reflect modifications to the following programs:

- ***The merger between AHCCCS and the Division of Behavioral Health Services.*** As part of the 2015 legislative session, Governor Ducey proposed and the Arizona

Legislature approved an administrative simplification effort that brought together the AHCCCS program with its longstanding partner, the Division of Behavioral Health Services (DBHS) within the Arizona Department of Health Services (ADHS). Historically, ADHS/DBHS has served as AHCCCS' contracted managed care organization (MCO) for the provision of behavioral health services to AHCCCS members. In turn, ADHS/DBHS contracts with Regional Behavioral Health Authorities (RBHAs) that provide the behavioral health benefit for members. Through the Governor's Administrative Simplification effort, DBHS will merge with AHCCCS and the RBHAs will become the AHCCCS contracted MCOs for administration of the behavioral health benefit. The terms of existing RBHA contracts for both Maricopa County and Greater Arizona (all other counties) will remain the same. Technical clean-up of the language in the State's Waiver will reflect this merger. The State will offer a redline of recommended language changes at a future date.

- **Aligning Benefits for Dual Eligibles.** Arizona currently has 45% of its approximately 130,000 dual eligible members aligned in the same health plan for both their Medicaid and Medicare benefits. This percentage of aligned dual members is the highest in the nation. Health plan alignment allows the plans to better administer health benefits, and simplifies the system for members. The results are improved health outcomes. Because Medicare pays for a significant portion of the behavioral health benefit and the AHCCCS acute plans are serving members as the Medicaid and Medicare plan, the State on October 1, 2015, will align the behavioral health benefit into the AHCCCS acute MCOs. This allows dual eligible members choice of health plan for their complete benefit package. Technical clean up language will be offered to reflect that dual eligible members are no longer subject to the waiver provision mandating enrollment into the RBHA only for their behavioral health benefit.
- **Continuing Existing Authorities.** Arizona will also seek to continue existing authorities that have served the State well. A table of these current authorities is attached. These include mandatory managed care, HCBS, uncompensated care payments for Indian Health Services and Tribal 638 Facilities, and others.
- **Critical Access Hospital Supplemental Payments.** Per legislative changes to 36-2903.01(U) made as part of the 2015 legislative session, the State is seeking to enhance its current payments to Critical Access Hospitals (CAH). The State has begun a dialogue with stakeholders around possible ways to structure this program and will include additional detail upon further stakeholder engagement. Specifically, the statute provides:
 - "U. Subject to the approval of the centers for medicare and medicaid services, political subdivisions of this state, tribal governments and any university under the jurisdiction of the Arizona board of regents may provide to the Arizona health care cost containment system administration monies in addition to any state general fund monies appropriated for critical access hospitals in order to qualify for additional federal monies. Any amount of federal monies received by this state pursuant to this subsection shall be distributed as supplemental payments to critical access hospitals."

PART VII

Safety Net Care Pool Transition Plan

Background

In April 2012, CMS approved the Safety Net Care Pool (SNCP) program designed to help hospitals with managing the burden on uncompensated care costs. This was approved at a time when the State had frozen new enrollment for its childless adult category (0-100% FPL). Many hospitals across the State participated in the SNCP, and the program proved to be incredibly valuable as a bridge to 2014. The program ended on December 31, 2013, in anticipation of the State's restoration of childless adult coverage and addition of new coverage for adults 100-133% FPL. However, SNCP was extended for Phoenix Children's Hospital (PCH) to address issues unique to freestanding children's hospitals that did not benefit from adult coverage restoration and expansion. Subsequently, PCH received two one-year extensions of SNCP.

During 2014, AHCCCS contracted with Public Consulting Group to conduct an independent evaluation of the use of SNCP funds prior to and after the January 1, 2014 extension period, an analysis of factors that contributed to the necessity of SNCP, and an analysis of the findings and conclusions drawn from the factors that contributed to the necessity of SNCP. Public Consulting Group made a number of observations and conclusions.

- PCH serves a population with a high rate of Medicaid coverage and a low proportion of uninsured patients in comparison to safety net hospitals.
- Before and after implementation of the ACA reforms, the uninsured have constituted a marginal group within the hospital's overall payer mix, with no significant changes in the proportion of "self-pay" clients over the past five years.
- Analysis revealed an 83% growth in overall uncompensated care costs between FFY 2011 and FFY 2012. This increase in costs is due to a number of causal factors introduced in that year, including major changes in PCH volumes, higher patient acuity, and significant rate reductions implemented by AHCCCS.
- Although PCH's financial picture in 2014 remains incomplete, some of the factors driving the hospital's higher uncompensated care since 2011 have been mitigated, if not eliminated. It appears that the effort to contain Medicaid costs is increasingly effective, and that the care delivery system has become more closely aligned with the payment system and new reimbursement rates established by AHCCCS.
- The hospital's Medicaid shortfall is the unique consequence of a convergence between the State's cost containment efforts and PCH's high quality, high cost delivery system. Public Consulting Group also states: "The high cost of care at the hospital is not merely a function of higher patient acuity, but must also be placed within the wider context of PCH's ambitious organizational growth and its aspirations to be a national leader in high quality pediatric care, equipped with cutting-edge medical technology, attracting top physician talent, and producing highly-respected research."

- While SNCP does not represent a permanent solution to assuring adequate Medicaid cost coverage to the hospital, it continues to serve as an essential mechanism for transitioning PCH to the post-ACA health care environment.
- SNCP funding has not adversely affected the hospital's capability or willingness to achieve greater efficiencies. Rather, they appear to have facilitated the hospital's ongoing movement in this direction, allowing PCH the budgetary room to implement additional efficiencies, including value-based delivery system and payment reforms, without substantially disruptive effects on the hospital's level of quality. For this reason, extension of SNCP authorization appears justifiable.

Public Consulting Group's full report can be found on the agency's website at: http://www.azahcccs.gov/reporting/Downloads/1115waiver/Doc2AZ_SNCP_Eval_Report_FIN_AL.pdf.

In addition to last year's report, AHCCCS contracted with Navigant Consulting to analyze the cost per inpatient discharge at Phoenix Children's Hospital compared to selected other children's hospitals, including those located in Alabama, California, Florida, Illinois, Minnesota, and Washington. These hospitals were chosen because of the ease of obtaining data. After adjusting for the differences in hospital specific Medicaid case-mix index and regional wage differences, as well as adjusting for inflation to make hospital years comparable, the average cost per discharge ranged from \$11,204 to \$27,377. The average cost per discharge at PCH was \$17,416, which was slightly below the average of \$17,536 and slightly above the median of \$16,823. The full analysis is attached.

PCH has also presented to AHCCCS a study conducted by the Children's Hospital Association that compared costs of 32 children's hospitals across the country. This study indicated PCH's cost of delivering care was 15% below the nationwide mean.

Transitioning Away from SNCP: Short and Long-Term Opportunities

The State is committed to working with PCH to move away from total reliance on SNCP. However, the State also recognizes that this transition cannot be achieved overnight. The State has committed to taking immediate action steps that will help PCH lessen its current SNCP reliance, as well as identify longer term goals to achieve a more complete transition away from SNCP.

Current AHCCCS Payment Reforms

APR-DRG Payment Methodology

On October 1, 2014, AHCCCS transitioned from a tiered per diem inpatient reimbursement system to an APR-DRG payment system to further AHCCCS' goals of enhancing quality of member care and promoting efficient delivery of services. AHCCCS contracted with Navigant Consulting to provide assistance in analyzing, acquiring and implementing a DRG-based inpatient hospital payment system, and sought and received an abundance of input from impacted hospitals on implementing the new payment methodology in a budget neutral

fashion. Navigant Consulting estimated that the change in payment methodology would **result in an increase in payments of \$9,704,392 for PCH**, which will be phased in over two years, achieving full implementation in the third year of APR-DRG.

Reimbursements for High-Acuity Pediatric Cases

Beginning with discharges on and after January 1, 2016, AHCCCS will address the costs associated with high-acuity pediatric services at all hospitals by increasing reimbursement for pediatric cases with Severity of Illness (SOI) levels 3 and 4 under the APR-DRG system. This change is projected to increase reimbursements to inpatient hospitals by nearly \$20 million annually. The projected **impact to Phoenix Children's Hospital is an annual increase of \$10,059,405.**

Other Payment Reforms and Solutions

While AHCCCS is committed to ensuring a transition away from SNCP, and is working to increase reimbursement rates to PCH outside of the SNCP program, any payment reforms to PCH must be taken in the larger context of the AHCCCS program as a whole. This is particularly challenging at a time when Arizona is still recovering from the Great Recession. Due to a continued budget shortfall, Arizona's State Fiscal Year 2016 budget included language which allowed AHCCCS to reduce rates for providers up to 5% in aggregate for Federal Fiscal Year 2016. Based on information received from providers and associations representing thousands of providers statewide, AHCCCS worked to find alternative solutions to a rate reduction while still living within the Legislature's lower appropriation for the program that factored in a 5% rate reduction. The resulting reimbursement rate strategy for FY 2016 includes some rate increases in areas identified as critical, among them the high-acuity pediatric cases discussed above.

AHCCCS requests a five year transition away from SNCP payments, whereby SNCP payments are reduced, from a maximum of \$137 million in 2015 to \$117 million in 2016, \$90 million in 2017, \$70 million in FY 2018, \$50 million in 2019 and \$25 million in 2020. During this phase-out period, AHCCCS will continue to implement solutions designed to account for the high-quality, high-cost services provided by PCH without adversely impacting other providers. Ultimately, any final reform needs to be multi-faceted and include increases in Medicaid reimbursement, as well as a continued focus by PCH on achieving greater efficiencies.

Some potential solutions appear below:

Graduate Medical Education Funding

AHCCCS intends to revise the Arizona Administrative Code detailing the Graduate Medical Education distribution process for the purpose of updating the method for determining a hospital's Indirect Medical Education (IME) costs. This change has the potential to increase IME funding by more than \$81,000,000 annually for Arizona training hospitals. The **projected impact to Phoenix Children's Hospital is an annual increase of \$12,500,000.** As Arizona is currently under a rule-making moratorium, the change will require approval from the Governor's Office in order to proceed. Including Executive approval and factoring in

the typical rulemaking process timeframe, this change could not be implemented any sooner than one year.

Value Based Purchasing

Under consideration for an effective date of October 1, 2016, AHCCCS registered Arizona hospitals that meet AHCCCS established value based performance metrics requirements (yet to be determined) may receive a Value Based Purchasing (VBP) Differential payment for both inpatient and outpatient hospital services. The purpose of the VBP Differential is to incentivize and reward facilities that have committed to supporting designated actions that improve patient care and health outcomes, and reduce cost of care growth. Preliminary analysis suggests PCH would likely be eligible for a VBP differential under any approach yet considered.

Increased Reimbursements for High-Acuity Pediatric Cases

AHCCCS will continue to evaluate whether additional increases for pediatric cases with Severity of Illness (SOI) levels 3 and 4 under the APR-DRG system should be made beyond the increase that will take place in January.

Other Delivery System Reform Opportunities

AHCCCS continues to develop opportunities for delivery system reform, which would support PCH's continued work to improve the efficiency and quality of the care received by its patients both in the hospital and throughout the community. These options include, but are not limited to, support for care coordination and integrated care efforts.

Section 4- Budget Neutrality

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
Total Funds - All Populations
For the Period October 1, 2011 - September 30, 2016
Revised September 2, 2015

	Estimate 2012 DY 1	Estimate 2013 DY 2	Estimate 2014 DY 3	Estimate 2015 DY 4	Estimate 2016 DY 5	Total
Without Waiver Expenditure Limit Calculation						
Member Months						
TANF/SOBRA	11,709,601	11,627,598	12,761,742	13,844,137	14,164,915	64,107,993
SSI	1,949,627	1,975,079	2,034,535	2,125,424	2,199,132	10,283,798
AC	1,636,981	975,427	228,509	-	-	2,840,917
ALTCS-EPD	343,024	344,727	343,347	349,951	356,514	1,737,562
ALTCS-DD	294,558	307,307	316,445	328,195	339,879	1,586,384
Family Planning Extension	50,036	56,207	25,025	15,638	16,559	163,465
Expansion State Adults	-	-	1,401,590	2,632,416	2,698,018	6,732,024
Combined	15,983,827	15,286,345	17,111,193	19,295,761	19,775,017	87,452,144
Without Waiver PMPM						
TANF/SOBRA	585.28	615.71	647.73	681.41	716.85	653.06
SSI	885.41	938.53	994.84	1,054.53	1,117.81	1,001.91
AC	573.60	559.29	696.05	-	-	578.53
ALTCS-EPD	4,737.37	4,983.71	5,242.86	5,515.49	5,802.30	5,261.35
ALTCS-DD	4,922.38	5,217.72	5,530.78	5,862.63	6,214.39	5,572.28
Family Planning Extension	16.60	17.63	13.01	13.40	14.07	15.84
Expansion State Adults	-	-	581.16	596.95	615.07	600.92
Weighted	787.94	842.64	865.77	886.24	933.14	867.25
Without Waiver Expenditure Limit						
TANF/SOBRA	6,853,395,200	7,159,228,400	8,266,163,000	9,433,533,500	10,154,119,400	41,866,439,500
SSI	1,726,219,200	1,853,670,900	2,024,037,200	2,241,323,600	2,458,212,200	10,303,463,100
AC	938,969,500	545,543,500	159,053,400	-	-	1,643,566,400
ALTCS-EPD	1,625,031,600	1,718,019,300	1,800,117,800	1,930,149,800	2,068,599,800	9,141,918,300
ALTCS-DD	1,449,926,300	1,603,441,900	1,750,185,900	1,924,087,400	2,112,141,600	8,839,783,100
Family Planning Extension	830,500	990,900	325,500	209,600	233,000	2,589,500
Expansion State Adults	-	-	814,548,100	1,571,418,400	1,659,467,800	4,045,434,300
Total	12,594,372,300	12,880,894,900	14,814,430,900	17,100,722,300	18,452,773,800	75,843,194,200
DSH Allotment	154,370,000	161,973,800	160,613,000	160,613,000	160,613,000	798,182,800
Total Without Waiver Expenditure Limit	12,748,742,300	13,042,868,700	14,975,043,900	17,261,335,300	18,613,386,800	76,641,377,000
With Waiver Expenditures						
TANF/SOBRA	3,414,757,500	3,314,309,400	4,086,187,500	4,533,829,000	4,828,175,000	20,177,258,400
SSI	1,363,661,300	1,319,080,900	1,548,762,100	1,653,968,300	1,777,314,300	7,662,786,900
AC	938,969,500	545,543,500	159,053,400	-	-	1,643,566,400
ALTCS-EPD	1,090,712,700	1,107,591,200	1,222,677,500	1,270,955,500	1,350,382,500	6,042,319,400
ALTCS-DD	942,977,200	993,531,600	1,059,006,400	1,120,377,200	1,192,654,100	5,308,546,500
Family Planning Extension	830,500	990,900	325,500	209,600	233,000	2,589,500
Expansion State Adults	-	-	814,548,100	1,571,418,400	1,659,467,800	4,045,434,300
AI/AN Uncompensated Care	22,866,700	119,766,200	40,833,600	13,947,500	3,486,900	200,900,900
SNCP/DSHP	352,000,000	352,000,000	83,000,000	-	-	787,000,000
City of Phoenix SNCP	-	385,000,000	96,250,000	-	-	481,250,000
HPE Serv for Preg Women	-	-	-	262,500	350,000	612,500
Tuba City	-	-	-	321,300	448,200	769,500
PCH SNCP	-	-	102,750,000	137,000,000	137,000,000	376,750,000
Expenditure Subtotal	8,126,775,400	8,137,813,700	9,213,394,100	10,302,289,300	10,949,511,800	46,729,784,300
DSH	154,370,000	161,973,800	160,613,000	160,613,000	160,613,000	798,182,800
Total With Waiver Expenditures	8,281,145,400	8,299,787,500	9,374,007,100	10,462,902,300	11,110,124,800	47,527,967,100
With Waiver Expenditure PMPMs						
TANF/SOBRA	291.62	285.04	320.19	327.49	340.85	
SSI	699.45	667.86	761.24	778.18	808.19	
AC	573.60	559.29	696.05	-	-	
ALTCS-EPD	3,179.70	3,212.95	3,561.06	3,631.81	3,787.74	
ALTCS-DD	3,201.33	3,233.03	3,346.58	3,413.75	3,509.05	
Family Planning Extension	16.60	17.63	13.01	13.40	14.07	
Expansion State Adults	-	-	581.16	596.95	615.07	
Budget Neutrality Variance	4,467,596,900	4,743,081,200	5,601,036,800	6,798,433,000	7,503,262,000	29,113,409,900
Cumulative Variance	4,467,596,900	9,210,678,100	14,811,714,900	21,610,147,900	29,113,409,900	
Variance by Waiver Group						
TANF/SOBRA	3,438,637,700	3,844,919,000	4,179,975,500	4,899,704,500	5,325,944,400	21,689,181,100
SSI	362,557,900	534,590,000	475,275,100	587,355,300	680,897,900	2,640,676,200
AC	-	-	-	-	-	-
ALTCS-EPD	534,318,900	610,428,100	577,440,300	659,194,300	718,217,300	3,099,598,900
ALTCS-DD	506,949,100	609,910,300	691,179,500	803,710,200	919,487,500	3,531,236,600
Family Planning Extension	-	-	-	-	-	-
Expansion State Adults	-	-	-	-	-	-
AI/AN Uncompensated Care	(22,866,700)	(119,766,200)	(40,833,600)	(13,947,500)	(3,486,900)	(200,900,900)
SNCP/DSHP	(352,000,000)	(352,000,000)	(83,000,000)	-	-	(787,000,000)
City of Phoenix SNCP	-	(385,000,000)	(96,250,000)	-	-	(481,250,000)
HPE Serv for Preg Women	-	-	-	(262,500)	(350,000)	(612,500)
Tuba City	-	-	-	(321,300)	(448,200)	(769,500)
PCH SNCP	-	-	(102,750,000)	(137,000,000)	(137,000,000)	(376,750,000)
	4,467,596,900	4,743,081,200	5,601,036,800	6,798,433,000	7,503,262,000	29,113,409,900

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
Total Funds - All Populations excluding Newly Eligible Adults
For the Period October 1, 2016 - September 30, 2021
Revised September 2015

	Estimate 2017 DY 1	Estimate 2018 DY 2	Estimate 2019 DY 3	Estimate 2020 DY 4	Estimate 2021 DY 5	Total
Without Waiver Expenditure Limit Calculation						
Member Months						
TANF/SOBRA	14,448,213	14,737,177	15,031,921	15,332,559	15,639,210	75,189,080
SSI	2,243,115	2,287,977	2,333,737	2,380,412	2,428,020	11,673,261
AC	-	-	-	-	-	-
ALTCS-EPD	363,644	370,917	378,335	385,902	393,620	1,892,418
ALTCS-DD	346,677	353,611	360,683	367,897	375,255	1,804,123
Family Planning Extension	-	-	-	-	-	-
Expansion State Adults	2,751,979	2,807,019	2,863,159	2,920,422	2,978,830	14,321,409
Combined	20,153,628	20,556,701	20,967,835	21,387,192	21,814,935	104,880,291
Without Waiver PMPM						
TANF/SOBRA	754.13	793.35	834.61	878.02	923.69	838.44
SSI	1,184.89	1,255.99	1,331.36	1,411.25	1,495.94	1,338.97
AC	-	-	-	-	-	-
ALTCS-EPD	6,104.02	6,421.43	6,755.35	7,106.63	7,476.18	6,786.31
ALTCS-DD	6,587.26	6,982.50	7,401.45	7,845.54	8,316.28	7,443.72
Family Planning Extension	14.77	15.51	16.29	17.10	17.96	-
Expansion State Adults	633.16	651.78	670.95	690.69	711.00	672.29
Weighted	982.43	1,033.53	1,087.34	1,144.03	1,203.74	1,092.40
Without Waiver Expenditure Limit						
TANF/SOBRA	10,895,830,900	11,691,739,400	12,545,791,600	13,462,293,500	14,445,781,900	63,041,437,300
SSI	2,657,844,500	2,873,676,200	3,107,044,100	3,359,356,400	3,632,172,200	15,630,093,400
AC	-	-	-	-	-	-
ALTCS-EPD	2,219,690,200	2,381,817,600	2,555,785,300	2,742,462,700	2,942,774,000	12,842,529,800
ALTCS-DD	2,283,651,500	2,469,088,800	2,669,577,200	2,886,350,600	3,120,725,700	13,429,393,800
Family Planning Extension	-	-	-	-	-	-
Expansion State Adults	1,742,441,200	1,829,563,300	1,921,041,500	2,017,093,600	2,117,948,300	9,628,087,900
Total	19,799,458,300	21,245,885,300	22,799,239,700	24,467,556,800	26,259,402,100	114,571,542,200
DSH Allotment	161,410,100	161,410,100	161,410,100	161,410,100	161,410,100	807,050,500
Total Without Waiver Expenditure Limi	19,960,868,400	21,407,295,400	22,960,649,800	24,628,966,900	26,420,812,200	115,378,592,700
With Waiver Expenditures						
TANF/SOBRA	5,069,583,800	5,323,063,000	5,589,216,200	5,868,677,000	6,162,110,900	28,012,650,900
SSI	1,866,180,000	1,959,489,000	2,057,463,500	2,160,336,700	2,268,353,500	10,311,822,700
AC	-	-	-	-	-	-
ALTCS-EPD	1,417,901,600	1,488,796,700	1,563,236,500	1,641,398,300	1,723,468,200	7,834,801,300
ALTCS-DD	1,252,286,800	1,314,901,100	1,380,646,200	1,449,678,500	1,522,162,400	6,919,675,000
Family Planning Extension	-	-	-	-	-	-
Expansion State Adults	1,742,441,200	1,829,563,300	1,921,041,500	2,017,093,600	2,117,948,300	9,628,087,900
AI/AN Uncompensated Care	3,661,200	3,844,300	4,036,500	4,238,300	4,450,200	20,230,500
SNCP/DSHP	-	-	-	-	-	-
City of Phoenix SNCP	-	-	-	-	-	-
HPE Serv for Preg Women	367,500	385,900	405,200	425,500	446,800	2,030,900
Tuba City	470,600	494,100	518,800	544,700	571,900	2,600,100
PCH SNCP	96,750,000	75,000,000	55,000,000	31,250,000	6,250,000	264,250,000
Expenditure Subtotal	11,449,642,700	11,995,537,400	12,571,564,400	13,173,642,600	13,805,762,200	62,996,149,300
DSH	161,410,100	161,410,100	161,410,100	161,410,100	161,410,100	807,050,500
Total With Waiver Expenditures	11,611,052,800	12,156,947,500	12,732,974,500	13,335,052,700	13,967,172,300	63,803,199,800
With Waiver Expenditure PMPMs						
TANF/SOBRA	350.88	361.20	371.82	382.76	394.02	
SSI	831.96	856.43	881.62	907.55	934.24	
AC	-	-	-	-	-	
ALTCS-EPD	3,899.15	4,013.83	4,131.88	4,253.41	4,378.51	
ALTCS-DD	3,612.26	3,718.50	3,827.87	3,940.45	4,056.34	
Family Planning Extension	-	-	-	-	-	
Expansion State Adults	633.16	651.78	670.95	690.69	711.00	
Budget Neutrality Variance	8,349,815,600	9,250,347,900	10,227,675,300	11,293,914,200	12,453,639,900	51,575,392,900
Cumulative Variance	8,349,815,600	17,600,163,500	27,827,838,800	39,121,753,000	51,575,392,900	
Variance by Waiver Group						
TANF/SOBRA	5,826,247,100	6,368,676,400	6,956,575,400	7,593,616,500	8,283,671,000	35,028,786,400
SSI	791,664,500	914,187,200	1,049,580,600	1,199,019,700	1,363,818,700	5,318,270,700
AC	-	-	-	-	-	-
ALTCS-EPD	801,788,600	893,020,900	992,548,800	1,101,064,400	1,219,305,800	5,007,728,500
ALTCS-DD	1,031,364,700	1,154,187,700	1,288,931,000	1,436,672,100	1,598,563,300	6,509,718,800
Family Planning Extension	-	-	-	-	-	-
Expansion State Adults	-	-	-	-	-	-
AI/AN Uncompensated Care	(3,661,200)	(3,844,300)	(4,036,500)	(4,238,300)	(4,450,200)	(20,230,500)
SNCP/DSHP	-	-	-	-	-	-
City of Phoenix SNCP	-	-	-	-	-	-
HPE Serv for Preg Women	(367,500)	(385,900)	(405,200)	(425,500)	(446,800)	(2,030,900)
Tuba City	(470,600)	(494,100)	(518,800)	(544,700)	(571,900)	(2,600,100)
PCH SNCP	(96,750,000)	(75,000,000)	(55,000,000)	(31,250,000)	(6,250,000)	(264,250,000)
	8,349,815,600	9,250,347,900	10,227,675,300	11,293,914,200	12,453,639,900	51,575,392,900

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
NEWLY ELIGIBLE ADULTS
For the Period January 1, 2014 - September 30, 2016
December 10, 2013

Without Waiver	Estimate	Estimate	Estimate	
Expenditure Limit Calculation	2014	2015	2016	
Member Months	DY 3	DY 4	DY 5	Total
Newly Eligible Adults	301,756	705,025	721,078	1,727,859
Without Waiver PMPM				
Newly Eligible Adults	578.54	605.73	634.20	612.86
Without Waiver Expenditure Limit				
Newly Eligible Adults	174,576,700	427,054,800	457,308,000	1,058,939,500
With Waiver Expenditures				
Newly Eligible Adults	174,576,700	427,054,800	457,308,000	1,058,939,500
With Waiver Expenditure PMPMs				
Newly Eligible Adults	578.54	605.73	634.20	
Budget Neutrality Variance	-	-	-	-
Cumulative Variance	-	-	-	-

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
NEWLY ELIGIBLE ADULTS
For the Period October 1, 2016 - September 30, 2021
September 2015 Draft

	Estimate 2017 DY 1	Estimate 2018 DY 2	Estimate 2019 DY 3	Estimate 2020 DY 4	Estimate 2021 DY 6	Total
Without Waiver						
Expenditure Limit Calculation						
Member Months						
Newly Eligible Adults	735,500	750,210	765,214	780,519	796,129	2,250,924
Without Waiver PMPM						
Newly Eligible Adults	664.01	695.22	727.89	762.10	797.92	696.13
Without Waiver Expenditure Limit						
Newly Eligible Adults	488,377,500	521,557,800	556,992,500	594,834,600	635,247,600	1,566,927,800
With Waiver Expenditures						
Newly Eligible Adults	488,377,500	521,557,800	556,992,500	594,834,600	635,247,600	1,566,927,800
With Waiver Expenditure PMPMs						
Newly Eligible Adults	664.01	695.22	727.89	762.10	797.92	
Budget Neutrality Variance	-	-	-	-	-	-
Cumulative Variance	-	-	-	-	-	-

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
BUDGET NEUTRALITY STATUS BY FEDERAL FISCAL YEAR
TOTAL FUNDS
FOR THE PERIOD OCTOBER 1, 2016 TO SEPTEMBER 30, 2021
ALL POPULATIONS

NOTES AND ASSUMPTIONS:

1) Baseline population and expenditure information for the new waiver period is the Demonstration Year 5 (FFY 2016) figures provided by AHCCCS on September 4, 2015 as part of the Safety Net Care Pool transition plan.

2) All population growth is assumed to be 2% annually.

3) Without waiver PMPMs are grown at the levels currently included in the existing waiver.

TANF/SOBRA	5.2%
SSI	6.0%
ALTCS EPD	5.2%
ALTCS DD	6.0%

4) In accordance with STC 62, a, iii, the without waiver pmpms for the Expansion State Adult group has been set equal to the with waiver expenditure pmpms such that the state may not derive savings/loss from this "pass-through" or "hypothetical State plan" population.

5) In accordance with STC 63, the new adult group is tracked seperately for budget neutrality. Like the Expansion State Adult group, the state may not derive savings/loss from this population.

6) Disproportionate Share allotment based on AHCCCS FFY15 estimate held constant. Does not incorporate projected national DSH allotment reductions.

7) With waiver expenditure growth is assumed to be 5% annually.

8) PCH SNCP is phased down in accordance with the waiver request. Note that the amounts in the waiver presentation are calendar year and have been adjusted to FFY in this model.

9) Assumes waiver period 2017-2021 represents a new waiver rather than renewal, therefore, 2016 ending positive variance is not carried forward.

10) All amounts are Draft and Subject to change. A full Budget Neutrality Update based on the AHCCCS SFY 2017 Budget Submittal is forthcoming.

**Section 5- Public Notice Update and Public Comments
with Attachments**

Public Notice Update with Attachments

AHCCCS developed multiple opportunities for public input and dialogue prior to the submission of Arizona's Section 1115 waiver application, consistent with the requirements outlined in 42 CFR Part 431 Subpart G as described in more detail below.

Public Website

On August 3, 2015, the State published the webpage for "Arizona's Section 1115 Waiver Process": <http://www.azahcccs.gov/shared/FiveYear.aspx>. The web page includes a fact sheet and video about the proposed AHCCCS CARE program, the schedule (locations, dates and times) of Community Forums across the State, the power point presented at the Community Forums, and instructions on how to submit comments by e-mail and mail (See Att. 1). On August 18, 2015, DRAFTS of the waiver template and narrative were posted to the webpage which include but are not limited to, a comprehensive description of the demonstration application, the program description, goals and objectives of the demonstration, the waiver and expenditure authorities necessary to authorize the demonstration.

The public comment period began on August 18, 2015 and closed on September 25, 2015. AHCCCS received written comments via e-mail and in the mail from over 138 organizations and individual stakeholders. AHCCCS acknowledged, reviewed, and considered all comments received. Common themes are identified and responses are attached along with all written comments received (See Att. 2).

Stakeholder Meetings

AHCCCS presented details about the Waiver application to the State Medicaid Advisory Committee on August 19, 2015 (See Att. 3) and held 5 Community Forums across the State to discuss the waiver concepts and solicit input from stakeholders (See Att. 4). The Forum held in Yuma included dial-in capability using a toll free number. Attendees included associations, providers, advocacy groups, members and their families, reporters and other interested individuals. The presentation provided at the Forums and a summary of the comments received, including responses, are attached. (See Att. 5 and 6). AHCCCS also presented this information to Arizona's tribal leaders, providers and members at a separate Tribal Consultation held on August 21, 2015 in Flagstaff Arizona, which also included dial-in capability using a toll free number. A summary of that meeting is attached (See Att. 7). AHCCCS also presented information about the Waiver application to various organizations and associations such as the Arizona Hospital and Healthcare Association on September 3, 2015, the Arizona Hemophilia Association on September 8, 2015, the Arizona Council of Human Service Providers and the Administrative Office of the Courts- Juvenile and Adult Probation Staff on September 11, 2015, and at a Community Forum hosted by UnitedHealthcare Community Plan on August 26, 2015.

Legislative Hearings

The following Legislative hearings were held regarding Senate Bills 1092 and 1475 (Waiver Section II) where the public had the opportunity to comment (See Att. 8):

- Senate Committee on Health and Human Services on February 11, 2015
- Senate Committee on Appropriations on March 5, 2015

Public Notice of Waiver Application

A public notice of the waiver application was published in the *Arizona Republic*, the newspaper of widest circulation in Arizona, on August 20, 2015, allowing for over a 30-day comment period. The notice included a brief summary of the Waiver requests, the locations, dates and times of the Community Forums, instructions on how to submit comments and a link to where additional information can be found on the AHCCCS website (See Att. 9). Additionally, the *Arizona Republic* and other local newspapers published a number of articles on elements of the waiver proposal and publicized the dates for the community forums throughout the public comment period as outlined below. While many of the reports confused elements of the proposal, the number of articles reflects the fact that the proposal was broadly discussed in the public sphere.

- 8/3: <http://www.azcentral.com/story/news/arizona/politics/2015/08/03/doug-ducey-arizona-medicaid-plan-lifetime-limits-copays/31088935/>
- 8/4: <http://www.phoenixnewtimes.com/news/ducey-care-only-makes-it-harder-for-the-poor-critics-say-7538123>
- 8/5: <http://kjzz.org/content/174997/effect-new-ahcccs-care-program-arizona>
- 8/17: <http://www.azcentral.com/story/news/arizona/politics/2015/08/17/ducey-medicaid-reform-plan-raises-questions-concerns/31835509/>
<http://www.azcentral.com/story/news/arizona/politics/2015/08/18/doug-ducey-plan-medicaid-criticized-hearing/31942289/>
- 8/21: http://www.peoriatimes.com/opinion/article_009c254a-4766-11e5-83f3-c7aac62fcf98.html
- 8/24: <http://knau.org/post/gov-duceys-medicaid-proposals-get-chilly-reception-public-meeting#stream/0>
- 9/17: <http://www.lexology.com/library/detail.aspx?q=f4c0ffb5-5bff-48af-987d-8a9df7b5c3dd>
- 9/19: http://www.svherald.com/opinion/a-lack-of-gubernatorial-logic/article_1b7d2376-5f50-11e5-8b86-671423519e20.html
- 9/22: http://www.gvnews.com/opinion/columns/editorial-lack-of-thought-on-ahcccs/article_e49e6c40-6196-11e5-8636-7f2d92306b95.html
- 9/30: <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/09/30/should-medicaid-recipients-have-to-work>

ATTACHMENT 1

Website and Fact Sheet

News & Updates

Draft Report for SB 1375 Open for Public Comment
 AHCCCS Payments, Financial and Utilization Data for Arizona Hospitals
 AHCCCS CARE Program Announced
 Arizona Comments to Medicaid Managed Care Proposed Rules
 The Case for Inclusion – Arizona Ranked #1
 Governor Ducey's Administrative Simplification
 Viewpoints: Arizona leads the nation in providing care for those needing skilled health services
 Results of AHCCCS Provider Rate Analysis
 Director Bellach appointed to serve on CBO Panel of Health Advisors.
 ASD Advisory Committee
 CMS HCBS Rule

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 AHCCCS Copayments
 Benefit Changes
 Before Filing a Claim Dispute
 New Physician Fee Schedule
 Public Input for Rate Changes

More

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Arizona's Section 1115 Waiver Process

Governor Ducey's Plan to Modernize Arizona's Medicaid Program

With over 1.6 million Arizonans enrolled in AHCCCS, Medicaid has a far greater responsibility for impacting population health. Despite past innovation, we have an opportunity and obligation to do more. The goals of Modernizing Arizona Medicaid are to: (1) Engage Arizonans to take charge of their health; (2) Make Medicaid a temporary option; and (3) Promote a quality product at the most affordable price.

AHCCCS will seek waiver authority to implement new programs and processes to carry this momentum forward to meet future challenges and respond to current economic realities through the AHCCCS CARE plan. More information about the AHCCCS CARE plan can be found below



Overview and Background of Arizona's 1115 Waiver

Arizona's current Section 1115 Waiver is scheduled to expire on September 30, 2016. The Waiver allows Arizona to run its unique and successful managed care model and exempts Arizona from certain provisions of the Social Security Act. It also includes expenditure authority for costs not otherwise matched by the federal government. Waiver programs are required to be budget neutral for the federal government – not cost more federal dollars than without a waiver. Specifically, the Waiver allows Arizona to:

- Mandate managed care;
- Provide Long Term Care Services in home and community-based settings rather than more costly institutions; and
- Implement administrative simplifications

AHCCCS will request CMS authority to continue current efficient and innovative programs, and will seek additional authority to implement new programs and processes such as the AHCCCS CARE program. AHCCCS will also include its Assessment and Transition Plan to comply with the CMS final rules regarding requirements for home and community based services. Additional information about the Plan and rule requirements can be found at this link: [HCBS Page](#)

Arizona's DRAFT Section 1115 Demonstration request with more detailed information on the proposal can be found on the link below:

- [AZ DRAFT Section 1115 Demonstration Program Template \(8/17/2015\)](#) [PDF]
- [AZ DRAFT Section 1115 Demonstration Program Narrative \(8/18/2015\)](#) [PDF]
- [AZ DRAFT Budget Neutrality 2017-2021](#) [PDF]

Process for Waiver Proposal Public Comment and Submittal

Over the next year, AHCCCS will work with the Centers for Medicare and Medicaid Services to negotiate the terms of the next Waiver. The public will have the opportunity to review and comment on the proposal in person at public forums throughout the State and in writing via e-mail to publicinput@azahcccs.gov or mail to:

AHCCCS
 c/o Office of Intergovernmental Relations
 801 E. Jefferson Street, MD 4200
 Phoenix, AZ 85034

All comments received by **Friday, September 25, 2015**, will be reviewed, considered and included in the final proposal sent to CMS.

Community Forums

AHCCCS is hosting community meetings across the state to provide the public with information about the upcoming Waiver submittal. These sessions will also provide the opportunity for AHCCCS to hear from stakeholders, including members and their families, advocates and providers. Space is limited so RSVP is required. Information about these meetings can be found at the links below:

- [AHCCCS Community Forums Flyer](#) [PDF]
- [Community Forum Presentation](#) [PowerPoint]

Español

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 - Emergency Preparedness

Modernizing Arizona Medicaid:

AHCCCS CARE – Choice, Accountability, Responsibility, Engagement

With over 1.6 million Arizonans enrolled in AHCCCS, Medicaid has a far greater responsibility for impacting population health. Despite past innovation, we have an opportunity and obligation to do more. The goals of Modernizing Arizona Medicaid are to: (1) Engage Arizonans to take charge of their health; (2) Make Medicaid a temporary option; and (3) Promote a quality product at the most affordable price.

The AHCCCS CARE Program: A Bridge to Independence

Personal Responsibility is a tool in the AHCCCS CARE program to build a bridge to independence with the right mix of requirements and incentives.

AHCCCS CARE: Requiring Member Contributions.

- **Strategic Copays¹**: Up to 3% of annual household income. Members will make monthly AHCCCS CARE payments reflecting copays for services already obtained. This also removes the burden of collecting the copay by providers at the point of service. Copays will not be applied to certain services such as primary care and medications for disease management.
- **Premiums**: Up to 2% of annual household income. Included in the monthly AHCCCS CARE payment is a monthly deposit set at 2% of income into a personal HSA.

The AHCCCS CARE Account: Giving People Tools to Manage Their Own Health.

- The AHCCCS CARE Account is like a Health Savings Account.
- Premium contributions go into the AHCCCS CARE Account.
- AHCCCS CARE Account funds are only for that individual and can be used for approved non-covered services, like dental, vision or chiropractic services.

- To be eligible, members must:
 - Make timely payments.
 - Participate in the AHCCCS Works program.
 - Meet the Healthy Arizona targets.
- Employers, and the philanthropic community can make tax-deductible contributions into individual accounts.

Personal Responsibility: Ensuring Member Contribution Requirements.

- Over 100% FPL: Members will be disenrolled from the AHCCCS program for a period of six months for failure to make AHCCCS CARE payments.
- Under 100%: Failure to pay is counted as a debt owed to the State.

Healthy Arizona: Promoting Healthy Behaviors.

- Healthy Arizona is a set of targets:
 - Promoting wellness: for example, wellness exams, flu shots, glucose screenings, mammograms, tobacco cessation.
 - Managing Chronic Disease: such as, diabetes, substance use disorders, asthma.
- Provides flexibility for Plans to design individualized targets.

The AHCCCS Works Program: Viewing AHCCCS as a Pit Stop.

AHCCCS Works builds greater partnerships with the business and philanthropic communities who share in the goal of healthy employees and healthy families.

AHCCCS Works: Getting Back to Work.

- AHCCCS Works requires individuals to be actively seeking employment.
- This requirement is satisfied if the individual is already employed or enrolled in school/training.

¹Member contributions do not exceed 5% of annual household income.

- Partner with existing employment supports programs to provide members the tools they need to build their skills and find their confidence.
- Building a Personal Safety Net: Members can transition their AHCCCS CARE Account into a private Health Savings Account when they transition to new employment and off of AHCCCS.

Private Sector Partnerships: Engaging the Business and Philanthropic Community.

- Employers may make direct contributions into their employees’ AHCCCS CARE Account.
- The Philanthropic community can make contributions for targeted purposes, such as smoking cessation or managing chronic disease.
- Private sector contributions are tax-deductible.

Today’s Medicaid: A Modern Approach

Electronic Communication: Apps, Texts and More!

- Avoid an emergency room visit by using an app to look up your primary care doctor or find an urgent care near you.
- Manage chronic illnesses or conduct your own health screenings using an app.
- Receive text alerts for an appointment reminder or managing medication.
- Manage your account online, including annual renewals, address or income changes or use a chat feature to ask questions instead of waiting on hold or in long lines.

Value Based Purchasing: Paying for Quality, Not Quantity.

- Increase number of value based arrangements between health plans and providers.
- Build partnerships. When there is a quality product – i.e. good health outcomes are achieved – providers will be rewarded.

Building a True Health Care System: Reducing Fragmentation.

- Strengthen existing efforts for integrated care: alignment of dual eligible members; Children’s Rehabilitative Services (CRS) program; and Regional Behavioral Health Authorities (RBHAs) offering physical and behavioral health services.
- Examine new opportunities to align incentives and achieve greater accountability.
- Support efforts to reduce stigma related to mental illness, substance use disorders, and physical or cognitive disabilities.
- Increase adoption of electronic health records and health information exchanges that will reduce duplication and offer better tools to manage patient care.

Fraud Prevention: Applying Modern Tools to Curbing Fraud, Waste and Abuse.

- Refine data analytics capacity related to program integrity.
- Support the AHCCCS Office of the Inspector General (OIG) with the tools and personnel to investigate bad actors within the Medicaid program.
- Confirm changes in family income using automated systems to ensure taxpayers are not paying for people who are over income for the program.

The Legislative Partnership

The Arizona Legislature is an important partner in this effort. Modernizing Arizona Medicaid will include legislative initiatives that:

- Limit lifetime enrollment to five years.
- Ensure copayment and premium obligations.
- Eliminate non-emergency transportation.

ATTACHMENT 2

Common Themes and Written Comments Received

Arizona's Draft Application for a New Waiver Public Comments: Common Themes and State Responses

Arizona received 138 written public comments to its application for a new Waiver. The State also received numerous comments through community forums held in Phoenix, Tucson, Flagstaff, Yuma, as well as through public meetings including the State Medicaid Advisory Committee. All written public comments are posted to the AHCCCS website. Summaries of comments provided at the community forums are also posted to the AHCCCS website. These comments form part of the State's application for a new Waiver.

This document highlights many of the common themes found throughout the public comments and offers the State's responses, clarification and how the comments may have shaped the State's proposal.

1. Which population will participate in the AHCCCS CARE program?

The State is proposing that the New Adult Group be required to participate in the AHCCCS CARE program. This group is comprised of the State's Prop. 204 eligible childless adults from 0-100% of the federal poverty level (FPL), as well as the expansion adults from 100-133% FPL. Only the expansion adults are subject to disenrollment for failure to make timely cost sharing and premium payments. The State has proposed making participation optional for the American Indian/Alaska Native population, persons with serious mental illness and TANF parents. All other eligibility categories, such as SSI-MAO, pregnant women, ALTCS and children are not part of the AHCCCS CARE program. The State has amended its proposal to include this further clarification.

2. Copayments may deter people from accessing care.

The AHCCCS CARE copayments are testing a new way of using copayments to direct care. The AHCCCS CARE copayments are not assessed at the point of service. Rather, members are billed retrospectively for services they already received for which a copayment applies. This way, members do not have to make the copayment before accessing care. In addition, because the AHCCCS CARE program is applying a new strategy, copayments are targeted to: deter opioid abuse; promote use of generic drugs; better manage missed appointments; curb non-emergency use of the emergency room; and support the medical home model by requiring a referral from your primary care physician (PCP) to seek specialty care.

There is no copayment: to see your PCP, OB-GYN, behavioral health provider, or any other specialist (with PCP referral); or to obtain prescription drugs (except opioids and

brand name drugs when generic is available)¹. The State has made further clarification to its proposal per the comments received. Accordingly, the AHCCCS CARE copayments will not deter people from accessing care, since, in most instances, a copayment will not apply.

3. Many people may not be able to afford the premiums, especially if they are caring for other family members with special needs.

The Arizona State Legislature already passed a measure requiring imposition of premiums for individuals enrolled in the New Adult Group.² The legislatively directed premium requirement is set at 2% of annual household income. The AHCCCS CARE program builds upon the legislative directive by allowing members to withdraw the premium dollars they have paid into their AHCCCS CARE Account and use those monies for non-covered services.

In response to concerns about affordability, the State has amended its premium requirement to allow for a ceiling of \$25. Accordingly, the State has clarified in its proposal that the annual premium will not exceed 2% of annual household income or \$25 per month, whichever is lesser.

In response to concerns about members who are also caregivers for individuals living with them who may be elderly or disabled, the State has amended its proposal to allow their participation in AHCCCS CARE to be optional.

4. Do Health Savings Accounts work in Medicaid? Are the premium amounts going to be enough to fund this Health Savings Account?

The AHCCCS CARE Account is not a health savings account. A true health savings account acts as the source of funds or insurance coverage for all of the individual's health care needs. Also, true health savings accounts follow numerous federal requirements. The AHCCCS CARE Account functions more like a flexible spending program that acts as a compliment to the member's existing full coverage. A member's AHCCCS covered services are not funded through the AHCCCS CARE Account. Adults that participate in the AHCCCS CARE program still receive all of their regular benefits through their AHCCCS health plan. There is no change to their benefits. Monies in the AHCCCS CARE Account are for the member's use for services that are not covered by Medicaid.

As pointed out previously, the Arizona Legislature has passed the premium requirement. The AHCCCS CARE Account offers members the opportunity to get their premium dollars back and reinvest those monies in their own health for services that

¹ There is no copay for opioids in cases if terminal illness or cancer. There is no copay for brand name drugs where a physician has determined that the generic is ineffective.

² See SB 1475 [http://www.azleg.gov/legtext/52leg/1r/laws/0014.pdf./](http://www.azleg.gov/legtext/52leg/1r/laws/0014.pdf/)

Medicaid does not cover, like vision and dental. A member that has paid their monthly premium – e.g., \$25 per month – can then use the money they have saved for a dental cleaning or glasses.

In addition, contributions from employers and charitable organizations will serve to either reduce member contribution amounts or augment savings already accrued in their AHCCCS CARE Account. Some commenters suggested that third party participation is unlikely. The State disagrees and will aggressively pursue partnerships with employers and charitable organizations that share Arizona’s goal of promoting better health outcomes. Any organization can participate and reinvest their funds to support the health of AHCCCS members as they choose. These goals could include supporting tobacco cessation efforts or investing in the AHCCCS CARE Accounts for members with bleeding disorders, substance use disorders or diabetes. Some commenters stated that employer contributions could be a burden, particularly to small businesses. There is no requirement that employers make contributions. To the extent employers wish to make contributions, the State is pursuing a strategy to allow those contributions to be tax deductible.

Accordingly, the State believes the AHCCCS CARE Account presents new and unique opportunities to invest in the health of Arizonans and add value to the AHCCCS membership. The AHCCCS CARE Account takes a fresh approach to the traditional view of premium payments by allowing those dollars to stay with the member. The goal is adding a tool to help members manage their overall health as an added benefit, not to replace their current benefits.

5. The cost sharing imposed is not going to reduce total expenditures.

The AHCCCS CARE program is not designed as a cost saving measure. The goal is to take the directives as set forward by the Arizona Legislature and build upon them to more strategically direct care to the right settings and offer tools to support AHCCCS members’ ability to manage their own health. The State is not counting any savings related to copayments and is allowing premium payments to stay with the member.

6. What are the administrative costs associated with this proposal?

The AHCCCS program already administers copayments and premiums and has done so for many years. Thus, these are not new components to the program. The only new components will be around education to members about (1) setting health goals and ways to achieve their goals and (2) connecting members to employment opportunities. These are positive investments in the AHCCCS membership. Costs for these investments in our members will be covered through copayments collected. The State has issued a Request for Information to seek additional information on third parties that currently administer similar type programs.

7. People who are sick or care for others who are elderly or disabled may not be able to keep up with premium or copayment requirements.

The State agrees with this comment. The State is already proposing to exempt persons with a serious mental illness, allowing their participation in AHCCCS CARE to be voluntary. As a result of public comment, the State is also seeking to exempt from AHCCCS CARE participation those who care for someone in their home who is elderly or disabled. Finally, the State will work with its federal partners at the Centers for Medicare and Medicaid Services (CMS) to build in exemptions for certain medically frail populations. The goal of AHCCCS CARE is to provide positive tools to better manage AHCCCS members' health, not to penalize members when they become ill.

8. There is no precedent for a work requirement or lifetime limit in Medicaid.

These comments reference Arizona Senate Bill 1092, which conditions Medicaid eligibility upon meeting specified work requirements and imposes a 5-year lifetime enrollment limit in Medicaid.³ This legislation was discussed as part of the regular public process during the 2015 legislative session and included opportunities for public comment and testimony. Very little public feedback was offered to the Legislature. The requirements are now part of state statute. Hence, the AHCCCS Administration is required by state law to seek these waiver authorities. While it is recognized that similar type proposals have not yet been approved in Medicaid, Arizona policymakers' goal is to advance the national dialogue around these issues.

9. Is the AHCCCS Works program also a condition of eligibility?

No, the AHCCCS Works program is not connected to an individual's eligibility. Participation in AHCCCS Works is a requirement in order to withdraw funds from the AHCCCS CARE Account. The AHCCCS Works program is a work incentive, rather than a work requirement, as detailed in SB 1092.

Employment is an important part of one's overall health and wellness. Accordingly, the State has several initiatives around supported employment for persons with disabilities or serious mental illness. Despite the fact that adults make up nearly half of the AHCCCS enrollment, there has been no concerted effort to engage this adult membership around work opportunities. The AHCCCS Works program is an effort to connect people to the resources they need to find employment. The Department of Economic Security, for instance, has a robust program to provide aid to job seekers.

³ For additional information and specific language around the requirements and exceptions, see the Arizona State Legislature's website at: http://www.azleg.gov/DocumentsForBill.asp?Bill_Number=1092&Session_Id=114. SB 1092 can be found here: <http://www.azleg.gov/legtext/52leg/1r/laws/0007.pdf>.

All that is required is that members take the step of getting connected to employment assistance opportunities. Most importantly, a member's AHCCCS eligibility is not connected to their participation in AHCCCS Works.

Some commenters suggested that there may be AHCCCS members that cannot achieve work or cannot take the step to participate in AHCCCS Works. The State fully recognizes that different individuals may have different health needs or challenges. Accordingly, the State will work to accommodate individuals who are medically frail and unable to meet the AHCCCS Works component. The State disagrees, however, with some commenters that suggested the mere fact of being enrolled in Medicaid creates an inability to participate in a work incentive program. Rather, the State believes in investing in every adult member to support their ability to achieve independence to that individual's greatest extent. Employment is a key to maximizing independence and achieving better overall health and quality of life.

10. Setting healthy targets is a positive step.

AHCCCS appreciates the positive support for the Healthy Arizona program. Some commenters suggested the program may be difficult for members to achieve. Setting targets that no one can achieve is not the State's goal. Rather, the Healthy Arizona targets start small. Meeting this objective can be as simple as getting a flu shot. Members only need to accomplish one of the health goals in order to meet this requirement. The purpose here is to build health literacy around basic health and wellness measures and public health concerns.

11. Non-emergency medical transportation is a critical part of ensuring health and wellness.

The Arizona Legislature passed Senate Bill 1475,⁴ which includes a requirement that the AHCCCS Administration seek a waiver allowing the State an exemption from providing non-emergency medical transportation to the expansion adult population – i.e. adults in the 100-133% FPL group. The State acknowledges and appreciates the concerns raised around ensuring that members have access to needed care and will explore opportunities to exempt certain medically frail populations from this directive.

12. There is broad support for proposals aimed at addressing health care disparities in the American Indian/Alaska Native population.

The State appreciates the broad support for the American Indian Medical Home, continuation of the uncompensated care payments for Indian Health Services and tribally owned or operated 638 facilities, and the opportunity to reimburse for traditional

⁴ See <http://www.azleg.gov/legtext/52leg/1r/laws/0014.pdf>.

healing practices. AHCCCS will further engage with tribes around the opportunities in a series of workgroups.

13. There are other initiatives, such as community paramedicine, that should be added to this application.

The State agrees that there are numerous initiatives taking shape throughout the State. AHCCCS is already working on several of these efforts, including opportunities to reimburse for certain types of services provided in community paramedicine programs. Similarly, many of the types of initiatives or system reforms identified in public comments are already being supported in the AHCCCS system.⁵ More importantly, there are many opportunities to include future reforms as part of the State's Waiver document. Reform initiatives require extensive research, stakeholder engagement and operational changes. Some of these dialogues are already occurring or will take place through current efforts or new ones, like the State Innovations Model (SIM) grant.⁶

14. While there is support for the Delivery System Reform Incentive Payment (DSRIP) program proposal, additional detail is needed.

The DSRIP section of the State's proposal is purposefully high level and outlines only the State's primary objectives. The details of what a DSRIP would entail for the State of Arizona requires an extensive level of stakeholder engagement, as such a proposal must be formed as part of a collaborative effort. In addition, the State is seeking opportunities to ensure long-term sustainability of any system reform efforts. Most of the issues highlighted in the DSRIP section are projects that are already underway in some form. The purpose of including the concept in the State's application is to ensure the development of language within the new Waiver that will further support these efforts.

15. There is support for the concepts of engaging adult members in healthy goals and allowing for innovative strategies that offer tools to help members direct their own care.

The State appreciates the support from commenters around the proposal's goals to empower adult members to manage their own health and have the flexibility pay for non-covered services. The State views this proposal as an exciting opportunity to build health literacy, connect people to work opportunities, and help prepare Arizonans for their transition from Medicaid to commercial coverage.

⁵ See AHCCCS Initiatives page on the AHCCCS website at: <http://azahcccs.gov/shared/initiatives.aspx>.

⁶ For more on the State's SIM grant, see: <http://ahcccsnew/reporting/federal/SIMInitiative.aspx>.

Vinyard, Christopher

From: Laurie [REDACTED]
Sent: Friday, July 31, 2015 3:49 PM
To: Public Input
Cc: Laurie Goldstein
Subject: AHCCCS Community Forums

Importance: High

Follow Up Flag: Follow up
Flag Status: Completed

The waivers that the Arizona legislators are seeking are highly likely to have a negative outcome. It seems like the measures do not recognize that people suffering from mental illness require continuity of care, and that without continuity of care, more costly alternatives are required. Look at the recent problem with transportation when Mercy Maricopa took over. It is alleged that clinics experienced a marked decrease (40-50%) in clients showing up for medication, appointments, and/or therapies. When a person with mental illness is symptomatic, the added stress of finding transportation is traumatizing. It is likely they will then miss their medication and decompensate resulting in a psychiatric emergency. These are some of the issues stemming from lack of continuous care:

1. Possibility of being hurt or killed by the police or others and the possible negative consequences resulting from lawsuits.
2. The likelihood that the person may end up in jail and require psychiatric care during incarceration (not to mention the cost of being jailed).
3. The likelihood that the person may end up in an emergency room, not an appropriate place for treating people in psychiatric crisis (again, not to mention the costs).
4. The likelihood that they will end up homeless.

People suffering from mental illness are likely to have poor employment histories unless they are working with a center designed for such folk, for example the MARC Center. People with mental illness should not be traumatized by the health care system created to help them. Please use evidence based practices (e.g. the San Antonio model for policing; SAMHSA for treatment) before taking such draconian measures. Look at where Arizona ranks in the latest Mental Health America report, we are 50th in the nation! These measures would ensure we do not improve.

<http://www.mentalhealthamerica.net/sites/default/files/Parity%20or%20Disparity%202015%20Report.pdf>

Overall Ranking

1	Massachusetts
2	Vermont
3	Maine
4	North Dakota
5	Delaware
6	Minnesota
7	Maryland
8	New Jersey
9	South Dakota
10	Nebraska
11	Connecticut
12	Iowa
13	Hawaii
14	Pennsylvania
15	Wisconsin
16	Illinois
17	New York
18	North Carolina
19	Kansas
20	Virginia
21	Ohio
22	Missouri
23	New Hampshire
24	Rhode Island
25	Tennessee
26	Florida
27	Kentucky
28	Colorado
29	California
30	District of Columbia
31	Alaska
32	Georgia
33	South Carolina
34	Indiana
35	West Virginia
36	Texas
37	Utah
38	Wyoming
39	Alabama
40	Oregon
41	Michigan
42	Idaho
43	Arizona
44	Montana
45	Oklahoma
46	New Mexico
47	Louisiana
48	Washington
49	Nevada
50	Mississippi
51	Arkansas

Need Ranking

1	New Jersey
2	Maryland
3	Florida
4	Alabama
5	North Carolina
6	Texas
7	Georgia
8	Illinois
9	Virginia
10	Kansas
11	North Dakota
12	Missouri
13	New York
14	Nevada
15	Connecticut
16	Colorado
17	Minnesota
18	Nebraska
19	South Dakota
20	Tennessee
21	Wisconsin
22	South Carolina
23	California
24	Hawaii
25	Louisiana
26	Mississippi
27	Delaware
28	Iowa
29	Pennsylvania
30	Indiana
31	Ohio
32	Massachusetts
33	Utah
34	Alaska
35	Idaho
36	New Hampshire
37	Maine
38	Kentucky
39	Arkansas
40	Arizona
41	Rhode Island
42	West Virginia
43	Wyoming
44	Montana
45	Oregon
46	Vermont
47	Oklahoma
48	Michigan
49	Washington
50	District of Columbia
51	New Mexico

Access Ranking

1	Vermont
2	Massachusetts
3	Maine
4	Delaware
5	Iowa
6	North Dakota
7	Pennsylvania
8	Minnesota
9	South Dakota
10	District of Columbia
11	Nebraska
12	Hawaii
13	Connecticut
14	Wisconsin
15	Rhode Island
16	New Hampshire
17	Ohio
18	New York
19	Maryland
20	Kentucky
21	Illinois
22	West Virginia
23	Michigan
24	Kansas
25	Wyoming
26	New Jersey
27	New Mexico
28	Oregon
29	Alaska
30	North Carolina
31	Missouri
32	Virginia
33	Tennessee
34	Oklahoma
35	Montana
36	Indiana
37	California
38	Washington
39	Colorado
40	Utah
41	Arizona
42	Idaho
43	South Carolina
44	Florida
45	Georgia
46	Arkansas
47	Texas
48	Louisiana
49	Alabama
50	Mississippi
51	Nevada

Comparing

Among the top an each ranking):

- Florida, Alab rates of men to care. Alab children with (EBD, ranked but among t limited, as a insurance ar
- Vermont and hand, have s the best acco percentage of children with only an estim insurance ar treatment.
- Arizona and poor access and Arkansa
- On the other having both treatment. f recovery.

Implications

- Cases like Ve significantly the overall r
- Similarly, ha poor access overall ranki

The Arizona Legislature has **mandated** that waivers be sought that:

1. Institutes a work requirement for all able-bodied adults receiving Medicaid services;
2. Restricts benefits for able-bodied adults to a lifetime limit of five years that begins on the effective date of the waiver or amendment to the current Section 1115 Waiver and does not include any previous time a person received benefits;
3. Develops and imposes meaningful cost-sharing requirements to deter nonemergency use of emergency departments and use of ambulance services for nonemergency transportation with differing levels based upon whether part of the expansion population or those at or below 100% of poverty;
4. Discontinues non-emergency medical transportation services from October 1, 2015 through September 20, 2016.

Sincerely,

Laurie Goldstein
Mother and guardian of an adult son suffering from mental illness

Barriers to Mental Health Treatment: Results from the National Comorbidity Survey Replication (NCS-R)

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Abstract

Background

To examine barriers to initiation and continuation of treatment among individuals with common mental disorders in the US general population.

Methods

Respondents in the National Comorbidity Survey-Replication with common 12-month DSM-IV mood, anxiety, substance, impulse control and childhood disorders were asked about perceived need for treatment, structural barriers, and attitudinal/evaluative barriers to initiation and continuation of treatment.

Results

Low perceived need was reported by 44.8% of respondents with a disorder who did not seek treatment. Desire to handle the problem on one's own was the most common reason among respondents with perceived need both for not seeking treatment (72.6%) and for dropping out of treatment (42.2%). Attitudinal/evaluative factors were much more important than structural barriers both to initiating (97.4% vs. 22.2%) and to continuance (81.9% vs. 31.8%) of treatment. Reasons for not seeking treatment varied with illness severity. Low perceived need was a more common reason for not seeking treatment among individuals with mild (57.0%) than moderate (39.3%) or severe (25.9%) disorders, whereas structural and attitudinal/evaluative barriers were more common among respondents with more severe conditions.

Conclusions

Low perceived need and attitudinal/evaluative barriers are the major barriers to treatment seeking and staying in treatment among individuals with common mental disorders. Efforts to increase treatment seeking and reduce treatment dropout need to take these barriers into consideration as well as to recognize that barriers differ as a function of socio-demographic and clinical characteristics.

keywords: mental health, treatment seeking, continuity of care

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INTRODUCTION

A substantial proportion of adults with common mental disorders fail to receive any treatment ([Kessler et al., 2005c](#); [President's New Freedom Commission on Mental Health, 2005](#); [Sareen et al., 2007](#); [Wang et al., 2007a](#); [Wang et al., 2005a](#); [Wang et al., 2005b](#)), even when these conditions are quite severe and disabling ([Kessler et al., 2001](#)). Furthermore, many who do receive treatment drop out before completing treatment ([Edlund et al., 2006](#); [Wang, 2007b](#)). Because individuals with psychiatric disorders would often benefit from a full course of treatment, the gap between the prevalence and treatment of disorders contributes to unmet need for care. An important step in reducing unmet need for mental health care involves understanding the reasons why individuals with mental disorders either do not seek treatment or drop out of care.

Several factors are thought to impede appropriate mental health care seeking including lack of perceived need for treatment ([Edlund et al., 2006](#); [Mojtabai et al., 2002](#); [Sareen et al., 2007](#)), stigma ([Van Voorhees et al.,](#)

2005, 2006; Wrigley *et al.*, 2005; Wynaden *et al.*, 2005), pessimism regarding the effectiveness of treatments (Bayer & Peay, 1997), lack of access due to financial barriers (Mojtabai, 2005), and other structural barriers such as inconvenience or inability to obtain an appointment (Sareen *et al.*, 2007). The contribution of these factors, however, may vary across populations, health care settings (Sareen *et al.*, 2007), and possibly over time (Mojtabai, 2005). In one recently published study, for example, low-income respondents from the US as compared with those from Ontario or the Netherlands were significantly more likely to report a financial barrier to mental health treatment (Sareen *et al.*, 2007). Nevertheless, in all three settings attitudinal/evaluative barriers were more commonly reported obstacles than financial factors (Sareen *et al.*, 2007).

Within the United States, financial barriers to mental health treatment seeking may have grown over the past decade (Mojtabai, 2005). During this period, however, public attitudes towards mental health treatment seeking became more favorable (Mojtabai, 2007). These trends, coupled with a marked increase in the use of mental health care (Kessler *et al.*, 2005c; Olfson *et al.*, 2002) call for a re-evaluation of reasons for not seeking treatment in the US. A better understanding of these barriers may inform the design of clinical services and public health campaigns aimed at improving access to mental health care.

In the present study, we use data from the National Comorbidity Survey-Replication (NCS-R), a representative survey of the US population in the early 2000s, to examine barriers to initiation or continuation of treatment among individuals who meet criteria for a mental disorder. More specifically, we examine the role of perceived need as well as structural and attitudinal/evaluative barriers in treatment seeking and in dropping out of treatment among those who have already started treatment. We also examine and compare the role of these factors at different levels of clinical severity. Finally, we use multivariate models to examine associations between socio-demographic characteristics and severity of illness on the one hand and barriers to mental health treatment seeking, on the other.

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METHODS

Sample

The NCS-R is a nationally representative household survey of respondents 18 years and older in the contiguous United States (Kessler *et al.*, 2004; Kessler *et al.*, 2005a). Face-to-face interviews were carried out with 9,282 respondents between February 5, 2001, and April 7, 2003. Part I included a core diagnostic assessment and a service use questionnaire administered to all respondents. Part II ($n = 5,962$) assessed risk factors, correlates and additional disorders, and was administered to all Part I respondents with lifetime disorders plus a probability subsample of other respondents. Because a number of disorders considered in rating severity level were asked only in Part II, the present analyses are limited to the Part II sample. This sample was appropriately weighted to adjust for the under-sampling of Part I respondents without any disorder. The overall response rate was 70.9%. NCS-R recruitment, consent, and field procedures were approved by the Human Subjects Committees of Harvard Medical School and the University of Michigan.

Reasons for not using services or not continuing to use them

Respondents who reported no use of mental health services were asked whether there was a time in the past 12 months that they felt that they might have needed to see a professional for problems with their emotions, nerves, or mental health. Those who answered affirmatively were then asked whether or not they endorsed each of a series of reason statements about why they did not see a professional from a list that included reasons involving low perceived need, structural barriers (e.g., lack of financial means, available treatments, personnel, or transportation or the presence of other inconveniences), and attitudinal/evaluative barriers (e.g., the presence of

stigma, low perceived efficacy of treatments, or the desire to handle the problem on their own). These reason statements are based on similar statements used in the baseline NCS and earlier studies as well as on focus group interviews about barriers to seeking treatment carried out to expand these earlier lists. Respondents who reported that there was never a time in the past 12 months when they felt they might need help were not asked about reasons and were coded as having “low perceived need” ([Appendix A](#)).

Respondents who reported having seen a provider within the mental health specialty, general medical, human service, or complementary-alternative medical sectors for help with emotional problems in the past 12 months were asked whether the treatment had stopped and, if so, whether they “quit before the [provider] wanted [them] to stop.” Those who answered affirmatively to both questions were then asked to endorse reasons for dropping out of treatment from a list of potential reason statements similar to the list of reasons for not seeking treatment ([Appendix B](#)). Only respondents who had stopped or quit *all* ongoing treatments were rated as having dropped out and asked questions about the reasons for dropping out of treatment. Those who continued treatment with providers in one sector while stopping treatment with any providers in other sectors were not rated as having dropped out of treatment. The 160 respondents who reported taking psychotropic medications for their emotional problems at any time in the past year but reported no contacts with a treatment provider over that time period were not counted as having received mental health treatment in the past 12 months even though some of them were presumably in long-term treatment and others made their last visit shortly before the beginning of the 12-month recall period (e.g., 13 months ago) and continued taking medications into the early part of that recall period. As we did not ask questions about treatment beyond the 12-month recall period, we had no way of classifying the treatment of these 160 respondents, leading us to delete them from the analysis.

Diagnostic assessment

DSM-IV diagnoses were based on Version 3.0 of the Composite International Diagnostic Interview (CIDI) ([Kessler & Üstün, 2004](#)), a fully-structured lay interview that generates diagnoses according to International Classification of Diseases, 10th Revision ([World Health Organization, 1992](#)) and *DSM-IV* ([American Psychiatric Association, 1994](#)) criteria. The analyses were restricted to respondents with at least one 12-month CIDI/*DSM-IV* disorder. Twelve-month disorders included anxiety disorders (panic disorder, generalized anxiety disorder, agoraphobia without panic disorder, specific phobia, social phobia, posttraumatic stress disorder, obsessive-compulsive disorder, separation anxiety disorder), mood disorders (major depressive disorder, dysthymic disorder, bipolar disorder I or II), impulse control disorders (oppositional defiant disorder, conduct disorder, attention-deficit/hyperactivity disorder, intermittent explosive disorder), and substance use disorders (alcohol and drug abuse and dependence). The disorders assessed in part 2 include the 4 childhood disorders (separation anxiety disorder, oppositional defiant disorder, conduct disorder, and attention-deficit/hyperactivity disorder), posttraumatic stress disorder, obsessive-compulsive disorder, and the substance use disorders. As described elsewhere ([Kessler *et al.*, 2005a](#)), blind clinical reinterviews using the Structured Clinical Interview for *DSM-IV* (SCID) ([First *et al.*, 2002](#)) with a probability subsample of NCS-R respondents found generally good concordance between WMH-CIDI diagnoses and SCID diagnoses. The above disorders were the only ones assessed in the survey. Exclusion of other disorders of clinical interest (e.g., non-affective psychosis, dementia, personality disorders) is a limitation.

Level of severity

Twelve-month cases were classified as serious if they had any of the following: a 12-month suicide attempt with serious lethality intent; work disability or substantial limitation due to a mental or substance disorder; positive screen results for non-affective psychosis; bipolar I or II disorder; substance dependence with serious role impairment, as defined by scores in the “severe” or “very severe” range on disorder-specific versions of the Sheehan Disability Scale ([Leon *et al.*, 1997](#)); an impulse control disorder with repeated serious violence; or any disorder that resulted in ≥ 30 days out of role in the last year. Cases not defined as serious were defined as moderate if they had any of the following: suicide gesture, plan, or ideation; substance dependence without

serious role impairment; at least moderate work limitation due to a mental or substance disorder; or any disorder with at least “moderate” role impairment in ≥ 2 domains of the Sheehan Disability Scale. All other cases were classified as mild. As reported elsewhere (Kessler *et al.*, 2005b), mean number of days in the past 12 months that respondents were completely unable to carry out their normal daily activities because of mental or substance use problems was 88.3 among respondents classified as having a serious condition, 4.7 among those classified as having a moderate, and 1.9 among those classified as having a mild condition ($F_{2, 5689}=17.7$; $p<.001$).

Socio-demographic predictor variables

Socio-demographic variables included age (18–34, 35–49, 50–64, 65+), sex, race-ethnicity (non-Hispanic white, Hispanic, non-Hispanic black, other), years of education (0–11, 12, 13–15, 16+), family income in relation to the federal poverty level (Proctor & Dalaker, 2001) (low [≤ 1.5 times the poverty line], low average [>1.5 –3 times the poverty line], high average [>3 –6 times the poverty line], high [≥ 6 times the poverty line]), and marital status (married/cohabitating, separated/widowed/divorced, never married).

Analysis methods

The NCS-R data were weighted to adjust for differences in selection probabilities, differential non-response, and residual differences between the sample and the US population on socio-demographic variables. An additional weight was used in the Part 2 sample to adjust for the over-sampling of Part 1 respondents (Kessler *et al.*, 2004). All descriptive statistics are based on these weighted data. Analyses of reasons for not initiating treatment or continuing treatment were conducted in three stages. First, reasons were examined and compared in the total group of respondents with any 12 month disorder as well as separately in subgroups defined by severity. Second, analyses of reasons other than those involving lack of need were repeated among respondents who reported perceived need for treatment. Third, multivariate logistic regression models were used to examine variation in reasons for not seeking treatment associated with socio-demographic characteristics and severity of illness. Three main-effect models were estimated, one for each of the three broad categories of reasons (low perceived need, any structural barrier, any attitudinal/evaluative barrier). These multivariate analyses were then repeated with the addition of interaction terms between severity and each socio-demographic characteristic to examine whether the association of each socio-demographic factor with each type of barrier was uniform regardless of level of severity. Logistic regression coefficients and their standard errors were exponentiated and reported as odds-ratios (OR) and 95% confidence intervals (CI).

Standard errors were calculated using the Taylor series method implemented in the SUDAAN software package (Research Triangle Institute, 2002) to adjust for clustering and weighting of data. Multivariate significance tests were conducted using Wald χ^2 tests based on coefficient variance–covariance matrices adjusted for design effects using the Taylor series method. Statistical significance was evaluated using two-sided design-based tests and the $p<0.05$ level of significance. Only when multivariate significance tests were significant did we interpret the significance of individual coefficients. This decision rule was used to guard against the possibility of false positive coefficients in an analysis that made a large number of individual tests. It is important to note, though, that although use of omnibus tests reduces the chance of false positive findings, the only definitive protection against this problem is replication in independent datasets.

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RESULTS

Reasons for not seeking treatment

Somewhat more than half (55.2%) of the 1,350 Part II NCS-R respondents who met criteria for at least one 12-month DSM-IV/CIDI disorder but did not use any 12-month services reported that they might have needed to see a professional for mental health problems. This perception of need was significantly associated with severity of psychopathology ($\chi^2_2 = 52.0$, $p < .001$), with 74.1% of nonusers who had a severe disorder reporting perceived need compared to 60.7% of those who had a moderately severe disorder and 43.0% of those who had a mild disorder. Low perceived need was the most commonly reported barrier to treatment across levels of severity. (Table 1) Over and above the effects of global measures of disorder severity, generalized anxiety disorder was the only individual disorder that predicted perceived need significantly, with an OR of 1.8 (95% CI: 1.1–2.9, $p = .020$). Among respondents who recognized a need for treatment, in comparison, the desire to handle the problem on one's own was the most commonly reported reason for not seeking treatment (72.6%), while attitudinal/evaluative barriers were much more commonly reported (97.4%) than structural barriers (22.2%). Reported reasons for not seeking treatment varied significantly across severity levels, with low perceived need more commonly reported by respondents with mild than moderate or severe disorders compared to structural and most attitudinal/evaluative barriers being reported by a higher proportion of respondents with perceived need who had severe or moderate than mild conditions.

	Total		Severe		Moderate		Mild		Sig. Chi-Square	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI		
I. Low perceived need										
None perceived need for treatment	44.6	3.8	25.5	3.3	60.3	7.2	57.0	3.4	52.0	.1
p <	13.2503		12.46		25.04		25.21			
II. Structural barriers among those with perceived need										
Expense	15.2	4.9	26.0	4.2	14.5	2.4	8.1	2.5	16.0	.1
Availability	12.8	2.8	24.7	3.5	11.3	2.0	1.8	1.3	18.2	.1

Table 1

Reported reasons for not seeking treatment by level of severity of disorder among respondents with 12-month DSM-IV disorders who did not seek treatment at any time in the past 12 months

The joint effects of socio-demographic variables and severity were significant as a set in predicting both low perceived need ($\chi^2_{17} = 159.9$, $p < .001$) and structural barriers among respondents with perceived need ($\chi^2_{17} = 53.6$, $p < .001$) but not attitudinal/evaluative barriers among respondents with perceived need ($\chi^2_{17} = 9.9$, $p = .54$). (Table 2) The failure to find significant predictors of attitudinal/evaluative barriers presumably reflects the fact that virtually every respondent with perceived need reported at least one such barrier (97.4%; detailed results for this model can be found in Appendix C). Age (65+ compared to 18–64), sex (males compared to females), education (0–11 vs. 16+ years), and severity (mild vs. moderate-severe) were significant predictors of low perceived need. Age (18–49 vs. 50+) and severity (severe vs. mild-moderate) were significant predictors of structural barriers.

	Low perceived need			Any structural barrier among those with perceived need		
	OR	95% CI	p	OR	95% CI	p
Age (65+, reference)						
18–34	0.4	0.17	.001	2.7	1.4–5.3	.001
35–49	0.17	0.08	.001	3.0	1.6–5.7	.001

Table 2

Socio-demographic and severity predictors of reported reasons for not seeking treatment among respondents with 12-month DSM-IV disorders who did not seek treatment at any time in the past 12 months^a

We also evaluated interactions between each socio-demographic variable and severity in predicting perceived need and structural barriers. The 30 interactions (15 socio-demographic variables × two severity variables) were

significant as a set in each of the two equations ($\chi^2_{30} = 74.1, p < .001$ predicting perceived need and = 163.0, $p < .001$ predicting structural barriers), although none of the more specific interactions between individual socio-demographics and severity was significant in predicting perceived need. Two of these specific interactions were significant, though, in predicting structural barriers. These involved race-ethnicity ($\chi^2_3 = 25.7, p < .001$) and marital status ($\chi^2_2 = 9.5, p = .023$). (Detailed results are available in [Appendix D](#).) In the case of race-ethnicity, the elevated OR of structural barriers among Hispanics compared to Non-Hispanic Whites was found to be confined to mild-moderate cases. In the case of marital status, married/cohabiting respondents were found to have a significantly elevated OR of structural barriers compared to the never married among mild cases but not moderate-severe cases.

Reasons for dropping out of treatment

A total of 851 respondents with 12-month disorders reported receiving treatment at some time in the past 12 months, of whom a weighted 10.6% ($n = 78$ actual respondents) reported dropping out of treatment in all service sectors where they received treatment. Wanting to handle the problem on one's own was the most commonly-reported reason for dropping out of treatment (42.2%) followed by perceived improvement in mental health (31.2%). ([Table 3](#)) Although disorder severity was not significantly related to any of the reported reasons for dropout ($\chi^2_2 = 0.5-5.6, p = .06-.78$), respondents with severe disorders reported a significantly higher mean number of reasons (2.3) than those with moderately severe (2.0) or mild (1.3) disorders ($F_{2,848} = 7.1, p = .002$). In multivariate analyses (data not shown but available in [Appendix E](#)), a standardized continuous measure of income was the only significant socio-demographic predictor of reporting attitudinal/evaluative barriers. This association was negative (OR: 0.2, 95% CI: 0.1-0.7; $\chi^2_1 = 7.5, p = .006$) and persisted when the sample was limited to respondents who perceived a need for continued treatment (OR: 0.1, 95% CI: 0.0-0.4, $\chi^2_1 = 8.6, p = .003$).

	Any severity		Severe		Moderate		Mild		χ^2
	%	se	%	se	%	se	%	se	
I. Low perceived need									
Could not help myself	25.9	4.0	19.0	7.5	26.2	13.5	38.5	14.7	0.7
II. Structural barriers									
Financial	14.7	4.7	16.8	8.0	25.1	9.9	7.8	7.3	0.6
Availability	3.3	2.5	7.3	4.5	4.0	3.0	4.8	4.0	0.2
Improvement or nonrecognition	17.4	5.2	12.6	5.4	25.7	11.0	5.4	4.0	2.4

Table 3

Reported reasons for dropping out of treatment by level of severity of disorder among respondents with 12-month DSM-IV disorders dropped out of treatment in the past 12 months

CONCLUSION

This study had several noteworthy limitations. First, results are subject to recall bias because disorders, treatments, and reasons were all assessed retrospectively over a 12-month recall period with self-report. It is noteworthy in this regard that self-reports of service use tend to underestimate service use reported in administrative records ([Clark et al., 1996](#); [Jobe et al., 1990](#); [Kashner et al., 1999](#); [Petrou et al., 2002](#); [Ritter et al., 2001](#)), although the underestimation of more recent service use tends to be modest ([Clark et al., 1996](#); [Petrou et al., 2002](#)). Second, the list of reasons for not seeking treatment and dropout was limited to those reported most commonly in past research and elicited in qualitative interviews carried out to expand these earlier lists. Some individuals may have had other reasons for not initiating treatment or dropping out that were not included in our lists. In addition, some reason statements were ambiguous or double-barreled (e.g., “The problem went away by itself, and I did not really need help”) and were aggregated into rational categories in ways that could be debated. Furthermore, the reliability of self-reports of reasons for not seeking treatment has not been assessed. Third, with regard to reasons involving severity and change in severity (problem was not

severe; problem went away), the analysis was limited by not having information on duration, which was almost certainly related to these reports and would be expected to be a strong predictor of seeking treatment.

Another weakness is that the analysis of treatment dropout had low power due to the small number of respondents defined as having dropped out of treatment. This may have been due to the stringent definition of drop-out we used, which classified respondents as having dropped out only they dropped out of treatment from all sectors in which they obtained treatment. A total of 81 respondents with a 12-month DSM-IV disorder dropped out of one or more types of treatments but stayed in some other type of treatment. We did not classify these respondents as having dropped out based on the fact that some number of them was presumably referred to a new treatment provider by their original provider or switched rather than dropped out of treatment. These 81 respondents did not differ significantly with regard to severity from those who stayed in the same type of treatment, but both groups were more severe than those who we defined as having dropped out. Given that this group is relatively large, it would be useful for future research to evaluate reasons for switching treatments among respondents of this type.

A final noteworthy limitation is that respondents who reported 12-month service use in one of the disorder-specific diagnostic sections but not in the general service section were not included in the analysis. There were 149 such individuals. These respondents were inconsistent in their reports, making it difficult to know how to classify them. Had we been aware of this inconsistency at the time of designing the interview, we could have included these cases by placing the general services section later in the interview and including respondents who reported disorder-specific treatment. It would be fairly easy to correct this problem in future surveys. Similar inconsistencies between reports of service use when assessed globally vs. separately after assessing each condition have been reported in other surveys (Duan *et al.*, 2007).

In the context of these limitations, the data provide a broad overview of perceived barriers to initiation and continuation of mental health treatments in the United States. Three patterns are especially noteworthy. First, low perceived need for treatment was a common reason for not seeking treatment, with attitudinal/evaluative reasons much more common than structural barriers among people with perceived need. This pattern is consistent with previous findings from the US and other settings in the 1990s (Sareen *et al.*, 2007) and suggests that low perceived need has remained a key barrier to seeking treatment for mental disorders.

Second, reasons for not seeking treatment varied significantly across levels of illness severity, with respondents who had more severe disorders being significantly less likely to report low perceived need as a barrier and significantly more likely to report structural and attitudinal/evaluative barriers than people with less severe disorders. These findings are consistent with findings from past research on the association of severity of illness with barriers to seeking treatment for mental disorders (Drapalski *et al.*, 2008, Wang *et al.*, 2007b). The disjunction between perceived need and our measure of severity highlights the fact that personal evaluations of perceived need do not fully capture objectively measured need. Notably, over one-quarter of respondents with severe psychopathology did not perceive a need for treatment and one in four of those who did perceive a need reported that they thought that the problem was not severe or that it would get better on its own. Furthermore, two-thirds of respondents with severe disorders who perceived a need for treatment and did not seek treatment, and more than one-half of respondents who dropped out, reported a wish to handle their problems on their own as a reason for not seeking treatment or dropping out. These results are consistent with an extensive clinical literature documenting a significant association between illness insight and treatment acceptance/adherence among patients with serious mental illness (Buckley *et al.*, 2007). Results such as these point to the importance of efforts to educate the public at large and patients about indicators of serious psychopathology and appropriate treatment options (Hickie, 2004; Hight *et al.*, 2006; Jorm *et al.*, 2005, 2006; Paykel *et al.*, 1997).

Third, over one-third of respondents who dropped out of treatment cited an attitudinal/evaluative barrier such as stigma, negative experience with providers, or perceived ineffectiveness of treatment, that show low perceived treatment quality leads to treatment dropout. It is sadly ironic that among those who dropped out of treatment,

patients with severe psychopathology were more likely than those with less severe disorders (albeit at a statistically insignificant level) to report attitudinal/evaluative obstacles to treatment, as those with the most severe conditions are likely to be in greatest need for treatment and potentially stand to benefit most from care. This finding points to the need to improve quality of mental health services for adults with severe mental disorders in the United States to better address the individual needs and preferences of this patient group (Adams & Drake, 2006).

It is also noteworthy that the reasons for not seeking treatment differed by respondent socio-demographic characteristics. Most notably, young and middle-aged adults were less likely than older adults to report a lack of perceived need for treatment but more likely to report structural and attitudinal/evaluative barriers to treatment seeking after they perceived a need. The effect of age may partly be explained by differences in access to care and lifestyle. Respondents ages 65+ typically are covered by a Medicare financed health plan and are more likely than younger people to be retired. Thus, they may be less likely than their younger peers to experience financial and time barriers to seeking treatment. Furthermore, younger people tend to have a less positive attitude toward mental health treatment seeking, although this pattern has been changing in recent years (Mojtabai, 2007).

Females compared to males and respondents with low compared to high education were less likely to report lack of perceived need as a reason for not seeking treatment. While past research generally supports an association between female gender and greater perceived need for mental health treatment (Meadows *et al.*, 2002, Sareen *et al.*, 2010), the association with education is puzzling and may suggest that formal education by itself does not significantly promote recognition of mental health care needs. The finding that married/cohabiting respondents had an elevated OR of reporting structural barriers, but only among mild cases, might reflect the fact that married people have more family responsibilities than single people that place demands on their time and financial resources, thereby creating barriers to seeking treatment that are only overcome when disorders become relatively serious. The finding that high income was associated with low odds of dropping out of treatment for attitudinal/evaluative reasons is consistent with earlier reports that high income is associated with positive attitudes toward mental health treatment (Mojtabai, 2007). This might be due to a higher quality of services accessible to individuals from higher income groups or more attitudes related to more general perceptions of medical care.

The results reported here reinforce other evidence that low rates of seeking treatment for common mental disorders remains a major public health problem in the United States (Gonzalez *et al.*, 2010). The President's New Freedom Commission on Mental Health recommended a campaign to improve treatment seeking by reducing the stigma associated with mental disorders and their treatments (President's New Freedom Commission on Mental Health, 2005). The 2008 mental health parity legislation has also sought to reduce financial barriers to accessing such treatments. The results of the current study show, consistent with these recommendations, that both attitudinal/evaluative and structural barriers are significant impediments to treatment seeking in the US. However, we also found that low perceived need is an even more important barrier. This might well reflect the fact that most of the mental disorders considered here are extreme variants on normal patterns of emotion, cognition, and behavior that are difficult for many people to see as distinct from the normal patterns. Our results suggest that new public education initiatives are needed to increase recognition of mental illness in conjunction with the efforts currently underway to reduce stigma and financial barriers.

Vinyard, Christopher

From: Jan Ogino [REDACTED]
Sent: Tuesday, August 04, 2015 6:00 AM
To: Public Input
Subject: AHCCCS Community Forums

Have you ever lived on \$12,000 a year? After one pays rent, utilities, food, transportation costs, with no hope that your wage will go up, but inflation might, this one person will not have access to the cost containment system. If they qualify at \$11,000 after all the above expenses, also with no hope that wages will rise, but inflation might, they will have to pay a premium for AHCCCS for five years then lose it. Wages won't rise because the policies of this administration will not discuss raising the minimum wage. Add to this, the plan doesn't take into account that most of these people work jobs that don't have sick leave. Therefore if they don't work they don't get paid and yet they have to pay something for AHCCCS. Sure they can help themselves buy using a smartphone and an app that tells him or her where to go for wellness classes. This assumes they can afford a smartphone and Internet access, time to go and transportation to and from these wellness classes. Try living like these working poor live for at least three months before you pass this legislation. The reason why I am no longer a republican is that they hate people who are poor no matter how much they work for little money. They don't want to hand out a little help because they assume the poor are lazy. Yet they don't mind handing out perks to rich people who don't need perks. They don't have work hard for those handouts.

Sent from my iPad

Vinyard, Christopher

From: Ginny Dickey [REDACTED]
Sent: Thursday, August 06, 2015 3:45 PM
To: Public Input; ahcccscare@azahcccs.gov
Subject: Arizona Medicaid waiver pending to CMS

Follow Up Flag: Follow up
Flag Status: Completed

Dear Administrator,

Please note that while I am not opposed to an emphasis on preventative care, with incentives to encourage early doctor visits and avoid the ER, other aspects of the waiver request are not helpful and do not demonstrate positive outcomes for the State's benefit or certainly for citizens needing assistance.

For families to set aside 2% of income is too much of a burden for them, and seems like it would be burden to administer the program, as well. Who will be overseeing the accounts? Is someone going to make a profit managing investments of them?

I also do not support the life time limits and increase in required applications to re-up for benefits.

Co-pays for preventive, well-care visits seem counterintuitive, if they would be mandated.

I will request that CMS deny the pending 1115 waiver.

Thank you,

Ginny Dickey

Former Councilwoman

Town of Fountain Hills

Vinyard, Christopher

From: erika jahneke <[REDACTED]>
Sent: Friday, August 14, 2015 8:23 PM
To: Public Input
Subject: Can't be there, but I'm leaving a comment...

Follow Up Flag: Follow up
Flag Status: Completed

At a time when many low-wage employers are tinkering with employee's schedules to see how few hours they can pay for, and how little benefits to offer, this "modernization" seems callous and damaging.

Sincerely,

Erika Jahneke

P.S. have you ever considered trying to get employers to provide more benefits? That would save the state money on Medicaid.

Vinyard, Christopher

From: Mary [REDACTED]
Sent: Monday, August 17, 2015 7:59 AM
To: Public Input
Subject: Phoenix meetings

Follow Up Flag: Follow up
Flag Status: Completed

I am just reading about Governor Ducey's new Medicaid reform plan.

I am unable to attend the meetings tomorrow due to work obligations. How do I keep informed about these changes? When do we find out how much the administration costs will be?

Though there is always room for improvement in Medicaid, I have grave reservations in tying care to more paperwork and bureaucracy.

Please let me know how I can stay informed.

