



*Primary Healthcare for All*

December 4, 2015

The Honorable Sylvia Mathews Burwell, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Dear Secretary Burwell,

The Arizona Alliance for Community Health Centers (AACHC) appreciates the opportunity to comment on Arizona's proposed new Section 1115 Medicaid Demonstration waiver titled the AHCCCS CARE program.

AACHC and AHCCCS have built a strong partnership over the years and we are committed to continue to work closely with AHCCCS on promoting ongoing positive changes in the delivery of healthcare to Arizona's 1.7 million Medicaid beneficiaries. While we want to acknowledge AHCCCS' positive efforts to foster innovative approaches to the delivery of health care to the most vulnerable populations in our state, we also have concerns about potentially negative impacts on Arizona's Medicaid Expansion.

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 dedicated 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 provide and 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 greatest 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 in the proposed 1115 waiver that may adversely impact AHCCCS members and/or healthcare providers as AHCCCS pursues long-term valued based care and the "modernization" of the Arizona Medicaid program.

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The Arizona legislature has mandated through SB1092/ Chapter 7, that AHCCCS secure a waiver to impose a *5-year lifetime ban on the receipt of Medicaid healthcare* coverage for able-bodied adults, with some exclusions. This approach is inconsistent with the 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 employment. These circumstances are not recognized or identified in the exceptions enumerated by the law. Additionally, members may reach their 5-year lifetime limit, but still experience financial barriers and need health services beyond the five year life-time restriction. It could result in individuals delaying care or not seeking care, which increases the cost of care for the patient who is now uninsured thus creating and placing the financial burden on the statewide healthcare system and the patients/families. **AACHC is not supportive of this proposal, but does support efforts to assist individuals in securing job training and employment that provides a livable wage and employer healthcare benefits.**

Second, another bill passed in the last legislative session, SB1475/ Chapter 14 eliminated the non-emergency medical transportation for AHCCCS members who are above 100% 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 needs. If a family lives in an auto-dependent community, which is most typical in Arizona, 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 most of these centers do not operate 24 hours a 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-emergent use of the emergency room compared to national averages. AHCCCS concluded that the health plans will continue 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 and 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) and another acute medical condition, such as a sinus infection, is discovered during the examination, would the member have a copayment for that condition, or would be left to the discretion of the provider as to how the visit is coded? Furthermore, research has shown that imposing cost-sharing requirements for AHCCCS/Medicaid eligible populations leads to avoidance of primary care and ultimately to the 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 which is modeled on 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. Will the member have the ability to accumulate sufficient funds in the account to cover the cost of vision screening, eye glasses, extensive 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 pay required co-payments. Furthermore, failure for the expansion population (100%-138% FPL) 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. If CARE Account members with incomes below 100% FPL neglect to pay the 2% monthly contribution they incur a debt to the State. Both approaches appear to be punitive.

AACHC is concerned that the penalties for not paying the premiums on the account or failure to pay the co-pays may present profound barriers to healthcare for the AHCCCS member as it does not address the fact that healthcare 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) providing clarity on the co-payment program in the hopes of assuring that members clearly understand the criteria under which a co-payment would be imposed; 2) specifying the rules by which CARE account funds can be used either to make required co-payments or 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 and remove the "debt to the state" provision.**

AACHC stands ready to work with AHCCCS and the State of Arizona to achieve the goal of a visionary, well-managed Medicaid program serving the healthcare needs of Arizonans. We appreciate your thoughtful review of the above mentioned concerns.

Sincerely,



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Chief Executive Officer  
Arizona Alliance for Community Health Centers