Mary Zimmerman
(480) 664-6008



Rio Rico Medical & Fire District

822 Pendleton Drive • Rio Rico • Arizona • 85648

(520) 281-8421 • Fax (520) 281-7670 • www.rioricofire.org

August 17, 2015

Mr. Tom Betlach
Director, Arizona Health Care Cost Containment System
801 East Jefferson Street, MD 4100
Phoenix, Arizona 85034

Re: Comments on Medicaid 1115 Waiver Application

Dear Mr. Betlach,

We are pleased the Arizona Medicaid 1115 waiver and State Healthcare Innovation Plan conversations have included a great deal of emphasis on Mobile Integrated Healthcare Community Paramedicine (MIHCP). As a promising practice model, CIP is well poised to reinforce rapid Medicaid transition to a value-based care model.

MIHCP is a method to employ existing fire-based Emergency Medical Services (EMS) infrastructure and workforce to strengthen the continuum of patient care; to support identifying the root causes of potential injury and exacerbation of chronic disease conditions that often lead to exorbitant costs, both physical and economic.

As a prime gatekeeper to the hospital system, Fire-Based EMS agencies are critically assessing how to decrease non-emergent call volume while also linking high utilizers of the 911-system to a level of care that best meets ongoing needs. Partnering in new ways with community hospitals, health care providers, and a variety of medical and non-medical resources reflects the need for greater collaboration between the healthcare delivery system and public health organizations. Only with this level of collaboration may community risk factors that drive up system costs be appropriately contained.

Rio Rico Medical & Fire District's MIHCP efforts are aimed at improving overall community health status while strategically linking customers to the most appropriate medical and support services in the local community. Among the growing number of success cases, the MedStar EMS Loyalty Program in Texas, which operates under the Texas Medicaid 1115 waiver, has observed dramatic reduction in 911 use and expenditures related to enrollees who are offered health system navigation and support services. Comparing 12 months prior to and post program enrollment MedStar observed a 52% (82% for 911-system abusers) reduction in ambulance transports to an Emergency Department, representing \$8.2 million in health care cost savings among 142 Loyalty Program enrollees.

We recommend Arizona include Mobile Integrated Healthcare Community Paramedicine demonstration as part of the Medicaid waiver renewal request. The ability to exhibit the efficacy of MIHCP holds a great deal of potential for improving population health while containing costs and supporting the evolution of value and quality-based health care delivery throughout Arizona. Please feel free to reach out to me if you have any questions or would like clarification on any of the recommendations contained in this letter.

[Redacted Signature]
Fire Chief

Vinyard, Christopher

From: Carmen <[REDACTED]>
Sent: Tuesday, August 18, 2015 10:22 AM
To: Public Input
Subject: C.Pacheco on Health Care changes

Follow Up Flag: Follow up
Flag Status: Completed

Hello, my name is Carmen and my husband Frank and I have an adult daughter who suffers with an auto-immune illness called Sjogrens Syndrome . I am retired and my husband plans to retire in January from his job of 51 years. He will turn 72 in Oct. and he continues to work to provide good healthcare for our daughter. She will have to apply for The state healthcare program because she is not able to work. Along with the many children and adults who need this healthcare assistance, our daughter will not afford the doctors and treatment she needs if the proposed cuts are made by this administration. We, along with the thousands of Arizona citizens who need this coverage, urge you reconsider such changes. Respectfully. Mr. & Mrs. Frank Pacheco

Sent from my iPhone



2345 W. Glendale Avenue
Phoenix, Arizona 85021
602.279.0008

August 18, 2015

Re: Arizona 115 Waiver Impact on HIV+ Arizonans

Director Tom Betlach
AHCCCS Administration
801 E. Jefferson Street, MD 4100
Phoenix, AZ 85034

Dear Director Betlach:

I fear that some of the proposed AHCCCS changes will negatively affect the health of hundreds of the HIV+ Arizonans enrolled in AHCCCS, most of them Childless Adults. HIV/AIDS remains an incurable but now chronic disease if medical care and antiviral medications are continuously available. With such care, thousands of HIV+ Arizonans live productive lives and avoid disability, though drug side effects such as fatigue and depression make continuous employment difficult for some to sustain.

The two provisions of 1) required work participation for adults who are childless and 2) the five-year lifetime limit on those able-bodied adults will impede the medical care for many living with the life-long chronic disease of HIV. With medications, Positive folks can stay off permanent Disability, though perhaps not work permanently.

Nor is the medical care solely of importance to these individuals. Healthy Positive people cannot transmit the virus to others. The AIDS Epidemic is at a turning point. With accessible and consistent medical and behavioral health care and HIV meds for all Positive persons, we can end AIDS. As you deliberate the future of AHCCCS, consider what a medical conquering of AIDS would mean for Arizona.

Yours most truly,



Keith A. Thomrson
CEO

Digitally signed by Keith A. Thompson
DN: cn=Keith A. Thompson,
o=Phoenix Shanti Group,
ou=Admin,
email=keitht@shantiaz.org,

Aug 18 15:08:23
-07'00'

Vinyard, Christopher

From: [REDACTED]
Sent: Tuesday, August 18, 2015 5:00 PM
To: Public Input
Subject: Changes to AHCCCS

Follow Up Flag: Follow up
Flag Status: Completed

As a social worker in the behavioral health field, I am in support of the major overhaul proposed by Governor Ducey to the AHCCCS system.

I have dedicated my career to assisting clients to become empowered when so many factors can be out of one's control. These changes support personal responsibility and discourage learned helplessness than can lead to dependency on others and greater systems at large. Having individuals learn how to manage their health and insurance can lead to empowerment and taking control of one's circumstances. Assisting people in job skills and training may also result in people shaping their own destiny. Self-determination is a key social work value.

One concern of mine is the harshness of suspending an individual's coverage for delinquent payment. This potentially hurts the tax payer, as the patient will just seek emergency treatment as an uninsured individual. Hospitals cannot turn patients away for treatment and care. I wonder if outstanding bills/payment can be obtained through the patient's AZ state income tax similar to the "penalty" imposed on Obama Care recipients through the IRS. I would hate for the Federal Government and the current administration to demonize this plan and bar changes to the AHCCCS system proposed in Ducey's plan. I'm even wondering if there may be a tiered system of contribution similar to Obama Care to avoid the argument that the proposed changes are too harsh for those with absolutely no income until they can obtain work through the work assistance programs. I guess I'm also wondering how these changes will affect children in poverty as well...

Anyway, I am encouraged to see advocacy away from the status quo that hopefully leads to positive changes to the lives of impoverished AZ residents.

Karissa Kater, LCSW candidate
Sent from my iPhone

Vinyard, Christopher

From: Kavita Bernstein [REDACTED]
Sent: Tuesday, August 18, 2015 9:00 PM
To: Public Input
Subject: Modernizing AZ Medicaid - Comment

Follow Up Flag: Follow up
Flag Status: Completed

Dear Governor Ducey,

I am writing to you as a resident of the City of Tempe. After reading the details found on the AHCCCS website regarding proposed changes, I must email you to express by complete dismay. These changes will have a drastic impact on families that depend on the health insurance coverage to ensure preventive and restorative care to their children and themselves. How do I know? I have work in the public healthcare field for over 15 years and I know our AHCCCS families. I know how they struggle to make ends meet. To make an assumption that they can afford copays, a premium and even contributions to a health savings account (even if they are over 100%FPL) displays your office's complete lack of understanding of who our Arizonans are. These are not families that can afford what you are proposing. This will have a DRASTIC impact on the public health of our residents and simply cannot move forward. Please listen to what the people are telling you and stop these measures moving forward. Your office has completely misheard the people of Arizona.

Sincerely,
Kavita Bernstein

Vinyard, Christopher

From: Hoa M [REDACTED]
Sent: Wednesday, August 19, 2015 4:13 AM
To: Public Input
Subject: I oppose the 1115 waiver proposal

Follow Up Flag: Follow up
Flag Status: Completed

I believe it's bad for arizona that AHCCCS and Governor Ducey to request changes in AHCCCS. If It is a huge mistake to take away non-emergency transportation for vulnerable people on AHCCCS. Transportation is essential for people to receive necessary services to stay healthy. Without transportation, people have no other ways to go to the doctors, pharmacies, and other services that they need to stay healthy.

They don't have the money to use other modes of transportation. They will be forced to stay at home and will get very sick, then will have to call 911 and be transported by ambulance to the hospital ER. Ambulance usage will increase by 10 folds and ER usage will triple. Therefore healthcare cost will sky rocket if you take eliminate non-emergency transportation.

I am a taxpayer and am willing to pay more taxes so that people on AHCCCS can have the essential services they need. They are in a tough spot already so we don't need to make it harder for them. Thank you for the chance to give my input.

Vinyard, Christopher

From: Eddie Sissons [REDACTED]
Sent: Wednesday, August 19, 2015 6:52 AM
To: Public Input
Cc: purplepagan1@cox.net
Subject: FW: RE: health coverage loss

From: Phoenix Lipshutz Benson (Pam Lipshutz) [<mailto:purplepagan1@cox.net>]
Sent: Tuesday, August 18, 2015 10:24 PM
To: Eddie Sissons
Subject: Fwd: RE: health coverage loss

Address w/below comment did not deliver. I tried, very frustrating.

----- Forwarded Message -----

Subject: RE: health coverage loss
Date: Tue, 18 Aug 2015 21:47:24 -0700
From: Phoenix Lipshutz Benson (Pam Lipshutz) <purplepagan1@cox.net>
Reply-To: purplepagan1@cox.net
To: publicinput@ahcccs.gov

To whom it may concern:

With out health coverage I would literally die as I have multiple and serious health issues that are being monitored & I would not be able to afford anything. Nothing like a person on SSDI having to declare bankruptcy! Please carefully consider the ramifications on poor peoples lives before making a bad decision.
Thank you, Pamela Jean Lipshutz aka Phoenix Lipshutz Benson

--
Phenix Lipshutz Benson

Vinyard, Christopher

From: MAURICIO OROZCO [REDACTED]
Sent: Wednesday, August 19, 2015 8:43 AM
To: Public Input
Subject: SB1475 Elimination of NEMT Benefits

Follow Up Flag: Follow up
Flag Status: Completed

Good Morning,

I was fortunate to attend the AHCCCS forum yesterday hosted by the Disability Empowerment Center. First, I would like to thank AHCCCS for providing Governor's Duce's vision for "Modernizing Arizona Medicaid"; we shared many concerns about this new plan, but a theme that seemed to touch a nerve was the elimination of Non-Emergency Medical Transportation benefits (**NEMT**) as stated in SB1475.

The transportation challenge is often cited as a barrier to obtaining healthcare access; but it's a basic and necessary step for ongoing health care and medication access, particularly for those with chronic diseases. Chronic disease care requires clinician visits, medication access, and changes to treatment plans in order to provide evidence-based care.

However, without transportation, delays in clinical interventions result in rescheduled or missed appointments, delayed care, and missed or delayed medication use. Such delays in care will lead to a lack of appropriate medical treatment, poorer management of chronic illness, chronic disease exacerbations or unmet health care needs, which can accumulate and worsen health outcomes and prove more costly in the long run.

SB1475 NEMT elimination totally contradicts Governor Ducey's new CARE plan which emphasizes "Promoting Healthy Behaviors"

Thank You,

Mauricio Orozco

Vinyard, Christopher

From: Brandi RC [REDACTED]
Sent: Wednesday, August 19, 2015 6:48 PM
To: Public Input
Subject: Please be careful of the risk of inhumane burdens and future lawsuits

Importance: High

Follow Up Flag: Follow up
Flag Status: Completed

Hello,

I've never been on AHCCCS though I have applied during a time of fear. Luckily, I became employed and didn't need to move forward with enrollment. I had all the tools I needed to become employed; manageable illness, car, home, husband, computer with internet access and retirement savings that I could deplete. I am a lucky Arizonan. PLEASE keep in mind that people on AHCCCS already have significant burdens without the tools I listed. I heard a friend say that poverty and disease exist much longer than five years in some cases and this is SO VERY TRUE. To impose one circumstance when too many people have unique challenges and hardships is petty and counter-productive to health and employment goals. Please do not move forward with HSA requirements or deadlines or premiums and co-pays based on dollar amounts already too low to live on.

Thank You,

Brandi Ryan-Cabot
602-292-1142



This email has been checked for viruses by Avast antivirus software.
www.avast.com

Vinyard, Christopher

From: Andrew Cabot [REDACTED]
Sent: Wednesday, August 19, 2015 8:38 PM
To: Public Input
Cc: Brandi Ryan-Cabot
Subject: Another Irresponsible Idea

Follow Up Flag: Follow up
Flag Status: Completed

The newest proposed changes to "modernize" the Arizona Health Care Cost Containment System seem like something out of a particularly bad let's-see-how-vindictively-mean-we-can-be-to-those-crappy-poor-people party. Especially distressing is the emphasis on "personal responsibility". Mostly this is making people pay money that they don't have for services they might not even use. And so far as I can tell, with the merger of AHCCCS and the Division of Behavioral Health Services, this is also forcing the burdens of "personal responsibility" on those in our population least prepared to assume it: the Seriously Mentally Ill. Creating penalties for missed appointments in this population will only drive them away in droves as the burdens of their care overcome their ability to seek it. That's only if they're not dropped for 6 months at a time for not managing to keep up on monthly payments. I mean, COME ON! They're SERIOUSLY MENTALLY ILL. That we would contemplate doing that to ANYONE in need of ANY kind of healthcare is monstrous.

I understand that the people in charge get to make the rules. But forcing right-wing ideology on our poorest and most vulnerable is a despicable tactic completely devoid of Christian morality. It also makes no fiscal sense as any savings will immediately be eaten up in court costs just like every other attempt at implementing state-wide ultra-right-wing policy has done in the past thirty years. I, for one, am heartily sick of seeing my tax dollars go to lawyers defending the indefensible when the money could be MUCH better spent helping those who need it.

My counter-proposal: Let those in the health and mental health care fields be involved in finding solutions to the fiscal crises that seem to appear so regularly under Republican leadership. Make the initiative broad-based so that we don't have ideological shift determining how to approach one of humanities most basic needs. Use successful health organizations like the VA as a model for cost containment. Regardless of their access-to-care issues, the VA reliably receives top marks in care outcomes at roughly half the cost, WHILE providing transportation for appointments, no penalties for missed appointments and just about everything else this plan proposes to cut.

Get your act together, AHCCCS. You, too, Doug Ducey.

Andrew Ryan-Cabot
Taxpayer
(602) 358-9230

Vinyard, Christopher

From: Austen [REDACTED]
Sent: Thursday, August 20, 2015 1:01 AM
To: Public Input
Subject: Gov. Ducey's plan to "modernize" Medicaid

Follow Up Flag: Follow up
Flag Status: Completed

August 20, 2015

To whom it may concern:

I am writing to express my opposition in the strongest possible terms to Governor Ducey's plan to "modernize" Medicaid. What he is proposing is not only unnecessary but also burdensome, harmful and needlessly punitive to those that would be affected by his proposed changes. It is, in essence, an attack on the poor who are already struggling and don't need to have their lives made even more difficult by changes that are completely unwarranted.

Thank you,
Austen Baier

Vinyard, Christopher

From: Denise Crawford [REDACTED] >
Sent: Thursday, August 20, 2015 1:20 AM
To: Public Input
Subject: health care plan

Follow Up Flag: Follow up
Flag Status: Completed

medical care is in great danger ,, and the danger comes from the high office of the state of Az ... and the one who fills the seat of destruction and disruption .

the guys plan to more harm to the people must be stopped ,, and not ever brought to the table again ,, !!!

his plan will kill many ,many , many ,, who do not deserve such , all so he can toss more money of the people's to private industry .. OUTRAGEOUS !!

no more hurting people, time to help people

Vinyard, Christopher

From: Linda Victoria [REDACTED]
Sent: Thursday, August 20, 2015 6:27 AM
To: Public Input
Subject: AHCCCS for senior single adult

Follow Up Flag: Follow up
Flag Status: Completed

Dear AHCCCS coordinators,

I will be 64 years old next November. I live alone. I have severe arthritis which makes me unable to work in the conventional workplace. Therefore, I am self-employed with two part-time jobs out of my home and am receiving Social Security. What will happen to me under the new ACHCCCS plan?

*Linda Victoria
PO Box 40741
Tucson, AZ 85717*

Vinyard, Christopher

From: Dorothy Wellington [REDACTED]
Sent: Thursday, August 20, 2015 9:39 AM
To: Public Input; AZGOV; Kyrstensinema Info; opinions@arizonarepublic.com; AZBP Editor; Jim; ed.montini@arizonarepublic.com; ainewspaper@qwestoffice.net; Elvia; council.district.8@phoenix.gov; Mr. Nowakowski; council.district.8@phoenix.gov; coolidgeexaminer@yahoo.com; newstips@arizonarepublic.com; news1@westvalleyview.com; newstips@aztrib.com
Subject: Modernizing Arizona Medicaid

Follow Up Flag: Follow up
Flag Status: Completed

Governor Ducey, you are in a desperate need to talk with sociologists, psychologists and economists in Arizona on the impact your proposed budget will have on the poor, sick and handicap and the entire State of Arizona. You are also in desperate need to talk with the people who provide direct services to the AHCCCS population, to include the medical field and mental illness, non-profit community organizations and agencies, faith-based organizations, and businesses.

Your proposed drastic changes to AHCCCS are inhumane to the poor, sick and handicap with detrimental effects on both the young and old. Your proposal, Modernizing Arizona Medicaid, is a written demonstration that you and your staff know little about the poor who AHCCCS was set up to help for medical care and treatment. The contents of your overhaul proposed plan illustrates that you only looked on paper and your budget numbers, but never seen the statistics as people, only manipulated numbers in a document on how you and your partners could win. By doing so, you have set up to crush all the poor, sick and handicap citizens in Arizona. You are bringing upon them an increase of hardships and suffering; you are adding burdens upon their sickness and diseases and will lead some to premature deaths.

This proposal, Modernizing Arizona Medicaid, is a disgrace of care to the "least of these" in our State. People in poverty, on disability, and the working poor are in a fight everyday to supply the basic survival needs for themselves and their families. Having the present AHCCCS, at least, provides the needed medical care in their lives. I strongly advise you not to put 1.6 million men, women and children in a black pit for your proposal, Modernizing Arizona Medicaid.

God has attention on this and His consequences will come upon those who scared the people Jesus loved. May His Mercy be upon all the poor, sick and handicap and that those who care for them continue to speak up in boldness, unity and power against the currently proposed Modernizing Arizona Medicaid so all the people in Arizona may live in health and wellness (the rich and the poor).

Rev. Dorothy Wellington
P. O. Box 87413, Phoenix, AZ, 85080
602-593-5903

Vinyard, Christopher

From: MAURICIO OROZCO [REDACTED]
Sent: Thursday, August 20, 2015 9:59 PM
To: Public Input
Subject: SB1092 Work Requirement

In spite of public perception (stereotypes), people living in poverty have to make tough choices with their money all day, every day, with no room for error but plenty of judgment from others. Many people who do not live in poverty have a tendency to criticize the poor and blame them for their supposed laziness, lack of intelligence, or willingness to make bad decisions. Many people assume the poor must have done something to deserve their fate.

Having said that, directives like SB1092 that require all able-bodied individuals be employed, actively seek employment or attend school or a job training program, do not seem unreasonable as long as the appropriate supports are put in place to make it a successful program. Besides transportation, one of the biggest barriers is affordable quality childcare.

This challenge is not unique to families living in poverty; many educated middle to upper middle class families often have to struggle with the decision of who is going to give up their job to stay at home with the kids since childcare costs today exceed every other household expense. A family of three receiving AHCCCS benefits has to survive on an income of \$19,790 per year.

Increased access to childcare for low-income working parents is a means to reduce poverty and increase family economic security. The impact is intergenerational; it gives parents the time to work, and kids the educational opportunities they need to succeed in an environment that supports their growth and learning.

Poverty is an exhausting, time-consuming struggle of trying to make ends meet. It is the daily stress of having to choose between whether to pay the rent, pay the electric bill, or pay for food. It is the daily worry about whether the car will break down, someone getting ill, or a child needing a new pair of shoes, and then deciding which necessity will have to be sacrificed to pay for the added expense of the unexpected bill. Poverty robs you of a sense of security, it destroys your self-esteem, and it undermines your plans and your hopes for the future.

Thank You,

Mauricio Orozco

Vinyard, Christopher

From: Carusetta, Jennifer
Sent: Friday, August 21, 2015 9:19 AM
To: Gonzales, Theresa; Vinyard, Christopher
Subject: FW: Input from someone I know on Gov. Ducey's AHCCCS reform program

Please include this in the public comment.

From: Debbie Lesko [mailto:████████████████████]
Sent: Thursday, August 20, 2015 4:59 PM
To: Carusetta, Jennifer
Subject: Input from someone I know on Gov. Ducey's AHCCCS reform program

Hi Jennifer,
Please see below for input.

Sincerely,

Debbie Lesko
Arizona State Senator, District 21
Chairman, Senate Finance Committee
Arizona Senate
1700 W. Washington St. S-302
Phoenix, AZ 85007
Office (602)926-5413
DLesko@azleg.gov

From: Chuck Roberts [mailto:████████████████████]
Sent: Thursday, August 20, 2015 9:04 AM
To: Debbie Lesko
Subject: Gpv. Ducey's AHCCCS reform program

Thanks for posting this, lots of good ideas, but I do have a couple questions/comments:

1. My son (mentally disabled) is on AHCCCS and he gets lots of notices promoting checkups and wellness information, so maybe that's not necessary as part of the plan. My kids are also on AHCCCS because we adopted them through the state, and I also get lots of notices---reminders for their checkups, information on flu shots and newsletters on wellness information.
2. Being disabled and unable to work, my son can't afford a Smartphone or any phone at all (He has in the past had the free Obamaphone which has no app capacity).
So, is the govt. going to provide Smartphones for everyone on AHCCCS, and if not, why do people that can't afford to pay some portion of their health insurance afford Smartphones. I have one and it was not cheap, and the monthly cost isn't cheap either.

3. On the personal health savings account - it's really hard for people with low income to put aside any money into savings, let alone for something they probably can't imagine anyway--future health issues. Would this money be taken directly from paychecks. (I recall being young and poor and there's no way we could have set aside money for health care and make copayments).

4. On AHCCCS for the unemployed, it seems that would be difficult, because if you become unemployed and you apply for AHCCCS, it takes months to get approved for it (I know from experience with my son), so by the time you get it, you could already have found a job, and then you wouldn't qualify anyway.

Thanks for hearing me out. I just read this article and these are random thoughts that came to mind.

Keep up the good work you are doing!

Margie Roberts

To: AHCCCS
C/O Office of Intergovernmental Relations
801 E. Jefferson Street, Mail Drop 42000
Phoenix, AZ. 85034

From

Date: August 20th, 2015
Re: Governor Ducey's Proposal

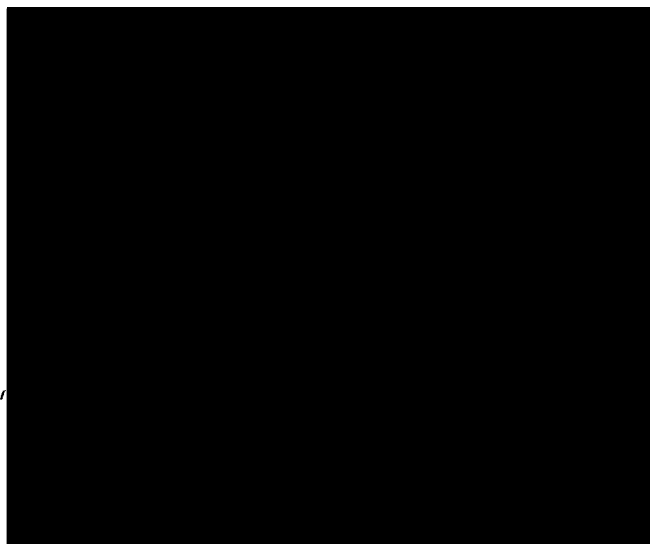
To whom it may concern,

I am writing this in hopes of the Governor having a change of heart. I am also writing this with the clients I work with, so that they may have a voice. If this proposal "Modernizing Arizona Medicaid" goes through I shudder to think of the repercussions. Many of our clients have to go to the food bank to get food as they just barely get enough to scrape by, and those are the ones that are on disability. The population I work with will depend on AHCCCS. There are three major points that affect some of the clients we serve here in Wickenburg. The biggest point is: Eliminating non-emergency transportation, this is a

1. Eliminate non-emergency transportation, this is a big one because of being out in Wickenburg and surrounding areas. We have no public transportation, our recipients depend on us to pay, set up and/or provide them transportation.

I work with the mentally ill, and some of them would be highly affected if the Governor Ducey's proposal goes through, some of our people would not be able to comprehend what is happening.

Sincerely yours,





Arizona Association of Health Plans

c/o Gallagher & Kennedy, P.A.
2575 E. Camelback Rd.
Phoenix, AZ 85016
602-530-8160

August 21, 2015

VIA ELECTRONIC MAIL – PublicInput@azahcccs.gov

AHCCCS
Office of Intergovernmental Relations
801 E. Jefferson St., Mail Drop 4200
Phoenix, AZ 85034

Re: *Proposed Changes to 1115 Medicaid Waiver*

Dear Director Betlach:

I write on behalf of the member companies who make up the Arizona Association of Health Plans (AZAHP) to comment on the proposed changes to our state's 1115 Medicaid Waiver.

As the contractors who provide health care to Arizona's most vulnerable citizens, we are deeply grateful for this opportunity to weigh in on the changes proposed by Governor Ducey, AHCCCS, and the Legislature. Representing the private half of the public-private partnership that makes the AHCCCS model one of the most successful managed care programs in the Nation, we are hopeful that our views, noted below, will inform and advance your final request of CMS, as well as their decision making.

Fundamentally, we are in total agreement with the Governor when he said we have the "opportunity and obligation to do more" to help our members take charge of their own health, all the while reducing costs and improving healthcare outcomes.

Part I: Modernizing Arizona Medicaid

The AZAHP supports the aims of the proposed "Modernizing Arizona Medicaid" in Part I of the draft waiver application and shares the Governor's goal of building a bridge to independence by helping able members transition from AHCCCS to the subsidized insurance market or to a commercial insurance health plan. Knowing what insurance looks like and how it works will aid their successful transition.

With a transition from government to commercial coverage in mind, we appreciate the rationale for strategic member co-pays and modest premiums for certain able-bodied adults, particularly if it comes with the opportunity to receive benefits not available today, such as dental and vision services. Good teeth and good vision are critical to becoming and remaining gainfully employed; these added incentive benefits are essential to making “AHCCCS Works” an important and meaningful program.

Along with adding a value to transformative life and jobs skills, we particularly appreciate the Governor’s decision allowing the health plans the flexibility to design individualized targets for our members’ healthy behaviors. We know our members better than anyone else and believe we are the people best equipped to help them get to a better and healthier place, individually and collectively.

Part II: The Legislative Partnership

As much as we support the Governor’s goals for advancing and modernizing the Arizona Medicaid program, there are certain items mandated by recently enacted legislation that raise concerns in Part II of the waiver proposal. We believe the legislative proposal for a five-year cut-off is draconian, the across-the-board proposal for co-pays and premiums goes too far, and the restriction on non-emergency transportation is misinformed. Non-emergency transportation in certain circumstances is the only way we can ensure our members keep critical medical appointments. In the long run, the cost of this, and the other legislative proposals, far outweighs any savings or benefits.

Part III: Delivery System Payment Reform Incentive Program (DSRIP)

Not all AHCCCS members are at the stage where a transition is possible, particularly the most vulnerable of our members. AHCCCS sets the national standard for home and community-based care (HCBS) in the long-term care program, and the cost savings associated with this delivery system are both staggering and well documented. Similarly, the member services available in the integrated RBHA program anticipate better health outcomes at reduced costs. We propose making the same services in the other existing AHCCCS programs – not new services – available to a very limited number of high cost, high need members in the acute care system. We believe that changing the delivery of their specific care will give us new tools to improve their health and allow us to find significant cost savings. This type of innovation is noted in Section III of the waiver draft under DSRIP, and we wholeheartedly support the inclusion of this initiative.

AHCCCS
Office of Intergovernmental Relations
August 21, 2015
Page 3

The convergence of the 1115 Waiver renewal and the transition to value-based purchasing provides an unparalleled opportunity to allow the health plans the flexibility to try new things – approved by AHCCCS and required to meet performance metrics and outcomes measures – not allowable today, but aimed at improving quality and reducing costs. We appreciate that this section of the Waiver reflects the value of innovation in the managed care marketplace and are hopeful it will allow plans the flexibility to respond quickly to emerging trends and needs.

We sincerely appreciate the opportunity to share with you our thoughts about the Governor's waiver proposal and look forward to working with you on its successful implementation.

Very truly yours,

ARIZONA ASSOCIATION OF HEALTH PLANS, INC.



By.

Deb Gullett
Executive Director

DAG/plp
23585-1/5008188

Vinyard, Christopher

From: debra martinez [REDACTED]
Sent: Saturday, August 22, 2015 11:23 AM
To: Public Input
Subject: Comments regarding AZ's Waiver and Other Initiatives

Follow Up Flag: Follow up
Flag Status: Completed

First, I wanted to thank AHCCCS (Monica and Staff) for the very informative and overwhelming meeting that was scheduled at the Disability Empowerment Center regarding the changes to AHCCCS that are being recommended for Arizona. Also, thank you for the opportunity to comment and have these as part of the record that goes to CMS.

1. Non-emergency transportation needs to be continued for the SMI population due to the fact that many clients of SMI services do not drive and do not live along any public transit system routes. There appeared to be some ambiguity on this topic, so I wanted to address it in my comments. Access to treatment for this population is **extremely** important, and putting a barrier up by excluding or charging for this benefit would be a real detriment to their overall continued care. Many are way under the poverty level and would not be able to afford transportation. I am concerned that this would effect people getting to their doctor appointments, therapy and counseling appointments. **Please do not removed the non-emergency transportation benefit for the SMI population.**

2. I am very concerned that adding co-pays and premiums for people on very limited incomes would be a huge barrier to healthcare. Access to healthcare should be a right that everyone has, and although the premise of this plan would be okay for those of us whose income levels far exceed the poverty level, it isn't humane for those that are just trying to eat and keep a roof over their heads. The choice of putting food on the table or seeing a doctor would be obvious. I believe this plan would be a major barrier for people obtaining the healthcare they need and deserve. Access to healthcare is the way that people are going to succeed to achieve upward mobility. Please, let's not block them from this basic need by placing barriers to their care.

3. Administrative oversight on these recommendations: I have worked for the State of Arizona for over 30 years and been through numerous programs that were **thought** to be "beneficial and cost-effective" which turned into administrative nightmares and a total waste of taxpayer dollars, often being scrapped or costing so much money no one wanted to admit it. It appears that no thought has been put into the "how" of these recommended changes, which is always an afterthought for many of these programs. We need to start considering the total effects of the programs (complete effects to those involved, costs, etc.) and have the data up front rather than trying to piece together a program after the fact. Too much is at stake especially when it effects some of the most vulnerable (the poor, the mentally ill and the disabled) of our populations of people.

Thank you again for the opportunity to comment.

Debbie Martinez

Vinyard, Christopher

From: duncan@azmcfarland.com
Sent: Monday, August 24, 2015 12:01 PM
To: Public Input
Subject: Concerns to Proposed AHCCCS changes

To whom it may concern,

We are parents to our son that has been declared SMI (seriously mentally ill). We would like to raise three concerns about the proposed changes to the AHCCCS benefits. Our son has a long term condition that requires continual treatment, most likely exceeding the five year limit being discussed.

- 1) Limit Lifetime enrollment to five years.
- 2) Eliminate non-emergency transportation.
- 3) Able bodies must work and participate in co-payment and premium obligation.

The five year limit will not work for people who are chronically ill, after the five year period they will simply move to the emergency room for treatment. This will actually result in higher costs.

In the case of non-emergency transportation, support is needed to help transition SMI patients from years of unemployment and isolation to a functioning and productive member of society. Presently our son is transported to a clinic where he receives injections once every two weeks. Prior to getting this medication he was hospitalized at least twice a year.

Our son is currently working 25 hours a week in a temporary work program that should make transition to a more permanent job possible. Transportation to the job site is critical for his present employment. We believe that co-payment and/or premium obligation is a responsible step to be taken as long as it does not become too much of a burden. Here again if the cost becomes too high the transition from SMI to functioning citizen is inhibited and the patients are left in an endless cycle of crisis, where the emergency room becomes method to deal with the crisis situation.

Duncan & Debbie McFarland

Vinyard, Christopher

From: John Newport [REDACTED]
Sent: Monday, August 24, 2015 5:09 PM
To: Public Input
Subject: Comments for Medicaid Waiver Application Public in Tucson on Wed, August 26
Attachments: Bio Health Services Consultant, 6.2015.doc

Importance: High

TO WHOM IT MAY CONCERN:

I am a former senior level health services policy analyst at UCLA and am currently a health services consultant, author and health care reform advocate based in Tucson.

I have very mixed feelings regarding our Governor's Federal Medicaid Waiver Application that will impact 350,000 recipients recently added to the program through legislation championed by former Gov Jan Brewer.

I applaud our Governor's inclusion of wellness incentives to motivate recipients to take charge of their health, and I also applaud the proposed requirement that recipients either be actively seeking work or enrolled in a job-training program.

I am EXTREMELY CONCERNED, however, that the proposed premium and co-payment requirements will block recipients from seeking treatment until they are very sick. This constitutes an INHUMANE APPROACH that will produce an enormous amount of needless suffering, accompanied by avoidable death and disability. It will also add substantially to our state's overall health care costs.

MY PROPOSAL: IF our Governor insists on retaining the premium, co-payment and health savings account aspects of his waiver proposal, I suggest that these provisions be modified as follows, to prevent the cost-sharing requirements from unduly blocking recipients' access to care.

(1) Cap total co-pays to the amount of the recipients' monthly premium, with co-pays to be charged to the health savings account, and

(2) Initially set up each recipient's health savings account with a one-time contribution by the state equivalent to the recipient's monthly premium.

I thank you for the opportunity to present my views and urge that your task force give serious consideration to my proposal.

Sincerely,

John Newport, PhD
Health Services Consultant, Author and Health Care Reform Advocate
Tucson
(520) 742-1880

PS: I have attached to this message a 1-page bio summarizing my qualifications as a health care reform advocate

John Newport, PhD, Author "The Wellness-Recovery Connection" and "The Tucson Tragedy"



Beatitudes
Campus

A Ministry of
Church of
the Beatitudes
United Church
of Christ

Affiliated with:

Duet:
Partners in Health
& Aging

Campus Services:

Independent Living

Assisted Living with Early
Memory Support

Beatitudes at Home
Companion Services

Comfort Matters
Dementia Care Education

August 24, 2015

Mr. Tom Betlach
Director
AHCCCS
801 E. Jefferson St. MD 4100
Phoenix, Arizona 85034

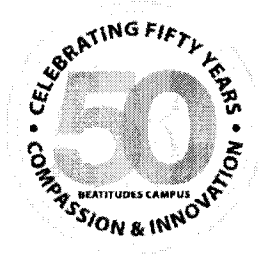
Dear Director Betlach,

Thank you for the opportunity to comment on the proposed Medicare Waiver. As a member of the health care community serving adults for over 50 years, Beatitudes Campus supports the efforts of AHCCCS to modernize Arizona's Medicaid program through choice, accountability, responsibility and engagement. The campus welcomes the opportunity to partner with AHCCCS to accomplish both the short- and long-term goals of this endeavor.

Founded in 1964, Beatitudes Campus is a faith-based not-for-profit continuing care retirement community offering a wide spectrum of services for older adults including independent living, assisted living, skilled nursing, memory support and home care services. Recognized nationally and internationally as a leader in the field of aging services, the campus supports the autonomy and intrinsic human value of all adults regardless of age, gender, race, ethnicity, national origin, disability, marital status or sexual orientation.

Like AHCCCS, Beatitudes Campus is dedicated to providing excellent healthcare to older adults using cost effective means. For the past several years the campus has identified an increase in the number of adults experiencing Alzheimer's disease and other dementias not only in our organization but in the broader community. ¹ The national Alzheimer's Association reports there are 120,000 people living with dementia in Arizona and that number is expected to nearly double in the next decade. It is not surprising that Alzheimer's disease and other dementias were identified as the fourth leading cause of death in Arizona, a trend that is sure to increase over the next several years. With no options for prevention, treatment or curative measures on the horizon for persons experiencing Alzheimer's disease or other dementias, there has never been a better time to embrace palliative care opportunities.

Using private sectors partnerships Beatitudes Campus has spent the past two decades developing an evidence-based palliative model of care designed to meet the needs of an ever increasing number of Arizonans with dementia. BHHS Legacy Foundation and Beatitudes Campus were compelled to address the needs of persons experiencing dementia which gave rise to the Comfort Matters program. Comfort Matters is dementia care practice and an evidence-based accredited education program that offers a holistic and integrated approach to improve quality of life and quality of care for persons living with dementia.



BHHS Legacy Foundation is a local public health charitable nonprofit Foundation based in Phoenix, Arizona with a mission to enhance the quality of life and health in the Foundation's service area of Maricopa County and the Tri-State Region of Bullhead City, AZ, Laughlin, NV, and Needles, CA. The Foundation has invested over \$600,000 with Beatitudes Campus over the last decade to expand the palliative care dementia model throughout Maricopa County. More recently we've worked with the campus to provide the Comfort Matters program in a digitally based format to make the education available worldwide. The staff and board of the BHHS Legacy Foundation are proud to have played a major role in the development of such an effective and innovative program that has made significant strides in the forefront for addressing the overwhelming impact of Alzheimer's disease and other dementias on patients and their families.

Beginning in 1998, the Comfort Matters program has been driven to improve quality of life and quality of care through educating long-term care staff about dementia-specific palliative care principles and integrating palliative operational adaptations in institutional settings serving persons with dementia. In partnership with BHHS Legacy Foundation, the Comfort Matters program has educated over 10,000 physicians, advance practice nurses, licensed nurses, social workers, administrators and other healthcare staff locally, nationally and internationally. To date, the Comfort Matters program has been replicated in eight states from Washington to New York. Working with the Centers for Medicare and Medicaid Services and the Institute of Medicine, Beatitudes Campus experts have been at the forefront of the national effort to make palliation available to persons with dementia. Comfort Matter has received the LeadingAge 2010 Excellence in Research and Education Award, the Mather's Lifeway Promising Practice Award in 2012 and the LeadingAge Public Trust Award in 2013. For more information about Comfort Matters please visit www.comfortmatters.org.

In addition to Comfort Matters education and practice, Beatitudes Campus has engaged in translational research aimed at developing evidence-based and cost-effective care strategies for persons with dementia. Our research is broad-based and conducted with people experiencing dementia, with their families and with the organizations where they live. Both AHCCCS and Beatitudes Campus have a strong stake in improved patient outcomes and reduced healthcare costs.

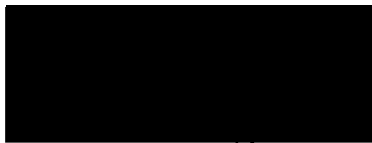
Research from the Comfort Matters program has revealed several positive outcomes including decreased reliance on ²antipsychotic and sedative medication and ³improved pain management. Outcomes indicate that when healthcare staff practice the tenets of the Comfort Matters program, challenging dementia-related behavior is minimized, pain management is improved and reliance on antipsychotic and sedative medications are vastly reduced.

A cost study conducted in 2008-2010 examined healthcare costs associated with the adoption of the Comfort Matters program. Results demonstrated a statically significant decrease in ⁴hospital and emergency department utilization and as well as a significant reduction in

²antipsychotic and sedative medication costs. This cost study was replicated in 2012-2014 with three nursing homes in New York City with similar cost savings.

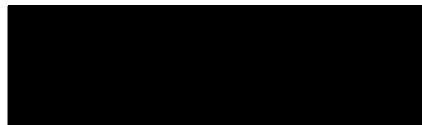
By reducing healthcare fragmentation and curbing waste, Beatitudes Campus identified ways to improve dementia care and service while decreasing costs associated with the needs of high utilizers of healthcare services (e.g., persons with Alzheimer's disease and other dementias). Now is the time to adopt palliative practice in nursing homes and assisted living organizations in Arizona. As a state, we have the unprecedented opportunity to lead the nation in offering healthcare that not only improves patient outcomes but does so in a manner that reduces financial burden on the community. In the spirit of partnership, representatives from Beatitudes Campus and BHHS Legacy Foundation request a meeting with the leaders of AHCCCS to discuss how palliation can benefit Arizonans with dementia.

Respectfully yours,



Michelle Just

President & CEO
Beatitudes Campus



Gerald Wissink, FACHE

Chief Executive Officer
BHHS Legacy Foundation

1. Alzheimer's Association Facts & Figures 2015; retrieved September 20, 2015:
http://www.alz.org/facts/own_new.asp
2. Long CO, & Alonzo TR, Palliative Care for Advanced Dementia: A Model Teaching Unit-Practical Approaches and Results. Arizona Geriatric Society, 2008; 13(2)14-17
3. Long CO, Morgan BM, Alonzo TR, Mitchell KM, Bonnell DK & Beardsley, ME, Improving Pain Management in Long-term Care: The Campaign against Pain. Journal of Hospice & Palliative Nursing 2010; 12 (3) 148-155
4. Bryant N, Alonzo T, & Long CO, Palliative Care for Advanced Dementia: Adopting the Practice of Comfort Future Age December 2010, 32-37

Vinyard, Christopher

From: Mary Ottman [REDACTED]
Sent: Tuesday, August 25, 2015 7:22 AM
To: Public Input
Subject: Medicaid Program Changes

I am writing on behalf of my college-educated daughters who are in there 20's but over 26 years of age. The health exchange directed both of them to AHCCCS for their health coverage. One is attending an intense RN program that did not allow her to work during the course of obtaining the degree (suggested by the program directors). The other suffers from a chronic abdominal pain that caused her to leave work as a successful stylist. Neither one of them intend to stay on this type of health coverage forever. This is just a tool for them to use while their circumstances do not allow them to hold a job.

If the governor gets his way, my daughters would not be able to afford the "free" health coverage and would avoid seeking medical attention until an emergency warrants such action. If they were able to work, both of my daughters would be. They were both employed prior to a change in their circumstances. They both intend to work again once their current situation can be solved.

To require an investment of money in a health savings plan and go to job interviews is unrealistic. If they had money and time they would both be doing that on their own.

For the daughter that is ill, she has submitted paperwork to be considered disabled. She was denied because physicians have not been able to determine what the cause of her illness is. She wants to work, her illness is preventing this, but she is not deemed disabled enough to be granted that distinction. Without a formal diagnosis, someone cannot be deemed disabled. Therefore, she would be considered an "able-bodied adult". To require her to go to job interviews would be detrimental to her recovery and she has no income to contribute to a savings plan or copays.

I believe Ducey needs one of his children in my children's circumstances to see the benefit of the program as stands. Do not ruin this working program based on the few individuals that abuse the program. Find a way to regulate the participants without compromising the individuals that truly need the program as is. Leave this alone and find money elsewhere.

Very concerned mom and registered voter,

Mary Ottman

Vinyard, Christopher

From: Darwin Cox <[REDACTED]>
Sent: Tuesday, August 25, 2015 10:02 AM
To: Public Input
Subject: Medicaid program changes

I am strongly opposed to the proposed changes in the states Medicaid program. Does this governor not understand that someone making less than \$15,500 per year is probably barely meeting basic needs of food and shelter. It appears an assumption is being made that people chose to be poor. The research has shown that this kind of approach will cause many to drop medicaid and in turn seek treatment in hospital emergency rooms. Hospitals will then add those costs to the bills of people like myself who have insurance. Then of course my insurance rates will go up.

Darwin Cox
djckcox@gmail.com

Vinyard, Christopher

From: Diane Wilson [REDACTED]
Sent: Tuesday, August 25, 2015 11:26 AM
To: Public Input
Subject: Proposed overhaul of Az Medicaid program

I am a voter in Pima County. I am registering my opposition to the proposed changes that Arizona is requesting from the federal government with regard to Medicaid. These changes will make it more difficult for low income people to get the health care they need and will result in more use of emergency care systems, thus costing more in the long run. Also the 5 year enrollment limit is a punitive one.

Diane Wilson
343 E. Florence Rd
Tucson, AZ. 85704

Vinyard, Christopher

From: Albert Dobson [REDACTED] >
Sent: Tuesday, August 25, 2015 2:48 PM
To: Public Input
Subject: Keep Health Care In AZ

Greetings,

I would like to see AZAHCCCS keep the coverage that is being provided by law for lower income older adults such as my self(working poor)and family.

I now can address the issues that I have, and not have to wait till a minor health issue becomes an emergency(life or death)out of control due to high blood pressure.

The cost now is lower and controllable, rather than my self going to the emergency room for treatment.

--

Albert Dobson
Parties Plus LLC
3510 S Campbell Ave
Tucson.AZ.85713
Ph.520.792.8368
Fx.520.322.0090
albert@parties-plus.com
www.parties-plus.com

August 26, 2015

Dear Governor Ducey,

Your proposed changes to the AHCCCS program create unnecessary economic obstacles for working and poor families and limit their access to healthcare services. These changes to AHCCCS will end up increasing costs for the program and cause unnecessary suffering for people.

By eliminating the non-emergency medical transportation, many people who lack transportation will not be able to see their providers for chronic medical conditions or preventive services.

Families who struggle to meet their financial obligations may find that a \$20 co-pay is too much to afford or may have to choose between lunch for a child or a clinic visit.

These are just two examples that demonstrate the likelihood that hundreds of people may not get the healthcare they need in a timely manner, causing illness and chronic disease to spiral out of control, ending up in costly care, like an ER visit or ICU admission.

I urge you, Governor Ducey, to preserve the AHCCCS non-emergency medical transportation benefit and avoid co-pays and premiums for AHCCCS beneficiaries.

Sincerely,

Hope Busto-Keyes, APRN
5040 N Camino de Oeste
Tucson, Az 85745
808-633-3196
culturaltones@cs.com

Vinyard, Christopher

From: james neuman <[REDACTED]>
Sent: Wednesday, August 26, 2015 4:09 PM
To: Public Input
Subject: Re: az medicaid program changes

On Wed, Aug 26, 2015 at 12:33 PM, james neuman <jmneuman911@gmail.com> wrote:
What is one term gov Ducey trying to do.He is trying to charge 2 percent of their total income and have a copayment on people who are on ahcccs.These people on ahcccs are poor people and trying to charge them a copayment and 2 percent of their income is ludicrous.We are the laughing stock of the nation concerning education,now we are going to be the laughing stock on medicaid.

Vinyard, Christopher

From: John Newport [REDACTED]
Sent: Thursday, August 27, 2015 1:18 PM
To: Public Input
Subject: Proposed Modifications to Health Savings Accounts Provision of 1115 Medicaid Waiver Application
Attachments: Bio Health Services Consultant, 6.2015.doc
Follow Up Flag: Follow up
Flag Status: Completed

TO WHOM IT MAY CONCERN:

First of all, I attended yesterday's Public Forum in Tucson and was impressed with the wealth of information presented and the public commentary, which I believe was conducted in a very professional manner. I wish to commend the moderator and other AHCCCS staff for putting this program together.

I have previously submitted my comments concerning the proposed premium and co-pay provisions of the waiver application. In this communication I will present my suggestions concerning the Health Savings Accounts (HSA) described in the draft document.

As previously stated, I applaud our Governor's inclusion of wellness incentives to motivate recipients to take charge of their health. I firmly believe that if every American practiced a wellness lifestyle, our nation's problem of wasteful health care spending and out-of-control HC cost inflation would rapidly disappear.

In this regard, I am pleased at the inclusion of wellness examinations, smoking cessation and fitness center dues as allowable spending items via the recipients' HSAs. Along these lines, I strongly urge inclusion of the following additional allowable items for HSA spending:

- Naturopathic Medicine, Acupuncture and Massage Therapy, provided by licensed practitioners.
- Vitamins, minerals and herbal, homeopathic and other nutritional remedies or supplements.

The above-listed practitioners are all licensed by the state of Arizona and should be accessible via the HSAs to beneficiaries who choose to utilize their services. Many Arizonans, myself included, believe that access to services via either insurance coverage or a related HSA should not be confined to conventional allopathic services. While I have not as yet used a naturopath, I have derived considerable benefit through both acupuncture therapeutic massage, as well as chiropractic.

Likewise, I believe that beneficiaries should also be able to access vitamins, minerals and herbal and homeopathic remedies via their HSAs. Through personal experience, I have found these remedies to often be less toxic than prescribed medication and more effective for certain conditions. As these supplements are not covered by my insurance (I am a Medicare patient), if I had a Health Savings Account I would certainly want to be able to access these products via the funds I have contributed to my account.

I should also point out that expanding the HSA provisions to allow access to these complementary/alternative services and remedies will not impose any additional costs to either the state or federal government, as under the waiver proposal these items will remain uncovered by Medicaid.

I thank you for the opportunity to present my views and urge that your task force give serious consideration to my proposal.

Sincerely,

John Newport, PhD
Health Services, Author and Health Care Reform Advocate
Tucson
[REDACTED]

PS: I have attached a 1-page bio summarizing my qualifications as a health care reform advocate.

Vinyard, Christopher

From: Michael Dean <[REDACTED]>
Sent: Thursday, August 27, 2015 6:48 PM
To: Public Input
Subject: Fwd: Medicaid solutions

Follow Up Flag: Follow up
Flag Status: Completed

I have been sending out the same email for years. So I shall try again. This is a response to your email that came in my inbox today so I shall try again. I have a further argument but need response to the general idea. Thank you

-----Original Message-----

From: DKL515 [REDACTED]
To: info [REDACTED]
Sent: Thu, Mar 21, 2013 7:12 pm
Subject: Fwd: Medicaid solutions

From: [REDACTED]
To: [REDACTED]
Sent: 3/12/2013 10:55:23 P.M. US Mountain Standard Time
Subj: Medicaid solutions

1. Retrofit the big box stores into mini-ERS for non life threatening circumstances complete with all diagnostic machines so that treatment can be done swiftly and humanely. These buildings are sitting in desirable areas complete with structurally sound buildings with adequate parking. Most are on bus lines and are able to open up in the many small stores that have been closed. Most have gone through bankruptcy so either they are sitting as toxic assets as so stated by the politicians that are trying to find occupancy.
2. Staff these mini-ERS with graduating medical students that has a student loan debt at a salary with contract of say 5 years and if the contract is fulfilled then reduce student loan by 1/3. Same with nurses. Arizona is losing MD's rapidly according to the Republic and we need to give med students a reason to stay here.....we need medical services in outlying areas and I'm sure it would be possible to find one of these big box stores in small towns also.
3. The best part would be the jobs created by electricians, plumbers, tillers, painters, sheet rockers, solar specialists to make the building as green as possible and of course the manufacturing of medical machines...JOBS
4. Eventually possibly nurses schools could be added so that students coming out of college won't have to wait 3 years to get into their chosen fields and maybe do their clinical's at the ER. I would imagine 200 medical professionals would be needed for each one for 24/7.....JOBS
5. To pay for this....main question....Betsy Bayless tried to get a 550.000.000 bond issue to upgrade the Maricopa Intergrated system on the 2012 ballot unsuccessfully so why not try to get a bond issue that all people could be treated.....accept all insurance, medicare, medicaid, VA and when the ER becomes successful with a net profit that profits would go directly back into medicaid so that within hopefully ten years tax dollars will not be funding but our own insurance dollars.
6. Needed professions needed: architectural engineers, solar specialists, construction estimators, survey for schools to see if enough students would grab at this chance, medical specialists that would set fees only to make

enough profit in order to sustain and make enough profit to make medicaid fungible. So these ER's would be run out of the State Medicaid system so that equates to more JOBS

Thank you
Linda Dean
Chandler, AZ

Vinyard, Christopher

From: Jackie Salamo [REDACTED]
Sent: Friday, August 28, 2015 10:03 AM
To: Public Input
Subject: Medicaid

The disabled should be exempt from the 5 year limit. Many of them will never be able to work.

Vinyard, Christopher

From: Joyce Millard Hoie [REDACTED]
Sent: Friday, August 28, 2015 12:02 PM
To: Public Input
Subject: AZ Waiver Application

Thank you for the opportunity to provide comment regarding the AHCCCS CARE Member Contributions, regarding co-payment and premiums as a percent of household income.

Nearly half of all Arizona families of CSHCN (Children with Special Health Care Needs) have incomes below 200% of FPL. (*Arizona Maternal Child Health Needs Assessment*)

Parents of CSHCN are nearly three times more likely to experience a loss of employment or a reduction in work hours to provide for the significant care needs of a child with a disability.

There is an exemption referenced in the section on SB 1092

A. 1. e. ii

Exempts a sole caregiver of a child who is under six years of age.

This exemption recognizes the special care needs of the young child.

AHCCCS is strongly encouraged to consider and include an exemption which recognizes the significant financial hardship and care-giving responsibility experienced by the parent of a child with a disability.

Joyce Millard Hoie, MPA
Executive Director, Raising Special Kids
5025 E. Washington St., Suite 204
Phoenix, AZ 85034
Phone: 602-242-4366 ext.211
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joycem@raisingspecialkids.org
www.raisingspecialkids.org



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Vinyard, Christopher

From: Smith, Wayne <[REDACTED]>
Sent: Friday, August 28, 2015 1:08 PM
To: Public Input
Cc: wayne152@cox.net; Smith, Wayne
Subject: AHCCCS Community Forums

Good morning,

I was unable to attend any of the meetings shown on your schedule, but have been working on the proposal shown below as a solution for reducing call volume and health care costs in the associated zip codes served by the Department of Economic Security. Below are the bullet points of the proposal I have made to DES and members of the State Legislature. I have significant data to support the reduction in cost by implementing this type of preventative and primary health care and would be anxious to discuss further.

Proposed changes to Department of Economic Security benefit application with contact to primary health care providers

- ❖ The 911 system is the primary care provider and transportation solution for most of the community within the zip codes serviced by the Glendale DES @ 6010 N.57dr..
- ❖ Most zip codes serviced by DES within the state follow this trend
- ❖ At the point of contact between DES and the community seeking food stamps, we have the best opportunity to educate and change behaviors related to accessing the health care system.
- ❖ The state controls how food stamps are processed and qualified for. Adding a primary care contact as part of the social benefit contact will not only provide for cheaper more efficient patient care. The level of care will increase by having all medical records available at the primary care provider.
- ❖ The primary care provider would then be able to formalize a follow up process including home visits through community paramedicine.
- ❖ AHCCCS has an existing voucher program for less expensive transport to non-emergent health care through Total Transit. Connecting transport and primary care through DES will change the behaviors of the community.
- ❖ The AHCCS 2011 Business performance improvement project (PIP) identifies these issues as well as the need for a formal follow up process that would prevent chronic illness from becoming critical illness.
- ❖ We have 2 universities that are anxious to be part of a public / private partnership proposed to operate a clinic within DES facilities.
- ❖ The City of Glendale, Az is looking for ways to reduce call volume of the 911 system while providing a higher level of care to the community.
- ❖ Cost saving to the State of Arizona and it AHCCS plan will be significant and will allow the community to have a primary care provider along with transport for healthcare and associated prescriptions

Wayne Smith

Deputy Chief, Resource Management

Glendale Fire Department
602-376-6885

Vinyard, Christopher

From: Carusetta, Jennifer
Sent: Friday, August 28, 2015 1:56 PM
To: Gonzales, Theresa; Vinyard, Christopher
Subject: FW: Public Forum

Can we include this in the public input? T- should I forward it to the public comment address? He asked that I withhold his name.

Thanks for inviting me to the Forum Jennifer. It was very informative. Consensus seemed to be lots of opposition to the whole thing in general. It appears that there will be significant increase in Administrative functions to control and regulate all these changes and not sure if the overall savings justify the increase in Administrative costs. It appears a cost/benefit analysis has not been done which can show that there could be a net increase in costs meanwhile several people will get less medical care at a higher cost. It does not appear there will be a Win/Win scenario. It appears our legislature did not really do the homework on this before passing these bills. That was what I took away from the session.

Thanks for inviting me and making me aware of what is to come. I am interested to know what defines the Work Requirement. Does this mean Full time(40 hours) Part Time (20 hours). It is not that easy in the current economic environment to get a Full time job 40 hour a week job. This requirement needs to be better thought out and defined because some people may only be able to get a few hours a week employment.

At what point will this get better defined?

AHCCCS
C/O Office Intergovernmental Relations
801 E. Jefferson Street, Mail Drop 4200
Phoenix, Arizona, 85034

Dear AHCCCS Representative,

The Partners In Recovery-West Valley Campus Advisory Council would like to thank you for allowing us to express our concerns regarding your proposal to Modernize Arizona Medicaid AHCCCS. The present structure provides our loved ones an economical access to treatment, medication, and support to help them overcome the crippling effects of mental illness and become productive Arizona citizens.

Your proposal to create AHCCCS CARE Accounts that would force monthly payments for members up to 3% of their income for medical co-pays is unreasonable. That charge places undue hardships on individuals that are least able to pay because they have low income from minimum wage jobs or they cannot find a job because of the seriousness of their mental condition which leaves them with no income at all. Your proposal states that if the member cannot pay, they will either be dropped from the program for six months or placed in debt to the State. For the mentally ill members, that is just wrong.

Dropping members who are not able to pay will leave no alternative for their treatment at all. No treatment or services, means those who are most in need will spiral further into the abysses of worsening mental health, homeless, and desperation. Many of the recipients of AHCCCS have no outside family system to back them up if their services were dropped. Additionally, eliminating non-emergency transportation for outlying areas such Sun City and Wickenburg would cut those members off from access to vital treatment, medicine and support which in turn would be contribute decline and relapse in their mental health conditions.

Furthermore, limiting lifetime enrollment in AHCCCS to five years makes the assumption that mental disabilities are cured or eliminated in a five year time frame. That is a most erroneous assumption. Mental illness is a lifetime of recovery and relapse. For those fortunate few that are leading productive lives, they will tell you that it took ten to twenty years of relapse, recovery, support and treatment to help them reach their most productive potential, and even now they must avail themselves to constant counseling and medication to continue their road to leading fulfilling lives. Limiting lifetime enrollment to AHCCCS members would be disastrous.

The elimination of program eligibility and/or removal of non-emergency transportation services may save Arizona some money in the short term, but in the long term these cuts would bring grief to the taxpayers in Arizona and remove access to preventative care for many of our state's most vulnerable.

In representation of the service recipients and family members of Partners In Recovery, the West Valley Advisory Council, for the reasons outlined above, ask that you please re-evaluate your proposal actions. Thank you for your time and consideration.

Partners In Recovery-West Valley
Campus Advisory Council Chair

[Redacted Signature]
Dyanne H. Johnson

Vinyard, Christopher

From: Joyce Millard Hoie [REDACTED]
Sent: Monday, August 31, 2015 12:36 PM
To: Public Input
Subject: AZ Strategic Assessment and Transition Plan - Comments

Follow Up Flag: Follow up
Flag Status: Completed

AHCCCS Systemic Assessment and Transition Plan

Thank you for the opportunity to comment on Arizona's Strategic Assessment and Transition Plan.

Collaboration with Stakeholders: We want to acknowledge the significant efforts being made by AHCCCS to provide numerous opportunities for stakeholder engagement on HCBS rules and requirements. While stakeholder engagement is important at the beginning of the process, we feel it would strengthen the plan to specify stakeholder engagement activities in each year and throughout the transition plan. Stakeholder engagement will be needed to re-assess and recalibrate transition activities as the plan moves toward implementation. The value of ongoing stakeholder engagement is that the tone and content may begin to shift from a recitation of weaknesses and problems toward systems improvement and quality outcomes. This type of dynamic stakeholder engagement moves systems beyond compliance toward results-driven accountability, transparency, and more appropriate services for its members.

Member-Directed Options and Person Centered Planning: The HCBS rules address the importance of individual needs, encouraging choice, and ensuring informed consent which is balanced with the PCP as the vehicle to limit access to those rights. While the plan encourages choice, one of the means to limit choice is the determination of a safety concern. The plan includes the use of positive interventions and support, but it also raises the question of *dignity of risk* – how will this be measured and what directions to providers will be provided as a best practice standard?

Member Experience: Case managers play a critical role in addressing barriers to access services and benefits in community settings. Case manager training will become a key factor in how skillfully and effectively individual members engage in meaningful choices, express their needs and preferences, and provide consent. Families frequently report concerns over the level of case manager training and experience, and currently play an important role in the education of professionals in health, education, and social services. Raising Special Kids would be pleased to offer its experience in this area by assisting in the development of training for case managers.

Families of members with guardianship have expressed the following concerns: If members living in a residential setting are under guardianship, will the guardian have the same rights of choice, visitation, providing food, assessment of risk, building and key access?

Families also acknowledge the significant shift in thinking that contractors, providers, guardians, and policy makers will need to make in order to realize true community integration and providing authentic opportunities for choice. Raising Special Kids is committed to encouraging, assisting, and advocating for this shared vision.

Monitoring of the Providers: We appreciate the considerable attention and effort focused on adequate assessment methods and appropriate tools to measure the quality of HCBS providers. We believe the transition plan would be strengthened by the addition of an external assessment process where stakeholders review data, and conduct and participate in additional assessments that provide AHCCCS with information about the family perspective and the member's experience. The value of external assessment would be to ensure a comprehensive quality assurance review that validates provider self-assessments.

Non-Residential Settings, DDD Day Treatment and Training: Is there a plan to ensure adequate HCBS provider availability to cover the full range of support needs? Families currently experience a lack of provider options for members with significant support needs. As provider capacity begins to expand for members with significant support needs, how will day treatment and training programs achieve compliance with the rules, while including opportunities for skill building in the community and inclusion? Have new models and approaches been developed and tested that Arizona providers could reference as promising practices?

DDD Center-Based Employment: Using the standard of what is culturally normative for individuals not receiving HCBS, the current center-based employment model appears to lack alignment on a number of points; individually-designed employment goals and options, to decline participation in group activities, to earn wages based on individual skills and experience, and more. We believe the proposed plan has set appropriate, time-limited steps for addressing the deficiencies of center-based employment. While strongly endorsing the development of integrated employment options as more appropriate and desirable, we recognize that center-based employment is a long-standing model of service chosen by some individuals and their families. We encourage AHCCCS to consider ways that a limited number of sites remain available to avoid a drastic disruption in the lives of members and families, while at the same time funding a significant expansion of integrated employment options that provide a continuum of support.

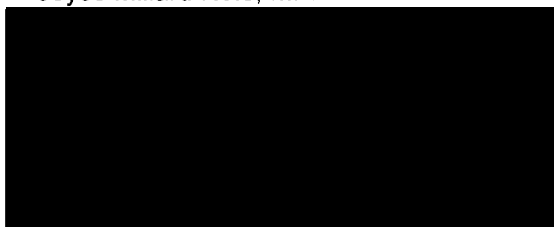
Residential Settings: Arizona takes justifiable pride in its very low rates of institutional placements for individuals with developmental disabilities. In recognizing the strengths of this system, we encourage AHCCCS to acknowledge the forecasts, data, and evidence that future demand for residential services will be considerable and costly. Arizona must also consider that families of its members will require increased support if they are to continue as the primary providers of residential services. The needs of aging caregivers have been well documented in research, with caregivers experiencing greater risk of depression, anxiety, declining health, and financial stress. Implementing a robust system of family supports will help to address the needs of families and members across the lifespan. The default position should not be the total burnout of care-givers who see no other option for their family members than out of home placements. Improving the system of residential settings will hinge on whether Arizona builds sufficient capacity to support aging and long-term family caregivers.

In considering residential options, it is not just the location where services are provided, but more importantly about the individual's experience and outcomes. *How will the quality of experiences be measured? What outcomes will show success? How is choice measured and substantiated?*

Residential services will benefit from considering new options, such as relationship-based living settings in which family members can stay involved, or housing models with privately-owned residences integrated within an "intentional community". Are there plans to review and address these newer possibilities? *The support and involvement of family members will be essential for monitoring and ensuring the quality of residential services, whether in-home or provided in other settings*

Raising Special Kids would be pleased to offer its assistance in developing policies to ensure adequate family and caregiver involvement and support in residential services.

Joyce Millard Hoie, MPA



Vinyard, Christopher

From: Dianne Post [REDACTED]
Sent: Tuesday, September 01, 2015 4:40 PM
To: Public Input
Subject: Waiver Plan

Follow Up Flag: Follow up
Flag Status: Completed

Dear Director,

I want to let you know how much I disagree with the plans for the waiver. People on AHCCCS cannot afford to do co-pays. They can't afford to pay a monthly premium when they are making as little as \$1,000 a month. Sometimes there is no other place to go than the ER and the ER should send them to urgent care, not treat them and then charge. Most of the fraud in medical care is from hospitals and doctors, not patients. They don't have the ability to figure out fraud, they are just trying to live.

People cannot be locked out of health care for 6 months - all we have is more sick people with worse problems. This program is so completely short sighted I can hardly believe it. It sounds like it was created in a room of sadists.

How can you ask people to work or be looking for work when there are no jobs. People want to work and would work if there were jobs. But the pay is so terrible in some that they work and are still on public benefits - that's nothing but a subsidy to the corporation. We should stop that and make them pay decent, livable wages. The CEO doesn't need to make \$4 million a year. No one does.

Able-bodied adults may not be mentally able to work. So you must take into consideration that issue. A 5 year limit is absolutely cruel. When someone is ill, it can take longer than that to recover. If they have babies or young children, it can take longer than that to get them into school. When someone is mentally ill, it can take longer than that to be stable. Again, some very cruel and mean and cold hearted people dreamed this up.

If you don't fund non ER transport, then you'll have more ER transport in an ambulance. How silly are these people?

Please do not adopt this idiotic plan. Be humane. Treat people like humans. Care a little.

Dianne Post
1826 E Willetta St
Phoenix, AZ 85006-3047



My name is Loyal Rabat and I am the Empowerment & Advocacy Manager at the Asian Pacific Community in Action. We primarily serve the Asian American, Native Hawaiian, and Pacific Islander community, targeting the linguistically isolated, low income members of the community because they face the largest obstacles in access to healthcare.

Community members already struggle with obtaining time off work, finding transportation to go to their appointments, and paying for medical costs such as dental & vision that are not covered under the current AHCCCS plans that are available. They will not be able to make their payments nor jump through additional administrative hoops.

5% of an \$1,100 average take home pay is \$55, and with rents averaging \$800, you can clearly see how this is an impossible requirement for most people to meet. The proposed personal responsibility incentives are actually huge obstacles and will create an immense burden not just on community members but will increase the number of non-paying visitors to emergency rooms, deny people access to preventative services, and undo the immense accomplishments community assistors and Arizona have made in greatly reducing the rates of uninsured and underinsured community members these past few years.

The compliance requirements are being called incentives, but for our community members, they are additional obstacles to access to care. The introduction of technology into the formula is an additional burden placed on people who need the care the most, assistors at my organization and many of our partner organizations are still struggling through HealthEArizonaPlus glitches, so I can't imagine introducing technology that community members would have to access on their own, if they can even afford Internet access.

The proposed waivers do not take into account households with children and single parent households. These proposed waivers also do not take into account the people who are either temporarily unable to work because of their health or are currently navigating the sometimes several years long labyrinth of applying for disability benefits.

We commend the state for looking to motivate people to be healthier and Healthy Arizona sounds like a fantastic campaign that our organization would love to support, but we cannot tie people's access to healthcare to its successes and failures.

Loyal Rabat, M.A.
Empowerment and Advocacy Manager
Asian Pacific Community in Action
loyal@apcaaz.org
O 602-265-4598 | C 602-492-2302
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Twitter/Instagram: @APCAAZ
FB: <https://www.facebook.com/AsianPacificCommunityInAction>

Vinyard, Christopher

From: Gloria Abril <msgloriaabril@gmail.com>
Sent: Monday, September 07, 2015 5:26 PM
To: Public Input
Cc: msgloriaabril@gmail.com
Subject: Comments and input about AHCCCS Waiver

I wanted to take the time to thank you for holding meetings that I was able to attend even if I arrived late in the afternoon.

One of my main complaints in how all of these public hearings work is that the people that work during the day (taxpayers) are not taken into consideration. The State of AZ, The Federal government, City Government all of you take it for granite that you all can get out of work and hold meetings during the day.

You all can attend meetings like the providers attend because it is your jobs. The providers send people to attend as part of their job. They are on working hours so to attend in the morning or afternoon is not big deal for any of you.

Did you stop to think about all of us that work Monday – Friday 8-5 p.m. are not able to attend these meetings because of that?

Did you stop and think that we have to make special arrangements with employers to either take time off without pay, or take vacation time.

I bring this up each time there is a public hearing meeting that we have to be taken into consideration. I was able to get my employer to allow me to take 2 hrs. of vacation time to attend, but leaving my job at 3:00 p.m. I still arrived late, so I missed the first portion of the meeting.

But I guess that is not important to anyone in the government. You guys work til 5:00 p.m. and I guess are not allowed to hold meetings when community members that work can attend.

The other draw back to this is – that so many community members did not know about these hearings because of the lack of notice.

How are they supposed to find out about the hearings if they are not on someone's email distribution list?

I found out because I am on so many distribution lists that I get most of the meetings, but none of my family members that are served by the public system and AHCCCS knew about the meeting or were able to attend because of lack of transportation. I was not able to pick them up and bring them to the meeting because I did not have the time needed to accomplish this.

Sad day I think.

I am very saddened by the State asking for a waiver on so many things that affect the community.

Discontinues non-emergency medical transportation services – whose bright idea was that?

How are people who need to get to the primary care for diabetic check up's, and other types of check-ups or follow ups to surgical procedures supposed to get to the doctor without the transport. To take 3-4 buses to the doctors for a follow up of a procedure or when you are not doing well with high blood sugar, it not possible.

This would mean that I will have to take time off from work once again to take my family member to the doctor. I stand a good chance of losing my job, and having to go on public system benefits after I lose my job because I have to take time off to take my family members to their appointments.

I make sure that my family members understand the importance of being ready for the transport and not abusing the system.

But if this is cut out – what will the choice be – don't go or me take the chance of asking for time off. I am afraid it might be don't go, until they are really bad off and end up in the hospital.

Cost sharing - this must be a joke – one of my family members gets \$734.00 a month by the time they pay their program fees, and other fees that are needed in order to live, and purchase their non-prescription medications, and food to maintain their diabetic health – there is no money left over. I have to help by making meals during the month to supplement that they eat in order for them to make it.

So put in cost sharing and you might as well kill my family members – the stress alone of trying to figure this out will kill them, and more than likely put them into a mental health crisis.

Restrict Benefits for able-bodied adults – who determines able-bodied – DES can't even determine what they are doing – how can they determine able-bodied. I would like to see the detailed explanation of how this will be determined and what will be taken into consideration.

Work requirements – I would like to see what these requirements are and who will evaluate them. If my family members could work they would be doing it – do you really think they like not working – but when it comes to others being in danger because they can't handle the stress of the working world, or can't hold a job because they can't get out of bed 2-3 days a week, then how is work requirements determined?

I think the Arizona Legislature – should have held public hearings on what they thought was going to be a good move. I think the Arizona Legislature – should have thought about what it is going to cost Arizona when people start getting really sick because they do not see their primary care when they are supposed too.

What it is going to cost Arizona when a diabetic cannot eat semi-correctly because they have cost sharing now – so less money will go to eating the right foods that cost more.

I think the Arizona Legislature should have though things out – maybe if they focused on bringing in money instead of how not to spend money they would not be asking for this waiver. The easy way out is not the solution, and maybe they should have given the people a chance to speak.

That is what I have to say at this time.

I am sorry I do not have time to go into more – but since this meeting was held that I attended on 8-18-2015 I have had three suicide attempts with my family members – attended 11 meetings with doctors, or residential staff, and had to go to the VA 4 times due to crisis with my veteran at my home.

So writing this up in a rush – is because my family comes first.

Thank you for reading all of this.

Gloria Abril

Taxpayer and family member of 5 people that live with mental illness



Douglas A. Ducey, Governor
Thomas J. Bellach, Director

June 23, 2015

Ms. Erin Long, Project Officer
Office of Supportive and Caregiver Services
Administration for Community Living
U.S. Department of Health and Human Services

**SUBJECT: Alzheimer's Disease Initiative – Specialized Supportive Services (ADI-SSS) Project,
HHS-2015-ACL-AOA-AL-0104**

Dear Ms. Long:

The Arizona Health Care Cost Containment System (AHCCCS) supports and is committed to participating in the proposed project, **“Dementia-Capable Palliative Care Services and Support System for Central Arizona.”**

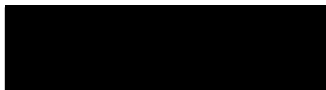
AHCCCS was created in 1982 as a unique partnership between State government and the private sector to provide quality health care in the most efficient manner possible. AHCCCS has a demonstrated record of success in providing cost-effective care to the State's most vulnerable populations.

Hospice of the Valley approached AHCCCS two years ago to ask if we would participate in the Palliative Care for Dementia (PCD) program for our ALTCS population. After hearing about the program and recognizing that opportunities exist to improve the program's dementia-capability, we agreed. Two of AHCCCS' three Long Term Care Contractors, Mercy Care and Bridgeway, are participating in the program. The results to date are very promising. This proposed project will serve two major goals: increasing the number of participants to improve the statistical significance of the quality measures; and providing appropriate care to AHCCCS members.

Dementia-capability is critical both to Arizona and to the AHCCCS program. We realize that there are opportunities to identify members with dementia, and to ensure the provision of appropriate services. We are collaborating with HOV's PCD program to work toward identifying those opportunities. AHCCCS' role in this project is to support our Contractors and providers, and to provide leadership in promoting the program's work toward improving dementia-capability.

Hospice of the Valley is a highly respected agency in central Arizona. It is a national leader not only in hospice and palliative care, but also in dementia care. Their dementia program is known in Arizona and nationally for providing a quality care for patients at all stages of dementia.

Sincerely,



Thomas J. Bellach
Director

Request for CMS 2016 Waiver to Include Palliative Care for Dementia Program for Arizona Medicaid (AHCCCS/ALTCS) Members

Palliative Care for Dementia is an innovative program for AHCCCS/ALTCS HCBS (Home and Community Based Services) members living in homes or group homes/assisted livings currently in Maricopa County (but can be scaled to Arizona state-wide) with any degree of Alzheimer's disease and related dementias. Goals of the program are to lower costs by avoiding nursing home placement, hospitalization, and pharmacy costs; and to improve quality of care. It is currently supported by Hospice of the Valley, with funding from the Virginia G. Piper Charitable Trust, BHHS Legacy Foundation, and St. Luke's Health Initiatives.

The program consists of Dementia Educators (social workers or comparable) visiting member and family twice a month the first month, then monthly; phone support from a physician geriatrician to review and simplify medications and to discuss advance directives; a 24 hour live nurse triage line for crises; and an optional 4 hours/week of volunteer respite care. The program cost is \$275/member/month for the first three months of care, then phone support if requested for \$50/member/month.

The Dementia Educators educate re the course of disease and behavioral management; educate about advance directives and the high risk of hospitalization for this population, asking "what would he/she want?"; educate to reduce expensive and harmful polypharmacy; and facilitate self-care for the caregiver to keep the member at home (where 68% of ALTCS members reside).

121 ALTCS members (Mercy Care and Bridgeway) have received the intervention for at least 3 months 2014-2015. Each intervention member has been paired with a control group member admitted at the same time.

Costs per month for ALTCS control group: \$1,862.

Costs per month for ALTCS Palliative Care for Dementia group: \$1,464

Savings per program participant: \$398/member/month.

Greatest savings by reduction in SNF placement (\$81,017 control group v. \$3,025 PCD group, over 70 months). Savings were also in reducing hospitalization, pharmacy costs, DME, chemotherapy, and transportation.

We request that payment for PCD be authorized by CMS as a pilot program beginning in 2016 for 300 ALTCS members in Maricopa County, with costs analyzed to determine whether continuing and expanding the program will be cost-effective and beneficial. This is an innovative and cost-saving program for persons with dementia and their caregivers, who are very much in need of support and education.

Contact: Gillian Hamilton, MD, Ph.D., Medical Director, Palliative Care for Dementia

[REDACTED]
602-748-3692

Hospice of the Valley, 1510 E. Flower, Phoenix, AZ 85014

William E. Morris Institute for Justice

3707 North Seventh Street, Suite 220, Phoenix, AZ 85014-5095

Phone 602-252-3432

Fax 602-257-8138

September 9, 2015

VIA EMAIL:

publicinput@azahcccs.gov

Arizona Health Care Cost
Containment System
801 East Jefferson Street
Mail Drop 4200
Phoenix, Arizona 85034

Attn: Office of Intergovernmental Relations

Re: Comments to AHCCCS Draft Section
1115 (1315) Demonstration Waiver
Request

Dear Office of Intergovernmental Relations:

The William E. Morris Institute for Justice (“Institute”), the Arizona Center for Law in the Public Interest (“Center”) and the Arizona Center for Disability Law (“ACDL”) submit these comments to Arizona’s draft demonstration waiver request for the 5 year period beginning on October 1, 2016.¹ The Institute is a non-profit program that advocates on behalf of low-income Arizonans. As part of our work, we focus on public benefit programs, such as Medicaid. The Center is a public interest law firm that has a major focus on access to health care issues. The ACDL is the protection and advocacy program in Arizona and works on issues concerning access to health care for persons with disabilities.

¹ Part IV of the demonstration waiver request concerns Home and Community Based Services and Arizona’s Assessment and Transition Plan. Comments to that part of the waiver request will be submitted separately.

On August 3, 2015, the Arizona Health Care Cost Containment System (“AHCCCS”) posted on its website a general outline of “Arizona’s Section 1115 Waiver Process” concerning “Governor Ducey’s Plan to Modernize Arizona’s Medicaid Program.” Initially, AHCCCS posted on its website a 2 page overview of the changes Arizona wants to make to its Medicaid Program. Also attached is a list of “public forums” AHCCCS has scheduled for August and a very short video by the Governor. On August 17, 2015, AHCCCS posted the Centers for Medicare and Medicaid Services (“CMS”) “Section 1115 Demonstration Program Template” on its website. On August 18, 2015, AHCCCS posted “Arizona’s Application for a New Section 1115 Demonstration.” AHCCCS also posted a PowerPoint presentation entitled “Modernizing Arizona Medicaid.” Although repackaged, the state’s waiver request continues to be hard to follow and understand. There is no self-contained document where the public can find out for each request: what is the current federal requirement; what does AHCCCS propose to change; who will be affected by the change; the reasons for the proposed change; what hypotheses will be tested by the change; the plan to test the hypotheses; how the proposed change furthers the objectives of the Medicaid Act, and other information required to be made public.

The Institute, Center and ACDL strongly support Arizona’s decision to restore Medicaid services to the Proposition 204 adults and to expand Medicaid to all persons with incomes up to 138% of the federal poverty level, with income disregard of 5%. Arizona’s restoration and expansion have been highly successful. Approximately 1.755 million persons are on AHCCCS as of August 2015. www.AHCCCS_Population_by_Category.pdf. Uncompensated care for hospitals has been substantially reduced.² In addition, thousands of health care jobs were created.

Unfortunately the demonstration waiver proposal contains requests that, if approved, will undo much of the health care gains of the last 2 years. The requests will

² A June 2014 survey of 75% of the state’s hospitals by the Arizona Hospital and Healthcare Association found that uncompensated care had dropped significantly as a result of the Medicaid expansion and restoration to \$170 million through the first four months of 2014. During the same period in 2013, uncompensated care was reported to be at \$246 million. See Arizona Hospitals and Healthcare Association, April 2014 Hospital Financial Results; see also Ken Alltucker, *Unpaid Hospital bills drop after Medicaid expansion*, THE ARIZONA REPUBLIC, July 13, 2014, <http://azcentral.com/story/money/business/2014/07/13/arizona-medicaid-reduce-unpaid-hospital-bills/12591331>.

depress participation, create financial instability, establish high barriers to care and fundamentally change the nature of the Medicaid program in Arizona.

For the reasons below, the Institute, Center and ACDL request that AHCCCS not proceed with the proposed waiver process because the process violates federal law. The template and application AHCCCS posted are inadequate for the public to understand fully what AHCCCS proposes. Rather, AHCCCS should publish a precise and comprehensive demonstration waiver request that complies with 42 U.S.C. § 1315 and provide for meaningful public input.

Also, as explained below, the undersigned object to the substance of the demonstration waiver proposal to the extent we can discern the particulars of the proposal. The proposal has no experimental value, will create barriers to health care and will impede, rather than promote, the objectives of the Medicaid Act.

I. Federal Requirements for a Demonstration Waiver Under 42 U.S.C. § 1315

A. Waivers Must Promote the Objectives of the Medicaid Act and Test Experimental Goals, Not Save Money

The Social Security Act grants the Secretary of the United States Department of Health and Human Services limited authority to waive the requirements of the Medicaid Act. The Social Security Act allows the Secretary grant a “[w]aiver of State plan requirements” in 42 U.S.C. § 1396a in the case of an “experimental, pilot, or demonstration project.” 42 U.S.C. § 1315(a) (“section 1315”).³ The Secretary may only approve a project which is “likely to assist in promoting the objectives” of the Title XIX and may only “waive compliance with any of the requirements [of the act] ... to the extent and for the period necessary” for the state to carry out the project. *Id.*⁴ This

³ Throughout this letter, the undersigned will refer to the demonstration waiver as “section 1315” not “section 1115” as § 1315 is the statutory cite. 42 U.S.C. § 1315.

⁴ Cost sharing waivers should not be permitted through section 1315 because they are not located in 42 U.S.C. § 1396a and section 1315 demonstrations can only waive provisions in § 1396a. Moreover, a waiver of cost sharing is not permissible under any authority unless it specifically complies with the requirements established in 42 U.S.C. § 1396o(f).

proposed waiver, even in its current skeletal form, clearly includes policies that would impede rather than promote the objectives of the Medicaid program by creating unnecessary barriers to enrollment and access to care.

Legislative history confirms that Congress meant for section 1315 projects to test experimental ideas. According to Congress, section 1315 was intended to allow only for “experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients” that are “to be selectively approved,” “designed to improve the techniques of administering assistance and related rehabilitative services,” and “usually cannot be statewide in operation.” S. Rep. No. 87-1589, at 19-20, *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961-62, 1962 WL 4692 (1962). *See also* H. R. Rep. No. 3982, pt. 2 at 307-08 (1981) (“States can apply to HHS for a waiver of existing law in order to test a unique approach to the delivery and financing of services to Medicaid beneficiaries.”).

No deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary, except as provided in subsections (a)(3) and (b)(3) of this section and section 1396o-1 of this title, unless such waiver is for a demonstration project which the Secretary finds after public notice and opportunity for comment—

- (1) will test a unique and previously untested use of copayments,
- (2) is limited to a period of not more than two years,
- (3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,
- (4) 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, and
- (5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

In addition, the Secretary is bound by the Ninth Circuit's precedent for any waiver requests under 42 U.S.C. § 1315. The Ninth Circuit described section 1315's application to "experimental, pilot or demonstration" projects as follows:

The statute was not enacted to enable states to save money or to evade federal requirements but to 'test out new ideas and ways of dealing with the problems of public welfare recipients'. [citation omitted] ... A simple benefits cut, which might save money, but has no research or experimental goal, would not satisfy this requirement.

Beno v. Shalala, 30 F.3d 1057, 1069 (9th Cir. 1994). Under *Beno* the record must show the Secretary considered the impact of the demonstration project on those the Medicaid Act was enacted to protect. *Newton-Nations v. Betlach*, 660 F.3d 370, 380 (9th Cir. 2011) (relying upon *Beno*).

Any waiver request by Arizona must meet these requirements. The State's proposal fails to establish any demonstration value and instead seems oriented around proposals that would ultimately limit enrollment through premiums and unprecedented cumulative time limits, while substantially raising beneficiary costs to access needed medical care. Premiums in Medicaid and the Children's Health Insurance Program have proven time and time again to be barriers to Medicaid enrollment. *See, e.g.*, Laura Snyder & Robin Rudowitz, Premiums and Cost-Sharing in Medicaid: A Review of Research Findings (Kaiser Family Foundation) (2013). <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417.pdf>; Jill Boylston Herndon et al., *The Effect of Premium Changes on SCHIP Enrollment Duration*, 43 Health Services Research 458-77 (2008). Research has shown that higher copayments lead low-income persons to cut back on essential health care due to the cost. Significantly, the proposal cites to no hypotheses to be tested. Finally, the proposal fails to even claim that any of the waiver requests would further the objectives of the Medicaid Act. Thus, as explained below, this proposal does not satisfy the § 1315 requirements.

B. The State is Required to Have a Robust Public Notice and Comment Process

In the Patient Protection and Affordable Care Act ("PPACA" or "Affordable Care Act"), Congress recognized the importance of meaningful public participation in the design of section 1315 demonstration waivers. 42 U.S.C. § 1315(d)(1). The PPACA

required the Secretary of the Department of Health and Human Services (“Secretary”) to promulgate regulations for transparency and public notice and comment procedures to ensure a meaningful level of public input for applications and renewals of demonstration projects that impact eligibility, enrollment, benefits, cost-sharing or financing. 42 U.S.C. § 1315(d)(1) and (2). The final regulations were effective April 27, 2012. 42 C.F.R. §§ 431.400-427.

Under the regulations, transparency and meaningful public input at the state level require three major components. First, there must be public notice including public hearings, 42 C.F.R. § 431.400(a)(8)(i). Public notice is defined as a notice that contains sufficient detail to notify the public of a proposed action and must be consistent with Section 408 of the regulation. 42 C.F.R. § 431.404. The state agency must provide sufficient detail to allow the public to understand the proposed demonstration changes and respond. 42 C.F.R. § 431.408(a)(1). Second, the state must allow a sufficient time and appropriate forum for the public to comment on the state's proposal with at least a 30-day comment period. *Id.* Third, the state must review and consider the public comments and include a summary of the response to the comments when it submits its proposal to CMS. 42 C.F.R. § 431.412(c)(2)(vii).

The federal regulations require that the public notice “shall include all of the following information.” 42 C.F.R. § 431.408(a)(1).

(i) A comprehensive description of the demonstration application or extension to be submitted to CMS that contains a sufficient level of detail to ensure meaningful input from the public, including:

(A) The program description, goals, and objectives to be implemented or extended under the demonstration project, including a description of the current or new beneficiaries who will be impacted by the demonstration.

(B) To the extent applicable, the proposed health care delivery system and the eligibility requirements, benefit coverage and cost sharing (premiums, co-payments, and deductibles) required of individuals that will be impacted by the demonstration, and how such

provisions vary from the State's current program features.

(C) An estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the demonstration requested by the State in its extension request.

(D) The hypothesis and evaluation parameters of the demonstration.

(E) The specific waiver and expenditure authorities that the State believes to be necessary to authorize the demonstration.

As explained below, AHCCCS has failed to comply with the regulations.

II. The AHCCCS Process Does Not Provide for the Meaningful Public Input Required by Federal Law

A. AHCCCS Has Failed to Provide the Public with a Precise and Comprehensive Waiver Proposal

AHCCCS has failed to show the public a precise and comprehensive draft waiver request that satisfies the requirements of § 1315 so the public can intelligently review the demonstration waiver being proposed. A precise and comprehensive proposal is required by 42 C.F.R. § 431.408. *See also* 42 C.F.R. § 431.412.

AHCCCS initially provided what can only be described as a cryptic overview of its proposal on the AHCCCS website. Subsequently, a PowerPoint presentation was posted on the AHCCCS website. On the same date as "public forums" were held in Phoenix, AHCCCS posted "Arizona's Application for a New Section 1115 Demonstration Section 1-Program Description." The prior day, AHCCCS had posted the "Section 1115 Demonstration Program Template."

The template is set up as an optional document to assist the state to provide the required elements for a demonstration project. The template has requests for specific information and the state is asked to respond. In many places on the template, AHCCCS' response is "See attachment entitled: 'Modernizing Arizona Medicaid.'" As an example, for what hypotheses will be tested by the demonstration and for the particulars of the plan to test, *see* page 2, AHCCCS' response is to refer to the Modernizing Arizona Medicaid attachment. A review of the Modernizing Arizona Medicaid attachment shows that there are no hypotheses listed and no plan of any testing.

The proposal is unclear and inconsistent about who will be subject to these new provisions. As an example, the template responses use terms such as "New Adult Group" and "AHCCCS Care Program." In some places "new adult group" is described as childless adults between "0-100% FPL," *see* page 8, or Expansion Adults between "100-133% FPL," *see* page 9. The template states "Newly Eligible Adults," "Prop 204 Expansion" and "TANF Adult Parents" are "eligible" for the AHCCCS Care Program. *See* page 3. This information is more confusing because AHCCCS has at times referred to childless adults with income under 100% of the federal poverty level as the AHCCCS "Care" group.

In the AHCCCS application, AHCCCS seeks permission to create the AHCCCS Care Program for persons in the "New Adult Group as well as TANF Parents." *See* page 2. It appears AHCCCS intends to seek fundamental changes to our Medicaid program, including creating the AHCCCS Care Program. Apparently, "CARE" stands for "Choice, Accountability, Responsibility, Engagement." The information provided is inadequate for the public to understand what AHCCCS proposes. Here are a few of the Institute's concerns.

On page 2 of the application, AHCCCS seeks a waiver for "strategic copays" of up to 3% and "premiums" of up to 2% of "annual" household income. It is unclear if AHCCCS wants to impose these requirements on every adult, no matter what the personal or family income. Certain services would not have a copay and there would be new copays for missed appointments as well as for the non-emergency use of emergency department. It is not clear who has to pay the copays. The Application recites verbatim the provisions of Senate Bills ("SB") 1092 and 1475, but to understand the requests, someone would need to know who is covered by the statutory provisions. Specifically, SB 1475 (Section 19(B)) covers copayments for persons eligible under A.R.S. § 36.2901.01. These are adults with income up to 100% of the federal poverty level. Section 19(C) covers person eligible under A.R.S. § 36-2901.07. These are expansion

persons with income up to 133% of the federal poverty level. Under this subsection is the exemption from providing non-emergency transportation. *See* Section (C)(4).

Nothing in the template and application come close to satisfying the requirements of paragraph A of 42 C.F.R. § 431.408(a)(1)(i) and there is nothing about the information required by paragraphs B-E. The demonstration proposal should be written so the public understands it. It should not take an attorney to decipher the proposal. The demonstration proposal should be a fully self-contained document that does not refer to other documents and is precise and comprehensive. The AHCCCS proposal fails to meet these standards. As an example, the template seeks information from AHCCCS on whether copayments and premiums are different from the state plan. For premiums, AHCCCS refers to the “Modernizing Arizona Medicaid” attachment. *See* page 8. For copayments, AHCCCS states the copayments will follow the state plan but notes AHCCCS has a “Plan Amendment currently pending.” What those amendments are, is not specifically stated. The link is to the amendment proposed last summer and is not updated to reflect any discussions with CMS since then. To add to the confusion, AHCCCS states “[t]he AHCCCS Care Demonstration includes exemptions to these amounts.” In addition, there is reference to legislative directives and two copayment charts that set forth the deviations from the state plan. *See* pages 8-9.

There is reference in the template to “Transitional Medical Assistance” as persons with an income level of “0-100% of the FPL.” What, if any, coverage or exemptions apply to these persons is not stated.

The application refers to a work-related requirement under “getting back to work.” There is no reference to the lifetime enrollment limit in the template, except on the attached chart, page 7, where it references Senate Bill 1092. The only reference in the application is where Senate Bill 1092 is recited verbatim. *See* page 6. Page 7 of a chart attached to the template contains waiver proposals under “legislative directives” and references Senate Bills 1092 and 1475. No information is provided on demonstration financing or budget neutrality. *See* page 15.

Significantly, the application and the template responses are totally devoid of any explanation or reference to what, if anything, will be tested by the waiver requests and how they further the objectives of the Medicaid Act. Nor is there any evaluation design as required by the section 1315 regulation. *See* 42 C.F.R. § 431.408(a)(1)(i)D. Rather the application reads as a policy statement for the state and not as an application intended to comply with the requirements of 42 U.S.C. § 1315(d).

Having failed to provide the public with the information needed to review the proposal, AHCCCS instead suggests that persons attend one of only 6 “public forums” AHCCCS has scheduled to learn more about the waiver. AHCCCS also informs the public that they can post comments about the waiver on the AHCCCS website.

While a limited number of persons may be able to attend a public meeting and listen to the presentations, it can be expected that this limited group will not have time to digest the information presented and make comments and objections at the meeting. Most interested persons will not be able to attend a public meeting and will not get any other information from AHCCCS, except for the inadequate and confusing information published online. As explained above, the information AHCCCS has provided is not helpful for the purpose of enabling the public to adequately understand the proposal and make intelligent comments.

In sum, the process AHCCCS proposes to utilize is fundamentally flawed and does not provide the transparency and meaningful public input intended by 42 U.S.C. § 1315(d) and the federal regulations. First, AHCCCS’ template and application do not adequately explain for whom waivers are sought and who is affected by such things as premiums and copayments.

Second, having failed to provide sufficient information to the public, the rest of the process remains fundamentally flawed. Apparently, AHCCCS intends to submit the draft section 1315 amendment to CMS by October 2015. Most of the public forums are for the public to find out more about AHCCCS’ intentions. They do not satisfy the requirements for § 1315 demonstration public forums; where the public after receipt and review of a fully developed draft proposal, provides comments and objections.

Third, critical to ensuring meaningful participation is the requirement that the state actually consider and address the matters raised by the public comments. The regulation emphasizes that public participation must be meaningful. If a state does not seek or consider public input, meaningful participation has not occurred. As explained above, the primary public forums in Phoenix, the largest city in the state, are not for public comment but rather for the public to find out more information about the proposed waiver. The state also must include in its submission a summary of issues raised by the public during the comment period and how the state considered those comments when developing the demonstration application. 42 C.F.R. § 431.412(c)(1)(vii). The process does not provide adequate public information and thus public input is suppressed. Without significant public input, AHCCCS will simply proceed with its proposal. Thus,

AHCCCS will deny the public a transparent process and meaningful public participation before it submits its proposal to change Arizona's Medicaid program.

Therefore, the state has failed to comply with federal requirements on meaningful public participation. The undersigned request that AHCCCS terminate the current process and then develop a precise and comprehensive demonstration waiver proposal that meets the requirements of § 1315, make the waiver request public, provide for a 30 day comment period, obtain public comment and respond to public comments before it submits any demonstration proposal to the federal government. For this reason, alone, the waiver request should not be submitted to CMS unless and until the public process requirements have been satisfied. The undersigned are aware CMS has sent back section 1315 proposals by other states for insufficient public notice and comment. If AHCCCS proceeds with this flawed process, the Institute, Center and ACDL may ask CMS to send the request back.

III. The AHCCCS Section 1315 Proposal Contains Requests that Serve No Experimental Purpose, Create Barriers to Health Care and Will Impede, Not Further, the Objectives of the Medicaid Act

Although the information in the template and application provided is general and hard to decipher it appears AHCCCS intends to submit substantive waiver components that will create barriers to enrollment and access to care and, thus, do not further the objectives of the Medicaid Act. These waiver requests do not appear to serve any valid experimental purpose and, moreover, represent bad policy for low-income Arizonans who need coverage. They are likely to increase administration complexity, reduce access to care, increase the number of uninsured and lead to worse health outcomes. In addition, some of these proposals undermine core elements of the Medicaid program and have never been approved by CMS.

At least one waiver request Arizona proposed before and withdrew from consideration. In addition, AHCCCS appears to propose waiver requests similar to those made by other states that CMS denied. In each of these matters, AHCCCS should not proceed.

A. Lifetime Limit on Enrollment

AHCCCS proposes a 5 year lifetime limit on enrollment for “able-bodied” persons. Chart attached to template, page 7. The Institute is not aware of any state that

has proposed a lifetime limit on enrollment. The only reason to suggest a lifetime limit is to save money, which is not a valid reason for a Section 1315 waiver. *See Beno*, 30 F.3d at 1069. Also, such a limit only creates a barrier to access to care and does not promote the objectives of the Medicaid Act.

Time limits have never been allowed in the history of the Medicaid program. As a matter of law, the Medicaid Act does not allow time limits in Medicaid, and numerous provisions of the Act explicitly prohibit them. Nothing related to the Affordable Care Act or Medicaid expansion changed the law in that regard.

Time limits also are far beyond CMS' demonstration authority. This year, the Medicaid program turns 50 years old. To our knowledge, in that entire half-century, CMS has never approved any Medicaid program to implement time limits on an eligibility category. Nor is there any reason to believe that CMS would suddenly consider such an extreme departure from established Medicaid law. Although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide assistance to all individuals who qualify under federal law.

More specifically, CMS does not have the authority to use § 1315 to invent new Medicaid law. There is no way to construe time limits as a feature that would "promote the objectives of the Medicaid Act" as is required under the law for § 1315 demonstration. Moreover, there is no corollary for time-limiting medical coverage in the Marketplace or in commercial health insurance, which both serve a higher income population with fewer health needs.

Time limits applied to health coverage are by nature arbitrary and capricious, and in this case would likely lead to individuals with chronic conditions and people with disabilities (who are more likely to have lower incomes over an extended period of time) to be put in a situation where they would be subject to higher premiums and cost sharing. For such individuals, who may not qualify as disabled or medically frail but still face serious or chronic health challenges that impede their ability to work, Medicaid offers dependable and affordable coverage that supports their ability to generate income (full-time or part time) and may prevent them from otherwise becoming fully destitute. Conditioning eligibility or raising coverage costs based on an arbitrary cumulative time limit would most certainly have a disproportionate impact on qualified individuals with a disability, and, as a result, may violate the Americans with Disabilities Act and Section 504 of the Rehabilitation Act – provisions the Secretary is not authorized to waive as part of a § 1315 experiment.

In addition, AHCCCS offers no evidence or support to justify imposing any time limit at all, let alone a specific time limit of 60 months. Finally, this waiver request has no evidentiary or experimental basis and, therefore, should not be submitted.

B. Mandatory Work-Related Requirements

AHCCCS proposes the mandatory work-related requirements passed last legislative session. Chart attached to template, page 7. For this waiver request, AHCCCS simply recites Senate Bill 1092. In general, the mandatory work-related requirements are that “able-bodied” adults work; actively seek work; or attend school or job training program, or both, for at least 20 hours per week; and verify compliance monthly. AHCCCS seeks to ban a person from medical coverage for one year if the person knowingly fails to report an income change or made a false statement about the work-related requirements.

For 50 years the Medicaid program has determined eligibility based on income. There is no explanation of what would be tested by the work-related requirements or how the mandatory work-related requirements further the objectives of the Medicaid Act. The proposed requirements obviously do not further the objectives of the Medicaid Act. Rather, they defeat the objectives.

Moreover, the undersigned are aware that other states have proposed mandatory work-related requirements and CMS has denied those requests. One example is Pennsylvania. This type of request does not promote the objectives of the Medicaid Act and it is only proposed to create a barrier to access to care and to make persons ineligible for AHCCCS. For these reasons, this request should not be submitted.

C. AHCCCS' Proposal for Premiums

AHCCCS intends to propose a premium of 2% of household income on certain unidentified participants. Chart attached to template, page 7; Application, page 2. The undersigned cannot tell whether the affected group is every adult or only certain adults. This lack of adequate explanation highlights the deficiencies of the proposal.

In 2014, AHCCCS proposed a similar premium on persons with income between 100-138% of the federal poverty level. That request was required by state legislation. In a letter dated December 15, 2014, CMS acknowledged that AHCCCS had withdrawn the request for premiums. The undersigned doubt if CMS had indicated it was prepared to

approve the request, that AHCCCS would have withdrawn it. Finally, as explained below, federal law prohibits premiums for persons under 150% of the federal poverty level. In addition, there is no experimental project proposed and no explanation of how this request is consistent with the objectives of the Medicaid Act.

1. Federal Limits on Premiums In the Affordable Care Act

The federal regulations under the Patient Protection and Affordable Care Act (“PPACA”) provide for premiums only for persons whose income is above 150% of the federal poverty level. 42 C.F.R. § 447.55(a). As explained above, to qualify for a waiver under 42 U.S.C. § 1315, a project must be experimental and test a novel idea. There is nothing novel or experimental about charging premiums on low-income persons.⁵

Research from other states shows that premiums significantly depress enrollment in Medicaid. As an example, Oregon increased sliding scale premiums and raised cost sharing on certain adults in its Medicaid program. In the month after implementation, enrollment for the affected population dropped 45%. Samantha Artiga & Molly O’Malley, Kaiser Fam. Found., *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (2005); Leighton Ku & Victoria Wachino, Center on Budget & Policy Priorities, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings* (2005). Other studies are noted on page 4 of this letter. Other states that implemented premiums or enrollment fees on lower-income persons on Medicaid or the Children’s Health Insurance Program also experienced substantial disenrollment in their programs. Samantha Artiga & Molly O’Malley, Kaiser Fam. Found., *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (2005).

In one study, the authors compared premiums for low to moderate income individuals in state public insurance programs. Their study estimated that charges of just 1% of family income reduce participation by approximately 15%. Premiums set at 3% of family income reduce total enrollment by roughly 50%. Leighton Ku & Teresa Coughlin, *Sliding Premium Health Insurance Programs: Four States’ Experiences*, 36

⁵ For a more in-depth discussion of the consistent, redundant research, which finds the negative effects of cost sharing on low-income persons, see David Machledt and Jane Perkins, National Health Law Program, *Medicaid Premiums and Cost Sharing* (March 26, 2014), <http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing#,U2Eos1d7R51>.

Inquiry 471 (1999/2000). These analyses together represent direct evidence that high out-of-pocket Medicaid expenses, such as premiums, lead to adverse outcomes such as qualified people avoiding or leaving the program.

All this proposal would do is either take away the limited funds from some of our most vulnerable persons that they need for rent, utilities, clothing, transportation and other necessities of life or lead to disenrollment. These are both unacceptable results and totally unjustified. This part of the proposal should not be pursued.

2. AHCCCS “CARE” Account

Premiums (and cost sharing) will go into what is called an “AHCCCS CARE” Account. Application, page 2. There are no specifics about how this account will work. There is reference that an AHCCCS “CARE Account” is “like” a Health Savings Account, but there is no information provided to substantiate this statement. Whether this is optional or mandatory and who is affected, is not adequately described. The Application, page 3, states that those over 100% of the federal poverty level will be disenrolled for 6 months if “AHCCCS CARE Payments” are not made.⁶

For persons under 100% of the federal poverty level, the failure to pay will be “counted as a debt” owed to the state. Application, page 3. AHCCCS states it will work with the Arizona Department of Revenue on how best to “operationalize” this aspect of the program.⁷ AHCCCS is required to tell the public now how this program will work, not at some later date. The mechanics of how low-income persons who do not have credit cards or checking or bank accounts will make these required Care payments are totally missing from the proposal. This superficial description of proposed fundamental changes to the state’s Medicaid program is alarming. Moreover, such drastic measures are the antithesis of the Medicaid program. Finally, there is no experimental project proposed nor any explanation of how this request is consistent with the objectives of the Medicaid Act. For all these reasons, this part of the request should not be submitted.

⁶ Adding to the confusion and inconsistent information, the AHCCCS PowerPoint at page 21 states these persons are “disenrolled” and barred from re-enrolling until all outstanding payments are made.

⁷ Continuing the confusion, the PowerPoint at page 21 states that “unpaid cost sharing for all members” becomes a state debt.

D. Elimination of Non-Emergency Transportation

AHCCCS publicized that it proposes to eliminate non-emergency transportation for some to all participants. *See* 2 page overview. Here, as well, the public does not know the parameters of who would be impacted by the proposal because no specifics are provided. As noted above, Senate Bill 1475 concerning the elimination of non-emergency transportation only applies to persons above 100% of the federal poverty level. Yet, AHCCCS' materials repeatedly state this is a benefit that AHCCCS proposes to eliminate. The proposal is found only in the Application in the verbatim recitation of SB 1475 and in a chart attached to the template, page 7, where it states to "See Senate Bill 1475." ⁸

A state is required to ensure necessary transportation for recipients to and from providers. 42 C.F.R. § 431.53. This requirement is based on the recognition from past experience that unless needy persons can actually get to and from providers of services, the entire purpose of the state Medicaid program is compromised. The requirement to provide transportation also is provided in state law. A.R.S. § 36-2907(A)(11) and (G).

AHCCCS' proposal will deny non-emergency transportation to persons with no other means to get to their medical appointments. They include the homeless, persons with disabilities, the unemployed because of medical conditions, persons who are in the process of applying for Social Security Disability Benefits, the elderly and persons with debilitating medical conditions such as cancer, heart complications, asthma and arthritis. These persons cannot walk miles to their medical providers' offices under normal conditions and certainly not in the Arizona scorching heat. Many may have no access to public transit, or it is too expensive to use to get a provider, or they are in no condition to use public transit because of their medical conditions. Refusing to provide access to transportation for such individuals will mean some of them simply will not get needed care, which can lead to expensive complications and more expensive care down the road. It represents bad policy and is contrary to the objectives of the Medicaid Act. As shown by all the examples above, low-income Medicaid recipients who cannot get to their

⁸ On page 34 of the PowerPoint, AHCCCS states that under SB 1475 for "100-133% FPL" there is an "exemption from providing non-emergency medical transportation." The question remains, what does this mean and how many different documents are needed to understand the proposal?

doctors will suffer if this request is granted. But these are just examples. The untold harm will go beyond these examples.

Finally, the only possible reason to eliminate the transportation service is to save money. A cost savings is not an appropriate basis to seek a waiver or to approve a waiver. *Beno*, 30 F.3d at 1069. There is no experimental project proposed nor any explanation of how this request is consistent with the objectives of the Medicaid Act.

1. AHCCCS Has Not Studied the Non-Emergency Transportation Copayments

Although the state has not proposed a valid experiment to be tested and the Institute knows of no valid experiment that could be evaluated by denying non-emergency transportation to participants, AHCCCS previously was allowed to experiment with charging copayments for non-emergency transportation. In a letter dated October 21, 2011, CMS allowed AHCCCS to charge certain participants in Pima and Maricopa Counties a copayment for non-emergency taxi transportation. Those copayments were in effect from approximately mid-2012 until the end of 2013. As part of the waiver authority, AHCCCS was required to study the effects of these copayments on access to healthcare. Although the Institute has requested public records of any copayment evaluation, none has been produced. The Institute is not aware of any evaluation of the transportation copayments. There is no evaluation of the transportation copayments on the AHCCCS website.

Despite this failure to evaluate the transportation copayments, AHCCCS proposes to now eliminate non-emergency transportation. Before AHCCCS seeks to eliminate the non-emergency transportation, it must evaluate the non-emergency transportation copayments previously imposed, prepare a written evaluation of the effects of the copayments on access to health care and publish the evaluation for the public's review. Depending on what the evaluation shows, it may not be appropriate for AHCCCS to consider the drastic measure of eliminating non-emergency transportation.

For all the reasons stated above, this request should not be submitted.

E. Heightened Copayments for the Non-Emergency Use of the Emergency Room

AHCCCS proposes to charge childless adults up to 100% of the federal poverty level ("FPL") an \$8.00 copayment for the first non-emergency use of the emergency

room (“ER”), and a heightened \$25.00 copayment for each subsequent non-emergency use of ER. Non-emergency is when the person is not admitted to the hospital. For childless adults under 100% of the FPL, they also will be charged \$25.00 for each non-emergency use of ER, if there is a community health center, rural health center or urgent care within 20 miles of the hospital. *See* pages 8-9 of the template.

For adults between 100-133% of FPL, a heightened \$25.00 copayment would be imposed for each non-emergency use of the ER if the person is not admitted to the hospital or if there is a community health center, rural health center or urgent care center within 20 miles of the hospital. *See* page 9 of the template.

AHCCCS should not submit these requests for several reasons. First, there is no evidence submitted that there is any inappropriate use of the emergency room in Arizona. This is not surprising because AHCCCS was required to report to the legislature on the use of the emergency room for non-emergency purposes and concluded based on a very general classification system that approximately 6% of the emergency rooms visits may be for non-emergencies and that “members have a relatively low rate of non-emergency ED utilization particularly when compared to national averages” *See* Arizona State Senate Fact Sheet for Senate Bill 1298 in the 2014 legislative session at www.azleg.gov. Thus, there is no emergency room problem in Arizona that needs to be addressed.

Second, there is no showing that the waiver request meets the requirements of 42 U.S.C. § 1396o(f) (*see* footnote 3.). Significantly, AHCCCS fails to set forth an evaluation design, including the use of control groups and state what hypothesis it would test. Instead, AHCCCS refers to the attachment “Modern Arizona Medicaid” which provides no required information, including any hypothesis to be tested. That is no doubt because there has been adequate research on the use of copayments for the non-emergency use of the emergency room. *See, e.g.*, the multi-state, multi-year study by K. Mortensen, *Copayments Did Not Reduce Medicaid Enrollees’ Nonemergency Use of Emergency Departments*, *Health Affairs*, 29(9): 1643-50, September 2010, and the study by David Becker, *Copayments and the Use of the Emergency Department Services in the Children’s Health Insurance Program*, presented at the Academy Health Annual Research Meeting, June 14, 2013, finding similar results to the Mortensen study. No doubt the Secretary’s familiarity with the research is one of the reasons why the \$8.00 copayment amount was selected for all individuals under 150% of the federal poverty level. *See* 42 C.F.R. § 447.54(b).

Finally, Arizona proposes to define a non-emergency visit by whether the person is admitted to the hospital and/or whether another facility was within 20 miles of the hospital. These differentiations clearly violate the prudent layperson standard in the Medicaid regulations. *See* 42 C.F.R. § 447.51, invoking 42 C.F.R. § 438.114. There is no way a person could know beforehand that his or her condition would require hospitalization. Medicaid also requires that individuals be screened, informed that their condition is not emergent, and appropriately referred to a provider with lower (or no) cost sharing *before* any copayment may be assessed. Arizona's proposal does not appear to meet any of these requirements. Also, the arbitrary distance of another facility from the hospital appears to violate Medicaid statute. Significantly, AHCCCS does not specify that the community health center or urgent care facility actually be available and accessible to the person at the time they visit the ER. The facility might be closed at that time or not accepting walk-ins. Finally, there is no requirement that the facility actually be an appropriate alternative for medical care. By the proposed standard, the overwhelming majority of Arizona Medicaid beneficiaries would be charged \$25 for nearly every visit to the ER, because nearly everyone lives within 20 miles of one of these facilities, and only a very small percentage of ER visits (including emergent visits) actually results in an inpatient admission.

Moreover, CMS has publicly acknowledged that such retrospective approaches will not satisfy the prudent layperson standard. In the preamble to the July 15, 2013 Final Eligibility and Enrollment regulations CMS stated:

We agree that it is difficult to implement a system to differentiate non-emergency from emergency services for cost sharing purposes in a way that ensures beneficiary protections consistent with the prudent layperson standard. We continue to believe that the use of diagnosis and procedure codes alone is not an appropriate process for determining non-emergency services, as doing so would not adequately protect beneficiaries legitimately seeking ED services based on the prudent layperson standard, for whom a CPT code assigned after care is provided may indicate a non-emergency condition. ... We sought comments on feasible methodologies for states and hospitals to make this distinction, but did not receive any recommendations.

78 Fed. Reg. 42278. AHCCCS' proposal will penalize legitimate emergency room use. Imagine a Medicaid patient with a history of heart disease who experiences chest pains and puts off calling the ambulance for fear of the heightened \$25 copayment they would face if their condition turned out to be merely indigestion or angina. This proposal, if approved, would literally put lives at risk. Hence, the waiver request would hinder, not promote the objectives of the Medicaid Act.

If AHCCCS wants to further reduce the non-emergency use of the emergency room, more public education or broader primary care networks would be a good start and would not infringe on recipients' access to medical care. There is no evidence that AHCCCS has tried any less drastic measures.

For all these reasons, this part of the request should not be submitted.

F. Missed Appointment Copayment

AHCCCS proposes to charge the "New Adult Group" between 0-133% of the FPL a missed appointment copayment. This is the charge that would have been imposed if the appointment had been kept. *See* page 9 of the template.

Previously, CMS approved allowing AHCCCS to impose a missed appointment fee but no physicians wanted to charge it and it was never implemented. The state has not cited to any evidence of a problem with missed appointments by Medicaid beneficiaries. The undersigned know of no other state that has imposed a "no-show" fee. Moreover, any such copay would require AHCCCS to comply with 42 U.S.C. § 1396o(f). *See* footnote 3. No such showing has been made. No information is provided on the hypothesis to be tested and how the copayment would further the objectives of the Medicaid Act as required by 42 U.S.C. § 1315(d). Nor is there any explanation of an evaluation that meets the requirements of 42 U.S.C. § 1396o(f)(1) with control groups.

A missed appointment fee is contrary to Medicaid policy that: (1) Medicaid sets a reimbursable rate for a service and a missed appointment is part of a provider's overall cost of doing business and is not a distinct reimbursable service; (2) Medicaid regulation 42 C.F.R. § 447.15 provides that as part of participating in the Medicaid program, providers agree to accept as payment in full the amounts paid by the state agency; and (3) a policy allowing missed appointment fees would hinder recipients from seeking needed medical care and would not be in the recipient's best interests. There is no reason to revisit this long-standing policy.

Moreover, this request is fraught with practical problems. What if a patient claims she called and left a voice message that she needed to cancel the appointment? What if a patient uses public transportation and the bus breaks down? What if there is no public or other transportation available? What if the person has debilitating cancer and the cab does not show up? What about persons with mental impairments? This request coupled with the State's request to reduce non-emergency transportation are the types of policies that will make it harder for persons to obtain needed care.

Finally, the Institute, Center and ACDL think it is hypocritical and perverse to take away non-emergency transportation and then charge persons when the ride they scrounge up to get to the doctor falls through.

For these reasons, this part of the proposal should not be submitted.

G. Promoting Healthy Behaviors

While not adequately developed, the proposal refers to wellness targets such as "wellness exams, flu shots, glucose screening, mammograms, tobacco cessation and chronic disease management such as for "diabetes, substance use disorders, asthma." If participants meet their "Healthy Arizona target," they can reduce their required AHCCCS Care Payments or rollover unused funds into the next benefit year. Significantly, participants can only access funds in their account if they met one healthy target. See page 3 of Application.

In addition, there is a reference to additional incentives through "corporate and philanthropic" partnerships the state is seeking. There also are references to employers making contributions to AHCCCS Care accounts. The Institute does not understand what is proposed because of the lack of any specificity. AHCCCS should wait until it has a fully developed proposal before it tries to sneak in waivers during negotiations with CMS.

Regulations implementing the nondiscrimination provisions of the Health Insurance Portability and Accountability Act ("HIPAA") make clear that health plans cannot discriminate in eligibility rules, premiums or contributions based on health status. 45 C.F.R. §§ 146.121(b)(1)(i), (c)(1)(i). The regulations provide exceptions for wellness

plans designed to promote health or prevent disease that meet specified requirements, 45 C.F.R. §§ 146.121(b)(2)(ii), (c)(3), (f).⁹

The HIPAA regulations make clear that even when it comes to rewarding individuals for wellness behaviors, if the condition for obtaining a reward is based on requiring an individual to satisfy a standard that is related to a health factor, the plan must meet specified requirements, one of which is that “[t]he program must be reasonably designed to promote health or prevent disease.” 45 C.F.R. § 146.121(f)(2)(ii).

AHCCCS has provided inadequate information and the Institute and the public are not able to evaluate this proposal and whether its design satisfies HIPAA. No information is provided on the hypothesis to be tested and how the proposal would further the objectives of the Medicaid Act as required by 42 U.S.C. § 1315(d). Finally, because of the barriers to eligibility, it is unclear how many persons would benefit from the reduction or rollover of Care payments. For all these reasons, this proposal should not be submitted.

H. Medical Services with No Copayment

The application lists certain medical services that will not have copayments. *See also* template on page 9. This list appears more restrictive than required by federal law. 42 C.F.R. § 447.56(a)(2). Services for which no copayments may be imposed for anyone include emergency services, family planning services, preventative services, pregnancy-related services and provider-preventable services. AHCCCS’ current regulation sets this out. R9-22-711(B). AHCCCS’ request should be clear that it is exempting all services that the federal law exempts from copayments. If AHCCCS wants to expand the medical services that have no copayments, then that should be explicit as well. The information provided is inadequate.

⁹ *Cf.* Equal Employment Opportunity Commission informal opinion letter (revised), (Match 6, 2009), stating that although medical inquiries are permitted as part of voluntary wellness programs, “a wellness program is voluntary if employees are neither required to participate nor penalized for non-participation,” and expressing the opinion that a county health risk assessment program is not voluntary if employees are required to participate and denied benefits if they do not. *Available at* www.eeoc.gov/foia/2009/ada_disability_medexam_healthrisk.html.

I. Persons Exempt from Copayments

The template and application do not affirmatively state that AHCCCS will exempt all persons in 42 C.F.R. § 447.56(a)(1) from all cost sharing. Given the way that AHCCCS has set up the answer and template, this information needs to be specified. AHCCCS' current regulation sets this out. R9-22-711(C). AHCCCS should exempt all persons from copayments as required by federal law.

IV. AHCCCS Should Not Seek Any Waivers Until It Completes Its Evaluation of the Heightened and Mandatory Copayments Imposed on Childless Adults

On October 21, 2011, AHCCCS obtained a waiver to impose heightened and mandatory copayments on childless adults with income less than 100% of the federal poverty level. AHCCCS was required to study several hypotheses concerning these copayments and to evaluate how these copayments impacted access to health care. Those copays ended December 2013, yet AHCCCS has not evaluated those copayments and has not published any findings.

The whole purpose of section 1315 waivers is to test experimental ideas. It is not to save the state money or to erect barriers to health care for low-income Arizonans. Before AHCCCS seeks more cost-sharing or other waivers of the Medicaid requirements, it should complete its evaluation of the heightened and mandatory copayments it imposed on childless adults and publish its findings so that the public can review the impact of the cost sharing on vulnerable participants. AHCCCS should not continue to seek waivers and then not comply with the evaluation requirements.

V. AHCCCS Proposes Yearly, Not Monthly or Quarterly Tracking of 5% CAP on Medical Expenses

The federal regulation limits the aggregate of all copayments and premiums to 5% of a person's monthly or quarterly household income. 42 C.F.R. § 447.56(f)(1). Pursuant to Arizona's Administrative Rule R9-22-711(G), the total aggregate amount for all household copayments and premiums is limited to 5% of the person's quarterly income. In addition, AHCCCS is required to track the incurred premiums and cost sharing through an "effective mechanism that does not rely on beneficiary documentation." 42

C.F.R. § 447.56(f)(2). The shorter time period is important because most medical expenses tend to be clustered in a single month or quarter.¹⁰

In the proposal, AHCCCS seeks to only aggregate medical expenses *yearly*, not monthly or quarterly. Here is another example of how inadequate the proposal is. Unless someone knows that the federal requirement is monthly or quarterly tracking of the cap, they will not know that AHCCCS seeks a waiver of the requirement. This is why it is crucial that **every** demonstration waiver request must be separately listed so the public understands what AHCCCS is seeking as a waiver.

In addition, such a proposal would have to satisfy all the requirements under 42 U.S.C. §1396o(f). Here as well, no such showing is made. Several other states, including Iowa and Indiana, included annual aggregate caps in early versions of their Medicaid expansion proposals but CMS refused to approve any of these requests.

Moreover, the Institute does not think AHCCCS currently tracks for the 5% aggregate cap on medical expenses as required by federal law. Previously, the Institute served AHCCCS with a public records request that requested the documents showing that AHCCCS tracked the 5% cap. No documents were produced.

Finally, as with all the demonstration waiver requests, there is no explanation what this waiver would test or how it would further the objectives of the Medicaid Act. For all these reasons, this part of the demonstration waiver should not be submitted.

VI. AHCCCS Proposes to Use a Third Party Vendor to Manage and Track AHCCCS CARE Accounts

Under the proposal, AHCCCS wants to contract with a third party vendor to manage and track the AHCCCS Care Program accounts. *See* page 13 of template. From the cursory explanation, this program is going to have very high administrative costs. The complexities include monitoring when the adults go on and off AHCCCS, their income changes, their exempt status changes, exclusions for exempt services and the calculation of the 5% aggregate cap figured monthly or quarterly. As explained above, the Institute understands that currently AHCCCS does not track the 5% aggregate cap

¹⁰ Thomas M. Selden, et al., *Cost Sharing in Medicaid and CHIP: How Does It Affect Out-of-Pocket Spending?* 28 Health Affairs W607, W614 (2009).

even quarterly. In addition, there is the huge problem of the largely unbanked population making these payments.

Before there is any request for a third party vendor, AHCCCS must monitor the 5% aggregate cap pursuant to federal law for several years. Then there will be a baseline of information to understand the implementation complexities of any proposed program waivers. Until AHCCCS complies with the federal law, there is no reason it should request a demonstration waiver to pass this administrative function on to a third party.

VII. AHCCCS' Other Proposals Are So Vague that No Meaningful Input Can Be Provided

Without waiving any of their objections to AHCCCS's other proposals, the Institute, Center and ACDL simply note that because of the lack of information provided, AHCCCS has denied the undersigned and the rest of the public an opportunity to provide any meaningful input. Moreover, AHCCCS has failed to provide any information on why these demonstration waivers are needed, what hypotheses will be tested and how the proposals promote the objectives of the Medicaid Act. All these requirements are AHCCCS' burden of proof. For these reasons, such a woefully inadequate proposal should not be submitted.

VIII. Federal Approval in Other States

Finally, if any of AHCCCS' requests are currently being imposed in other states, then the undersigned do not think AHCCCS' requests satisfy the novel or experimental prong of the waiver statute. In those situations, AHCCCS should wait to see what the results are of the testing in the other states before proceeding with the requests.

Arizona's Medicaid expansion and restoration are working. AHCCCS should complete the evaluations on its current and previous waiver requests before embarking on any new waiver requests.

IX. The AHCCCS Program No Longer Should Continue as a Demonstration Project

AHCCCS was initiated in 1982, over 33 years ago. Whatever reasons may have justified it being a demonstration project, those reasons no longer exist. Managed care is no longer experimental. Rather, as long as AHCCCS continues as a demonstration

project, every 5 years, a whole new proposal is required. This process encourages more waiver requests with the public struggling to understand what is being requested.

As explained above, AHCCCS should be required to state that it accepts all federal requirements, except for a specific list of items. For the listed items, AHCCCS should clearly disclose to the public, what is the current federal requirement; what does AHCCCS propose to change; what group will be affected by the change; the reasons for the proposed change; what hypotheses will be tested by the change; the plan to test the hypotheses; how the proposed change furthers the objectives of the Medicaid Act, and other required information.

Conclusion

For all the above reasons, AHCCCS should not continue with its current process. Rather, AHCCCS should withdraw the current proposal, publish a comprehensive draft demonstration waiver request that the public can easily understand, follow the requirements in 42 U.S.C. § 1315 and provide for meaningful public input. In addition, AHCCCS failed to show that any of these requests comply with federal requirements that they be experimental and test something experimental and also further the objectives of the Medicaid Act rather than save money. Finally, the undersigned were unable to address much of the proposal because of the insufficient and cursory information provided.

Thank you for the opportunity to comment on the draft proposal. If you have any questions concerning this letter, please contact Ellen Katz at (602) 252-3432 or at eskatz@qwestoffice.net.

Sincerely,

/s/

Ellen Sue Katz, on behalf of

Arizona Center for Disability Law
Arizona Center for Law in the Public Interest
William E. Morris Institute for Justice

Vinyard, Christopher

From: Carolyn Willmer [REDACTED]
Sent: Monday, September 14, 2015 1:48 PM
To: Public Input
Subject: AHCCCS Changes

I attended the 8/26 United Health Care Community Meeting about the AHCCCS changes, and have a few comments.

First, presentations or handouts about changes should be **very clear, upfront**, about who will be affected by the changes. At the 8/26 presentation, and on the "Modernizing Arizona Medicaid" handout it was not initially clear who would be impacted by the discussed changes. The handout doesn't seem to explain it at all.

Second, adults on AHCCCS who are also parents of children with Special Health Care Needs (such as children who receive CRS services) face special challenges. I'm concerned about these families managing if there are new requirements for co-pays, etc. Could there be special consideration and adjustments for these families?

Third, all the Head Start/Early Head Start programs in AZ are required to have all children get the AHCCCS EPSDT services. I believe there are about 16,000 children enrolled annually. The new electronic communication component may be helpful; such as cellphone text alerts about doctor's appointments. Handouts in English and Spanish that Head Start could share with families about this component might be very helpful.

Carolyn Willmer, MS, MPH
Head Start Health Specialist
602-534-3037



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September 15, 2015

The Honorable Doug Ducey
Governor of the State of Arizona
1700 West Washington Street
Phoenix, AZ 85007

Ms. Monica Coury
Office of Intergovernmental Relations
AHCCCS
801 East Jefferson Street, Mail Drop 4200
Phoenix, AZ 85034

Dear Governor Ducey and Ms. Coury:

The Arizona Psychiatric Society offers the following comments on Governor Ducey's proposal for Modernizing Arizona Medicaid. The proposal includes some provisions which propel our healthcare system in a positive direction: promoting wellness, managing chronic disease, advancing electronic communications (including electronic health records), increasing value-based purchasing, strengthening integrated care, achieving accountability, preventing fraud, and reducing stigma. However, the proposal also raises substantial concerns. They relate to the issues of member contributions and lifetime eligibility requirements.

The recent Medicaid expansion has made healthcare more accessible to the working poor population. These individuals face tough choices in allocating their last few dollars going to food, rent, childcare, transportation, or healthcare. Requiring copays and monthly deposits will create a barrier to accessing healthcare. The predictable result will be situations where attending to health care needs is delayed until people are far sicker and their symptoms are intolerable. This, in turn will lead to more visits to emergency rooms and hospitalizations to fix problems that could have been avoided by accessing care earlier and with prevention measures. These consequences profoundly impact individuals' personal health, work, families, and finances.

The lifetime eligibility requirement of 5 years will also limit access. Many people work for more than five years in positions that pay below the federal poverty line. Losing Medicaid benefits because of that will again create instances where people do not access care in a reasonable time to address their symptoms. Most of the people whom this proposal addresses are working, and mostly they qualify as

PROMOTING THE WELFARE OF THOSE WITH MENTAL ILLNESS AND FOSTERING PRINCIPLES OF PSYCHIATRY

September 15, 2015

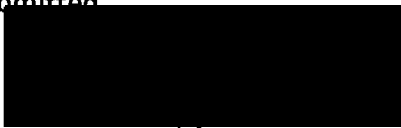
AHCCCS

Page 2

“the working poor.” As psychiatrists, we often see patients who have difficulty recognizing the signs of mental illness and their need for treatment. The Governor’s proposal would simply make it less likely that they would obtain the care that they require in order to be safe and productive members of the community.

Implementation of the proposal will result in an increased number of people without adequate access to healthcare. In the long run, this will cost Arizona more in poor health outcomes, loss of work time, and money paid for emergency health care. In light of these concerns, we urge you to make revisions to the proposal to ensure Arizonans have timely access to healthcare without barriers.

Respectfully submitted,



Roland Segal, MD, President
Arizona Psychiatric Society

Vinyard, Christopher

From: Teri [REDACTED]
Sent: Wednesday, September 16, 2015 7:04 AM
To: Public Input
Subject: Arizona Psychiatric Society Comments on Modernizing Arizona Medicaid

The Arizona Psychiatric Society offers the following comments on Governor Ducey's proposal for Modernizing Arizona Medicaid. The proposal includes some provisions which propel our healthcare system in a positive direction: promoting wellness, managing chronic disease, advancing electronic communications (including electronic health records), increasing value-based purchasing, strengthening integrated care, achieving accountability, preventing fraud, and reducing stigma. However, the proposal also raises substantial concerns. They relate to the issues of member contributions and lifetime eligibility requirements.

The recent Medicaid expansion has made healthcare more accessible to the working poor population. These individuals face tough choices in allocating their last few dollars going to food, rent, childcare, transportation, or healthcare. Requiring copays and monthly deposits will create a barrier to accessing healthcare. The predictable result will be situations where attending to health care needs is delayed until people are far sicker and their symptoms are intolerable. This, in turn will lead to more visits to emergency rooms and hospitalizations to fix problems that could have been avoided by accessing care earlier and with prevention measures. These consequences profoundly impact individuals' personal health, work, families, and finances.

The lifetime eligibility requirement of 5 years will also limit access. Many people work for more than five years in positions that pay below the federal poverty line. Losing Medicaid benefits because of that will again create instances where people do not access care in a reasonable time to address their symptoms. Most of the people whom this proposal addresses are working, and mostly they qualify as "the working poor." As psychiatrists, we often see patients who have difficulty recognizing the signs of mental illness and their need for treatment. The Governor's proposal would simply make it less likely that they would obtain the care that they require in order to be safe and productive members of the community.

Implementation of the proposal will result in an increased number of people without adequate access to healthcare. In the long run, this will cost Arizona more in poor health outcomes, loss of work time, and money paid for emergency health care. In light of these concerns, we urge you to make revisions to the proposal to ensure Arizonans have timely access to healthcare without barriers.

Roland Segal, MD, President
Arizona Psychiatric Society

Alicia Cowdrey, MD
4th Year Resident
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September 17, 2015

AHCCCS c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Re: SB1375 Draft Report

To Whom It May Concern:

The Arizona chapter of the American Academy of Pediatrics which represents over 900 Arizona pediatricians and other health care providers has reviewed the SB1375 Draft Report and would like to make the following comments regarding the medical and behavioral health services for these children.

As pediatricians we provide ongoing health care services for foster children and have been disappointed by the lack of timely behavioral health services available to these children under the state's regional behavioral health system. Foster children are in great need of behavioral health services and these services must be provided in a timely manner. The availability of behavioral health services is critical to the developmental, emotional and behavioral health of these children. By providing the needed behavioral health services and medical services for these children we can improve their chances of successful reunification with their family. If reunification is not possible, then these services will be most helpful in achieving a successful permanent placement outside of their home.

Foster children are a unique group of children who have experienced trauma and neglect. They require additional healthcare services that go beyond the usual definition of medical necessity. Their families also have unique needs that must be addressed if a child will ultimately be able to return home. It is especially important that these behavioral health services be integrated with the acute and preventive health care services they receive from their pediatrician or health care provider in their medical home.

The American Academy of Pediatrics and the Child Welfare League of America has developed standards for the health care of children and teens in foster care which we hope will be incorporated into your plan of action. These standards include the recommendation that all children entering foster care should have comprehensive evaluations within 30 days of placement and include a mental health evaluation, a developmental evaluation (if the child is < 6 years old), an educational evaluation (if the child is > 5 years old) and a dental evaluation. We also recommend that the information gathered from these evaluations be shared with their primary care provider and the other professionals who are caring for the child as well as their parents. This information should also be made available to DCS and the courts so that the information can be incorporated into permanency planning for the child or teen.

In addition to a comprehensive evaluation within thirty days of placement, the AAP also recommends that children and teens in foster care receive a health screening within 72 hours of placement in order to assess for signs of child abuse and neglect, current medical and mental health problems. This screening visit will also ensure that the child has all necessary medications and medical equipment they need and will provide support and education to the family caring for the child regarding the child's immediate and potential long term needs. Because of the high prevalence of health care problems in this population



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of children, follow-up visits should be scheduled more frequently than is typical for children without special health care needs. For infants < 6 months old, the visits should be:

- Monthly for infants from birth to age 6 months
- Every 3 months for children age 6 to 24 months
- Twice a year for children and teens between 24 months and 21 years of age

We appreciate the opportunity to provide input to your agencies regarding the SB1375 draft report and stand ready to assist your agencies with the development of a more appropriate system of care for this vulnerable population of children and teens in foster care.

Sincerely,



*Delphis C. Richardson, MD, FAAP
President, Arizona Chapter American Academy of Pediatrics*

HMA

HEALTH MANAGEMENT ASSOCIATES

*Arizona Stakeholder Consensus:
Opportunities for Healthcare Delivery System
Transformation and Payment Reforms*

PRESENTED TO
ST. LUKE'S HEALTH INITIATIVES

JULY 2015

*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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Executive SUMMARY

Beginning this summer, Arizona has a unique opportunity to shape the future of its Medicaid program. Innovations made could affect the 1.6 million Arizonans served by Medicaid, as well as our state's overall healthcare system.

Every five years, the Centers for Medicare and Medicaid Services (CMS) is required to approve Arizona's plan for operating its unique Medicaid program, called the Arizona Health Care Cost Containment System (AHCCCS). The renewal of this authority ("1115 waiver") allows AHCCCS to continue operating AHCCCS differently from other state Medicaid programs. It also provides an opportunity for AHCCCS to propose new Medicaid-funded initiatives that promise to improve AHCCCS beneficiaries' health and reduce overall healthcare costs.

New funding recently received by AHCCCS also provides opportunities for our state to innovate. In December of 2014, AHCCCS was awarded a State Innovation Model (SIM) planning grant from the Center for Medicare and Medicaid Innovation. The purpose of the SIM planning grant is for Arizona to develop a State Healthcare Innovation Plan.

To take advantage of the convergence of these two opportunities, St. Luke's Health Initiatives (SLHI), an Arizona-based public foundation, organized a series of meetings with key health and human services stakeholders. These stakeholders were invited to share their perspectives on opportunities to improve our healthcare system and reflect on changes occurring in healthcare delivery and how providers are paid and incentivized. The meetings also provided a forum to discuss delivery system transformation and value-based payment reforms occurring locally and nationally. At the meetings, stakeholders discussed:

- Best practices being implemented in other states, including how states are using their SIM planning grants and Medicaid waiver renewals to spur improvements in healthcare delivery and population health;
- Other opportunities available through the Affordable Care Act and Medicaid to improve the cost-effectiveness of our state's Medicaid program and health;
- Additional opportunities to support community health improvement strategies through Medicaid.

Key Areas of Focus

During the meetings, stakeholders focused on six areas for AHCCCS to focus new innovation efforts:

Integrating ACOs into AHCCCS – One area of discussion focused on the role of Accountable Care Organizations (ACOs) in our state. These new networks of care are rapidly spreading in Arizona, organizing providers to better serve Medicare fee-for-service beneficiaries. Stakeholders noted that Arizona could take advantage of federal efforts to accelerate the spread of Accountable Care Organizations by including ACOs in the AHCCCS delivery system. This would also support AHCCCS’ goal of integrating behavioral and physical health. Inclusion of ACOs as part of AHCCCS provider networks could also help accelerate the transition to value-based payment models by AHCCCS, since ACOs are specifically designed to operate under such payment models.

Implementing health homes – Health homes and primary care medical homes (PCMH) are delivery system models that are designed to better manage the care of high cost, high utilizer patients. Fostering their spread to address the complex needs of patients could help improve health outcomes and reduce healthcare costs.

Strengthening linkages between health and community supports – Lack of housing, substance abuse, physical disability, and economic factors add significant costs to the healthcare system. Better linkages between the healthcare system and community supports could help our state to more effectively address the social determinants of health, improving health outcomes and better controlling healthcare costs in the process.

Further supporting behavioral health and physical health integration – Stakeholders agreed that by supporting the integration of behavioral health and physical healthcare, AHCCCS has made great strides in improving health delivery. Nonetheless, participants agreed that AHCCCS should do more to strengthen changes in the delivery system. Greater investments are needed in areas such as electronic health record systems and health information exchange to make integration efforts truly effective.

Supporting healthcare transitions using alternative health workers – Community health workers can help bridge language, cultural, and socio-economic challenges that affect the patient’s access to care and improve patient self-care management and medication compliance. These health workers (who go by names ranging from *promotoras de salud* to health coaches) can be integral members of care delivery teams. In underserved and rural communities, community health workers can serve as liaisons between patient and provider. They are also part of the evidence-based strategy for community care transitions. Nurturing the development of this alternative health workforce could help reduce unnecessary use of more costly healthcare settings such as hospital and nursing homes.

Fostering collaborative efforts aimed at improving population health – AHCCCS could play a central role in encouraging collaborations among a wide array of partners to address population health.

Many states are actively engaging in the efforts in this area focusing on new models for collaboration such as accountable care communities, and new methods of financing improvements in population health, such as social impact bonds.

These six areas of focus complement efforts aimed at improving health of specific populations through Arizona's SIM grant efforts. As part of the SIM planning grant, AHCCCS identified key populations in which it wished to focus its systems improvement effort. These include:

- High cost, complex patients;
- Chronically ill patients with mental illness;
- Medicaid members who are transitioning from the justice system;
- Arizona Native Americans;
- AHCCCS beneficiaries who are also eligible for Medicare; and
- Children with special needs.

The stakeholders concluded that AHCCCS has the opportunity to help redesign and improve our state's health delivery system and create a more cost effective health care system. The SIM planning grant provides resources to develop evidence-based strategies for changing how care is delivered so that costs can be better controlled and health outcomes improved. Further, the AHCCCS waiver renewal can be used to provide federal funding for health system and infrastructure investment needed to better integrate the service delivery system. The waiver can also be used to bolster payment reform and encourage improvements to population health.

The following is a summary of the stakeholders' discussions and conclusions on opportunities to strengthen Arizona's health care system through its Medicaid program, as identified through a series of meetings organized by St. Luke's Health Initiatives.

INTRODUCTION

In March 2015, St. Luke's Health Initiatives, a public foundation focused on improving the health of Arizonans, convened key Arizona health and human service stakeholders to discuss potential opportunities for delivery system redesign and value-based payment reforms in Arizona. Participating in the discussions were stakeholders representing hospitals, health systems, healthcare providers, private health plans, Medicaid health plans, behavioral health providers, human service and housing organizations, public health representatives, and Federally Qualified Health Centers. Stakeholders reviewed potential strategies related to delivery systems redesign, payment reforms, and integrated health improvement initiatives that could be incorporated into the next Arizona Medicaid 1115 Waiver renewal proposal. The stakeholders also more broadly discussed the potential to:

- Improve health and encourage health delivery system innovation;
- Leverage opportunities to improve health through Medicaid, the Affordable Care Act, and federal innovation grants;
- Advance best practices being implemented in other states; and
- Best use the \$2.5 million State Innovations Model (SIM) planning grant recently awarded to Arizona.

Arizona has long been recognized as a laboratory for Medicaid managed care innovation and cost effectiveness. AHCCCS has been at the forefront of Medicaid managed care for both acute care services and long-term care. It also provides health coverage to 1-out-of-5 Arizonans. Furthermore, it oversees a healthcare delivery system that touches Arizona's most vulnerable citizens. Given AHCCCS' past successes and the breadth and scope of the program it administers, AHCCCS has an opportunity to drive broad delivery system redesign, value-based payment reforms, and improvements in population health in Arizona.

While stakeholders recognized that opportunities exist for AHCCCS to play a critical role in driving delivery system reform and improved health outcomes, concerns were expressed regarding the impact of recent budget cuts on the agency and the system it oversees. Budget cuts made over many years have taken their toll. Several healthcare providers noted that it is becoming increasingly challenging for providers to innovate given the financial stresses they are experiencing. They also expressed concerns about the viability of some providers and the impact on access to care in the state. That said, stakeholders also recognized that intelligent planning and redesign of the healthcare delivery system could mitigate the impact of budgetary cuts, especially if it meant accelerating the implementation of value-based payment reforms, where providers share financial risk and reward with health plans and managed care organizations. Through implementation of such reforms, providers could also be incentivized to reduce acute care utilization and overall costs. Value-based

payment also gives providers a strong rationale for keeping patients healthy through early treatment, management, and prevention of illness, reducing financial stresses on the overall healthcare system.

From the stakeholder discussions evolved a consensus on key elements that are essential for successful and sustainable transformation of Arizona's healthcare delivery system, which is noted below. Many of these key opportunities will require the leadership and engagement of AHCCCS if they are to succeed.

National and Local Context for Potential Change

At three meetings in March 2015, eighteen stakeholders were provided information on the state and national context of healthcare delivery system redesign, value-based payment reform, and opportunities to improve population health. The overview and discussion addressed:

The Direction of the Centers for Medicare and Medicaid Services (CMS)

Participants were provided with an overview of CMS's push to accelerate accountable care delivery system redesign and value-based payment. It was noted that CMS is interested in improving health care and population health and reducing healthcare costs to help ensure the long-term viability of both Medicaid and Medicare. Accordingly, CMS is partnering with states to develop patient-centered medical and health homes, Medicaid ACOs, and strategies for integrating population health with community-based collaborative health improvement initiatives.

CMS's Center for Medicare and Medicaid Innovation (CMMI) is also providing states funding to develop and test delivery system redesign models and payment reforms through its State Innovation Model Initiative.

CMS will continue to accelerate the expansion of accountable care organizations and value-based payment reforms into the foreseeable future. Recently, CMS announced its initiative for the next generation of "Advanced ACOs." These ACOs must be capable of managing financial risk for Medicare patients with complex chronic care needs. CMS has encouraged states to integrate the ACO delivery system model into their Medicaid delivery system redesign initiatives. CMS recognizes that individual physicians and small group practices cannot successfully manage value-based payments without organized provider networks where risks can be spread. As more providers organize into ACOs, these providers will be less likely to accept fee-for-service Medicaid. This is especially true if the rate gap between Medicare and Medicaid continues to increase. Including ACOs in the Medicaid provider network will assure Medicaid beneficiaries' access to ACO providers. It also offers a potential platform for Medicaid to implement value-based payment strategies.

The Arizona Health Improvement Plan

Increasingly, public health and healthcare organizations are collaborating to develop coordinated approaches for improving health outcomes in our state, mirroring a trend seen nationwide. Over the past two years, the Arizona Department of Health Services and county health departments have worked with Arizona stakeholders to develop the State Health Improvement Plan. The Plan is built upon a comprehensive assessment of the health status of Arizona residents in each county of the state. The Plan documents population health issues and presents a set of health improvement priorities and strategic actions. Engaging AHCCCS in strategies to address these health priorities and concerns provides an opportunity for improving population health in Arizona.

These key health priorities identified for Arizona in the State Health Improvement Plan include:

- Access to Well Care
- Behavioral Health Services
- Chronic Diseases (Cancer, Lower Respiratory Disease/Asthma, Heart Disease, Diabetes)
- Health Insurance Coverage
- Healthcare Associated Infections
- Obesity
- Oral Health
- Substance Abuse
- Suicide
- Teen Pregnancy
- Tobacco Use
- Unintentional Injuries/Accidents

On the national front, CMMI is encouraging states to develop innovative strategies to integrate delivery system and value-based payment reforms with population health improvement strategies. Greater collaboration between the healthcare delivery system and public health could reduce community risk factors that drive up costs.

Broad Stakeholder Engagement

Other states are increasingly focusing on the social determinants of health as a means of addressing health disparities and poor population health. The federal government is encouraging such efforts, and urging Medicaid programs to engage a wide array of stakeholders in their innovation efforts. States that have received CMMI-funded planning grants are being urged to engage a broad array of stakeholders to participate as they develop their State Healthcare Innovation Plans. Other states have found that engaging key stakeholders in their redesign planning better informs model development and increases the potential for successful implementation.

In many states, models developed have included those focused on integrated behavioral and physical health provider networks, person-centered health homes, and Medicaid ACOs. States are also finding innovative ways to create greater linkages between healthcare and human services. As part of the second round of State Innovation Model test awards, states are testing models and strategies that integrate community-based health improvement initiatives with delivery system models and payment reforms.

Medicaid 1115 Waiver Renewal

The 1115 Waiver under which Arizona's Medicaid program operates provides AHCCCS with time-limited federal authority to operate Arizona's Medicaid program in a different manner than required by federal law. 1115 waivers are typically granted for a period of five years. The current AHCCCS waiver term ends September 2016. Renewal of the AHCCCS 1115 Medicaid Waiver typically involves submitting a proposal to CMS to request to continue the AHCCCS Medicaid managed care model. In each waiver proposal that AHCCCS requests, AHCCCS also includes a request for any new changes or authority in how it might operate the AHCCCS program.

The next renewal of the AHCCCS waiver provides an opportunity for Arizona to integrate Medicaid delivery system redesign and payment reforms into the waiver request. Stakeholders and the general public will have the opportunity to provide input into the waiver renewal proposal.

AHCCCS could use its SIM planning grant to include delivery system redesign and payment reform models as part of its AHCCCS waiver renewal request. Other states have used their waiver renewal to include new delivery system models and payment reform authority as part of their waiver proposal. Delivery System Redesign Incentive Pools (DSRIP) can also be requested and have been approved by CMS for this very purpose.

The Delivery System Redesign Incentive Pool program provides federal Medicaid dollars to fund investments in health system infrastructure, implement new delivery system models, and establish quality performance improvement initiatives, payment reforms, and community-based population health strategies. Medicaid DSRIP is a relatively new waiver program opportunity. As Disproportionate Share Hospital Pools (which paid hospitals for the cost of uncompensated care from uninsured patients) are reduced as part of implementation of the Affordable Care Act, DSRIP has provided states with an alternative pool of Medicaid dollars to invest in delivery system redesign and value-based payment reforms.

In most states approved for the DSRIP program, funds have provided the resources for implementation of health homes and the integration of behavioral and physical health. More recently, DSRIP programs have been approved to support investments in the meaningful use of electronic health records and health information exchange (HIE), primary care medical homes, support for expanding primary care and community medicine training programs, alternative workforce development, infrastructure for performance reporting, and incentivizing evidence-based clinical care performance improvements.

States are also requesting authority for DSRIP programs to fund community partnerships and collaborations to reduce health disparities and impact population health. For example, Texas has requested authority to use its Medicaid DSRIP program to invest in innovations aimed at improving care delivery systems and capacity, while emphasizing accountability and transparency. Texas has also requested CMS to allow the DSRIP funds to be used to support regional community partnerships that include public health and other key collaborators. The regional partnerships would work toward the goal of addressing social determinates of health and root causes of the regional population's poor health. At the present time, CMS has not approved Texas's DSRIP proposal for funding regional partnerships.

Recently, CMS has stated they would limit future DSRIP approvals to states that have expanded their Medicaid program to cover the adult populations. Having expanded Medicaid, DSRIP continues to be an option for Arizona.

Areas of Stakeholder Consensus

Arizona is currently engaging in a number of initiatives that support innovation and improvement in population health. AHCCCS has directed its managed care plans to expand the number of providers receiving value-based payments. AHCCCS has also integrated behavioral and physical health at the health plan level, and is starting to integrate behavioral health at the provider level.

While these efforts are to be lauded, a scan of what is occurring in other states suggests that more opportunities exist to innovate and drive improved health outcomes in our state. For example, other states are implementing multi-payer delivery system redesign and payment reform initiatives. Many of these initiatives include payment reforms that reward providers for prevention, patient self-care management efforts, health improvement outcomes, and collaborative community-based health improvement initiatives. Stakeholders concluded that Arizona could take advantage of the State Innovation Model planning grant to develop innovative models and value-based payment methods that reflect Arizona unique Medicaid managed care model.

The following presents key areas of consensus among stakeholders on opportunities for innovation and improvement for Arizona's Medicaid program:

1. Including ACOs in Health Plan Networks

An Accountable Care Organization (ACO) is a network of providers that collectively assumes responsibility for the care of a defined patient population and shares in payer savings if set quality and

cost performance metrics are met. As ACOs have matured, they have begun to invest in health information technologies and evidence-based care models that support their ACO providers in effectively managing their patients and lowering the overall cost of care. For ACOs to be sustainable, they need a critical mass of assigned or enrolled patients. CMS currently lists nine active ACOs participating in Medicare Shared Savings Programs in Arizona, in addition to Banner Health Network (which is the only Pioneer ACO in operation in Arizona). Pioneer ACOs were part of a CMS Innovation Center model test and are considered the prototype for the Advanced ACO initiative announced by CMS. From CMS Innovation Center demonstrations, we have learned that there are some common characteristics of successful ACOs. These characteristics include:

1. A clinically integrated practice model that includes primary, specialty, and acute care services so that patients have predictable access to required clinical services;
2. A common governance structure;
3. The broad deployment and meaningful use of EHRs with health information exchange connectivity for each of the ACOs medical practices;
4. Robust data analytic capability to monitor and improve provider quality, cost, and population health performance; and
5. Financial and management systems and tools to manage value-based payment financial and performance risk for their network providers.

Medicare and commercial health plans are contracting with ACOs using various alternative payment strategies. The ACO model is emerging as an important part of the Arizona healthcare landscape.

AHCCCS has set a target that 20 percent of the payments by managed care health plans to their contracted healthcare providers be value-based payment by 2016. That target will increase to 50 percent by 2018. Small groups and independent practices are an important part of the AHCCCS network in Arizona. As value-based payment alternatives become more prevalent, many solo and small group practices could join ACOs or be acquired by hospital-based provider networks.

Value-based payments have two required elements:

1. Quality Requirements: The quality of the clinical procedure, treatment, or service provided; and
2. Resource Use: The efficient use of resources in producing the care by provided the patient.

Increasingly, CMS and state Medicaid programs are adding a third element to the value-based payment equation, namely that population health outcomes be achieved. Value-based payment models have imbedded economic incentives that change the financial model from treating sickness to keeping people healthy. This means greater emphasis is placed on prevention, early intervention, and timely access to primary care. There has been a slow adoption of value-based payment because providers have not been ready to manage performance and financial risk; however, as public payers continue to accelerate value-based payments reforms, we move closer to a tipping point.

Stakeholders agree that it is challenging for individual and small group physician practices to participate in value-based payment reforms where they share financial risk with payers. For providers to fully participate in new risk-based payment methods, they must be organized into accountable care networks. This is especially important for managing new risk-based payment reforms that require providers to integrate care across the healthcare delivery system or to achieve population health outcomes.

The stakeholders' conclusions about the impact of value-based payments on individual and small group physician practices are supported by a recent Rand study. The American Medical Association (AMA) commissioned Rand to assess the impact of new payment alternatives on small groups and independent practices. The study was based on a survey of practice leaders and market interviewees. The study found that practices were changing their organizational models—predominantly by affiliating or merging with other physician practices or aligning with or becoming owned by hospitals. This was in response to new payment models. “From the practice leader perspective, the most prominent payment model–related reasons for these mergers were to enhance practices’ ability to make the capital investments required to succeed in certain alternative payment models (especially investments in computers and data infrastructure), to negotiate contracts with health plans (including which performance measures and targets would be included), and to gain a sense of “safety in numbers.” The report observed that, “Leaders and physicians in multiple practices described uncertainty about how they would fare in alternative payment programs (and how such programs might evolve over time). For some of these practices, joining with a larger organization was seen as providing a general sense of security, no matter what payment programs might be introduced.”¹ The Rand study supports the conclusion that as more payers move to value-based alternative payment methods, ACOs and hospital-based provider network delivery system models will expand, while the percent of independent and small group practices will continue to shrink.

Pioneer ACOs have proven they can be effective in managing high risk and complex patients. As the ACO model expands in Arizona, the question for AHCCCS and Medicaid managed care plans is how to contract with these emerging healthcare organizations to assure access to primary and specialty services, especially as more community providers join ACOs and hospital systems consolidate their networks. CMS has stated it wants to accelerate ACOs and advance the ACO model. AHCCCS should take advantage of this opportunity by:

1. Developing quality and performance guidelines for managed care plans that contract with ACOs as part of their value-based payment strategy;
2. Include the ACOs serving high risk, high need Medicaid beneficiaries as eligible entities for special funding (such as DSRIP funds) as part of AHCCCS’ Medicaid renewal proposal.

¹ Mark W. Friedberg, Peggy G. Chen, Chapin White, et.al. “Effects of Health Care Payment Models on Physician Practice in the United States”, Rand Health, www.rand.org/health, 2014.

In return for receiving such special funds, the ACO would be required to serve a specific percentage of AHCCCS members. The ACOs, in turn, could use DSRIP funds to finance HIT, care management, and alternative workforce development.

Among stakeholders representing healthcare providers, there was consensus that Accountable Care Organizations and integrated provider networks should be an integral part of the AHCCCS Medicaid network. Some stakeholders felt that AHCCCS could do more to encourage managed care plans to contract with ACOs, especially for the management of high cost, complex needs patients. These patients are often high utilizers of hospital emergency rooms and acute care services. Advanced ACOs should be able to better manage Medicaid patients with complex chronic illness and behavioral health needs.

Dual eligible beneficiaries (those enrolled in both Medicaid and Medicare) are a logical target population for managed care contracts with ACOs. AHCCCS managed care plans could contract with ACOs to provide both the Medicare and Medicaid services. The strong quality performance of Accountable Care Organizations could have a positive impact on the Medicaid managed care organizations star ratings.

2. Expanding Health Homes and Care Management for Patients with Complex Chronic Care and Health Needs

Health homes and primary care medical homes (PCMH) are delivery system models that are designed to better manage the care of high cost, high utilizer patients. Health homes have expanded capacity to address behavioral and social service needs of the patient.

The most effective models of care are organized around the patient's health needs. CMS has encouraged state Medicaid agencies to develop and support "health homes" as evidence-based clinical practice models for patients with chronic illness and mental health disorders or who have other complex needs that affect their overall health. At the practice level, person-centered health homes are a proven model of care. Medicaid programs that have successfully implemented the health home model have seen improvements in the patient care experience and have been successful at lowering total cost of care.

Challenges exist in implementing health homes. It is difficult to develop a health home as a stand-alone provider practice to adequately meet the need of high risk and high need patients. Moreover, many patients needing health homes are dual eligible beneficiaries, creating complexity in how the health home is financed.

Health homes require a lot of infrastructure to achieve consistent results. Some states pay health homes a care management fee or even per-member-per-month capitation to provide the necessary

capital for the required infrastructure and staff development investments. ACOs and integrated healthcare networks can also support the health home model. States are just beginning to implement the health home practice model through contracts with ACOs or integrated provider networks.

Health homes have five primary capabilities and functions that ACOs can readily support:

1. Risk-stratification of patient population and customized care management to individual patient care needs so that patients get the right care, at the right time, and in the right setting;
2. 24/7 access and continuity of care management to assure the health home is coordinating care for these complex patients full time;
3. A structured system of planned care for each patient's chronic conditions and a plan for preventive care and self-care management that is developed in conjunction with the patient and the caregiver;
4. Tools, structure methodologies, and evidence-based techniques to support patient and caregiver, and/or family engagement; and
5. The systems, community linkages, and formal relationships to coordinate care across social services and community resources.

Arizona has just begun to deploy a version of health homes ("look-alikes") as part of its integrated behavioral and physical health model of care. Some Federally Qualified Health Centers have organized their clinical practice around this model of care.

The biggest challenge to the broad deployment of health homes is the infrastructure cost and fee-for-service payment by managed care organizations. Fee-for-service payments do not account for the additional infrastructure and staff costs associated with health homes and care management requirements. Moving to value-based payments and integrating the health home into the ACO or integrated delivery systems will assure health home sustainability.

Some stakeholders support including infrastructure support for the integrated health home model in the 1115 waiver renewal. The health home model holds a lot of promise for addressing the complex needs of high cost patients. Including health homes as part of ACO networks is being explored by a number of states and has been used as an effective model of care for the medical management of the outpatient-based Seriously Mentally Ill (SMI) and non-SMI Medicaid beneficiary population, which need more intensive care management and care coordination to avoid acute care costs.

Another important element of caring for individuals with complex care needs identified by the stakeholders is assignment of care managers to complex beneficiaries. Care managers are an essential element for the coordination of care and needed social services for patients who have complex

chronic illnesses, especially individuals with moderate to severe mental illness. Care managers are typically responsible for performing a variety of tasks, including:

1. conducting medical assessments;
2. developing care plans;
3. arranging visits to care providers;
4. ensuring medication reconciliation;
5. connecting individuals to social and community supports; and
6. developing a trusted relationship that supports the care team's ability to best serve the individual.

Effective care coordination and care management are essential to cost-effective, person-centered quality healthcare. Effective care coordination reduces the over utilization of emergency room and acute care services. Complex, high need patients that are assigned a care manager to coordinate their care have better health outcomes and reduced costs. Care managers help to navigate the patient through the delivery system and assure that patient care is provided in a timely fashion. High risk patients that are assigned care managers have significantly better patient experiences with health systems.

CMS demonstration projects have tested varying models of care management for various types of Medicare and Medicaid patients. Care managers that operated independently from a primary treating physician had limited success and had a higher percentage of inpatient acute care episodes than patients managed by physician practices with an imbedded care manager. Managed care plans operating care management programs outside of the primary care provider's clinical practice are also less effective in managing high cost high utilizers, especially those patients who have mental illness. However, just paying a primary care physician a care management fee also has also shown mixed results. The best model of care management has a specialized nurse or care manager (often a clinical social worker) embedded within the practice. When a care manager was embedded in the practice, medical compliance improved and acute care utilization decreased. AHCCCS should encourage its managed care contractors to embed the care manager more closely with primary care health homes. This can be done by managed care plans delegating care management to contracted ACOs, health systems, or integrated care networks, which could employ a single care manager per health home for all its contracted health plans rather than each health plan employing their own care manager. This model has proven to be much more effective and less cumbersome for the physician practice.

AHCCCS could also consider expanding care coordination for those with behavioral health needs. While care coordination is provided to those who have been deemed as having a serious mental illness, many of those who have general health needs or depression may have a need for care coordination. In addition, many chronically ill patients have moderate or general mental health conditions that go undiagnosed or untreated. According to a report by Milliman, healthcare costs for individuals with both a general mental health condition and one or more chronic illnesses is 2 to 3

times higher than individuals with just chronic illness.² It is just as important to provide integrated behavioral health and physical health and care management for many of these individuals as it is to individuals with serious mental illness.

3. Providing Enhanced Community Supports for Those Who are High-Risk, High Need

Despite the availability of effective evidence-based medical treatments, chronic diseases are often poorly controlled and remain a leading cause of preventable morbidity, mortality, and high costs. Health outcomes are generally worse for low-income patients from communities with health risk factors. To be most effective, the model of care for patients with these complex co-morbidities should be an integrated multi-disciplinary care team model. These patients also often require significant social service supports, which necessitates linkages to social services and community resources.

Stakeholders recognized that Arizona's Long Term Care System (ALTCS) program has proven the value of integrated behavioral and physical health care management with linkages to social services and community resources for those long-term care beneficiaries. One of the key elements of delivery system redesign should be to support integrated models of care for additional high risk, high need patients who are served by AHCCCS's acute care and integrated behavioral health systems.

To improve population health, there is a growing recognition that there must be investment in strategies that address the social determinants of health (e.g. education, job development, and housing). It is only by collectively addressing these issues that optimal health improvement can be achieved.

Lack of housing, substance abuse, physical disability, and economic factors are key social determinants of health that add significant costs to the healthcare system. Addressing these challenges requires solutions that provide for both the health and social services needs of the patient. This means linking the healthcare and human service systems to support the "whole person" needs of the patient.

The opportunities to expand linkages between Medicaid, social services, and housing supports have increased with the passage of the Affordable Care Act. State Medicaid agencies were encouraged to use expanded Medicaid authority to collaborate with social services agencies and housing programs. As part of the federal Community Living Initiative, the departments of Health and Human Services (HHS) and Housing and Urban Development (HUD) are organizing collaborative efforts to increase

² Stephen P Melek, FSA, MAAA, D.T. Norris, FSA, MAAA PhD, J Paulus, FSA MAAA
Economic Impact of Integrated Medical-Behavioral Healthcare, Implications for Psychiatry, Milliman American Psychiatric Association Report, 2014.

the availability of affordable and accessible housing for people with disabilities. The stakeholders felt that such collaborative programs could be expanded between AHCCCS and Arizona's housing programs. AHCCCS could encourage and support managed care plans developing collaborative strategies with assisted housing programs. Some states even employ housing coordinators in their health department or Medicaid agency to work with local housing authorities to assure homeless Medicaid beneficiaries are given priority for housing assistance. Such collaborative strategies could be included in the 1115 waiver renewal to support individuals with mental illness as well as individuals and families who are homeless.

An Arizona example exemplifying the results that can be achieved by coordinating Medicaid services with local community-based efforts can be found in the Maricopa FUSE program. The Frequent Users Systems Engagement (FUSE) model is a local adaptation of the national FUSE model, which helps break the cycle of homelessness and crisis among individuals with complex behavioral and physical health challenges who are the highest users of emergency rooms and other costly crisis service systems. The FUSE program is administered by Circle the City and systematically addresses the needs of individuals who have histories of chronic homelessness and high emergency room use through intensive engagement, medical assessment and psychiatric stabilization, medication management, social support and linkages to federally-funded permanent, supportive housing. FUSE provides housing stability and reduces multiple crisis service use, which reduces healthcare expenses and improves outcomes for the most vulnerable homeless adults in the Maricopa County region. Expanding on the success of the FUSE program, Circle the City has partnered with Mercy Maricopa Integrated Care to launch Arizona's first homeless-specialty Assertive Community Treatment (ACT) Team. This multi-disciplinary mental health team will provide comprehensive, community-based treatment and rehabilitation to people with serious and persistent mental illnesses. Circle the City has also received federal funding and support for a new health center which will serve individuals with mental illness and other medical conditions and at risk for homelessness in the central Phoenix area.

AHCCCS should use its 1115 waiver renewal to expand programs like FUSE statewide, and encourage more partnerships between health plans and community-based providers that address the broader social determinants of health for those with significant health needs.

Many individuals that experience recurring and persistent homelessness have moderate to severe mental illness and disproportionately suffer from multiple chronic illnesses. AHCCCS needs to expand strategies that help to stabilize housing for these individuals. These individuals struggle to receive appropriate health care services in a timely manner. This results in a high percentage becoming high utilizers of emergency care services and result in a high number of hospital readmissions after an acute inpatient episode.

California's Medicaid program has recognized that broadening the skill sets and accountability of care managers to include training on linking beneficiaries to social services and housing support programs is critical to reducing healthcare cost of California's high risk Medicaid beneficiaries.

California included strategies for care manager training and skill development in homelessness prevention in their 1115 waiver renewal. Homelessness has a dramatic impact on healthcare costs and health outcomes. AHCCCS should require its managed care health plans to assure care managers have training in securing stable housing and preventing homeless for high risk high need individuals.

AHCCCS's goal to improve the transition of Medicaid members from the justice system back into the community could be facilitated by care managers with knowledge of housing resources and armed with strategies to prevent homelessness. AHCCCS Medicaid managed care plans should be encouraged to work with low income housing developers, county housing agencies, and even property managers to prevent enrolled high-risk Medicaid beneficiaries from becoming homeless. AHCCCS could support this effort by requesting broader authority to leverage Medicaid dollars for housing support services in its 1115 waiver renewal. AHCCCS and its managed care contractors should apply greater focus on collaborating with counties and community stakeholders to develop new strategies to assure high risk Medicaid beneficiaries have stable housing. This would go a long way towards achieving the goal of lowering Medicaid healthcare costs by reducing ER visits, hospital inpatient days, and hospital readmissions.

Other Arizona examples of community collaborations that are proving effective in reducing unnecessary healthcare utilization and costs for those with significant health needs are emerging throughout the state. Community paramedicine is a new and evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care, reduce hospital readmission rate and enhance access to primary care for medically underserved populations. Community paramedicine programs are designed to address specific local problems and to take advantage of locally developed community resource linkages and collaborations between and among city and county emergency medical services (EMS), health plans, and other health care and social service providers.

Community paramedicine programs have shown a great deal of promise improving access to care and reducing cost in high risk high need Medicaid and Medicare populations. The Mesa Fire and Medical Department community paramedicine project is one such example. The project received a grant from the Centers for Medicare and Medicaid Services to test a community paramedicine model that is aimed at reducing the healthcare costs of Mesa residents with complex health needs and history of high healthcare costs. The community paramedicine model specifically targets readmissions and emergency care episodes of high-risk patient discharged from the hospital. High-risk patients receive follow-up evaluations in their home or place of residence by a community paramedic after a hospital discharge to reduce the incidence of readmission. The program also aims to provide low-acuity patients with on-site evaluation and treatment by a nurse practitioner when they call 9-1-1, and refer patients to appropriate services rather than bringing them to the emergency room unnecessarily. Preventative services are also provided, including immunizations and support to improve medication compliance. Chandler, Scottsdale, Rio Rico, and other Arizona communities are currently at various stages of implementing similar community para-medicine programs.

The stakeholders supported AHCCCS including these types of innovative delivery system solutions in the State Healthcare Innovation Plan. AHCCCS should use the planning grant to bring stakeholders together to discuss how to deploy models like Mesa's community paramedic program statewide, and well as develop other innovative models of care to address Medicaid's most challenging problems.

4. Further Supporting Behavioral Health and Physical Health Integration

AHCCCS should be commended for recognizing that fragmented delivery of care can be particularly problematic for individuals with serious mental illness (SMI). A high percentage of the SMI population has physical health and chronic acute care needs. AHCCCS has been consistently moving forward with the integration of behavioral and physical health at the managed care health plan level.

The stakeholder participants agreed that AHCCCS should make greater investments at the provider level to address gaps in infrastructure, health information systems, staff resources, and integrated care management tools. Federal waivers approved for other states have included approval of the use of Medicaid matching funds to help support and expand the implementation of health home and integrate care infrastructure.

Stakeholders identified four key inter-dependent delivery system redesign recommendations that AHCCCS could support for the delivery of integrated primary care and behavioral health services:

Integrate physical health services into existing community mental health centers where the seriously mentally ill receive care;

1. Invest in telehealth and mobile technology tools for self-management for adults with serious mental illness;
2. Provide financial support for the installation and meaningful use of integrated electronic health record systems and health information exchange connectivity for health homes; and
3. Utilize an alternative workforce that is trained to support community care transitions, care management, and patient self-care management.

Stakeholders agree that AHCCCS should expand the deployment of integrated health homes models and use the waiver renewal proposal to request authority for providing Medicaid funding for infrastructure investments such as electronic health record systems and health information exchange connectivity. The infrastructure investment required to support these integrated health home models could be provided as part of a DSRIP 1115 waiver program. Both California and New York received authority to set a DSRIP program that included support for integrated health home models infrastructure.

5. Supporting Alternative Workforce Development

It is challenging to manage the health of low-income, vulnerable, frail, and elderly individuals that suffer from chronic diseases like diabetes, heart disease, and chronic obstructive pulmonary disease. This is especially true when they also suffer from mental health conditions or dementia. Unfortunately, primary care providers have limited capacity to manage their patients' chronic diseases outside of the practice or clinic. Those with complex conditions often need additional support to care for their health in community settings. Low-income individuals with high risk conditions often need help transitioning to the community from healthcare settings such as a hospital, as well as assistance navigating the system, or assistance with self-care management outside the provider's office.

Community health workers can help bridge language, cultural, and socio-economic challenges that affect the patient's access to care and improve patient self-care management and medication compliance. Indeed, one private insurer stressed the importance of such efforts in the stakeholder sessions, noting that the health plan that he represents is seeing cost savings and improved health outcomes by utilizing health coaches for those with complex health needs.

Community health workers may go by many titles including healthcare outreach workers, patient navigators, health coaches, *promotores de salud*, home visitors, etc. Regardless of the title, these workers can be integral members of care delivery teams. In underserved and rural communities, community health workers can serve as liaisons between patient and provider. They are also part of the evidence-based strategy for community care transitions. As patients are discharged from a hospital or nursing facility, community health workers assist them to transition back to their home and assure they reconnect with their primary care providers.

Community health workers can help individual patients assigned to primary care medical and health homes by:

1. Ensuring patients on multiple prescriptions are properly taking their medications;
2. Transitioning patients being discharged from a hospital or nursing facility;
3. Providing home visitation and gathering health assessment information;
4. Following up on individuals with mental illness or who are homeless;
5. Reinforcing care plans and promoting patient compliance;
6. Improving patient and caregiver health literacy through education; and
7. Connecting individuals to social support.

The Community-Based Care Transitions Program sponsored by CMS focuses on improving care transitions and requires the participation of community-based organizations to help improve quality of care for Medicare beneficiaries who are at high risk of readmission in their communities. Under this program, the community-based organizations, or acute care hospitals that partner with community-based organizations, provide care transition services across the continuum of care, which could

include patient-centered self-management support specific to the beneficiary's condition and comprehensive medication review and management.

There are currently 102 participating sites nationally, including three in Arizona funded by CMS: Carondelet Chronic Care Navigation in partnership with Pima Council on Aging (PCOA), Maricopa Area Agency on Aging Healing@Home Community-Based Care Transition program (CCTP), and the Sun Health Community-based Care Transition program. The Carondelet/PCOA care transition program is aimed at countering the high rate of readmissions experienced by Medicare beneficiaries. The PCOA/Carondelet Chronic Care Navigation Program (CCNP) provides personalized follow up care with an individualized holistic approach, partnering professional navigators and transitional care coaches/care coordinators with experienced Carondelet nurses to assess and advocate for patients' social and medical needs post-discharge. The Maricopa County Area Agency on Aging Healing@Home program works with Medicare beneficiaries who have recently been discharged from a local hospital and are at high risk for readmission, similar to the Sun Health CCTP effort.

CMS encourages state Medicaid agencies to build on its investment in community-based care transitions. AHCCCS should further build on these strategies to address readmissions and care transition back to the community of "high cost high utilizer" patients. This model could be expanded to including high-risk patients and individuals transitioning from correctional institutions back to the community as a proven strategy to avoid emergency room visits and hospital admissions.

Current federal Medicaid authority allows states to use community workers to support prevention, health education, and counseling regardless of whether these services are delivered in a medical office or clinic, the patient's home, or a community-based setting, such as a child care center. Several states have been successful using community health workers as part of a comprehensive home visitation program as part of their Medicaid waiver programs. The stakeholders agreed that community health workers could be an important part of the care delivery team for patients with complex care needs.

This is another area in which states are using their 1115 waiver to address improving community health. States are requesting authority to use DSRIP pool funds to support the training and deployment of alternative workforce. AHCCCS would benefit by creating a ready pool of community health workers that could support health homes and improve hospital to community transitions to reduce rates of readmission.

6. Driving Improvements in Population Health

The stakeholders believe there is a convergence of interest by healthcare providers and public health officials to address population health. Healthcare providers, ACOs, and health plans would mutually benefit from organized strategies that engage Arizona's communities in collective health improvement strategies.

The goal of population health management is improving health outcomes. A population can be defined by a healthcare beneficiary group, by demographic groupings, or by geographical boundaries. When population health is discussed in relationship to Arizona "health improvement," all three of these "population definitions" are within the scope of delivery system redesign and payment reforms. Addressing population health has traditionally been the domain of the public health sector. However, limited public health budgets necessitate a broader, collaborative approach to addressing population health outcomes.

Accountable Care Communities

Accountable Care Communities (ACCs) are one type of collaborative model that addresses population health. The Accountable Care Community model takes the ACO one step further by holding entities outside the healthcare system (such as community-based prevention organizations, local health departments, or social service providers) accountable for the health outcomes of a community in addition to healthcare providers. The Austen Bio-Innovation Institute (ABIA), a non-profit, organized the first Accountable Care Community in Akron, Ohio. ABIA brought together a wide range of stakeholders and groups to launch the first-of-its-kind Accountable Care Community (ACC) in 2011. The ACC was an organized collaborative of health providers, public health officials, other local government agencies, and community-based organizations. The charge of the ACC was to develop new health information tools while also engaging in policy analysis and advocacy work needed to promote wellness. This collaborative reflects a broad vision for the next evolution of the Accountable Care model. The ACC provides a community-based structure that ACOs, health plans, health system, public health, and community stakeholders can join in developing health improvement strategies, policy advocacy, secure social impact investment that support expansion of community-based social and economic resources, health promotion, and disease prevention.

The National Association of Counties has taken the lead to champion the continued development and deployment of ACCs throughout counties across the US. For example:

- Live Well San Diego was developed as a 10-year plan to make San Diegans healthy, safe, and thriving. The region aims to improve its service delivery system by developing an Accountable Care Community. Increases in chronic disease rates and health care costs prompted the county to take action, adopting a comprehensive plan for population health and safety that began with the Building Better Health agenda. The current Thriving agenda

will address quality of life issues. Championed by the Board of Supervisors, county staff supports this collective effort, as do its 44 recognized partners—cities, school districts, businesses and faith- and community-based organizations—each committed to a shared vision for healthy, safe, and thriving communities. The Accountable Care Community provides the structure for organizing the contributions of health providers, public health and other stakeholders in San Diego.

- The Akron ACC, which has already gained recognition for its work addressing community prevention and wellness in Akron, is continuing to work on the following initiatives: (1) expanding the concept of “public lands for public health” with the Cuyahoga Valley National Park — including extending public transportation such as bus lines to make the park more accessible to more members of the community; (2) conducting a regional health impact assessment of the Akron Marathon; (3) forming partnerships with the faith-based community for health education and screening for individuals who are underserved including refugees and Native-Americans; and (4) working with the Akron Metropolitan Transportation System to better understand how to design or redesign systems transportation and the built environment to provide increased opportunities to access safe places for physical activity and healthy, affordable food options.
- Summit County Ohio, working with Austen Bio-Innovation Institute, is developing its Accountable Care Community model, which is defined as a “collaborative, integrated, and measurable strategy that emphasizes shared responsibility for the health of the community, including health promotion and disease prevention (and) access to quality services.” Hospitals, public health, the private sector and nonprofits work together to prevent — or lessen the burden of — chronic diseases such as cancer, diabetes, and heart disease.

The model of Accountable Care Communities continues to evolve as more states and counties adopt this model as an extension of their delivery system reforms. CMS and the Centers for Disease Control and Prevention (CDC) encourage formation of ACCs as a vehicle to align community health improvement, social and economic community capacity building, housing, and education to address the social and economic determinants of health.

The National Association of Counties (NACO) has articulated a broad mission for ACCs. NACO's focus for ACCs is to expand the capacity of the public and private sectors to align their programs, services and workforce to address the community's needs. ACCs mobilize the entire community to address one specific goal or multiple goals such as obesity, education, safe streets and/or economic vitality. The involvement of all facets of the community – from economic development to schools to safety-net hospitals – through partnerships must be viewed as a shared responsibility. Examples of ACC actions and activities can include:

1. Developing integrated medical and public health models to deliver clinical care in tandem with health promotion and disease prevention efforts;

2. Utilizing inter-professional teams including, but not limited to, medicine, pharmacy, public health, nursing, social work, mental health, and nutrition to align care management and improve patient access and care coordination;
3. Coordinating health systems and public health to enhance communication and planning efforts;
4. Developing a robust health information technology infrastructure to enable access to comprehensive, timely patient health information that facilitates the delivery of appropriate care and execution of effective care transitions across the continuum of providers;
5. Implementing an integrated surveillance data system to monitor and report systematically and longitudinally on the health status of the community, measuring change over time and assessing the impact of various intervention strategies;
6. Creating an infrastructure to rapidly share best practices;
7. Designing and implementing specific tactics and impact measurement tools; and
8. Garnering stakeholder investment and financial support to facilitate ACC success and sustainability.

AHCCCS could have a significant impact on encouraging ACC formation in Arizona. AHCCCS could use the SIM planning grant and the stakeholder engagement process to encourage the formation of ACCs as part of Arizona's delivery system transformation strategy. AHCCCS could also use the Medicaid Waiver renewal to seek authority to use Medicaid funds to support the infrastructure required for the development of ACCs. At a minimum, AHCCCS should encourage its managed care contractors and healthcare delivery systems to organize community-based collaborative impact strategies that focus on prevention and improving overall community health status.

Community Health Trust Funds

There are also other models for collaborative community engagement to address population health. For example, a "Community Health Trust Fund" is a partnership of community stakeholders that jointly contributes to fund collective health improvement impact strategies. This model of organized community collaboration has been implemented in Massachusetts and is called a Prevention and Wellness Trust Fund. The Massachusetts Prevention & Wellness Trust Fund is investing \$60 million over 4 years in evidence-based community prevention activities, with the goal of reducing costly preventable health conditions.

A community health trust fund is created by the financial contribution of relevant stakeholders (such as payers, health systems, and businesses). The payments are used for financing community health initiatives that improve health, reduce community health risk factors that increase healthcare costs, and improve the quality of life and productivity of the community residents.

Collaborations with Banks

Collaborations to improve population health have expanded beyond more traditional healthcare organizations to also include financial institutions. The Federal Reserve and commercial banks can be

important partners with AHCCCS in leveraging local community development resources to address population health. Banks and community-development organizations are partnering with health organizations to develop multi-sector strategies to create infrastructure for healthy communities. This trend is being spurred in part by the Federal Reserve System, who has recognized the relationship between poor health and economic vitality.

There is a symbiotic relationship between the health and resilience of a country's economy, and the health and resilience of a country's people. The Health Community Framework is important because it provides strategic direction to financial institutions on how to invest in healthy communities, and how to communicate the value of these investments to stakeholders."

—Richard W. Fisher *President and CEO, Federal Reserve Bank of Dallas*

The Federal Reserve is encouraging financial institutions to take a proactive role in developing healthy community strategies by connecting with local health organizations, state and county public health departments, and hospitals. Financial institutions can be important collaborators in such initiatives by addressing issues related to access to safe and affordable housing, healthy foods, pedestrian walkways and/or bike trails.³ The Arizona Partnership for Healthy Communities is a local example of such a collaborative. The San Francisco Federal Reserve Bank participates in this partnership. At the national level, the Healthy Communities Initiative (a collaboration between the Federal Reserve System and the Robert Wood Johnson Foundation) is fostering cross-sector and place-based strategies aimed at revitalize neighborhoods and improving health.⁴ Those engaged in this initiative address issues related to increasing the availability of high-quality affordable housing, financing small businesses, and creating community assets (such as charter schools, clinics, or daycare centers) as a means of addressing long-term health outcomes.

Social Impact Bonds

States are also considering how to integrate Social Impact Bond (SIB) strategies to support population health strategies that align with their delivery system and payment reforms. The bond arrangements typically involve: an intermediary organization (usually a non-profit organization), a government agency, a service provider, and private investors. The government contracts with the intermediary to obtain social services, such as transitioning high-need homeless individuals into stable living situations (e.g. Circle the City). For payment, the intermediary receives money from the government in an arrangement called pay-for-success contracting (or outcome-based contracting or

³ Jonathan Greenblatt and Annie Donovan, *The Promise of Pay for Success*, CMTY. DEV. INV. REVIEW, FED. RESERVE BANK OF SAN FRANCISCO 18, 20 (2013), available at <http://www.nj.gov/state/programs/pdf/faith-based-investment-success-financing.pdf> (issue hereinafter "COMMUNITY DEVELOPMENT REVIEW"); Maria Hernandez, et al., *Impact Investing in Sources of Health*, Collective Health (2012)

⁴ <http://www.frbsf.org/community-development/initiatives/healthy-communities/about/>

performance-based contracting). The intermediary only receives payment if certain performance targets are met. Performance is subject to careful evaluation, which the government itself is responsible for arranging. This is a fundamental characteristic of SIB models—the government pays the intermediary *after* the services are provided, with the idea that the money will come, at least in part, out of the savings the government reaps from reduced usage of health services (such as emergency room visits, Medicaid, etc.).

In South Carolina, the state is beginning to plan to use social impact bonds to leverage private investment to finance interventions to improve early childhood health outcomes, such as the evidence-based Nurse Family Partnership intervention. It is expected that these early childhood interventions will create measurable savings, including reduced Medicaid expenditures from preterm births and emergency room visits. If the interventions succeed in obtaining their savings goals, South Carolina will compensate the intervention's investors.

Other Community Development Partnerships

Other examples also exist on how partnerships among community development organizations and the healthcare community can be formed to address community health.

For more than 30 years, the mission-driven Cathedral Square Corporation in Vermont has provided high-quality affordable homes to 2,000 low-income seniors. The organization relies on a variety of funding sources programs, including federal tax credits and foundation support. Over the years, Cathedral Square has come to understand the day-to-day needs of its residents and has uncovered gaps in needed services. Recently, they realized a pressing need for coordinated medical and wellness services. None of the health needs are “housing problems” per se, but they affected the lives of Cathedral Square's residents. Leveraging Vermont's Medicare reform pilot, Cathedral Square established a Support and Services at Home program, which provides a nurse and care coordinator for each group of 100 seniors. In its first year alone, the program saved Medicare 30 percent in health care costs, mostly through improved monitoring, better coordination of services, and more at-home care.

Cathedral Square also worked with partners beyond Medicare to improve the health of residents. Realizing that the physical layout and condition of their units and common areas was contributing to trips and falls, they sought to make small capital investments in improving their facilities. Since such capital investments could not be made with Medicare funds, they sought out new funding partners. Enterprise Community Partners, a national housing and community development funder, is developing a new Pay-for-Success product called the Socially Aligned Value Investment, or SAVI. The SAVI is structured more like equity than a bond, but it is consistent with the Social Investment Bond model.

The Vermont initiative works by leveraging ACO and private investors:

- The Vermont government or possibly an Accountable Care Organization—whichever has exposure to the health care costs of this population and is interested in reducing cost—acts as the “payer” and sets measurable goals for improved health outcomes and reduced costs. If those goals are met, the payer agrees to cover all associated costs plus a premium.
- Private investors provide upfront capital for the necessary services and capital improvements. If the goals are met over a defined period of time, they are repaid plus a premium. If not, they lose this initial investment. Cathedral Square provides the necessary services and capital improvements, with meaningful discretion over how the money is spent.
- Enterprise serves as the sponsor or intermediary of the transaction, coordinating and implementing all of the contractual relationships among investors, Cathedral Square, and the payer.

Collective Impact Strategies

Collaborations to improve community health can also be fostered through collective impact strategies.

Collective impact strategies leverage multiple stakeholders’ interests in health improvement outcomes into an integrated effort with common performance improvement goals. They can provide a means of leveraging diverse population health improvement efforts such as hospital community benefit requirements, health plans’ population health and health promotion investments, and ACO requirements to improve population health, and the responsibility of community banks to provide capital for housing and community development. Each community’s collective impact strategies requires stakeholders to contribute some level of equity (sweat equity, capital investment, or in-kind contribution) to have a collective impact, such as increasing fresh food consumption to affect the prevalence of obesity in a community. Collective community impact strategies have begun to move to the mainstream as local communities, states, Accountable Care Communities, health plans, and health systems get serious about impacting population health.

Collective impact strategies are gaining traction due to the recognition more entities have “skin in the game” for improving population health. Since more individuals now have continuous health insurance coverage due to the Affordable Care Act, there is a growing awareness that improving population health is a shared responsibility among the payer, the health system, and the community. Payers now have a financial incentive to keep people healthy, since they may have to pay for the healthcare costs of individuals who are covered by the plan over a longer period of time.

Michigan is organizing stakeholders into a collective impact effort named the Community Health Innovation Region (CHIR). The underlying concept of the CHIR is to create a stakeholder-led organization where each stakeholder has some financial or equity stake in the health improvement results. The risk-based capital for investing in health improvement projects comes from health plans,

health systems and ACOs, public health, county redevelopment funds, and other community contributions (such as foundations and other philanthropy). By establishing an organizational framework, Michigan hopes to test the sustainability and innovation potential of stakeholder-led collaboratives. Michigan is using its SIM model testing grant to provide as start-up capital for CHIR formation and has included CHIR financial support in its payment reform models.

Other state examples of organized community collaborations include:

- *Connecticut's "Health Enhancement Communities" (HECs)* – These communities focus on areas with the greatest disparities, targeting resources and facilitating local coordination and accountability among providers, local public health departments, nonprofits, schools, housing authorities and others through innovative financing strategies (e.g., wellness trusts) and multi-sector governance solutions (e.g., local coalitions led by a fiduciary agent). Evidence-based initiatives and strategies are linked with reimbursement for addressing social determinants of health and health equity.
- *NC Public Health–Hospital Collaborative* – In North Carolina, public health organizations and hospitals are implementing initiatives based on priorities listed in community health needs assessments. North Carolina's legislature uses tobacco tax money dedicated to a Health and Wellness Trust Fund to fund programs that promote preventive health, community-based collaborations and collective health improvement impact projects. The Health and Wellness Trust fund has also supported healthcare provider quality performance dashboards that make provider performance more transparent for consumers.

Examples of such collaborations aimed at improving population health are growing more prevalent across the country. AHCCCS could play a prominent role in fostering such collaborations. It could collaborate with the Arizona Department of Health Services, the Arizona Department of Economic Security, other state agencies, local health, and tribal governments to foster and support collective impact strategies that address Arizona health priorities. AHCCCS should use its SIM grant funds to solicit input and strategies from stakeholders about how AHCCCS could support collaborative community health improvement and collective impact structures, as part of delivery system redesign and payment reform and incorporate innovative strategies in its waiver renewal.

Arizona Issues Affecting Successful Delivery System Improvement

The stakeholders identified a number of concerns that could severely impact Arizona's opportunity for successful delivery system redesign and payment reform. Chief among the concerns is the possibility that Arizona would roll back the expansion of Medicaid for the adult population after 2016.

The coverage of adult Medicaid beneficiaries has reduced the amount of uncompensated care burden experienced by Arizona hospitals. Expanded coverage made it possible for the adult population to access primary care and preventive services instead of having to use emergency services. Rolling back Medicaid adult expansion will increase uncompensated care. With the virtual elimination of Medicaid disproportionate share hospital funding, hospitals will shift uncompensated care costs to private payers increasing the premiums to private insured patients.

Provider rate cuts are another major concern for stakeholders. AHCCCS Medicaid provider rates have been cut over the last few years. The Kaiser Commission for Medicaid and the Uninsured 2012 report on Medicaid rates shows AHCCCS Medicaid primary care FFS rates at 75 percent of Medicare FFS rates for the same level of service and 82 percent for all FFS rates. The gap between Medicare rates and Medicaid rates endangers primary care and specialty provider participation in the AHCCCS provider network.

Arizona's failure to implement an adequate statewide Health Information Exchange continues to limit other efforts to improve our state's health system. A health information exchange infrastructure is necessary for meaningful use of electronic health records. More importantly, it is critical for coordinating care across the delivery system. This is especially true for integrating behavioral and physical health services. The stakeholders agree that expansion of the health information exchange infrastructure is critical to success delivery system redesign and the acceleration of value-based payment.

Stakeholders also expressed concern about the movement towards requiring increased cost sharing by Medicaid recipients. Medicaid beneficiaries often face unique challenges adhering to personal responsibility programs due to their limited resources. Many states have tested personal responsibility policies but there is limited evidence of their success. AHCCCS is now required by law to include such personal responsibility provisions in its submission of waiver amendments each year. Stakeholders believe that delivery system redesign and payment reform is the best approach to achieving the goal of cost reduction in the Medicaid program. Enhanced engagement and personal responsibility among consumers can best be achieved by greater access to primary care and enhanced efforts aimed at improving health literacy.

Conclusion

AHCCCS should be commended for the strides it is making to improve Arizona's healthcare system. It is actively working to better integrate care delivery for those with a serious mental illness (SMI) statewide. It is also moving towards implementing value-driven payment through Medicaid, and it has been successful in obtaining a federal State Innovation Models planning grant from the Centers for Medicare and Medicaid Services.

Stakeholders agreed that Arizona needs to take full advantage of the state innovation grant. In combination with the waiver renewal, AHCCCS should support accelerated delivery system and payment reforms in Arizona. Value-based payment should have financial incentives and reimbursements for keeping patients well and supporting self-care management. AHCCCS should consider how it might partner with the growing number of accountable care organizations in the state to assure solo and small group practice providers ability to participate in value-based payment methods.

There was also consensus among stakeholders that a key to improving our healthcare system is to better address those whose care is most complex and costly. That includes addressing the needs of those with a behavioral health diagnosis (including some with serious needs who may not have a SMI designation) and significant physical health needs. Addressing the complex needs of individuals through the creation of health homes and better care management can help lower costs and improve health outcomes. Encouraging the spread of health homes and care coordination, in turn, requires upfront investment in electronic health records and care management systems. Addressing the needs of high utilizers of healthcare also requires partnerships to address the social determinants of health that play a role in affecting health outcomes, such as housing.

Health homes need trained community health workers and other types of alternative health workers to expand the health homes' capacity and to support patient care management. Value-based payment must reflect these additional infrastructure and resource costs. Accountable care networks are one means of providing infrastructure support for health homes.

There was also consensus that delivery system reform needs to incentivize community-based collaborative efforts to improve population health. Accountable Care Communities and other collaborative and financing models hold promise for fostering cooperative efforts among public health, the healthcare system, health plans, and community stakeholders. AHCCCS could play an important role in fostering such collaborations.

Even with the budgetary challenges facing the state, Arizona can continue to be a laboratory for healthcare delivery system and payment reform innovation in Medicaid managed care. The 1115 Waiver renewal provides the vehicle to support Arizona in achieving the triple aim of better care, population health improvement, and lower healthcare costs.

Because of the number of Arizonans that AHCCCS touches through each of its coverage programs -- acute care, long-term care, or behavioral health coverage --- AHCCCS has become a major contributor to the health and vitality of Arizona's citizens. This is a significant responsibility -- and an opportunity. AHCCCS should look beyond its historical role as payer and managed care contract manager to envision a broader role and its potential to drive health improvement for nearly one-out-of-five Arizonans, especially Arizonans that are disproportionately affected by health disparities and health risk factors.

The SIM grant provides AHCCCS with the financial resources to support a robust and productive stakeholder engagement process which could generate innovation and produce a roadmap for improving the health of Arizona's citizens. The waiver renewal can become a seminal document that sets the direction and authorities for AHCCCS through 2021. The convergence of these two opportunities creates an opportunity for AHCCCS to have a major impact on delivery system redesign, value-based payment, and population health in Arizona. AHCCCS should embrace this opportunity to create the next generation Medicaid program.



A Catalyst for Community Health

September 17, 2015

Mr. Tom Betlach
Director
AHCCCS
801 E. Jefferson St. MD 4100
Phoenix, AZ 85034

Dear Director Betlach:

Thank you for the opportunity to comment on the proposed Medicaid waiver. As a public foundation based in Arizona, we are committed to improving the health of all Arizonans. We strongly believe the direction of our state's Medicaid program influences Arizona's overall health system and the health outcomes of millions of people in our state.

We enthusiastically support many aspects of the proposed waiver. We support AHCCCS' proposed approach to Delivery System Reform Incentive Payments (DSRIP). This summer, St. Luke's Health Initiatives convened community leaders representing hospitals, FQHCs, behavioral health providers, community development representatives and public health officials to discuss opportunities to more fully leverage Medicaid and federal funding opportunities to improve the health of Arizonans. (A copy of the ideas and priorities discussed in the report is attached.) The consensus among the group was that priorities should include further addressing:

- the integration of behavioral health and acute care (including further supporting health information exchange),
- the needs of high utilizers of health services,
- improved coordination of care, and,
- new collaborations to improve population health.

As a grant-making foundation, we welcome opportunities to share best practices that we have gleaned from existing Arizona efforts that we have funded, and we are open to discussing other types of public-private partnerships. For

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example, we welcome sharing information on collaborations that we are involved with related to community paramedicine and addressing the needs of high utilizers of services such as portions of the homeless population.

We enthusiastically endorse efforts supporting American Indian medical homes. We also support the broader use of technology to communicate with AHCCCS members, and efforts to further reduce fragmentation among healthcare programs. Finally, we support efforts to promote the use of chronic disease self-management, and strategies to incentivize attainment of defined wellness targets among AHCCCS members.

While we support many aspects of AHCCCS's waiver request, there are also areas of concern. These include provisions related to:

Co-Pays: While we appreciate AHCCCS's strategic approach to implementing co-pays, we believe that these provisions may be too broad, potentially inflicting harm on a low-income, vulnerable population. In particular, we believe that the co-pay provisions could be strengthened by altering co-pay requirements related to opioids and non-emergency use of hospital emergency departments.

We are concerned that those suffering from chronic pain may be limited in their ability to access pain-reducing medicine. Evidence suggests that effective pain management (including appropriate use of opioids) can reduce ED utilization.¹ We suggest that this co-pay requirement allow for further exceptions for those engaged in palliative care or under the supervision of a pain management specialist.

As for the emergency department co-pays, we have concerns that it may be difficult to determine what constitutes appropriate versus inappropriate use of an emergency room.² If such co-pays were to be implemented, we suggest that AHCCCS use a reasonably prudent person standard.³ We also believe it is important to couple any strategic co-pay for inappropriate emergency department use with efforts aimed at providing viable alternatives for people to seek care when they need it. If implemented, we encourage AHCCCS to couple the co-pays with efforts to expand primary care, ambulatory clinics and urgent care hours and locations. We also believe efforts aimed at addressing the needs of high-utilizers of health services and strengthening health homes for those with behavioral health and physical health needs could further curb emergency department use.⁴

Premiums and HSAs: St. Luke's Health Initiatives has helped convene and support the Cover Arizona coalition for the last two years. Due in part to the efforts of this coalition's 800+ members, more than 500,000 Arizonans have gained health coverage through AHCCCS and the Marketplace. We are *very concerned* that a new requirement for monthly premiums will stymie that progress, resulting in many Arizonans losing coverage. Research suggests that cost-sharing for Medicaid enrollees has a negative impact on enrollment, and may lead to decreased use of primary care and increased use of emergency care.

¹ The New York Times http://well.blogs.nytimes.com/2013/12/02/palliative-care-the-treatment-that-respects-pain/?_r=0; See also The New England Journal of <http://www.nejm.org/doi/full/10.1056/NEJMe1004139> and Health Affairs <http://healthaffairs.org/blog/2015/04/23/more-from-the-grantmakers-in-health-annual-conference-diane-meier-on-palliative-care-a-film-on-elder-care/>

² American Journal of Emergency Medicine <http://www.sciencedirect.com/science/article/pii/S0735675797900838> See also Health Affairs <http://content.healthaffairs.org/content/29/9/1630.full>

³ See 45 CFR 147.138(b)(4)(i). See also A.R.S. 20-2801(3).

⁴ Centers for Medicare and Medicaid Services. <http://www.medicare.gov/Federal-Policy-Guidance/Downloads/CIB-01-16-14.pdf>

For example, cost-sharing implemented by the Oregon Health Plan was recently reported to have led to an exodus of the plan's poorest members.⁵ We also question whether consumers will be able to make such payments easily, given that nearly 13 percent of Arizonans are "unbanked."⁶ Finally, we question whether the administrative cost of implementing cost-sharing requirements will undermine the administrative efficiency of the Medicaid program.⁷

If monthly premiums and HSAs are to be implemented, we encourage AHCCCS to allow individuals to withdraw money from their account to be reimbursed for co-pays. By allowing AHCCCS recipients to use their HSAs for this purpose, AHCCCS will be mirroring practices of the private sector, further preparing AHCCCS recipients to better prepare themselves for utilizing private health insurance in the future. While we are pleased to see that the current waiver plan encourages the use of HSAs to fund preventive, non-covered services such as dental care, we are concerned that those who have chronic or costly medical conditions may be limited in their ability to access their HSA to address the cost of their immediate health care needs.

Finally, we want to make clear that foundations such as ours do not typically contribute to individuals (or their HSAs) to address their healthcare needs. Instead, we typically contribute to organizations or programs that more broadly or systemically address health issues. That said, foundations such as ours are eager to find ways to more broadly partner with government to help improve health systems and population health, and we have a strong history of putting this into action.

Five-Year Limit and Work Requirements: We strongly oppose arbitrary time limits on Medicaid and requirements tying Medicaid to work. We believe that defining "able-bodied" will be very challenging. Currently, many very sick, physically or mentally impaired individuals are not able to work, yet do not qualify under existing disability categories. For example, older adults with serious health conditions who lost their jobs in the Great Recession and retired early to receive social security benefits may not qualify for work requirements or time limit exceptions. Caregivers who need to stay home to care for a physically or mentally disabled loved one would be required to work, potentially resulting in costly institutionalization of their loved one.

While we take exception to these requirements, we do commend AHCCCS' desire to connect those receiving AHCCCS with information on employment services available through the Arizona Department of Economic Security, and encourage AHCCCS to continue to partner more broadly with other public and private sector organizations to address the social determinants of health of Medicaid recipients, including employment and housing.

Non-Emergency Transportation: We are concerned about the proposal to eliminate non-emergency transportation. In Arizona, there are profound health workforce shortages, and many areas of the state are deemed medically underserved by the federal government. Couple that with relatively weak public transit use in some of the state's major urban areas and vast swaths of rural and frontier areas, and the ability to access medical services becomes especially problematic without access to paid transportation for those who need it.⁸

⁵ Health Affairs <http://content.healthaffairs.org/content/24/4/1106.full>

⁶ FDIC <https://www.fdic.gov/householdsurvey/2013appendix.pdf>

⁷ Modern Health Care

http://www.modernhealthcare.com/article/20150608/NEWS/150609910?utm_campaign=KHN:%20Daily%20Health%20Policy%20Report&utm_source=hs_email&utm_medium=email&utm_content=18203796&hsenc=p2ANqtz-8EsNq2ACZZyF3Zg5hPJBH_ERXwzZITMniDJuPP0mEyonop-GPDYNgwJQmIDXVxfn2GKWp32Fjq9W3RPpb84Mvydd6OQ&hsmi=18203796

⁸ 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/>

Thank you for the opportunity to respond to the waiver proposal. We deeply value AHCCCS's continued commitment to innovation and improvement, and we welcome opportunities to collaborate on many of these efforts in the future.

Sincerely,

A solid black rectangular box redacting the signature of Suzanne Pfister.

Suzanne Pfister
President and CEO



faith, hope, love

SOCIETY of ST. VINCENT de PAUL P. O. Box 13600, Phoenix, Arizona 85002-3600 tel 602.254.3338 fax 602.261.6829 www.stvincentdepaul.net

September 17, 2015

AHCCCS Cares Response

The Society of St. Vincent de Paul (SVdP) is an international lay Catholic organization whose mission is offering person-to-person service to the needy and suffering regardless of race, origin, religion or gender. The Diocesan Council of Phoenix includes 84 conferences of charity in central and northern Arizona.

The SVdP Diocesan Council of Phoenix appreciates the positive changes proposed by AHCCCS Care including:

- Development of tools to curb fraud, waste and abuse.
- Promotion of wellness programs such as flu shots, glucose screenings and tobacco cessation.
- Management of chronic diseases such as diabetes and asthma.

While the SVdP Diocesan Council of Phoenix appreciates the positive changes proposed by AHCCCS Care, we are called by our mission to oppose the punitive changes to the current AHCCCS program proposed by AHCCCS Care for the following reasons:

- The purpose of health insurance is to provide health care. The changes proposed by AHCCCS Care will make health care more difficult to obtain and sustain.
- The proposed work requirement does not take into consideration that it may require two or more years for a person to qualify for federal disability benefits.
- SVdP supports the current system of copays and is concerned that many of the people served by SVdP cannot afford the combined 5% Strategic Copays and premium, resulting in a significant portion of the current AHCCCS population returning to their previous uninsured status.
- Transportation services which will be completely eliminated will severely impact two groups of people, the mentally ill, particularly in rural areas, and diabetics many of whom do not drive.

AHCCCS Cares Response
September 17, 2015
Page 2

In addition to our concern regarding the impact of these changes on the poor and vulnerable in our communities, SVdP has concerns regarding the transparency of AHCCCS Care.

- There is no provision for a Citizens Oversight Committee.
- No cost/benefit analysis has been made to determine the amount of savings if AHCCCS Care is approved or if any extra costs are involved to implement these changes.

The Phoenix Diocesan Council of SVdP urges reconsideration of the AHCCCS Care changes to the existing Arizona AHCCCS program. Arizona's duty to its citizens does not include depriving basic medical care to its most vulnerable population.

Thank you for your consideration of our concerns.

For the Diocesan Council of Phoenix



Mary Ann Hunter
Acting President

AHCCS Response/MAH/rcj

Vinyard, Christopher

From: Tobiason, Beverly [REDACTED]
Sent: Thursday, September 17, 2015 3:09 PM
To: Public Input
Subject: Arizona's Medicaid program

Follow Up Flag: Follow up
Flag Status: Completed

I appreciate the opportunity to comment on the proposal *Modernizing Arizona Medicaid* since I was unavailable for any of the public forums.

Although my middle/upper middle class sensitivities agree with some of your attempts to build independence and personal responsibility in our clients, the reality and depths of true poverty throughout the state of Arizona, coupled with your recommendations, will likely show long term negative health outcomes. Families living in poverty have limited resources thus are often forced between where such resources will be spent on a day-to-day basis. Living in a hand-to-mouth existence, doesn't allow for planning and paying for health insurance coverage or anything above real basic necessities. Instead, families will be forced to decide whether to purchase back-to school shoes and supplies, Holiday gifts in the coming months, groceries, or to pay for AHCCCS for primary care. Many of our most at-risk families will forego primary care and will wait for more chronic conditions to arise due to such medical neglect. Conditions that are more effectively treated up-front but not addressed, can become more chronic, thus more expensive to treat in the long run. These same families will evidentially be forced to seek care in highly expensive emergency rooms and in some cases, live out shortened life spans. Especially at risk will be those adults with chronic mental health and substance use disorders. This plan clearly penalized those struggling the most to make ends meet with their mental and health care access, adding to hopelessness, and in adding more potential for debt, use of payday lender services, and other negative financial outcomes.

Although it is the rare person who does not wish to find meaningful work and to earn a decent wage, Arizona jobs are not overwhelming available and tend to be primarily minimum wage. High unemployment rates and lack of work in many of our rural counties only further destroys this "pipe-dream" for clients. Access to transportation, reliable and safe daycare, safe neighborhoods, and limited affordable work programs, can be a major obstacle in the lives of struggling families, especially single parents. In addition, expecting families living in poverty to have access to electronic devices, unless you also have plans to supply them, is also not realistic. Many of these same families lack any computer access, even though needed for school children to keep up academically.

Please reconsider your *Modernizing Arizona Medicaid* plan, due to the long term negative effects and punitive nature to those clients living in the most marginal of circumstances.

Thank you,

Beverly Tobiason PsyD
Clinical Director
Pima County Juvenile Court Center
520-724-2233

Vinyard, Christopher

From: Sheryl Umphrey [REDACTED]
Sent: Thursday, September 17, 2015 5:53 PM
To: Public Input
Subject: Ahccs rates

My husband is a waiting SSD and is unable to work. I am already on SSD , we both are on Ahccs, along with Medicare and Quim. How does the changes with contributing % of income work when you are on disability and can not work? Does the part about requiring individuals to work apply?

Sent from my iPhone

Vinyard, Christopher

From: Michelle Antolik [REDACTED]
Sent: Thursday, September 17, 2015 9:49 PM
To: Public Input
Subject: Question from Psych UM RN

Follow Up Flag: Follow up
Flag Status: Completed

I would like to know what we can do about more placement options for mental health patients after discharge from an acute psych facility. There are limited group homes and residential facilities with T19 patient. If patient's do not have T19 then they do not receive placement services and most likely live on the streets. Due to their limited insight, they usually do not follow up in the clinics due to transportation or living arrangements; they decompensate if they do not receive their meds and then are readmitted or petitioned into acute psych again.

We need to have more placement services in place. We need to get them off the street and keep them and our communities safe.

Thank you,

Michelle C .Antolik ,RN, BSN



A Catalyst for Community Health

September 17, 2015

Mr. Tom Betlach
Director
AHCCCS
801 E. Jefferson St. MD 4100
Phoenix, AZ 85034

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⁵ Health Affairs <http://content.healthaffairs.org/content/24/4/1106.full>

⁶ FDIC <https://www.fdic.gov/householdsurvey/2013appendix.pdf>

⁷ Modern Health Care

http://www.modernhealthcare.com/article/20150608/NEWS/150609910?utm_campaign=KHN:%20Daily%20Health%20Policy%20Report&utm_source=hs_email&utm_medium=email&utm_content=18203796&hsenc=p2ANqtz-8EsNq2ACZZyF3Zg5hPJBH_ERXwzZITMniDjuPP0mEyonop-GPDYNgwJQmIDXVxfn2GKWp32Fiq9W3RPpb84Mvdd6OQ&hsmi=18203796

⁸ 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/>

Thank you for the opportunity to respond to the waiver proposal. We deeply value AHCCCS's continued commitment to innovation and improvement, and we welcome opportunities to collaborate on many of these efforts in the future.

Sincerely,



Suzanne Pfister
President and CEO



**PHOENIX
CHILDREN'S
Hospital**

AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034
Email: publicinput@azahcccs.gov

As Chief Nursing Officer and Vice President of Critical Care Services at the state's only free standing children's hospital, I would like to voice my support of the Safety Net Care Pool funding program that supports Arizona's most vulnerable children. On behalf of nursing leadership, I feel privileged to represent and advocate for both patients and staff at Phoenix Children's Hospital (PCH).

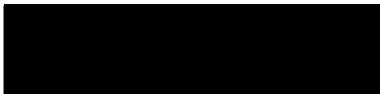
Phoenix Children's Hospital is unique in the state when it comes to the specialization of care we provide to the most underserved children in our community. Currently, over 60% of the patients our physicians and nurses see each year are on Medicaid. This waiver is critical to ensuring that this population of patients continues to receive the highest quality care available.

Our hospital provides the most comprehensive pediatric care in the state of Arizona. As a nurse with over thirty years of experience including bedside nursing as well as various leadership roles, I can tell you that the ability of PCH to provide the highest level of care is dependent on programs such as the Safety Net Care Pool.

If the Safety Net Care Pool funding is not continued, it will directly impact Phoenix Children's Hospital's ability to administer health care solutions to a population that is increasingly finding fewer providers able to see them.

Thank you for your time and I urge you to support continuation of the Safety Net Care Pool for Phoenix Children's Hospital.

Respectfully,



Julie Bowman, MSN, RN
Chief Nursing Officer
Vice President of Critical Care Services
Phoenix Children's Hospital

September 18, 2015

Thomas Betlach, State Medicaid Director
AHCCCS
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Re: Proposed Elimination of Non-Emergency Medical Transportation from Arizona'
Section 1115 Waiver

Dear Mr. Betlach:

Dialysis Patient Citizens (DPC) submits the following comments on Arizona's Proposed Application for a new Section 1115 demonstration. As America's largest patient-led organization representing dialysis patients, DPC's membership consists of more than 26,000 dialysis and pre-dialysis patients and their families. We seek to ensure the patient point of view is considered by policy makers.

Among AHCCCS's goals in "modernizing" Medicaid in Arizona are increased patient engagement and better managing chronic disease. In the case of dialysis patients who are Medicaid recipients, we believe that eliminating non-emergency medical transportation is contrary to these goals. Individuals with end-stage renal disease (ESRD) must undergo dialysis treatment three times weekly. For many patients, particularly those who have been impoverished by this illness, transportation is a major hurdle to managing their disease. This especially true in places like Arizona that have low population density and where people tend to be dependent on automobiles.

When patients miss dialysis treatments they become overloaded with fluids and toxins that their kidneys can no longer process. The result is usually an acute hospital episode, which of course is more costly than transportation.

In our view, the language in Section 19(C)(4) of SB 1475 is ambiguous—the state cannot charge and collect "an exemption" from a Medicaid enrollee—and therefore need not be considered a mandate upon AHCCCS. We urge you to exercise sound discretion and strike this provision from the waiver application.

Respectfully submitted,



Jackson Williams
Policy Director

Vinyard, Christopher

From: Carla Warner [REDACTED]
Sent: Friday, September 18, 2015 8:48 AM
To: Public Input
Subject: concerns

Follow Up Flag: Follow up
Flag Status: Completed

I have a family member with mental illness. Their income is \$400 a month. Taking 3% of that could have a drastic effect on their ability to pay their bills. And I have major concerns about the mentally ill being cut off after 5 years. There are a lot of people who have a mental illness that even with medicine who can barely maintain home life. And cannot function to work. Personally I think that if you cut them off you will have a lot more patients in the state hospital or worse in our prisons. Which will cost a lot more in the long run. This also puts the general public in danger.

Thank you for taking input on this matter.

Carla Warner
cwnana3@aol.com



September 18, 2015

Thomas J. Betlach
AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Director Betlach,

On behalf of the four largest health systems in the state—Banner Health, Dignity Health, Honor Health, and Tenet Healthcare, we appreciate this opportunity to comment on AHCCCS' proposed 1115 Waiver. Collectively, our systems provided 67.3% of inpatient care and 62.7% of emergency care in 2014¹ in Arizona. We also provided 65.3% of the inpatient care provided to AHCCCS members in 2014, and 60.2% of emergency care¹ in the state.

For more than 30 years, AHCCCS has played a critical role in providing health care to Arizonans from low-income families. In that time, AHCCCS has become a national model for Medicaid programs. The proposed 1115 Waiver ensures that AHCCCS will continue to help cover those most in need in our communities while promoting self-responsibility and accountability which we support strongly.

As you work with the Centers for Medicare and Medicaid Services over the next year on the details to modernize the acute care program and implement this Waiver, we offer the following suggestions for your consideration.

Encouraging Self-Responsibility and Accountability

Under the AHCCCS CARE proposal, specific AHCCCS members will be required to pay premiums up to 2% of their annual household income. This policy, specifically for those with income between 100% and 133% of the federal poverty level, is consistent with premium costs at that income level through the federally-facilitated Marketplace. We believe the premiums and ability for members to use their own premium dollars for non-covered services will increase member engagement and personal wellness.

It is proposed that those who fail to pay their premiums timely will be disenrolled and blocked from the program for a 6-month period. To mitigate the potential loss of this important and needed coverage, we urge the Administration to work with the health plans and providers to identify members who are at risk of a 6-month lockout period. As the largest providers of care to the Medicaid population, we would appreciate the opportunity to work with patients to help find available resources so that they may maintain AHCCCS coverage. This will be particularly important for high risk, high needs patients, patients with chronic disease or cancer, transplant patients or patients who are covered under value-based or risk-sharing arrangements. This continuity of coverage will also reinforce to the member the advantages of health care coverage.

¹ Inpatient data are from ADHS full-year 2014 database; ED data is 2014 Jan-June.



Further, there is a 3-month grace period in which individuals can make premium payments to purchase subsidized health insurance through the federally-facilitated Marketplace. During the 3-month grace period, insurers cannot disenroll members. We urge AHCCCS to adopt the same 3-month grace period to remain consistent with the Marketplace policy governing the failure of members to pay premiums.

We appreciate and agree with efforts to reward members who make smarter health care choices when selecting the most appropriate level of care and believe the proposed selection of strategic copayments will help facilitate a change in behavior. This will ensure that the most cost effective level of care is being appropriately utilized and that AHCCCS members will be more active and engaged consumers, seeking the right care, at the right time, by the right provider. Furthermore, thank you for eliminating any barriers to care by proposing a retrospective payment process rather than a point of service collection of copayments, which may result in bad debt.

Non-Emergency Medical Transportation

The AHCCCS CARE proposal takes a thoughtful approach in promoting self-responsibility and accountability in making health care decisions and promoting preventative care and personal wellness. However, section two of the proposed Waiver seeks to impose copayments on non-emergency medical transportation (NEMT) or eliminate NEMT as a covered benefit.

Traditionally, AHCCCS has covered NEMT to help ensure patients get to their clinic appointments, dialysis treatment, pharmacy, among other services. NEMT is critical for patients who have medical or physical conditions or financial challenges that prevent them from driving. Arizona is the sixth largest state in the nation, and thousands of AHCCCS members live in suburban and rural communities with few public transportation options. Limiting NEMT as a covered benefit will result in missed medical appointments and less preventative care, resulting in higher health care costs. We strongly urge the Administration to reconsider this proposed change and continue including NEMT as a covered benefit to ensure thousands of AHCCCS members have unfettered access to providers.

Delivery System Payment Reform Incentive Program

We are very pleased that AHCCCS is initiating steps to continue efforts to improve the delivery system by developing a Delivery System Payment Reform Incentive Program. We support the Administration's goals to improve the integration of acute and behavioral health services, focus on the high needs/high cost members and develop primary care models to improve population health – something each of our respective organizations have experience in with Medicare and/or the commercial market. We firmly believe the incentives under this program can lead to improved clinical integration, outcomes and population health, which is consistent with the triple aim.

We support the Governor's efforts to continue Arizona's innovative Medicaid legacy by introducing new reform measures that can modernize AHCCCS. We believe this proposal will empower AHCCCS members to take charge of their health, and better prepare them for when they transition to the private health insurance market.



We are committed to working with the Administration and greatly appreciate the opportunity to provide feedback. Thank you for your time and consideration.

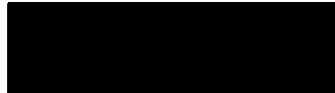
Sincerely,



Peter S. Fine
President & CEO
Banner Health



Tom Sadvary
CEO
Honor Health



Linda Hunt
President & CEO
Dignity Health Arizona



Reginald M. Ballantyne III
Senior Strategic Advisor
Tenet Healthcare

PAUL A. GOSAR, D.D.S.

FOURTH DISTRICT, ARIZONA

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Congress of the United States
House of Representatives
Washington, DC 20515-0301

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ALASKA NATIVE AFFAIRS

September 18, 2015

Arizona Health Care Cost Containment System
Attn: Director Thomas J. Betlach
Attn: Office of Intergovernmental Relations
801 E. Jefferson St., MD 4100
Phoenix, AZ 85034

Dear Director Betlach,

Thank you for accepting my comments on the proposed Waiver and Safety Net Care Pool (SNCP). The proposed Waiver outlines many opportunities for Arizona to continue to demonstrate its innovative and cutting edge care delivery to ensure the Medicaid program remains a success. As the Congressional Representative for Arizona's 4th District, a dentist, and a member of several Congressional caucuses related to healthcare including the GOP Doctor's Caucus and the Health Care Caucus, I am very familiar with the part funding plays in providing quality healthcare services across the state of Arizona. Residents of the 4th District in northern Arizona visit Phoenix Children's Hospital (PCH) close to 8,000 times per year. These visits are from constituents on the state's Medicaid plan who travel past several other hospitals in order to get the highest degree of pediatric care possible in the state.

While PCH has been working closely with you and your Agency to lay the foundation for phasing out the need for SNCP funding, it is not a task that can be accomplished quickly, as the volume of under payments and uncompensated care realized by PCH has been untenable without the support of SNCP. Approval of the proposed Waiver, particularly SNCP funding, will allow the hospital an additional five years to develop and identify additional programs and funding. During the phase-out period, I have encouraged PCH to continue to work with you and your staff to develop secure funding methods without sacrificing the quality or breadth of services offered.

My constituents travel a great distance to be seen at Phoenix Children's Hospital by highly trained pediatric specialists and staff. The supplemental funding to Phoenix Children's Hospital has been a necessary mechanism to ensuring that children in my district and throughout the state have access to the very best pediatric specialists and sub-specialists. Support of this waiver benefits children from across the state that struggle to find specialized physicians in their own community. The Waiver and the Safety Net Care Pool funding are vital to the continuation of quality and effective care at Phoenix Children's Hospital, which in turn provides the highest quality care for children across the State of Arizona.

Sincerely,

Paul Gosar
Member of Congress

received
9-25-15

Vinyard, Christopher

From: Laurie [REDACTED]
Sent: Monday, September 21, 2015 8:06 AM
To: Public Input
Cc: Laurie Goldstein
Subject: Public comment of proposed waiver

Follow Up Flag: Follow up
Flag Status: Completed

To whom it may concern,

I am not sure where you are getting your information to penalize the underserved populations for ER usage. Most of the time a visit to the emergency room does not result in an admission. In fact less than 50% are admitted. Most of the time the emergency room doctor has to:

1. Rule out any potential life threatening illness or disease
2. Provide comfort if the patient is in pain
3. Discuss a safe plan to go home, provided the person is capable and competent to follow orders which generally consists of monitoring and follow up care with instructions to return if symptoms return or become more intense. The trend is to send people home whenever possible. Some ED providers tell me it is up to 75% of the patients that are sent home in Phoenix.

So how are you coming up with this fictitious number?

Sincerely,

Laurie Goldstein

Enacted last session, SB 1475 imposed these requirements

1. Imposes a premium of up to 2% of income for those enrolled under Prop 204
 2. Requires copayment of \$8 for non-ER use of the ER for 1st incident & \$25 for each subsequent incident if the not admitted to hospital
 3. Eliminates non-ER transportation for the members over 100% of FPL
-

STATISTICAL BRIEF #174

June 2014

Overview of Emergency Department Visits in the United States, 2011

Audrey J. Weiss, Ph.D., Lauren M. Wier, M.P.H., Carol Stocks, Ph.D.,
R.N., and Janice Blanchard, M.D., Ph.D.

Introduction

Emergency departments (EDs) provide a significant source of medical care in the United States, with over 131 million total ED visits occurring in 2011.¹ Over the past decade, the increase in ED utilization has outpaced growth of the general population, despite a national decline in the total number of ED facilities.^{2,3} In 2009, approximately half of all hospital inpatient admissions originated in the ED.⁴ In particular, EDs were the primary portal of entry for hospital admission for uninsured and publicly insured patients (privately insured patients were more likely to be directly admitted to the hospital from a doctor's office or clinic).⁵

ED utilization reflects the greater health needs of the surrounding community and may provide the only readily available care for individuals who cannot obtain care elsewhere.⁶ Many ED visits are "resource sensitive" and potentially preventable, meaning that access to high-quality, community-based health care can prevent the need for a portion of ED visits.

This HCUP Statistical Brief presents data on ED visits in the United States in 2011. Patient and hospital characteristics for two types of ED visits are provided: ED visits with admission to the same hospital and ED visits resulting in discharge, which includes patients who were stabilized in the ED and then discharged home, transferred to another hospital, or any other disposition. The most frequent conditions treated by patient age group also are presented for both types of ED visits. All differences between estimates noted in the text are statistically significant at the .0005 level or better.

¹ HCUPnet. 2011 National Statistics, All ED Visits.
<http://hcupnet.ahrq.gov/HCUPnet.jsp>.
Accessed May 7, 2014.

² Tang N, Stein J, Hsia RY, Maselli JH, Gonzales R. Trends and characteristics of US emergency department visits, 1997–2007. *Journal of the American Medical Association*. 2010;304(6):664–70.

³ Goodell S, DeLia D, Cantor JC. Emergency Department Utilization and Capacity. 2009, Robert Wood Johnson Foundation Policy Brief No. 17. Princeton, NJ: Robert Wood Johnson Foundation.
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2009/rwjf43566. Accessed May 7, 2014.

⁴ Morganti-Gonzalez K, Baufman S, Blanchard J, Abir M, Iyer N, Smith A, et al. The Evolving Role of Emergency Departments in the United States. RAND RR 280-ACEP.

Highlights

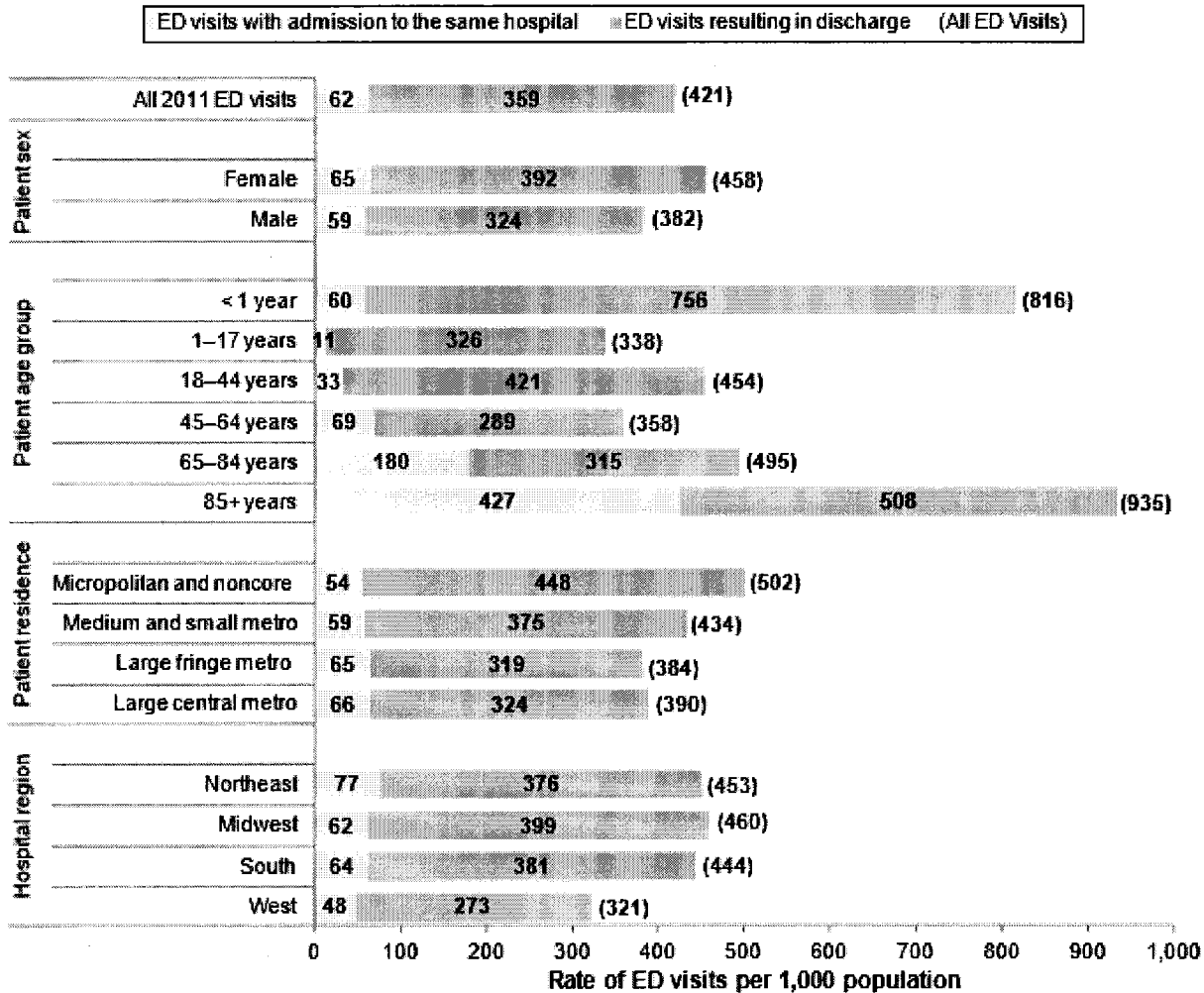
- In 2011, there were about 421 visits to the emergency department (ED) for every 1,000 individuals in the population.
- More than five times as many individuals who visited an ED were discharged as were admitted to the same hospital.
- Among patients younger than 18 years, the most common reasons for admission to the hospital after an ED visit were acute bronchitis (infants younger than 1 year), asthma (patients aged 1–17 years), and pneumonia (infants and patients aged 1–17 years).
- For adults aged 45–84 years, septicemia (infection in the bloodstream) was the most frequent reason for admission to the hospital after an ED visit.
- Medicare was the primary payer for more than half of ED visits that resulted in admission to the same hospital.
- The most common reasons for ED visits resulting in discharge were fever and otitis media (infants and patients aged 1–17 years), superficial injury (all age groups except infants), open wounds of the head, neck, and trunk (patients aged 1–17 years and adults aged 85+ years), nonspecific chest pain (adults aged 45 years and older), and abdominal pain and back pain (all adult age groups except those aged 85+ years).
- Rural areas had a higher rate of ED visits resulting in discharge compared with urban areas.

Findings

Emergency department visits by selected patient and hospital characteristics, 2011

In 2011, rates of ED visits varied by the patient's sex, age group, residence, and hospital region (Figure 1).

Figure 1. Rate of emergency department visits by the patient's sex, age group, residence, and hospital region, 2011



Note: "ED visits resulting in discharge" includes patients who were stabilized in the ED and then discharged home, transferred to another hospital, or any other disposition.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2011

- In 2011, more than five times as many individuals who visited the ED were discharged as were admitted to the same hospital.

Overall, in 2011 there were 421 ED visits per 1,000 population. More than five times as many individuals who visited the ED were discharged (359 per 1,000 population) as were admitted to the same hospital (62 per 1,000 population).

	A	B	C	D	E	F
	Category of first-listed diagnosis	All Ages	Age group			
			<15	15-19	20-44	45-64
6	Total	1,989,183	406,473	125,486	750,175	406
7	Infectious and parasitic diseases	43,282	20,757	2,908	12,133	4
8	Neoplasms	3,045	202	64	881	
9	Endocrine nutritional metabolic and immunity diseases	32,802	2,852	1,186	10,175	10
10	Diabetes	11,789	448	306	3,755	4
11	Mental disorders	69,599	2,765	6,166	35,471	19
12	Psychoses	14,544	418	836	6,976	4
13	Alcoholic psychoses	2,249	0	19	1,226	
14	Drug psychoses	3,221	16	166	1,924	
15	Schizophrenic disorders	1,580†	*	57	950	
16	Manic-depressive disorders	3,320	304	366	1,588	
17	Neurotic disorders	55,039	2,346	5,329	28,489	15
18	Anxiety states	15,387	368	1,146	8,692	3
19	Depression	6,885	497	1,047	3,083	1
20	Drug dependence	756	0	54	503	
21	Nondependent abuse of drugs	17,689	215	1,733	9,844	5
22	Alcohol dependence syndrome	5,008	8	88	2,206	2
23	Diseases of the nervous system	118,678	36,879	5,474	42,740	23
24	Diseases of the circulatory system	53,961	458	613	9,220	17
25	Diseases of the respiratory system	201,982	91,023	11,182	54,069	27
26	Acute bronchitis and bronchiolitis	26,288	11,258	931	7,518	3
27	Pneumonia	18,772	7,562	683	4,035	3
28	Chronic bronchitis	6,652	8	7	326	2
29	Asthma	26,034	10,845	1,675	8,023	4
30	Diseases of the digestive system	123,112	21,672	6,270	53,183	24
31	Diseases of the genitourinary system	119,249	10,539	9,736	59,981	21
32	Diseases of the skin and subcutaneous tissue	71,119	15,398	4,833	29,649	14
33	Diseases of the musculoskeletal system	132,851	6,946	5,650	55,861	39
34	Symptoms signs and ill-defined conditions	499,020	82,795	26,453	179,470	118
35	Injury and poisoning	410,597	100,534	33,791	140,544	74
36	Fractures, all sites	54,160	13,643	3,773	13,934	11
37	Sprains	77,285	9,221	7,882	36,701	16
38	Intracranial	11,169	3,134	1,673	3,374	1
39	Open wounds	81,654	24,722	5,925	26,905	12
40	Superficial	20,799	7,027	1,618	6,762	3
41	Contusions	56,790	12,254	4,516	18,953	10
42	Foreign bodies	9,783	4,433	353	2,479	1
43	Burns	2,666	716	196	1,119	
44	Trauma complications and unspecified injuries	41,700	13,619	3,327	11,603	6
45	Poisonings	18,436	4,599	1,937	6,871	3
46	Surgical and medical complications	11,479	972	318	2,723	3
48	Notes: * Cell suppressed due to non-zero count less than 6; † Sum rounded to nearest tens unit due to non-zero addend less than 6; * Based on first-listed diagnosis.					

Vinyard, Christopher

From: Maddy Urken [REDACTED]
Sent: Monday, September 21, 2015 10:51 AM
To: Public Input
Subject: Public Comment on AHCCCS Section 1115 waiver package

The so-called CARE plan, and any other plan that takes money out of the pockets of people who have little or none and/or deprives them of medical care is an obscene distortion of American values. That is especially true when that plan comes under the guise of giving the poor more choice about where to spend the money they don't have--a choice that often becomes a choice between food or medicine for themselves or their children.

If you CARE, don't block poor people from AHCCCS to the medical care they need.

Madeline Urken
maddyurken@hotmail.com
1 E Broadway Blvd, Apt 612
Tucson, AZ 85701
520-820-5173

Vinyard, Christopher

From: Debi Guilmette [REDACTED]
Sent: Monday, September 21, 2015 2:49 PM
To: Public Input
Subject: re: proposal of 5% monthly payment

Follow Up Flag: Follow up
Flag Status: Completed

Gov. Ducey,

I would like to express my opinion about requiring recipients of AHCCCS to pay 5% of monthly income towards co-pays. That would be fine if those receiving it had any discretionary income. Most people that receive the help are barely making it through to the next month. You have working single parents, elderly, disabled, full-time students (living on loans) and chronically/terminally ill. I would think that none of these people even have 2% of their income to pay let alone 5%. They would then need additional state services to pay for this one.

A little common sense is needed here. If, those receiving help are working and have the ability, great! But, I venue to say that most on assistance, don't have any extra. Many of these people don't have the ability to improve their lot in life; they don't have the ability to 'fight' the system; and they most likely don't vote. They learn to live with less and less, with the state eventually paying for more and more. As stated in the article they are already below the federal poverty income level. This is just kicking them a little harder when they are already struggling to survive.

As governor, you need to rethink this proposal. It is part of your job to protect the rights of all citizens and this is clearly not protecting this group of people.

Sincerely,
Debra Guilmette

Vinyard, Christopher

From: Michele Stokes [REDACTED]
Sent: Wednesday, September 23, 2015 7:42 AM
To: Public Input
Subject: Public Comments on the 1115 Waiver
Attachments: ACCCHS 1115 comments final.docx

Dear Thomas J. Betlach,

Please see attached comments on the 1115 Waiver.

There are some good measures that are much needed included in the 1115 Waiver proposal pertaining to integrating Behavioral Health services and medical care. This is much needed. However, there are concerns regarding the proposal's impact on many people, including childless adults, married caregivers of youth and foster children who are medically fragile, and those who have limited transportation. Additionally the provisions relating to transportation are particularly troublesome as they affect many in rural areas. Public transit is not available in many places.

The attached also includes comments that pertain to the Senate Bills that facilitate this 1115 Waiver: SB 1475 and SB 1092. The grave concern with these two SB's is that it extends the time frame by which a person loses their medical coverage by being disenrolled up to a year, if they fail to report a change or fail to pay a payment. This will lead to the most needy, who may not be able to report changes, or have to make the decision between food and medical care, to be disenrolled by default and on top of that become indebted to the state. Additionally SB 1475 has tucked all the way at the bottom this "exemption" from providing non-emergency medical transportation for a year – how does that work for people who requires stretcher and/or wheelchair transport for dialysis services?

The other concern is that the bulk of the program will be managed online. Few people who are low income have computers at home and phone apps are seldom workable for complex systems. Service coverage in rural areas for computer access and phone access is not yet 100%. The cheap phones with very limited minutes provided by social systems will not allow enough time for their use with "apps" as they are intended to be for emergency and limited use, unless the additional time is paid for... back to square one: food and housing or phone and medical care. Additionally while public computers at libraries and other locations may be available, people with disabilities and who have chronic illnesses may be precluded from getting to those locations, especially in rural areas.

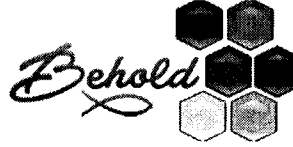
While cost savings must be realized to be sustainable, there are some serious impacts that this 1115 Waiver and its implementing SB's need to be reviewed for, so as to not harm those who need the services the most. Please consider the populations served as well.

See attached.

[REDACTED]
Behold Charities International

[REDACTED]
"Housing to Behold – Facilitating Independent Living, Universal Design and Inclusion"

Behold Charities International
3017 E. Yale Street
Phoenix, AZ 85008



September 23, 2015

AHCCCS
C/o Office of Intergovernmental Relations,
801 E. Jefferson Street, MD 4200,
Phoenix, AZ 85034.

Comments Regarding Section 1115 Waiver

These comments are being submitted, for your consideration, on behalf of Behold Charities International, a non-profit charity that facilitates universal design, inclusion and independent living for people with disabilities. The comments are based on information provided on the Section 1115 Waiver information at <https://www.azahcccs.gov/shared/Downloads/WaiverTemplateDRAFT8-18-15.pdf> and on the Governor's AHCCCS CARE information as indicated: <https://www.azahcccs.gov/shared/FiveYear.aspx> and from information presented by the Arizona Department of Health Services.

In accordance with section 1937(a)(2)(B) of the Act, the following populations **are to be exempt** from benchmark equivalent benefit packages: pregnant women, blind or disabled individuals, people who are dual eligible, terminally ill hospice patients, individuals eligible on basis of institutionalization, medically frail and special medical needs individuals, beneficiaries qualifying for long-term care services, children in Foster care or receiving adoption assistance, mandatory section 1931 parents, and women in the breast or cervical cancer program.

However, it appears that the Section 1115 Waiver as presented may NOT exempt these populations if they are "childless adults." So who are these "childless adults" that the Section 1115 Waiver will impact negatively? It will impact homeless individuals, veterans who are homeless, people who are older, who have no children living with them who are on a fixed poverty level income; who are widowed or are not married. As the population ages, there are more and more childless adults. Marriage or the lack thereof should not be a basis of qualification to receive health care!

The Program Description on line says: "We have the tools to truly modernize Medicaid. The goal of AHCCCS CARE is to: (1) Engage Arizonans to take charge of their health; (2) Make Medicaid a temporary option; and (3) Promote a quality product at the most affordable price." Engaging Arizonans to "take charge of their health" ought not to be achieved by taking life sustaining services away when they cannot pay. Making Medicaid a temporary option is not modernizing Medicaid, it is taking medical services away from those who need it most. Promoting a quality product at the most affordable price cannot mean requiring the poorest of the poor, the senior without children who has chronic disabilities to be

disenrolled from the AHCCCS program and lose their medical care because they have to choose between food, rent or making an AHCCCS payment and then becoming a debtor to the state!

The Program Description states that the “key to transforming health care in Arizona is the ability to move away from federal prescriptions that hamper private sector innovation.” The effect of the 1115 waiver request has no impact on “private sector innovation”, rather as currently written, the 1115 waiver request, will severely affect and potentially cause considerable harm to those who are medically fragile, foster parents, those requiring wheelchair accessible transportation, sole caregivers of people who are elderly, parents of children who are medically fragile, people who are homeless and childless, people who live in rural areas, who currently qualify or may qualify for ACCCHS due to low income levels.

We strongly request exemptions for these listed below:

- **Parents of children or foster children.** Those parents of children who have severe disabilities, or who are medically fragile or who live in rural areas; areas with no nearby (within 1 mile) child care centers; or areas with no nearby child care centers who accept children who are medically fragile or who have disabilities should be exempted.
- **Homeless.** Counting family income v individual income may create a negative impact on those who are homeless living with extended families. Services are provided to the individual. They are not necessarily provided to the family, so the income basis should be individual. Just because one person in an extended family has a decent job and they are trying to help a homeless or medically fragile family members, benefits should not be calculated on that basis. It has a chilling effect on the provision of family supports for people who have behavioral health and medical needs.
- **Foster youth exiting out of the foster care system, and foster adults who have disabilities or who are medically fragile;** they should also be exempted from these provision as they generally have less resources and supports available to them.
- **People living in rural areas who cannot obtain services of a doctor in a timely manner except via emergency departments;** they should be exempted from these provisions as services are not within a reasonable distance and public transportation is not available.
- **People who use wheelchairs or stretchers who require accessible lift-equipped or ramp-equipped vehicles for transport;** should be exempt. The existing medical transportation system, specifically that provide via (Contract ADHS 13-043918) Mercy Maricopa Integrated Care via LogistiCare, is woefully inadequate and fraught with failure to provide and effectively coordinate medically necessary transportation causing people who have high risk medical and behavioral health issues to miss appointments; this exposes them to potential for harm or negative outcomes. They recently received a notice to cure regarding the provision of timely non-emergency medically necessary transportation services. Personally, we have witnessed medically fragile individuals using wheelchairs stranded at doctor’s offices who have been told that their transport will be there in two hours, but the office closes in an hour and they are left having to wait in the heat outside the doctor’s office. There is no other form of transportation available as some locations are not on bus lines.
- **Young adults who are only temporarily able to live independently.** (i.e., who are medically fragile, or have cyclical medical issues or who are caretakers of their parents, grandparents, etc.), should be exempt from the 5 year life-time limit.
- **Married parents or guardians who are joint caretakers of their elders, family members, foster children, foster adults or children with disabilities** should be exempted from the “sole caretaker” requirement, as it may take more than one person to care for them. People who are caregivers are seldom the “sole” caregiver. Five years of benefits or those “able-bodied” who may be unemployed during a life time, is not realistic when people have chronic cyclical illnesses or have chronic

Comment [E1]: You might want to use the term medically fragile which is broad enough to capture these kids but also adults with SMI, physical disabilities, etc.

Comment [E2]: Eligibility is based on household/family. An extended family member, i.e. brother or sister NOT in the household wouldn't have his/her income considered

Comment [E3]: On this bullet & the next aren't you advocating that they be exempted from the elimination of the NEMT

Comment [E4]: Are you relating this to the concern on the 5 year lifetime limit?

Comment [E5]: Don't understand your point here.

conditions that make them medically fragile; or there are economic downturns that last a decade, or natural disasters such as fires and floods that destroy homes, or civil unrest.

- **People using wheelchairs, mobility devices or stretchers who live in rural areas or areas without public transit services or wheelchair accessible taxi/shuttle services should be exempt.**

No Dial-a-Ride or similar voucher supported transportation is available when there is no bus service nearby. Where no ADA compliant transportation is available to access medical or behavioral health care, these areas should be exempt from the non-emergency transportation requirement. While the Waiver indicates that the contracts between AHCCCS and the MCOs require that contractors have a sufficient network to provide covered services within designated time and distance limits, the reality is that such service is extremely insufficient, especially for those who use mobility equipment such as wheelchair, scooters, or those who must be transported via stretchers. This has been documented by Arizona Behavioral Health Services already.

This 1115 Waiver is supposed to work in conjunction with two Senate Bills – 1475 and 1092. Some of the provisions of these bills do not line up with the AHCCCS CARE system proposed or they add additional ways to eliminate people from AHCCCS. While the publicity materials indicate that a person could lose up to 6 months of AHCCCS coverage for non-payment of a co-pay, SB 1092 extends that for a year IF THEY FAIL TO REPORT A CHANGE! It also requires that there be MONTHLY VERIFICATION of work seeking activity. This is onerous for both AHCCCS and agencies that provide such services. So in effect, if someone doesn't report in monthly their activity in seeking work or finding a job, they could be banned from AHCCCS health care for a year!

Tucked into the last few lines of SB 1475 is “an exemption from providing nonemergency medical transportation services from October 1, 2015 to September 30, 2016. NO NONEMERGENCY MEDICAL TRANSPORTATION SERVICES FOR A YEAR! How does that work with people who require transport for dialysis? That is a great way to provide cost savings...at the expense of health!

There are strong concerns regarding the AHCCCS CARE system planned and member contributions. When you have insufficient income for housing, food, clothing or basic necessities adding “Strategic Copays” and “Premiums” and a payment system which affects health care when they miss a payment is brutal. Many on AHCCCS are homeless – and will not receive notices, chronically disabled, elderly, are on fixed incomes which doesn't even cover the cost of housing, let alone basic needs. Dis-enrolling people or “locking them out” from health care who are the poorest, least able to contribute, most medically fragile is cruel, and will cause harm/injury. And then adding insult to injury, you want to make failure to pay a debt owed to the state. This is absurd! A person on SSDI receives about \$800 a month, if that which is not even enough to live on!

As stated in the 8-18-2015 draft, the bulk of the program will be managed on line. Few people who are low income have computers at home. And phone “apps” are seldom workable for complex systems. There are strong concerns with using “apps” to avoiding an emergency room visit by using an app to look up a doctor or urgent care, or manage chronic illnesses or conduct your own health screenings. People who are low income, homeless can't afford computers to do this. Public computers at libraries or the like may not be nearby, or you can be just too sick or injured to do this. If someone is looking to get to an emergency room, someone is in severe pain, not breathing well, or bleeding! They are not going to be on an “app”. There is a place for technology in the provision of services. But this is not one of them!

In SB 1475, there are concerns with the non-emergency use of emergency departments in rural areas where there may be other resource WITHIN 20 MILES. What if there is no accessible transportation

available to get to the medical or behavioral health service needed, even if it is not perceived to be an emergency. Higher copays disparately impact those who qualify for ACCCHS i.e. low income. Rather you might do better to add incentives for using available non-emergency resources i.e. eliminate those co-pays.

In SB 1092, there is a concern with the ages and time frames mentioned. They are too restrictive with regards to employment requirements, lifetime limit, and exceptions. Child care centers will seldom accept a child who has severe disabilities prior to school age, if then, and children with disabilities may not start school as young as their peers.

There are concerns with the “able-bodied” adult definition as it doesn’t exempt people who have cyclical disabilities, people with chemical sensitivities, people who have a cyclical history of behavioral health diagnosis. Being “physically and mentally capable of working” has no basis in employment. A person has to be able to perform the essential functions of a job with or without an accommodation to be employed. Trying to use the AHCCCS program to make people work or else they lose their right to medical care is unconscionable.

There are concerns with the AHCCCS Works program. If the Social Security Ticket to Work program has not been successful in Arizona over the past 5 years; what makes you think that adding yet another requirement to seek work is going to be successful for people who have chronic disabilities, people who are medically fragile, people who are caregivers of their family members who are aging, have dementia, or children with fragile medical conditions. There needs to be exemptions for these individuals. Additionally DES will not be able to handle the bulk of the added rolls of people at their current staffing level, they have trouble with the existing case load, especially regarding Rehabilitation Services Administration. They cannot serve the existing need, let alone an increased need based on mandatory enrollment.

We submit these comments in hopes that those making these decisions will understand the medical and financial limitations of the people they serve. This is not the way to modernize Arizona Medicaid by making it harder to obtain medical services and putting the poorest of the poor, the medically fragile and foster system participants in debt to the state! This is not the way to help Arizonans take charge of their health. This is the way to make them abandon any hope of obtaining health care.

Finally, for something that has this much impact on people, providing only five public hearings of which two were in the Phoenix area, held mid-day, when people are generally working, is not sufficient notice. Allowing a little over ONE MONTH to provide public comments is not sufficient.

Facilitating change ... In hopes of a better Arizona,

[Redacted]

Behold Charities International

[Redacted]

Housing to Behold – Facilitating Universal Design and Inclusion

Comment [E6]: Good point on the disabled child care and access to services. There's a concern that caring for a disabled child over age 6 doesn't exempt the able bodied adult from work

Comment [BS7]:



Arizona Alliance
FOR COMMUNITY HEALTH CENTERS
Primary Healthcare for All

September 23, 2015

Mr. Tom Betlach
Director
AHCCCS
801 E. Jefferson St. MD 4100
Phoenix, AZ 85034

Dear Director Betlach:

As AHCCCS begins final preparation of the waiver package and negotiations with the Centers for Medicare and Medicaid Services (CMS), the Arizona Alliance for Community Health Centers (AACHC) wants to acknowledge the positive efforts that have been undertaken by your agency to foster innovative approaches to the delivery of health care in our state. AACHC is pleased to partner with AHCCCS in promoting ongoing positive changes in the delivery of health care in Arizona to the 1.7 million people enrolled in the program.

AACHC has served as Arizona's Primary Care Association since 1985 and strives to promote and facilitate the development and delivery of affordable and accessible community-oriented, high quality, culturally effective primary healthcare for everyone in the state of Arizona. AACHC is committed to serving as a resource for member organizations providing primary healthcare to the underserved, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics, Tribal organizations, behavioral health facilities and other organizations that promote the primary care safety net. AACHC comprises the state's largest network of primary care providers and is committed to working with a variety of partners, including AHCCCS, to expand tools that health centers and organizations serving vulnerable populations utilize to improve health outcomes and establish cost savings for the healthcare system.

Many positive actions have been taken by AACHC members that support valued based care with the intention of fostering outcomes that move the health centers towards achieving the Triple Aim. In addition, there are ideas and proposals in the waiver package that are intended to promote improvements in the delivery of care. The positive provisions that can have the most impact on the system of care are: 1) focus on the coordination of care, especially the efforts to integrate behavioral health and acute care; 2) efforts to identify and address the inappropriate utilization of health resources; 3) plans to better utilize medical homes for AHCCCS members who are American Indians; 4) promotion of chronic disease management programs and tools that assist AHCCCS members in achieving wellness targets; and 5) exploration of technologies that promote AHCCCS members and healthcare providers the ability to effectively communicate with patients and their families about the member's plan of care.

There are, however, some proposals that may adversely impact AHCCCS members and/or healthcare providers as they work to provide long-term valued based care.

The Arizona legislature has mandated through SB 1092 or Chapter 7 that AHCCCS secure a waiver to impose a 5-year lifetime ban on the receipt of health care benefits for able-bodied adults, with certain exclusions. This approach is inconsistent with Medicaid law and fails to recognize the churn of many AHCCCS members who receive health care benefits because of an underlying health condition that impacts their ability to secure and/or retain full-time

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AACHC.org

employment, yet are not identified in the exceptions enumerated by the law. Additionally, members may reach their 5-year lifetime limit, but still need health services beyond the five year time restriction. Individuals may delay care or not seek care, resulting in higher costs that has to be absorbed by the statewide healthcare system or patients/families. **AACHC is not supportive of this proposal, but does support efforts to assist individuals in securing employment and/or job training.**

Second, this past Session, AHCCCS in chapter 14 (SB 1475) was charged to no longer provide non-emergency medical transportation for AHCCCS members who are above 100% of FPL. According to a 2010 report by the U.S. Department of Transportation Federal Highway Administration, transportation is the second highest cost for families following housing. If a family lives in an auto-dependent community, their costs for transportation could be as much as 25% of their income. There are rural or frontier communities in Arizona where public transportation is basically non-existent. Additionally, this blanket prohibition fails to recognize when transportation for non-emergency purposes (i.e. for therapy, appointments or treatment) are truly medically necessary.

Transportation is an important enabling service provided by most FQHCs and behavioral health organizations. Lack of reliable transportation is a barrier to healthcare for many health center patients. Transportation services are vital to communities with the most acute health disparities, including low income populations, racial and ethnic minorities, uninsured and underinsured individuals and geographically isolated populations.

Providing transportation services to support access to primary healthcare can reduce the cost of healthcare by decreasing inappropriate use of EMS services. Transportation as a community-based service helps improve the utilization of healthcare services, and decreases no-show rates. **AACHC urges a modification of this blanket prohibition on non-emergency transportation services.**

Third, we are concerned about the planned imposition of a tiered copayment of \$8 and then \$25 for use of the emergency department for non-emergency purposes. The higher copay is also triggered if there is a community health center, rural health center or urgent care center within 20 miles of the hospital. While we appreciate the recognition that community health centers, rural health centers and urgent care centers are the appropriate place to receive non-emergent, primary care services the added restriction fails to acknowledge that many of these centers do not operate 24 hours per day, 7 days a week. Nor does it appear that the Legislature recognized the study conducted by AHCCCS in FY 2012 wherein AHCCCS members were found to have a low rate of non-emergency use of the emergency room, compared to national averages. AHCCCS concluded that the health plans are continuing to develop and use interventions that ensure appropriate use of the emergency room. **AACHC urges AHCCCS to continue its efforts to promote alternatives to the use of the emergency room for non-emergency purposes. We urge that the standard be a prudent layperson's assessment as to whether the member's condition warrants care outside normal hours of the member's medical provider and subsequent use of the emergency room.**

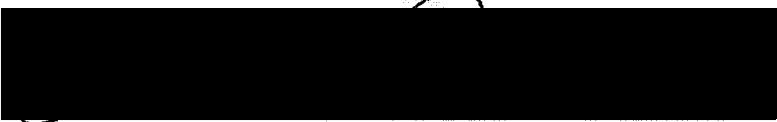
The proposed AHCCCS CARE Program requires members to contribute up to 3% of their annual income in co-pays, after receiving services, upon receipt of a bill from a third party vendor. The proposal as presented lacks clarity on when a member would be required to make the co-payment. Some care categories fall outside the co-payment requirement, and it is not clear as to which category of care requires a member to pay a co-payment. For instance, if the care was provided by a PCP for a wellness check (i.e. well-woman exam) but the need to treat another acute medical condition (sinus infection) was discovered during the examination, would the member have a copayment, or would that be at the discretion of the provider as to how the visit is coded? Research has shown that imposing cost-sharing requirements for AHCCCS/Medicaid eligible populations leads to avoidance of primary care and ultimately to use of the emergency room.

The other component of the AHCCCS CARE Program would have members pay a monthly premium of 2% of their income into an AHCCCS CARE Account that is like a Health Savings Account (HSA). One positive aspect of this proposal is that

members can use the premium contributions for non-covered services, i.e. vision or dental. It is not clear how the account will be administered in order to allow a member to accumulate sufficient funds in the account to cover the cost of eye glasses, dental care or other non-covered services. It is also concerning that, unlike a traditional HSA account, funds from the members' CARE account cannot be used to cover required copayments. Furthermore, failure to make the CARE Account monthly deposits or pay the billed co-payments will result in a "lockout" period of 6 months with benefits restored only when 1) outstanding balances are paid, 2) a member is participating in the AHCCCS Works program, and 3) s/he is meeting an identified Healthy Arizona target. AACHC is also concerned about the penalties for not paying the premiums on the account or failing to pay the co-pays. This may present profound difficulties for the member and does not address the fact that health care needs remain even during the "lockout" period. If care needs are not addressed in a timely manner they could lead to more costly healthcare due to delayed intervention and the resulting complications of acute problems leading to the utilization of higher levels of care such as emergency rooms. **We urge 1) revising the planned copayment and CARE Account program in the hopes of assuring that members clearly understand the criteria under which a copayment would be imposed, 2) specifying the rules by which CARE account funds can be used either to make required copayments or used for non-covered services; 3) establishing clear rules by which CARE payments can be reduced because a member has been meeting Healthy Arizona targets; and 4) removing the "lockout" period for nonpayment of copayments and CARE Account deposits.**

AACHC stands ready to work with you and the State of Arizona to achieve the goal of a visionary, well-managed program serving the health care needs of Arizona individuals and families. We appreciate your thoughtfulness and review of the above mentioned concerns.

Sincerely,



John C. McDonald, RN, MS, CPHQ
Chief Executive Officer
Arizona Alliance for Community Health Centers

Vinyard, Christopher

From: Wheeler, Margaret - SJHMC <[REDACTED]> on behalf of
Hunt, Linda - SJHMC <Linda.Hunt@DignityHealth.org>
Sent: Wednesday, September 23, 2015 4:20 PM
To: Public Input
Subject: Safety Net Care Pool

Director Thomas Betlach:

On behalf of Dignity Health Arizona Service Area and as an affiliate partner of Phoenix Children's Hospital (PCH), we support the five-year transition away from Safety Net Care Pool payments as proposed in the 2015, Arizona Health Care Cost Containment (AHCCCS) 1115 Waiver. Phoenix Children's Hospital plays a critical role in serving some the most complex and acute healthcare cases of children in Arizona.

As you know, the industry as a whole is facing ongoing challenges as it adjusts to reform measures and works to establish a sustainable cost structure. In order to realize the full potential of health reform it is vital that all sectors of the industry work together to build a national health system that truly works for people.

We recognize the unique patients and payment structure Phoenix Children's Hospital faces and support their efforts to appropriately fund services provided to the poor and underserved families in our community.

Sincerely,

[REDACTED]

Linda Hunt
Sr. Vice President of Operations & President/CEO, Arizona
Dignity Health
3030 N. Central Ave., #1402
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Linda.Hunt@DignityHealth.org

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**PHOENIX
CHILDREN'S**
Hospital

AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034
Email: publicinput@azahcccs.gov

Dear Mr. Betlach,

I would like to provide comments to the waiver proposal, specifically in support of the Safety Net Care Pool. My name is Rhonda Baldwin and I am the Manager of Social Services at Phoenix Children's Hospital (PCH) responsible for leading a team of 32 social workers supporting patients and their families during the stressful time when their child is ill. As members of the interdisciplinary medical team, part of our social work role is helping to ensure safe discharges through support mechanisms for families and removing barriers that may restrict the families' ability to focus on healing. The goal of connecting families to critical support services outside of the hospital also ensures safe discharges.


The financial assistance that the hospital provides to struggling families in their time of need would not be possible without the support and supplemental funding that AHCCCS has provided through the waiver and Safety Net Care Pool.

In addition to providing financial assistance, Phoenix Children's Hospital will see the most complex and difficult pediatric cases due to our physician specialties. This includes children with both complex physical and psychiatric issues. In order to better serve these children, our hospital has the only on-site child psychiatry department for an acute care pediatric hospital. This unique specialty of Phoenix Children's Hospital, having child psychiatrists and pediatricians in the same building, allows our hospital to integrate physical and mental health care for these patients and help them receive that integrated care after discharge.

As a Phoenix Children's Hospital employee and advocate for countless families who walk through our door, I urge you to continue your support for the waiver and specifically the Safety Net Care Pool. The supplemental funding ensures that children suffering from the most acute cases are seen and supported by pediatric specialists only found at Phoenix Children's Hospital.

Thank you for consideration of my comments and support for continuation of the Safety Net Care Pool.

Regards,


Rhonda Baldwin, LCSW
Manager, Social Services
Phoenix Children's Hospital



VALLEY INTERFAITH PROJECT

September 24, 2015

Mr. Tom Betlach
Director
AHCCCS
801 E. Jefferson St. MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

Thank you for the opportunity to comment on the proposed Medicaid waiver. As a non-partisan organization in Arizona, we are committed to support the improvement of the health of all Arizonans. Valley Interfaith Project supports the state's Medicaid program that influences Arizona's overall sustainability of the health system that affects the health outcomes of millions of people in our state.

Valley Interfaith Project (VIP) was integral in supporting the expansion of Medicaid in Arizona through community involvement and action. VIP is a broad-based non-partisan organization of dues-paying members from diverse faith congregations, schools, unions and non-profit organizations committed to building sustainable social and economic change. VIP brings together low, middle, and upper income communities to develop and organize participation in public life, drawing on the strengths of faith and democratic traditions, to create a more just society. For 25 years VIP has been working on issues that promote human development in Arizona. VIP supports:

1. The integration of behavioral health and acute care that includes further support for the health information exchange.
2. The extensive needs of those individuals who are high utilizers of health care services.
3. Improving the coordination of health care in all venues.
4. Any new collaborations to improve the general health of Arizona's population.

While VIP supports many aspects of AHCCCS' waiver request, there are areas of concern that include the following provisions:

- **Co-Pays:** The introduction of co-pays may inflict harm on low-income, vulnerable populations. VIP opposes this provision as onerous on those members of Arizona's population that can least afford this provision. In particular VIP is concerned that those suffering from chronic pain may be limited to their access to pain-reducing medicine. Emergency access co-pays would be difficult to determine what constitutes appropriate versus inappropriate use of an emergency room.
- **Health Care Premiums:** Valley Interfaith Project has been part of and supports the Cover Arizona coalition. This coalition of 800 plus members has helped more than 500,000 citizens gain health care coverage through AHCCCS and the Health Care Marketplace.

Any attempt to establish a new requirement for monthly premiums will hinder progress that could result in many Arizonans losing health care coverage. Monthly premiums for those who can least afford this stipulation will cause a negative impact on enrollment. Research suggests that cost sharing for Medicaid enrollees leads to a decreased use of primary care and actually increases the reliance on emergency room treatment.

- ***Five-Year Limit and Work Requirements:*** Valley Interfaith Project opposes arbitrary time limits on Medicaid and the requirement of binding Medicaid to work. There is no adequate definition of “able-bodied.” There are many very sick, physically or mentally impaired individuals that are not able to work. These same individuals may not qualify under any existing disability category. Example: there are older adults who may have lost their job during the Recession, have a serious health condition, and have accessed their Social Security Benefits who will not qualify for the work requirement or time limit exceptions. VIP supports caregivers who stay home to care for a physically or mentally disabled loved one. This provision would require such an individual to work threatening the institutionalization of their loved one.
- ***Non-Emergency Transportation:*** The proposal to eliminate non-emergency transportation in Arizona would have detrimental consequence on the access of health care for individuals that live in areas that have little public transportation. Many areas of the state are deemed medically underserved by the federal government. Losing access to paid transportation for those who need health care services impacts residents of vast areas of rural country and suburban territory on the fringes of adequate transportation corridors.

Thank you for the opportunity to respond to the waiver proposal. Valley Interfaith Project values the worth of AHCCCS’s commitment to sustainable health care services for those citizens who require Medicaid.

Sincerely,

Valley Interfaith Project and the undersigned clergy

Rev. Martha Seaman, Deacon, the Episcopal Diocese of Arizona

Rabbi John Linder, Senior Rabbi, Temple Solel

Rev. David Harriss, Gilbert

Rev. Jayne Baker, Ascension Lutheran Church, Paradise Valley

Rev. Jeff Proctor-Murphy, Senior Pastor, Dayspring United Methodist Church

Rev. Lara Forbes, Pastor, Faith Lutheran Church, Phoenix

Rev. Sarah Stadler-Ammon, Pastor, Grace Lutheran Church, Pheonix

Rev. Marvin D. Arnpriester, Senior Pastor, Sun Lakes United Methodist Church

Rev. Steven L. Davis, Pastor Emeritus,

Shepherd of the Hills United Church of Christ, Phoenix

Rev. David Summers, Senior Pastor, Paradise Valley United Methodist Church

Rev. Doug Bland, Pastor, Community Christian Church, Tempe

Rev. Susan E. Wilmot, Vicar, St. James the Apostle Episcopal Church. Tempe

Rev. Judith E. Boroto, Phoenix

Sr. Georgene Faust, Phoenix
Ahmad Shqeirat, Imam, Islamic Community Center of Tempe
Rev. Jim Bade, Deacon, The Episcopal Diocese of Arizona
Rev. Kim Gladding, Senior Pastor, First United Methodist Church Glendale
Fr. Mártir Vásquez, Rector, St. Andrew's Episcopal Church, Glendale
Rev. Terry Sims, Minister, Unitarian Universalist Church, Surprise
Rev. Dr. Ken Brown, District Executive, Pacific Southwest District/ UUA
Brother Timothy T. Tomczak, O.S.C., Phoenix
Rabbi Jeremy Schneider, Temple Kol Ami, Scottsdale
Rev. Deborah Lerner, Gilbert
Fr. Eric Tellez, Pastor, St. Patricks Catholic Parish, Scottsdale
Rev. Dr. Robin B. Hollis, Deacon AZ Episcopal Diocese St. James Episcopal Church, Tempe
Patti Sills-Trausch, Director of Faith in Action Ministry,
Franciscan Renewal Center, Phoenix
Rev. James B. Pennington, Sr. Pastor, First Congregational United Church of Christ, Phoenix
Rabbi Dr. Shmuly Yanklowitz, Scottsdale
Bob Klassen, Senior Warden, St. James the Apostle Episcopal Church, Tempe



HENSLEY
Beverage Company

September 24, 2015

AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034
Email: publicinput@azahcccs.gov

Mr. Betlach,

I would like to offer my comments supporting the waiver application recently submitted by the Arizona Health Care Cost Containment System (AHCCCS). Specifically, I believe that the Safety Net Care Pool program within the waiver should continue to be supported. Phoenix Children's Hospital is the provider of choice for Arizonan's pediatric needs. The hospital has the state's only Level I Pediatric Trauma Center as well as the highest number of specialized pediatric staff.

As President and CEO of Hensley Beverage Company and its hundreds of employees and their children here in the valley, I strongly support the new waiver and the continuation of the Safety Net Care Pool. Hensley Beverage Company has a long history of giving back to the community in which our employees live and work and supporting organizations that help create strong foundations in our community. Arizona's healthcare foundation is important to our company and with twenty-five percent of Arizona's children receiving health care coverage through Medicaid, it is important that there are adequate and competent providers delivering the highest quality care possible.

Phoenix Children's Hospital is also unique due to its exceptionally high volume of Medicaid patients and its growth in uncompensated care resulting from AHCCCS payment reductions since 2010.

I appreciate the efforts of AHCCCS and the federal government in recognizing the unique funding challenges experienced by Phoenix Children's Hospital. Their support of the Safety Net Care Pool has allowed the hospital to continue to provide pediatric health care that is not available anywhere else in the state.

Thank you for your consideration of my comments and I urge you to support continuation of the Safety Net Care Pool.

Sincerely,

Robert M. Delgado
President and CEO
Hensley Beverage Company

September 22, 2015

AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034
Email: publicinput@azahcccs.gov

Dear Mr. Betlach,


My name is Dr. P. David Adelson, and I am the Director of Barrow Neurological Institute at Phoenix Children's Hospital and Chief of Pediatric Neurosurgery at Phoenix Children's Hospital. I am writing today in support of the continuation of the Waiver and Safety Net Care Pool because of the important role they play in support of Phoenix Children's Hospital.

Barrow Neurological Institute at Phoenix Children's Hospital offers the most comprehensive inpatient and outpatient neurological care and services to infants, children and teens in Phoenix and across the state of Arizona. As a Center of Excellence for Pediatric Neuroscience our collaborative and comprehensive approach to medicine, education and research has resulted in Barrow at Phoenix Children's being the largest pediatric neuroscience center and the highest nationally ranked neuroscience service line in the Southwest.

We are proud to be one of the few hospitals to offer pediatric neurosurgery, neurology, psychology, psychiatry, developmental pediatrics and rehabilitation in one central location. Specialized medical equipment, pediatric patient rooms, and pediatric specialists -- in addition to our family-centered focus -- make the Center uniquely qualified to treat complex neurological disorders in pediatric patients.

The advancement of the Barrow at Phoenix Children's Hospital and its unique focus on pediatric neurosciences represents an immense resource for Arizona children now and into the future. The ability to continue state of the art programs like the above could not be possible without support from the community and local government. I strongly support the Waiver and continuing the Safety Net Care Pool for Phoenix Children's Hospital.

Thank you,


P. David Adelson, MD, FACS, FAAP
Director, Barrow Neurological Institute at Phoenix Children's Hospital
Diane and Bruce Halle Endowed Chair for Pediatric Neurosciences
Chief, Pediatric Neurosurgery/Children's Neurosciences



September 24, 2015

AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034
Email: publicinput@azahcccs.gov

Dear Director Betlach:

On behalf of Phoenix Children's Hospital (PCH), I am writing to strongly endorse Arizona's application for a new Medicaid waiver to continue the Arizona Health Care Cost Containment System (AHCCCS). The proposal includes a large vision for modernizing Arizona Medicaid, while paying close attention to the needs of our state's children, particularly those with complex medical needs. In particular, the proposed phased-down continuation of the Safety Net Care Pool for PCH, accompanied by a series of payment reforms to improve reimbursement, will help stabilize our funding so that we may continue to provide access to comprehensive pediatric care for Arizona's children.

The **Safety Net Care Pool** (SNCP) was first implemented in 2012 to help support hospitals serving the largest volume of AHCCCS and uninsured patients with the increasing burden of uncompensated care arising from cutbacks in eligibility and reimbursement. When AHCCCS eligibility for childless adults was restored and expanded in January 2014, general acute care hospitals realized a significant increase in reimbursement and reduction in uncompensated care, and the state legislature terminated the authority for the SNCP for general acute care hospitals. However, the eligibility expansion for adults did not help PCH.

As part of the coverage restoration legislation, therefore, the legislature authorized a limited extension of the SNCP for freestanding children's hospitals with 100 beds or more. AHCCCS has obtained federal approval for two one-year extensions of the SNCP for PCH, and has proposed a third extension through the end of the current waiver, September 30, 2016. This new waiver proposal would phase the SNCP down over five years while transitioning PCH to a **more sustainable reimbursement system** that would reduce the need for supplemental support. PCH wholeheartedly supports this goal. And we believe that the proposal that you have developed sets up the appropriate framework to achieve it. In particular, we are appreciative of the transition to the APR-DRG payment methodology with a new adjustment for high-acuity pediatric cases, and the proposed changes to the graduate medical education methodology, which will provide more equitable reimbursement for PCH. We look forward to working with you as you explore other options to improve reimbursement, especially through value-based payment systems, under which we believe PCH is well-positioned to succeed.

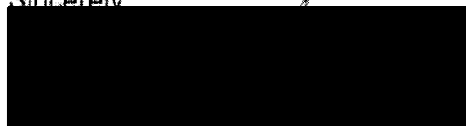
PCH also supports AHCCCS' proposal to jump-start delivery system reform through a **Delivery System Reform Incentive Payment (DSRIP) program**. PCH has invested significant resources in developing an integrated delivery system with our community pediatricians, our subspecialists and the hospital through the establishment of the Phoenix Children's Care

Letter to Director Betlach
September 24, 2015
Page - 2

Network. This work would not have been possible without the support for our uncompensated care costs provided through the SNCP. We have also been actively working to improve pediatric behavioral health care services on an integrated basis. Our work would align well with the priorities AHCCCS has outlined for the DSRIP, and we look forward to working closely with you in developing and participating in this exciting new initiative.

In short, PCH supports AHCCCS' proposal to modernize Arizona Medicaid, and we are grateful for the particular concern the proposal demonstrates for the needs of Arizona's children. We stand ready to assist you in any way needed as you move forward to further implement these ideas.

Sincerely,

A large black rectangular redaction box covers the signature area.

Robert L. Meyer
President and Chief Executive Officer
Phoenix Children's Hospital

October 23, 2015

AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034
Email: publicinput@azahcccs.gov

Dear Mr. Tom Betlach,

I am pleased to submit this letter as public comment in support of the application submitted by the Arizona Health Care Cost Containment System (AHCCCS) for a new Medicaid waiver for the state of Arizona.

As chairman of the board of directors for Phoenix Children's Hospital, I see first-hand the significant impact the AHCCCS program has on children and their families, as well as with our staff providing care. With more than 60% of our patients receiving health care benefits through AHCCCS, the quality and sustainability of this program is critical to the unique and highly-specialized care provided by Phoenix Children's.

We respect and support the need for modernization of the program and the new opportunity for a more sustainable reimbursement system. The Safety Net Care Pool (SNCP) was first implemented in 2012 for hospitals with the greatest volume of Medicaid and uninsured patients. This funding provided supplemental payments to off-set the reduction in eligibility and reimbursements. Most recently, an extension of SNCP was authorized for free-standing children's hospitals of more than 100 beds as part of the state's Medicaid Restoration plan. This has remained a critical source of funds given that PCH has the highest level of patients that are on AHCCCS. We believe that the phase-down approach to SNCP proposed in the new waiver, coupled with the new payment methodology, and Delivery System Reform Incentive Payment program will allow PCH to continue delivering the highest quality services to children in the Southwest.

On behalf of my board of directors, we applaud AHCCCS for their continued innovation and CMS for their wisdom in understanding that all hospitals and patients are not alike. We strongly support the new Arizona waiver and approval of the proposed SNCP transition plan.

Sincerely,



Jon Hulburd

Chairman, Board of Directors Phoenix Children's Hospital



100% FOR CHILDREN

AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034
Email: publicinput@azahcccs.gov

Dear Director Betlach,

My name is Randy Christensen, M.D., and as the Medical Director for Crews'n Healthmobile at the state's only free standing children's hospital, I would like to voice my support of the Safety Net Care Pool funding program for Arizona's most vulnerable children.

As Medical Director for the Crews'n Healthmobile, my team and I see over 7,000 unique visits in a year providing them with a comprehensive holistic medical home model of treatment. Most of the children that my team and I treat have no insurance or are on AHCCCS. The children we see are the most vulnerable in our community consisting of runaways, victims of abuse and children that are systemically neglected. The median age for these children is 10-11 years old. Our 38 foot Mobile Medical Units partner with a wide array of non-profits supporting the valley's underserved youth. This close community partnership allows us to build relationships with the youth and provide them with additional resources such as mental health, education, parenting skills, mentorship and other critical life lessons.

For 15 years the Crews'n Healthmobile has been operating as a unique entity in the Valley, transporting physicians and nurses to critical neighborhoods where children are not able to receive the quality medical care they deserve. This program costs \$2.5 million to operate and is compensated for roughly one third of that cost; the rest is borne by Phoenix Children's Hospital through donations and grants. With the Crews'n Healthmobile program on track to seeing a 50% increase in patients in 2015, the continued support of Safety Net Care Pool waiver will allow us to be able to meet the growing demand of critical need children in our community.

On behalf of the children who receive needed health care in the hospital setting and on the streets, I am proud to voice my support for the Arizona waiver and the Safety Net Care pool proposal.

Thank you for your time.

Respectfully,


Randy Christensen, M.D.
Medical Director, Crews'n Healthmobile
rchrste@phoenixchildrens.com
602-933-5345

September 21, 2015

Tom Betlach, Director
AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Director Betlach,

Thank you for the opportunity to comment on the proposed Medicaid waiver. We are committed to improving the health of all Arizonans. We strongly believe the direction of our state's Medicaid program influences Arizona's overall health system and the health outcomes of millions of people.

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Ensure cost-sharing does not discourage individuals from obtaining necessary care. Over the years, Medicaid premiums and cost sharing have been used to limit state program costs, encourage more personal responsibility over health care choices and to better align public coverage with private coverage where states have expanded coverage. ¹

In general, cost-sharing deters individuals from seeking medical care, while premium requirements deter individuals from enrolling in coverage. According to a recent study

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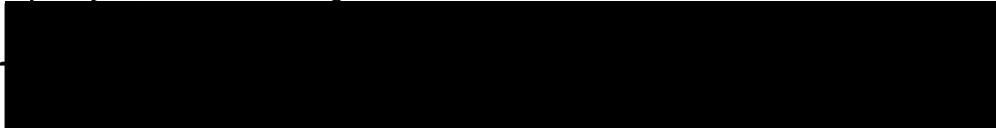
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The price sensitivity of households with low incomes *must* be a consideration when imposing premium or co-payment requirements for any public health program. Fortunately, federal Medicaid regulations do not allow providers to require individuals with incomes less than 100% FPL to pay the applicable cost-sharing as a condition for receiving the item or service, and prohibits premiums for most individuals with income below 150%.

Thank you for the opportunity to respond to the waiver proposal. We deeply value AHCCCS’ commitment to innovation and improvement, and we welcome opportunities to collaborate on these efforts.

Sincerely,

A large black rectangular redaction box covers the signature and name of the sender.

This letter is supported by the Arizona Coordinating Body of the American Association of Diabetes Educators (AADE).

² Abdus S, Hudson J, Hill SC, Selden TM, Children’s Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014.

³ Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013

Vinyard, Christopher

From: Ingrid S <isawyer@azlivingwellinstitute.org>
Sent: Thursday, September 24, 2015 11:54 AM
To: Public Input
Subject: [Caution: Message contains Redirect URL content] Input for Medicaid 1115 Waiver Renewal

Follow Up Flag: Follow up
Flag Status: Completed

Tom Betlach, Director

AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

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Thank you for the opportunity to respond to the waiver proposal. We deeply value AHCCCS’ commitment to innovation and improvement, and we welcome opportunities to collaborate on these efforts.

Sincerely,



Ingrid Sawyer

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[3] Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013

Ingrid Sawyer RN, BSN
Outreach & Training Coordinator
2066 W. Apache Trail, Ste 116
Apache Junction, AZ 85120
office: (623) 239-7240



Arizona Public Health Association

Affiliated with the American Public Health Association
700 E. Jefferson St., Suite 100 – Phoenix, AZ 85034
Phone: 602-258-3361 Fax: 602-258-5497 www.azpha.org

September 24, 2015

Mr. Tom Betlach, Director
AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

2015-2016 AzPHA
Executive
Committee

Executive Director
Daniella Smith

President
Joshua Beck

President Elect
Kate Goodin

Vice President
Marcus Johnson

Immediate Past
President
Tracy Lenartz

Secretary
Felicia Trembath

Treasurer
Eddie Sissons

Representative to
APHA
Patti Taylor

Dear Director Betlach:

On behalf of the Arizona Public Health Association (AzPHA), we thank you for the opportunity to comment on Arizona's 1115 Medicaid waiver application.

Founded in 1928, AzPHA is a membership organization that works to improve the level of health and well-being for all Arizonans. Our members include healthcare professionals, state and county health employees, health educators, community advocates, doctors, nurses and students. The comments below are reflective of our vision to create healthy communities for all Arizonans.

AzPHA would like to extend our support for a number of concepts included in the waiver application intended to empower individuals to make informed and appropriate choices regarding their health. First, we commend the Administration's inclusion of system improvements through Value-Based Purchasing (VBP) strategies and Delivery System Reform Incentive Payments (DSRIP). Specifically, we are encouraged by the Administration's commitment to better integrate behavioral and physical health care services, address chronic disease in populations of high need, and develop primary care models which value population health. Public health professionals, including but not limited to community health workers, are capable of contributing to these pursuits by enhancing coordination of care across systems and connecting individuals to social services in the community. Expanding the role of public health professionals into traditional healthcare settings has been associated with reduced costs, especially for those individuals suffering from chronic disease. AzPHA welcomes the opportunity to work further with the Administration to identify and develop innovative, cost-effective strategies that incorporate public health professionals.

We are also encouraged by the Administration's commitment to address health care disparities of American Indians and Alaskan Natives through the development of medical homes. We are optimistic that this model will allow

individuals receiving care in Indian Health Services and Tribal 638 facilities to receive services from a variety of qualified public health professionals who are experts in case management, care coordination and other triage services. Additional strategies to improve payments to critical access hospitals are another step in the right direction to ensure that rural Arizonans have access to high quality, affordable healthcare. Finally, we applaud the Administration's recognition that many AHCCCS members face unique challenges (e.g., parents with young children, and adults with serious mental illness) which merit exemptions from some of the AHCCCS CARE requirements. We are confident that such provisions will help protect and promote access to care for these populations, thus allowing them to maintain coverage and continue receiving pivotal health services.

The members of AzPHA respectfully share the following concerns with you about the waiver application:

Coverage for Preventive Services

Currently, AHCCCS covers preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF) for individuals living between 100%-138% federal poverty level (FPL). However, these same services are not covered for individuals living under 100% FPL. AzPHA advocates for coverage of the USPSTF Category A and B services to be included for all AHCCCS members under the new waiver, and would like to bring attention to 2013 CMS guidance indicating a 1% reduction in the Federal Medical Assistance Percentages (FMAP) rate for states which pay for those services for individuals living under 100%FPL:

<http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-002.pdf>. Adequate coverage of A and B services is important in our collective work to promote health equity across all populations since federal law also requires commercial and marketplace health insurance plans to include this in benefit packages.

Lifetime Limits and Disenrollment

Whereas AzPHA and its members are committed to ensuring equitable access to care for all Arizonans, we strongly oppose the legislative proposal to place lifetime limits on AHCCCS coverage. Similarly, we oppose the Administration's proposal to disenroll members in the expansion population who fail to pay copays, premiums and fees. We understand the aim to encourage consumers to improve life circumstances and transition away from AHCCCS, but we believe there are alternative, less severe approaches to achieve this aim. We are proud of the great strides Arizona has made to increase coverage levels, thereby laying the groundwork for improved population health outcomes. Any removal of coverage will negatively impact our collective efforts, threaten the viability of public and private investments and jeopardize access to care for vulnerable populations.

Copayments and Premiums

Additionally, we are concerned that the application of premiums and copays – if assessed as currently proposed – may have negative unintended

consequences. Low-income individuals frequently must make difficult financial choices in order to secure or maintain adequate housing, nutrition, and other services necessary simply to survive. What might seem like nominal copayments and premiums might be enough to sway a low-income individual's decision to afford health insurance over other basic needs. We are concerned that individuals may choose, for example, to purchase food instead of paying for premiums, and that this choice may result in a loss of coverage. Furthermore, we believe that the implementation of premiums and copays will result in fewer eligible members applying for AHCCCS coverage due to financial concerns.

We understand the Legislature's intent to lessen excessive use of emergency room visits for non-emergencies through emergency department (ED) copayments. However, it may be difficult to determine appropriate use, especially if the criterion is based on hospital admission. Often, it is difficult to know if an emergency is indeed an emergency, until an individual has been seen in the ED. Also, most urgent care facilities are closed past 10 p.m. and there is no other place to go during a late night health scare. This policy may discourage individuals needing emergency care from going to the hospital for fear that they will have to pay a copay if their visit is deemed a non-emergency.

The prescription drug abuse epidemic is of major concern to the public health community. We commend the Administration for addressing the misuse of opioids, but we suggest expanding copayment exemptions beyond "persons who have cancer or are terminally ill." Many Arizonans living with chronic pain and other illnesses are properly medicated with opiates under the supervision of a qualified health care provider. Thus, copayments for these individuals may not be appropriate. AzPHA welcomes the opportunity to work with AHCCCS further on this important issue and looks forward to continued collaboration with our partners in health care, social services, substance abuse, and the faith-based community to implement evidence-based strategies and policies to decrease opiate abuse and misuse.

We urge the Administration to consider exempting copayments from any services delivered by a county health department not operating as a federally qualified health center. This is not clear in the current materials, and is critical to the strength of our health departments.

AHCCCS Works

The work requirements directed by the Legislature provide some latitude in regards to special populations exempt from seeking employment. Additional consideration should be given to individuals who are not able to seek employment because they suffer from illnesses characterized by periods of good health followed by long periods of poor health (e.g., multiple sclerosis, lupus, etc.). Also, caregivers required to be in the home to care for teenage or adult children who suffer from complex health conditions and experience frequent unavoidable hospitalizations also face challenges in their ability to maintain employment.

Emergency Transportation

Ensuring individuals have access to reliable transportation to medical services is of the utmost importance. AzPHA is very concerned that the legislative proposal to remove emergency transportation benefits will negatively impact members' ability to access appropriate care – especially for those members living in rural Arizona. Additionally, there are vulnerable populations (e.g., immunocompromised cancer patients) who should not be using mass public transportation due to potential exposure to common illnesses.

AHCCCS CARE Accounts

While AzPHA values the Administration's goal to provide members a bridge to independence through AHCCCS CARE accounts, we have concerns regarding specific proposals. First, we recommend AHCCCS consider separating Healthy Arizona targets from access to one's CARE account. The current proposal leaves us to question what happens to CARE account investments if a member fails to meet their Healthy Arizona targets. In alignment with similar strategies in the commercial market, AzPHA suggests that members who pay into individual CARE accounts maintain access to their invested funds, regardless of their ability to achieve predetermined health targets.

Second, given the aim to prepare members for the commercial market via corporate wellness strategies (i.e., implementing health targets and health savings accounts (HSAs)), AzPHA recommends the Administration examine guidelines governing corporate wellness. Specifically, 71 FR 75014 requires the inclusion of reasonable alternatives to health targets for medically unfit individuals. Consideration of this existing guidance may help maximize the effectiveness and approval of AHCCCS CARE.

Finally, we are encouraged that the Administration has proposed allowing members to use CARE account funds to pay for specific non-covered services, yet we urge AHCCCS to broaden its language to allow for additional services which currently may be overlooked. We also seek clarification related to members' ability to apply CARE account funds toward copayments. Should the CARE accounts be approved by CMS, we believe this permission would accurately prepare members for the commercial market, where HSAs are commonly used to pay for copayments.

AzPHA is enthusiastic about AHCCCS' intention to engage community stakeholders during implementation of our improved Medicaid program. We look forward to partnering with the Administration, and welcome any opportunities to offer our unique expertise. As with any system-wide change, it is critical that we identify appropriate ways to not just monitor compliance, but also to measure the effectiveness and efficiency of the new program in terms of improved health outcomes and decreased cost. AzPHA is happy to assist in this matter. In addition, we hope to partner in implementing educational initiatives to inform public health workers about the intricacies of the new program, since many of our members partner with Medicaid-eligible individuals in a variety of settings, including providing

direct application assistance and helping identify points of care. We value our partnership with AHCCCS and are encouraged by the innovative ideas embodied in the 1115 application.

Again, thank you for the opportunity to respond to the waiver proposal and for your commitment to improving the health and well-being of all Arizonans.

Sincerely,



Daniella V. Smith
Executive Director
Arizona Public Health Association

Vinyard, Christopher

From: Jennifer Hardy <JHardy@azkrmc.com>
Sent: Thursday, September 24, 2015 12:48 PM
To: Public Input
Subject: [Caution: Message contains Redirect URL content] Medicaid 1115 Waiver Renewal for AHCCCS

Follow Up Flag: Follow up
Flag Status: Completed

September 224, 2015

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Ensure cost-sharing does not discourage individuals from obtaining necessary care. Over the years, Medicaid premiums and cost sharing have been used to limit state program costs, encourage more personal responsibility over health care choices and to better align public coverage with private coverage where states have expanded coverage.^[1]

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Sincerely,

Jennifer Hardy

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² Abdus S, Hudson J, Hill SC, Selden TM, Children’s Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014.

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September 21, 2015

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AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

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Sincerely,

Ann Bonpensiero RD CDE

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September 21, 2015

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AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

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Sincerely,



Donna M. Heun

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³ Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013

DATE (**will email to public comment email address)

AHCCCS

Attn: Director Thomas J. Betlach
Attn: Office of Intergovernmental Relations
801 E. Jefferson St., MD 4200
Phoenix, AZ 85034

Dear Director Betlach,

Thank you very much for your continued support of Arizona's healthcare infrastructure. As a former member of Congress who submitted an original request for approval of an extension of Safety Net Care Pool (SNCP) funding, I have seen firsthand the benefits that stem from this financing. I wrote a letter last year and I am writing again this year to emphasize my continued efforts to ensure the continuation of SNCP funding for Phoenix Children's Hospital (PCH).

As you know, PCH sees a high number of Medicaid patients, one of the highest in the state. A great number of those Medicaid children come from the district that I previously represented. In addition to a high number of Medicaid patients, PCH has also seen an 83% growth in uncompensated care. It is vital that the waiver and Safety Net Care pool be continued in order for PCH to maintain its high level of care to all children in Arizona.

Thank you for your consideration of the above information, and for your continued work to support communities across Arizona. The proposed waiver and Safety Net Care Pool will be critical for PCH to maintain its strong support for vulnerable populations of children in the future.

Sincerely,

Ed Pastor
Former Member of Congress

September 21, 2015

Tom Betlach, Director
AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Director Betlach,

Thank you for the opportunity to comment on the proposed Medicaid waiver. We are committed to improving the health of all Arizonans. We strongly believe the direction of our state's Medicaid program influences Arizona's overall health system and the health outcomes of millions of people.

Access to health care is imperative to people with diabetes. In particular, self-management education and training are integral components of diabetes management. Multiple studies have shown general-population diabetes self-management training programs can reduce resource utilization among recipients and ultimately improve diabetes outcomes.

We ask that you:

Support Comprehensive Coverage by Closing Gaps in Benefits: Coverage for services of particular importance to individuals with diabetes, such as diabetes self-management education (DSME) and training (DSMT) should be a standard component of coverage. DSME is a covered benefit of Medicare beneficiaries.

Additionally, we also support Medicaid offering Medical Nutrition Therapy (MNT) and the Diabetes Prevention Program (DPP) as a covered benefit. DPP is an evidence-based lifestyle change program designed to prevent type 2 diabetes. The program has demonstrated effectiveness in helping people at high risk lose a moderate amount of weight (5% to 7% of their current body weight) and increase their physical activity to 150 minutes per week. The result of these two lifestyle changes has been proven to prevent or delay the onset of type 2 diabetes by nearly 60%.

Ensure cost-sharing does not discourage individuals from obtaining necessary care. Over the years, Medicaid premiums and cost sharing have been used to limit state program costs, encourage more personal responsibility over health care choices and to better align public coverage with private coverage where states have expanded coverage.¹

In general, cost-sharing deters individuals from seeking medical care, while premium requirements deter individuals from enrolling in coverage. According to a recent study

¹ <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf>

conducted by staff at the Agency for Healthcare Research and Quality (AHRQ), a premium increase of \$10 per month is associated with a decrease in public coverage of children in families with incomes above 150% of the federal poverty level (FPL), with a greater decrease in coverage for those below 150% FPL.²

A Kaiser Family Foundation review of research related to cost-sharing and premiums in state Medicaid and CHIP programs found that “[f]or individuals with low income and significant health care needs, cost-sharing can act as a barrier to accessing care, including effective and essential services, which can lead to adverse health outcomes.”³

The price sensitivity of households with low incomes *must* be a consideration when imposing premium or co-payment requirements for any public health program. Fortunately, federal Medicaid regulations do not allow providers to require individuals with incomes less than 100% FPL to pay the applicable cost-sharing as a condition for receiving the item or service, and prohibits premiums for most individuals with income below 150%.

Thank you for the opportunity to respond to the waiver proposal. We deeply value AHCCCS’ commitment to innovation and improvement, and we welcome opportunities to collaborate on these efforts.

Sincerely,

Rebecca Gill, MBA, RN, CDE

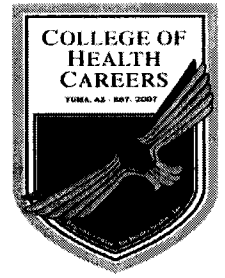
This letter is supported by the Arizona Coordinating Body of the American Association of Diabetes Educators (AADE).

² Abdus S, Hudson J, Hill SC, Selden TM, Children’s Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014.

³ Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013



Regional Center for Border Health, Inc.
San Luis Walk-In Clinic, Inc.



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September 21, 2015

Tom Betlach, Director
AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Director Betlach,

Thank you for the opportunity to comment on the proposed Medicaid waiver. We at Regional Center For Border Health, Inc. San Luis Walk In Clinic, (Rural Health Clinic) are committed to improving the health of all Arizonans. We strongly believe the direction of our state's Medicaid program influences Arizona's overall health system and the health outcomes of millions of people.

Access to health care is imperative to people with diabetes. In particular, self-management education and training are integral components of diabetes management. Multiple studies have shown general-population diabetes self-management training programs can reduce resource utilization among recipients and ultimately improve diabetes outcomes.

We respectfully ask that you:

Support Comprehensive Coverage by Closing Gaps in Benefits: Coverage for services of particular importance to individuals with diabetes, such as diabetes self-management education (DSME) and training (DSMT) should be a standard component of coverage. DSME is a covered benefit of Medicare beneficiaries.

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Ensure cost-sharing does not discourage individuals from obtaining necessary care. Over the years, Medicaid premiums and cost sharing have been used to limit state program costs, encourage more personal responsibility over health care choices and to better align public coverage with private coverage where states have expanded coverage.

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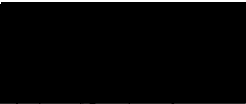
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The price sensitivity of households with low incomes must be a consideration when imposing premium or co-payment requirements for any public health program. Fortunately, federal Medicaid regulations do not allow providers to require individuals with incomes less than 100% FPL to pay the applicable cost-sharing as a condition for receiving the item or service, and prohibits premiums for most individuals with income below 150%.

Thank you for the opportunity to respond to the waiver proposal. We deeply value AHCCCS’ commitment to innovation and improvement, and we welcome opportunities to collaborate on these efforts.

Sincerely,



Anayida Aguirre
President & CEO

This letter is supported by the Arizona Coordinating Body of the American Association of Diabetes Educators (AADE).

² Abdus S, Hudson J, Hill SC, Selden TM, Children’s Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014.

³ Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013

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September 24, 2015

Director Thomas J. Betlach
Office of Intergovernmental Relations
AHCCCS
801 E. Jefferson St., MD 4200
Phoenix, AZ 85034

Dear Director Betlach:

I write today regarding Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Waiver request to the Centers for Medicare and Medicaid Services (CMS). Specifically I write in support of the Safety Net Care Pool (SNCP) framework included in the Waiver, which provides critical funding to Phoenix Children's Hospital (PCH).

PCH is a critical part of the network of hospitals that provide high-quality, accessible care to Arizona families. As a free-standing children's hospital, PCH faces unique resource challenges including high volumes of underpayments and uncompensated care. The supplemental funding allocated by the SNCP enables PCH to provide children from throughout Arizona with access to the very best pediatric specialists and sub-specialists. Patients statewide, including 19,000 patients from the 9th Congressional District where I serve, depend on PCH's pediatric transplant, neuroscience, cardiac, orthopedic and oncology units.

While not a permanent solution, the SNCP is an important tool that will help PCH achieve a stable and successful future. As noted in the Waiver Application Narrative:

"SNCP funding has not adversely affected the hospital's capability or willingness to achieve greater efficiencies. Rather, they appear to have facilitated the hospital's ongoing movement in this direction, allowing PCH the budgetary room to implement additional efficiencies, including value-based delivery system and payment reforms, without substantially disruptive effects on the hospital's level of quality. For this reason, extension of SNCP authorization appears justifiable."

Approval of the SNCP transition plan gives PCH an additional five years to collaborate and develop additional programs and funding. As a crucial provider of care to many of our state's most critical and complex pediatric patients, we should support this valuable state resource.

I appreciate your work on behalf of Arizona families and taxpayers. The Waiver, and the SNCP funding, is vital to the continuation of quality and effective care at Phoenix Children's Hospital and Arizona's many other high quality hospitals.

Thank you for considering this letter. Please contact me or Michael Brownlie of my staff if you require additional information.

Sincerely,



Kyrsten Sinema
Member of Congress

RUBEN GALLEGO
7TH DISTRICT, ARIZONA

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September 24, 2015

AHCCCS

Attn: Director Thomas J. Betlach
Attn: Office of Intergovernmental Relations
801 E. Jefferson St., MD 4200
Phoenix, AZ 85034

Dear Director Betlach,

On behalf of the constituents that I represent, thank you for allowing me to write in support of the Medicaid program in Arizona and the continuation of the Safety Net Care Pool (SNCP). I represent Arizona's 7th Congressional District, where Phoenix Children's Hospital (PCH) is located. The patient visits from the 7th Congressional District at Phoenix Children's Hospital on AHCCCS are over 80,000 a year. As a community leader, I can tell you that the continuation and support of the SNCP is essential for those families in my district to have the best possible medical care for their children.

The proposed waiver describes many opportunities for Arizona to continue its innovative care delivery to ensure the Medicaid program remains successful. Of particular interest to me is the continuation of SNCP, as I have first-hand knowledge of its significance. The additional funding to Phoenix Children's Hospital is necessary to ensure that children in my district and throughout the state have access to the very best pediatric doctors and nurses. The sheer volume of under-payments and uncompensated care undertaken by PCH would have been unsustainable without the additional support of SNCP.

Arizona faces unique challenges and barriers to care for children across our state. As you know, Arizona is the only state without a Children's Health Insurance Program (CHIP). A recent report by Georgetown University's Center for Children and Families estimates that since Arizona canceled its CHIP program in 2014, over 14,000 children have lost their insurance coverage. While the Affordable Care Act has made strides in increasing access to coverage for working families, many children in Arizona will still fall into coverage gaps – making SNCP funding critical for our providers who continue to care for these patients. While I will continue to press my colleagues at the local, state, and federal levels to find solutions to address this unacceptable state of coverage for Arizona's children, providers who care for our most vulnerable patients must be able to count on the critical funding SNCP provides to continue that care.

Thank you again for taking comments on this very important issue. The residents of Arizona's 7th Congressional District deserve the best medical care possible for their children. In order to help provide this high level of care, the need for the Safety Net Care Pool continuation is critical.

Sincerely,



Ruben Gallego
Member of Congress



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.

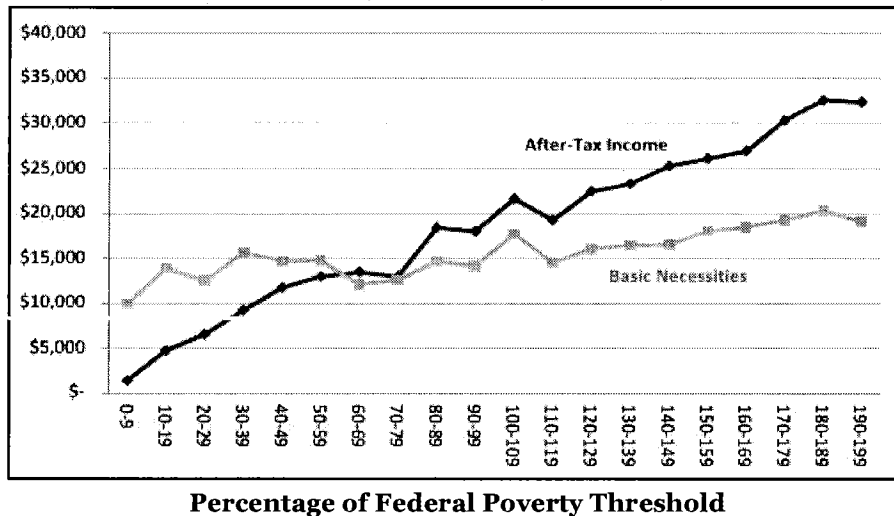
The proposed waiver, in conjunction with the crucial policy step taken in 2013 to restore and expand coverage for 350,000 Arizonans, offers great promise for the future of the Medicaid program. We share several principles embodied in the waiver proposal— incentivizing improved outcomes and quality of 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**



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

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 Arizona⁹, 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

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

¹¹ Amy S. Kelley, M.D and Diane E. Meier, M.D. “Palliative Care—A Shifting Paradigm,” *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 members¹⁵ 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.

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

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.”

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

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



Sept. 24, 2015

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

Re: AHCCCS Care program

Dear Director Betlach:

Tucson Medical Center is appreciative of the opportunity to provide input on the proposed waiver to restructure Arizona's Medicaid program in several critical areas.

The Arizona Health Care Cost Containment System has long served as a model for managed care, leveraging a public-private partnership to deliver effective, comprehensive healthcare for the most vulnerable among us.

Protecting that legacy at a time when AHCCCS is now the largest insurer in the state of Arizona, serving approximately 2 million Arizonans in the course of a year, is imperative. So, too, is the need to ensure the long-term sustainability of the program and the ability to respond to best practices, including engaging patients in their care and providing them with the tools they need to be successful in building a lifestyle of wellness.

As a safety net hospital that directs 12.7 percent of net revenues to community benefit, Tucson Medical Center is committed to ensuring the community has access to necessary and appropriate levels of care.

Although TMC understands the Administration's goal of ensuring patients make a personal investment in their own healthcare, we encourage thoughtful implementation of any proposed premiums and copays. Although we do appreciate the strategic application of copays that protect those with chronic and mental illness and exempts preventive and OB/GYN services, we hope the Administration continues to evaluate the impact the changes will have on affordability and access and respond appropriately as more information becomes available.

TMC also appreciates the state's efforts to creatively address, through the AHCCCS Care Account, some of the very serious gaps in care that exist now, including dental and vision needs – both of which have long-term impacts on the ability of residents to obtain and maintain employment. The state may consider allowing individuals to withdraw money from their accounts to cover necessary co-pays to ensure they do not delay needed interventions.

As an urban area that was caught up in a lengthy transit strike over the late summer, the importance of transportation in allowing patients to access medical services has been more apparent than ever. We are hopeful that the state may be able to find a way to stave off the wholesale elimination of non-emergency transportation, and particularly in areas with weak transit systems, such as in rural areas.

September 24, 2015

Director Thomas Betlach, AHCCCS

Page 2

As a hospital that is active in building a culture of wellness outside the walls of the hospital, TMC is supportive of the wellness efforts outlined in Healthy Arizona. We know that medical practitioners are only part of the equation. The other piece requires supporting patients in their efforts to proactively manage their health conditions and prevent illness in the first place. Providing financial incentives is one way to motivate behavioral change.

At TMC, we also recognize and strongly encourage the continuation of the Safety Net Care Pool for its critical support of Phoenix Children's Hospital. As the only freestanding children's hospital in the state, their continued strength is important to the children and families throughout Arizona.

TMC is very pleased with the state's proposed approach to the Delivery System Reform Incentive Payments (DSRIP). In practice, DSRIP initiatives have demonstrated that they can promote collaboration, improve care coordination and better integrate the delivery of physical and behavioral health care.

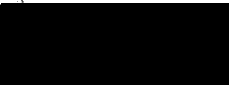
In a time of diminished supplemental payments to hospitals and of increasing demands for transformative health care, DSRIP initiatives hold promise. TMC also appreciates the areas of priorities of that been identified: infrastructure development, program innovation, clinical improvements in care and population focused improvement.

Although TMC understands the language will be tightened as negotiations with CMS continue over the coming year, outstanding questions that must be addressed include identifying the source of the funding for the initiatives as well as determining the degree of flexibility that will be built into the program. The details of implementation are critical and will dramatically affect how effectively the health care system can respond to the complex, nuanced work of building the necessary relationships and infrastructure to support these efforts.

We are confident that the state will be an effective partner in working with stakeholders to build a workable structure and in sharing sufficient guidance with its hospital partners in outlining expectations and opportunities.

Thank you again for the opportunity to comment. If you have any questions, please feel free to contact Julia Strange, Vice President, Community Benefit at 520-324-2017.

Sincerely,



Judy Rich
President & CEO



September 24, 2015

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

Dear Director Betlach:

On behalf of Mental Health America of Arizona we would like to thank you and your staff for the opportunity to comment on the Medicaid Section 1115 waiver. We would like to compliment the AHCCCS staff members who have presented at the community forums around the state and have made themselves available to respond to questions, comments and concerns regarding the Section 1115 waiver that will be submitted shortly by the agency. AHCCCS has a long history of providing quality health care for individuals and families in Arizona. We look forward to a future which continues to steward access and high quality care for Arizona's most underserved populations.

Mental Health America is a national organization founded in 1909 and dedicated to helping all Americans achieve wellness by living mentally healthier lives. The Arizona state affiliate was founded in 1954 and is the state's oldest organization dedicated to all aspects of mental health, mental illness and behavioral health disorders. Our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, and integrated care and treatment for those who need it, with recovery as the goal. As the waiver process moves forward, we offer our partnership to ensure the safety and well-being of individuals currently served by AHCCCS through information sharing and advocacy, especially for individuals with mental illness.

We are pleased with the Administration's plans to improve care coordination as integration of behavioral health and physical health care becomes the statewide norm. We know that a variety of payment improvements are under consideration from value based purchasing to Delivery System Reform Incentive Payment (DSRIP). Knowing the significant correlation between mental health disorders and chronic disease, we are supportive of efforts to address chronic disease in Arizona's populations of highest need. Towards that aim MHA-AZ urges the Administration to consider the needs of Arizona's behavioral health populations – those suffering from severe mental illness (SMI) and those with general mental health (GMH) disorders – throughout the waiver.

MHA-AZ shares the Administration's principles to: engage individuals in taking charge of their health care; provide tools for transitioning members to the commercial market; and promote a quality product at an affordable price. Achieving such worthy aspirations will require a heavy lift, made all-the-more

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To promote the mental health and well-being for all Arizonans through education, advocacy, and the shaping of public policy.

difficult when addressing the needs of the behavioral health populations. The following comments articulate areas of concern we believe will hinder the program and have unfavorable consequences for Arizonans suffering from mental illness. Specifically, we are concerned about four elements of the proposed 1115 waiver: member financial requirements; 5-year lifetime limit; work requirements; and non-emergency transportation ban. The bases of our concerns are summarized below.

Member Financial Requirements

Copayments and Premiums

MHA-AZ is opposed to the proposed financial requirement and enforcement provisions, and suggests they be withdrawn. If CMS does approve these provisions, MHA-AZ urges the Administration to consider implementing a tiered pricing system for copayment requirements, the details of which we are happy to assist in developing.

The proposed waiver would require members to pay up to 3% of their annual income to receive health care and to contribute monthly 2% of their income to the AHCCCS CARE Program. Members who fail to meet financial requirements are subject to disenrollment for six months or have a debt that accumulates to the state, and lose access to their CARE account funds. Our concern about the proposed copayment requirements is informed by the results of the Kaiser Foundation's study "Premium and Cost Sharing in Medicaid: A Review of Research Findings" from February 2013 that found that premiums and copayments for the Medicaid population act as barriers to accessing care which can lead to adverse health outcomes. Given that individuals living in poverty and suffering from mental illness often face difficult financial decisions to afford life's basic needs, we are concerned that such enforcement will lead to disenrollment of the most vulnerable and unstable populations. Such action is likely to exacerbate mental and chronic illness, ultimately leading to increased ED and crisis service usage, strain on the criminal justice system, or worse, suicide or violence against others.

To ensure undeterred access to mental health care, MHA-AZ strongly encourages the Administration to include mental health services in its definition of "preventive services," "wellness," or "services to manage chronic illness," all of which are currently exempt from copayments. The waiver proposal, as written, leads us to question whether the copayments will vary for mentally ill populations based on income or the setting where care is received. It is clear that copayment exemptions exist for services provided by one's primary care physician, as well as for emergency services provided by an ED; however, we are concerned that general mental health services (outside of those provided to persons with SMI) will be subject to copayment. Stigma associated with mental illness is fueled by extrinsic and intrinsic motivations, and we are concerned that copayments for general mental health services will further repel populations away from seeking care.

Non-Emergency Use of the ED

The proposed waiver also includes a tiered copayment of \$8 and then \$25 for use of the emergency department for non-emergency purposes. The higher copay is triggered when other providers are within 20 miles of the hospital without any recognition that those centers or facilities may not be open

during the time of the emergency. Recent evidence suggests imposing copayments for non-emergency use of EDs may be particularly onerous and unsubstantiated. First, a recent report, "Comparison of Presenting Complaint vs Discharge Diagnosis for Identifying 'Nonemergency' Emergency Department Visits" published on March 20, 2013, in the Journal of the American Medical Association concluded that, "The limited concordance between presenting complaints and ED discharge diagnoses suggests that these discharge diagnoses are unable to accurately identify nonemergency ED visits." This conclusion was based on the finding that chief complaints of primary care-treatable ED visits mirrored 90% of the chief complaints for all ED visits. Second, in December 2014, AHCCCS reported to the Governor and the Joint Legislative Committee in a report titled "Regarding Emergency Department Utilization," that AHCCCS members had a low rate of non-emergency use of the emergency room compared to national averages. The study found that the AHCCCS health plans were developing and using interventions that ensured appropriate use of the emergency room. These factors contribute to our concern that higher copayment is not based upon recent data and analysis, and should be omitted. An AHCCCS member must use his/her best judgement to determine when to seek ED care based upon the 'prudent person standard,' which states that the combination of medical history and presenting health symptoms are the best guide of when or where to seek care. We gladly offer our assistance in working with the Administration to identify alternatives means to encourage members' proper use of EDs.

AHCCCS CARE Accounts

In addition to the requirement of co-payments, the Administration has proposed a 2% income contribution to the AHCCCS CARE Program. These funds when accumulated could be used to pay for services not covered by AHCCCS such as dental or vision services. If CARE account contributions are approved, MHA-AZ recommends that AHCCCS CARE funds be allowed to cover billed copayments. We also recommend that individuals be granted access to their CARE account funds, regardless of their enrollment status. The current proposal does not mention what happens to one's accumulated CARE funds in the event they are disenrolled.

5 year Lifetime Limit

MHA-AZ is opposed to the legislative requirement that imposes a 5-year lifetime limit on AHCCCS coverage. Mental illness can be a lifelong debilitating condition; individuals who experience poverty are at significantly greater risk of mental illness; and individuals experiencing a mental illness may experience periods of wellness, interrupted by periods of severe illness. Imposing an arbitrary 5-year lifetime limit on AHCCCS eligibility denies the realities of what is known about disability and chronic illnesses such as mental illness.

Work Requirements

MHA-AZ supports efforts to assist individuals in moving towards economic self-sufficiency. It is our hope that the involvement of private employers and the Department of Economic Security's employment programs may provide opportunities for any able-bodied adult enrolled in the AHCCCS program to secure employment if they are not already employed. However, we are unclear how and if the proposed employment audit tools are robust enough to capture the breadth of professions attained

by beneficiaries. Furthermore, evidence suggests that Medicaid work requirements may be cost prohibitive and misdirected. According to Jessica Schubel, Senior Policy Analyst, for the Center for Budget and Policy Priorities in her May 1st blog “No Need for Work Requirements in Medicaid”, she found the majority of recipients of Medicaid work full- or part-time. She further noted of those not working, 29 percent weren’t working because they were caring for a family member, 20 percent were looking for work, 18 percent were in school, 17 percent were ill or disabled, and 10 percent were retired. We also note that many individuals may apply for Social Security Disability with many being denied on their first application. The identified exceptions to the 5-year ban do not recognize the needs of parents caring for disabled children over the age of six. There too may be able-bodied adults who have episodes of mental or physical illness that may be a barrier to employment.

Non-emergency Transportation

AHCCCS is further required to submit a waiver eliminating non-emergency medical transportation as a covered service for members above 100% of FPL. Rather than a blanket prohibition of this service, MHA-AZ recommends pursuing alternative strategies which enhance access to primary care services for consumers and encourage providers to better manage nonemergency transportation. In light of the geographic diversity of urban, rural and frontier Arizona, and the lack of adequate public transportation in many areas of the state, this denial of coverage would present significant barriers to the well-being of AHCCCS members. This concern is, in part, identified in a sanction letter from ADHS to MMIC in February 2015 that states, “...transportation ...led to widespread disruption of the behavioral health and acute care system and has resulted in direct impact to members...” That statement highlights the necessity of assuring that members have an ability to get to their medical appointments. Eliminating this vital service may cause harm.

We look forward to working with AHCCCS to continue to improve the quality of health care delivered to families and individuals in need of health care. Thank you for the opportunity to comment on the proposal.

Sincerely,



Eddie L. Sissons, C.P.M.
Executive Consultant

September 24, 2015

Tom Betlach, Director
AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Director Betlach,

Thank you for the opportunity to comment on the proposed Medicaid waiver. I am committed to improving the health of all Arizonans. I strongly believe the direction of our state's Medicaid program influences Arizona's overall health system and the health outcomes of millions of people.

Access to health care is imperative to people with diabetes. In particular, self- management education and training are integral components of diabetes management. Multiple studies have shown general-population diabetes self-management training programs can reduce resource utilization among recipients and ultimately improve diabetes outcomes.

I ask that you:

Support Comprehensive Coverage by Closing Gaps in Benefits: Coverage for services of particular importance to individuals with diabetes, such as diabetes self- management education (DSME) and training (DSMT) should be a standard component of coverage. DSME is a covered benefit of Medicare beneficiaries.

Additionally, we also support Medicaid offering Medical Nutrition Therapy (MNT) and the Diabetes Prevention Program (DPP) as a covered benefit. DPP is an evidence-based lifestyle change program designed to prevent type 2 diabetes. The program has demonstrated effectiveness in helping people at high risk lose a moderate amount of weight (5% to 7% of their current body weight) and increase their physical activity to 150 minutes per week. The result of these two lifestyle changes has been proven to prevent or delay the onset of type 2 diabetes by nearly 60%.

Ensure cost-sharing does not discourage individuals from obtaining necessary care. Over the years, Medicaid premiums and cost sharing have been used to limit state program costs, encourage more personal responsibility over health care choices and to better align public coverage with private coverage where states have expanded coverage.¹

In general, cost-sharing deters individuals from seeking medical care, while premium requirements deter individuals from enrolling in coverage. According to a recent study

¹ <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf>

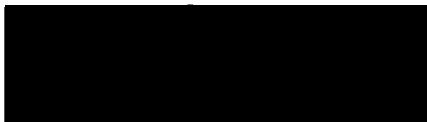
conducted by staff at the Agency for Healthcare Research and Quality (AHRQ), a premium increase of \$10 per month is associated with a decrease in public coverage of children in families with incomes above 150% of the federal poverty level (FPL), with a greater decrease in coverage for those below 150% FPL.²

A Kaiser Family Foundation review of research related to cost-sharing and premiums in state Medicaid and CHIP programs found that “[f]or individuals with low income and significant health care needs, cost-sharing can act as a barrier to accessing care, including effective and essential services, which can lead to adverse health outcomes.”³

The price sensitivity of households with low incomes *must* be a consideration when imposing premium or co-payment requirements for any public health program. Fortunately, federal Medicaid regulations do not allow providers to require individuals with incomes less than 100% FPL to pay the applicable cost-sharing as a condition for receiving the item or service, and prohibits premiums for most individuals with income below 150%.

Thank you for the opportunity to respond to the waiver proposal. I deeply value AHCCCS’ commitment to innovation and improvement, and we welcome opportunities to collaborate on these efforts.

Sincerely,

A black rectangular redaction box covering the signature of Nicole Scovis.

Nicole Scovis, PharmD, BCPS, BCACP
Pharmacist

² Abdus S, Hudson J, Hill SC, Selden TM, Children’s Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014.

³ Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013

Vinyard, Christopher

From: roms623@juno.com
Sent: Thursday, September 24, 2015 8:36 PM
To: Public Input
Subject: Request that the Governor's request for waiver for AHCCCS program be denied

Follow Up Flag: Follow up
Flag Status: Completed

I have just read Lanny A. Kope, EdD Commentary titled "A lack of Gubernatorial logic" in my newspaper, the Sierra Vista Herald/Review. I agree 100% with Dr. Kope evaluation that the request for this waiver indicates a lack of understanding of the needs of the AHCCCS population.

AHCCCS currently contains costs so much that, in the experience of my daughter, health care is not provided, resulting in her long term on going health issues that may prevent her from ever being able to return to work. Specifically, she was denied health care by AHCCCS even though the Obamacare indicated it was the only insurance she could qualify for based on her income. In spite of having some chronic health issues my daughter put herself through college, with a degree in education. Two automobile accidents (at signals where the other driver did not stop) left her with even more chronic pain and migraines. Attempting to support herself and herself son by substitute teaching she worked as many days as her health would handle. That did not make enough money, so she attempted to take long term substitute jobs - which has resulted in a complete breakdown of her health, including severe breathing problems with bronchitis and pneumonia. During the time she was denied coverage she became even more ill.

AHCCCS eventually reinstated her, but even so medications or treatments that her AHCCCS doctor prescribes are often not allowed. For example medications that the doctor prescribes that she is not allergic to are not covered, and physical therapy that she needs is not allowed at the number of treatments that the doctor wants to prescribe. This means they know something that would help, but AHCCCS will not approve it! That is an issue that should not be allowed!

If what my daughter has experienced from AHCCCS would be multiplied to others by approving the waiver and its provisions, it will only increase the ill, poor and needy in our community. That is not what logic and understanding would desire for Arizona.

Seeking to contain costs by denying the working poor who cannot afford medical care, and not allowing the people covered by AHCCCS access to the medical treatment needed that might really help them is not right. Anything that makes it harder for the chronically ill, physically and mentally disadvantaged and working poor to have medical help is not the type of improvement to the system that is needed. Scrooge might approve of all the waiver is seeking to do, but not anyone who actually knows firsthand what a person on AHCCCS has to go through to get help.

I believe that Dr. Kope opinion should count very heavily in considering the merits of the proposed waiver. He is obviously a man of great knowledge and experience, not just on the Cost Containment side, but more importantly on the Health Care side of AHCCCS for the people of Arizona.

In my opinion, the best interests of the people of Arizona, sick and well, rich and poor, will be better served by denying the request for a waiver of the AHCCCS program.

Sincerely,

Kathryn E. DeKeizer

1201 N. Colombo Ave. Apt. 11106
Sierra Vista AZ 85635

Vinyard, Christopher

From: Cassalyn David <cassalyn@gmail.com>
Sent: Thursday, September 24, 2015 9:13 PM
To: Public Input
Subject: AHCCCS 1115 Waiver

Follow Up Flag: Follow up
Flag Status: Completed

As a member of the Arizona Public Health Association, I am writing to express my full support for the comments AzPHA submitted on the AHCCCS 1115 waiver. I wish to highlight a few specific points.

As a resident and health professional in a rural county, I know that ensuring individuals have access to reliable transportation to medical services is of the utmost importance. I am very concerned that the legislative proposal to remove emergency transportation benefits will negatively impact members' ability to access appropriate care especially for those members living in rural Arizona. Additionally, there are vulnerable populations (e.g., immunocompromised cancer patients) who should not be using mass public transportation due to potential exposure to common illnesses.

Specifically I strongly oppose the legislative proposal to place lifetime limits on AHCCCS coverage. Similarly, I oppose the Administration's proposal to dis-enroll members in the expansion population who fail to pay copays, premiums and fees. I believe there are alternative, less severe approaches. Any removal of coverage will negatively impact our collective efforts, threaten the viability of public and private investments and jeopardize access to care for vulnerable populations.

I oppose the premiums and copays. What might seem nominal would be enough to sway a low-income individual's decision to afford health insurance over other basic needs. I am concerned that individuals may choose, for example, to purchase food instead of paying for premiums, and that this choice may result in a loss of coverage.

It may be difficult to determine appropriate use, especially if the criterion is based on hospital admission. Often, it is difficult to know if an emergency is indeed an emergency, until an individual has been seen in the ED. Also, most urgent care facilities are closed past 10 p.m. and there is no other place to go during a late night health scare. This policy may discourage individuals needing emergency care from going to the hospital for fear that their will have to pay a copay if their visit is deemed a non-emergency.

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Children's Action Alliance

A Voice for Arizona's Children since 1988

September 25, 2015

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Tucson Office

33 S Fifth Avenue
Tucson, AZ 85701
(520) 329-4930
dhiguera@azchildren.org

Mr. Tom Betlach
Director, AHCCCS
801 E Jefferson St MD 4100
Phoenix, AZ 85034

Dear Director Betlach:

Children's Action Alliance appreciates the opportunity to provide comments regarding the proposed Medicaid waiver. As a non-partisan, non-profit children's advocacy organization, Children's Action Alliance has worked over the past 27 years to improve the health, education and security of Arizona's children. We believe that AHCCCS is an important partner to our mission given that 40% of Arizona's children have health coverage through the Medicaid program.

We support efforts by AHCCCS to improve the health outcomes of its enrollees more efficiently and effectively. Proposals around Delivery System Reform Incentive Payments and scale up of American Indian Medical Homes are promising approaches that help Arizona adapt to a dynamic health system.

Much of the waiver proposal targets enrollees in the New Adult Group and TANF Parents, which as we understand it involves parents with children older than six. We are concerned that these proposals will have a negative spillover effect on children's health coverage and on the well-being for children related to the health of their parents.

Numerous studies, including one by the US Government Accountability Office, show that a child is significantly more likely to have public insurance if his or her parent has public insurance. Due to the close connection between parent and child enrollment, we are concerned that several elements of the AHCCCS proposal may result in more uninsured kids.

Parental coverage also affects children's economic security and children's overall well-being – healthier parents make better parents with more stable families. We are concerned that the loss of coverage for parents who don't meet the new requirements will negatively affect the health and security of their children.

As a state that ranks among the highest in the percentage of uninsured children, any reform proposal should aim to give children in Arizona more opportunity to access affordable, quality health care. Novel approaches to payment and delivery reform such as those proposed in this waiver will also be more effective, efficient, and sustainable if the uninsured are enrolled in health coverage.

Premiums and AHCCCS CARE Account: Requiring enrollees to pay premiums will roll back some of the significant coverage gains for Arizonans in the past two years. Participants in the Medicaid program are extremely cost sensitive and research has shown that cost sharing through premiums has a negative impact on enrollment. Although a 2% cap on premiums may sound reasonable, this unfortunately translates to a financial burden that many Medicaid enrollees will not be able to afford.

We are also concerned that required contributions to the AHCCCS CARE Account will have the unintended consequence of limiting enrollees' use of those household funds for important purchases that have an upstream impact on their health and employment, such as money for food, utilities, rent, transportation, school supplies and more. It seems counterproductive for the state to mandate contributions to an account with very limited uses, while impeding parents from spending their household funds on other expenses that may be directly related to their ability to attain or continue employment and better health outcomes.

For families with incomes below 150% of the federal poverty level, premiums for KidsCare total less than 1% of family income. A single parent with two children and an income at 135% of the federal poverty level would pay \$15 per month in premiums for covering both children with KidsCare, but would be required to pay \$45 per month under this proposal for coverage of the parent. To reduce any unintended impact of the cost-sharing requirement on coverage and children's stability, we suggest capping the premium at \$26 monthly for each able-bodied adult in the household (this is 2% of income for a single person household earning 135% of the federal poverty level).

Punitive enforcement measures aimed at fostering self-responsibility can instead prevent enrollees from maintaining continuity of health care and coverage. A debt to the state or disenrollment for someone who cannot afford contributions to the CARE Account does nothing to improve an enrollee's health or work prospects. Removal of Medicaid benefits from a parent for failure to pay premiums or co-pays will diminish health and stability for both parents and their children.

To better meet the objective of expanding health options for enrollees, we recommend that the CARE Account serve as an optional feature that participants can choose. We also suggest allowing participants to use their contributions to the account for co-pays.

AHCCCS Works program: Health coverage itself is a work support – it helps people get and stay healthy enough to find jobs and keep working. Making work search a precondition for parents to access their own accounts may prevent needed health care purchases and add another barrier to employment. The proposal exempts parents of children younger than six in recognition of the need for full-time care for young children. Similarly, work search requirements do not make sense for parents who are full-time caregivers for children or other family members with special health care needs. We recommend expanding the exemption to these families as well.

Time limitations and work requirements: We oppose arbitrarily assigning time limitations on Medicaid and tying Medicaid to a work requirement. Making work a requirement for health coverage reverses and undermines the importance coverage brings as a work support. This will result in parents losing coverage and worse economic and health outcomes for the whole family.

Children's health coverage and the Safety Net Care Pool: We see a large gap in the proposal since reinstatement of the state's Children's Health Insurance Program, or KidsCare, is not being discussed as part of a comprehensive effort to address the high percentage of uninsured children in Arizona.

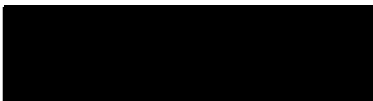
The SNCP was originally established to support safety net, rural and critical access and Disproportionate Share Hospital providers to address uncompensated care costs. We understand the importance of the proposed Safety Net Care Pool transition to address the Medicaid shortfall for the high acuity patients served by Phoenix Children's Hospital (PCH). But this SNCP proposal does nothing to address the disproportionate impact of uninsured children across the entire health system, particularly in safety net hospitals, which the evaluation commissioned by AHCCCS notes as serving a higher proportion of uninsured kids in comparison to children's hospitals.

Many children who use other providers face incredibly high cost sharing without the availability of KidsCare. Arizona's high rate of uninsured children underscores the need to provide strong coverage options for kids. In fact, the 2014 Census data show that Arizona has the highest rate in the nation of uninsured children in the KidsCare income eligible range (138% to 199% of FPL).

Lifting the freeze on KidsCare should be part of a more comprehensive plan to address uncompensated care across the entire health system. Working with CMS on Arizona's allotment of federal CHIP funds, this can be accomplished without any cost to the state for at least two years. While KidsCare operates under a separate funding mechanism, this waiver represents an important opportunity for Arizona to propose how its waiver strategy complements broader efforts to address issues around children's health coverage.

Thank you for the opportunity to respond to the waiver proposal. We commend your leadership and commitment to high quality, accessible, value based health care for Arizonans. We welcome any opportunities to collaborate or discuss further our comments and concerns.

Sincerely,



Dana Wolfe Naimark
President and CEO

The Implications of the Proposed Section 1115 Research & Demonstration Waiver Proposed by the Arizona Health Care Cost Containment System (AHCCCS) on American Indian Nations and Tribes and the Indian Health Care System in Arizona

The twenty one member Tribes of the Inter Tribal Association of Arizona (ITAA) are requesting that the Centers for Medicare and Medicaid Services (CMS) reject harmful aspects of the proposed Medicaid Demonstration Waiver that is based on provisions in Senate Bill (SB) 1092, that was signed into law by Governor Douglas Ducey on March 6, 2015. The member Tribes of the ITAA and the Navajo Nation collectively sought the rejection of the bill and requested a veto by Governor Ducey. While the legislative process is a public process and should have involved the bill sponsors reaching out to tribal governments in the formation of policies impacting such a large portion of the American Indian population, this was not the case with this particular bill and another bill, SB 1475, signed into law on March 12, 2015, that contains other elements of the proposed Demonstration Waiver, that include increases to co-payments paid by Medicaid beneficiaries and the elimination of non-emergency transportation coverage.

Of the latest AHCCCS figures from AHCCCS, as of July 2015, there are 114,296 American Indians/Alaska Natives (AI/AN) enrolled in the American Indian Health Program (AIHP). AIHP is the only fee-for-service non-managed care health plan in the state of Arizona. In addition, there are approximately 40,000 AI/AN enrolled in Managed Care Organizations (MCO's). The estimated total 154,300 AI/AN enrolled in Medicaid, includes childless adults up to 100% of the Federal Poverty Level (FPL) who were restored to coverage and childless adults included in the new expansion group up to 133% FPL on January 1, 2014. This figure represents approximately half of the AI/AN population in Arizona who identify themselves in the U.S. Census (American Community Survey, 2013) as "AI/AN only."

Numerous Tribes, Tribal and Urban Indian Organizations informed ITAA of their concerns regarding the legislatively mandated Waiver that requires AHCCCS to develop and the Governor submit a proposed Demonstration Waiver based on SB 1092 provisions on an annual basis. The current Waiver expires on September 30, 2016. AHCCCS is seeking comment on a proposed 5-year Demonstration Waiver that would cover the period of October 1, 2016, through September 30, 2021.

Comments of the ITAA reflect the concerns of its member Tribes on certain sections of the proposal.

AHCCCS CARE Program – Part I

The proposal to modernize Medicaid in Arizona is called AHCCCS CARE. *"The goals are to engage Arizonans to take charge of their health, make Medicaid a temporary option and promote a quality product at the most affordable price."* Tribal Leaders are concerned that populations who are eligible for Medicaid in Arizona, including American Indian people are the most economically disadvantaged and at risk individuals in terms of health status. Less than two years ago, the state of Arizona restored coverage to the poorest of childless adults up to 100% FPL and expanded Medicaid eligibility to childless adults up to 133% FPL. These policy changes alone greatly remedy access to health care and assure improved health status of these individuals. If AHCCCS CARE is approved as proposed, an adult, age 19 and older who does not meet exemption criteria, would only be eligible for Medicaid for 5 years in one's lifetime. This cap reduces health coverage just afforded to them 21 months ago.

A five year cap on Medicaid eligibility is an extreme measure that does not appear to be in keeping with the purpose of Section 1115 of the Social Security Act which provides states the flexibility to manage, design, and improve their programs to enhance an individual's ability to improve and sustain their health over

time. Further, while the state match would decline, thereby reducing costs, simply capping Medicaid eligibility should not be considered “innovative” by CMS in terms of reducing costs and improving the efficiency of the health care system as these individuals will likely become the burden of emergency and urgent care providers.

The Legislative Partnership – Part II

The legislatively mandated provisions of SB 1092 in the Section 1115 Demonstration Waiver include many of the more impactful changes to the current Demonstration which is in effect until September 30, 2016. A number of the Tribes, including the Colorado River Indian Tribes, Tohono O’odham Nation and Navajo Nation who have passed resolutions or submitted letters citing the components that would negatively impact tribal members that obtain their health care at Indian Health Service (IHS) and Tribal hospitals, clinics and Urban Indian health programs. These components include:

- SB 1092 requires AHCCCS to propose a five-year lifetime eligibility limit on imposed on able-bodied adults. Despite some exemptions to the lifetime cap on Medicaid in the proposal, this policy change is not supported by the Inter Tribal Association of Arizona. The legislation stipulates that in order to be eligible for Medicaid, beyond 5 years, in addition to the income limits, one would have to be: 1) pregnant; 2) the sole caregiver of child under the age six; 3) receiving long term disability benefits from the government or a private insurer; 4) at least 19 years of age and still in high school; or 5) under the age of 26 and in the custody of the Department of Child Safety when the individual turned 18 years of age.

The Indian Health Care Improvement Act of 1976, authorized Indian Health Service, Tribes and Urban Indian programs participation in Social Security Act programs. Medicare, Medicaid and the Children’s Health Insurance Program provides reimbursement to these programs which allows more medical and preventative services to be provided to AI/AN beyond what is possible through Indian Health Service appropriations alone. IHS funded programs must meet CMS credentialing requirements and quality of care standards in order to receive these payments. These reimbursements account for at least 1/4 of the resources needed for the IHS system to operate. A capped Medicaid program will reduce these resources at IHS, Tribal and urban Indian programs across the board. This is a major concern of the member Tribes in Arizona.

- SB 1092 necessitates AHCCCS to institute a work requirement on able-bodied adults. The statute specifies they must become employed, actively seek employment, attend school or a job training at least 20 hours per week and verify on a monthly basis they are in compliance. Changes in family income must be reported by the eligible person. The AHCCCS administration must verify income and re-determine eligibility. SB 1092 allows the administration to ban an eligible person from enrollment for one year, if the person knowingly fails to report a change in family income or made a false statement. The information provided at the AHCCCS Tribal Consultation on August 21, 2015, did not clarify how this section of the law would be implemented in Tribal communities. ITCA believes that individuals in Tribal communities will have the most difficulty meeting the work requirements and likely lose their Medicaid eligibility quickly due to the high unemployment rates on tribal reservations.
- SB 1475 increased co-payments and annual premiums will be charged to AHCCCS members to the maximum level allowed by CMS. A co-payment at the point of service will not be collected, but instead AHCCCS members will pay into Health Service Accounts (HSA’s) from which payments will

be made to the providers. Copayments may not exceed 3% of annual household income and they will not be collected for certain types of preventive services, such as wellness visits, services for a chronic illness obtained from a primary care physician or OB-GYN. Co-payments will be required for non-emergency use of an emergency department if the person is not admitted to the hospital or if there was a health center or urgent care within 20 miles of the hospital. Tribal representatives were informed at the AHCCCS Tribal Consultation on August 21, 2015, that AI/AN will not be charged co-payments and premiums if they receive their care at an IHS or Tribal facility. It is recommended that CMS clarify that AI/AN AHCCCS members not be charged if they are referred to specialists by the IHS or Tribes. Further AI/AN should not be charged copayments and premiums as stipulated in Section 5006 of the American Recovery and Reinvestment Act (ARRA) if they receive health services in AHCCCS CARE provider networks.

- SB 1475 eliminates the coverage of non-emergency medical transportation for adults between 100% - 133% FPL. AHCCCS and the Tribes have made significant strides in addressing issues surrounding non-emergency medical transportation. This is an extremely important service in Tribal communities. The current system allows Tribes that have contracted with IHS to operate these services, the ability to generate revenue and Tribal governmental oversight, includes the requirement that outside companies obtain Tribal business licenses to operate on Tribal lands. The member Tribes of ITAA does not support eliminating this covered service as it addresses a critical need.

The description of AHCCCS CARE does not inform Tribes if the establishment of the program alters the American Indian Health Program. In that regard, it is recommended that AHCCCS revise the waiver application to clarify that it will be voluntary for AI/AN enrollees to participate in AHCCCS CARE, and that AI/AN who do not wish to participate may continue to access Medicaid services by enrolling in the American Indian Health Program (AIHP). These revisions should include:

- the right of any AI/AN who participates in a managed care plan to choose their IHS, Tribal or urban Indian facilities as their primary care provider and not be auto-assigned to other providers,
- the right of IHS, Tribal and urban facilities to be paid by managed care plans regardless of whether they are in-network or not,
- the right of AI/AN not to be charged any premiums or cost-sharing amounts of any kind,
- the obligation of managed care plans not to reduce payments due to IHS, tribal and urban facilities by the amount of any premiums or cost-sharing that would otherwise be due, and
- the right of IHS, Tribal and urban facilities to be paid the full OMB rate by the State and those plans.

American Indian Medical Home – Part V

- ITAA seeks the approval of the Indian Health Medical Home Program (IHMHP) in the Arizona Section 1115 Demonstration. In order to receive reimbursement for services provided by IHMHP, the facilities that agree to participate must present their proposal to AHCCCS for review every three years or sooner if their program structure changes. This model involves a level of patient care coordination that has not occurred before in the Indian health care system in Arizona to assure that services meet the needs of AI/AN AHCCCS members that receive their health care at IHS and Tribal hospitals and clinics and through referrals to non-IHS providers. IHS and Tribal facilities that seek the IHMHP designation would have numerous requirements that include;

- a. Assigning an AHCCCS member to a primary care team led by a primary care physician, nurse practitioner or physician's assistant to provide care coordination and continuity of care. Realizing IHS and tribal staffing limitations, AHCCCS would require that a primary care physician must be available for consultation and advisement as needed.
- b. Providing or coordinating medically necessary primary and preventive services and organizing clinical data in an electronic format for individual patients.
- c. Developing a system to track the patients medication, tests and follow-up, medical referrals and patient support, and a 24/7 voice telephone call-in line with immediate availability of an on-call medical professional.

ITAA recognizes that care coordination will involve stepping up the IHS Improving Patient Care (IPC) efforts by IHS and Tribal primary care teams. It should be expected that establishing IHMHP's may require continued refinement over time in order to implement a program that meets the needs of AI/AN patients resulting in improved outcomes. It is commendable that AHCCCS recognizes that a Primary Care Team would consist of personnel such as social workers, case managers, community health representatives (CHRs) and diabetes health educators. It is these professionals that may be the most involved in communicating information to the patient recommended by the team.

Building Upon Past Successes – Part VI

- **Uncompensated Care Payments to IHS and Tribes** - ITAA supports the continuation and permanent renewal of the uncompensated care payments to IHS and Tribes for optional Medicaid benefits no longer covered in the state plan. At the present time, these include services of a podiatrist, emergency dental care for adults and well exams. In 2015, the Arizona State Legislature restored coverage of orthotics, but eliminated coverage of non-emergency medical transportation (NEMT). ITAA recommends that claims for NEMT be added to the list of eliminated services that would qualify for uncompensated care payments.

ITCA submitted letters to Thomas Betlach, AHCCCS Director, on July 24, 2015, and August 17, 2015, addressing the need to re-evaluate the payment methodology and requested that an interim Tribal workgroup be created to study the formula and associated values (i.e., user population, historical payments, provider rates, etc.) which have been used to calculate the Per Member/Per Month (PMPM) rate of reimbursement. The concerns relate to claims for payments, that have not kept in pace with the costs of care provided to the population. This became evident after AHCCCS adjusted the payment methodology on January 1, 2014, due to what was reported by AHCCCS as a high administrative burden of the prior claims methodology option that the agency indicated it could no longer maintain.

- **Traditional Healing /Traditional Practitioner Services** - These services were identified as being examined for possible coverage at the AHCCCS Tribal Consultation on August 21, 2015. The agency said it is now seeking specific input on covering the services of Traditional Practitioners. AHCCCS staff indicated it would be included as a placeholder in the Demonstration proposal submitted to CMS. ITAA recommends that a workgroup of Tribal and urban Indian health program representatives be established to address this request.
- **Former Tribal Foster Care Youth Medicaid Eligibility** - This topic is not addressed in the Demonstration proposed by AHCCCS, however, from a Tribal government perspective, it is an outstanding issue. Inter Tribal Council of Arizona (ITCA) submitted a letter to Thomas Betlach,

AHCCCS Director on December 31, 2014, requesting that a tribal workgroup be established to discuss what would be required for AHCCCS, Arizona Department of Security (ADES) and Tribal government implementation. With the concurrence of the agencies, the workgroup comprised of Tribal representatives, ITCA and state personnel met to address the concerns on the process. However, the actual signing up of American Indian youth up to the age of 26 in this new Affordable Care Act eligibility group with no income/asset test has not been rolled out as of this writing. ITCA submitted the recommendations of the workgroup on July 14, 2015, and Director Betlach's response was received on September 9, 2014. The issues addressed include:

- a. Revisions to the application for benefits (Medicaid Electronic/Paper Application)
 - b. Development of a cover page for the paper application to be used by Tribal Social Services agencies to identify youth in Tribal custody.
 - c. Establishing centralized processing at ADES Division of Benefits and Medical Eligibility (DBME) for youth aging out of tribal foster care.
 - d. Developing a Young Adult Transitional Insurance eligibility (YATI) – Referral and DCS/FAA Turn-Around Document (TAD) – Families Assistance Administration (FAA) form FAA-1097T for youth aging out of tribal foster care.
 - e. Amending the appropriate sections of the AHCCCS Medicaid Eligibility Manual
 - f. Discussion on self-attestation by former foster youth who were eligible as of March 23, 2010, to begin processing Medicaid applications of tribal youth that would have qualified since that date for the YATI program in Arizona.
 - g. Continuation of the workgroup to develop and implement an information dissemination and training plan.
- **100% Federal Medical Assistance Percentage (FMAP) Expansion** - Currently CMS matches the amount paid for services provided for AI/AN beneficiaries at IHS and Tribal facilities with 100% federal dollars. The pass-through, of these resources is vital to sustain services and improve the delivery of care to Medicaid beneficiaries. On September 21, 2015, CMS consulted with Tribes on expanding the 100% FMAP for the following services:
- a. Emergency/Non-Emergency Transportation
 - b. Coverage for Urban facilities
 - c. Coverage for telehealth services
 - d. Purchased Referred Care services outside of IHS/Tribal facilities

ITAA supports this expansion and requests that if these changes are approved by CMS that they be incorporated into the Arizona Section 1115 Demonstration.

Comments Submitted by:

Maria Dadgar, M.B.A.
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September 21, 2015

Tom Betlach, Director
AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Director Betlach,

Thank you for the opportunity to comment on the proposed Medicaid waiver. We are committed to improving the health of all Arizonans. We strongly believe the direction of our state's Medicaid program influences Arizona's overall health system and the health outcomes of millions of people.

Access to health care is imperative to people with diabetes. In particular, self- management education and training are integral components of diabetes management. Multiple studies have shown general-population diabetes self-management training programs can reduce resource utilization among recipients and ultimately improve diabetes outcomes.

We ask that you:

Support Comprehensive Coverage by Closing Gaps In Benefits: Coverage for services of particular importance to individuals with diabetes, such as diabetes self- management education (DSME) and training (DSMT) should be a standard component of coverage. DSME is a covered benefit of Medicare beneficiaries.

Additionally, we also support Medicaid offering Medical Nutrition Therapy (MNT) and the Diabetes Prevention Program (DPP) as a covered benefit. DPP is an evidence-based lifestyle change program designed to prevent type 2 diabetes. The program has demonstrated effectiveness in helping people at high risk lose a moderate amount of weight (5% to 7% of their current body weight) and increase their physical activity to 150 minutes per week. The result of these two lifestyle changes has been proven to prevent or delay the onset of type 2 diabetes by nearly 60%.

Ensure cost-sharing does not discourage individuals from obtaining necessary care. Over the years, Medicaid premiums and cost sharing have been used to limit state program costs, encourage more personal responsibility over health care choices and to better align public coverage with private coverage where states have expanded coverage.¹

In general, cost-sharing deters individuals from seeking medical care, while premium requirements deter individuals from enrolling in coverage. According to a recent study


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conducted by staff at the Agency for Healthcare Research and Quality (AHRQ), a premium increase of \$10 per month is associated with a decrease in public coverage of children in families with incomes above 150% of the federal poverty level (FPL), with a greater decrease in coverage for those below 150% FPL.²

A Kaiser Family Foundation review of research related to cost-sharing and premiums in state Medicaid and CHIP programs found that "[f]or individuals with low income and significant health care needs, cost-sharing can act as a barrier to accessing care, including effective and essential services, which can lead to adverse health outcomes."³

The price sensitivity of households with low incomes *must* be a consideration when imposing premium or co-payment requirements for any public health program. Fortunately, federal Medicaid regulations do not allow providers to require individuals with incomes less than 100% FPL to pay the applicable cost-sharing as a condition for receiving the item or service, and prohibits premiums for most individuals with income below 150%.

Thank you for the opportunity to respond to the waiver proposal. We deeply value AHCCCS' commitment to innovation and improvement, and we welcome opportunities to collaborate on these efforts.


Ruston Hill, PhD
Lifestyle Coach for Diabetes Prevention (CMS)
Integrated Wellness Club,
1968 Mesquite Ave,
Lake Havasu City, Arizona 86403

Tel# 480-703-4227

This letter is supported by the Arizona Coordinating Body of the American Association of Diabetes Educators (AADE).

² Abdus S, Hudson J, Hill SC, Selden TM, Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs B, August 2014.

³ Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013

Mona Morstein, ND, DHANP
Arizona Integrative Medical Solutions
4657 S. Lakeshore Dr. Ste 1
Tempe, AZ 85282
Ph: 480-284-8155

September 21, 2015

Tom Betlach, Director
AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Director Betlach,

Thank you for the opportunity to comment on the proposed Medicaid waiver. We are committed to improving the health of all Arizonans. We strongly believe the direction of our state's Medicaid program influences Arizona's overall health system and the health outcomes of millions of people.

Access to health care is imperative to people with diabetes. In particular, self-management education and training are integral components of diabetes management. Multiple studies have shown general-population diabetes self-management training programs can reduce resource utilization among recipients and ultimately improve diabetes outcomes.

We ask that you:

Support Comprehensive Coverage by Closing Gaps in Benefits: Coverage for services of particular importance to individuals with diabetes, such as diabetes self-management education (DSME) and training (DSMT) should be a standard component of coverage. DSME is a covered benefit of Medicare beneficiaries.

Additionally, we also support Medicaid offering Medical Nutrition Therapy (MNT) and the Diabetes Prevention Program (DPP) as a covered benefit. DPP is an evidence-based lifestyle change program designed to prevent type 2 diabetes. The program has demonstrated effectiveness in helping people at high risk lose a moderate amount of weight (5% to 7% of their current body weight) and increase their physical activity to 150 minutes per week. The result of these two lifestyle changes has been proven to prevent or delay the onset of type 2 diabetes by nearly 60%.

Ensure cost-sharing does not discourage individuals from obtaining necessary care. Over the years, Medicaid premiums and cost sharing have been used to limit state program costs,

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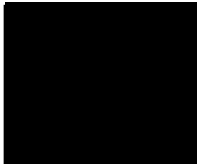
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Thank you for the opportunity to respond to the waiver proposal. We deeply value AHCCCS’ commitment to innovation and improvement, and we welcome opportunities to collaborate on these efforts.

Sincerely,

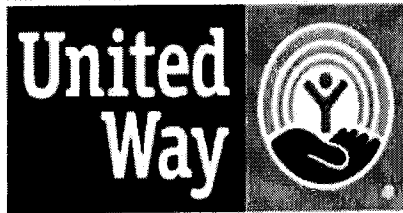


This letter is supported by the Arizona Coordinating Body of the American Association of Diabetes Educators (AADE).

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² Abdus S, Hudson J, Hill SC, Selden TM, Children’s Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014.

³ Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013



LIVE UNITED

September 24, 2015

Mr. Tom Betlach, Director
AHCCCS

Dear Director Betlach:

The United Way of Tucson and Southern Arizona (UWTSA) unites a force against poverty in our community by creating conditions for individuals and families to achieve financial stability and independence. UWTSA does this primarily by assisting residents to obtain the Earned Income Tax Credit (EITC) and health insurance coverage either through AHCCCS or the ACA Marketplace. UWTSA has been assisting Southern Arizonans with AHCCCS enrollment since 2009.

UWTSA supports efforts to give individuals and families a hand up out of poverty and applauds the intent of AHCCCS to improve the health outcomes of members. However, many of the elements proposed by the Governor and the Legislature in the 1115 Waiver— Modernizing Arizona Medicaid— will not achieve that. Instead the proposed waiver will make it more difficult for many families who are already financially challenged to get out and stay out of poverty. This has consequences for not only the health of families, but also the health of our community and state.

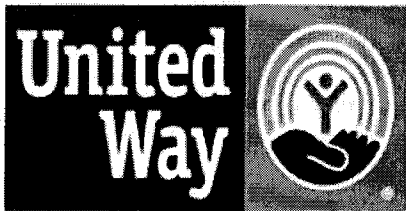
Life time enrollment limits

The Affordable Care Act (ACA) and Medicaid Expansion have greatly reduced the number of uninsured in Arizona. A five year lifetime enrollment limit, a provision of SB 1092 passed by the Arizona Legislature and signed by the Governor will essentially reverse the gains that have been made as a result of the Affordable Care Act. If this provision of the 1115 waiver is granted by CMS, the number of uninsured will once again increase as will the amount of uncompensated care provided, both of which impact our community. The end result will be both poorer health and economic outcomes for our community.

Premiums and Copayments

Studies have shown that consumers are less likely to seek services if there is a copay for the service. Financially strapped individual and families are likely to forgo basic needs – food, clothing and shelter to access care. Even though member contributions (copays and premiums) would be capped at 5% of annual household income, this is not an insignificant amount for households at 100-133% of FPL. Furthermore, the penalties associated with failure to pay appear excessive and punitive.

UWTSA does not support AHCCCS disenrollment as a penalty for non-payment of premiums and copayments. Not only does that leave individuals and families vulnerable to medical and financial catastrophe, but also leaves them with limited alternatives for coverage. Individuals who are otherwise eligible for Medicaid are unable to get subsidized care in the Marketplace and will be assessed a penalty for being uninsured.



LIVE UNITED

UWTSA recommends greater clarity regarding the consequences associated with failure to pay premiums and copayments in a timely manner. It is unclear if individuals are disenrolled from AHCCCS for a six month period or if they are disenrolled until all outstanding payments are made. In materials presented by AHCCCS at public forums both were presented as consequences for members over 100% FPL who fail to pay.

Work Requirements

UWTSA recommends that the requirement for all able-bodied adult members to be employed, seeking employment or attending school/job training in order to maintain AHCCCS coverage be flexible and reasonable. There are a number of population sub groups that will find it difficult, if not impossible to fulfill the work requirement. Primary caregivers and parents of special needs and disabled individuals (over the age of six years) should be exempt from the work requirement. These parents and caregivers should not be expected to abandon caregiving responsibilities to keep their AHCCCS coverage. Formerly incarcerated individuals reentering society often have difficulty obtaining employment and may need extra time to comply with the work requirement. Individuals residing in rural parts of Pima County and the State face limited employment opportunities which may make it difficult for them to comply with the work requirement.

HSA like accounts

The proposed AHCCCS CARE account has none of the tax advantages of a conventional HSA and a very limited list of eligible services. Recent research has shown that upstream factors such as safe, stable housing, healthy food and transportation are as important to health as is traditional medical care yet these expenses would not be allowed.


Elimination of non – emergency transportation

Transportation, even in urban areas can be a significant barrier to accessing health care. Tucson's public transit system recently ended a 42 day strike, one which left many low income residents stranded, unable to get to work or to medical appointments. The recent strike is an example of circumstances that cannot be planned for and for which there are few transportation alternatives. Under the proposed 1115 waiver, members not only lose the transportation benefit but also would be penalized for a missed appointment, which may be due to circumstances beyond their control (such as a strike). UWTSA does not support the elimination of non-emergency transportation.

Thank you for the opportunity to provide input on the proposed 1114 waiver to the CMS.

We appreciate your commitment to the health of low income Arizonans and look forward to potential future opportunities to collaborate.

Sincerely,


Tony Penn, President & CEO
The United Way of Tucson and Southern Arizona



VALLEY INTERFAITH PROJECT

September 24, 2015

Mr. Tom Betlach
Director
AHCCCS
801 E. Jefferson St. MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

Thank you for the opportunity to comment on the proposed Medicaid waiver. As a non-partisan organization in Arizona, we are committed to support the improvement of the health of all Arizonans. Valley Interfaith Project supports the state's Medicaid program that influences Arizona's overall sustainability of the health system that affects the health outcomes of millions of people in our state.

Valley Interfaith Project (VIP) was integral in supporting the expansion of Medicaid in Arizona through community involvement and action. VIP is a broad-based non-partisan organization of dues-paying members from diverse faith congregations, schools, unions and non-profit organizations committed to building sustainable social and economic change. VIP brings together low, middle, and upper income communities to develop and organize participation in public life, drawing on the strengths of faith and democratic traditions, to create a more just society. For 25 years VIP has been working on issues that promote human development in Arizona. VIP supports:

1. The integration of behavioral health and acute care that includes further support for the health information exchange.
2. The extensive needs of those individuals who are high utilizers of health care services.
3. Improving the coordination of health care in all venues.
4. Any new collaborations to improve the general health of Arizona's population.

While VIP supports many aspects of AHCCCS' waiver request, there are areas of concern that include the following provisions:

- **Co-Pays:** The introduction of co-pays may inflict harm on low-income, vulnerable populations. VIP opposes this provision as onerous on those members of Arizona's population that can least afford this provision. In particular VIP is concerned that those suffering from chronic pain may be limited to their access to pain-reducing medicine. Emergency access co-pays would be difficult to determine what constitutes appropriate versus inappropriate use of an emergency room.
- **Health Care Premiums:** Valley Interfaith Project has been part of and supports the Cover Arizona coalition. This coalition of 800 plus members has helped more than 500,000 citizens gain health care coverage through AHCCCS and the Health Care Marketplace.

Any attempt to establish a new requirement for monthly premiums will hinder progress that could result in many Arizonans losing health care coverage. Monthly premiums for those who can least afford this stipulation will cause a negative impact on enrollment. Research suggests that cost sharing for Medicaid enrollees leads to a decreased use of primary care and actually increases the reliance on emergency room treatment.

- ***Five-Year Limit and Work Requirements:*** Valley Interfaith Project opposes arbitrary time limits on Medicaid and the requirement of binding Medicaid to work. There is no adequate definition of “able-bodied.” There are many very sick, physically or mentally impaired individuals that are not able to work. These same individuals may not qualify under any existing disability category. Example: there are older adults who may have lost their job during the Recession, have a serious health condition, and have accessed their Social Security Benefits who will not qualify for the work requirement or time limit exceptions. VIP supports caregivers who stay home to care for a physically or mentally disabled loved one. This provision would require such an individual to work threatening the institutionalization of their loved one.
- ***Non-Emergency Transportation:*** The proposal to eliminate non-emergency transportation in Arizona would have detrimental consequence on the access of health care for individuals that live in areas that have little public transportation. Many areas of the state are deemed medically underserved by the federal government. Losing access to paid transportation for those who need health care services impacts residents of vast areas of rural country and suburban territory on the fringes of adequate transportation corridors.

Thank you for the opportunity to respond to the waiver proposal. Valley Interfaith Project values the worth of AHCCCS’s commitment to sustainable health care services for those citizens who require Medicaid.

Sincerely,

Valley Interfaith Project and the undersigned clergy

Rev. Martha Seaman, Deacon, the Episcopal Diocese of Arizona

Rabbi John Linder, Senior Rabbi, Temple Solel

Rev. David Harriss, Gilbert

Rev. Jayne Baker, Ascension Lutheran Church, Paradise Valley

Rev. Jeff Proctor-Murphy, Senior Pastor, Dayspring United Methodist Church

Rev. Lara Forbes, Pastor, Faith Lutheran Church, Phoenix

Rev. Sarah Stadler-Ammon, Pastor, Grace Lutheran Church, Pheonix

Rev. Marvin D. Arnpriester, Senior Pastor, Sun Lakes United Methodist Church

Rev. Steven L. Davis, Pastor Emeritus,

Shepherd of the Hills United Church of Christ, Phoenix

Rev. David Summers, Senior Pastor, Paradise Valley United Methodist Church

Rev. Doug Bland, Pastor, Community Christian Church, Tempe

Rev. Susan E. Wilmot, Vicar, St. James the Apostle Episcopal Church. Tempe

Rev. Judith E. Boroto, Phoenix

Sr. Georgene Faust, Phoenix
Ahmad Shqeirat, Imam, Islamic Community Center of Tempe
Rev. Jim Bade, Deacon, The Episcopal Diocese of Arizona
Rev. Kim Gladding, Senior Pastor, First United Methodist Church Glendale
Fr. Mártir Vásquez, Rector, St. Andrew's Episcopal Church, Glendale
Rev. Terry Sims, Minister, Unitarian Universalist Church, Surprise
Rev. Dr. Ken Brown, District Executive, Pacific Southwest District/ UUA
Brother Timothy T. Tomczak, O.S.C., Phoenix
Rabbi Jeremy Schneider, Temple Kol Ami, Scottsdale
Rev. Deborah Lerner, Gilbert
Fr. Eric Tellez, Pastor, St. Patricks Catholic Parish, Scottsdale
Rev. Dr. Robin B. Hollis, Deacon AZ Episcopal Diocese St. James Episcopal Church, Tempe
Patti Sills-Trausch, Director of Faith in Action Ministry,
Franciscan Renewal Center, Phoenix
Rev. James B. Pennington, Sr. Pastor, First Congregational United Church of Christ, Phoenix
Rabbi Dr. Shmuly Yanklowitz, Scottsdale
Bob Klassen, Senior Warden, St. James the Apostle Episcopal Church, Tempe

September 25, 2015

Tom Betlach, Director
AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Director Betlach,

Thank you for the opportunity to comment on the proposed Medicaid waiver. We are committed to improving the health of all Arizonans. We strongly believe the direction of our state's Medicaid program influences Arizona's overall health system and the health outcomes of millions of people.

Access to health care is imperative to people with diabetes. In particular, self- management education and training are integral components of diabetes management. Multiple studies have shown general-population diabetes self-management training programs can reduce resource utilization among recipients and ultimately improve diabetes outcomes.

We ask that you:

Support Comprehensive Coverage by Closing Gaps in Benefits: Coverage for services of particular importance to individuals with diabetes, such as diabetes self- management education (DSME) and training (DSMT) should be a standard component of coverage. DSME is a covered benefit of Medicare beneficiaries.

Support Pharmacists as recognized providers with AHCCCS: Pharmacists are a vital member of the health care team and their services are crucial to both acute and chronic care management. The work that pharmacists do contributes to improved health outcomes and help support the growing need for primary care providers especially in rural and underserved sites.

Additionally, we also support Medicaid offering Medical Nutrition Therapy (MNT) and the Diabetes Prevention Program (DPP) as a covered benefit. DPP is an evidence-based lifestyle change program designed to prevent type 2 diabetes. The program has demonstrated effectiveness in helping people at high risk lose a moderate amount of weight (5% to 7% of their current body weight) and increase their physical activity to 150 minutes per week. The result of these two lifestyle changes has been proven to prevent or delay the onset of type 2 diabetes by nearly 60%.

Ensure cost-sharing does not discourage individuals from obtaining necessary care. Over the years, Medicaid premiums and cost sharing have been used to limit state program costs,

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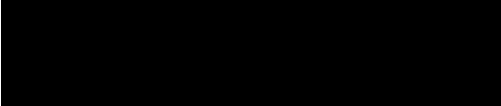
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The price sensitivity of households with low incomes *must* be a consideration when imposing premium or co-payment requirements for any public health program. Fortunately, federal Medicaid regulations do not allow providers to require individuals with incomes less than 100% FPL to pay the applicable cost-sharing as a condition for receiving the item or service, and prohibits premiums for most individuals with income below 150%.

Thank you for the opportunity to respond to the waiver proposal. We deeply value AHCCCS’ commitment to innovation and improvement, and we welcome opportunities to collaborate on these efforts.

Sincerely,



Sandra Leal, PharmD, MPH
slealpharmd@gmail.com
520-302-5325

¹ <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf>

² Abdus S, Hudson J, Hill SC, Selden TM, Children’s Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014.

³ Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013

September 21, 2015

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AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

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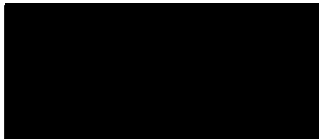
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Thank you for the opportunity to respond to the waiver proposal. We deeply value AHCCC’s commitment to innovation and improvement, and we welcome opportunities to collaborate on these efforts.

Sincerely,



Rachel Head, RD, CDE
2015 AZAADE Chari

Arizona Coordinating Body of the American Association of Diabetes Educators (AADE)

² Abdus S, Hudson J, Hill SC, Selden TM, Children’s Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014.

³ Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013

September 25, 2015

Arizona Healthcare Cost Containment System (AHCCCS)
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Office of Intergovernmental Relations Staff,

The National Association of Social Workers Arizona Chapter (NASWAZ) writes today to take a position on elements of Governor Ducey's plan to modernize Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS). NASWAZ represents over 1,500 social workers that work with vulnerable clients statewide, including people that receive care from AHCCCS.

The proposed reforms in the AHCCCS CARE plan will cause more problems than it solves. We believe that the proposed plan will not only negatively impact those in poverty, but cause fiscal problems for our state. To be forward thinking, we must look at the ripple effect of such restrictive policies. The state will see more people in ill health, more people utilizing emergency rooms as their primary care source, more Department of Child Safety neglect cases, and more unemployment. Access to health care for the poorest among us can mitigate these negative public health concerns and provide for a healthier and more prosperous community. NASWAZ is vehemently opposed to the current Medicaid reform proposal. With vulnerable Arizonans in mind, we raise the following concerns regarding the proposed reforms:

Members are required to pay up to 3% of income for copayments.

"While studies have shown that cost-sharing does reduce the use of less-essential services, these studies have also shown that individuals are just as likely to reduce the use of essential and effective services. Cost-sharing can act as a financial barrier to accessing care, particularly for those with low income and significant health care needs. Such individuals often end up either delaying care or not seeking needed care that in some research has shown to result in adverse health outcomes." (Kaiser Family Foundation, 2013)

Members are required to pay a premium of up to 2% of income.

Funds are to be deposited in the AHCCCS CARE account which "looks like" a Health Savings Accounts (HSA). These accounts will cover services not covered by AHCCCS i.e. dental, vision, and chiropractic care.

"For individuals with low income, such as those served by the Medicaid program, this financial cost can prevent individuals from enrolling in coverage or later being able to maintain coverage. With limited availability of other affordable coverage options, surveys of low income populations affected by premium increases show that many individuals who lost coverage due to cost often became uninsured and reported an increased likelihood of having unmet health care needs" (Kaiser Family Foundation, 2013).

Members will be penalized for failing to make copayments and premiums payments.

The level of penalty depends on the member's income. Members with incomes below 100% FPL (\$980/month for one) will have a debt to the state. Members with incomes above poverty will be dis-enrolled or "locked out" of AHCCCS for six months. To restore eligibility the person must pay off debt, meet work requirements and meet at least one personal health target.

“Research shows that premiums and cost-sharing can result in declines in coverage and utilization which can generate some savings for states in Medicaid. Any new revenues may be offset by additional administrative costs to implement the policies. As a result of premiums and cost-sharing, Medicaid beneficiaries may rely more on an already strained safety net. Medicaid providers frequently report difficulty collecting cost-sharing, effectively lowering provider reimbursement” (Kaiser Family Foundation, 2013).

When an individual is locked out of care and they become sick, their only option becomes the emergency room. This policy does not benefit the person or the state.

The proposal requires work participation for “able-bodied” adults with children over age 6 as well as for members who are childless. Optional participants may persons with serious mental illnesses, pregnant women or Native Americans. Physicians will have to make a case-by-case determine if others should work.

Those on Medicaid have limited incomes. Even if a child is in school, after care must be paid for someone working full-time. Families that qualify for Medicaid do not have extra funds to pay for after school care. If we mandate that the parent work full-time without making it possible for them to earn a living wage and eliminate their need for state assistance, then we may inadvertently add to the already increasing caseload in the Department of Child Safety by creating environments where children are not supervised because their parent has to work and cannot afford after school care.

A five-year lifetime limit is imposed on able-bodied adults. There are criteria outlined when the lifetime limit would not apply, i.e. being pregnant, sole caregiver of child under age six.

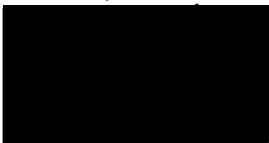
Again, this policy is not effective for the person or the state. With many full-time jobs not paying a living wage or offering health care benefits, families/individuals tend to stay in poverty for many years even when they have employment. When the lifetime limit is reached, we will see our healthcare costs rise at the ER because of a lack of primary care coverage. Additionally, when a worker at a minimum wage job is not able to prevent illness or does not have the capacity to manage their illness there is a high probability that they will lose their job, thus making them even more dependent on public programs.

The proposal discontinues funding for non-ER medical transportation for adults between 100-133% FPL.

Lack of transportation to healthcare appointments is a serious issue for rural and tribal communities. With services many miles away and no vehicle, someone living in rural Arizona will effectively be cut off from healthcare.

Thank you for providing communities the opportunity to comment on the proposed AHCCCS CARE Plan. We welcome an invitation to help create meaningful reform that will benefit all Arizonans.

Sincerely,



Timothy J. Schmaltz, MSW
President
NASW Arizona Chapter



Jeremy D. Arp, MSW, ACSW
Executive Director
NASW Arizona Chapter



Partners in Recovery
East Valley Campus
4330 E. University Drive
Mesa, AZ 85205
Campus Advisory Council
480-218-3280

September 25, 2015

AHCCCS-Arizona Health Care Cost Containment System
Office of Intergovernmental Relations
801 E. Jefferson Street, Mail Drop 4200
Phoenix, AZ 85034

**RE: Arizona's 1115 Waiver & other initiatives
Non-Emergency Transportation**

AHCCCS CARE-Choice, Accountability, Responsibility, and Engagement has an opportunity and obligation to do more, and they can commit to affect positive change by keeping non-emergency transportation. In order for Arizonan's to take charge of their health and focus on recovery, they need the resources, especially transportation, to get them where they need to be, both physically and mentally.

Everyone should have the opportunity to improve and to succeed in their community, and transportation is often required to do so to keep individuals that are already employed or enrolled in school/training and engaged in meaningful activities within their communities. In order to live well in our community we have to get to the places that give us the support to thrive and come alive, thus building a bridge to independence. Here is an example of the classes and groups that we offer at Partners in Recovery East Valley representing all the dimensions of health and wellness:

On the Move Work Readiness Group, Vocational Rehabilitation/Employment Resource Meeting, PSA Art Awakenings, ART Group, Family Support Group, Walk & Talk, Mall Walk, Pathways to Wellness, Nutrition and You, Coffee Clutch, WRAP: Wellness Recovery Action Plan, At the Movies, BINGO, Wii Games, Positive Life, Social Bonanza, and Terros Groups: Improving Anger Management Skills, Relapse Prevention and Co-Occurring Symptom Management.

These groups provide a structured, supportive environment facilitating change and progress. Not having transportation would affect the quality of life and block the resilience and recovery that people experience when they are gaining self acceptance, including connections and pathways to wellness by being a part of something meaningful.



"Transportation makes it possible for the participants to get out of the house and socialize. Having a breakdown is no laughing matter. "I am concerned that if I was returning from a hospital stay and could not get the medications by that day that I would start possibly relapsing." These are actual quotes and concerns from our members!

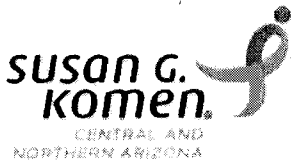
Transportation has been a privilege and with that comes responsibility. People are encouraged to recognize that they are in charge of their own destiny and need to respect the services that are available to them. By collaborating with AHCCCS we can find the solution that will allow people to continue to grow and flourish. However, removing transportation we do not feel is an appropriate or viable solution to achieve this goal.

The Partner's in Recovery East Valley Campus Advisory Council would like to thank you for this opportunity to share our concerns about the Modernizing Arizona Medicaid Proposal. As stated, the issue that we are concerned about is the elimination of non-emergency transportation. The change would affect the quality of life for a countless number of people that are productive members in our communities. We ask that you re-evaluate your proposal and consider the effect it would have and the cost it would amass with increased hospitalizations when people are not in recovery.

Thank you for your time and consideration.

Respectfully,

East Valley Campus Advisory Council



2040 W. Bethany Home Road, Suite 120, Phoenix, Arizona 85015
602-544-2873 Helpline 1-877 GO KOMEN
www.komen.org/CANAZ.org

Mr. Tom Beltach
Director
AHCCCS
801 E. Jefferson St. MD 4100
Phoenix, AZ 85034

RE: Comment Response to Arizona's 1115 Demonstration Waiver Request

Dear Director Beltach:

Thank you for the opportunity to submit comment on Arizona's 1115 demonstration waiver request which will be submitted to CMS for review and approval.

Susan G. Komen® Central and Northern Arizona's (Komen® CAN AZ) promise is to save lives and end breast cancer forever by empowering people, ensuring quality care for all and energizing science to find the cures. Komen CAN® AZ is Arizona's largest breast cancer foundation, funding \$20.2 million in community grants in Arizona since 1993 to those who are low income, uninsured and underinsured. These funds have provided for 157,771 education contacts, 34,696 screening mammograms, 6,048 diagnostics and 2,624 individuals who have received lifesaving breast cancer treatment.

Komen CAN AZ's mission is to cover the gaps in breast cancer services and resources for those in Arizona who are low income, uninsured or underinsured. Komen CAN AZ does not receive federal grants or funding. To ensure Komen CAN AZ's limited community grant dollars are used ONLY as last resort to reach as many of those the who do not have access to or qualify for any other resources, such as AHCCCS, Komen CAN AZ leverages and depends on community partnerships, collaborations between the public and private sectors and robust and impactful public policy initiatives. The expansion of Medicaid to cover the population 100-133% of the Federal Poverty Limit (FPL) has had the most impact in closing the gap of services for low income, uninsured and underinsured individuals.

"The Medicaid expansion adds 57,000 more people to state Medicaid, Arizona Health Care Cost Containment System (AHCCCS), between 100 and 133 percent FPL. It also restored insurance to 300,000 Arizonan's who were previously dropped from the program in 2011. This occurred when AHCCCS received federal approval to cap coverage for childless adults, denied new applicants to AHCCCS and denied coverage for those who failed to re-enroll or who dropped off the rolls for any reason. It is estimated that there are currently 5,000 cancer patients on AHCCCS." ¹

The expansion was a significant achievement and success for the state of Arizona. It is because of this achievement that Komen CAN AZ is concerned about the proposed section 1115 demonstration waiver request and the potential negative impact some of the items contained within the waiver could have on the recently insured population of low income individuals 100-133% FPL.

¹ Betlach, Thomas J. (2013). AHCCCS strategic plan state fiscal years 2014-2018."

AHCCCS CARE: Requiring Member Contributions (Copays and Premiums)

AHCCCS CARE: Requiring Member Contributions

- *Copays: Up to 3% of annual household income. Members will make monthly AHCCCS CARE payments reflecting copays for services already obtained.*
- *Premiums: Up to 2% of annual household income. Included in the monthly AHCCCS CARE payment is a premium requirement set at 2% of income.*
- *Member contributions do not exceed 5% of annual household income.*

Komen CAN AZ does not support or endorse the recommendation to require copays or premiums.

"The findings of our analyses of copayments in Utah indicate that even "nominal" copayments in the range of \$2 or \$3 can significantly reduce patients' use of medical care or prescription drugs when they are applied to poor Medicaid patients. Medicaid patients may be particularly vulnerable to cost-sharing because they are both poorer and, in general, less healthy than middle-class privately-insured patients."²

"Supporters of the expanded use of premiums and cost-sharing in Medicaid expansion waivers argue that individuals receiving Medicaid coverage should have some "skin in the game" and be responsible for some of their health care costs. However, research from pre-health reform waivers and other state-funded programs for low-income people shows that changing premiums to low-income people results in many eligible people foregoing or delaying coverage and remaining uninsured. For those with coverage, copays and other cost sharing charges have been shown to keep low-income people from accessing needed care."³

In regards to cost effectiveness, in 2006 AHCCCS completed a study which illustrated that required copays and premiums for low income individuals could create barriers to access to care. More low income individuals would become uninsured and there would be a negative impact on the state budget. In 2006, Arizona's Medicaid agency conducted a fiscal impact study for the state legislature to determine how much the state could save from charging premiums as well as the higher co-pays allowed by the Deficit Reduction Act of 2005.⁴ "The fiscal impact study showed that it would cost Arizona about \$15.8 million to collect premiums and cost-sharing charges while raising only about \$2.9 million in premiums and \$2.7 million in co-pays."⁵ Therefore, it is highly possible that administration costs for collection of premiums and copays would far outweigh any perceived cost savings benefits.

² Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" Inquiry, 40:323-42, Winter 2003/2004.

³ Laura Snyder and Robin Rudowitz, "Premiums and Cost-Sharing in Medicaid: A Review of Research Findings," Kaiser Commission on Medicaid and the Uninsured, February 2013, <http://kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/>

⁴ Jessica Schubel and Judith Solomon, "States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility," Centers on Budget and Policy Priorities, April 2015.

⁵ **Arizona Health Care Cost Containment System**, "Fiscal Impact of Implementing Cost Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act of 2005," December 13, 2006, http://www.azahcccs.gov/reporting/Downloads/CostSharing/FINAL_Cost_Sharing_Report.pdf.

Employing Strategic Copays (Emergency Room Department Use)

Komen CAN AZ does not support the use of strategic copays to reduce ED visits and costs when the usage is cited by AHCCCS as relatively low and other evidence based best practices show this can be accomplished without strategic copays included.

“Overall, AHCCCS members have a relatively low rate of non-emergency ED utilization particularly when compared to the national averages. AHCCCS and its Contracted health plans continue to develop and use interventions that insure appropriate ED utilization.”⁶

“CMS is very supportive of efforts to ensure that appropriate care is delivered in the most appropriate settings. Successful strategies to reduce inappropriate ED use can have the enhanced benefit of improving care and lowering costs.”⁷ Indiana is just one of several states which implemented successful targeted strategies without the use of strategic copays, which lead to a 72% reduction in inappropriate ED use.⁸

The AHCCCS CARE Account: Giving People Tools to Manage Their Own Health (Health Savings Accounts)

Personal Responsibility: Enforcing Member Contribution Requirements

- *Over 100% FPL: Members will be disenrolled from the AHCCCS program for a period of six months for failure to make AHCCCS CARE payments.*
- *Under 100%: Failure to make AHCCCS CARE payments is counted as a debt owed to the State. AHCCCS will work with the Arizona Department of Revenue as to how best to operationalize this aspect of the program.*

Komen CAN AZ does not support Health Savings Accounts for Medicaid patients, or reinforcement requirements for contributions into members’ AHCCCS CARES accounts.

Previously, CMS has not supported requiring payments from individuals who are lower than 100% FPL. Komen CAN AZ asks CMS to continue to support this position given that the manner in which the state has laid out how it will collect the payment (which has been described as a “debt”) is not specific or explicit. The administrative cost of collecting and monitoring payments is likely to outweigh any perceived savings while working to create barriers to access to insurance and care for the low income individuals 100-130% FPL.⁹

⁶ REPORT TO THE DIRECTORS OF THE GOVERNOR’S OFFICE OF STRATEGIC PLANNING AND BUDGETING AND THE JOINT LEGISLATIVE BUDGET COMMITTEE, “Arizona Health Care Cost Containment System: Emergency Department Utilization,” December 1, 2013, <http://www.azahcccs.gov/reporting/Downloads/NonERuseER.pdf>

⁷ Centers for Medicare & Medicaid Services, “Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings,” CMCS Informational Bulletin, January 16, 2014, <http://www.medicare.gov/Federal-Policy-Guidance/downloads/CIB-01-16-14.pdf>.

⁸ Medicaid Health Plans of America, “2011-2012 Best Practices Compendium,” <http://www.mhpa.org/upload/2011-2012%20Compendium%20WEB.pdf>.

⁹ 13 Andy Davis, “Bill asks pause to care changes,” Arkansas Democrat-Gazette, January 24, 2015, <http://www.arkansasonline.com/news/2015/jan/24/bill-asks-pause-to-care-changes-2015012-2/>.

AHCCCS Works: Getting Back to Work

- *The Requirements: Per legislative directives like SB1092, all able-bodied individuals must be employed, actively seek employment or attend school or a job training program.*
- *Work Incentives: In addition, AHCCCS Works builds in Work Incentives.*
 - *Employers that contribute to their employee's AHCCCS CARE Account can reduce their employee's contribution requirements or that member can use their employer's contribution to build up funds in their AHCCCS CARE Account that can be used for non-covered services.*
 - *The AHCCCS Works program will also partner with existing employment supports programs, like the program administered by the Arizona Department of Economic Security (DES) to provide members the tools they need to build their skills and find their confidence.*
 - *Once a member's income exceeds AHCCCS eligibility, their AHCCCS CARE Account transfers to a private HSA account or can be maintained through the AHCCCS CARE administrator that they can continue to use.*

Komen CAN AZ does not support requiring employment for "able-bodied individuals." "Able-bodied" is defined in the 1115 demonstration waiver request as "an individual who is physically and mentally capable of working." There are far too many existing physical and mental health issues for this vague term to be applied and universally accepted.

Senate Bill 1092:

36-2903.09. Waivers; annual submittal; definitions

2. Place on able-bodied adults a lifetime limit of five years of benefits under this article that begins on the effective date of the waiver or amendment to the current section 1115 waiver and does not include any previous time a person received benefits under this article.

Komen CAN AZ does not support the lifetime limit of five years for "able bodied" adults. As the state's largest breast cancer foundation, we know that breast cancer treatment and its side effects can last longer than five years. For instance, metastatic breast cancer arises months or years after a person has completed treatment.

Delivery System Reform Incentive Payment (DSRIP):

"The specific transformation models and arrangements will be established based on the findings of the stakeholder driven State Health System Innovation Plan, developed through the Arizona SIM Model Design award."

The DSRIP can be an effective and important tool allowed under the 1115 demonstration waiver request. However, Komen CAN AZ has concern that this process through the AZHIP has not been fully transparent, inclusive and diverse. Komen CAN AZ will not support any initiative in which the DSRIP may be used to threaten or create barriers to care and insurance for the 100-133% FPL low income population, or any initiative through the DSRIP which may increase the likelihood or opportunity for low income individuals (0-100% FPL) to self disenroll from insurance coverage through AHCCCS.

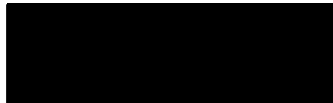
Komen CAN AZ will support the opportunity the DSRIP allows to improve efficiencies, streamline systems and improve patient outcomes (Ex. New York DSRIP to reduce ED visits by 25% through community collaborations). In the true spirit of the DSRIP, Komen CAN AZ suggests the following changes are implemented moving forward:

- a DSRIP which defines “stakeholders” at a minimum as those who represent hospitals systems, Federal Qualified Community Health Centers, Public Health Professionals, Public Health non profit organizations, community organization which represent disparate populations and AHCCCS beneficiaries, Insurance Plans, etc.
- The stakeholders will select a leader to represent the interests of the stakeholders at any State Innovation Models (SIM) or AZHIP meetings.
- Consensus and approval for any DSRIP initiatives must be gained through a majority vote at stakeholder meetings and this must be documented in meeting minutes.
- Any and all meeting materials will be made available and accessible to stakeholders before, during and after meetings.
- All materials relating to the DSRIP (meeting dates, meeting minutes, initiatives, progress and outcomes, etc.) will be made available and accessible on the Arizona Department of Health Services website.

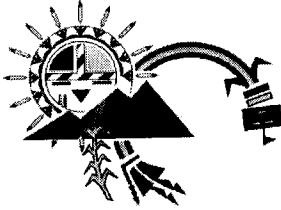
Komen CAN AZ ‘s promise is to save lives and end breast cancer forever by empowering people, ensuring quality care for all and energizing science to find the cures. Items listed in the waiver appear to threaten or work to undo the Medicaid expansion and insurance provided to the newly insured population of 100-133% FPL, creating barriers to care and access to care and ultimately limiting quality care for all. As a public health foundation that fills the gaps in breast cancer services for those with limited or non-existent resources, Komen CAN AZ resources alone cannot meet the need and demand for services which continues to increase. As shown, public health publications evidence and research show that the 1115 demonstration waiver request measures outlined in this document will neither improve health outcomes for low income individuals nor reduce costs. Help us keep affordable, comprehensive health care available to the most vulnerable populations in Arizona.

Thank you for your time and thoughtful consideration in reviewing the concerns of Komen CAN AZ.

Sincerely,



Heather Roberts, Executive Director
Susan G. Komen® Central and Northern Arizona



TUBA CITY REGIONAL HEALTH CARE CORPORATION

167 North Main Street, P.O. Box 600
Tuba City, Arizona 86045-0600
(928) 283.2501

September 25, 2015

AHCCCS
Attn: Office of Intergovernmental Relations
801 E. Jefferson St., MD 4200
Phoenix, AZ 85034

Re: Tuba City Regional Health Care Corporation Comments on AHCCCS Application for a New Section 1115 Waiver Demonstration

The Tuba City Regional Health Care Corporation (TCRHCC) is pleased for the opportunity to comment on AHCCCS' draft application for a new Section 1115 Demonstration Waiver, and appreciates AHCCCS' effort to reach out to consult with Arizona Tribes on the proposed waiver on August 21, 2015. As discussed below, the Tribe is very supportive of AHCCCS' proposal to renew the Uncompensated Care Waiver for Indian Health facilities, but is concerned about several other aspects of the proposed waiver. We believe that many if not all of those concerns could be alleviated through additional consultation. Accordingly, in addition to the comments below, we formally request that the State conduct an additional consultation with TCRHCC on the proposed waiver as soon as is practicable and before AHCCCS submits the waiver proposal to the Center for Medicare and Medicaid Services (CMS).

TRCHCC is a Navajo Nation corporation that operates under a Title V Compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act, P.L. 93-638. TCRHCC provides services to over 100,000 beneficiaries in a 6,000 square mile area and serves as a referral center for the western part of the Navajo and Hopi Reservations. TCRHCC relies on billing the Arizona Medicaid program for the Medicaid-enrolled individuals its serves to supplement its inadequate IHS funding.

We provide the comments on the following aspects of AHCCCS' proposal: (1) Proposed revisions to the AHCCCS program; (2) the proposed American Indian Medical Home program; and (3) the proposal to renew the Uncompensated Care Waiver for Indian health facilities.

I. Comments on Proposed Revisions to AHCCCS Program

AHCCCS is proposing significant changes to the AHCCCS program in order to implement the requirements of S.B. 1092 and 1475. The proposal would impose copays up to 3% of annual household income, premiums up to 2% of annual household income, impose work requirements, and a five year lifetime limit, among other proposals. It would create AHCCCS CARE accounts that function like Health Savings Accounts, and provides for reductions in payments based on meeting healthy behavior metrics. It would also require mandatory enrollment in AHCCCS.

TCRHCC is concerned that neither the summary of the proposed AHCCCS waiver nor the actual draft waiver state that American Indians and Alaska Natives

(AI/AN) are exempt from mandatory enrollment in AHCCCS in order to access Medicaid benefits, and can continue to receive services through the FFS American Indian Health Program. The only mention of the continued availability of the American Indian Health Program is contained in the summary regarding the American Indian Medical Home. Although we do not believe it is the intent of AHCCCS to make the new AHCCCS CARE plan mandatory for AI/AN, the waiver proposal must be amended before it is submitted in order to make that clear. TCRHCC urges AHCCCS to specifically state in the actual waiver application that it would allow AI/AN to opt-out of participation in the new AHCCCS CARE waiver being proposed.

In addition, the waiver must also be revised so as to ensure that those AI/ANs who elect to participate in the new AHCCCS waiver and the IHS and tribal facilities that bill the new AHCCCS CARE plans may do so in a manner consistent with their rights under the Social Security Act. As you know, AI/AN are exempt from mandatory enrollment in managed care systems, and the new proposed AHCCCS waiver contains a number of provisions that are inconsistent with the rights of AI/AN and tribal health providers. Under the Social Security Act:

- American Indians and Alaska Natives are exempt from premiums and cost-sharing associated with care provided at an I/T/U or through contract health services;¹
- Certain trust related income is exempt from income determinations for purposes of Medicaid eligibility determinations;²
- Certain American Indian and Alaska Native resources are exempt from Medicaid estate recovery;³
- American Indians and Alaska Natives enrolled in managed care can elect to choose their Indian health provider as their primary care provider;⁴ and
- Managed care plans must promptly pay Indian health programs whether they are in-network or not, and Indian health programs have a right to be paid the amount they would be paid under the State plan regardless of what the managed care plan pays for the service.⁵

TCRHCC would like AHCCCS to include the following Special Terms and Conditions as part of its waiver proposal to memorialize these rights. These Special Terms and Conditions have been adopted in other state managed care waivers, and TCRHCC believes they should also be included in AHCCCS' waiver.

Special Terms and Conditions for AI/AN in the AHCCCS Waiver Proposal:

American Indian/Alaska Native Individuals. Individuals identified as American Indian or Alaskan Native (AI/AN) are excluded from this demonstration unless an individual chooses to opt into the demonstration

¹ 42 U.S.C. §§1396o(j) and 1396o-1(b)(3)(A)(vii), as added by Sec. 5006(a) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009).

² 42 U.S.C. §§1396a(ff) and 1397gg(e)(1)(H), as added by Sec. 5006(b) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009).

³ 42 U.S.C. §1396p(b)(3)(B), as added by Sec. 5006(c) of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) (Feb. 17, 2009).

⁴ 42 U.S.C. §1396u-2(h), as added by Sec. 5006(d) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009).

⁵ 42 U.S.C. §1396u-2(h), as added by Sec. 5006(d) of the American Recovery and Reinvestment Act (P.L. 111-5) (Feb. 17, 2009).

and access coverage pursuant to all the terms and conditions of this demonstration. Individuals who are AI/AN and who have not opted in to an AHCCCS CARE plan will receive the ABP generally available under the State Plan through the FFS American Indian Health Plan system. An AI/AN individual, whether receiving direct coverage or coverage through an AHCCCS CARE plan will be able to access covered benefits through Indian Health Service (IHS), Tribal or Urban Indian Organization (collectively, I/T/U) facility funded through the IHS. AI/AN individuals who receive services directly by an I/T/U or through referral under Purchased/Referred Care services shall not be imposed any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing or similar charges, and payments to an I/T/U or a health care provider through referral under Purchased/Referred care services for services provided to an eligible AI/AN shall not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing or similar charges. Notwithstanding any other provision in this demonstration, to the extent that an AHCCCS CARE plan pays at a rate lower than the rate I/T/Us are entitled to receive under the State Plan, the plan shall provide for payment to the Indian health care provider, whether the provider is a participating or nonparticipating provider with respect to the entity, of the difference between such applicable rate and the amount paid by the managed care entity to the provider for such services. Under Section 206 of the Indian Health Care Improvement Act, (IHCIA), I/T/U facilities are entitled to payment notwithstanding network restrictions.

1. **Notices.** Notices must include information explaining that AI/ANs are excluded from the demonstration unless they opt-in, and that AI/ANs who have not opted in may still receive the ABP available to the new adult group through the American Indian Health Plan FFS system, with access to covered benefits through I/T/U facilities.
2. **No Auto-Assignment for AI/ANs.** Auto-assignment will not apply to AI/ANs unless they have opted in to participate in an AHCCCS CARE Plan, provided that AI/ANs may elect to choose their I/T/U as their primary care provider.

TCRHCC requests consultation on the inclusion of these Special Terms and Conditions and ensuring that the AHCCCS waiver proposal states in writing that it will be optional for AI/AN in Arizona, and contain these provisions to protect AI/AN who elect to participate in the program and the Indian health facilities that serve them.

In addition, TCRHCC also requests consultation on other aspects of the waiver, including the work requirements and lifetime limits. Congress authorized the IHS and tribal health facilities to access Medicaid resources in 1976 in furtherance of the federal trust responsibility and to provide additional federal health care resources to support the systematically underfunded Indian health system. When it did so, it ensured that States would not have to bear any novel costs associated with that new authority by also enacting an amendment to Section 1905(b) of the Social Security Act to ensure a 100 percent Federal Matching Assistance Percentage applied to all services received through an IHS or tribal health facility.

TCRHCC opposes work requirements and lifetime limits to the Medicaid program as it applies to AI/AN in the State, as such conditions are inconsistent with the federal trust responsibility and the intent of Congress in shielding states like Arizona from any costs associated with allowing IHS and tribal health facilities to access the Medicaid program. Lifetime limits and work requirements are inconsistent with Congressional purpose in making Medicaid a resource intended to improve health care delivery through the Indian health system, and TCRHCC opposes such requirements as applied to the Indian health system.

TCRHCC recognizes that AHCCCS undoubtedly intends to submit its waiver proposal to CMS as soon as possible, and as a result requests consultation on these issues, either in person or telephonically, as soon as practicable.

II. Comments on the American Indian Medical Home

TCRHCC was somewhat surprised to see the State's American Indian Medical Home proposal included in this waiver, as it had not heard about it for some time. As a general matter, TCRHCC strongly supports the proposal, as it will provide TCRHCC with the resources and tools it needs to better manage care for individuals in the American Indian Health Program. However, TCRHCC has questions regarding the formula used to set the rate of payment, and questions about payments to non-Indian health providers for care coordination staffed by employees of TCRHCC. Accordingly, we request consultation on this proposal as well.

TCRHCC is a leader in care management for the beneficiaries it serves, and has already met or will meet most of the Medical Home criteria set out in the waiver proposal. Meeting these criteria is very costly for TCRHCC, however, as it does not receive any additional funds to do so. TCRHCC therefore strongly supports the proposal to provide a PMPM rate for I/T/Us that meet the Medical Home criteria, as well as a PMPM reimbursement for diabetes education.

In addition, TCRHCC urges AHCCCS to make the following clarifications to its mandatory criteria. The criteria should reflect that behavioral health is often offered by referral outside the "Medical Home," and referrals should qualify as meeting the criteria for behavioral health. In addition, the reporting required should not be tied to RPMS, the technology used by the IHS. TCRHCC, like many other tribes that have compacted IHS services, have adopted more modern reporting programs, and the criteria should be flexible enough to allow reporting using those systems. Finally, the enhanced access to care metric should be implemented in a manner that allows I/T/Us to gradually meet that goal. Most I/T/Us do not, for example, allow open scheduling, as doing so is too costly, and because it can result in inefficiencies due to missed appointments. Care must be taken that this metric is not implemented in a manner that prevents I/T/Us from participating in the program.

TCRHCC would like to consult with AHCCCS on the formula used to set the PMPM rates proposed in the waiver. It is difficult for TCRHCC to comment on the appropriateness of the rate itself without a better understanding of how it was generated, and how it might change.

TCRHCC also has concerns with regard to non-I/T/Us also qualifying for reimbursement under this program. Currently, TCRHCC empanels its own employees whose salaries it pays with non-I/T/U health facilities to coordinate and manage care.

TCRHCC believes it should receive an additional PMPM reimbursement for the provision of such services at non-I/T/U facilities, as TCRHCC is the entity doing the care coordination and management, not the non-I/T/U facility. To the extent that a non-I/T/U does care coordination for AI/AN on its own, TCRHCC believes they should meet the same metrics as the I/T/Us. In practice, such care coordination may be difficult for non-I/T/U facilities in identifying which patients are AI/AN, and which I/T/U they are empaneled in. In addition, the proposal should also clarify how the non-I/T/Us will communicate care back to the I/T/Us. These questions and concerns would best be addressed through additional consultation with the I/T/Us in the State.

III. Comments on Uncompensated Care Proposal

TCRHCC continues to strongly support the extension of the Uncompensated Care Waiver, and thanks AHCCCS for including it once again in its waiver proposal. The Uncompensated Care Waiver has made a significant difference in TCRHCC's ability to narrow the funding gap between what it receives in appropriations and the needs of the population it serves. TCRHCC strongly supports the extension of the Uncompensated Care Waiver, and stands ready to provide AHCCCS with any information it needs to support the waiver with CMS.

TCRHCC continues to be concerned, however, that the rate of reimbursement made available by the Uncompensated Care Waiver continues to drop. Initially, the Uncompensated Care Waiver was paid on a per encounter basis at the OMB rate. TCRHCC believes this approach most accurately reimburses I/T/Us for the uncompensated care they must provide, not the PMPM rate. TCRHCC encourages AHCCCS to reconsider using an encounter based reimbursement at the OMB rate. To the extent that approach results in administrative burdens to the program, TCRHCC encourages AHCCCS to discuss reimbursement alternatives with CMS, such as withholding some portion of the rate to meet those costs. In the interim, TCRHCC has asked and would like to meet with AHCCCS to discuss the actual formula used to generate the PMPM rate currently being used. TCRHCC is concerned that the formula uses population numbers that are too low, and thus generates a rate that does not accurately reflect the amount of care being provided. Again, TCRHCC believes that CMS would be amenable to discussing changes to the rate or the formula used to generate the rate.

Thank you again for consulting with Tribes on this proposal, and we look forward to discussing it with you further as soon as possible.

Sincerely,



Lynette Bonar, CEO
Tuba City Regional Healthcare Corporation

Cc: Mr. Thomas J. Betlach, Director, AHCCCS
Ms. Bonnie Talatke, Tribal Relations Liaison, AHCCCS
Mr. Elliott Milhollin, Esq.
Mr. Gehl Tucker, Esq.
Honorable Nathaniel Brown, HEHSC Member

Vinyard, Christopher

From: Sarah Edmonds <sedmondsphd@gmail.com>
Sent: Friday, September 25, 2015 3:01 PM
To: Public Input
Subject: proposed AHCCCS changes

As a psychologist in private practice, I have had clients who have Medicare as their primary insurance and AHCCCS as their secondary insurance. These clients are on Social Security Disability because of mental health issues.

The clients that I have seen have been in the mental health system for years, if not decades. They are on multiple psychiatric medications, and many have chronic health problems. To give people like this a 5 year limit on AHCCCS coverage seems unfair. Patients that have spent many years in a system that relies on giving people larger and larger doses of psychotropic medications that cause brain damage, unpleasant side effects, and contribute to medical conditions are often not able to reverse the damage that has been done, even with the best psychotherapy.

If the state of AZ is going to limit AHCCCS coverage to 5 years, then the entire mental health system needs to change. Medications should be used sparingly, and patients tapered off of them ASAP. There needs to be much more access to effective psychotherapy delivered by experienced clinicians, rather than bachelors's level case managers and groups run by the same. Rather than masking symptoms by giving medications, symptoms need to be viewed as the result of trauma and treated as such, and early intervention, family support, and support of K-12 education needs to be prioritized. Mental health problems are at least partially a reflection of how a society is treating its most vulnerable people.

Sarah Edmonds, PhD

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September 25, 2015

Thomas J. Betlach M.P.A., Director
Arizona Health Care Cost Containment System
801 E. Jefferson St., MD 4100
Phoenix, AZ 850

RE: Section 1115 Waiver Renewal

Dear Director Betlach,

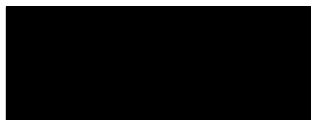
On behalf of the University of Arizona Center for Population Science and Discovery, a division of the Arizona Health Sciences Center, we are grateful to have the opportunity to comment on the Arizona Health Care Cost Containment System (AHCCCS) 1115 waiver proposal. We reviewed the current literature to determine how existing empirical evidence may help us anticipate the prospective impacts of the various components of the AHCCCS proposal. Based on this investigation we are very impressed with the overall innovative nature of this proposal, and believe that many aspects of it will go a long way towards meeting the needs of patients, providers, health care systems, and AHCCCS.

Accordingly, we have prepared a summary of the peer-reviewed literature on a number of prominent components included in the waiver application. In our review, we found encouraging evidence for some aspects (copays for non-emergency use of the emergency department and for brand name prescription drugs) while for others (health savings accounts, copays for opioids, and AHCCCS Care accounts) we either were unable to identify relevant evidence or found a lack of substantive consensus regarding potential impacts. In all cases, we encourage rigorous monitoring and evaluation of the waiver implementation, as it presents Arizona with a unique opportunity to contribute to our specific and general understanding of public health policy and the needs of our state's diverse population. In these efforts, our Center would be happy to work with AHCCCS on any evaluation needs identified by the agency. Our immediate team includes economists, health services researchers, public health leaders, epidemiologists, and public health evaluation researchers and we maintain collaborations across many other disciplines both within and outside the University.

The waiver represents an important opportunity to help researchers and policy makers at the state and national levels learn from the Arizona experience. With respect to age, race, ethnicity, and socioeconomic status, Arizona has a truly unique population and geography. As a result, tracking and evaluating the implemented components has the potential to impact healthcare policy nationwide and further cement our state's position as one of the country's leading laboratories for Medicaid policy.

In summary, we are happy to have this opportunity to provide the current "state of the science" regarding the objectives and interventions proposed in the waiver. We hope that as this waiver moves forward, AHCCCS commits to rigorous evaluations in order to enhance your ability to implement effective policy. Furthermore, as opportunities arise we are eager to collaborate on measuring and analyzing the impact of the components of the new waiver.

Sincerely,



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Copays

Any increase in copayments is likely to cause utilization declines for both preventive and emergency visits (Machledt and Perkins, 2014). In general, cost sharing shifts costs from the state to low income enrollees (Keeler, 1992). Cost sharing has been shown to disproportionately negatively impact the poor and sick populations (Newhouse, 2004), populations that tend to rely on Medicaid coverage. Halpern et al. (2014) find that copays reduce the likelihood of cancer screening for Medicaid beneficiaries. Wallace et al. (2008) report that copays did not provide the expected savings and total expenditures per person remained unchanged in Oregon. However, in most of the studies we reviewed, copayments or increases in copayments were bundled with premiums and/or informational interventions, making it difficult to isolate the impact of a rise in copays by itself.

Copays and non-emergency use of the emergency department

Several studies indicated that higher copays for unnecessary ED use resulted in reduced ED visits and costs when implemented.¹ A copay increase from \$100 to \$200 and an informational brochure reduced ED utilization for conditions that could have been treated outside of the ED (DeVries, Chia-Hsuan, and Oza, 2013). This study also indicated that those liable for a higher copayment were nearly five times more likely to choose retail health clinics over ED visits for non-emergency care (ibid). Additional studies noted a 4% decrease in ED visits for Medicaid beneficiaries with a copay between \$20 and \$50, compared to a group with no copay (Hsu, Price, Brand et al., 2006). Selby, Fireman, and Swain (1996) found a reduction in ED visits by 15% with a copay between \$25 and \$35. In a study on the implementation of premiums, informational brochures, and \$50 copayments for unnecessary ED use, ED visits were reduced by 18% (Lowe, Fu, and Gallia, 2010). Finally, in a commercial insurance marketplace, subjects with cost sharing had expenditures 14% lower than subjects with free care (O'Grady, Manning, Newhouse et al., 1985). These results were consistent across subgroups. Hospitalization rates and ICU admissions among low SES groups declined with higher ED copayments (Hsu, Price, Brand et al., 2006).

Other authors have found no effect or a negative effect for ED copays. For example, using data from the Medical Expenditure Panel Survey data across nine states, Mortenson (2010) determined that non-emergency copays did not decrease ED use by Medicaid enrollees. Similarly, Siddiqui, Roberts, and Pollack (2015) found that granting states permission to collect copayments for non-urgent visits did not significantly change ED or outpatient medical provider use among Medicaid beneficiaries.

This conflicting evidence suggests that increasing copays for non-emergency ED visits may or may not result in cost savings and reductions in ED visits. If this waiver component is approved and implemented we recommend monitoring the impact on ED visits and costs. Additionally, we recommend investigating how these copays may differentially impact different racial, ethnic, geographic, and socioeconomic subgroups in Arizona. Understanding the reasons for these differences could lead to a significant contribution to policy and the general understanding of the incentives behind ED use.

Copays and use of opioids

To our knowledge nothing specific to opioids has been published in the literature. There is evidence to suggest that prescription cost-sharing leads to decreased utilization. In a meta-analysis 85% of studies of cost sharing and medication adherence showed a negative correlations (Eaddy, Cook, O'Day et al., 2012). Anis et al. (2005) find that prescription co-payments led to fewer prescriptions filled per month. Ku, Deschamps, and Gilman (2004) report that Utah's \$2 prescription copays for Medicaid enrollees reduced

¹ The definition of an "unnecessary" ED visit varies across studies.

utilization by 8 percent. Bae et al. (2008) estimate that raising copays by \$1.50 for Massachusetts Medicaid adults increased the rate of nonadherence amongst adult asthmatics by 10%. Gatwood et al. (2014) calculate the price elasticity for 8 categories of medication including Opioids. Opioids were nearly perfectly price inelastic; in other words, utilization did not respond to the increase in price. This last study suggests that the nominal copays proposed in the AHCCCS waiver are unlikely to impact utilization. If this waiver component is approved and implemented, a rigorous evaluation provides an important opportunity for informing similar future policies.

Copays and missed appointments

There is evidence that individuals on Medicaid often miss more appointments than those on commercial insurance (Majeroni, Cowan, Osborne et al., 1996; Lamberth, Rothstein, Hipp et al., 2002). Bech (2005) reviews the literature on the impact of fines for non-attendance and concludes that they are effective in reducing the number of missed appointments. However, other evidence suggests that instituting copays for missed appointments will have a disproportionately negative impact on minorities and low income individuals (Parker, Moffet, Schillinger et al., 2012).

Copays and use of brand name over available generic drugs

In general the existing literature fails to find evidence that requiring a copayment for brand name drugs yields significant cost savings. In one study, larger cost-sharing differentials between generic and brand name drugs were associated with higher rates of generic drug use but were not associated with lower expenditure rates (Hong and Shepherd, 1996). Plan design can facilitate use of less costly drugs (Thomas, Wallack, Lee et al., 2002). This was shown in a study by Rector, Finch, Danzon et al. (2003), where tiered prescription copayments were associated with a significant shift from non-preferred to preferred brand medications. However, this shift in preference was also not shown to lead to a significant cost savings for the individuals or for the plans.

Accessing specialist services without a referral from a PCP

There is little evidence that suggests this initiative will significantly impact total expenditures. One study indicated that the gate-keeper model did not show significant savings (Kapur, Joyce, Van Vorst et al., 2000). Total physician expenditures were 4 percent higher in the gatekeeper HMO than in the point of service plan when copayments were \$0. When the copayments for PCP-referred specialist visits were \$10, total physician expenditures ranged from equal to 7 percent higher in the gatekeeper HMO (Kapur et al., 2000). Due to this limited evidence an evaluation of this waiver component (if approved) would represent a significant contribution to our cost containment policy understanding.

Premiums

There is strong evidence that even small premiums reduce new enrollment, lower renewal rates, shorten the length, and lower the likelihood of continuous enrollment. Morrissey, Blackburn, Sen et al. (2012) find that a \$50 increase in premiums led to a 6-8% reduction in renewal rates among Alabama's Children Health Insurance (CHIP) members. Ku and Coughlin (1999) find that raising premiums from 1 to 3% of income in Hawaii, Minnesota, Tennessee, and Washington reduced enrollment from 57 to 35%. Abdus et al. (2014) find that a \$10 increase in monthly premiums is associated with a 6.7 percentage point reduction in Medicaid enrollment for children in families within 101-150% FPL range (a 3.3 percent point increase in having no insurance). Marton (2007) finds that a \$20 monthly premium reduces the length of enrollment. Dague (2014) finds that the first premium dollars (i.e. going from \$0 to \$10) are the most

likely to reduce enrollment. She finds that an increase from \$0 to \$10 reduces the probability of continuous enrollment over a 12 month period by 12 percentage points.

AHCCCS CARE Account

Very little peer-reviewed literature addresses the effectiveness of financial incentive programs for healthy behaviors among Medicaid enrollees. A few articles, although not specific to the AHCCCS CARE Account may provide insight should this component of the waiver be approved and implemented. The three themes surrounding incentive programs are 1) incentives to promote healthy behaviors must be developed so that all members have a clear understanding of the program (Blumenthal, Saulsgiver, Norton et al., 2013; Hall, Lemak, Landry et al., 2013), 2) incentive programs must be developed to be accessible to the populations in need, and 3) providers must be engaged in providing the preventive services to members (Hall et al., 2013). Blumenthal et al. (2013) indicate that incentive programs should clearly identify how much of a potential payment was earned and use simple communication materials. Additionally, incentive programs should be designed for ease of understanding by the enrollees and quick turnaround by “delivering incentives with little delay after a beneficiary completes a task or reaches a goal” (Hall et al., 2013).

West Virginia’s experience of implementing an “Enhanced Health Plan” failed in part due to a lack of education for members. Specific implementation tactics were not developed “to address the novelty of the choice members were facing” (Walsh, Plein, Fitzgerald et al., 2014). Hall et al. (2013) also suggests that, even within a state, interventions need to be tailored to specific populations and locations in order to succeed.

There was some evidence that preventive services are not provided to patients equally based on insured status (McMorrow, Long, Fogel, 2015). A Florida study investigating the impact of incentives on participating in health-related activities concluded that “initial engagement in such a program can prove challenging as different groups are not equally likely to be aware of or participate in an approved activity or redeem a credit” (Hall, et al, 2013). Furthermore, they state that “Physicians may play important roles in encouraging participation in programs to incentivize healthy behaviors”.

Health Savings Accounts (HSAs)

Although CMS has granted waivers allowing the implementation of Medicaid health savings accounts (HSAs)², their impact on the utilization of services and health outcomes in a Medicaid setting are unknown. There is evidence that HSAs reduce utilization in commercially-insured populations. Lo Sasso, Shah, and Frogner (2010) find that HSA enrollees spend 5-7 percent less than non-HSA enrollees with the greatest impact on services where utilization was driven by consumer choices rather than providers. Charlton et al. (2011) also find that HSA enrollees spend significantly less (17%) but also that decreased spending reduces the rate at which enrollees follow through with recommended preventive care. Fronstin and Roebuck (2013) report the five year experience of a single large employer that adopted a high deductible HSA plan. The authors find that the largest reduction from the adoption of an HSA plan occurred in the first year and then eroded over time. Furthermore, HSAs had limited impact on high utilizers. Ultimately, caution should be taken when projecting the commercial results onto a Medicaid population because the commercial HSAs were paired with high deductible health plans.

² See Wishner et al. (2015) for a review of 1115 waivers to implement Medicaid expansion under the ACA.

Work Requirement

We are not aware of any past or present requirement tying labor-force engagement directly to Medicaid eligibility. The Temporary Assistance for Needy Families (TANF) work requirement is the most similar social program to what is proposed in the AHCCCS waiver. As a result, the following is a brief background on TANF, its work requirement, current work participation rates, literature related to the efficacy, and the impact of TANF's work requirement. Following this is a description of the current work status of Arizonans in the 100-138% range of the federal poverty level (FPL). In brief, welfare work requirements were successful "on average" in reducing welfare caseloads and increasing employment, however a large portion of both TANF and unemployed potential Medicaid beneficiaries experience significant barriers to employment such as less than a high school level of education, chronic illness, and young children. The majority, approximately 70 percent, of Arizonan households in the 100-138% FPL have a full- or part-time working adult. Two thirds of Arizonans who are not employed report health or family obligations as being the main reason for their work status.

The Personal Responsibility and Work Opportunity and Reconciliation Act (PRWORA) of 1996 replaced Aid to Families with Dependent Children (AFDC) with block grants to the states.³ As part of welfare reform, TANF recipients are required to engage in work activity (e.g. training, job search, employment). Those who do not meet the minimum work effort can have their benefits reduced or even terminated. Single parents with children less than age 6 are required to engage in 20 hours of work activity per week. Single parents with older children must work at least 30. Two-parent families are required to jointly engage in 35 hours of work activity. For their part, states must have 50 percent of single parents meet their targeted work hours and 90 percent of two-parent families or risk their block grant funds being reduced. Those state-level targets can be lowered with credits for additional state spending or caseload reductions.

In the most recent fiscal year available, Patel (2015) reports that the TANF recipient FY 2012 national average work participation rate was 34.4 percent. Arizona's overall participation rate was 27.1 percent, though it met its state-specific target due to offsetting credits. The relatively low work participation rate can be explained, in part, by the number of barriers that the TANF population faces. Bloom, Loprest, and Zedlewski (2011) review the TANF barriers to employment literature, reporting that 80 percent had at least one barrier (e.g. low educational status, young children, poor health) and 42 percent had two or three.

The TANF welfare work requirement has been credited, along with the earned income tax credit and expanding economy in the late 1990s, with reducing welfare caseloads. Blank (2002) and Moffitt (2008) review a vast literature on the impact of welfare reform including work requirements and time limits. In general, studies show a reduction in welfare caseloads coupled with an increase in employment rates for those on and those leaving welfare. Moffitt (2008) cautions that these findings represent "average" outcomes across a heterogeneous population with differing barriers to employment. Both he and Blank advocate for transition to employment programs to assist welfare recipients facing barriers. The strength of the connection between existing employment support programs to AHCCCS Works described in the waiver narrative and the capacity to handle more beneficiaries will be a key factor for success if the work requirement is approved by CMS.

Turning our focus to the newly eligible Medicaid adult population, the Henry J. Kaiser Family Foundation (2015) uses the March 2014 Current Population Survey (CPS) to estimate the work status of

³ This description is based upon Schott (2012).

uninsured adults who would get access to Medicaid if all states expanded eligibility. Three in four households eligible for Medicaid expansion nationally have a full- or part-time worker. Among those not working, nearly half report that an illness/disability or family obligation was the main reason for their work status. Another 18% were going to school and 20% could not find work. The Kaiser report provides a national context to evaluate the degree to which low-income families are engaged in work activity. To our knowledge, no such analysis has been done for the state of Arizona.

We utilized the 2013 American Community Survey (ACS) and March 2014 CPS to evaluate the work status of adults age 19-64 in the 100-138% FPL range, comparing Arizona to regional and national characteristics. Table 1 reports the ACS results for Arizonans only. The ACS has two primary measures for work activity. The first is determined by two questions about the respondent's work activity over the last twelve months. If the respondent worked 50 weeks or more in the previous 12 months and averaged more than 35 hours of work, they are classified as full-time. If the respondent worked 50 weeks or more in the previous 12 months and averaged less than 35 hours of work, they are classified as part-time.⁴ Those who worked 49 weeks or less in the previous year are not identified as either full- or part-time. This first definition of work activity (see columns 1 and 3, Table 1) represents the strictest definition of sustained work engagement. Even with this definition, one out of two workers (Panel A) and one out of two households (Panel B) were either full- or part-time. The ACS also asks respondents whether they were employed in the last week. This question does not differentiate between full- and part-time employment but serves as an aggregate measure of work engagement that is more comparable to the CPS (which uses a one week retrospective employment status question). This less strict ACS definition of work engagement (columns 2 and 4, Table 1) is strikingly similar in magnitude to the Kaiser results (72% of households are full- or part-time). There are no significant differences when restricting the analysis to those who are uninsured or covered by Medicaid (columns 3 and 4).

The ACS does not provide any detail on barriers to employment. We therefore replicated the Kaiser (2015) results using the March 2014 CPS for Arizona, the four-corner states (AZ, CO, NM, and UT), and the entire USA, restricting the samples to adults age 19-64 in the 100-138% FPL range. The aggregate measure of full- or part-time employment across all three geographic groupings in Table 2 (the third row in Panel A and B) is similar to the ACS measure (cols 2 and 4, Table 1). As the geographic region narrows from the entire USA, to the four-corner states, to Arizona the precision of the estimates declines (reflected in the higher standard errors in column 1). Nonetheless, the results are consistent across all geographic regions within the CPS and with the larger, more precise, ACS Arizona estimate.

Finally, we turn our analysis to the main reason why Arizonans are not employed among the 100-138% FPL in Table 3. Those not employed represent an even smaller subset than those used to generate the results of Table 2 (again, as evidenced by the increasing standard error). At all geographic levels 60-70% report that an illness or family obligation are the main reasons they are not employed. Once more the results are largely consistent with the Kaiser report which found that one out of two individuals had issues related to health or family. This Arizona 100-138% FPL adult population is best characterized as low-income working families with some families facing significant barriers to employment.

⁴ This strict definition follows the U.S. Census definition, accessed September 24, 2015, <https://www.census.gov/hhes/www/laborfor/faq.html>.

Tables

Table 1: Work status for Arizonans age 19-64 between 100-138% FPL (2013 ACS)

	All respondents		Respondents reporting no health insurance or Medicaid at time of the interview	
	12-month retrospective (1)	One-week retrospective (2)	12-month retrospective (3)	One-week retrospective (4)
Panel A: Person-level work status				
Full-time employment	32.1% (1.0)		32.2% (1.4)	
Part-time employment	17.0% (0.9)		16.4% (1.2)	
Full- or part-time employment		69.1% (1.1)		67.2% (1.5)
Panel B: Household-level work status				
At least one full-time employed	32.0% (1.2)		32.1% (1.6)	
At least one part-time employment	17.6% (1.0)		17.4% (1.4)	
At least one full- or part-time employed		70.5% (1.2)		69.1% (1.7)

Source: 2013 American Community Survey. Notes: Point estimates were generated using full-sample weights. Successive difference replication standard errors are reported below point estimates in parentheses.

Table 2: Work status for adults age 19-64 between 100-138% FPL (2014 March CPS)

	Arizona only (1)	Four-corner states (2)	USA (3)
Panel A: Person-level work status			
Full-time employment	42.3% (7.4)	44.4% (3.7)	41.9% (0.9)
Part-time employment	26.2% (8.0)	21.9% (4.0)	20.0% (0.7)
Full- or part-time employment	68.5% (4.1)	66.3% (2.2)	62.0% (0.8)
Panel B: Household-level work status			
At least one full-time employed	42.3% (7.1)	44.0% (3.8)	42.0% (0.9)
At least one part-time employment	25.5% (7.9)	24.0% (3.9)	21.7% (0.7)
At least one full- or part-time employed	67.9% (5.1)	68.0% (2.7)	63.7% (0.8)

Source: March 2014 Annual Social and Economic Supplement of the Current Population Survey.

Notes: Point estimates were generated using full-sample weights. Successive difference replication standard errors are reported below point estimates in parentheses. The four-corner states are AZ, CO, NM, and UT.



Table 3: Main reason for not working in the previous calendar year (2014 March CPS)

	Arizona only (1)	Four-corner states (2)	USA (3)
Could not find work	12.2% (6.4)	10.5% (3.4)	6.5% (0.7)
Ill or disabled	20.5% (14.9)	26.9% (6.9)	42.8% (1.6)
Taking care of home/family	41.7% (14.6)	42.4% (7.3)	28.8% (1.4)
Going to school	0% (0)	4.63% (2.1)	7.3% (0.8)
Retired	25.6% (10.1)	14.7% (5.5)	13.7% (1.4)
Other	0% (0)	0.8% (0.9)	0.9% (0.3)

Source: March 2014 Annual Social and Economic Supplement of the Current Population Survey.

Notes: Point estimates were generated using full-sample weights. Successive difference replication standard errors are reported below point estimates in parentheses. The four-corner states are AZ, CO, NM, and UT.

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Vinyard, Christopher

From: Caples, Heather - SJHMC <Heather.Caples@DignityHealth.org>
Sent: Friday, September 25, 2015 3:12 PM
To: Public Input
Subject: Proposed changes to Medicaid/AHCCCS

I am deeply concerned about the impact that the proposed changes to AHCCCS would have on the patients whom I serve. I have worked for more than 13 years in the state of Arizona with people who are newly adjusting to life-changing disabilities, such as brain tumors, strokes, spinal cord injuries, and traumatic brain injuries. I also work with people recovering from significant illnesses, such as encephalitis, and people coping with chronic and unpredictable conditions such as multiple sclerosis. People are dealing with devastating situations, and AHCCCS is a lifeline in allowing people to receive at least some basic medical services, equipment, and rehabilitation therapies.

Specifically, I am very much against proposed changes to AHCCCS that would:

1. Limit participation to 5 years (lifetime).

- a. Many of the patients I see are reliant on AHCCCS for basic medical care (particularly if they have some disability that impacts their ability to work, but if they may or may not qualify for SSDI/Medicare).
- b. If a person meets criteria for the Arizona Long Term Care System (ALTCS), again, their needs are typically longer than just 5 years. ALTCS services such as in-home caregiving help save the state money by allowing people to stay in their homes.
- c. Where are people supposed to go after 5 years if they are unable to work or to find work that allows them to purchase their own health insurance or use employer insurance? This sounds like more people would just end up in the ERs again which is a very ineffective way to pay for health care services. We should support proactive health efforts. It costs a lot less to pay for PCP visits and hypertension medication than it does to pay for care needs following a stroke due to uncontrolled hypertension.

2. Require poor people to pay for a portion of their health care, when they are already struggling to have enough food on the table. They don't have the ability to pay for this service, or they would not need AHCCCS in the first place. I cannot follow the reasoning that AHCCCS members will be disenrolled if they cannot make AHCCCS CARE payments. How does that help people to follow through with health care behaviors and reduce drain on our ERs and preventable, costly health complications from postponing seeking medical attention or not being able to get needed medications?

3. Require recipients (including those with life-changing disabilities, it appears) to be looking for work. The people with whom I work are trying to maximize their health and reduce their level of dependence on family members for basic activities of daily living (dressing, bathing, etc.). Some of my patients are confused and require a family member to be with them 24/7 for their own safety. Going to work is not a reality for many of them. If they were to be able to progress toward readiness to return to work, it would help if AHCCCS were willing to pay for outpatient speech therapy services for cognitive rehabilitation (instead of just physical therapy) to help give them a fighting chance at being able to be progressing toward work re-entry.

4. Eliminate transportation to and from medical appointments. Many of our patients rely on transportation to go to and from medical appointments, including rehabilitation therapies and/or mental health appointments. If they had someone to give them a ride, reliable transportation, and/or money for gas and car maintenance, that would be one thing, but many people in desperate financial situations (AHCCCS eligible) do not. If they cannot get to their appointments, the state ends up paying more on the back end when they do not get necessary interventions to reduce risk of secondary complications.

I appreciate the opportunity for public comment on this proposal, and I hope you will take to heart how we can best serve our most vulnerable populations while still maintaining cost-effectiveness.

Sincerely,

Heather Caples, Ph.D.

Clinical Neuropsychologist

Department of Clinical Neuropsychology

Dignity Health

St. Joseph's Hospital and Medical Center

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Caution: This email is both proprietary and confidential, and not intended for transmission to or receipt by any unauthorized persons. If you believe that it has been received by you in error, do not read any attachments. Instead, kindly reply to the sender stating that you have received the message in error. Then destroy it and any attachments. Thank you.

September 24, 2015

Mr. Tom Betlach

Director, Arizona Health Care Cost Containment System (AHCCCS)

801 E. Jefferson St.

Phoenix, Arizona 85034

Dear Mr. Betlach:

Pima County Interfaith Council (PCIC) appreciates the opportunity to comment on the proposed AHCCCS waiver. Serving Pima County for over twenty-five years, we are a non-profit, non-partisan organization comprised of a broad range of faith communities and other non-profit organizations. PCIC brings low, middle and upper income communities together to develop partnerships in civic engagement and education based on the strengths of our faith and democratic traditions in order to build a more just society. Although our dues paying member organizations come from many different denominations and congregations and organizations, we share a commitment to building sustainable social and economic change that benefits the common good.

We have a long standing commitment to improving access, quality, affordability and cost effectiveness of our state's health care system. Thankfully, AHCCCS, Arizona's Medicaid program, is one of the best in the nation. We strongly supported and applaud the improvements in accessibility made possible by the expansion of Medicaid and the development of the marketplace for low income citizens in Arizona. We want to see the AHCCCS system build on its strengths and improve even more and it is in that spirit that we submit the following comments on the proposed waiver:

We enthusiastically support those elements of the waiver that that will improve members' health outcomes, streamline and integrate care, and reduce overall healthcare costs, as well as those that will continue to help AHCCCS deliver high quality healthcare to underserved populations, improve access to care, and help reduce health disparities in our communities.

We applaud the provisions for improved chronic disease management and coordination of care through the establishment of American Indian Medical homes and Delivery System Reform Incentive Payments (DSRIP) provisions. In fact, we would encourage additional Medical Home related provisions for other vulnerable populations that can benefit from care provided in accordance with Medical Home criteria, such as children with special health care needs (CSHCN), dually-eligible adults, the frail elderly, those with chronic illnesses and high-utilizers of services. Specifically, we support:

- The integration of behavioral health, primary care and acute medical services, including increased support for health information exchanges.

- Dealing with the extensive needs of high risk and vulnerable populations, including CSHCN, the dually-eligible disabled and elderly, chronically-ill and high utilizers of health care services.
- Improving the coordination of care across the spectrum of health care settings.
- Outcomes-driven incentives and the establishment of wellness targets.
- Any new partnerships and collaborations that will enable the improvement of general health in Arizona, including those that consider member needs more holistically and take into account their broader environment and challenges.

On the other hand, we are deeply concerned about other provisions that appear to lack any realistic understanding of the actual day to day lives of members and their families and the burdens that some of these proposed waiver provisions will impose on those daily lives. There are many potential unintended consequences which will act in direct contradiction to the stated goals and objectives of the waiver proposal and are likely to negate the positive benefit of the changes highlighted above for the affected individuals and their families. For these reasons, we strongly oppose the following proposed waiver provisions:

- **The five year limit and work requirements** - PCIC opposes any arbitrary time limits on AHCCCS (Medicaid) eligibility and the linkage of any work-related requirements to eligibility for Medicaid coverage. AHCCCS is not a work program, it is a vehicle for providing adequate health care services to Arizona's citizens who are unable to afford health coverage on their own. Able-bodied adult is not adequately defined, nor does it clearly include a number of critical exceptions. For example, it does not include those caring for a child with special health care needs or a disabled or chronically ill adult. Forcing a caregiver to work under these circumstances could lead to having to institutionalize their loved one or make much more costly alternative arrangements for in-home care. It does not specify step-parents who are caring for step-children under 6 years old. It does not include older adults who were displaced from employment during the recession and have since accessed their Social Security benefits due to a health condition. The definition of able-bodied adult does not cover those who are very sick or physically or mentally disabled, but not covered under existing disability criteria, nor does it cover the many people who we know are suffering from an as yet undiagnosed mental condition. This work requirement also significantly disadvantages those who have been convicted of a crime and are now unable to secure employment because they have been labeled as undesirable, despite paying for their crime and regardless of present good behavior.
- **The HSA-like requirements** - Clearly, this is one of the most wasteful, costly and impractical of the proposed provisions. We believe that HSA-like accounts will add a very complex and basically unworkable level of bureaucracy to the AHCCCS system that will benefit only the third party administrator who is contracted to administer the program. This program will add costly and complex administrative procedures that divert money away from supporting the direct delivery of healthcare services with no value-added benefit to either AHCCCS members or providers. It is a proposal that is not well-tailored to the AHCCCS population or anyone with limited means. Even where

HSA plans exist in the private sector, they are complex for consumers to manage without access to the advisory support and resources of company human resources and benefits managers, something not available to those covered by AHCCCS. The level of health literacy and financial literacy required to benefit from these HSA-like waiver provisions are beyond many in the middle class and clearly not a realistic solution for those who may not have the knowledge base to manage these accounts on their own or the money to spare from more pressing needs for food, shelter and other basic necessities. This is a total waste of taxpayer dollars and agency resources that could be put to much greater use.

- **Premiums and Co-payments** - We strongly oppose requiring the payment of premiums and excessive co-pays for AHCCCS members and the potential for very detrimental health consequences and debt burden for those who cannot make timely payments. Requiring this population to pay 5% of their incomes for premium and co-pays combined will have unintended negative consequences for the member and for every other family member, including children. It is shortsighted to view the impact of these proposals in a vacuum when they have consequences for the entire family. In order to comply with these provisions, money will be redirected to paying premiums and co-pays, and be unavailable for competing necessities like food, shelter and clothing. For the able bodied adult with limited resources, these payments will pose additional barriers to both health care access and upward mobility. Research shows that premiums and co-pays pose a barrier for low-income vulnerable populations, and may deter individuals from seeking healthcare in both emergent and non-emergent situations. The highly punitive measures for not paying (dis-enrolling those who can't or don't pay and putting members and their families deeper into debt) will work at cross-purposes to the positive goals of reducing uncompensated care and providing access to health coverage for those who cannot otherwise afford it, which the public has supported through the initiative process. If individuals are barred from AHCCCS, they may be at risk for tax penalties. They would not be eligible to purchase health insurance and receive financial assistance through the Health Insurance Marketplace which defeats the intent of both Medicaid expansion and the Affordable Care Act to improve access to healthcare.
- **Emergency Department Co-pays** - Emergency department use may be necessary in non-emergent situations if there are no alternatives to seek care, especially in rural settings. Individuals may not seek medical services until they believe it is an emergency since the cost is waived only if the patient is admitted or meets other requirements. This provision should be extensively modified and clarified. It does not realistically reflect the fact that many true emergencies may not result in a hospital admission, even though they are and should be treated as an emergency. Symptoms of a heart attack or stroke that is ruled out after evaluation and monitoring, or stabilization of a broken limb are examples of situations that should not be subject to a higher co-pay. It would be more effective to create programs that provide better proactive case management and care coordination for those who are clearly identified as "frequent flyers", then to impose these requirements in general on the entire population affected by the waiver.

- **Elimination of non-emergency transportation** - We strongly oppose the elimination of non-emergency transportation. Failure to provide this benefit is pennywise and pound foolish. Lack of transportation is a significant barrier to receiving healthcare in rural areas as well as within metropolitan city limits. Public transit services are not always accessible to all and cannot reach appointments for needed care without transportation support. The recent strike of Tucson's primary public transit system, Sun Tran, illustrates how crucial it is to have available transportation resources available. Medically necessary appointments, especially for those with chronic illnesses or ongoing treatment for serious conditions, are critical. These and other patients should have transportation support to all healthcare appointments, and not wait until they need to receive care at the emergency room. It is important to maintain non-emergency transportation to encourage continued care and positive health outcomes for AHCCCS Members.

Again, we recognize that we have an excellent Medicaid program in AHCCCS and very much want to see the program sustained and improved. PCIC appreciates the opportunity to support the many positive elements of proposed waiver that will enable the AHCCCS program to serve our most vulnerable citizens even better. We also appreciate the opportunity to comment on the concerns we have about the parts of this proposal which are likely to have a negative impact on the program and its recipients and may result in a number of unintended consequences.

Sincerely,

Judith Keagy and Health Team

Pima County Interfaith Council

3200 N. Los Altos

Tucson, AZ 85705



Stephen A. Purves
President & CEO

September 25, 2015

Director Tom Betlach
AHCCCS
801 E. Jefferson Street, MD 4100
Phoenix, AZ 85034

RE: SECTION 1115 WAIVER RENEWAL

Dear Director Betlach,

On behalf of the Maricopa Integrated Health System, we want to express our appreciation for the work the Governor's Office and AHCCCS Administration have put into developing the waiver proposal. We also want to thank you for the opportunity to offer our comments.

We have reviewed the comments put forth by the Arizona Health and Hospital Association and are in support of their position. There are two areas in the waiver request that we would like to single out for comment. These areas directly affect the future ability of MIHS to meet our publicly mandated and essential mission to serve all citizens of Maricopa County, regardless of their ability to pay.

Delivery System Reform Incentive Payments (DSRIP)

MIHS supports the Administration's intention to include a DSRIP program in the waiver. It is our understanding that the proposal is currently a "placeholder". MIHS understands that considerable work will need to be done to develop the structure of the program, such as identifying authorized projects, metrics, financing, and eligible providers/organizations. We look forward to collaborating with the Administration and other stakeholders in this process.

We support the initial direction the Administration has taken by utilizing findings from the State Health Improvement Plan and State Innovation Model grant to shape DSRIP priorities. Over the last two years, MIHS has identified projects to drive delivery system transformation that we believe would bring in considerable DSRIP federal funds to help transform the health care delivery system for the citizens of Maricopa County. We believe there is significant synergy between these projects and the goals of a DSRIP program, and we look forward to exploring opportunities for alignment via the stakeholder process outlined in the Waiver Narrative.

Safety Net Care Pool

MIHS was originally one of the driving forces behind the development and implementation of the Safety Net Care Pool (SNCP) as a mechanism for offsetting increases in our uncompensated care resulting from the freeze on Proposition 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" until the implementation of health care reform. Beginning in January 2014, more Arizonans

Director Betlach Letter re: Section 1115 Waiver Renewal

Page 2

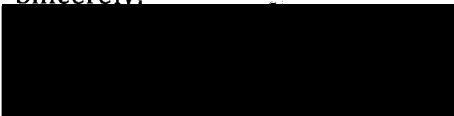
September 25, 2015

gained access to insurance coverage through the Marketplace and Medicaid expansion, and while uncompensated care was reduced for MIHS, it was not reduced to the level anticipated. Yet access to SNCP federal funds expired for MIHS and other safety net systems. As part of 2013 legislation to restore Proposition 204 and expand Medicaid, the Legislature reauthorized the SNCP program for only Phoenix Children's Hospital (PCH), and the waiver request includes a continuation of that SNCP, again only for PCH.

MIHS would request that the continuation of the SNCP program as proposed on pages 17 through 20 of the Waiver Narrative, be expanded to include MIHS, Arizona's only public safety net healthcare system and teaching hospital. MIHS could match these funds, which means there would be no impact to the state general fund to access these much needed federal dollars. Access to these funds will support MIHS in finding ways to offset the gap in funding that exists today in the Disproportionate Share Hospital (DSH) funds generated each year by MIHS which provides millions of dollars for the State general fund.

In closing, we would like to thank the Administration again for the efforts it has put into the waiver proposal. We look forward to continuing to work with you and Governor Ducey on the issues we have raised and are thankful for the opportunity to respond to the waiver proposal.

Sincerely,

A large black rectangular redaction box covering the signature area.

Stephen A. Purves
President & CEO



September 25, 2015

Director Thomas J. Betlach
AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034
publicinput@azahcccs.gov

Dear Director Betlach:

We appreciate the opportunity to provide public comment on Arizona's Medicaid Section 1115 Waiver Application submitted by the Arizona Health Care Cost Containment System (AHCCCS) for implementation October 2016.

The Arizona Council of Human Service Providers (Arizona Council) is an association of 84 member agencies that provide child welfare, behavioral health and juvenile justice services. Our members operate over 700 facilities and employ more than 17,000 people throughout the state of Arizona. The Arizona Council provides training, resources, research, policy analysis and advocacy, and opportunities to directly impact public policy on a local, state, and national level. Together we address gaps in services and funding, and work to improve access to quality behavioral health, substance abuse, child welfare, and juvenile justice services for individuals and families in Arizona.

Arizona Council representatives attended community forums and raised questions and concerns about the potential impact of Arizona's application for New Section 1115 Demonstration on access to care and communities. Arizona Council staff reached out to members, partners, providers, AHCCCS representatives and experts to obtain relevant information to assess the impact of the proposed AHCCCS CARE plan.

While we support Arizona's decision to expand Medicaid funding to provide coverage to newly eligible low-income adults, we urge AHCCCS and CMS to reconsider key elements of Arizona's request that include premiums, copays, enforcement of contribution requirements through disenrollment, work requirements, limit lifetime enrollment to five years and elimination of Non-Emergency Medical Transportation (NEMT). Some of these elements are inconsistent with the objectives of the Medicaid program and run counter to the overall goal of the Affordable Care Act to increase access to health care services for all. Other requirements may impose hardships on low income families and result in unintended consequences.

PART I: AHCCCS CARE: Choice, Accountability, Responsibility, Engagement

Bridge to Independence

It is important when evaluating requirements for copays and premiums to be paid by Medicaid recipients to keep in mind that the recipients have very low incomes. The Bridge to Independence program requires Medicaid recipients to pay copays (3%) and premiums (2%), not to exceed 5% of annual income. For very low income people this is a hardship.

Medicaid plays a key role in efforts to reduce the number of uninsured by expanding eligibility to nearly all low income adults with incomes at or below 133% FPL (\$15,654 per year for an individual in 2015). The chart below illustrates the cost of premiums at 2% of annual income and maximum copays at 3 % of annual income. For example, a family of four could be required to pay \$1,213 to \$1,613 per year for premiums and copays.

2015 Annual Income Guidelines Federal Poverty Level (FPL)								
100% of Federal Poverty Level					133% of Federal Poverty Level			
Persons in Family	Annual Income	Premiums @ 2% of Annual Income	Maximum Copays @ 3% of Annual Income	Premiums and Maximum Copays	Annual Income	Premiums @ 2% of Annual Income	Maximum Copays @ 3% of Annual Income	Premiums and Maximum Copays
1	\$11,770	\$235	\$353	\$588	\$15,654	\$313	\$470	\$783
2	\$15,930	\$319	\$478	\$797	\$21,186	\$424	\$636	\$1,060
3	\$20,090	\$402	\$603	\$1,005	\$26,719	\$534	\$802	\$1,336
4	\$24,250	\$485	\$728	\$1,213	\$32,252	\$645	\$968	\$1,613

<http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf>

It is important to note that many individuals and families on Medicaid have incomes less than 100% of federal poverty level, making paying premiums and copays an additional hardship. According to 2014 Census data recently released, approximately 9% of Americans are “deeply poor” with incomes less than half of the FPL—or under \$6,000 for an individual or \$12,000 for a family of four.¹

A recent article in the Arizona Capitol Times² stated “Arizona has one of the most regressive tax systems in the country.” Because Arizona governmental entities rely heavily on sales tax for almost 50% of their budgets, people with lower incomes are disproportionately affected because “they pay more of income in taxes on what they purchase”. According to the Institute on Taxation and Economic Policy³, high income families in Arizona pay 4.6 percent of their income on Arizona taxes (income, property, sales), while the poorest 20% of Arizonans pay 12.5% of their limited income. “Arizona’s

¹“An In-Depth Look at 2014 Census Data and Policy Solutions to Address Poverty”, CLASP, 2015

²“Arizona ranks in bottom fifth of states for tax fairness, report says”, Howard Fischer, Capitol Media Services, September 19, 2015

³“Low Tax for Whom? Arizona is a “Low Tax State” Overall, But Not for Families Living in Poverty”, Institute on Taxation and Economic Policy, September 2015

imbalanced tax system, with its heavy reliance on sales and excise taxes, is pushing the state's impoverished taxpayers deeper into poverty."⁴ Adding copayments and premiums for Medicaid will only add to their poverty.

Copays would be required for non-emergency use of emergency room, use of opioids with exceptions for cancer treatment or terminal illness, missed appointments, specialist care without referral from PCP, and use of brand name drugs when generics are available. While these are cost cutting measures, for some it will mean they will be unable to receive the level of care that they need. For instance, there are individuals with behavioral health conditions that require brand name medications, because the generics may not be as effective. People with chronic pain conditions, other than cancer or terminal illness, often find opioids to be the only treatment option that allows them to have any quality of life.

A February 2013 Kaiser Commission on Medicaid and the Uninsured report ⁵ reviews the impact of requiring premiums and copays on Medicaid recipients. They found:

- Premiums and fees are shown to be barriers to obtaining and maintaining health insurance coverage for low income individuals and families
- Copays can be a barrier to accessing care leading to adverse health outcomes

Strategic co-pays are not required for preventative and wellness services, chronic illness management, those with SMI diagnoses, and PCP and OB-GYN services. We suggest that outpatient services for all behavioral health services (General Mental Health and Substance Abuse as well as SMI services) be exempted from co-pays, if co-pays remain a part of the AHCCCS CARE plan.

AHCCCS CARE Account (HSA)

While the concept of the AHCCCS CARE Account seems reasonable, the implementation presents multiple concerns. Being able to have premium payment dollars available to the Medicaid member to pay for uncovered medical services is a good idea. However, in order to access these funds, the member must be in good standing, participating in the work program, and meeting Healthy Arizona targets. Our largest concern is the potential for disenrollment from Medicaid for six months for failure to make payments. Disruption in treatment for persons with behavioral health conditions most often leads to decompensation, resulting in the need for intensive outpatient or inpatient treatment. Without an insurance benefit, the cost of treatment and medication may well exceed what for low income individuals and families can pay on their own. Again, this puts very low income families into the untenable position of having to choose between healthcare and basic needs.

Additionally, it appears the plan is to have a third party administer the AHCCCS CARE funds. The cost of implementation of the program is unknown. Funds paid to a third part administrator are funds that cannot be used to provide health care to vulnerable Arizona families. In the past when providers had to collect co-payments, the administrative costs exceeded what was collected.

AHCCCS Works

Under the AHCCCS Works and legislative proposals, all able bodied individuals must be employed, seeking employment, or attending school or job training program to remain

⁴ "Low Tax for Whom? Arizona is a "Low Tax State" Overall, But Not for Families Living in Poverty", Institute on Taxation and Economic Policy, September 2015

⁵ "Premiums and Cost Sharing in Medicaid: A Review of Research Findings", The Kaiser Commission on Medicaid and the Uninsured, February 2013

eligible for Medicaid. This proposal fails to take into consideration several realities for families eligible for Medicaid. For instance, research indicates that nationally the majority of those eligible for Medicaid are already employed. They are often working full time at minimum wage jobs that do not offer health insurance coverage. Others on AHCCCS are primary caretakers for family members.

Lack of transportation options and access to affordable child care further restrict low income families' ability to seek work and retain employment. In 2009, Arizona cut eligibility for child care subsidies for low income families, eliminating a critical piece of the social safety net.

The behavioral health population includes many people with disabling conditions that are permanent or episodic. Persons with Serious Mental Illness (SMI) are exempt from the work requirements, but those with General Mental Health and Substance Abuse (GMH/SA) conditions are not. A substantial percentage of the behavioral health population is in the GMH/SA category. People with GMH/SA conditions may be very ill and need intensive treatment to be able to function. Sixty six (66) percent of the 20,000 monthly calls to the crisis system in Maricopa County are from the GMH/SA population, as are fifty-five (55) percent of mobile team calls. Fifty (50) percent of those brought by police and crisis teams to the Urgent Psychiatric Center in downtown Phoenix are in the GMH/SA category. Imposing a work requirement on this population may not be realistic because of the intensity of their illness and treatment needs. **An exception to the work requirement for those with behavioral health concerns needs to be clearly articulated.**

PART II: The Legislative Partnership

SB1092 and the Legislative Package requires all "able bodied" adults to be employed with exemptions for high school students up to age 19, sole caregivers of children under 6 years of age, those on short or long term disability, and those determined to be physically or mentally unfit for employment by a health care professional. Clearly, employment should be a goal for all Arizonans able to work. Unfortunately, the economic recovery has not created living wage employment opportunities.

Many of those eligible for Medicaid are working at low wage jobs. According to the Kaiser Commission on Medicaid and the Uninsured, February 2015 Fact Sheet⁶, most uninsured and Medicaid eligible adults are already working or living in a family with a worker. Seventy-two percent live in a family with a full or part time worker and 57% are working themselves. The majority of employees in this group work for small employers who are not required to provide health insurance coverage under the ACA. Of those not working, almost a third were family caretakers, 20% were students, 17% were ill or disabled, and 10% were retired. Only 20% of those unemployed were looking for work. In 2008, prior to the ACA Expansion, approximately 40% of those on AHCCCS were employed.

For the reasons described above, there needs to be exemptions to the work requirements in the legislative proposal. The "medically frail" exemption to able bodied employment requirements needs to be broad enough to include people with behavioral health conditions that make it difficult to participate in sustained employment. Some behavioral health clients do participate in the Freedom to Work program, which provides opportunities for restoration of disability benefits if the person's health declines.

⁶ "Are Uninsured Adults Who Could Gain Medicaid Coverage Working", The Kaiser Commission on Medicaid and the Uninsured, February 2015

There is an additional requirement for a five year lifetime cap on Medicaid benefits. This requirement flies in the face of national health care policy which wisely sees the social and economic benefit of available preventative and affordable access to medical care for everyone. Individuals and families with incomes below 133% FPL, whose employers do not offer health coverage, have no other option for health insurance other than AHCCCS because they are not eligible for Marketplace plans or subsidies. In essence then, the five year lifetime cap will create a group of uninsured and uninsurable individuals and families.

Interruptions in services to the SMI population have long term consequences. After the reduction in benefits to the SMI population during the recession, providers found it very difficult to re-engage the clients. Unfortunately, despite outreach efforts, many were not re-engaged and re-enrolled into AHCCCS until they were in a crisis center or an inpatient facility.

Elimination of Non-Emergency Medical Transportation (NEMT)

Health insurance coverage alone does not guarantee access to healthcare services. Waiving the NEMT benefit could prevent Medicaid beneficiaries from accessing the primary, specialty, and preventive services that enable them to identify and address their health needs as they arise and preventing more costly care as undiagnosed medical problems worsen.⁷

Studies have identified transportation as a barrier for low-income individuals in accessing timely, necessary and continuing medical care. Many low-income patients do not have automobiles and cannot afford public transportation. The availability of medical transportation ensures access to physicians' offices and outpatient facilities to receive routine and preventive care, as well as care for chronic conditions, such as dialysis and cancer treatment. Additionally, persons with disabilities may have special transportation needs and barriers that require specialized vehicles and additional safety measures.

- Missing preventive care or prescribed medication can lead to more costly, resource intensive care and hospitalization. Many studies have documented the impact of poor transportation on lower use of preventive and primary care and increased use of emergency department services. The provision of and access to transportation increases the likelihood of primary care physician visits in the pediatric population, HIV--positive adults, and frequent emergency room users.⁸
- Treatment for behavioral health issues helps patients be productive members of society, maintain employment and take care of themselves and their family members. Transportation is integral to treatment of behavioral health issues. Lack of transportation is a particular problem for beneficiaries with mental illness, whose illness may impede their willingness or ability to be compliant with their treatment plan and unable to find transportation on their own.⁹

⁷ Medicaid Expansion and Premium Assistance: The Importance of Non-Emergency Medical Transportation (NEMT) to Coordinated Care for Chronically Ill Patients by MJS & Company, March 2014 (<http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTreportfinal.pdf>)

⁸ Kim, Norton, E, Stearns, S, "Transportation Brokerage Services and Medicaid Beneficiaries" Access to Care," Health Services Research, 44:1, February 2009.

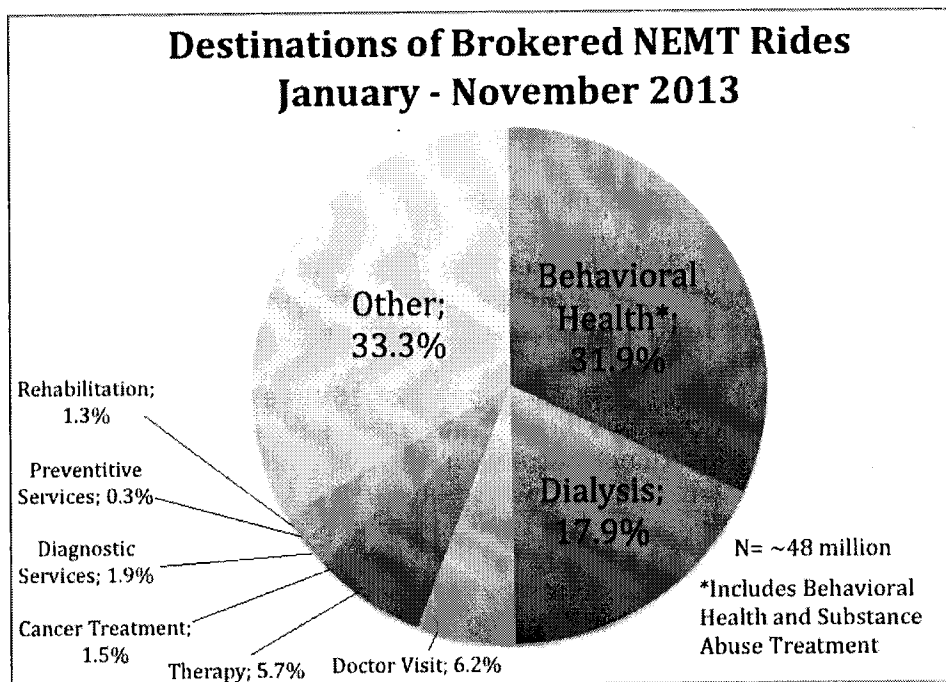
⁹ Medicaid Expansion and Premium Assistance: The Importance of Non-Emergency Medical Transportation (NEMT) to Coordinated Care for Chronically Ill Patients by MJS & Company, March 2014 (<http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTreportfinal.pdf>)

NEMT plays an important role in ensuring Medicaid beneficiaries' access to medically necessary and preventive care.

Data collected from other states corroborate the importance of the NEMT benefit in ensuring Medicaid beneficiaries' access to medically necessary and preventive care and key findings are highlighted in articles by the National Conference of State Legislatures and MJS & Company with a forward by the Community Transportation Association of America. If comparable Arizona data were available (from AHCCCS) on NEMT, we are confident Arizona would be comparable to other states. Key findings include:

- Approximately 3.6 million Americans miss or delay medical care because they lack appropriate transportation to their appointments. Many low-income Americans lack the disposable income necessary to have access to a working automobile, and may lack public transit options to get to and from medical appointments. Medicaid provides a nonemergency medical transportation benefit that pays for the least costly and appropriate way of getting people to their appointments whether by taxi, van, public transit, or mileage reimbursement.¹⁰
- According to data collected by the Community Transportation Association of America from a transportation broker that administered the NEMT benefit in 39 states for the period between January and November 2013, half of all NEMT trips were provided to access dialysis treatment (17.9 percent) or behavioral health services (31.9 percent). See chart below. The most rides were for individuals with chronic illness for whom the lack of treatment would be life threatening or would result in need for a higher level of care or institutionalization in the criminal justice system or psychiatric hospital.

¹⁰ Non-Emergency Medical Transportation: A Vital Lifeline For A Healthy Community, National Conference of State Legislatures, Amelia Myers (<http://www.ncsl.org/research/transportation/non-emergency-medical-transportation-a-vital-lifeline-for-a-healthy-community.aspx>)



- As the chart above illustrates, the majority of current NEMT services are for regularly scheduled, non-emergency medical trips for individuals requiring additional assistance with transportation to coordinated care for behavioral health services, substance abuse treatment and dialysis services. Thus, the majority of NEMT rides are more than a transportation subsidy to low-income patients. Most Medicaid subsidized rides transport chronically ill beneficiaries requiring a more robust, specialized transportation benefit to more intensive and recurring treatments and services. The dominance of the chronically ill as users of the NEMT benefit underscores the danger of eliminating the NEMT benefit. More than 75% of health care costs are due to chronic conditions and therefore account for a growing share of Medicaid costs. The NEMT benefit is a key element of a coordinated care plan and if eliminated, could prevent the implementation of new strategies to coordinate care for the highest cost beneficiaries.¹¹
- The "Other" category in the chart above represents destinations such as: adult day care, federally qualified health centers, outpatient surgery facilities, pharmacies, or smoking cessation services. It also includes transportation to specialists such as gastroenterologists, dermatologists, neurologists, obstetricians and gynecologists, orthopedists, pulmonologists, or urologists. In most cases, NEMT rides to these facilities and providers are provided in standard vehicles or through the use of public transportation.¹²

A NEMT benefit would ensure members receive the preventive care needed to avoid unnecessary and more costly treatment.

¹¹ Medicaid Expansion and Premium Assistance: The Importance of Non-Emergency Medical Transportation (NEMT) to Coordinated Care for Chronically Ill Patients by MJS & Company with a forward from the Community Transportation Association of America, March 2014. (<http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTreportfinal.pdf>)

¹² Medicaid Expansion and Premium Assistance: The Importance of Non-Emergency Medical Transportation (NEMT) to Coordinated Care for Chronically Ill Patients by MJS & Company with a forward from the Community Transportation Association of America, March 2014. (<http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTreportfinal.pdf>)

- Eliminating NEMT will increase transportation barriers to life sustaining services for chronic illness. Despite having health insurance, Medicaid beneficiaries will have poor health outcomes, increased hospitalization, or preventable deaths if they are unable to access care. Additionally, lack of a NEMT benefit will likely increase Medicaid spending through overuse of expensive ambulance services and need for higher levels of care.
- Providing a NEMT benefit to Medicaid beneficiaries would reduce unnecessary visits to the emergency department and overutilization of ambulance services. When Medicaid beneficiaries need transportation to medical care, without an NEMT benefit they are likely to call an ambulance that is only permitted to transport them to the emergency department, where they will receive care at almost 15 times the cost of routine treatment. A study conducted by Florida State University concluded that if only one percent of the medical trips funded resulted in the avoidance of an emergency room hospital visit, the payback to the state would be 1,108%, or about \$11.08 for each dollar the State invested in its medical transportation program.¹³
- Community Health Centers are required by federal statutes and regulations to provide transportation services to enable patients to access health center services when transportation would otherwise be a barrier to care (e.g. providing transport vans, bus tokens or vouchers for public transportation, or linkages to other community transportation programs).¹⁴
- NEMT is especially important for individuals receiving behavioral health services. According to a 2015 Service Capacity Assessment of Priority Mental Health Services conducted for the Arizona Department of Health Services, Division of Behavioral Health Services a lack of transportation was identified as one of three common factors that negatively impact accessing peer and family support services.¹⁵ These critical support services have proven to increase positive outcomes for treatment.

Eliminating NEMT for the Expansion Population will decrease the capacity of in a critical statewide specialized transportation infrastructure and increase the cost per ride.

The Arizona Medical Transportation Association (AMTA) is made up of 10 large and medium-size providers serving Maricopa and Pima Counties. The members solely provide medical transportation for AHCCCS, Insurance Companies, and other payers. A few companies have additional contracts with Dial a Ride. Rural areas are primarily served by small providers (often with 1 vehicle). None of the small providers belong to the association.

According to the AMTA "Evidence shows best outcome and cost of care result from adequate, reliable transportation."

The number of individuals who would be impacted by the elimination of the NEMT benefit is not clear. According to the AHCCCS Draft Waiver Demonstration Program Proposal

¹³ Florida Transportation Disadvantaged Programs Return On Investment Study Prepared By The Marketing Institute/Florida State University's College of Business –Dr.J. Joseph Cronin, Jr.

¹⁴ Arizona Alliance of Community Health Centers, Statute Reference- Section 330 (b)(1)(A) and Regulation Reference -42 CFR,Part51c.102(h). (<http://www.aachc.org/>)

¹⁵ Service Capacity Assessment, Priority Mental Health Services, 2015, Arizona Department of Health Services, Division of Behavioral Health Services., Mercer.

approximately 570,883 individuals would be impacted by the AHCCCS CARE Program including: ¹⁶

Newly Eligible Adults	62,763
Prop 204 Restoration	251,987
TANF Adult Parents	256,133
<hr/>	
Subtotal	570,883 (represents 34% of 1.7 million AHCCCS members)

No exceptions for individuals who are medically frail, pregnant or disabled are addressed in the Section 1115 Waiver Application or legislation requiring AHCCCS to seek the Waiver for NEMT (SB 1475). If the entire population between 100 – 133%FPL is effected by the elimination of NEMT, then persons with SMI in this category will lose their transportation benefit.

Experience of Other States with Waiver Approvals for NEMT is Not Yet Known or Understood.

Iowa and Indiana received waiver approvals to eliminate Non-Emergency Medical Transportation (NEMT) as a benefit to the population (between 100-133% of the FPL) for one year, pending evaluations of access to care. The impact of the elimination of the NEMT benefit on access to care in these states is not yet known or understood.

- Unlike Arizona’s proposal, Iowa continues to provide NEMT to beneficiaries who are medically frail and those under age 21.¹⁷ Similarly, Indiana’s plan waives non-emergency medical transportation (NEMT) for newly eligible adults, except pregnant women and those who are medically frail.¹⁸ Each state defines medical frailty, but federal regulations require that the definition include at least certain groups of children, individuals with disabling mental disorders, individuals with serious and complex conditions, and individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living.¹⁹
- In addition to defining “medically frail” within basic federal guidelines, States must have a process to evaluate individuals to determine whether they meet established criteria which could be cumbersome and discourage or delay participation. For example, Indiana Medicaid has an extensive list of 30 conditions covering medical, mental health and activities of daily living that may qualify someone as medically frail.²⁰

Arizona Lacks Feasible Alternative Transportation Options for Low Income Arizonans to replace NEMT

¹⁶ AHCCCS, Arizona’s Application for a New Section 1115 Demonstration, Section I-Program Template, August 18, 2015, p. 3.(<https://www.azahcccs.gov/shared/Downloads/WaiverTemplateDRAFT8-18-15.pdf>).

¹⁷ ¹⁷ Medicaid Expansion in Iowa, The Henry J. Kaiser Foundation, p.2.(<http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-iowa>)

¹⁸ ¹⁸ Medicaid Expansion in Indiana, The Henry J. Kaiser Family Foundation, p.2. February 3, 2015 (<http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/>)

¹⁹ 42 CFR 440 § 440.315

²⁰ Healthy Indiana Plan, (<http://www.in.gov/fssa/hip/2465.htm>)

The focus of the 2015 Arizona Town Hall was Transportation and Arizona.²¹ Key findings and recommendations include:

- There are two types of public transportation: (1) scheduled, fixed-route service by bus, van, light rail, and streetcar (mass transit) and (2) paratransit provided in response to specific requests for service. Arizona's public transit operates in suburban and rural areas as well as urban areas. Arizona's larger Transit Agencies (more than 2 million boardings per year) are located in Phoenix, Tempe and Tucson.²² It is mostly local or metropolitan, with minimal long-distance service. Across Arizona, regional authorities operate transit, coordinating public transit service among several municipalities or within single cities or towns. More than 60 transit systems operate in Arizona including 18 federally funded rural systems).²³
- Public transit ridership in Arizona has grown significantly over the past decade because of population growth and demographics, rising gasoline prices, expansion of transit services, and perhaps a change in cultural attitudes. Nevertheless, in Phoenix, only 2.4% of the total commuting trips rely on mass transit. In Tucson, the percentage is about the same. In rural areas (less than 50,000 people), local and regional transit systems reported 1.48 million bus boardings and 1.7 million paratransit boardings in 2013.
- The largest group of public transit users have a lower income and often cannot travel by automobile. The majority of public transit users in Tucson (65%) and Phoenix (61%) are low income (earning \$30,000 or less per year), while 47% of passengers in Phoenix and 46% of passengers in Tucson have no working vehicle in their household.²⁴
- Low-income families face a variety of challenges related to the costs and convenience tradeoffs of different forms of mobility. While relying solely on public transit and forgoing automobile ownership can save households money, the level of service provided by transit in most places is simply not adequate for many poorer Arizonans.
- Rural communities face many transportation challenges. Because of the generally longer distances between origins and destinations, non-motorized transportation is often not an option except within towns. Due to lower population densities, public transit services are expensive, and therefore, infrequent in most areas or lacking altogether. Rural households tend to be more car-dependent as a result, but have lower incomes on average, making car ownership less affordable. Rural residents also have to drive

²¹ Transportation and Arizona 106th Arizona Town Hall, April ,2015, Tucson, (<http://www.aztownhall.org/Resources/Documents/106%20background%20report%20web%20final.pdf>)

²² Arizona Public Transit Association, (<http://www.apta.com/resources/links/unitedstates/Pages/ArizonaTransitLinks.aspx>), including 18 federally funded rural systems)

²³ ADOT (2011). "What Moves You Arizona: Long-Range Transportation Plan, 2010-2035." azdot.gov/docs/default-source/planning/lrtp-2011-1129.pdf?sfvrsn=2.

²⁴ Beimborn, E. and R. Puentes (2003). "Highways and Transit: Leveling the Playing Field in Federal Transportation Policy."

Washington, DC: Brookings Institution.

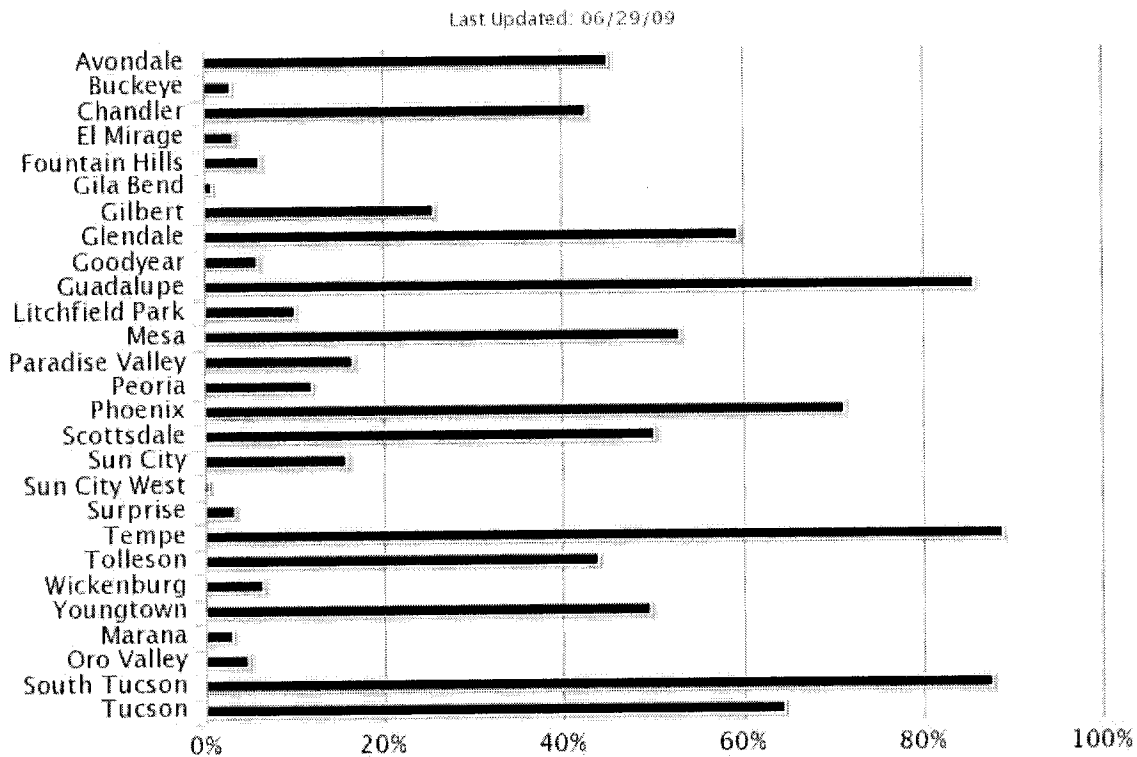
www.brookings.edu/research/reports/2003/12/metropolitanpolicy-beimborn.

Charles River Associates (1997). "Building Transit Ridership: An Exploration of Transit's Market Share and the Public Policies that Influence It." Transportation Research Board: Transit Cooperative Research Program, Report 27. onlinepubs.trb.org/onlinepubs/tcrp/tcrp_rpt_27.pdf.

farther to get to schools, shopping, and services, some of which are only available in larger cities and towns. Compared to just 8,400 miles for urban Arizonans, rural Vehicle Miles Traveled (VMT) per capita averaged more than 13,100 miles per year.²⁵

- Proximity to public transit stops is one of the factors that determines the likelihood of a person using public transit. Bus Service is provided by Valley Metro in the Phoenix metropolitan region and by Sun Tran in the Tucson area. METRO light rail, which runs through Phoenix, Tempe and Mesa in the Phoenix metro area, and city circulator buses expand the range of the bus system. Coverage is present on many of the two regions' arterial streets, but the area or population likely to be served by that stop is within a 10-minute walk—defined here as one-quarter mile. These data show the percentage of people in various cities living within walking distance to a bus stop. Light rail and circulator bus stops were also considered in the analysis of the Phoenix metro area, although not in the Tucson area due to the lack of necessary data.²⁶

Percent of Population within Walking Distance to a Public Transit Stop



Source: Valley Metro (Phoenix); Sun Tran (Pima County)

PART III: DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP)

The Arizona Council has been a leader, with other provider organizations, in a provider led initiative on behavioral health payment reform. The providers have worked with AHCCCS to educate and prepare providers for value based purchasing. Many of the members of the

²⁵ Federal Highways Administration. Traffic Volume Trends. www.fhwa.dot.gov/ohim/tvtw/tvtpage.cfm. US Census Bureau, Population Estimates. www.census.gov/popest/estimates.php.

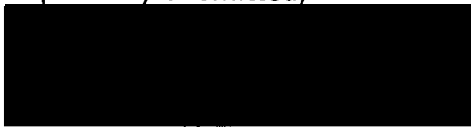
²⁶ Arizona Indicators, <http://arizonaindicators.org/transportation/public-transit-opportunities>

Arizona Council have implemented integrated physical and behavioral health services. The providers stand ready to collaborate with AHCCCS on DSRIP initiatives.

In Closing

The members of the Arizona Council look forward to working with Governor Ducey and the AHCCCS Administration to continue to seek ways to achieve the Triple Aim of improving individual outcomes from treatment, improving the health of the populations we serve, and reducing the per capita cost of health care. We believe that the administration and the provider community have the commitment to achieve this aim without the need to eliminate key services and impose requirements that may, in the long, defeat the achievement of the goal.

Respectfully submitted,



Emily L. Jenkins
President/CEO
2100 N. Central, Suite 225
Phoenix, AZ 85004
ejenkins@azcouncil.com



September 24, 2015

Thomas J. Betlach
Director, Arizona Health Care Cost Containment System
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Director Betlach:

On behalf of the Arizona Chamber of Commerce and Industry, I appreciate the opportunity to comment on Governor Ducey's thoughtful and innovative proposal to modernize Arizona's Medicaid waiver.

A robust healthcare sector is a vital part of any healthy economy. Employers want to do business in a state where employees have access to world-class care, and the healthcare industry creates high-skilled, high-wage jobs that cannot be outsourced. Arizona currently benefits from a strong healthcare industry, of which our Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), is a critical component.

In order to modernize the AHCCCS program and continue to move our economy forward, the Arizona Chamber of Commerce and Industry supports a waiver that is patient-centered, expands access to appropriate care, and drives down the cost of care in the state. We support the components of the AHCCCS CARE proposal that advance these principles.

A. Patient-centered

Arizona's Medicaid program should offer opportunities for patients to have a stake in both the cost and the outcomes of their care. The AHCCCS CARE proposal achieves this by creating a "CARE account" for able-bodied adults in the AHCCCS system. We support this proposal to incentivize healthy behaviors and empower patients to make decisions about their care.

We especially support the use of CARE accounts, which help participants transition successfully to the private market, and eliminate incentives to stay on a public benefit.

B. Expands access to appropriate care

The AHCCCS CARE proposal allows and encourages patients to access the most appropriate care for their individual needs. By incentivizing patients through strategic copays to manage their healthcare needs at the primary and preventative care level, AHCCCS CARE expands participants' access to appropriate care

We support the AHCCSS CARE proposal's option to allow patients to use CARE accounts to access other approved, non-covered services to further empower patients to access the care they need.

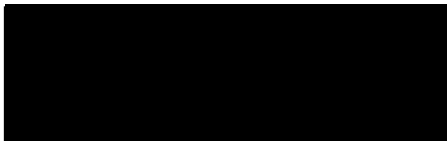
C. Drives down healthcare costs

The principles of accessing appropriate care and driving down healthcare costs are closely related. By empowering participants to access primary and preventative care, fewer people will rely on more costly emergency rooms visits as their primary healthcare provider. This reduces the impact of cost shifting and helps to reduce rates for employers and their employees with private health insurance.

We support the provisions of the AHCCSS CARE proposal that further drive down healthcare costs to the system by incentivizing healthy behaviors. The flexibility provided to health plans to set 50 percent of the health indicator benchmarks that predicate eligibility for the AHCCSS CARE program represents the kind of innovative public-private partnership that can seriously move the needle with respect to healthcare costs.

We appreciate the opportunity to comment, and look forward to working with you to implement the waiver program once it is final.

Sincerely,



Glenn Hamer
President and CEO



Pima County Enrollment Coalition
Certified Navigators
Certified Application Counselors
Community Health Providers
Community Volunteers and Advocates

Mr. Tom Betlach
Director
AHCCCS
801 E Jefferson St MD 4100
Phoenix, AZ 85034

September 25, 2015

Dear Director Betlach:

On behalf of the Pima County Enrollment Coalition, we are writing in response to Arizona's Section 1115 Waiver proposal. As a community coalition forged to improve access to medical services for Pima County residents, we support the changes to AHCCCS that will improve members' health outcomes, streamline and integrate care, and reduce overall healthcare costs. The Coalition recommends that CMS give careful consideration to both the intended and unintended consequences of the proposed Arizona's Section 1115 Waiver. We support a Waiver that will continue to help AHCCCS deliver high quality healthcare to underserved populations, improve access to care, and help reduce health disparities in our communities.

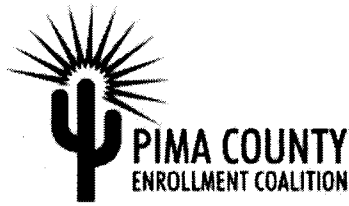
Overall, we believe the proposed cost sharing, lifetime limits, elimination of non-emergency transportation, and work requirement provisions related to AHCCCS Cares and AHCCCS Works to be barriers to care that will result in poorer health outcomes and increases in the number of uninsured. Furthermore, the Coalition questions the prudence of adding potentially costly and complex administrative procedures that risk diverting money away from the delivery of direct health services and provides little value added benefits to AHCCCS members and providers. We are concerned about the establishment and added burden of managing consumer payables, withdrawals, and debts to the state that may lead to high administrative costs and additional workload for several state departments that are already working with limited staffing. . As a community coalition comprised of community partners and stakeholders who routinely have high levels of interaction with AHCCCS members and their families, we propose the following recommendations to the 1115 Waiver proposal currently under consideration.

Life time limits

We strongly oppose setting lifetime limits, as this severely undermines the intent of Medicaid and the Affordable Care Act to improve access to healthcare. A lifetime limit will increase the rate of the uninsured, increase the rate of uncompensated care and result in poorer health outcomes. The health of the community will suffer.

Premiums and Co-payments

We strongly oppose requiring the payment of premiums for AHCCCS members. This may result in severe healthcare suspension consequences and debt accruals for those who cannot make timely payments. Finances for those in highly vulnerable situations will be redirected to paying required premiums and co-pays, and be unavailable for competing necessities like food, shelter and clothing. For the able bodied adult with limited resources, these payments will pose additional barriers to both health care access and



Pima County Enrollment Coalition

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upward mobility. Additionally, co-payments pose a barrier for low-income vulnerable populations, and may deter individuals from seeking healthcare in both emergent and non-emergent situations which may result in more people becoming more acutely ill and requiring greater and more expensive medical intervention. Emergency department use may be necessary in non-emergent situations if there are no alternatives to seek care, especially in rural settings. Individuals may choose to not seek medical services until they believe it is an emergency since the cost is waived only if the patient is admitted or meets other requirements.

HSA-like accounts

We strongly oppose the proposed AHCCCS Cares Account, which has been characterized as an “HSA-like” account. The proposed AHCCCS Cares Account seems to have few of the benefits of a true Health Savings Accounts (HSA) such as tax advantages and coverage of expenses such as copayments. Instead, the AHCCCS Cares account is limited to a list of non-covered services.

It is the Enrollment Coalition’s experience that there is low health and financial literacy levels among the AHCCCS population that may make navigating the proposed changes difficult. Many of our Coalition members have worked with Pima County residents to improve health literacy and while we have seen gains, there is significant work to be done. We believe that HSA-like accounts pose an unnecessary layer of bureaucracy and will be difficult for AHCCCS member to understand and manage on their own. Even in the private sector, consumers find the management of the HSA-like accounts requires a high level of financial literacy, time management, and access to adequate advisory resources.

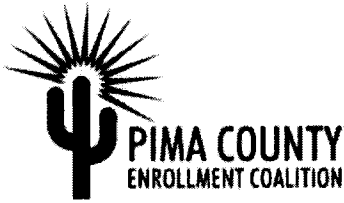
If, however, HSA-like accounts are implemented, we recommend that individuals should be able to withdraw funds from their accounts to be reimbursed for co-pays, similar to a conventional HSA account. It is a pity that funds set aside for healthcare expenses cannot be used to purchase necessary health services, and members must instead default into debt to the state, forgo receiving health services, or lose coverage altogether. We also recommend that access to these accounts not be limited by work requirements and payment of premiums.

Work requirements and definition of able-bodied adult

We strongly recommend a reasonable and flexible work requirement. Exemption from the work requirement should be extended to several sub groups of individuals who would fit the definition of “able-bodied adults.” Primary caregivers and family members caring for disabled individuals older than five years of age or a special needs child should not be expected to abandon their responsibilities to comply with a state imposed work requirement. Formerly incarcerated individuals reentering society often have difficulty obtaining employment and may need extra time to comply with a state imposed work requirement. Individuals with undiagnosed physical or mental impairments may also have difficulty complying with a state imposed work requirement. Finally, individuals cannot be expected to find work if jobs are not available.

Elimination of non-emergency transportation

We strongly oppose the elimination of non-emergency transportation and the narrow view of appropriate and medically necessary use of emergency department services. In our experience,



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transportation is a significant barrier to receiving healthcare, even within metropolitan city limits. Public transit services are not always accessible to all and many are unable to reach appointments for needed care without transportation support. Tucson's public transit system recently ended a 42 day strike, one which left many low income residents unable to get to work or medical appointments. The recent strike is an example of circumstances that cannot be planned for and for which there are few alternatives. Medically necessary appointments, especially for those on dialysis or undergoing chemotherapy, are critical. To support the Delivery System Reform Incentive Payments, maintain non-emergency transportation to encourage continued care and positive health outcomes for AHCCCS Members.

Delivery System Reform Incentive Payments (DSRIP) and American Indian Medical Homes

We applaud the provisions for improved chronic disease management and coordination of care through the establishment of American Indian Medical homes and Delivery System Reform Incentive Payments. We also support outcomes-driven incentives and the establishment wellness targets.

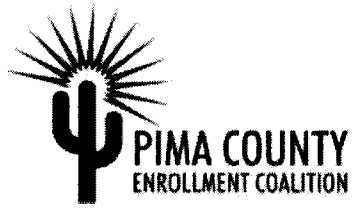
Please clarify the consequences of untimely payments on premiums and co-payments. Official documents have cited the consequence as a **suspension of services for a 6 month period** or suspension until premium payments are made. If individuals are barred from AHCCCS, they may be at risk for tax penalty under the Affordable Care Act. They also may be ineligible to purchase health insurance and receive financial assistance through the Health Insurance Marketplace which seems to defeat the intent the Affordable Care Act to improve access to healthcare.

We thank you for the opportunity to share our insights on Arizona's Section 1115 Waiver proposal. We applaud the innovative efforts to continue the legacy of high quality healthcare, improved access, and fiscal responsibility to Arizona's Medicaid program.

Sincerely,

The Pima County Enrollment Coalition

Arizona PIRG
CODAC Behavioral Health Services
COPE Community Services
El Rio Community Health Center
HOPE
Marana Health Center
Mariposa Community Health Center
Northwest Medical Center
Pima Community Access Program
Pima County Community Services
Pima County Health Department
Planned Parenthood
St. Elizabeth's Health Center
United Way of Tucson and Southern Arizona
Wellness Connections
Yumi Wong
Mary Wong



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Community Health Providers
Community Volunteers and Advocates

Edward Wong
Gabriela Acuna
Carol Montgomery
Charmayne Ortega
Laura Morgan
Susan Yager
Penny North
Hope Busto-Keyes, APRN
Sylvia Brown

Vinyard, Christopher

From: Karl L. Sachs, Psy.D. <karlsachspysyd@aol.com>
Sent: Friday, September 25, 2015 3:39 PM
To: Public Input
Subject: the changes are "pound wise and penny foolish"

Follow Up Flag: Follow up
Flag Status: Completed

As I understand these changes, there might be a savings initially (and I'm not sure about that), but down the road there will be loss from visits to emergency rooms, lost productivity of family members of disabled folks picking up the slack and etc.

Please reconsider.

Karl L. Sachs, Psy.D.
5210 E. Pima Street - 105A
Tucson, Arizona 85712
Tel (520) 869-4166

Regarding the Use of Email -- Although I use a firewall and my computer is password protected, my emails are not encrypted. Therefore, I cannot guarantee confidentiality of email communication. If you choose to communicate confidential information with me via email, I will assume that you have made an informed decision and I will view it as your agreement to take the risk that email may be intercepted. Please be aware that email is never an appropriate vehicle for emergency communication. This message is private and confidential communication intended for the addressee only. If you are not the intended recipient of this message, please do not disclose, copy, distribute, share or take any other action with this communication, other than to notify the sender of the error and delete this message from your records. **WARNING:** the unauthorized interception or retrieval of e-mail may be a criminal violation of the Electronic Communications Privacy Act, 18 USC 2510-2521. Thank you for respecting privacy and observing the law.



Mr. Tom Betlach
Director
AHCCCS
801 E. Jefferson St. MD 4100
Phoenix, AZ 85034

September 25, 2015

Dear Director Betlach,

The Arizona Family Health Partnership (AFHP) competes for and has been awarded since 1983 the largest of three Title X grants in Arizona. As a non-profit entity that provides, promotes and protects access to comprehensive quality reproductive healthcare services and education for all Arizonans, regardless of income, through its support and monitoring of regional healthcare providers we are specifically concerned about the safety net in Arizona. Often times Title X health centers are the only source of health care for people living at or below the Federal Poverty Limit and it is these clients that will be most affected by the more dramatic proposed changes.

Thank you for the opportunity to comment on the proposed Medicaid waiver. While we support many aspects of AHCCCS's waiver request, we also have areas of concern. AFHP's specific concerns regarding certain proposed changes to the AHCCCS 1115 waiver being put forth are listed below.

Proposed Changes

Require Member Contributions/Copays of up to 3% of Annual Income and 2% for Premiums – The requirement of copays and premiums by members below or close to the Federal Poverty Level will result in members' delaying care until they are in an emergency situation, thereby increasing costs and reducing timely and effective access to care.

Penalties for Failing to Make Copayments and Premium Payments – The proposed disenrollment provision that requires members be locked out of AHCCCS for 6 months upon failure to make timely copayments or premium payments will further reduce access to care.

Five year Lifetime Limit Imposed on Able-Bodied Adults - The arbitrary eligibility time limit of 5 years does not take into consideration long-term employment or health circumstances.

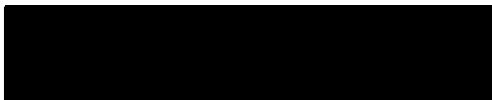
Eliminate non-emergency transportation – Transportation is a major barrier to AHCCCS member care. Patients will not access care without available transportation.

Work requirements – While working or seeking work is an admirable goal, Arizona's economic recovery specifically in the area of job growth lags behind much of the USA.

Page 2

We welcome any opportunity to collaborate with you on many of the other proposed and positive changes being submitted for approval.

Sincerely,



Brenda L. "Bré" Thomas, CEO

Vinyard, Christopher

From: dennis grimm <drgcastaway@live.com>
Sent: Friday, September 25, 2015 4:14 PM
To: Public Input
Subject: request for waiver for ahcccs

Follow Up Flag: Follow up
Flag Status: Completed

Please deny the Govs request for a waiver as if approved it will harm the most needy and poorest including the working poor

Dennis and Janice Grimm

Vinyard, Christopher

From: Andy Bernstein, PhD <adbpsy@gmail.com>
Sent: Friday, September 25, 2015 4:15 PM
To: Public Input
Subject: comment on proposed new Medicaid rules

As a provider both in the public and private health care systems of Arizona, I wish to register my strong opposition to several aspects of the proposed new Medicaid rules, namely the 5 year participation limit, the requirement of all recipients to be seeking employment, and the elimination of transportation to and from medical appointments.

My reasons are as follows: many disabilities and illnesses are life-long, so an arbitrary 5-year cap on service eligibility essentially presents an endpoint in many people's access to health care. Let the decisions on need chronicity be made by medical providers and not legislators. Moreover, if the intention of this is to force patients to pursue private insurance, I think it will not work. Instead of pursuing that avenue towards health care, I believe that affected individuals are more likely to just present themselves for more expensive health care when their situations become crises, placing the burden on all of the taxpayers of Arizona to pay for these more complex and time-sensitive services through indirect cost increases throughout the system.

Requiring all Medicaid recipients to be searching for work is unrealistic, and I believe will encourage a system of dishonesty and "workarounds" for people whose truly disabling illnesses or conditions make it simply unrealistic for them to work. It makes more sense to focus efforts on more effective methods of ascertaining the degree and type of impairments that folks actually have, providing the truly eligible with a correct disabled status and the "malingerers" with education and training that can lead to rehabilitation and employment.

Finally, to deprive patients of a way of getting to medical appointments that is commensurate with their medical needs is short-sighted and unfair, placing a financial burden on them which I suspect will lead to a decrease in their use of more timely medical services with a resulting increase of their use of emergency services, which again, will cost the system more money in the long run, not to mention the human costs of delaying treatment for diseases which compromise people's quality of life.

Arizona can do better and be smarter than this.

Sincerely,

Andy Bernstein, PhD

Community and Clinical Psychologist

--

Andy Bernstein, PhD, CPRP

5930 E. Pima Street # 120

Tucson, AZ 85712

520-396-4956

www.AndyBernsteinPhD.com <<http://www.andybernsteinphd.com/>>



Nathan Laufer, MD
President

Chic Older
Executive Vice President

September 24, 2014

Mr. Tom Betlach, Director
AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

VIA EMAIL: publicinput@azahcccs.gov

Dear Director Betlach:

On behalf on the Arizona Medical Association (ArMA), we appreciate the opportunity to provide comments on the proposed AHCCCS CARE program and Arizona's 1115 Medicaid waiver application.

ArMA applauds the overarching aspirations of the plan to promote personal-responsibility, encouraging engagement for one's own healthcare, and help patients find a pathway to self-reliance. We agree that we must look to modernizing the AHCCCS program in order to adjust to changing needs and effectively leverage technology to achieve long-term sustainability.

ArMA's primary focus is patient care. Upon consideration, there are two areas of the waiver application that have a direct impact on patients' access to care that raise concerns to physicians. First, any new policies that could ultimately lead to or create gaps in coverage due to suspension or termination of benefits for patients otherwise eligible for AHCCCS, including a lifetime enrollment limit of five years. Second, elimination of non-emergency transportation.

1. Policies Creating Gaps in Coverage / Lifetime Enrollment Limit

ArMA is concerned with any new policies that could create gaps or loss of AHCCCS coverage for otherwise qualified members (i.e. termination/suspension of AHCCCS coverage for failure to pay premiums), including a lifetime enrollment limit of five years. These types of limits will create barriers to access to care. Access to care is key to ensuring that individuals receive timely services in the most efficient setting. Under the proposal, a triggering event may occur that causes a member's AHCCCS benefits to terminate while an underlying health condition and need for medical services does not likewise cease. It is key that patients have adequate and appropriate coverage to ensure care without insurmountable barriers. Our member physicians have first-hand experience how destructive the lack of adequate health care coverage is for those in our community that are the most vulnerable.

If an otherwise eligible AHCCCS member were to lose coverage, it is very likely they will not have access to any other type of coverage and will ultimately be uninsured. If they require medical care, lack of coverage may lead to postponement of needed care due to access barriers and prohibitive costs. This will create a situation where health outcomes worsen overtime by deferring and delaying care, and could ultimately shift care to the most expensive and less effective setting – the emergency department. Ultimately, these policies create a cost-shift to the private sector by forcing providers to shoulder the financial burden of caring for those emergency department patients as uncompensated care. As has become all too apparent, the safety nets of our healthcare system have been stretched due to increasing demand and limited resources.



Nathan Laufer, MD
President

Chic Older
Executive Vice President

ArMA recognizes and agrees it is imperative that individuals are empowered and charged with self-responsibility for one's own healthcare and are incentivized to achieve self-efficiency. We are concerned that policies terminating/suspending benefits, that are not related to AHCCCS eligibility, would deter patients securing needed care in the most appropriate and cost effective setting.

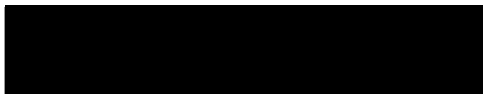
2. Elimination of non-emergency transportation

ArMA is concerned that the proposal to eliminate non-emergency transportation will directly affect access to care and will have unintended consequences. Non-emergency medical transportation in Arizona is often essential for AHCCCS members to obtain medically necessary covered services. Elimination of the non-emergency transportation services, particularly for patients living in rural, outlying urban, or medically underserved areas, will be crippling to patients appropriately trying to secure timely medically necessary care. Our member physicians identify failure to secure needed services often leads to what should have been an avoidable escalation of symptoms requiring far more expensive modes of treatment.

We understand and agree that there is a need to assure appropriate utilization of non-emergency transportation. However, we are concerned that a blanket elimination of non-emergency transportation would be prohibitive for patients' access to care that is given in the most timely, appropriate, and cost effective setting.

Thank you for the opportunity to provide feedback on the proposed AHCCCS CARE program and Arizona's 1115 Medicaid waiver application. We greatly appreciate the accomplishments, innovations, and continuous improvements of the AHCCCS system. We remain committed to continued collaboration to help improve Arizona's healthcare system for patients.

Sincerely,



Nathan Laufer, MD, FACC
President, Arizona Medical Association

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VOLUNTEER LAWYERS PROGRAMS
Maricopa County - Central Office
Mohave County - Kingman Office
Yavapai County - Prescott Office
Yuma/La Paz Counties - Yuma Office

September 25, 2015

VIA EMAIL:
publicinput@azahcccs.gov

Arizona Health Care Cost Containment System
801 East Jefferson Street
Mail Drop 4200
Phoenix, Arizona 85034

Attn: Office of Intergovernmental Relations

Re: Comments to AHCCCS Draft Section 1115
(1315) Demonstration Waiver Request

Dear Office of Intergovernmental Relations:

Community Legal Services submits these comments to Arizona's draft demonstration waiver request for the 5 year period beginning on October 1, 2016 during the period for public comment. For over sixty years, Community Legal Services has provided low-income Arizonans free legal advice, advocacy and assistance on a variety of civil matters. On average, CLS handles about 7,000 cases annually across five county service areas, focusing primarily on public benefits, healthcare, employment, consumer protection, family law and housing.

Most CLS clients rely on the Arizona Health Care Cost Containment System ("AHCCCS"), Arizona's designated Medicaid agency, as their primary source of health care coverage. Without this coverage, our clients would be unable to meet their basic healthcare needs. Because of the population that we serve, we are highly concerned with the proposed Demonstration Waiver Request. Although the issues with the Draft Waiver are legion, we write to address a few salient issues. We agree with concerns raised by the William E. Morris Institute for Justice (the Institute) in their September 9, 2015 Comment. We would like to reiterate and emphasize some of these concerns.

The overall tenor of the Draft Waiver gives new meaning to the war on poverty by declaring a war on the neediest Arizonans. The extreme proposals appear to serve no legitimate purpose. In fact the Waiver is simply an attempt to balance the budget on the backs of the working poor, struggling individuals and families living paycheck to paycheck.



*Community Legal Services is committed to eliminating poverty-based inequities in the civil justice system
by providing high-quality legal advice, advocacy and assistance to low-income Arizonans.*



While the proposal does provide exemptions to some harmful provisions, such as the new work requirements, it does not account for people who do not have the ability to meet the proposed requirements due to disabling medical conditions. For instance, many residents of our state have mental health conditions that not only prohibit them from working, but also render them unable to seek out medical treatment. Others may not qualify or have yet to qualify for Social Security benefits despite being medically disabled. Currently, there are over 15,000 people in Arizona waiting for a Social Security determination which could take upwards of two years. These individuals are in disability determination limbo, unable to work and without incomes, and, should this proposal go into effect, at risk of losing medical care. Barring this group of individuals from receiving essential healthcare during a time when they need treatment the most clearly demonstrates the disparate impact of the proposal.

If fiscal conservation is the goal, the proposal certainly misses the mark. The cost of not providing healthcare to otherwise qualified individuals will far outweigh the cost associated with continuing the coverage as it stands now. As raised by the Institute, certain provisions may discourage or prevent people from obtaining care until a health issue has become a medical emergency, increasing emergency room costs. Moreover, the sweeping changes will raise administrative costs due to the burden of managing the new requirements.

Costs associated with adhering to due process responsibilities will invariably increase. The proposal establishes numerous new reasons to deny or terminate coverage that will require generation of even more decision notices, which will necessarily have embedded in them the due process right to a Fair Hearing. This will increase costs not only for the AHCCCS Administration, but also the Department of Economic Security, which administers many eligibility decisions. Perhaps AHCCCS should discuss with the Department of Economic Security its capacity to handle what promises to be an extreme increase in due process costs.

This letter in no way addresses all of the legal problems with the AHCCCS Draft Demonstration Waiver Request. Overall, the Draft Waiver appears to penalize low-income individuals and families for their inability to afford private healthcare. The proposed requirements directly attempt to circumvent the purpose of the Medicaid Act and AHCCCS Program. The proposed changes disparately impact people with disabilities and also carry with them the risk of disparate impact on other protected classes who are dependent on this essential service.

The proposed AHCCCS CARE Program (Choice, Accountability, Responsibility, Engagement) provides *no care at all* to many of Arizona's most vulnerable individuals and families. The Draft Waiver shows a complete lack of Engagement in ensuring AHCCCS's Accountability and Responsibility to those that do not have a Choice.

Thank you for the opportunity to comment on the Draft Waiver. Please direct any questions concerning this letter to Dina Lesperance or Anna Marie Gulotta at (602) 258-3434 exts 2350 and 2430 or at dlesperance@clsaz.org and agulotta@clsaz.org.

Sincerely,

/Dina Lesperance/
/Anna Marie Gulotta/

Dina Lesperance and Anna Marie Gulotta,
on behalf of Community Legal Services



September 25, 2015

Director Tom Betlach
AHCCCS, Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034
publicinput@azahcccs.gov

Dear Director Betlach,

On behalf of Terros, I am providing public comment regarding the Arizona Health Care Cost Containment System's submission of Arizona's Medicaid Section 1115 Waiver Application.

For more than four decades, Terros has provided behavioral health, family support, addiction, crisis and recovery services to adults and children throughout the Phoenix metro-area, Tucson and Flagstaff. More recently, and in support of AHCCCS initiatives, we have begun providing integrated behavioral and physical health and wellness services in Phoenix.

During our long history in Arizona, we've witnessed significant changes in health care delivery to our state's citizens, including the advent of AHCCCS. While we support Arizona's decision to expand Medicaid funding to provide coverage to newly eligible low-income adults, we urge AHCCCS and the Centers for Medicaid Services to please reconsider two key components of the waiver application: limit lifetime enrollment to five years and elimination of Non-Emergency Medical Transportation. These elements are inconsistent with the objectives of the Medicaid program and run counter to the overall goal of the Affordable Care Act to increase access to health care services for all.

Our specific concerns and comments are outlined below.

Thank you for your consideration.

Sincerely,

Peggy Chase
President and CEO

Limit Lifetime Enrollment to Five Years

The five-year lifetime cap on Medicaid benefits is an imprudent and impractical idea that runs counter to national health care policy, and the clear economic and societal benefits of affordable access to health care. Individuals and families with incomes below 133% FPL, whose employers do not offer health coverage, have no other option for health insurance other than AHCCCS, because they are not eligible for marketplace plans or subsidies. The five-year lifetime cap will create a group of uninsured and uninsurable individuals and families—severely stressing Arizona’s first responders and emergency services.

Non-Emergency Medical Transportation

At Terros, we are very concerned that waiving the Non-Emergency Medical Transportation benefit will significantly impact Medicaid beneficiaries’ ability to access critical primary, specialty and preventive resulting in more costly care as undiagnosed medical problems worsen. NEMT plays an important role in ensuring Medicaid beneficiaries’ access to medically necessary as well as preventative care. This concern is corroborated by national data in articles by the National Conference of State Legislatures and the Community Transportation Association of America. Key findings include:

- Approximately 3.6 million Americans miss or delay medical care because they lack appropriate transportation to their appointments.
- Many low-income Americans lack the disposable income necessary to have access to a working automobile, and may lack public transit options to get to and from medical appointments.
- Half of all NEMT trips were provided to access dialysis treatment (17.9 percent) or behavioral health services (31.9 percent).
- Most NEMT rides were for individuals with chronic illness for whom the lack of treatment would be life threatening or would result in need for a higher level of care or institutionalization in the criminal justice system or psychiatric hospital.

We implore AHCCCS and CMS to seriously reconsider this portion of the 1115 waiver application and continue to provide NEMT to vulnerable populations, ensuring adequate and timely medical and behavioral health care.



09/24/2015

Mr. Tom Betlach, Director
AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Director Betlach:

On behalf of The Arizona Partnership for Immunization (TAPI), thank you for the opportunity to provide feedback on Arizona's 1115 Medicaid waiver application. The mission of TAPI is to foster a comprehensive, sustained community program for the immunization of Arizonans against vaccine preventable diseases. TAPI leverages the expertise of our partners in the public and private sectors to ensure individuals have access to affordable, high quality healthcare and wellness services – including, but not limited to immunizations – provided by trusted healthcare professionals. TAPI strongly supports many aspects of the proposed waiver, including:

- A conscious effort to leverage technology in partnering with individuals to meet their personal wellness goals.
- A priority on developing systematic ways to engage AHCCCS members in “taking charge” of their own health.
- An effort to utilize the cost-sharing components of the AHCCCS CARE Program to potentially improve access to non-covered services, such as dental.
- Utilizing a promising public health practice of incentivizing healthy behaviors through the “Healthy Arizona Targets” component of the AHCCCS CARE program, especially including wellness exams and flu shots as important metrics.
- Inclusion of innovative payment strategies for Indian Health Services and Tribal 638 facilities that will enhance connections to public health services outside the medical home setting.
- Consideration for some special populations who will be exempt from some work requirements and cost-sharing initiatives.
- An approach to Delivery System Reform Incentive Payment (DSRIP) which will lay the groundwork to pay for improved health outcomes through appropriate utilization of lay health workers to coordinate care, provide case management and partner with individuals in meeting their health goals. We are equally happy the DSRIP approach will enhance integration of behavioral health and healthcare sectors.

TAPI and our partner organizations have some concerns related to several aspects of the waiver. We recognize that several of our concerns are related to specific requirements mandated by the Arizona State Legislature through the passage of SB1092 and SB1495 in the previous legislative session. Our concerns include:

Consumer cost-sharing initiatives. TAPI and our partners are concerned that some cost-sharing initiatives may have unintended consequences; especially if implementation is not done through a somewhat flexible and individualized lens. Many Medicaid-eligible families we serve struggle to maintain employment, housing and adequate food supply. While a family may be able to afford a premium payment one month, they may be unable the following few months as a result of decreased income, increased household expenses, or ill health. For example, during the “back to school” season when parents are responsible to purchase new school supplies for their children, community food banks and other programs providing free services see a drastic influx. Using the same logic, it would follow that low income or impoverished families will not have funds for premium and/or co-pay fees during that time. Many families will be forced to make a choice to not pay co-pays or premiums so they can afford housing, food, household supplies or non-covered healthcare services such as dental care. These difficult choices may result in a loss of coverage and will create more health inequities among our population. Furthermore, cost-sharing may have a negative impact on enrollment in coverage, which could cause Arizona to lose traction on positive advancements gained since Medicaid restoration. It is unclear how cost sharing will be assessed, but this should not apply to public health departments.

Suspension/ Termination of Benefits. For two years, TAPI has been partnering to increase public and private health insurance coverage through the Cover Arizona Coalition. Improved coverage rates have enhanced our ability to connect individuals to important preventative healthcare services such as immunizations. A small investment in these types of prevention programs save tax payers and private organizations more down the road in treatment costs. TAPI does not support the removal of Medicaid benefits from an individual who is eligible to receive them for any reason, including failure to pay premiums or co-pays or any lifetime limit. The proposed work requirements add another level of complexity depending on how “able-bodied” is interpreted.

Transportation. Having access to reliable transportation is critical for an individual to access the healthcare and public health systems. This is especially important when considering the unique geography of Arizona and our current public transit systems in various areas of the State. TAPI believes all AHCCCS members should receive transportation benefits so they can attend important medical visits. Similarly, when implementing policies to reduce inappropriate emergency department usage, it should be recognized that for some individuals, a hospital may be only a 5 minute bus ride away, while a bus ride to an urgent care center 19 miles away would take several hours. In a situation where an individual is in moderate pain or needs stitches (which could be cared for in either setting) it would be unreasonable to expect they would not access the healthcare services closest to their home. Most importantly we are concerned about potential disease exposure to the community by requiring patients to use public transportation while infectious.

Provision of Category A and B preventative services to all AHCCCS beneficiaries. The Affordable Care Act Section 4106 establishes a 1% increase in the federal medical assistance percentage (FMAP) for spending on preventative services assigned a grade of A or B by the United States Preventative Services

Task Force (USPSTF). Included in these types of preventative services are adult vaccines. Currently, AHCCCS provides all Category A and B services to the “Medicaid Restoration” population, but not to individuals living below 100% FPL. Our partners recommend AHCCCS include coverage for all Category A and B preventative services to the entire population, which will promote health equity in the population.

We look forward to partnering with AHCCCS during the implementation phase of the new Medicaid program. We are especially interested in thinking creatively about ways we can share data across government agencies to improve population health measures, including immunization rates. We would also welcome opportunities to identify ways to measure whether the new program is achieving its intended results of improving health status, decreasing costs, and ensuring all Arizonans have access to care.

Thank you for the opportunity to respond to the waiver proposal. We value the long-standing trusting relationship we have with AHCCCS and appreciate your commitment to innovation and improvement.

Sincerely,



A.D. Jacobson, MD, FAAP
Board President
The Arizona Partnership for Immunization
www.WhyImmunize.org

Vinyard, Christopher

From: Richard Bitner <rebitner@cs.com>
Sent: Friday, September 25, 2015 4:58 PM
To: Public Input
Subject: AzCEP Comments - New Section 1115 Demonstration Waiver Application

Follow Up Flag: Follow up
Flag Status: Completed

September 25, 2015

Mr. Tom Betlach, Director
Arizona Health Care Cost Containment System
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Subj: AzCEP Comments - New Section 1115 Demonstration Waiver Application

Dear Director Betlach,

Thank you for the opportunity to comment on Arizona's Application for a New Section 1115 Demonstration Waiver on behalf of the more than 700 members of the Arizona College of Emergency Physicians (AzCEP).

We have some very specific concerns relating to those aspects of the proposed plan that provide new enhanced co-pays for what is determined to be "Non-Emergency Use of the Emergency Department". And, also to those related aspects of the proposal that would terminate certain members enrollment in AHCCCS based on failure to pay the enhanced co-pay for such use, as well as for non-compliance with other new participation requirements being proposed.

As you know, AzCEP is a champion of the Medicare, Medicaid and ACA requirements for use of the "prudent layperson standard" for accessing emergency care, along with the companion state requirement governing payment for ED visits. While AzCEP appreciates the determination that collection of enhanced co-pays for "non-emergency use of the ED" will not be the responsibility of providers, we remain concerned about the impact on our patients, and on how the administration of this new requirement may involve ED providers in insurance claims adjudications and appeals when an action is taken against a patient that they disagree with.

We assume the proposed co-pay will comply with federal and state law definitions of the "prudent layperson standard" in making determinations, but find the proposal very unclear on how the evaluation will be made, by whom, what appeal rights the patient has, and what the role of the provider is with respect to such a "non-emergency use" finding. Concerns have been expressed that even with a well-designed system establishing a fair basis for making such a determination, which we believe should be reviewed by a physician with the appropriate specialty credentials, where applicable, that the administrative cost of imposing such a requirement may well exceed any perceived benefit.

We would propose considering alternative use of available resources to educate patients about the benefits of seeking regular and preventive care from their primary care physician and appropriate specialty care to their individual circumstances. In our experience, developing medical home models and helping direct care would

be a far better use of resources that is more likely to produce direct clinical benefits to the patient while avoiding some hospitalization costs.

Of perhaps even greater concern is the proposal that AHCCCS enrollees in the Medicaid expansion group above 100% FPL would lose their eligibility as a result of failing to pay required co-pays. This seems contrary to the objective of expanding Medicaid coverage to those of limited means. While removing members from the AHCCCS rolls may appear to be a win to those desiring to limit expenses, these disenfranchised patients will continue to need care somewhere. Without insurance and little ability to self-pay due to their economic circumstances, the direct result will be to increase their use of the ED as about the only choice left to many of them. In the meantime, many will delay seeking care, further increasing the costs of treating their conditions, and, for some, leading to poorer outcomes. Increasing the rate of the uninsured runs contrary to the objectives of state and federal health reform efforts, and will increase the burden of uncompensated care on hospitals and hospital providers serving under the EMTALA mandate, while again leading to cost-shifting to others and threatening the financial viability of our emergency services safety net.

We understand and appreciate that AHCCCS is under a legislative mandate to propose most of these reforms, but would recommend you recognize the short-comings inherent in these efforts to reduce ED use through punitive measures and instead seek an approach focused on educating enrollees and working to coordinate care among providers to obtain better outcomes for patients, with lower costs for insurers.

Respectfully,

Dale P. Woodridge, MD, PhD, FACEP
President

Donald J. Lauer, MD, MPH, FACEP
President-Elect

Richard E. Bitner
Legislative Counsel

ARIZONA COLLEGE OF EMERGENCY PHYSICIANS
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Richard Bitner
Legislative Counsel
Arizona College of Emergency Physicians

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AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Director Betlach,

In August of 2015 the Department of Health Services released their waiver plan for Arizona's Medicaid program the Arizona Health Care Cost Containment System (AHCCCS). This plan, which is in response to changes requested by the Governor's Office and legislation passed by the Arizona State Legislature, includes significant changes that will have negative impacts on the lives of sexual and domestic violence survivors.

Sexual and domestic violence has lasting health problems for survivors. Domestic violence survivors experience a higher than normal rate of chronic health problems such as arthritis, hormonal disorders, asthma, diabetes, hypertension, chronic pain, severe headaches and irritable bowel syndrome¹. As a result survivors spend an average of nearly 20 percent more money on medical costs with most survivors not having health insurance².

The changes proposed below will limit survivor's ability to access affordable health care that addresses their ongoing health care needs.

Work Requirement

Many survivors of sexual and domestic violence experience periods of time where they are unable to work. This can be due safety concerns, their perpetrator preventing them from working, or a variety of other reasons. Mandating a work requirement puts survivors at risk of losing their health insurance at a time when they may need it the most.

5 Year Lifetime Limit

Sexual and domestic violence has long term physical and mental health impacts on survivors. Limiting health insurance to 5 years puts survivors at risk of not being able to attend to their health care needs due to this arbitrary lifetime limit.

Monthly Costs

Financial abuse is a common form of abuse that survivors experience. Financial abuse is a tactic used to control the survivor by making them completely dependent on the abuser³. Abusers are known to ruin survivor's credit, prevent them from working, and control their access to money. Another concern is that

¹ Jetter, A. (2013, November 1). Domestic Violence: A Hidden Cause of Chronic Illness. Retrieved August 27, 2015, from <http://www.more.com/health/wellness/domestic-violence-hidden-cause-chronic-illness>

² Jetter, A. (2013, November 1). Domestic Violence: A Hidden Cause of Chronic Illness. Retrieved August 27, 2015, from <http://www.more.com/health/wellness/domestic-violence-hidden-cause-chronic-illness>

³ Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. *American journal of public health, 100*(2), 292.

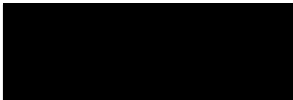
between 35 and 56 percent of survivors report being harassed at work by their abuser and a quarter and a half reported they have lost a job as a result of the violence⁴. As a result, requiring a monthly payment could be difficult for many survivors experiencing or who have experienced financial abuse.

Co-Pays

In addition to the monthly costs, the co-pays being proposed by this waiver will also put survivors at risk. While survivors may have limited access to income, this proposal will require that information about paying the co-pays be sent back to the survivor to be paid later. Sending this information could put survivors who are still with their abuser at risk of further, especially if their abuser did not know they were seeking medical treatment or had been preventing them from seeking medical treatment.

Health care is an important and much needed right for Arizonans. We urge you to reconsider these changes as they will have lasting impacts on survivors of sexual and domestic violence.

Sincerely,



Allie Bones, MSW
Chief Executive Officer
Arizona Coalition to End Sexual and Domestic Violence

⁴ Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. *American journal of public health, 100*(2), 292.



ABIL

ARIZONA BRIDGE TO INDEPENDENT LIVING

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Phoenix, AZ 85034-2005
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To: AHCCCS Administration

Submitted by:
Amina Donna Kruck
VP Advocacy
Arizona Bridge to Intendent Living (ABIL)
5025 E. Washington Street, Suite 200
Phoenix, AZ 85034
aminak@abil.org
602-443-0722

Re: Comments on AHCCCS Public Hearing: AZ's 1115 Waiver and other Community Initiatives Community Forums

Part I: The ACHCCCS Care Program

1. Co-pays up to 3% of annual household income

- a. **Co-pay exclusions** - I applaud the list of individuals that are excluded from co-pays: those with chronic illness, prevention and wellness visits as well as primary care physician appointments. I assume individuals with disabilities (those on SSI who may have chronic illness) may not be required to pay co-pays either because they often need specialists – for instance someone who is quadriplegic.
- b. **Opioids** - I am concerned about the co-pay for opioids in that there are other very painful health conditions that require opioids for pain management. I understand the desire to reduce dependency. Perhaps they could be automatically referred for some specialist review of use rather than co-pay. It seems unfair to financially punish people who actually have the kind of pain that need opioids for relief.
- c. **Non-emergency use of hospital** - Physicians, health plan emergency call nurses and urgent care facilities refer some patients to the ER for health issues that do not result in hospitalization. Two examples would be that a physician could be concerned that the individual had a stroke or broken bones.
- d. **Missed appointments** – Work, illness and lack of transportation can result in missed doctor appointments. Hopefully, someone arriving late would not be considered a missed appointment since public transportation is not always reliable, particularly paratransit. Low income individuals often have transportation problems or have trouble getting off work for doctor appointments.
- e. **Co-pay billing** – If there are going to be co-pay requirements, having AHCCCS bill members for co-pays is better than requiring payment at the time of the service. I am sure the health plans and their providers appreciate this idea.
- f. **What are the criteria for putting someone in the chronic illness category?** We have a concern about how someone gets categorized as a “person with chronic illness” that will be exempt from the co-pay requirement. After working 30 years with individuals with disabilities, I have observed it can sometimes take a long time for some chronic illnesses to be appropriately diagnosed and treated. Does pneumonia count as chronic illness? It can take a year or more to recover. Employed individuals meeting the income

requirements for AHCCCS typically work in jobs that don't provide paid time off for sick days. As a result, when very disturbing health symptoms come up, they put off going to the doctor. By the time they go to the doctor, it can take several appointments before the illness is diagnosed and treated successfully. Our main concern is that we would not want them to lose AHCCCS health care coverage because they were unable to pay the co-pays required during the period before they get accepted into the "chronic illness" category, becoming exempt from the co-pays.

2. Premiums of 2% annual household income

- a. How does this premium get paid?** If the annual income of a family is \$15,000, that would mean they would have a monthly premium of \$25. A family living on this income makes about \$1250 per month while trying to pay rent, clothing, school supplies, transportation, utilities and food. The idea of helping these families save for health care sounds good, until you have lived at this level of income. In reality, it is punitive and unrealistic. This will require a monthly income reporting of the family which results in bigger government involvement not less, requiring more staff and resources. Also, if AHCCCS intends to calculate this based on the previous year's income tax return and someone has lost their job or has dramatic income changes – again this could be punitive, especially for those who are struggling to live on lower incomes than on the previous year.
- b. Requires more resources**—The management of this new financial system will require more Arizona resources, and we question the conjecture that co-pays collected will cover this added expense. How will the use of the premiums be tracked and scrutinized to determine if they are being used by the member for items allowed under the proposed program rules? It sounds like it will require more oversight, calling for more government resources and more reporting from the members.
- c. A penalty for Failure to Pay** – Our main concern is what will happen when an AHCCCS participant has a health crisis and has fallen into the penalty period. I assume people with SMI would not be in this category even if their income is between 100 – 138% FPL. I hope so because they may have trouble tracking payments and making choices with their income due to their illness.

3. Promoting Healthy Behaviors

- a. Wellness goals** Targeting wellness goals and/or goals to help managing chronic illness is admirable – I don't understand the consequences. How will this be tracked and by whom?
- b. Reduce "care payments"** – Does this mean the premiums or co-pays?
- c. Supporting work incentives** – This sounds great if the supports for employment are really there and/or for those not experiencing a health crisis that truly prevents them from being able to work. ABIL is a longtime supporter of financial self-sufficiency through employment. However, the definition of disability as created by Social Security in 1956 is outdated since the American's with Disabilities Act passed 25 years ago. There is confusion about who is "disabled" and who is not. Vocational Rehabilitation, due to budget constraints, are only able to serve the "most significantly disabled" Arizonans, leaving many who need assistance to be gainfully employed without the supports they need to achieve this goal.
- d. Employers contributing to ACCES Cares account** – I don't think they could legally contribute to an individual's account so this may provide some group health promotion projects.

Legislative Partnership

- **SB1092**
 - **Employment criteria for AHCCCS eligibility**
 - **Exemptions**—I assume caregivers of children under the age of 6 are considered exempt because at age 6 a child is likely in school for at least part of the day. This provides no consideration for a parent, child or spouse who is a caregiver for a family member in the home, which may be saving the state the expense of long term care.
 - **“Mentally or physically unfit for work”** – What does this mean and what are the criteria? See comments above. Physicians typically do not have the training to make this kind of determination. They know about the health issue, not the requirement of a certain job. Research has shown that health professionals consistently underestimate the quality of life and life satisfaction of a person with a disability.
 - **Lifetime 5 year limit for AHCCCS eligibility**— I doubt this is legal from the view of CMS— it seems counter to their mission. Life can be very long to have this limit! This approach views healthcare as a carrot or reward rather than it being something that citizens need to be better functioning citizens, parents, worker, etc. A healthy citizenry is better for everyone.
- **SB 1475**
 - **0-100% FPL** – Premium concerns discussed above.
 - **1000 – 138% FPL** – Co-pays more punitive for ER (discussed above)
 - **No non-emergency medical transportation**—This will prohibit sick people from getting to their doctor appointments. No medical appointment should be considered “optional” and transportation assures their ability to get to physical therapy, a primary physician or counseling appointment. Some communities do not have public transit available. Some people are too sick to ride on the bus and riding on the bus while sick is not good public health. Part of good mental health is transportation assistance. This decision will likely lead to people being unable to get to medical appointments.

Vinyard, Christopher

From: Phil Barry PhD <pbarryphd@cox.net>
Sent: Friday, September 25, 2015 5:04 PM
To: Public Input
Subject: proposed changes to AHCCCS benefits

Follow Up Flag: Follow up
Flag Status: Completed

As a longtime health care provider I feel that charging co-payments for public health care services will be harmful to the people who need the services. Research from many years ago concluded that co-payments do not improve compliance or positively affect the cost of care. Instead, they will serve as negative pressure to get help promptly when it could prevent much more expensive healthcare later.

I also think limiting AHCCCS enrollment to 5 years will hurt people I have worked with who manage to remain independent but live in poverty. Many, if not most, of them have no hope of improving their financial standing. Many, if not most, have chronic medical and/or mental health problems and struggle to get by day to day and week to week. Telling them they no longer qualify for help after an arbitrary period of time is senseless and cruel.

Please do not impose these sanctions on people who are least likely to speak for themselves.

Dr. Philip Barry

17626 N. 57th Street
Scottsdale, AZ 85254

September 25, 2015

Mr. Tom Betlach, Director
Arizona Healthcare Cost Containment System (AHCCCS)
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Mr. Betlach,

On behalf of Planned Parenthood Arizona, I thank you for the opportunity to comment on Arizona's 1115 Medicaid waiver application. Planned Parenthood Arizona provides a full range of reproductive and primary health care services to 35,000 patients annually at 11 clinics across Arizona.

Planned Parenthood believes in the power of individuals to make informed and appropriate choices regarding their health. We support the Administration's commitment to better integrate behavioral and physical health care services, address chronic disease in populations of high need, and develop primary care models to better serve the public. However we feel strongly that many of the proposed reforms will create rather than solve problems. We are concerned especially about the impact of the plan on poor and marginalized populations. We object to the following provisions:

Requirement of work participation for "able-bodied" adults with children over age 6 as well as for members who are childless. Participation optional for persons with serious mental illnesses, pregnant women or Native Americans. Physicians will have to make case-by-case determinations if others should work.

Families that qualify for Medicaid do not have extra funds to pay child care. If Arizona mandates that parents work full-time without making it possible for them to earn a living wage (impossible at the current minimum wage level) it will almost certainly add to staggering caseload in the Department of Child Safety by creating environments where children are not supervised because their parent has to work and cannot afford child care/after school care. In addition we seriously question whether state agencies already stretched to the limit have sufficient resources to properly administer this labor-intensive program requirement.

Requirement of up to 3% of income for copayments and up to 2 % of income for premiums and financial penalties for those who fail to make copayment or premium payments.

As more and more Arizona families struggle to meet basic needs, we know that many cannot afford to prioritize health care. Indeed, cost-sharing can act as a financial barrier to accessing care, particularly for those with multiple demands on low income and significant health care needs. As health professionals we too often observe that such individuals end up either delaying care or not seeking needed care at all, to the detriment of themselves, their families, and the public. Further, when individuals are locked out of care and they become sick, their only option becomes the emergency room. This policy does not benefit the person or the state.

The proposal discontinues funding for non-ER medical transportation for adults between 100-133% FPL.

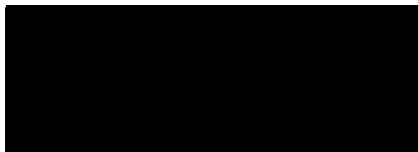
Even in Maricopa County, public transportation, which many low income individuals depend on, is a hit-and-miss proposition in many communities. Lack of transportation to healthcare appointments is an even more serious issue for rural and tribal communities. With services many miles away and no vehicle, some living in rural Arizona will effectively be cut off from healthcare.

Five-year lifetime limit on "able-bodied" adults.

Most full-time jobs available to those on Medicaid do not pay a living wage or offer health care benefits. In Arizona, families/individuals tend to stay in poverty for many years even when they have employment. When large numbers of Arizonans reach their lifetime benefit limit, Arizona will certainly see healthcare costs rise at the ER because of a lack of primary care coverage, once again saddling hospitals and the public with the costs of uncompensated care. Worse, a vicious cycle is created when workers at minimum wage jobs are not able to prevent illness or manage their illnesses; there is a high probability that they will lose their job, thus making them even more dependent on other public programs.

Thank you for providing communities the opportunity to comment on the proposed AHCCCS CARE Plan. We welcome an invitation to help create meaningful reform that will benefit all Arizonans.

Sincerely,



Jodi R. Liggett
Vice President for Public Affairs
Planned Parenthood Arizona

Vinyard, Christopher

From: Aynne Henry Ph. D. <drayne@cox.net>
Sent: Friday, September 25, 2015 10:45 PM
To: Public Input
Subject: reform

Follow Up Flag: Follow up
Flag Status: Completed

Dear Sir and Madam:

For those who have not read the documents, please note that they include proposals to limit participation in AHCESS to 5 years (over an individuals' lifetime). It requires the infirm and disabled to pay for a portion of their health care (some of these individuals may be making less than \$400.00 a month. It requires recipients (including those with life-changing disabilities; to look for work.) It eliminates transportation to and from medical appointments, among other changes. In short it turns a model of effectiveness into a sham operation that will end up costing lives.

Sincerely,

Aynne

Aynne Henry, Ph.D.
4047 North 40th Place
Phoenix AZ 85018

Clinical Psychologist
AZ License #910

Office Phone: 602-957-2336
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Vinyard, Christopher

From: Arti Radhika Sarma <artiradhika@gmail.com>
Sent: Friday, September 25, 2015 11:19 PM
To: Public Input
Subject: Objection to proposed revisions to AHCCCS

Follow Up Flag: Follow up
Flag Status: Completed

I'm deeply troubled by the proposed revisions to AHCCCS services for those in our community who are most in need. As a psychologist in training I've witnessed the severe impact that health issues and lack of access to resources has on individuals, families, and communities. Limiting access to this care and setting arbitrary requirements based on statutes rather than actual medical need seems inappropriate for the government to set such regulations on versus involving professionals in making these determinations. I strongly oppose these revisions to our health care system. Please feel free to contact me for any follow up.

Dr. Arti Sarma
Graduate Psychologist
Phoenix VA Hospital

343 W Leah Ave
Gilbert, AZ 85233
(602) 295 -1200

Vinyard, Christopher

From: Jason J. Baker, Ph.D. <jasonbaker@bakerneuropsychology.com>
Sent: Friday, September 25, 2015 11:19 PM
To: Public Input
Subject: Proposed changes to AHCCCS

Follow Up Flag: Follow up
Flag Status: Completed

I am writing this email to express my deepest concerns regarding the newest proposed changes to AHCCCS. I am a clinical neuropsychologist in Phoenix, and among my various responsibilities, I have evaluated over 1500 clients through DES Vocational Rehabilitation. Most of the clients I evaluate have had some type of neurological injury (e.g., traumatic brain injury, stroke, etc.), or have neuropsychiatric conditions (E.g., Bipolar Disorder, Psychotic disorders, severe learning disabilities, etc.) that make it very difficult to work and independently take care of themselves. I can't tell you how many times clients have presented as highly distressed due to the possibility that I may say they are not gainfully employable. Many of these clients have significant deficits in areas like memory and problem-solving which clearly make it difficult for them to function. In fact, many of these clients minimize the problems they are experiencing in my evaluation due to their desire to begin working and provide for themselves. To deny these clients health insurance benefits is completely inhumane, and leaves them helpless to take care of themselves (which they can't). The number of clients I evaluate who genuinely do not want to work despite the fact they can are minimal, and individuals with genuine disabilities want more than anything to be normal and provide for themselves and their families, as I have witnessed many tears of people discussing the frustration they feel over their limitations. I am hoping this information is helpful in understanding the reasons the proposed changes in AHCCCS are a huge mistake and would work against people who desperately need these services.

Sincerely,

Jason J. Baker, Ph.D.
1515 E. Missouri Ave., Suite 110
Phoenix, AZ 85014
602-274-1462
www.bakerneuropsychology.com

Arizona College of Emergency Physicians

State Chapter of the American College of Emergency Physicians

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Executive Director

Stephanie A. Butler Phone: 602-692-2376

September 25, 2015

Mr. Tom Betlach, Director

Arizona Health Care Cost Containment System

c/o Office of Intergovernmental Relations

801 E. Jefferson Street, MD 4200

Phoenix, AZ 85034

Subj: AzCEP Comments - New Section 1115 Demonstration Waiver

Dear Director Betlach,

Thank you for the opportunity to comment on Arizona's Application for a New Section 1115 Demonstration Waiver on behalf of the more than 700 members of the Arizona College of Emergency Physicians (AzCEP).

We have some very specific concerns relating to those aspects of the proposed plan that provide new enhanced co-pays for what is determined to be "Non-Emergency Use of the Emergency Department". And, also to those related aspects of the proposal that would terminate certain members enrollment in AHCCCS based on failure to pay the enhanced co-pay for such use, as well as for non-compliance with other new participation requirements being proposed.

As you know, AzCEP is a champion of the Medicare, Medicaid and ACA requirements for use of the "prudent layperson standard" for accessing emergency care, along with the companion state requirement governing payment for ED visits. While AzCEP appreciates the determination that collection of enhanced co-pays for "non-emergency use of the ED" will not be the responsibility of providers, we remain concerned about the impact on our patients, and on how the administration of this new requirement may involve ED providers in insurance claims adjudications and appeals when an action is taken against a patient that they disagree with.

We assume the proposed co-pay will comply with federal and state law definitions of the "prudent layperson standard" in making determinations, but find the proposal very unclear on how the evaluation will be made, by whom, what appeal rights the patient has, and what the role of the provider is with respect to such a "non-emergency use" finding. Concerns have been expressed that even with a well-designed system establishing a fair basis for making such a determination, which we believe should be reviewed by a physician with the appropriate specialty credentials, where applicable, that the administrative cost of imposing such a requirement may well exceed any perceived benefit.

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Page 2

We would propose considering alternative use of available resources to educate patients about the benefits of seeking regular and preventive care from their primary care physician and appropriate specialty care to their individual circumstances. In our experience, developing medical home models and helping direct care would be a far better use of resources that is more likely to produce direct clinical benefits to the patient while avoiding some hospitalization costs.

Of perhaps even greater concern is the proposal that AHCCCS enrollees in the Medicaid expansion group above 100% FPL would lose their eligibility as a result of failing to pay required co-pays. This seems contrary to the objective of expanding Medicaid coverage to those of limited means. While removing members from the AHCCCS rolls may appear to be a win to those desiring to limit expenses, these disenfranchised patients will continue to need care somewhere. Without insurance and little ability to self-pay due to their economic circumstances, the direct result will be to increase their use of the ED as about the only choice left to many of them. In the meantime, many will delay seeking care, further increasing the costs of treating their conditions, and, for some, leading to poorer outcomes. Increasing the rate of the uninsured runs contrary to the objectives of state and federal health reform efforts, and will increase the burden of uncompensated care on hospitals and hospital providers serving under the EMTALA mandate, while again leading to cost-shifting to others and threatening the financial viability of our emergency services safety net.

We understand and appreciate that AHCCCS is under a legislative mandate to propose most of these reforms, but would recommend you recognize the short-comings inherent in these efforts to reduce ED use through punitive measures and instead seek an approach focused on educating enrollees and working to coordinate care among providers to obtain better outcomes for patients, with lower costs for insurers.

Respectfully,

Dale P. Woodridge, MD, PhD, FACEP

President

Donald J. Lauer, MD, MPH, FACEP

President-Elect

Richard E. Bitner

Legislative Counsel

MCAP

**Maricopa Consumers Advocates and Providers
1406 N. 2nd Street
Phoenix, AZ 85004**

VIA EMAIL: publicinput@azahcccs.gov

September 25, 2015

Mr. Tom Betlach,
Director
Arizona Health Care Cost
Containment System
801 East Jefferson Street
Mail Drop 4200
Phoenix, Arizona 85034

Re: Comments on Draft Section 1115 Waiver Request

Dear Director Betlach:

On behalf of Maricopa Consumers, Advocates and Providers (MCAP), thank you for the opportunity to comment on the proposed Medicaid waiver. MCAP, whose membership includes more than 60 behavioral health provider agencies and advocates have worked with AHCCCS to ensure a quality and cost effective public behavioral health system. MCAP enthusiastically supported Medicaid restoration, as well as the integration of behavioral health and acute care services. MCAP interest in this proposed waiver is related to how it will impact those in need behavioral health services through our Medicaid system.

There are several aspects of the proposed waiver which MCAP supports. We applaud efforts to reduce fragmentation among healthcare programs and incentivize wellness targets among AHCCCS members. We also support AHCCCS' Delivery System Reform Incentive Payments proposal. We believe that Arizona should take advantage of all opportunities to leverage federal funding to further the integration of behavioral health and acute care.

Nevertheless, several other aspects of the proposed waiver cause us some concern. We will focus on those provisions that we believe pose the most risk to persons with serious mental illness and other behavioral health issues.

- Elimination of Non-Emergency Transportation

AHCCCS' proposal will deny non-emergency transportation to persons with no other means to get to their appointments. Those living in poverty have limited access to transportation. In rural and frontier areas, there may be no public transportation available at all. Even if transportation is available, many individuals cannot use it because of their health conditions, the expense or other reasons. Refusing to provide access to transportation will simply lead to a lack of access to necessary mental and physical health care. This will often result in the need for more expensive care down the road and other system costs.

- Lifetime Limit on Enrollment and Work Requirements

MCAP fully supports efforts to increase employment, but believes that the proposed time limits and work requirements are arbitrary and ill-advised. There are many physically or mentally impaired individuals who are unable to work, but who may not meet the definition of disabled under existing disability categories. The current proposal will have a disproportionate effect on individuals with chronic conditions and disabilities and lead to worse economic and health outcomes.

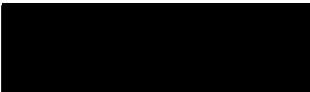
- Co-payments and Premiums

MCAP appreciates AHCCCS' attempt to "target" co-payments so as not have unintended negative consequences. Unfortunately, the co-payment proposal may still be overly broad and harm on vulnerable populations. MCAP is also concerned about the new requirement for monthly premiums. The current proposal would take funds from those with limited means to pay for rent, utilities, clothing, transportation and other basic needs. Research from other states shows that premiums significantly depress enrollment in Medicaid. Moreover, the proposed lock-out period for non-payment of premiums will disrupt continuity of care and lead to greater costs in the long run. We question whether these proposals will achieve any administrative efficiency as they will be costly to implement and monitor. We would prefer to see an effort to strengthen health homes of those with behavioral health and physical health needs as a mechanism for creating efficiencies in the system.

AHCCCS's proposal for heightened copayments and inappropriate use of the emergency room in Arizona is particularly troubling. It is difficult to determine what constitutes appropriate versus inappropriate use, and therefore AHCCCS' proposal may penalize or deter legitimate emergency room use. We are also concerned that AHCCCS does not specify that other facilities actually be available and accessible to the person at the time they visit the ER. Any such facility might be closed at that time or not accept walk-ins. We would encourage AHCCCS to focus on enhancing the accessibility of urgent care and primary care networks as a means to reducing the non-emergency use of the emergency room.

Thank you for allowing us to comment on this proposal. We appreciate your consideration of MCAP's perspective.

Sincerely,



Ted Williams
Chairman
cc. MCAP



September 24, 2015

Mr. Tom Betlach, Director
Arizona Health Care Cost Containment System
801 E. Jefferson St. MD 4100
Phoenix, AZ 85034

Dear Director Betlach:

Thank you for the opportunity to comment on the proposed Section 1115 Waiver request.

As you know, Empowerment Systems, Inc. is an Arizona non-profit family of health education and wellness programs. Our focus on multidimensional wellness, personal responsibility, self-management of health, health education and workforce development makes it easy for us to support many of the proposals in the request.

We support plans to bring training and employment assistance to AHCCCS enrollees. Although we work closely with the Department of Economic Security jobs and employment programs, connecting them with the people we help enroll for AHCCCS is not always easy. We support the proposal for more collaboration and coordination. We work closely with other workforce development efforts and hope that there will be access to them in addition to DES, such as the AZ Commerce Authority and Workforce Innovation and Opportunities Act programs.

We also support plans to engage business through private sector partnerships. Hopefully, the Governor's business experience and connections will help make this a reality. But as an employer that is part of the philanthropic community, we are concerned that it may be unrealistic to expect financial contributions from that sector for the AHCCCS Care Accounts. For we are already strapped for funding existing charitable activities such as outreach, health education, benefit enrollment assistance, food distribution, food stamps, etc.

2066 West Apache Trail, Suite 116 Apache Junction, Arizona 85120
Phone: (480) 367-6937 Fax: (480) 982-7320
Email: info@emsysonline.org

Empowerment Systems, Inc. is a nonprofit family of health education and wellness programs



EMPOWERMENT SYSTEMS, INC.

"Empowering People to Improve Lives"

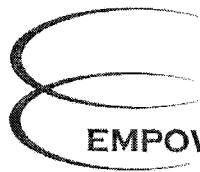
Operating the AZ Living Well Institute, which sponsors evidence-based programs such as the Chronic Disease Self- Management Program (CDSMP), we truly appreciate the attention paid to promoting wellness and managing chronic disease. Over the past few years, we have trained and manage hundreds of facilitators of CDSMP workshops throughout Arizona. Peer Support Specialists in the behavioral health system have been trained and employed by community organizations to facilitate CDSMP workshops, which are covered and paid AHCCCS services. Thus the workforce is appropriately expanded and greater access to effective services is improved. However, at this time health plans and program contractors for AHCCCS acute and long term care have not covered these programs. We urge you to specifically include in the Waiver evidence-based wellness and health management programs in addition to traditional screening and prevention that will be covered once the waiver is approved.

All of our programs focus on motivation through positive reinforcement and reward for success rather than punishment for failure. We believe that many of the provisions of the Waiver are punitive in nature and simply will not work. Charging premiums, strategic copays, cost sharing, forced savings accounts and other penalties for low income people will further restrict their access to needed care and treatment. Life time limits and disenrollment for six months for not making contributions and then requiring individuals to make back payments in order to restore care will further limit access. These individuals will simply not go to the doctor when they need to and will get worse, eventually costing more as a result of waiting.

The costs will be shifted to other taxpayers and we will see an increase in uncompensated care. It has also been found that collecting from low income people costs more than its worth in administrative expense. We are very concerned as well that plans to eliminate payment for non-emergency medical transportation, especially in rural regions where public transportation is virtually non-existent, will also restrict access to needed care, leading to health deterioration and higher costs.

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Empowerment Systems, Inc. is a nonprofit family of health education and wellness programs



EMPOWERMENT SYSTEMS, INC.

"Empowering People to Improve Lives"

These serious concerns lead us to recommend:

- Removal of the punitive copay, cost sharing, premium, and health savings account charges that will restrict access to care and result in greater taxpayer expense in the long run.
- Replace these punitive practices with positive incentives and rewards for effective health management and wellness program accomplishments.
- Elimination of enrollment suspensions and lifetime limits.
- Continuation of non-emergency medical transportation coverage with appropriate controls and accountability.
- Recognition and coverage for evidence-based wellness and health management programs in addition to traditional screening and prevention.
- Inclusion of other employment assistance and workforce development programs in addition to Department of Economic Security offerings.
- Continued support for Arizona's managed care approach and integration of behavioral health and primary care and recognition that DSRIP will provide opportunities for this to happen.

We truly hope that these comments and suggestions are helpful in what we realize are difficult policy decisions about the provision of health and human services for vulnerable populations in Arizona.

Sincerely,



Jack Beveridge
President and CEO
Empowerment Systems, Inc.

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Empowerment Systems, Inc. is a nonprofit family of health education and wellness programs

September 25, 2015

Tom Betlach, Director
Arizona Health Care Cost Containment System
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Director Betlach,

Thank you for the opportunity to comment on the proposed Medicaid waiver. We are committed to improving the health of all Arizonans. We strongly believe the direction of our state's Medicaid program influences Arizona's overall health system and the health outcomes of millions of people.

Access to health care is imperative to people with diabetes. In particular, self- management education and training are integral components of diabetes management. Multiple studies have shown general-population diabetes self-management training programs can reduce resource utilization among recipients and ultimately improve diabetes outcomes.

We ask that you:

Support Comprehensive Coverage by Closing Gaps in Benefits: Coverage for services of particular importance to individuals with diabetes, such as diabetes self- management education (DSME) and training (DSMT) should be a standard component of coverage. DSME is a covered benefit of Medicare beneficiaries.

Additionally, we also support Medicaid offering Medical Nutrition Therapy (MNT) and the Diabetes Prevention Program (DPP) as a covered benefit. DPP is an evidence-based lifestyle change program designed to prevent type 2 diabetes. The program has demonstrated effectiveness in helping people at high risk lose a moderate amount of weight (5% to 7% of their current body weight) and increase their physical activity to 150 minutes per week. The result of these two lifestyle changes has been proven to prevent or delay the onset of type 2 diabetes by nearly 60%.

Ensure cost-sharing does not discourage individuals from obtaining necessary care. Over the years, Medicaid premiums and cost sharing have been used to limit state program costs, encourage more personal responsibility over health care choices and to better align public coverage with private coverage where states have expanded coverage.¹

¹ <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf>

In general, cost-sharing deters individuals from seeking medical care, while premium requirements deter individuals from enrolling in coverage. According to a recent study conducted by staff at the Agency for Healthcare Research and Quality (AHRQ), a premium increase of \$10 per month is associated with a decrease in public coverage of children in families with incomes above 150% of the federal poverty level (FPL), with a greater decrease in coverage for those below 150% FPL.²

A Kaiser Family Foundation review of research related to cost-sharing and premiums in state Medicaid and CHIP programs found that “[f]or individuals with low income and significant health care needs, cost-sharing can act as a barrier to accessing care, including effective and essential services, which can lead to adverse health outcomes.”³

The price sensitivity of households with low incomes *must* be a consideration when imposing premium or co-payment requirements for any public health program. Fortunately, federal Medicaid regulations do not allow providers to require individuals with incomes less than 100% FPL to pay the applicable cost-sharing as a condition for receiving the item or service, and prohibits premiums for most individuals with income below 150%.

Thank you for the opportunity to respond to the waiver proposal. We deeply value AHCCCS’ commitment to innovation and improvement, and we welcome opportunities to collaborate on these efforts.

Sincerely,



Veronica De La Garza, Advocacy Director
American Diabetes Association
vdelagarza@diabetes.org; 1-512-472-9838, ext. 6017

This letter is supported by the Arizona Coordinating Body of the American Association of Diabetes Educators (AADE).

² Abdus S, Hudson J, Hill SC, Selden TM, Children’s Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014.

³ Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013

Writing Accus
When companies do
not provide benefits
in low-wage jobs
is wrong, not modern
"Don't get sick,
but if you do,
die quickly"
is not a new idea
Sincerely,

Phoenix, AZ

Celexa
citalopram HBr ™

AHCCCS
C/O OFFICE INTERGOVERNMENTAL
RELATIONS
801 E JEFFERSON STREET
MAIL DROP 4200
PHOENIX AZ 85034

DEAR ACCCS REPRESENTATIVE

I HAVE BEEN COMING TO METRO
CAMPUS FOR 7 YEARS AND WAS
DIAGNOSED WITH BIPOLAR AND
PTSD & SCHIZOPHRENIA AND
WITHOUT SERVICES. I WILL
NOT BE ABLE TO GET MEDICATIONS,
CAB RIDES AND PSYCHIATRIC
SERVICES.

Celexa
citalopram HBr



TM

WITH FIVE YEAR CAP I WOULD
NOT BE ABLE TO PAY FOR
MENTAL HEALTH SERVICES,
AND WOULD SLIDE BACK INTO
RELAPSE. IT HAS TAKEN ME
7 YEARS TO BE SEMI WELL-
NESS WITHOUT THESE
SERVICES I WILL SLIP BACK
INTO DELUSIONAL ANGRY
BEHAVIOR. I WOULD BEG
THAT YOU WILL RECONSIDER
NOT ELIMINATION OF
PROGRAM SERVICES

SINCERLY

9-5-2015



Aches
c/o OFFICE, INTERGROUP MENTAL SERVICES
8018 JEFFERSON STREET
MAIL DROP 4000
PHOENIX AZ 85034

DEAR ACHES REPRESENTATIVE,

I WAS DIAGNOSED 12 YEARS AGO
WITH BIPOLAR. AFTER MOVING HERE TO
BE WITH FAMILY. I SELF REFERRED
MY SELF TO METRO CAMPS AND
SEEING CASE MGR. DEBBIE MEETER
AND PSYCHIATROS. I WAS THEN DIAGNOSED
WITH BIPOLAR, PTSD AND SCHIZOPHRENIA
TENDENCIES.

I THEN RECEIVED PROPER MEDICATION,
THERAPY, MENTAL HEALTH CLASSES AND
CASE MGR. AND PSYCHIATROS.

I HAVE BEEN IN AND OUT OF

Celexa 
citalopram HBr TM

mental Health Hospital with stays
of up to 56 Day Treatment programs
I am now taking correct medication
and live on my own for last 7
years. Without these services
I would relapse into disabling
uncontrollable insanity.

I looked how well az takes
care of the mentally handicapped
and az scored a "D" nothing to
be proud of.

I am begging you to reconsider
this decision

Sincerely



SEP 29 2015

Mr. Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
801 E. Jefferson St., MD 4100
Phoenix, AZ 85034

Re: Arizona Health Care Cost Containment System's Proposed Waiver

Dear Mr. Betlach:

The Phoenix Area Indian Health Service (PAIHS) appreciates the opportunity to provide comment, per Centers for Medicare and Medicaid Services (CMS) and Arizona Health Care Cost Containment System's (AHCCCS) consultation and transparency requirements, regarding the proposed waiver package that will be submitted by the State of Arizona to the CMS which will be effective on October 1, 2016.

The purpose of this letter is twofold. The first is to provide a high-level analysis of certain components within AHCCCS' proposed waiver and their potential impacts to the PAIHS while the second is to request further information on the anticipated impacts of these changes presented at the AHCCCS Consultation Meeting on August 21, 2015.

As you are aware, the PAIHS oversees the delivery of health care services to approximately 172,247 American Indians and Alaska Natives (AI/AN) primarily in the tri-state area of Arizona, Nevada and Utah. In Arizona specifically, the PAIHS oversees the delivery of comprehensive health care services to AI/AN 147,264 through direct care services provided by the Indian Health Service, tribal health programs operated under P.L. 93-638, and urban Indian health programs (I/T/U). Approximately 37,671 AI/AN adults aged 18 & over were enrolled in AHCCCS and received 346,024 services between July 1, 2014 – June 30, 2015. These services include primary care (inpatient and outpatient), tertiary care and specialty services.

We anticipate that a number of AI/ANs served by the I/T/U system within the Phoenix Area will be impacted by various changes within the proposed waiver. Likewise, I/T/U provider reimbursements from the AHCCCS program will also be impacted. For purposes of this letter, the PAIHS would like to call attention to three proposed changes in particular. Those include: (1) Uncompensated Care Payments; (2) Work Requirements for Able-Bodied Adults; and, (3) Five-Year Lifetime Limit for Able-Bodied Adults.

Uncompensated Care Payments

The PAIHS is pleased to see that AHCCCS intends to propose the continuation of uncompensated care payments to IHS and tribal health programs operated under P.L. 93-638 (hereafter referred to as 638 facilities). From April 2013 to July 2015, the PAIHS has received approximately \$13.6 million in uncompensated care payments. Although beneficial in covering the cost of uncompensated care, the PAIHS' concern is that the payments for uncompensated care are significantly lower than the amount of services currently provided at the PAIHS facilities.

The PAIHS determined that the historical payment methodology used for payments to PAIHS facilities from January 1, 2013 through June 30, 2015 did not cover approximately \$12 million in uncompensated care at PAIHS facilities for adult services no longer covered by AHCCCS. The PAIHS would be supportive of the exploration of changes to the uncompensated care methodology to ensure that the formula reflects a more accurate estimation of uncompensated care costs for current services provided by the PAIHS to adult AHCCCS members, which are no longer covered. The PAIHS understands that AHCCCS will compose a workgroup which will provide recommended changes to the current methodology. The PAIHS will dedicate staff to provide available data and technical advisement from a PAIHS perspective.

Work Requirements and Five-Year Lifetime Limit for Able-Bodied Adults

The PAIHS is aware of the changes mandated by SB 1092, including the work requirements for able-bodied adults and lifetime enrollment limit of five (5) years.

The PAIHS has requested impact data from AHCCCS regarding the two proposed changes. Unfortunately, AHCCCS has indicated that no impact data has been compiled. Any impact data, even if only enrollment related, which pertains to AI/AN AHCCCS adult members would be helpful to better determine the impact to patients and services within the PAIHS.

The PAIHS is concerned that AI/ANs served would be disproportionately impacted by such changes, if approved, given the limitations in employment opportunities; access to health care services and other basic resources; and, significant health disparities in AI/AN communities in Arizona. These health disparities and socioeconomic issues need to be considered when determining the impact of these proposed changes particularly in remote tribal communities.

The PAIHS also requests clarification from AHCCCS pertaining to (1) the estimated impact of the two mandated changes on AI/AN AHCCCS members, and (2) whether or not AHCCCS would consider including services which are no longer covered (if these waiver changes are approved by CMS) in the uncompensated care payment methodology.

We are appreciative of the opportunity to provide comment and the continued support by AHCCCS to increase access to quality health care for AI/ANs. Do not hesitate to contact me if you have any questions.

Sincerely,



Rose Weahkee, Ph.D.
Director (Acting)
Phoenix Area Indian Health Service

cc: Lane Terwilliger, CMS
Kitty Marx, CMS
Dixie Gaikowski, Director, Tucson Area IHS
John Hubbard, Director, Navajo Area IHS

ATTACHMENT 3

State Medicaid Advisory Committee

Agenda and Summary



State Medicaid Advisory Committee (SMAC)

Wednesday, August 19, 2015

AHCCCS

Gold Room - 3rd Floor

701 E. Jefferson Street

1 p.m. – 3 p.m.

Agenda

I. Welcome	Director Tom Betlach
II. Introductions of Members	ALL
III. Approval of April 8, 2015 meeting summary	ALL

Agency Updates

IV. AHCCCS Update <ul style="list-style-type: none">• SIM Update	Director Tom Betlach
V. Integration Update	Tom Betlach
VI. CMS Update	Theresa Gonzales
VII. PCH SNCP	Monica Coury
VIII. Waiver	Monica Coury
IX. Voluntary Resolution Agreement (VRA)	Matt Devlin
X. Membership <ul style="list-style-type: none">• New Members• Terms	ALL

Discussion

XI. Call to the Public	Director Thomas Betlach
XII. Adjourn at 3:00 p.m.	ALL

2015 SMAC Meetings

Per SMAC Bylaws, meetings are to be held the 2nd Wednesday of January, April, July and October. All meetings will be held from 1 p.m.- 3 p.m. unless otherwise announced at the AHCCCS Administration 701 E. Jefferson, Phoenix, AZ 85034, 3rd Floor in the Gold Room:

January 20, 2015

April 8, 2015

August 19, 2015

October 7, 2015

For more information or assistance, please contact Theresa Gonzales at (602) 417-4732 or theresa.gonzales@azahcccs.gov

<p>State Medicaid Advisory Committee (SMAC) Meeting Summary Wednesday, August 19, 2015, AHCCCS, 701 E. Jefferson, Gold Room 1:00 p.m. – 3:00 p.m.</p>	
<p>Members in attendance: Tom Betlach Cara Christ Tara McCollum Plese Peggy Stemmler Kevin Earle</p>	<p>Leonard Kirschner Phil Pangrazio Steve Jennings Vernice Sampson Kim VanPelt Amanda Aguirre by phone</p>
<p>Members Absent: Kathleen Collins Pagels, Kathy Waite</p>	
<p>Staff and public in attendance: Theresa Gonzales, Exe Const. III, AHCCCS Monica Coury, Assistant Director, AHCCCS Matt Devlin, Assistant Director, AHCCCS Deb Gullett, Executive Director, AzAHP Kelly Brauns, DM, Otsuka Krystal Joy, AE, Otsuka Kelli Strother, Acct. Executive, Otsuka Brian Hummell, Director of Relations, ACS CAN Pete Wertheim, Executive Director, AOMA Patrick Moty, Director, Supernus Eddie Sissons, Executive Consultant, MHA AZ Kurt Barry, RD, Otsuka Barb Fanning, Director Gov't. Affairs, AzHHA Matt Jewett, Grants Director, Mountain Park</p>	<p>Shannon Groppenbacher, Director Health Policy, JNJ Melissa Higgins, Staff Attorney, Community Legal Svcs. Becky Gonzales, Acct. Executive, ViiV Healthcare David Large, Director Gov't. Accts., Supernus Camille Kerr, National Acct. Manager, Omeros Susan Lawrence, Acct. Manager, Amgen Brian Brown, Sr. Acct. Director, Amgen Alan Bailey, Acct. Director, Pfizer Jon Bloomfield, RAM, JAZZ Deron Grothe, NAM, Teva Pierre T., NAM, Hospice Julie Trueblood, Acct. Executive, BMS Torrey Powers, Regional Gov't. Manager, ADT Health</p>

AGENDA

- | | |
|---|--------------------|
| I. Welcome & Introductions | Tom Betlach |
| II. Introductions of Members | All |
| III. Approval of April 8, 2015 Meeting Summary/Minutes | Unanimous |

AGENCY UPDATES

- | | |
|--|--------------------|
| IV. AHCCCS Updates | Tom Betlach |
| <ul style="list-style-type: none"> • Medicaid 50th Anniversary • Medicaid Population and Spending • Federalism • Proposed Managed Care Regs • AHCCCS Population as of July 1, 1985 – 2015 • Restoration and Expansion • Population Changes • Prop 204 and Expansion Ages (CY14) • Percent of Auto-Renewals • AHCCCS/DES Call Volume | |

AHCCCS Updates (continued)

- Average Speed of Answer (min)
- Average Annual Capitation Growth
- AHCCCS Contract Timeline
- GAO – Conditions of Members (%)
- Economic Impact of Integration (Milliman)
- Continuum of Integration
- Milbank Integration Paper
- Social Determinants – Opportunities
- Administrative Simplification
- DBHS/AHCCCS Merger Update
- MMIC First Year Results
- Employee Survey
- AHCCCS Staffing Levels
- Q and As
 - Q: Any movement re CHIP?
 - A: The Legislature would need to make policy decision
 - Q: Has the State looked at the issue of members who go to emergency pediatric care and need inpatient behavioral health stays but sit in the Emergency Department?
 - A: Dr. Salek is working on the issue to better manage and will present at the next SMAC meeting

V. Integration Update

Tom Betlach

VI. CMS Update

Theresa Gonzales

- **AZ Medicaid State Plan Amendments**
- **Waiver Activity**

VII. & VIII. PCH SNCP & Waiver

Monica Coury

- **Section 1115 Defined**
- **Current Waiver Structure**
- **Arizona's 1115 Waiver**
- **Federal Process**
- **Arizona's Application**
- **Public Comment Process**
- **AHCCCS Initiatives**
- **Modernizing Arizona Medicaid**
- **The AHCCCS CARE Program: Requiring Member Contributions**
- **Strategic Copays**
- **AHCCCS CARE Premiums**
- **The AHCCCS CARE Account: Giving People Tools to Manage Their Health**
- **Healthy Arizona: Promoting Healthy Behaviors**
- **AHCCCS Works: Viewing AHCCCS as a Pit Stop**
- **A Modern Approach**
- **The Requirements: SB 1092**
- **SB 1092 Work Requirement – Exemptions**
- **SB 1475 100 – 133% FPL**

- **Delivery System Reform Incentive Payment (DSRIP)**
- **Home and Community Based Services File Rule (HCBS)**
- **American Indian Medical Home**
- **Building Upon Past Successes**
- **Safety Net Care Pool (SNCP) Phase Down**

IX. Voluntary Resolution Agreement (VRA)

Matt Devlin

- VRA Handout

X. Membership

All

- SMAC Committee Members Handout
- Provider and Public Members Handout
- SMAC Nominees
- Q and As/Comments
 - Dr. Stemmler supports term limits
 - Kim Van Pelt supports term limits
 - Dr. K would like to continue to serve
 - Request to update the Member roster for Steve Jennings title

DISCUSSION

XI. Call to the Public

Tom Betlach

XII. Adjourn at 3:00 p.m.

All

ATTACHMENT 4

Community Forum Schedule



AHCCCS Community Forums RE: Arizona's 1115 Waiver and other initiatives.

Purpose

To provide the public with information about Arizona's 1115 Waiver and other initiatives.

RSVP

Please RSVP as space is limited: PublicInput@azahcccs.gov

Locations	Dates
Phoenix Disability Empowerment Center (DEC) 5025 E Washington St, Suite 200, Phoenix, AZ 85034	Session 1: Tuesday, August 18, 2015 12:30-2:30 PM Session 2: Tuesday, August 18, 2015 3:00-5:00 PM
Yuma Regional Center for Border Health - 2nd floor Conference Room 214 W. Main Street, Somerton, AZ 85350 <i>Call-in Toll free: 1-877-820-7831</i> <i>Participant Passcode: 108903</i>	Session 1: Thursday, August 20, 2015 10:00-12:00 PM
Flagstaff Flagstaff Medical Center - McGee Auditorium 1200 N Beaver St, Flagstaff, AZ 86001	Tribal Consultation: Friday, August 21, 2015 10:00-12:00 PM Session 2: Friday, August 21, 2015 1:00-3:00 PM
Tucson Casino Del Sol - Ballroom B 5655 W Valencia Rd, Tucson, AZ 85757	Session 1: Wednesday, August 26, 2015 10:00-12:00 PM

Public Input

Comments and questions will be taken at the meeting but can also be submitted by

Email: PublicInput@azahcccs.gov

Mail: AHCCCS

c/o Office of Intergovernmental Relations
 801 E. Jefferson Street, Mail Drop 4200
 Phoenix, AZ 85034

ATTACHMENT 5

Community Forum Presentation



Modernizing Arizona Medicaid

Arizona's Application for a New Section 1115 Demonstration
August 2015



Section 1115 Defined

- Section 1115 of the Social Security Acts gives states authority to waive selected Medicaid requirements in federal law
- Two types of authority may be requested:
 - Waiver of provisions of Section 1902
 - Expenditure of federal funds under Section 1903
- Projects must be budget neutral – i.e. project cannot cost more than it would have without the waiver
- New Demonstrations are generally approved for 5 years; Arizona's waiver has been a 5 year contract



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The Waiver Allows Arizona to:

- Run its unique Medicaid model built around a statewide managed care system
- Provide health care to expanded populations
- Serve members enrolled in the Arizona Long Term Care System (ALTCS) in the community rather than more costly institutions
- Allow spouses as paid caregivers in ALTCS
- Implement administrative practices that increase efficiency



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Current Waiver Structure

- Federal authorities are granted to the State and detailed through three major sections:
 1. Waiver List
 2. Expenditure Authority List
 3. Special Terms and Conditions
- Additional Attachments provide more detail on various programs and guidelines



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Arizona's 1115 Waiver

- Arizona's current waiver scheduled to expire September 30, 2016
- Current terms require the State to give notice of its intentions one year in advance
- Arizona will submit its letter of intent to apply for a new Demonstration by September 30, 2015



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Federal Process

- The Centers for Medicare and Medicaid Services (CMS) is the federal agency responsible for oversight of State Medicaid agencies
- Arizona must obtain final approval from CMS
- The Office of Management and Budget and the Department of Health and Human Services also review waiver proposals
- 1115 Waivers are approved at the discretion of the HHS Secretary



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Arizona's Application

- Arizona's application for a new 5-year waiver includes:
 - Part I: Governor Ducey's vision to modernize Medicaid: The AHCCCS CARE program
 - Part II: The Legislative Partnership
 - Part III: DSRIP: Arizona's Approach
 - Part IV: HCBS Final Rule
 - Part V: American Indian Medical Home
 - Part VI: Building Upon Past Successes
 - Part VII: Safety Net Care Pool



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Public Comment Process

- Five public hearings and tribal consultation are scheduled to seek input
- For schedule and how to submit comments, <http://www.azahcccs.gov/publicnotices/Downloads/WaiverForumFlyer.pdf>
- Written comments (by mail or electronic) should be submitted and received no later than September 25, 2015
- For more information, <http://www.azahcccs.gov/shared/FiveYear.aspx>



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Part I: Modernizing Arizona Medicaid

The AHCCCS CARE Program
Choice
Accountability
Responsibility
Engagement



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AHCCCS Initiatives

"I also believe we are not close to achieving maximum efficiency in our Medicaid program"

Governor Ducey



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AHCCCS Today

- Largest Insurer in the State of Arizona
- \$12.0 billion program
- Mandatory Managed Care
- Public-Private Partnership
- System built on competition and choice
- Integrated delivery system—over 60,000 providers
- Covers two-thirds of nursing facility days
- Covers nearly as many adults as traditionally eligible populations, such as pregnant women, children, elderly, persons with disabilities

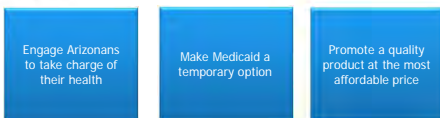


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Modernizing Arizona Medicaid

- Expanding Private Sector Partnerships and Leveraging Today's Technology to Reinvent AHCCCS



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The AHCCCS CARE Program: Requiring Member Contributions

- Copays:
 - Up to 3% of annual household income
 - Members will make monthly AHCCCS CARE payments reflecting copays for services already obtained
 - This also removes the burden of collecting the copay by providers at the point of service



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Strategic Copays

No Copays

- Preventive Services
- Wellness
- Chronic illness
- Persons with Serious Mental Illness
- Services obtained at your Primary Care Physician or OB-GYN

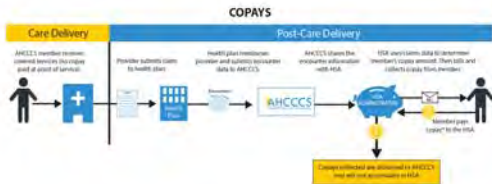
Copay Required

- Opioids, except cancer and terminal illness
- Non-Emergency use of ED
- Missed Appointments
- Specialist services without PCP referral
- Brand name drugs when generic available unless physician determines generic ineffective



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*Members pay up to 3% of income in copays. Cost sharing (premiums and copays) cannot exceed 3% of household income as required by federal law.



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AHCCCS CARE Premiums

- Included in the monthly AHCCCS CARE payment
- Premium requirement set at 2% of annual household income
- Member contributions do not exceed 5% of annual household income



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PREMIUMS



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The AHCCCS CARE Account: Giving People Tools to Manage Their Health

- Functions like a Health Savings Account
- Members must be in good standing to be eligible for the AHCCCS CARE Account by
 - Making timely payments
 - Participating in AHCCCS Works
 - Meeting the Healthy Arizona targets
- Employers and the Philanthropic community can make AHCCCS CARE Account contributions



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Qualified Members
Members can earn Qualified Member status by:

- Completing Preventive Services
- Making Timely Payments
- Meeting Work Requirement

Healthy Incentives for Qualified Members

Premiums collected can be used by Qualified Members to offset costs for health related services not covered by AHCCCS or be added over to offset ongoing payment amounts in the next benefit period.

AHCCCS
Arizona Health Care Cost Containment System

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The AHCCCS CARE Account (cont.)

- Contributions for premiums go into the AHCCCS CARE Account, which can be used for non-covered services
 - Dental
 - Vision
 - Chiropractic services
 - Nutrition counseling
 - Recognized weight loss programs
 - Gym memberships
 - Sunscreen

AHCCCS
Arizona Health Care Cost Containment System

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Arizona Proposed HSA Model Penalties for Failure to Pay

Members (100-138% FPL) who fail to make timely payments are disenrolled from AHCCCS, and are barred from reenrolling until all outstanding payments are made. Members with incomes below 100% of FPL are not disenrolled. Unpaid cost sharing amounts for all members becomes debt owed to the State.

Note: Indiana and Michigan received approval to disenroll only those over 100% FPL, if not medically frail.

AHCCCS
Arizona Health Care Cost Containment System

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Healthy Arizona: Promoting Healthy Behaviors

- Healthy Arizona is a set of targets
 - Promoting wellness: wellness exams, flu shots, glucose screenings, mammograms, tobacco cessation, and others.
 - Managing Chronic Disease: such as, diabetes, substance use disorders, asthma.



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Healthy Arizona (cont.)

- If members meet their Healthy Arizona target, they have the choice of either:
 - Reducing their required AHCCCS CARE payments; or
 - Rolling unused AHCCCS CARE Account funds over into next benefit year.



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AHCCCS Works: Viewing AHCCCS as a Pit Stop

- Supporting Work Incentives:
 - Partner with existing employment supports programs to build skills and promote work
 - Arizona Department of Economic Security manages numerous programs that provide support to job seekers
- **Unused AHCCCS CARE funds roll over into private HSA or AHCCCS CARE account can be maintained when member transitions out of Medicaid**



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AHCCCS Works (cont.)

- Employers will be able to make direct contributions into their employees' AHCCCS CARE Account that employees can use toward non-covered services
- Employer contributions reduce employee's contribution requirements or help build up funds in their AHCCCS CARE Account that can be used for non-covered services



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AHCCCS Works (cont.)

- Targeted Participation:
 - The Philanthropic community can make contributions for targeted purposes, such as smoking cessation or managing chronic disease
- Private sector contributions are tax-deductible



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A Modern Approach



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Part II: The Legislative Partnership



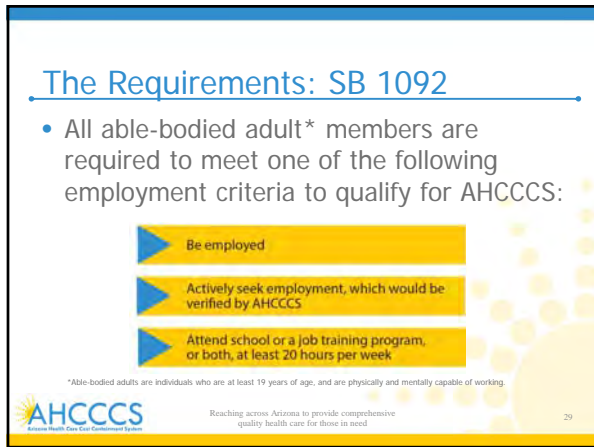
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The Requirements: SB 1092

- All able-bodied adult* members are required to meet one of the following employment criteria to qualify for AHCCCS:
 - Be employed
 - Actively seek employment, which would be verified by AHCCCS
 - Attend school or a job training program, or both, at least 20 hours per week

*Able-bodied adults are individuals who are at least 19 years of age, and are physically and mentally capable of working.

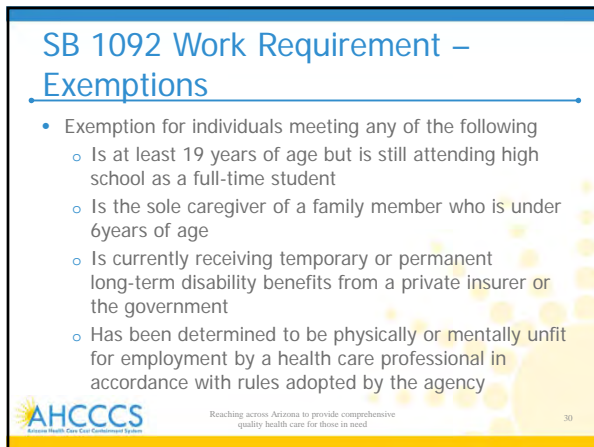


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SB 1092 Work Requirement – Exemptions

- Exemption for individuals meeting any of the following
 - Is at least 19 years of age but is still attending high school as a full-time student
 - Is the sole caregiver of a family member who is under 6 years of age
 - Is currently receiving temporary or permanent long-term disability benefits from a private insurer or the government
 - Has been determined to be physically or mentally unfit for employment by a health care professional in accordance with rules adopted by the agency



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SB 1092 (cont.)

- Limit lifetime enrollment to five years
 - Begins on effective date of waiver change
 - Does not include time during which person is
 - Pregnant
 - Sole caregiver of family member under 6
 - Receiving long-term disability benefits
 - At least 19 and still attending high school full time
 - Employed full time, meets AHCCCS income eligibility
 - Enrolled before age 19
 - Former foster child under 26 years of age



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SB 1092 (cont.)

- Develop cost sharing requirements to deter:
 - Non-emergency use of the ED
 - Use of ambulance services for non-emergency transportation when not medically necessary
- “Able-bodied” means an individual who is physically and mentally capable of working
- “Adults” means at least 19 years of age



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SB 1475

0-100% FPL:

- Premium of 2% of household income
- Copay of \$8 for non-emergency use of ED for first incident and \$25 for each subsequent incident if the person is not admitted to the hospital. No copay if a person is admitted to the hospital by the ED.
- Copay of \$25 for non-emergency use of ED for first incident and \$25 for each subsequent incident if there is a community health center, rural health center or urgent care center within twenty miles of the hospital.



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SB 1475 (cont.)

100-133% FPL:

- Premium 2% household income
- Copay of \$25 for non-emergency use of ED if the person is not admitted to the hospital. No copay if a person is admitted to the hospital by the ED.
- Copay of \$25 for non-emergency use of ED if there is a community health center, rural health center or urgent care center within twenty miles of the hospital.
- Exemption from providing non-emergency medical transportation



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Part III: Delivery System Reform Incentive Payment (DSRIP)

Arizona's Approach



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DSRIP: Arizona Approach

- DSRIP initiatives will focus on:
 - Behavioral Health – Physical Health Care Delivery and Payment Integration
 - Chronic diseases associated with persons identified as having High Needs/High Costs
 - Primary Care models with accountability for population health outcomes
- Results of State Innovation Plan will inform additional areas of focus



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DSRIP (Cont.)

- Performance measures will include:
 - Measures of infrastructure development – e.g., participation in Health Information Exchange
 - System redesign – e.g., value based payment arrangements to achieve collaboration and integration
 - Clinical outcome improvement – e.g., establishing targets for hospital readmission or asthma related hospitalizations
 - Population health improvement – e.g., percentage of homelessness among persons with SMI



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DSRIP (cont.)

- Incentive payment methodology based on milestones and tied to specified measures
- Learning collaborative will be established for providers to share best practices, etc.



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Part IV: Home and Community Based Services Final Rule

Arizona's Assessment and Transition Plan



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HCBS Final Rule

- Final Rule released by CMS 1-16-14
- Rule defined what qualifies as HCBS setting
- Arizona largely complies; modest changes
- HCBS program lives in 1115 Waiver; thus, Assessment and Transition Plan are part of this broader process
- Because of specificity to this topic, separate public process
- See <http://www.azahcccs.gov/hcbs/default.aspx>



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Part V: American Indian Medical Home



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American Indian Medical Home

- Health plans provide members with assigned PCP and assistance in managing chronic illness, case management, care coordination
- American Indians/Alaska Natives (AI/AN) are exempt from mandatory managed care
- Individuals who opt out of managed care receive services on a fee-for-service basis through American Indian Health Program



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AI Medical Home (cont.)

- To assist Indian Health Services (IHS) and Tribal 638 facilities to offer similar medical home services, AHCCCS is proposing to reimburse qualifying facilities for:
 - Primary Care Case Management
 - Diabetes Education
 - After-hospital care coordination
 - 24-hour call lines staffed by medical professionals



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Part VI: Building upon Past Successes



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Arizona's 1115 Waiver: An Evolution

- Modest changes are required as Arizona's program matures and evolves. Some of these include:
 - Technical changes to reflect AHCCCS / Division of Behavioral Health Services merger
 - Aligning behavioral health benefits for duals
 - Enhancing payments to Critical Access Hospitals
 - Adding traditional healing services for AI/AN



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Part VII: Safety Net Care Pool Phase Down

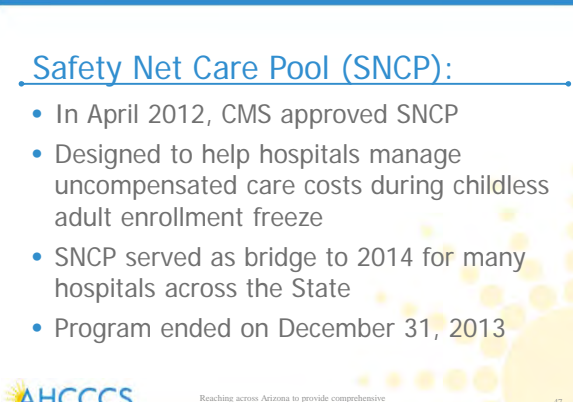


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Safety Net Care Pool (SNCP):

- In April 2012, CMS approved SNCP
- Designed to help hospitals manage uncompensated care costs during childless adult enrollment freeze
- SNCP served as bridge to 2014 for many hospitals across the State
- Program ended on December 31, 2013

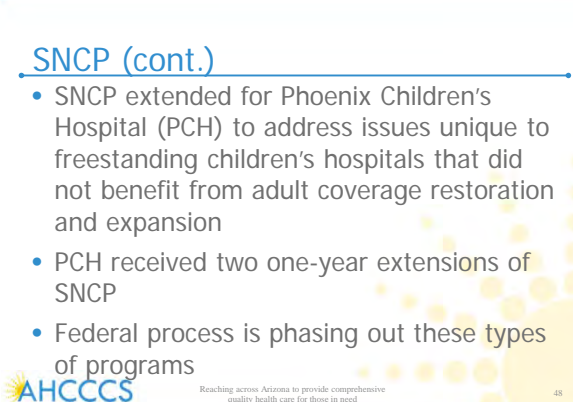


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SNCP (cont.)

- SNCP extended for Phoenix Children's Hospital (PCH) to address issues unique to freestanding children's hospitals that did not benefit from adult coverage restoration and expansion
- PCH received two one-year extensions of SNCP
- Federal process is phasing out these types of programs



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SNCP: Transition Plan

- AHCCCS requests a 5-year transition reducing SNCP payments from current max of \$137 million in 2015 to:
 - \$117 million in 2016
 - \$90 million in 2017
 - \$70 million in FY 2018
 - \$50 million in 2019
 - \$25 million in 2020



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SNCP: Transition Plan

- Arizona is working with PCH to move away from reliance on SNCP through:
 - APR-DRG payment methodology
 - Raising reimbursement for high-acuity pediatric cases across the board
 - Updating method for determining Indirect Medical Education Costs
 - Value-Based Purchasing rate differentials



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Our Goal: Raise the Standard by Building on Past Success



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Questions and Public Comments



AHCCCS
Arizona Health Care Cost Containment System

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Thank You.



AHCCCS
Arizona Health Care Cost Containment System

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ATTACHMENT 6

Summary of Comments Received

AHCCCS New Waiver Application: Community Forums Summaries

The Arizona Healthcare Cost Containment System (AHCCCS) held public forums regarding Arizona’s 1115 waiver proposals. Public forums were held in four locations, Phoenix, Flagstaff, Tucson, and Yuma, between August 18 and August 26. Participants were provided the opportunity to comment and ask questions about Arizona’s proposed waiver. Participants were provided with speaker slips and comments could be provided verbally or in writing. The following is a summary of questions and comments from the public and Agency’s responses during the forums. The summary is divided into five major sections: (1) Modernizing Arizona Medicaid, the AHCCCS CARE Program; (2) Legislative Partnership; (3) Delivery System Reform Incentive Payment (DSRIP); (4) American Indian Medical Home; and (5) Building upon the Past. The questions under each section are organized by subjects such as member eligibility, member cost sharing, work requirements, etc.

I. Modernizing Arizona Medicaid: The AHCCCS CARE Program

➤ Member Eligibility:

	Name/Organization	Question	Response
1.	AHCCCS Member, Flagstaff	Does the AHCCCS CARE program apply to elderly members over 65 years old?	No, AHCCCS CARE does not apply to members over the age of 65.
2.	Arizona Council for Human Service Providers, Phoenix	Which AHCCCS CARE provisions are applicable to persons with serious mental illness (SMI)?	AHCCCS CARE does not apply to members with SMI. Participation in AHCCCS CARE is optional for persons with SMI.
3.	Community Clinic Provider, Phoenix	Does the AHCCCS CARE program apply to all adults including GMH/SA (General Mental Health and Substance Abuse) population?	Yes, the AHCCCS CARE program is for all adults in the New Adult Group – Prop. 204 childless adults 0-100% FPL and expansion adults 100-133% FPL.
4.	AHCCCS Member, Phoenix	Does the AHCCCS CARE apply to members with disabilities?	AHCCCS CARE does not apply to people who have already been determined as disabled – e.g., ALTCS members, SSI-MAO, Freedom to Work.
5.	Arizona Hospital and Healthcare Association, Phoenix	Can you clarify for which populations the AHCCCS Care program will be mandatory?	All adults in the New Adult Group (Prop. 204 childless adults 0-100% FPL and expansion adults 100-133% FPL), unless otherwise exempt (e.g., persons with SMI).
6.	Pima Council on Aging, Tucson	Please take into account family caregivers who are caring for older	Noted.

	Name/Organization	Question	Response
		adults at home. We must ensure that those individuals do not lose AHCCCS coverage.	
7.	Family Caregiver, Tucson	What populations are impacted by the AHCCCS CARE program?	All adults in the New Adult Group (Prop. 204 childless adults 0-100% FPL and expansion adults 100-133% FPL), unless otherwise exempt (e.g., persons with SMI).
8.	Retired Healthcare Executive and Family Member, Tucson	What members are enrolled in the AHCCCS CARE program? Are disabled members and/or members with children enrolled in to the AHCCCS CARE program?	All adults in the New Adult Group (Prop. 204 childless adults 0-100% FPL and expansion adults 100-133% FPL), unless otherwise exempt (e.g., persons with SMI).
9.	Family Caregiver, Tucson	What is the income level for AHCCCS childless adult members?	0-138% FPL
10.	Tucson Area- Indian Health Service (IHS), Tucson	Are American Indians and Alaskan Natives required to participate in the AHCCCS CARE program?	Federal law exempts American Indians and Alaskan Natives from all cost sharing requirements. AHCCCS CARE will be an optional program for American Indian and Native Alaskan members.
11.	Children's Action Alliance, Phoenix	Does AHCCCS CARE impact former foster care members enrolled in YATI (Young Adult Transition Insurance)? Consider exemptions for stay at home parents of children over age 6 that have special healthcare needs.	No, the AHCCCS CARE program does not apply to YATI. Noted.
➤ Member Cost Sharing:			
12.	Advocate Mothers of Seriously Mentally Ill (MOMI), Phoenix	Are individuals with Serious Mental Illness (SMI) exempt from cost sharing and work requirements?	Yes
13.	Arizona Hemophilia Association, Phoenix	How is AHCCCS interpreting specialty medications with regards to copayments and coinsurance?	Copayments for medications are only applied to opioids (except cases of terminal illness or cancer) and brand name drugs where a generic is available (unless a physician has determined the generic is not efficacious).

	Name/Organization	Question	Response
14.	Community Clinic Provider, Phoenix	<p>How will copays and premiums apply to individuals receiving care involuntarily and on court-ordered treatment (who do not have a SMI)?</p> <p>Are members required to pay 5% of income in cost sharing regardless of service utilization?</p> <p>How much of the members copay/premiums are spent on administrative cost?</p>	<p>The copays and premiums will apply to all adults in the New Adult group unless otherwise exempted. Through discussions with the Centers for Medicare and Medicaid Services (CMS), the State will discuss possibilities for exemptions for individuals considered medically frail.</p> <p>No. Copayments are only made for services received that required a copayment. Members will have to pay monthly premiums at 2% of income regardless of service utilization.</p> <p>Members' copay will be used to offset program cost. Premiums collected remain with the member to be used by Qualified Members to pay for healthy incentives.</p>
15.	Patient Advocate, Phoenix	AHCCCS should concentrate its efforts on on-going system integration projects such as Administrative Simplification and Integrated Behavioral Health (RHBA). The agency needs to educate consumers about strategic copays. Premiums are burdensome for individuals experiencing financial crisis.	Noted.

	Name/Organization	Question	Response
16.	Community Legal Services, Phoenix	<p>Are individuals with chronic illnesses required to pay copays for opioids?</p> <p>Are members required to make copay if they cannot afford paying for them?</p> <p>How are member copays used?</p> <p>Does the copay for missed appointments apply to missed preventative visits? What if the appointment is missed due to lack of transportation?</p> <p>Consider allowing people to use HSAs for copays.</p>	<p>The only exemptions to the copay for opioids are in cases of cancer and terminal illness.</p> <p>Members are required to pay copays based on service utilization. Copays requirements are limited.</p> <p>Members' copays will be used to offset program cost.</p> <p>Copays for missed appointments only apply if the copays would otherwise have applied for that service. Since there is no copay for preventive visits, a missed appointment copay would not apply.</p> <p>Noted.</p>
17.	Community Clinic Provider, Phoenix	How will debts to the State be paid?	The State is exploring options.
18.	Healthcare Advocate, Tucson	The AHCCCS CARE Program requires members pay copay for missing a doctor's appointment. How does AHCCCS save money by penalizing members for missing an appointment?	The AHCCCS CARE program is not designed as a cost savings measure. There are no copays for doctor visits, except to see a specialist without a PCP referral. The AHCCCS CARE program is designed to help individuals transition from Medicaid to private health insurance where things like missed appointment penalties, copays, premiums and deductibles apply, even for individuals just over the Medicaid income threshold. In light of this objective, AHCCCS CARE will engage adult members in experiences similar to private health insurance to enhance members' readiness to successfully transition from Medicaid.

	Name/Organization	Question	Response
		Copays no matter when you collect them at the point of service or later is a barrier for members. We know that AHCCCS members are discouraged from seeking services when they are required to make a copay. The State will pay more in the long run when members stop seeking vital chronic and preventive healthcare services.	The AHCCCS CARE copay requirements do not apply to physician visits.
19.	NAZCARE (Northern Arizona Consumers Advancing Recovery by Empowerment), Flagstaff	The American Journal for Public Health published that approximately 60 percent of people who experience a healthcare crises do not receive continuous care. If we are requesting those individuals to pay 3% of their incomes in copays, how could we ensure that they will continue receive care after a healthcare crisis?	CMS has historically exempted medically frail individuals from disenrollment for failing to pay cost sharing. AHCCCS will begin discussion with CMS about cost sharing and disenrollment for members identified as medically frail.
20.	Retired Healthcare Executive and Family Member, Tucson	The goal of Medicaid is to improve access to care for vulnerable citizens. Copayments for non-emergency medical transportation and paying premiums to HSAs reduce member's access to care. Furthermore, the program's administrative costs exceed the proposed savings. AHCCCS should instead focus on as promoting healthy behaviors, partnering with the private sector, HIT, value based purchasing, reducing fragmentation, and preventing fraud.	Noted.
21.	National Association of Social Workers, Arizona Chapter, Tucson	Although cost-sharing can reduce the use of non-essential services, studies show premiums and copays are barriers to accessing care particularly for those with low incomes and significant healthcare needs. Furthermore, research shows reduced access to care causes adverse health outcomes.	Noted.
➤ AHCCCS CARE Account:			
22.	Coconino County Public Health District, Flagstaff	Will providers get reimbursed through the AHCCCS CARE Account for non-covered services?	Members will pay directly as self-pay for approved non-covered services using funds from their AHCCCS CARE Account.

	Name/Organization	Question	Response
23.	Arizona Hemophilia Association, Phoenix	If an AHCCCS member transitions to private insurance and has money in their AHCCCS CARE Account, can he or she only use the money for health insurance costs?	No definitive decisions have been made on restrictions related to use of AHCCCS CARE Account funds post-Medicaid eligibility.
24.	Community Clinic Provider, Phoenix	How will members access their AHCCCS CARE Account funds? What can individuals purchase with their AHCCCS CARE Account funds? Can members use the funds to purchase medical marijuana or gender reassignment surgery?	AHCCCS is exploring ways members can access funds. AHCCCS has issued a Request for Information (RFI) to potential vendors and will seek additional information related to operating the AHCCCS CARE Account. AHCCCS CARE Account fund purchases are limited to non-covered services. At this time, approved services include: dental, vision care, nutritional counseling, recognized weight loss programs, chiropractic care, gym membership and sunscreen. Members cannot use CARE account funds to pay for other products/services including medical marijuana and gender reassignment surgery.
25.	Healthcare Advocate, Tucson	The theory of a Health Savings Account (HSA) is based on market concepts that do not exist in healthcare, and the research is quite clear that HSAs for low income people result in worse outcomes. The notion that employers are going to contribute to the members CARE account is wishful thinking. Businesses are looking for ways to reduce their costs and the State is assuming that these businesses are going to pay into this system.	Noted
26.	Family Member , Tucson	Small employers in particular are struggling to pay a living wage for their employees. These employers cannot afford contributing funds into the AHCCCS CARE Account.	Noted.

	Name/Organization	Question	Response
27.	Family Member, Flagstaff	How does a person with limited education and experience navigate the complex requirements of the AHCCCS CARE program?	AHCCCS does not assume that all members have a limited education or ability to understand. However, AHCCCS recognizes programs that call for high consumer engagement can pose a challenge for some consumers. The State sees AHCCCS CARE as an opportunity to educate members on premiums, copays, and healthy targets in order to better prepare members for their transition to private insurance. AHCCCS will contract with a Third Party Administrator (TPA) to manage the AHCCCS CARE program. The TPA will be responsible for collecting enrollee premiums and copays, and educating members on healthy targets and AHCCCS Works.
28.	Registered Nurse, Phoenix Allies for Community Health, Phoenix	The goal of AHCCCS CARE should be to increase access to healthcare. Research states that copays (regardless of payment amount) are barriers to care and have no impact on ED utilization. AHCCCS CARE members are required to contribute \$320 per year in premium payments. If funds are put off limit to members as punishment, the state could make up \$112 million in a year. The program rules and regulations are likely to be profit-oriented for private corporations. Lastly, the federal government has never approved work requirements or a lifetime limit for Medicaid. Why does Governor Ducey think this time is going to be different?	The Legislative component does include the work requirement. Participation in AHCCCS Works is not a condition of Medicaid eligibility. Premiums do not go to the state, but stay in member's AHCCCS CARE Account.
29.	Phoenix Allies for Community Health, President, Midwives Alliance of North America, Phoenix	AHCCCS CARE impedes members' ability to receive care by placing a greater financial burden on families. Penalties and punitive measures imbedded in the program harm members. The new rules also stiffen healthcare workers ability to provide	Noted

	Name/Organization	Question	Response
		<p>care.</p> <p>The cost of administrating AHCCCS CARE can instead be used to cover more lives and expand healthcare services.</p>	
30.	Phoenix Allies for Community Health, Phoenix	<p>AHCCCS CARE is neither modern nor humane. The program’s requirements will reduce access to care, and as a result lead to poor health outcomes. Members with limited resources are forced to carry the burden of administrative costs of AHCCCS CARE.</p> <p>Medicaid should not have barriers for care. We are opposed to the following changes: copays, premiums, HSAs, disenrollment for failure to pay, lack of access to care via transportation, lifetime enrollment limits, and unreasonable work expectations</p>	Noted
31.	Casa de los Ninos, Tucson	Will the AHCCCS CARE program increase administrative cost for the program?	AHCCCS already administers copayment and premium requirements and has done so for many years. The new areas are education to members related to healthy targets and work opportunities. These costs will be covered by existing copayments which can now be reinvested to support members.
➤ GENERAL COMMENTS ON AHCCCS CARE			
32.	Arizona Community Action Association, Phoenix	Most vulnerable members had no input in the development of AHCCCS CARE. Many provisions demonstrate lack of understanding for the needs of low income individuals. Members are faced with challenges of maintaining a household and paying the bills with a low-income wage, no sick days, and unpredictable work schedule—these individuals are unfairly punished under AHCCCS CARE for missing an appointment or premium payment.	Noted. Calling to cancel an appointment obviates the missed appointment copayment.

	Name/Organization	Question	Response
		<p>Employment is key to prosperity- 20% of Arizona jobs are low wage- it is unfair to place so much on these low wage employees when jobs and training are scarce.</p> <p>What will you do with this feedback? Is there a part of this process to reevaluate this proposal?</p>	<p>Part of the goal is to promote connecting members to work opportunities and building up job training programs.</p> <p>We will consider all comments, make changes to the proposal and show where we took public comment/feedback., and incorporate all comments as part of the State's submittal.</p>
33.	Provider, Phoenix	The AHCCCS CARE program requirements are too complex. Who is responsible for educating members?	With regards to member education, we will look to the third party administrator to assist in those efforts. We will do a Request for Information to get information on what kinds of vendors/capabilities are out there.
34.	Retired Educator and President of the Arizona Hispanic Community Forum, Phoenix	Members in our community cannot afford premiums and copays. The job market discriminates against people of color. Governor Ducey should do away with this proposal.	Noted.
35.	Northern Arizona Regional Behavioral Health Authority (NARBA), Flagstaff	Will the AHCCCS CARE program go through an administrative rulemaking process?	Yes. Once CMS approves AHCCCS CARE, the Agency will enter a rulemaking process where needed to operationalize the program.
36.	Nurse Practitioner, ARNP , Tucson	AHCCCS CARE is highly bureaucratic and cost ineffective program diverting dollars from healthcare services. The program assumes members are lazy and must be forced to work, have discretionary time to navigate this very complex HSA system, and have higher health and financial literacy than general population.	The State strongly disagrees with this comment. In fact, many AHCCCS members already work, are hard-working and engage in their own health. In addition, the State believes it should invest in tools that support an individual's efforts to maximize their independence and quality of life.
37.	Health Services Consultant and Reform Advocate, Tucson	The inclusion of healthy targets and work incentives are noteworthy. However, premium and copays are prohibitive for individuals seeking care. If the State insists on premiums and copays, its proposal should be modified to prevent the cost sharing	Noted.

	Name/Organization	Question	Response
		requirements for the dual members and cap copays at 2 percent. Furthermore, the State should provide each CARE program participants with a one-time contribution equivalent to the monthly premium.	
38.	Retired Physician, Phoenix	It is our responsibility to provide care to more people, rather than find ways to deny care. Physicians under Hippocratic Oath must provide care to anyone who needs it.	Noted.
39.	Registered Nurse, Phoenix	Did the Governor seek the input of members before developing his plan? People are on AHCCCS because they have no choice. They are looking for a hand up, not a hand out.	The AHCCCS Administration is seeking the input of members through these Community Forums. In addition, since many of these requirements – copays and premiums – are already required in state law, the Governor’s plan is to build upon those requirements to offer additional tools to members so their premium payments stay with them and can be put to use.
40.	Developmental Pediatrician, Phoenix	Copays for missed appointments are not effective. We have tried to implement such copays in the past, as a result, many patients stopped coming to our office. AHCCCS should consult physicians before implementing new copays.	Noted.
➤ AHCCCS Works Program:			
41.	Inter-Tribal Council of Arizona (ITCA), Flagstaff	Does the AHCCCS CARE work incentive program apply to American Indian members?	AHCCCS CARE is an optional program for Indian American and Native Alaskan members including the work incentive program. However, the work requirement in SB1092 is required for American Indian members.
42.	Flagstaff Bone and Joint, Flagstaff	Is AHCCCS Works Program the same as the work requirements in SB1092?	The AHCCCS Works is distinct from the SB1092 Work Requirements. AHCCCS Works builds upon the legislature’s desire for a work component for the adult population by creating a work incentive. Governor Ducey has put

	Name/Organization	Question	Response
			forward an alternative concept that incentivizes member employment. AHCCCS Works would be a voluntary program for the American Indian population.
43.	Community Provider, Phoenix	How will work incentive requirements be funded?	The proposal contemplates tapping into already existing resources, such as those available through the Arizona Department of Economic Security .
➤ Comment Period/ Submission Deadline/ Waiver Evaluation Process			
44.	Casa de los Ninos, Tucson	Does AHCCCS have the mechanism/tools to evaluate the outcome of the AHCCCS CARE program? Will AHCCCS evaluate the impact of the AHCCCS CARE program on members' access to care, hospital emergency department (ED) utilization rate, uncompensated care, etc.?	AHCCCS is required to conduct a rigorous and independent evaluation of the demonstration. The evaluation will reflect all of the programs covered by the waiver including AHCCCS CARE.
45.	Family Member, Phoenix	Why was a cost-benefit analysis or financial analysis of this proposal not prepared and included in the summary document? The only financial result of this proposal is to ensure that people living in poverty will have to decide between feeding their families and providing healthcare for them.	At this point, we have not done a full analysis since we do not know how many and what types of exclusions will apply. In addition, the State needs more information from potential vendors to be able to assess cost. Copays have been used to offset the cost of the program in the past.
46.	NAMI (National Alliance on Mental Illness), Phoenix	Since you have not done a cost-benefit analysis, are the Governor and the Legislature determined to do this even if it costs more money?	The State already has an existing infrastructure to collect copayments and premiums. The AHCCCS Works component taps into already existing work support programs. The Healthy Arizona targets are services that are already covered in AHCCCS. Copayments will be used to administer the program.
47.	Mothers of Seriously Mentally Ill (MOMI), Phoenix	Are quality of life outcome measures being changed/improved for SMI members?	AHCCCS is working toward capturing population health measures, particularly through the DSRIP proposal. One such measure that is being considered, for instance, is reducing homelessness for persons with SMI.
48.	Arizona Academy of Pediatrics, Phoenix	What is the goal that Arizona has set for itself in this health scenario? How	AHCCCS is required to conduct a rigorous and independent evaluation of

	Name/Organization	Question	Response
		do we promote health in Arizona? How do we evaluate whether the system we set up is actually achieving results we want?	the demonstration. The evaluation will reflect all of the programs covered by the waiver including the AHCCCS CARE.
49.	Family Advocate, Phoenix	The Monitor's office should be reinstated to evaluate the performance of AHCCCS programs.	Noted.
50.	Arizona Hospital and Healthcare Association, Phoenix	Is a draft of the waiver language going to be shared with stakeholders prior to the end of the comment period? Will there be more details in the draft?	The draft narrative is on website. Not all details are covered, particularly operational ones, because we don't know what components of the proposal the federal government will and will not allow. There is sufficient information with regard to the concepts on the website to allow for public comments. We are hoping to develop additional details based on that public feedback.
51.	Community Clinic Provider, Phoenix	If copayments do in fact increase no-show rates among members, will AHCCCS consider this impact on no-show rates as a quality measure?	There are no copayments for office visits, except for specialty care where there is no PCP referral.
52.	Navajo Department of Behavioral Health Services, Flagstaff	When will AHCCCS submit the 1115 waiver to CMS? When do you expect CMS to approve or deny Arizona 1115 waiver?	AHCCCS will submit the 1115 waiver by October 1, 2015. The draft of the waiver is posted on the AHCCCS website. There is no formal time frame by which the federal government has to approve or deny the waiver. Typically, it takes about a year to go through the process. Our current waiver expires by September 30, 2016. AHCCCS anticipates having the new 1115 waiver approved by CMS prior to that expiration date.
53.	AHCCCS Member, Tucson	When will AHCCCS submit the 1115 waiver to CMS?	AHCCCS will submit the 1115 waiver by October 1, 2015. The draft of the waiver is posted on the AHCCCS website.

	Name/Organization	Question	Response
54.	Healthcare Executive, Tucson	When do you expect CMS to approve or deny Arizona 1115 waiver?	There is no formal time frame by which the federal government has to approve or deny the waiver. Typically, it takes about a year to go through the negotiation process. Our current waiver expires by September 30, 2016. AHCCCS anticipates having the new 1115 waiver approved by CMS prior to that expiration date.
55.	Arizona Council for Human Service Providers, Phoenix	Is there a deadline for written comments?	September 25, 2015
56.	Not Disclosed, Phoenix	Is the approval process for AHCCCS still forty days? What if someone has to wait that long to get access to care. The last two days I have been on hold with the hotline for two hours.	There is no change to the eligibility process. We encourage you to bring those cases directly to AHCCCS, so that we may resolve them.
➤ Miscellaneous			
57.	Family Caregiver, Tucson	Do Medicare members with incomes below 138% FPL qualify for AHCCCS coverage?	AHCCCS covers dual eligible members— i.e. members who are eligible for both Medicare and Medicaid coverage. The income threshold depends on whether the individual is acute care enrolled (SSI-MAO covers up to 100% FPL) or ALTCS (300% of the federal benefit rate).
58.	Provider, Flagstaff	Will AHCCCS provide training for ICD-10?	AHCCCS typically does not provide training to providers on claiming issues except for some of our tribal and FFS providers.
59.	Not Disclosed, Phoenix	Can those with serious mental illness be accepted into ALTCS? Why or why not?	Yes, ALTCS is for anyone who is determined to be at risk for institutionalization. You are welcome to apply for ALTCS coverage.
60.	AHCCCS Member, Tucson	AHCCCS should consider bringing KidsCare back.	Noted.

II. The Legislative Partnership: SB 1475 & SB 1092

#	Name/Organization	Question	Response
61.	The Hopi Foundation , Flagstaff	Does SB1092 require AHCCCS to submit a waiver or an amendment on an annual basis to CMS?	Yes. SB 1092 mandates that AHCCCS submit on a yearly basis the waiver amendments that have not been approved by CMS.
➤ Non-Emergency Transportation (NEMT)			
62.	Inter-Tribal Council of Arizona (ITCA), Flagstaff	Does the elimination of NEMT benefit apply only to adults? Will AHCCCS request uncompensated care payments for NEMT services provided by IHS/638 facilities?	Yes, the language of the statute states that the elimination of the NEMT benefit applies to the expansion adult population (100-138% FPL) only. The elimination of NEMT services does not extend to ALTCS, children, and other AHCCCS members. Yes, AHCCCS is seeking to continue this authority into the new Waiver.
63.	AHCCCS Member, Flagstaff	Will the provision on non-emergency use of ED apply to AHCCCS members who live in rural areas?	SB 1475 requires AHCCCS members to pay a \$25 fee for a non-emergency use of the Emergency Department (ED), if there is a community health center, rural health center, or urgent care center within 20 miles of the hospital.
64.	Advocate Mothers of Seriously Mentally Ill (MOMI), Phoenix	Is the SMI population exempt from the elimination of non-emergency transportation? What services are provided to people who need transportation to appointments?	The legislature in SB1475 did not exempt any populations from the elimination of NEMT services. However, AHCCCS will work with CMS to identify certain populations that could be excluded. Non-emergency medical transportation is provided to all members currently to assist them in getting to medical appointments.
65.	Independent Living Facility-Tanner Terrace Apartments, Phoenix	Are dual eligible members exempt from SB 1092?	Yes. The legislative directive applies to the new adult group, not dual eligible members.
66.	Arizona Medical Transportation Association, Phoenix	NEMT service elimination impedes the ability for AHCCCS to promote wellness.	Noted.

#	Name/Organization	Question	Response
		<p>Did the legislature consider studies about the importance of NEMT transportation before developing SB 1475 and SB 1092?</p> <p>Can members use AHCCCS CARE funds to pay NEMT copays?</p>	<p>AHCCCS does not have this information.</p> <p>The legislature has required elimination of NEMT for the expansion adult population. There are not copays for NEMT.</p>
67.	NEMT Service Provider – ComTrans, Phoenix	The NEMT provisions SB 1475 and SB 1092 should apply only to “able-bodied” members. Housing Department should be included in transportation discussions. Public transportation services are inadequate for individuals in Section 8 housing.	The legislative language did not apply exemptions to the NEMT elimination. AHCCCS can explore with CMS opportunities for exempting medically frail populations.
68.	NEMT Provider-Safe Wing Medical Transportation, LLC., Phoenix	<p>The proposal to cut NEMT affects 50 percent of our client base.</p> <p>Did the legislature consider the impact on communities for people who are genuinely trying to seek help?</p>	We would defer to the Legislature on what considerations went into their proposal.
69.	Undisclosed, Phoenix	SMI population exempt from the NEMT elimination?	The legislative mandate applies to all expansion adults above 100% and did not identify any exclusions. AHCCCS will work with CMS to consider exemptions for SMI population.
70.	Provider, Flagstaff	The copays for NEMT services are prohibitive, and will diminish access to healthcare services for members.	Noted.
71.	Family Member, Flagstaff	<p>Communities in Northern Arizona lack access to local transportation. The removal of NEMT services will prevent members from getting access to healthcare services they need.</p> <p>Does SB 1092 exempt rural communities from NEMT elimination?</p>	No, SB 1092 makes no exemptions for members in rural areas. AHCCCS is required by state law to request the authority from the federal government to eliminate NEMT benefits as mandated by SB 1092.
72.	Provider, Tucson	CARE Program will create unnecessary economic obstacles for working	Noted.

#	Name/Organization	Question	Response
		families and will harm access to health services. The elimination of the NEMT program will weaken members' ability to seek treatment for their health needs.	
73.	Pima Council on Aging, Tucson	The elimination of AHCCCS NEMT will create barriers for members to access care, and will drive the cost of healthcare by increasing the number of hospital readmissions.	Noted.
74.	Advocate Mothers of Seriously Mentally Ill (MOMI), Phoenix	Is the SMI population exempt from the requirements of SB 1475?	The legislature did not carve out any populations in SB 1475. However, in looking at implementation of the Governor's plan, AHCCCS is looking for ways to engage at risk populations and for opportunities to partner with providers to better engage these populations.
75.	Arizona Hospital and Healthcare Association, Phoenix	With regards to the copays outlined in legislative directives, when will you be able to release those? Are they tiered by income band?	Copays in the legislative directives are \$8 or \$25 for non-emergency use of the emergency room and premiums set at 2% of income. All other copay amounts are as prescribed in the State Plan.
76.	Arizona Department of Juvenile Corrections (ADJC), Phoenix	Is there consideration of exemptions for punitive requirements for work requirements, copays, and premiums for families in the Department of Child Safety?	The legislative mandates (SB 1092 and SB 1475) do not apply to children. Exemptions for requirements outlined in SB1092 and 1475 are as outlined in the legislation.
77.	Provider Asian Pacific Community in Action, Phoenix	This targets isolated members in our community. My concerns are that our community members already struggle to get time off work and get transportation to services that are not available. If a minimum wage worker in Phoenix pays 5%- that is about \$55 a month. Average rent in Phoenix is \$800- \$55 a month is a lot. This places an immense burden on community members and increases the burden on emergency rooms. The compliance	Noted.

#	Name/Organization	Question	Response
		<p>requirements are called incentives, but are barriers to access to care. Assistors are still struggling through Health-e-Arizona glitches. The proposed waivers do not take into account additional obstacles people face. They don't account for people who are unable to work because of their health or are currently navigating the often several years labyrinth of getting disability benefits. Healthy Arizona sounds like a wonderful idea, if it is voluntary.</p>	
78.	Arizona Bridge to Independent Living (ABIL), Phoenix	Concerned AHCCCS will use federal SSI definitions for "able-bodied." The premiums are punitive for low income individuals who struggle to meet basic needs.	AHCCCS will not replicate the federal disability process. We are putting forward a number of proposals, all of which have to go through the federal review/approval process. AHCCCS will define terms such as "able-bodied" through the rule making process should the federal government approve these legislative provisions.
79.	Arizona Academy of Pediatrics, Phoenix	With regards to value-based purchasing payments how will the legislative mandate impact health plans and ACOs ability to achieve health outcome targets set by AHCCCS?	It is impossible to address this until CMS approves Arizona proposed framework for the waiver.
80.	Representative Juan Mendez- Arizona House of Representatives, Phoenix	<p>What will the average person be expected to pay?</p> <p>What is 3% of the household income?</p> <p>How many people are enrolled in AHCCCS for longer than 5 years?</p>	<p>Copayments will be based on service utilization. At this time, we cannot assess what the average amount to be paid will be. However, for premiums, it is 2% of income. So for an individual at the 133% FPL range, that could be \$25 per month.</p> <p>3% of income for a single individual at the 133% FPL level would be approximately \$450.</p> <p>AHCCCS does not have an estimate of this figure at this time.</p>

#	Name/Organization	Question	Response
81.	Registered Nurse and President of a Phoenix Allies for Community Health, Phoenix	<p><u>Phoenix: Comment Re SB 1092 and SB 1475</u></p> <p>Concerned that members are disenrolled for not meeting healthy targets and work requirements. NEMT services are vital for member's ability to seek timely care. There are many valid reasons to seek ED care for non-emergent conditions.</p>	<p>To clarify, there is no disenrollment for failure to meet Healthy Arizona or AHCCCS Works targets. Hopefully, you articulated your concerns during the legislative process.</p>
82.	Arizona Council for Human Service Providers	<p><u>Phoenix: Comment Re SB 1092 and SB 1475</u></p> <p>Concerned about the adverse effect of copays and disenrollment for members with chronic illness and medically frail populations.</p>	<p>In states that were granted the ability to disenroll for failure to pay, they were also required to exclude persons who are medically frail. We will work with CMS on this going forward. The Governor's plan calls for strategic copays, so there would be no copay for basic services.</p>
83.	NAMI Valley of the Sun, Phoenix	<p><u>Phoenix: Comment Re SB 1092 and SB 1475</u></p> <p>What about a family member caring for child who will reach 7 and then fall under the 5 year lifetime rule. I don't understand the logic. This is still a single parent taking care of a minor. It looks like there are lots of unanswered questions to be answered in a short timeframe. Do we need to pass it before we know what's in it? It seems you are in a rush to put this together and get it to CMS. Many of the General Mental Health population who are non-Title XIX are receiving some mental health services to help keep them from progressing to more disability symptoms. What do we do with their needs in 5 years? Without ongoing services, the cost to provide care will increase.</p>	<p>This is not the first opportunity for public comment on these bills. Both of these bills went through the public process as part of the 2015 legislative session and there were opportunities for public comment, though little was provided. With respect to the non-legislative components of the waiver, there is not a rush. We have the draft up for comment and then will have a yearlong process with CMS. We welcome feedback from NAMI.</p>
84.	Representative Sally Ann Gonzales - Arizona House of Representatives, Tucson	<p>Concerned people will lose access to healthcare as a result of stringent requirements in SB 1475 and SB 1092. Worried that AHCCCS will fail to come up with a suitable definition for "able-bodied" person</p>	<p>Noted.</p>

#	Name/Organization	Question	Response
➤ Work Requirement			
85.	Arizona’s Children Association, Flagstaff	Does the work requirement apply to former foster youth under the Young Adult Transition Insurance (YATI)?	The former foster care members in the Young Adult Transition Insurance (YATI) are exempt from the AHCCCS CARE program as well as the work requirement, lifetime limits and NEMT benefit elimination in SB 1092 and SB 1475.
86.	Arizona Hemophilia Association, Phoenix	How is AHCCCS defining “actively seeking work”?	If the federal government approves this plan, we would look to the Department of Economic Security for guidance on how they define it. AHCCCS will define “actively seeking work” after indication from the federal government that approval is forthcoming.
87.	Community Legal Services, Phoenix	State must not mandate work requirements for individuals who are disabled but have not completed SSI determination process.	Noted. Hopefully, these comments were articulated as part of the legislature’s public process.
88.	Partners in Recovery, Phoenix	Members with disability should not be labeled as permanently unemployable.	The language is taken directly from the statute. Comments regarding appropriateness of language should be directed to the legislature.
89.	Retired Government Employee, Phoenix	The Work requirement provision in SB1092 assumes poor people are lazy and must be forced to work. Communities need more employment opportunities	Noted.
90.	Healthcare Advocate, Tucson	The work requirement provision in SB1092 implies many individuals on AHCCCS are able to work but are not working. What percentage of AHCCCS enrollees are “able-bodied” members who are unemployed?	AHCCCS has not defined “able-bodied” for this purpose and, hence, cannot provide an estimate of number of members unemployed who could seek employment.
91.	CODAC—Behavioral Health Services, Tucson	Will the State change policies to reduce barriers for employment for formerly incarcerated AHCCCS members?	AHCCCS does not manage these policies nor does the State directly mandate who employers can hire. AHCCCS will work closely with the Arizona Department of Economic

#	Name/Organization	Question	Response
			Security (DES) and others to develop a process to help AHCCCS members gain employment.
92.	Tucson Area- Indian Health Services (IHS), Tucson	<p>How will SB 1092 work requirements and 5 year enrollment limit specifically impact Native American member on AHCCCS?</p> <p>Are American Indians exempt from the work requirement and 5 year program enrollment limit stipulated in SB 1092?</p>	<p>SB 1092 does not include specific exemptions for American Indian and Alaskan Native members regarding the work requirement and 5 year enrollment limit. AHCCCS will provide clarification related to impact on American Indian and Alaskan Natives with respect to the work requirement and 5 year limit once terms such as able-bodied are further defined should CMS approval the requirement.</p> <p>SB 1092 does not exempt American Indian and Native Alaskans members from work requirements and 5 year program enrollment limit.</p>
93.	Family Member, Tucson	It will be difficult for individuals to fulfill the work requirements in SB 1092. The legislation is mandating AHCCCS members to seek employment, but there are no jobs within our communities. Furthermore, taking care of family is an important cultural value for members in our community which at times may conflict with the individual's ability to seek employment.	Noted.
94.	NAMI-Southern Arizona , Tucson	The work requirement provisions in SB1092 are punitive towards SMI members and individuals with the least education, job skills, and work experience.	Persons who are "currently receiving temporary or permanent long-term disability benefits" or "persons who have been determined to be physically or mentally unfit for employment" are exempt from the SB 1092 work requirement. This would likely include persons with serious mental illness.

#	Name/Organization	Question	Response
95.	Casa de los Ninos, Tucson	Who will determine the definition for “able-bodied” adult? And how will “able-bodied” adult be defined?	If the federal government were to approve the legislative mandate, AHCCCS would have to define the term “able-bodied.” AHCCCS will not convene this assessment process until the federal government approves the work requirement provision in SB 1092.
96.	MIKID (Children Behavioral Health Services), Phoenix	<p><u>Phoenix: Comment Re Work Requirement</u></p> <p>As we look at legislative and AHCCCS plans, how much of either actually talked to people receiving services? We have access to folks who could have given wisdom. It feels like there is an overarching assumption that people who are poor need disincentives to do better. What we know is punishment doesn't work. If you are teaching people to take care of themselves better, then incentives work. Take away the disincentives and create incentives for providers do better. Get feedback from customers. Can incentive systems to do better?</p> <p>With regards to the cutback on nonemergency use of the emergency room and non-emergency transportation, this means people will not get regular services. I hope you get all comments in the record.</p> <p>Around youth and young adults, there is a huge number not in the system who come back at 23 and it took more than five years to figure it out. In the legislation, those who took six years to figure it out would be done per the 5-year limit. Now they are ready to get a job, but are still in poverty. But, they can't get a job. You need healthcare while getting yourself out of poverty.</p>	Noted.

#	Name/Organization	Question	Response
➤ Five Year Lifetime Enrollment Cap			
97.	Inter-Tribal Council of Arizona (ITCA), Flagstaff	Does SB1092 include an exemption for American Indian in regards to the 5 year life-time limit?	No, SB1092 does not exempt American Indian and Native Alaskan members from the 5 year life -time enrollment limit.
98.	Advocate For Hemophilia Clients, Phoenix	Please exclude members with hemophilia from the 5 year program limit.	Noted.
99.	Arizona Department of Juvenile and Corrections (ADJC), Phoenix	Do the criteria that result in adult disenrollment result in disenrollment of children as well?	The 5 year limit does not apply to children. Children may still be eligible if their parent has been disenrolled.
100.	Provider, Phoenix	Are retroactive payments to providers impacted when members are disenrolled from AHCCCS due to the 5 year limit?	Providers receive payment for services furnished to persons who are AHCCCS eligible.
101.	Juvenile Probation, Phoenix	Are youth and adolescents impacted by the disenrollment, lifetime cap, work requirements clauses in SB 1092?	Youth are not included in in AHCCCS Care Program or legislative directives. The legislation also provides for specific exemptions for a single parent with a child under 6.
102.	Healthcare Advocate, Tucson	The 5 year enrollment limit implies that members are on AHCCCS for an extended period of time. What is the average enrollment period for an individual on AHCCCS?	AHCCCS currently does not have information available on average enrollment period for members.

III. Delivery System Reform Incentive Payment (DSRIP)

#	Name/Organization	Question	Response
103.	Provider, Flagstaff	Will the DSRIP program change payments for all providers contracted with AHCCCS?	No, DSRIP will not change payments for all providers contracted with AHCCCS. Providers can participate on a voluntary basis in DSRIP to implement delivery system and payment reform projects. Participating providers are then reimbursed an incentive payment for achieving system reform goals.

#	Name/Organization	Question	Response
104.	Reporter- The Hertel Report, Phoenix	What is the funding source for the DSRIP?	AHCCCS is exploring various ways to fund DSRIP. Some states have used Medicaid savings or Designated State Health Programs (DSHP) to fund the initiative.
105.	Arizona Hospital and Healthcare Association	We appreciate the DSRIP provisions in the waiver.	Noted.
106.	Retired Healthcare Executive and Family Member, Tucson	The Medicaid system in Arizona is a model for the country. Programs like DSRIP have the potential to improve care coordination, quality, and cost effectiveness of care.	Noted.

IV. American Indian Medical Home

107.	Retired Healthcare Executive and Family Member, Tucson	The medical and behavioral health and the native American medical home model are programs that can improve our delivery system for Medicaid populations. But, more needs to be done in terms of developing multidisciplinary medical homes for children with complex healthcare needs, disabled adults, and chronically ill members.	Noted.
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V. Building upon Past Successes

108.	Utilization Director-Tuba City Regional Health Care (TCRHCC), Flagstaff	With the request for renewal of the IHS and tribal 638 uncompensated care payments included in this waiver, it is important that we at our facility are able to reconcile those payments to look at the services provided, cost services, patient utilization, and reimbursement for services. Is AHCCCS willing to share with our facility the values used in the calculations for those payments for the historical and current value of the enrollment numbers, and the descriptive rates of the payments?	AHCCCS is willing to share with IHS and 638 facilities the data for calculating uncompensated care payments. Furthermore, AHCCCS is prepared to work with stakeholders through the tribal consultation process to revise the uncompensated care payment methodology.
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#	Name/Organization	Question	Response
109.	Inter-Tribal Council of Arizona (ITCA), Flagstaff	Will the Urban Indian program be included as a provider that will receive uncompensated care payments?	If the workgroup around this issue recommends including Urban Indian programs, the State will consider the request.
110.	Partners in Recovery, Phoenix	Will there be changes to service delivery as a result of AHCCCS and DBHS merger? I am concerned because a couple PNOs have recently dissolved.	Merger is between DBHS and AHCCCS so that the RBHA is under a direct contract to AHCCCS and not a subcontract to DBHS. There are no changes to the RBHA contracts or changes to covered services or service delivery as a result of the merger. The PNO dissolution in Maricopa county is not related to the merger.
111.	Community Activist, Phoenix	AHCCCS and DBHS merger should accelerate transformation in service delivery. Members with SMI should have access to all physicians and pharmacies to enhance member choice and access to timely care.	Noted.

ATTACHMENT 7

Tribal Consultation Summary



TRIBAL CONSULTATION MEETING

August 21, 2015

Conference Bridge: 1-877-820-7831, Participant Passcode: 108903#

NOTIFICATION TO TRIBES:

Good Afternoon,

This is a reminder of the August 21, 2015 AHCCCS Tribal Consultation meeting to be held in Flagstaff at the Flagstaff Medical Center in the McGee Auditorium from 10:00 a.m. to 12:00 p.m. For those who cannot attend in-person, the meeting can be accessed by teleconference at, 1-877-820-7831, Participant Passcode: 108903#. All meeting presentations and handouts can be viewed or downloaded at the AHCCCS website at the following link:

<http://www.azahcccs.gov/tribal/consultations/meetings.aspx>.

Finally, the AHCCCS 1115 Waiver Tribal Forum will be held at the same location from 1:00 p.m. to 3:00 p.m. Teleconference access is not available for the Waiver Forum.

Sincerely,
Bonnie

Bonnie Talakte

Tribal Relations Liaison
AHCCCS Office of Intergovernmental Relations
801 E. Jefferson, MD-4100 | Phoenix, AZ 85034
(602) 417-4610 (Office) | (602) 256-6756 (Fax)
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AHCCCS TRIBAL CONSULTATION MEETING

With Tribal Leaders, Tribal Members, Indian Health Services, Tribal Health Programs Operated Under P.L. 93-638
and Urban Indian Health Programs

Date: August 21, 2015
Time: 10:00 a.m. – 12:00 a.m. (MST)
Location: Flagstaff Medical Center, McGee Auditorium, 1200 N. Beaver St. Flagstaff, AZ 86001
Conference Call-In: 1-877-820-7831 Participant Passcode: 108903#

AGENDA

TIME	TOPIC	PRESENTER
10:00 –10:10 a.m.	Welcome Opening Prayer Introductions	<i>Thomas Betlach</i> AHCCCS Director <i>Cheryl Stover,</i> Reverend, White Mountain Apache Assembly of God Church <i>Thomas Betlach</i>
10:10 –10:40 a.m.	AHCCCS Update: <ul style="list-style-type: none"> • Community Based Behavioral Health Centers • Division of Behavioral Health Services Merger • General Mental Health/Substance Abuse Service Changes (GMH/SA) • Enrollment 	<i>Thomas Betlach</i>
10:40 –11:00 a.m.	1115 Waiver Update	<i>Monica Coury,</i> Assistant Director Office of Intergovernmental Relations
11:00 –11:15 a.m.	1. Care Coordination Update 2. 0516 Language	<i>Denise Taylor-Sands,</i> Tribal Health Care Coordinator <i>Markay Adams,</i> Behavioral Health Care Coordinator <i>Elizabeth Carpio,</i> Assistant Director, DFSM
11:15 –11:30 a.m.	Home and Community Based Services (HCBS) Rules	<i>Dara Johnson,</i> Program Development Officer Division of Health Care Management <i>Virginia Rountree,</i> Operations Administrator, DHCM
11:30 –11:45 a.m.	1. Electronic Health Record (EHR) Program 2. Teledentistry	<i>Jakenna Lebsock,</i> Quality Improvement Manager Clinical Quality Management
11:45 – 12:00 p.m.	Promising Practice - White Mountain Apache Tribe NEMT Provider Training Process	<i>Cheryl Stover,</i> White Mountain Apache Tribe Director, Client Business Office Patient Transportation/ALTCS Program
12:00 p.m.	Wrap-Up/Announcements/Adjourn	<i>Thomas Betlach</i>

ATTENDEES:

Tribes	<p><u>Gila River Indian Community:</u> Deannah Neswood-Gishey <u>Havasupai Tribe:</u> Cody Susanyatewa <u>Hopi Tribe:</u> Angelina James, Jan Manuel, Danny Honanie, Leon Lomakema, Laverne Dallas <u>Hualapai Tribe:</u> Sandra Irwin <u>Navajo Nation:</u> Clarence Chee, Theresa Galvan, Martha Shorty, Sheena Lee, Walt Jones, Gen Holona, Lucy Nez, Lonnie Witt <u>White Mountain Apache:</u> Cheryl Stover <u>Yavapai Apache Nation:</u> Robin Hazelwood, Annette Mendez</p>
I/T/Us	<p><u>Fort Defiance Indian Health Care:</u> Christine Becenti, Terrilynn Chee <u>Native Health:</u> Evelina Maho, Deanna Sangster <u>Navajo Area IHS:</u> K. Dempsey <u>Phoenix Area IHS:</u> Carol Chicharello, Patsy Nulls <u>Phoenix Indian Health Center:</u> John Meeth, Doreen Pond <u>Tuba City Regional Health Care Corporation:</u> Bill Dey, Selena Simmons, Lynette Bonar, Violet Skinner, Melverta Barlow, Christine Keyonnie <u>Tucson Area IHS:</u> Bernard DeAsis <u>Winslow Indian Health Care Center:</u> Alice McCabe, Kelly Saganey, Dyanne Medina-McCabe, Louise Furcap, Beverly Lewis</p>
State Agencies	<p><u>Advisory Council on Indian Health Care:</u> Kim Russell <u>Arizona Department of Economic Security:</u> Kelly Norris, Joe Goitia, <u>Arizona American Indian Oral Health Initiative:</u> Hermina Frias <u>Arizona Department of Behavioral Health Services:</u> Anne Dye</p>
State Legislature	<p><u>AZ State Representative:</u> Jennifer Benally <u>AZ State Senator:</u> Caryle Begay</p>
Other	<p><u>Apache Behavioral Health:</u> Shannon Gollner <u>Association for Disabled Citizens, Inc.:</u> Katherine Nez <u>Cenpatico:</u> Julia Chavez, Sheina Yellowhair <u>Dine Association:</u> Rose Bizardie <u>Flagstaff Bone & Joint:</u> Shannon Linvill <u>Flagstaff Medical Center:</u> Mark Carole <u>Hozhoni:</u> Monica Attridge, Jennie Key, <u>Inter Tribal Council of Arizona (ITCA):</u> Alida Montiel, Verna Johnson, Anne Susan <u>Mercy Maricopa Integrated Care:</u> Faron Jack <u>Native Resource Development:</u> Jermiah Kanuho, Penny Emerson <u>Northern Arizona Regional Behavioral Health Association (NARBHA):</u> Gabe Yaiva, Holly Figueroa <u>Raising Special Kids:</u> Trudy John <u>Saint Michaels Association for Special Education (SMASE):</u> Alex Pina, Helene Hubbard, Bob Brown, Michele Spencer <u>The Hopi Foundation:</u> Marissa Nuwayestewa</p>
AHCCCS Representatives	<p>Tom Betlach, Elizabeth Carpio, Monica Coury, Bonnie Talakte, Denise Taylor-Sands, Markay Adams, Linda Cram, Shannon Shiver, Mohamed Arif, Virginia Rountree, Dara Johnson, Jakenna Lebsock</p>

MEETING SUMMARY

TOPICS	SUMMARY
AHCCCS Updates	<p>Thomas Betlach, AHCCCS Director, provided the AHCCCS Update on the following topics. The AHCCCS Update PowerPoint Presentation can be viewed at the AHCCCS website under Tribal Consultation meetings: http://www.azahcccs.gov/tribal/consultations/meetings.aspx</p> <p>Enrollment: As of July 2015, there is a slight decrease in AIHP enrollment. The number of AIHP adults with dependent children has seen a slight increase over the 2014 forecasted number. To date, there are 1.75 million Arizonan's enrolled in state Medicaid with 458,000 added since December of 2013.</p> <p>AHCCCS/DBHS Merger Update: AHCCCS has been working with DBHS on operational issues including systems and contracting. Starting August of 2015 DBHS staff has transitioned into new positions at AHCCCS. By the end of the 2015 calendar year, 90% of DBHS staff will be transferred. In regard to the merger, Director Betlach and DFSM staff has met with TRBHA's to discuss current IGAs and to hear their concerns about the merger.</p> <p>October 1, 2015 Transitions: American Indians will continue to retain choice of FFS for physical services and choice of TRBHAs and RBHAs for behavioral health services. AHCCCS members have choice of RBHAs through two contractors; Cenpatico Integrated Care who will provide services to the Southern Arizona region and Health Choice Integrated Care who will provide services to the northern region of the state. The San Carlos Apache Tribe will receive BH services from Cenpatico Integrated Care. Behavioral health services for 80,000 dual eligible members will move from the RBHA system to AHCCCS health plans.</p> <p>Other Merger Issues: All TRBHAs will remain the same. IGAs with TRBHAs will continue. DBHS is the single state agency receiving SAMSA funding. As part of the merger, this funding will be transferred to AHCCCS. In addition, funding for state grants used for housing SMIs will be transferred to AHCCCS. AHCCCS will not be applying for planning grants for community behavioral health clinics at this time.</p>
1115 Waiver Update	<p>Monica Coury, Assistant Director of Intergovernmental Relations, provided the 1115 Waiver Update. The PowerPoint presentation can be viewed at the AHCCCS website under Tribal Consultation meetings: http://www.azahcccs.gov/tribal/consultations/meetings.aspx.</p> <p>Definition of Section 1115: Monica provided a definition of Section 1115 as a Social Security act that gives states authority to waive selected Medicaid requirements in federal law. Arizona's Waiver allows the State to run a unique Medicaid model build around a statewide managed care system that;</p> <ul style="list-style-type: none"> • provides health care to expanded populations • services members enrolled in the Arizona Long Term Care system (ALTCS) in communities rather than institutions

- allows spouses as paid caregivers in ALTCS and,
 - implements administrative practices that increase efficiency.
- Arizona's current waiver is scheduled to expire on September 30, 2016. The State is required to give notice of its intentions one year in advance and will submit a letter of intent to apply for a new demonstration by September 30, 2015. The process of approval requires Arizona's application to go through a lengthy process including obtaining approval from the Center for Medicare and Medicaid (CMS) which is responsible for oversight of State Medicaid Agencies. The Office of Management and Budget and the Department of Health and Human Services (DHHS) also reviews waiver proposals. 1115 Waivers are approved at the discretion of the HHS Secretary.

Arizona's Application

The application for a new 5-year waiver includes:

- Part I: Governor Ducey's vision to modernize Medicaid: the AHCCCS CARE program
- Part II: The Legislative Partnership
- Part III DSRIP: Arizona's Approach
- Part IV: HCBS Final Rule
- Part V: American Indian Medical Home
- Part VI: Building Upon Past Successes
- Part VII: Safety Net Care Pool

Each section of the application was discussed in detail by Monica. The application can be viewed in its entirety at:

<http://www.azahcccs.gov/shared/Downloads/WaiverApplicationNarrative.pdf>

Public Comment Process:

Five public hearing and tribal consultation are scheduled to seek input.

Comments can be submitted at:

<http://azahcccs.gov/publicnotices/Downloads/WaiverForumFlyer.pdf>

Written comments (by mail or electronic) should be submitted and received no later than September 25, 2015.

1115 Waiver Questions & Answers

Question: "How did AHCCCS determine the PMPM rate of \$7.11 for the medical home model and why does this differ from the 2011 AIHMP recommended PMPM rate of \$11.83 in a report prepared for AHCCCS?"

Answer: "We'd be happy to take additional information on that. The dollar amount was what we came to through tribal consultation and the stakeholder process. We're happy to look at that again."

Question: "Under the Medical Home model, would IHS/tribal facilities be reimbursed for allocating their care coordination staff to non-IHS/tribal to help those non-IHS/tribal facilities reduce their re-admission rates that they are being financially rewarded for. Is that correct?"

Answer: "Yes. We want to spark those partnerships. Flagstaff Medical Center is a great example that has a high population of our American Indian members. We're looking for ways to support partnerships with non-IHS/638 facilities that supports both sides and allows you to better manage care of your members"

Question: “Can you clarify the premiums and co-pays, if ALTCS children and adults will be exempt from those and if not what the basis will be.”

Answer: “The premiums and co-pays are for the expansion adult populations and not ALTCS.”

Question: “What are the expenditure authorities are you proposing to CMS and how long (if approved) are you considering the demonstration programs?”

Answer: “We are seeking a 5 year contact with the federal government. The entire package includes a number of different expenditure authorities. We don’t have a large number of new authorities except as it relates to the American Indian Medical Home, as an example. We are looking for expenditure authority to make reimbursements as it relates to primary care case management which is not a covered service as is diabetes education for the rest of our population just some examples of expenditure authorities we are seeking from the federal government. The special terms and conditions are contract terms that get negotiated over time over the coming year.”

Question: “Can you explain how expenditure authority would cover traditional services.”

Answer: “Currently we don’t reimburse for those services. It’s not a benefit covered by Medicaid so that’s another expenditure authority we’d need to get federal authorization for so we could pay for those services. Right now it’s just listed so that the federal government knows we are seeking its authority. To really develop what it might look like, what might be covered, what might not be covered, what kind of qualified providers would provide these services, those are details we have to develop in partnership through the tribal consultation process. As we get to discussions a workgroup might be formed. We need to learn from all of you who you think are qualified providers. Those types of details will need to be provided to CMS as part of the final language that will live in our Waiver. They will want to see all those parameters

Questions: 1) “Would co-pays, deductibles, premiums and non-emergency use of ED charges apply to AI/AN in acute care plans (MCOs) as opposed to AIHP?”

2) “Please summarize all proposed charges to be imposed on AHCCCS members”

Answer: 1) “Co-pays can’t be assessed on any American Indian whether they are MCO enrolled or Fee-for Service enrolled. Those would not apply. The AHCCCS CARE Program would be strictly voluntary, optional for American Indians.”

2) “There aren’t any co-pays that apply except for pharmaceuticals that would apply to opioids. In terms of specialist care it (co-pays) would apply if you haven’t been through your PCP, non-emergencies to the ED, missed appointments.. We’re moving away from co-pays in the traditional sense and moving toward co-pays that steer care to the right place and provider to support your effort to manage your own care.”

	<p>Question: “How soon after September 30th do we need to have some sort of document submitted to CMS in regard to traditional services?”</p> <p>Answer: “We don’t have to wait until September 30th let’s start a workgroup as soon as people are ready. As soon as the group can come up with some parameters the ideal would be to do something before the end of the year that gives CMS enough time to walk it through their process of federal review. If we’re getting into the work and we’re not finish by the end of the year we can submit parts of it or dialogue with CMS and get feedback.”</p> <p>Question: “Is there a piece in the legislature that requests an exemption from providing NEMT services from October 1, 2015 to September 30, 2016? Is that in the Waiver as well?”</p> <p>Answer: “Yes, that is in Senate Bill 1475 and applies to the expansion adult group, 100-133%. I have seen a couple of states get that exemption from NEMT. We’ll have a conversation with CMS about what that exemption looks and might have a requirement that may not include medically frail, people with special health care needs in that exemption. The legislature did not make exemptions for American Indians. I recommend you submit your comments on the exemption so we can share them with legislature and the Governor’s Office.”</p>
<p>Care Coordination Update & 0516 Language</p>	<p>Due to time constraints, the Care Coordination and 0516 Language presentation was postponed until a later date..</p>
<p>Home and Community Based Services (HCBS)</p>	<p>Dara Johnson and Virginia Rountree provided information on the HCBS rule changes required by CMS. The PowerPoint presentation on this topic can be viewed at the AHCCCS website under Tribal Consultation meetings: http://www.azahcccs.gov/tribal/Downloads/consultations/meetings/2015/HCBS82115.pdf</p> <p>The presentation included: HCBS Rules Orientation, Arizona’s Systemic Assessment and Transition Plan and Public Comments Submissions. Dara and Virginia defined what settings are Home and Community Based settings and what residential and non-residential settings are assessed. They provided the 10 HCBS rules that can be viewed in their entirety at the Tribal Consultation website.</p> <p><u>Purpose of HCBS Rules:</u></p> <ul style="list-style-type: none"> • Enhance the quality of HCBE • Provide protections to participants • Assure full access to benefits of community living <p>Scope:</p> <ul style="list-style-type: none"> • Licensed settings • Residential and Non-Residential <p><u>Purpose of Systemic Assessment and Transition Plan</u></p> <ul style="list-style-type: none"> • Review and evaluation of standards and requirements for setting types <ul style="list-style-type: none"> • Arizona Revised Statutes • Arizona Administrative Code • AHCCCS and MCO Policy • AHCCCS Contracts with MCOs

<p>HCBS Question & Answer</p>	<ul style="list-style-type: none"> • MCO contracts with providers <p>Process:</p> <ul style="list-style-type: none"> • Assessed each specific rule requirement for each setting type • Answered the question “What is culturally normative for individuals not receiving Medicaid HCBS?” • Utilized exploratory questions provided by CMS • Only captures what is outlined on paper • The HCBS Rules may be implemented in practice • Site specific assessments will be implemented as part of the Transition Plan • Includes policies that are not specific to the setting type (i.e. role of the Case Manager) <p><u>Public Comment (August 2015):</u> Public engagement in the HCBS process is accomplished through the following:</p> <ul style="list-style-type: none"> • Statewide public forums • Public comment <ul style="list-style-type: none"> ○ Written correspondence (email or mail) • Check the AHCCCS website regularly for updates www.azahcccs.gov/HCBS <p>Question: “If I have a group home and my clients will live in the facility and they receive Medicare/Medicaid will the facility have to comply with the Medicare/Medicaid rules?”</p> <p>Answer: “Yes, if the facility is receiving Medicare/Medicaid dollars and they provide payment for clients to live there, the facility will have to comply.”</p>
<p>Electronic Health Record Program & Teledentistry</p>	<p>Due to time constraints, the Electronic Health Record Program and Teledentistry presentation was postponed until a later date..</p>
<p>White Mountain Apache Tribe, NEMT Provider Training Process: Promising Practice Presentation</p>	<p>Cheryl Stover, Director of the White Mountain Apache Tribe (WMAT) Client Business Office, was requested by AHCCCS to provide a presentation on the successful WMAT Non-Emergency Medical Transportation (NEMT) Program. The program was developed to address the illegal activity of NEMT’s operating on tribal land without the approval of the Tribe. As a new Director, Ms. Stover found that the Tribe’s oversight of NEMT lacked management and structure. The PowerPoint presentation on this topic can be viewed at the AHCCCS website under Tribal Consultation meetings: http://www.azahcccs.gov/tribal/Downloads/consultations/meetings/2015/WhiteMountainApacheTribe.pdf</p> <p>Steps taken to bring about order and cooperation include:</p> <ul style="list-style-type: none"> • Cease & Desist Letter from the Attorney General <ul style="list-style-type: none"> • Issued with support of Tribal Council • Completed Contract / NEMT Policies and Procedures Manual <ul style="list-style-type: none"> • Set up Flow Chart / Limitations • Who was responsible for WHAT???? • Signing meeting to review & sign new contract <ul style="list-style-type: none"> • Companies that had all required documents in.

- Orientation for All Employees
 - Inspected All Vehicles ready to operate
 - Inspections Continue for every new vehicle
 - Constant Monitoring / Communication with Owners
 - Designated a Point of Contact (Tribal Member)
 - Follow-up on all complaints
- The program focuses on four goals :
- Networking
 - Team Work
 - Sticking to Rules and Regulations set
 - Quarterly Meetings
- Successes include:
- Organization and Management by a Network of Programs
 - Improved Communication among
 - NEMT Owners, POC, New Position-NEMT Clerk
 - Decrease in Complaints
 - Due to fines and really sticking to Policies and Procedures
 - Smoother Operations
 - Everyone knows the rules and CBO is WATCHING!!!
 - Safe Transportation
 - Owners are more accountable for their drivers
 - Patients are transported in Vehicles that are in Good Condition.

Attachment 8
Legislative Hearings

Agendas can be obtained via the Internet at <http://www.azleg.state.az.us/CommitteeAgendas.asp>
 Persons with a disability may request a reasonable accommodation such as a sign language interpreter, by contacting the Senate Secretary's Office: (602) 926-4231 (voice). Requests should be made as early as possible to allow time to arrange the accommodation.

ARIZONA STATE SENATE

Fifty-second Legislature - First Regular Session

MEETING NOTICE

COMMITTEE ON HEALTH AND HUMAN SERVICES

DATE: Wednesday, February 11, 2015

TIME: 2:00 P.M.

ROOM: SHR 1

SENATORS:	Bradley Hobbs Lesko	Pancrazi Yee	Ward, Vice-Chairman Barto, Chairman
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1. Call to Order
2. Roll Call
3. Approval of Minutes
4. Consideration of Bills

Bills	Short Title	Subject of Strike Everything Amendment
SB1092	_____ AHCCCS; annual waiver submittals. (Barto)	
SB1214	_____ homeopathic board; licensure; regulation (Barto)	
SB1226	_____ parent-child relationship; termination; petition (Pancrazi)	
SB1241	_____ AHCCCS; contractors; providers (Barto)	
SB1257	_____ medical licensure; state programs; prohibition (Ward)	
SB1267	_____ schools; exempt fundraisers (Lesko, Allen, Barto, et al)	
SB1283	_____ outpatient treatment centers; colocation; respite (Barto)	
SB1318	_____ abortion; health care exchange; licensure (Barto, Allen, Burges, et al)	

**Subject of Strike Everything
Amendment**

Bills

Short Title

SB1329	_____	nutrition assistance; limitations; benefit card (Ward)
SB1370	_____	controlled substances prescription monitoring program (Kavanagh)
SB1400	_____	human rights committees; members (Barto: Ward)
→ SB1420	=====	health insurance; formulary; disclosure (Barto)
SCR1003	_____	interstate medical licensure compact; opposition (Ward)
→ SB1282	=====	tele-dentistry; dental hygienists; dental assistants (Ward, Bradley, Dalessandro, et al)
↘ SB1439	_____	judicially appointed psychologists; complaints (Smith)



~~2/5/15~~
~~2/6/15~~
2/9/15
SAS

Agendas can be obtained via the Internet at <http://www.azleg.state.az.us/CommitteeAgendas.asp>
Persons with a disability may request a reasonable accommodation such as a sign language interpreter, by contacting the Senate Secretary's Office: (602) 926-4231 (voice). Requests should be made as early as possible to allow time to arrange the accommodation.

ARIZONA STATE SENATE

Fifty-second Legislature - First Regular Session

MEETING NOTICE

COMMITTEE ON APPROPRIATIONS

DATE: Thursday, March 5, 2015

TIME: 3:00 P.M. OR
UPON RECESS
OF FLOOR*

ROOM: SHR 109

SENATORS: Allen Hobbs Kavanagh, Vice-Chairman
 Cajero Bedford Lesko Shooter, Chairman
 Farley Ward

1. Call to Order
2. Roll Call
3. Approval of Minutes
4. Consideration of Bills

Bills	Short Title	Subject of Strike Everything Amendment
SB1469	_____ general appropriations; 2015-2016. (Biggs, Allen, Griffin, et al)	
SB1470	_____ capital outlay; 2015-2016. (Biggs, Allen, Griffin, et al)	
SB1471	_____ revenue; budget reconciliation; 2015-2016. (Biggs, Griffin, Shooter, et al)	
SB1472	_____ budget procedures; 2015-2016. (Biggs, Allen, Griffin, et al)	
SB1473	_____ government; budget reconciliation; 2015-2016. (Biggs, Allen, Griffin, et al)	
SB1474	_____ environment; budget reconciliation; 2015-2016. (Biggs, Allen, Griffin, et al)	
SB1475	_____ health; budget reconciliation; 2015-2016. (Biggs, Allen, Griffin, et al)	
SB1476	_____ K-12 education; budget reconciliation; 2015-2016. (Biggs, Allen, Griffin, et al)	

Bills	Short Title	Subject of Strike Everything Amendment
SB1477	_____ higher education; budget reconciliation; 2015-2016. (Biggs, Allen, Griffin, et al)	
SB1478	_____ criminal justice; budget reconciliation; 2015-2016. (Biggs, Allen, Griffin, et al)	
SB1479	_____ human services; budget reconciliation; 2015-2016. (Biggs, Allen, Griffin, et al)	
SB1480	_____ agency consolidation; budget reconciliation; 2015-2016. (Biggs, Allen, Griffin, et al)	
SCR1018	_____ trust land management; budget reconciliation. (Biggs, Allen, Griffin, et al)	

* With permission of the President

3/4/15
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Attachment 9

Arizona Republic Publication

Order Confirmation

<u>Ad Order Number</u> 0008439748	<u>Sales Rep.</u> weavert	<u>Order Taker</u> weavert	<u>Ordered By</u>
<u>Customer</u> AHCCCS	<u>Payer Customer</u> AHCCCS		
<u>Customer Account</u> 6024174000AHCC	<u>Payer Account</u> 6024174000AHCC		
<u>Customer Address</u> 801 E. JEFFERSON ST,MD4200,THERES Phoenix AZ 85034 USA	<u>Payer Address</u> 801 E. JEFFERSON ST,MD4200,THERES Phoenix AZ 85034 USA		
<u>Customer Phone</u> 602-417-4000	<u>Payer Phone</u> 602-417-4000		
<u>Customer Fax</u>	<u>Order Source</u>		
<u>Customer Email</u> Monica.Coury@azahcccs.gov	<u>PO Number</u>		

Ad Content Proof

Public Notice:

This notice is to inform the public that the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid Agency, is seeking public input on its proposed Section 1115 Demonstration application to the Centers for Medicare and Medicaid Services. The Demonstration application will seek waiver authority to continue its current efficient and innovative model and will seek additional authority to implement new programs and processes proposed to be effective beginning October 1, 2016 through September 30, 2021. The current authority AHCCCS will seek to continue includes the ability for AHCCCS to run its unique and successful managed care model and exempts Arizona from certain provisions of the Social Security Act. It also includes expenditure authority for costs not otherwise matched by the federal government. Specifically, the proposed Demonstration application will request that Arizona be permitted to:

- Mandate managed care;
- Provide Long Term Care Services in home and community-based settings rather than more costly institutions; and
- Implement administrative simplifications.

AHCCCS will seek new authority to implement Governor Ducey's vision to modernize Medicaid through the AHCCCS CARE Program that will engage Arizonans to take charge of their health through premiums of up to 2% of income for use in a health savings account and through copays of up to 3% of annual household income. The proposed Demonstration application will also request authority to:

- Administer delivery system reform incentive payments;
- Establish the American Indian Medical Home;
- Conduct an assessment and transition plan for Arizona's successful Home and Community Based Services program;
- Eliminate non-emergency transportation for certain populations;
- Impose a lifetime enrollment limit of 5 years for certain populations;
- Require certain individuals to be actively seeking employment; and
- Other modifications to achieve greater health outcomes for members and long-term sustainability for the program.

Public hearings (also called Community Forums) where the public can provide comments and questions about the proposed Demonstration application will be taking place throughout the State beginning on Tuesday, August 18 from 12:30pm to 2:30 pm in Phoenix at the Disability, Empowerment Center (5025 E. Washington Street, Phoenix, AZ 85034). Other public hearings and community forums will be held as follows:

- 8/20/2015 from 10am to 12pm in Yuma at the Regional Center for Border Health (214 W. Main St; Somerton, AZ 85350)
- 8/21/2015 from 1pm to 3pm in Flagstaff at the Flagstaff Medical Center McGee Auditorium (1200 N. Beaver St; Flagstaff, AZ 86001)
- 8/26/2015 from 10am to 12pm in Tucson at the Casino Del Sol Ballroom B (5655 W. Valencia Rd., Tucson, AZ 85757)

More information about the public hearings and community forums scheduled throughout the State can be found on the following link: <http://www.azahcccs.gov/publicnotice/Downloads/WaiverForumFlyer.pdf>

Comments and questions about the proposed Demonstration application can also be submitted by e-mail to: publicinput@azahcccs.gov or by mail to: AHCCCS c/o Office of Intergovernmental Relations, 801 E. Jefferson Street, MD 4200, Phoenix, AZ 85034. All comments must be received by September 25, 2015. More information about the proposed Demonstration application, including the proposed Demonstration application and the full public notice and public input process, can be found on the AHCCCS website at: <http://www.azahcccs.gov/shared/FiveYear.aspx>
Pub: August 20, 2015

<u>Tear Sheets</u>	<u>Proofs</u>	<u>Affidavits</u>	<u>Special Pricing</u>	<u>Promo Type</u>
0	0	0	None	

<u>Package Name</u>	<u>Blind Box</u>	<u>Payment Method</u>

Invoice Text

Materials

<u>Net Amount</u>	<u>Tax Amount</u>	<u>Total Amount</u>	<u>Payment Amt</u>	<u>Amount Due</u>
\$1,713.60	\$0.00	\$1,713.60	\$0.00	\$1,713.60

<u>Ad Number</u> 0008439748-01	<u>Ad Type</u> C-CLS Liner	<u>Ad Size</u> : 2.0 X 84 Li
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<u>External Ad Number</u>	<u>Ad Released</u>	<u>Ad Attributes</u>
	No	

<u>Color</u> <NONE>	<u>Pick Up</u>	<u>Production Method</u> Internal
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Production Notes

<u>Product Information</u>	<u>Placement/Classification</u>	<u># Inserts</u>	<u>Cost</u>
<u>Run Dates</u> <u>Sort Text</u> <u>Run Schedule Invoice Text</u>			

C-Classified::	Legals	1	\$1,713.60
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8/20/2015
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Public Notice: This notice is to inform the publi